



October 16, 2026

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 HEALTH¹** will be held **THURSDAY, OCTOBER 22, 2026, AT 4:00 P.M., DOWNING RESOURCE CENTER, CONFERENCE ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

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

A handwritten signature in black ink, appearing to read "Allen Radner".

Allen Radner, MD
President/Chief Executive Officer

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

**REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH¹**

**THURSDAY, OCTOBER 22, 2026, 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** *Joel Hernandez Laguna*
(Estimated time 4:30 pm)
- 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 Regular Meeting of the Board of Directors September 24, 2026
 - B. Minutes of Special Meeting of the Board of Directors September 15, 2026
 - C. Policies/Plans Requiring Approval
 1. Cardiac Rehab: Nutritional Services Phase II
 2. Fluoroscopy Practice Guidelines
 3. Grant Solicitation
 4. Inpatient Nutrition Assessment for Adult Patients
 5. IV Therapy: Peripheral
 6. Macy Catheter
 7. Mission, Vision, and Values
 8. Nursing Nutrition Screening for Acute Care (Adults, Pediatrics, & Neonates)
 9. Nutrition Screening Audit
 10. Nutrition Services Measure of Success
 11. Patient Identification
 12. Registered Dietitian Clinical Chart Audit
 13. Scope of Service: Facilities Management
 14. Scope of Service: Medical Staff Services
 15. Scope of Service: Perinatal

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

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

7. BOARD MEMBER COMMENTS AND REFERRALS

Joel Hernandez Laguna

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the October 12, 2026 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF PATIENT SAFETY PLAN

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

B. PERSONNEL, PENSION & INVESTMENT COMMITTEE

Catherine Carson

Minutes of the October 12, 2026 Personnel, Pension and Investment Committee meeting have been provided to the Board for review. The following recommendation has been made to the Board.

1. CONSIDER FOR RECOMMENDATION TO THE BOARD OF AN ACTION ITEM WITH FINDINGS SUPPORTING RECRUITMENT INCENTIVE PLAN FOR PHYSICIANS TO SALINAS VALLEY EMERGENCY MEDICAL GROUP AND APPROVAL OF RECRUITMENT INCENTIVES

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

C. FINANCE COMMITTEE

Victor Rey, Jr.

Minutes of the October 19, 2026 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL TO INCREMENTAL FUNDING IN CONJUNCTION WITH THE EMERGENCY DEPARTMENT AND HOSPITAL EXPANSION PROJECT

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

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF INCREMENTAL FUNDING AND AWARD OF ELEVATOR MODERNIZATION CONTRACT TO TK ELEVATOR FOR 1188 PADRE RENOVATIONS

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

3. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF PROJECT BUDGET FOR THE GIFT SHOP RELOCATION & RETAIL PHARMACY EXPANSION PROJECT

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

D. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE

Victor Rey, Jr.

Minutes of the October 14, 2026 Transformation, Strategic Planning & Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF OCTOBER 8, 2026 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS:

Alison Wilson, D.O.

A. Reports

1. Credentials Committee Report (Including the following)
 - Cardiology – Revision to Clinical Privileges Delineation
 - Gastroenterology – Revision to Clinical Privileges Delineation
 - Revised Initial and Reappointment criteria for all subspecialties within the Department of Medicine with the exception of Gastroenterology (addressed separately)
2. Interdisciplinary Practice Committee Report

- B. Policies/Procedures/Plans and Agreements Recommended for Approval:
1. Care of the Total Hip and Knee Replacement Surgery Patient
 2. Dispensing Oral Alcohol in the Inpatient Setting
 3. Patient Safety Program Plan
 4. RC POCT Laboratory Safety-Chemical Hygiene Plan
- Chief of Staff Report
 - Questions to Chief of Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote

10. EXTENDED CLOSED SESSION *(if necessary)*

Joel Hernandez Laguna

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

Joel Hernandez Laguna

12. ADJOURNMENT

Joel Hernandez Laguna

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, November 19, 2026, 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-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2026/>, 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 831-759-3208 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, OCTOBER 22, 2026, 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. Medical Executive Committee
 - Report of the Medical Staff Executive Committee (With Comments)
2. Report of Medical Staff Quality and Safety Committee
 - Quality and Safety Board Dashboard Review

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 LABOR NEGOTIATOR

(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session): Robert Andersen

Employee organization: (Specify name of organization representing employee or employees in question): National Union of Healthcare Workers (NUHW)

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

CONFERENCE WITH REAL PROPERTY NEGOTIATORS

(Government Code §54956.8)

Property: (Specify street address, or if no street address, the parcel number or other unique reference, of the real property under negotiation): Imjin Parkway & 3rd Avenue, Marina, CA

Agency negotiator: (Specify names of negotiators attending the closed session): Gary Ray and Matthew Ottone

Negotiating parties: (Specify name of party (not agent): To Be Determined

Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both): Price & Terms _____

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 HEALTH¹
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
SEPTEMBER 24, 2026

Board Members Present: President Joel Hernandez Laguna, Vice-President Catherine Carson, Isaura Arreguin, Victor Rey, Jr., and Rolando Cabrera, M.D. appearing via teleconference pursuant to Government Code Section 54953(b)(3).

Absent: None.

Also Present:

Allen Radner, M.D., President/Chief Executive Officer
Alison Wilson, D.O., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Hanna Hitchcock, Esq.

Director Dr. Cabrera joined the meeting at 4:09 p.m.

Director Dr. Cabrera left the meeting at 6:05 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:06 p.m. in the Downing Resource Center, Conference Rooms A, B, & C and JW Marriott Nashville, 201 8th Avenue South, Nashville, TN 37203.

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *Hearings and Reports, Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, Conference with Labor Negotiator, Conference with Real Property Negotiators, and Public Employee Performance Evaluation*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:08 p.m. The Board completed its business of the Closed Session at 4:30 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:37 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Hearings and Reports* and *Conference with Labor Negotiator*. The Board received and accepted the reports as presented. No action was taken. President Hernandez Laguna announced there will be a need for 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 Meeting. The following was presented:

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

- **DAISY Award: Brian Ambrosini, RN, Telemetry/1 Main:** Carla Spencer, CNO, recognized Brian who was honored with a DAISY Award due to his dedication for his patients and supporting his fellow nurses. Brian has worked as a nurse at SVH for almost 32 years. Described by his colleagues as a trusted mentor and role model, Brian was commended for providing not only excellent clinical care, but also compassionate support to all his patients.

5. PUBLIC COMMENT: None.

6. CONSENT AGENDA – GENERAL BUSINESS

The following items were removed from the published Consent Agenda: Item 6(B)(6) IV Therapy: Peripheral, and Item 6(B)(9) Utilization Management Plan. These items will return at a later date.

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors August 27, 2026

B. Policies/Plans Requiring Approval

1. Audio Visual Support of Public Board Meetings
2. Car Seat Clinical
3. Electronic Communications (Acceptable Use)
4. Fetal Demise/Stillborn/Neonatal Death
5. Fetal Fibronectin Vaginal Specimen
6. Nitrous Oxide Analgesia for Use in Obstetrics
7. Time, Attendance and Badging
8. Visitors

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: Requested a meeting to review the past year's metrics of the employee incentive plan and a written update on the construction and maintenance projects approved by the Board.

Director Catherine Carson: None.

Director Victor Rey, Jr.: Commented that he was pleased to see four upcoming community flu clinics and thanked everyone who worked to coordinate the clinics.

Director Isaura Arreguin: Asked a question to staff on whether there is a limit to how many vaccines can be provided at the community flu clinics. Dr. Orlando Rodriguez, CMO responded that there is no

set cap on the number of vaccines to be administered. Director Arreguin also highlighted the recent news story covering Dr. Rakesh Singh's personal experience as an emergency medicine resident in Brooklyn during the September 11th attacks.

Director Hernandez Laguna: Highlighted the news story about Dr. Singh, and an article in the Salinas Valley Chamber of Commerce's Business Journal covering the Salinas Valley Speaks event this past August, which featured the local healthcare system CEOs discussing healthcare policy and fiscal challenges following the implementation of H.R. 1.

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Carson regarding the Quality and Efficient Practices Committee. The minutes of the September 14, 2026 meeting were provided for Board review. Director Carson stated that the presentations were: Patient Care Services Update – Professional Development Council, Accreditation & Regulatory Update and Performance Improvement Reports. There are no recommendations.

B. PERSONNEL, PENSION & INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension & Investment Committee. The minutes of the September 14, 2026 meeting were provided for Board review. The following recommendation was made.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF ANA ABRIL ARIAS, MD (ii) CONTRACT TERMS FOR DR. ARIAS' RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. ARIAS' FAMILY MEDICINE AND OBSTETRICS PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Orlando Rodriguez, CMO reported that Dr. Arias completed her family medicine residency at University of California, San Diego and her obstetrics fellowship at Natividad Hospital. Dr. Arias is fluent in English and Spanish. If approved by the Board, Dr. Arias would join the Taylor Farm Family Health and Wellness team.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

1. The Findings Supporting Recruitment of Ana Abril Arias, MD:
 - That the recruitment of family medicine and obstetrics physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
 - That the recruitment benefits and incentives the 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;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Arias; and

2. The Contract Terms of the Family Medicine and Obstetrics Professional Services Agreement for Dr. Arias.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF SAFA GUL, MD (ii) CONTRACT TERMS FOR DR. GUL'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. GUL'S PEDIATRICS PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Orlando Rodriguez, CMO reported that Dr. Gul completed her pediatrics residency at University of California, San Francisco at the Fresno branch. Dr. Rodriguez reported that, if approved by the Board, Dr. Gul will fill an important need for a pediatrician at the Central Coast Pediatrics clinic.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera and second by Director Arreguin, the Board of Directors makes the following findings:

1. The Findings Supporting Recruitment of Safa Gul, MD:
 - That the recruitment of pediatrics 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 the recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Gul; and
2. The Contract Terms of the Pediatrics Professional Services Agreement for Dr. Gul.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

3. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF CAROL NADER, MD (ii) CONTRACT TERMS FOR DR. NADER'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. NADER'S PEDIATRICS PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Orlando Rodriguez, CMO reported that Dr. Nader is a native of Pacific Grove and she completed her pediatrics residency at Valley Children's Hospital in Madera.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

1. The Findings Supporting Recruitment of Carol Nader, MD:
 - That the recruitment of pediatrics 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;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Nader; and
2. The Contract Terms of the Pediatrics Professional Services Agreement for Dr. Nader.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, 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 September 21, 2026 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 STRATAJAZZ COST ACCOUNTING AGREEMENT RENEWAL AS SOLE SOURCE AND CONTRACT AWARD

STAFF REPORT: Iftikhar Hussain, CFO reported that this proposal is a renewal of SVH's Cost Accounting agreement with StrataJazz for a five year term, which includes a subscription fee for the

platform and professional services fees for ongoing support, for a total cost of \$810,958 through September 30, 2031.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Dr. Cabrera, the Board of Directors approves the StrataJazz Cost Accounting Agreement Renewal with Strata Decision Technology as a sole source contract award. The proposed five-year agreement includes both subscription fees and professional services, with a total contract value of \$801,958, covering the period through September 30, 2031.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF THE PRIMARY TRANSFORMER EQUIPMENT REPLACEMENT PROJECT BUDGET AND THE PURCHASE OF THE PRIMARY TRANSFORMER FROM MGM TRANSFORMERS

STAFF REPORT: Bradley McCoy, VP Facilities, Construction and Real Estate, reported that the SVH Medical Center's primary electrical transformer is over 30 years old and equipment testing demonstrated that a replacement is due. This proposal seeks Board approval for the purchase and installation of a new primary transformer, and District ownership of the transformer will result in reduced electricity rates and thousands of dollars saved annually.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves of (i) the Primary Transformer Equipment Replacement project budget in the amount of \$789,000 and (ii) the capital equipment purchase from MGM Transformers for the 2500kVA Dry Substation in the amount of \$221,792.00.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

3. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF DESIGN DEVELOPMENT AND EQUIPMENT PROCUREMENT BUDGET, EQUIPMENT PURCHASE AND A SERVICE MAINTENANCE AGREEMENT FOR THE 240 SAN JOSE MAMMOGRAPHY EQUIPMENT REPLACEMENT PROJECT

STAFF REPORT: Clement Miller, COO reported that this proposal seeks to upgrade the imaging equipment and expand infrastructure at the Nancy Ausonio Mammography Center in order to expand this service line to meet patient need for breast health services.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Arreguin asked approximately how long the expansion will take, and will the expansion reduce wait time for patients to be seen? Clement Miller responded that he will provide a timeline for the Board and yes, upgrading equipment and adding an additional room is expected to expand capacity to meet the growing demand for these services. Director Carson commented that the extended hours at the clinic have done a great job to meet growing demand and commends the medical staff for their work at the clinic.

MOTION:

Upon motion by Director Carson and second by Director Dr. Cabrera, the Board of Directors approves (i) the initial design development, permitting and equipment procurement budget of \$2,960,000 for the 240 San Jose Mammography Equipment Replacement project, (ii) authorize equipment purchase for the Hologic 3Dimensions & Envision Platforms package in the amount of \$2,569,121.44, and (iii) enter into a 4-year Hologic Preferred Advantage service agreement totaling \$1,234,500 commencing after the equipment's one-year warranty period.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

4. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF ENTERPRISE HEALTH, EMPLOYEE HEALTH ELECTRONIC HEALTH RECORDS (EHR); RFP UTILIZED

STAFF REPORT: Michelle Barnhart Childs, CHRO reported that the current employee health electronic record system is being phased out due to lack of ongoing support and upgrades; therefore, SVH underwent a Request for Proposal (RFP) process to find a new Employee Health electronic record system. Following the RFP, Enterprise was chosen as the optimal system to improve efficiency and reporting compliance. This proposal seeks a three year term for a total cost of \$432,080.00.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera and second by Director Arreguin, the Board of Directors approves the three year agreement with Enterprise Health for the Electronic Health Record System at a cost in the amount of \$432,080.00.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

5. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF VMWARE INFRASTRUCTURE RENEWAL

STAFF REPORT: Alysha Hyland, CAO reported this proposal seeks to renew SVH's infrastructure software agreement with VMware, which manages and operates the server infrastructure for onsite clinical and administrative information systems. This three year renewal for a total cost of \$703,050 will realize a 20% savings over the life of the agreement.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera and second by Director Carson, the Board of Directors approves the VMware Infrastructure software multi-year agreement in the amount of \$703,050.00.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

6. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF STRYKER POWER SYSTEM 9

STAFF REPORT: Alysha Hyland, CAO reported that proposal seeks to upgrade to the Stryker Power System 9 Large Power System for a total cost of \$963,636.87, including a two year service agreement. This provides reliable power equipment to support orthopedic, podiatry, cardiac, and TAVR surgical procedures.

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 the Stryker Power System 9 in the amount of \$817,598.31 and a two-year service agreement with Stryker in the amount of \$146,038.56, for a total purchase amount of \$963,636.87, subject to final legal review.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.**9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON SEPTEMBER 10, 2026, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:**

Alison Wilson, D.O., Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of September 10, 2026. A full report was provided in the Board packet.

The following item was removed from the published Agenda: Item 9(B)(1): Fire Safety for Surgery and Procedural Areas. This item will return at a later date. The MEC recommends for Board Approval of the following Reports and Policies/Procedures/Plans and Agreements as listed below.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey and second by Director Carson, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report, Interdisciplinary Practice Committee Report, and Policies/Procedures/Plans and Agreements as listed in (A) through (B) below:

- A. Reports
 - 1. Credentials Committee Report
 - 2. Interdisciplinary Practice Committee Report
- B. Policies/Procedures/Plans and Agreements
 - 1. Peripheral Nerve Stimulators
 - 2. Quality Assessment and Performance Improvement Plan
 - 3. RC Laboratory Safety/Chemical Hygiene Plan

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

10. EXTENDED CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Extended Closed Session are *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, Conference with Real Property Negotiators, and Public Employee Performance Evaluation*. The meeting recessed into Closed Session under the Closed Session Protocol at 5:20 p.m. The Board completed its business of the Closed Session at 6:41 p.m.

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:41 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, Conference with Real Property Negotiators, and Public Employee Performance Evaluation*. No action was taken.

12. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for Thursday, **October 22, 2026**, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:45 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

DRAFT SALINAS VALLEY HEALTH¹
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
SEPTEMBER 15, 2026

Board Members Present: President Joel Hernandez Laguna; Vice President Catherine Carson; and Victor Rey, Jr.

Absent: Rolando Cabrera, M.D. and Isaura Arreguin.

Also Present:

Allen Radner, M.D., President/CEO;
Hanna Hitchcock, Esq.

1. READING OF THE NOTICE OF SPECIAL MEETING

President Joel Hernandez Laguna read the following: A Special Meeting of the Board of Directors of Salinas Valley Health¹ will be held Tuesday, September 15, 2026, at 5:00 p.m., at the Heart Center Teleconference Room, Salinas Valley Health Medical Center, 450 E. Romie Lane, Salinas, California 93901.

2. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 5:05 p.m. at the Heart Center Teleconference Room.

3. PUBLIC COMMENT: None.

4. CLOSED SESSION

President Hernandez Laguna announced item to be discussed in Closed Session as listed on the posted Agenda is *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services*. The meeting recessed into Closed Session under the Closed Session Protocol at 5:07 p.m. The Board completed its business of the Closed Session at 6:17 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:17 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services*. No action was taken.

6. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, September 24, 2026**, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:18 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Memorandum

To: Board of Directors
 From: Carla Spencer, CNO
 Date: October 22, 2026
 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.	Cardiac Rehab: Nutritional Services Phase II	Updates were made to the Purpose and Procedures. One Reference was updated.	Clement Miller, COO
2.	Fluoroscopy Practice Guidelines	Regularly schedule review. No changes.	Clement Miller, COO
3.	Grant Solicitation	Material Management corrected to Supply Chain.	Bazillia Gutierrez, CPO
4.	Inpatient Nutrition Assessment for Adult Patients	Updated to Aramark policy per consulting agreement.	Clement Miller, COO
5.	IV Therapy: Peripheral	Previously rejected by the Board. Minor change made per request.	Carla Spencer, CNO
6.	Macy Catheter	New policy to align with Epic procedure.	Carla Spencer, CNO
7.	Mission, Vision, and Values	Updated Goals to Values in Title Under definitions, added values, STAR values and definition of each.	Alysha Hyland, CAO
8.	Nursing Nutrition Screening for Acute Care (Adults, Pediatrics, & Neonates)	Renamed and rewritten to focus on nursing nutrition screening process and align with Aramark policy. Added comment regarding neonates meeting criteria listed in this protocol.	Clement Miller, COO
9.	Nutrition Screening Audit	New policy per Aramark agreement.	Clement Miller, COO
10.	Nutrition Services Measure of Success	New policy per Aramark agreement.	Clement Miller, COO
11.	Patient Identification	Changed Materials Management to Supply Chain. Changed reference to National Performance Goal per Joint Commission effective Jan 1, 2026.	Carla Spencer, CNO
12.	Registered Dietitian Clinical Chart Audit	New policy per Aramark agreement.	Clement Miller, COO
13.	Scope of Service: Facilities Management	Updated to focus on Plant operations, Biomed, and project management. Removed references to safety, security, emergency management.	Clement Miller, COO
14.	Scope of Service: Medical Staff Services	Regularly schedule review. No changes.	Timothy Albert, CCO

	Policy Title	Summary of Changes	Responsible Exec
15.	Scope of Service: Perinatal	Changes Policy tech to Policy Stat, added ASPAN as an standard setting organization, changed order of abbreviations for standard organizations	Carla Spencer, CNO
MEC			
Nursing Standardized Procedures			
1.	None		
MEC Policies/Plans			
1.	Care of the Total Hip and Knee Replacement Surgery Patient	Previously rejected by the Board. Updated clinical practice guideline references and separated hip and knee protocols.	Carla Spencer, CNO
2.	Dispensing Oral Alcohol in the Inpatient Setting	Regularly scheduled review. Materials Management changed to Supply Chain.	Clement Miller, COO
3.	Patient Safety Program Plan	Addition of Patient Safety Structural Measures, National Performance Goals, and goals to match health and safety code.	Carla Spencer, CNO
4.	RC POCT Laboratory Safety/Chemical Hygiene Plan	Changed Materials Management to Supply Chain.	Clement Miller, COO
Board Policies			
1.	None		



Origination 4/17/2020
Approved N/A
Expires 3 years after approval

Owner Marissa Gonzalez:
Manager Cardiology Clinical
Area Cardiology Departments

Cardiac Rehab: Nutritional Services Phase II

I. POLICY STATEMENT

- A. Nutritional counseling and education will be available to all participants in the Phase II Cardiac Rehabilitation Program.

II. PURPOSE

- A. Case Managers (CMs), encompassing Exercise Physiologists and Registered Nurses, are responsible for the initial nutrition assessment. Case Managers will document a nutrition goal and monitor its progress. The Case Managers report directly to the Cardiac Rehabilitation Manager.
- B. The Registered Dietitian (RD) is responsible for providing nutritional counseling and education to Phase II Cardiac Rehabilitation program participants. The Registered Dietitian directly reports to the Director of Nutritional Services or the Clinical Nutrition Manager and reports to the Cardiac Rehabilitation Director regarding Cardiac Rehabilitation issues/concerns.

III. DEFINITIONS

- A. Body Mass Index:
$$\text{BMI} = \frac{(\text{weight in kg})}{(\text{Height in meters})^2}$$

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Case Managers (CMs) complete a comprehensive nutrition assessment using a 24-hour dietary recall as a tool to evaluate the patient's nutritional habits. The assessment is completed during the initial intake. Nutrition goals are established based on the assessment findings when applicable. Progress toward goals is monitored during follow up assessments at the 30-day mark in program as well as at discharge.
- B. Patients in the Outpatient Cardiac Rehabilitation Program are highly encouraged to attend a nutrition appointment with the RD to assess their dietary habit and provide recommendations.
- C. Patients may refuse counseling.
 - 1. Refusal will be documented in the patient's chart.
- D. Individual nutritional counseling will be provided to assist patients in:
 - 1. Adhering to a low saturated fat, and/or 2 gram sodium diet.
 - 2. Decreasing body weight/body fat, if applicable.
 - 3. Controlling diabetes.
 - 4. Managing heart failure.
 - 5. Understanding dietary guidelines/restrictions related to anticoagulation therapy.
 - 6. Reading food labels.
- E. Individual nutritional counseling will consist of:
 - 1. Reported dietary habits and 24-hour food recall completed during nutrition appointment.
 - 2. Nutritional assessment based on diet history.
 - 3. Diet instruction based on health and personal goals.
 - 4. Follow-up consultation based on RD recommendation or as per patient request.
- F. Diet instruction provided will be low saturated fat and/or 2 gram sodium diet guidelines unless:
 - 1. Physician specifies an alternative diet plan.
 - 2. Patient has other medical diagnoses requiring additional diet instruction, i.e. diabetes mellitus, renal insufficiency, congestive heart failure.
 - 3. Patient's BMI >30.
 - a. Diet recommendations for weight loss will be added to diet plan.
 - 4. Patient's blood test results indicate abnormal triglyceride level.
 - a. Emphasis on restricted alcohol, refined grains, and added sugar consumption will be added to diet plan.
- G. Group nutrition education classes will be provided by the Registered Dietitian. Patients and their families will be encouraged to attend. Topics, though subject to change, are as follows:
 - 1. Heart Healthy Cooking

2. Heart Healthy Shopping
3. Saturated Fat's Impact on Cholesterol
4. Dietary Approaches to Stop Hypertension Guidelines

Documentation:

1. Epic/ Electronic Medical Record
2. Education Class Attendance Sheet.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

- A. <https://www.nutritioncaremanual.org/go/r.cfm?link=https%3A%2F%2Fwww.anddeal.org%2F>
- B. https://www.nutritioncaremanual.org/welcome?_lid=6F7DC204-F236-11AF-DDFF0F3E195E6B39#

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cath Lab Medical Director - Dr. Zetterland	Megan Giovanetti: Director Cardiovascular Services and Sleep	9/29/2026
COO	Clement Miller: Chief Operating Officer	9/23/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/23/2026
Policy Owner	Marissa Gonzalez: Manager Cardiology Clinical	7/7/2026

Standards

No standards are associated with this document



Origination 5/18/2020
Approved N/A
Expires 1 year after approval

Owner Jorge Sanchez:
Supervisor Imaging Operations
Area Diagnostic Imaging

Fluoroscopy Practice Guidelines

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To guide the staff in safe practices and guidelines to follow during procedures requiring fluoroscopy.

III. DEFINITIONS

- A. Fluoroscopy-The regulations (CCR, title 17, § 30400) define fluoroscopy as "a radiological examination utilizing fluorescence for the observation of the transient image."
B. ALARA – As Low As Reasonably Achievable

IV. GENERAL INFORMATION

- A. Only CRT's who possess the Radiologic Technologist Fluoroscopy Permit and who are acting under the supervision of a licentiate of the healing arts who possesses a Radiology Supervisor and Operator Certificate or a Fluoroscopy Supervisor and Operator Permit may expose patients to x-ray in the fluoroscopy mode, or do one or more of the following during fluoroscopy of a patient:
- Position the patient
 - Position the fluoroscopy equipment
 - Select exposure factors
- B. A fluoroscopy supervisor and operator permit issued by the California Department of Public

Health –Radiation Health Branch shall be required of any licentiate of the healing arts who does one or more of the following:

- Actuates or energizes fluoroscopy equipment.
 - Directly controls radiation exposure to the patient during fluoroscopy procedures.
 - Supervises one or more persons who hold radiologic technologist Fluoroscopy permits pursuant to Section 30451.
- C. Due to the potential for a high dose exposure from a fluoroscopy procedure, guidelines will be established for tracking and reporting high dose events. Please refer to the **RADIATION SAFETY** policy.
- D. Appropriate Fluoroscopy machine set up and operation will occur to ensure ALARA principles are followed for staff and patient safety during procedures.

V. PROCEDURE

- A. Only qualified (Certified) individuals are to operate the equipment. Fluoroscopy may only be performed by those individuals holding a Fluoroscopy permit/License. (Users must be on Medical Staff Office list of approved users).
- B. There must be a valid order for all exams.
- C. Double check patient identity (two identifiers) before beginning case.
- D. Ensure machine is in proper working order (weekly fluoroscopy checks will occur to confirm mA and kV constancy).
- E. Patient age/size will be taken into consideration when applying dose techniques.
- F. Always confirm proper machine settings before taking an exposure.
- G. Fluoroscopy time and air kerma (mGy) will be recorded.
- H. Real time exposure (mGy's) will be monitored during the procedure.
- I. High dose cases (i.e. greater the 3,000 mGy single field exposure and greater than 5,000 mGy multiple field exposure) will be reported to the Radiologist and RSO for follow up per protocol.
- J. Optimal dose factors and techniques will be used when imaging patients. These factors include kV, mA, pulse, filtration, and field size. Low dose techniques will be used whenever possible.
- K. For C-Arm fluoroscopy equipment equipped with a removable spacer cone, the spacer cone shall be attached to the x-ray source during use at all times unless it interferes with the clinical procedure (see attachment A). **Do not allow the patient to get within 12 inches of the x-ray tube target under any circumstances. If the spacer cone is removed it must be replaced immediately following the procedure for which it was removed.**
- The manufacturer's published precautions with respect to the spacer cone must be readily available.
 - Fluoroscopy personnel shall receive training regarding spacer cone use restrictions. Documentation of training must be maintained for state inspections.
- L. Each fluoroscopy unit shall be equipped with a manual-reset cumulative timing device, activated by the exposure switch, which will either indicate elapsed exposure time by a signal

audible to the fluoroscopist or turn off the apparatus when the total exposure exceeds a predetermined limit not exceeding five minutes in one series of exposures.

- M. Proper shielding techniques will be followed. (Patient and staff members in the room).
- N. Portable shielding devices will be used by staff in the procedure room.
- O. Personnel monitoring devices are to be used by all individuals in X-ray room that are within 10 feet of the X-ray field and are not fully shielded by a portable shield.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Radiologic Health Branch- Policy Title: Fluoroscopy Permit Requirements.

Attachments

 [A: Procedures in Which the Spacer Cone May be Temporarily Removed](#)

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/8/2026
Policy Owner	Jorge Sanchez: Supervisor Imaging Operations	9/2/2026

Standards

No standards are associated with this document



Origination 12/6/2022
Approved N/A
Expires 3 years after approval

Owner Bazillia Gutierrez:
Chief Philanthropy Officer
Area Administration

Grant Solicitation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To clearly define the Salinas Valley Health Medical Center (SVHMC) policy and procedure for non-research-based grant funding solicitation, management, and stewardship, to define the roles and responsibilities necessary to administer this process, and to standardize communication channels between departments, administrators, and clinical staff. Grant funding will be sought and obtained as approved by the Chief Philanthropy Officer of Salinas Valley Health Foundation for advancement of SVHMC's capabilities to better serve our patients and community.

III. DEFINITIONS

- A. Grant - a sum of money given by governmental, or nongovernmental public or private organizations for a particular purpose.
- B. Proposal - a plan or suggestion, especially a formal or written one, put forward for consideration or discussion by others; an act of stating or putting forward something for consideration.
- C. Submitter – Employee, either a department director or leader designee, who is submitting a funding request following the procedure outlined in this policy.
- D. Department Director – Leader responsible for overall management of a department or program. Reports to an administrator.
- E. Administrator – SVHMC core management team member, i.e., Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, etc.

IV. GENERAL INFORMATION

- A. Noncompliance of this policy can result in fines from government agencies and could impact the 501c3 nonprofit status of the organizations.
- B. Department Heads will monitor their staff and ensure that policy is followed.
- C. For Salinas Valley Health Medical Center (SVHMC), ensuring that there is a standardized and consistent process for requesting and managing grant funding is critical to the advancement of efficiency, reduction of regulatory and capital risk, as well as a strong pillar for growth of grant revenue.
- D. Whether the request is for funding directly from the Salinas Valley Health Foundation (SVHF), or from external entities like nonprofits, corporations, or governmental institutions, it shall be the policy of SVHMC to ensure that all requests be administered through SVHF to ensure the formal review/approval process identified below is followed.

V. PROCEDURE

- A. SVHMC requires all employees, medical staff, and volunteers to adhere to the following procedures when requesting funding support. The Foundation Department shall serve as the primary facilitator of grant proposal development and submission, working in collaboration with the Administrative, Finance, and Compliance teams of SVHMC to ensure institutional necessity, strategic alignment, and regulatory qualifications for the funding are present for those that need a proposal submission.
- B. All funding requests shall follow one of the three flowcharts identified below. Additionally, for requests > \$100k, or in the event that there are ongoing expenses tied to a request, review by both SVHMC CEO and CFO, or their approved leader designee shall be required. All departments and leaders that would need to be consulted must be contacted prior to submitting a funding request. Examples of this would be Supply Chain for funds that would be initiating the purchase of equipment or care items on campus, equipment or services under the scope of Information Technology, devices that would need to be reviewed, and or approved by medical leadership, etc.
- C. Any department director who has an interest in making a funding request must first contact their appropriate administrator for approval prior to submitting a request form to the Foundation department.
- D. Each funding request shall be evaluated by the responsible administrator to determine if it is consistent with SVHMC objectives and operational plans. Electronic request forms are to be used to request funding from SVHF, as well as from external funding organizations.
 - 1. [Foundation Funding Request](#)
 - 2. [External Funding Request](#)
- E. Once approved by the department's administrator to move forward in the process, each request must be submitted to SVHMC on either the "Foundation Funding Request" or "External Funding Request" electronic forms to initiate the review process.
- F. In the event of an external funding request, the submitter must include any associated terms and conditions of the grant to move forward in the process.

- G. If the funding request is approved, the Director of Strategic Development in the Foundation Department will contact the submitter in order to gain necessary information in preparation of the grant proposal.
- H. All funding requests are to be reviewed by the Chief Philanthropy Officer prior to submission to ensure all processes identified above have been met.
- I. The Director of Strategic Development in the Foundation Department shall enter the project in the Foundation's database, maintain a file of all development materials, monitor the progress of awarded projects, and act as institutional liaison with external funding agencies.
- J. All approved funding requests will be processed through the Foundation Department to ensure all procedures of this policy are followed.
- K. Upon notification of the release of funds, the Director of Strategic Development of the Foundation Department, in collaboration with the Finance/General Accounting team, the Compliance Officer of SVHMC, and when necessary the Contract Administrator will contact the assigned submitter to schedule a grant management orientation. This training session will include a review of roles and responsibilities, the expectations of compliance and reporting for the funding agency, as well as recordkeeping requirements for audit.
- L. Submitter and Director of Strategic Development will work together to create after-action and follow-up reports as needed per grantors requirements.
- M. The Director of Strategic Development, SVHMC Compliance Officer, SVHMC Contract Administrator, and others as necessary will monitor the progress of the project to ensure compliance and effectiveness, including developing and filing required reports and other appropriate stewardship activities throughout the project period to grant close-out.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. N/A

Attachments

- [!\[\]\(2db03af98131304521eb5bbaa12180d1_img.jpg\) External Funding Diagram SVH.pdf](#)
- [!\[\]\(4a77986520ce333763e6f0d85c5a4a64_img.jpg\) External Funding Diagram through 501c3.pdf](#)
- [!\[\]\(c8ad3ce9ecefbf62ef989a7cd29c4fd9_img.jpg\) Funding Diagram Directly From Foundation.pdf](#)

Approval Signatures

Step Description	Approver	Date
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Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/14/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/25/2026
Policy Owner	Bazillia Gutierrez: Chief Philanthropy Officer	7/16/2026

Standards

No standards are associated with this document

COPY



Origination 3/30/2021
Approved N/A
Expires 3 years after approval

Owner Chessaly Miller:
Manager Clinical Nutrition
Area Nutritional Services

Inpatient Nutrition Assessment for Adult Patients

I. POLICY STATEMENT

Based on hospital approved criteria, all patients will be screened for nutrition risk and prioritized. The Registered Dietitian Nutritionist (RDN) will review patients identified at nutrition risk and initiate the Nutrition Care Process. The patient's Nutrition Care Level (NCL) and re-assessment needs will be determined based upon hospital approved criteria.

II. PURPOSE

- A. To provide a standardized process for proactively identifying and prioritizing patients who may benefit from nutrition intervention.
- B. To allocate nutrition resources to patients based on nutrition care level.
- C. To provide guidelines for reassessment and follow-up.
- D. To provide standards for initiating the Nutrition Care Process (NCP), which provides nutrition professionals a framework to recognize, diagnose, and intervene upon nutrition-related health concerns.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. A patient needing nutrition intervention as identified by a positive nursing nutrition screening, physician consult, or continuous nutrition monitoring will be seen by the Registered Dietitian Nutritionist (RDN) within 24-48 hours of referral.

1. Nursing will complete a nutrition screen on all patients within 24 hours of admission.
(Refer to Policy and Procedure: Nursing Nutrition Screening)
 - a. The RDN will receive notification of all positive nursing nutrition screen triggers and nutrition consults via EHR
 - b. The RDN will initiate the NCP for all patients identified at potential nutrition risk via the nutrition screen and nutrition consults.
2. A nutrition consult can be ordered by the provider via Electronic Medical Record (EMR).
 - a. Consult types include but are not limited to- nutrition education/teaching, calorie counts, evaluation of nutrition care needs, nursing screening, provider consult based on disease state, etc.
3. Continuous Nutrition Monitoring:
 - a. The RDN will review patients for potential nutrition risk via continuous nutrition monitoring criteria below.
 - b. The RDN will initiate the Nutrition Care Process within 24 - 48 hours of identification via the continuous nutrition monitoring criteria. (Refer to section B: The Nutrition Care Process for Acute Care.)
 - c. The RDN will initiate the Nutrition Care Process for all patients who are not identified as a nutritional risk when patient's hospitalization extends one day beyond the hospital's average length of stay.
 - d. Continuous nutrition monitoring criteria includes review of the following diet orders, primary diagnosis and /or contributing conditions and may also include other evidence-based hospital required continuous nutrition monitoring criteria.

Continuous Monitoring Criteria:

ADULT	
Full Liquid Diet > 7 days NPO / Clear Liquid Diet > 4 days Parenteral Nutrition or Enteral Nutrition	
ADULT	
Anorexia/Bulimia Aspiration Pneumonia Bariatric Surgery Burns Cancer involving GI Tract or Head & Neck Chronic Diarrhea Cirrhosis Chronic Kidney Disease Current Organ Transplantation	Cystic Fibrosis Diabetes (newly diagnosed, uncontrolled or gestational) Heart Failure Malnutrition Pressure Ulcer (stage II or greater) Severe Acute Pancreatitis Short Bowel Syndrome Ventilator Dependent

B. The Nutrition Care Process for Acute Care

The RDN will utilize the Nutrition Care Process (NCP). The NCP provides framework and common language used across clinical nutrition professionals. For Nutrition and Dietetics Technicians, Registered (NDTRs) refer to **Attachment 5** for Nutrition Care Process Scope of Practice role

delineation for the NDTR working under the supervision of an RDN.

1. The steps of the Nutrition Care Process (NCP) are as follows:

Step 1: Nutrition Assessment – obtains, verifies, and interprets data needed to identify nutrition-related problems, their causes, and significance related to food/nutrition-related history; anthropometric measurements; biochemical data, medical test, and procedures; nutrition-focused physical findings; and patient history. The nutrition assessment will also include identifying nutrient/drug interactions, cultural, religious, ethnic food preferences, and age-related nutrition issues.

Step 2: Nutrition Diagnosis - identifies and describes a specific nutrition problem(s) that can be resolved or improved through treatment/nutrition intervention by the clinical nutrition staff. A nutrition diagnosis is not a medical diagnosis and can include one or more nutrition problems. The results of the nutrition diagnosis, including any conclusion that no nutrition problem exists, will be documented in the medical record.

Step 3: Nutrition Intervention – resolves or improves the identified nutrition problem by planning and implementing appropriate nutrition interventions that are tailored to the patient needs related to food and/or nutrient delivery; nutrition education; nutrition counseling; and/or coordination of nutrition care.

Step 4: Nutrition Monitoring and Evaluation - determines the amount of progress made and whether goals/expected outcomes are being met as it relates to food/nutrition-related history outcomes; anthropometric measurement outcomes; biochemical data, medical tests, and procedure outcomes; and/or nutrition-focused physical finding outcomes.

2. An initial nutrition-focused physical exam will be completed by the RDN when a patient is identified as moderate or high nutrition care level. An NFPE may also be conducted when a patient is identified as having risk factors for malnutrition (such as but not limited to unintentional weight loss, significantly reduced oral intake, and contributing medical conditions).

3. The RDN may use clinical judgement to include an additional nutrition-focused physical exam during nutrition monitoring and evaluation.

4. Nutrition-focused physical exam will include the examination and evaluation of body fat, muscle mass, fluid accumulation and micronutrient deficiencies in conjunction with energy intake and weight loss.

5. For adult patients, a minimum of two nutritional characteristics should be obtained to support a diagnosis of malnutrition. ([Refer to attachment # 6: Table 1-2 A.N.D & A.S.P.E.N clinical characteristics to support a diagnosis of adult malnutrition](#)).

6. When nutritional parameters are consistent with malnutrition, the RDN classifies the malnutrition according to the Academy of Nutrition and Dietetics / American Society of Parenteral and Enteral Nutrition Consensus Statements.

7. Each step of the NCP will be documented in the medical record with appropriate medical nutrition therapy recommendation to the medical team. A multidisciplinary plan of care including criteria used to classify a patient with malnutrition will be developed and documented.

C. Nursing

1. Completes in electronic health record (EHR) the admission history to include nutrition risk screen, identification of food allergies, medications and supplements used prior to admission. Completes nursing physical assessment to include gastrointestinal symptoms noting swallowing problems, weight changes, intake/output, home tube feeding or parenteral nutrition, and pressure injury documentation.
2. Patients' weights are obtained upon admission and then:
 - a. As ordered by MD.
 - b. Daily for nutrition support patients (enteral and parenteral nutrition) and based on MD order.
 - c. Twice-weekly for all other patients or as ordered.
 - d. Additional weights obtained pre- and post-dialysis for renal patients.

D. Prioritizing Patients for Nutrition Intervention in Acute Care

1. The RDN will execute the nutrition care process and classify the patient's nutrition care level during the nutrition assessment using the age-appropriate nutrition care indicator categories and work sheet.
2. The priority points assigned for each nutrition care indicator category will be the highest point rated in that category. **(Refer to attachment #1: Nutrition Care Priority Points: Adults)**
 - a. All categories should be used to assess nutrition care level. However, a minimum of three nutrition care indicator categories will be assessed and assigned points.
 - b. If unable to assess at least three categories, then the RDN will use clinical judgment to assign a nutrition care level. **(Refer to Attachment # 1: Adult Calculation of Nutrition Care Points: Nutrition Care Worksheet)**
 - c. All patients classified as moderate or high nutrition care level will have a documented NFPE by the RDN.
 - (1) The nutrition care risk level for patients identified at risk of malnutrition indicated per NFPE will be determined as follows despite the calculated nutrition risk level. **(Refer to attachment #2: Physical Findings)**
 - (a) Severe Malnutrition = High Nutrition Care Level Risk
 - (b) Moderate or Unspecified = Moderate Nutrition Care Level
3. If, during the screening and on-going monitoring process, the patient was falsely identified as having a nutrition need, a note will be placed in the medical record indicating no nutrition need was identified and no intervention is warranted at this time **(Refer to attachment # 4 & 5: Nutrition Care Flow chart)**
4. Time frames for patient reassessment and follow-up will be based on the patient's nutrition care level or more frequently based upon RDN clinical judgement. Reassessments will be documented in the medical record. **(Refer to attachment # 4 & 5: Nutrition Care Flow chart)**

Determine nutrition care as follows:

Nutrition Care Level	Priority Points	Time Frames for Reassessment/Follow-up
----------------------	-----------------	--

No Nutrition Needs Identified	0-1	7-10 days
Low Level Care	2-6	5-7 days
Moderate Care Level	7-10	3-5 days
High Care Level	>=11	1-4 days

5. If, during the patient's hospitalization, orders for hospice or comfort care due to terminal illness are active, the clinical nutrition staff will sign off as directed by the physician's order. A clinician may not sign off if active orders for enteral and parenteral nutrition are in place. A physician may order a nutrition consult, reinitiating the nutrition care process, at any time after the nutrition staff have signed off.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

1. Nutrition Screening Systematic Review (2009-2010).” Academy of Nutrition and Dietetics Evidence Analysis Library, www.andeal.org/topic.cfm?menu=3584&cat=5437 Accessed April 2025.
2. 2024 Comprehensive Accreditation Manual for Hospitals (CAMH PDF Manual)
3. Nutrition Care Process page. Academy of Nutrition and Dietetics website. [Nutrition Care Process](#) Accessed April 2025
4. CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (rev. 220 issued 04-19-24;); Accessed April 2025; Interpretive Guidelines §482.28. [SOM Appendix A](#)
5. Academy of Nutrition and Dietetics Evidence Analysis Library. <https://www.andeal.org> Accessed April 2025
6. Academy of Nutrition and Dietetics Nutrition Care Manual. <http://www.nutritioncaremanual.org>.
7. Nutrition Terminology Reference Manual (eNCPT): Dietetics Language for Nutrition Care. <http://ncpt.webauthor.com>. Academy of Nutrition and Dietetics. Accessed April 2025.
8. International Classification of Diseases, Tenth Revision (ICD-10). <http://www.icd10data.com/ICD10CM/Index/M/Malnutrition>. Accessed April 2025.
9. International Classification of Diseases, Tenth Revision (ICD-10) BMI. <https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z68-Z68/Z68-> Accessed April 2025.
10. Revised 2024 Scope and Standards of Practice for the Nutrition and Dietetics Technician, Registered. Commission on Dietetic Registration Scope and Standards of Practice Task Force
11. White, Jane V., et al. “Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition).” *Journal of the Academy of Nutrition and Dietetics*, vol. 112, no. 5, May 2012, pp. 730–738.
12. Charney, Pamela, and Ainsley Malone. *Academy of Nutrition and Dietetics Pocket Guide to Nutrition Assessment*. 4th ed., Academy of Nutrition and Dietetics, 2022.
13. Comprehensive Accreditation Manual for Critical Access Hospitals, Standards Elements of Performance Accreditation Policies and procedures; Provision of Care, Treatment and Services version January 2022.

Accessed August 2022

14. Hummell, Christine A., Cummings, Michael, American Society of Parenteral and Enteral Nutrition (ASPEN), A Role if tge Bytrtuib -focused Physical examination in identifying malnutrition and its effectiveness.
Accessed June 2024

Attachments

[!\[\]\(170e59302cebbfee6a99b18d0365de57_img.jpg\) Attachment 1 Nutrition Care Priority Points.docx](#)

[!\[\]\(133e5144baf9c90220b67ca9e7f162e0_img.jpg\) Attachment 2 Physical Findings.docx](#)

[!\[\]\(8598a6c426d71ae19605d46138ac97d9_img.jpg\) Attachment 3 Points Worksheet.docx](#)

[!\[\]\(a80fb6830acb1cf4906e86ddade0b6a0_img.jpg\) Attachment 4 Risk Flow Chart.docx](#)

[!\[\]\(4b2f2379722fee353aef1050e327f0bf_img.jpg\) Attachment 5 Scope of Practice.docx](#)

[!\[\]\(ddec2cbbac1319bb1377b96771b151ee_img.jpg\) Attachment 6 Malnutrition Diagnosis.docx](#)

Approval Signatures

Step Description

Approver

Date

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/31/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Chessaly Miller: Manager Clinical Nutrition	7/31/2026

Standards

No standards are associated with this document



Origination 5/25/2021
Approved N/A
Expires 3 years after approval

Owner Stephanie Frizzell:
Director Education
Area Patient Care

IV Therapy: Peripheral

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance to the staff in the insertion technique and subsequent management of peripheral IV cannula.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. INSERTION

1. Verify physician orders.
 - a. Exception: Patients arriving to the Emergency Department (ED) with pre-hospital IV infusion may continue treatment until ED physician order supersedes.
 - b. Aseptic technique shall be used in all infusion-related procedures, to include healthcare worker (HCW) hand hygiene prior to procedure.
 - c. Appropriate catheter gauge will be selected for intended therapy based upon medications, size of veins, etc. Use the smallest gauge size for the therapy to protect veins

- d. Extension tubing set (single or bifurcated) should be used on all peripheral IV's.
2. Site Selection
- a. Select site for insertion beginning distally and moving proximally.
 - b. Use patient's non-dominant side if possible.
 - c. When selecting site and catheter size consider:
 - i. Vein Assessment
 - ii. Patient History including history affecting site choice such as arteriovenous fistula, mastectomy, lymph node dissection, etc...
 - iii. Drug Assessment
 - iv. Right Line decision
 - d. If the vein is not visible, consider using a vein visualization device.
 - e. If the assessment warrants a skilled nurse to place the peripheral intravenous catheter place a referral through the EMR system.
3. Provide local anesthesia as indicated.
- a. A physician's order is required for:
 - i. Subcutaneous injection of lidocaine for PICC insertion
 - ii. Intradermal injection of lidocaine on pediatric patients
 - b. A physician's order is NOT required for the following and may be ordered by the nurse "per policy:"
 - i. Topical anesthetic cream or intradermal injection of lidocaine on adults
 - ii. Topical anesthetic cream application on a pediatric patient
 - c. The nurse will assess for any allergies prior to lidocaine use.
4. Sodium chloride 0.9% 10ml flush for maintenance of peripheral IV catheter.
- a. A nurse can discontinue TKO orders per policy and follow standard flushing protocols.
5. Topical Anesthetic Cream: To apply the topical local anesthetic, squeeze cream directly onto the skin forming a thick layer at the site of the intended venipuncture. ****DO NOT RUB THE CREAM INTO THE SKIN****. Cover the creamed area with a transparent semipermeable membrane, smooth down the transparent dressing edges carefully. Ensure edges are secured to avoid leakage and record the time the cream was applied. The cream should remain undisturbed for at least sixty (60) minutes prior to venipuncture or per manufacturer's recommendation. Immediately before the venipuncture, remove the dressing and cream and cleanse the entire area.
6. Cream may be left in place for up to four (4) hours without diminishing its effectiveness if IV procedure is not immediate. Intradermal Lidocaine: Assess the patient for allergy to Lidocaine. Draw up 0.2 ml of Lidocaine Hydrochloride 1% in a

Tuberculin syringe. Prep site with alcohol wipe. Raise a wheal in the skin just over or to the side **of the vein by slowly injecting Lidocaine**. Aspirate for blood prior to injecting Lidocaine to assure that the needle is in the intradermal space and not a vein. Wait a few seconds to allow medication to take effect before initiating venipuncture.

7. Apply a tourniquet or a BP cuff on the extremity. Cleanse site with Chlorhexidine gluconate for a minimum of 30 thirty seconds and allow the site to air dry.
8. Perform venipuncture and slide catheter over needle. **DO NOT REINSERT NEEDLE INTO CATHETER AT ANY TIME.**
9. Attach extension set primed with saline and flush. Maintain clamp in closed position after flushing.
 - a. Twin cath" 20/22 IV technique: Due to the length, the twin cath requires a larger, straighter peripheral vein, preferably in forearm.
 - b. After successfully entering the blood vessel, blood flashback appears in the distal **lumen port**.
10. **Stabilize IV catheter** in a manner that does not interfere with asepsis, assessment and monitoring of IV therapy. No tape should be placed under or over a transparent dressing. Sterile gauze dressing is discouraged, however, may be used if the patient is diaphoretic or experiencing excessive oozing at site. When sterile gauze is in place, the dressing and gauze must be changed / removed a minimum of every 48 hours. Apply transparent dressing according to package directions to avoid problems with tubing change. To increase security of IV site, a securement device may be applied or a stockinet may be used to cover the site.
11. Dispose of sharps in sharps container.
12. **Ultrasound-Guided Peripheral Intravenous Catheter**
 - a. Specially trained clinicians insert ultrasound-guided peripheral intravenous catheters.
 - b. A physician's order is not required for an ultrasound-guided peripheral intravenous catheter as long as IV therapy is ordered.
 - c. The skilled nurse will make the determination if an ultrasound-guided peripheral intravenous catheter is appropriate.
 - d. Ultrasound-guided peripheral intravenous catheters are not acceptable for therapy requiring a central line, such as TPN, etc.
13. Site should be assessed frequently and IV re-started if any sign of inflammation, infiltration, or infection is present. No scheduled restart of peripheral IV cannula is recommended.
 - a. When adherence to aseptic technique cannot be ensured, such as for catheters inserted during a medical emergency (field start), the catheter should be replaced as soon as possible (within 48 hours).

B. SITE CHECKS

1. Check IV site every shift and prn. Educate patient on signs / symptoms of infiltration:

- a. Pain at the site.
- b. Discoloring (blanching, erythema)
- c. Tenderness or numbness
- d. Edema
- e. Localized swelling or induration
- f. Exudate
- g. Increase in skin and body temperatures
- h. Induration with palpable cord

C. IV SITE CARE AND MAINTENANCE Refer to CENTRAL VASCULAR ACCESS DEVICES

- 1. Peripheral IVs will be flushed with 0.9% sodium chloride for injection:
 - a. Immediately after placement
 - b. Prior to and after fluid infusion or injection
 - c. With IV assessment if not infusing fluids
- 2. Flush peripheral IV catheter using a pulsatile flushing technique (push-pause motion)

D. IV Solution and Tubing change schedule (Refer to attachment A)

E. DISCONTINUE

- 1. Discontinue IV when there is evidence of complications such as infection, infiltration, or occlusion, or when IV therapy is terminated.

F. DOCUMENTATION:

- 1. IV fluids are documented on the MAR
- 2. Document IV site selection size of catheter used, etc. and/or removal in appropriate EMR screen.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. CDC (2017). HICPAC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011. Retrieved from <https://www.cdc.gov/infectioncontrol/pdf/guidelines/bsi-guidelines-H.pdf>
- B. Dunn,H.,& Weston, V. (2016). A framework for selection of vascular access devices. *Nursing times*, 112 (35)16-19.
- C. Frank, Robert. (2021.) Peripheral Venous Access in Adults. *UpToDate*. Retrieved from [UpToDate/contents/peripheral-venous-access-in-adults](https://www.uptodate.com/contents/peripheral-venous-access-in-adults)
- D. Infusion Nurse Society (INS). (2024). Infusion Therapy Standards of Practice. 9th edition. *Journal of Infusion Nursing*. 47 (1S)

Attachments

 [A_ IV Tubing and Solution Change Schedule.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	9/29/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/23/2026
Policy Owner	Stephanie Frizzell: Director Education	9/22/2026

Standards

No standards are associated with this document



Origination N/A
Approved N/A
Expires 3 years after approval

Owner Michelle Orta:
Director
Continuum
of Care
Area Patient Care

Macy Catheter

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance for the insertion, use, and maintenance of the Macy Catheter.

III. DEFINITIONS

A. Macy Catheter: a simple, discreet, and comfortable small silicone catheter designed for the rectal administration of liquids and medications.

1. Quick Flush technique: With a 3ml oral syringe, inject 3ml cool tap water very quickly over less than 1 second.

IV. GENERAL INFORMATION

A. A physician order must be obtained prior to inserting a Macy Catheter.

1. Review indications and contraindications to ensure Macy Catheter is appropriate.
2. The Macy Catheter can remain in the rectum up to 28 days after which time the Macy Catheter should be replaced with a new catheter if indicated.
3. Indications
 - a. The Macy catheter should be utilized
 - i. As an option for symptom management when a patient does not have IV access.

- ii. When a patient loses the ability to take needed PO medications
 - a. When oral dosage volumes are too large to effectively or safely be administered sublingually
 - b. And when necessary medications are not absorbed sublingually
- iii. Prior to discharging patient home with hospice who requires medication that cannot be administered PO or SL for symptom management.

4. Contraindications

- a. This device should not be used for patients with rectal lesions, tumors or active rectal bleeding
- b. Do not use on patients with recent bowel surgery (less than 6 weeks)
- c. Do not use if rectal mucosa is compromised (i.e. ulcerations or ischemic proctitis)

V. PROCEDURE

A. Insertion

1. Obtain the Macy Catheter Bedside Care Kit from Supply Chain and place at bedside.
 - a. Inspect the package for the expiration date prior to opening.
 - i. All supplies needed for insertion and medication administration are included in the kit.
 - b. Lubricate Catheter
 - i. With catheter on a non-sterile poly-towel, lubricate the first 3 inches of the catheter from the tip to the first marker arrows with water soluble lubricant
 - c. Insert Catheter
 - i. Position the patient in the side-lying position for easy access to the rectum. (If the patient has difficulty turning, the catheter may be inserted with the patient in the supine position)
 - ii. Insert the catheter into the rectum to the marker line between the two arrows. One marker arrow will be visible when properly placed.
 - d. Inflate Balloon

- i. Temporarily remove the red safety cap from the Balloon Inflation Port
 - ii. Inflate balloon by injecting 15ml of cool tap water with a luer syringe
 - iii. Replace red safety cap back on Balloon Inflation Port
- e. Check Placement
 - i. Gently Tug to assure that the balloon is against the rectal sphincter
 - ii. One marker arrow should be visible once properly placed
- f. Secure Catheter
 - i. Position the tubing of the catheter between the legs
 - ii. Secure the Macy Catheter to the anterior aspect of the patient's thigh or lower abdomen with a catheter securing device

2. Administration of Liquid or Suspension Medications

- a. Draw
 - i. Pull the prescribed amount of liquid or suspended medications into the 3ml or 10ml enteral/oral syringe
- b. Inject
 - i. The medication Administration Port is Marked "MEDS"
 - a. Please note that ONLY oral/enteral syringes will fit into this port
 - ii. Insert the syringe into the Medication Administration Port
 - iii. Inject medication over 3-5 seconds
- c. Quick Flush
 - i. Once all medications have been injected, flush the Medication Administration Port using the Quick Flush technique

3. Administration of Tablet Medications

- a. Grind Tablets
 - i. Place tablets through slotted opening on top of LiquiPill grinder
 - ii. Grind tablets by turning the grinder top with a back and forth movement until grinder moves smoothly

- iii. For capsules:
 - a. Remove the grinder cap
 - b. Open capsule and pour directly into the medication reservoir
- b. Add Water
 - i. Remove grinder top and add 10mls water to the medication reservoir
- c. Shake and Swirl
 - i. Place syringe adapter cap on medication receptacle then shake and swirl for 10 seconds
- d. Draw and Inject
 - i. After shaking and swirling, attach syringe to adaptor cap
 - ii. Turn upside down
 - iii. Draw solution into the oral syringe
 - iv. Insert syringe into Macy Catheter Medication Port marked "MEDS"
 - v. Inject over 3-5 seconds
- e. Quick Flush
 - i. Once all medications have been injected, flush the Medication Administration Port using the Quick Flush technique

4. Maintenance & Care

- a. Check catheter placement prior to first medication administration per shift, after each bowel movement and PRN
- B. The catheter tube should remain between the legs and secured with a catheter securing device to the front portion of the thigh or lower abdomen
 - 1. Assess the skin and clean the anal area and catheter with soap and water or wet wipes when soiled and during routine bathing
 - a. Clean the medication port using a clean cloth dampened with only water if it becomes sticky with medication residue (DO NOT use soap or other cleaning products)
- C. Rinse medication syringe after each use with water only (do not use soap)
 - 1. Medication administration syringes may be stored for repeated use and changed out

every 28 days along with the Macy Catheter.

- a. The Macy Catheter can be removed if the patient experiences the urge to defecate, however it is designed to be easily expelled during defecation and therefore removal is optional
- b. If expelled or removed, the Macy Catheter can be reinserted immediately in the same patient for up to 28 days.
 - i. Do not store the catheter for later use.

2. Removal

- a. Deflate balloon with the luer syringe
 - i. Attach 20ml luer syringe to balloon inflation valve and gently withdraw the 15ml water from the balloon
 - ii. Gently remove catheter
- b. OR cut the catheter at balloon inflation port
 - i. Using scissors, cut below the inflation port
 - ii. Allow water to drain out completely
 - iii. Gently remove catheter
 - iv. *Note: Catheter will not be able to be reinserted after cutting catheter at balloon inflation port*

3. Troubleshooting

- a. Clogs
 - i. If you are not able to inject the solution through the medication administration port, gently push and pull on the plunger while gently shaking the syringe until the medication goes through.
- b. Leakage from the Medication Port
 - i. If leakage occurs, using the 3ml syringe, quickly inject 3mls of water over less than one second.
 - ii. Repeat if necessary
- c. Leakage from the Rectum
 - i. If leakage is noticed, check that the balloon is inflated with 15mls of water and gently tug to ensure it is against the rectal sphincter

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Critical Care Director	Frank Mensah: Director Critical Care Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/14/2026
Policy Owner	Michelle Orta: Director Continuum of Care	10/14/2026

Standards

No standards are associated with this document



Origination 8/11/2014
Approved N/A
Expires 3 years after approval

Owner Tiffany DiTullio:
Vice President
Partner and
Community
Relations

Area Administration

Mission, Vision, and Values

I. POLICY STATEMENT

- A. It is the policy of the Salinas Valley Health Medical Center (SVHMC) and its affiliates to envision and implement as part of its Strategic Plan, the Mission and Vision for the organization. These concepts shall be incorporated in organizational policies, procedures, plans, and operational requirements.
- B. The Board of Directors and Administration will annually evaluate the Local Health Care District's performance in relation to its vision and mission.

II. PURPOSE

- A. SVHMC, organized and operating pursuant to Division 23 of the California Health and Safety Code, is committed to serving the healthcare needs of its constituents. To that end, this policy defines the strategic vision of the Board of Directors, elected to represent the constituency for the Mission of the Local Health Care District and System.

III. DEFINITIONS

- A. **MISSION.** It is the Mission of SVHMC to provide quality healthcare to our patients and to improve the health and well-being of our community.
- B. **VISION.** Growing a healthier community through every action, in every place, for every person.
- C. **VALUES STATEMENT.STAR Values**
 - 1. **SUPPORT.** We support each other to put our patients and families first.
 - 2. **TEAMWORK.** Together we pursue excellence and exceptional performance with passion.

- 3. ACCOUNTABILITY. We take personal responsibility for our professional conduct in delivering results.
- 4. RESPECT. We respect our patients, each other, the community and the environment by demonstrating integrity, honesty and fiscal responsibility in everything we do.

IV. GENERAL INFORMATION

- A. Documentation
 - 1. References made to the Mission and Vision Statement by the Board of Directors, its Committees, as well as the Medical Staff and its Committees, shall be contained within the meeting minutes. Documentation of employee training will be included in the individual employee's educational and training file.

V. PROCEDURE

- A. N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Division 23 of the California Health and Safety Code Section 32000 and following.
- B. Comprehensive Accreditation Manual for Hospitals: The Official Handbook; The Joint Commission Leadership Standards.

Approval Signatures

Step Description	Approver	Date
Policy Owner	Tiffany DiTullio: Vice President Partner and Community Relations	Pending

Standards

No standards are associated with this document



Origination 9/14/2020
Approved N/A
Expires 3 years after approval

Owner Chessaly Miller:
Manager Clinical Nutrition
Area Nutritional Services

Nursing Nutrition Screening for Acute Care (Adults, Pediatrics, & Neonates)

I. POLICY STATEMENT

- A. All patients will be screened for nutrition risk by nursing within 24 hours of admission using predetermined, hospital-approved nutrition screening triggers.

II. PURPOSE

- A. To identify patients with potential nutrition risk and initiate the Nutrition Care Process.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Nursing will complete a nutrition screen on all patients within 24 hours of admission.
- B. The nutrition screening protocol for the adult population shall be the Malnutrition Screening Tool (MST) in addition to documenting home total parenteral nutrition and/or home tube feeding.
- C. The nutrition screening protocol for the pediatric population shall be the Pediatric Nutrition Screening Tool (PNST).

- D. A nutrition screening tool for neonates has not been validated. The nutrition protocol for the neonate population shall be the use of the recommended screening triggers identified below.
- E. The clinical nutrition staff (Registered Dietitian or diet technician/dietetic intern supervised by a Registered Dietitian) will be notified by the EMR if any triggers are identified.
- F. The clinical nutrition staff will initiate the Nutrition Care Process for all patients identified at potential nutrition risk via the above nutrition screening mechanism within 24-48 hours of notification. (Refer to: [Inpatient Nutrition Assessment for Adult Patients policy](#)).
- G. A multidisciplinary performance improvement monitor will be conducted to evaluate the effectiveness of the nutrition screening process.
- H. Screening Triggers
 - 1. **ADULTS: (MST) – see attached MST for scoring guidelines**
 - a. Have you recently lost weight without trying?
 - b. If yes, how much weight have you lost?
 - c. Have you been eating poorly because of a decreased appetite?
 - 2. **PEDIATRICS: (PNST) – 2 or more positive responses initiates nutrition trigger**
 - a. Has child unintentionally lost weight lately?
 - b. Has child had poor weight gain over the last few months?
 - c. Has child been eating/feeding less in the last few weeks?
 - d. Is child obviously underweight/significantly overweight?
 - 3. **NEONATES:**
 - a. Hospital-approved nutrition screening triggers will include:
 - b. Low birth weight (<1500 g) even in the absence of gastrointestinal, pulmonary, or cardiac disorders
 - c. Less than 32 weeks gestational age
 - d. Small for Gestational Age
 - e. Receiving parental nutrition support

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. "Nutrition Screening Systematic Review (2009-2010)." Academy of Nutrition and Dietetics Evidence Analysis Library, www.andeal.org/topic.cfm?menu=3584&cat=5437. Accessed August 23, 2017.
- B. White, Melinda, et al. "Simple Nutrition Screening Tool for Pediatric Inpatients." *Journal of Parenteral and Enteral Nutrition*, vol. 40, no. 3, May 2016, pp. 392–398. First published date: August 5, 2014.
- C. State Operations Manual Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Rev.151. Issued November, 20, 2015. Center for Medicare and Medicaid Services website. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed August 23, 2017.
- D. The Joint Commission E-dition. The Joint Commission Standard PC.01.02.03. EP 6. The Joint Commission website. <https://e-dition.jcrinc.com/MainContent.aspx> Accessed August 23, 2017.
- E. Malnutrition Screening Tool page. Abbott Nutrition website. http://static.abbottnutrition.com/cms-prod/abbottnutrition.com/img/Malnutrition%20Screening%20Tool_FINAL.pdf Accessed August 23, 2017.
- F. Ferguson, Maree, et al. "Development of a Valid and Reliable Malnutrition Screening Tool for Adult Acute Hospital Patients." *Nutrition*, vol. 15, no. 6, 1999, pp. 458–464.
- G. Nutrition Care Process page. Academy of Nutrition and Dietetics website. <http://www.eatrightpro.org/resources/practice/practice-resources/nutrition-care-process>. Accessed August 23, 2017.

Attachments

[Malnutrition-Screening-Tool-MST.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026

LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/31/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Chessaly Miller: Manager Clinical Nutrition	7/31/2026

Standards

No standards are associated with this document

COPY



Origination N/A

Approved N/A

Expires 3 years after approval

Owner Chessaly Miller: Manager Clinical Nutrition

Area Nutritional Services

Nutrition Screening Audit

I. POLICY STATEMENT

Performance Improvement monitoring will be conducted to ensure nutrition screening, patient referral and patient intervention are completed according to policy.

II. PURPOSE

- A. To monitor regulatory compliance with nutrition screening and intervention.
- B. To monitor timeliness of intervention upon receipt of referral.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

Performance Improvement: Nutrition Screening

- A. Randomly select at least five medical records monthly from each nursing unit and complete the PI Nutrition Screening audit.
- B. Utilizing the web-based application, review the medical record for compliance with nutrition screening.

1. Complete the audit in the web-based application by indicating whether or not (Yes/No) evidence supports compliance to each indicator for nutrition screening.
 2. Corrective action, including training and education, will be conducted for all individuals and departments whose performance consistently falls below the 90% performance standard.
- C. Utilize the web-based application reporting dashboard(s) for **Nutrition Screening audit** results at the close of each month.
1. Results of all audits completed for the month will be summarized in the web-based application reporting dashboard(s).

Performance Improvement: Nutrition Screening Results Trending and Communication

- A. Monthly trending will be completed on audit results and reviewed with nursing. Action plans will be developed, implemented, and monitored for all indicators falling below the 90% compliance threshold. If applicable, coordinate with nursing to develop action plans.
1. Utilize the [Plan-Do-Check-Act \(PDCA\)](#) Tool (on Aramark website) to track, trend and action plan QA data results.
- B. If a nursing unit is at greater than 90% compliance for 3 consecutive months, then move to quarterly Nutrition Screening Audits for that unit.
1. If quarterly Nutrition Screening Audit results fall below 90% compliance threshold, then resume monthly audit requirements until 3 consecutive months of greater than 90% is met.
- C. Monthly compliance results will be submitted to the front-line manager (FLM) for review and discussion.
- D. Quarterly reports will be submitted to the FLM, Nursing, DM, and hospital performance improvement or quality committee as appropriate.
- E. For each indicator, the following is documented:
- a. data source
 - b. persons responsible for collecting data
 - c. method for reporting data
 - d. Sample size
 - e. frequency of data collection

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/31/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Chessaly Miller: Manager Clinical Nutrition	7/31/2026

Standards

No standards are associated with this document



Origination N/A
Approved N/A
Expires 3 years after approval

Owner Chessaly Miller:
Manager Clinical Nutrition
Area Nutritional Services

Nutrition Services Measure of Success

I. POLICY STATEMENT

The Food and Nutrition Department implements an ongoing data collection for any non-complaint Joint Commission standard which has an element(s) of performance requiring demonstration of achievement with a Measure of Success.

II. PURPOSE

- A. To provide tools to evaluate compliance with key Joint Commission standards
- B. To meet Joint Commission requirements when certain standards are found to be noncompliant.
- C. To provide a method to determine and to document whether a corrective action has been effective and is being sustained.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. The Front Line Manager, along with the ADPS/CNM, reviews compliance with all Food and Nutrition Department-related Joint Commission standards as a component of the facility's

Periodic Performance Review. Any noncompliant Joint Commission standard, which has an Element of Performance (EP) and requires a Measure of Success, is identified.

- B. A Measure of Success is defined as a quantifiable measure, usually related to an audit, which can be used to determine whether an action has been effective and is being sustained. Measures of Success are required for certain Joint Commission standards and are indicated next to the EP (Element of Performance) with an **M**.
- C. Attachment #1 provides a list of Joint Commission Standards, with EPs requiring implementation of a Measure of Success. See Measurements policies #11B, 11C, 11E.
- D. The results of data collection must show $\geq 90\%$ compliance.
- E. Any results which have been evaluated at $< 90\%$ compliance (or the threshold as indicated in the specific Performance Improvement Plan) will have an action plan developed. See Measurements #11B, 11C, 11E.
- F. (Describe information that might assist persons to understand the processes)
- G. (Include ALL steps to take to implement the policy)
- H. 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. Joint Commission Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals*. 2007.
- B. Joint Commission Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Long Term Care*. 2007.
- C. Joint Commission Accreditation of Healthcare Organizations. *2009 Accreditation Requirements Chapters: Accreditation Program: Hospital*

Attachments

 [Attachment Measure of Success Policy.docx](#)

Approval Signatures

Step Description

Approver

Date

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/31/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Chessaly Miller: Manager Clinical Nutrition	7/31/2026

Standards

No standards are associated with this document

COPY



Origination 8/4/2014
Approved N/A
Expires 3 years after approval

Owner Stephanie Frizzell:
Director Education
Area Patient Care

Patient Identification

I. POLICY STATEMENT

- A. All patients entering the Salinas Valley Health Medical Center (SVHMC) will be identified using two (2) unique identifiers as defined under General Information.
- B. The patient room/bed number MAY NOT be used to identify a patient.

II. PURPOSE

- A. To assure patient safety by establishing the patient's correct identity prior to administering medications, blood products, and providing clinical care or treatment.

III. DEFINITIONS

- A. Date of Birth (DOB): The month, day and year of the patient's birth.
- B. Identification Band (ID): A tamperproof non-transferable wristband that includes the patient's full name and date of birth. NOTE: additional information on the patient's ID band includes, but is not limited to: medical record (unit) number; account number;
- C. Medical Record (UNIT) Number: this is a number assigned to a patient the first time that they enter the SVHMC system. This is a unique number associated with all hospital admission/outpatient treatments for this patient.
 - 1. The Electronic Health Record (EHR) identifies the Medical Record Number as the UNIT number.
- D. Account Number: this is a second number assigned to the patient that changes with each hospital admission/outpatient treatment. This is the number that begins with the letter "H" followed by eight numbers and is used for billing purposes.
- E. Face Sheet: Document containing patient demographic information including the name, DOB, Medical Record (Unit) number, Account number (etc).

- F. Two Dimensional Barcode: A matrix barcode printed on the hospital identification band that contains patient identifying information including the patient name and date of birth. This barcode is scanned for patient identification during eMAR medication administration.
- G. AMR # - EMS # assigned to each patient and identified on the EMS Run Sheet

IV. GENERAL INFORMATION

- A. Generally patients will have their identity confirmed using these two-identifiers:
 - 1. Name
 - 2. Date of birth (DOB)
- B. If the patient has the same name and/or DOB as another patient, a third identifier will be used and that would be the patient's unique Medical Record number or Account Number.
- C. Patients unable to provide identifying information and are experiencing a condition requiring immediate emergency care, will receive treatment prior to identification if such care and treatment is necessary to stabilize their emergency medical condition.
 - 1. EMS arrivals - Will utilize the AMR number and the account number assigned at the arrival time.
 - 2. Non EMS Arrival - may be processed as John/Jane Doe using the John / Jane Doe name and account number.
 - 3. Once identification is made the armband and all corresponding documents will be updated.

V. PROCEDURE

- A. Initial Registration to Identify and Band Patients for clinical areas that use identification bands.
 - 1. The Identification Band is prepared during the registration process and placed on the patient by the Registration Departments upon entry.
 - a. A picture ID will be compared with the patient when available.
 - b. Registration staff will compare the patient name and DOB on the face sheet with the band.
 - c. Registration staff will ask the patient to state their name and DOB comparing the response against the face sheet.
 - d. Registration staff will then place the band on the patient.
 - 2. The John/Jane Doe Procedure is followed in the event that a patient is unable to provide identifying information.
 - a. Direct admissions to clinical areas may have the identification band placed on the patient by the clinical care provider at the bedside.
- B. Identifying Patients with Existing Bands
 - 1. Patient identification will be confirmed by checking the name and DOB on the Identification band worn by the patient with the name and DOB on the accompanying paperwork or in the electronic health record (EHR) prior to conducting any

healthcare procedures.

2. Hospital staff will ask the patient to state their name and DOB for comparison against the accompanying paperwork or in the EHR.
3. Procedures include, but are not limited to:
 - a. Administration of medication
 - b. Transfusion of blood or blood components
 - c. Obtaining blood or other specimens from the patient
 - d. Procedures requiring Universal Protocol (Pre-procedure verification; side/site marking; Time Out)
 - e. Performing a treatment / procedure
 - f. Performing a diagnostic test
 - g. Performing the discharge process (verify the name on each document before handing to the patient).
 - h. Transport of patients to another location
 - i. Providing meal tray
4. Defective or missing bands shall be replaced immediately. DO NOT tape to the bedside table, bed frame or crib.
5. Procedure to re-band a patient
 - a. Replacement Identification (ID) bands will be obtained from the Admitting Department.
 - i. Process to re-band patients wearing Identification bands
 - Clinician will compare the name and DOB on the replacement ID band with the ID band on the patient
 - Clinician will place the new ID band on the patient prior to removal of the old ID band
 - b. Process for patients with removed Identification bands or initial banding of patients not done in Registration
 - i. Clinician will compare new ID band against the face sheet using the patient name and DOB.
 - ii. Clinician will ask the patient their name and DOB comparing answers with the patient face sheet in the presence of the patient.
 - iii. Clinician will then place ID band on patient.

C. Hospital locations, including clinic settings, that do not require Identification bands

1. Will ask the patient to state their name and DOB. The response will be compared with the name and DOB on the accompanying procedural paperwork or in the EHR.

D. Department/Procedure Specific Exceptions

1. In Emergency Department Registration, the clerks will ask the patient to state their

name and DOB, view Picture ID on file as available, to validate patient. Complete Reception process & band patient prior to triage.

2. Laboratory will follow the identification process outlined in [IDENTIFICATION OF EMERGENT PATIENTS](#).
3. The patient name and DOB will be used for medication verification except as limited by equipment, software technology or billing purposes.
 - a. The Medication dispensing machine printout does not contain the DOB. In the event the Medication dispensing machine printout must be used for medication administration, it is acceptable to use the patient name and Account number as the two-identifiers.
 - b. The printout for items ordered through Supply Chain does not contain the DOB. It is acceptable to use the patient name and Account number as the two-identifiers.
4. Neonatal Intensive Care Unit (NICU) may have Velcro Identification bands that will be immediately replaced on a limb when removal of the regular ID band occurs or the regular ID band will not fit securely on the patient.
5. Registration does not band Neonate or NICU admissions. Neonate identification will follow the process outlined in [IDENTIFICATION, SECURITY AND PREVENTION OF ABDUCTION-NEONATES](#)

E. Identifying Patients Transferred from other Facilities for Procedures

1. Non-emergent
 - a. Registration will follow the procedure as listed in section A.
2. Emergent
 - a. Patient identification will be confirmed by use of the existing ID band placed by transferring facility. Clinical staff will compare the name and DOB on the ID band against the accompanying face sheet from the transferring facility.
 - i. In the event the patient is transferred without an ID band, the patient will be asked to state their name and DOB to compare against the transferring facility face sheet.
 - b. The transferring facility ID band will be used for patient identification until the patient is admitted by SVHMCRegistration.

F. Identifying patients transferred to the morgue.

1. Per [POST MORTEM-NOTIFICATION \(CORONER, DONOR NETWORK\), AUTOPSY AND RELEASE OF REMAINS](#). Patient identification band is to remain in place. Follow procedure to re-band patient if necessary.
2. RN only, will verify the information on the deceased patient's identification band with the two (2) labeled morgue pack tags. This identification process will occur at the bedside.
3. Morgue tags to be applied following policy ([POST MORTEM-NOTIFICATION \(CORONER, DONOR NETWORK\), AUTOPSY AND RELEASE OF REMAINS](#).)

EDUCATION/TRAINING

A. Education and/or training is provided as needed

REFERENCES

A. The Joint Commission – National Performance Goal

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	10/15/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/15/2026
Policy Owner	Stephanie Frizzell: Director Education	9/22/2026

Standards

No standards are associated with this document



Origination N/A

Approved N/A

Expires 3 years after approval

Owner Chessaly Miller: Manager Clinical Nutrition

Area Nutritional Services

Registered Dietitian Clinical Chart Audit

I. POLICY STATEMENT

Performance Improvement monitoring will be conducted to ensure the Nutrition Care Process is completed according to policy.

II. PURPOSE

- A. To monitor regulatory compliance with nutrition assessment, re-assessment, care planning, patient education, and medical record documentation.
- B. To evaluate clinical competency on a monthly and quarterly basis.

III. DEFINITION

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

Performance Improvement: PI Clinical Audit

- A. Select at least two charts to review monthly for each practicing clinician who documents in the medical record. At least one chart must be from a high-risk patient with PPN/TPN orders or nutrition support recommendations, micronutrient deficiencies (e.g. Thiamin) as potentially seen in post bariatric populations, etc.

- B. For acute care, utilizing the web-based application review the medical record for compliance with nutrition assessment, diagnosis, intervention, monitoring/evaluation, nutrition education and general documentation standards.
1. Complete the audit in the web-based application by indicating whether or not (YES/NO) documentation is present in the medical record for each of the indicators.
 2. Corrective action, including training and education will be conducted for all individuals whose performance falls below performance standards.
- C. Utilize the web-based application reporting dashboard(s) for **Registered Dietitian (RD) Chart Audit** results at the close of each month.
1. Results of all audits completed for the month will be summarized in the web-based application reporting dashboard(s).

Performance Improvement: PI Clinical Audit Results Trending and Communication

- A. Monthly trending will be reviewed, and action plans will be developed, implemented and monitored for all indicators falling below the 90% compliance threshold.
- B. a. Utilize the Plan-Do-Check-Act (PDCA) Tool (on Aramark website) to track, trend and action plan QA data results.
- C. If a clinician is at greater than 90% compliance for 3 consecutive months, then you may move to quarterly Clinical Audits for that clinician.
1. If quarterly Clinical Audits results for the clinician fall below 90% compliance threshold, then resume monthly audit requirements until 3 consecutive months of greater than 90% is met.
- D. Monthly compliance results will be submitted to the front-line manager (FLM) for review and discussion.
- E. Quarterly reports will be submitted to the FLM, DM, and hospital performance improvement or quality committee as appropriate.
- F. For each indicator, the following is documented:
1. data source
 2. persons responsible for collecting data
 3. method for reporting data
 4. Sample size
 5. Frequency of data collection.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Attachments

 [Attachement RD Chart Audit Form.xlsx](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/31/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Chessaly Miller: Manager Clinical Nutrition	7/31/2026

Standards

No standards are associated with this document



Origination	7/24/2020	Owner	Laura Zerbe:
Approved	N/A		Director
Expires	1 year after approval		Facilities
		Area	Scopes Of Service

Scope of Service: Facilities Management

I. SCOPE OF SERVICE

Facilities Management supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community

The purpose of Facilities Management is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Facilities Management is to ensure that customers will receive high quality service in the most expedient and professional manner possible.

Facilities Management encompasses the following:

- Plant Operations and Plant Maintenance
- Biomedical Engineering ([SCOPE OF SERVICE: BIOMEDICAL SERVICES](#))
- Project Management

II. GOALS

In addition to the overall SVHMC goals and objectives, Facilities Management develops goals to direct short-term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of Facilities Management:

- To ensure that all equipment and facilities where patients are treated and staff work will be maintained in the highest quality and safe condition. All repairs will be performed in the most expedient and professional manner possible in order to promote safe working conditions and timely service.
- To provide a safe physical environment in which to facilitate the delivery of patient care and

the overall maintenance/selection/replacement of facility equipment throughout the organization.

- C. To ensure compliance with all state, federal and all other applicable regulatory agencies.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- E. To evaluate staff performance on an ongoing basis.
- F. To provide appropriate staff orientation and development.
- G. To monitor Facilities Management function, staff performance, and service for quality management and continuous quality improvement.

IV. POPULATION SERVED

All departments that are part of SVHMC

- A. Hours of Operation

Plant Operations and Plant Maintenance

The department offers services 24 hours a day, 7 days per week. Office hours are Monday-Friday 7:00 am-3:30 pm, with after-hours and weekend support from Boiler Watch Engineer and on-call Supervisors.

Biomedical Services

Operates Monday through Friday between 6:00 am to 5:00 pm. Emergency support needs are provided for after hours, weekends, and holidays by Biomed On-Call. **Project**

Management Operates Monday through Friday between 8:00 am to 4:30 pm.

- B. Location of department (s)
 - Plant Operations and Plant Maintenance: Basement level of the Medical Center
 - Biomed: Downing Resource Center
 - Project Management: Basement level of the Medical Center

- C. Admission, Discharge, Transfer Criteria
N/A

- D. Major Services:
The Facilities Management Department provides the following services organization-wide:
 1. Maintains, repairs, and services utilities (life support systems, emergency power systems, water, compressed gases, sterilization, elevator systems and hospital equipment).
 2. Maintains a safe and comfortable environment for all patients, visitors, and staff.

3. Completes work orders for repair and maintenance of the facility and its equipment.
4. Responds to the physical plant and maintenance needs of the hospital staff.
5. Maintains daily logs of essential utility systems and equipment.
6. Obtains technical support for equipment repair or modification from the manufacturer as needed.
7. Assists the construction team on renovation and building projects as needed.
8. Maintains the grounds and provides landscaping services.
9. Develops and implements Physical Environment programs including:
 - a. Biomedical Engineering Program
 - b. Utility Management Program
 - c. Water Management Program
10. Provides consultative service to all SVHMC departments to assist in compliance with applicable regulations. Works with federal, state, and local health and safety regulatory agencies.
11. Supports programs including but not limited to employee occupational safety and infection prevention.
12. Participates actively in emergency drills, code pink drills, haz-mat spill drills and other exercises as requested.

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

A. N/A

VI. REQUIREMENTS FOR STAFF

A. Licensure / Certifications:

Within Plant Operations and Plant Maintenance, one of the following roles are required to maintain:

1. Medical Gas Maintenance Certification:

- Chief Engineer
- Assistant Chief Engineer
- Lead Engineer

2. Office of the State Fire Marshal Weekly Fire Pump Testing License:

- Chief Engineer
- Assistant Chief Engineer
- Lead Engineer

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit 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:

- A. Plant Operations and Maintenance Engineers
 - Monday through Friday, Day Shift: 12
 - Holidays, weekends, evening and night shifts: 2 per shift
- B. Biomedical Engineers:
 - Monday through Friday, Day Shift: 6
 - Holidays, weekends, evening and night shifts: on call
- C. Project Management:
 - Monday through Friday, Day Shift: 2

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is:

- A. Plant Operations and Plant Maintenance: 5
- B. Biomedical Engineering: 4

VIII. EVIDENCE BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

IX. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Facilities Management supports SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Facilities Management Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/13/2026
VP Facilities	Laura Zerbe: Director Facilities	9/22/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Laura Zerbe: Director Facilities	6/16/2026

Standards

No standards are associated with this document

COPY



Origination	6/23/2022	Owner	Katherine DeSalvo: Director Medical Staff Services
Approved	N/A		
Expires	1 year after approval	Area	Scopes Of Service

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.

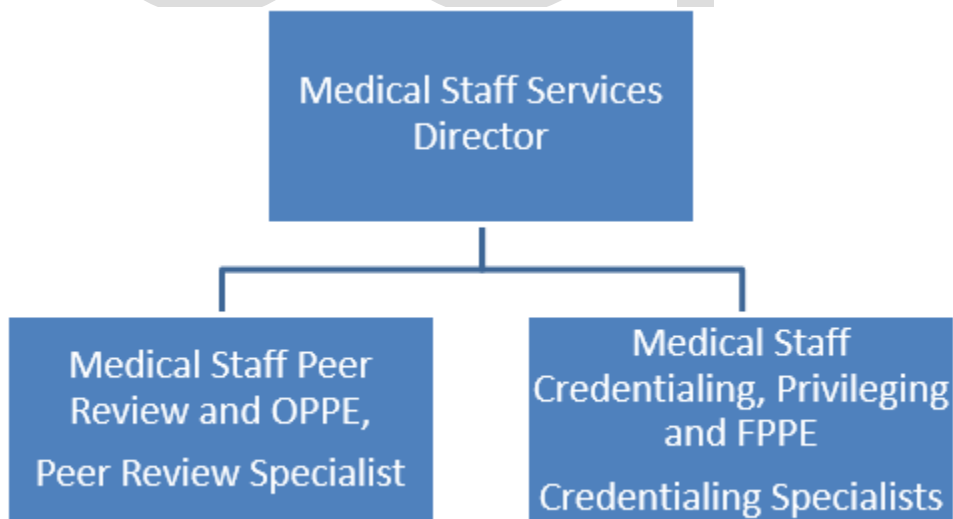
III. DEPARTMENT OBJECTIVES

- 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 Providers
 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 Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CCO	Timothy Albert: Chief Clinical Officer/Chief Innovation Officer	9/29/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/14/2026
Policy Owner	Katherine DeSalvo: Director Medical Staff Services	7/14/2026

Standards

No standards are associated with this document



Origination 9/28/2020
 Approved N/A
 Expires 1 year after approval

Owner Julie Vasher:
 Director Women's & Children's Services
 Area Scopes Of Service

Scope of Service: Perinatal

I. SCOPE OF SERVICE

Perinatal 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.

The purpose of Perinatal Services is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Perinatal Services is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Perinatal Services unit develops goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

- A. The goal of *Perinatal Services* (Units) is to provide family-centered care of maternal/child patients, gynecological/medical-surgical overflow patients; and newborns. The perinatal services include: antepartum testing, obstetrical emergency services, labor and delivery, operating rooms, post-partum, well newborn, neonatal intensive care and lactation services.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

- C. To plan for the allocation of human/material resources.
- D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to the highest level of wellness as possible.
- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Perinatal Services function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Women of child bearing ages to geriatric as well as newborn and pre-term infants.

V. ORGANIZATION OF THE DEPARTMENT

- A. Hours of Operation:
Perinatal Services provides services seven (7) days a week, 24 hours a day. Lactation Specialist scheduled five (5) days per week on the day shift and as available.
- B. Location of departments: 2nd floor of SVHMC.
- C. Admission, Discharge, Transfer Criteria
 - The Perinatal services has policies and procedures located within Policy STAT to identify admission, discharge and transfer criteria.
- D. Major Services / Modalities of care may include:
Overall, Perinatal care includes:
 - Antepartum Testing for fetal well-being.
 - Obstetrical Emergency Department utilizing Maternal Fetal Triage Index (MFTI) for evaluation and triage. In addition, the Obstetrical Emergency Department evaluates and treats appropriate postpartum patients utilizing Emergency Severity Index (ESI) for evaluation and triage.
 - Labor, Delivery & Recovery, management of labor, delivery and immediate postpartum recovery care. Cesarean sections, with other incidental appropriate GYN / obstetrical procedures as necessary (appropriateness defined as no additional personnel or equipment is needed); as well as the ability to provide a trial of labor after a cesarean section.
 - Mother/Baby provides maternal childcare with rooming in.
 - Neonatal Intensive Care Nursery cares for premature infants as well as newborns with a co-morbidity requiring interventions.

- Lactation consultation supports both in and out patients in breastfeeding in accordance with Baby Friendly designation.

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

- A. The inpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients. ADMISSION ASSESSMENT & RE-ASSESSMENT A registered nurse (RN) performs an immediate, brief, focused assessment for the obstetrical patients. The RN selects and initiates the nursing care plans on admission and updates as indicated. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

VII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide patient care services are licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence.

Standards of practices are consistent with Basic Life Support (BLS), (Neonatal Resuscitation Provider (NRP), Association of Operating Room Nurses (AORN), American Society of PerAnesthesia Nurses (ASPAN) , National Association of Neonatal Nurses (NANN) and Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) standards of practice.

- A. Licensure / Certifications:

The basic requirements for **Registered Nurses** include:

1. Current state licensure
2. Current BLS
3. Current ACLS Labor & Delivery RNs (within six (6) months of hire)
4. Current Neonatal Resuscitation Program (within six (6) months of hire)
5. Completion of competency-based orientation
6. Completion of annual competencies
7. Labor & Delivery RNs only: Fetal monitoring education within three (3) months of hire and as directed

The basic requirements for **Obstetrical Technicians** include:

1. Successful completion of a Surgical Scrub Technician program or prior experience as a Surgical Scrub Technician
2. Certified Nursing Assistant Current BLS
3. Completion of competency-based orientation

4. Completion of annual education

The basic requirements for **Unit Assistants** include:

1. Completion of competency-based orientation
2. Completion of annual education

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

- Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit 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. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

Perinatal Care Units are staffed primarily with Registered Nurses, supported by unit assistants, obstetrical technicians and Charge nurses. Assignments are made by the charge nurse based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, the level of supervision available.

IX. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

X. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management

system.

- OB Hospitalist
- Neonatologists
- Perinatologists
- Anestheologist

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Perinatal Services supports the SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Perinatal Services Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

 [Organization of the Department](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	10/12/2026

Policy Committee

Rebecca Alaga: Regulatory/
Accreditation Coordinator

10/12/2026

Policy Owner

Julie Vasher: Director Women's
& Children's Services

7/14/2026

Standards

No standards are associated with this document

COPY

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

*QUALITY AND EFFICIENT
PRACTICES COMMITTEE*

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

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

(CATHERINE CARSON)



Origination 1/1/2022

Approved N/A

Expires N/A

Owner Amy
Grooters:
Patient
Safety
Manager

Area Plans and
Program

Patient Safety Program Plan

I. PURPOSE

- A. The purpose of the Patient Safety Program Plan is to establish a proactive, organization-wide framework for patient safety at Salinas Valley Health Medical Center (SVHMC), under Salinas Valley Health (SVH). The plan is designed to create a comprehensive, organization-wide framework dedicated to achieving zero preventable harm and fostering a Just Culture. The Patient Safety Plan supports the mission, vision, and strategic plan of SVH.
 - **SVH Mission:** It is the mission of Salinas Valley Health to provide quality healthcare to our patients and to improve the health and well-being of our community.
 - **SVH Vision:** A community where good health grows through every action, in every place, for every person.
- B. The organization prioritizes safe patient care practices and ensures systems, resources, policies, and culture are in-line with established healthcare quality and safety frameworks, such as the Patient Safety Structural Measures (PSSM) established by the Centers for Medicare & Medicaid Services (CMS), and the National Performance Goals (NPG) established by The Joint Commission (TJC).

II. GUIDING PRINCIPLES

- A. All staff, physicians, volunteers, patients, patient's families and their support persons are accountable and have a role to play in patient safety.
- B. Implementation of this plan is dependent on integrating validated safe practices across all departments in the hospital.
- C. A safe and secure work environment for staff, volunteers and physicians contributes to safe patient care.

- D. That patients and families are aware of safety practices and expectations and feel encouraged to ask for clarification of process or procedure.

III. SCOPE

- A. The scope of the organizational Patient Safety Program Plan at SVMH establishes a comprehensive, organization-wide framework designed to develop, implement, and evaluate a robust patient safety system. The program actively reduces risk and eliminates preventable harm by fostering an environment that encourages:
- Recognition and acknowledgment of risks to patient safety and medical/health care errors that impact outcomes.
 - The initiation of actions to promote a culture of safety throughout the facility, including the safe integration of technology.
 - Creation of a non-punitive, transparent approach for reporting, analyzing and evaluating errors and problems.
 - Facilitation of sharing knowledge to effect behavioral changes.
 - Implementation of proactive practices that decrease variation and waste, alongside the rapid redesign of unsafe care processes in response to validated adverse events.
 - Interdisciplinary communication, collaboration, and organization-wide education regarding patient safety and error reduction.
- B. The Patient Safety Program is an organization-wide initiative that applies universally across all sites, services, care settings, and departments (both patient care and non-patient care) under SVHMC.
- **Populations Encompassed:** The program directly encompasses the entire hospital community, including patients, visitors, volunteers, students, and all categories of staff, including the Medical Staff.
 - **Functional Reach:** The program spans all administrative, medical staff, nursing, and support activities, ensuring that patient safety priorities are deliberately integrated into the new design and redesign of all relevant organizational processes, functions, and services.
- C. SVH supports a Just Culture philosophy and approach to adverse event investigation and response. SVHMC has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner. (Appendix A).
- D. To satisfy and exceed national benchmarks, the scope of the Patient Safety Program incorporates the CMS Patient Safety Structural Measures (PSSM) framework. This structure ensures that SVHMC prioritizes safety across five foundational domains:
1. **Leadership Commitment to Eliminating Preventable Harm:** Senior leadership and the SVHMC Board of Directors set the tone, oversee safety self-assessments, hold organizational leadership accountable for outcomes, and maintain safety as a key

institutional value.

2. **Strategic Planning and Organizational Policy:** Integration of patient safety priorities into the organization's strategic vision, quality and process improvement plans, and daily operational workflows.
 3. **Culture of Safety and Learning Health System:** Regular assessment of safety culture, deployment of team communication training, and utilization of data infrastructure (such as electronic health record data and tiered safety huddles) to track precursor events and serious safety incidents.
 4. **Accountability and Transparency:** Utilization of communication and resolution programs to respond thoroughly and transparently when unexpected events occur.
 5. **Patient and Family Engagement:** Meaningful incorporation of patients and families as active partners in safety, including leveraging feedback mechanisms to inform continuous improvement.
- E. The scope of the program operationalizes The Joint Commission National Performance Goals (NPGs) to maintain rigorous compliance and drive clinical excellence. Key performance objectives integrated into the safety scope include:
1. Ensuring the correct patient receives the correct care at the correct time.
 2. Fostering a governance-backed culture of safety.
 3. Prioritizing infection prevention and control, medication management safety, safe prescribing practices, and pain management.
 4. Respecting patient rights to safe, informed care while addressing specialized clinical risks such as suicide risk reduction, safe imaging services, and clinical staffing competency.
- F. Staff are required and encouraged to report all safety incidents, near-misses, hazardous conditions, and sentinel events via the electronic Incident Reporting System. Evaluations of reported events focus on investigating system, process, and design flaws (the "how" of errors) rather than placing blame on individuals (the "who" of errors).
- G. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet SVHMC's annual patient safety goals and Strategic Plan:
1. The Patient Safety Plan is approved by the SVHMC Quality and Safety Committee, Medical Executive Committee and the Quality and Efficient Practice Committee of the Board and the Board of Directors on an annual basis.
 2. The Board of Directors delegates the responsibility for SVHMC Patient Safety Program oversight to the SVHMC Medical Executive Committee and the Quality and Safety Committee.
 3. The designated Patient Safety Officer for SVHMC has administrative responsibility for the program and reviews and updates the Patient Safety Plan as needed.

IV. OBJECTIVES and GOALS

- A. The overarching goal and objective of the Patient Safety Program Plan is to cultivate a proactive, transparent, and highly-reliable safety culture with a goal of zero preventable harm, empowering staff to speak up, report errors, and deliver high-quality care to every patient, all the time.
- B. Support and encourage a culture of safety through an environment where employees can report safety concerns, near misses, and incidents without the fear of blame or retribution, and trust that the information will be used for improvement.
- C. A team of appropriately skilled healthcare professionals (e.g. physicians, nurses, pharmacists, risk management, and frontline staff), within the organization, will conduct standardized Root Cause Analysis (RCA) for all significant patient safety events.
- D. Proactive risk assessments will be conducted for all new programs and services, or conducting one on a topic of interest, at eighteen-month intervals.
- E. Integration of a process to conduct analysis of patient safety events, which include the following sociodemographic factors, to identify disparities in these events:
 - Age
 - Race
 - Ethnicity
 - Gender identity (when voluntarily provided)
 - Sexual orientation (when voluntarily provided)
 - Preferred language spoken
 - Disability status
 - Payor
 - Sex
- F. Maintain continuous patient safety competence across all hospital personnel and affiliated medical staff. Deliver comprehensive patient safety training to newly hired staff during orientation, and supplement annually. Training includes event reporting, Just Culture principles, hazard identification and team communication strategies.
- G. Systematically address racism, discrimination, and implicit bias to eliminate its impact on patient health and safety including, but not limited to:
 - Monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.
 - Encourage facility staff to report suspected instances of racism and discrimination.

V. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

- A. The SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: Quality & Safety Committee of the Medical Staff, Medical Executive Committee, Quality and Efficient Practices Committee of the Board and the SVHMC Board of Directors. At all levels, SVHMC leaders provide the foundation for an effective patient safety system by: promoting learning; motivating staff to uphold a fair and just safety culture; providing a transparent environment in which quality measures and patient harms are freely shared with staff; modeling professional behavior; removing intimidating behavior that might prevent safe behaviors; and providing the resources and training necessary to take on improvement initiatives.

1. Board of Directors

- a. The SVHMC Board of Directors (the Board), through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the Board to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board regarding Patient Safety are seen in activities such as:
- Approves the Patient Safety Program Plan.
 - Reviews SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.

2. Patient Safety Officer

- a. The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
- b. The Patient Safety Officer will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non-critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
- c. The Patient Safety Officer communicates and collaborates with Administration, department leaders and others as necessary, in an effort to ensure coordination in reduction of harm, promotion of safe practices, and a safe culture of reporting.

- d. Oversees the Culture of Safety survey as defined by the organization.
- e. Meets routinely with leaders and staff on the Patient Safety Program goals, objectives and outcomes.
- f. Is available to all persons under SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.

3. Patient Safety Advisory Team (PSAT)

- a. This ad-hoc committee comprises key representatives from leadership to:
 - i. Evaluate reported events related to patient safety and quality care that occur within SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.
 - ii. The Regulatory and Accreditation team oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

4. Staff

- a. To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in SVHMC's Patient Safety Program. SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

VI. PATIENT SAFETY PROGRAM ELEMENTS

- A. Design or Re-design Processes — When a new process is designed (or an existing process is modified), the organization will use information from both internal and external sources to reduce medical errors and incorporate this information into its design or re-design strategies.
- B. Identification of Potential Patient Safety Issues — As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care process that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus are processes identified through:
 - 1. A review of the literature.
 - 2. The organization's performance improvement program.
 - 3. Occurrence reports and sentinel events.
 - 4. The result of findings by regulatory and/or accrediting agencies.
 - 5. Patient Safety Organizations (PSO), including but not limited to Press Ganey, NQF,

- C. Performance Related to Patient Safety – Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.
1. Performance measurement data will be collected, aggregated, and analyzed as necessary to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.
- D. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).
- E. Proactive Risk Assessments – The organization is committed to utilizing proactive risk assessments to identify potential hazards, analyze their likelihood and impact, and develop strategies to prevent or mitigate harm before incidents occur.
- F. Reporting of process/system failure and/or medical/health care errors and response.
1. The organization is committed to responding to errors in care in a manner that supports the patient's rights, clinical needs, emotional needs, and protects the patient and others from any further risk. The facility will strive to preserve information critical to understanding the proximal and/or root cause of the error. The organization has established policies and procedures to address the following:
 - Medical/health errors and occurrences, including sentinel events, will be reported internally to the appropriate administrative or medical staff entity.
 - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
 - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.
 2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care team member(s) will:
 - Perform necessary interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary interventions to contain the risk as to not reach others
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;

- Preserve any information (including physical) or equipment related to the error. Examples of preservation of physical information are: removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluid bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record as appropriate to organizational policy and procedure;
 - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit an occurrence report in the occurrence reporting system (RLDatix).
 - Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Officer.
3. Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified.
 4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
 5. Supporting staff Involved in errors – An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
 - All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining individuals involved in errors and occurrences. A focus will be placed on remedial actions to ensure an appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
 - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission or the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting a safety or quality of care concern.
 - Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
 - a. Staff and leaders value transparency, accountability, and mutual

respect.

- b. Safety is everyone's first priority.
- c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction.
- d. Collective mindfulness is present, wherein staff realize that systems have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
- e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to, or enable, patient safety events. Staff know that their leaders will not focus on blaming providers involved in errors, but rather focus on the system issues that contributed to, or enabled, the patient safety event.
- f. By reporting and learning from patient safety events, staff create a learning organization.
 - The organization recognizes that individuals involved in an error may need emotional and psychological support. The organization has defined processes to assist employees and members of the Medical Staff.
 - a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
 - b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.

G. Educating the Patient on Error Prevention – The organization recognizes that the patient is an integral part of the healthcare team. Patients will be educated about their role and responsibility in preventing medical errors.

- 1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

H. Informing the Patient of Errors in Care – Patients, and when appropriate their families, are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from what was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.

I. Dissemination of Information – Lessons learned from root cause/comprehensive causative analysis, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

VII. PATIENT SAFETY PLAN MANAGEMENT

A. Patient Safety Program Resources

1. Designated resources have been provided to assist the organization in meeting the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management, Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
 - Human Resources
 - Employee Assistance Program
 - Clinical Social Work Department
 - Rights and Ethics Committee

B. Patient Safety Problem Identification, Notification & Resolution Process

1. When a situation occurs that may risk patient safety, SVHMC staff is requested to report unusual occurrences and/or unexpected events as outlined in the [ADVERSE EVENTS - REPORTABLE](#) Policy using any of the following reporting mechanisms:
 - Online Occurrence/Event Report or may elect to notify Administration directly.
 - a. Direct Notification can include:
 - Notification to Department manager/supervisor
 - Notification to the Patient Safety Officer
 - Notification to Administrative Supervisor
 - Notification to Quality, Risk, Infection Control
2. When a situation arises that requires immediate response to a patient safety event, the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. [DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY](#)

C. Patient Safety Program – SVHMC Staff & Medical Staff Education

1. SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
 - Posters in key locations.

- Medical Staff intranet portal.
 - Patient Safety on STARnet (<http://starnet/>)
 - Patient Safety Awareness Events.
 - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals, objectives, and accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
 3. Ongoing education is provided through various mechanisms such as but not limited to:
 - In-service training to increase knowledge of patient safety requirements
 - In-service training to encourage reporting of unanticipated adverse events and near-misses and in identifying patient safety events that should be reported.
 - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
 - Patient Safety Awareness activities.
 - Computer-based learning modules.

D. Patient Safety Program Patient & Community Education

1. Patients are given information about their rights and responsibilities while receiving services. Patients, and when appropriate their families, are informed about the outcomes of care, treatment and services, including unanticipated outcomes.
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

VIII. REFERENCES

- A. Center for Medicare Services (CMS) Conditions of Participation
- B. Joint Commission Sentinel Event Policy
- C. The Joint Commission Standards.
- D. To ERR is Human: Building a Safer Health System
- E. Crossing the Quality Chasm: A New Health System for the 21st Century
- F. OIG Report on Medical Error 12-00
- G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
- H. National Patient Safety Foundation

- I. The Just Culture Community, www.justculture.org
- J. California Senate Bill 1058, (Infection Control and Prevention)
- K. California Senate Bill 444 (Patient Safety Plan)
- L. Healthcare Performance Improvement (2011) The HPI SEC & SSER Patient Safety Measurement System for Healthcare. https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0008/569537/Known-Complications-HPI-White-Paper.pdf
- M. National Healthcare Safety Network – Patient Safety Structural Measures

Attachments

 [BETA 4.0 JC Algorithm-rv1.pdf](#)

Approval Signatures

Step Description	Approver	Date
Standards		

No standards are associated with this document

*PERSONNEL, PENSION & INVESTMENT
COMMITTEE*

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

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

(CATHERINE CARSON)

SVH Board Paper

Agenda Item: **Consider for Approval Findings By the Board Supporting Recruitment of Physicians to Salinas Valley Emergency Medical Group and Approval of Recruitment Incentives**

Executive Sponsor: Tim Albert, MD, MHCM, Chief Clinical Officer
Molly Heacox, Director Clinic Services

Date: October 12, 2026

Executive Summary

In consultation with members of the Salinas Valley Health (SVH) medical staff, and in compliance with requirements of Stark Law, SVH executive leadership has identified the recruitment of **emergency medicine** physicians as a recruiting priority for the hospital's service area.

Recruitment for the hospital-based specialty of emergency medicine is evaluated based on the needs of the hospital to ensure appropriate levels of coverage to meet patient care needs. Service line volumes and program coverage needs are the primary drivers of recruitment to these specialties.

To support physician recruitment to the District's service area, SVH collaborates with local, independent medical groups in the recruiting process through contributions of recruitment incentives paid to physicians that relocate to our community to practice at SVH. Salinas Valley Emergency Medical Group (SVEMG), the hospital-based emergency medicine group that exclusively covers the SVH Medical Center Emergency Department, has requested assistance from SVH in the form of recruitment incentives for three physicians to join the group.

Recruitment Incentive

The proposed physician recruitment support requires the execution of a three-party Recruitment Agreement for each recruited physician with standard terms and conditions which provide for a recruitment incentive in the amount of \$25,000 to each recruited physician, structured as a forgivable loan over two years of service at SVH.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of emergency medicine physicians is aligned with our strategic priority for growth. SVH continues to support community physician groups that provide care to our patients in the hospital. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by increasing access to necessary care.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of emergency medicine physicians at SVH has been identified as a need for recruitment and demonstrates the support from SVH to private medical groups. The recruitment incentives proposed for these recruitments are within fair market value and are commercially reasonable.

Recommendation

Administration requests that the SVH Board of Directors take the following actions:

- (i) Make the following findings supporting the recruitment of emergency medicine physicians:**
 - **The assistance by SVH in the recruitment of emergency medicine physicians is in the best interest of the public health of the communities served by the District; and**
 - **The recruitment incentives requested are necessary in order to attract and relocate appropriately qualified physicians to practice in the communities served by the District.**
- (ii) Approve the recruitment incentives for emergency medicine physicians in the amount of \$25,000 for each physician up to a maximum of three recruited physicians to be set forth in Recruitment Agreements among SVH, SVEMG, and each physician.**

Attachments: None

FINANCE COMMITTEE

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

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

(VICTOR REY, JR.)

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval to Incremental funding in conjunction with the Emergency Department and Hospital Expansion Project**

Executive Sponsor: Clement Miller, Chief Operating Officer
Brad McCoy, Vice President – Construction, Real Estate & Facilities

Date: October 6, 2026

Executive Summary

Salinas Valley Health is pursuing a revised Master Plan that accomplishes replacement of the Emergency Department, increases Parking Infrastructure and optimizes the Campus Site circulation, and reconfigures the Perioperative Department in the areas decanted by the existing Emergency Department as a final phase. Significant renovations to Medical Center on-site and off-site Energy and Civil infrastructure are anticipated to support the new building expansion.

Background/Situation/Rationale

Project funding in the amount of \$2,356,742 has been previously authorized to cover fiscal year 2026, with the majority of that funding directed to the engagement of the architectural firm HDR and their subconsultants to produce preliminary studies and schematic design "Bridging Documents." That work will achieve substantial completion over the new few months and the next phase of work, involving jurisdictional entitlements, procurement of a design-build team, and preparation of construction documentation needed to secure construction permits is ready to commence.

SVH Administration requests board approval of incremental funding in the amount of an additional \$6,500,000 for fiscal year 2027, bringing the total committed funding level to \$8,856,742. These funds will be used for further design development and bridging documents, entitlement costs, permit fees, bidding, supervision and project management expenses. The requested amount is consistent with the overall 2027 Board approved capital budget produced and presented to the Board during the July 2026 meeting. Future incremental budget requests will be made to align with yearly capital budgets and as the overall project budget is finalized. Other ancillary Master Plan project components will secure separate funding in subsequent requests for Board action. This request is limited to funding of expenses specific to the Emergency Department Expansion building.

Timeline/Review Process to Date

Project Program Definition & Schematic Design	Dec. 2025 - Dec. 2026
Design/Build Team Selection & Permit Plans	Dec. 2026 – Dec. 2027
City & State Entitlements & Permitting	Sept. 2026 – Dec. 2028
'Make Ready' precursor moves & site preparations	April 2027 – July 2028

Pillar/Goal Alignment

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

Financial/Quality/Safety/Regulatory Implications

Budget Summary	
1. Amount of current request	\$6,500,000
2. Amount previously approved	\$2,356,742
3. Total	\$8,856,742
4. Budgeted ?	Yes. FY2027 Capital Plan

Recommendation

SVH Administration requests that the SVH Finance Committee recommend to the SVH Board of Directors to approve incremental Project Funding for costs associated with the Emergency Department and Hospital Expansion project, in the amount of \$6,500,000 for a revised total budget amount of \$8,856,742.

Finance Committee Board Paper

Agenda Item: **Consider recommendation for Board Approval of incremental funding and award of elevator modernization contract to TK Elevator for 1188 Padre renovations.**

Executive Sponsors: Clement Miller, COO
Brad McCoy, VP Facilities, Construction, Real Estate

Date: October 6, 2026

Executive Summary

Salinas Valley Health acquired 1188 Padre Ln as part of a broader strategic initiative to relocate non-clinical functions, thereby enabling the Emergency Department and Hospital Expansion, conversion of 611 Abbott 2nd Floor into Clinic Space and other opportunities to eliminate and consolidate external leases. This request supports the renovation of 1188 Padre, which is currently a multi-tenant space, into a future state configured solely for Salinas Valley Health’s use.

Timeline

- February 2027 – Project budget approval and award of construction contract
- April 2027 – Start of construction
- August 2027 – Occupancy of 1188 Padre

Meeting our Mission, Vision, Goals—Strategic Plan Alignment

Renovation of 1188 Padre is a key enabling project for several master plan initiatives: the Emergency Department and Hospital Expansion and the 611 Abbott Second Floor Clinic and other future space planning needs.

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

Financial/Quality/Safety/Regulatory Implications

The request for \$2,000,000 in incremental funding provides for early demolition, assessment of existing conditions, surveying hazardous materials and abatement, design & engineering services through permitting and procurement of long-lead items. The request also seeks award of a contract to TK Elevator (Thyssenkrupp Elevator) to modernize the existing elevator to meet current safety standards and replace end-of-life equipment that is 42 years old. Awarding the elevator equipment contract now will allow the elevator modernization to be completed prior to SVH taking occupancy of the building. The SVH Administration will return to the Board with a second request to approve the full project budget and award the construction contract after the design and engineering has been completed.

Budget Summary	
1. Amount of current request	\$2,000,000
2. Amount previously approved	\$125,000
3. Total	\$2,125,000
4. Budgeted	Yes. FY2027 Capital Plan

TK Elevator	
1. One Time Cost	\$397,000
2. Payment Terms	55% due at contract execution, 20% due at delivery of materials, balance due on a progress of completion basis.
3. Warranty	1-year parts and labor warranty.
4. Service Agreement	Does not amend service agreement currently in place.

Recommendation

SVH Administration requests that the Finance Committee recommend that the SVH Board of Directors to (i) approve \$2,000,000 in incremental funding for the 1188 Padre renovation, an enabling project for the Emergency Department and Hospital Expansion, and the 611 Abbott 2nd Floor Clinic Renovation, and (ii) award the elevator modernization contract to TK Elevator in the amount of \$397,000.00 pending final negotiations.

Attachments

- A. TK Elevator Contract (Draft format pending review with Contracts)

MODERNIZATION PROPOSAL



Modernization Proposal



October 06, 2026

1188 Padre Dr. Salinas

Purchaser: SALINAS VALLEY
MEMORIAL HEALTHCARE
SYS

Address: PO BOX 3827
SALINAS, CA 93912-3827

Project 1188 Padre Dr.

Location:

Address: 1188 PADRE DR
SALINAS, CA 93901

TK Elevator Corporation (hereinafter "TK Elevator") is dedicated to delivering SALINAS VALLEY MEMORIAL HEALTHCARE SYS (hereinafter "Purchaser") the safest, highest quality vertical transportation solutions. I am pleased to present this customized Proposal (the "Proposal") in the amount of **\$397,000.00** inclusive of all applicable sales and use taxes to modernize the elevator equipment described in the pages that follow at the above-referenced location.

Our modernization package is engineered specifically for your elevator system and will include the elevator mechanical and electrical components being replaced, refurbished or retained.

Benefits of Modernization include:

- Increased durability and reliability
- Improved fire and life safety features
- Decreased waiting times
- Reduced energy consumption
- Reduced operational cost
- Reduced troubleshooting time

The price above includes those value added taxes, tariffs, duties, and/or similar charges that are in effect as of the date of this proposal. The price of this Proposal is subject to escalation - even after Purchaser's acceptance of this Proposal - under certain circumstances including any new or increase in taxes, tariffs, or other charges imposed by applicable governmental authorities and/or TK Elevator being subjected to increased charges by its suppliers, shippers and/or freight forwarders as set forth in the terms and conditions in this Proposal.

Furthermore, all preparatory work by other trades must be completed and elevator equipment shipped by 12-29-2026 and the installation must be completed by 01-06-2028, otherwise, the price is also subject to increase.

If not accepted within twenty-one (21) calendar days of the date of this Proposal or the date presented to Purchaser, this Proposal shall automatically be revoked and shall be null and void.

In the event you have any questions regarding the content of this Proposal please contact me at -

We appreciate your consideration.

Regards,

Matthew Schmid

Matthew Schmid
TK Elevator Corporation
14400 Catalina Str
San Leandro, CA 94577
matt.schmid@tkelevator.com | -

SCOPE OF WORK

Building : 1188 PADRE
DR

Groups Included

Group Name	# of units	Equipment Type
1	1	Hydraulic

Group : 1
Equipment Classification: Hydraulic

Units Included

Nickname	State ID	Product	Landings	Speed	Capacity
1	69615	H-Power	3 / 0 / 0	125	2500

Modernization Proposal



Description of Work

Controller

Item Description	Option	Installed On
TAC 32H Controller (Includes Options listed below) 24 VDC Signal Voltage - Electronic Door Detector Interface	New	1
eMax Monitoring Device Provisions	New	1
Solid State Starters (6 or 12 leads) 460 / 575 VAC	New	1
Viscosity Control (Required over 150 FPM)	New	1
Battery Lowering in Controller (10-D-0C)	New	1
Seismic Features	New	1
Tenant Security 3-1 (Card Reader)	New	1
eMax	New	1
THY Board / CE Driver Board	New	1
Position Indicator	New	1
MAX Link 2-Line ATA kit	New	1
Auto Fan Light Shutdown (Sleep Mode)	New	1
Car Riding Lantern	New	1
Fire Service	New	1
Hall Lanterns	New	1
Hoistway Access	New	1
Door Operator Controls	New	1
User Interface Tool	New	1
Hoistway Enable/Inspection Operation	New	1
Independent Service	New	1

Power Unit

Item Description	Option	Installed On
EP-80 Power Unit (Submersible)	New	1
Seismic Requirements for EP units	New	1
Viscosity Control (Required over 150 FPM)	New	1
5 gallon drum of Biodegradable oil (Citgo NZ)	New	1
55 gallon drum of Biodegradable oil (Citgo NZ)	New	1
2" Shutoff Valve Kit (Pump)	New	1
Isolation Couplings	New	1
Overspeed Valve Kit for 2" (less than 150 GPM)	New	1

Modernization Proposal



Jack

Item Description	Option	Installed On
3-S Jack (Standard Wall)	New	1
3-S Jack Joint(s)	New	1
PVC for 3-S Jack with Moisture Sensor (Complete Enclosed System)	New	1
Pit Mounting Channels	New	1
Pipe Stands	New	1
Packing	New	1

Pit Equipment

Item Description	Option	Installed On
Spring Buffer Model 6M (pair) (Max Gross Load 6000 lbs)	New	1
2" Shutoff Valve Kit (Pit)	New	1
Pit Stop Switch	New	1

Hoistway Equipment

Item Description	Option	Installed On
Steel Tape with Mounting hardware, Selector and magnets (terminal limits included)	New	1
TAC 32 Field Friendly Wiring Package Includes single traveling cable, hoistway wiring, interlock wiring, interlock connectors, and serial wiring.	New	1
HN Boxes (per each 2 cars, grouped)	New	1
Additional Hoistway Wiring for TAC 32 with Remote Machine Room	New	1

Car

Item Description	Option	Installed On
Car Top Inspection Station (Stand Alone)	New	1
Retainer Plates for Seismic (T Rails) for TKE or Elscot guides only	New	1
Fan: Two Speed	New	1
21" Toe guard	New	1
Guide shoe mounting plates (set of 4 - only with shoe purchase from tkE)	New	1
Cab Wiring Material (200MK1)	New	1
5 Pin Lock with electric contact for Car Top Exit	New	1
4" Car Roller Guides (set of 4)	New	1

Cab

Item Description	Option	Installed On
Car Door (SSSS, #4 S/S (441))	New	1
Interior	New	1

Car Door Equipment

Item Description	Option	Installed On
Micro Light (Front)	New	1
Door Operator	New	1

Modernization Proposal



Hoistway Door Equipment

Item Description	Option	Installed On
Other Vendor Hoistway Door Equipment Costs	New	1
Closer	New	1
Interlocks	New	1
Pick Up Rollers	New	1
Retain Hoistway Doors	Retain	1

Car Fixtures

Item Description	Option	Installed On
Main Car Station Includes Options Below	New	1
• Applied Panel	New	1
Vandal Resistant Floor Buttons	New	1
Cast Braille Plates for Car Features	New	1
Emergency Stop Switch, Alarm and Door Open/Close Buttons (in locked compartment)	New	1
Fan Keyswitch (two speed) (in locked compartment)	New	1
Emergency Light mounted in COP	New	1
2004 and later Fire Service Phase II Features (includes instructions signage)	New	1
Handicap Signal (Passing signal)	New	1
Position Indicator (2" CE Segmented)	New	1
Hoistway Enable (in locked compartment)	New	1
ADA Phone System integral with COP (Rath)	New	1
Speaker Pattern for Intercom System/ADA Phone	New	1
Locked Service Cabinet	New	1
Certificate Window	New	1
Light Keyswitch (in locked compartment)	New	1
#4 Stainless Steel Finish (441)	New	1
Independent Service (in locked compartment)	New	1
Car Riding Lantern (Standard) #4 S/S (441)	New	1

Modernization Proposal



Hall Fixtures

Item Description	Option	Installed On
Terminal Hall Stations (Surface Mounted) with - Appendix O (Polycarbonate insert flame) (#4 S/S (441))	New	1
Hoistway Access Switch in Hall Stations	New	1
Hoistway Jamb Braille (Pair of Standard) (# of Floors)	New	1
Intermediate Hall Stations (Surface Mounted) with - Appendix O (Polycarbonate insert flame) (#4 S/S (441))	New	1
Serial Boards for Hoistway Access	New	1
Serial Boards for Hall Lanterns/PIs	New	1
Serial Boards for Front Risers	New	1
TAC Serial Boards, Base Charge	New	1
Horizontal Combination Hall Lantern and 2" Digital Hall Position Indicator (Standard) White Up/Down LEDs #4 S/S (441)	New	1
Standalone Fire Service Phase I with Plastic Instructions #4 S/S (441)	New	1

Clarifications to Architectural Plans and Specifications:

Logistical Plan: Any required deviation from the stated logistical plan will be submitted as a change order to the project agreement.

1. Material Movement: TK Elevator shall deliver materials to the building during normal business hours.
2. Storage: The Purchaser agrees to provide adequate, dry, and secure storage of the vertical transportation equipment at the time of delivery including adequate ingress and egress to the area. Any relocation of the equipment as directed by the Purchaser after its initial delivery will be at Purchaser's expense. In addition, should a separate storage container be required, the purchaser will arrange for the delivery, placement and cost of the storage container unless otherwise clarified. Moreover, should a project be delayed not by the fault of TK Elevator, additional storage fees may apply depending on the time frame of such delay.
3. Parking: Purchaser shall provide a minimum of two (2) onsite parking spaces capable of accommodating standard work trucks at no cost to TK Elevator.
4. Working Hours: All work specified herein, including testing, painting, as well as inspections, will be performed from 6:00 AM to 2:30 PM, except scheduled union holidays ("regular working hours of regular working days") -- Monday through Friday. If, after the execution of the project agreement, overtime is mutually agreed upon, an additional charge at TK Elevator's usual rates for such work shall be added to the price of the project.
5. Barricades: TK Elevator will provide its standard OSHA-compliant barricades for all working areas accessible to the public. Should the Purchaser require custom barricades be provided, additional cost based on the required design will be submitted as a change order to the project agreement.
6. The Owner shall provide an onsite restroom for the use of TK Elevator and any subcontractors. If one is not provided, a change order will be provided for a portable restroom.

Modernization Proposal



7. This bid does not include cutting and patching of walls or floors.

Related Work by Others

1. This bid includes a \$70,000 allowance for related electrical and fire/life/safety work by others. Once a proposal is received, TKE will provide updated costs.
 2. This bid includes the related drilling scope detailed in Exhibit A.
 3. This bid includes the related cab interior scope detailed in Exhibit B and C.
- If any additional work is required a change order will be provided.

Additional Items

1. We have included provisions for security devices. Any card readers or cameras are to be provided by the Owner. Any additional time needed to program/test devices will be provided as a change order.
2. Feedline for electrical wiring and hydraulic fluid will be retained and reused.

Jack Replacement

The hydraulic jack replacement "rock clause" applies:

- i. Adequate ingress and egress, including ramping, for a truck-mounted drill rig.
- ii. In-ground protection systems other than TK Elevator's standard HDPE or PVC protection system with bottomless corrugated steel casing.
- iii. Any required trenching and backfilling for underground piping or casings, and conduit as well as any compaction, grouting, and waterproofing of block-out.
- iv. Engineering, provision and installation of methane barriers or coordination/access.
- v. TK Elevator has been contracted to re-drill the elevator hole(s) based on drilling the hole under typical conditions with standard equipment, encountering soil free from rock, boulders, building construction members, sand, water, quicksand, underground caves or any other obstruction or unusual condition. If such an obstruction or unusual condition is encountered, the price shall be increased by the amount of the additional labor at TK Elevator's usual billing rates, and the cost of any additional material or equipment. Removal of spoils from the job site is included in this bid. Included in our bid is 10 barrels on site before scheduling of work to be completed. If additional barrels are needed, will advise customer. Our price includes 40 hours for removal of the existing cylinder. Should we encounter any problems; the Owner will be billed at \$810.00 per hour plus any and all equipment and materials used to remove the cylinder. Our price includes 24 hours on-site for cleaning out the jack hole. Should unforeseen conditions require additional labor and materials, Owner will be billed at \$595 per hour plus materials.
- vi. Purchaser agrees to provide a safe, accessible storage area for placement of D.O.T. 55 Gallon containers for the purpose of spoils containment. Any spoils or water testing by others or delays due to such testing are not included in this proposal. The hiring of a disposal company is the responsibility of Purchaser, and MUST be discussed prior to any material being ordered or work being scheduled. TK assumes no responsibility and/or liability in any way whatsoever for spoils or other contamination that may be present as a result of the cylinder breach and/or other conditions present on the work site.

Modernization Proposal



vii. For the purpose of providing this estimate, we assume no unusual conditions as outlined in Items above. If necessitated by unusual conditions, a proposal for additional labor and materials shall be submitted to Purchaser for approval prior to performance of additional work. TK shall not be responsible for delays due to such causes.

viii. Purchaser will be notified immediately of any circumstances that will require more than the allotted time and materials provided in this proposal. Written authorization will be required for any labor or materials required beyond this original proposal amount.

ix. The hiring of a disposal company which MUST be discussed prior to any material being ordered or work being scheduled. TK Elevator will provide environmental services ONLY if this is specifically included under the "Scope of Work" section above. TK Elevator assumes no responsibility and/or liability in any way whatsoever for spoils or other contamination that may be present as a result of the cylinder breach and/or other conditions present on the work site. Moreover; the purchaser will be required to provide the proper EPA number for handling and disposing any spoils from the project.

01

Key Tasks and Approximate Lead Times

Approximate Durations/Lead Times	
Contract execution (can run concurrently with layout drawing package preparation and approval)	TBD by Purchaser
Survey and Order of Materials (additional time required for cab, signal, entrance preparation and approval, if applicable)	2 - 4 Weeks
Fabrication time (from receipt of all approvals, fully executed contract, Material Release Form* and initial progress payment)	6 Weeks
Shipping: (Tennessee to local distribution center)	2 Weeks
Modernization of elevator system (Per Unit): (Upon completion of all required preparatory work by others and the signed pre-installation checklist + state insp)	9 - 11 Weeks
*If equipment is delivered to TKE's staging facility in accordance with the date shown on the TKE Material Release Form, and the preparatory work required by other trades is not completed, all storage charges as a result of site delays are to be paid by the Purchaser based on the storage rates noted below in this proposal.	

The durations or lead times listed above are strictly approximations that can vary due to factors both within and outside of TK Elevator's control, are subject to change without notice to Purchaser and shall not be binding on TK Elevator.

02

Payment of Work

- 55% of the price set forth in this Proposal as modified by options selected from the section entitled "Value Engineering Opportunities & Alternates" (if applicable) will be due and payable as an initial progress payment within 30 days from TK Elevator's receipt of a fully executed copy of this Proposal. This initial progress payment will be applied to project management, permits, engineering and shop drawings, submittals, drilling mobilizations (if required) and raw material procurement. Material will be ordered once this payment is received and the parties have both executed this Proposal and the Material Release Form.
- 20% of the price set forth in this Proposal as modified by options selected from the section entitled "Value Engineering Opportunities & Alternates" (if applicable) shall be due and payable when the material described above has been furnished. Material is considered furnished when it has been received at the jobsite or TK Elevator staging facility. Supporting documentation of materials stored shall be limited to stored materials certificates of insurance and bills of lading. Pictures will not be provided. Receipt of this payment is required prior to mobilization of labor.
- 25% of the price set forth in this Proposal shall be made as progress payments throughout the life of the project. In the event TK Elevator fails to receive payment within thirty (30) days of the date of a corresponding invoice, TK Elevator reserves the right to demobilize until such a time that the payments have been brought up to date, and TK Elevator has the available manpower.

It is agreed that there will be no withholding of retainage from any billing and by the customer from any payment.

The payment terms breakdown above shall be considered the Schedule of Values for the project as written. Billing shall be submitted on or before the 25th day of the month according to the payment schedule above and accompanied by a form of G702-703 pay application/schedule of values and a conditional waiver, the format of which is hereby acknowledged and accepted.

The use of online Portals for the submission of billing shall follow the terms of the Proposal and Purchaser agrees to permit billing in accordance with the executed contract terms. Portal access and usage is to be provided free of

Modernization Proposal



additional charge to TK Elevator and any additional cost for such use is to be reimbursed to TK Elevator via a reimbursable change order immediately upon acceptance.

Purchaser agrees that TK Elevator shall have no obligation to complete any steps necessary to provide Purchaser with full use and operation of the installed equipment until such time as TK Elevator has been paid 100% both of the price reflected in this Proposal and for any other work performed by TK Elevator or its subcontractors in furtherance of this Proposal. Purchaser agrees to waive any and all claims to the turnover and/or use of that equipment until such time as those amounts are paid in full.

Proposal price:		\$397,000.00
Initial progress payment:	(55%)	\$218,350.00
Material furnished:	(20%)	\$79,400.00
Total of remaining progress payments:	(25%)	\$99,250.00

Purchaser may elect to finance all or a portion of the purchase price for the work described in this Agreement through TK Elevator's financing partner ("Financing Partner"), subject to the Financing Partner's approval and the terms of a separate financing agreement ("Financing Agreement") between Purchaser and Financing Partner. Purchaser acknowledges and agrees that [(i) Financing Partner is in no way affiliated with TK Elevator, (ii) Financing Partner will make any decision to offer financing to Purchaser independently and in accordance with its internal lending policies, (iii) TK Elevator cannot guaranty that Financing Partner will agree to provide financing to Purchaser on acceptable terms or at all, (iv) TK Elevator may be compensated by the Financing Partner in the event Purchaser enters into a Financing Agreement, and TK Elevator will not be a party to the Financing Agreement and shall have no responsibility for, and hereby expressly disclaims any liability arising out of or relating to, any decision on the part of Financing Partner to provide or decline to provide financing to Purchaser, and the negotiation, execution, performance, enforcement, or termination of any Financing Agreement. Purchaser acknowledges and agrees that Purchaser shall remain unconditionally and irrevocably liable to TK Elevator for any unpaid balance owing hereunder and TK Elevator's acceptance of the Financing Partner as a payment source shall not constitute a novation, satisfaction, waiver, or release of Purchaser's payment obligations under this Agreement.

Notwithstanding the foregoing, in the event Purchaser enters into a Financing Agreement with the Financing Partner and the Financing Partner fails or refuses to disburse any portion of the purchase price to TK Elevator for any reason, including without limitation default by either party under the Financing Agreement, bankruptcy or insolvency of either party, or termination of the Financing Agreement for any reason any unpaid purchase price then owing by Purchaser which shall be payable immediately by Purchaser upon demand by TK Elevator in accordance with this Agreement. Purchaser hereby waives any right of setoff, counterclaim, defense, or deduction against TK Elevator based on any act or omission of the Financing Partner. Purchaser further agrees that any assignment by TK Elevator to the Financing Partner of the right to receive payment hereunder shall not impair TK Elevator's rights or remedies in the event of nonpayment. The obligations of Purchaser under this paragraph shall survive any termination, cancellation, or expiration of this Agreement.

Any work that Purchaser may require prior to turnover of the equipment that is outside of the scope described in this Proposal - other than Temporary Use as described below - will be performed only after the full execution of a mutually agreeable change order and only at the following rates:

Mechanic (Standard) per hour	\$450.06
Mechanic (OT) per hour	\$742.50
Team (Standard) per hour	\$810.10
Team (OT) per hour	\$1,335.66

Rates are not inclusive of any per diem, mileage or other expenses which may be dependent on jobsite location and are valid until 01-06-2028 .

Modernization Proposal



03 Warranty

TK Elevator warrants any equipment it installs as described in this Proposal against defects in material and workmanship for a period of one (1) year from the date of Purchaser's execution of TK Elevator's "Final Acceptance Form" on the express conditions that all payments made under this Proposal and any mutually agreed-to change orders have been made in full and that such equipment is currently being serviced by TK Elevator. In the event that TK Elevator's work is delayed for a period greater than six (6) months, the warranty shall be reduced by the amount of the delay. This warranty is in lieu of any other warranty or liability for defects. TK Elevator makes no warranty of merchantability and no warranties which extend beyond the description in this Proposal, nor are there any other warranties, expressed or implied, by operation of law or otherwise. Like any piece of fine machinery, the equipment described in this Proposal should be periodically inspected, lubricated, and adjusted by competent personnel. This warranty is not intended to supplant normal maintenance service and shall not be construed to mean that TK Elevator will provide free service for periodic examination, lubrication, or adjustment, nor will TK Elevator correct, without a charge, breakage, maladjustments, or other trouble arising from normal wear and tear or abuse, misuse, improper or inadequate maintenance, or any other causes other than defective material or workmanship. In order to make a warranty claim, Purchaser must give TK Elevator prompt written notice at the address listed on the cover page of this Proposal and provided all payments due under the terms of this Proposal and any mutually agreed to written change orders have been made in full, TK Elevator shall, at its own expense, correct any proven defect by repair or replacement. TK Elevator will not, under any circumstances, reimburse Purchaser for cost of work done by others, nor shall TK Elevator be responsible for the performance of any equipment that has been the subject of service, repair, replacement, revisions or alterations by others. The Purchaser agrees to provide us access to the elevator equipment at any reasonable time for the purpose of making good this warranty. Purchaser and/or Owner agree to maintain the confidentiality of the TK Elevator's software that is licensed for the Owner's use. The software will not be copied, modified, distributed, or reverse engineered. The software is licensed to the Purchaser and/or Owner exclusively for the location of installation, and the license will not transfer except as part of a transfer, assumption, or succession of ownership. If there is more than one (1) unit which is the subject of work described in this Proposal, this section shall apply separately to each unit as accepted.

04 Preventative Maintenance Program

This Proposal does not include any maintenance, service, repair or replacement of the equipment or any other work not expressly described herein. TK Elevator may submit a separate proposal to Purchaser covering the maintenance and repair of this equipment to be supplied to Purchaser at an additional cost. In the event the Purchaser and TK Elevator have a new or existing maintenance Agreement in effect at the time of the acceptance of this proposal and/or during the scope of this work, the terms of the Agreement shall remain in full force and effect throughout the performance of this scope of work and continue throughout the duration of the stated term in that Agreement.

05 TKE Digital

The cost of TK Elevator digital hardware is included in the price of this Proposal. Activation of the digital service package(s) listed below, as outlined in the attached Service Agreement Addendum(s), are contingent on Purchaser's (or Owner's, as applicable) signed acceptance of these Addendum(s) which includes both pricing and scope for such digital service(s).

MAX

MAX is a cloud based Internet of Things (IoT) platform that we, at our election, may connect to your elevators by means of installing a remote-monitoring device or modem (each a "device"). MAX will analyze the unique signal

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output of your equipment 24/7 and when existing or potential outages are identified, MAX will automatically communicate with our dispatch centers. With an eligible MAX digital service, our dispatch center will alert our technicians through a generated service ticket during normal working hours. These MAX alerts provide the technician with precise diagnostics detail, which greatly enhances our ability to fix your equipment right the first time, MAXimizing the equipment uptime.

- a. Purchaser authorizes TK Elevator and its employees to access purchaser's premises to install, maintain and/or repair the devices and, upon termination of the service agreement, to remove the same from the premises if we elect to remove.
- b. TK Elevator is and shall remain the sole owner of the devices and the data communicated to us by the devices. The devices shall not become fixtures and are intended to reside where they are installed. TK Elevator may remove the devices and cease all data collection and analysis at any time.
- c. If the service agreement between TK Elevator and Purchaser is terminated for any reason, TK Elevator will automatically deactivate the data collection, terminate the device software and all raw data previously received from the device will be removed and/or expunged or destroyed.
- d. Purchaser consents to the installation of the devices in your elevators and to the collection, maintenance, use, expungement and destruction of the daily elevator data as set forth in this agreement.
- e. The devices installed by TK Elevator contain trade secrets belonging to us and are installed for the use and benefit of our personnel only.
- f. Purchaser agrees not to permit purchaser personnel or any third parties to use, access, tamper with, relocate, copy, disclose, alter, destroy, disassemble or reverse engineer the device while it is located on purchaser's premises.
- g. The installation of this equipment shall not confer any rights or operate as an assignment or license to you of any patents, copyrights or trade secrets with respect to the equipment and/or any software contained or imbedded therein or utilized in connection with the collection, monitoring and/or analysis of data.

MAX Link

"MAX Link" is a service by which TK Elevator will provide eligible Units, through a MAX Device, a cellular connection as outlined in the attached Service Agreement Addendum entitled "TK Elevator Communications."

Multimedia Monitoring Service

The latest versions of both ASME A17.1 and the International Building Code now require the Purchaser to have video and text messaging capabilities added within the elevator cab for all elevators. TK Elevator's Multimedia Monitoring Service satisfies the Purchaser's obligation to meet these new code requirements as outlined in the attached Service Agreement Addendum entitled "TK Elevator Communications."

06 Work Not Included

There are certain items that are not included in this Proposal, many of which must be completed by Purchaser prior to and as a condition precedent to TK Elevator's performance of its work as described in this Proposal. In order to ensure a successful completion of this project, it shall be solely Purchaser's responsibility to coordinate its own completion of those items with TK Elevator. The following is a list of those items that are not included in this Proposal:

A. Hoistways and Equipment Rooms

- Purchaser shall provide the following
 - A dry legal hoistway, properly framed and enclosed, and including a pit of proper depth and overhead. This is to include steel hoist beam, inspection or access platforms, access doors, sump pump, lights, waterproofing and venting as required; dewatering of pit(s) and required permanent screening.
 - A dry legal machine/control room, with clear rollable access adequate for the elevator equipment, including floors, trap doors, properly sized legal machine room doors, gratings, machine room or roof access platforms, roof/loading protection, ladders, railings, foundations, all hoist beams, lighting, ventilation sized per the TK Elevator shop drawings and/or code requirements. Purchaser must maintain machine/control room (or

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machine/control space within the shaft for MRL equipment) temperature between 55 and 90 degrees Fahrenheit, with relative humidity less than 95% non-condensing at all times.

- Adequate bracing of entrance frames to prevent distortion during wall construction.
- All grouting, fire caulking, cutting, x-ray and removal of walls and floors, patching, coring, setting of sleeves/knockouts, penetrations and painting (except as specified) and removal of obstructions required for elevator work; along with all proper trenching and backfilling for any underground piping and/or conduit.
- All labor and materials necessary to support the full width of the hoistway at each landing for anchoring or welding TK Elevator sill supports, steel angles, sill recesses;
- The furnishing, installing and maintaining of the required fire rating of elevator hoistway walls, including the penetration of firewall by elevator fixture boxes;
- Ensuring that the elevator hoistways and pits are dewatered, cleaned and properly waterproofed;
- TK Elevator is not responsible for verifying field dimensions or related work by others. Purchaser must verify all dimensions on the submittal drawings prior to equipment fabrication.

B. Electrical and Life Safety - Refer to Allowance for Electrical Fire/Life/Safety:

- Purchaser shall provide a 120V, 1P, 60C power supply in the locations as directed by TK Elevator for the cellular equipment being furnished and installed by TK Elevator for the communication devices within the elevator cab;
- Purchaser shall provide:
 - permanent 3-phase power with suitable connections from the power main to each controller and signal equipment feeders as required, including necessary circuit breakers and fused mainline disconnect switches per N.E.C. prior to installation. Permanent 3-phase power supply capable of operating the new elevator equipment under all conditions, no generator power, or manufactured power, will be acceptable;
 - piping and wiring to controller for mainline power, car lighting, and any other building systems that interface with the elevator controls per N.E.C. Articles 620-22 and 620-51;
 - any required hoistway / wellway, machine room, pit lighting and/or 110v GFCI service outlets;
 - conduit and wiring for remote panels to the Unit machine room(s) and between panels. Remote panels required by local jurisdictions are not included in this proposal;
 - a bonded ground wire, properly sized, from the Unit controller(s) to the primary building ground; and all remote wiring to the outside alarm bell as requested by all applicable code provisions;
 - installed sprinklers, smoke/heat detectors on each floor, machine room and hoistways / wellways, shunt trip devices (not self-resetting) and access panels as may be required as well as normally open dry contacts for smoke/heat sensors, which shall be terminated by Purchaser at a properly marked terminal in the Unit controller;
 - a means to automatically disconnect the main line and the emergency power supply to the unit prior to the application of water in the Unit machine room that shall not be self-resetting;
 - emergency power supply including automatic time delay transfer switch and auxiliary contacts with wiring to the designated Unit controller and along with electrical cross connections between elevator machine rooms for emergency power purposes;
 - the following emergency power provisions are not included: interface in controller, pre-testing and testing, emergency power keyswitches;
 - emergency power operation is included as part of the design of the Unit control system and based on each car in the group only, to properly sequence, one at a time to the programmed landing, and park. The design requires that the generator, transfer switch, and related circuitry are sufficient to run this function or any other function for any building other system that is associated with this project. In the event that the generator, transfer switch, and related circuitry are not sufficient, TK Elevator will provide Purchaser with a written change order for Purchaser's execution.
 - a dry set of contacts which close 20 seconds prior to the transfer from normal power to emergency power or from emergency power to normal power whether in test mode or normal operating conditions in the event that an emergency power supply will be provided for the Unit;
 - confirmation that the emergency standby power generator and/or building can accept the power generated to and from the Unit during both Hi-Speed and Deceleration. In cases where the generator and/or building load is not electrically sized to handle the power return from the regen drive, additional separate chopper and resistor units are available for purchase but not included in this proposal. The additional chopper and resistor units allow regenerated power to be dissipated in the resistor bank and not sent back into the building grid.

C. Miscellaneous:

- Purchaser shall provide all work relating to the finished flooring including, but not limited to, the provision of materials and its installation to comply with all applicable codes;
- Hydraulic jack replacement Refer to Exhibit A:
 - the excavation of the elevator cylinder well hole in the event drilling is necessary through soil that is not free from rock, sand, water, building construction members and obstructions. Should obstructions be encountered, TK Elevator will proceed only after written authorization has been received from the Purchaser. The contract price

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shall be increased by the amount of additional labor at TK Elevator's standard labor rates as per the local office along with any additional expenses and materials required;

- adequate ingress and egress, including ramping, for rail-mounted or truck-mounted drill rig;
- Purchaser is responsible for pumping truck contractor to remove and dispose of spoils from the site. In the event that unforeseen and unfavorable below ground conditions are encountered, including but not limited to concrete around the cylinder, construction debris, adverse water and/or soil conditions, erosion, cavitations, oil contamination, or circumstances necessitating increased hole depth, etc., which require the employment of specialized contractors, TK Elevator shall immediately advise the Purchaser and costs will be extra to the contract;
- in ground protection systems other than TK Elevator's standard HDPE or PVC protection system with bottomless corrugated steel casing;
- any required trenching and back filling for underground piping or casings, and conduit as well as any compaction, grouting, and waterproofing of block-out;
- engineering, provision and installation of methane barriers or coordination/access;
- a safe, accessible storage area for placement of D.O.T. 55 gallon containers for the purpose of spoils containment; obtaining of local environmental or disposal permits
- any spoils or water testing;

07 Working Hours, Logistics and Mobilization

- All work described in this Proposal shall be performed during TK Elevator's regular working days – defined as Monday thru Friday and excluding IUEC recognized holidays – and regular working hours – defined as those hours regularly worked by TK Elevator mechanics at the TK Elevator branch office that will provide labor associated with the performance of the work described in this Proposal - unless otherwise specified and agreed to in writing by both TK Elevator and Purchaser (hereinafter TK Elevator's regular working days and regular working hours shall be collectively defined as “normal working hours”). TK Elevator shall be provided with uninterrupted access to the Unit hoistway and machine room areas to perform work during normal working hours.
- Purchaser shall provide on-site parking to all TK Elevator personnel at no additional cost to TK Elevator.
- Purchaser shall provide traffic control, lane closures, permits and flagmen to allow suitable access/unload of tractor trailer(s).
- Purchaser agrees to provide unobstructed tractor-trailer access and roll-able access from the unloading area to the Unit hoistways or wellways (as applicable).
- Purchaser will be required to sign off on the Material Release Form, which will indicate the requested delivery date of equipment to the site. If Purchaser is not ready to accept delivery of the equipment within ten (10) business days of the agreed upon date, Purchaser will immediately make payments due for equipment and designate an area adjacent to the elevator shaft where Purchaser will accept delivery. If Purchaser fails to provide this location or a mutually agreeable alternative, TK Elevator is authorized to warehouse the equipment at the TK Elevator warehouse or designated distribution facility at Purchaser's risk and expense. Purchaser shall reimburse TK Elevator for all costs due to extra handling and warehousing. Storage beyond ten (10) business days will be assessed at a rate of \$125.00 per calendar day for each unit listed in this Proposal, which covers storage and insurance of the elevator equipment and is payable every (30) calendar days.
- Purchaser agrees to provide a dry and secure area adjacent to the hoistway(s) at the ground level for storage of the Unit equipment and tools within ten (10) business days from receipt at the local TK Elevator warehouse. Any warranties provided by TK Elevator for vertical transportation equipment will become null and void if equipment is stored in any manner other than a dry, climate controlled enclosed building structure. Any relocation of the equipment as directed by Purchaser after initial delivery will be at Purchaser's expense.
- You agree that if you are not ready to permit us to begin the installation of the equipment when we notify you when all or part of it is ready for shipment, you will immediately pay us a sum equal to the amount which would be payable to us if the elevator equipment or such part of it had actually been shipped and delivered. Unless you promptly provide to us a secure and convenient storage area, we are authorized to warehouse the elevator(s) at your risk and in any event, you shall reimburse us for all costs due to extra handling and warehousing.
- TK Elevator includes one mobilization to the jobsite. A mobilization fee of \$5,000.00 (minimum) per crew per occurrence will be charged for pulling off the job or for any delays caused by others once material has been delivered and TK Elevator's work has commenced.
- Access for this project shall be free and clear of any obstructions. A forklift for unloading and staging material shall also be provided by Purchaser at no additional cost.

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- Purchaser shall provide an on-site dumpster. TK Elevator will be responsible for cleanup of Unit packaging material; however, composite cleanup participation is not included in this Proposal.
- The hiring of a disposal company which MUST be discussed prior to any material being ordered or work being scheduled. TK Elevator will provide environmental services ONLY if this is specifically included under the "Scope of Work" section above. TK Elevator assumes no responsibility and/or liability in any way whatsoever for spoils or other contamination that may be present as a result of the cylinder breach and/or other conditions present on the work site.
- One or more of the units described in this Proposal will be out of service and unavailable to move passengers and/or property during entire duration of the performance of the work described in this Proposal until re-certified by the applicable authority(ies) having jurisdiction and in good standing with payment schedules.
- If site specific rules and regulations classify the elevator pit as confined space, elevator pits will need to reclassify a permit-required space to a non-permit required space prior to mobilization.

08 Temporary Use, Inspection and Turnover

- Unless required by specification, TK Elevator will not provide for "temporary use" of the Unit(s) described in this Proposal prior to completion and acceptance of the complete installation. Temporary use shall be agreed to via a change order to this Proposal which shall require Purchaser's execution of TK Elevator's standard Temporary Use Agreement. All labor, parts, repairs, adjustments, and/or refurbishment including callbacks required during the temporary use period will be billed at TK Elevator's billing rates listed in this proposal or TK Elevator's local service billing rates.
- Cost for temporary use of a Unit shall be \$200.00 per calendar day per hydraulic elevator for rental use only (minimum rental period is 30 calendar days), excluding personnel to operate.
- In the event that a Unit must be provided for temporary use, TK Elevator will require 30 days to perform final adjustments and re-inspection after the elevator has been returned to TK Elevator with all protection, intercoms and temporary signage removed. This duration does not include any provisions for finish work or for repairs of same, which shall be addressed on a project-by-project basis.
- Cost for preparation of controls for temporary use, refurbishment due to normal wear and tear, readjustment and re-inspection is \$5,000.00 per Unit in addition to costs for replacement or refurbishment of equipment based on special circumstances.
- These costs are based on work performed during normal working hours. Temporary use excludes vandalism or misuse. Any required signage, communication devices, elevator operators, and protection are not included while temporary use is being provided. All overtime premiums for repairs during the temporary use period will be billed at the billing rates listed in this proposal or TK Elevator's local service billing rates.
- The Proposal price set forth above includes one (1) inspection per Unit by the applicable authority having jurisdiction and/or third party inspectors where the equipment is located. In the event the equipment fails that inspection due to no fault of TK Elevator, TK Elevator will charge Purchaser for both the entire cost of each re-inspection which shall be \$1,500.00 per Unit and a remobilization fee which shall be \$5,000.00 per Unit, plus any additional costs that may apply, via change order prior to scheduling a re-inspection. In the event the inspection fails due to items caused by both parties, the aforementioned fees will be prorated based on the number of items by each party.
- Upon notice from TK Elevator that the installation and/or modernization of the equipment is complete, Purchaser will arrange to have present at the jobsite a person authorized to make the final inspection and to execute TK Elevator's "Final Acceptance Form" prior to turnover of each Unit. The date and time that such person will be present at the site shall be mutually agreed upon but shall not be more than ten (10) business days after the date of TK Elevator's notice of completion to Purchaser unless both TK Elevator and Purchaser agree to an extension of that ten (10) day period in writing. Such final inspection and execution of TK Elevator's "Final Acceptance Form" shall not be unreasonably delayed or withheld.
- Should the Purchaser or the local authority having jurisdiction require TK Elevator's presence at the inspection of equipment installed by others in conjunction with the work described in this Proposal, Purchaser agrees to compensate TK Elevator for its time at TK Elevator's billing rates as shown in this proposal.
- At the conclusion of its work, TK Elevator will remove all equipment and unused or removed materials from the project site and leave its work area in a condition that, in TK Elevator's sole opinion, is neat and clean.
- Purchaser agrees to accept a live demonstration of equipment's owner-controlled features on the same day as the turnover of each unit in lieu of any maintenance training required in the bid specifications.
- Purchaser agrees to accept TK Elevator's standard owner's manual in lieu of any maintenance, or any other, manual(s) required in the bid specifications. Any additional electronic copies or hard copies required will be subject

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to an additional charge of \$275.00. No program source coding, printed circuit board schematics, diagnostic hardware or codes will be provided.

- Should use of equipment be required prior to substantial completion, the Purchaser agrees to the signing of an interim maintenance agreement as outlined in Section 04. Any repairs, re-balancing, and cleaning as a result of interim use to restore equipment to as new condition will be extra to the Proposal.

09 Additional Terms and Conditions

- In no event shall TK Elevator be responsible for liquidated, consequential, indirect, incidental, exemplary, and special damages associated with the work described in this Proposal.
- This Proposal is made without regard to compliance with any special purchasing, manufacturing or construction/installation requirements including, but not limited to, any socio-economic programs, such as small business programs, minority or woman owned business enterprise programs, or local preferences, any restrictive sourcing programs, such as Buy American Act, or any other similar local, state or federal procurement regulations or laws that would affect the cost of performance. Should any such requirements be applicable to the work described in this Proposal, TK Elevator reserves the right to modify this Proposal or rescind it altogether.
- TK Elevator is an equal opportunity employer.
- TK Elevator's performance of the work described in this Proposal is contingent upon Purchaser furnishing TK Elevator with any and all necessary permission or priority required under the terms and conditions of government regulations affecting the acceptance of this Proposal or the manufacture, delivery or installation of the equipment. All applicable sales and use taxes, permit fees and licenses imposed upon TK Elevator as of the date of the Proposal are included in the price of the Proposal. Purchaser is responsible for any additional applicable sales and use taxes, permit fees and licenses imposed upon TK Elevator after the date of the Proposal or as a result of any law enacted after the date of the Proposal.
- The price of this Proposal includes value added taxes, tariffs, duties, and/or similar charges that are in effect as of the date of this Proposal. Purchaser is responsible to pay TK Elevator any and all additional amounts for the materials and/or components described in this Proposal above and beyond the pricing set forth in this Proposal for the reasons set forth in any of the following three (3) categories along with profit and overhead: (1) value added taxes, tariffs, duties, and/or other charges imposed by applicable governmental authorities that are in effect when such materials and/or components are ready to ship; (2) additional or increased charges to TK Elevator from any of the material and/or component suppliers after the date of this Proposal; and/or (3) additional or increased charges to TK Elevator from its shippers and/or freight forwarders of such materials and/or components after the date of this Proposal. When the materials and/or components called for in this Proposal are ready to ship, if required TK Elevator will provide Purchaser with a change order(s) covering all additional amounts mentioned in the preceding sentence which must be executed and fully paid for prior to and as a condition precedent to delivery of those materials and/or components to the jobsite or to the provision of any labor on the project.
- Purchaser agrees to provide TK Elevator's personnel with a safe place in which to work and TK Elevator reserves the right to discontinue work at the jobsite whenever, in TK Elevator's sole opinion, this provision is being violated.
- The pricing set forth in this Proposal assumes that the elevator pits will not be classified as a confined space. TK Elevator will follow its standard safety policy and procedures. Any job specific safety requirements over and above TK Elevator's standard practices and policies may require additional costs.
- TK Elevator will furnish and install all equipment in accordance with the terms, conditions, scope and equipment nomenclature as noted herein. Requested changes or modifications to such provisions will require a written change order issued on the Purchaser's letterhead and accepted by TK Elevator in writing prior to the execution of such work. This change order shall detail the current Proposal price, the amount of the change, and new Proposal value.
- This Proposal does not include a schedule for the work described and any such schedule shall be mutually agreed upon by an authorized representative of both TK Elevator and Purchaser in writing before becoming effective.
- In the event asbestos material is knowingly or unknowingly removed or disturbed in any manner at the jobsite, Purchaser shall monitor TK Elevator's work place and prior to and during TK Elevator's manning of the job, Purchaser shall certify that asbestos in the environment does not exceed .01 fibers per cc as tested by NIOSH 7400. In the event TK Elevator's employees or those of TK Elevator's subcontractors are exposed to an asbestos hazard, PCP's, lead or other hazardous substances, Purchaser agrees, to the fullest extent permitted by law, to indemnify, defend, and hold TK Elevator harmless from all damages, claims, suits, expenses, and payments

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resulting from such exposure. Identification, notification, removal and disposal of asbestos containing material, PCP's lead or other hazardous substances are the responsibility of the Purchaser.

k. TK Elevator retains title to and a security interest in all equipment it supplies – which TK Elevator and Purchaser agree can be removed without material injury to the real property – until all payments including deferred payments and any extensions thereof, are made. In the event of any default by Purchaser on any payment, or any other provision of this Proposal, TK Elevator may take immediate possession of the equipment and enter upon the premises where it is located – without legal process – and remove such equipment or portions thereof, irrespective of the matter of its attachment to the real estate or the sale, mortgage or lease of the real estate. Pursuant to the Uniform Commercial Code, and at TK Elevator's request, Purchaser agrees to execute any financial or continuation statements which may be necessary for TK Elevator to file in public offices in order to perfect TK Elevator's security interest in such equipment.

l. TK Elevator reserves the right to assign payments owed to TK Elevator under this Proposal.

m. TK Elevator shall not be liable for any loss, damage or delay caused by acts of government, labor troubles, strikes, lockouts, fire, explosion, theft, floods, riot, civil commotion, war, malicious mischief, acts of God or any cause beyond its control.

n. The rights of TK Elevator under this Proposal shall be cumulative and the failure on the part of the TK Elevator to exercise any rights hereunder shall not operate to forfeit or waive any of said rights. Any extension, indulgence or change by TK Elevator in the method, mode or manner or payment or any of its other rights shall not be construed as a waiver of any of its rights under this Proposal.

o. In the event TK Elevator engages a third party to enforce the terms of this Proposal, and/or to collect payment due hereunder, either with or without suit, Purchaser agrees to pay all costs thereof together with reasonable attorney's fees. Purchaser does hereby waive trial by jury and does hereby consent to the venue of any proceeding or lawsuit under this Proposal to be in the county where the work covered by this Proposal is located.

p. TK Elevator can furnish Certificate of Workers' Compensation, Bodily Injury and Property Damage Liability Insurance coverage to Purchaser upon written request.

q. Should loss of or damage to TK Elevator's material, tools or work occur at the project site, Purchaser shall compensate TK Elevator for such loss, unless such loss or damage results from TK Elevator's own acts or omissions.

r. Purchaser, in consideration of TK Elevator performing the services set forth in this Proposal, to the fullest extent permitted by law expressly agrees to indemnify, defend, save harmless, discharge, release and forever acquit TK Elevator Corporation, TK Elevator Manufacturing, Inc., their respective employees, officers, agents, insurers, affiliates, and subsidiaries (hereinafter singularly a "TK Elevator party" and collectively the "TK Elevator parties") from and against any and all claims, demands, suits, and proceedings for loss, property damage (including damage to the equipment which is the subject matter of this Proposal), personal injury or death that are alleged to either have arisen out of or be connected with the sale, marketing, presence, use, misuse, maintenance, installation, removal, modernization, manufacture, design, operation or condition of the equipment that is the subject matter of this Proposal or the labor and materials furnished in connection with this Proposal. Purchaser's duty to indemnify a TK Elevator party does not apply to the extent that the loss, property damage (including damage to the equipment which is the subject matter of this Proposal), personal injury or death is determined to be caused by or resulting from the negligence of that TK Elevator party. Purchaser recognizes that its obligation to defend the TK Elevator parties under this clause, which is separate and apart from its duty to indemnify the TK Elevator parties, includes payment of all attorneys' fees, court costs, judgments, settlements, interest and any other expenses of litigation arising out of such claims, demands, suits or proceedings.

s. Purchaser further expressly agrees to name TK Elevator parties along with their respective officers, agents, affiliates and subsidiaries as additional insureds in Purchaser's liability and any excess (umbrella) liability insurance policy(ies). Such insurance must insure TK Elevator parties for those claims and/or losses referenced in the above paragraph and those claims and/or losses arising from the negligence of TK Elevator parties. Such insurance must specify that its coverage is primary and non-contributory. Purchaser hereby waives its right of subrogation.

t. TK Elevator's participation in any controlled insurance program is expressly conditioned upon review and approval of all controlled insurance program information and documentation prior to enrollment. Any insurance credits if applicable, will be provided at that time.

u. Unless so mutually agreed upon in a separate signed agreement, TK Elevator shall not be required to interact or correspond with any third party with whom Subcontractor is not in privity of contract concerning matters pertinent to this Agreement.

v. The Purchaser must inform TK Elevator if Purchaser is, or becomes, an individual or entity that is - or that is majority owned or controlled by a party that is - included on any list of restricted parties maintained by (i) the United States of America; (ii) Canada; (iii) the European Union or any EU member state; (iv) the UK; (v) the United Nations; or (vi) any other national authority binding the parties of this contract.

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In case the Purchaser, or any other beneficiary of this transaction, e.g. the end-user, is or becomes an individual or entity that is - or that is majority owned or controlled by a party that is - included on any list of restricted parties, TK Elevator reserves the right to cancel this Proposal immediately.

If the goods subject to this Proposal would be exported, re-exported, resold, used, transferred or otherwise disposed of in violation of any sanctions applicable to TK Elevator, TK Elevator also reserves the right to cancel this Proposal immediately. In this respect, the Purchaser shall be obliged to disclose the final delivery address, end-user and end-use of the goods upon request - insofar as legally permissible - and to notify TK Elevator of all circumstances that indicate an aforementioned infringement.

"Sanctions" means here any economic, trade or financial sanctions, laws, regulations, embargoes or restrictive measures imposed, enacted, administered or enforced by any Sanctions Authority. "Sanctions Authority" means (i) the United States of America; (ii) Canada; (iii) the European Union or any EU member state; (iv) the UK; (v) the UN Security Council; or (vi) any governmental institutions of any of the foregoing which administer Sanctions, including HM Treasury, OFAC, Global Affairs Canada and The Department of Treasury Board and Finance, the US State Department and the US Department of the Treasury.

Acceptance

Purchaser's acceptance of this Proposal and its approval by an authorized manager of TK Elevator will constitute exclusively and entirely the agreement between the parties for the goods and services herein described and full payment of the sum of Three Hundred Ninety Seven Thousand Dollars (\$397,000.00) inclusive of all applicable sales and use taxes.

All other prior representations or regarding this work, whether written or verbal, will be deemed to be merged herein and no other changes in or additions to this Proposal will be recognized unless made in writing and properly executed by both parties as a change order. Should Purchaser's acceptance be in the form of a purchase order or other similar document, the provisions of this Proposal will exclusively govern the relationship of the parties with respect to this transaction. No agent or employee shall have the authority to waive or modify any of the terms of this Proposal without the prior written approval of an authorized TK Elevator manager.

SALINAS VALLEY MEMORIAL HEALTHCARE SYS (Purchaser):		TK Elevator Corporation Management Approval	
By: _____		By: _____	
(Signature of Authorized Individual)		(Signature of Branch Representative)	
_____ (Print or Type Name)		Kristin MacDonald Sales Manager	
_____ (Print or Type Title)			
_____ (Date of Acceptance)		_____ (Date of Execution)	

Service Agreement Addendum

TK Elevator Corporation ("TK Elevator Corporation," "TK Elevator," "we," "us," and "our") and SALINAS VALLEY MEMORIAL HEALTHCARE SYS (the "Purchaser," "you," and "your") hereby amend and supplement their duly executed and existing elevator maintenance agreement dated , contract number (the "Agreement"), as set forth in this addendum. This addendum shall be made a part of the Agreement, and in the event of conflict with other terms, conditions, purchase orders or contract documents, this addendum shall govern. All terms and conditions set forth in the Agreement will remain in full force and effect and apply to this addendum where no conflict exists. This addendum shall become effective starting on the date of activation of the services described herein.

TK Elevator Communications

TK Elevator offers an additional suite of services through our TK Elevator Communications call center separate and apart from those services included with your Agreement. We have notated below each additional TK Elevator Communications Service that you have selected for each of the Units covered under your Agreement and the corresponding total price per month of those services per Unit.

Building Name	Equipment Type	Nickname	Multimedia Monitoring	MAX Link	Price
1188 Padre Dr.	Hydraulic	1	Current Selection	Current Selection	\$80

A description of each available TK Elevator Communications service and the additional applicable terms and conditions follow.

Multimedia Monitoring Service

The latest versions of both ASME A17.1 and the International Building Code now require the Purchaser to have video and text messaging capabilities added within the elevator cab for all elevators. TK Elevator's Multimedia Monitoring Service satisfies the Purchaser's obligation to meet these new code requirements. "Multimedia Monitoring" is selected for specific Units in the chart above and those specified Units will, through its centralized TK Elevator Communications call center, receive 7 days per week, 24 hours per day, 365 days per year dispatching service provided by TK Elevator for calls placed by Purchaser outside of Regular Time to the local TK Elevator branch office and emergency telephone and multimedia monitoring on all Units maintained under this Agreement that have fully operational telephone and in-cab video and text equipment capable of placing a call to or initiating multimedia contact with that call center.

Depending on the nature of the call and/or multimedia contact and circumstances, TK Elevator's operators can call one or more of the following: Purchaser's Designated Contacts set forth below; Local Emergency Services at phone numbers provided by Purchaser below; and/or a local TK Elevator service technician to be dispatched to the location of the affected Unit. Please note that calls cannot be placed to "9-1-1" as the centralized TK Elevator Communications call center does not have dialing access to local "9-1-1" numbers.

This Multimedia Monitoring Service specifically excludes any maintenance, repair or replacement of any type or kind of the Purchaser's telephone and any other type of audio or video communication equipment. The Purchaser retains exclusive possession and control of all of the Unit's communication equipment and is solely responsible for ensuring uninterrupted operation of that equipment so that it is continuously capable of communicating with TK Elevator Communication's call center as designed.

MAX Link

"MAX Link" is selected for specific Units in the chart above and TK Elevator will provide those specified Units, through a MAX Device, with a cellular connection for one or more of the following: Purchaser's in-car emergency video, text or audio communication equipment compatible with such a connection (the "Communication Equipment") for the duration of this Agreement so long as that communication equipment meets all applicable laws and codes. For units with analog phone devices, MAX Link service will specifically include maintenance, repair or replacement of Purchaser's emergency analog telephone where TKE's VoIP analog telephone adapter is deployed.

In no event shall TK Elevator be liable or responsible to you or any other party for failure of a cellular connection, or for receipt of the same by a MAX Device when such failure is due in whole or in part to a temporary or permanent failure

of any type of hardware, systems, networks or telecommunications infrastructure provided by you, or by your, or by TK Elevator’s third party service providers or by any other third party, or is due in whole or in part to any circumstances beyond TK Elevator’s reasonable control including, but not limited to, any of the following: acts of God, flood, fire, wind, rain, water, soil movement, earthquake, explosion, virus, disease, unlawful cyber activity, vandalism, abuse, misuse, war, terrorism, power outages, power fluctuations, and/or national or regional shortages of power or telecommunication infrastructure.

Price
In light of the modifications to Agreement set forth above, you agree to an additional price of \$80.00 per month which will be billed to you separately from the price of the Agreement (the “TK Elevator Communications Services Charge”). The cost of your selected TK Elevator Communications Services is not subject to any discounts.

Acceptance
Your acceptance of this addendum and its approval by an authorized manager of TK Elevator will constitute exclusively the entire understanding of the Parties with respect to the subject matter contained herein and it shall thereafter become part of the Agreement. All other prior representations or agreements, whether written or verbal, will be deemed to be merged herein and no other changes in or additions will be recognized unless made in writing and properly executed by both Parties. Should your acceptance be in the form of a purchase order or other similar document, the provisions of this addendum and the Agreement will govern, even in the event of a conflict.

No agent or employee shall have the authority to waive or modify any of the terms of this Agreement without the prior written approval of an authorized TK Elevator manager.

SALINAS VALLEY MEMORIAL HEALTHCARE SYS (Purchaser): TK Elevator Corporation Management Approval	
By: (Signature of Authorized Individual)	By: (Signature of Branch Representative)
(Print or Type Name)	Kristin MacDonald Sales Manager
(Print or Type Title)	
(Date of Acceptance)	(Date of Execution)

Service Agreement Addendum



TK Elevator Communications Contact Information - To Be Completed by Purchaser

Purchaser hereby acknowledges that as a condition precedent to TK Elevator's placement of calls to Purchaser's Designated Contacts and any Local Emergency Services under this Agreement, Purchaser must first complete all sections of the TK Elevator communications Contact Information section below. Purchaser further acknowledges that it is Purchaser's sole responsibility to advise TK Elevator immediately in writing of any changes to the information contained in this exhibit during the term of this Agreement. Purchaser acknowledges that no revision to that information will be made without TK Elevator first receiving such request in writing from Purchaser's authorized representative.

Under those circumstances where TK Elevator is unable to reach Purchaser's Designated Contacts, Purchaser hereby gives TK Elevator express permission to dispatch a TK Elevator service technician to the location of the equipment at Purchaser's expense in accordance with TK Elevator's applicable billing rates. Purchaser further agrees that TK Elevator does not assume any duty or responsibility to advise any caller, regardless of his or her location within or outside the elevator, to take or not take any specific action resulting from a medical or other emergency or any other situation including, but not limited to, entrapment of persons, evacuation, repair or return to service of any equipment.

In the event of an emergency, or perceived emergency, one or more of the following are to be Purchaser's Designated Contacts:

Contact Name	Title	Primary Telephone #	Secondary Telephone #

In the event of an Emergency or perceived emergency, TK Elevator has the express permission to contact one or more of the following **(911 is not sufficient, local phone numbers are required)**:

Police Department: () -

Fire Department: () -

Special instructions/remarks:

In the event that a TK Elevator call center operator perceives that a call from within the elevator constitutes a medical or other emergency, Purchaser hereby gives TK Elevator the express permission to call Local Emergency Services at the telephone numbers provided above at TK Elevator's sole discretion. Under those circumstances, Purchaser agrees to pay all related charges for services provided by any Local Emergency Services in response to that call. Purchaser agrees that TK Elevator shall not be responsible for ensuring an appropriate (or any) response by Local Emergency Services to that call.



DOWN PAYMENT REQUEST

Attn: SALINAS VALLEY MEMORIAL HEALTHCARE SYS
PO BOX 3827
SALINAS CA, 93912-3827

Date	Terms	Reference ID	Customer Reference # / PO
October 06, 2026	Immediate	TK-2026-00616245	
Total Contract Price:			\$397,000.00
Initial progress payment:			(55%) \$218,350.00

For inquiries regarding your contract or services provided by TK Elevator, please contact your local account manager at -. To make a payment by phone, please call 770-799-0400 with the reference information provided below.

Current and former service customers can now pay online at:
<https://tke.ssoaccount.com/>

Thank you for choosing TK Elevator. We appreciate your business.

Please detach the below section and provide along with payment.

Customer Name: SALINAS VALLEY MEMORIAL
HEALTHCARE SYS

Location Name: 1188 Padre Dr.

Customer Number: 140257

Quote Number: 2026-4-62649

Reference ID: TK-2026-00616245

Remittance Amount: \$218,350.00

Remit To:

TK Elevator
PO Box 3796
Carol Stream, IL
60132-3796

For overnight checks,
please send to:

Deluxe
TK Elevator 3796
5450 N. Cumberland Ave.
Chicago, IL 60656



MODERNIZATION FINANCING PROGRAM

Need to modernize your elevator or escalator quickly but it's not in the budget?
TK Elevator has partnered with GreatAmerica Financial to offer financing for
Modernization Projects in the United States and Canada.

Program Details:

Term Durations: 12 - 60 months

Loan Size: \$50,000 - \$5,000,000*

100% of Project Financing Available

Fixed Interest Rates

FAST Credit Approval!

Loans under \$500,000 – SAME DAY

Loans over \$500,000** – 24 to 72 Hours

Example of \$150,000 financed over a 60-month period at various interest rates:

Rate	Number of Payments	Payments per month
9.99%	60	\$3,186.32
10.99%	60	\$3,260.62
11.99%	60	\$3,335.91
12.99%	60	\$3,412.19

The above example's finance rates, number of payments, payment frequency and payment amounts are for illustrative purposes only and subject to change.

* Loans larger than \$5,000,000 may be accepted.

** All loans subject to credit approval.

Additional Information:

Program eligibility requires execution of 5-year maintenance agreement with TK Elevator.

Specific financing terms, rates and conditions will vary based on creditworthiness and GreatAmerica Financial's other terms and conditions.

Not all applicants will qualify.

TK Elevator may receive compensation from GreatAmerica as part of this program.

TK Elevator is not a licensed lender and does not originate or arrange financing.

TK Elevator is not responsible for GreatAmerica Financial's products or services, or how GreatAmerica Financial handles an applicant's information.

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of Project Budget for the Gift Shop Relocation & Retail Pharmacy Expansion Project**

Executive Sponsor: Clement Miller, Chief Operating Officer
Brad McCoy, Vice President of Facilities, Construction and Real Estate

Date: October 7, 2026

Executive Summary

Seeking approval of costs associated with expansion of the existing Retail Pharmacy inside the Downing Resource Center and relocation of the existing Gift Shop into a modular trailer beside the building to allow the increase in Pharmacy size. This Pharmacy project enlarges the 'retail pharmacy' component and adds a 'specialty pharmacy' component to allow dispensing of medications where Salinas Valley Health (i) expands its capture of eligible population needs, (ii) provides an opportunity to ensure all patients leave the hospital with their required medications thus reducing the risk of readmission, and (iii) this development will be used to drive down the medication cost of our employee health plan.

Background/Situation/Rationale

To expedite the completion date of the project and to maintain strict control over the project site as the Pharmacy is required to maintain service and public access throughout the course of construction, a multi-prime contracting delivery process is recommended where oversight of project activities is closely kept by Salinas Valley Health's Program Management team. Both informal and formal competitive bidding procurement regulations will be followed, depending upon the value of separate scopes of construction work. The project is being executed in phases, commencing with the relocation of Gift Shop activities, followed by a 3-phase Pharmacy renovation meant to maintain public access to a functioning retail pharmacy component throughout the renovation/expansion process.

Timeline

Project Programming & Design	October 2025 – September 2026
Gift Shop Relocation	October 2026 – November 2026
Retail Pharmacy Construction	November 2026 – February 2027
Specialty Pharmacy Construction	February 2027 – March 2027

Pillar/Goal Alignment

✓ Service People ✓ Quality ✓ Finance Growth ✓ Community

Financial Implications

Fiscal Year 2027 capital project budget planning included \$3M in funding for this project. Current project planning anticipates the total project costs at \$1.35M, which includes design, permitting, equipment, construction renovations required to facilitate the relocation activities and expansion of the existing pharmacy.

1. Total Estimated Project Cost	\$1,350,000
2. Amount of Construction Contract(s)	\$580,000
3. Construction Duration	5 Month Anticipated Duration (Excluding Modular Building)
4. Payment Terms	Percentage of completion progress payments
5. Budgeted	Yes

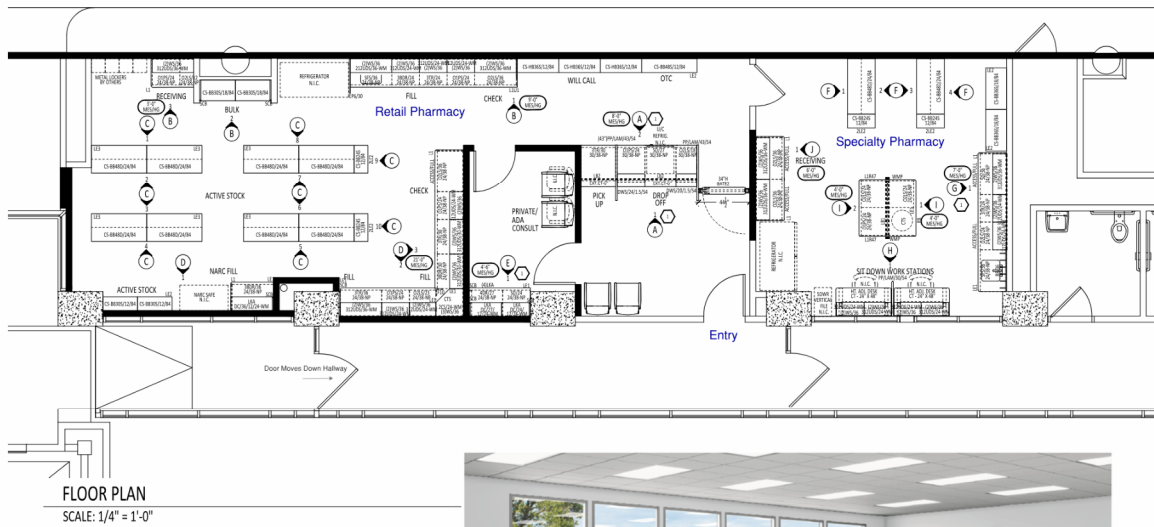
Recommendation

SVH Administration requests the Finance Committee recommend to the SVH Board of Directors to approve the project budget for the Gift Shop Relocation & Retail Pharmacy Expansion Project in the amount of \$1,350,000.

Attachments

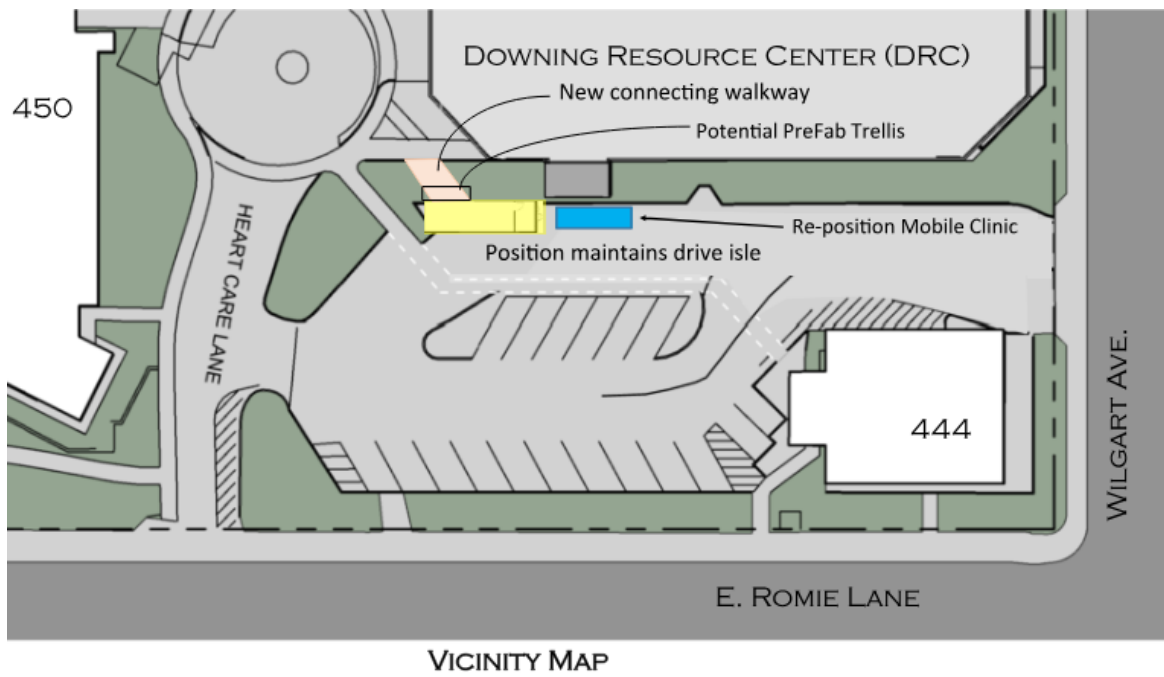
- Design documentation of the gift shop trailer & expanded pharmacy plan
- Current Budget prepared September 29, 2026

Attachment A



Sample
Finish/Layout

Proposed Pharmacy Expansion (Retail + Specialty)



Proposed Modular Structure for Gift Shop

Attachment B

Salinas Valley Health

Project Cost Model: Gift Shop Relocation & Retail Pharmacy Expansion Project

Architect: WRD

Subject: 100 CD's budget projection

Date Printed:

9/29/2026

Budget Amount:

\$1,350,000

Budget Approved Date:

PENDING

Version 1

Anticipated Completion:

Q4 FY2027

Budget Summary			
			A
Line Item	Description		Original Budget
	1	Construction	
100		Construction - Pharmacy	\$410,000
100		Construction - Gift Shop Relocation	\$120,000
101		Owner Contingency	\$50,000
	2	Design	
200		Professional Fees	\$125,000
	3	Inspections and Consultation	
301		Special Inspections	\$10,000
	4	AHJ Fees	
400		City Fees	\$35,000
	5	Soft Costs	
502		Program Management	\$120,000
	7	FF&E	
702		Medical, Data & Non-Medical Equipment	\$380,000
	9		
9900		Project Contingency	\$100,000
Totals			\$1,350,000

Financial Performance Review

August 2026

Iftikhar Hussain
Chief Financial Officer

Consolidated Financial Results August 2026

Month					\$ in Millions	YTD				
August			Bud Variance (unfav)			August			Bud Variance	
Actual	Budget	Prior Year	\$	%		Actual	Budget	Prior Year	\$	%
\$ 71.1	\$ 69.6	\$ 69.3	\$ 1.5	2.2%	Operating Revenue	\$ 146.5	\$ 142.1	\$ 145.5	\$ 4.4	3.1%
72.8	72.0	68.2	(0.8)	-1.1%	Operating Expense	147.8	145.2	139.4	(2.6)	-1.9%
(1.7)	(2.4)	1.1	0.7	29.2%	Income from Operations	(1.3)	(3.1)	6.1	1.8	29.7%
-2.3%	-3.4%	1.5%	1.1%	32.35%	Operating Margin %	-0.9%	-2.2%	4.2%	1.3%	31.0%
					Op. margin % full year target		2.4%			
3.0	4.0	5.2	(1.0)	-25.0%	Non Operating Income	2.1	8.0	6.2	(5.9)	-73.8%
1.3	1.6	6.3	(0.3)	-18.7%	Net Income	0.8	4.9	12.3	(4.1)	-33.3%
1.8%	2.3%	9.0%	-0.5%	-21.74%	Net Income Margin %	0.6%	3.4%	8.5%	-2.8%	-33.3%

Operating margin for the month and year is ahead of budget but lower than prior year and lower than the threshold target

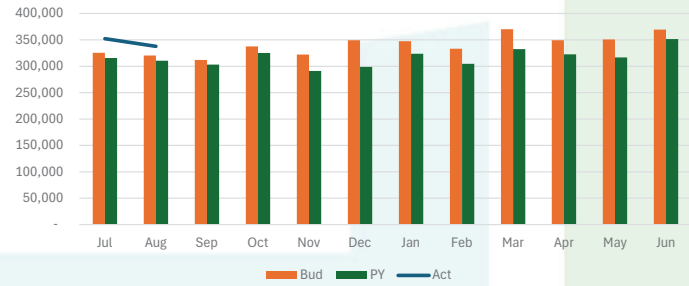
There were no material supplemental payments received in thru August

Consolidated Monthly Trend

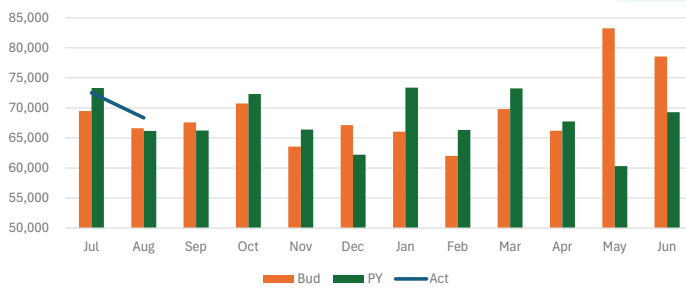
Consolidated Operating Margin



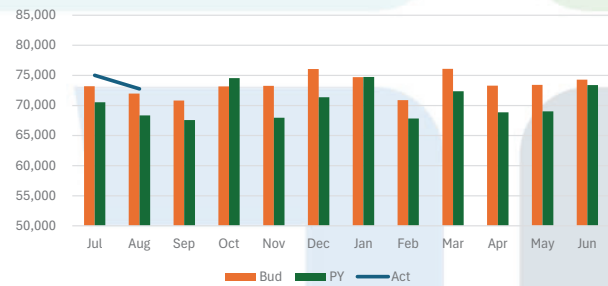
Gross Revenue



Consolidated Net Revenue



Consolidated Expenses



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Key Financial Indicators

Indicator Metric		YTD 8/31/2026	Budget	S&P A+ Rated	Prior Year
Operating Margin		-0.9%	-2.2%	4.0%	2.4%
Total Margin		0.6%	3.4%	6.6%	4.7%
EBITDA Margin		4.3%	3.3%	13.6%	7.5%
Days of Cash		346	355	249	353
Days of Accounts Payable		52	48	-	46
Days of Net Accounts Receivable		65	57	49	64
Supply Expense as % NPR		16.3%	17.3%	-	14.7%
Labor Expense as % NPR		52.7%	53.8%	53.7%	50.7%
Operating Expense per APD		7,325	7,408	-	7,414

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Executive Summary

- YTD hospital volume, measured in charges was 7% higher than budget mainly due high inpatient volume
- YTD Deliveries were up 8% from PY
- YTD Admissions were 13% higher than PY mainly due to high volume from the ER
- YTD Cath Lab cases were up 14% from PY
- YTD total ER outpatient visits down 4% from PY
- YTD Surgery cases were down 5% from PY
- YTD Infusion cases was off 6% from PY
- YTD Imaging was higher than budget and PY

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Executive Summary: August Financial Performance – Continued

Cost and Utilization:

- **Worked FTEs** on a per Adjusted ADC basis were **4%** favorable at **6.9** - compared to a target of **7.2**
- **Days in AR** at **65** flat with prior month
- **Payor Mix** was unfavorable with higher Medi-Cal and lower commercial as a percentage of gross revenue
- **Days Cash on Hand** decreased by 5 days to 346 mainly due to \$11.5 million payment CCAH for the supplemental payment program. The supplemental payment is expected in October
- **Non-Operating Income** was under budget by \$1.0 million due to investment income unrealized losses due to higher interest rates

Key Metrics	Prior 3 Months			Current Month	
	May-26 Actual	Jun-26 Actual	Jul-26 Actual	Aug-26 Actuals	Aug-26 Budget
Total Gross Revenue	\$ 299,504	\$ 324,206	\$ 327,747	\$ 319,965	\$ 300,791
Medicare %	46%	47%	46%	47%	46%
Medicaid %	29%	27%	29%	30%	30%
Commercial %	21%	21%	20%	19%	21%
All Other %	4%	5%	5%	4%	3%

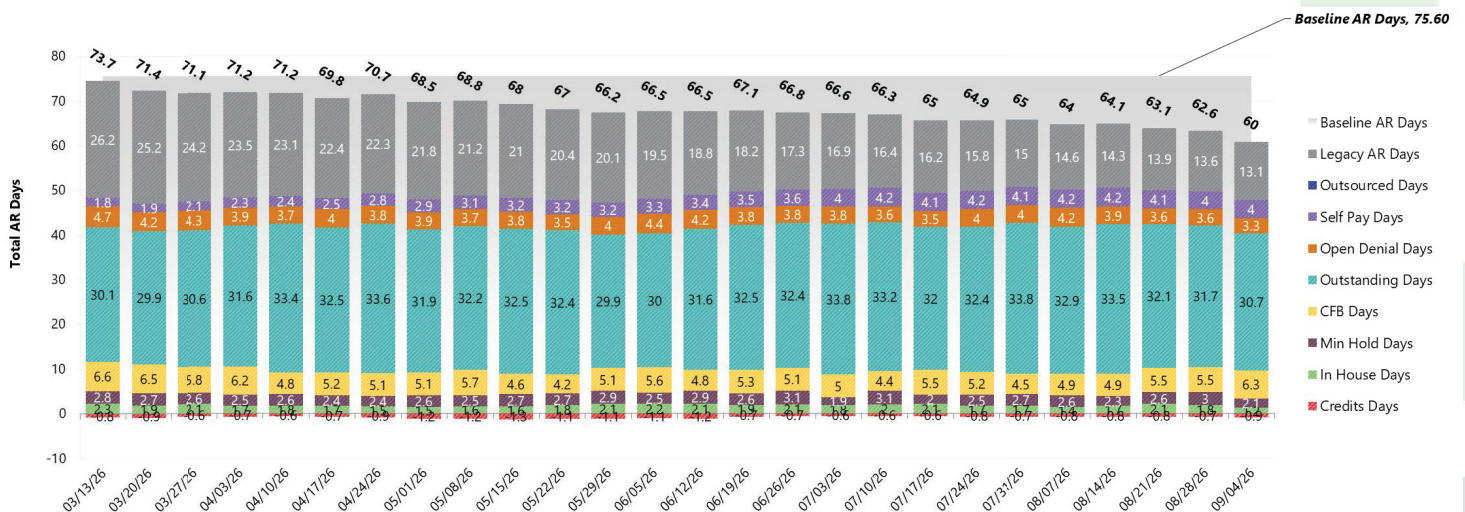
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Volume Summary – August 2026

Actual	Prior Year	Aug Bud	Bud Var	Key Statistics	YTD	YTD-PY	Var PY	YTD Aug Bud	YTD Bud Var
Inpatient									
108	108	104	↑ 4%	ADC	109	104	↑ 5%	104	↑ 6%
1,009	943	1,087	↓ -7%	Admissions	2,082	1,848	↑ 13%	2,158	↓ -4%
118	105	105	↑ 12%	Deliveries	235	217	↑ 8%	216	↑ 9%
1.9	2.1	2.1		Medicare Traditional ALOS CMI Adjusted	1.8	2.1	(0.1)	2.1	
1.78	1.79	1.73		Medicare Traditional Case Mix	1.72	1.79	-4%	1.73	
Emergency Room									
4,303	4,671	4,248	↑ 1%	ER OP Visits	8,283	8,957	↓ -8%	8,900	↓ -7%
801	736	745	↑ 8%	ER IP Admissions	1,654	1,422	↑ 16%	1,459	↑ 13%
5,104	5,407	4,993	↑ 2%	Total ER	9,937	10,379	↓ -4%	10,359	↓ -4%
Procedures									
155	151	148	↑ 5%	IP Surgeries	305	319	↓ -4%	303	↑ 1%
313	350	293	↑ 7%	OP Surgeries	635	667	↓ -5%	614	↑ 3%
468	501	441	↑ 6%	Total Surgeries	940	986	↓ -5%	917	↑ 3%
335	263	319	↑ 5%	Cath Lab	724	633	↑ 14%	644	↑ 12%
1,291	1,370	1,357	↓ -5%	OP Infusion Cases	2,524	2,674	↓ -6%	2,842	↓ -11%
358	297	306	↑ 17%	MRI Procedures	726	604	↑ 20%	618	↑ 17%
2,215	2,102	1,944	↑ 14%	CT Scans	4,463	4,202	↑ 6%	3,971	↑ 12%
Observation Cases									
161	205	149	↑ 8%	Obs Cases	352	408	↓ -14%	305	↑ 15%

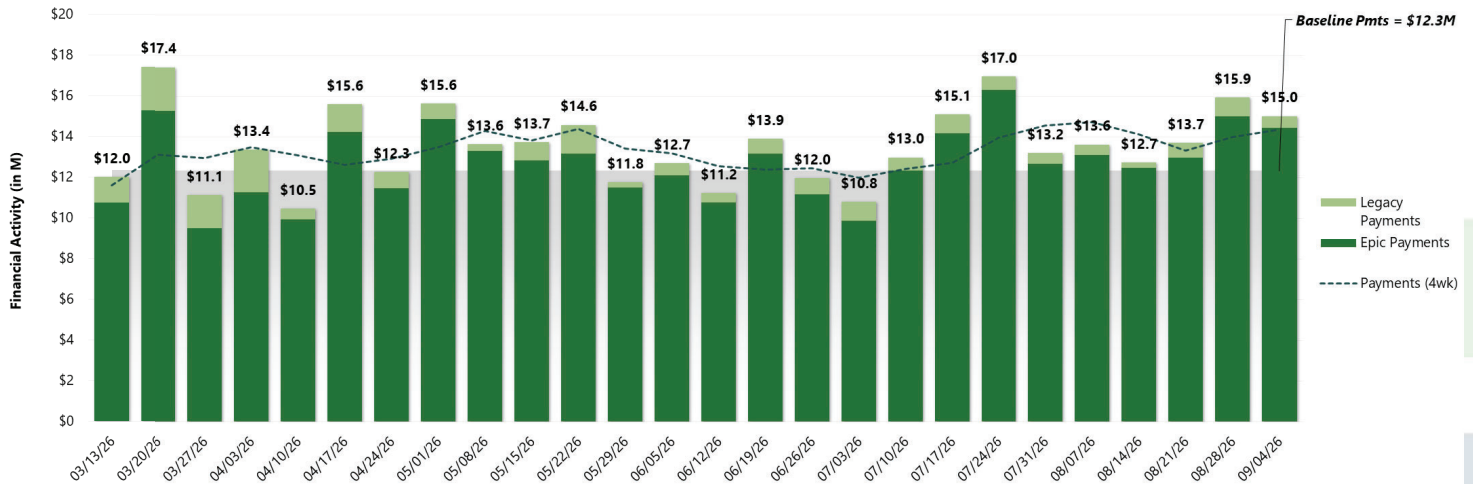
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Accounts Receivable – AR Days Trend



8

Accounts Receivable –Payment Trend



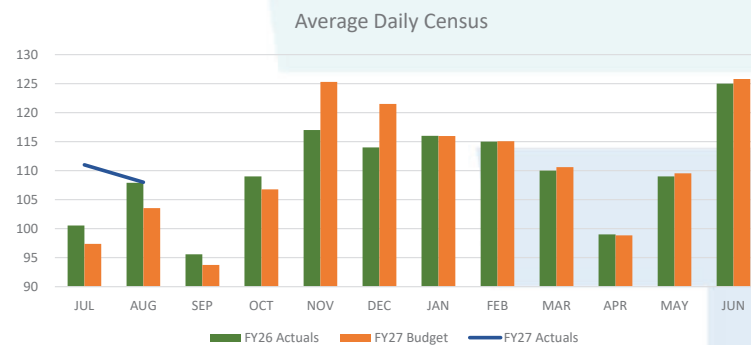
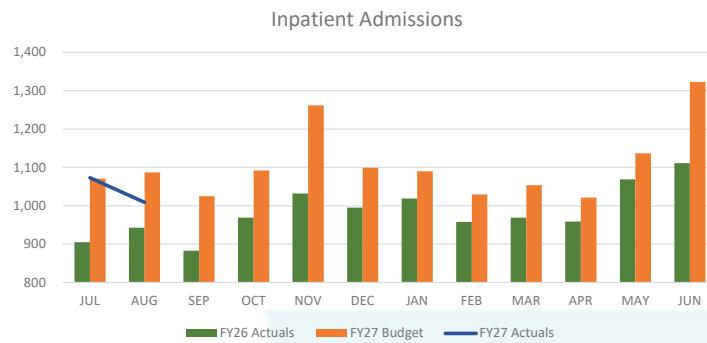
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Medi-Cal and Other Supplemental Payments

FY 2027					
Date	Payor	Description	Total Amount	Regular	One Time
Oct 2026	CAAH	DMPH-Quality Incentive Payment CY 2025 Interim	2,508,508	2,508,508	
Jan 2027	CAAH	Voluntary Rate Range-CY 2025 (net)	2,789,777	2,789,777	
Apr 2027	CAAH	DMPH-Quality Incentive Payment CY 2025 (net)	2,508,508	2,508,508	
Apr 2027	CAAH	Direct Payment Program (net) Phase 2- CY 2025	18,081,596	18,081,596	
May 2027	DHCS	Medi-Cal OP Supplemental (net) CY 2025-26	1,118,413	1,118,413	
Quarterly	CAAH	CAAH-SVMC HIP Program CY 2026	3,350,000	3,350,000	
Jun 2027	CAAH	Hospital Quality Incentive Program	2,600,000	2,600,000	
Jun 2027	DHCS	Medi-Cal Rate Range (net) CY 2026-27	1,774,995	1,774,995	
Oct 2027-Receiveable	CAAH	Direct Payment Program (net) Phase 1- CY 2026	17,826,925	17,826,925	
Estimated FY 2027			52,558,721	52,558,721	-
FY 2026					
Date	Payor	Description	Amount	Regular	One Time
Oct 2025	CAAH	Direct Payment Program (net) Phase 2- CY 2023	\$ 4,474,778	\$ 4,474,778	
Oct 2025	CAAH	DMPH-Quality Incentive Payment CY 2024 Interim	3,326,677	3,326,677	
Dec 2025	CAAH	CAAH-EPIC Training & Implementation	12,000,000		12,000,000
Jan 2026	CAAH	Voluntary Rate Range-CY 2024 (net)	5,579,554	5,579,554	
Apr 2026	CAAH	Medi-Cal Quality Incentive Program (net)	2,944,592	2,944,592	
Apr 2026	CAAH	Direct Payment Program (net) Phase 1- CY 2024	3,902,248	3,902,248	
May 2026	DHCS	Medi-Cal OP Supplemental (net) CY 2024-25	955,663	955,663	
Jun 2026	DHCS	Medi-Cal Rate Range (net) CY 2025-26	2,218,743	2,218,743	
Oct 2026-Receiveable	CAAH	Direct Payment Program (net) Phase 2- CY 2024	3,899,576	3,899,576	
Oct 2026-Receiveable	CAAH	Direct Payment Program (net) Phase 1- CY 2025	18,190,740	18,190,740	
Total FY 2026			57,492,571	45,492,571	12,000,000

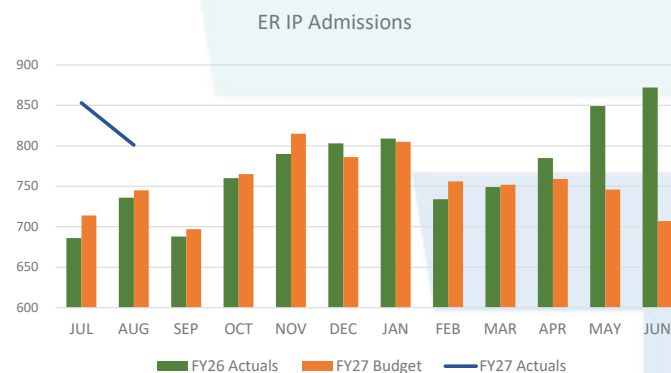
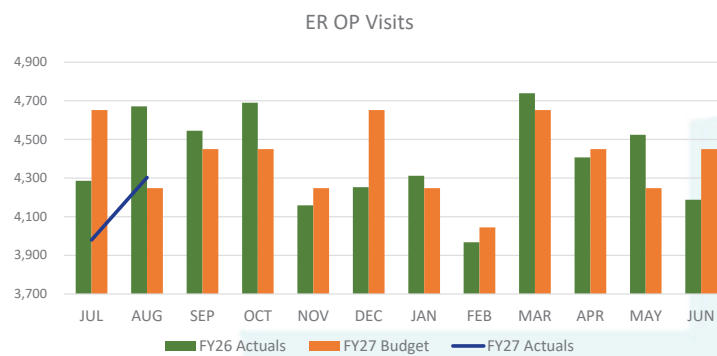
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Volume Trends – Admissions & ADC



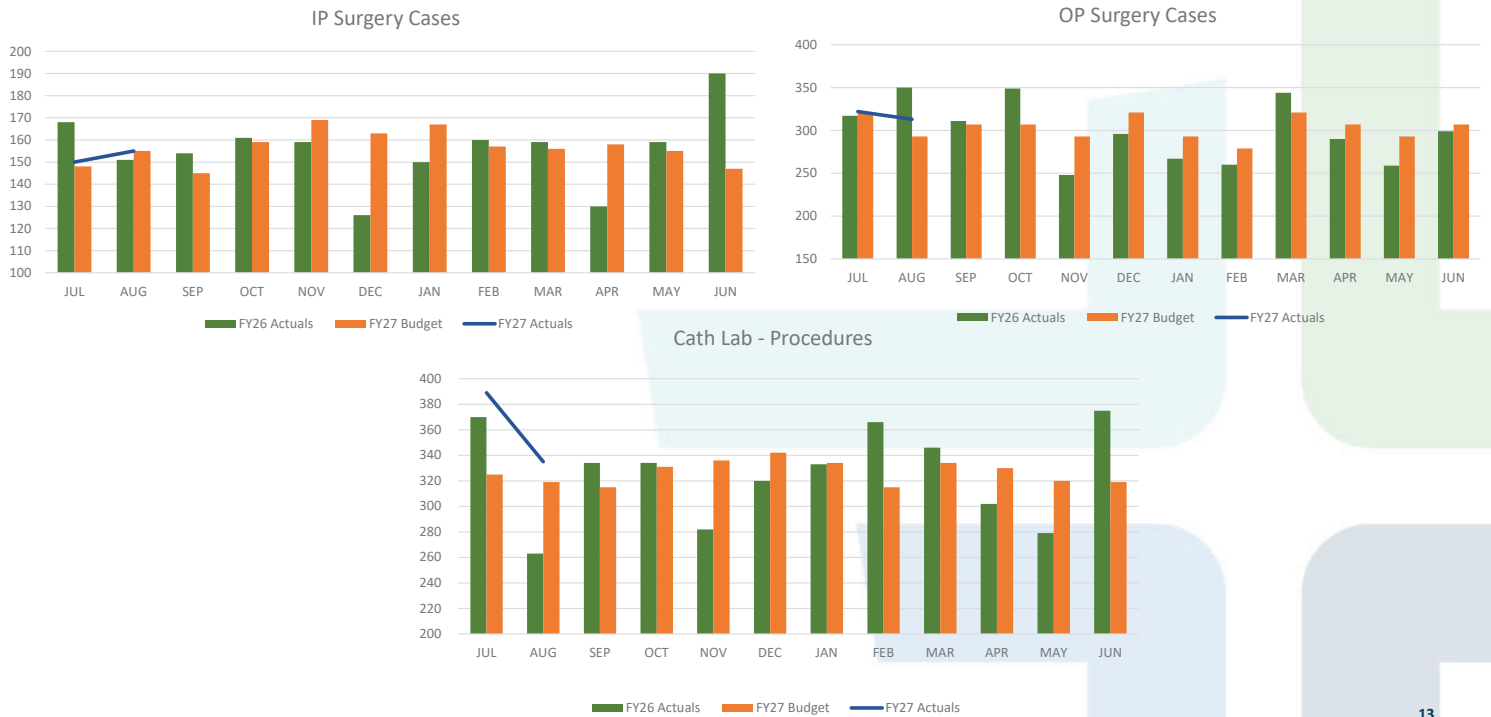
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Volume Trends – ER



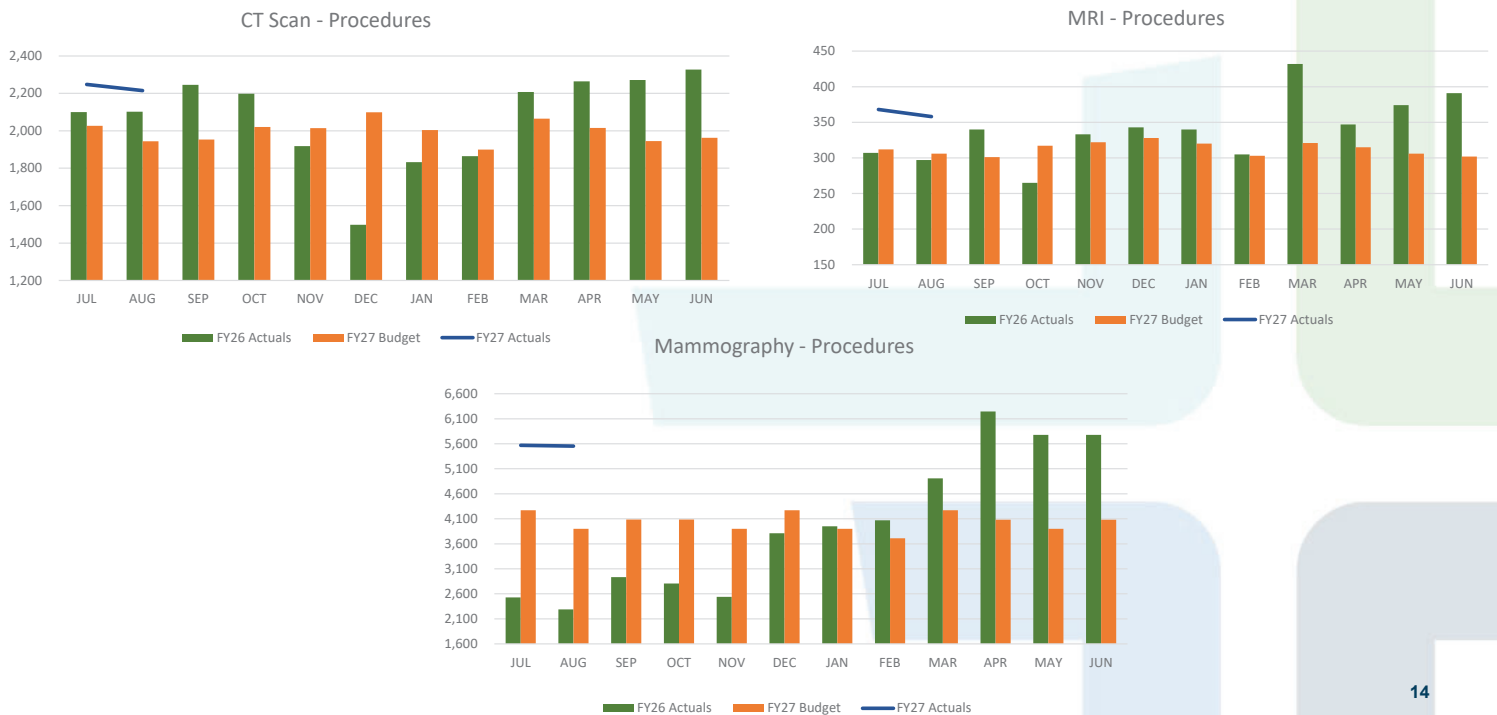
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Volume Trends - Surgery and Cath Lab



13

Volume Trends - Imaging



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Labor Productivity Key Indicators

Current Month					Year-to-Date			
Prior Year	Actual	Target	Variance (in FTE)		Prior Year	Actual	Target	Variance (in FTE)
1,694.3	1,741.3	1,774.9	33.6 FTE	Worked FTE	1,636.0	1,728.0	1,783.0	55.0 FTE
4.0%	3.1%	4.1%	16.1 FTE	Overtime as a % of Worked Hours	4.1%	3.5%	4.1%	10.2 FTE
4.7%	4.1%	4.0%	(2.5 FTE)	Contract Labor as a % of Worked Hours	4.4%	4.1%	4.0%	(2.7 FTE)

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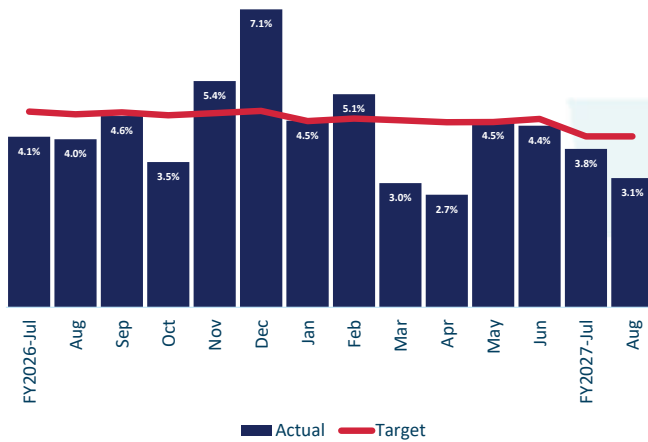
Labor Productivity As of August 2026 Year-to-Date

- **Worked FTE:** Worked FTE is favorable to target by 33.6 in the month (as defined by pay periods 4 – 5) and by 55.0 on a YTD basis. The variance is primarily driven by:
 - **Volume:** ADC was higher than target by 9.0 resulting in an increased target
 - **Vacancies:** Open positions budgeted in FY2027 have not yet been filled leading to a positive variance
 - **Contract Labor:** Contract labor usage is over budget at 4.1% of Worked FTE in the month (compared to a target of 4.0%) resulting in a negative FTE variance of 2.7
 - The overage is related to filling positions that are currently orienting, as well as hard to recruit positions
 - This is much improved compared to the prior year average of 5.7% driven by the Epic implementation

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Overtime & Contract Labor Trends

Overtime as a Percent of Worked FTE

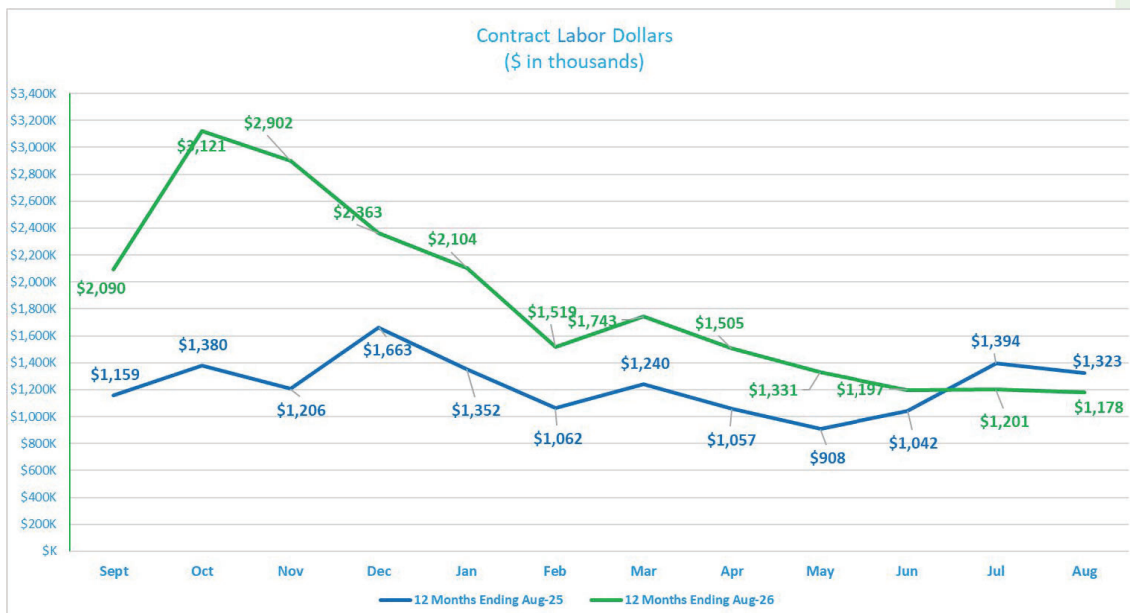


Contract Labor as a Percent of Worked FTE



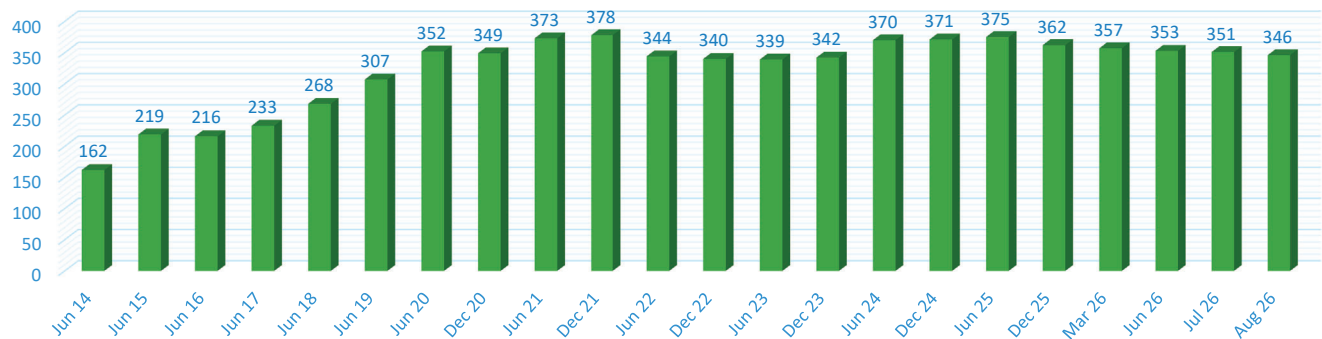
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Contract Labor Trends

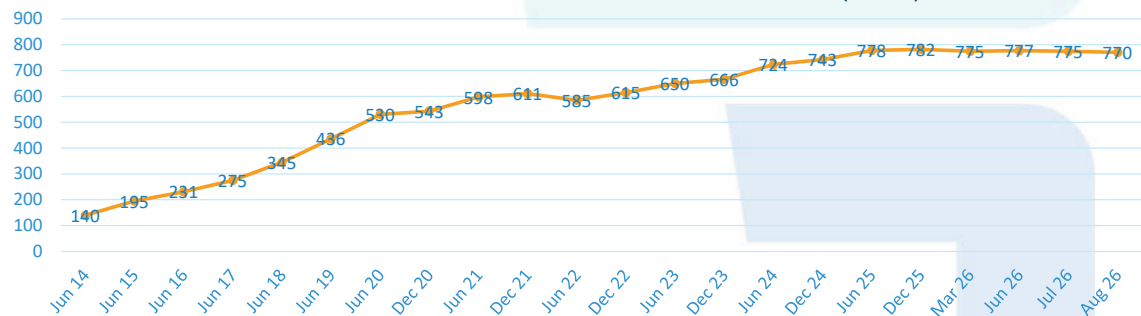


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Days Cash on Hand = 346 Days (\$770M) - August 2026



Consolidated Cash & Investments-Millions (\$000)



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Questions/Comments

*TRANSFORMATION, STRATEGIC PLANNING
AND GOVERNANCE COMMITTEE*

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

(VICTOR REY, JR.)

Medical Executive Committee Summary – October 8, 2026

Items for Board Approval

Credentials Committee

Initial Appointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Arredondo, Christina, MD	Psychiatry	Medicine	Tele-Psychiatry
Bourke, Dalton, MD	Psychiatry	Medicine	Tele-Psychiatry
Colvin, Stephen, MD	Radiology	Surgery	Salinas Valley Health Imaging Remote Radiology Salinas Valley Health Advanced Imaging – Remote Radiology
Juarez Casillas, Jesus, MD	Radiation Oncology	Medicine	Radiation Oncology
Karim, Shah Nawaz, MD	Neurology	Medicine	Tele-Neurology
Mahendrarajah, Sulagshan, MD	Neurology	Medicine	Tele-Neurology
Mohiuddin, Abid, MD	Hematology/ Oncology	Medicine	Hematology Medical Oncology General Internal Medicine
Nguyen, Khoa, DO	Psychiatry	Medicine	Tele-Psychiatry
Resendez, Elpidio, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Sidhu, Simran, MD	Gastroenterology	Medicine	Gastroenterology
Vazquez, Itzel, MD	Sleep Medicine	Medicine	Sleep Medicine Taylor Farms Family Health & Wellness Center – Ambulatory Procedural Privileges - Sleep Medicine

Reappointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bajaj, Tarun, MD	General Surgery	Surgery	General Surgery Robotic Surgery - daVinci
Blanchard, Johnny, MD	Internal Medicine	Medicine	Medicine – Active Community
Cole, Mario, MD	Pulmonology/ Critical Care	Medicine	Critical Care General Internal Medicine
Kashif, Farheen, MD	Internal Medicine	Medicine	Adult Hospitalist
Le, Catherine, MD	Neurology	Medicine	Tele-Neurology
Lim, Jerrie, MD	Pediatrics	Family Medicine/ Pediatrics	Pediatrics
Martinez, Cristina, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Oppenheim, Peter, MD	Family Medicine	Family Medicine/ Pediatrics	Family Medicine – Active Community
Radner, Allen, MD	Infectious Disease	Medicine	Infectious Disease General Internal Medicine
Romans, Matthew, MD	Plastic Surgery	Surgery	Plastic and Reconstructive Surgery
Taich, Lior, MD	Urology	Surgery	Urology Robotic Surgery - daVinci Core
Wagner, Elliott, MD	Radiology	Surgery	Salinas Valley Health Imaging Remote Radiology Salinas Valley Health Advanced Imaging – Remote Radiology

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Hayrapetian, Artineh, MD	Radiology	Relinquishing remote Mammography Reading and Stereotactic Core-cut Breast Biopsy
Yanus, Matthew, MD	Neurology	Adding Taylor Farms Family Health & Wellness Center – Ambulatory Procedural Privileges – Neurology

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Andrade, Jacob, MD	Radiation Oncology	Leave of Absence effective 8/30/2026
Biehl, Kenneth, MD	Radiation Oncology	Leave of Absence effective 8/30/2026
Blanchard, Johnny, MD	Internal Medicine	Move f to Active Community status
Hayrapetian, Aetineh, MD	Radiology	Move to Telemedicine Status
Rodnick, Jeffrey, MD	Radiation Oncology	Leave of Absence effective 9/30/2026
Abdalla, Adel, MD	Tele-Radiology	Resignation effective 10/31/26
Azad, Farsam, MD	Ob/Gyn	Resignation effective 9/11/2026
Gali, Helena, MD	Ophthalmology	Resignation effective 9/14/2026
Hays, Johnathan, MD	Tele-Radiology	Resignation effective 10/31/26
Lin, Alex, DO	Emergency Medicine	Resignation effective 9/28/2026
Mark, Ron, MD	Tele-Radiology	Resignation effective 10/31/26
Maybody, Majid, MD	Tele-Radiology	Resignation effective 8/5/206
Munn, Charles, MD	Tele-Radiology	Resignation effective 8/21/26
Pham, Justin, MD	Tele-Radiology	Resignation effective 10/31/26
Toor, Jiwan, DO	Family Medicine	Resignation effective 9/29/2026
Uyesugi, Walter, DO	Tele-Radiology	Resignation effective 10/31/26

Other Items: (Attached)

ITEM	RECOMMENDATION
Cardiology – Revision to Clinical Privileges Delineation	Removal of Laser Lead Extraction from special privileges
Gastroenterology – Revision to Clinical Privileges Delineation	Revision of initial and reappointment criteria
Revised Initial and Reappointment criteria for all sub-specialties within the Department of Medicine with the exception of Gastroenterology (addressed separately)	Revision of initial and reappointment criteria Includes archiving privileges for Psychiatry and Clinical Psychiatry

Interdisciplinary Practice Committee**Initial Appointment:**

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Thomas Doverspike, PA-C	Physician Assistant – Orthopedics	Surgery	John Bonano, MD Matthew Griffin, MD Allen Hershey, MD Kelvin Lim, MD David Roy, MD Justin Swan, MD Bert Tardieu, MD Willard Wong, MD

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Aliotti, Alexandria, PA-C	Physician Assistant – Cardiology	Medicine	Steve Regwan, DO
Gates, Cristina, PA-C	Physician Assistant – Surgery	Surgery	Matthew Romans, MD Travis Holcombe, MD
Lay, Ashley, NP	Nurse Practitioner	Medicine	Shehzad Aziz, MD Geetha Varma, MD

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Mosley, Jacqueline, NP	Nurse Practitioner – Palliative Care	Resignation effective 10/10/2026

Policies/Procedures/Plans:

- A. Care of the Total Hip and Knee Replacement Surgery Patient
- B. Dispensing Oral Alcohol in the Inpatient Setting
- C. Patient Safety Program Plan
- D. RC POCT Laboratory Safety-Chemical Hygiene Plan

Informational Items:

I. Committee Reports:

- a. Credentials Committee
- b. Interdisciplinary Practice Committee
- c. Quality and Safety Committee
 - Accreditation Update
 - Environmental Health and Safety Program Update
 - Nutrition Services Performance Improvement Update
 - Laboratory Services Performance Improvement Update
 - Patient Safety Program Plan Update
- d. Medical Staff Excellence Committee

II. Other Reports:

- a. Summary of Executive Operations Committee Meetings
- b. Summary of Medical Staff Department/Committee Meetings September 2026
- c. Medical Staff Statistics Year to Date
- d. Financial Presentation August 2026
- e. Executive Updates
- f. HCAHPS Update October 1, 2026

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Myocardial Perfusion Imaging	Certification in nuclear cardiology by the Certification Board of Nuclear Cardiology (CBNC) OR Board certified in cardiology and completion of a minimum of a four (4) month training program in nuclear cardiology (1995 or later) OR Board certified in Nuclear Medicine OR Board certified in radiology with at least four (4) months of nuclear cardiology training OR Board certified in radiology with at least one (1) year of nuclear cardiology practice experience with independent interpretation of at least 600 nuclear cardiology studies AND Documentation of having read at least 30 cardiac nuclear studies within the past 24 months.	1	Read at least 30 cardiac nuclear studies within the past 24 months
				Laser Lead-Extraction	Documentation of successful completion of approved course for utilization of laser AND Successful completion of five (5) laser lead-extraction procedures performed with the laser vendor company trainer.	First 3 Retrospectively Reviewed	Performance of at least two (2) procedures within the past 24 months.
				Permanent Pacemaker Insertion For Non-Electro Physiologists	Successful completion of 12 Pacemaker procedures within the past 12 months	1	Performance of at least 24 procedures within the past 24 month.

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M:\MEDSTAFF SHARE\Privilege Forms\Cardiology\Clinical Privilege Delineation DRAFT 10-2026-11-2025.docx

Clinical Privileges Delineation Gastroenterology

Applicant Name: _____

Qualifications:

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

- Documentation of inpatient or consultative services for a minimum of 100 patients during the past 12 months ~~or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship and the following minimal endoscopic experience which included:~~

1. ~~Diagnostic EGD~~	~~100 procedures~~
2. ~~Total colonoscopy~~	~~100 procedures~~
3. ~~Snare polypectomy~~	~~20 procedures~~
4. ~~Nonvariceal hemostasis (upper and lower); includes 10 active bleeders~~	~~20 procedures~~
5. ~~Flexible sigmoidoscopy~~	~~25 procedures~~
6. ~~PEG~~	~~10 procedures~~
7. ~~Tumor ablation~~	~~20 procedures~~
8. ~~Pneumatic dilation for achalasia~~	~~5 procedures~~
9. ~~Esophageal stent placement~~	~~5 procedures~~

AND

Current certification or active participation in the examination process leading to certification in gastroenterology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine with Special Qualifications in Gastroenterology.

OR

- Successful completion of an ACGME or AOA-accredited post-graduate training program in gastroenterology: within the past 12 months

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

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.

Gastroenterology core privileges:

Admit, evaluate, diagnose, treat and provide consultation to patients with diseases, injuries, and disorders of the digestive organs including the stomach, bowels, liver and gallbladder, and related structures such as the esophagus, and pancreas including the use of diagnostic and therapeutic procedures using endoscopes to see internal organs. 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.

Gastroenterology Core Privileges require privileges for moderate sedation (see Special Privileges Procedures).

General internal medicine core privileges

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to patients with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

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 five (5) patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.~~
- ~~• 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.~~

~~Documentation of inpatient or consultative services for a minimum of 100 patients with the past 24 months.~~

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 (C)=Recommended w/Conditions (N)=Not Recommended

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

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	Current ACLS Certification AND Signed attestation of reading SVMH Sedation Protocol and learning module, AND Completion of written moderate sedation exam with minimum of 75% correct.	1	Current ACLS Certification AND Completion of written moderate sedation exam with minimum 75% correct AND Performance of two (2) Cases within the past 24 months
				ERCP Therapeutic and Diagnostic	Current California State X-Ray S&O Fluoroscopy Certification AND Successful completion of an ACGME- or AOA-accredited program in gastroenterology that included training in ERCP of a minimum of 200 procedures (including 40 sphincterotomies and 10 stent placements). Required current experience: Demonstrated current competence and evidence of the performance of at least 50 therapeutic ERCP procedures (20 sphincterotomies and five (5) stent placements) within the past 12 months, or completion of training within the past 12 months	1	Ten (10) of each therapeutic and diagnostic procedures during within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification
				Endoscopic Ultrasound (EUS) (includes esophagus, stomach, rectum, pancreaticobiliary and nonpancreatic)	Documentation of advanced endoscopy fellowship training with a minimum of 350 EUS during fellowship AND Documentation of 150 EU cases performed within the past 24 months.	1	Performance of 150 cases within the past 24months

Salinas Valley Memorial Healthcare System

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

Gastroenterology

- Interpretation of percutaneous cholangiography
- Interpretation of percutaneous endoscopic gastrostomy
- Interpretation of gastric, pancreatic, and biliary secretory tests
- Diagnostic EGD
- Total colonoscopy
- Snare polypectomy
- Nonvariceal hemostasis
- Flexible sigmoidoscopy
- Esophageal stent placement
- Pancreatic tube stent placement
- Biliary tube/stent placement
- Therapeutic EGD
- Esophagogastroduodenoscopy
- Esophageal dilation
- Proctoscopy
- Flexible sigmoidoscopy
- Colonoscopy with polypectomy
- Percutaneous endoscopic gastrostomy
- Biopsy of the mucosa of esophagus, stomach, small bowel and colon
- Nonvariceal hemostasis (upper and lower)
- Liver biopsy
- Sengstaken/Minnesota tube intubation
- Thoracentesis
- Paracentesis

Internal Medicine: core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Vice President of Medical Affairs and/or the Chief of Staff

- Arthrocentesis
- Arterial Line Placement - Percutaneous
- Biopsy of superficial lymph nodes
- Breast cyst aspiration
- Burns, superficial and partial thickness
- Central Venous Line Placement
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- I & D abscess
- Local anesthetic techniques
- Nasogastric tube placement
- Perform simple skin biopsy or excision
- Placement of anterior and posterior nasal hemostatic packing
- Preliminary interpretation of electrocardiograms, own patient
- Remove non-penetrating corneal foreign body, nasal foreign body
- Thoracentesis

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

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

Signature:

Date

Acknowledgment of practitioner

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

- (a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature

Date

Department Chair’s Recommendation

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

☐ Recommend all requested privileges

☐ Recommend all requested privileges with the following conditions/modifications:

☐ Do not recommend the following requested privileges:

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

Department Chair Signature

Date

Current reappointment Criteria for all of the specialties:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not be eligible for reappointment.

Specialty	Core Initial Appointment Criteria – Proposed Edits	Proposed Reappointment Criteria
Allergy & Immunology	Documentation of the provision of allergy/immunology services to a minimum of 24 inpatients or outpatients within the past 12 months OR Documentation of successful participation in an ~~hospital-affiliated~~ <u>formalized/accredited</u> residency or special clinical fellowship <u>during the past 12 months.</u>	<u>Documentation of a minimum of 24 inpatient or outpatient allergy/immunology consultations within the past 24 months</u>
<u>Clinical Psychology</u>	<u>Documentation of the provision of inpatient, outpatient, or consultative psychological services for at least 30 patients during the past 24 months.</u>	<u>Recommend this clinical privilege delineation be archived.</u>
Critical Care/Pulmonary Med	Documentation of inpatient care to a minimum of 30 <u>hospitalized patients in the critical care/pulmonology</u> ~~and~~ <u>patients</u> during the past 12 months <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of inpatient care for a minimum of 60 hospitalized critical care/pulmonology patients within the past 24 months</u>
Dermatology	Documentation of the provision of inpatient or outpatient care to ~~at least a minimum of 12 dermatologic patients as the attending physician (or senior resident)~~ during the past 12 months <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or outpatient care to a minimum of 14 patients within the past 24 months</u>
Endocrinology	Documentation of the provision of inpatient or consultative services for <u>at least a minimum of 24 patients during the e-past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or consultative services for a minimum of 40 patients within the past 24 months</u>
Hematology/Oncology	Documentation of the provision of inpatient or consultative hematology and/or oncology services for ~~at least a minimum of 24~~ <u>patients during the past 12 months.</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or consultative services for a minimum of 50 patients within the past 24 months.</u>
Infectious Disease	Documentation of the provision of inpatient or consultative services for ~~at least a minimum of 24 infectious disease~~ <u>patients during the past 12 months.</u> <u>OR</u>	<u>Documentation of the provision of inpatient or consultative services for a minimum of 50 infectious disease patients within the past 24 months.</u>

	<u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient services to a minimum of -60 patients with-in the last 24 months.</u>
Internal Medicine	<u>Documentation of the provision of inpatient services to at least a minimum of 30 patients in the last 12 months.</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient services to a minimum of -50 patients within the past 24 months</u>
Neurology	<u>Documentation of the provision of inpatient or outpatient neurological services to at least a minimum of 24 patients during the past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or outpatient services to a minimum of -50 patients within the past 24 months</u>
Nephrology	<u>Documentation of the provision of inpatient or consultative services for at least a minimum of -24 patients during the past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or consultative services for a minimum of -50 patients within the past 24 months</u>
Pain Medicine	<u>Document of the provision of inpatient, outpatient, or consultative services for at least a minimum of -15 patients during the past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Document of the provision of inpatient, outpatient, or consultative services for a minimum of -30 patients within the past 24 months</u>
Palliative Medicine	<u>Documentation of the provision of inpatient palliative care services to at least a minimum of -32 patients in the last 24 months.</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient services to a minimum of 32 patients within the last 24 months.</u>
Physical Medicine & Rehab	<u>Documentation of the provision of inpatient or consultative services for at least a minimum of -24 patients during the past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient or consultative services for a minimum of -50 patients within the past 24 months</u>
Psychiatry	<u>Documentation of the provision of inpatient, outpatient, or consultative services for at least a minimum of -30 patients during the past 24 months</u>	<u>Recommend this clinical privilege delineation be archived.</u>
Radiation Oncology	<u>Documentation of the performance of at least a minimum of 125 irradiation procedures and 25 inpatient consultations during the past 12 months</u> <u>OR</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the performance of a minimum of 25 inpatient consultations and 125 irradiation procedures within the past 24 months</u>

Rheumatology	Documentation of the provision of inpatient/outpatient consultative services for <u>at least a minimum of 2450 rheumatology patients in the last 24 months,</u> OR <u>Documentation of successful participation in a hospital-affiliated formalized residency or clinical fellowship in rheumatology during the past 12 months.</u> <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Document of the provision of inpatient, outpatient, or consultative services for a minimum of 50 patients within the past 24 months</u>
<u>Tele-Psychiatry</u>	<u>Documentation of the provision of inpatient, outpatient, or consultative services for a minimum of 30 patients during the past 24 months,</u> OR <u>Documentation of successful participation in an accredited residency or special clinical fellowship during the past 12 months.</u>	<u>Documentation of the provision of inpatient, outpatient, or consultative services for a minimum of 30 patients within the past 24 months,</u>



Origination 10/29/2021
Approved N/A
Expires 3 years after approval

Owner Lilia Meraz
Gottfried:
Director
Clinical
Development
Area Patient Care

Care of the Total Hip and Knee Replacement Surgery Patient

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in the management and care of the joint replacement surgery patients according to the program's mission and goals (Attachment A)

III. DEFINITIONS

- A. Clinical Practice Guidelines – refers to standard interventions for a specific patient population to direct care toward evidence-based practice and improve collaboration and efficiency between all other healthcare team members.
- B. Joint Replacement Surgery – this includes total knee replacement/arthroplasty and/or total hip replacement/arthroplasty
- C. AAOS – American Academy of Orthopaedic Surgeons
- D. NAON – National Association of Orthopaedic Nurses
- E. ASA – American Society of Anesthesiologists
- F. ASPAN – American Society of PeriAnesthesia Nurses
- G. AORN – Association of Perioperative Nurses
- H. NICE – National Institute for Health and Care Excellence
- I. OOB – out of bed
- J. OPS - Out Patient Surgery

- K. ADL – activities of daily living
- L. ERAS -Enhanced Recovery After Surgery

IV. GENERAL INFORMATION

- A. Patients undergoing elective joint replacement surgery are managed according to evidence-based clinical practice guidelines (See Attachment B).
- B. Care of the joint replacement surgery patient involves an interdisciplinary approach utilizing nursing, medicine, rehabilitation services, pharmacy and case management. Whenever possible, joint replacement surgery patients are placed in the Joint Replacement Center of the Ortho/Neuro/Spine (ONS) – when general medical-surgical care is needed.

V. PROCEDURE

- A. Candidates for joint replacement surgery are highly encouraged to attend a Pre-operative orientation class at Salinas Valley Health Medical Center (SVHMC). The goals of this orientation class are: (1) provide information to help patients prepare for joint replacement surgery; (2) facilitate smooth transition from the Joint Replacement Center to home or other discharge disposition as needed; (3) provide guidance to optimize health preoperatively with information on exercises and nutrition, and answer questions as needed.
- B. Prior to scheduling surgery the informed consent process is initiated in the Surgeon's office.
- C. Once patients decide to proceed with joint replacement surgery, an appointment for pre-surgery visit and pre-admission testing (PAT) is scheduled.
- D. Pre-operative care is provided at the Outpatient Services (OPS) department.
- E. Standardized order sets for post-operative knee replacement surgery and post-operative hip replacement surgery are available for provider use.
- F. Clinical pathway for total knee and/or total hip replacement surgery is initiated. (See Attachment C)
- G. Joint replacement patients and their caregivers are educated pre-operatively; education is reinforced, during their hospital stay to address the following: inpatient care clinical pathway, pain management, medications, related orthopedic equipment, treatments, pertinent exercises, incision/wound care, prevention of complications, and follow-up care after discharge.
- H. Nursing assessments and interventions include, but not limited to, the following:
 - 1. Vital signs and neurovascular assessment
 - 2. Positioning/activity/mobility
 - 3. Knee precautions and/or hip precautions as applicable
 - 4. Hydration and nutrition
 - 5. Pain management
 - 6. Medication management
 - 7. Safety assessment

8. Incision/wound care
9. Bowel/bladder/skin assessment
10. Psychosocial support
11. Implementation of Clinical Practice Guidelines for mobility activities, pain management, venous thromboembolism (VTE) prophylaxis, prevention of surgical site infection (SSI) and management of post-operative nausea/vomiting (PONV).
12. Patient/family education
 - a. Written educational materials are provided and reviewed
 - b. Document patient/family education provided

I. Rehabilitation Services (Physical and Occupational Therapy)

1. Provide physical therapy and occupational therapy evaluations upon receipt of a physician or authorized provider order and in accordance with the Total Joint Replacement clinical pathway.
2. Complete a standardized functional assessment to establish baseline mobility, self-care status, discharge needs, and individualized rehabilitation goals.
3. Initiate rehabilitation interventions as medically appropriate, emphasizing early mobilization, progressive functional mobility, transfer training, gait training, stair negotiation (when applicable), and activities of daily living.
4. Assess and document the patient's mobility status, functional progress, pain impact on function, tolerance to activity, and achievement of established rehabilitation goals.
5. Educate patients and caregivers regarding:
 - a. Expected recovery progression
 - b. Safe mobility techniques
 - c. Use of assistive devices and adaptive equipment
 - d. Fall prevention strategies
 - e. Home safety recommendations
 - f. Activity progression following discharge
 - g. Joint precautions, if applicable based on surgical approach and surgeon preference
 - h. Collaborate with nursing, case management, physicians, and other members of the interdisciplinary team to coordinate care, address barriers to discharge, and support achievement of patient-centered goals.
 - i. ERAS Preoperative hydration 8 ounces of clear fluids allowed 3 hours pre-operatively. Preoperative health optimization with parameters on A1c <

8mg/dl , BMI>40, no current nicotine use. Medications Zenrelef, •(Bupivacaine –Meloxicam) Identified by a gold wristband , has been effective for reduction of pain and post op inflammation. Effective in 8-12 hours post- operative can reduce the use of Opioids.IV hydration bolus for Hip Arthroscopy patients.

6. Implement the Total Joint Protocol for rehabilitation of knee and/or hip replacement surgery patients (See Attachment C)

J. Psychosocial Support

1. Provide emotional and psychosocial support to patient/families.

K. Case Management

1. Facilitate transition from acute care to discharge disposition to home with home healthcare assistance, or to skilled nursing facility/acute rehab as needed with input from the interdisciplinary team (provider, physical therapist, occupational therapist, nursing as needed)

L. Documentation:

1. Patient care and assessments are documented in the electronic health record.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

Constantinescu, D. S., Lobaton, G. O., Eskenazi, J., Samineni, A. V., & Hernandez, V. (2025). Outpatient Total Joint Arthroplasty in an Academic University: Advanced Review of Concepts. *Orthopedic reviews*, 17, 143094. <https://doi.org/10.52965/001c.143094>

de Souza, D. N., Lorentz, N. A., Charalambous, L., Galetta, M., Petrilli, C., & Rozell, J. C. (2024). Comprehensive pain management in total joint arthroplasty: A review of contemporary approaches. *Journal of Clinical Medicine*, 13, 6819. <https://doi.org/10.3390/jcm13226819>

Rodriguez-Merchan, E.C.;Delgado-Martinez, A.D. Risk Factors for Periprosthetic Joint Infection after Primary Total Knee Arthroplasty. *J.Clin. Med.* 2022, 11, 6128. <https://doi.org/10.3390/jcm11206128>

Roham Borazjani MD a, Roya Khorram MD (2025) Aspirin Versus Other Anticoagulants for the Initial Prevention of Venous Thromboembolism Following Elective Total Hip and Knee Arthroplasty: An Umbrella Review and Meta-Analysis": <https://www.sciencedirect.com/science/article/pii/S0883540325007120>

Speth, J. (2025). Guidelines in Practice: Implementation of Enhanced Recovery After Surgery: Earn 2.3 Contact Hours. *AORN journal*, 121(5), 361-370. <https://doi.org/10.1002/aorn.14332>

Tarabichi, S., Parvizi, J. Prevention of surgical site infection: a ten-step approach. Arthroplasty 5, 21 (2023). <https://doi.org/10.1186/s42836-023-00174-7>

Uzel, K., Azboy, İ., & Parvizi, J. (2023). Venous thromboembolism in orthopedic surgery: Global guidelines. Acta orthopaedica et traumatologica turcica, 57(5), 192–203. <https://doi.org/10.5152/j.aott.2023.23074>

Attachments

- [!\[\]\(664b65aee2ef68ee55eaa1b5dd419738_img.jpg\) A: Joint Replacement Program Mission and Goals](#)
- [!\[\]\(0e7a7388023604da1cb7b0507f4b1828_img.jpg\) B: Clinical Practice Guidelines for Care of the Joint Replacement Surgery Patients](#)
- [!\[\]\(f1a3dedbc96830073d95aebcf83671f3_img.jpg\) C - Interdisciplinary Clinical Care Pathway for the Joint Replacement Surgery Patient. 2026.docx](#)
- [!\[\]\(f6d11d10b1f5931e1473c84d1185a431_img.jpg\) D - Total Hip Protocol 2026.docx](#)
- [!\[\]\(cd93ff3ef5459236654993d10bcd0051_img.jpg\) E - Total Knee Protocol 2026.docx](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/12/2026
CNO	Carla Spencer: Chief Nursing Officer	9/9/2026
Joint Committee (Dr. Tardieu)	Lilia Meraz Gottfried: Director Clinical Development	9/8/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/28/2026
Policy Owner	Lilia Meraz Gottfried: Director Clinical Development	8/6/2026

Standards

No standards are associated with this document



Origination3/28/2025

ApprovedN/A

Expires2 years after approval

OwnerGenevieve delos Santos: Director Pharmacy

AreaPharmacy

Dispensing Oral Alcohol in the Inpatient Setting

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide oral alcohol for inpatients (21 years and older) at Salinas Valley Health Medical Center.

III. DEFINITIONS

- A. For the purposes of this program, the definition of single-dose oral alcohol includes:
- 1. Beer (12 oz)
 - 2. Hard liquor (1 oz)
 - 3. Wine (5 oz)
- B. CSM: Controlled Substance Manager
- C. eMAR: Electronic Medication Administration Record
- D. ABC: Alcoholic Beverage Control license

IV. GENERAL INFORMATION

- A. DISPENSING: Single-dose oral alcohol will be dispensed based on the discretion of providers caring for inpatients at Salinas Valley Health Medical Center. Families and visitors are not permitted to supply alcohol to the patient.
- B. PROCUREMENT: Supply Chain will be responsible for the purchase and procurement of single-dose oral alcohol under the hospital's ABC license.

- C. STORAGE: Oral alcohol will be handled as a controlled substance. As such, the Pharmacy will be responsible for the secure storage of single-dose oral alcohol in the CSM.

V. PROCEDURE

1. Provider will enter the order for oral alcohol using appropriate order set.
2. Pharmacist will review and verify the order set.
3. Single-dose oral alcohol will be dispensed from the CSM under a patient-specific label.
4. RN will pick up the single-dose oral alcohol from the Pharmacy.
5. Administration will be documented by scanning the patient and the associated barcode in the eMAR.
6. Waste shall be recorded and documented as per the Controlled Substance and Drug Diversion Management policy.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Department of Alcoholic Beverage Control: <https://www.abc.ca.gov/law-and-policy/legislation/abc-act/> (Accessed on November 5, 2024).

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/12/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	9/30/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/11/2026
Policy Owner	Genevieve delos Santos: Director Pharmacy	8/7/2026

Standards

No standards are associated with this document

COPY



Origination1/1/2022

ApprovedN/A

Expires1 year after approval

OwnerAmy Grooters: Patient Safety Manager

AreaPlans and Program

Patient Safety Program Plan

I. PURPOSE

- A. The purpose of the Patient Safety Program Plan is to establish a proactive, organization-wide framework for patient safety at Salinas Valley Health Medical Center (SVHMC), under Salinas Valley Health (SVH). The plan is designed to create a comprehensive, organization-wide framework dedicated to achieving zero preventable harm and fostering a Just Culture. The Patient Safety Plan supports the mission, vision, and strategic plan of SVH.
 - **SVH Mission:** It is the mission of Salinas Valley Health to provide quality healthcare to our patients and to improve the health and well-being of our community.
 - **SVH Vision:** A community where good health grows through every action, in every place, for every person.
- B. The organization prioritizes safe patient care practices and ensures systems, resources, policies, and culture are in-line with established healthcare quality and safety frameworks, such as the Patient Safety Structural Measures (PSSM) established by the Centers for Medicare & Medicaid Services (CMS), and the National Performance Goals (NPG) established by The Joint Commission (TJC).

II. GUIDING PRINCIPLES

- A. All staff, physicians, volunteers, patients, patient's families and their support persons are accountable and have a role to play in patient safety.
- B. Implementation of this plan is dependent on integrating validated safe practices across all departments in the hospital.
- C. A safe and secure work environment for staff, volunteers and physicians contributes to safe patient care.

- D. That patients and families are aware of safety practices and expectations and feel encouraged to ask for clarification of process or procedure.

III. SCOPE

- A. The scope of the organizational Patient Safety Program Plan at SVMH establishes a comprehensive, organization-wide framework designed to develop, implement, and evaluate a robust patient safety system. The program actively reduces risk and eliminates preventable harm by fostering an environment that encourages:
- Recognition and acknowledgment of risks to patient safety and medical/health care errors that impact outcomes.
 - The initiation of actions to promote a culture of safety throughout the facility, including the safe integration of technology.
 - Creation of a non-punitive, transparent approach for reporting, analyzing and evaluating errors and problems.
 - Facilitation of sharing knowledge to effect behavioral changes.
 - Implementation of proactive practices that decrease variation and waste, alongside the rapid redesign of unsafe care processes in response to validated adverse events.
 - Interdisciplinary communication, collaboration, and organization-wide education regarding patient safety and error reduction.
- B. The Patient Safety Program is an organization-wide initiative that applies universally across all sites, services, care settings, and departments (both patient care and non-patient care) under SVHMC.
- **Populations Encompassed:** The program directly encompasses the entire hospital community, including patients, visitors, volunteers, students, and all categories of staff, including the Medical Staff.
 - **Functional Reach:** The program spans all administrative, medical staff, nursing, and support activities, ensuring that patient safety priorities are deliberately integrated into the new design and redesign of all relevant organizational processes, functions, and services.
- C. SVH supports a Just Culture philosophy and approach to adverse event investigation and response. SVHMC has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner. (Appendix A).
- D. To satisfy and exceed national benchmarks, the scope of the Patient Safety Program incorporates the CMS Patient Safety Structural Measures (PSSM) framework. This structure ensures that SVHMC prioritizes safety across five foundational domains:
1. **Leadership Commitment to Eliminating Preventable Harm:** Senior leadership and the SVHMC Board of Directors set the tone, oversee safety self-assessments, hold organizational leadership accountable for outcomes, and maintain safety as a key

institutional value.

2. **Strategic Planning and Organizational Policy:** Integration of patient safety priorities into the organization's strategic vision, quality and process improvement plans, and daily operational workflows.
 3. **Culture of Safety and Learning Health System:** Regular assessment of safety culture, deployment of team communication training, and utilization of data infrastructure (such as electronic health record data and tiered safety huddles) to track precursor events and serious safety incidents.
 4. **Accountability and Transparency:** Utilization of communication and resolution programs to respond thoroughly and transparently when unexpected events occur.
 5. **Patient and Family Engagement:** Meaningful incorporation of patients and families as active partners in safety, including leveraging feedback mechanisms to inform continuous improvement.
- E. The scope of the program operationalizes The Joint Commission National Performance Goals (NPGs) to maintain rigorous compliance and drive clinical excellence. Key performance objectives integrated into the safety scope include:
1. Ensuring the correct patient receives the correct care at the correct time.
 2. Fostering a governance-backed culture of safety.
 3. Prioritizing infection prevention and control, medication management safety, safe prescribing practices, and pain management.
 4. Respecting patient rights to safe, informed care while addressing specialized clinical risks such as suicide risk reduction, safe imaging services, and clinical staffing competency.
- F. Staff are required and encouraged to report all safety incidents, near-misses, hazardous conditions, and sentinel events via the electronic Incident Reporting System. Evaluations of reported events focus on investigating system, process, and design flaws (the "how" of errors) rather than placing blame on individuals (the "who" of errors).
- G. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet SVHMC's annual patient safety goals and Strategic Plan:
1. The Patient Safety Plan is approved by the SVHMC Quality and Safety Committee, Medical Executive Committee and the Quality and Efficient Practice Committee of the Board and the Board of Directors on an annual basis.
 2. The Board of Directors delegates the responsibility for SVHMC Patient Safety Program oversight to the SVHMC Medical Executive Committee and the Quality and Safety Committee.
 3. The designated Patient Safety Officer for SVHMC has administrative responsibility for the program and reviews and updates the Patient Safety Plan as needed.

IV. OBJECTIVES and GOALS

- A. The overarching goal and objective of the Patient Safety Program Plan is to cultivate a proactive, transparent, and highly-reliable safety culture with a goal of zero preventable harm, empowering staff to speak up, report errors, and deliver high-quality care to every patient, all the time.
- B. Support and encourage a culture of safety through an environment where employees can report safety concerns, near misses, and incidents without the fear of blame or retribution, and trust that the information will be used for improvement.
- C. A team of appropriately skilled healthcare professionals (e.g. physicians, nurses, pharmacists, risk management, and frontline staff), within the organization, will conduct standardized Root Cause Analysis (RCA) for all significant patient safety events.
- D. Proactive risk assessments will be conducted for all new programs and services, or conducting one on a topic of interest, at eighteen-month intervals.
- E. Integration of a process to conduct analysis of patient safety events, which include the following sociodemographic factors, to identify disparities in these events:
 - Age
 - Race
 - Ethnicity
 - Gender identity (when voluntarily provided)
 - Sexual orientation (when voluntarily provided)
 - Preferred language spoken
 - Disability status
 - Payor
 - Sex
- F. Maintain continuous patient safety competence across all hospital personnel and affiliated medical staff. Deliver comprehensive patient safety training to newly hired staff during orientation, and supplement annually. Training includes event reporting, Just Culture principles, hazard identification and team communication strategies.
- G. Systematically address racism, discrimination, and implicit bias to eliminate its impact on patient health and safety including, but not limited to:
 - Monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.
 - Encourage facility staff to report suspected instances of racism and discrimination.

V. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

- A. The SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: Quality & Safety Committee of the Medical Staff, Medical Executive Committee, Quality and Efficient Practices Committee of the Board and the SVHMC Board of Directors. At all levels, SVHMC leaders provide the foundation for an effective patient safety system by: promoting learning; motivating staff to uphold a fair and just safety culture; providing a transparent environment in which quality measures and patient harms are freely shared with staff; modeling professional behavior; removing intimidating behavior that might prevent safe behaviors; and providing the resources and training necessary to take on improvement initiatives.

1. Board of Directors

- a. The SVHMC Board of Directors (the Board), through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the Board to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board regarding Patient Safety are seen in activities such as:
- i. Approves the Patient Safety Program Plan.
 - ii. Reviews SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.

2. Patient Safety Officer

- a. The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
- b. The Patient Safety Officer will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non-critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
- c. The Patient Safety Officer communicates and collaborates with Administration, department leaders and others as necessary, in an effort to ensure coordination in reduction of harm, promotion of safe practices, and a safe culture of reporting.

- d. Oversees the Culture of Safety survey as defined by the organization.
- e. Meets routinely with leaders and staff on the Patient Safety Program goals, objectives and outcomes.
- f. Is available to all persons under SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.

3. Patient Safety Advisory Team (PSAT)

- a. This ad-hoc committee comprises key representatives from leadership to:
 - i. Evaluate reported events related to patient safety and quality care that occur within SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.
 - ii. The Regulatory and Accreditation team oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

4. Staff

- a. To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in SVHMC's Patient Safety Program. SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

VI. PATIENT SAFETY PROGRAM ELEMENTS

- A. Design or Re-design Processes — When a new process is designed (or an existing process is modified), the organization will use information from both internal and external sources to reduce medical errors and incorporate this information into its design or re-design strategies.
- B. Identification of Potential Patient Safety Issues — As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care process that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus are processes identified through:
 - 1. A review of the literature.
 - 2. The organization's performance improvement program.
 - 3. Occurrence reports and sentinel events.
 - 4. The result of findings by regulatory and/or accrediting agencies.
 - 5. Patient Safety Organizations (PSO), including but not limited to Press Ganey, NQF,

- C. Performance Related to Patient Safety – Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.
1. Performance measurement data will be collected, aggregated, and analyzed as necessary to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.
- D. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).
- E. Proactive Risk Assessments – The organization is committed to utilizing proactive risk assessments to identify potential hazards, analyze their likelihood and impact, and develop strategies to prevent or mitigate harm before incidents occur.
- F. Reporting of process/system failure and/or medical/health care errors and response.
1. The organization is committed to responding to errors in care in a manner that supports the patient's rights, clinical needs, emotional needs, and protects the patient and others from any further risk. The facility will strive to preserve information critical to understanding the proximal and/or root cause of the error. The organization has established policies and procedures to address the following:
 - Medical/health errors and occurrences, including sentinel events, will be reported internally to the appropriate administrative or medical staff entity.
 - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
 - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.
 2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care team member(s) will:
 - Perform necessary interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary interventions to contain the risk as to not reach others
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;

- Preserve any information (including physical) or equipment related to the error. Examples of preservation of physical information are: removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluid bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record as appropriate to organizational policy and procedure;
 - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit an occurrence report in the occurrence reporting system (RLDatix).
 - Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Officer.
3. Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified.
 4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
 5. Supporting staff Involved in errors – An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
 - All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining individuals involved in errors and occurrences. A focus will be placed on remedial actions to ensure an appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
 - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission or the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting a safety or quality of care concern.
 - Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
 - a. Staff and leaders value transparency, accountability, and mutual

- respect.
 - b. Safety is everyone's first priority.
 - c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction.
 - d. Collective mindfulness is present, wherein staff realize that systems have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
 - e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to, or enable, patient safety events. Staff know that their leaders will not focus on blaming providers involved in errors, but rather focus on the system issues that contributed to, or enabled, the patient safety event.
 - f. By reporting and learning from patient safety events, staff create a learning organization.
- The organization recognizes that individuals involved in an error may need emotional and psychological support. The organization has defined processes to assist employees and members of the Medical Staff.
 - a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
 - b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.
- G. Educating the Patient on Error Prevention – The organization recognizes that the patient is an integral part of the healthcare team. Patients will be educated about their role and responsibility in preventing medical errors.
- 1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- H. Informing the Patient of Errors in Care – Patients, and when appropriate their families, are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from what was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.
- I. Dissemination of Information – Lessons learned from root cause/comprehensive causative analysis, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

VII. PATIENT SAFETY PLAN MANAGEMENT

A. Patient Safety Program Resources

1. Designated resources have been provided to assist the organization in meeting the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management, Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
 - Human Resources
 - Employee Assistance Program
 - Clinical Social Work Department
 - Rights and Ethics Committee

B. Patient Safety Problem Identification, Notification & Resolution Process

1. When a situation occurs that may risk patient safety, SVHMC staff is requested to report unusual occurrences and/or unexpected events as outlined in the [ADVERSE EVENTS - REPORTABLE](#) Policy using any of the following reporting mechanisms:
 - Online Occurrence/Event Report or may elect to notify Administration directly.
 - a. Direct Notification can include:
 - Notification to Department manager/supervisor
 - Notification to the Patient Safety Officer
 - Notification to Administrative Supervisor
 - Notification to Quality, Risk, Infection Control
2. When a situation arises that requires immediate response to a patient safety event, the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. [DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY](#)

C. Patient Safety Program – SVHMC Staff & Medical Staff Education

1. SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
 - Posters in key locations.

- Medical Staff intranet portal.
 - Patient Safety on STARnet (<http://starnet/>)
 - Patient Safety Awareness Events.
 - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals, objectives, and accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
 3. Ongoing education is provided through various mechanisms such as but not limited to:
 - In-service training to increase knowledge of patient safety requirements
 - In-service training to encourage reporting of unanticipated adverse events and near-misses and in identifying patient safety events that should be reported.
 - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
 - Patient Safety Awareness activities.
 - Computer-based learning modules.

D. Patient Safety Program Patient & Community Education

1. Patients are given information about their rights and responsibilities while receiving services. Patients, and when appropriate their families, are informed about the outcomes of care, treatment and services, including unanticipated outcomes.
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

VIII. REFERENCES

- A. Center for Medicare Services (CMS) Conditions of Participation
- B. Joint Commission Sentinel Event Policy
- C. The Joint Commission Standards.
- D. To ERR is Human: Building a Safer Health System
- E. Crossing the Quality Chasm: A New Health System for the 21st Century
- F. OIG Report on Medical Error 12-00
- G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
- H. National Patient Safety Foundation

- I. The Just Culture Community, www.justculture.org
- J. California Senate Bill 1058, (Infection Control and Prevention)
- K. California Senate Bill 444 (Patient Safety Plan)
- L. Healthcare Performance Improvement (2011) The HPI SEC & SSER Patient Safety Measurement System for Healthcare. https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0008/569537/Known-Complications-HPI-White-Paper.pdf
- M. National Healthcare Safety Network – Patient Safety Structural Measures

Attachments

 [BETA 4.0 JC Algorithm-rv1.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/15/2026
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/15/2026
Quality & Safety Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/15/2026
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/15/2026
Policy Owner	Amy Grooters: Patient Safety Manager	9/28/2026

Standards

Standard Body: A.1.c

Chapter: General Entrance List



Origination 1/1/2021
 Approved N/A
 Expires 1 year after approval

Owner Louis Villaneda Sr.: Respiratory Care Manager
 Area Plans and Program

RC POCT Laboratory Safety/Chemical Hygiene Plan

I. SCOPE

- A. Salinas Valley Health Medical Center (SVHMC) is responsible for providing a safe place of employment and for furnishing safeguards, safety devices, and methods of operation to safeguard employees. In accordance with the SVHMC Safety Plan and the Environment of Care Committee, the following is in place to protect respiratory care practitioners (RCP) from health/chemical hazards associated with performing arterial blood gas collection and analysis. It is designed to identify actual and potential employee exposure, as well as set forth responsibilities and activities to enhance employee safety. This policy, as well as the OSHA standard (1910.1450) requiring that this policy be implemented, shall be available to employees at all times.
- B. All procedures (and use of chemicals and chemicals compounds) are listed, approved and reviewed in RC POCT ABG Policies: [EPOC BLOOD ANALYSIS PROCEDURE](#)

II. DEFINITIONS

- A. N/A

III. PLAN MANAGEMENT

A. Plan Elements

1. SAFETY EQUIPMENT/APPAREL:

- a. Personal protective equipment is the last line of defense against injury. Lines of defense may include:
 - i. Using proper technique, appropriate training, and methods
 - ii. Using engineering controls such as those listed below:

- EYEWASH Bottle – Located RC laboratory
 - Fire Extinguishers - extinguishers labeled ABC can be used for any kind of fire occurring in the Laboratory
 - Face Shields - located in par level areas
 - Gloves - Located throughout the hospital
 - Fire Alarm- Located throughout the hospital
 - Chemical Spill Kits – Located in engineering
- b. POCT Supervisor shall be responsible for assuring their personnel use the protective equipment and apparel and that they use it properly.
- c. The following personal protective equipment (PPE) rules shall apply to all Laboratory personnel:
- Proper protective gloves and other protective clothing shall be worn when there is potential for contact with corrosive or toxic materials or materials of unknown toxicity
 - Gloves shall be selected on the basis of the materials being handled and the degree of hazard involved
 - All personal protective equipment must be appropriately stored, cleaned and cared for on an ongoing basis. Cleaning is especially important after exposure to chemicals
 - Prior to using any personal protective equipment, it should be thoroughly examined and inspected for unusual wear, deterioration, holes, cracks or other imperfections which could result in exposure of an employee.

2. HOUSEKEEPING, MAINTENANCE AND INSPECTION:

- a. Hospital Environmental Services perform general housekeeping. RCP personnel, however, will be responsible for keeping their respective work areas orderly and clean.
- Waste materials shall be appropriately segregated in disposed of in appropriate receptacles.
 - Spilled chemicals must be cleaned up immediately in an approved manner. (See spill control section)

3. WASTE HANDLING AND DISPOSAL COMPLIANCE:

- a. Wastes will be handled and disposed of in a manner consistent with the hospital chemical and medical waste management program as well as Federal, State and Local regulations.
- b. The goal of the waste management program is to assure minimal harm to people, other organisms, and the environment as result from the disposal of waste laboratory chemicals.

4. CHEMICAL WASTE PICK UP – ALL HAZARDOUS CHEMICALS:

- a. Containers must be in good condition and wastes must be stored in compatible containers according to hazardous material disposal guidelines.
- b. Keep different types of wastes in separate containers.
- c. Unlabeled containers of chemicals and solutions should undergo prompt disposal. If partially used, they should not be opened.

5. GENERAL GUIDELINES:

- a. All RCPs shall familiarize themselves with all procedures associated with the use of chemicals.
- b. The application of safety rules and safe work procedures shall be considered as important as the quality and professionalism of work performance.
- c. Supervisors at each management level shall be responsible for enforcing safety rules and safe work performance through regular performance evaluations and an application of the standard hospital disciplinary policy when infractions occur.

6. GENERAL LABORATORY SAFETY:

- a. Smoking is prohibited.
- b. Eating and drinking are prohibited in the technical work areas.
- c. Cosmetic application is prohibited in the technical work areas.
- d. Food is prohibited in technical refrigerators.
- e. Face shields or eye protectors must be worn when handling caustic chemical or when pouring chemicals.
- f. Shoes should be comfortable; rubber soled, and covers the entire foot.
- g. Hair shall be secured back and off the shoulders in a manner as to prevent it from coming into contact with contaminated materials or surfaces and also to prevent shedding. Hair must be kept away from any machinery. Beards must be handled in the same manner.
- h. All accidents shall be immediately reported to the immediate supervisor or lead regardless of injury severity.
- i. Always wear appropriate protective gloves when handling hazardous chemicals and wash hands thoroughly afterwards.
- j. Inspect gloves before use.
- k. Flammable liquids should be kept away from sources of ignition.
- l. Always know the exact location of all safety and emergency equipment.
- m. Report any unusual odors, vapors or smoke at once to your immediate supervisor.
- n. If you should happen to splash a caustic liquid on your skin or in your eyes, flush and/or wash the affected area immediately with copious amounts of

water.

- o. Never drink from a laboratory container.
- p. Do not smell or taste chemicals.
- q. Learn the uses and potential hazards of all equipment
- r. Use equipment only for its intended purpose.
- s. All containers shall be labeled & dated plainly to identify contents and provide warnings
- t. Labels on original containers shall not be removed or defaced.
- u. Never fill a container with a material other than that called for on the label.
- v. Know the proper disposal method for chemical substances.
- w. Always check with an SDS sheet when using chemical and procedures with which you are not familiar.
- x. Become familiar with chemical incompatibilities. Chemicals which could react should not be stored together.
- y. Refrigerators shall not be used for the storage of chemicals unless the refrigerator is specifically designed for the appropriate hazard (flammability, explosion proof lighting and electrical fixtures.)

7. CHEMICAL PROCUREMENT, DISTRIBUTION AND STORAGE:

- a. PROCUREMENT –All supplies are received at the dock, in the Supply Chain (SC) Department. Refer to SC Procedures for receiving supplies.

8. STOCKROOM/STOREROOM:

- a. Hazardous substances should be clearly identified and segregated from other supplies or chemicals.
- b. The store room shall not be used as a preparation area, repackaging area or chemical transfer area.

9. LABORATORY STORAGE:

- a. Amounts permitted should be as small as practical.
- b. Exposure to heat or direct sunlight should be avoided.

10. EMPLOYEE MEDICAL SAFETY PROGRAM:

- a. Employees annually receive a health examination in accordance with Employee Health policies and procedures.
- b. In the event of over-exposure, exposure to a spill or leak or if an employee develops signs or symptoms associated with a hazardous chemical, they shall receive medical consultation and evaluation. This shall include follow-up medical examination thought to be necessary by the examining physician.
- c. First aid for exposure to toxic substance should be administered through the Employee Health Services. Some exposures may require immediate treatment (Employee taken directly to the Emergency Room). Listed below

are some conditions which may require immediate treatment.

- Thermal and chemical burns
- Cuts and fracture wounds from glass or metal, including possible chemical contamination
- Skin irritation by chemicals
- Poisoning by ingestion, inhalation or skin absorption
- Asphyxiation (chemical or electrical)
- Injuries to the eyes from splashed chemicals

11. SIGNS AND LABELS (SEE ALSO HAZARD COMMUNICATION PROCEDURES):

- a. Emergency telephone numbers of emergency personnel, internal hospital codes and home phone numbers for key laboratory personnel available in multiple locations throughout the Lab.
- b. Original chemical containers must not have original labels removed or defaced. All containers must have identity labels showing the contents of the container as well as the associated hazard.
- c. Signs showing the location of the eyewash station and other safety and first aid equipment, exits, fire alarm and fire extinguishers. Signs are also posted where special or unusual hazards exist.
- d. Special hazards throughout the laboratory shall be clearly identified with symbols and working labels. Such signs and labels as listed below:
 - flammable liquid storage
 - biological waste receptacles
 - storage areas for strong alkalis or acids
- e. Safety equipment shall also be clearly marked and identifiable.

12. CHEMICAL/ REAGENT LABELING:

- a. Every container in the Laboratory should be labeled, regardless of size, with the following information:
 - name of chemical as it appears on the SDS sheet
 - the strength or concentration of the chemical
 - an appropriate warning where applicable
 - "Hazardous" warning label where applicable for hazardous chemicals
- b. Any new reagent/chemical acquisition must be approved by the RC POCT Director before ordering and must have SDS data sheet on file. New reagents/chemicals that are added to arterial blood gas program must be included in an appropriate training program for that chemical.

13. SPILLS AND ACCIDENTS:

- a. The Laboratory Department participates in the hospital wide internal and

external disaster plans. Personnel shall:

- Be familiar with exits and evacuation routes
- Participate in both types and drills
- Be familiar with alarms, hospital codes and know their responsibilities with respect to these alarms and codes.

14. CHEMICAL SPILL PROCEDURE:

- a. The organization Hazardous materials Spill procedure will be followed.

15. SPECIFIC HAZARDOUS CHEMICAL SPILL CONTROL INFORMATION for Common Laboratory Chemicals:

- a. ALLERGENS: Wear suitable gloves to prevent hand contact with allergens or substances of unknown allergenic activity.

B. Plan Responsibility

1. The RC POCT Director / designee is responsible for ensuring that the policies and procedures contained within the Chemical Hygiene plan are followed and that appropriate protective equipment is used.
 - a. Responsibilities include:
 - Ensuring that workers know and follow the chemical hygiene rules and appropriate training has been provided.
 - Determining the required level of protective equipment, availability of equipment, and ensuring it is in working order
 - Provide regular inspections including routine inspections of emergency equipment.
 - The current legal requirements concerning regulated chemicals
 - Reporting lack of compliance to the RC POCT Director or RC POCT Supervisor for corrective actions.
2. No new chemical, chemical compound or laboratory procedure may be applied without the specific prior approval of the RC POCT Laboratory Director.

C. Training and Information

1. All employees that perform analysis on bodily fluids are at risk must be informed about the work hazards on performing these types of analysis, the proper work procedures to follow to prevent exposures and accidents and what to do if an accident occurs. It is the intent of this department to make available as much information and literature as possible regarding the chemicals employees must work with. Personnel are encouraged to request information and utilize textbooks and reference materials to become as knowledgeable as possible regarding chemical hazards and appropriate precautions needed.
2. Textbooks and reference materials are available and are located on line using the SDS online library and/or the Hospital Library. This can be found on the organizational intranet.
3. Other materials and information may also be found in the Laboratory Safety Manual

or online. Materials found include:

- The Laboratory Safety/Chemical Hygiene Plan
 - OSHA's Permissible Exposure Limits for Regulated Substances
 - OSHA's Laboratory Standard (CFR 1910.1450)
 - Signs and Symptoms Associated with Exposures
 - Material Safety Data Sheets/Safety Data Sheets in Lab and/or on STARnet.
4. Initial and ongoing training is provided and participation by department employees is required.
 5. Information shall be provided at the time of an employee's initial assignment to a work area or prior to new exposure assignments.
 6. Ongoing training will be provided as part of the facility annual training process.

IV. REFERENCES

- A. National Institutes of Health (2023) Chemical Hygiene Plan retrieved from:
<https://ors.od.nih.gov/sr/dohs/Documents/chemical-hygiene-plan.pdf>

Approval Signatures		
Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/12/2026
Quality & Safety Committee	Lisa Pietro: Department Coordinator	9/15/2026
Lab Medical Dir.	Johnny Hu: PHYSICIAN	6/25/2026
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/23/2026
Policy Owner	Louis Villaneda Sr.: Respiratory Care Manager	6/23/2026

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