VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

August 17, 2023

a. Policies & Procedures / Clinical Practice Guidelines / Forms / Orders

VENTURA COUNTY HEALTH CARE AGENCY

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Last Approved:	*7/11/2023*
Last Revised:	*7/11/2023*
Next Review:	*7/10/2026*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.015 Patient Assessment and Reassessment

POLICY:

To ensure that patients admitted to Ventura County Medical Center and Santa Paula Hospital receive regular, timely, and appropriate nursing assessments and/or reassessments in order to enable sound clinical decision-making. Patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) receive nursing care based on a documented assessment and reassessment of their needs.

Each patient's need for nursing care related to his/her admission is assessed by a Registered Nurse (RN). The initial assessment is conducted by the RN within a specified time frame. Assessment consists of two parts: (1) data collection (e.g., observation, interview, palpation, auscultation, information obtained from any medical jewelry, clinical laboratory and diagnostic tests, and (2) data analysis, synthesis, and evaluation. Certain aspects of data collection may be delegated by the RN to a Licensed Vocational Nurse (LVN) or Licensed Psychiatric Technician (LPT). Data may be collected by physicians, Allied Health Professionals, laboratorians, dietitians, physical therapists, occupational therapists, social workers, and by other providers of nursing care such as LVNs, PTs, and Nursing Assistants. *Only the RN may evaluate nursing care and make changes to the patient's plan of care. The RN must assess, analyze, synthesize and evaluate nursing care on all in-patients at least once every 24 hours.*

Patient needs and nursing care are assessed and reassessed on an ongoing basis throughout the patient's hospital stay as warranted by the patient's condition.

Definitions:

Definition of Types of Nursing Assessments/Reassessments:

A. **Admission (Initial) Assessment**:

1. The admission (initial) admission patient assessment is considered a comprehensive assessment and includes a head to toe physical assessment completed by the RN. Data collection is subjective and objective and includes the following:

    a. A physical systems evaluation that includes: Central Nervous System, Cardiovascular, Musculoskeletal, Pulmonary, Skin, Gastrointestinal, Genitourinary, Metabolic, Reproductive, and Pain.

    b. Assessment of psychosocial, environmental, functional (level of self-care), educational and discharge planning areas are documented. Whenever possible, data from the patient's significant other(s) is included.

c. A nutritional risk screening assessment is completed upon admission. Nutritional Services is notified of the nutrition risk score and provide further evaluation to patients who have a nutrition risk score greater than or equal to six (6).

d. A functional risk assessment is completed upon admission to identify any limitations that may require referral for rehabilitation services. A patient's functional status, i.e., ability to perform activities of daily living, provides cues or indicators for potential risks for fall, development of deep vein thrombosis, and aspiration. Risk for falls is assessed using the Morse Fall Scale.

e. e. A skin assessment is a visual assessment done for the purpose of identification of impaired skin integrity. A Braden Risk assessment is done for identification of risk for impaired skin integrity utilizing the Braden Index. Patients admitted with existing skin impairment or breakdown will have this noted both in the physical assessment and as a Braden Score.

f. An individualized plan of care is developed by the RN based on this comprehensive assessment and identified patient care needs and care standards. The plan is consistent with the therapies of other disciplines. Nursing staff collaborate with physicians and other clinical disciplines through an interdisciplinary team approach in making decisions regarding patient's need for nursing care. It is a Patient Right to participate in decisions related to the formulation of the plan of care, and is discussed with and developed as a result of coordination with the patient's family or other representative when appropriate (Title 22, CMS).

g. Throughout the patient's stay, the patient and, as appropriate, his/her support person(s) receive education specific to the patient's health care needs. An assessment of the patient's learning needs, as well as their ability to learn, is started at admission and completed within 12 hours of admission. Reassessment and evaluation of learning needs is based on identified needs. The following factors are considered when addressing the patient's specific learning needs including:

h. Patient's/support person's ability to comprehend and implement the provided education

i. Nature and complexity of the patient/family learning needs

j. Readiness to learn

k. Language/Communication barriers

l. In preparation for discharge, continuing care needs are assessed and referrals for such care are documented in the patient's medical record.

B. Head to Toe Assessment involves the detailed examination of the body from head to toe using the techniques of observation/inspection, palpation, percussion, and auscultation. The Head to Toe assessment includes the following components/systems:

a. General Status

b. Vital signs

c. Head, Ears, Eyes, Nose, Throat

d. Neck

e. Respiratory

f. Cardiac

g. Abdomen

h. Pulses

i. Extremities

j. Skin

k. Neurological

C. Shift Assessment is a comprehensive Head to Toe assessment that must be completed at least once a shift. This may be performed by a LVN or a RN, but at least once every 24 hours it must be completed by a RN.

D. **Reassessment** is done at designated intervals and/or when there is a change in the patient's level of care (unit transfer) or status/condition (e.g. after a medical procedure). A reassessment may be as simple as an assessment of a body system or may be a thorough as a shift (head to toe) assessment and indicates the response to and effectiveness of the care and interventions.

E. Reassessment is done at designated intervals and/or when there is a change in the patient's level of care (unit transfer) or status/condition (e.g. after a medical procedure). A reassessment may be as simple as an assessment of a body system or may be a thorough as a shift (head to toe) assessment and indicates the response to and effectiveness of the care and interventions.

PROCEDURE:

All patients will be assessed or reassessed according to the following grids.

All revision dates: 7/11/2023, 8/10/2021, 5/1/2006

Attachments

Attachment A - Assessment and Reassessment Parameters

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	7/11/2023
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	7/11/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	7/7/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/7/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/7/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/7/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1996*
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.060 Hospital Plan for Provision of Patient Care

POLICY:

The purpose of the Hospital Plan for the Provision of Patient Care (the "Plan") is to provide the framework for the appropriate provision of health care services at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) including:

- Identifying existing and new patient services
- Directing and integrating patient care and support services throughout VCMC/SPH
- Implementing and coordinating services across departments
- Directing and supporting a comparable level of patient care throughout VCMC/SPH

The ~~Plan~~plan outlines the organizational components integral in the provision of safe and effective patient care.

PROCEDURE:

The leadership of VCMC/SPH recognizes its role in providing the frame-work for planning, directing, coordinating~~,~~ and improving health care services that are responsive to the community and patient needs and that result in positive patient care outcomes. The leadership further recognizes the complexity of the acute care hospital organization as composed of many professional disciplines, each of which brings a unique expertise to patient care. The coordination and integration of each of these disciplines is embodied in the mission and the leadership process defined for VCMC/SPH and is guided by values. The ~~Plan~~plan is appropriate to the scope and level of care required by the patients served.

ORGANIZATION-WIDE PLAN/DESIGN

I. **MISSION:**

Provide comprehensive, cost effective, compassionate health care for our diverse community, especially those facing barriers, through an exceptional workforce, education and forward thinking leadership.

II. **VISION:**

Setting the standard in health care excellence. Healthy people in healthy communities throughout Ventura County.

III. **PHILOSOPHY OF PATIENT CARE SERVICES**

1. ~~VCMC/SPH's primary responsibility is to provide quality care to the patient to enhance his or her return to an optimal state of health. This quality of care revolves around caring, education, coordinating health team members, and family participation in health planning and adjustments for the patient after hospitalization.~~
2. ~~The individual patient or employee as a total person has rights and needs that should be respected regardless of nationality, color, creed or status of life. We are committed to promoting self-worth and personal growth.~~
3. ~~VCMC/SPH staff are individually accountable for the quality and compassion of the patient care rendered and for upholding the standards of care as delineated by the Management Team.~~
4. ~~VCMC/SPH believes in intelligent cooperation as we endeavor to establish and maintain a collegial relationship with all allied professional practitioners.~~
5. ~~VCMC/SPH participates in the development and education of the staff to meet patient and professional needs.~~
6. ~~VCMC/SPH operates as a community resource reflecting the community's total health care needs.~~
7. ~~We shall strive toward mutual trust and understanding among medical staff, nursing and allied health professionals to provide an atmosphere for developing the fullest possible potential of each member of the health care team.~~

A. VCMC/SPH's primary responsibility is to provide quality care to the patient to enhance his or her return to an optimal state of health. This quality of care revolves around the provision of care, education, coordination of health team members, and family participation in health planning as well as adjustments for the patient after hospitalization.

B. The individual patient or employee as a total person has rights and needs that should be respected regardless of nationality, color, creed or status of life. We are committed to promoting self-worth and personal growth.

C. VCMC/SPH staff are individually accountable for the quality and compassion of the patient care rendered and for upholding the standards of care as delineated by the Management Team.

D. VCMC/SPH believes in intelligent cooperation as we endeavor to establish and maintain a collegial relationship with all staff and professional practitioners.

E. VCMC/SPH participates in the development and education of the staff to meet patient and professional needs.

F. VCMC/SPH operates as a community resource reflecting the community's total health care needs.

G. We shall strive towards mutual trust and understanding among medical staff, nursing and allied health professionals to provide an atmosphere for developing the fullest possible potential of each member of the health care team.

IV. **DEFINITION OF PATIENT SERVICES, PATIENT CARE~~,~~ AND PATIENT SUPPORT**

Patient services at VCMC/SPH occur through organized and systematic processes designed to ensure the delivery of safe, effective and timely care and treatment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, patient services will be planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the

unique physical, emotional and spiritual needs of each person. Patient care encompasses the recognition of both disease and health, patient teaching, patient advocacy, spirituality and research. Under the auspices of VCMC/SPH Medical Staff, registered nurses and allied health care professionals function **collaboratively** as part of a multidisciplinary team to achieve positive patient outcomes.

In the strictest sense, patient services are provided by those departments that have direct contact with patients. The full scope of patient care is provided by professionals responsible for patient assessment and planning patient care based on findings from the assessment. Patient services and patient care are provided by licensed staff with assistance from unlicensed staff.

Patient support is provided by a variety of individuals and departments, which may not have direct contact with the patients, but who provide the necessary support required by the direct caregivers.

V. **ACCOUNTABILITY TO ADMINISTRATION AND THE MEDICAL STAFF**

1. ~~**TO ADMINISTRATION:**~~

   a. ~~To provide patient care consistent with defined standards and document such care in the medical record according to departmental policies and procedures;~~

   b. ~~To protect the financial resources of the hospital through sound management practices, to practice cost-effective use of human and material resources, and to protect patients and property (risk management);~~

   c. ~~Through Management, to actively participate in hospital planning and service projection activities;~~

   d. ~~To make recommendations related to the number of staff, competencies of staff, and type of material resources needed to provide quality care;~~

   e. ~~To comply with all applicable regulatory standards relative to the provision of care and services~~

   f. ~~To provide communication regarding care issues and management through formal and informal channels on a regular and as needed basis.~~

   g. ~~To provide buildings and equipment that are safe and free from hazards through repairs and preventive maintenance.~~

2. ~~**TO THE MEDICAL STAFF:**~~

   a. ~~To provide patient care consistent with the defined standards~~

   b. ~~To collaboratively participate as an integral member of the patient care team;~~

   c. ~~To notify the attending independent practitioner and other relevant medical staff members of significant changes in a patient's condition, concerns expressed by the patient or family related to the patient's medical care, and/or instances in which prescribed treatment cannot be rendered;~~

   d. ~~To clarify any unclear orders or orders that may not represent community practice (such as medication dosages, medication contraindications, and/or therapy contraindications).~~

   e. ~~To inform the independent practitioner of the effects of the prescribed therapy and to record such therapy and effects in the medical record according to departmental policies and procedures; and~~

~~f. To maintain current knowledge related to the types of patients seen at VCMC and SPH through relevant staff education.~~

A. **TO ADMINISTRATION:**

1. To provide patient care consistent with defined standards and document such care in the medical record according to departmental policies and procedures;
2. To protect the financial resources of the hospital through sound management practices, to practice cost-effective use of human and material resources, and to protect patients and property (risk management);
3. Through management, to actively participate in hospital planning and service projection activities;
4. To make recommendations related to the number of staff, competencies of staff, and type of material resources needed to provide quality care;
5. To comply with all applicable regulatory standards relative to the provision of care and services
6. To provide communication regarding care issues and management through formal and informal channels on a regular and as needed basis.
7. To provide buildings and equipment that are safe and free from hazards through repairs and preventive maintenance.

B. **TO THE MEDICAL STAFF:**

1. To provide patient care consistent with the defined standards;
2. To collaboratively participate as an integral member of the patient care team;
3. To notify the Attending Physician and other relevant medical staff members of significant changes in a patient's condition, concerns expressed by the patient or family related to the patient's medical care, and/or instances in which prescribed treatment cannot be rendered;
4. To clarify any unclear orders or orders that may not represent community practice (such as medication dosages, medication contraindications, and/or therapy contraindications);
5. To inform the Licensed Practitioner of the effects of the prescribed therapy and to record such therapy and effects in the medical record according to departmental policies and procedures; and
6. To maintain current knowledge related to the types of patients seen at VCMC and SPH through relevant staff education.

VI. PATIENT POPULATION

The plan for patient care is based upon the patient population served, hospital mission, identified patient care/family needs and information obtained from patient satisfaction/complaint surveys.

The design of services is consistent with patient needs and has been developed with the involvement of appropriate leaders and other disciplines involved in the strategic planning process. Patient care is provided in a timely manner to meet the needs of the patient.

Information obtained from performance improvement data is utilized to plan, design, measure, assess and improve services.

VII. **SCOPE**

A. VCMC/SPH serve as public hospitals providing comprehensive hospital care ~~from acute hospital care to both specialty and family practice clinics throughout the County~~.

B. ~~Acute Patient~~**Acute Patient Care Services:**
Care ~~Services:~~

~~Care~~ is delivered by competent ~~registered nurses~~Registered Nurses, ~~licensed vocational nurses~~Licensed Vocational Nurses, ~~nursing assistants~~Nursing Assistants, and Operating Room ~~technicians~~Technicians. Non-patient care duties are performed by ~~medical office assistants and supervising clerks~~Medical Office Assistants and Supervising Clerks.

1. **Maternal Child Health Service**

   a. High Risk Perinatal Care

      ~~1. Nurseries~~
      ~~Neonatal Intensive Care (Level III)~~
      ~~Intensive & Intermediate Care~~

      ~~2. Pediatrics and Pediatric Intensive Care (VCMC campus only)~~
      ~~Provides the type of therapeutic milieu that will allow for optimal care of the child and their families. The care may be diagnostic, preventative, curative, supportive, restorative, and palliative in a family centered care environment.~~

      ~~3. Obstetrics~~
      ~~Antepartum~~
      ~~L&D~~
      ~~Postpartum~~
      ~~Recovery~~
      ~~Provides care to the obstetric patient including high-risk antepartum, labor and delivery, and post-partum recovery and education of the mother and baby~~

      i. Nurseries
      Neonatal Intensive Care (Level III)
      Intensive & Intermediate Care

      ii. Pediatrics and Pediatric Intensive Care (VCMC campus only)
      Provides the type of therapeutic milieu that will allow for optimal care of the child and their families. The care may be diagnostic, preventative, curative, supportive, restorative, and palliative in a family centered care environment.

      iii. Obstetrics
      Antepartum
      Labor and Delivery (L&D)
      Postpartum
      Recovery
      Provides care to the obstetric patient including high-risk antepartum, L&D and post-partum recovery and education of the mother and baby

2. **Perioperative Services**
   Perioperative services are provided for patient ages from neonates to geriatrics.

   a. Same Day Surgery - ~~G.I.~~Gastrointestinal Laboratory (GI Lab

1. ~~Same Day Surgery~~
   ~~Provides nursing care to patients scheduled for minor local procedures. Provides preparation for patients scheduled for outpatient and inpatient (AM Admits) surgical procedures. Emphasis is placed on pre procedure assessment, potential problem identification, patient education pre and post procedure, and post recovery assessment and discharge care.~~
2. ~~G.I. Lab~~
   ~~Provides nursing and medical care, assessment, and monitoring to patients requiring invasive G.I. procedures.~~

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i. Same Day Surgery
   Provides nursing care to patients scheduled for minor local procedures. Provides preparation for patients scheduled for outpatient and inpatient (AM Admits) surgical procedures. Emphasis is placed on pre procedure assessment, potential problem identification, patient education pre- and post-procedure, and post-recovery assessment and discharge care.

ii. GI Lab
   Provides nursing and medical care, assessment and monitoring to patients requiring invasive GI procedures.

b. Surgery

   Provides nursing and medical care to patients requiring surgical intervention. Services are provided for inpatients and outpatients. Procedures include scheduled cases, urgent cases~~,~~ and emergency cases as needed. Surgical intervention is available 24 hours a day.

c. Post-Anesthesia Care Unit (PACU)
   Provides care to patients requiring recovery from surgery, invasive procedure or procedural sedation.

d. ~~Perioperative services are provided for patient ages from neonates to geriatrics.~~Sterile Processing
   Provides competent staff to perform decontamination, cleaning, inspection, assembly, packing and sterilization of equipment and sterilization for patient care areas throughout the hospital. Sterile Processing is also responsible for transporting soiled and sterile trays to and from the department for case cart building. Sterilization methods include high-temperature (steam) and low-temperature (hydrogen peroxide) sterilization and high-level disinfection for semi-critical devices.

3. **Critical Care/Emergency Services**
   a. Intensive Care
   b. Definitive Observation Unit
   c. Telemetry
   d. Emergency/Trauma Services (Adult Level II)
   e. Primary Stroke Services

Provides 24-hour medical and nursing care to patients presenting with conditions of various degrees of severity from life threatening conditions such as cardiopulmonary arrest and multiple trauma to others frequently seen in physician's offices. Emphasis is placed on appropriate triage and treatment based on immediacy of need using the Emergency Severity index triage process.

4. **Medical/Surgical Care**

   Nursing care and medical care are provided to adult patients requiring inpatient care. This includes units authorized for special emphasis on orthopedics, and surgical pre- and post-procedure care, isolation ~~precaution~~precautions, oncology care and cardiac monitoring for stable patients.

5. **Inpatient Psychiatric Unit (IPU) (VCMC campus only)**

   Provides inpatient psychiatric assessment and management for those patients not stable, from a psychiatric point of view, for discharge to outpatient care.

6. **Crisis Stabilization Unit (CSU) (VCMC campus only)**

   Provides acute psychiatric assessment and referral for those patients not requiring acute hospitalization.

~~**Ambulatory Care Services**~~

~~Ventura County Medical Center provides outpatient services, both specialty, primary care and urgent care. These clinics hold typical office hours with extended hours into the evenings and weekends. The clinics are staffed by full-time and part-time physicians, nurse practitioners, physician assistants, registered nurses and clinic assistants. This care is provided throughout Ventura County, including the cities of Ventura, Oxnard, Camarillo, Thousand Oaks, Moorpark and Simi Valley.~~

C. **Ancillary Services**

1. **Utilization Review~~/~~Case ~~Utilization Review~~ Management**
   Utilization Review/Case Management audits admissions for level of service and acuity. Continued stay reviews and Medi-cal and California Children's Services (CCS) denials are also processed. The staff prepares appeals to third party ~~payors~~payers and participates in the discharge planning process. Problems are identified and discussed with ~~physicians~~Physicians, ~~nursing staff~~Nursing Staff, ~~social service and home health~~Social Service and Home Health Care Providers. Proper referrals and interventions are made to facilitate smooth and timely transfers through an acute level of care ~~providers.~~
   ~~Proper referrals and interventions are made to facilitate smooth and timely transfers through an acute level of care~~ to the discharge or rehabilitation/placement of the patient. Utilization review is accomplished by registered nurses with clerical support.

2. **Infection Control**
   Infection Control coordinates activities that identify, control, and eliminate infections. The basic elements of the program are the following: Surveillance, education, consultation, analysis and identification of problems. The main two areas of focus are to identify and reduce the risk of infections of the inpatients and ~~VCMC~~ health care workers and to support ~~HCA~~ efforts to educate the employees regarding infection and their impact upon health care. ~~Activities are coordinated by a qualified registered nurse.~~

~~**Rehabilitation Service** includes inpatient and outpatient physical therapy, occupational therapy, hand therapy, high risk infant follow-up, and speech therapy provided by contract.~~

~~**Physical Therapy** provides physical therapy treatments to outpatients and to patients who are hospitalized with a variety of diagnoses. Age ranges from pediatrics to geriatrics. Emphasis is placed on providing identification, prevention, remediation, and rehabilitation of acute and examination and analysis of patients and the therapeutic application of physical agents exercise and other procedures to maximize functional independence. Neonatal follow-up provides ongoing growth and development assessment of infants born prematurely. Services are provided by Senior Physical Therapists, Physical Therapy Assistants, Physical Therapy Aides, and a Supervising Physical Therapist.~~

3. **Palliative Care**
   The Palliative Care team is a decentralized interdisciplinary program aimed at helping patients and their families cope with serious illnesses. The core interdisciplinary team includes physicians, palliative care nurses, chaplaincy services and social workers.

4. ~~**Occupational Therapy** provides~~**Rehabilitation Service**
   Rehabilitation Services includes inpatient and outpatient physical therapy ~~to outpatients and inpatients hospitalizes for a variety of diagnoses~~, occupational therapy, hand therapy, high risk infant follow-up, and speech therapy. ~~Patients are seen for functional skills assessment and training related to their age and their needs. OT will utilize professionally selected graded self-care tasks, daily living tasks, therapeutic exercise, therapeutic activities, facilitation techniques, and sensorimotor training to improve function. Therapy is provided by Senior Occupational Therapists.~~

   a. **Physical Therapy (PT)**
      Physical Therapy provides physical therapy treatments to outpatients and to patients who are hospitalized with a variety of diagnoses. Age ranges from pediatrics to geriatrics. Emphasis is placed on providing identification, prevention, remediation, and rehabilitation of acute and examination and analysis of patients and the therapeutic application of physical agents exercise and other procedures to maximize functional independence. Neonatal follow-up provides ongoing growth and development assessment of infants born prematurely. Services are provided by Senior Physical Therapists, Physical Therapy Assistants, Physical Therapy Aides and a Supervising Physical Therapist.

   b. **Occupational Therapy (OT)**
      Occupational Therapy provides therapy to outpatients and inpatients hospitalized for a variety of diagnoses. Patients are seen for functional skills assessment and training related to their age and their needs. OT will utilize professionally selected graded self-care tasks, daily living tasks, therapeutic exercise, therapeutic activities, facilitation techniques and sensorimotor training to improve function. Therapy is provided by Senior Occupational Therapists.

5. **Respiratory ~~Services~~ Care**~~The scope of care in the~~
   Respiratory ~~Department has been established to provide~~Care provides quality therapy, monitoring and diagnostic tests to adults, children, infants and neonates suffering from respiratory, neurologic~~,~~ or metabolic disturbances~~,~~ which require the administration of oxygen or other therapeutic treatments .

   Care is provided by ~~Registered~~ Respiratory ~~Technicians and Certified Respiratory Technicians~~

~~and several~~Therapists and perform other care modalities such as delivery of respiratory medications, pulmonary function testing~~,~~ and blood gas analysis. ~~Certain technicians have further training in the care and treatment of neonates.~~

6. **Imaging Services**

   The Imaging Services Department provides radiological service 24 hours per day for inpatients. Outpatient services are provided during scheduled hours. The range of treatment comprises diagnostic procedures, invasive intraoperative and non-invasive techniques~~,~~ and modalities using ionizing and non-ionizing radiation, with or without contrast media. Specific modalities available include: diagnostic imaging, magnetic resonance imaging, nuclear medicine, computerized axial tomography, ultrasound, mammography, non- invasive vascular studies and other invasive and interventional diagnostic procedures.

   In addition to actual procedures performed, daily activities include: monitoring and evaluation, quality control, image interpretation, dictation, transcription, record management, ~~patient billing,~~ image~~/film~~ processing and continuing education.

7. **Laboratory Department and Anatomical Pathology~~:~~**
   The scope of services provided by the Laboratory Department include the provision of clinical and pathological laboratory services for inpatients and outpatients, and autologous blood donors. These include testing in hematology, coagulation, urinalysis, routine and special chemistry, blood bank, serology, immunology, microbiology, pathology~~,~~ and histology. The Laboratory also provides services for phlebotomy, handling and transport of blood, body fluids~~,~~ and tissue specimens for testing. The ~~Laboratory Manager/~~Director Laboratory Services will be responsible to the Medical Staff and Administration to ensure all clinical laboratory tests are performed accurately, that systems are in place to identify the correct patient~~,~~ and that results are reported accurately and in a timely manner. Services are delivered by licensed Clinical Laboratory Scientists, ~~board~~Board ~~certified pathologists~~Certified Pathologists, ~~certified phlebotomists~~Certified Phlebotomists, ~~laboratory assistants, and office staff~~Medical Laboratory Technicians and Office Staff.

8. **Pharmacy ~~Department:~~ Services**~~Provides services to VCMC/SPH inpatients and the Ambulatory Care system.~~
   Pharmacy Services ~~are also provided for outpatients in~~is responsible for ensuring the safe and effective maintenance, distribution, and administration of medications throughout the hospital and clinics. ~~Services are provided by Pharmacists, Pharmacy Technicians, and clerical support. Management and education is provided by a Doctor of Pharmacy (PharmD).~~

   ~~The Pharmacy Department is responsible for ensuring the safe and effective maintenance,~~Inpatient services include distribution~~, and administration of medications throughout the hospital, and clinics.~~

   ~~Inpatient services include distribution~~ and control of medications, inpatient intravenous admixture service, preparation and dispensing of medications, and informational services to the Medical Staff or staff upon request.

   The Inpatient Pharmacy at VCMC is open 24 hours every day, and from 08:00 to 16:30 at Santa Paula Hospital with protocols for medication access after hours. Services are provided by

Pharmacists, Pharmacy Technicians and Clerical Support.

9. **Social Services**
   Social Services are available to all patients within the VCMC/SPH system. The team evaluates the patient and the family in planning for post-hospitalization needs. This function includes a general psychosocial problem assessment of each patient targeted by the department.

10. **Admitting Department~~:~~**
    The scope of service in the Admitting Department encompasses several functions. These functions include, but are not limited to~~:~~

    - ~~Admission of inpatients, same day surgery, and Emergency Department~~
    - ~~Financial counseling for each patient~~
    - ~~Verification of insurance for inpatients and same day surgery patients~~
    - ~~Self Pay discount eligibility verification~~
    - ~~Initial screening for MediCal eligibility~~

    admission of inpatients, Same Day Surgery and Emergency Department, financial counseling for each patient, verification of insurance for inpatients and same day surgery patients, self pay discount eligibility verification and initial screening for MediCal eligibility. These activities are carried out by Medical Office Assistants (MOA's). Some ~~MOA's~~MOAs are trained in financial activities having to do with the Medi-Cal and ~~Self Pay Discount~~self pay discount programs. Others are trained in Admitting Department procedures and collections. The staff ~~is~~are cross-trained as ~~is~~ appropriate.

    ~~**Telecommunication/Paging**~~

    ~~**Facilities Maintenance**~~

11. **Telecommunications/Paging**
    Telecommunications/Paging is responsible for answering and directing all calls, monitoring all emergency panels and alarms, and notifying various response teams during an emergency.

12. **Facilities Maintenance/Biomedical Engineering**
    The scope of services provided by Facilities Maintenance includes general maintenance of all electrical, mechanical, carpentry, plumbing, painting and other repairs of the physical structure of the hospitals. Biomedical Engineering works to ensure that all equipment is in an operative and safe condition in accordance with manufacturer's specification and regulatory requirements.

13. **Environmental Services**
    Environmental Services (EVS) provides for the cleaning of all patient, public and employee areas of the facility. ~~Housekeeping~~The EVS Department provides routine daily cleaning, scheduled project cleaning, conference room set-up, trash, biohazardous and hazardous waste disposal, discharge cleaning and moving of departments. Hazard Surveillance rounds are conducted and housekeeping problems are reported to the ~~Manager~~Director Support Services to better control quality. Housekeeping is accomplished by ~~housekeeper~~Housekeeper I staff and supervised by a working ~~housekeeper~~Housekeeper II and a ~~custodial manager~~Supervisor.

14. **Food and Nutrition Services**
    The scope of services provided by Food and Nutrition ~~include:~~
    ~~Provision~~includes the provision of meals for patients ~~for~~of all age groups~~.~~
    ~~Provision~~, provision of food services for employees, visitors, and physicians

~~Nutritional~~, nutritional assessment for all patients, with emphasis on high-risk patients, nutritional education and counseling for both inpatients and outpatients, and catering for special functions.
~~Nutritional education and counseling for both inpatients and outpatients.~~
~~Catering for special functions~~
Employees involved in these services are the ~~Department~~ Director Support Services, Clinical Dietitians, Cooks, Diet Technicians~~,~~ and Food Service Workers.

15. **Health Information Management**
The scope of service includes analysis of deficiencies and coding the electronic medical record; maintenance and control of all medical records; preparing correspondence for medical disability claims, copying and mailing medical records as a response to billing or legal requests. All significant clinical information shall be incorporated into the patient record in sufficient detail to enable the responsible practitioner to provide continuing care to the patient to determine what the patient's condition was at a specific time and to review the diagnosis and therapeutic procedures performed and the patient's response to treatment. Medical Records duties are carried out by Record Technicians who are trained in various duties of the Medical Record Department.

16. **Cardiology and Electroencephalogram (EEG) Services**
The scope of care in the Cardiology Department has been established to provide quality diagnostic testing to adults, children and infants, which require~~:~~
~~Electrocardiograms~~ electrocardiograms and rhythm strips
~~Treadmill~~, treadmill stress testing and ~~Thallium Treadmill Testing~~
~~Neurology Testing,~~thallium treadmill testing and electroencephalograms (~~EEG~~EEGs)
. These exams are performed by ~~Cardiology~~Diagnostic Technicians with training in electrocardiograms~~, and electroencephalogram~~ and electroencephalograms.

VIII. **SCOPE OF NURSING SERVICE:**

Nursing is an organized and systematic process provided by or under the direction of a Registered Nurse. The practice of nursing encompasses the provision of care to patients and their families. It requires specialized knowledge, judgment, and skills derived from the principles of biological, physical, behavioral, social and nursing sciences and research. The nursing process is the basic tool for identifying and assessing patient's needs and planning appropriate care. The nursing process also encompasses evaluation of the interventions and implementing revisions when necessary to provide the most effective care.

The nursing profession serves as a foundation for health care, optimizing, restoring and maintaining physical and psychosocial functions of the individual. As such, nursing includes the recognition of priority health care needs, health care teaching, managing interdisciplinary patient care and patient advocacy. Nursing services are provided in a collaborative atmosphere, working with other disciplines to provide quality, cost effective and individualized health care to all patients. The services offered are designed to meet the unique needs of Ventura County, which is composed of all ages, diverse cultures and socioeconomic backgrounds.

Nursing care is provided based upon the needs of the ~~patients in acute care, Ambulatory care and Behavioral Health services~~patient:

A. **NURSING DEPARTMENT ORGANIZATION:**

The Nursing Department consists of an ~~Administrative Function~~administrative function, ~~Clinical Function~~clinical function and an educational function, ~~Educational Function, and an Infection Control Function,~~ which are under the jurisdiction of the Chief Nursing Officer.

The Chief Nursing Officer is a Registered Nurse licensed in the state of California with appropriate education and experience. The Chief Nursing Officer is employed on a full time basis and reports to the Hospital ~~Administrator/~~Chief Executive Officer. The Chief Nursing Officer is accountable for providing an optimal level of patient care in an environment conducive to professional practice. The Chief Nursing Officer will oversee the provision of nursing care that is in compliance with requirements of Title 22, The Joint Commission (TJC) ~~Standards and~~standards as well as other regulatory bodies. The Chief Nursing Officer is responsible to the Hospital Chief Executive Officer for meeting the staffing standards of the Nursing Units.

The administrative function consists of staffing standards, budgetary needs, timekeeping and payroll duties. The Nursing Supervisors and Clinical Nurse Managers are responsible each shift for providing competent staff based on the needs of the patients. Nursing Supervisors function as the Administrative ~~function consists of staffing standards, budgetary needs, timekeeping, and payroll duties. The Nursing Supervisors and Clinical Nurse Managers are responsible each shift for providing competent staff based on the needs of the patients. Nursing Supervisors function as the Administrative~~ representative in the absence of the Hospital Chief Executive Officer and Chief Nursing Officer. An Administrator~~/Chief Executive Officer and Chief Nursing Officer. An Administrator~~ On Duty (AOD) provides back-up support. The Nursing Administrative team is responsible for ensuring one level of nursing care throughout the facility. The ~~Administrative~~administrative team is responsible for ensuring all appropriate staff possess current licensure and competency. The Clinical Nurse Managers are responsible for establishing annual departmental goals. Each Clinical Nurse Manager is responsible to the Chief Nursing Officer for the planning, implementation~~,~~ and evaluation of quality nursing care delivered in their respective service area. Patient care will be delivered by competent Registered Nurses, Licensed Vocational Nurses, Nursing Assistants~~,~~ and Operating Room Technicians. Job duties will be assigned based on scope of practice, regulatory requirements and competency. The Registered Nurse is responsible for overseeing the nursing process. Non-patient care duties will be performed by Medical Office Assistants and supervising clerks to support and assist patient care providers.

The education function is directed by the Clinical Nurse Manager, Education ~~Function is directed by the~~. The Education program consists of staff development and community education. The Clinical Nurse Manager is responsible for overall needs assessment, ~~Education. The Education program consists of~~planning, implementation and evaluation of educational programs designed for the professional and technical growth of the nursing staff ~~development and community education~~and orientation of new nursing staff. The Clinical Nurse Manager is responsible for ~~overall needs assessment,~~ planning, ~~implementation, and evaluation of educational programs designed for the professional and technical growth of the nursing staff and orientation of new nursing staff. The Clinical Nurse Manager is responsible for planning,~~ implementing~~,~~ and evaluating patient/family education. The Clinical Nurse Manager will network with agency and community resources to provide quality patient education.

PHILOSOPHY

Nursing does not occur in a vacuum. Nursing consistently collaborates in practice with ~~resident and attending physicians~~Resident and Attending Physicians, ~~ancillary support and~~Ancillary Support and Hospital Administration. VCMC/SPH Nursing Services strive to:

- Deliver care across the continuum
- Ensure patients are the center of nursing care
- Provide the highest quality nursing care for our patients and their families.
- Promote patient and family education allowing for the optimal level of health
- Maintain the nursing process as an integral part of practice
- Develop patient focused goals allowing for collaboration from all care providers, the patient and families.
- Exhibit ethical and professional behavior allowing for a culture that supports empowerment and accountability.
- Utilize evidence based practice through continuous quality improvement

B. **NURSE STAFFING**

The Chief Nursing Officer is responsible for coordinating the overall Nursing Department Staffing Plan. The staffing will be reviewed annually and on an ongoing basis to ensure appropriate staff mix, numbers of staff~~,~~ and cost effectiveness. Daily staffing will be assessed by the Clinical Nurse Managers, Nursing Supervisors and the Nursing Administration Staffing Coordinator.

All reasonable steps will be taken to ensure that a sufficient ~~numbers~~number of qualified staff are assigned to assess, identify problems, intervene, evaluate, delegate and coordinate safe patient care. There shall be a documented method of determining staffing requirements based on the assessment of patient needs (see ~~Administrative~~ policy ~~108.006~~*108.006 Nurse Staffing and Scheduling*) in conjunction with adhering to California mandated staffing ratios.

Positions within the Department of Nursing are outlined in a position description which includes the scope, responsibilities, requirements, line of authority and demands of the position. In addition, each position has an evaluation, which includes specifically measurable performance criteria.

C. **NURSING STANDARDS**

The Nursing Department will maintain established Standards of Care and Standards of Practice to meet the needs of the patients and their families. The Nursing Departmental Standards will be based on nationally recognized standards and/or community standards when appropriate (see ~~Administrative~~ policy ~~108.004~~*108.004 Nursing Standards*).

VCMC/SPH Nursing leadership has the responsibility to promote one standard of nursing care when appropriate. This is accomplished through:

- Professional networking
- Department Head Team meetings

- Inter-agency participation in Agency-wide New Employee Orientation, ~~EOC~~Environment of Care Committee and Emergency Preparedness/Planning
- Integrated Infection Control activities
- Hazardous surveillance audits
- VCMC/SPH Administrative policy adherence when appropriate
- Adherence to Ventura County Administrative (~~CAO~~CEO) policies
- ~~Adherence to S.E.I.U. and C.N.A. MOU's~~Adherence to Service Employees International Union and California Nurses Association (CNA) Memorandum of Agreements
- Shared ancillary services

~~Inter-agency participation in the PPC Committee~~

D. **NURSING STAFF DEVELOPMENT/ EDUCATION PLAN**

VCMC/SPH will provide an educational system that will promote staff growth, the advancement of the nursing profession, and the health and safety of VCMC/SPH staff, patients, and visitors. The education function will be a written, organized in service education program for all nursing staff, including temporary staff.

The Chief Nursing Officer or designee is responsible for ensuring all nursing staff:

1. Receive mandated education;
2. Receive orientation to hospital and unit before patient care is assigned; will complete competency validation and have the appropriate documentation in the employee staff file;
3. Will be assigned only duties with validated documented competency;
4. Receive education and training based on current Standards of Practice, established standards of staff performance, staff needs, and issues identified through the Performance Improvement process.

~~**PERFORMANCE IMPROVEMENT**~~

~~All departments are an integral part of the performance improvement process and actively participate in the agency-wide Quality Assessment Performance Improvement (QAPI) Program designed to monitor, evaluate and improve the quality and appropriateness of clinical services and patient care by:~~

~~Following the Plan, Design, Measure, Assess, Improve philosophy adopted by the facility~~
~~Identifying opportunities for improvement through a collaborative, interdisciplinary process.~~
~~Implementing solutions and actions, which will bring about desired changes.~~
~~Participate in the PI committees and Task teams~~
~~Assist with monitoring to assess for improvement and identify problem areas~~
~~Indicators will be established to monitor in an ongoing manner, and provide linkage between risk management and performance improvement.~~
~~Establishing indicators and thresholds to assist with performance monitoring. The Pre-established levels, that when exceeded, may trigger an intensive evaluation. External and internal benchmarking will be utilized when appropriate.~~

~~Participate in Sentinel Event task force and root cause analysis~~

~~All managers are active members of the Performance Improvement Coordinating Council (PICC). Examples of Indicators for ongoing monitoring may include, but not be limited to:~~

- ~~Patient Satisfaction~~
- ~~Infection Rates~~
- ~~Medication Errors~~
- ~~Patient injuries~~
- ~~Documentation~~
- ~~Employee Injuries~~
- ~~Blood borne Pathogen Exposures~~
- ~~Unit specific indicators to address High risk, High volume, Problem Prone issues~~

Indicators are subject to change based on the multidisciplinary, collaborative process of Performance Improvement.

~~ORGANIZATIONAL AND FUNCTIONAL RELATIONSHIPS BETWEEN DEPARTMENTS~~

~~A management philosophy that combines realistic delegation of authority with principles of participative management has been adopted to carry out our mission and fulfill our vision. This philosophy is based on three interrelated management structures designed to provide support, direction and achievement:~~

- ~~Line Structure – provides goods and services for the care, treatment and comfort of our patients.~~
- ~~Staff Structure – provides support elements (goods, services, manpower) to assist the line structure of the organization.~~
- ~~Strategic Planning Accountability and Resourcing Council (SPARC) Structure – provides venue for proposal and review; coordinate, demonstrate and arbitrate issues, policies and procedures that have medical center-wide impact. SPARC is composed of administrative level representatives and physicians. Its purpose is to act as a coordinating, reviewing and proposing body for senior management on matters both operational and social, that have broad medical center implications. It is the approving authority for all VCMC/SPH committees (other than Medical Staff committees). It is the responsibility to report to the Chief Executive Officer the approval/disapproval of proposals, policies or procedures that have medical center-wide implications. SPARC reports decisions to the Oversight Committee.~~

The VCMC/SPH organizational chart is attached (see Attachment A). In addition, functional relationships between departments are evidenced by multidisciplinary Performance Improvement activities, Information Management, Care Coordination Rounds, Management meetings and collaborative development of policies and procedures.

Specific collaboration is evident in departmental plans for provision of patient care. These functional relationships foster communication between and among individuals and components of the organization to coordinate internal activities.

Unit-focused interdisciplinary committees, (e.g. Intensive Care, NICU, Perinatal) will plan, design,

measure, assess and improve all key functions, (e.g. assessment of patient, treatment of patient, patient education, etc.) within their units. These committees integrate their work regarding functions with the responsible hospital-wide services, committees and groups.

IX. **PERFORMANCE IMPROVEMENT**

A. Every department plays an integral role of the performance improvement process and actively participate in the Quality Assessment Performance Improvement (QAPI) Program designed to monitor, evaluate and improve the quality and appropriateness of clinical services and patient care by:

- Following the Plan, Do, Study, Act (PDSA) philosophy adopted by the facility.
- Identifying opportunities for improvement through a collaborative, interdisciplinary process.
- Implementing solutions and actions, which will bring about desired changes.
- Participates in the Performance Improvement committees and ad hoc teams.
- Assists with monitoring to assess for improvement and identify problem areas.
- Indicators will be established to monitor in an ongoing manner, and provide linkage between risk management and performance improvement.
- Establishing indicators and thresholds to assist with performance monitoring. The pre-established levels, that when exceeded, may trigger an intensive evaluation.
- External and internal benchmarking will be utilized when appropriate.
- Participate in Sentinel Event and root cause/event analysis reviews.

B. All managers are active members of the Performance Improvement Coordinating Council (PICC) and Patient Safety Committee. Examples of indicators for ongoing monitoring may include, but not be limited to:

- Patient satisfaction surveys
- Infection rates
- Medication errors
- Patient injuries
- Documentation
- Employee injuries
- Bloodborne pathogen exposures
- Unit specific indicators to address high risk, high volume, problem prone issues
- Regulatory required standards

C. Indicators are subject to change based on the multidisciplinary, collaborative process of Performance Improvement.

X. **DIRECTING SERVICES**

The Leadership Team at VCMC/SPH ensures appropriate direction, management and leadership of all services and/or departments to assure that uniform delivery of patient care services is provided throughout the organization. The Leadership Team provides organizational communication in order to guide the day-to-day activities of its personnel and to create an environment that encourages staff to be

innovative, and to implement, and/or improve programs and plans for patient care. As well, leadership strives to ensure that systems are in place to promote the integration of services that support the patients' continuum of care needs in a way that promotes consumer understanding.

VCMC/SPH continuously develops leaders at every level who help to fulfill the organization's mission, vision, values, and goals to accurately assess the needs of patients. In doing so, VCMC/SPH has developed an organizational culture that focuses on quality and patient safety, and continuously examines opportunities to improve performance to meet these needs. In addition, education and development of staff is consistent with standards of practice and competency requirements and is the joint responsibility of the individual employee and the Hospital. As well, leadership plays a role in teaching and coaching staff. Communication of the aforementioned begins in Hospital Orientation and continues at Department level meetings, Senior Leadership employee forums, as well at interdisciplinary team meetings, on an ongoing basis.

The management philosophy is one that combines realistic delegation of authority with principles of participative management. Principles of shared governance are inherent in the organization and are designed to promote participative decision making, invest directors with the authority and responsibility to direct and guide assigned departments, foster staff involvement and assure current standards of practice. VCMC/SPH leadership appoints appropriate committees and task force(s) to ensure interdepartmental collaboration on issues of mutual concern that require multidisciplinary input. The organized Medical Staff is represented through the Medical Executive Committee as well as the VCMS Strategic Planning, Accountability, and Resourcing Council (SPARC), a subcommittee of the medical staff that is tasked with supporting senior leadership by representing medical staff interests in strategic planning, optimizing operations and evaluating.

As well, the leadership at VCMC/SPH promotes a budgeting process that allows leaders an opportunity to identify the expected resource needs of their departments, and to have direct input into both the budgetary process and resource allocation. This includes, but is not limited to identifying, investigating, and budgeting for new technologies which can be expected to improve the delivery of patient care and services and eliciting input from the Hospital Staff and Medical Staff.

XI. STAFFING FOR PATIENT CARE

Patient care services are organized, directed and staffed in a manner commensurate with the scope of services offered. Staff members are assigned clinical and managerial responsibilities based on education preparation, applicable licensing laws and regulations~~,~~ and an assessment of current competence. Staff providing patient care are identified in specific departmental plans for the Provision of Patient Care.

STAFFING PATTERNS

Staffing plans for patient care service departments are developed based on the level and scope of care that needs to be provided, the frequency of the care to be provided and a determination of the level of staff that can most appropriately (competently, comfortably and confidently) provide the type of care needed.

Budgeted full time equivalents (FTEs) are determined based upon the following:

1. ~~Prior year volumes and projected volumes for current year.~~

2. ~~Internal acuity measurements based upon daily acuity indicators.~~
3. ~~Prior year case mix and projected case mix.~~
4. ~~Number of registered nurses required to provide care, supervise nursing activities, plan and coordinate care, collaborate with other disciplines and perform management functions.~~
5. ~~Number of unlicensed staff and other patient care providers, and auxiliary staff required to provide technical and basic care for patients.~~

A. Prior year volumes and projected volumes for current year.

B. Internal acuity measurements based upon daily acuity indicators.

C. Number of registered nurses required to provide care, supervise nursing activities, plan and coordinate care, collaborate with other disciplines and perform management functions.

D. Number of unlicensed staff and other patient care providers, and auxiliary staff required to provide technical and basic care for patients.

Daily and shift staffing is both decentralized and centralized and determined based upon standards, regulatory guidelines, judgment of supervisor and manager making rounds, ~~assess~~assessment of patient needs~~,~~ and skills and abilities of staff. Alterations in staffing are made, as appropriate, whenever the needs of the patients change significantly. All patient care areas are staffed with individuals deemed competent to perform duties to which assigned. Records of staff competency are kept in employee files. Skill mix utilized by each nursing area is individualized to the patient mix, the patient needs and the skills and abilities of the staff. Each cost center's (patient care unit) specific budget, including FTEs, skill mix, productive/non-productive time and projected volumes, are available to Clinical Nurse Managers and their staff. Other variables affecting staffing include regulatory guidelines for minimal staffing unusual events that affect productivity and patient outcomes, i.e. census and acuity levels, physical plant issues, system changes and training and development.

XII. RESPONSIBILITIES OF LEADERSHIP

VCMC/SPH leadership is defined as the Management Team, ~~SPARC,~~ the Medical Executive Committee~~,~~ and the Oversight Committee.

VCMC/SPH leadership will be responsible for providing a framework for planning health care services provided by the organization based on the hospital's mission and for developing and implementing an effective planning process that allows for defining timely and clear goals. The planning process includes a collaborative assessment of our customer and community needs, defining a long range strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation and policies and ongoing evaluation of the plans implementation and success. The planning process minimally addresses both patient care functions (access, treatment, patient rights, patient teaching, discharge planning, and assessment) and organizational support functions (Information ~~systems~~Technology, ~~infection control~~Infection Control, ~~safety~~Safety, ~~environment and performance assessment and improvement~~Environment of Care and Quality Assessment and Performance Improvement).

The VCMC/SPH leadership is responsible for ensuring collaboration with community leaders and organizations to design services to be provided by the organization that are appropriate to the scope and level of care required by the patients served.

The VCMC/SPH leadership team will ensure communication of the organization's mission, goals, objectives and strategic plans across the organization.

The VCMC/SPH leadership will establish standards of care that all patients can expect and which can be monitored through the hospital's ~~performance assessment and~~Quality Assessment and Performance Improvement Plan. The Quality Assessment and Performance Improvement Plan is approved by hospital leadership and is designed in order to prioritize areas for improvement ~~plan. The performance assessment and improvement plan is approved by hospital leadership and is designed to be able to~~ and re-prioritize ~~areas and improvement and reprioritize~~ in response to untoward and unexpected events, incorporate available information about risks to patients, including the occurrence of ~~sentinel events~~Sentinel Events in order to minimize risks to patients.

VCMC/SPH leadership ensures uniform delivery of patient care services provided throughout the organization.

VCMC/SPH leadership provides appropriate job enrichment, employee development and continuing education opportunities, which serve to promote retention of staff and to foster excellence in care delivery and support services.

VCMC/SPH leadership ensures staffing resources are available to appropriately meet the needs of the patients served.

VCMC/SPH leadership strives to ensure that systems are in place to promote the integration of services during the patients' continuum of care, in a way which makes sense to the consumer.

VCMC/SPH leadership appoints appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concern and requiring multi-disciplinary input.

VCMC/SPH leadership ensures the implementation of an integrated patient safety program throughout the organization.

VCMC/SPH leadership involves department heads in evaluating, planning and recommending annual expense and capital objectives, and expense budgets based on the expected resource needs of their department. Department heads are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies, which can be expected to improve the delivery of patient care and services.

XIII. RELATIONSHIP WITH GOVERNANCE

Quarterly reports to the Oversight Committee include patient satisfaction surveys, performance improvement, risk management, competencies and safety/disaster summaries. Multidisciplinary performance improvement efforts for VCMC/SPH are detailed. The report includes significant accomplishments or creative approaches that VCMC/SPH chooses to share with the governing body as well as an annual report on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and on a proactive basis.

XIV. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

The importance of a collaborative multidisciplinary team approach which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes serves as a foundation for integration. Open lines of communication need to exist between all departments providing patient care, patient services and support services within VCMC/SPH, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.

To facilitate effective interdepartmental relationships, problem solving is encouraged at the lowest levels within the organization. Staff will be open to addressing one another's issues and concerns and seeking mutually acceptable solutions. Supervisors and managers have the authority to mutually solve problems and seek solutions within their spans of control; positive interdepartmental communications are strongly encouraged.

When problems/issues involve two or more patient care areas, patient services or support services, supervisors or managers may elect to establish an interdepartmental task force of the staff from the areas involved for the purpose of identifying mutually acceptable solutions. Administrators have several options for seeking solutions to interdepartmental issues; some of these options include: establishing interdepartmental task forces/committees (ad hoc or permanent); referring to the Performance Improvement Coordinating Council for consideration in forming an interdisciplinary team; addressing issues in management team meetings; addressing issues with Administrative or Medical Staff.

Employees from departments providing patient care services need to maintain open communication channels and forums with one another, as well as with service support departments to ensure continuity of patient care, maintenance of the patient's environment and positive patient outcomes.

XV. RECRUITMENT, RETENTION AND EDUCATION

Programs to promote recruitment, retention, development and continuing education of all staff members are provided to enhance and promote patient care. Recruitment and retention is the responsibility of the Human Resources Department and the department manager with assistance from Hospital Administration. Education and orientation of staff is the responsibility of the department manager with the support of Human Resources.

XVI. RIGHTS OF THE PATIENT AND ORGANIZATIONAL ETHICS

VCMC/SPH supports the rights of each patient through policies and procedures that describe the mechanisms by which these rights are protected and exercised.

A. General Medical Consent

General medical consent is obtained from the patient or representative at the first point of contact by the physician, nurse or admitting clerk. This consent is documented through the formal admission process executed by the Admitting Department.

B. Informed Consent

Procedures requiring further explanation of risks and benefits are separately consented to by the patient. Education of the patient is provided by the physician and consent for the procedure is given ~~by the physician and consent for the procedure is given~~ by the patient. Documentation of education

and consent is entered into the medical record. When the patient is unable to give consent and a procedure is necessary to prevent harm to the patient, the procedure may be done without consent following ~~the hospital's Consent Policy~~policy *100.008 Consent for Medical Care*.

C. Patient Complaints/Grievances

There is a mechanism for the initiation, review and, when possible, resolution of patient grievances concerning the quality of care (see ~~Administrative~~ policy ~~100.005, *Patient Complaint Advocacy*~~*100.005 Patient Complaint Advocacy*).

D. Advance Directives

Patients are informed regarding Advance Directives at the time of admission. The presence or absence of an ~~advance directive~~Advance Directive is noted on the patient record. ~~Advanced~~Advance Directives are included in the assessment process during admission to the hospital (see ~~Administrative~~ policy ~~100.049, *Advance Healthcare Directives*~~*100.049 Advance Healthcare Directives*). Patients and their families, when appropriate, are informed about the outcomes of care, including unanticipated outcomes.

There are hospital-wide policies ~~on the~~regarding withholding of resuscitative services from patients and the foregoing or ~~withdrawing~~withdrawal of life-sustaining treatment (see ~~Administrative~~ policy ~~100.022, *Withdrawal of Life Support*~~*100.022 Withdrawal of Life Support*).

E. Patient Restraints

Should restraint of the patient become necessary, hospital policy will be followed (see ~~Administrative~~ policy ~~100.075, *Restraint and Seclusion*~~*100.075 Restraint and Seclusion*).

F. Ethics Committee

~~a. The VCMC/SPH Ethics Committee has two primary functions: staff education and patient case conference consultation. Members of the Ethics Committee include a multidisciplinary group of administrative, physician, nursing, and respiratory staff as well as community representatives.~~

1. The VCMC/SPH Ethics Committee has two primary functions: staff education and patient case conference consultation. Members of the Ethics Committee include a multidisciplinary group of administrative, physician, nursing, and respiratory staff as well as community representatives.

XVII. PATIENT ASSESSMENT

All patients admitted for care or treatment throughout the organization are assessed by qualified professionals. Each service within the hospital organization has developed a scope of assessment and reassessment. The processes involved in achievement of this goal are:

~~1. Data is collected to assess the needs of the patient.~~

~~2. Data is analyzed to create the information necessary to develop a plan for meeting care or treatment needs.~~

~~3. Decisions made regarding patient care or treatment are based on analysis of information.~~

A. Data is collected to assess the needs of the patient.

B. Data is analyzed to create the information necessary to develop a plan for meeting care or treatment needs.

C. Decisions made regarding patient care or treatment are based on analysis of information.

The assessment and reassessment of the patient will continue throughout the patient's ~~contact with this organization~~stay in the hospital.

~~A. Initial Assessment~~

~~Physicians perform a complete history and physical examination either within 30 days prior to admission or within two (2) hours after admission. Based on this examination and other clinical information, the physician establishes a plan of medical care and gives admitting and subsequent orders for patient evaluation and treatment. Initial assessments are performed by clinical and support department staff per policy.~~

~~B. Reassessment~~

~~Patients are reassessed according to the discipline-specific policy on reassessments.~~

~~C. Plan of Care~~

~~Based on the initial and ongoing assessments of the patient, an appropriate plan of care is developed collaboratively by the clinical disciplines. This plan of care is reviewed and updated by the multidisciplinary clinical team.~~

Based on the initial and ongoing assessments of the patient, an appropriate plan of care is developed collaboratively by the clinical disciplines. This plan of care is reviewed and updated by the multidisciplinary clinical team. See policy *100.015 Patient Assessment and Reassessment.*

XVIII. ENTRY INTO SETTING OR SERVICE

Patients enter the hospital by:

A. Self-referral from an ambulatory care setting, transfer from other institutional health care settings (such as community hospitals and skilled nursing services).

B. Scheduled surgeries.

C. Emergency admissions

~~i. Patients seeking acute medical care are referred to the Emergency Department. Women in labor may present to the Emergency Department.~~

1. Patients seeking acute medical care are referred to the Emergency Department. Women in labor may present to the Emergency Department.

D. Patients arriving via ambulance are seen in the Emergency Department unless a direct admission has been arranged in advance by the physician.

E. Patients may also be referred from ambulatory care clinics directly to the unit if arrangements are made
in advance.

XIX. TREATMENT OF PATIENT

All treatments are ~~given~~provided under the direction of a physician with professional staff privileges and membership. All treatments are ~~administered~~prescribed by physicians, nurse practitioner, physician

assistants, midwives, optometrists, prosthetist, perfusionists~~,~~ and registered nurse first assistant.

Medication Use

All medications are obtained from the inpatient pharmacy upon the order of a provider legally authorized to prescribe. All medications orders are screened by the pharmacy for appropriateness against approved criteria. Doses for certain medications are adjusted according to approved protocols by properly trained pharmacists in accordance with the physicians. See specific department plans for medication ordering, preparation, dispensing, administration and monitoring polices and procedures.

Parenteral nutrition is a multidisciplinary guided treatment coordinated with the physician, ~~the~~ Pharmacy ~~Department~~Services, Food and Nutrition Services, Nursing and ~~the~~ Laboratory ~~Department~~Services.

The Pharmacy and Therapeutics ~~committee~~Committee is responsible and accountable for monitoring compliance of this key function.

XX. **OPERATIVE AND OTHER INVASIVE PROCEDURES**

The Surgery Committee is responsible and accountable for monitoring and improving performance of this key function. These monitors include:

A. Selection of an appropriate procedure.

B. Preparation of patient.

C. Monitoring of patient.

D. Discharge of patient.

E. Invasive procedures are performed in the following environments:

~~a. Main Operating Room~~

~~b. Labor and Delivery suite~~

~~c. Gastroenterology Laboratory and Day Surgery~~

~~d. Emergency Department~~

~~e. Radiology~~

~~f. Intensive Care Unit~~

~~g. Neonatal Intensive Care Unit (NICU)~~

~~h. Pediatric Intensive Care Unit (PICU)~~

~~i. Pediatrics Department~~

~~j. Medical / Surgical Department~~

1. Main Operating Room
2. Labor and Delivery suite
3. Gastroenterology Laboratory and Day Surgery
4. Emergency Department
5. Radiology

6. Intensive Care Unit (ICU)
7. Neonatal Intensive Care Unit (NICU)
8. Pediatric Intensive Care Unit (PICU)
9. Pediatrics Department
10. Medical / Surgical Department

XXI. EDUCATION OF PATIENT AND FAMILY

The patient and/or, when appropriate, his/her family receive education specific to the patient's assessed needs, abilities, readiness to learn, cultural and religious practices, emotional barriers, physical and cognitive limitations ~~and~~, language barriers~~,~~ and financial considerations. Initial assessment and reassessments are performed by all patient care disciplines and include assessments of patient/family learning needs. The goal is to provide patients and families with the knowledge and skills to:

- Promote recovery and return to function
- Change health behaviors leading to preventative health activities
- Make appropriate ~~healthcare~~health care decisions
- Understand health status and options for treatment
- Anticipate risks, benefits of treatment, and cost

XXII. COORDINATION OF CARE

Patients are identified who require discharge planning to facilitate continuity of medical care and/or other care to meet their identified needs. Discharge planning is initiated by any member of the hospital team and will be initiated ~~on~~in a timely ~~basis~~manner. Discharge planning is addressed and monitored through the Utilization Review committee. The Utilization Review Committee is responsible and accountable for monitoring this key function.

XXIII. EVALUATION OF PLAN/SERVICES

The hospital plan for the provision of patient care shall be reviewed ~~every 3 years~~annually by the leadership of the medical center. It will also be reviewed and revised in response to changes in patient care needs and findings from ~~Performance Improvement~~performance improvement activities. Leadership considers:

A. Information from the organizations strategic planning process.
B. Proposed innovations/improvement.
C. Comparable level of care issues.
D. Performance Improvement activities, Risk Management, Utilization Review and any evaluation activity.
E. Staffing variance reports.
F. Staffing implications based upon patient requirements.

   ~~Budget variance information~~

G. Review of sources that address adequacy of fiscal and other ~~sources that address adequacy of fiscal and other~~ resource allocations.

H. Organizations ability to attract and develop staff.

I. Patient safety issues including the occurrence of ~~sentinel events~~Sentinel Events.

XXIV. **CLINICAL FACILITIES**

Clinical facilities are provided for students based on a sense of commitment to community, patient care, education and research, but also as part of our recruitment effort.

Formal written agreements are in place for each school with regular and ongoing affiliations~~,~~ and special agreements are written for individual student placements, i.e., master's students with clinical specialists. These agreements will stipulate that VCMC will retain ultimate responsibility for the care of the patient.

XXV. **MEDICAL STAFF AND FAMILY PRACTICE RESIDENCY**

The Medical Staff means the formal organization composed of duly licensed medical and osteopathic physicians, oral surgeons, dentists, psychologists and podiatrists who are privileged to attend patients. A cooperative, collaborative and harmonious relationship is encouraged between VCMC/SPH departments and the Medical Staff. It is recognized that the Medical Staff possesses the position of ~~Medical~~medical authority and in that capacity gives orders to the authorized and/or appropriate staff in caring for their patients. Authorized nursing staff is responsible to the Medical Staff for carrying out their orders in accordance with Medical Staff Rules and Regulations and VCMC/SPH policies and procedure.

In instances of Medical Staff/VCMC/SPH/departmental/nursing department conflicts or issues related to patient care, the appropriate medical department chief or director is contacted and consulted with regarding appropriate resolution. In the absence of the medical staff departmental representative, the medical director is consulted.

Residents, selected members of the Department of Nursing~~,~~ and appropriate clinical department staff sit on Medical Staff committees and department meetings.

The Family Practice Residency is associated with ~~the~~Keck Medicine of University of Southern California~~, Los Angeles~~ (~~UCLA~~USC) ~~School of Medicine~~. Residents train in family-centered medicine and their office practice occurs in the Academic Family Medicine Center, which is to approximate private practice.

The Resident Medical Staff rotate through all services provided at VCMC~~,~~ and provide the majority of medical care to the patients under the direct supervision of the Medical Staff.

All revision dates: 4/7/2023, 9/2/2021, 4/17/2020, 7/1/2017, 5/1/2006, 10/1/2001, 10/1/1998

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	7/24/2023
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	5/17/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/7/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/7/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/7/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/7/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/1999*
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Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.070 Moderate and Deep Sedation

POLICY:

To outline the patient care and management of inpatients or outpatients who receive medication with the intent to produce moderate or deep sedation for diagnostic or therapeutic procedures. To ensure the safe and effective administration of moderate and deep sedation.

PROCEDURE:

DEFINITIONS

There are varying levels of sedation. Increased depth of sedation increases the likelihood that the patients airway, ventilation, and cardiovascular function will be affected. In addition, medications administered with the intent to induce one level of sedation may result in a lighter or deeper level of sedation, depending upon the agent(s) used and the physical status and drug sensitivities of the individual patient.

A. **Minimal Sedation** (Anxiolysis): A drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

B. **Moderate Sedation** (previously known as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

C. **Deep Sedation**: A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilations may be inadequate. Cardiovascular function is usually maintained.

D. **General Anesthesia**: A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

COROLLARIES

A. This policy only applies to the administration of medication(s) with the intent to produce moderate or deep sedation to permit performance of a procedure. This policy does not include patients who receive calming agents for the sole purpose of managing anxiety and behavioral emergencies, patients who receive analgesia with the goal of pain control without moderate sedation or patients who are intubated.

B. Individuals administering moderate or deep sedation must be qualified and have credentials to manage and rescue patients at whatever level of sedation is achieved, either intentionally or unintentionally.

C. If the intent is to induce a state of depressed consciousness beyond deep sedation then the physician must have the expertise and advanced airway management as ordinarily provided to patients undergoing general anesthesia.

QUALIFIED STAFF AND PHYSICIANS

A. For moderate sedation, care and medication administration shall be provided by either a licensed nurse or a physician. For deep sedation, care shall be provided by a licensed nurse, however deep sedation medications MUST be administered by the physician. The nurse will satisfy the following conditions:

1. For pediatric moderate or deep sedation, a current Pediatric Advanced Life Support (PALS) or Emergency Nurses Pediatric Course (ENPC) card and completion of the *Pediatric Procedural Sedation Module*.
2. For adult moderate or deep sedation, a nurse requires a current Advanced Cardiovascular Life Support (ACLS) card and completion of the *Adult Procedural Sedation Module*.
3. If assistance is needed with procedure, additional personnel is required while the primary nurse focuses only on monitoring/caring for the patient.

B. A. Physicians who seek privileges in moderate and deep sedation must ~~also~~ be ~~credentialed by~~granted sedation privileges through the Medical Staff ~~office~~credentialing process, complete the sedation modules and post-test, and maintain a current ACLS (adult privileges) and/or PALS (pediatric privileges) certificate. ACLS/PALS requirements may be waived for physicians board certified in Anesthesia, Emergency Medicine, and Critical Care specialties unless otherwise specified in the department/specialty privileging requirements. Physicians must undergo initial proctoring in accordance with established privileging criteria.

C. In addition to the individual performing the procedure, a sufficient number of qualified staff must be present to evaluate the patient, to provide the sedation, to help with the procedure, and to monitor and recover the patient.

PRE-SEDATION ACTIVITIES

A. ASSESSMENT

1. Within 48 hours prior to the procedure, the physician will complete a pre-sedation assessment in the electronic health record (EHR). Components of the pre-sedation assessment will include:
   a. Patient's diagnosis, planned procedure and location of sedation
   b. Last solid and liquid intake
   c. Presence of food, drug, latex, or contrast allergies

d. Current medications have been reviewed and documented
e. Patient's pertinent review of systems (presence of any acute illness or chronic condition that may place the patient at higher risk to experience complications during sedation)
f. Presence of previous complications from sedation or anesthesia
g. Patient's weight in kilograms
h. Patient's temperature, blood pressure, heart rate, respiratory rate, pulse oximetry
i. Focused physical exam consisting of the following:
    i. Mental status examination
    ii. Mallampati Classification (Attachment A)
    iii. Respiratory exam
    iv. Cardiovascular exam

2. The physician will assign an American Society of Anesthesiologists (ASA) status and document the ASA status in the procedural sedation note. If the patient is ASA class 3 or higher then the physician will consider consultation with anesthesiology (See Attachment B).
3. The physician will document the sedation plan.
4. The physician will perform an informed consent that includes a discussion of all reasonable risks and benefits of sedation, alternatives of sedation, risks and benefits of alternatives, and the monitoring plan.
5. Just prior to the administration of moderate or deep sedation, the physician will perform and document a Pre-Induction Assessment, which should include the following:
    a. Vital signs
    b. Status of the airway
    c. Response to any pre-procedure medications

B. VERIFICATION

1. The nurse will verify that an informed consent form is completed.
2. The nurse will verify that current medications have been reviewed and documented.
3. The nurse will verify that the physician orders for medication are completed.
4. The nurse and physician will verify the allergy status of the patient.
5. A time out will occur according to policy 100.062 Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.
6. The physician and nurse will assess the patient's NPO status. The physician will consider the ASA guidelines in proceeding with sedation.

Clears	Breast Milk	Formula/Milk	Light Meal
2 hours	4 hours	6 hours	6 hours

Although recent food intake is not an absolute contraindication for administering sedation, the physician must weigh the risk of pulmonary aspiration and the benefits of providing sedation in accordance with the needs of each individual patient. In accordance with the American Society of Anesthesiologists, do not delay moderate procedural sedation based on fasting times alone in urgent

or emergent situations where complete gastric emptying is not possible.

7. The nurse and physician shall verify the following emergency support is available:
    a. Intact crash cart and defibrillator is secured and immediately available. The crash cart will contain emergency medications for resuscitation and reversal agents according to policy 100.113 Crash Cart Checks and Restocking Process.
    b. Appropriate resuscitation equipment is available in the sedation area.
    c. The pediatric airway bag is present for pediatric patients.
    d. An oxygen tank is available if the patient is to be transported.
    e. Medications needed for emergent intubation are available.
    f. An intra-procedure monitor that is capable of performing capnography.
    g. The presence of a portable monitor if the patient is to be transported while sedated.

INTRA-PROCEDURE ACTIVITIES

A. MODERATE SEDATION: ADMINISTRATION, MONITORING AND DOCUMENTATION

1. Connect automated blood pressure cuff, pulse oximetry, electrocardiogram (EKG) leads, and respiratory leads and place patient on continuous monitor. During moderate sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and continual monitoring with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment.
2. Place patient on supplemental oxygen as ordered by the physician.
3. Record the blood pressure and heart rate every five (5) minutes. Record the EKG rhythm, respiratory rate, pulse oximetry, and Richmond Agitation Sedation Scale (RASS) Score (Attachment C) every 15 minutes.
4. The physician or nurse may administer the ordered medication(s) intended to produce moderate sedation. If the nurse administers the medication(s), the physician must be present when the dose is administered.
5. Vital sign documentation may be performed by the physician or nurse.

B. DEEP SEDATION: ADMINISTRATION, MONITORING AND DOCUMENTATION

1. Connect automated blood pressure cuff, pulse oximetry, EKG leads, and respiratory leads and place patient on continuous monitor. During deep sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and continual monitoring with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment.
2. Place patient on supplemental oxygen as ordered by the physician.
3. Record the blood pressure and heart rate every five (5) minutes. Record the EKG rhythm, respiratory rate, oximetry, and RASS score every 15 minutes.
4. Only the physician shall administer the medication(s).
5. Two physicians shall be present: one physician responsible for managing the sedated patient and another physician responsible for the procedure being performed.
6. Vital sign documentation may be performed by the physician or nurse.

EMERGENCY MANAGEMENT

A. In the event of respiratory depression/compromise, perform the following immediately:
    1. Stop the medication infusions.
    2. Suspend the procedure
    3. Support the airway as needed e.g. suction, position and oral airway.
    4. Administer increased FIO_2 as needed to maintain oxygen saturations at pre-procedure levels.
    5. Elevate head of bed (HOB) as permitted and reposition patient's chin, neck, and shoulders.
    6. Monitor vital signs as frequently as needed.
    7. Observe for changes in tissue perfusion.

B. In the event of hypotension, perform the following immediately:
    1. Stop or decrease the medication infusion per the physician orders.
    2. Administer IV fluids per the physician's orders.
    3. Await further orders from the physician.
    4. Monitor vital signs closely.
    5. Observe for changes in tissue perfusion.

C. In the event of cardiac arrest, perform the following immediately:
    1. Stop the medication infusions.
    2. Call for "Code Blue" for adult patients or "Code White" for pediatric patients.
    3. Initiate cardiopulmonary resuscitation (CPR).

POST-PROCEDURE ACTIVITIES

A. Post-Procedure expectations of physician
    1. For all patients who are deeply sedated, the physician will continue to remain at the bedside until the patient meets criteria for moderate sedation.
    2. If a patient meets criteria for moderate sedation, the physician may leave the bedside but must remain in the immediate area until the patient meets criteria for minimal sedation.
    3. If a patient meets criteria for minimal sedation, the physician or designee must remain available in the hospital until the patient meets discharge criteria or is no longer minimally sedated.

B. Post-Procedure expectations of nurse
    1. For deeply sedated patients, the nurse will remain at the bedside and ensure that vital signs continue to be documented every five (5) minutes.
    2. Once the patient meets criteria for moderate sedation, the nurse will chart vital signs at least every 15 minutes. The nurse will remain at the bedside until the patient meets criteria for minimal sedation.
    3. Once the patient meets criteria for minimal sedation, the nurse may leave the bedside. Vital signs will be documented at least every 15 minutes until the patient meets criteria for discharge or is no longer minimally sedated.

C. In addition to the above monitoring parameters, the nurse will also monitor the following:
    1. Pain level
    2. Procedure site and dressing as applicable
    3. Ability to follow instructions as appropriate
    4. Patency of peripheral IV site
D. Prolonged or overnight monitoring should be considered for the following:
    1. Full term infant who is less than 46 weeks post-gestation
    2. Pre-term infant who is less than 52 weeks post-gestation
    3. Infants with a history of apnea of prematurity
E. Any patient who has received a reversal agent must be observed for at least two (2) hours from the time of administration of the agent.
F. If procedural sedation was used to facilitate a medical procedure, a procedural sedation note should be documented in the EHR by the physician upon completion of the operation or procedure and before that patient is transferred to the next level of care.

DISCHARGE/TRANSFER ACTIVITIES

A. The physician is responsible for discharging the patient from the recovery area or from the hospital.
B. For adult patients who will be discharged, the patient and adult responsible for the patient will be given Cerner *Procedural Sedation Discharge Instructions - Adult* (Attachment D).
C. For pediatric patients who will be discharged, the adult responsible for the patient will be given Cerner *"Recovery After Procedural Sedation (Child)"* discharge instructions (Attachment E) in either English or Spanish. The nurse will review instructions verbally with the parent(s) or legal guardian(s) prior to discharge.
D. The patient may be discharged when the following criteria are met:
    1. The patient has returned to baseline function.
        a. The patient's mental status has returned to baseline
        b. Cardiovascular and respiratory status has returned to baseline
        c. Patient is able to move and coordinate all muscle groups according to baseline
        d. Skin color has returned to baseline
    2. If appropriate, patient can verbalize post-sedation/discharge instructions.
    3. Pain management is effective (if appropriate).
    4. Procedure site and dressing are acceptable (if appropriate).
    5. IV has been discontinued.
    6. A responsible adult is present to accompany the patient from the hospital and assume responsibility for the patient upon discharge.

REFERENCES:

American Society of Anesthesiologists: Practice Guidelines for Moderate Sedation and Analgesia.

Anesthesiology 2018; 128: 437-79. American Society of Anesthesiologists: Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology* 2002; 96: 1004-1017.
The Joint Commission. Nursing Standard PC.03.01.01
The Joint Commission. Nursing Standard PC.03.01.03
The Joint Commission. Nursing Standard PC.02.01.03
Yale-New Haven Hospital Clinical Administrative Policy and Procedure Manual
The Joint Commission. Standard PC.03.01.05
UCLA Pediatric Anesthesia Manual (http://www.anes.ucla.edu/PedsResManual.pdf)
The Joint Commission. Nursing Standard PC.03.01.07
Centers for Medicare and Medicaid Services, Pub. 100-07 State Operations Provider Certification,Transmittal 59; May 21, 2010
Goodwin et al: Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department. *Annals of Emergency Medicine* 2005; 45: 177-196
The Society for Pediatric Sedation, "Sedation Provider Course."

All revision dates:

Attachments

Attachment A - Mallampati Classification
Attachment B - ASA Status
Attachment C - Richmond Agitation Sedation Scale (RASS).pdf
Attachment D - Procedural Sedation (Adult) Discharge Instructions.pdf
Attachment E - Recovery After Procedural Sedation (Child).pdf

VENTURA COUNTY
HEALTH CARE AGENCY

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Last Approved:	*N/A*
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Owner:	*Todd Flosi, MD: Associate Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.216 Electronic Pharmacy Prescriptive Order Entry Authority

POLICY:

Pharmacists have State Board of Pharmacy-approved prescriptive authority under specific protocols. These orders are active upon signing.

PROCEDURE:

Pharmacy Order Entry – Pharmacy and Therapeutics Initiatives:
Communication Type "Written – No Cosign"

a. The Pharmacy and Therapeutics Committee approves initiatives that include therapeutic substitution and Pharmacist-initiated dose rounding.
b. If an order is entered as a result of these initiatives, the "Written-No Cosign" communication type will be used.
c. These orders are active upon signing.

Pharmacy Order Entry/Modification to clarify billing and/or dispensing:
Communication Type "Written – No Cosign"

a. Billing Clarifications
    i. To ensure correct billing Pharmacy personnel will modify order entry fields and will enter orders.
    ii. These changes will not change the intent of the order.
    iii. Examples of changes would be correcting the pricing on a non-formulary item and changing the product assigned to an order (not changing the medication itself).
    iv. These changes may require discontinuing the original order and re-entering a new order.
b. Dispensing Clarifications
    i. To ensure correct dispensing, Pharmacy personnel will modify order entry fields and enter new orders.
    ii. These changes would not change the intent of the order.
    iii. Examples include changing frequencies based on standard dosing times and changing routes and products when patients have nasogastric tubes.

All revision dates:	6/9/2020, 5/31/2017, 5/1/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Policy Owner	Todd Flosi, MD: Associate Chief Medical Officer, VCMC & SPH	5/9/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Last Revised:	*7/28/2023*
Next Review:	*3 years after approval*
Owner:	*Michelle Meissner: AC Quality Improvement Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.27 Patient Complaints at Clinic Facilities

PURPOSE:

To meet the regulatory requirements related to delegated agreements from managed care plans.

POLICY STATEMENT:

Member complaints related to the quality of all ambulatory care clinic facilities will be monitored and investigated, including those pertaining to physical accessibility, availability of appropriate equipment (including accessibility equipment), appearance and adequacy of waiting areas and examination rooms, and quality of medical care and records.

PROCEDURE:

Patients will have access to the Ambulatory Care (AC) complaints and grievances phone number to report concerns regarding the clinic environment. Additionally, clinics will be required to report any patient complaints to the AC Quality team. All environmental complaints will be tracked by each contracted health plan, via the Industry Collaboration Effort (ICE)/Patient Complaints of Clinic Facilities Audit Tool. For contracted health plans that do not delegate environmental complaints, patients will be guided to communicate those concerns directly to their health plan.

AC Administration has established three (3) complaints within a 12-month period as the minimum threshold at which further action will be required in the form of an office-site visit. When 3 complaints have been received related to physical accessibility, availability of appropriate equipment, appearance and adequacy of waiting and examining room spaces or the quality of medical care or records, a site visit will be performed within 60 days of the third complaint to assess these elements.Complaints that did or are at risk for causing harm or physically prevent a patient from being ~~card~~cared for will trigger a site visit regardless of meeting the 3 complaint minimum threshold.

- When a clinic has met the minimum threshold, the clinic will be required to develop and submit to AC Administration a Corrective Action Plan (CAP) for improvement, within 30 days of receipt of notification from AC Administration.
- AC Administration will revisit the site at least every 3 months until the deficiencies related to the complaints are remedied. Documentation of the revisit will be included in the AC Quality incident reporting log.
- AC Administration will conduct a follow-up site visit of a previously deficient clinic if any additional complaints are received within 6 months of the initiation of a CAP. Follow-up site visits must be conducted within 60 calendar days of the new complaint. If the site continues to be out of compliance for clinic facilities access, appearance and or medical records safety, AC Administration or the Clinic must develop

and implement a CAP for Improvement.

Definitions:

Minimum threshold: Three complaints related to the clinic facility within 1 year.

CHC Approval 2/23/23

All revision dates: 7/28/2023, 10/30/2020

Attachments

ICE Patient Complaints of Clinic Facilities Audit Tool.pdf

Approval Signatures

Step Description	Approver	Date
MEC/Oversight	Tracy Chapman: VCMC - Med Staff	pending
AC Chief Executive Officer	Theresa Cho: Chief Executive Officer, Ambulatory Care	8/1/2023
Chief Medical Quality Officer	Rachel Stern: Chief Medical Quality Officer	7/28/2023
AC Quality Improvement Manager	Michelle Meissner: AC Quality Improvement Manager	7/28/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Emergency Services*
References:	

ER.54 Papoose: Stabilization/Safety Device for Transport of Infant/Pediatric Patients

PURPOSE

To ensure safe transport of Infant/Pediatric patients being transported to and from the Emergency Department (ED) Trauma Bay at Ventura County Medical Center (VCMC) a Pediatric Immobilizer may be used as a stabilization device to ensure the immediate physical safety of the patient.

The stabilization device will be discontinued immediately after the patient has arrived at his/her destination and/or the procedure is complete.

The device is radiotransparent and fully MRI compatible, allowing stabilization during performance of imaging procedure which includes in the MRI.

The device will be utilized in accordance with the Manufacturer's Instructions for Use (MIFU).

INDICATION FOR USE:

To facilitate stable transport of an infant/pediatric patient for imaging and/or procedures. The device may be used in stabilization for transport and enable safe completion of treatment in a timely fashion during the golden hour of trauma.

PROCEDURE

1. **Positioning**
   1.1 Position the board next to the patient (Figure 1.1)

   1.2 Open the harness system as shown in Figure 1.1

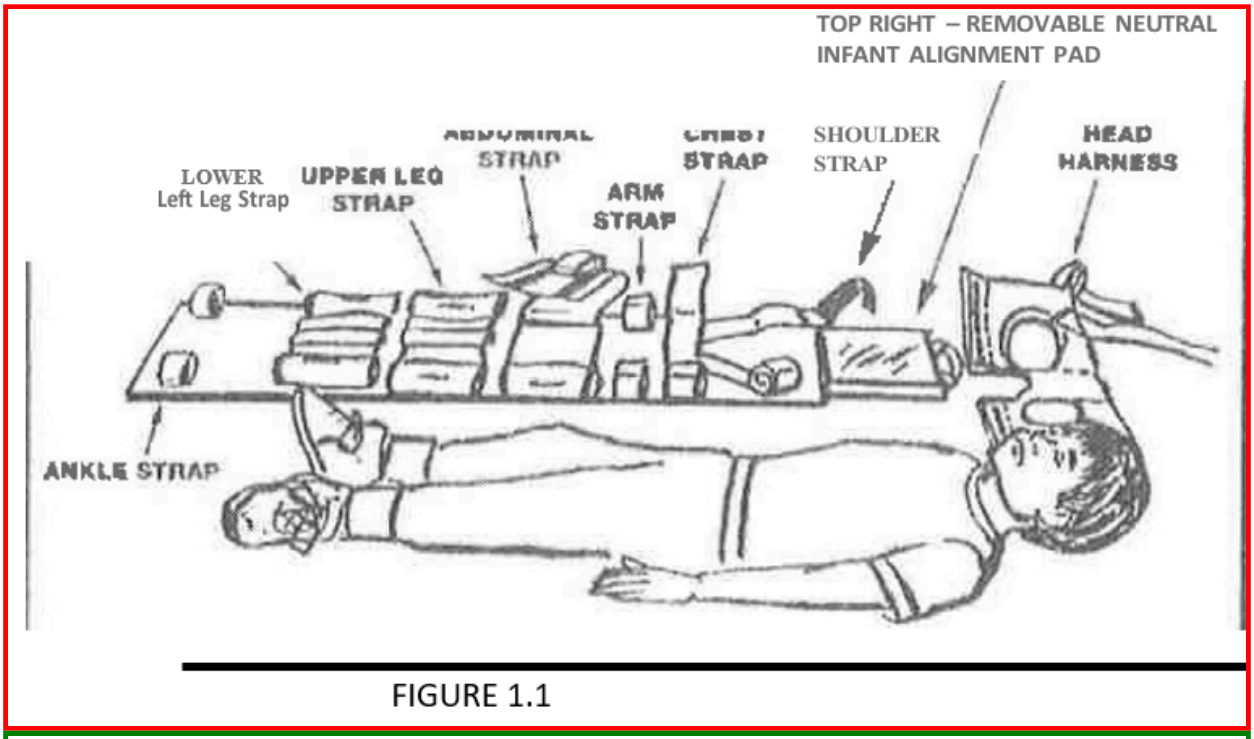


FIGURE 1.1

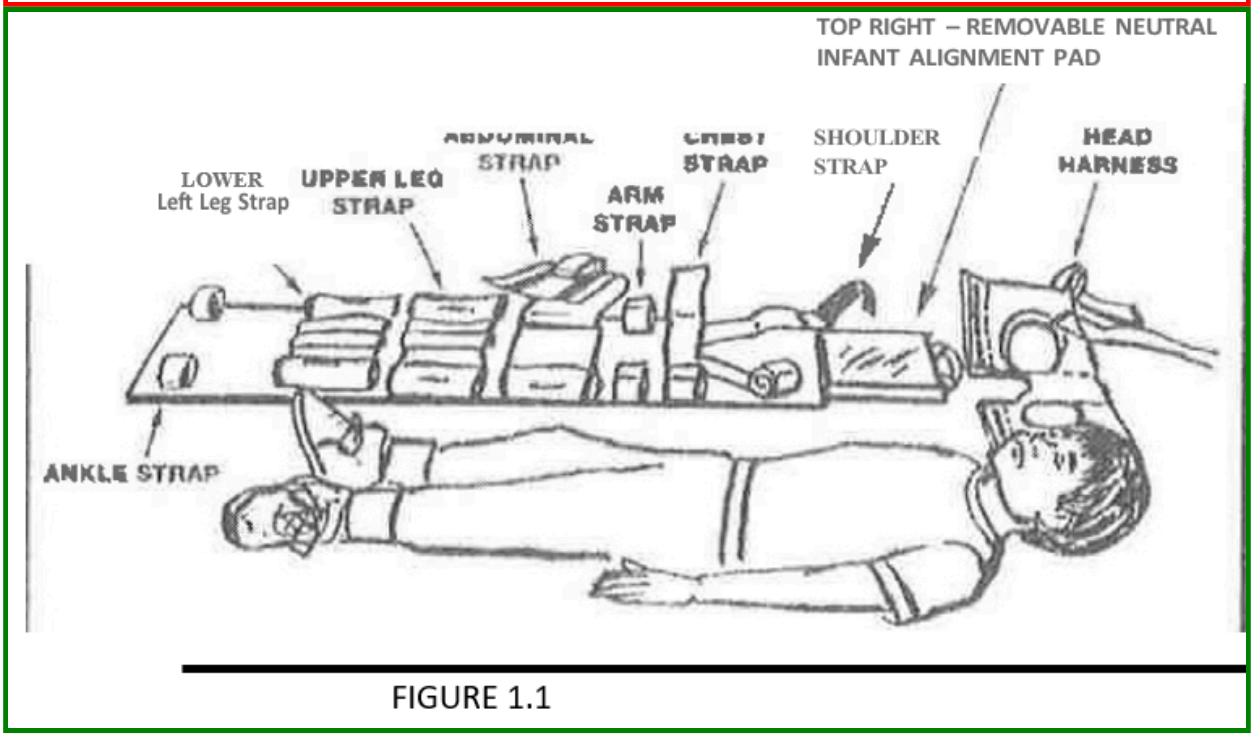


FIGURE 1.1

2. **Patient Alignment**

   2.1 Align the child's shoulders (under all circumstances) with the stitching of the shoulder straps as shown in (Figure 2.1)

   2.2 Proper shoulder alignment is essential to provide "vertical" and "horizontal" stabilization of the child's spine. This pattern of stabilization prevents shoulder as well as head movement., either of which may cause spinal displacement. (Figure 2.2)

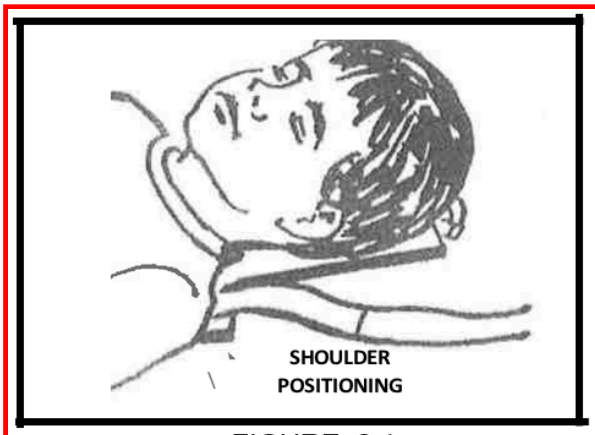


FIGURE: 2.1

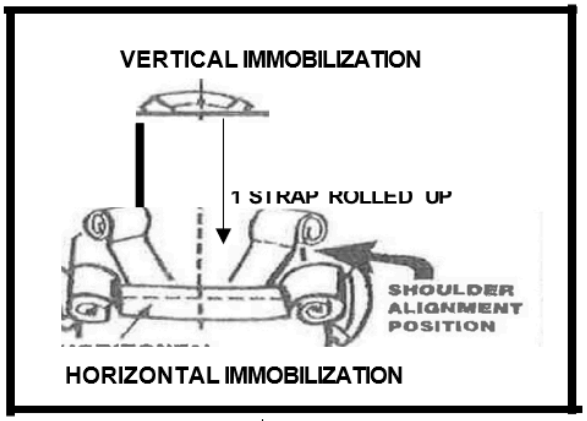


FIGURE 2.2

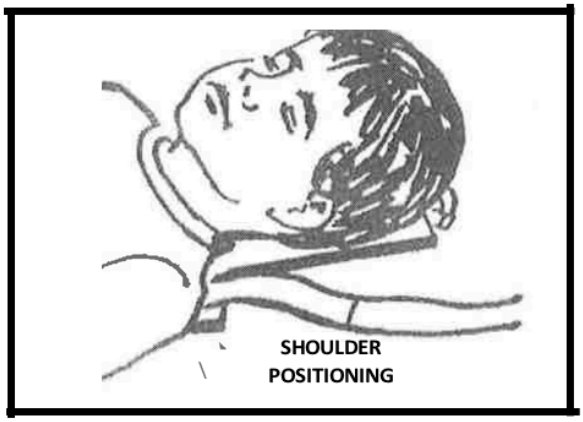


FIGURE: 2.1

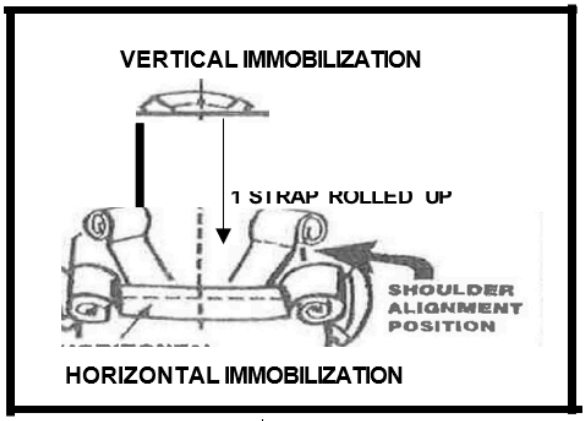


FIGURE 2.2

3. **Placement of Chest And Shoulder Straps**
   3.1 After the patient has been properly positioned on the device, place the chest strap and secure it. (Figure 3.1)

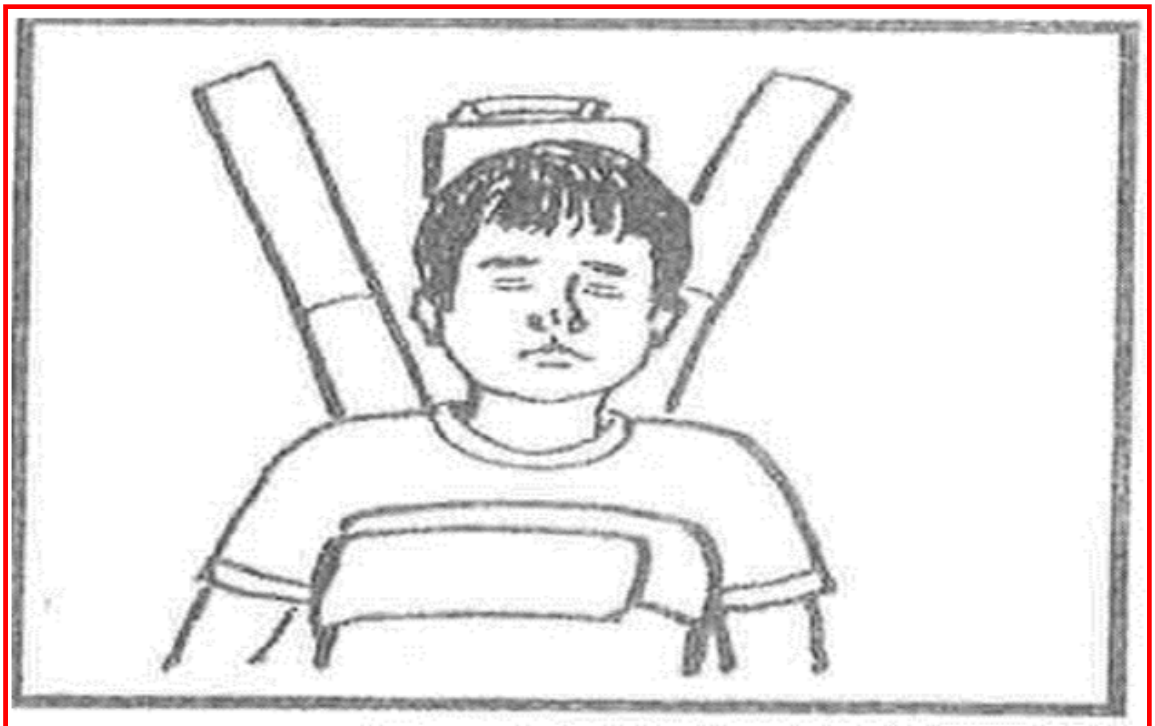


Figure 3.1

Figure 3.1

3.2 Position and secure the shoulder straps based on anatomical considerations and the condition of the child's chest. (Figure 3.2)

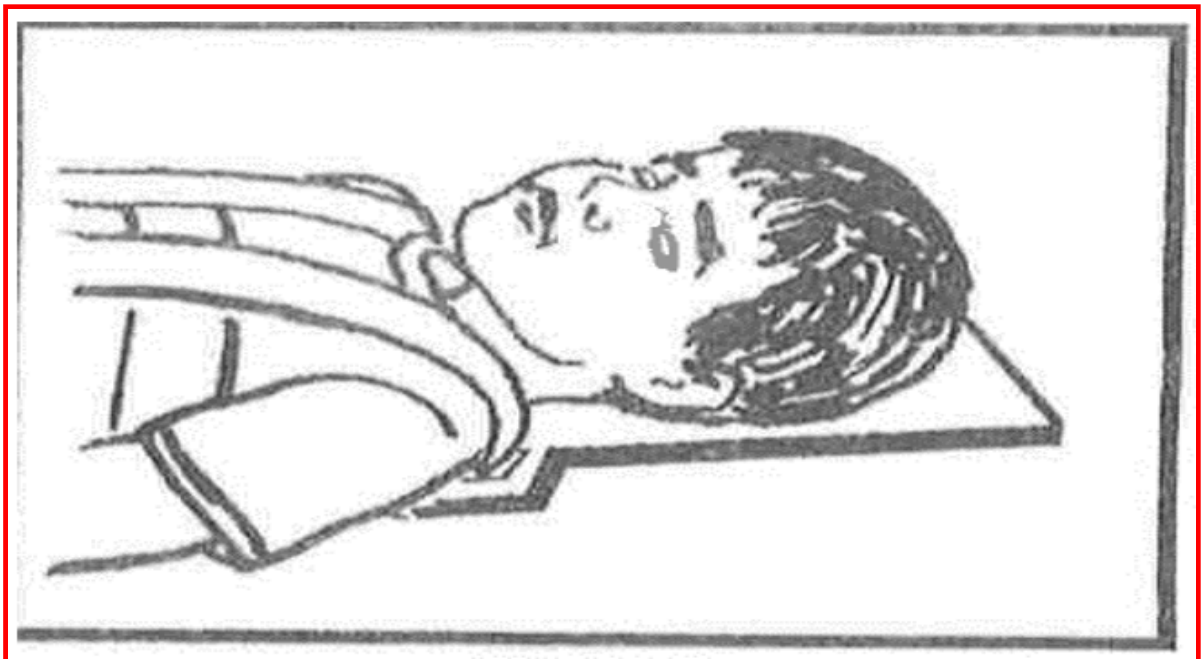


Figure 3.2

Figure 3.2

** NOTE : Avoid over tightening either the shoulder or chest straps since they could obstruct chest expansion. also ensure they are secured enough to stabilize the upper torso.*'*

4. **Attaching The Head Harness and Stabilizing the Head**
   4.1 Hold the head harness by the hook and loop fasteners at the bottom of the foam rubber sections. (Figure 4.1)

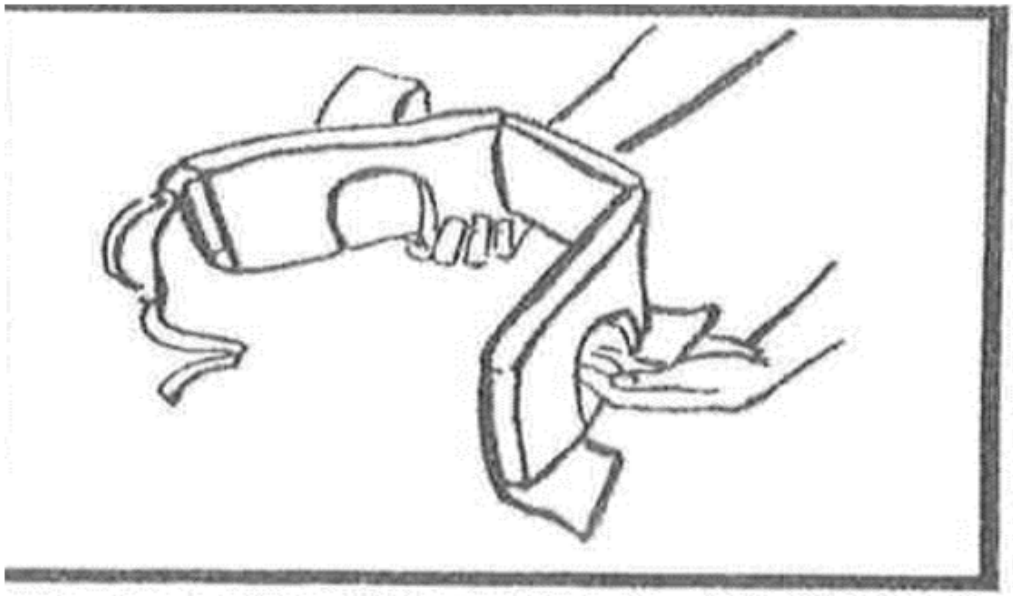


Figure 4.1

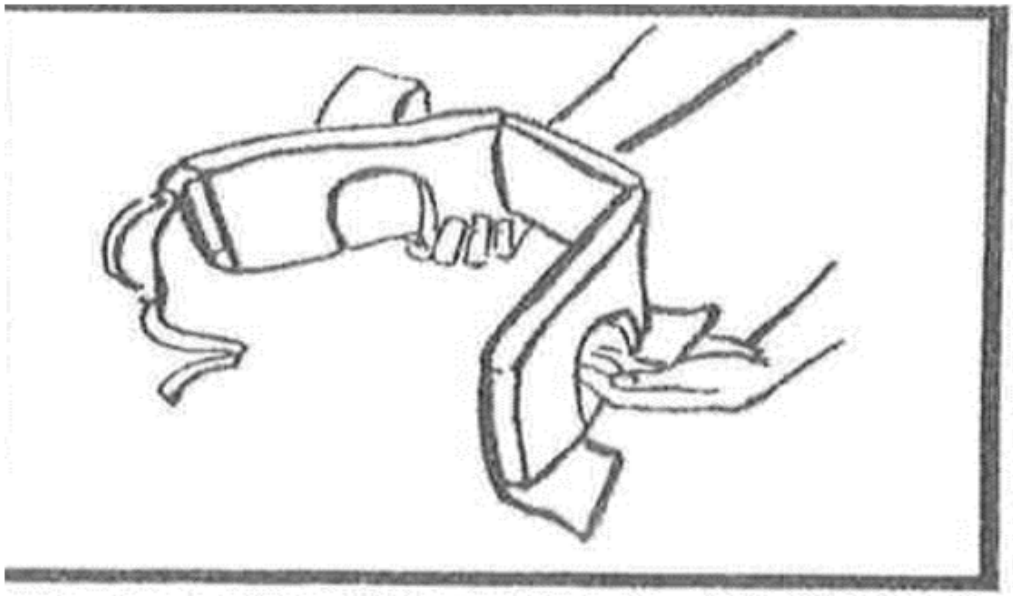


Figure 4.1

4.2 Position the center foam rubber section against the top of the victim's head while its bottom rests on the surface of the device (Figure 4.2 & 4.3)

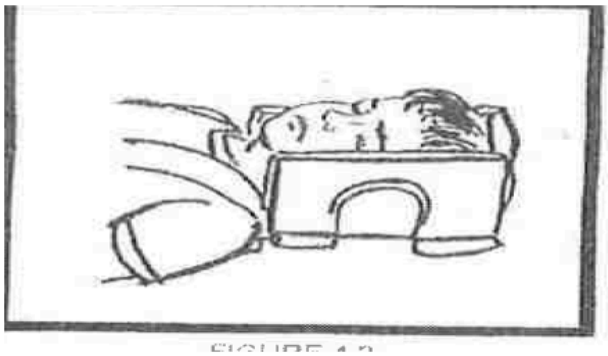


Figure 4.2

Figure 4.3

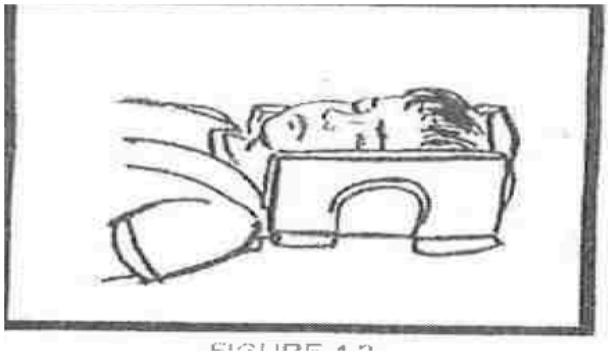


Figure 4.2

Figure 4.3

4.3 While applying counter pressure to one side of the head, gently press the opposite side foam section against the patient's head and secure the hook and loop flap to the underside of the board. Repeat the procedure for the other side. (Figure 4.3)

** NOTE: The head harness design allow use with most standard cervical collars.**

4.4 Firmly adjust the forehead strap while applying counter pressure to the left side of the patient's head by using an arching motion over the child's eyebrows so the head does not move. When properly positioned, the forehead strap should connect to both outer sides of the head harness at the same angle. (Figure 4.4)

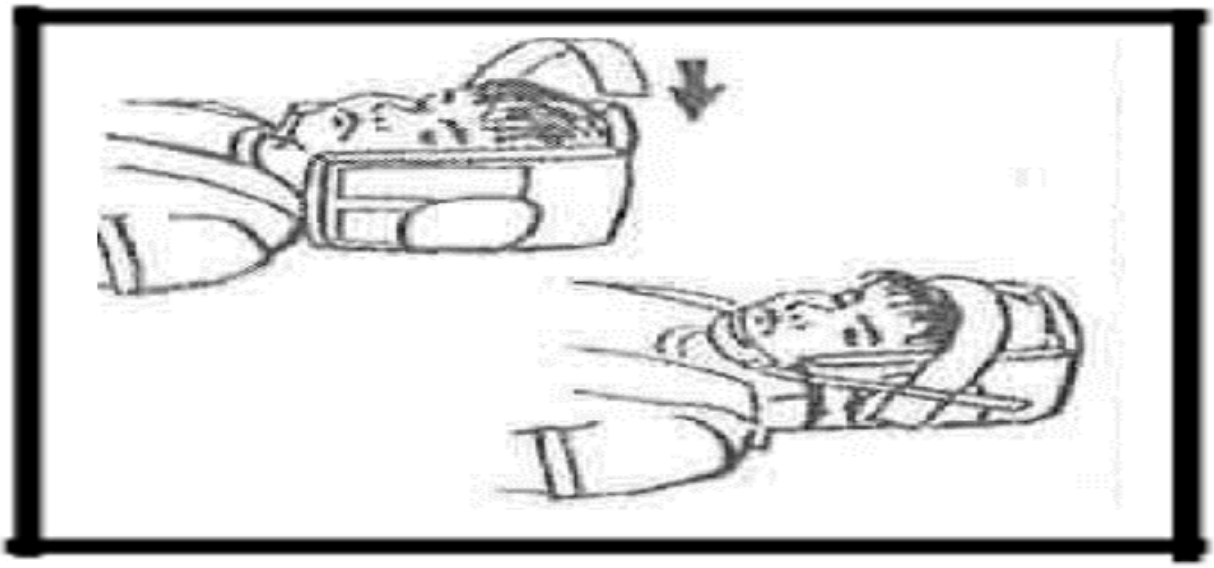


Figure 4.4

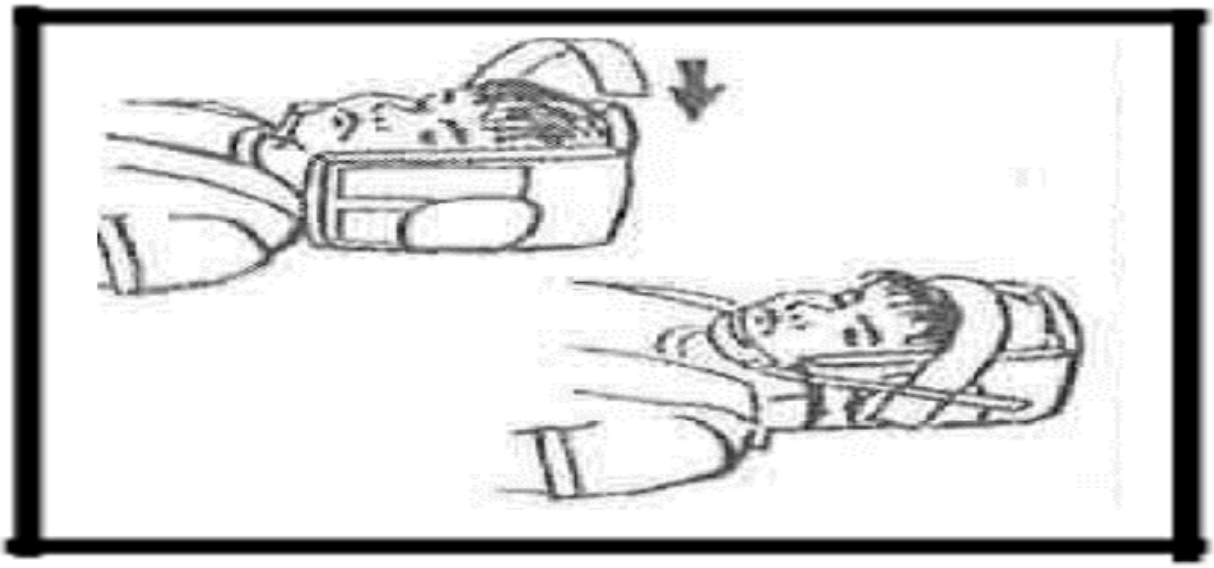


Figure 4.4

4.5 Adjust the chin strap snugly, Allowing the mouth to open if necessary. (Figure 4.4)

4.6 When immobilizing an infant, it may be necessary to remove the neutral infant alignment pad to provide neutral alignment. By removing the head pad, the infant's head will be allowed to drop down, thereby providing proper neutral alignment positioning and stabilization. (Fig 4.5)

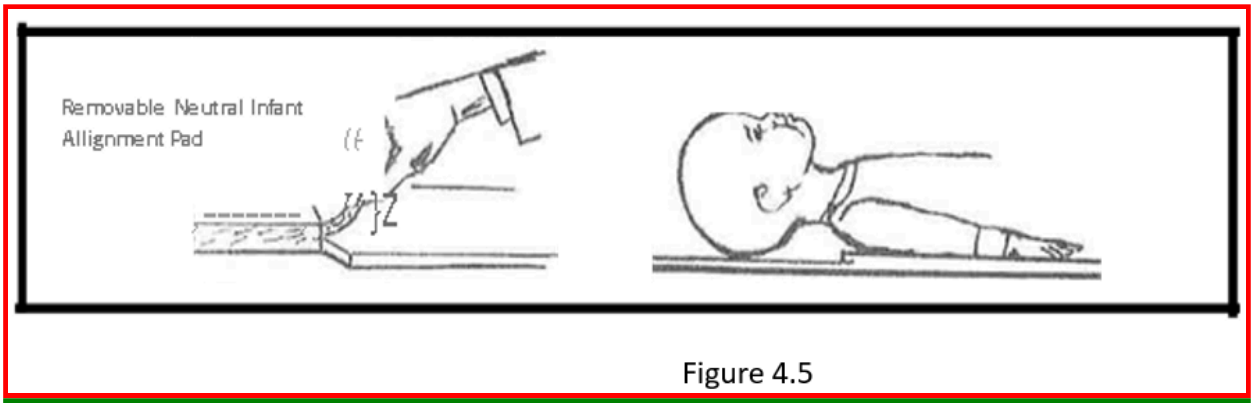


Figure 4.5

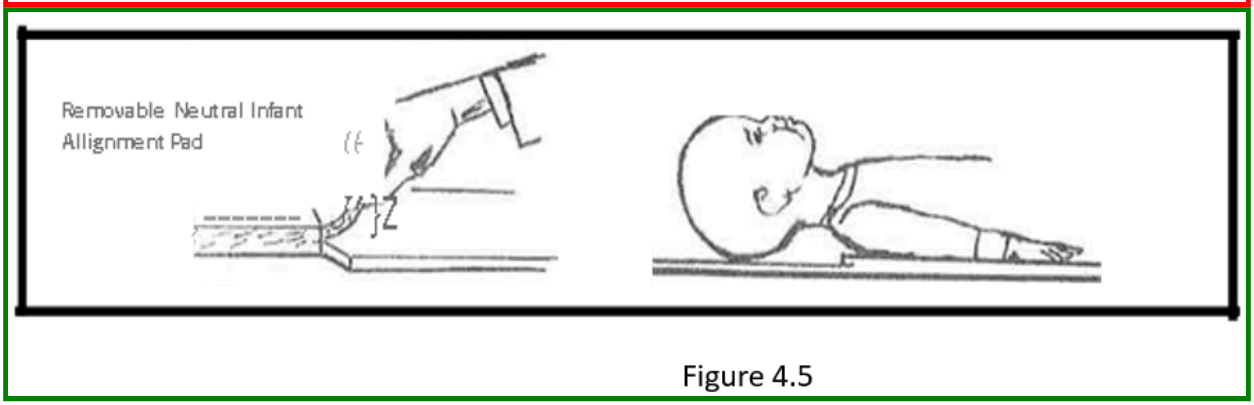


Figure 4.5

4.7 The padded head rest may be stored in the storage pouch located on the back of the LSP device. (Fig. 7.1)

5. **Adjusting The Abdominal Or Lower Torso Strap**
   5.1 Place the abdominal strap over the child's abdominal or in the case of smaller children or infants, across their thighs or lower legs respectively. (Figure 5.1-A & B)

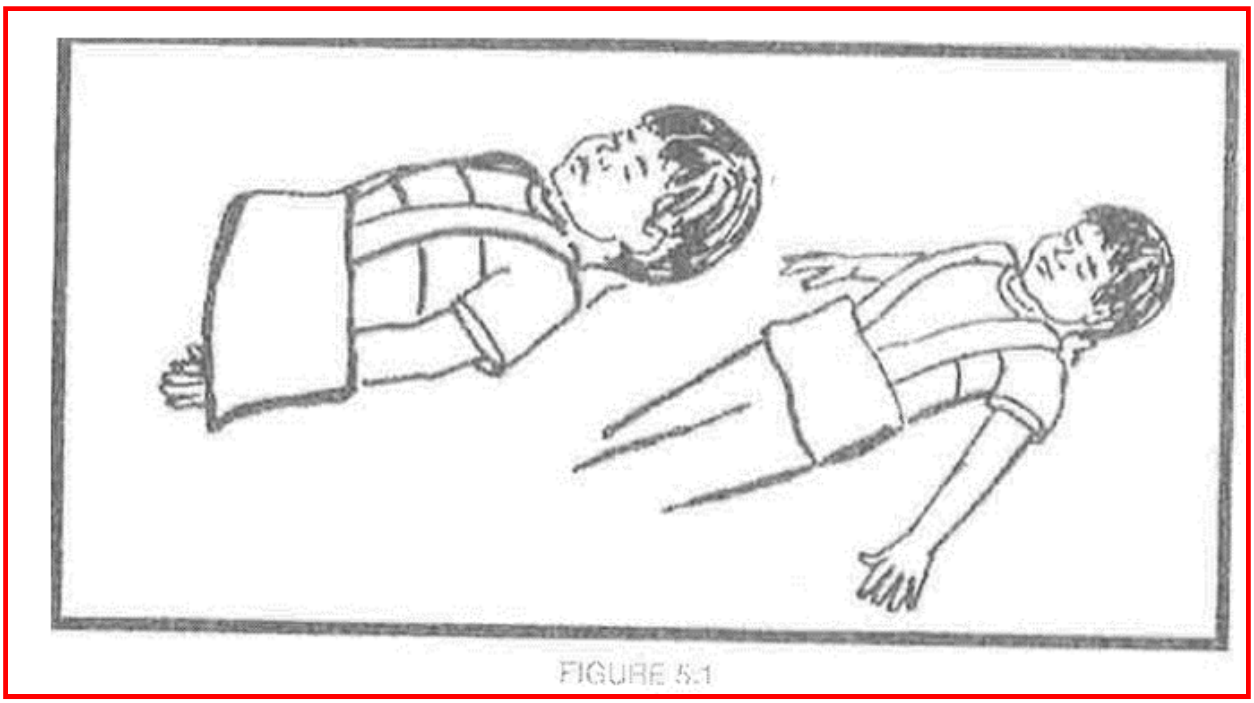


FIGURE 5.1

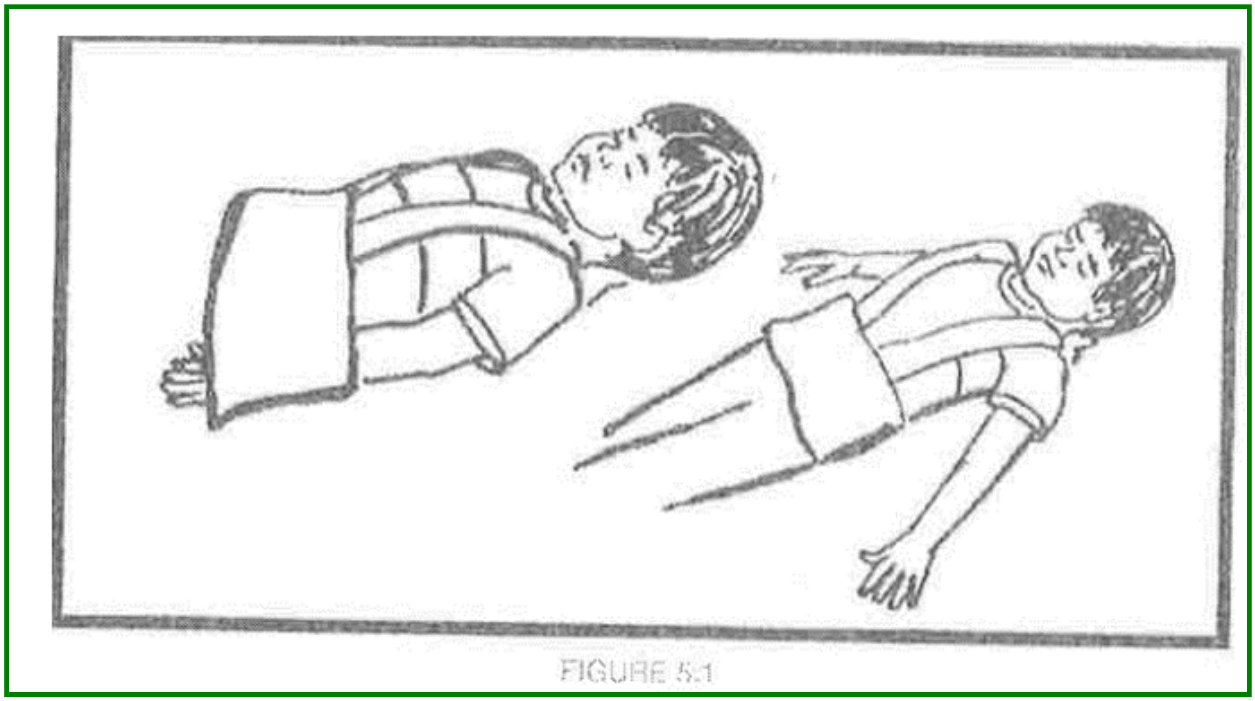
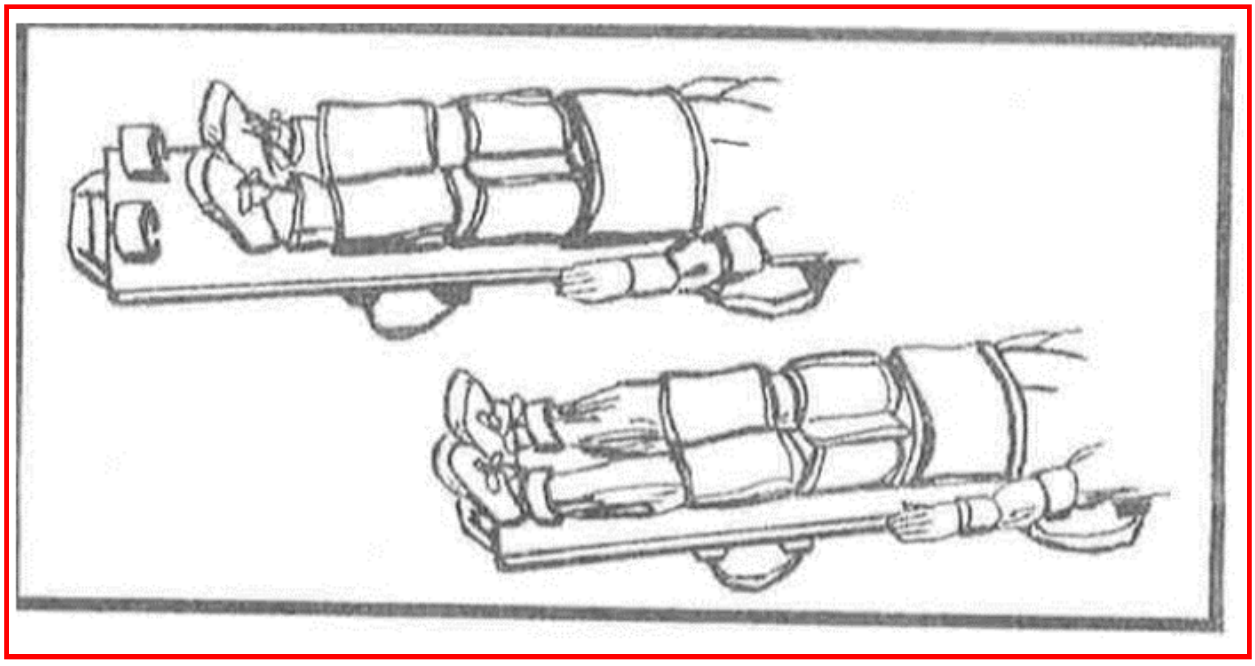


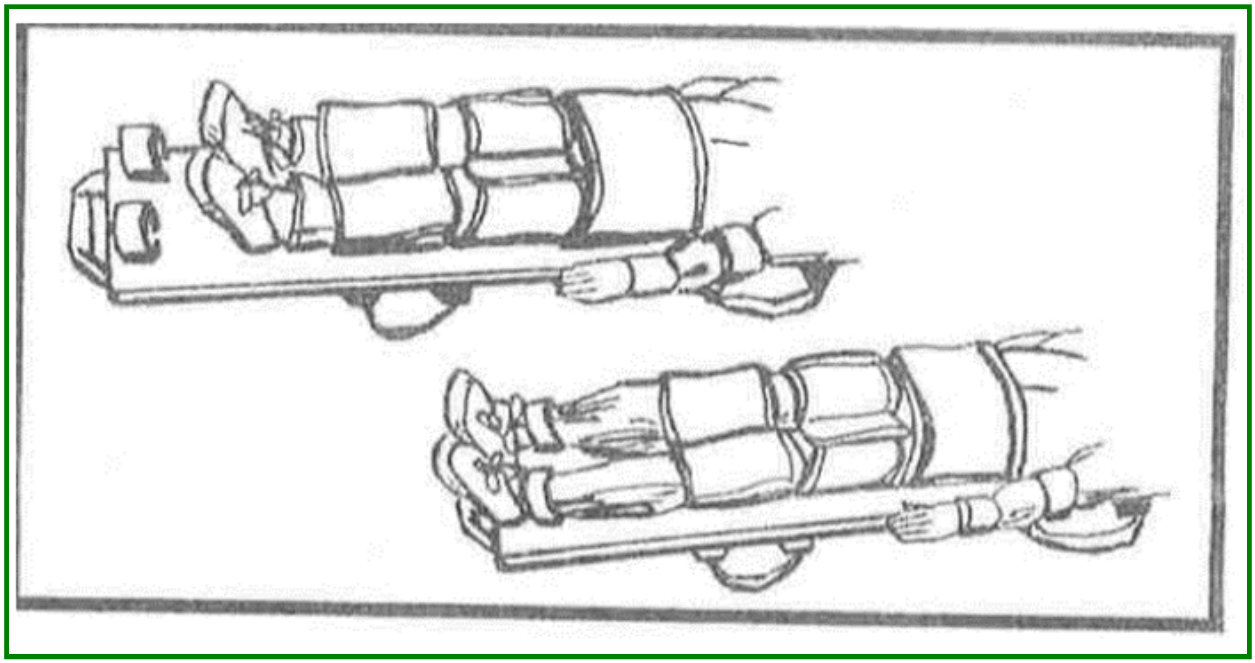
FIGURE 5.1

5.2 The child's arms may be secured within this strap or left outside and secured with the arm straps.

NOTE: if hands are secured within the abdominal strap ensure that circulation is not impaired.

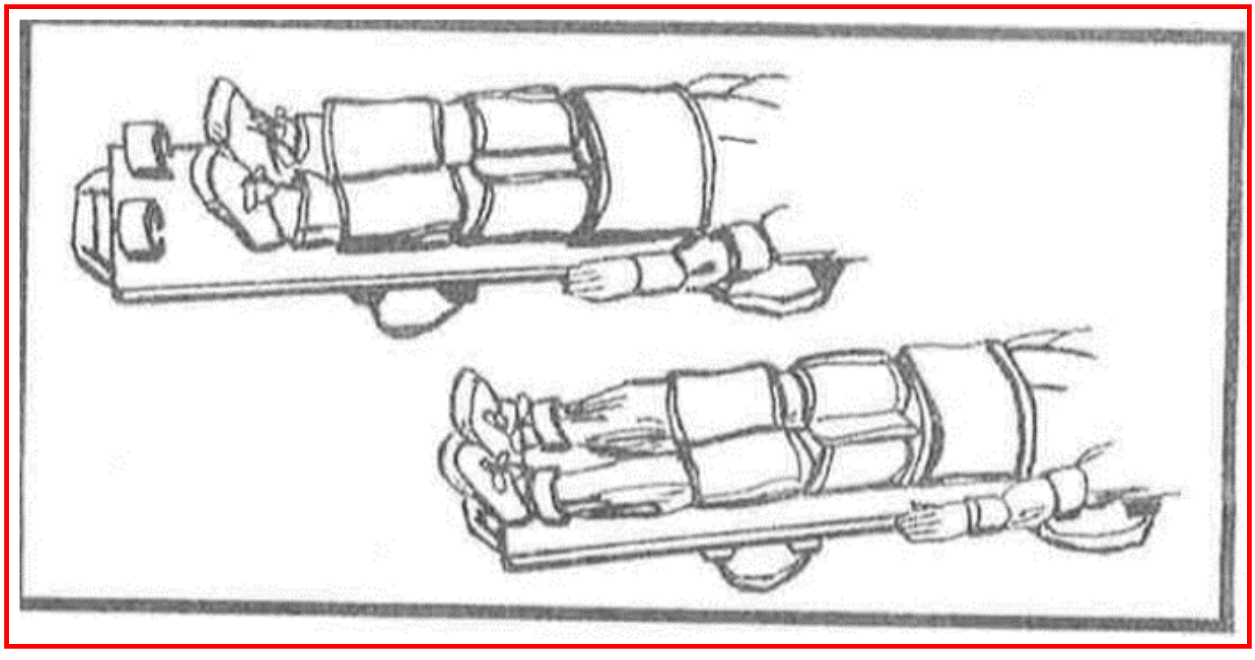
6. **Adjustment Of Leg Straps**
   6.1 Adjust the leg straps according to the size of the child. A small child or infant may not require the use of these straps while a large child may (Figure 6.1)

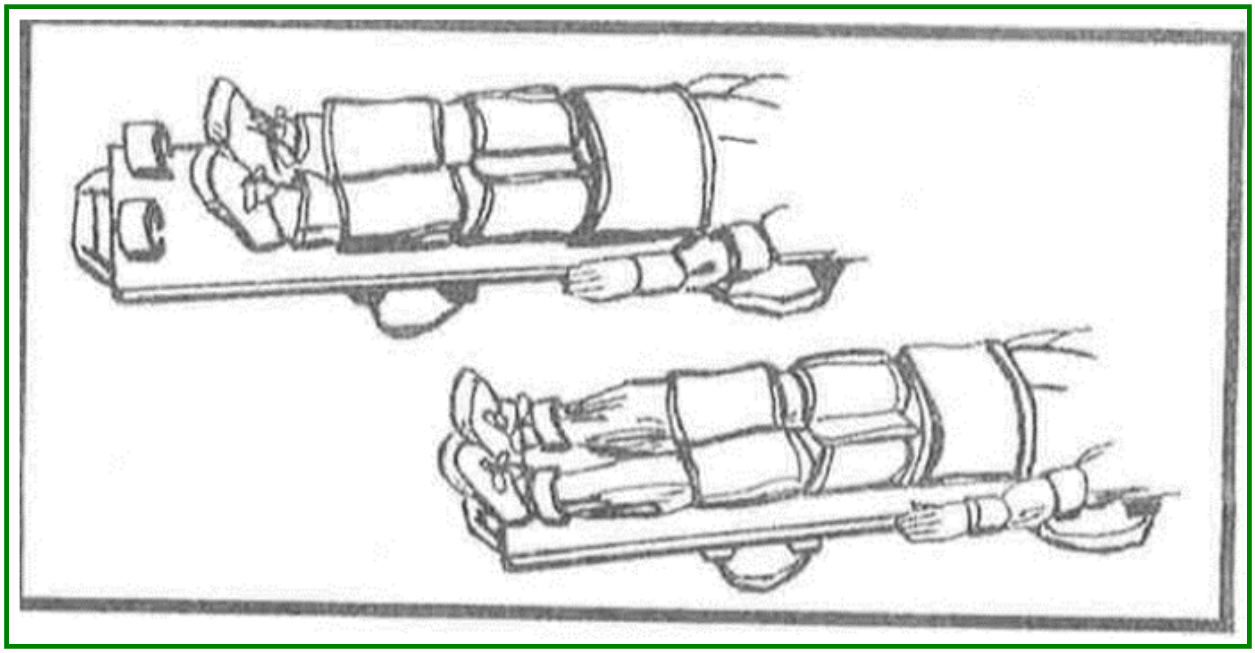




6.2 If both levels of leg straps are to be used, secure the thigh straps first and the ankle straps second.

7. **Attaching The Pediatric Immobilization Board To The Miller Full Body Splint Or A Standard Backboard**
   7.1 Release the attachment straps from the storage pouches on the back of the Pediatric Immobilization Board and thread them through the appropriate handles on the backboard to secure the Pediatric Immobilization Board to the backboard or Miller Board (Figure 7.1)





NOTE: The integral handles may be used to lift or transport the child once he is properly attached to the Pediatric Immobilization Board.

8. **Cleaning Instructions**
    1. After use, staff will clean and disinfect device using a Sani-cloth. Bleach is only to be used with patients suspected of Clostridium difficile or Norovirus
9. **Location**
    1. This device will be located in the ER equipment storage room.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED & Pediatrics	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/26/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/26/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/26/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*OB Nursing*
References:	

OB.30 Oxytocin use for Labor Induction/ Augmentation

POLICY:

Labor induction is the initiation of labor prior to spontaneous onset by artificial means with the purpose of accomplishing delivery.

PROCEDURE:

A. Medical indications for induction/delivery include:

~~Abruptio placentae~~

1. Chorioamnionitis
2. Fetal demise
3. Gestational hypertension
4. Preeclampsia, eclampsia
5. Premature rupture of membranes
6. ~~Postterm pregnancy~~Post term pregnancy exceeding 41 0/7 weeks gestation
7. Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
8. Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios)

B. Non-medically indicated induction/delivery does not occur prior to 39 weeks gestation.

C. For non-medically indicated inductions 39 weeks or greater, a pelvic assessment is performed to include pelvic adequacy and a Bishop Score ≥ six.

D. Upon receiving physician's order, RN may administer oxytocin drugs for induction or augmentation of labor.

INDICATIONS

To prevent iatrogenic prematurity, full term should be confirmed unless fetal ~~pulmonary~~ maturity ~~should~~can be ~~confirmed before scheduled delivery at less than 39 weeks of gestation unless fetal maturity can be~~ inferred from any of the following historic criteria:

- Ultrasound measurement at less than 22 weeks of gestation supports gestational age of 39 weeks or greater.
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.

If any of these criteria confirms a gestational age of 39 weeks or more, it is appropriate to schedule delivery at that time. Ultrasonography may be considered to confirm menstrual dates if there is a gestational age agreement within one (1) week by crown-rump measurements obtained in the first trimester or within 10 days by an average of multiple fetal biometric measurements (e.g., crown-rump length, biparietal diameter, head and abdominal circumference, and femur length) obtained in the second trimester (up to 22 weeks of gestation). (ACOG, 2017).

DEFINITIONS

A. ~~Induction of~~**Induction of labor**: The use of pharmacologic methods to initiate uterine contractions before spontaneous labor~~: The use of pharmacologic methods to initiate uterine contractions before spontaneous labor~~ occurs in order to affect vaginal birth. Oxytocin is a drug used in the medical induction of labor and is also used to augment existing contraction patterns that may not be adequate for progression of labor.

B. ~~Augmentation of labor:~~**Augmentation of labor:** The process of increasing the strength, frequency or duration of already present uterine contractions with pharmacologic methods when spontaneous contractions have failed to result in progressive cervical dilation or descent of the fetus.

C. **Tachysystole:** Uterine Tachysystole is defined as more than five contractions n 10 minutes, averaged over a 30-minute window.

D. **Montevideo Units**- A measurement used to calculate uterine contraction strength. Montevideo units are calculated by measuring the peak intensity, or amplitude in mmHg for each contraction occuring in a 10-minute period of time and adding these numbers together. Contraction amplitude is the difference between the resting tone and peak of the contraction. A contraction pattern totaling at at least 200 MVU's per 10-minute period is considered as adequate labor.

EQUIPMENT

A. Calibrated infusion pump/IV tubing.

B. Fetal monitor and central fetal monitoring for continuous fetal monitoring.

C. Pre-mixed bag of Pitocin in N/S.

D. O2 and suction.

E. BP cuff.

GUIDELINES

A. The patient will be admitted to the hospital with a physician's order indicating appropriate indication. Physician will also order type and screen.

B. Vertex presentation will be determined by physician with exam or ultrasound.

C. Obtain a twenty-minute recording of the baseline fetal heart rate and uterine contraction pattern with reassuring fetal strip before ~~begining~~beginning infusion of oxytocin.

D. The patient's cervix must be examined by the RN or physician within the 2 hour period preceding the

initiation of the oxytocin infusion, to assess for contraindications and establish the baseline for future examinations.

E. A controlled infusion system must be used for oxytocin administration.

1. A two-bottle infusion set will be used. ~~There~~Oxytocin should never be ~~no oxytocin in the "~~used as the primary~~"~~ IV ~~solution~~line.
2. Oxytocin requires a double-check when initiating an infusion or changing a bag.
3. The secondary IV shall be a pre-mixed solution of 500 ml NS with 30 units of oxytocin.
   2 milliunit per minute = 2 ml/hr
   4 milliunit per minute = 4ml/hr
   8 milliunit per minute = 8 ml/hr
   10 milliunit per minute = 10 ml/hr
   12 milliunit per minute= 12 ml/hr
4. The secondary IV shall be "piggybacked" to the primary IV infusion at the insertion port closest to the venipuncture site. Label tubing with red medication label near the IV pump. When starting infusions or changing bags, trace the tubing by hand from the IV bag to the pump and then to the patient for verification.
5. An IV administration pump must be used for administration of Pitocin.

F. A registered nurse may initiate and monitor an oxytocin infusion as follows upon a physician's order for Oxytocin induction/augmentation per protocol.

1. Initiation and infusing oxytocin.
   a. Unless specified otherwise by written physician's order, the initial dose of oxytocin shall be two (2) milliunits per minute, 2 ml/hr.
   b. Prior to each increase in oxytocin rate of infusion, the fetal heart rate and uterine contraction pattern should be assessed.
   c. Refer to the Induction/Augmentation Physician Orders.
2. Monitoring an oxytocin infusion.
   a. The uterine contractions and fetal heart rate shall be electronically monitored during the administration of oxytocin. Patient may be off monitor for bathroom privileges for <10 minutes per event. Tachysystole can occur with oxytocin drugs. Contractions are monitored by quantity and strength by palpation or Intra Uterine Pressure Catheter (IUPC~~:~~)mmHg.
   b. The rate of oxytocin infusion shall be increased no sooner than every 30 minutes until labor pattern is established, meaning contractions every 2-3 minutes of moderate intensity to palpation, or 50-60 mmHg above baseline with IUPC use, or Montevideo units or >200. ~~Uterine activity should not exceed contractions occurring more frequent than every 2 minutes.~~
   c. Uterine activity should not to exceed 5 contractions occurring more frequent than 5 in a 10 minutes, averaged over a 30 minute window.
   d. Increase infusion rate until adequate uterine activity is achieved to a maximum dose of 20 milliunits/minute of oxytocin. ***A physician order is needed to increase oxytocin beyond 20 milliunits/minute.***
   e. Adequate uterine activity is defined as:
      a. 3-5 contractions in a 10 minute period with a maximum, not to exceed 5 contractions in a

10 minute period.

b. Contraction duration of 40-90 seconds.

f. Fetal heart rate and uterine activity shall be recorded in the Electronic Health Record (EHR). (Refer to Policy OB .45 Management of Fetal Heart Rate Tracing) **Assessment of maternal-fetal status occurs every 15 minutes during oxytocin administration.**

g. Document in the EHR each time oxytocin in increased or decreased. If the dose remains unchanged, no further oxytocin rate documentation is required until a change in rate is made.

h. Maternal blood pressure, pulse and respiration shall be recorded in the EHR ~~with each increase in oxytocin until labor pattern is established, then every~~ hourly, unless otherwise clinically indicated.

i. Assess maternal temperature every 4 hours, or every 2 hours if membranes ruptured or more frequent if clinically indicated.

j. Intake and output shall be monitored and recorded in the EHR as ordered.

~~The rate of oxytocin infusion shall not exceed 20 milliunits per minute unless the physician is notified and authorizes it.~~

G. During the administration of oxytocin, the attending physician must be directly available by phone. A physician capable of performing a cesarean delivery should be readily available and manage complications of induction including tachysystole.

H. The oxytocin rate of infusion shall be titrated and decreased if contractions are more frequent then every 2 minutes or when the baseline resting uterine tone increases to 30 mmHg by internal monitor.

I. ~~Treatment of Tachysystole. Tachysystole is defined as more than 5 contractions in 10 minutes, averaged over 30 minutes (See Addendum A).~~**Decrease Oxytocin for:**

1. Uterine Tachysystole
2. Contractions lasting 2 minutes or more
3. Insufficient return of uterine resting tone between contractions via palpation or
4. Intraamniotic pressure above 25 mmHg between contractions via IUPC.

Note: Decreasing the oxytocin dose by half rather than stopping it may correct the abnormal contraction pattern, and prevent delay in delivery. Additionally changing patients position, giving an IV fluid bolus of lactated ringers solution.

J. Observe for and discontinue oxytocin, for: ***Notify Providers when oxytocin will be discontinued***

1. Signs and symptoms of uterine rupture-may be asymptomatic; possible signs or symptoms include vaginal bleeding, non-reassuring fetal heart rate, abdominal pain

~~Prolonged decelerations~~

~~Severe variable decelerations~~

~~Tachysystole- (series of uterine contractions lasting 2 minutes or more or a contraction frequency of 5 contractions or more in 10 minutes)~~

~~Uterine hypertonus-abdormal high resting tone and/or contraction frequency~~

~~Hypotension~~

~~Tachycardia~~

~~Maternal Shock/vascular collapse~~

~~Respiratory Distress. Water intoxication-combination of pitocin and large amounts of fluids.~~

~~Vaginal Bleeding~~

~~Precipitous Delivery~~

2. Non-reassuring fetal heart pattern:
    a. Recurrent variable decelerations
    b. fetal tachycardia or bradycardia
    c. minimal to absent baseline FHR variability
    d. late decelerations
    e. Tachysystole- (series of uterine contractions lasting 2 minutes or more or a contraction frequency of 5 contractions or more in 10 minutes
    f. Hypotension
    g. Tachycardia
    h. Maternal Shock/vascular collapse
    i. Respiratory Distress. Water intoxication-combination of pitocin and large amounts of fluids.
    j. Vaginal Bleeding

Oxytocin infusion may be restarted with physician order, not more than half the dose if it had been discontinued for <20 to 30 minutes. If oxytocin is discontinued for >30 to 40 minutes, it may be resumed at the initial dose ordered.

~~Physician to be notified for all decrease or discontinuation of oxytocin infusion.~~

~~DOCUMENTATION~~

~~A. Record all vital signs and procedures in the EHR.~~

~~B. Start of induction/augmentation~~

~~C. Decrease/increase or stopping of oxytocin infusion~~

~~D. Label all IVs, tubings, and IV site.~~

~~E. Document effects of oxytocin by quantifying contraction rate and strength by palpation or IUPC: mmHg~~

KEY POINTS

A. Intravenous infusion is the only accepted method of oxytocin administration before delivery. It should be infused using a volumetric pump and never as an IV bolus.

B. Pharmacologic effects:
    1. Half-life 3 – 6 minutes (IV infusion)
    2. Contractility effect on uterus (target organ)
    3. Milk ejection
    4. Antidiuretic (vasopressin effect)
    5. Cardiovascular

C. Logistic factors to be considered:

1. Available resources for immediate intervention
2. Risk of rapid labor
3. Cesarean Section capabilities

~~Indications include but are not limited to:~~

~~1. Pregnancy induced hypertension~~
~~2. Premature rupture of membranes~~
~~3. Chorioamnionitis~~
~~4. Suspected fetal jeopardy as evidenced by biochemical or biophysical indications (e.g. fetal growth restriction, post term gestation, isoimmunization)~~
~~5. Maternal medical problems (e.g. diabetes mellitus, renal disease, chronic obstructive pulmonary disease)~~
~~6. Fetal demise~~
~~7. Posterm gestation~~

D. Relative contraindications include but are not limited to:

1. Placenta or vasa previa
2. Non-longitudinal lie
3. Cord presentation
4. Presenting part above the pelvic inlet
5. Prior caesarean section
6. Active genital herpes infection
7. Pelvic structural deformities
8. Invasive cervical carcinoma

REFERENCES:

AWHONN: Perinatal Nursing, 4TH edition, 2013.
~~ACOG Practice Bulletin, Number 97, September 2008.~~
~~ACOG Bulletin #107, August 2009, Reaffirmed 2015~~
~~ACOG Practice Bulletin Number 107~~

ACOG Practice Bulletin, Number 97, September 2008.

ACOG Practice Bulletin #106, July 2009
ACOG Bulletin #107, August 2009, Reaffirmed 2015
ACOG Practice Bulletin Number 107

All revision dates: 8/2/2023, 6/13/2019, 3/1/2016, 5/1/2015, 11/1/2013, 5/1/2011, 8/1/2010, 3/1/2009, 3/1/2008, 9/1/2004, 12/1/2001, 12/1/1992

Attachments

A: Uterine Tachysystole Algorithm for Use with Oxytocin Administration

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/26/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/27/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/27/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	2/27/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

PH.80 Handling and Dispensing of Blood-Derived Products

POLICY:

The Pharmacy Department shall oversee the procurement, storage, control, distribution, administration and monitoring of the following blood-derived products:

- Albumin
- Blood factor replacement products (See Table 1)
- Immune Globulin, Intravenous (IVIG)

During the order verification process, the pharmacist may adjust the dose of blood factor replacement products to match the amount available in the manufacturer's original packaging to minimize waste.

PROCEDURE:

A. Each blood derivative received directly from the vendor contains a receiving report with the lot number of the items received. The Pharmacy Department maintains a file of all receiving reports for a period of six years.

B. Dose Adjustment Protocol for Blood Factor Replacement Products

1. The Licensed Independent Practitioner (LIP) shall enter an order in the electronic health record (EHR).
2. The pharmacist verifying the order shall use the following table to determine the correct dosing component and units of for any blood factor replacement products:
3. **Table 1: List of Formulary Blood Factor Replacement Products**

Medication (Brand)	Components	Dosing Unit
Kcentra	Plasma derived: Factor II, Factor VII, Factor IX, Factor X, Protein C and S	Factor IX in units

	Heparin, Albumin	
Benefix	Recombinant: Factor IX	Factor IX in units
Novoseven	Recombinant: Factor VIIa	Factor VII in mg
Advate	Recombinant: antihemophilic factor (Plasma/Albumin-free)	Factor VIII in units
Recombinate	Recombinant: antihemophilic factor	Factor VIII in units
Wilate	Plasma derived: von Willebrand factor, antihemophilic factor	von Willebrand factor:Ristocetin cofactor (VWF:RCo) in units

4. The pharmacist shall check the inventory available to match the order to the closest unit of measurement without wasting factor products. Do not create partial doses.
    a. Example order: Kcentra 25 units/kg for an 87 kg patient = 2,175 units of factor IX is ordered.
    b. The pharmacist checks the shelf and locates 2 boxes of 1,000 unit range which contains 1,087 units of factor IX and 989 units of factor IX to equal 2,076 units of factor IX.
5. Once closest unit of dose has been identified, the pharmacist shall discontinue the original order and enter a new order with the correct dose unit of measure that will be dispensed. The order shall be designated as "Written/Fax – No co sign" (See policy 100.216 Electronic Pharmacy Prescriptive Order Entry Authority)
    a. Example continued: Discontinue order for Kcentra for 2,175 units IVPB once.
    b. Enter new order for Kcentra for 2,076 units IVPB once.
6. The pharmacist shall enter the lot number and the expiration date of all the factors used to complete the full dose.

C. For IVIG dose adjustments, see policy PH.113 Intravenous Immune Globulin Dosing.

D. Each time a blood derivative is administered, the nurse shall record the product name, manufacturer, lot number and the expiration date in the electronic health record.

E. Any dose adjustments made by a pharmacist shall be documented as a clinical intervention in the electronic health record.

All revision dates: 7/20/2020, 5/15/2019, 5/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/2/2023

Step Description	Approver	Date
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	8/2/2023

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Policy Area:	*Pharmacy Services*
References:	

PH.88 Controlled Substances

POLICY:

The Ventura County Medical Center/Santa Paula Hospital Department of Pharmacy Services is responsible for the acquisition, disposition and administration of all controlled substances used within this facility.

PROCEDURE:

The Department of Pharmacy Services is legally responsible for the procurement, disposition and administration of all controlled substances used within the Hospital. Physicians, nurses, and pharmacists shall be responsible for maintaining proper records for controlled substances.

Definition of Controlled Substances

A. Controlled substances includes all drugs listed on Schedules CII, CIII, CIV, and CV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, or the California Uniform Controlled Substances Act, as amended.

B. The disposition of these medications shall be regulated as outlined in these acts.

C. Violation of these laws can lead to dismissal, license revocation and/or criminal prosecution.

I. Procurement of Controlled Substances

   A. All orders for Schedule CII controlled substances shall be authorized by the Director of Pharmacy Services or designee (through the "Power of Attorney"). Such orders shall be completed on the Drug Enforcement Agency (DEA) form 222.

   B. All orders for Schedule CIII, CIV, and CV controlled substances may be ordered directly from drug wholesaler or direct from the manufacturer.

II. Receiving Controlled Substances

   A. All Schedule CII controlled substances received by the pharmacy shall be checked in immediately and placed in the narcotic vault.

   B. All Schedule CII controlled substances shall be received and checked in by a pharmacist.

      a. The pharmacist shall document the receipt of all CII medications on DEA Form 222, under the column titled "to be filled by purchaser".

      b. The pharmacist shall record the number of packages received, the date of shipment and the pharmacist's initials.

C. Schedule CII, CIII, CIV, and CV medications shall be placed in the narcotic vault after receiving the medications.

D. All controlled substances in the hospital shall be stored in locked conditions at all times. The Pharmacy Department shall assume overall responsibility for the storage of all controlled substances throughout the Hospital.

III. Dispensing Controlled Substances in Automated Dispensing Cabinets (ADCs)

A. See policy *PH.92 Automated Drug Cabinet Usage and Documentation*.

IV. Dispensing Controlled Substances in Areas Without ADC's

A. The Department of Pharmacy Services shall utilize the Controlled Substance Requisition Sheet to issue specific quantities of controlled substances for nursing unit that are not automated.

a. Variety of controlled substances stocked on each unit, as well as the number of doses, shall be established by the Department of Pharmacy Services and Nursing Department and is to be updated as needed.

B. Nursing Narcotic Floor Stock Requisition

a. Narcotics may be requested by pre-printed Controlled Substance Administration Record (CSAR) and delivered by the Pharmacy to the requesting department or can be picked up at the Pharmacy.

b. The requesting nurse shall sign the request form, acknowledging the quantity to be ordered from the CSAR.

c. All requests shall be maintained on file for three (3) years.

C. Controlled Substance Administration Records

a. Under the appropriate medication column, the quantity dispensed shall be added to the existing inventory, such that the number recorded reflects the revised inventory of that medication.

b. The pharmacy technician and the licensed health care professional accepting the medication shall sign the appropriate line with the following information:

- Date
- Time
- Medications added to inventory

D. Drug Administration using the CSAR documentation:

a. When a drug is administered to a patient, the following information and record keeping will take place.

- Date
- Time dose given
- Patient's name (last name, first name)
- Patient account number
- Dose given
- Amount wasted (if applicable)
- The signature of the person administrating the medication

- A signature of a witness if wasting a controlled substance when applicable

E. Procedure kits shall be returned to the Department of Pharmacy Services at the end of procedure

V. Dispensing Controlled Substances in Adult Infusion Center

A. Dispensing of controlled substance for patients receiving treatment at the Infusion Center requires a valid prescription.

a. Controlled substance class II: Prescriber must submit a valid prescription using tamper evident security prescription pad. The prescription is valid for 30 days from the written date and for one dispense. Refills are not allowed.

b. Controlled substance class III-V: Prescriber may submit a valid prescription using tamper evident security prescription pad or called-in to the Infusion Center Pharmacy. All orally transmitted prescriptions shall be produced in hard copy form by the pharmacist receiving the order including initials of the pharmacist. This prescription is valid up to 180 days from date written or up to 6 dispenses which ever comes first.

c. Infusion Center pharmacist will transcribe the prescription order details into the electronic health record (EHR) system and label individual medication dispensed to nursing staff for patient administration during the visit. See Policy PH.55 Medication Order Management for details on labeling requirements.

d. All controlled substances (class II-V) will be kept and dispensed by the infusion center pharmacy and perpetual inventory shall be maintained.

e. All dispense must be reported to Controlled Substance Utilization Review and Evaluation System (CURES) within 24 hours of dispense.

B. No controlled substance (class II-V) shall be dispensed directly to patient for home use.

VI. Nursing Administration and Documentation

A. A current physician's order for administration of controlled drugs is required prior to administration of any controlled substance.

B. Administered doses shall also be recorded on the respective patient's Medication Administration Record (MAR).

C. Discrepancies: Any discrepancy in the controlled drugs must be reported immediately to the charge nurse on duty**.** A nurse whose shift involved discrepancy shall not leave the facility until the discrepancy is resolved or thoroughly investigated. A notification form shall be completed if the discrepancy cannot be resolved.

a. The Department of Pharmacy Services shall be notified if any discrepancy cannot be accounted by nursing staff.

D. Lockboxes and portless tubing shall be used for the following controlled substance infusions:

a. All end-of-life controlled substance infusions (e.g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL). See Attachment A - Lockbox and portless tubing workflow

b. Patient controlled analgesia (PCA) locked in the Alaris Pump PCA module

c. Epidural infusions locked into the appropriate pump

d. Other controlled substance infusions (e.g. fentanyl drip) may be placed in lockboxes with portless tubing at the discretion of the care team.

VII. Nursing: Creating a New Controlled Substance Administration Record (CSAR)

A. At any one time, there may be up to ten numbered yellow and/or blue controlled substance administration sheets distributed to each unit/department.

B. Controlled substances shall be counted and documented each shift on the CSAR and signed by two licensed healthcare professionals.

C. A new sheet shall be prepared daily. The following information shall be recorded:

a. Previous day's sheet: On the bottom line "Ending inventory/Transfer Total" the existing inventory is to be brought down to the bottom line with the signature of the individual bringing down the inventory.

b. Transfer the existing inventory from the old sheet to the top line of the new sheet with the signature of the person creating the new sheet.

VIII. Nursing: Discontinuation of Controlled Substance Infusion

A. In the event a controlled substance infusion is discontinued, stopped or titrated off, the nurse shall immediately perform one of the following:

a. Remove the controlled substance infusion bag from the patient room and waste the controlled substance, OR

b. Disconnect the tubing from the patient's intravenous line and secure the bag and tubing in the medication room if the nurse anticipates the controlled substance infusion may be restarted.

i. Controlled substances in a bag and tubing secured in the medication room under this circumstance shall be wasted if order is not restarted within 2 hours or at shift change, which ever is shorter.

IX. Disposal of Controlled Substances

A. Controlled substances shall be disposed of in a controlled substance waste container.

B. Disposal of controlled substances shall be performed by a licensed individual, with disposal activity witnessed by another licensed individual. Both individuals shall record all disposal/waste events in the automated dispensing cabinets in patient care areas.

C. Fentanyl Patches shall be disposed of in the following manner:

a. All fentanyl patches removed from patients shall be disposed of in such a manner to prevent the diversion of the fentanyl patches.

b. After being removed from the patient, the patches shall be folded in half so that the adhesive parts are attached together.

c. Steps A & B of this section shall be completed thereafter.

D. Pharmacy Only: Expired controlled substances which are intact may be removed from hospital premises by a reverse ~~distibutor~~distributor. All controlled substances removed in this manner shall be itemized for proper documentation.

X. Handling of Damaged, Refused or Wasted Medications Must be Documented

A. Documenting Controlled Substance wasted from ADC's:

a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste. ~~Controlled Substance waste shall be rendered unusable by dumping into a locked pharmaceutical waste container and removed from~~

~~the medication area in a timely manner.~~

b. Witness must observe the wasting and cosign in the ADC. The witness must have an existing user account.

c. Controlled Substance waste shall be rendered unusable by dumping into a locked pharmaceutical waste container and removed from the medication area in a timely manner.

B. Documenting Controlled Substance waste using CSAR:

a. All wastage shall be clearly documented on the controlled substance record.

b. Doses that are refused, contaminated, and/or a dosage other than what was ordered for administration to patients shall be considered doses not administered and shall be documented as wasted immediately.

c. The entry line on the CSAR is to include comments, indicating the following:

- Date
- Time
- Patient's name
- Chart Number
- Dose Given
- Amount Wasted
- A description of the events, (i.e., wastes, refused, damaged, contaminated, unused, etc.)
- Two health care professionals' signatures documenting waste of control has occurred

d. All items listed above shall be disposed of in the presence of a witness. The signatures of both the person administering the dose and the witness are required. The waste from controls are rendered unusable and destroyed in a locked pharmaceutical waste container.

e. For losses and thefts, see Pharmacy policy PH.23, *Reporting Controlled Substance Loss or Diversion*.

XI. Returned Controlled Substances

A. When narcotics are returned to the Pharmacy, the pharmacist shall verify the quantity received immediately.

a. Physical inspection shall be made of the items to be returned, particularly noticing whether vials or pre-filled syringes have been tampered or resealed.

b. An entry shall be recorded on the Controlled Substance Administration Record indicating the "return" of medications to the pharmacy. The signature of both the nurse and the licensed pharmacy staff member receiving the drug shall be recorded on the Controlled Substance Administration Record.

c. The returned medication shall be returned to the Pharmacy inventory.

B. If the drugs are not reusable, they shall be disposed of with a witness. The items disposed of will be itemized on the Pharmacy controlled substance disposal log.

C. The signature of a nurse and pharmacist or two pharmacists shall be required.

D. Controlled substances may also be surrendered to a pharmaceutical waste management company for proper disposal.

XII. Nursing Inventory of controlled substances

1. Nursing staff shall complete at least weekly inventory count on ADCs of all controlled substance class II to V.
2. Nursing staff shall complete at least weekly inventory count on CSAR for units that do not have ADCs.

XIII. Pharmacy department will comply with Title 16 California Code of Regulation section 1715.65

A. Physical Count Inventories of controlled substances shall be performed by Pharmacist(s).
   1. C-II controlled substances shall be inventoried quarterly.
   2. C-III to C-V controlled substances shall be inventoried yearly.
   3. The inventory report shall be signed by the involved Pharmacist(s) and the Pharmacist in Charge.

B. Quarterly reconciliation report shall be prepared for the following medications and dated/signed by the Pharmacist in Charge
   1. C-II controlled substances
   2. C-IV controlled substances: alprazolam 1 mg/unit, alprazolam 2 mg/unit ,and tramadol 50 mg/unit.
   3. C-V controlled substance: promethazine with codeine 6.25 mg/10 mg per 5 mL of product

C. The inventory, quarterly reconciliation report, and records used to compile the reports shall be kept in the Pharmacy for three (3) years.

All revision dates: 7/25/2023, 6/7/2023, 3/8/2022, 11/10/2021, 11/26/2018, 10/5/2018, 5/1/2016, 5/1/2013

Attachments

Attachment A - Lockbox and Portless Tubing Workflow

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/2/2023
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PH.92 Automated Dispensing Cabinet (ADC) Usage and Documentation

POLICY:

This document is directed to all Ventura County Medical Center/Santa Paula Hospital staff using the automated drug cabinet system for documentation and medication administration.

Definition:

Pyxis ES Medstation System: A computerized storage and dispensing device which is utilized for dispensing controlled substances and floor stock medication. The Pyxis ES Medstations work in coordination with the electronic health record (EHR) and the Pharmacy Healthsight Viewer to allow for efficient dispensing of medications and monitoring of all transactions. Procedures are designed to provide safe and accurate provision of medication, secure storage, accurate accountability for controlled substances and other drugs, accurate patient billing, and compliance with State and Federal regulations.

PROCEDURE:

I. Access to the Pyxis ES Medstation:

A. Nurses (RN, LVN, Psychiatric technician, student), respiratory therapists, licensed independent practitioner (LIP), pharmacist, pharmacy technicians, radiology technicians, and contract staff may be granted access to Pyxis ES Medstation.

B. Department manager/Clinical Nurse Manager (CNM) or their designee shall request permanent Logon identification (ID) creation through the Information Technology (IT) department for hospital wide Active Directory. Contract staff or student must have contract end date submitted to IT. Once ID is created by IT, the user must complete the online tutorial via hospital learning software platform and complete "Pharmacy Pyxis ES Medstation Assignment Statement" form (see Attachment A) to be submitted to the pharmacy department.

C. The department manager/CNM or their designee shall review, sign, and submit the completed form to the Pharmacy Department for proper assignment of roles and access.

D. Upon first logon to Pyxis ES Medstation, the system will prompt the user to scan their fingerprint, which shall serve as the user's biometric identification (BioID) password. If the biometric identification scan is not successful, the employee shall use a password instead.

E. In the event the password is forgotten or lost, the user shall call the IT department (Helpdesk

support: 805-677-5119) to request a password reset. If there is no existing user account, steps A-D in this section must be completed.

F. Upon termination of the user, the department manager/CNM or Human Resources shall notify the IT department for removal from AD.

G. If the user does not log off the Medstation upon completion of the transaction, the Medstation will log off the user after 30 seconds.

II. Pyxis ES Medstation Medication Stock:

A. Non-profile Pyxis ES Medstations list medications available within the device for removal. Non-profile stations are limited to the Emergency Department, GI Lab, Operating Rooms, Post-Anesthesia Care Unit, Nuclear Med, Interventional Radiology, Adult and Pediatric Oncology, and the Crisis Stabilization Unit.

B. Profile Pyxis ES Medstations operate on an interface with the EHR to display the list of ordered medications for each patient.

1. Inventory may be modified to accommodate active medication orders for patients residing in that patient care unit. This requires ongoing loading and unloading of medications as patient's therapy changes or that patient care unit's patient population changes. Par levels are set according to reasonable doses dispensed.

2. As new orders are initiated, Pharmacy staff will verify the needed medication is available in the Medstation that services that patient's location. If the medication is not loaded in that Medstation, the Pharmacy will send doses for administration.

3. The following medications will be handled through the Medstation: Injectable drugs, limited pre-mixed solutions, capsules, tablets, suppositories, and controlled drugs.

C. The Pharmacy Department is responsible for loading, unloading, and refilling all medications within the devices. The outdate tracking function shall be utilized to manage drug expiration dates. Items close to expiration shall be replaced.

D. Assigning, Loading or Unloading a Medication to Pyxis Medstation Inventory

a. Assignment of a new medication to a Pyxis Medstation's inventory shall only be done by the Pyxis System Administrators designated by the Pharmacy Director.

b. Pharmacy technicians and pharmacist may load and unload medication.
Use BD Pyxis Medication ES Station Quick Reference Guide* for full details.

E. Stock Replenishment

a. Refills reports shall be printed at least once daily for Pyxis Medstations.

b. Gather medications based on the delivery portion of the report, which list all medications and quantities needed to restock each unit specific Pyxis Medstation.

i. Do not overfill above assigned maximum quantity to prevent jamming of cubies.

c. Package medications for each Pyxis Medstation in a separate bag.

d. To provide a double check, the pharmacy technician shall pull the medications to refill the Pyxis Medstation and a pharmacist shall check the medications and quantity pulled against the delivery report before the technician delivers the medications to the Pyxis Medstations.

e. For CardinalASSIST medications, pharmacists shall double check prior to delivery of

CardinalASSIST to Pyxis Medstations.

f. Deliver medications and refill the Pyxis Medstation*.

i. Use the barcode for medication refilling process.

ii. If the medication barcode is unreadable, return medication to pharmacy, where a pharmacist shall enter the new barcode into the Pyxis Healthsight Viewer.

III. Patients and Temporary Patients:

A. Patient information for the Pyxis ES Medstation is obtained via an interface with the EHR. If the patient is not listed in the Pyxis ES Medstation, contact the Admitting Department to ensure the admission or transfer function is complete.

B. A temporary patient may be added to the system.

1. To enter a temporary patient, go to "All available patients" tab and select "Add temporary patient." The user shall accurately enter the patient's last name, first name, and the financial identification number (FIN) or medical record number (MRN).

2. Temporary patients will be kept on the system for 2 hours.

3. If the patient was transferred from another inpatient location, the orders shall display within 2-5 minutes.

4. Patients entered as John or Jane Doe will be added as temporary patient

C. Pharmacy will reconcile temporary patients.

IV. Removing Medications:

A. Remove medications for only one patient at a time.

B. Accuracy of the recorded quantity of medications removed from the Medstation is required for accurate patient billing and accurate inventory count of the medication.

C. Removal of controlled substances shall require the user to complete an inventory count and record the count in the Medstation prior to removal of the controlled substance. This is also known as a "Blind Count." If the count is inaccurate, the Medstation will fire a red "Please Recount" alert. A second blind count shall be performed. If the inventory count is inaccurate a second time, a discrepancy is created (see Section VIII, Resolution of Controlled Substance Discrepancies).

D. At the time of medication removal, ensure the medication is not expired prior to adminstration.

E. If the drawer/door opens and no medications are available in the pocket for removal, cancel the transaction and notify the Pharmacy Department.

F. Never remove items from the Medstation to dispense to patients as discharge medications. All discharge medications require a prescription and shall be dispensed according to State Regulations.

V. Override Medications (Profile Stations Only):
See policy PH.96 Medication Override from Automated Dispensing Cabinets.

VI. Returning Medications:

A. Unused medications will be returned to the return bin located in each Medstation within one (1) hour from the time of removal. Scanning of medication is required. Bulky items may be returned to the original pockets. Unused refrigerated medications shall be returned to the pharmacy via external return bin.

B. Witness will not be required for return of non-controlled substance medication into the return bin.

C. Do not return opened patient controlled analgesia (PCA) syringes, used multi-dose containers, or any medication taken out of its original container. These must be discarded; controlled substance waste shall be documented in the Medstation (See Section VII, Wasting Controlled Substances).

D. A witness and scanning of medication are needed for return transactions involving controlled substances. A witness must be a licensed health care professional with an existing user account.

E. The pharmacy technicians shall remove the medications from the Return Bin daily and either replaced back into Medstation inventory if usable (via scanning) or returned back to the pharmacy if unusable.

   a. Pharmacy technician shall verify the quantity of each item in the Return Bin and document quantity found.

   b. For controlled substances, when the expected count and actual count do not match, it will create a discrepancy. Notify supervisor or controlled substance surveillance personnel as soon as possible.

VII. ~~Wasting Controlled Substances:~~

~~A. Full or partial doses of controlled substances not administered to the patient shall be wasted and documented in the Medstation by using the Waste function.~~

~~B. Controlled substance waste will be rendered unusable by dumping into a controlled substance waste container and removed from the medication area in a timely manner.~~

~~C. Wasting and documentation of waste requires a witness, who must observe the wasting and cosign in the Medstation with the nurse administering the medication. The witness must be a licensed health care professional with an existing user account.~~

~~D. The amount used is documented and the Medstation calculates the amount wasted from the total dose. Some drugs waste in mg and other in mL; unit of measure is indicated by the system during the removal process.~~

Wasting Controlled Substances:

1. See Policy PH.88 Controlled Substances

VIII. Resolution of Controlled Substances Discrepancies:
See policy PH.98 Automated Dispensing Cabinet Controlled Substance Discrepancy Resolution.

IX. System Maintenance:

A. Medstations shall be plugged in to outlets with emergency power or an uninterruptable power supply device.

B. Inventory Quantities

   1. Ideal inventory quantity for each Medstation is a three (3) day minimum inventory.

C. Refill

   1. Medstations shall be refilled at least once daily by the Pharmacy Department.

   2. Pharmacists are responsible for checking all medications from Pyxis refill lists and CardinalASSIST prior to refilling medications into Medstations.

   3. Stock out bulletin/stock low bulletin shall be managed by the Pharmacy Department.

D. Load/Unload Medications

1. Only system administrators will have privileges to assign both non-controlled and controlled substance medications.
2. Authorization to change medications from the Medstation shall be done by the system administrators.
3. Nursing or LIP staff may request changes in the inventory quantity and medication changes by writing to the Director of Pharmacy or Pharmacy Supervisor.
4. Pharmacy staff shall remove and handle expired medications at least once daily and return expired medications to the Pharmacy Department.
5. Outdated tracking will be used for all medications.

E. Management of recalled medication
1. Pharmacy should block the use of medication at the Pyxis Medstation in the event of a medication recall.
2. Any recalled medication may be removed by using the Inventory function.

F. Reports
1. See policy PH.93 Pyxis Reports for more information.

G. Failed Drawer
1. The most common type of Medstation failure occurs when one of the drawers fails to close completely because the medication package extends above the pockets. A Failed Drawer icon will appear on the Medstation screen.
2. Attempt to recover the drawer by selecting "More" from the main screen then select "Recover Storage Space" option and follow the on screen prompts. At the completion of the procedure, the system will state if the drawer is functional.
3. If the "Recover Storage Space" procedure does not correct the problem, the system will state the drawer needs maintenance. Contact the Pharmacy Department for further assistance.

H. Pyxis activity data shall be kept for at least three (3) years on BD Knowledge Portal.

I. Interface Outage
1. In the event of the EHR-Pyxis interface is out for more than 30 minutes, all medications stored in the Medstations shall be accessible as override medications. This is known as Pyxis Critical Override.
2. The Pharmacy Department shall notify the CNM or the nursing supervisor in the event of a Pyxis Critical Override.
3. The Medstation patient profiles will not be updated during interface outages.
4. Nurses must use caution when selecting drugs for removal from this expanded override list to ensure they have the correct drug, dose, and dosage form.
5. Once the EHR-Pyxis interface is restored, the Pharmacy staff shall turn off the Pyxis Critical Override.

J. Troubleshooting Problems
1. A "BD Pyxis Medstation ES System Quick Reference Guide." is available for viewing on the Main home page under "Help" icon.

2. In the event the problem cannot be resolved, the user should contact the Pharmacy Department.
3. The Pharmacy Department is responsible for contacting Pyxis service personnel.
4. Pyxis Medstations utilize emergency power outlets and uninterrupted power supply devices. In the event a Pyxis Medstation cannot be accessed during a power outage, contact the Pharmacy Department.

K. Care of the Touchscreen and BioID

1. Clean the touchscreen and BioID with an alcohol pad and allow to air-dry.
2. If the touchscreen requires recalibration, contact the Pharmacy Department.

L. Help/Support

1. For more information regarding the operation of the Pyxis ES Medstation, refer to the "BD Pyxis Medstation ES System Quick Reference Guide."
2. If further assistance is required, contact the Pharmacy Department at 805-652-6220 (VCMC) or 805-933-8636 (SPH).

All revision dates: 8/2/2023, 1/10/2023, 2/9/2022, 3/4/2020, 2/15/2018, 3/1/2015, 10/1/2008

Attachments

Attachment A: Pyxis ES Medstation Assignment Statement Form

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/2/2023
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PH.98 Automated Dispensing Cabinet Controlled Substance Discrepancy Resolution

POLICY:

Ventura County Medical Center and Santa Paula Hospital requires automatic dispensing cabinet (ADC) users to resolve all discrepancies which they identify prior to the end of the work shift and to document this resolution. The following procedure ensures a consistent means for documenting the resolution of controlled substance discrepancies.

PROCEDURE:

A. ADC require that the user perform an inventory count of any Schedule II, III, IV or V medication prior to removal. If the actual inventory count does not match the expected inventory count after two consecutive attempts, a controlled substance discrepancy is created.

B. To avoid a delay of medication administration to the patient, the discrepancy can be resolved after the medication is administered. The user discovering the discrepancy shall be responsible for starting the resolution process as soon as possible. The discrepancy shall be resolved by the change of shift. See Policy PH.88 Controlled Substance for further discrepancy resolution process.

C. Discrepancy details should be reviewed, which lists the name of the last user who accessed the medication. From the **Main Menu,** select **Discrepancies,** then select line item of the unresolved discrepancy for details**.**

D. Resolve the discrepancy with a witness prior to the end of the shift. Use the information from the details of the transaction history to note unusual activities. Review the medication administration record (MAR) for patients on the specific medication.

E. Record the resolution within the ADC.

   1. From the Main Menu, select **Discrepancies**.
   2. Select discrepancy to document.
   3. Select **Resolve** to enter the reason for the discrepancy.
   4. Resolution of each controlled substance discrepancy shall require a witness.
      a. The witness shall sign-in using their logon ID and BioID to complete the transaction.

F. The unit charge nurse ~~should~~or designee shall log-on to ADC to check for pending discrepancies at the

end of every shift ( ).

1. From the Main Menu, select **Discrepancies**
2. Review and resolve any discrepancies listed.

G. If the discrepancy is not resolved before change of shift, the Clinical Nurse Manager or nursing supervisor shall be involved in resolving the discrepancy. The charge nurse and/or direct patient care nurse may be asked to return to assist in resolution if they have already left the premises.

H. If the discrepancy is not resolved by the Clinical Nurse Manager, the Pharmacy Department shall be notified.

I. If no resolution is obtained, then an incident report should be generated. The nurse manager and pharmacy department will address user access based on policy PH.89 Controlled Substance Surveillance.

J. Users with frequent discrepancies may have controlled drug access privileges removed and disciplinary actions taken up to and including termination.

All revision dates: 7/25/2023, 1/10/2023, 3/1/2015, 8/1/2011, 8/1/2008

Attachments

No Attachments

Approval Signatures

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Owner:	*Jessica Rodriguez: Manager-Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.94 Automatic Spacer Protocol

POLICY:

At Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), all metered dose inhalers (MDI) shall be administered to patients with an ~~appropriately~~appropriate spacer device.

PROCEDURE:

A. A Licensed ~~Independent~~ Practitioner (~~LIP~~LP) places an order for an MDI in the electronic health record (EHR). Example MDI treatments include but are not limited to the following formulary medications:

1. Albuterol (Ventolin HFA)
2. Ipratropium (Atrovent HFA)
3. Albuterol-Ipratropium (Combivent Respimat)
4. Budesonide/formoterol (Symbicort)
5. Fluticasone (Flovent HFA)

B. An order for an appropriately sized ~~Aerochamber~~ spacer (with or without mask) shall be automatically entered to accompany the MDI order as a "protocol/standardized procedure – cosign."

C. The appropriate size is auto-selected based on the patient's age.

1. Age <2 years old: ~~Aerochamber~~Spacer with infant mask
2. Age 2-6 years old: ~~Aerochamber~~Spacer with pediatric mask
3. Age >6 years old: ~~Aerochamber~~Spacer
4. Use of the ~~Aerochamber~~spacer with adult mask will be determined on an individual basis.

D. To reduce duplicate orders, this automatic ~~Aerochamber~~ spacer order shall occur only once per patient encounter.

E. Pharmacy reviews the respiratory therapy order for appropriateness before verifying for distribution and administration (see policy *PH.55 Medication Order Management*).

F. Respiratory Therapists retrieves the appropriate sized ~~Aerochamber~~ spacer and places a patient label on the spacer for patient administration with the MDI.

G. If the ~~Aerochamber~~ spacer size is deemed inappropriate for the patient, the Respiratory Therapist may re-enter the spacer order for the corrected size as a "protocol/standardized procedure – cosign"

communication order.

H. All MDI treatments shall be administered with the ordered ~~Aerochamber~~ spacer.

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Attachments

No Attachments

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Policy Area:	*Surgical Services*
References:	

S.20 Elective Surgery Procedure Scheduling

POLICY:

In order to maintain a thorough, effective and consistent method which all parties can depend upon when scheduling elective surgical procedures in the Operating Room, elective cases will be scheduled with the Surgery Scheduler weekdays between the hours of 08:00 and 16:30 for privileged physicians using a Block Schedule Plan which has been approved by the Surgery Committee.

PROCEDURE:

A. Physicians scheduling surgery must have privileges at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and specific privileges for the procedure being scheduled. Physician privilege lists are available ~~for reference on each computer~~through the Medical Staff privileging portal desktop ~~computer under the Health Care Agency~~icon (ePriv), or the Medical Staff ~~and Resident privilege tab, or the Medical Staff~~ office can be contacted at 1-805-652-6062. All privileges for procedures will be verified at the time of scheduling the surgery.

B. The scheduled time for the first case of the day is 7:~~30~~15 a.m. every weekday except the first Wednesday and the third Thursday of the month, when the starting time will be 8:30 a.m. to allow for the nursing, medicine, and anesthesiology meetings taking place.

   1. Surgeons will be present in the operating room area ~~at~~before 7:15 a.m. (8:15 on the first Wednesday and third Thursday of the month).
   2. The starting time is defined as time from when the patient is in the room.

C. Block Scheduling and Management: Specialty blocks will be held for the named surgeon or group. Block rules are as follows:

   1. Requests for new block time or additional block time must be submitted in writing to the Director, Surgical Services. The Director or the Surgical Leadership Group will review the request and determine the availability of the requested time. The Director or the Surgical Leadership Group will review each request and make recommendations based on: Requester's current block utilization, current use of open block time, case volumes and demonstrated ability to increase case volume~~;~~, efficiency, availability of requested time~~;~~, availability of supplies and equipment~~;~~, potential impact on postoperative care units~~;~~, and seniority when all other factors are equal.
   2. The request will be submitted to the Surgery Leadership Group (Chief of Surgery, ~~Chief of~~ Anesthesia Director, and ~~Chairman of the~~ Surgery ~~Committee~~Chair.)

3. Blocks will be allocated as the requested time becomes available. Until the requested time is available, the request is on a "wait list."
4. Block time will be allocated to individual surgeon, groups of surgeons, and/or specialty. Groups must have a designated surgeon assigned as "block manager" to act as spokesperson for the group.
5. Automatic block release: Blocks are released one week prior to the date at VCMC, and 2 weeks prior to the date at SPH. Upon release of the blocks, open scheduling will be available to all services on a first request basis.
6. Block release times are subject to adjustment by the Surgery Leadership Group.
7. The first case in any block must be scheduled at 7:~~30~~15 AM. If the first case is not scheduled at 7:~~30~~15 AM, the open time will be considered open and scheduled in on a first request basis.
8. End of block time: The last case scheduled in the block is to be completed by block time ending. Scheduled cases running over the end of block will be considered elective add on cases, unless approved by the charge nurse and the appropriate anesthesia provider. These cases will be prioritized day of surgery with urgent add-ons.
9. Holidays: All VCMC and SPH surgery block time is suspended on observed holidays.

D. Block Utilization Management:

1. Block Utilization: Total Time Used In Block/Total Block Time Allocated - voluntary block release (up to 10% of total).
2. Block time must be utilized at a minimum of ~~65~~75% and will be monitored on a monthly and detailed quarterly basis.
3. If utilization is below ~~65~~75% for two (2) months of a quarter, the Surgery Leadership Group will notify the surgeon/group and his/her office about the low utilization.
4. If utilization is below ~~65~~75% for one quarter, a notification letter will be sent by the ~~Chief of~~ Surgery Leadership Group with a recommendation for improving utilization, i.e. a loss or decrease of block time, combination of block days, or change in block day(s). Block time must be a minimum of half a day (four hours).
5. If the surgeon does not reply and/or adjust block usage and his/her utilization remains low in the following quarter the recommended change will occur automatically. The change will take effect at the beginning of the following month. Procedures already scheduled will not be affected.
6. A request for re-instatement of block time can be submitted in writing to the Director of Surgical Services or the Surgical Leadership Group.
7. Total time used in block includes add on, and scheduled cases performed in assigned block time.
8. Surgeons or groups with assigned block times must see their first patient no later than 7:15 AM on the assigned block day. This will be monitored by the Surgery Leadership Group and failure to follow this policy will result in a loss of assigned block time.
9. Block allocation will take into consideration block utilization, total case volumes, and efficiency.

E. Information to give to the Surgery Scheduler when scheduling shall include:

1. Patient's name
2. Patient's age
3. Patient's hospital number or birth date

4. Surgeon and assistant's name
5. Exact procedure to be done
6. Estimated duration of the procedure (Note: ½ is allocated for turn over time)
7. Special health problems of the patient
8. Special equipment of supplies needed
9. Frozen section or other special pathology needs
10. FIN number

This information will be recorded in Cerner (scheduling book for backup). Special Order requests are given to the Purchasing Tech or Clinical Nurse Manager. Except in emergency cases, Special Equipment requests must be submitted as soon as known or 48 hours prior to surgery. VCMC/SPH cannot be financially responsible for special equipment delivered without prior authorization.

Patient documents such as current history and physical, perioperative orders, informed consent, etc. must be ~~submitted to the Pre-op area~~entered into the electronic health record (EHR) no later than 48 hours prior to the day of surgery (see Attachment A, High Risk Anesthesia General Guidelines).

Time requests are accommodated within the limits of operating room personnel and space management. Start time is defined as patient in the room. If a room is empty, awaiting a requested starting time, it may be filled with another case which is ready to proceed. The surgeon whose time request case is waiting will be given the opportunity to move up their case before another case is scheduled in that room. This might delay the requested starting time unless that case is declared an emergency requiring a "bump."

When inadvertent delays occur due to departmental or lengthy case problems, the team leader or his/her designee is responsible for notifying the next surgeon, assistants, assigned resident and the nursing unit where the patient is waiting.

At VCMC, when a resident's assistance is required for cases scheduled by attending surgeons from outside the hospital or clinics, the attending is expected to notify the chief surgical residents in advance.

When disputed issues occur, the team leader shall notify the ~~Clinical Nurse Manager and/or Director of Surgery~~Anesthesiologist of the day. Further escalation should go to the Surgical Leadership Group.

References:

OR Manager, July 2009, Vol 25, Fine Tuning the Block Schedule
AORN Journal: Nov 09, Vol 90, No 5, Managing Variability in Perioperative Services

All revision dates: 8/1/2023, 10/12/2021, 4/24/2018, 10/1/2016, 12/1/2013, 4/1/2010, 6/1/2006, 2/1/2005, 11/1/2004, 10/1/1998, 2/1/1996, 12/1/1995, 5/1/1995, 11/1/1992

Attachments

S.A.3 Attachment A - High Risk Anesthesia General Guidelines.docx

Approval Signatures

Step Description	Approver	Date
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	pending

Ventura County Medical Center

Delineation Of Privileges

Family Medicine Privileges.

Name:

Privilege	Requested	Granted	Deferred	Suspended

BASIC CRITERIA:
a. Successful completion of an ACGME or AOA-accredited residency in Family Medicine **AND;**
b. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Medicine within 1 year of completing the training **AND**;
c. Documentation of the management of general medical problems for at least 100 inpatients and/or outpatients as the attending physician (or senior resident) during the past 2 years

RENEWAL CRITERIA: A minimum of 100 inpatient and/or outpatient combined encounters during the previous 24 months

EVALUATION REQUIREMENTS: A minimum of 3 cases evaluated

If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity.

If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.

CORE PRIVILEGES: ___ ___ ___ ___
Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED.

Privileges include but are not limited to the following:

Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for **ADULT** patients
Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for **PEDIATRIC** patients
Anoscopy
Arthrocentesis & therapeutic injection, large/small joint
Aspiration of subcutaneous cysts, furuncles, etc.
Assist in surgery
Breast mass aspiration, breast cyst aspiration
Cryodestruction (liquid nitrogen) of skin lesions
Diaphragm/pessary fitting/placement
Excision of nail from digit
I&D abscess, cysts, hematomas
I&D of hemorrhoid, thrombosed
IUD insertion/removal
Endometrial biopsy
Management of burns
Neonatal resuscitation standby at C-section
Reduction of displaced fractures and dislocations
Regional nerve blocks of digits
Removal of non-penetrating corneal or conjunctival foreign body
Removal of foreign body from ear, nose, skin
Skin biopsy or excision
Suture of uncomplicated lacerations
Waived testing: Rapid strep A test, amnio test, dipstick for urine, urine pregnancy test, fecal occult blood by hemoccult

CORE PRIVILEGES REQUIRING ADDITIONAL CRITERIA, DOCUMENTATION OR COMPETENCIES:

Frenulotomy - **1st case evaluated*	___	___	___	___
Implantable sub-dermal contraception - **Documentation of certification required*	___	___	___	___
Laser Tattoo Removal - **Documentation of 1-hour training with privileged physician*	___	___	___	___
Neonatal circumcision - **A minimum of 5 within the previous 2 years, 1st case evaluated*	___	___	___	___

Delineation Of Privileges

Family Medicine Privileges.

Name:

Privilege	Requested	Granted	Deferred	Suspended
Osteopathic Manipulative Treatment (OMT) - **Criteria: Doctor of Osteopathic Medicine (DO) Initial evaluation requirements: A minimum of 3 OMT case reviews*	___	___	___	___
Provider-Performed Microscopy (PPM); wet mount for presence/absence of bacteria, fungi, parasites & human cellular elements; KOH preparations, urine sediment examination, fern testing - **Annual competency assessment required*	___	___	___	___
Limited bedside ultrasound - **A minimum of 1 case evaluated*	___	___	___	___
Vasectomy - **A minimum of 5 within the previous 2 years, 1st case evaluated*	___	___	___	___
CORE OBSTETRICS **Excludes high-risk pregnancies as outlined in MS.102.023 Family Medicine Obstetrical Risk Stratification (Must also meet core privileging criteria)*				
INITIAL CRITERIA: a. New graduates - Documentation of a minimum of 40 deliveries during residency training b. Established physicians - Documentation of a minimum of 25 deliveries during the previous 2 years c. Completion of BETA annual obstetrical module requirements				
RENEWAL CRITERIA: a. Documentation of a minimum of 20 deliveries in the previous 2 years b. Completion of BETA annual obstetrical module requirements				
EVALUATION REQUIREMENTS: A minimum of the first 3 deliveries evaluated				
Prenatal care	___	___	___	___
CORE OBSTETRIC PRIVILEGES: ***Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED.***	___	___	___	___
Management of labor and delivery equal to or greater than 36 weeks gestation Limited obstetrical ultrasound, includes evaluation of presenting part, amniotic fluid index, placental position, viability Pudendal nerve blocks Paracervical nerve blocks Episiotomies & laceration repair of 1st, 2nd-degree lacerations				
WOMEN'S HEALTH PRIVILEGES REQUIRING ADDITIONAL CRITERIA AND/OR EVALUATION: *(Must also meet core privileging criteria)* Unless otherwise indicated, a minimum of 1 case (1st case) evaluated for each of the following privileges				
Amniocentesis under ultrasound guidance to determine fetal maturity	___	___	___	___
Fetal biometry - **A minimum of the first 3 cases evaluated*	___	___	___	___
Biopsy of cervix, vagina, vulva	___	___	___	___
Colposcopy with biopsy and cryotherapy - **A minimum of the first 3 cases evaluated*	___	___	___	___
Manual vacuum aspiration (MVA)	___	___	___	___
Dilation and curettage:				
Diagnostic	___	___	___	___
Incomplete abortion	___	___	___	___
Suction curettage-therapeutic abortion	___	___	___	___

Delineation Of Privileges

Family Medicine Privileges.

Name:

Privilege	Requested	Granted	Deferred	Suspended
Loop electrosurgical excision procedure (LEEP) - **A minimum of 3 within the previous 2 years, first 3 cases evaluated*	___	___	___	___
Low forceps delivery	___	___	___	___
Marsupialization of glands, Bartholins, etc	___	___	___	___
Repair of 3rd-degree lacerations *(no additional criteria or evaluation required)*	___	___	___	___
Vacuum extraction delivery *(no additional criteria or evaluation required)*	___	___	___	___

ADULT PROCEDURES
(Must also meet core privileging criteria)

INITIAL/RENEWAL CRITERIA: Documentation of a minimum of 1 of each procedure requested in the previous 2 years

EVALUATION REQUIREMENTS: 1st case evaluated for each procedure requested

Arterial line placement	___	___	___	___
Central venous catheter placement	___	___	___	___
Chest tube placement	___	___	___	___
Endotracheal intubation	___	___	___	___
Lumbar puncture	___	___	___	___
Paracentesis	___	___	___	___
Peripherally Inserted Central Cetheter (PICC) - require the first placement with experienced physician (i.e. interventional radiology or other physician)	___	___	___	___
Pleural catheter placement	___	___	___	___
Posterior nasal pack for epistaxis management	___	___	___	___
Repair of extensor tendons	___	___	___	___
Revision of minor amputations-digits	___	___	___	___
Thoracentesis	___	___	___	___

SPECIAL PRIVILEGES:
(Must also meet core privileging criteria)

Pediatric Moderate or Deep Sedation and Analgesia
Initial Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria: A minimum of 3 cases evaluated

Renewal Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If volume not met, the next case evaluated

Light to moderate sedation	___	___	___	___
Deep sedation	___	___	___	___

Delineation Of Privileges

Family Medicine Privileges.

Name:

Privilege	Requested	Granted	Deferred	Suspended

Adult Moderate or Deep Sedation and Analgesia

Initial Criteria:

a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria: A minimum of 3 cases evaluated

Renewal Criteria:

a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
   - If volume not met, the next case evaluated

Light to moderate sedation	___	___	___	___
Deep sedation	___	___	___	___

ACKNOWLEDGEMENT 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 the Ventura County Medical Center, Santa Paula Campus Hospital and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges. Applicant's electronic signature on file

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

_____

Chief, Department of Family Medicine Date

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

Basic Criteria:
a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology*
b. Current board certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology **OR**:
c. Active participation in the examination process leading to certification within 5 years of completion of training
d. Completion of BETA annual obstetrical module requirements
e. Documentation of case volumes as outlined in each requested privilege section

Evaluation Criteria: A minimum of 5 cases representative of requested privileges, specific requirements outlined in each privilege section

Renewal Criteria:
a. Documentation of case volumes as outlined in each requested privilege section for renewal of privileges
b. Compliance with BETA annual obstetrical module requirements

** Advanced obstetrics may be requested by family medicine physicians with the appropriate obstetrics fellowship training*

If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity. The Return to Practice Plan policy may be used to guide monitoring and/or training requirements.

If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.

OBSTETRICS

Low-Risk Obstetrics Core Privileges

Initial Criteria:
a. Documentation of a minimum of 40 deliveries in the previous 24 months **OR;**
b. Documentation of a minimum of 20 deliveries in the previous 24 months **AND** a minimum of 40 during residency training

E**valuation Criteria:** A minimum of 1 vaginal delivery

Renewal Criteria: Documentation of a minimum of 20 deliveries in the previous 24 months

Low-Risk Obstetrics Core Privileges ___ ___ ___ ___
Indicate in the comment section below, any portion of the core privileges NOT being requested

Privileges include but are not limited to the following:
Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any low risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include;
Prenatal care
Perform history and physical examination
Vaginal delivery
Fetal monitoring
Vacuum extraction
Episiotomy and/or other vaginal laceration repairs (up to 3rd-degree laceration repair)
Limited obstetric ultrasound
Resuscitation of infant

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended
Advanced Obstetrics Core Privileges **Initial Criteria:** a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology **OR**; b. Completion of an ACGME or AOA approved family medicine residency program and an obstetrics fellowship c. Documentation of a minimum of 100 cesarean sections during fellowship **AND** 20 within the previous 24 months **Evaluation Criteria:** a. A minimum of 2 cesarean sections (1 primary and 1 repeat) b. Management of 1 complicated prenatal patient (desired but not required) **Renewal Criteria:** A minimum of 20 patients in the previous 24 months, including a minimum of 20 cesarean sections if requesting c-section privileges				
Advanced Obstetrics Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested***	___	___	___	___
Privileges include but are not limited to the following: Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any high-risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Perform history and physical examination Breech delivery Forceps delivery Cerclage placement Amniocentesis and other procedures related to normal and complicated deliveries Multiple pregnancies Postpartum tubal ligation Obstetric ultrasound 4th-degree laceration repair Dilation and curettage (for pregnancy				
Cesarean section (including tubal ligation done at c-section)	___	___	___	___
Special Privileges **Initial Criteria:** a. Completion of an Obstetrics and Gynecology residency program b. A minimum of 2 cases in the previous 24 months **Evaluation Criteria:** A minimum of 1 case evaluated **Renewal Criteria:** A minimum of 1 case in the previous 24 months				
2nd Trimester dilation and evacuation	___	___	___	___
Use of Laser - *CO2 Laser Surgery course certification required*	___	___	___	___

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

GYNECOLOGY

Initial Criteria:
a. Completion of an Obstetrics and Gynecology residency program or completion of a Urology residency program and a Female Pelvic Medicine and Reconstructive Surgery fellowship
b. Documentation of a minimum of 100 patients within the previous 24 months, including 20 surgical cases, unless only requesting outpatient privileges

Evaluation Criteria:
a. A minimum of 1 major gynecology procedure
b. A minimum of 1 minor gynecology procedure (may be fulfilled by satisfactory completion of a major procedure)

Renewal Criteria: A minimum of 20 patients, including 10 surgical cases, unless only requesting outpatient privileges

Gynecology Core Privileges ___ ___ ___ ___

Indicate in the comment section below, any portion of the core privileges NOT being requested

Privileges include but are not limited to the following:
Admission, evaluation, consultation, diagnosis, pre, intra-, and post-operative care and treatment of female patients of all ages presenting with illnesses, injuries, and disorders of the gynecological system and nonsurgical treatment of illnesses, and injuries of the mammary glands and urinary tract, and include:
Perform history and physical examination
Outpatient management
Diagnostic and operative hysteroscopy
Operative laparoscopy
Cautery of endometriosis
Hysterectomy, including cesarean hysterectomy
Repair of bladder injury
Repairs for pelvic relaxation and evaluation and treatment of stress urinary incontinence (suspension techniques)
Endometrial ablation
Reconstruction of vagina/vulva
Myomectomy
Bartholin cystectomy and catheter placement
Biopsy (cervix, vulva, vagina, endometrium)
Cervical conization
Dilation and curettage
Hymonotomy,
Hysteroscopy
I&D of abscess
Oophorectomy
Ovarian cystectomy
Perineorrhaphy
Removal of cervical polyps
Repair of recto-vaginal fistula
Pelvic ultrasound
Presacral neurectomy
Salpingectomy
Suction curettage
Trachelectomy
Incidental cystoscopy
IUD placement/removal and other contraceptive procedures
Tubal ligation
Uterine suspension
Vaginal exam under anesthesia
Simple vulvectomy

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

GYNECOLOGIC ONCOLOGY

Initial Criteria:
a. Completion of a gynecologic oncology fellowship program
b. Documentation of a minimum of 100 patients within the previous 24 months

Evaluation Criteria:
a. A minimum of 1 major procedure
b. A minimum of 1 laparoscopy procedure

Renewal Criteria: A minimum of 20 patients within the previous 24 months

Gynecologic Oncology Core Privileges ___ ___ ___ ___

Indicate in the comment section below, any portion of the core privileges NOT being requested

Privileges include but are not limited to the following:
Admission, evaluation, consultation, work-up, diagnosis, and provision of surgical and therapeutic treatment to patients of all ages with malignant diseases, including carcinomas of the cervix, fallopian tubes, ovaries, uterus, vulva, and vagina, and include:
Perform history and physical examination
Outpatient management
Radical hysterectomy with or without lymph node dissection
Sentinel node biopsy
Operative laparoscopy
Retroperitoneal surgery for cancer
Microsurgery
Chemotherapy
Pelvic exenteration
Vulvectomy
Procedures on the bowel, urethra, and bladder as indicated

MATERNAL AND FETAL MEDICINE

Initial Criteria:
a. Completion of a maternal and fetal medicine fellowship program
b. Documentation of a minimum of 100 patients within the previous 24 months

Evaluation Criteria: A minimum of 1 complicated patient, procedure, or ultrasound

Renewal Criteria: A minimum of 20 patients in the previous 24 months

Maternal and Fetal Medicine Core Privileges ___ ___ ___ ___

Indicate in the comment section below, any portion of the core privileges NOT being requested

Privileges include but are not limited to the following:
Admit, evaluate, diagnose, treat and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications, connective tissue disorders, and fetal malformations, conditions, or disease, and include:
Perform history and physician examination
Chorionic villus sampling
Intrauterine transfusion
Transuterine fetal procedures
Ex Utero Intrapartum Treatment (EXIT) procedures
Fetal umbilical cord blood sampling
Level II ultrasound

ADDITIONAL PRIVILEGES

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended
Provider Performed Microscopy (PPM) - ***Annual competency modules required for each exam***	___	___	___	___

Indicate in the comment section below, any portion of PPM privileges NOT being requested

Fecal WBC
Fern Test
Pinworm Preparations
Qualitative Semen
Skin KOH
Urine Sediment
Vaginal KOH Prep
Vaginal Wet Prep

Adult Moderate or Deep Sedation and Analgesia

Initial Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria: A minimum of 3 cases evaluated

Renewal Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If volume not met, the next case evaluated

Light to moderate sedation	___	___	___	___
Deep sedation	___	___	___	___

ACKNOWLEDGEMENT 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 the Ventura County Medical Center, Santa Paula Campus Hospital, and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's electronic signature on file

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

_____
Chief, Department of Obstetrics & Gynecology Date

Delineation Of Privileges

Psychiatry Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

Initial Criteria:
- MD or DO with successful completion of an ACGME or AOA accredited residency/fellowship in Psychiatry.
- Current certification or active participation in the examination process leading to certification within 4 years of initial privileges by the American Board of Psychiatry & Neurology or the American Osteopathic Board of - Psychiatry & Neurology.
- Documentation of the provision of psychiatric services for at least 30 inpatients or outpatients at an accredited facility during the past 2 years.

Evaluation Requirements:
2 evaluators assigned
3 cases per evaluator per privilege

Renewal Criteria:
Documentation of the provision of care to a minimum of 15 patient encounters within the previous 2 years.

Core Privileges: ___ ___ ___ ___
Privileges to admit, evaluate, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis, and adjustment disorders.
If appropriate and clinically indicated, a history and physical examination, and provide basic medical management within the scope of practice
Consultation with physicians in other fields regarding mental, behavioral, emotional, and geriatric psychiatric disorders
Psychopharmacology
Psychotherapy
Consultations in the courts
Emergency Department and Crisis Team Consultations
Chemical dependency intervention and therapy
Emergency Psychiatry

Inpatient Privileges: ___ ___ ___ ___
Privileges to admit and treat patients hospitalized in the inpatient psychiatric units, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis and adjustment disorders.

* *Physicians requesting inpatient privileges must complete first shift(s) in person (and be proctored) prior to working telemedicine shifts in the IPU/CSU.*

Special Privileges
(Must also meet the criteria above)

Child Psychiatry ___ ___ ___ ___
(less than 13 years of age)
Additional Criteria:
Successful completion of a 2-year fellowship in Child and Adolescent Psychiatry or equivalent training or experience as determined by the Department of Psychiatry.

Adolescent Psychiatry ___ ___ ___ ___
(13 years of age and above)
Additional Criteria:
A minimum of 1 year verified work experience specifically related to the psychiatric treatment of adolescents (13 years of age and above)

Delineation Of Privileges

Psychiatry Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

ACKNOWLEDGEMENT 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 the Ventura County Health Care Agency facilities. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's Electronic Signature on File

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

Department Chief's Signature: _____ Date: _____

FISCAL YEAR 2022 / 2023

ANNUAL REVIEW - PROVIDER GROUPS

Contractor Name	Terms and Scope of Service Provide	Term Dates	Verified by Physician Mgmt	Notes
California Cardiovascular and Thoracic Surgeons	Cardiac Surgical Services	7/1/21-6/30/23	BD 5.15.23	Amend 1 eff 7/1/22 - 6/30/23; additional language added
Channel Islands Inpatient Pediatrics	Director of Inpatient Pediatric Hospitalist Services	7/1/22-6/30/23	BD 5.15.23	New AGR eff 7/1/22
Coastal Foot and Ankle	Podiatry Division Director and Attneding Physician, Podiatry Services	7/1/22-6/30/23	BD 5.15.23	
Coastal Vascular Center	Vascular Surgery Division Director and Attending Physicians, Vascular Surgery Services	7/1/22-6/30/23	BD 5.15.23	
Critical Care Associates	Attending Physician, Critical Care Department Services	1/1/22-6/30/23	BD 5.15.23	
Gold Coast Neonatal	Neonatal Services	7/1/22-6/30/23	BD 5.15.23	
Institute for Head & Neck Surgery Medical Group, Inc.	Medical Director and Attending Physicians, Otolaryngology Services	11/1/22-6/30/24	BD 5.15.23	New AGR eff 11/1/22
Island View Gastroenterology	Gastroenterology Services	7/1/22-6/30/23	BD 5.15.23	
Lee Medical Corp DBA California Pediatric Surgical Group	Medical Director and Participating Physicians, Pediatric Surgery Services	1/1/23-6/30/24	BD 5.15.23	New AGR eff 1/1/23-6/30/24; replacing Pediatric Subspecialty Network Inc.
Oceanview Medical Specialists	Medical Specialty Care Services / Medical Directorships: Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Immunology, Neurology, Physical Medicine and Rehabilitation, Pulmonary, Rheumatology, MSCW Clinic, Infusion Center, Oncology Clinic, Cardiology Clinic, Program Director: Stroke, Program Director: E-consult, Program Director: HIV combined with Immulogy, Pulmonary Function Lab, Program Director: Continuous EEG.	11/1/22-12/31/23	BD 5.15.23	New AGR eff 11/1/22-12/31/23
Pacific Coast Brain and Spine Associates (formerly Anacapa Neurological Associates)	Medical Director and Attending Physicians of Neurosurgery Services	7/1/22-6/30/23	BD 5.15.23	
Pediatrix Medical Group of California	Medical Director and Professional Services VCMC Pediatric Intensive Care Unit/PICU Services; Sedation Services	7/1/22-6/30/23	BD 5.15.23	
Reinassance Imaging Medical Associates	VCMC /SPH/ AC Radiology	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 2/1/23; Dictation removed, VCMC & SPH Base and Med Director added, Ambulatory Care X-ray and Ultrasound interpretation added
Renal Consultants of VC	Nephrology Services	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 7/1/21 - 6/30/23 language added that was missing in AGR eff 7/1/21
Salutem	Health Care for the Homeless Program Services	7/1/23-6/30/24	DP 5.15.23	New Agreement eff 7/1/23
Seaside Emergency Associates	VCMC Emergency Department Director and Attending Physician Services	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 7/1/22-6/30/23; metrics updated
Traditions Behavioral Health Inc.	Behavioral Health - Hillmont Psychiatric Center	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 2/1/22
Ventura County Anesthesia Medical Group	Anesthesia Physician Services VCH/SPH	7/1/22-6/30/23	BD 5.15.23	New AGR eff 7/1/22
Ventura County Hospitalists, Inc.	VCMC Director and Attending Physicians, Hospitalist Services and SPH Director and Attending Physicians, Hospitals and Critical Care Services	7/1/22-6/30/23	BD 5.15.23	Amend 3 eff 7/1/22; additional hours added
Ventura County Orthopaedic Associates	Orthopaedic Surgery Services	11/1/22-10/31/23	BD 5.15.23	New AGR eff 11/1/22-10/31/23
Ventura County Surgical Associates	Director and Attending Physicians, General Surgical, Trauma Services and Quality Improvement	7/1/22-6/30/23	BD 5.15.23	New AGR eff 7/1/22-6/30/23
Ventura County Women's Health Specialists Medical Group	Director, Associates Directors, and Attending Physicians, Obstetics and Gynocological Services, and Perinatology Services	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 6/1/22; additional language added; Amend 2 eff 1/1/23
Ventura Faculty Associates	VCMC Residency, Academic Family Medicine Center, Urgent Care and Palliative Care Services, OBGYN, Family Practice, and Psychiatric Fellowships Services, IPU History & Physical Services	7/1/22-6/30/23	BD 5.15.23	Amend 2 eff 11/1/22
Ventura Pulmonary & Critical Care	Professional Attending Physicans, Pulmonary Services	7/1/22-6/30/23	BD 5.15.23	Amend 1 eff 7/1/21 - 6/30/23 adding language omitted from AGR eff 7/1/21 and extending term
Zarrinkelk and Siavash Dental Partnership	Oral & Maxillofacial Surgery Services	7/1/22-6/30/23	BD 5.15.23	
TERMED/CXL'D/REPLACED VENDORS				
Anacapa Urology Associates	Medical Director and Associates of Urology Services	7/1/21-6/30/22	BD 5.15.23	AGR terminated eff 6/30/22 and replaced with individual Urology agreements with Drs. Silverman, Bowman and Mills (Central Coast Men's Health).
Pediatric Subspecialty Network, Inc.	Director and Participating Physicians, Pediatric General and Thoracic Surgery Services	7/1/22-12/31/22	BD 5.15.23	Term eff 12/31/23; replaced with Lee Medical Corporation DBA California Pediatric Surgical Group

FISCAL YEAR 2022-2023 — Service Vendors - Annual Review of Contracted Services

	VENDOR NAME	SCOPE AND TERMS OF SERVICE	PO TERM DATES	DEPT	MET EXPECTATIONS	DID NOT MEET EXPECTATIONS	APPROVED WITH MONITORING	APPROVED WITHOUT MONITORING	CANCEL CONTRACT
	Note: If you use(d) a vendor not listed below, please return a completed Contract Review Form for the vendor and they will be added to the spreadsheet. This list should include all contracted service providers directly related to the provision of care and treatment of hopsital patients.								
*	ABBOTT & BURKHART REGISTRY	PEDIATRIC PT/OT/SPEECH SERVICES	7/1/2022-6/30/2023	REHAB	X				
	ACCESS INFO MGMNT / CLIENTCARE WEST	MEDICAL RECORD OFFSITE STORAGE	7/1/2022-6/30/2023	HIM	X				
	ALL AROUND COURIER	COURIER/DELIVERY SERVICE FOR LAB SPECIMENS AS REQUESTED	7/1/2022-6/30/2023	COURIER/LAB	X				
	AMERICAN MEDICAL RESPONSE (frmly Lifeline)	PROVIDE TRANSPORTATION FOR PATIENTS AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	AMN HEALTHCARE STAFFING AGENCY	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	AYA	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	BASELINE DIAGNOSTIC	NEURO MONITORING	7/1/2022-6/30/2023	OR	X				
	BC SOLUTIONS	OPERATIONAL QUALIFICATION VALIDATION OF BLOOD BANK SOFTWARE	7/1/2022-6/30/2023	LAB	X				
	BECKMAN COULTER	HEMATOLOGY ANALYZERS FOR PATIENT TESTING (CBC & AUTO DIFF)	7/1/2022-6/30/2023	LAB	X				
	BIOMERIEUX, LTD	Micro Instruments & Reagents		LAB	X				
	CARDIOVASCULAR SPECIALTIES	TEMPORARY ECHO SERVICES AS REQUESTED	7/1/2022-6/30/2023	RAD	X				
	CROSS COUNTRY HEALTHCARE	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	DATEX-OHMEDA	PROVIDE PARTS AND SERVICE FOR VAPORIZERS AND ANESTHESIA MACHINES FOR BIOMED	7/1/2022-6/30/2023	BIO	X				
	DIGITRAX	ISBT Printer Labels for Blood Products		LAB	X				
	DYNATRONICS	PROVIDE REHAB THERAPY SUPPLIES	7/1/2022-6/30/2023	REHAB	X				
	ECHO TECH IMAGING	PROVIDE TEMPORARY ECHO TECH AS REQUESTED BY VCMC/SPH	7/1/2022-6/30/2023	RAD	X				
	ENBIO CORPORATION	PROVIDE BIOMEDICAL ENGINEERING SERVICES	7/1/2022-6/30/2023	BIO	X				
	EP RADIOLOGICAL SERVICES	PROVIDE REPAIRS AND PM'S ON X-RAY EQUIPMENT	7/1/2022-6/30/2023	RAD	X				
	FISHER HEALTHCARE	Phlebotomy Supplies		LAB	X				
	GENERAL ELECTRIC	PACS SALES & SERVICE		RAD	X				
	HAEMOSTAT, INC - (FRESENIUS)	PROVIDE DIALYSIS SERVICES AS REQUESTED BY VCMC	7/1/2022-6/30/2023	NURSING	X				
	HOLOGIC	PROVIDE REPAIRS/PM'S ON DIDGITAL MAMMOGRAPHY EQUIPMENT	7/1/2022-6/30/2023	RAD	X				
	HUFFMASTER / BLUEFORCE	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	IRON MOUNTAIN (formerly SHRED IT)	DOCUMENT SHREDDING SERVICES AS REQUESTED BY VENTURA COUNTY	7/1/2022-6/30/2023	EVS	X				
	KEYSTONE PERFUSION SERVICES	CELL SAVER SERVICES / AUTOTRANFUSIONS	7/1/2022-6/30/2023	LAB	X				
	LEICA	CRYOSTAT INSTRUMENTATION & SERVICE/PM	7/1/2022-6/30/2023	LAB	X				
	LIFESIGNS INC	PROVIDE SIGN LANGUAGE INTERPRETER SERVICES AS REQUESTED BY VCMC	7/1/2022-6/30/2023	HCA/AUX	X				
	MAXIM HEALTHCARE	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	McCALL /MLEE STAFFING	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	ADMIN	X				
	MEDICAL SOLUTIONS	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X				
	MEDISCAN DIAGNOSTIC SVCS INC	PROVIDE TEMPORARY X-RAY TECHNOLOGIST AS REQUESTED BY VCMC/SPH	7/1/2022-6/30/2023	RAD		X			X
	MEDITECH HEALTH SERVICES INC	PROVIDE NURSING STAFF AS NEEDED FOR VCMC	7/1/2022-6/30/2023	NURSING	X				
	MEDPARTNERS	PROVIDE CODING SERVICES	7/1/2022-6/30/2023	HIM	X				
	MISSION STAFFING	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	ADMIN	X				
	NEOGENOMICS (FORMERLY Clarient)	PROVIDE PATHOLOGY / HISTOLOGY DIAGNOSTIC TESTING	7/1/2022-6/30/2023	LAB	X				

	OLYMPUS AMERICA INC	PARTS & LABOR FOR ENDOSCOPY, BRONSHOSCOPE, FOR BIOMED	7/1/2022-6/30/2023	RESP	X			
	ORTHO-CLINICAL DIAGNOSTICS	INSTRUMENTATION / SERVICE FOR BLOOD BANK PRETRANSFUSION TESTING	7/1/2022-6/30/2023	LAB	X			
	PERFORMANCE HEALTH	PROVIDE REHAB THERAPY SUPPLIES	7/1/2022-6/30/2023	REHAB	X			
	PHILIPS HEALTHCARE	PROVIDE REPAIRS AND SERVICE ON CT SCANNERS AND US EQUIPMENT	7/1/2022-6/30/2023	RAD	X			
	PREFERRED STAFFING REGISTRY	PROVIDE TEMPORARY REHAB STAFFING	7/1/2022-6/30/2023	REHAB	X			
	QUEST DIAGNOSTICS	PROVIDE SENDOUT LAB TESTING	7/1/2022-6/30/2023	LAB	X			
*	QUINCY LLC	PROVIDE REHAB SERVICES REGISTRY (PT/OT/SPEECH)	7/1/2022-6/30/2023	REHAB	X			
	QUINCY MD LLC (formerly PHARMPRO NETWORK)	PROVIDE PHARMACY PROFESSIONALS/PHARMACY STAFFING AS REQUESTED	7/1/2022-6/30/2023	PHARM	X			
	RX RELIEF	PROVIDE PHARMACISTS AS REQUESTED	7/1/2022-6/30/2023	PHARM	X			
	SIEMENS HEALTHCARE	Analyzers, Reagents, Supplies for Chemistry Testing		LAB		X		X
	THE KEY STAFFING (formerly Sr. Planning)	PROVIDE TEMPORARY NURING STAFF AS REQUESTED	7/1/2022-6/30/2023	NURSING	X			
	THERAPEUTIC RESOURCES	PROVIDE REGISTRY SERVICES (PT/OT/SPEECH)	7/1/2022-6/30/2023	REHAB	X			
	THYSSENKRUPP ELEVATOR	PROVIDE ELEVATOR PARTS AND REPAIRS AS REQUESTED	7/1/2022-6/30/2023	FAC	X			
	VITALANT	PROVIDE BLOOD BANK SERVICES	7/1/2022-6/30/2023	LAB	X			
	WERFEN USA	MEDICAL EQUIPMENT TESTING/CALIBRATION SERVICES	7/1/2022-6/30/2023	LAB	X			
		TERMINATED / CANCELLED / REPLACED						
*	Services not utilized; contract remains in force							