VENTURA COUNTY MEDICAL CENTER
SANTA PAULA HOSPITAL
A Division of Ventura County Health Care Agency

Ventura County Health Care System Oversight Committee
Administrative Policies
June 8, 2023

The following administrative policies were reviewed and recommended for approval by appropriate departments and committees.

1. 100.011 Hospital Visiting Hours and Regulations
2. 101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements
3. 101.027 Food and Drink in the Workplace
4. 106.015 Bloodborne Pathogen Post-Exposure Evaluation and Management
5. 106.045 Utilities Management Plan
6. 106.082 Fire Response Plan
7. 107.023 Adverse Events, Sentinel Events, Unusual Occurrences
8. 107.055 Pager Procedure
9. 108.006 Nurse Staffing and Scheduling
10. 108.050 Patient Safety Attendant Care
11. AD.20 Self-Pay Patient Admissions
12. D.38 Food and Nutrition Services Menus
13. EHS.01 Occupational Exposure to Tuberculosis
14. F.13 Fire Alarm System
15. F.44 Compressed Gas Cylinders
16. F.46 Utility System Shutdown
17. F.89 Construction and Renovation Guidelines
18. F.99 Emergency Water Suppliers
19. L.BB.05 Irradiation of Blood Products
20. L.BB.47 Antibody Detection by Gel Card – Pre-Warm Modification
21. PH.23 Reporting Controlled Substance Loss or Diversion
22. PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays
23. 101.014 Employee/Contract Agency Personnel Competence Assessment
24. 106.010 Employee Identification
25. 106.021 Bomb Threat
26. 106.035 Hazardous Materials & Waste Management Plan
27. 106.044 Security Management Plan
28. 106.066 Hospital Evacuation Plan
29. 107.004 Purchasing Policy
30. 107.050 Recognition and Evaluation of Abuse
31. 110.030 Charity Care Policy
32. 110.032 Discount Payment Policy
33. F.116 Ambient Temperature and Humidity Monitoring Critical Spaces
34. IS.01 Radiation Safety & Protection Program
35. IS.16 Code Red in the MRI Department
36. P.02 Hospital Pediatrics Indoor Playroom/Outdoor Play Area and Guidelines for Toy Maintenance and Donations

Status **Active** PolicyStat ID **8565536**

Origination	11/22/2017	Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices
Last Approved	3/8/2023		
Effective	3/8/2023		
Last Revised	3/8/2023	Policy Area	Administrative - Operating Policies
Next Review	3/7/2026		

100.011 Hospital Visiting Hours and Regulations

POLICY:

In order to ensure the safety and security of patients, employees and volunteers of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), to maintain an orderly environment and assist patients and visitors with finding their destination, there is controlled access to both facilities. The Hospital Visiting Rules have been adopted and will be posted prominently in English and Spanish at both the front lobby entrance and the Emergency Department entrance.

At designated entrances only, all guests will be required to sign in as either a visitor or a vendor and will then be issued an armband designating the department they intend to visit.

PROCEDURE:

There are specific designated entrances at both VCMC and SPH available for patients, visitors, vendors and employees. Any person in the hospital without a visitor or vendor arm band or employee badge should be directed to one of the hospital entrances so that they may sign in and be issued an arm band.

Staff will make every effort to treat our visitors with kindness and courtesy. Staff may be firm in explaining the visiting rules and that our concern is for the welfare of the patients entrusted to our care.

HOSPITAL VISITING REGULATIONS

For the welfare of our patients and to contribute to each patient's recovery, we urge all visitors to please observe the following visiting practices:

A. Patients require adequate rest and attention. Please observe the following visiting hours:

   9:00 AM to 9:00 PM DAILY

We ask that all visitors leave the patient rooms during the times of 6:30 AM to 8:00 AM and 6:30 PM and 8:00 PM so that the nursing staff can discuss patient care as they change shifts. Visitors may wait in waiting rooms or lobby until shift change is over.

B. Patient visits should not exceed two (2) visitors at any given time, unless there is a special circumstance.

C. Visitors must be in good health.

    1. Signage will be placed at all entrances instructing visitors, regardless of COVID-19 vaccination status, to screen themselves prior to entry as follows:

        a. Visitors with signs or symptoms suggestive of COVID-19, or a temperature of 100 degrees Fahrenheit and higher, should not enter.

        b. Visitors who have tested positive for COVID-19 within the last 10 days should not enter.

            i. Visitors who have attested that they have neither signs or symptoms of possible COVID-19, nor have tested positive for COVID-19 within the last 10 days, should proceed directly to their destination within the hospital.

        c. No visitors under the age of 18 shall be allowed unless they are parents of hospitalized children, or the significant other of a laboring woman.

        d. Service animals will continue to be allowed entrance.

    2. Visiting is not allowed if visitor is ill.

D. Visitors are required to comply with all hospital infection control policies, which includes wearing a well-fitting face covering at all times when in the hospital.

    1. Single-ply cotton face coverings (bandana, neck gaiter, t-shirt) are not approved face coverings.

    2. For visitors who prefer to wear a cloth mask, these visitors will be asked to place a medical mask over their cloth mask.

E. No visitors under the age of 13 are permitted in patient care areas, with the EXCEPTION of a brother or sister of a child who is a patient in Neonatal Intensive Care Unit (NICU), Pediatrics Unit, Pediatric Intensive Care Unit (PICU), Obsterics Unit(OB) or family members of a terminally ill patient. Visitors meeting this criteria may visit under these conditions:

    1. Siblings may visit during regular visiting hours only. They must be accompanied by a responsible adult.

    2. The child visitor must be in good health which is determined as necessary by a nurse or physician in the unit.

    3. Siblings will receive a green identifying arm band to wear.

F. Shoes and shirts are required for all visitors.

G. Noise levels should be kept to a minimum in the corridors and while in patient rooms.

H. No food should be brought in from outside the hospital for patients and visitors should not eat

in patient areas. Visitors may go to the cafeteria to purchase food.

1. A guest tray may be ordered for visitors of known or suspected COVID-19 positive patients.

I. Smoking is prohibited anywhere on hospital grounds, including all parking areas. Smoking includes the use of cigarettes, cigars, water pipes, pipes, hookahs, marijuana (including medical marijuana) and electronic smoking devices, such as e-cigarettes and vaping pens. There are no designated smoking areas on Hospital property. See policy *106.004 Smoking Policy* for more information.

J. Pediatrics Unit- We invite parent participation in the Pediatrics Unit. One parent may stay with the patient at all times as space allows. Siblings must be identified with a green armband. Grandparents or other significant adult may visit with a parent and should be wearing a green identification band, with the impression of the child's identification and the first name of the person wearing it.

K. NICU - Both parents may visit around the clock except during the hours mentioned above. Parents will be required wear their identification armband when visiting. Siblings must be at least two (2) years of age and show proof of current immunization. Each time a sibling visits, it will be necessary to complete an infection screening form. Siblings who visit will be identified with a green arm band and will be free from illness. Grandparents or other significant adult may visit with a parent and should be wearing a green identification band, with the impression of the infant's identification and the first name of the person wearing it.

L. Emergency Department (ED)

1. No children under the age of 13 unless they are the patient.
2. Children must be accompanied by an adult, when in the ED or the waiting room.
3. In critical situations, family members can stay at bedside at the nurse's discretion.
4. The Quiet Room may be utilized for families in critical situations.
5. To provide a safe environment, visitors are asked to refrain from multiple entries and exits from the patient care area.
6. The ED is not to be used as a thoroughfare to other areas of the hospital. Visitors should use an alternate entrance to gain entry into the hospital.

M. Intensive Care Unit (ICU) - Visitors will be restricted to immediate family and others as allowed by ICU staff. The visiting hours are for fifteen (15) minutes per hour, 24 hours a day, at nursing staff's discretion. No children under the age of 13 are allowed; however, sibling visits may be arranged. No visitors with communicable diseases will be permitted to visit. Flowers can be a source of infection and a safety hazard in the unit; therefore, they will not be allowed in the unit.

N. Obstetrics Unit (OB)

1. The non-birthing parent of the baby may stay in post-partum or ante-partum until 9:00 pm and overnight if in a private room. Only two (2) visitors at a time are allowed during visiting hours. A sibling must be accompanied by an adult. Within Labor and Delivery, patients are allowed two (2) visitors at a time, 24 hours a day. The non-birthing parent will receive green identification bands at the time of delivery. Identification (ID) bands will be distributed according to number of children to

identify siblings at the entrance of the hospital and in the OB department.

2. Overnight stays for the non-birthing parent are allowed in post-partum if the birthing parent is in a private room. Every effort will be made by the department to ensure a private room for the family.

O. Post Anesthesia Care Unit (PACU) - Visitors will be restricted to the parent(s) of a minor, the parents(s) or caregiver of persons with special needs and under special conditions.

P. Visiting hours for the Inpatient Psychiatric Unit (IPU) are Monday through Friday, 5:30 p.m. through 7:20 p.m., and on weekends and holidays, 12:30 p.m. to 2:30 p.m. We do attempt to accommodate visits during times other than those posted on an individual basis. It requires a physician's order and should be arranged in advance.

Q. Exceptions to the visiting policy may be made in extenuating circumstances. This will be done with collaboration between Medical Staff, Nursing Supervisor, the patient and their family.

R. In the event of an infectious disease outbreak, the visitor policy may be adjusted at the recommendation of the Infection Control Committee. If adjusted, the policy will be reviewed on a monthly basis.

The VCMC entrance will be open daily from 5:00 am until 9:00 pm. The Customer Service desk at VCMC will be staffed by one to two Security Guards 24 hours a day, 7 days a week, as well as a Customer Service employee and/or volunteer from 6:30 am to 3:00 pm. At SPH the entrance will be open from 5:00 am to 9:00 pm. A volunteer will be available to assist visitors from 9:00 am to 4:30 pm, as available.

Upon entering, guests will sign in as a visitor or sign in as a vendor, note their "time in," and be issued either a visitor or vendor armband. Employees entering the facility through the Main Entrance must wear Hospital ID badges. Employees without Hospital ID badges will be issued a visitor armband which must be worn for the duration of their time spent in the Hospital. All visitors and vendors must sign out upon exiting the facility. If a visitor or vendor is noted anywhere in either hospital without an armband, they will be instructed to obtain an armband from the unit. All vendors shall comply with policy *106.083 Vendor Access and Registration*.

The Emergency Department (ED). The ED at VCMC and SPH will be staffed with a Security Guard 24 hours a day, 7 days a week.

VCMC Radiology. This entrance is closed to everyone.

VCMC Ortho Clinic. This entrance is closed to everyone.

VCMC Lab Entrance. This entrance will be designated as keycard-access only. No patients or visitors will be permitted to enter the Hospital through this entrance. Employees with keycards may enter through this entrance 24 hours a day, 7 days a week.

All Revision Dates

3/8/2023, 11/22/2017

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/8/2023
Policy Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices	3/8/2023

Status **Active** PolicyStat ID **13281743**

Origination	5/1/1983	Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH
Last Approved	3/16/2023		
Effective	3/16/2023	Policy Area	Administrative - Employee
Last Revised	3/16/2023		
Next Review	3/15/2026		

101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements

POLICY:

In order to promote optimal patient safety, effective resuscitation services will be available throughout Ventura County Medical Center, Santa Paula Hospital, Inpatient Psychiatric Unit and licensed clinics. In order to meet this requirement, employees and medical staff shall maintain the following current certifications:

PROCEDURE:

A. **Basic Life Support (BLS) Provider -** Every two (2) year recertification required. Must be an approved/accrediated American Heart Association course or American Red Cross course with a "hands on" skills component.

- Nursing (Registered Nurse (RN), Licensed Vocational Nurse (LVN), LIcensed Psychiatric Technician (LPT), Operating Room Technician (ORT), Medical Office Assistant (MOA), Nursing Assistant (NA), Medical Assistant (MA), Clinical Assistant (CA))
- Imaging Services (Radiologic Technologist, Radiologic Specialist, Radiologic Supervisor)
- Physical Therapist/Occupational Therapist/Speech Pathologist
- Respiratory Therapist
- Resident Physicians

B. **Advanced Cardiac Life Support/Advanced Life Support (ACLS/ALS) –** every two (2) year recertification required. Must be an approved/accredited American Heart Association or American Red Cross course with a "hands on" skill component.

- Resident physicians
- Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
    - Post-Anesthesia Care Unit (PACU)
    - Preoperative Care Unit
    - Emergency Department (ED)
    - Definitive Observation Unit (DOU)
    - Telemetry (TELE)
    - Intensive Care Unit (ICU)
    - RNs and LVNs assigned monitoring for moderate sedation
- Respiratory Therapist
- ACLS/ALS is strongly recommended for RNs and LVNs who work in the perioperative and medical-surgical (Med-Surg) setting.

C. **Neonatal Resuscitation (NRP):** every two (2) year recertification required. Must be an approved/accredited American Academy of Pediatrics course with a "hands on" skill component.
    - Resident physicians
    - Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
        - Neonatal Intensive Care Unit (NICU)
        - Obstetrics (OB)
        - OR/PACU RNs participating in c-sections
    - Respiratory Therapists working in the NICU and Santa Paula Hospital

D. **Pediatric Advanced Life Support (PALS)** every two (2) year recertification required. Must be an approved/accredited American Heart Association course with a "hands on" skill component.
    - Resident physicians
    - Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
        - Pediatrics
        - Pediatric Intensive Care Unit (PICU)
        - Intensive Care Unit (ICU) ONLY if function as Rapid Response Nurse
        - Emergency Department (ED)/(unless they have completed Emergency Nursing Pediatric Course (ENPC))
    - Respiratory Therapists
    - PALS is strongly recommended for RNs and LVNs who work in the perioperative

setting.

E. Medical staff members shall comply with the requirements specified in the Medical Staff bylaws, rules and regulations regarding BLS, ACLS/ALS, PALS and NRP certification/ recertification. BLS must be an approved/accredited American Heart Association or American Red Cross equivalent course with a "hands on" skills component. ACLS/ALS and PALS must be an approved/accredited American Heart Association course with a "hands on" skills component. NRP must be an approved/accredited American Academy of Pediatrics course with a "hands on" skills component.

Course Offerings:

- All courses shall be taught according to the standards of, and approved/accredited by, the American Heart Association (AHA) or the American Red Cross (ARC) or the American Academy of Pediatrics (AAP).
- Cardiopulmonary Resuscitation (CPR) recertification courses (BLS Provider) shall be offered at least monthly.
- ACLS/ALS, NRP and PALS certification/recertification courses shall be offered at least biannually.
- Scheduling of AHA courses is the responsibility of the VCMC Nursing Education Department's AHA Training Center Coordinator. Continuing Education (CE) units shall be awarded for completion of ACLS, PALS and/or NRP courses.
- Maintaining required certification and scheduling of employees for courses is ultimately the responsibility of the individual employee (in conjunction with each department manager).

All Revision Dates

3/16/2023, 12/5/2022, 7/18/2022, 2/12/2019, 5/1/2006, 12/1/2004, 9/1/2001, 11/1/1998, 3/1/1995, 8/1/1992, 11/1/1989, 10/1/1986

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/16/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/15/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/15/2023

Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/15/2023

Status **Active** PolicyStat ID **13325043**

Origination	2/12/2019
Last Approved	3/16/2023
Effective	3/16/2023
Last Revised	3/16/2023
Next Review	3/15/2026
Owner	Diana Zenner: Chief Operating Officer, VCMC & SPH
Policy Area	Administrative - Employee

101.027 Food and Drink in the Workplace

POLICY:

Employee food and drink shall be restricted to certain areas.

PROCEDURE:

Eating and drinking is prohibited in patient care work areas such as in nursing units and the laboratory stations, where there is potential for exposure to bloodborne pathogens. Food consumption shall be restricted to the hospital cafeteria or employee break rooms or meeting rooms. Food and drink shall not be kept in areas where blood or other potentially infectious materials are present, such as refrigerators or freezers, shelves, countertops, cabinets, bench tops or other storage areas. Covered beverages may be kept in the units designated location away from the workstations and WOWs.

Employees are encouraged to visit the cafeteria for meals and snacks. Any food brought from the cafeteria to other departments shall be transported in covered containers and consumed only in permitted areas.

Employees who do not have public contact and who do not work in areas where there is a potential for exposure to bloodborne pathogens (i.e., Health Information Management, IT, Performance Improvement) may have a beverage in a container (provided the beverage does not come in contact with computer equipment) as well as snacks.

All Revision Dates

3/16/2023, 2/12/2019

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/16/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/16/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/16/2023
Policy Owner	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/16/2023

Status **Active** PolicyStat ID **12701292**

Origination	10/1/1986
Last Approved	3/7/2023
Effective	3/7/2023
Last Revised	3/7/2023
Next Review	3/6/2026
Owner	Honeylette Wong: Nurse Practitioner-Employee Health Services
Policy Area	Administrative - Environment of Care

106.015 Bloodborne Pathogen Post-Exposure Evaluation and Management

POLICY:

This policy outlines the procedure to follow when a health care worker (HCW) at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) or an Ambulatory Care clinic is exposed to a bloodborne pathogen.

DEFINITION(S):

Bloodborne Pathogens (BBP)- pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include but are not limited to Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV).

Engineered Sharps Injury Protection (ESIP)- Devices that include non-needle sharps or needle devices containing built-in safety features that are used for collecting fluids or administering medications or other fluids, or other procedures involving the risk of sharps injury, such as shielded or retracting needles.

Exposure Incident- A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

LAB-Needle Stick Exposed Employee (NSE)- Initial post-exposure bloodwork panel for testing exposed employee. Includes HIV 1-2 Ab/Ag EIA Reflex to Confirmatory Testing-PH Lab, Hepatitis B Surface Antibody (HBsAb), and Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C

Genotype (Quest).

LAB-Needle Stick Source Patient (NSS)- Post-exposure bloodwork panel for testing source patient. Includes Human Immunodeficiency Virus Enzyme-STAT (HIV STAT), Hepatitis B Surface Antigen (HBsAg), and Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C Genotype (Quest).

Occupational Exposure- Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials (OPIM)- Includes but is not limited to human body fluids (semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva during dental procedures, any other body fluid that is visibly contaminated with blood); any unfixed tissue or organ; and any cell, tissue, or organs, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV. Urine, feces, vomit, sweat, tears and saliva are not considered to be a risk for BBP transmission unless there is visible blood in them.

Parenteral Contact- piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Post-Exposure Prophylaxis (PEP)- Medication to prevent HIV following possible exposure. Must be started within ***72 hours*** after a recent possible exposure to HIV.

PROCEDURE(S):

Exposed Health Care Worker Responsibilities

A. Remove all soiled clothing and perform first aid:
    1. Wash the site of the needlestick or cut with soap and water.
    2. Flush splashes to the nose, mouth, or skin with water.
    3. Irrigate eyes with clean water, saline, or sterile irrigant.

B. Immediately notify manager/supervisor of the exposure incident. If exposure occurs after hours or on the weekend, hospital staff report to the House Supervisor.

C. Obtain printed copies of all forms and documents contained within the "Employee Form Package" tab of the *Employer's First Report of Injury Form (RM-75)*- see section "C" under Manager/Supervisor/House Supervisor Responsibilities for complete list.

D. County and Non-County Employees present **within (≤) 2 HOURS** to the Santa Paula Hospital (SPH) or Ventura County Medical Center (VCMC) Emergency Department (ED) for laboratory testing & counseling on need for post-exposure prophylaxis (PEP) retroviral therapy. If source patient known, provide Medical Record Number (MRN) to ED staff.

E. County Employees notify Employee Health Services of exposure incident within **3-7 days** at

(805) 654-3813 and schedule a visit to obtain requisition for future lab draws, establish monitoring for bloodwork results, and assess medication tolerance (if appropriate). Non-County Employees contact their Human Resources Department and/or Worker's Compensation Representative to provide notification of the incident and obtain guidance on their employer's post-exposure management procedures.

F. Provide manager/supervisor with the following forms when complete:
    1. *Worker's Compensation Claim Form (DWC-1)* - Complete employee portion and return to manager/supervisor within **one working day** of the exposure incident.
    2. *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* - Obtain completed form from ED provider at time of initial exam and provide a copy to manager/supervisor within **one working day** of ED visit.

G. Any absence consisting of more than three (3) consecutive workdays also requires the completion of an electronic *Leave of Absence (LOA) Request* form, which can be accessed using the desktop link to Liquid Office at https://hr.ventura.org/benefits/leave-of-absence-steps.

Manager/Supervisor/House Supervisor Responsibilities:

A. Immediately meet with employee upon receiving notification of exposure incident.

B. Identify and document source individual Medical Record Number (MRN) and if available, obtain consent and arrange for source patient blood work.
    1. **Ambulatory Care Clinics:** Immediately notify provider of exposure incident and provide source patient MRN. Patient provider will order **LAB- Needle Stick Source Patient (NSS**). If patient consents, labs will be drawn ***prior to source patient departure from clinic***. Transport specimen/s to VCMC Laboratory via STAT courier.
    2. **VCMC/SPH:** Immediately notify ED of exposure incident at (805) 652-6168 and provide source patient MRN. ED provider will order **LAB- Needle Stick Source Patient (NSS)**. If patient consents, labs will be drawn ***prior to source patient discharge home.***

C. Provide employee with printed copies of all forms and documents contained within the "Employee Form Package" tab of the *Employer's First Report of Injury Form (RM-75)*, which can be accessed from the desktop icon link to http://myvcweb.co.ventura.ca.us/index.php/supervisor-reporting-landing-page.
    - Employee Injury Reporting Informational Handout
    - Disability & Absence Management Team Contacts Handout
    - Authorized Medical Network for Treatment of Occupational Injury or Illness Handout
    - Pharmacy First Fill Card
    - *Worker's Compensation Claim Form (DWC-1)*
    - *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)*
    - *Application for Paid Industrial Leave (RM-67)* (if applicable)

D. Advise employee to report within **(≤) 2 HOURS** to the VCMC or SPH Emergency Department for laboratory testing & counseling on need for post-exposure prophylaxis (PEP) retroviral therapy.

E. Complete and submit all required notifications:

1. Complete *Employer's First Report of Injury Form (RM-75)* and submit electronically **within 24 hours of the exposure** to alert Employee Health Services, Human Resources, and Risk Management of the incident.
2. Instruct employee to complete "Employee Section" of the *Worker's Compensation Claim Form (DWC-1)*. **Within one working day of receipt**, complete the "Employer Section" and submit to Sedgwick Claims Administrator and Leave of Absence/ Return to Work Coordinator for employee work location.
3. Complete and electronically submit *RL Datix Report for Employee Event-Exposure to Blood/Body Fluid* **within one working day** of the exposure incident.

ED Admitting Clerk Responsibilities:

A. Upon completion of patient registration, provide both County & Non-County employees with the *State of California Doctor's First Report of Occupational Injury or Illness (390-220)* with instructions to complete the Employee Section (#1-17). The document can be obtained on the State of California's Division of Workers' Compensation web page athttps://www.dir.ca.gov/dwc/forms/5021.pdf

B. Ensure all County employees have also been provided a hard copy of the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* by their manager/supervisor. If employee cannot provide a copy, obtain a copy from https://vcportal.ventura.org/CEO/risk/docs/PhysiciansNoticeOfReturnToWork_ver20210309.pdf. Instruct employee to complete Employee Section (#1-17) of the form.

C. Place the partially completed *Doctor's First Report of Occupational Injury or Illness (390-220)* and the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* on the ED chart.

ED Medical Office Assistant (MOA) and/or Clerical Supervisor Responsibilities:

A. When ED chart is received, fax *State of California Doctor's First Report of Occupational Injury or Illness (390-220)* to Sedgwick Claims Administrator and scan a copy to Medical Records. This is required for both County & Non-County employees.

B. For County employees only, fax the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* to Sedgwick Claims Administrator ***within 5 days*** of employee ED visit. Provide a hard copy to the employee and email a copy to the Leave of Absence/Return to Work Coordinator assigned to employee work location.

ED Registered Nurse (RN) Responsibilities:

A. Verify employee has completed the Employee Section (#1-17) of the *State of California Doctor's First Report of Occupational Injury or Illness (390-220)*.

B. Document MRN ONLY of source patient on ED chart.

C. Provide employee with educational materials from the Centers for Disease Control &

Prevention (CDC).

1. *Exposure to Blood: What Health Care Personnel Need to Know*
2. *PEP 101*
3. *Occupational HIV Transmission and Prevention among Health Care Workers*

D. ED nurse or phlebotomist draws blood on exposed employee and source patient (if appropriate) in anticipation of physician order/s.

E. If Post Exposure Prophylaxis (PEP) is ordered, verify that a Comprehensive Metabolic Panel (CMP), Complete Blood Count with Differential (CBCD), & Urine Pregnancy test have also been ordered by the provider and drawn/collected on the employee.

ED Licensed Practitioner (LP) Responsibilities:

A. Review employee medical history and medications.

B. Conduct assessment of exposed employee to determine whether post-exposure bloodwork and/or Post-Exposure Prophylaxis (PEP) is indicated.

C. Utilize the ***"EMER Post Exposure Prophylaxis (Needlestick) Powerplan"*** in Cerner to:

1. Document the source patient Medical Record Number.
2. Order **LAB-Needle Stick Exposed Employee (NSE)** on exposed employee if indicated.
3. Order Post-Exposure Prophylaxis (PEP) if indicated.
4. Alert Employee Health Nurse Practitioner of the exposure incident through Cerner Message Center. NOTE: Notification occurs automatically only if "EMER Post Exposure Prophylaxis (Needlestick)" Power Plan is used. ***Employee Health Services should NOT be notified of incident if Non-County Employee or Source Patient***.

D. Order **LAB-Needle Stick Source Patient (NSS)** on source if available and not already completed by clinic provider. Source patient labs are NOT ordered through the "EMER Post Exposure Prophylaxis (Needlestick) Powerplan".

E. Contact the Infectious Disease Specialist or national resource such as the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at 1-888-448-4911 as needed for consultation.

F. Discuss treatment options with exposed employee.

G. If placing employee on Post Exposure Prophylaxis (PEP) medications:

1. Order baseline Comprehensive Metabolic Panel (CMP) and Complete Blood Count with Differential (CBCD) through the **"EMER Post Exposure Prophylaxis (Needlestick)" Powerlan**. Urine Pregnancy test is ordered by protocol for every woman of childbearing age.
2. Provide employee with first 7 days of treatment from VCMC/SPH Pharmacy. E-prescribe remaining 21-days of therapy to Farmacia Estrella and instruct patient to pick up prescription. Review side effects, precautions, and drug interactions with employee.

H. Refer employee to Employee Health Services (805) 654-3813 for follow-up care within **3-7**

working days.

I. Complete the practitioner section (#18-26) of the *State of California Doctor's First Report of Occupational Injury or Illness (390-220)*, including signature and license number. Provide completed form to MOA for submission to Sedgwick Claims Administrator and Medical Records.

J. Complete the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)*. Provide completed form to MOA for submission to Sedgwick Claims Administrator & employee Leave of Absence Coordinator and provide employee with a copy to give to their manager/supervisor.

K. Provide specific discharge instructions depending on employment status and whether or not PEP was prescribed.

1. County Employee, PEP not offered
2. County Employee, PEP offered
3. Non-County Employee, PEP not offered
4. Non-County Employee, PEP offered

Employee Health Services (EHS) Responsibilities:

A. The EHS nurse practitioner will meet with employee within 3-7 days post exposure to provide requisition for future lab draws, monitor blood work results, and assess medication tolerance (if appropriate).

B. EHS will offer Tetanus, Diphtheria, Pertussis (Tdap) and Hepatitis-B (Help-B) vaccines if employee is not up to date with vaccinations or if Hep-B titer was negative.

C. EHS will monitor follow-up blood work in 6 weeks, 12 weeks and 6 months for employees not taking PEP. Labs will include:

1. Alanine Transaminase (ALT)
2. Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C Genotype (Quest)
3. HIV 1-2 Ab/Ag EIA with reflex to Confirmatory Testing (Public Health Lab)

D. If employee is taking PEP, there is an additional blood draw 2 weeks from start of treatment to monitor drug toxicity.

1. Complete Blood Count with Differential (CBCD)
2. Complete Metabolic Panel (CMP)

E. If the 6-month blood draw is normal, employee will be discharged, and Worker's Compensation case will be closed.

F. In the event there is seroconversion, EHS will refer employee to Public Health.

Safety Officer Responsibilities:

A. The Safety Officer will receive electronic notification of all exposure incidents via the *Employer's First Report of Injury Form (RM-75).*

B. Work-related bloodborne exposure incidents that meet one or more of the following requirements will be recorded on the *OSHA 300 Log* by the Safety Officer.
    1. The incident requires medical treatment beyond first aid.
    2. The incident results in the diagnosis of a bloodborne illness, such as HIV, Hepatitis B, or Hepatitis C.
    3. The incident results in a significant injury or illness diagnosed by a physician or other licensed health care professional.
    4. The incident results in loss of consciousness.
    5. The incident results in death.
    6. The incident results in days off work, restricted work, or transfer to another job.

C. Exposure incidents involving a needlestick or other sharps injury will also be recorded on the Sharps Injury Log, and will include the following:
    1. Date and time of the sharps-related exposure incident.
    2. Type and brand of the sharp involved in the incident.
    3. A description of the incident including:
        - The job classification of the exposed employee
        - The department or work area where the incident occurred;
        - The procedure being performed
        - How the incident occurred
        - The body part injured
        - If the engineered sharps injury protection (ESIP) safety mechanism was or was not activated.
        - If the incident occurred before action, during activation or after activation of the safety mechanism
        - If the incident involved a sharp without ESIP, the employee's opinion if ESIP could have prevented the injury.

D. For any case that is later diagnosed with an infectious bloodborne disease, the Safety Officer will update the case description and classification on the *OSHA 300 Log*.
    1. The case description will identify the infectious disease.
    2. The case classification will be changed from an injury to an illness.

REFERENCE(S):

1. Centers for Disease Control and Prevention. (2003, July). *Exposure to Blood: What Healthcare Personnel Need to Know*. Retrieved November 29, 2022, from https://stacks.cdc.gov/view/cdc/6853.
2. Centers for Disease Control and Prevention. (2022, October). *PEP*. Retrieved November 29, 2022 from https://www.cdc.gov/hiv/pdf/library/consumer-info-sheets/cdc-hiv-consumer-info-

sheet-pep-101.pdf.

3. Centers for Disease Control and Prevention. (2015, June). *Occupational HIV Transmission and Prevention among Health Care Workers*. Retrieved November 29, 2022 from https://www.cdc.gov/hiv/pdf/workplace/cdc-hiv-healthcareworkers.pdf.
4. Centers for Disease Control and Prevention. (2001, June 29). *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendation for Postexposure Prophylaxis*. Morbidity and Mortality Weekly Report (MMWR) Series, Volume 50 (No. RR-11). Retrieved November 1, 2022 from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm .
5. United States Department of Labor (n.d.). Occupational Safety & Health Administration. Standard Number 1904.7- General Recording Criteria. Retrieved December 15, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.7.
6. United States Department of Labor (n.d.). Occupational Safety & Health Administration. Standard Number 1904.8- Recording Criteria for Needlestick Sharps Injuries. Retrieved December 15, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.8.
7. United States Department of Labor (n.d.). Occupational Safety & Health Administration. *Standard Number 1910.030- Bloodborne Pathogens*. Retrieved November 1, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030.

All Revision Dates

3/7/2023, 5/1/2012, 9/1/2009, 5/1/2006, 10/1/2004, 9/1/2001, 11/1/1989

Attachments

BBP Exposure Response Poster.pdf

Approval Signatures

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	3/7/2023
Employee Health Services	Rachel Stern: Chief Medical Quality Officer	3/7/2023

Employee Health Services	Honeylette Wong: Nurse Practitioner-Employee Health Services	3/2/2023
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	3/2/2023
Policy Owner	Honeylette Wong: Nurse Practitioner-Employee Health Services	12/23/2022

Status **Active** PolicyStat ID **13605933**

Origination	3/1/2010	Owner	Ian McGraw: Manager Facility Operation
Last Approved	5/9/2023	Policy Area	Administrative - Environment of Care
Effective	5/9/2023		
Last Revised	5/1/2023		
Next Review	5/8/2024		

106.045 Utilities Management Plan

POLICY:

Ventura County Medical System (VCMS) strives to provide a facility that is functionally safe and maintains a secure health care environment for patients of all ages, visitors, medical staff, employees and volunteers by requiring and supporting the establishment and maintenance of an effective Utilities Management Plan (UMP). The UMP is based on applicable laws and regulations, and accepted practices, and applies to Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU) and Ambulatory Care clinics (AFMC).

The UMP is established to provide for the operational reliability, assess the special risks of and respond to failures within the utility systems that support patient care, so as to provide a safe, controlled and comfortable environment for patients, visitors, employees, volunteers and medical staff. The utility systems and associated staff will be managed so that risks can be minimized and benefits maximized.

PROCEDURE:

Authority

1. The Facilities Manager has been selected by the Environment of Care Committee to be responsible for UMP management, monitoring and reporting regarding UMP.
2. The Facilities Manager has immediate and complete access to all areas of the VCMS campuses, all physical plant records and any other records that become necessary in carrying out UMP.

Organization

1. The Facilities Manager shall report to the Environment of Care Committee. This report shall provide information and trends concerning systems indicators.

2. The Environment of Care Committee shall receive, review, investigate and take action as appropriate on all UMP reports.
3. The Facilities Manager shall provide annual reports regarding the UMP to Hospital Administration and Environment of Care Committee.

RESPONSIBILITIES

1. The Facilities Manager shall be responsible for ongoing monitoring, reporting, documentation, compiling of statistics and education aspects of the UMP.
2. All department heads are responsible for compliance with the requirements of the UMP as far as their individual department responsibilities mandate and will provide appropriate documentation relating to the requirements of the UMP as requested.
3. All individuals are responsible for compliance with the requirements of the UMP as far as their individual responsibilities mandate and shall cooperate with all appropriate provisions of the UMP.
4. The Facilities Maintenance department is responsible for collecting data, performing or overseeing repairs/preventive maintenance work and other aspects required of this program.
5. All employees have a role in the UMP, by effectively and safely utilizing resources such as electrical equipment, conserving energy, and by obtaining education regarding the utility systems and specific actions to be taken in the event of a utility failure. The goal of these actions is to maintain continuity of care and service.
6. All policies in the UMP are designed to apply to all departments, employees, volunteers, medical staff, patients and visitors.
7. The Environment of Care Committee will communicate UMP issues and summaries of activities, annually, to Administration, Executive Committee, Oversight Committee, and Managers of all departments/services. The department heads will communicate this information to staff.

ACTIVITIES

1. The UMP includes utilities that are considered to be critical/necessary to support safe, reliable treatment, diagnosis, or monitoring of patients and provide a safe, controlled and comfortable work environment for employees, volunteers, and medical staff.
2. The individual utilities included in the UMP (normal electrical power, emergency electrical power, fire systems, potable water, steam, natural gas, sewer, telephone, diesel fuel, medical gas systems, HVAC and elevators) are of such importance that separate policies, procedures, inspections and maintenance programs have been established by Facilities Maintenance and are individually managed.
3. Each utility will have a unique inventory of equipment/items made and maintained. This will be made and maintained by Facilities Maintenance. As equipment is added or deleted to the system, the inclusion of the equipment to this program will be set in Facilities Maintenance, or at the discretion of the Facilities Manager. The decision will be based on the nature of the equipment, the role it plays in the performance and effect of equipment on the overall environment.
4. When a problem is identified, the system will be evaluated for cause and necessary remedial

action. Action will be taken by appropriate parties, including staff and/or outside resources. Actions taken will be documented, monitored, and revised, if not effective. Once action has proven to be effective, no other monitoring will be required, unless the problem recurs.

5. A summary of the UMP system indicators and problem will be reported to the Environment of Care Committee on a quarterly basis.
6. The UMP provides an integrated and coordinated effort to comply with State Licensing and the Department of Health Care Access
and Information (HCAI), meet The Joint Commission (TJC), National Fire and Protection Association (NFPA) and, Occupational Safety and Health Administration (OSHA) standards and assists the facility in controlling losses related to professional and general liability.
7. The implementation of the UMP is a collaborative effort coordinated by the Facility Manager. All departments shall have a role in the success of the program. Through this arrangement, surveillance, monitoring, tracking and reporting is done. When problems are identified, action will be taken by the appropriate individuals to resolve them. Action will be documented, monitored and reported. Once the corrective actions have proven to be effective, no other monitoring will be required.
8. The UMP is a dynamic program because of the ever changing needs, monitoring results, reporting, laws and regulations.
9. The UMP program includes, but is not limited to the following:
    A. Inspecting, testing and maintaining critical operating components in accordance with manufacturers' recommendations
    B. Developing and maintaining current utility system operational plans to help provide for reliability, minimize risks, and reduce failures.
    C. Mapping the layout of utility systems and labeling controls for a partial or complete emergency shut-down.
    D. Investigating utility systems management problems, failures or user errors and reporting incidents and corrective actions.
    E. Building Maintenance Plan with priority codes and Equipment Management Program
10. The organization defines the intervals for maintenance, inspection, and testing of all equipment under preventative maintenance program. The equipment and the maintenance activity are based upon in accordance with manufacturers' recommendations, evaluated risk levels, and maintenance experience. Most intervals are annual, semi-annual, quarterly, monthly, and weekly maintenance activities. The preventative maintenance activity is scheduled by a maintenance management system that generates work orders. The work orders are distributed to the appropriate staff, and when complete, the data is entered into the CMMS system.
11. VCMS has identified and implemented emergency procedures for responding to utility system disruptions or failures that address the following:
    1. What to do if utility systems malfunction (on a departmental and organization wide basis)
    2. Identification of an alternative source of organization-defined essential utilities (where alternate sources are appropriate)

3. Shutting off the malfunctioning systems and notifying staff in affected areas
4. Obtaining repair services (this includes both internal and external resources)

The plans for these emergency responses are integrated with the Emergency Management Plan.

These plans are developed to include: the criteria and indications for implementing a utility response plan; the staff responsible for making the decisions; activities and resources used to mitigate the emergency (such as an emergency power system to mitigate external power failure); and preparation for the failure (e.g., flashlights, staff training about how to respond to a power failure).

12. The organization has identified and implemented processes to minimize pathogenic biological agents in cooling towers, domestic hot/cold water systems, and other aerosolizing water systems.

ORIENTATION AND EDUCATION PROGRAM

1. UMP in-service training is provided at new employee orientation for all employees, contractual service providers and volunteers. This is part of a structured staff development program that includes general safety practices which are supplemented by organization experience.
2. This training addresses the specific roles and responsibilities of personnel who would be affected by the loss of a utility.
3. Incident report training is provided at orientation for all employees, contractual service providers, and volunteers.
4. Each employee responsible for maintenance of utilities is provided departmental and job specific-related UMP training which is documented in his/her individual education file. Such training includes;
    - Capabilities, limitations and special application of utility systems
    - Emergency procedures in the event of system failure, identification of an alternative source of essential utilities; shut off of malfunctioning systems and notification of staff in affected areas, obtaining repair services, how/when to perform emergency clinical interventions when utility systems fail
    - Information/skills necessary to perform assigned maintenance responsibilities
    - Processes for reporting utility system management problems, failures and user errors.
5. Training for personnel maintaining utilities will be documented. Techniques of demonstration, appropriate actions, competency evaluation, etc. will be used to monitor training effectiveness.
6. The Facilities Manager will be available for departmental or individual in-service training as requested.
7. The Department heads will provide for orientation and training of new employees, and for the ongoing training of all their employees.

DATA SOURCES

Information is gathered for the UMP through various means and sources including, but not be limited to VCMS incident reports, hospital staff EOC surveillance rounds, safety surveys, maintenance rounds, utility vendor information. In addition, the computerized Facilities CMMS is utilized to track, maintain, report, and assess the performance measures.

PERFORMANCE STANDARDS

1. Employee's knowledge of policies, procedures and responsibilities under the program are assessed:
    - Following each educational session by a competency evaluation
    - Staff meeting discussions with Q & A
2. Employees will be able to demonstrate or describe;
    - VCMS Incident reporting systems for events that involve UMP
    - Communication of reports to the Facilities Manager
    - Actions to prevent, eliminate, minimize or report Utilities Management risks
    - Staff utility management knowledge/skill
    - Monitoring and inspection with documentation in the work order
3. The Facility Manager and Department Heads can describe their roles in developing organizational utility policies and procedures reflecting the goals and performance standards of the UMP.

ANNUAL EVALUATION

At least annually, there will be an evaluation and review of the Utilities Management Plan's scope, objectives, performance and effectiveness. This will be reviewed by the Environment of Care Committee

All Revision Dates

5/1/2023, 3/24/2023, 12/5/2022, 2/13/2019, 4/1/2013, 3/1/2012, 4/1/2011, 6/1/2010

Attachments

Annual Evaluation of the Utilities Management Plan

Approval Signatures

Step Description	Approver	Date

Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Environment of Care Committee	Ian McGraw: Manager Facility Operation	5/9/2023
Safety	Fernando Medina: Director, Support Services	5/8/2023
Policy Owner	Ian McGraw: Manager Facility Operation	5/8/2023

Status **Active** PolicyStat ID **13489362**

Origination	12/13/2001	Owner	Ian McGraw: Manager Facility Operation
Last Approved	5/9/2023	Policy Area	Administrative - Environment of Care
Effective	5/9/2023		
Last Revised	5/9/2023		
Next Review	5/8/2026		

106.082 Fire Response Plan

POLICY:

The Fire Response Plan – (Code Red) is to provide guidelines for hospital personnel to follow during a Code Red. As more fully described below, this plan provides for an organized and effective response to a fire at Ventura County Medical Center Campus and Santa Paula Hospital. Providing for the safety of patients, visitors, staff, and other occupants of the building in a fire situation is the primary goal of the Fire Response Plan. Property loss is of secondary importance.

DEFINITIONS

- **Code Red:** The hospital's emergency code word to initiate a response to a FIRE. A notification of “Code Red” alerts hospital personnel to respond properly to a fire while keeping patients, visitors, and the general public from undue alarm or panic.
- **Code Red All Clear:** An announcement which indicates to hospital personnel that the danger of the fire or the fire drill has ended.
- **Fire's Point of Origin:** Location in which the fire originated.
- **Near the Fire's Point of Origin:** Proximate to the fire’s point of origin – generally within the same smoke compartment in which the fire originated.
- **Away from the Fire's Point of Origin:** The parts of the building that are remote from the fire, separated by firewalls, smoke doors, or smoke compartments.

General

Employees are required to know their department’s fire response plan or procedures and follow the fire response plan and any instructions that are announced over the fire alarm and PA systems for **ALL** fire alarms. Employees are also required to know the locations of all manual pull stations in their work area.

Alarm Activation

When there are visible flames, visible smoke, smell of smoke, unusual heat, or other indications of fire – even if uncertain if the conditions are caused by a fire – employees and staff shall activate the manual pull stations. **TO REPORT ALL FIRES AND SMOKE - STAY CALM!! and DIAL "7-6666" VCMC or DIAL "8-6666" FOR SANTA PAULA HOSPITAL and "911" CLINICS AND OUTLINING BUILDINGS**

When reporting a fire:

- Give the floor number,
- Location,
- Building number (if applicable),
- Room number (if applicable).

Fire Alarm and Public Address System Notifications

Upon fire alarm initiation, for Ventura Conuty Medical Center and Santa Paula Hospital, the location of the alarm activation will be shown on the fire alarm system annunciator panel in the paging office (PBX). At both campus, the fire department will be notified by alarm company and the local fire department will contact the paging office to varify the alarm. For off campus and leased facilities, the fire department will be notified via the initial alarm call to 911. Upon fire alarm initiation, visible and audible alarms will be signaled throughout the building where the alarm was activated. In areas with fire alarm annunciation capabilities, in addition to visible and audible alarms occupants will hear the following:

- At the point of origin, adjacent areas, and floors below and above, the alarm annunciation message:
    - May I have your attention please! (2 - Times)
    - A Code Red condition has been detected in the building, initiate Code Red procedure at once. (3 - Times)
- For all remaining areas of building, the alert notification message:
    - May I have your attention please! (2 - Times)
    - A Code Red condition has been detected in the building, please await further instructions. (3 - Times)

In addition to automatic fire alarm notifications, the hospital Page Operator will announce “Code Red and the location” (3 – Times) over the PA system.

Employee and Staff Response

Follow the fire procedure known as R.A.C.E., before attempting to extinguish any fire:

- **R**escue/remove anyone in danger,
- **A**ctivate Alarm,
- **C**lose doors and windows, within the hazard or fire area,
- **E**xtinguish the fire using the closest fire extinguisher, if the fire impedes your evacuation.
    - Automatic extinguishing equipment should operate for fires under the kitchen hood.
    - All employees shall be familiar with the location and operation of fire extinguishers, through the fire safety education program.
- Evacuate to your designated meeting location.

Upon activation of a Code Red, personnel, including physicians and LIP's, who are **away from the fire's point of origin** shall do the following:

- Be ready to accept patients from near the fire's point of origin if required (especially for areas adjacent to the fire's point of origin). Also, be aware that the fire event in the facility may have an effect on their ability to effectively care for patients.
- Listen for additional instruction.
- Keep patients and visitors in rooms if possible until directed to do otherwise.
- Keep all fire doors closed except when passing through them in order to avoid the spread of smoke and fire.
- Be ready to evacuate if directed.
- DO NOT use Elevators.

In addition to the above, upon activation of an alarm, physicians and LIP's are specifically requested to:

- If in a patient area, go to the nurses' station to be available for response to a medical emergency.
- Assist other staff (when needed) in moving patients and visitors to safety, and evacuate with the other staff.

Oxygen Shut-Off

Respiratory technician in charge, or manager/supervisor in charge of area has the responsibility and authority to direct the shut-off of a medical oxygen gas valve in any life threatening situation. Provisions will be made to provide patients with portable O2. It is the responsibility of staff in all clinical areas to know the location of the shut-off valves.

Emergency Response Team (ERT)

For Ventura County Medical Center and Santa Paula campus buildings, response to fire incidents will be handled by the VCFD/VCFD and the ERT. The ERT is a coordinated team of Security, Facilities, and EVS personnel who respond to Code Red incidents.

Upon notification of the alarm, Security Officers will respond to the location of the fire or alarm. In the event of an actual fire, responding officers shall assist as needed and also call backup security officers to ensure free unobstructed access for emergency response vehicles and personnel. The Security Officers will meet the VFD and direct them to the fire location, maintain communication at the fire location, and may direct those not involved in the emergency response to evacuate the area. Security Officers will also prevent non-emergency responders from entering the building.

Upon receipt of the fire alarm, the adminting operator will dispatch via mobile radio all ERT responders to the fire location. The Control Room operator will notify Security to ensure that they received the fire alarm notification. Facilities Operations and Facilities Management
personnel shall respond to assist and to manage any building related issues.

Environmental Safety (EVS) personnel shall respond, when available, to the scene to render assistance as necessary and monitor life safety in the area. All ERT responders should bring an extinguisher with them when responding to a Code Red.

For proper use of a Fire extingisher follow the following procedure know as **P.A.S.S.**

- Discharge the extinguisher within its effective range using the **P.A.S.S.** technique (pull, aim, squeeze, sweep).
    - **P**ull:
      Pull the pin. There is a small pin that prevents the fire extinguisher from accidentally being discharged, all you have to do is pull it out and continue on to the next step.
    - **A**im:
      Aim the nozzle of the fire extinguisher low at the base of the fire.
    - **S**queeze:
      Squeeze the trigger you just pulled the pin out of. Remember to squeeze it slowly and evenly, so the extinguisher is as effective as possible.
    - **S**weep:
      Sweep the extinguisher from side to side to cover all areas the fire may have spread to.
      Before operating a fire extinguisher, you must take some safety precautions. First, assess the fire, if it is too big or uncontrollable don't risk your safety by trying to put it out. If the fire is small enough and can easily be put out and contained, continue to use the P.A.S.S. technique to extinguish the fire. Make sure to hold the fire extinguisher with the nozzle pointing AWAY from you, and keep your back towards a clear exit so you can safely exit if the fire becomes too dangerous.

Fire Department

Once the Fire Department arrives, the ranking officer will have authority at the fire scene.

Evacuation

In buildings where immediate building evacuation is not required, patient, visitor, employee, and staff evacuation shall be initiated when there is immediate danger due to fire, smoke, chemical release, structural failure, or similar condition. Evacuation of patients by bed or mattress from a room or floor may not be practical due to the large number of non-ambulatory patients. If required, direct evacuation of patients shall be conducted per the following guidelines:

- Partial Evacuation - Partial evacuation or relocation to other areas of the building may be used depending on the particular emergency and the level of danger that it poses. When partial evacuation is indicated, horizontal followed by vertical evacuation will be used.
- Horizontal Evacuation - Horizontal evacuation is preferred over vertical. As directed, patients will be moved typically to an adjacent smoke compartment on the same floor, away from the fire's point of origin.
- Vertical Evacuation - If necessary and as directed, patients may be moved to another floor - typically the floor below. If it becomes necessary to evacuate patients to a lower floor, stairwells should be used.
- Complete Patient Evacuation - Should the emergency condition persist or be of a severity such that the building is endangered, a complete evacuation of the building shall be initiated. Directions given by the senior officer in charge of the fire department shall be carried out immediately.
- Patient Removal - Patients are to be removed horizontally by stretcher, wheelchair, blankets, or other method of transportation to an adjacent fire/smoke compartment. Patients in immediate danger shall be removed first - including those who might be subject to danger should the fire spread into their area. Ambulatory patients should be accompanied or directed to an appropriate fire/smoke compartment, depending on the situation. Non-Ambulatory patients should be moved using wheelchairs or stretchers
  when available to an appropriate fire/smoke compartment. Patients being evacuated should be wrapped in blankets before placing in wheelchairs.

Code Zero - Evacuation

106.066 Hospital Evacuation Plan

Code Red All Clear

The Ventura County Fire Departemnt/Ventura City Fire Department (VCFD/VCFD), Safety Officer or Hospital Incident Commander at the scene will verify that the situation has been resolved. Any of these individuals can declare the incident "All Clear". The Adminting operator will be notified and will announce "Code Red All Clear" (3 – Times) over the PA system and perform a phone wide page. Security will advise of the "All Clear" to any in areas not covered by the PA system.

Employees and staff shall continue Code Red procedures until a “Code Red All Clear” signal has been announced.

Training and Education

Each department shall ensure that employees are sufficiently trained on Code Red procedures. This is accomplished by New Employee Orientation, department-specific education, and annual recurrent education.
All employees are required to attend New Employee Orientation upon the start of their employment. New Employee Orientation education includes the following:

- RACE procedures
- How to initiate a Code Red / Use and function of the alarm system in the hospital.
- Procedures all personnel should follow to contain smoke and fire through building compartmentalization.
- Emergency Evacuation Procedures.

Each department is also required to conduct department specific training that details the responsibility of personnel within the department’s fire plan. The department training must be reviewed with personnel at department orientation at the start of employment and periodically at staff meetings. The department’s training must include the following (as applicable):

- How to initiate a Code Red
- Primary and alternate exits and fire/smoke compartments to be used in a fire
- Specific roles of staff related to fire response
- Location and proper use of equipment for transporting patients between fire/smoke compartments
- Location and proper use of fire-fighting equipment, pull-stations, fire/smoke compartments and other important fire related equipment within the department
- Specific departmental responsibilities in preparation for evacuation
- Anything that makes the department unique from a life safety standpoint (chemicals, flammable liquids, special patient’s needs)
- Emergency Evacuation Procedures

Recurrent education required of every employee typically includes a fire safety module which educates on RACE and PASS procedures.

RELATED POLICIES, PROCEDURES, AND ASSOCIATED FORMS

106.043 Fire Safety Management Plan

Fire Safety Management Plan

Fire Safety in the Operating Room

S.30 Fire Safety in the Operating Room

D.55 Dietary/Food Services Fire Safety

D.55 Dietary/Food Services Fire Safety

IS.16 Code Red in the MRI Department

IS.16 Code Red in the MRI Department

All Revision Dates

5/9/2023, 3/27/2023, 12/12/2022, 12/5/2022, 7/1/2016, 12/9/2013, 8/25/2009, 1/4/2008, 10/30/2004, 12/13/2001

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/8/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/8/2023
Safety Committee	Fernando Medina: Director, Support Services	5/8/2023
Policy Owner	Ian McGraw: Manager Facility Operation	5/8/2023

Status **Active** PolicyStat ID **13151403**

Origination	4/1/2000
Last Approved	3/16/2023
Effective	3/16/2023
Last Revised	3/16/2023
Next Review	3/15/2026
Owner	Alicia Casapao: Director of Quality and Performance Improvement
Policy Area	Administrative - Operating Policies

107.023 Adverse Events, Sentinel Events, Unusual Occurrences

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) shall comply with reporting requirements of unusual occurrences, adverse events and sentinel events to the California Department of Public Health (CDPH) in accordance with Policy 107.008 California Department of Public Health Adverse Event Reporting. VCMC/SPH will also inform the patient or responsible party by the time the report is made. VCMC/SPH prohibits retaliation against anyone who reports an unusual occurrence, adverse event or sentinel event.

As well, VCMC/SPH shall comply with The Joint Commission (TJC) standards related to the identification, voluntary reporting and management of unusual occurrences, adverse events and sentinel events. An appropriate response may include conducting a timely, thorough and credible root cause or event analysis, developing an action plan designed to implement improvements to reduce risk, implementing the improvements and monitoring the effectiveness of those improvements.

PROCEDURE:

DEFINITIONS

Sentinel Event: is defined by The Joint Commission as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.

Such events are considered "sentinel" because they signal the need for immediate investigation and response. The following events (even if the outcome was not death or major permanent loss of

function) are considered Sentinel Events:

1. Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the health care organization's Emergency Department (ED).
2. Unanticipated death of a full term infant.
3. Homicide of any patient receiving care, treatment and services while on site at the organization or while under the care or supervision of the organization.
4. Homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization or while providing care or supervision to patients.
5. Any intrapartum maternal death.
6. Severe maternal morbidity (leading to permanent harm or severe harm).
7. Sexual abuse/assault abuse/assault of any patient receiving care, treatment and services while on site at the organization or while under the care or supervision of the organization.
    - Sexual abuse/assault is defined as the nonconsensual sexual contact of any type with an individual. Sexual abuse includes but is not limited to, the following:
        - Unwanted intimate touching of any kind, especially of the breasts, buttocks, or perineal area
        - All types of sexual assault or battery, such as rape, sodomy, and coerced nudity (partial or complete)
        - Forced observation of masturbation and/or sexually explicit images, including pornography, texts, or social media
        - Taking sexually explicit photographs and/or audio/video recordings of an individual and maintaining and/or distributing them (for example, posting on social media); this would include, but is not limited to, nudity, fondling, and/or intercourse involving an individual
    - Generally, sexual contact is nonconsensual in the following situations:
        - When the individual lacks the cognitive or legal ability to consent even though appearing to want the contact to occur
        - When the individual does not want the contact to occur
    - Other examples of nonconsensual sexual contact may include, but are not limited to situations where an individual is sedated, is temporarily unconscious, or is in a coma. An individual's apparent consent to engage in sexual activity is not valid if it is obtained from the individual lacking the capacity to consent, or consent is obtained through intimidation, coercion, or fear, whether it is expressed by the individual or suspected by staff. Any forced, coerced, or extorted sexual activity with an individual, regardless of the existence of a preexisting or current sexual relationship, is considered to be sexual abuse.
    - Organizations are required to conduct an investigation and protect an individual(s) from nonconsensual sexual relations anytime the organization has reason to suspect that the individual(s) does not wish to engage in sexual activity or may not

have the cognitive or legal ability to consent.

8. Sexual abuse/assault of a staff member, licensed practitioner, visitor or vendor while on site at the organization or while providing care or supervision to patients. *(See above definition of sexual abuse/assault)*.
9. Physical assault (leading to death, permanent harm or severe harm) of any patient receiving care, treatment and services while on site at the organization or while under the care or supervision of the organization.
10. Physical assault (leading to death, permanent harm or severe harm) of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization or while providing care or supervision to patients.
11. Surgery or other invasive procedure performed at the wrong site, on the wrong patient or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome.
12. Discharge of an infant to the wrong family.
13. Abduction of any patient receiving care, treatment, or services.
14. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient.
15. Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions or transfusions resulting in death, permanent harm or severe harm.
16. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.
17. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
18. Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed.
19. Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure or >25% above the planned radiotherapy dose.
20. Fire, flame or unanticipated smoke, heat or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do no need to be present.
21. Fall in a staffed, around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:
    1. Any fracture.
    2. Surgery, casting or traction.
    3. Required consult/management or comfort care for a neurological (e.g. skull fracture, subdural or intracranial hemorrhage) or internal (e.g. rib fracture, small liver laceration) injury.
    4. Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall).

The above list is current as of January 1, 2022 The Joint Commission (TJC) Comprehensive Accreditation Manual for Hospitals (CAMH) chapter on Sentinel Events (SE).

Close Call or Near Miss: is defined by TJC as a patient safety event that did not reach the patient.

Adverse Event: is a patient safety event that resulted in harm to a patient. Per TJC definition, adverse events shall prompt notification of hospital leaders, investigation, and corrective actions, in accordance with VCMC/SPH's process for responding to patient safety events that do not meet the definition of sentinel event. An adverse event may or may not result from an error.

Serious Reportable Events (SREs) as defined by the National Quality Forum (NQF) include:

1. **Surgical or Invasive Procedure Events**
    a. Surgery or other invasive procedure performed on the wrong site.
    b. Surgery or other invasive procedure performed on the wrong patient.
    c. Wrong surgical or other invasive procedure performed on a patient.
    d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
    e. Intraoperative or immediately post-operative/post-procedure death in an ASA Class 1 patient.
2. **Product or Device Events**
    a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting.
    b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
    c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting.
3. **Patient Protection Events**
    a. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
    b. Patient death or serious injury associated with patient elopement (disappearance).
    c. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting.
4. **Care Management Events**
    a. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration).
    b. Patient death or serious injury associated with unsafe administration of blood products.
    c. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting.

d. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.

e. Patient death or serious injury associated with a fall while being cared for in a health care setting.

f. Any Stage 3, Stage 4 and unstageable pressure ulcers acquired after admission/ presentation to a health care setting.

g. Artificial insemination with the wrong donor sperm or wrong egg.

h. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.

i. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results.

5. **Environmental Events**

a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a health care setting.

b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.

c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting.

d. Patient death or serious injury associated with the use of physical restraints or bed rails while being cared for in a health care setting.

- (Reporting is <u>not</u> required for deaths involving ONLY a soft, non-rigid, cloth-like material, wrist restraint, and NO seclusion). The facility is required to record in a log or other system and must make this information available to the Centers for Medicare and Medicaid (CMS) in either written or electronic form immediately upon request. The log will be maintained by the Quality Assurance and Performance Improvement Department. The internal reporting log or system must record the following elements:
    - Each entry must be made no later than seven days after the date of death of the patient
    - The record must include the patient's name, date of birth, date of death, attending practitioner or other licensed practitioner responsible for the care of the patient, primary diagnosis(es), and medical record number
    - Any death that occurs within 24 hours after a patient has been removed from such restraints. This information is recorded within seven days of the date of death of the patient.
    - Documentation in the patient record must include the date and time that the death was recorded in the log or other system

6. **Radiologic Events**

a. Death or serious injury of a patient or staff associated with the introduction of a

metallic object into the magnetic resonance imaging (MRI) area.

7. **Potential Criminal Events**
    a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
    b. Abduction of a patient/resident of any age.
    c. Sexual abuse/assault on a patient or staff member within or on the grounds of a health care setting.
    d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting.

Unusual Occurrences: any occurrence that constitutes an interference with facility operations that affect the welfare, safety, or health of patients, personnel or visitors. The occurrences listed below are not intended to be all inclusive, but are examples of the types of events that should be reported. It is the policy of VCMC/SPH to report all unusual occurrences, adverse events and sentinel events to the California Department of Public Health (CDPH) in accordance with Administrative Operating Policy 107.008 California Department of Public Health Adverse Event Reporting.

1. Earthquakes, floods, gas explosions, severe fires, power outages or other calamities which cause damage to the facility or threaten the safety and welfare of patients, visitors and/or staff.
2. An epidemic outbreak of any disease, prevalence of communicable disease, infestation by parasites.
3. Poisonings.
4. Death or near death or injury of patient, employee or visitor because of unnatural causes (suicide, attempted suicide, homicide, accidents).
5. Actual or threatened employee walkout/strike or other curtailment of services or interruption of essential services provided by the facility/agency. Examples of essential services are: heating, air conditioning, food, water, linens, sewage or needed medical supplies.
6. Patient to patient altercations that result in an immediate threat to life, or patient to patient altercations involving three or more patients.

REPORTING

A. **Identification of an Unusual Occurrence, Adverse Event or Sentinel Event**
    1. Potential Adverse Events, Sentinel Events, Unusual Occurrences, and "Near Misses" are to be immediately reported internally through the chain of command.
    2. An appropriate designee or committee will be assigned by the Hospital Administrator or assigned designee(s) to determine if the incident(s) constitute an Adverse Event, Sentinel Event or Unusual Occurrence.
    3. The Chief Executive Officer (CEO) or assigned designee(s) will conduct an investigation into the reported incidents. If an Adverse Event, Sentinel Event or Unusual Occurrence is substantiated, the Hospital will take immediate steps to

correct the violation and prevent it from reoccurring.

B. **Reporting**

1. The Chief Executive Officer (CEO) or assigned designee has the authority to report the Adverse Event to CDPH. All Adverse Events will be reported to CDPH within five (5) days after the Adverse Event was identified or within 24 hours after detection, if the event is ongoing, urgent or emergent or a threat to the welfare, health, safety of a patient, visitor, or staff. Adverse Events will be reported via the Department's Secure Electronic Web-Based Portal. The CDPH provides alternative means, by email or telephone, for submission when the web-based portal is unavailable. This requirement preserves patient confidentiality and standardizes reporting requirements. Reports are limited to factual information and statements or speculation in causation are to be avoided.
    a. Secure Electronic Web-Based Portal: https://healthcareportal.cdph.ca.gov/.
    b. California Department of Health Services,
    Ventura District Office,
    1889 North Rice Road, Suite #200
    Oxnard, CA 93030
    Toll Free Phone: 800.547.8267
    Phone No. 805.604.2926
    Fax: 805.604.2997
    Email: CDPH-LNC-VENTURA@cdph.ca.gov
2. CDPH will investigate all reports. If there is ongoing threat of imminent danger of death or serious bodily injury, CDPH must perform an on-site investigation within 48 hours/2 business days. CDPH has 45 days to complete its investigation.
3. The penalty for failing to report an Adverse Event is a civil fine of $100 per each day the event was not reported within the established time frame. If a deficiency is substantiated as causing an immediate jeopardy to the health or safety of a patient, the administrative penalty may be up to $50,000 per violation. Administrative penalty for non-immediate jeopardy may by up to $17,000 per violation.
4. All adverse report information is considered public information under the Public Records Act request.
5. The Chief Executive Officer or assigned designee has the authority to make a Sentinel Event Report to The Joint Commission (TJC).
6. VCMC/SPH will inform patient or responsible party of the Adverse Event at the time the report is made (see Policy MS.102.002 Disclosure of Unanticipated Outcomes).

C. **Root Cause Analysis** (see Policy 107.024 Root Cause Analysis).

All Revision Dates

3/16/2023, 12/22/2022, 4/17/2020, 9/1/2016, 12/1/2009, 6/1/2007

Approval Signatures

Step Description	Approver	Date
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	3/16/2023
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/18/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/15/2023
Hospital Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/14/2023
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	2/14/2023

Status **Active** PolicyStat ID **13435344**

Origination	6/1/1990	Owner	Lisa Prather: Admitting
Last Approved	4/7/2023	Policy Area	Administrative - Operating Policies
Effective	4/7/2023		
Last Revised	4/7/2023		
Next Review	4/6/2026		

107.055 Pager Procedure

POLICY:

To outline the responsibility for the acquisition, distribution and retrieval of pagers at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

The Paging Department will be responsible for the acquisition, distribution, and the return of pagers assigned to various staff/departments.

The Paging Department will be responsible for acquiring, distribution, and retrieval of any assigned paging unit. Procurement, repair and/or replacement will be requested by contacting the vendor, SPOK. Changes (including loaner pagers) are entered into the Pager Assignment Log.

The Paging Department will distribute pagers to HCA Hospital employees as follows:

A. Paging Operator will assist user with completing the Pager Release Form, which shall contain:
    1. Date Pager Assigned
    2. Employee Name (Last Name, First Name only)
    3. Employee ID
    4. User Department Name
    5. User Department Manager
    6. User Contact Information (phone number other than assigned pager)
    7. Assigned Pager Number
    8. Pager Cap Number
    9. Pager Serial Number

Paging Department will activate the pager and assign pager to employee. Employee will sign Pager Release Form acknowledging they will return pager to the Paging Department upon end of employment ***or*** if pager is no longer needed. Paging Operator will provide copy of the Pager Release Form to employee and file copy in Paging Department.

Paging Department will activate the pager and enter all information from Pager Release Form into the Pager Assignment Log.

Employee will be responsible for returning the pager to the Paging Department upon termination or if pager is no longer needed, releasing them from any further liability.

Upon the pager's return, paging will locate the Pager Release Form from file, note the date of return, and have employee sign stating it was returned. The Paging Department will deactivate pager with SPOK and return pager to SPOK within 30 days.

All Revision Dates

4/7/2023, 5/1/2006, 2/1/1995, 8/1/1991

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/7/2023
Policy Owner	Lisa Prather: Admitting	4/5/2023

Status **Active** PolicyStat ID **13367270**

Origination	9/1/1985	Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH
Last Approved	3/24/2023		
Effective	3/24/2023	Policy Area	Administrative - Nursing
Last Revised	3/24/2023		
Next Review	3/23/2026		

108.006 Nurse Staffing and Scheduling

POLICY:

The Department of Nursing Services recognizes its obligation to provide an adequate number of skilled and qualified staff to meet the needs of the patients and scope of services required. It is the policy of the Nursing Department that a variety of nursing staff is used to provide necessary staffing. We believe that RN, LVN's, Nursing Assistants, Telemetry Technicians and Medical Office Assistants (MOAs) all contribute to safe efficient care when properly trained, supervised and assigned.

This policy further recognizes the rights and responsibilities of the Department of Nursing Services and Nursing staff in meeting mutual obligations for the care of the patients of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), ensuring adequate staffing is available to meet patient care requirements, while utilizing staff in an optimal manner. It provides a clearly outlined sequential process for providing necessary nursing staff, on all nursing units, and allowing requested employee time off, while meeting projected patient care needs, which provide written records of staffing assignments on all units, and allow retrospective analysis, as necessary, and meet external regulatory requirements.

PROCEDURE:

The hospital is flexible in its staffing, in order to respond to day-to-day shifts in census and workload. On low census days, or other periods of low workload, (and the hospital is adequately staffed throughout with qualified staff), employees may voluntarily take off hours of leave without pay in order to appropriately reduce the level of staff. The employee may choose to use accrued paid vacation instead.

If an excess of staff can be anticipated before the beginning of the shift, the Clinical Nurse Manager/ Supervisor may initiate phone calls to employees and offer them the opportunity to take the day off. When necessary, in times of low census, the guidelines described in the California Nurse Association Memorandums of Agreement (CNA MOA) will be followed. The employee may also initiate a call to the

supervisor, prior to the beginning of the shift, to see if he/she is needed for duty. Leaves given in this way will also follow the plan developed by the Manager. Leave will be granted only after the needs of the hospital have been covered.

The Supervisor will note on the schedule, the number of hours and type of leave used by any employee.

Leave without pay may not be used or granted in advance and/or pre-planned. Leave without pay may be granted, at the employee's request, after the Supervisor has reviewed the staffing needs for the shift.

VCMC/SPH utilizes an automated scheduling system to create, project and print long-range schedules. This system automates daily staffing allocation of available staff, based on census, patient acuity and budgetary provisions.

Staffing for the nursing units will be reviewed for a 24-hour time frame, on a daily basis, and adjustments are made prior to the start of each shift, as indicated. The Nursing Supervisor/Clinical Nurse Manager assumes this responsibility.

Nursing staff may be temporarily reassigned on a shift-by-shift basis, when changes occur in either the workload, the staffing requirements and/or availability of assigned staff. In these cases, Nursing Administration has the responsibility and right to assign staff to best meet the determined needs of the patient, with the licensure, skill and qualification levels available. Reassignment of nursing staff, on a pre-scheduled basis, is made through careful consideration of all facts, which include but are not limited to the following:

1. Patient census and acuity;
2. Number and classification of staff available;
3. Qualifications, experience and competence of staff, that is required and available;
4. Unfilled positions.

Daily shift assignments to the unit are finalized and are posted in the Nursing Administration Office at the beginning of the shift.

Any changes posted in staff assignments must be verified by the Nursing Supervisor/Clinical Nurse Manager.

Nursing staff are routinely assigned to areas in which they are qualified and have received training and proper orientation. It is the intent of the Nursing department that when a temporary and/or immediate assignment must be made, the needs of the patient and the needs of the employee will be considered. If immediate assignment is necessary, a "helping hands" orientation to the unit will be given and a resource person will be available. Employees are encouraged to discuss their assignments with their coordinator or supervisor in the event of concerns or problems.

Holidays: Refer to the appropriate union contract.

Vacation:

1. All employees, full-time, part-time and per diem, will submit vacation requests, in writing, to the Clinical Nurse Manager for approval prior to finalization of each four-week schedule (at the

latest).

2. During the months of June through September, no more than two (2) weeks will be granted per employee, without special approval of the Clinical Nurse Manager.
3. During the period between December 1st and January 1st, requests for vacation hours in excess of 24 hours will require special approval by the Clinical Nurse Manager.

PROCEDURE

The 24-hour care of patients is planned, directed and evaluated by Registered Nurses. Staffing, both in numbers and competency, will be sufficient to ensure that:

A. An RN defines, directs, supervises and evaluates care of all patients.
B. Assessment and identification of patient care needs occurs on admission, during the patient's stay, on transfer and at discharge.
C. A staff RN retains responsibility for all patients co-assigned to students and agency staff.
D. Infection control measures are strictly adhered to.
E. Staff competency is matched to patient needs.
F. Patient emergency and safety requirements are met with appropriate equipment and staff
G. Only direct patient care providers are included in the Patient Classification System.

The RN Resource/Charge Nurse, Clinical Nurse Manager or designee in each nursing area is responsible for assigning staff for daily patient care. The following information is taken into consideration when these assignments are made:

A. The diagnosis and acuity of illness of each patient (category of nursing care required).
B. If a patient is in isolation, the type of isolation and acuity of illness is considered when assigning the number of patients to a nurse.
C. The job classification, experience and level of competence of each employee is considered, so that those patients requiring more acute assessment and deliberative nursing intervention are assigned to the more competent, experienced employee.
D. Unit geography, the availability of support services, and the method of patient care delivery, i.e., team or primary care is taken into consideration when staffing the nursing floor.
E. The hospital nursing department/service shall retain responsibility and global oversight for the nursing care and related duties when nursing students provide care within the patient care unit.
F. Supervision and evaluation of nursing care being given will be the responsibility of the Charge Nurse during hours on duty. The Clinical Nurse Manager shares this responsibility for 24-hour patient care.
G. The patient classification system will be annually reviewed and updated as necessary.

Schedules are printed every four (4) weeks (a four-week cycle) and further definition of scheduling includes:

Schedules will be posted three (3) weeks (21 days) prior to the start of the new schedule and contain the following four (4) weeks of scheduled work time.

Changes in Schedule/Special Requests:

For changes to the final posted schedule or special requests, the employee fills out the "Schedule Change Request Form" and obtains signature approval from the Clinical Nurse Manager before submitting the Form to the staffing office.

Schedules:

1. Prepared on a four (4) week basis, in order to provide a method of planning basic staffing of all nursing units within the Department of Nursing;
2. Updated every shift to reflect cancellations, illness, special requests and additional alterations or additions to the general staffing;
3. This record will be maintained for a period of three (3) years.

The Clinical Nurse Manager or their designee assists in this responsibility by reviewing the staffing levels and patient care requirements and communicating special needs/problems to the Nursing office. The Clinical Nurse Manager assists in this responsibility by monitoring sick calls and unexpected absences and communicates this activity to the Nursing office.

Approvals for exchange of days worked, are made on the basis that the exchange is made with someone of the same job class and skill level; the exchange is made within the same pay period and when minimum employment agreements are met. Approval for changes is made on the basis that no overtime is incurred and that appropriate staffing and skill mix is accomplished. Any emergency situation that is unexpected in nature, will be handled on an individual basis, by the Nursing Supervisor, if it occurs on weekends, holidays or after hours.

Daily Staffing:

The Clinical Nurse Manager/House Supervisor reviews and makes necessary adjustments to daily staffing.

1. Census activities will be reported at 4:00 AM, noon, and 2000 (twenty hundred hours or 8:00 PM.). Additional census confirmation may also be done at 1600 hours (4:00 P.M.). The Inpatient Psychiatric Unit (IPU) collects census information at 05:00 and 1700 hours (5:00 P.M.); all are used to plan daily staffing.
2. Staffing is reviewed and adjustments are made, based on staffing guidelines and census/ acuity requirements.
3. The Clinical Nurse Manager will be responsible for covering staffing needs. The Clinical Nurse Manager may request assistance to place phone calls from the Staffing Office, or ask staff on the unit to make calls.

Acuity and Staffing

1. Acuity determination is done once per shift by the primary nurse. The charge nurse is responsible for ensuring that staffing is aligned to the acuity levels of the patients.

2. Annually, the Patient Classification System will be reviewed by nursing leadership and by the Registered Nurses who provide direct patient care, to establish unit-specific quality indices. Results will be discussed and alterations made as requested.
3. The staffing plan and individual staffing patterns will be evaluated at least annually by Nursing Leadership in order to determine their effective and efficient delivery of patient care.

Patient Classification System

This plan includes, but is not limited to, a method of determining staffing requirements based on the assessment of patient needs, including:

A. Acuity
B. The ability of the patient to care for himself/herself
C. Degree of illness
D. Requirements for special nursing activities
E. Skill level of personnel required in his case
F. Placement of the patient in the nursing unit

A method for the formulation of staffing determinations, including:

A. State mandated staffing requirements
B. The number of staff required
C. The categories of staff available for patient care

A method for scheduling staff on a daily basis to ensure the availability of appropriate skill levels, and a method to facilitate the organization of a nursing care delivery system which will optimize the utilization of all resources and provide the best possible patient care.

The Resource/Charge Nurse, in conjunction with the Clinical Nurse Manager and the RN caring for the patient, will assess each patient, every shift, using the VCMC/SPH Patient Classification System (see attached).

The individual patient acuity will be documented on the acuity tool or in the Electronic Health Record.

The Acuity numbers will be obtained by the Nursing Office three (3) times a day to facilitate staffing for the upcoming shift.

The Nursing Supervisor/Clinical Nurse Manager will take into consideration the reported acuity values of each unit when making staffing decisions for the next shift. Annual interrater reliability testing will be completed on the acuity tools.

A. Assignment of Patient Care

   Each shift's acuity values will be used by the Clinical Nurse Manager or Resource Nurse to make appropriate patient care assignments, using policy guidelines.

B. Staffing Plan

As part of this obligation, the Nursing Department has developed a master staffing plan to meet the needs of each unit in the most efficient manner. Census staffing plans, maintained in the Nursing Office, are based on average acuity assessments and state staffing requirements.

Increases in overall acuity of a particular unit may indicate the need for additional resources. The Nursing Supervisor is to be notified of such need. Every effort will be made to meet staffing needs.

For specifics see the attached Unit Specific Plans. Nurse staffing plans for each unit define specific unit needs.

Weekend Commitment:

1. Each full-time (F/T), part-time (P/T) and Per Diem staff member may be scheduled to work a minimum of two (2) weekends out of four (4), as needed by the unit.
2. All Staff: Weekend absences:
    a. One (1) shift weekend absence allowed every calendar year
    b. All others are subject to make up the time, i.e., automatically scheduled by the Clinical Nurse Manager for an extra weekend as needed by unit. The manager has the authority to replace another upcoming shift with a weekend shift for makeup purposes.
    c. For the day shift, weekends are defined as any shifts where the majority of hours falls on Saturday or Sunday. For night shift, weekends are defined as any shift that starts at 6 pm or later on Friday and Saturday nights. Sunday nights may also be considered if meets operational needs.

It is the daily responsibility of the Staffing Office, the Clinical Nurse Manager and Nursing Supervisor(s) to assign the available staff so that it matches the pattern required by the acuity and census.

Skill Mix Substitutions - If insufficient numbers of staff are available in a particular skill level, then substitutions may be made within certain guidelines:

1. A higher skill level may always be substituted for a lower level, e.g., RN for LVN.
2. A lower level may be substituted for a higher level only where there is adequate RN coverage on the unit, in order to assess patients and meet the State Nurse staffing ratios, to make appropriate assignments and to carry out complex care.

Assignment of Nursing Care of Patients

The Clinical Nurse Manager/Nursing Supervisor reviews the census and staffing for all units within the first two (2) hours of each shift.

Staffing Shortage - When there are insufficient numbers of staff in a given skill level, the Clinical Nurse Manager, Staffing Coordinator and/or Nursing Supervisor will be responsible for finding adequate coverage by doing one of the following:

1. Assign an alternate assignment for extra personnel on duty.
2. Request a regular part-time person to come in.

3. Request a per diem person to come in.
4. Request on-duty staff to work overtime.
5. Request off-duty staff to work overtime.
6. Request Registry personnel to come in.
7. Reassign on-duty staff for optimum coverage.
8. Mandate overtime (requires approval by a Nurse Executive or their designee).

The supervisor moves staff from low-census to high census areas, where possible. Moves are made based upon levels of licensure, training and competency of staff available.

All staff are expected to comply with appropriate requests to change their areas of work on short notice, in order to provide for safe patient care throughout the Hospital.

Unscheduled Leave:

1. It is the expectation that unscheduled leave will be minimal for a 12-hour shift program.
2. When it is necessary to use unscheduled leave, whenever possible, the employee will call in sick two hours before the start of the scheduled shift. For example, the 06:45 to 19:15 shift employee will notify the night shift supervisor by 04:45. The 1900 to 0700 shift employee shift will notify the day shift supervisor by 1645 (4:45 pm). For other shift starts, staff are expected to call in sick no later than two hours before the start of the scheduled shift.
3. No call, no shows and/or excessive absenteeism may be cause for disciplinary action.
4. If an employee is out pending a leave of absence approval, he/she must also notify the clinical nurse manager in addition to call off sick.

Scheduled Leave:

1. All requests for scheduled leave (annual leave, educational leave, etc) will be planned in advance and must be submitted in writing, at least 14 days prior to the posting of the current four (4) week master schedule.
2. No more than one (1) employee may be scheduled off, at any one time, unless coverage is available.
3. All requests submitted **AFTER** the posting of the four week master schedule, may require the employee to arrange his/her own coverage.
4. All scheduled leave requests are subject to the approval of the Clinical Nurse Manager.

Overtime:

1. It is the policy of County of Ventura to avoid the necessity for overtime, whenever possible.
2. Overtime work may sometimes be necessary, in order to meet emergency situations, seasonal peak workload requirements or other defined times of need, as determined by Nursing Administration.
3. No employee shall work overtime unless authorized to do so, by his/her supervisor.

Guidelines:

1. An Employee anticipated need includes:
    a. Anticipated need for overtime must be communicated to the Clinical Nurse Manager/Nursing Supervisor;
    b. When possible, give a two (2) hour notice;
    c. If notice is given in less than two (2) hours before the end of shift, give notice as soon as possible (ASAP);
        - The Clinical Nurse Manager or Nursing Supervisor will decide on a course of action, which may include:
            - Authorize overtime
            - Provide assistance to eliminate the need for overtime
            - Another action, as appropriate
    d. Failure to notify in advance of overtime hours, may be grounds for disciplinary action.
2. The Clinical Nurse Manager/Staffing Personnel/Nursing Supervisor anticipated need includes:
    a. Anticipated needs for overtime in an existing or upcoming shift, is identified;
    b. The Clinical Nurse Manager or Nursing Supervisor will make telephone calls to off-duty staff and/or Registry and offer overtime, etc., to meet patient care needs.

Mandatory Overtime: In the event that the procedures above fail to provide safe, adequate staffing levels, it may be necessary to institute mandatory overtime.

1. Any need to mandate overtime must be authorized by the Nurse Executive or their immediate designee.
2. All mechanisms to provide safe patient care, without mandatory overtime, will have been exhausted.
3. At the decision to mandate overtime, employees on duty will be polled, to determine their ability to stay.
4. Otherwise, the Nurse Executive, working with the Clinical Nurse Manager or Nursing Supervisor, will make the final staffing decisions.
5. Mandatory overtime will continue for as short a time as possible, while continuing efforts are made to provide alternate staffing.
6. Failure to abide by these decisions may result in disciplinary action.

REFERENCES

1. California Code of Regulations 22 CCR.
2. United States Department of Health & Human Services.
3. California Department of Public Health.

All Revision Dates

3/24/2023, 1/30/2023, 1/10/2023, 11/14/2022, 11/14/2022, 8/27/2021, 5/1/2016, 11/1/2013, 12/1/2010, 12/1/2001, 3/1/2000, 1/1/2000, 1/1/1999, 12/1/1992, 9/1/1988, 9/1/1987, 9/1/1986

Attachments

Nurse Acuity MedSurgTele.xlsx

Nurse Acuity NICU

NurseAcuity ICU.docx

NurseAcuity L&D.docx

NurseAcuity Peds.docx

NurseAcuity PICU.docx

NurseAcuity PP.docx

VCMC IPU Patient Acuity.docx

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/24/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/24/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/24/2023

Status **Active** PolicyStat ID **13567290**

Origination	4/11/2023
Last Approved	4/28/2023
Effective	4/28/2023
Last Revised	4/28/2023
Next Review	4/27/2026
Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH
Policy Area	Administrative - Nursing

108.050 Patient Safety Attendant Care

PURPOSE:

To define Patient Safety Attendant Care and the guidelines for the use of Patient Safety Attendants within Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH).

POLICY:

1. An individual assigned to the role of a Patient Safety Attendant is a member of the healthcare team of Ventura County Medical Center/Santa Paula Hospital who will remain with a patient throughout a designated period of time for the purpose of maintaining patient's safety (prevention of falls, disruption of patient care, suicidal/5150/5585, delirium, confusion, etc.).

2. A Patient Safety Attendant assures patient safety for individuals deemed to be either suicidal or on 5150 status. This requires 1:1 Observation in which an assigned staff member stays within close proximity of the patient and provides direct observation at all times.

3. A Patient Safety Attendant provides and maintains a safe environment (for pulling tubes, airway devices, etc.) for identified patients who have not been classified as either suicidal or on 5150/5585 status. A Patient Safety Attendant can observe 1-2 patients in close proximity for these purposes.

PROCEDURE(S):

1. Patient's families will be encouraged to partner with VCMC/SPH Hospital staff in order to provide a safe environment for the patient. As families provide a stabilizing emotional support for the patient, they will be asked to participate by staying with the patient to prevent pulling tubes, climbing out of bed, etc. Family members will not be permitted to provide sitter care for suicidal/homicidal or 5150/5585 patients.

2. Care provided by a Patient Safety Attendant will be delegated and overseen by the assigned bedside nurse. The nurse will retain the responsibility of the nursing process and administration of medications. A Patient Safety Attendant will provide physical care, within their scope of practice and training, for the patient for whom they are assigned including the documentation of vital signs and intake and output. Patients who are suicidal/homicidal require every 15 minute documentation on the patient observation log.

3. The Patient Safety Attendant as directed by the nurse will complete all aspects of Activities of Daily Living (ADL's) for the patient provided they have demonstrated competency. This includes, but is not limited to, the following: bathing, feeding, toileting, and range of motion (ROM). Exception: Security Personnel may provide observation only, not the ADLs/physical care. Patient Safety Attendants (unless Registered Nurses) may not perform assessments.

4. The Patient Safety Attendant will accompany the patient for any clinical tests or procedures off the unit unless patient is already accompanied by the bedside nurse. The staff member accompanying the patient will remain within line of sight of the patient unless otherwise directed by the person performing the test or procedure.

5. The Patient Safety Attendant will remain within direct sight of the patient while patient is using the bathroom or shower. The Patient Safety Attendant will attempt to maintain the patient's dignity and privacy by having same gender assistant assume temporary responsibility of the patient as needed.

6. While on duty, the Patient Safety Attendant will not leave the patient's room without the bedside nurses' approval and/or relief. If a break is needed, a hand-off to the temporary staff member will occur prior to reporting off the unit.

7. The Patient Safety Attendant will refer the patient to the nurse or physician to answer any questions regarding the plan of care.

8. **Patient Safety Attendant/Suicidal/Homicidal or Patient on a 5150/5585**

a. If a Patient Safety Attendant is required for a suicidal or patient on a 5150/5585, the Charge Nurse will assign a staff member to provide 1:1 observation of the patient.

b. All Patient Safety Attendants used for violent or aggressive behavior must have Crisis Prevention Institute (CPI) training or comparable (e.g., AVADE).

c. If a patient is a danger to self or others, creating a safe environment is essential. The patient will not be permitted to use sharps or other items that could be used to harm self or others. For assistance in creating a safe environment see policy 100.268 Suicidal Environmental Risk Assessment.

d. The Patient Safety Attendant will immediately inform the nurse:

1. If the patient expresses an intention to hurt self/others.
2. If there is a sudden change in the patient's condition/behavior.
3. The Patient Safety Attendant may not leave the patient for any reason until coverage is

obtained and present.

e. The Patient Safety Attendant may not be discontinued without Licensed Practitioner order.

9. **Patient Safety Attendant: Non-Suicidal/Homicidal/5150/5585 Patient**

a. Initiation of Patient Safety Attendant will require review and approval every shift. The justification for the need is documented on the 'Patient Safety Attendant Care Justification for the Non-Suicidal Patient' form (Attachment C). The patient's bedside nurse completes the form and submits to the Charge Nurse. If criterion is met, the Charge Nurse will speak to the Nursing Supervisor to arrange a Patient Safety Attendant. All completed forms are submitted to the Unit Nursing Clinical Director.

b. The Charge Nurse will assign a Patient Safety Attendant to provide observation of the patient. A Patient Safety Attendant may be assigned to monitor two patients in the same room or in adjoining rooms. The Patient Safety Attendant will position him/herself to maintain an unobstructed view of both patients. If one patient requires individual attention, the Patient Safety Attendant will notify the Primary RN or Charge Nurse to provide temporary monitoring for the other patient.

c. Primary RN or Charge Nurse approval required to allow family or other visitor to replace Patient Safety Attendant. The patient's visitor will be instructed to notify the nurse to resume Patient Safety Attendant care when they are leaving the room.

d. Once Patient Safety Attendant care is initiated, patient will not be left unattended until the nurse notifies the Patient Safety Attendant that the assignment is discontinued.

e. The Patient Safety Attendant will immediately inform the nurse if there is a sudden change in the patient's condition/behavior.

10. **Documentation**

a. All patient care will be documented in the Electronic Health Record.

b. Patient Safety Attendant will complete the Line of Sight Documentation Form (Attachment A).

c. Patient Safety Attendant will complete the C.A.S.E. Safety Check form (Attachment B).

11. Competency

a. All Patient Safety Attendants must complete training prior to assuming the role. Training includes a didactic course and results in a Competency Assessment.

b. All Patient Safety Attendants must participate in an annual refresher course to ensure maintenance of competency.

All Revision Dates

4/28/2023, 4/13/2023, 4/11/2023, 4/11/2023

Attachments

C.A.S.E. Safety Checklist.pdf

Patient Observation Record.PDF

Patient Safety Attendant Care Justification for the Non-Suicidal Patient.docx

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/28/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/28/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/28/2023

Status **Active** PolicyStat ID **13435797**

Origination	12/1/1998	Owner	Lisa Prather: Admitting
Last Approved	4/14/2023	Policy Area	Admitting
Effective	4/14/2023		
Last Revised	4/14/2023		
Next Review	4/13/2026		

AD.20 Self-Pay Patient Admissions

POLICY:

To state the processing for admitting Self-Pay patients at Ventura County Medical Center (VCMC).

PROCEDURE:

A Patient Representative interviews all patients admitted as Self-Pay.

The Patient Representative determines if the patient qualifies for Medi-Cal and initiates a Medi-Cal referral.

If there is no linkage to Medi-Cal, the Patient Representative will take an application for the Discount Program (DP) or provide information on the Covered California program.

If the patient completes an application for the DP, the Patient Representative will refer the information to the Heath Care Agency collections representative at VCMC.

If the patient does not qualify for Medi-Cal or other insurance, and is found to be a true self-pay, the Patient Representative will complete the Payment and Security Agreement (VCHCA-546-010) and patient will sign. Patient Representative will acknowledge and sign the Payment and Security Agreement as Deputy County Clerk, stamp with the Ventura County seal. The Payment and Security agreement will be scanned into the patient encounter and forwarded to the Deputy County Clerk to file.

All Revision Dates

4/14/2023, 1/1/2014, 10/1/2011, 5/1/2006, 12/1/2001

Attachments

Payment and Security Agreement.pdf

Approval Signatures

Step Description	Approver	Date
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	4/14/2023
Patient Access	Lisa Prather: Admitting	4/14/2023

Status **Active** PolicyStat ID **12274067**

Origination	11/1/1992
Last Approved	3/24/2023
Effective	3/24/2023
Last Revised	3/24/2023
Next Review	3/23/2026
Owner	Fernando Medina: Director, Support Services
Policy Area	Dietary - Patient Care

D.38 Food and Nutrition Services Menus

POLICY:

To ensure that our menu offers patients a nutritious selection and a system established for distributing and monitoring them.

PROCEDURE:

1. The menu is a seven-day selective cycle for Ventura County Medical Center, the Inpatient Psychiatric Unit, and Santa Paula Hospital patients.
2. The regular menu will meet the current Dietary Reference Intakes (DRI) for all nutrients as determined by the National Research Council. Certain modified menus may not meet DRIs - this will be specified in the Diet Manual. The menu nutrient analysis is available through the Nutritionist Pro Program.
3. The Registered Dietitian evaluates and adjusts the menus to reflect the availability of food items or traditional seasonal items. All changes in modified diets must be approved by a Registered Dietitian and posted on the production sheets.
4. A copy of the complete seven-day menu is available in the Dietary Office and the Kitchen.
5. The daily menu pattern for all patients not selecting a menu will be as follows, and modification made as appropriate for modified diets.

BREAKFAST	LUNCH AND DINNER
Juice or Fruit	Appetizer
Cereal	Protein Entree
Toast, Margarine, Jelly	Starch
Milk	Vegetable
Hot Beverages	Salad

	Dessert or fruit Beverage

Guidelines:

1. Preparation and distribution of menus.
    A. The Diet Aide heads all menus with the patient's name and room number the day prior to distribution.
    B. The Diet Aide will modify the combination diets, before distribution, using the Diet Manual as a guide.
    C. Menus for the following day are provided to patients by the Diet Aide during the menu collection process.
    D. The Diet Aide may also help assist patients in filling out their menus.
    E. Completed menus are brought back by the diet aide for processing tally sheets for the next day.
2. Patient's preferences can be expressed through their choices on the menu. Additional foods are available from a standard list, but these special requests will require 24-hour notification.
    A. Standing orders for patient's allergies or intolerances will be transmitted to the Diet Office via the electronic health record (EHR). Likes and dislikes can be documented on the comment section of the diet order or Adhoc comment section.
3. If a patient does not select a menu, a standard meal will be given. Patient preferences and choices will be honored even when their selections are less than the standard diet pattern. However, if the patient is on a Consistent Carbohydrate Menu, the patient will receive the minimum required carbohydrates for the meal, i.e., 45 grams of carbohydrates or a maximum of 60 grams of carbohydrates. If a patient selects less than the standard diet pattern for more than three consecutive meals, the Diet Aide will notify the Registered Dietician.
4. Modified Menus
    A. Modified menus will be selective to the greatest extent possible within the restrictions of the diet.
    B. The Diet Aide will check the menus selected by patients to be sure it adheres to the current diet order.
    C. If a patient on a modified diet has not selected the menu, the Diet Aide will complete it, using the Diet Patterns/Manual honoring the patient's recorded food preferences as available.
5. Modified menus will be easily identifiable and color-coded.
6. Diet combinations will be listed on the menu with the appropriate condiments.
7. Every attempt will be made to provide appropriate food items for any patient with specific religious and/or ethnic preferences.

All Revision Dates

3/24/2023, 11/13/2019, 2/1/2016, 9/1/2014, 10/1/2012, 6/1/2006, 11/1/2004, 12/1/2001, 1/1/1999, 12/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	3/24/2023
Dietary Department	Alex Jose: Supervisor, Dietary Services [FM]	3/23/2023
Dietary Department	Fernando Medina: Director, Support Services	3/22/2023

Status **Active** PolicyStat ID **13282151**

Origination	12/1/2005	Owner	Honeylette Wong: Nurse Practitioner-Employee Health Services
Last Approved	4/17/2023		
Effective	4/17/2023	Policy Area	Employee Health Services
Last Revised	4/17/2023		
Next Review	4/16/2026		

EHS.01 Occupational Exposure to Tuberculosis

POLICY:

To ensure the appropriate care and treatment of Ventura County Medical System (Ventura County Medical Center, Santa Paula Hospital, Inpatient Psychiatric Unit, and Ambulatory Care) staff experiencing an occupational exposure to Tuberculosis disease when such an exposure requires medical evaluation, serology studies or antibiotic prophylaxis. Tuberculosis disease is known to be of significance in hospital epidemiology and infection control. For this reason, and to ensure a safe environment for both staff and patients, it is important that appropriate follow-up and interventions be given to staff.

PROCEDURE:

A. Exposure Determination: The Infection Prevention Practitioner and the Infection Control Committee Chairman/Infectious Disease Physician will determine the case definition for the "Tuberculosis exposure" based on Ventura County Public Health guidelines.

B. The Infection Prevention Practitioner will notify the Department or Clinic Manager of the exposure and the criteria for significant exposure.

C. The Department or Clinic Manager will determine who meets the criteria for significant exposure and submits a list of the exposed staff to the Employee Health Services.

D. The Department or Clinic Manager shall file an RM-75 report for each identified staff member.

E. The Department or Clinic Manager or designee shall file a notification report of the occupational exposure.

F. Employee Health Services:

    1. The Employee Health Licensed Practitioner will be responsible for informing the staff member of their exposure and the recommended intervention and the clinical management of the staff member's exposure.

a. The Infection Prevention Practitioner and/or Medical Director of Infection Control may be consulted for further guidance.

2. Employee Health Services will refer any staff who develop a new latent or active tuberculosis infection to Ventura County Public Health.
3. Employee Health Services will notify the Infection Control & Prevention Department of any new tuberculosis infection.

G. Staff:

1. Staff who are concerned that they have been exposed to tuberculosis should notify their manager immediately.
2. Exposed staff do not need to be restricted from work.
3. If a staff member is determined to have a tuberculosis exposure, a tuberculosis test will need to be performed within two weeks of their exposure, unless they have previously tested positive for tuberculosis.
    a. If a staff member undergoes initial testing, they will need to be retested in 8-12 weeks.
    b. Individuals who have a new positive test will be referred to Ventura County Public Health for treatment.
4. If a staff member is determined to have a tuberculosis exposure and has previously tested positive for tuberculosis, they should be assessed by Employee Health Services within 2 weeks.
5. Staff are expected to comply with all tuberculosis testing and follow up procedures.

All Revision Dates

4/17/2023, 1/10/2023, 3/1/2014, 5/1/2008

Approval Signatures

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/17/2023
Employee Health Services	Rachel Stern: Chief Medical Quality Officer	4/17/2023
Employee Health Services	Honeylette Wong: Nurse Practitioner-Employee Health Services	4/11/2023

Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	4/11/2023
Policy Owner	Honeylette Wong: Nurse Practitioner-Employee Health Services	3/9/2023

Status **Active** PolicyStat ID **13300497**

Origination	12/13/2001
Last Approved	3/13/2023
Effective	3/13/2023
Last Revised	3/13/2023
Next Review	3/12/2026
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.13 Fire Alarm System

POLICY:

The Ventura County Medical Center/Santa Paula Hospital fire alarm system shall be continuously monitored by an appropriate outside monitoring system. The monitoring system shall be tested quarterly by the service to ensure alarms are being transmitted.

PROCEDURE:

The Ventura County Medical Center/Santa Paula Hospital fire alarm equipment is maintained by the Rincon Inspection Group Inc and Monitoring service is provided by S.A.S. Bay Alarm Company.

All Revision Dates

3/13/2023, 7/1/2016, 12/9/2013, 8/25/2009, 1/4/2008, 12/13/2001

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/13/2023
Facilities Department	Ian McGraw: Manager Facility Operation	3/13/2023

Status Active PolicyStat ID 13374567

VENTURA COUNTY HEALTH CARE AGENCY

Origination	12/13/2001
Last Approved	3/27/2023
Effective	3/27/2023
Last Revised	3/27/2023
Next Review	3/26/2026
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities Maintenance/ Biomed/Support Services

F.44 Compressed Gas Cylinders

POLICY:

The purpose of this procedure is to ensure that all gas cylinders that are received, handled or stored are done so in accordance with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) standards, Occupational Safety and Health Administration (OSHA), Environmental Health and Safety Guidelines (EHS), as well as safe practices, in order to minimize potential hazards.

PROCEDURE:

Transporting

A. Compressed gases are high-energy sources and should be treated as a potential explosive.

B. Cylinders should never be dropped or permitted to come into violent contact with each other.

C. Do not roll or drag a cylinder.

D. When transporting a cylinder, only use hand trucks and carts that are specially designed for this task. Make sure the cylinder is secured with a strap, for stability. While transporting, you should push the cart rather than pull it.

Storage

1. Never store compressed-gas cylinders near heat sources, such as heaters or steam lines, in direct sunlight, or in areas where the temperature exceeds 130 degrees F. (54 degrees C). This will help prevent explosions.
2. Always store a compressed-gas cylinder in an upright position by one of the following methods: • Chain it in a four-wheeled cart specifically designed for cylinder storage. • Chain it in a rack designed for cylinder storage. • Chain it to a wall. • Store it in a cylinder stand.

3. Never store industrial and medical grade gases together.
4. Per National Fire Protection Association's (NFPA) 99-2012 – Centers for Medicare and Medicaid Services' interpretation of the code is: Storage of < 300 cf of bottled medical oxygen may NOT be within 20 feet of electrical outlets, combustibles, flammable liquids, vapors, and gases if the area is not sprinklered and 5 feet if the area is sprinklered.
5. Never leave a compressed-gas cylinder in a corridor or passageway, even if the cylinder is properly secured. This will help prevent a heavy object, such as a portable x-ray machine, from striking the cylinder and breaking or damaging the regulator or its valve.
6. Always immediately remove the tear-offs from the cylinder tag to indicate when the cylinder is empty.
7. Always cap a compressed-gas cylinder if its regulator has not been installed.
8. The medical gas storage areas are to remain locked at all times to prevent the theft of any medical gas products. Nothing other than medical gas cylinders, carts, and regulators are to be located in the storage areas.
9. Never store any compressed gas cylinders in the vicinity of an MRI. There is a chance that the magnetic field will pull the loose tank into its magnet. If a compressed gas is required in the vicinity of an MRI, an aluminum cylinder must be requested.
10. The 2012 Edition of NFPA 99 section 9.4.3 states that: The "Storage for nonflammable gases with a total volume compressed equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 9.4.3(A) and (B). An E-cylinder holds about 25 ft3 of gas; therefore, twelve cylinders would be allowed to be in an area. The number is based on cubic feet of gas, not just the number of cylinders. An H-cylinder in the same area reduces the number of E-cylinders that can be stored to two (2)."
11. Cylinders attached to beds, wheelchairs, or other patient-care equipment, or in a patient room for "as needed" (but regular) individual use is not required to be stored in an enclosure when properly secured.
12. Cylinders must be segregated and separated by Full *(Green)*, Partial *(Yellow)* and Empty *(Red)* so that staff select the proper cylinder during emergency situations.
13. Rooms used to store positive pressure gases doors shall be labeled: Medical Gases: NO Smoking or Open Flame

Handling

1. Carefully handle all compressed-gas cylinders. If the contents are not completely exhausted, the energy stored inside can cause fatal injuries if released through a broken valve.
2. Always keep the valve cap on a compressed-gas cylinder when it is not in use or when in transport, to prevent the possibility of accidental valve damage or breakage.
3. Always keep the valve of a flammable compressed-gas cylinder closed when not in use.
4. Immediately tag and report as "damaged" any compressed-gas cylinder that is damaged or malfunctioning. This will help prevent others from using it.
5. Never oil or lubricate connector throats and surfaces. They always must be clean and tight fitting.

6. When opening the valve of a compressed-gas cylinder, always open the valve slowly and never stand directly in front on the valve's gauge. This will help prevent injury if the gauge face blows out.
7. When setting the maximum flow rate, always use only the high-pressure valve. When making fine adjustments, use the needle/regulator valve.
8. Never change the fitting on cryogenic vessels under any circumstances. If a cryogenic vessel fitting does not seem to connect to a supply system fitting, contact the supplier immediately. The vessel should be returned to the supplier to determine the filling or connection problems
9. Identify a gas and its dangers before using it. Look for this information on labels, Material Safety Data Sheets (MSDS) and cylinder markings. If you do not know what is in a cylinder, do not use it.
10. Examine cylinders as soon as you receive them. If you detect signs of damage or leakage, move them to a safe, isolated area and return them to the supplier as soon as possible.
11. Use only regulators, pressure relief devices, valves, hoses and other auxiliary equipment that is designed for the specific container and compressed gas/cryogenic liquid to be used.
12. Do not lift a cylinder by its cap unless using hand trucks specifically designed to do so.
13. It is the responsibility of staff to ensure there is enough oxygen to complete transport, therefore, staff is responsible to check the pressure gauge to determine if the tank is adequately full.
14. Staff is responsible for reading the cylinder label, not just relying on the color of the cylinder.
15. When opening the valve on a cylinder, the user should position the cylinder with the valve pointing away from them and others nearby.
16. When a cylinder is empty the regulator must be removed and the cylinder must be capped.
17. **Never use a compressed-gas cylinder if:**
    - It lacks a printed content label affixed to the side of the cylinder.
    - Its contents are identified merely with a tag. The tag may be in error.
    - Its contents are identified merely on the basis of a color code. Not all manufacturers use the same color coding system.

Label and Signs

1. Cylinders should be clearly identifiable by means of attached labels or stencil. Labels should identify the individual components and their proportions.
2. Do not deface, alter or remove labels.
3. Never use a cylinder for which the contents are unknown. If a cylinder cannot be identified it should be marked as "unidentified" and returned to the vendor

All Revision Dates

3/27/2023, 6/9/2020, 12/9/2013, 8/25/2009, 12/13/2001

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/27/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/27/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/27/2023
Environment of Care Committee	Ian McGraw: Manager Facility Operation	3/27/2023
Policy Owner	Ian McGraw: Manager Facility Operation	3/27/2023

Status **Active** PolicyStat ID **13378771**

Origination	12/13/2001	Owner	Ian McGraw: Manager Facility Operation
Last Approved	3/28/2023	Policy Area	Facilities
Effective	3/28/2023		
Last Revised	3/28/2023		
Next Review	3/27/2026		

F.46 Utility System Shutdown

POLICY:

To maintain drawings and documents which indicate the locations of controls for the partial or complete shutdown of each utility system and to ensure thorough training of Facilities Maintenance staff so that proper procedures are followed in the shutdown of any utility system components.

PROCEDURE:

Ventura County Medical Center drawings are located in the Facilities Maintenance Department, Building 348.

A. Procedures specific to the following utility systems are located at the Facilities Maintenance Office. Utility systems include, but are not limited to:
    - Steam
    - Hot Water
    - Water Distribution/Plumbing System
    - HVAC System
    - Communication System
    - Electrical Distribution System
    - Elevators
    - Fire Alarm System
    - Medical Gas Delivery System
    - Medical Air System
    - Vacuum System

- Natural Gas

B. VCMC Facility Maintenance staff will secure any system as needed.
   - Facilities affected are as follows:

◦ Ventura County Medical Center campus buildings	300 Hillmont Avenue
◦ IPU	200 Hillmont Aveue
◦ Medical Examiner/Coroners building	3100 Foothill Road
◦ Public Health	3147 Loma Vista Road
◦ IPU	200 Hillmont Avenue

C. The securing of the steam system and water distribution/plumbing systems are the joint responsibilities of the Stationary Engineers and the plumbers. The main components of the steam system are located in the Central Plant. Main water feeds are located on Loma Vista Road, at the corner of Hospital Road and Foothill Road and at the North Tower loading dock. Detailed drawings are located in the Central Plant, Facilities Maintenance building in the Plan Room.

D. The securing of the HVAC system is the joint responsibility of the Air Conditioning and Heating Mechanics and the Hospital Maintenance Engineers. All pertinent drawings are located in the Facilities Maintenance building.

E. Communication Systems, Electrical Distribution Systems, Elevators, Fire Alarm systems, Medical Gas Systems and Vacuum Systems are the responsibility of the Hospital Maintenance Engineers and specific authorized contractors. All pertinent drawings and call-in sheets are located at the Facilities Maintenance office.

PROCEDURES:

When a utility system must be shutdown, notify Administration, the Chief Nursing Officer/Nursing Supervisor and the managers of each affected department.

Facilities Maintenance Office hours are:

Monday through Friday 7:00 AM to 5:00 PM 652-3219

Off-shifts contact Paging at 652-6075 and they will contact the Hospital Maintenance Engineer on duty.

All Revision Dates

3/28/2023, 3/27/2023, 5/1/2017, 7/1/2016, 12/9/2013, 8/25/2009, 12/13/2001

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/28/2023
Facilities Department	Ian McGraw: Manager Facility Operation	3/27/2023

Status Active PolicyStat ID 13605964

VENTURA COUNTY HEALTH CARE AGENCY

Origination	3/1/2010
Last Approved	5/8/2023
Effective	5/8/2023
Last Revised	3/27/2023
Next Review	5/7/2026
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.89 Construction and Renovation Guidelines

POLICY:

To state the processes to be followed when undergoing construction or renovation of facilities.

PROCEDURE:

- Mandatory adherence agreements for infection control shall be incorporated into construction contracts, with penalties for noncompliance and mechanisms to ensure timely correction of problems.
- Applicable state rules and regulations shall be followed when HCAVCMC/SPH/AMB CARE/BH/PH facilities undergoes facility renovation and construction.
- Guidelines for Design and Construction of Hospitals and Healthcare Facilities (American Institute of Architects) shall also be followed.
- When this facility undergoes construction, renovation, remediation, repair or demolition, a multi-disciplinary team that includes infection control staff shall be established to coordinate demolition, construction and renovation projects, consider proactive preventive measures at the inception, and document and maintain summary statements of the team's activities.
- Planning for facility renovation and construction projects at HCA VCMC/SPH/AMB CARE /BH/PH shall include early consultation with Infection Control to ensure that:
    - The design of treatment areas and other structures will facilitate desired infection control practices, and
    - Dust and other microbial contamination is minimized during the work phases of construction/renovation projects.

PRECONSTRUCTION PREVENTIVE MEASURE:

- Infection Control Practitioner shall be notified of plans for renovation and/or new construction

during the planning phases.

- A Risk Assessment and Preventative Measure Checklist must be completed during the design process to assist the multidisciplinary team to identify the patient population at risk and the preventive measures to be initiated. A copy of the risk assessment must be sent to the Infection Control Department.
- Risk criteria shall be used that addresses the impact of demolition, renovation or new construction on:
    - Air quality requirements
    - Infection control
    - Utilities requirements
    - Noise
    - Vibration
    - Alternative life safety measures
    - Emergency procedures
    - Other hazards that affect care, treatment or services

Infection Control expectations will be incorporated into initial agreements to ensure contractor accountability, i.e., an infection Control Construction Permit. Specific areas of consideration for Infection Control input include:

- Identification of patient population that may be at risk and the prevention measures to ensure their safety (i.e., patient care areas including rooms for isolation precautions)
- Surveillance shall be maintained for airborne environmental disease (i.e., aspergillosos) as appropriate during construction, renovation, repair and demolition activities to ensure the health and safety of immunocompromised patients through:
- Active surveillance: immunocompromised patients shall be monitored for airborne infections
- The periodic review of the hospital's microbiologic, histopathology and postmortem data to identify additional cases
- Aggressively pursuing the diagnosis with tissue biopsies and cultures as feasible if cases of aspergillosis or other healthcare associated airborne fungal infections occur

- Educating and training all staff involved in the construction or renovation activity regarding infection prevention measures
- Educating the construction team and hospital in immunocompromised patient care areas regarding the airborne, infection risks associated with construction projects, dispersal of fungal spores during such activities, and methods to control the dissemination of fungal spores
- Identify essential services (i.e., water supply, electricity and ventilation systems) that may be disrupted and measures to compensate for the disruption
- Hand washing facilities
- Traffic patterns for people and supplies

- Designation of an elevator to be used solely by the construction workers
- Air handling systems
- Dust containment and removal of construction debris
- Water supply and plumbing materials that are durable and resistant to corrosion and bacterial growth; materials must meet the Code Regulation
- Storage of equipment and supplies, and disposal of regulated medical waste and any other hazards associated with internal renovation and construction projects which may require preventive or remedial action

Infection Control Measures for External Demolition and Construction Activities:

The Infection Control Risk analysis should determine if:

- The facility can operate temporarily on recirculated air; if feasible, seal off adjacent air intakes.
- If this is not possible or practical, check the low-efficiency (roughing) filter banks frequently and replace as needed to avoid buildup of particulates.

Implement Infection Control Measures for Internal Construction Activities:

- Construct barriers to prevent dust from construction areas from entering patient care areas; ensure that barriers are impermeable to fungal spores and in compliance with local fire codes.
- Seal off and block return air vents if rigid barriers are used for containment.
- Implement dust control measures on surfaces and divert pedestrian traffic away from work zones.
- Relocate patients whose rooms are adjacent to work zones, depending on their immune status, the scope of the project, the potential for generation of dust or water aerosols, and the methods used to control these aerosols.

CONSTRUCTION PREVENTIVE MEASURE:

To minimize infectious risk associated with internal renovation projects in patient care areas, the following control and interventions are in place:

- Renovation areas shall be isolated from patient-occupied areas using "airtight" barriers.
- Ensure proper operation of the air-handling system in the affected area after erection of barriers and before the room or area is set to negative pressure.
- Create and maintain negative air pressure in work zones adjacent to patient care areas and ensure that required engineering controls are maintained.
- Monitor negative airflow inside rigid barriers.
- Monitor negative airflow inside rigid barriers.
- Monitor barriers and ensure integrity of the construction barriers; repair gaps or breaks in barrier joints.
- Exhaust airflow in the renovation area will maintain negative air pressure as possible (i.e., windows closed, supply air to the renovation area suspended, exhaust fans utilized)
- Dust and debris allowed to become aerosolized is a risk to hospitalized patients because it

carries microbes, such as Aspergillus and other fungus species. Because of the potential for dislodging dust collected above suspended ceiling panels, a ceiling-to-floor, sealed plastic barrier must be constructed to contain the dust whenever more than one ceiling tile is to be removed within a patient care area.

- Whenever ceiling tiles are removed or other work is performed in which dust contamination has occurred, the area is cleaned as soon as possible using a wet vacuum or damp mopping procedure to prevent "trafficking" of dust throughout the facility. Sweeping and dry mopping is never appropriate in a hospital environment.
- Pedestrian traffic is directed away from construction/renovation areas and materials.
- Demolition debris is covered and sealed during transport. Transport is done during lowest activity periods. Elevators are avoided for debris transport as possible. If an elevator must be used, one will be designated. If using a chute, HEPA filtered air machines/fans are used as possible.
- Care is taken to ensure air from construction/renovation areas is not recirculated to other areas of the facility. This may necessitate temporarily closing dampers and reducing air circulation. Changes in airflow are communicated to the affected units prior to beginning and at the completion of the project.
- The Engineering Department staff shall maintain and clean the ventilation system on a regular basis, and after construction/renovation projects likely to increase contamination of such systems.
- The Engineering Department shall monitor and document the presence of negative airflow within the construction zone or renovation area on a daily basis.
- Acoustic ceiling tiles and other porous materials used for fireproofing and filters which become wet after breaks or flooding are a reservoir for fungal spores)i.e., Aspergillus sp), and are therefore removed and replaced as quickly as possible. Non-porous materials and tiles may be cleaned with diluted bleach solution and dried before replacement.
- Water lines are thoroughly flushed after an interruption in water service and in areas adjacent to construction due to the increased risk of loosening internal debris/corrosion in water pipes, which harbors microbes and may lead to water contamination.
- Contractors and subcontractors are educated about infection risk and informed of expected compliance with the previously specified infection control practices. A copy of the Recommended Infection Control Preventive Measure for Construction Activity and Risk Group Matrix shall be provided.
- Exposure of seriously immunocompromised patients to construction and renovation projects is minimized by avoiding admission of such patients during major construction projects, and locating such patients in areas remote from any renovation project areas.
- Clean or sterile supplies and equipment should not be transported through a construction zone to reduce the risk of contamination.
- The Engineering Department staff and other staff members are educated to look for visible dust, footprints, opened doors (and insects), wet ceiling tiles and other internal hazards that may compromise infection control efforts and require prompt action.

Provide construction crews with:

- Designated entrances, corridors and elevators wherever practical
- Essential services (i.e., toilet facilities)
- Convenience services (i.e., vending machines)
- Protective clothing (i.e., coveralls, footgear and headgear) for travel to patient care areas
- Space or anteroom for changing clothing and storing equipment.

POST CONSTRUCTION PREVENTIVE MEASURES:

- Thoroughly clean the construction zone, including all horizontal surfaces, before the barrier is removed, and again after the barrier is removed and before patients are readmitted to the area. Install barrier curtains to contain dust and debris before removing rigid barriers. Allow time for all dust to settle before doing final cleaning.
- Commission the HVAC system for newly constructed healthcare facilities and renovated spaces before occupancy and use, with emphasis on ensuring proper ventilation for operating rooms, all rooms and PE areas.
- Infection Control should check the area before patients are readmitted to the finished area.
- Ensure that multidisciplinary project committee or designee conducts a final walkthrough to ensure ventilation system is functioning properly in construction zone and adjacent area.
- Flush the water systems to clear sediment from pipes to minimize waterborne micro-organism proliferation.
- If there are concerns about Legionella, consider hyper chlorinating stagnant water, or superheating and flushing all distal sites before restoring or re-pressurizing the water system.
- Disinfect unused cooling towers and water supply in unoccupied portions of building before they are put to use.
- Assess hot water temperature to determine that it meets the standards set by the hospital.
- Ensure that multidisciplinary project committee or designee evaluates the preventive measures and reviews their effectiveness for any problems and positive outcomes.

Contractor Training

Construction ICRA: Patient Safety & Best Practices in Healthcare Construction

(15) Construction ICRA: Patient Safety & Best Practices in Healthcare Construction - YouTube

All Revision Dates

3/27/2023, 2/1/2017, 12/9/2013

Attachments

preprojectpreconstruction Risk Asseessment & Safety Plans.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/8/2023
Infection Prevention	Magdy Asaad: Infection Prevention Manager	5/8/2023
Facilities Department	Ian McGraw: Manager Facility Operation	5/8/2023

Status **Active** PolicyStat ID **13621318**

Origination	7/28/2017	Owner	Ian McGraw: Manager Facility Operation
Last Approved	5/8/2023	Policy Area	Facilities Maintenance/ Biomed/Support Services
Effective	5/8/2023		
Last Revised	4/25/2023		
Next Review	5/7/2026		

F.99 Emergency Water Suppliers

POLICY:

In the event that a loss of municipal water supplied from the Main-Foothill Road primary and the secondary bypass, Main-Loma Vista Road to Ventura County Medical Center, emergency non-potable water may be obtained from the following;

Vendors:

COUNTY OF VENTURA FIRE DEPARTMENT

(805) 389-9710

Sunbelt Rentals

(805) 643-0996

EMS

(805) 981-5301

All Revision Dates

4/25/2023, 7/28/2017

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/8/2023
Safety	Fernando Medina: Director, Support Services	5/8/2023
Facilities Department	Ian McGraw: Manager Facility Operation	5/8/2023

Status **Active** PolicyStat ID **11421645**

Origination	3/11/1993	Owner	Michelle Doan-Le: Blood Bank Supervisor
Last Approved	4/24/2023	Policy Area	Blood Bank
Effective	4/24/2023		
Last Revised	4/24/2023		
Next Review	4/23/2025		

L.BB.05 Irradiation of Blood Products

PRINCIPLE:

Cellular components are required to be irradiated for certain patient populations to prevent transfusion-associated graft-vs-host disease. The current gamma irradiation dose recommended to prevent proliferation of donor T lymphocytes in the recipient is a minimum of 25 Gy (2500 cGy/rads) to the central point of the blood container and 15 Gy (1500 cGy/rads) to any other part of the container. The expiration date of irradiated RBCs is 28 days after irradiation or the original expiration date, whichever date is earliest.

SPECIMEN COLLECTION:

N/A

MATERIALS:

N/A

PROCEDURE:

1. All requests for irradiated blood products must be approved by the pathologist (first request only). Add attribute to patient's "transfusion requirements" and document date and ordering physician in BB comment. Charge "IRR" fee for each irradiated unit ordered.
2. Patients in the following categories should receive irradiated blood products:
    a. Patients at risk for graft-versus-host disease (GVHD).
    b. Directed donations from blood relatives.
    c. All neonates.

d. Pediatric patients who are actively receiving chemotherapy.
e. Patients who are immunodeficient.
f. Patients who have bone marrow failure or are status post bone marrow or solid organ transplant.
g. At the discretion of the Attending Physician.

3. All irradiated blood and blood components are a special order from the blood supplier.

CALIBRATION:

N/A

CALCULATIONS:

N/A

RESULTS:

N/A

LIMITATIONS:

N/A

REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, Current Edition.

2. Roback, John D. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.

All Revision Dates

4/24/2023, 6/5/2020, 12/1/2016, 12/1/2011

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	4/24/2023

Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	4/22/2023
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/10/2022
Laboratory Services Department	Michelle Doan-Le: Blood Bank Supervisor	10/25/2022

Status **Active** PolicyStat ID **10084460**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	9/6/2001
Last Approved	4/24/2023
Effective	4/24/2023
Last Revised	4/24/2023
Next Review	4/23/2025
Owner	Michelle Doan-Le: Blood Bank Supervisor
Policy Area	Blood Bank

L.BB.47 Antibody Detection by Gel Card – Pre-Warm Modification

PRINCIPLE:

The antibody detection or screening test is an indirect antiglobulin test used to detect unexpected blood group antibodies. In the anti-IgG gel card method of this test, reagent red blood cells in a hypotonic buffered saline solution are combined with the serum or plasma sample to be tested. Incubation of these reactants at 37°C in the upper chamber of the gel card microtube promotes antigen-antibody interaction. Detection of antibody occurs when sensitized red blood cells react with the anti-IgG gel in the microtube during centrifugation. A modification of this technique, referred to as pre-warming, can be employed to diminish or eliminate the reactivity of unwanted cold reactive antibodies, while maintaining sensitivity for clinically significant, warm-reactive antibodies.

SPECIMEN:

No special preparation of the patient is required prior to specimen collection. Blood should be collected by approved techniques. A completely clotted or EDTA anti-coagulated sample drawn within three days of testing may be used. Fresh serum may be used to assure the presence of adequate complement and calcium. If plasma is used for the indirect antiglobulin test, complement-dependent antibodies may not be detected.

REAGENTS:

1. MTS Anti-IgG Card™, Anti-IgG (Rabbit) suspended in gel
2. 0.8 % Antibody screen cells comprised of three vials of human red blood cells
3. MTS Diluent 2™, a hypotonic buffered saline solution (for in-house preparation only)
4. 3%, to be prepared in-house for use in MTS Anti-IgG testing

Do not use beyond expiration date. Store cards at 2 to 25°C. Store diluent and red cells at 2 to 8°C. Bring reagents to room temperature (18 to 25°C) prior to use.

QUALITY CONTROL:

To recognize reagent deterioration, the reagents must be tested daily with appropriate controls. MTS Diluent 2™ must be visually checked to ensure that the liquid is not discolored, turbid, or showing any signs of bacterial contamination. To confirm the specificity and reactivity of the MTS Anti-IgG Card, it is recommended that each lot be tested on each day of use with known positive and negative antibody samples with the appropriate red cells. Reactivity must be present with the positive sample only.
(See Daily Reagent Quality Control)

PROCEDURE:

Antibody Screen Cell Preparation, if necessary:

Method 1 (For 60 tests, from 3% cell suspensions)

1. Label three test tubes I, II, and III; Include the lot number, date and time of preparation.
2. With an appropriate pipette, dispense 1.0 mL of each antibody screen cell sample into its appropriately labeled tube and centrifuge one (1) minute to pack the red blood cells.
3. Decant the supernatant and then add 3.0 mL of MTS Diluent 2™ to each tube. Mix gently. The final cell suspension should be approximately 0.8% and is stable for 24 hours. For best results, the suspension should not be less than 0.6% or exceed 1.0%.

Method 2 (For 20 tests, from packed cells)

1. Label three test tubes I, II, and III; include the lot number, date and time of preparation. Prepare a volume of cells sufficient to provide 10 µL of packed red blood cells of each of the antibody screen samples.
2. In separate labeled tubes, dispense 1.0 mL of MTS Diluent 2™**.** Add 10 µL of each of the packed antibody screen cell samples to the appropriately labeled tube.
3. Mix gently. Final cell suspension should be approximately 0.8% and is stable for 24 hours. For best results, the suspension should not be less than 0.6% or exceed 1.0%.

ANTIBODY SCREEN TEST PROCEDURE

1. Label the MTS Anti-IgG Card™ with the appropriate identification and test information.
2. Remove the foil from the mircrotubes to be used.
3. Place a small aliquot of the screening cells in a test tube in the MTS incubator for 5-10 minutes.
4. Place the card and an aliquot of the test serum/plasma in the MTS incubator for 5-10 minutes.
5. Using an appropriate pipette, add 50 µL of the 0.8% antibody screen cell suspensions(s) to the labeled microtubes(s). Do not touch pipette to gel card.
6. While keeping the card in the incubator, add 25 µL of pre-warmed serum or plasma to the

labeled microtubes.

7. Incubate at 37 ± 2°C for a minimum of 15 minutes. Refer to package insert for comment on extending incubation times.
8. Centrifuge the gel card at the preset conditions of 895 ± 25 RPMs for 10 minutes (or 1032 ± 10 RPMs for 10 minutes if using the Ortho Workstation centrifuge).
9. Read the front and the back of each microtube and record reactions.

RESULTS:

Hemolysis in the absence of a hemolyzed sample or agglutination of any of the red cells in the gel card indicates the presence of an antibody directed against the corresponding antigen, which is present on the screening cells.

No agglutination or hemolysis of the screening cells in the gel card is a negative test result and indicates the absence of an antigen/antibody reaction.

PROCEDURE NOTES:

1. Although centrifugation is performed at room temperature, pre-warming of the reactants prior to mixing may eliminate reactivity due to cold antibodies.
2. Interpretation of mixed-field reactions must be done with caution. The presence of fibrin, clots or particulates may result in some cells layering at the top of the gel. Mixed-field reactions are generally only observed in tests containing a dual population of red cells, such as a transfused patient, bone marrow recipient or when a pooled cell sample is used for testing. However, not all mixed cell situations have a sufficient minor population to be detected.

LIMITATIONS:

1. Some antibodies of clinical importance may be eliminated by pre-warm technique.
2. Antibodies below the threshold level may not be detected with this test.
3. Antibodies specific for low-incidence antigens not represented on the test cells will not be detected.
4. False-positive results may occur if antibodies to components of the preservative solution are present in the serum/plasma tested.
5. Significant variations in red blood cell suspensions (<0.6 or >1.0%) may result in false-positive or false-negative reactions.
6. Anomalous results may be caused by fresh serum, fibrin or particulate matter in serum or plasma, or red cells that stick to the sides of the microtube. Anomalous results with fresh serum (i.e., a line of red cells on top of the gel) may be minimized by the use of EDTA plasma.
7. Adherence to the manufacturer's package insert is critical to test performance.

REFERENCES:

1. Current package inserts.

2. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, 2015. Current Edition.
3. Fung, Mark K MD, PhD. Technical Manual. Bethesda, MD: American Association of Blood Banks. Current Edition.
4.

All Revision Dates

4/24/2023, 12/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	4/24/2023
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	4/22/2023
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/10/2022
Laboratory Services Department	Michelle Doan-Le: Blood Bank Supervisor	10/25/2022

Status **Active** PolicyStat ID **13300269**

Origination	3/1/2009	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	3/13/2023		
Effective	3/13/2023	Policy Area	Pharmacy Services
Last Revised	3/13/2023		
Next Review	3/12/2026		

PH.23 Reporting Controlled Substance Loss or Diversion

POLICY:

This policy defines the responsibilities and procedures for the reporting of diversion and/or loss of controlled substances at Ventura County Medical Center/Santa Paula Hospital in accordance with laws and regulations to pertinent regulatory bodies and the hospital Chief Executive Officer. The Pharmacist in Charge for each Pharmacy shall be responsible for reporting diversion and/or loss of controlled substances to pertinent regulatory bodies. The Director of Pharmacy Services shall be responsible for reporting of diversion and/or loss of controlled substances to the hospital Chief Executive Officer.

PROCEDURE:

1. The Director of Pharmacy Services shall use professional judgment and discretion as what amount of loss shall be deemed reportable to the hospital Chief Executive Officer.
2. Any discovery of diversion and/or loss of controlled substances during routine monitoring through discrepancy reports and through auditing of the controlled substance inventory shall be investigated thoroughly.
3. Reportable items shall include the following:
    1. Loss of controlled substance aggregate amount of unreported losses discovered on or after the same day of the previous year to equal or exceed:
        a. For tablets, capsules, or other oral medications: 99 dosage units
        b. Single-dose injectable, lozenges, films, sublingual, suppositories, or patches: 10 dosage units
        c. Multi-dose injectable medications, continuous infusion, other multi-dose not described by 3.1.a. of this policy: 2 multi-dose vials, infusion bags, or other containers.

This report must be made within 30 days after discovery meeting the requirement of 3.1.a-c.

4. Any suspected or confirmed theft shall be immediately reported to the Director of Pharmacy Services (or designee) or the hospital Administrator on Duty. The Director of Pharmacy Services (or designee) may also consider filing a report with the Ventura City Police Department after discussion with the hospital Chief Executive Officer.
5. The California State Board of Pharmacy shall be notified of any theft or diversion of controlled substances within 14 days of discovery regardless of the amount. This includes
    1. Any self admission by a licensed individual or video/documentary evidence of chemical, mental, or physicial impairment affecting their ability to practice or theft, diversion, or self-use of dangerous drugs.
    2. Any termination based on chemical, mental, or physicial impairment of a licensed individual to the extent it affects their ability to practice or based on theft, diversion, or self-use of dangerous drugs.
6. If diversionary activity involves Nursing Staff, the California State Board of Registered Nursing shall also be notified.
7. If diversionary activity involves Medical Staff, the Medical Board of California shall also be notified.
8. A DEA Form 106, "Theft or Loss of Controlled Substances," shall be completed and submitted to the DEA for any significant loss of controlled substances within one (1) business day of discovery.
    A. A significant loss of a controlled substance shall be defined as a quantity greater than or equal to 20% of average daily utilization of the controlled substance for each pharmacy or any loss related to diversionary activity.
    B. A copy of the DEA Form 106, "Theft or Loss of Controlled Substances," shall be retained in the Pharmacy Department for a minimum of three (3) years.
9. The California Department of Public Health in Oxnard, California shall also be notified of loss of controlled substances reported to California Board of Pharmacy.

All Revision Dates

3/13/2023, 6/8/2021, 11/26/2018, 9/1/2015, 6/1/2014, 5/1/2013, 3/1/2009

Approval Signatures

Step Description	Approver	Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	3/13/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/13/2023

Status **Active** PolicyStat ID **13280716**

Origination	9/2/2020	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	3/24/2023		
Effective	3/24/2023	Policy Area	Pharmacy Services
Last Revised	3/24/2023		
Next Review	3/23/2026		

PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays

POLICY:

Radio-frequency identification (RFID) technology may be utilized by pharmacy staff to improve the medication box/kit replenishment process and for inventory management including management of expiration dates, lot numbers and recalled medications. The Kit Check system utilized RFID technology and is available at the Ventura County Medical Center inpatient pharmacy only.

PROCEDURE:

A. Assigning of user name and password
    1. Each staff member will have his/her own unique user name and password.
    2. Security level will be based on job category, pharmacy technician or pharmacist, assigned by a pharmacy supervisor.
    3. Users are to change their password as prompted by the Kit Check system.

B. Education and training
    1. All personnel with access will receive training prior to use of Kit Check.
    2. Training consists of the following:
        a. On line training and competency assessment provided by Kit Check.
        b. Live training of Kit Check with a Kit Check certified trainer/super user.

C. Responsibility
    1. Pharmacy technician
        a. Affix the RFID labels to the medications and maintain adequate inventory

levels.

2. Pharmacist
    a. Ensure accuracy of the national drug code (NDC), lot number and expiration date associated to the medication.
    b. Confirm the Kit Masters medication list is correct and updated in the system.
        i. Contact pharmacy supervisor if medication list needs to be revised.
    c. Perform final inspection of the trays, kits, and boxes and place a lock if applicable.
    d. Assign the location of the boxes, kits, and trays when it leaves the pharmacy.

D. Kit Check medication storage
    1. Medications with the RFID labels attached are kept separately in a designated area to be used exclusively with Kit Check technology.

E. List of Kit Check boxes, kits and trays
    1. Adults crash cart tray
    2. Anaphylaxis kit
    3. Anesthesia Pyxis tray
    4. Anesthesiologist medication box
    5. Cardiac drawer medication box
    6. Code Blue medication box
    7. Malignant Hyperthermia Cart
    8. Neonatal crash cart tray
    9. NICU transport box
    10. Pediatric crash cart tray

F. Restocking procedure
    1. Used, opened, or expired boxes, kits, or trays must be returned to the pharmacy for replenishment of the content with RFID labeled medications.
        a. Boxes and kits including anesthesiologist medication box: See policy PH.115 Medication Boxes and Kits.
        b. Crash cart: See policy 100.113 Crash Cart Checks and Restocking Process.
        c. Anesthesia Pyxis tray exchange process will be performed by a pharmacy technician.
    2. The pharmacist shall use the Kit Check technology as outlined in Attachment A to

replenish the medications associated with each box, kit, or tray.

3. The pharmacist shall assign a specific location to each box, kit, or tray for tracking purposes (if applicable) and secure it with appropriate locks.
4. The expiration date and name of the earliest expiring medication shall be readily available/visual on the box, kit, or tray.

G. System Management and Maintenance

1. Kit Check inventory
    a. The pharmacy department shall be responsible for maintaining inventory including restocking, modifying medication inventory due to shortage, and removing outdates.
    b. Outdates shall be tracked by Kit Check and will be routinely checked at least once monthly.
2. Kit Check support shall be called when Kit Check technology complications/ problems cannot be resolved by staff or Kit Check superuser.
    a. Website: http://app.kitcheck.com
    b. Email: help@kitcheck.com
    c. Phone number: 786-548-2432 ext 2

All Revision Dates

3/24/2023, 9/13/2022, 9/2/2020

Attachments

Attachment A: Kit Check Procedure Manual

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	3/24/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/23/2023

Status **Active** PolicyStat ID **7441583**

Origination	12/1/1998
Last Approved	5/11/2023
Effective	5/11/2023
Last Revised	5/11/2023
Next Review	5/10/2026
Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices
Policy Area	Administrative - Employee

101.014 Employee/Contract Agency Personnel Competence Assessment

POLICY:

It is the policy of Ventura County Medical System (VCMS), which includes Ventura County Medical Center(VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit/Crisis Stabilization Unit (IPU/CSU), and Ambulatory Care clinics to identify and provide an adequate number of competent staff whose qualifications are consistent with job responsibility, to meet the needs of our patient population based on the following:

- The hospital's mission
- The hospital's care, treatment and services
- The complexity of care provided
- The technology used
- The health status of the staff

PROCEDURE:

VCMS leadership will ensure the following:

A. Provide new employee orientation information, for both organization-wide and department-specific responsibilities, to promote safe and effective job performance.

B. Assess employee competence initially and on an ongoing basis thereafter.

C. Document and maintain performance expectations (including age/development skills) for each position in objective measurable terms.

D. Measure employee performance regularly and expect each employee to perform competently.

E. Assess staff development on a hospital-wide, departmental and individual level and use the results to provide continuing education.

F. Acknowledge the importance of ongoing improvement by the encouragement and support of continuing educational activities, professional association memberships and formal/informal interactions with peers and colleagues.

G. Require all staff members to participate in ongoing in-services or other educational programs (appropriate to patient age groups) designed to increase knowledge of work related issues including team work, reporting adverse events, patient safety and the employee's ability to carry out job responsibilities especially with new procedures, techniques, technology, equipment, regulations, legislation, and other needs identified through process improvement findings, staff surveys and learning needs assessments.

Department Directors and Managers are responsible:

A. For coordinating new employee orientation attendance.

B. To provide new employees with a preceptor or close supervision until initial competence requirements are complete.

C. For considering unique patient needs (including age-specific requirements) when defining contents of job descriptions, performance expectations and competence assessments.

D. To provide and document departmental job-specific orientation, training and ongoing education of each employee.

E. For documentation of each person's ability to carry out assigned responsibilities safely, competently and in a timely manner, upon completion of orientation and placing in the employees file.

F. For assessing and monitoring ongoing competence, including age/development specific requirements, by observation of work and absence of negative patient outcomes related to performance.

G. For documenting the results of ongoing competence assessment and performance evaluations every year and placing in the employee's personnel file.

H. For the use of qualified individuals to assess each employee's competence.

I. For addressing individuals with performance problems by assignment modification, reassignment and/or taking appropriate action per the County of Ventura's progressive disciplinary process.

J. For coordination, verification and documentation of contract/agency personnel competence.

Initial competence assessment may include (but is not limited to):

A. Minimum hiring qualifications including compliance with applicable health screening requirements.

B. Education requirements.

C. Current licensure, certification, or registration as appropriate.

D. Appropriate background check clearance.

E. Previous experience and knowledge appropriate for assigned responsibilities.

F. Basic Life Support Certification if appropriate to job assignment.

G. New Employee Orientation will include (but is not limited to):

- Safety procedures including appropriate response/reporting of risks, common problems, failures and errors within the health care environment.
- Infection control practice (PPE, SDS, HazCom).
- Hospital mission, goals, policies and procedures.
- Performance Improvement program.
- Principles of Information Management (confidentiality, computer access, etc.).
- Ergonomics (injury prevention including back injury program – IPPP).
- Compliance training.
- Cultural diversity and sensitivity.
- Patient rights and ethical aspects of care treatment.
- The process used to address ethical issues.
- Review of specific job duties (signed job description).
- Initial job training and necessary information to fulfill job responsibilities.
- Implementation and monitoring of restraints and seclusion where appropriate.

Ongoing competency assessment includes (but is not limited to):

A. Maintaining current licensure, certification, or registration as appropriate.

B. Maintain knowledge and skill regarding patient safety, emergency response, infection control, restraint/seclusion, team work, and reporting adverse events (mandatory annual fire/safety update).

C. Basic Life Support (BLS) re-certification, if appropriate.

D. Ongoing educational activities such as classroom lectures, staff meetings, journal articles, video presentations, product demonstrations from manufacturers, and self-learning modules (particularly when job responsibilities change or with the implementation of new programs, policies, procedures or equipment).

E. Observations of daily work when appropriate.

F. Performance Evaluation based upon individual job duties and responsibilities.

Contract/Agency personnel verification may include:

A. Valid written agreement with the County of Ventura. The agreement shall address contractor compliance with The Joint Commission.

B. Competence assessment for contract/agency will include:

1. Current license/certification/registration verification.
2. Minimum education requirements are met.
3. Current BLS or other certifications as appropriate for patient assignment.
4. Clinical Competence Checklist.

5. Department orientation.
6. Performance Evaluation checklist upon initial visit and periodically thereafter.

All Revision Dates

5/11/2023, 5/1/2016, 6/1/2011, 1/1/2011, 5/1/2006, 2/1/2006, 11/1/2004, 7/1/2001

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/11/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/11/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/11/2023
Policy Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices	5/11/2023

Status **Active** PolicyStat ID **9950357**

Origination	8/1/1992	Owner	Ian McGraw: Manager Facility Operation
Last Approved	5/9/2023	Policy Area	Administrative - Environment of Care
Effective	5/9/2023		
Last Revised	5/9/2023		
Next Review	5/8/2026		

106.010 Employee Identification

POLICY:

All staff, physicians and volunteers of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) must display a Ventura County Health Care Agency-issued picture identification employee name badge at all times while on duty.

PROCEDURE:

Any person not displaying their picture identification employee name badge may be asked to leave VCMC/SPH.

In the event of a declared disaster, staff **will not** be able to gain access to VCMC/SPH unless they display their HCA-issued picture identification badge.

All Revision Dates

5/9/2023, 6/1/2008, 5/1/2006, 4/1/2004

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023

Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Safety Committee	Fernando Medina: Director, Support Services	5/9/2023
Policy Owner	Ian McGraw: Manager Facility Operation	3/27/2023

Status **Active** PolicyStat ID **6231377**

Origination	6/1/1996	Owner	Fernando Medina: Director, Support Services
Last Approved	5/9/2023	Policy Area	Administrative - Environment of Care
Effective	5/9/2023		
Last Revised	5/9/2023		
Next Review	5/8/2026		

106.021 Bomb Threat

POLICY:

Bomb threats received by Ventura County Medical Center/Santa Paula Hospital staff must be handled in as consistent and reasonable a manner as possible in order to protect lives and property. It is the responsibility of department managers to disseminate this information to staff.

PROCEDURE:

1. **If a bomb threat is received:**
    A. Remain calm.
    B. Attempt to keep the caller in conversation and at the same time:
    C. Report the incident immediately to the local Police Department by 2nd employee from another line.
    D. Under no circumstances break the circuit with the caller or be abrupt or speak in other than a normal tone.
    E. When the connection is broken complete the "BOMB THREAT" Form with as much information as possible.
    F. Give the completed bomb threat document and/or other pertinent information or evidence to the **first** officer that arrives.
    G. DO NOT OPEN any suspicious letter or package.
2. **Telephoned Threats Received at Work Site**

    Bomb threats are delivered in a variety of ways. The majority of threats are carried in to the target and most bomb threat calls are very brief. The caller states his or her message and hangs up. Whenever possible, however, every effort should be made to follow the procedure

outlined on the bomb threat form. The employee should try not to agitate the caller but should try to listen carefully to the exact wording of the threat.

Pretending difficulty with hearing may keep the caller talking longer. If the caller will converse beyond essential questions at the top of the bomb threat form, ask the following questions:

A. Where are you now?

B. How do you know so much about the bomb?

C. Inform the caller that the building is occupied and that detonation could cause injury or death.

3. **Written Threats Received at Work Site**

Keep the threatening letter, envelope and any wrappings in a plastic bag, if possible, and give them to the first officer that arrives. Do not pass the letter around or handle it more than absolutely necessary. If a threatening note or letter is found, i.e., left on desk while unattended, found taped to public phones or other areas of the building, actually written on the walls, doors, or windows, etc., make a note of the time first discovered, how long area was unattended (if known), description of others in the vicinity, etc. Provide this information to the **first** officer who arrives.

4. **Building Search**

Upon receiving a report of a bomb threat to County facilities, the Police Department will contact Hospital Administration. Security will be notified by Administration to coordinate the location and method of searching the buildings.

A. Hospital Administration will notify department heads that are in the affected area of the incident.

B. A search may be undertaken by the Police.

C. Department heads may be asked to quietly and calmly check work areas with the assistance of their employees for the purpose of identifying any unfamiliar objects or anything that appears out of place.

D. Buildings may be evacuated if, in the judgment of Bomb Squad personnel, the threat is deemed sufficient to warrant such action. In the event evacuation is ordered, it will be directed per the evacuation policy.

All Revision Dates

5/9/2023, 5/1/2006, 11/1/2004

Attachments

Bomb Threat Form

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Safety Committee	Fernando Medina: Director, Support Services	5/9/2023
Policy Owner	Fernando Medina: Director, Support Services	5/9/2023
Hospital Administration	Leticia Rodriguez: Associate Hospital Administrator, Support Service	4/9/2020
Environment of Care Committeee	Leticia Rodriguez: Associate Hospital Administrator, Support Service	3/10/2020
Environment of Care Committeee	Joey Carmona: VCMC Maintenance	1/30/2020
Hospital Administration	Leticia Rodriguez: Associate Hospital Administrator	11/27/2019
Environment of Care Committeee	Joey Carmona: VCMC Maintenance	11/6/2019

Status **Active** PolicyStat ID **13518137**

Origination	9/1/2009	Owner	Sandro Cruz: Hospital Hazardous Materials Coordinator
Last Approved	5/9/2023		
Effective	5/9/2023	Policy Area	Administrative - Environment of Care
Last Revised	5/9/2023		
Next Review	5/8/2024		

106.035 Hazardous Materials & Waste Management Plan

POLICY:

Each Ventura County Medical System facility (Ventura County Medical Center, Santa Paula Hospital, the Inpatient Psychiatric Unit, and the Ambulatory Care Clinics) will provide employees with information and training on hazardous chemicals in their work area at the time of their initial assignment, and/or at the time of all subsequent assignments to other work areas, and whenever a new hazardous chemical is introduced into their work area.

Authority and Responsibilities

A. The Hazardous Materials Coordinator is appointed by the Hospital Safety Officer and approved by Administration.

B. The Hazardous Materials Coordinator is the chair of the Hazardous Materials and Waste Committee. The Committee will meet at least quarterly to review elements of the Hazardous Materials and Waste Management Plan.

C. Membership of the Hazardous Materials and Waste Committee will include representatives from the following:

- Hazardous Materials Coordinator
- Hospital Safety Officer
- Laboratory
- Pharmacy
- Infection Control
- Environmental Services
- Surgery

- Oncology
- Radiology/Nuclear Medicine
- Facilities
- Ambulatory Care
- Disaster Coordinator

D. The Hazardous Materials Coordinator serves on and reports to the Environment of Care (EOC) Committee. The Hazardous Materials Coordinator is responsible for the maintenance of the Hazardous Materials and Hazardous Waste Management Plan.

PROCEDURE:

A. Record keeping

The involved departments are responsible for maintaining all pertinent records including, but not limited to, hazardous chemical lists and Safety Data Sheet (SDS). Documentation of the addition of new products to the hazardous chemical lists and the deletion of products from the hazardous chemical lists is subject to verification by the Hazardous Materials Coordinator.

B. Method of monitoring

In order to ensure compliance by each department, an audit will be conducted annually, along with periodic inspections to be held throughout the year. The audit will ensure that the hazardous chemical lists and labeling are up to date and accurate. The Hazardous Materials Coordinator and/or a Hospital Safety Officer will perform the audits. The adequacy of training will be assessed by interviewing randomly selected employees during safety inspections.

HAZARDOUS CHEMICALS

Policies that address the safe handling and disposal of chemical substances are designed to ensure that employees are informed of the hazards of the materials with which they are working. In addition, there are provisions for personal protective equipment for eye, skin and respiratory protection.

A. Department Hazardous Materials Inventory

Departments who store or use hazardous materials considered potentially hazardous to employees maintain an inventory of Hazardous Materials in compliance with the California Code of Regulations, Title 8, Section 5194, "Hazard Communication".

The inventory is updated annually and as new materials are introduced into the department others are discontinued. In most cases the chemical name of the hazardous substance is used, however the product or trade name may be used provided the name corresponds with the SDS.

1. The Hazardous Materials Coordinator will work with department managers to create an initial hazardous materials inventory list.
2. At the beginning of each year, the Hazardous Materials Coordinator will meet with

each department manager to review the hazardous materials inventory list and make any changes as needed.

3. Department managers will inform the Hazardous Materials Coordinator of any changes to their hazardous materials inventory list throughout the year.
4. Employees are oriented to their department's inventory and how to access relevant chemical use safety information. See policy *106.013 Hazardous Substance Communication - Right to Know*.

B. Business Plan

The Hazardous Materials Coordinator and/or Hospital's Safety Officer maintains an inventory of the locations of bulk storage of hazardous chemicals and gases in compliance with the Chemical Inventory and Business Plan requirements in the California Health and Safety Code, California code of Regulations, Titles 19 and 24, and the Ventura County Certified Unified Program Agency (CUPA).

This inventory is available to assist emergency responders with their planning and response efforts associated with hazardous materials emergencies within hospital facilities.

This inventory is reviewed and updated at least annually.

C. Handling and Use

Chemical handling and use policies must be specific to the hazards associated with particular substance. This ensures that employees are provided the most accurate and current information regarding ways to minimize the hazards and risks associated with the specific materials. Chemicals are used in accordance with manufacturer instructions.

Handling guidelines and polices include information regarding:

- Hazard class (e.g. flammable, toxic, corrosive, reactive, explosive, other)
- Information obtained from container labels, SDS and other resources
- Engineering controls and personal protective equipment
- Substance-specific hazard minimization strategies
- Potentially incompatible adjacent activities
- Chemical state (solid, liquid, gas)
- Disposal requirements

D. Storage

Chemical storage parameter include temperature control, ventilation, segregation, isolation, ignition control, and regulatory considerations. Departments are responsible for ensuring that chemicals they use or are otherwise under their administrative control, are stored safely. Safety data sheets provide chemical-specific storage requirements.

Observing the following general guidelines can minimize risks.

- Chemicals and cleaning products should be segregated according to hazard class and away from clinical supplies.
- Chemical containers should be properly labeled with contents, hazard and date opened.
- Isolate flammable liquids from heat sources.
- Store bulk solvents and flammable liquids in safety cans and/or cabinets.
- Do not store chemicals in areas accessible to visitors and children.
- Store incompatible chemicals in separate compartments.
- Store chemicals in well-ventilated areas.
- Store large containers on lower shelves. Do not place at or above eye level.
- Store chemicals in secondary containers.

E. Transportation

Chemical must be transported safely to minimize the potential for spills, releases or accidental exposures. The following general guidelines should be followed:

- Chemicals should be transported in sealed and labeled, primary containers.
- Primary containers should be transported in secondary containers.
- Only manageable quantities of chemicals should be hand carried. Heavier quantities should be placed on a cart.
- Only persons knowledgeable about the chemicals' hazards should transport the chemical.
- Any person who transports hazardous waste in a vehicle must have a valid registration issued by DTSC in their possession while transporting the hazardous waste.

F. Waste and Disposal

Federal, state and local regulations specific to the labeling, packaging and disposal of hazardous materials govern hazardous waste. All chemical waste policies and procedures comply with these regulation and accepted safe handling protocol.

G. Hazardous Chemical Identification

"Hazardous chemical" means any substance that is flammable, corrosive, toxic, and reactive or is a physical hazard.

H. Hazard Assessment

Individual departments are responsible for those chemicals identified and know to be present in their areas. Accordingly, departments assess which employees may potentially come into contact with these substances, by inhalation, ingestion, or direct skin contact. The Hazardous Materials Coordinator and/or Hospital's Safety Officer is available to assist department managers with this evaluation.

An effort is made to substitute a hazardous material with a less hazardous chemical whenever possible.

Chemical Spills

A. Any response to hazardous materials spills shall be in accordance with policy 106.077 Code Orange - Hazardous Material Spills.

B. Department Managers are responsible for ensuring that their employees are trained and competent regarding the safe use of the hazardous materials they may encounter during the course of their work. This includes precautions for selection, handling, storage, use, and disposal. They are also instructed about emergency procedures for hazardous materials releases and exposures including the health hazards of mishandling hazardous materials and emergency reporting procedures. See also policy *106.013 Hazardous Substance Communication - Right to Know*.

C. All new employees attend New Employee Orientation, which includes information regarding hazardous materials and hazardous waste safety issues, along with an overview of available resources. In addition, employees' role in maintaining a safe patient care environment is explained.

D. The employees completes a computer-based training annually on subjects that includes Hazard Communication.

E. Every employee is given department-specific safety training annually which may include a hazardous materials component, if appropriate. In addition, specific job or area specific training may be given more frequently to address potential safety hazards associated with the introduction of hazardous materials.

HAZARDOUS WASTE

VCMS will promote the correct handling, storage, and disposal of all hazardous waste, in accordance with its concern for and respect for the safety and welfare of patients, visitors, associates, the community, and the environment. The responsibility for establishing guidelines in connection with the storage, handling, transfer, and disposal of hazardous waste lies with the Hazardous Materials Coordinator in conjunction with the Hospital Safety Officer and the Environment of Care Committee. The County resource for Hazardous Waste is the Risk Management Department.

A. Definition of "Hazardous Waste"

"Hazardous waste" is defined by the Environmental Protection Agency under the Resource Conservation and Recovery Act (RCRA), Title II, Subtitle C, "Hazardous Waste Management." To be a hazardous waste, a material must be either a "listed waste" or a "characteristic waste." A listed waste is a waste that appears on one of the four EPA' waste lists. The lists, referred to as the F, K, P, and U, represent the following categories:

- F List - Generic industrial process waste includes solvents and solvent mixtures such as xylene and methanol
- K List - Process waste from specific industries

- P List - Acute hazardous waste includes pesticides, organic chemicals, cyanides, and certain heavy metal compounds
- U List - Toxic waste includes mostly natural and synthetic organics, such as formaldehyde and chemotherapy waste

A characteristic hazardous waste is a waste that meets one or more of the following criteria:

- Ignitability - A liquid with a flash point below 140°F (when tested in a closed-cup method)
- Corrosivity - Aqueous, pH < 2 or pH > 12.5
- Reactivity - Unstable, reacts violently, water-reactive, detonates, or explodes
- Toxicity - Toxicity Characteristic Leachate Procedure (TCLP) simulates effects of waste mismanagement upon the groundwater in a municipal landfill. Regulatory thresholds are derived by using an attenuation factor to decide if the test is passed for a certain material.

B. Hazardous Waste Produced at VCMS and Disposal Criteria

VCMS is considered a "Large Quantity Generator" under EPA RCRA. These regulations are found at 40 CFR Part 262.

VCMS produces hazardous waste that falls under the "F List", the "U" list, and "Characteristic Waste" classifications. An unused portion of a material that is to be designated "Hazardous Waste, if more than a trace amount, will be shipped to an approved Hazardous Waste facility. An empty container, or one with a trace or residual amount of Hazardous Material, will be disposed of with regular trash.

The following materials are examples of materials present at VCMS that are considered Hazardous Waste under the federal Resource Conservation and Recovery Act (RCRA) and must be disposed of as Hazardous Waste:

a. Antineoplastics/cytotoxins/chemotherapeutic drugs – bulk (busulfan, cytarabine, tamoxifen, doxorubicin, fluorouracil)
b. Alcohols – isopropyl alcohol, reagent alcohol

VCMS also produces waste that is deemed hazardous because it meets characteristic hazardous waste criteria. An example of a characteristic hazardous waste is mercury (toxicity).

For characteristic wastes, there is an exclusion referred to as the "Domestic Sewer Exclusion," which makes it legal to dispose of small amounts of materials such as alcohol and other water soluble compounds in the domestic sewer or "pour them down the drain," provided they are diluted with copious amounts of tap water and the city waste water standards are not violated. This works on the principle of dilution in that small amounts of these chemicals can be diluted in the wastewater from the facility and therefore pose no environmental threat or harm. Mercury and compounds that are characteristic because of toxicity are disposed of only off-site by appropriate EPA methods. VCMS does dispose of large quantities of chemicals by

shipping them to an approved hazardous waste facility by an approved waste hauler.

C. Hazardous Waste Storage

1. Transfer to the storage area

   Prior to disposal, these wastes are collected at a Hazardous Waste Storage Area. Each storage area is secured 24-hours a day. The Laboratory collects Hazardous Waste including, but not limited to, xylene, formaldehyde, and alcohols. The designated Laboratory employee coordinates removal.

2. Labeling and accumulation time

   Hospital - Drums storing hazardous waste in a storage area are required to have a "Hazardous Waste" label, stating the content of the drum and the date that waste was first deposited in the drum. This date is then referred to as the accumulation date. Hazardous Waste may not be stored in the central accumulation site more than 90 days past the accumulation date. *Reference: Title 22 CCR Section 66262.34(a).*

   Other Locations - Other locations should not accumulate Hazardous Waste and should contact the Hazardous Materials Coordinator to arrange for proper disposal. In addition, all other locations are required to properly label the waste with the identity of the contents and an appropriate hazard warning.

3. Off-site transport and tracking

   At the time of transfer for disposal, Hazardous Waste are manifested per state and federal requirements for tracking purposes. All manifest records, certificates of insurance and permits from the transporter and landfill permits are maintained on site with the waste generating department.

4. Inspection and review

   The hazardous waste storage area is inspected by the Hazardous Materials Coordinator, and all hazardous waste programs and records are reviewed at least annually.

D. Other wastes

1. Infectious waste

   Waste such as bloodborne pathogen contaminated sharps and other materials are classified as "Infectious Waste" and are governed by other federal and state regulations. (See Infectious Waste section in this policy for more information.)

2. Special waste

   Some wastes fall under the classification entitled "Special Waste." These wastes do require special handling and disposal procedures. Examples of Special Wastes are asbestos or asbestos-contaminated materials, antifreeze, and oil. A company would be contracted for asbestos abatement. Other Special Waste removal would be

coordinated by the Facilities Department.

E. Additional information regarding proper disposal of any type of waste may be obtained by calling the Hazardous Materials Coordinator.

PHARMACEUTICAL WASTE

For this section, "trace amounts" shall be defined as a volume <1 mL.

A. Pharmaceutical Waste in Ambulatory Care Clinics

1. Expired sample drugs are disposed of in sealed bins and sent to the VCMC Pharmacy.
    a. Sample medications not removed by the pharmaceutical manufacturer shall be returned to VCMC Pharmacy for proper disposal.
2. Vials to be discarded containing more than a trace amount of medication shall be placed in the Pharmaceutical Waste Containers (white bins with the blue covers) or Co-mingled Waste Disposal Bin. Do not remove the drug from the vials.
3. *For clinics with Pharmaceutical Waste Containers:* Medications in syringes can be squirted in a Pharmaceutical Waste Container. The syringe shall then be disposed of in a Sharps Container.
   For clinics with Co-Mingled Waste Disposal Bins: Syringes partially-filled with medications can be discarded directly into the Co-mingled Waste Disposal Bin.
4. Controlled substances must be disposed of in the presence of a witness. The wastage shall be disposed of in the proper controlled substance waste container.
5. Aerosol canisters and medications filled under pressure (e.g., inhalers) shall be discarded in a "characteristic" waste bin (formerly D-listed RCRA container).
6. Sharps, broken glass and ampules must be discarded in the sharps container or Co-Mingled Waste Disposal Bin.
7. Trace amounts of hazardous drugs such as chemotherapy medications must be disposed as hazardous waste in a Hazardous Waste Container. Bulk amounts of hazardous drugs must be disposed as hazardous waste in the appropriate RCRA container. Do not place bulk amounts of hazardous drugs in a Pharmaceutical Waste Container.
8. Do not overfill the Pharmaceutical Waste Containers or place force on the container to close the lid. Once closed, the container shall not be reopened.

B. Pharmaceutical Waste in the Hospital

1. Any vial or bag containing any pourable amount of medication, any syringe containing medication, or any used needles, empty syringes and empty ampules shall be disposed of in a Co-Mingled Waste Disposal Bin.
2. Non-hazardous empty vials and IV bags or vials and bags containing non-pourable amounts of pharmaceuticals can be placed in regular trash bins.
3. Remove any identifying information on the medication containers to protect patient privacy.

4. Expired aerosol canisters shall be returned to the pharmacy and disposed of in a "characteristic" waste bin (formerly D-listed RCRA container).
5. Chemotherapy gloves, syringes with needles or luer-locks uncapped, IV administration sets, IV bags, absorbent pads and any other equipment will be disposed of in a Hazardous Waste Container.

C. Pharmacy Department

1. The Department shall use a Pharmaceutical Reverse Distributer for the removal of expired medications for disposal and credit.
2. Any expired medications, partially used medications, opened medications or opened vials found in the patient drawer can be disposed of in a Co-Mingled Waste Disposal Bin.
3. For the disposal of chemotherapy waste, a Hazardous Waste Container shall be available in the Biological Safety Cabinet to discard excess drug solution. Fluid left in ampules shall remain in the ampule and be placed in a zip-lock bag containing absorbent gauze pads before disposal in an appropriate waste container. Chemotherapy vials with trace amount of drug shall be disposed in a Hazardous Waste Containers.
4. All disposable items that have been used during hazardous drug preparation must be discarded as Hazardous Waste. Removal of waste from the hazardous waste area should be arranged with Environmental Services as needed.
5. Chemotherapy vials and IV bags with more than trace amounts remaining in the container must be disposed of in the appropriate RCRA waste container.

INFECTIOUS WASTE

All infectious materials and waste generated within Ventura County Medical System must be handled in such a manner so as to ensure the safety of patients, employees, visitors, and the community environment. Handling practices must be in compliance with the applicable state laws.

The responsibility for establishing guidelines in connection with the generation, handling, containment, storage, treatment, transportation, and disposal of infectious materials and waste rests with the Hazardous Materials & Waste Committee and the Infection Control Committee.

Guidelines:

A. Infectious Waste

As used in this policy and in accordance with applicable law, infectious waste is waste that is capable of transmitting a dangerous communicable disease.

Handling of all such materials shall be in accordance with policy *106.030 Bloodborne Pathogen Exposure Control Plan*.

In accordance with regulations, the following wastes are designated as infectious:

1. Contaminated sharps or contaminated objects. This includes scissors, lancets, and all needles and syringes. (Note: Contaminated means having the presence or the reasonably suspected presence of blood or other potentially infectious materials on an item or surface).
2. Infectious biological cultures, infectious employed biologicals, and infectious agent stock.
3. Pathology Waste, such as tissues, organs, body parts, and blood or body fluids in liquid or semi-liquid form that are removed during surgery, biopsy, or autopsy.
4. Blood, blood products, and body fluids in liquid and semi-liquid form. Such wastes must be of sufficient quantity as to be capable of flowing. Dressings contaminated with such liquids should be handled as infectious waste if they are excessively moist and dripping with blood or body fluids.
5. Other waste that has been intermingled with any of the above-defined infectious wastes.

B. Packaging

1. Any waste designated as infectious must be clearly identified as such by either placing it in a biohazard bag or must have a biohazard label affixed to it (i.e. needle disposal system). Items should be tied shut as needed and containers should have secure lids. If the outside of a bag or container becomes contaminated, then it should be placed in a second bag or container.
2. Waste designated as infectious must be handled with caution to minimize potential exposure. Personal protective equipment, as described in hospital policy and procedure, must be utilized in order to ensure safe handling practices. Infectious waste that is to be bagged should be placed in a biohazard bag. Hospital-approved methods of disposal are as follows:
    a. Needles, sharps, and contaminated objects that could become sharps (example: glass tubes, pipettes) must be placed within biohazard-labeled, rigid, impervious, puncture-proof, lidded containers. Closed boxes must be taken to the designated collection point for the area—e.g., soiled utility. Such containers should be leak-proof or placed within a biohazard bag, as needed.
    b. Biological cultures and agent stock shall be placed within a biohazard bag with the international biohazard symbol. These cultures shall then be collected in the laboratory area designated for infectious waste.
    c. Pathology waste:

        A small quantity of tissue removed in clinical areas but not sent for laboratory analysis shall be placed in a red bag and transported to the designated collection site for the area. This waste would include tissue from circumcisions.

        Any quantity of tissue to be examined shall be placed in an appropriate container and transported to the laboratory/morgue per established

departmental guidelines. Upon completion of laboratory examination and analysis, such material will be placed in a Pathology Waste container and then transported by Environmental Services personnel to the Pathology Waste storage area. When tissues are released by Pathology, Environmental Services will take the waste to the Biohazardous Waste storage area for release to the contracted hauler.

d. Discarded blood and blood products shall be placed in a biohazard bag. Such items shall be taken to the designated collection site for the area.

e. Body fluids/waste may be disposed of via the sanitary sewer. Hoppers in dirty utility rooms or toilets from the generating patient are suitable disposal sites. Handwashing sinks shall be considered off-limits for disposal of body fluids.

f. Large collection systems for body fluids (e.g., wound-drainage systems, auto-transfusion systems, suction canisters) will be placed in a biohazard bag and securely tied to prevent spilling. The item should then be taken to the designated collection site for the area.

C. Handling

1. Handling of infectious waste requires the wearing of protective gloves until the infectious material is properly contained. Handwashing should be done once the disposal process is complete.
2. Additional personal protective equipment, such as the wearing of gowns, mask, or goggles may be necessary according to policy *106.018 Infection Control Standard Precautions*.

D. Collection/Storage

Infectious waste collected within the individual departments must comply with the applicable restrictions and be properly contained. Areas must be separate from clean patient care or equipment areas. Collection areas have controlled access. Areas already designated as such within the Hospital includes soiled utility rooms, designated trash bins, and collection/storage returns. Environmental Services will pick up infectious waste from collection areas at least once per shift. If an additional pickup is necessary, Environmental Services should be notified. Areas where infectious waste is stored must have signage stating "Biohazard", exhibit the universal biohazard symbol, and be restricted to authorized personnel only.

E. Disposal

1. Employees must separate infectious from noninfectious waste at the point of use and place each in an appropriate container. An EVS employee is to pick up waste on a regular schedule and deliver it to the main collection area.
2. All infectious waste is to be sealed and clearly designated as biohazard. The items to be disposed of will be placed in an appropriate container designated by a qualified hazardous waste hauler. The hauler will pick up the infectious waste according to a schedule provided by the hauler. The appropriate forms must be completed. A copy of the manifest will be kept at each generation site.
3. The disposal of infectious waste in any other manner than the manner described

above must be included in the department policy after being approved by the Infection Control Committee and the Hazardous Materials & Waste Committee.

F. Spills

1. Infectious waste spills are to be cleaned up immediately. Gloves will be worn throughout the procedure. Additional Personal Protective Equipment (cover suit, safety glasses or goggles, mask) will be used when appropriate. Paper towels should be used to wipe up the initial spill, followed by cleanup and disinfectant with an appropriate agent.
2. For large infectious waste spills, EVS shall be contacted for containment and clean up.

COMPRESSED GASES

Compressed gases are managed, used, transported and stored in compliance with California Occupational Safety Health Administration (Cal/OSHA), National Fire Protection Association (NFPA) and other applicable regulations and standards to ensure the safety of staff, patients and visitors.

A. Management
Compressed gases are managed by Facilities Department.

B. Facilities Department
Facilities Department is responsible for the management of compressed gases for use with ventilators and other equipment utilized by respiratory therapists and other clinical staff. This includes inventory management, storage, utilization, and return of empty cylinders. Facilities Department is responsible for the management of cylinders connected to distribution system that serves the main operating rooms, including oxygen, nitrous oxide and nitrogen. In addition, Facilities oversees the bulk storage oxygen tank and piped gas system that provides gas to the bedside.

C. Inventory
The Hazardous Materials Coordinator and/or Hospital Safety Officer maintains a listing of hazardous chemicals and gases bulk storage locations in compliance with the Chemical Inventory and Business Plan requirements in the California Health and Safety Code, California Code of Regulations, Titles 19, 24 and the Ventura County Unified Program Agency (CUPA).

This inventory is available to assist emergency responders with planning and response efforts associated with emergency events involving hazardous materials within hospital facilities.

The inventory is reviewed and updated periodically, including during construction and department moves.

D. Storage and Transport
Cylinders are securely stored and safely transported in compliance with applicable regulations and good safety practice according to policy *F.44 Compressed Gas Cylinders*.

E. Disposal
Empty or partially used compressed gas cylinders are collected, stored and transported in the same manner as full cylinders. Cylinders are returned to the vendor for reuse.

ELECTRONIC WASTE

Electronic waste such as computer hard drives and monitors, etc. are disposed of as hazardous waste if the equipment or its components cannot be reused or recycled. Prior to disposal, all memory is erased from the computer. E-waste is staged in blue bin near the upper parking lot of VCMC. The vendor picks up e-waste from the bin provided as scheduled by the EVS Department.

Batteries are collected as a separate waste stream and sent to a contract facility for recycling.

ENVIRONMENTAL MONITORS AND SURVEYS

VCMC will maintain alarmed monitors on all hazardous materials that require continuous monitoring. Radiology and Nuclear Medicine staff will wear the required badge monitors in accordance with *IS.56 Radiation Protection*. VCMC will complete chemical hygiene and exposure assessment testing as required by regulatory guidelines and standards.

Procedure

1. Annual assessment of environmental safety compliance and exposure will be performed by a contracted company for each chemical that requires such surveys, according to Cal/OSHA (Title 8, Calif. Code of Regulations, Section 5194) and other applicable regulatory standards. The results reports will be reviewed upon receipt and retained on file.
2. All employees that perform Radiology and Nuclear Medicine procedures will wear the appropriate sensor badge during all working hours. Exposure level tests on the badges will be performed by the contracted company and the results reports will be reviewed on receipt, reported to the Safety Committee, and retained on file.

PERFORMANCE STANDARDS AND IMPROVEMENT

The following performance measures have been established as follows and will be reported to Environment of Care Committee (EOC) at least annually:

1. Reported chemical spills, incidents, leaks, and exposure.
2. Measure the amount of Biohazard Waste produced for VCMC/SPH.

ANNUAL REVIEW

The annual evaluation will include a review of the Hazardous Materials and Waste Management Plan by the EOC Committee and hospital administration, including the plan's scope, objectives, performance, effectiveness and goals.

All Revision Dates

5/9/2023, 10/24/2022, 3/1/2017, 8/1/2016, 4/1/2013, 3/1/2012, 4/1/2011, 6/1/2010, 9/1/2009

Attachments

Annual Evaluation of Hazardous Materials and Waste Management Plan

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Environment of Care Committee	Ian McGraw: Manager Facility Operation	5/9/2023
Policy Owner	Sandro Cruz: Hospital Hazardous Materials Coordinator	4/28/2023

Status **Active** PolicyStat ID **13087523**

Origination	3/1/2010	Owner	Ian McGraw: Manager Facility Operation
Last Approved	5/9/2023	Policy Area	Administrative - Environment of Care
Effective	5/9/2023		
Last Revised	5/9/2023		
Next Review	5/8/2024		

106.044 Security Management Plan

POLICY:

The Security Management Plan describes the methods of providing security for patients, visitors, staff and equipment for Ventura County Medical System (VCMS). Security protects individuals and property against harm or loss, including workplace violence, theft, infant abduction, and unauthorized entry. All security incidents are documented, tracked and trended for analysis.

The program applies to the Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU) and Ambulatory Care Clinics.

PROCEDURE:

FUNDAMENTALS

A. A visible security presence in the hospitals helps reduce crime and increase feelings of security by patients, visitors, and staff.

B. The incident tracking and trending is essential for the reduction in crime, injury and prevention as well as theft.

C. Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.

D. Training hospital staff is critical to ensuring their performance. Staff is trained to recognize and report either potential or actual incidents to ensure a timely response.

E. Staff are trained and provided post orders to guide them with their roles and responsibilities for their designated areas.

F. Violence in the workplace is a growing problem in health care. De-escalation training is essential for addressing workplace violence.

OBJECTIVES

The Objectives for the Security Program are developed from information gathered during annual statistical data tracking and trending and risk assessment, which provide measures for improvement of the program.

The objectives for this plan are to:

- Provide the safest environment for all patients, staff, and visitors
- Provide and document adequate Security rounds on all shifts
- Respond to emergencies and requests for assistance in a timely fashion.
- Continue Security Guard training and competency evaluation
- Continue to provide a visual presence to deter crime.

ORGANIZATION & RESPONSIBILITY

A. The Safety Committee receives regular reports of the activities of the Security Program. The Safety Committee reviews reports and, as appropriate, communicates concerns about identified issues with regards to safety.

B. The Director of Security, in collaboration with the Safety Officer, is responsible for monitoring all aspects of the Security Program. The Director of Security advises and reports to the Safety Committee on security related issues which may necessitate changes to policies and procedures, orientation or education of staff.

C. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific security procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Director of Security provides department heads with assistance in developing department security programs or policies.

D. Individual staff members are responsible for learning and following job and task-specific procedures for secure operations.

SECURITY DEPARTMENT ORGANIZATION

Authority:

- The Chief Executive Officer (Hospital Administrator) has delegated Allied Universal Guard to provide contractual security services for the Ventura County Medical System.
- The Safety Officer and Director of Security have immediate and complete access to all areas of the Hospitals and to all physical facility records that become necessary in carrying out security management responsibilities.

Security Services:

- Unarmed Security Guard Services are required for Ventura County Medical System. The focus in this area is to ensure that Ventura County Medical System employees and the general public are provided a safe environment to conduct official business. Security services include patient

watches, roving patrol, escort services, code response, temporary posts and many other security fire watch and other related requirements.

- Allied Universal coordinates the collection, processing, and reporting of security activity throughout the facility to support a reliable, efficient flow of information. The security staff oversees the daily operation of the VCMS security program and assists staff, patients and visitors with support and problem solving. Confidentiality will be maintained in accordance with VCMS policy.
- Respond to requests at VCMS for support and intervention. This intervention includes de-escalation of verbal irrate patients/vendors/staff, and intervention of physical altercations.

Elite Officers:

- Elite Officers must be physically capable and willing to assist VCMS staff in restraining violent persons at VCMS until authorities arrive. In the event of a physical altercation, guards may be required to physically intervene for the protection and safety of VCMS staff, clients and themselves. This response should be considered ONLY if verbal intervention fails, but it **must** be stipulated in the post instructions for all assigned guards. Assigned guards are special guards for special areas (Emergency Department/Inpatient Psychiatric Unit) and possess specific training.

PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Security program. Performance measures have been established to measure at least one important aspect of the Security program.

The performance measures for the Security program which are also reported to leadership include:

- 100% in performance of quarterly Code Pink Drills with appropriate written critique
- 100% in performance of quarterly Code Purple Drills with appropriate written critique
- 100% proper documentation of monthly security statistical data
- 100% camera surveillance

PROCESSES FOR MANAGING SECURITY RISKS

Management Plan

Ventura County Medical System develops, maintains and annually evaluates Security Management Plan for its effectiveness in managing the security risk of the staff, visitors, and patients at VCMS.

Security Risk Assessment

The Safety Officer and Director of Security manage the security risk assessment process for VCMS. In coordination with the Director of Security, the Safety Officer is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The Safety Officer, Director of Security and the Risk Management department ensure compliance with applicable codes and regulations.

VCMS identifies security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of annual proactive risk assessment of high-risk processes, and from daily observation and surveillance by Allied Universal, Department Managers, patients and incident reports.

The risk assessment is used to evaluate the impact of the environment of care on the ability of VCMS to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, the performance of everyday tasks, workplace violence, theft, infant abduction, and unauthorized access to the facility.

Use of Risk Assessment Results

A Risk Assessment is used to evaluate the impact of the environment of care on the ability of VCMS to perform clinical and business activities. A risk assessment will be performed by type of risk/threat to the organization. Where risks are identified, the current programs and processes to manage those risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled, action must be taken to eliminate or minimize the risk. The actions may include creating new programs, processes, procedures and training programs. Monitoring programs may be developed to assure the risks have been controlled to achieve the lowest potential for adverse impact on the security of patients, staff, and visitors.

Identification Program

All staff are required to display an identification badge on their upper body while on duty. Identification badges are to be displayed on the individual with the picture showing. Identification badges are retrieved by Department Managers upon termination of employment.

Visitors are required to wear the appropriate wristbands in order to visit a specific patient in the hospital. Wristbands are blue with the exception of Labor and Delivery, Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU), Pediatrics, Post-Partum and Obstetrics, in which case they are pink.

If a patient wristband is damaged, nursing staff shall replace it. Patient identification is not removed upon discharge. Patients are instructed to remove their identification band at home.

The Front Desk and Facilities Departments provides vendor and contractor identification. All vendors are required to have appropriate identification and a green wristband while in the hospital. See also policy *F.2 Vendor Access and Registration*.

Sensitive Areas

The Director of Security works with hospital leadership to identify security sensitive areas by utilizing risk assessments and analysis of incident reports.

The following areas are currently designated as sensitive areas:

Ventura County Medical Center

a. *Intensive Care Unit*

b. *Emergency Department*
c. *Obstetrics*
d. *Newborn Nursery*
e. *NICU*
f. *Pharmacy*
g. *Health Information Management*
h. *Pediatrics*
i. *IPU*
j. *Crisis Stabilization Unit (CSU)*
k. *Operating Room*
l. *PICU*

Santa Paula Hospital

a. *Intensive Care Unit*
b. *Emergency Department*
c. *Obstetrics*
d. *Newborn Nursery*
e. *Pharmacy*
f. *Health Information Management*
g. *Operating Room*

Security staff are reminded during their annual in-service about those areas of the facility that have been designated as sensitive. Security staff assigned to work in sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area.

Security Incident Procedures

The Director of Security, in coordination with VCMS leadership, develops post orders for area security covers. These post orders describes the written instructions for the security team. The Director of Security assists department heads in development of departmental security procedures, as requested. These policies and procedures include infant and pediatric abduction, workplace violence, and other events that are caused by individuals from either inside or outside the organization.

Individual department heads assist in the development of department-specific security policies and procedures for risks unique to their area of responsibility. The Director of Security also assists department heads in the development of new department security procedures. Organization-wide departmental security policies and procedures are distributed to all departments. Department heads are responsible for distribution of department level policies and procedures to their staff and for ensuring enforcement of security policies and procedures needed.

Security Incident Response

Upon notification of a security incident, the Director of Security or designee will assess the situation and implement the appropriate response procedures. The Director of Security will notify Administration if necessary to obtain additional support. Security incidents that occur in the Emergency Department will be managed initially by the Security Officer on Duty, or Law Enforcement officer on duty, by following the appropriate policies and procedures for that area. The Director of Security will be notified about the incident as soon as possible.

Security incidents that occur in the departments will be managed according to the departmental or facility-wide policy. The Director of Security will be notified about any incident that occurs in a department as soon as possible. Additional support will be provided from the Security Department.

In the event there is a workplace violence incident, see policy *106.075 Workplace Violence Prevention Plan*.

In the event of an infant or child reported missing, see policy *106.002 Code Pink/Code Purple-Known/ Suspected Infant Abduction*.

In the event there is an active shooter situation, see policy *106.064 Code Black - Active Shooter*.

Following any security incident, a written "Incident Report" will be filed by the Security Officer managing the incident. The Report will be reviewed by the appropriate Security Supervisor or Security Director if necessary. Any deficiencies identified in the report will be corrected. A summary of these Reports will be furnished to the Safety Committee on a regular basis.

Evaluating the Management Plan

On an annual basis, the Safety Committee and Director of Security evaluate the scope, objectives, performance, and effectiveness of the Security Plan for the safety of the staff, visitors and patients at Ventura County Medical System.

EDUCATION

Security Management in-service training is provided at the initial orientation level and subsequent annual retraining of all Security personnel. This is part of a structured staff development program that includes general security practices supplemented by sensitive areas. Sensitive areas are identified based on criteria to include the impact on the building, grounds, and organizational experience.

Security personnel receive the following training annually and/or when required by job description:

- Health Insurance Portability and Accountability Act (HIPAA)
- Emergency Medical Treatment & Labor Act (EMTALA)
- Blood Borne Pathogens (BBP)
- Crisis Prevention Intervention
- Workplace Violence
- Sexual Harassment

- Infant and Child Abduction Prevention
- First Aid/Cadiopulmonary Rescuscitation (CPR)/Automated External Defibrillator (AED)
- Fire and Safety Procedures
- FEMA 100/200
- Interactions with patients, visitors and staff
- Safe Driving Procedures
- Management of aggressive behavior
- Metal detector training

ENVIRONMENT OF CARE

SECURITY RISK ASSESSMENT INSTRUCTIONS:

Evaluate every potential event in each of the three categories of probability, risk, and preparedness. Add additional events as necessary. Events are defined as potential hazards or risk categories that may be consequential to effective operations of a facility and ability to render safe, secure, efficient and effective services to patients, staff and visitors.

Issues to consider for probability (the probability of occurrence at the facility) include, but are not limited to:

1. Known risks at VCMS facilities
2. Historical data of occurrence
3. Reported and observed recent data
4. Known sensitive areas

Issues to consider for risk level potential (in response to threat to life, health and safety, high disruption, moderate disruption, low disruption) include, but are not limited to:

1. Threat to life and/or health
2. Disruption of services
3. Damage/failure possibilities
4. Loss of community trust
5. Inability to render services in a community emergency
6. Financial impact
7. Legal issues

Issues to consider for preparedness include, but are not limited to:

1. Status of current plans, policies and procedures to identify and reduce risks
2. New employee orientation on identifying and reporting potential risks
3. Continuing education for identification and reporting of risks

4. Financial commitment of leadership to reduce risks
5. Effectiveness of hazard surveillance rounds
6. 24 hour camera surveillance.

All Revision Dates

5/9/2023, 12/12/2022, 2/13/2019, 4/1/2013, 3/1/2012, 4/1/2011, 6/1/2010

Attachments

Annual Evaluation of Security Management Plan

Security Risk Assessment

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/9/2023
Safety Committee	Fernando Medina: Director, Support Services	5/9/2023
Policy Owner	Ian McGraw: Manager Facility Operation	3/20/2023

Status **Active** PolicyStat ID **13645641**

Origination	12/1/2012
Last Approved	5/11/2023
Effective	5/11/2023
Last Revised	5/11/2023
Next Review	5/10/2026
Owner	Fernando Medina: Director, Support Services
Policy Area	Administrative - Environment of Care

106.066 Hospital Evacuation Plan

POLICY:

The objective of this plan is to provide guidance in the event that a horizontal, vertical, or total hospital emergency patient evacuation is required. It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and Ambulatory Care (AC) clinics to provide an emergency response plan to evacuate patients, visitors and staff in the event that an evacuation is required.

PROCEDURE:

A. **It will be the responsibility of the Chief Executive Officer (CEO) and/or their designee, to make the following decisions:**

1. **Decision to evacuate the building:**
    a. The Hospital Incident Command System (HICS) will be initiated.
    b. Departments will confer with the CEO or their designee, regarding the need to evacuate their area, and will not take independent action.
    c. Notify all staff to evacuate patients and visitors. A "Code Zero" will be announced in the overhead paging system.
    d. The Family Assistance Center will be established to disseminate information regarding the status and location of evacuated patients.
    e. A press release area will be determined by the CEO or their designee.
    f. Discharge patients immediately, as appropriate.
2. Coordination of and selection of evacuation site(s):
    a. The Emergency Department (ED) charge nurse will initiate "Internal Disaster" via Reddi-net.

b. Staging, for patients needing evacuation by ambulances, will be beds 1-4 in the ED.

c. The ED charge nurse will communicate with Emergency Medical Services (EMS) and the different departments, in order to coordinate the evacuation of patients via ambulances.

3. Each department will initiate call-back procedures.
4. Notification of outside agencies for assistance as needed:
    a. American Red Cross: 1-800-764-6760
    b. California Department of Public Health (CDPH): 1-805-652-5754
    c. Emergency Medical Services (EMS) Officer on Duty: 1-805-388-4279

B. **Evacuation Sites:**

1. Alternative care site(s) for inpatients will be designated by the CEO or their designee, in conjunction with EMS.
2. Evacuation locations for staff are pre-determined by each department or CEO or their designee, as needed (see Attachments A and B).
3. Evacuation locations for visitors will be designated by Hospital Administration or Incident Command.

C. **Patient Evacuation Priority and Procedures:**

1. Ambulatory Patients
    a. Ambulatory patients should be directed to the designated exit on the posted evacuation sign and escorted from the building by assigned staff.
    b. The CEO or their designee will post staff at exits, to maintain order and direct exiting patients, visitors and staff to the designated evacuation site.
2. Infants
    a. Mothers will carry their infants from the building.
3. Non-ambulatory patients
    a. All bed-bound patients within the acute care facility will be triaged by designated staff using the Reverse START Triage System (see table below). Priority decisions made by the charge nurse will be based on mobility and prognosis. The charge nurse will designate staff to provide or facilitate:
        i. A blanket to each patient;
        ii. Loosen bedding and roll linen closely to the patient in readiness for transport;
        iii. Loosen traction on orthopedic patients;
        iv. Patients on respirators and other life-support systems will be triaged by the designated physician(s) and evacuated by the Respiratory staff and nursing staff based on prognosis, if safe to

do so.

4. Neonatal Intensive Care Unit (NICU)
    a. Patients in these departments will be triaged by the neonatologist(s), nurse practitioner(s) or the charge nurse and evacuation priority will be based on prognosis, if safe to do so.
5. Labor and Delivery Room
    a. Patients will be triaged by the physician or charge nurse.
    b. Wrap patients loosely in blankets and evacuate via the designated exit on the evacuation sign, if safe to do so.

D. **Surgery and Recovery Room:**
    1. If surgery is in process and the Operating Room must be evacuated:
        a. Patients will be triaged by the anesthesiologist.
        b. Wrap the patient loosely in blankets and remove them from the building using the designated exit on the evacuation sign, if safe to do so.
        c. Surgical teams will be under the control of the surgeon.
        d. The Surgical supervisor and/or designee will be responsible for the orderly evacuation of the suites, if safe to do so.

E. **ED/Clinics:**
    1. Ambulatory patients should be directed to the designated exit on the posted evacuation sign.
    2. Wrap non-ambulatory patients loosely in blankets, prior to evacuation.
    3. Staff in these areas will be responsible for patient evacuation, if safe to do so.

F. **Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU):**
    1. Staff will escort patients to IPU, Courtyard A.
    2. Patient roll call shall be conducted by staff members assigned to do rounds.
    3. The charge nurse shall verify all patients and staff have exited the building by verifying the names of the current assignment sheet. Information shall be reported to the Administrator on Duty (AOD).
    4. In the event of a major evacuation, an alternate evacuation site shall be determined by Incident Command (Rally Point Area 1, Lot B).

G. When a **Total Emergency Patient Evacuation** is ordered by the Fire Department or CEO, the CEO, AOD or their designee will be responsible to facilitate one (1) of two (2) evacuation protocols:
    1. **A Horizontal Evacuation**
        a. Move patients who are closest to the danger first.
        b. Children should be handled like adults, except during ambulatory evacuation. In this case, alternate the older and younger children in the

evacuation line.

c. Next, start moving ambulatory patients toward the nearest and safest protected area. Assign one employee to follow in the rear of each patient group. Do not leave ambulatory patients without guidance, as they may be in a state of fear or panic.

d. Move wheelchair patients to a safe area on the same floor. Return wheelchairs for additional patient use.

e. Move helpless patients via stretchers, litters or stair chairs. If stretchers, litters or stair chairs are not available, use the cradle drop method to place a patient on a blanket which has been set on the floor. Then, pull the patient out along the floor, to a safe location. If blankets are unavailable, use sheets (double-folded) or bedspreads to drag patients to safety.

2. **A Vertical Evacuation**

a. Lead ambulatory patients up or down the nearest and safest protected exit/stairway. Refuge should normally be found one floor below the disaster or fire. However, if time permits, evacuate patients two floors downward. In all situations, patients should be evacuated by means of fire exits and **NOT elevators**, unless use is authorized by Hospital Administration or the Fire Department.

b. Non-ambulatory and helpless patients should be moved down stairways by means of litters, stair chairs, sleds or carried by emergency staff. The recommended stairway or fire escape carry methods are the two-man swing carry or the three-man and four-man blanket carries.

REVERSE START TRIAGE

A systematic method for triaging inpatients is vital to a successful evacuation. A rational movement of patients from the inpatient unit to a staging area, prior to transfer to another location/healthcare facility, is necessary to move patients quickly and safely. It is essential, however, to realize that the triage priorities that most clinical staff are accustomed to in an emergency response (i.e. the traditional START system), must be approached differently in an evacuation. Inpatients that are ambulatory and relatively stable will have first priority for moving off the inpatient nursing units. These patients are less resource-intensive and many can be led off the unit with only one (1) or two (2) staff members. Patients who are non-ambulatory, acutely ill, unstable or require life-saving equipment will require the most resources for moving.

As stated, for the purpose of evacuation triaging, the categories of START are reversed for the evacuation; however, they will revert back to the original priority once the patient reaches the staging area, prior to transfer, because the most unstable patients will be moved to a healthcare facility first. See the chart below for patient evacuation prioritization.

Triage Level	Priority for EVACUATION of patients off of nursing unit: Reversed Start Triage Priority	Priority for TRANSFER to another healthcare facility: Traditional Start Triage Priority
RED – STOP	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient unit. These patients may require 2-3 staff members for transport.	These patients require maximum support to sustain life in an evacuation. These patients move **FIRST** as transfers from your facility to another healthcare facility.
YELLOW - CAUTION	These patients require some assistance and should be moved **SECOND** in priority from the inpatient unit. Patients may require wheelchairs or stretchers and 1-2 staff members to transport.	These patients will be moved **SECOND** in priority as transfers from your facility to another healthcare facility.
GREEN-GO	These patients require minimal assistance and can be moved **FIRST** from the unit. Patients are ambulatory and 1 staff member can safely lead several patients who fall into this category, to the staging area.	These patients will be moved **LAST** as transfers from your facility to another healthcare facility.

These assessments must be made with clinical staff on units. As the assessments are completed, it is recommended that staff utilize a tagging system to clearly indicate what level of priority the patient has been given, such as colored wristbands. Colored wrist bands are located in Nursing Administration and the ED.

Please refer to Administrative Environment of Care Policies 106.064 Code Black - Active Shooter and **106.077 Code Orange - Hazardous Material Spill/Release,** 106.026 Code Silver – Weapon or Hostage Situation.

All Revision Dates

5/11/2023, 1/13/2021, 6/1/2016

Attachments

Attachment A - VCMC Rally Point Map.pdf

Attachment B - VCMC Campus Lots and Evacuation Rally Points.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/11/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/11/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/11/2023
Emergency Management Committee	Fernando Medina: Director, Support Services	5/11/2023
Policy Owner	Fernando Medina: Director, Support Services	5/11/2023

Status **Active** PolicyStat ID **13625751**

Origination	5/1/1983
Last Approved	5/9/2023
Effective	5/9/2023
Last Revised	5/9/2023
Next Review	5/8/2026
Owner	Jill Ward: Chief Financial Officer, VCMC & SPH
Policy Area	Administrative - Operating Policies

107.004 Purchasing Policy

POLICY:

To delegate authority for approval of requests for purchases of supplies, services, equipment and furnishings to facilitate efficient, effective and compliant procurement practices.

All purchases made by or on behalf of Ventura County Medical System (VCMS) staff must be supported by a Purchase Requisition that was reviewed and approved by appropriate authority to assure the legitimacy and cost effectiveness of the requisition. Purchases are confirmed and binding only upon completion of an approved requisition and issuance of a purchase order (PO) by the General Services Agency (GSA) of the County of Ventura.

PROCEDURE:

A. Purchase request equal to or less than $1,000.00:
    1. Request for purchase of supplies, services or equipment with a total value, tax included, equal to or less than $1,000.00 needs approval by the department manager.

B. Purchase request greater than $1,000.00, but equal to or less than $5,000.00:
    1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than $1,000.00, but equal to or less than $5,000.00 needs approval by the Associate Hospital Administrator, Chief Nurse Executive or Ambulatory Care Regional Administrative Director.

C. Purchase request greater than $5,000.00, but equal to or less than $10,000.00:
    1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than $5,000.00, but equal to or less than $10,000.00 needs approval by the Chief Operations Officer or Chief Executive Officer.

D. Purchase requests greater than $10,000.00:

    1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than $10,000.00 needs approval by the Chief Financial Officer.

E. Fixed Assets Equipment:

    1. Request for fixed asset equipment will be reviewed and approved by the Fixed Assets Committee. See policy *107.078 Review and Approval of Fixed Assets Equipment Over $5000*.

All Revision Dates

5/9/2023, 4/25/2023, 8/11/2021, 1/1/2008, 5/1/2006, 1/1/2005

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	5/9/2023
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	5/8/2023
Policy Owner	Jill Ward: Chief Financial Officer, VCMC & SPH	5/8/2023

Status **Active** PolicyStat ID **13610299**

Origination	12/1/1998
Last Approved	5/9/2023
Effective	5/9/2023
Last Revised	5/9/2023
Next Review	5/8/2026
Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH
Policy Area	Administrative - Operating Policies

107.050 Recognition and Evaluation of Abuse

POLICY:

To provide Ventura County Medical Center/Santa Paula Hospital staff and physicians with the most common criteria for identifying, handling, and reporting possible physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse or neglect. To outline the responsibilities of mandated reporters.

PROCEDURE:

I. **GENERAL EXPECTATIONS:**

1. Patients are evaluated for signs of potential abuse or neglect upon entry into the hospital.
2. The hospital maintains a list of agencies to refer patients to for continuing care.
3. Hospital staff are educated about the signs and symptoms of possible abuse and neglect via this policy, as well as in department- specific trainings.
4. Suspected abuse or neglect should be reported into RL Datix, as well as to external agencies in accordance with local law.

II. **SUSPECTED CHILD ABUSE REPORT:**

Any mandated reporter who has knowledge of or observes a child, in his /her professional capacity or within the scope of his/ her employment, whom s/he knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to the designated Child Welfare Services office immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The contact information for the local Child Welfare Services Office is:

Director, Ventura County Child Welfare Services
4651 Telephone Rd, Suite 300
Ventura, CA 93003
(805) 654-3200
Fax (805) 654-5597

III. A "child" is a person under the age of 18 years.

IV. The term "Mandated Reporter" within the context of suspected child abuse includes but is not limited to the following: A social worker, a physician, psychiatrist, psychologist, resident, licensed nurse, marriage, family and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code .

The mandated reporter will make all the necessary reports (Suspected Child Abuse, Dependent Adult / Elder Abuse, Domestic Violence - only required by those who provide medical services) on behalf of all of the mandated reporters within the facility.

A mandated reporter of suspected child abuse must complete and submit the Suspected Child Abuse Report Form, SS 8572, to be completed by Mandated Child Abuse Reporters, pursuant to Penal Code Section 11166, even if some of the requested information is not known.

After completing the form, the reporting party should file one photocopy in the patient's chart with a label to be scanned into the electronic health record EHR, and send the original to the designated agency.

V. **REPORT OF SUSPECTED DEPENDENT ADULT / ELDER ABUSE** :

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, abduction, isolation, financial abuse, or neglect (including self-neglect), or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate Adult Protective Services agency.

The contact information for the local Adult Protective Services Office is:

Adult Protective Services
1001 Partridge Drive, Suite 365
Ventura, Ca 93003
Hotline: 805-654-3200

Link for online direct reporting: https://www.ventura.org/human-services-agency/adult-protective-services/

I. An "Elder" is any person residing in this state who is 60 years of age or older.

A "Dependent Adult" is any person residing in this state, between the ages of 18 and 59, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

Dependent adult includes any person between the ages of 18 and 59 who is admitted as an inpatient to a 24-hour health facility as defined in Sections 1250,1250.2, and 1250.3 of the Health and Safety Code.

A mandated reporter of suspected dependent adult/elder abuse must complete and submit the Report of Suspected Dependent Adult/Elder Abuse, SOC 341, as required under Welfare and Institutions Code (WIC) Sections 15630 and 15658. After completing the form, the reporting party should file one photocopy in the patient's chart, with a label to be scanned into the EHR and send the original to the designated agency.

A mandated reporter shall not be required to report a suspected incident of elder or dependent adult abuse where all of the following conditions exist:

A. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

B. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

C. In the exercise of clinical judgment, the mandated reporter reasonably believes that the abuse did not occur.

D. When a Report is not made based upon the above circumstances, the clinical record should include notes describing the patient's report, the patient's diagnosis and conservatorship status, if applicable, attempts made to seek evidence of the patient's report and the lack of evidence, and the clinical judgment and decision-making on the part of the mandated reporter.

E. **SUSPECTED VIOLENT INJURY / SUSPECTED DOMESTIC VIOLENCE INJURY REPORT**

Mandated reporters must report domestic violence issues if they believe a crime has been committed and no report has yet been filed. VCMC staff may assist the patient in making such reports themselves with support. Patients shall be routinely screened for signs and symptoms of domestic abuse. Any health practitioner employed in a health facility, who provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows:

1. Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm
2. Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct or if there is imminent serious risk, staff shall make a report to the local law enforcement agency in the jurisdiction where the domestic violence occurred for appropriate intervention.

3. The facility/staff will take reasonable measures to protect the victim.
4. Provide patient references including Hot lines, Women's shelters, Legal service and information about temporary restraining orders.

The reporting requirement is as follows:

1. A report by telephone shall be made immediately or as soon as practically possible to the police station in the city of origin where the domestic violence occurred
2. Law enforcement may request a face-to-face interview or assign a case number, and request the form be mailed as a matter of record for future reference.
3. Complete the Suspected Violent Injury /Suspected Domestic Violence Injury Report form.
4. Copy the completed form; send the original to the designated law enforcement agency within two working days of receiving the information regarding the person.
5. File a photocopy in the patient's chart with a label to be scanned into the EHR.
6. Copy page 2 of the form and give this to the patient.
7. Document in the patient's medical record that the patient received this information.

A mandated reporter with respect to domestic violence must complete and submit the Suspected Violent Injury/Suspected Domestic Violence Injury Report, pursuant to Penal Code Section 11160-11163.

After completing the form, the reporting party should file one photocopy in the patient's chart with a label to be scanned into the EHR, and send the original report to the designated law enforcement agency. F or assistance in obtaining appropriate forms, contact Social Services.

PHYSICAL ABUSE

PHYSICAL AND BEHAVIORAL OBSERVATIONS THAT MAY SUGGEST ABUSE

PHYSICAL :	BEHAVIORAL:
Cachexia (physical wasting and malnutrition)	Depression
Poor Hygiene	Agitation
Inappropriate dress	Fearfulness
Mobility impairment	Cringing
Sensory impairment	Withdrawal
Absence of assistive devices(e.g., glasses, hearing aid,cane or walker)	Confusion
	Unresponsiveness
	Inappropriate behavior
	Aggressiveness
Communication impairment (e.g., language barrier, sensory impairment, cognitive impairment)	Obsession
	Paranoia
	Hallucinations
	Suicidal Ideation
Debilitation	Quality of interactions with care giver

INDICATORS OF PHYSICAL AND PSYCHOSOCIAL ABUSE

PHYSICAL :	PSYCHOSOCIAL:
Bruises	Post-Traumatic Stress Disorder
Welts	Fear, Anxiety, Mistrust
Lacerations	Shame, Humiliation
Scratches	Strong ambivalent feelings toward abuser.
Abrasions	
Puncture Wounds	
Bleeding	
Human Bite Marks	
Bilateral Bruises on Forearms, suggesting shaking	
Imprint Injuries, (i.e. marks in the shape of fingers, thumbs, hands, belts, sticks, rulers)	
Burns, (e.g., inflicted by cigarettes, matches, rope, irons, immersion in hot water)	
Marks left by a gag	
Sprains, Dislocations, Fractures	
Alopecia (spotty balding) from pulling hair	
Eye Injuries (black eye, conjunctivitis [red eye], detached retina)	
Missing Teeth	
Unexplained Scars	
Internal Injuries	
Adapted from Ramsey-Klawsnik	

SEXUAL ABUSE

INDICATORS OF SEXUAL ABUSE/RAPE

PHYSICAL

- Trauma (e.g., bruising, bleeding, wound, infection, scarring, redness, irritation, pain) about the genitals, breasts, rectum, mouth
- Presence of sexually transmitted disease, particularly if patient has not engaged in consensual sexual activity
- Injury to face, neck, chest, abdomen, thighs, buttocks
- Human bite marks

PSYCHOSOCIAL

- Post-Traumatic Stress Disorder
- Fear, anxiety, mistrust
- Shame, humiliation
- Strong ambivalent feeling toward abuser
- Extreme discomfort or upset when bathed, toileted, or undergarments changed

---

Adapted from Ramsey-Klawsnik (1993a)

INDICATORS OF SEXUAL ABUSE/RAPE IN THE CHILD

PHYSICAL

- Difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Pain, swelling, or itching in genital area
- Pain on urination
- Bruises, bleeding or lacerations in external genitalia, vaginal or anal areas
- Vaginal/penile drainage
- Venereal disease, especially in pre-teens
- Poor sphincter tone
- Pregnancy

BEHAVIORAL

- Unwilling to change for gym or participate in physical education class
- Withdrawal, fantasy or infantile behavior
- Bizarre, sophisticated, or unusual sexual behavior or knowledge
- Poor peer relationships
- Delinquent or runaway
- Reports sexual assault by care taker
- Change in performance in school

RECOGNIZING AND RESPONDING

TO DOMESTIC VIOLENCE IN A HOSPITAL SETTING

STEP BY STEP CHECKLIST

Compiled from *The Physician's Guide to Domestic Violence* , by Patricia R. Salber, M.D. and Ellen Taliaferro, M.D.

1. **Look for Clues from the Patient**
    - the history of the accident is not consistent with the kind of injury
    - there is a time delay between injuries and presentation
    - the patient may have an accident-prone history
    - suicide attempts or depression
    - repetitive psychosomatic complaints
    - signs and symptoms of alcoholism and drug abuse
    - injury during pregnancy
    - signs and symptoms of post-traumatic stress syndrome
    - patient is frightened, ashamed, embarrassed or evasive
2. **Patient's Companion Can Be a Clue**
    - if batterer has accompanied patient for medical visit, he asks to stay with patient for entire visit
    - s/he answers questions for the patient
    - patient may seem afraid or reluctant to disagree with her companion's explanation of what occurred.
    - patient does not attempt to speak for him/herself
    - companion may display hostility or anger directed at patient or medical staff
3. **Clues from the Physical Examination**
    - victims of domestic violence may try to hide injuries by wearing long sleeves or turtlenecks
    - they may conceal black eyes with dark glasses or heavy make-up
    - whenever possible, have patients change from their street clothes into a hospital gown.
    - injuries due to domestic violence may have a central pattern - injuries to the face, neck, throat, chest, breasts,
      abdomen and genitals

- be suspicious of injuries suggestive of a defensive posture, such as bruises to the ulnar aspect of the forearm
- multiple injuries in various stages of healing suggest physical violence occurring over a period of time

4. **What to Do When Patient Says Yes to Questions About Abuse**
    - most important: assess, with the patient, her safety and that of her children
    - ask if she has protective friends or family with whom she can stay
    - ask where her children or other dependents are and if she thinks they will be safe
    - ask if she wants immediate access to a shelter; if not, provide phone numbers in case she needs to go later
    - consider whether she needs immediate physical or psychiatric intervention
    - if she wants to go home, be sure a definite follow-up appointment is scheduled
    - ask if she wants to report the incident to the police (Medical Staff should be familiar with the response of local police and attorney to battering so they can help the victim understand what to expect)
    - involve social worker if available
5. **Document Findings**
    - record a description of the abuse as the patient described it
    - record all physical findings using a body map
    - if the patient agrees, take instant photographs of injuries - documented evidence of injuries sustained by the patient can play an integral part in both prosecuting the batterer and protecting the victim
    - name, date, time, medical record number, as well as doctor's name and that of a witness should be recorded at the bottom of the photo or attached, with photo, to the chart
    - efforts should be made to have follow-up pictures taken 24-48 hours after bruises are received because heir heightened discoloration will make them more apparent
    - If actual size and location of the injuries sustained cannot be adequately determined by standard photographs, use Polaroid Spectra GridFilm, which superimposes a grid over the victim's body to provide an accurate scale - or superimposes a grid over the victim's body to provide an accurate scale - or take photos next to a ruler or a familiar household object to indicate actual size
    - photograph from different angles, full body and close-up , taking at least two pictures of every major trauma area
    - include the patient's face in at least one picture
    - preserve all physical evidence - torn or bloodstained clothing or a weapon can be sealed in an envelope or paper bag.
    - if the patient does not confirm the abuse, but you are still suspicious, be sure to record this in the record and explain why

6. **Important Messages to Give Patient**
    - her options - safety plan, referrals, counseling, social services, legal services, law enforcement
    - she is not alone and that help is available - from you and your staff as well as a host of resources in the community
    - that battering is a common problem affecting millions of women and family members
    - she does not deserve to be battered - no matter what

CHILD ABUSE

CHECKLIST OF PHYSICAL AND BEHAVIORAL

INDICATORS OF CHILD ABUSE/NEGLECT

PHYSICAL ABUSE

PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
Unexplained bruises or welts • on face, lips, mouth • torso, back, buttocks, thighs • in various stages of healing • clustered, forming rectangular patterns, reflecting shape of article used to inflict (Electric cord, belt buckle) • on several different surface areas • regularly appear after absence, weekend or vacation	Feels deserving of punishment
Unexplained burns • cigar, cigarette burns, especially on soles, palms, back or buttocks • immersion burns (sock-like, glove-like, doughnut-shaped on buttocks or genitalia) • patterns like electric burner, iron, etc. • rope burns on arms, legs neck or torso • infected burns, indicating delay in seeking treatment	Wary of adult contact
Unexplained fractures/dislocations • to skull, nose, facial structure • in various stages of healing • in various stages of healing	Apprehensive when other children cry
Unexplained lacerations or abrasions • to mouth, lips, gums, eyes • to external genitalia • in various stages of healing	Behavioral extremes
Bald patches on scalp	Aggressiveness or Withdrawal
	Frightened of parents
	Afraid to go home
	Reports injury by parents
	Vacant or frozen stare
	Lies very still while surveying surroundings (infant)
	Responds to questions in monosyllables

PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
	Inappropriate or precocious maturity
	Manipulative behavior to get attention
	Capable of only superficial relationships
	Indiscriminately seeks affection
	Poor self-esteem

PHYSICAL NEGLECT:

PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
Underweight, poor growth pattern, e.g., small in stature failure to thrive	Begging or stealing food
Consistent hunger, poor hygiene, inappropriate dress	Extended stays at school (early arrival, late departure)
Consistent lack of supervision especially in dangerous activities or for long periods	Rare attendance at school
Wasting of subcutaneous tissue	Constant fatigue, listlessness or falling asleep in class
Unattended physical problems or medical records	Delayed speech
Bald patches on the scalp	Inappropriate seeking of affection
Abandonment	Doesn't change expression
Abdominal distention	Assuming adult responsibilities and concerns
Delinquency (e.g., thefts)	Alcohol or drug abuse
	Talks in a whisper or whine
	States there is no caretaker

ELDER ABUSE

PHYSICAL ABUSE POSSIBLE INDICATORS:

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury which has not been properly cared for (injuries are sometimes hidden on areas of the body normally covered by clothing)

- Poor skin condition or poor skin hygiene
- Absence of hair and/or hemorrhaging below scalp
- Dehydration and/or malnourished without illness-related cause
- Weight loss
- Burns may be caused by: cigarettes, caustics, acids, friction from ropes or chains, or contact with other objects
- Soiled clothing or bed

PSYCHOLOGICAL/EMOTIONAL ABUSE POSSIBLE INDICATORS:

Helplessness	Fear
Hesitation to talk openly	Withdrawal
Implausible stories	Depression
Confusion or disorientation	Denial
Anger	Agitation

FINANCIAL ABUSE POSSIBLE INDICATORS:

- Unusual or inappropriate activity in bank accounts
- Signatures on checks, etc., that do not resemble the older person's signature, or signed when older person cannot write
- Power of Attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by care giver that an excessive amount of money is being expended on the care of the older person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate
- Lack of amenities, such as TV, personal grooming items, appropriate clothing that the estate can well afford
- Missing personal belongings such as art, silverware, or jewelry
- Deliberate isolation, by a housekeeper, of an older adult from friends and family, resulting in the care giver alone having total control

NEGLECT BY CAREGIVER POSSIBLE INDICATORS:

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice on elder
- Elder is inadequately clothed
- Elder is malnourished or dehydrated

- Elder has an untreated medical condition

SELF-NEGLECT POSSIBLE INDICATORS:

- Inability to manage personal finances, e.g., hoarding, squandering, giving money away or failure to pay bills
- Inability to manage activities of daily living, including personal care, shopping, meal preparation, housework, etc.
- Suicidal acts, wanderings, refusing medical attention, isolation substance abuse
- Lack of toilet facilities, utilities or animal infested living quarters (dangerous conditions)
- Rashes, sores, fecal/urine smell, inadequate clothing, malnourished, dehydration, etc.
- Changes in intellectual functioning, e.g., confusion, inappropriate or no response, disorientation to time and place, memory failure, incoherence, etc.
- Not keeping medical appointments for serious illness

ABUSE FROM THE CAREGIVER POSSIBLE INDICATORS:

- The elder may not be given the opportunity to speak for him or herself, or see others, without the presence of the care giver (suspected abuser)
- Attitudes of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family member or care giver blames the elder (e.g. accusation that incontinence is a deliberate act)
- Aggressive behavior (threats, insults, harassment) by care giver toward the elder
- Previous history of abuse of others
- Problems with alcohol or drugs
- Inappropriate display of affection by the care giver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the care giver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the care giver to comply with service providers in planning for care and implementation
- Inappropriate or unwarranted defensiveness by care giver

All Revision Dates

5/9/2023, 10/3/2022, 2/1/2016, 12/1/2013, 8/1/2009, 5/1/2006, 2/1/2005

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/8/2023

Status **Active** PolicyStat ID **13566185**

Origination	12/1/2009
Last Approved	5/3/2023
Effective	5/3/2023
Last Revised	5/3/2023
Next Review	5/2/2026
Owner	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH
Policy Area	Administrative - Fiscal

110.030 Charity Care Policy

PURPOSE:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and hospital clinics strive to provide compassionate, quality patient care for the community we serve. This policy demonstrates VCMC and SPH's commitment to our mission and vision by helping meet the needs of low income and uninsured patients in our community.

POLICY:

The Ventura County Health Care Agency (HCA) hospitals, Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) and hospital clinics, will offer a Charity Care Program for hospital, ambulatory care and urgent care services to patients who meet the eligibility tests described below, pursuant to Health & Safety Code sections 127400 through 127446.

PROCEDURE:

Eligibility for Participation in Charity Care Program

Self-Pay Patients: A patient qualifies for the Charity Care Program if all of the following conditions are met:

- The patient does not have third party coverage from a health insurer, health care service plan, Medicare or Medi-Cal as determined and documented by the hospital; or
- The patient has incurred annual out-of-pocket medical costs at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months, or annual out-of-pocket medical expenses that exceed 10 percent of the patient's family income; and
- The patient's injury is not a compensable injury for purposes of workers' compensation,

automobile insurance, or other insurance as determined and documented by HCA; and

- The patient's family income does not exceed 400% of the Federal Poverty Level; and
- The patient has monetary assets of less than $10,000.00. Monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans (the patient's first $10,000 of monetary assets, and 50 percent of the patient's monetary assets in excess of $10,000, shall not be considered in determining eligibility).

Hospital staff shall make reasonable efforts to obtain from the patient, or his or her representative, information about whether private or public health insurance, including eligibility for the California Health Benefit Exchange, may fully or partially cover the charges for care. If the patient does not have proof of third party coverage, hospital staff shall provide the patient with application forms and other information explaining how the patient may be eligible for specified health coverage programs, including, but not limited to, Medi-Cal, California Children's Services, the California Health Benefit Exchange or other government-funded health care programs.

The fact that a patient is applying for any of the above described health care coverage shall not preclude such patient from qualifying for the Charity Care Program or Discount Payment Program.

Other Circumstances: A patient may also qualify for the Charity Care Program if:

a. The patient qualifies for limited benefits under Medi-Cal, i.e., limited pregnancy or emergency benefits, but does not have benefits for other services provided at the hospital.

b. The patient qualifies for a medically indigent adult program offered by a county other than Ventura County.

c. Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the HCA Director or designee has reason to believe that the patient would qualify for charity or a discount (i.e., the patient is homeless).

d. A third party collection agency has made efforts to collect the outstanding balance and has recommended to the HCA Director or designee that charity care or a discount be offered.

Definition of Patient's Family and Determination of Family Income: The "patient's family" is defined as the following:

- For persons 18 years of age and older, family is defined as a spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.
- For persons under 18 years of age, family is defined as a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Documentation of family income shall be limited to recent pay stubs or tax returns. In determining a patient's monetary assets, the hospital/clinic shall not consider retirement or deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, the first ten thousand dollars ($10,000.00) of monetary assets, or fifty percent (50%) of the patient's monetary assets in excess of the first ten thousand dollars ($10,000.00).

Federal Poverty Levels: The measure of 400% of the Federal Poverty Level shall be made by reference to the most up-to-date Department of Health and Human Services poverty guidelines for the number of

persons in the patient's family or household. *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines*.

Charity Care

Balances for those patients who qualify to participate in the Charity Care Program, as determined by HCA, shall be reduced to a sum equal to $0 with the remaining balance eliminated and classified as charity care.

Resolution of Disputes

Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed to and resolved by the Health Care Agency Chief Financial Officer.

Notices

To ensure that patients are aware of the existence of the Charity Care Program, the following actions shall be taken:

Written Notice to Patients - Each patient who is seen at the hospital, whether admitted or not, shall receive the notice attached hereto as Exhibit 1. The notice shall be provided in English and non-English languages spoken by a substantial number of the patients served by the hospital.

In addition, the notice attached hereto as Exhibit 1 shall also be clearly and conspicuously posted in locations that are visible to patients in the following areas:

- Emergency Department
- Billing Office
- Admissions Office
- Other outpatient settings
- Prominently displayed on the hospital's internet website with a link to the Charity Care Program

Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include a statement of charges for services rendered by the hospital and the notice attached hereto as Exhibit 2. The notice shall be provided in English and non-English languages spoken by a substantial number of the patients served by the hospital.

Collection Activities

HCA may use the services of an external collection agency for the collection of patient debt. No debt shall be assigned for collection until the HCA Director or his/her designee has reviewed the account, and either 1) the patient has been found to be ineligible for financial assistance, or 2) the patient has not responded to any attempts to bill or offer financial assistance for 180 days. The notice attached hereto as Exhibit 3 will be provided to the patient prior to an account being assigned to an external collection agency.

HCA shall obtain an agreement from each collection agency that it utilizes to collect patient debt that the agency will comply with the requirements of Health & Safety Code Sections 127425, 127426 and 127430

and the Charity Care Program.

Neither HCA nor any collection agency utilized by HCA shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 180 days after the initial billing if the patient lacks third party coverage, or if the patient who provides information that he or she may qualify for the Charity Care Program.

In addition, if a patient is attempting to qualify for eligibility under the Charity Care Program or Discount Payment Program and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or making regular partial payments of a reasonable amount, HCA shall not send the unpaid bill to any collection agency unless that entity has agreed to comply with Health & Safety Code Sections 127425, 127426 and 127430, and the Charity Care Program.

Any collection agency shall comply with any payment plan entered into by a patient. HCA shall not, in dealing with patients eligible under the Charity Care Program or Discount Payment Program, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

EXHIBIT 1

Charity Care and Discounted Payment Program

Patients who lack insurance or have inadequate insurance and meet certain low- and moderate-income requirements may qualify for discounted payments or charity care. Patients should contact the Ventura County Health Care Agency at **805-648-9553 or VCHCA.PatientAssistance@ventura.org** to obtain further information. Emergency Department physicians, who are not employees of the hospital, must also provide a discounted payment program. Please contact **626-447-0296** for further information.

There are organizations that will help patients understand the billing and payment process. For assistance, patients may contact the Health Consumer Alliance (*https://healthconsumer.org*.)

For information and eligibility for Covered California, please visit *www.coveredca.com*.

For Medical eligibility, please visit *www.medi-cal.ca.gov*.

For a list of the hospital's shoppable services, please visit *https://apps.para-hcfs.com/PTT/FinalLinks/Ventura_V3.aspx*.

EXHIBIT 2

Notice to Accompany Bills to Potentially Eligible Patients

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, or other similar programs. If you have such coverage, please contact our office at **805-648-9553** as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medi-Cal, the Ventura County Health Care Agency's Discounted Payment Program, or the Charity Care Program. For more information about how to apply for Medicare, Medi-Cal, the California Health Benefit Exchange, or other similar programs, please contact the Ventura County Health Care Agency by telephone at **805-648-9553** or via email at VCHCA.PatientAssistance@ventura.org and speak to a representative who will be able to answer questions and provide you with applications for these programs.

Emergency Department physicians, who are not employees of the hospital, must also provide a discounted payment program. Please contact **626-447-0296** for further information.

For additional assistance, patients may contact the Ventura County consumer assistance center toll free at **866-904-9362** or visit the Ventura County Human Services Agency website at ***www.vchsa.org.***

EXHIBIT 3

Notice of Commencement of Collection Activities

John Doe
123 Main Street
Ventura, CA 93001
Re: Encounter #: 2000000001
Balance: $100.00

Dear Mr. Doe,

State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment.

Before assigning your account to a collection agency, a newly enacted California law requires that we notify you of the following information:

The date or dates of service of this account: XX/XX/XXXX
The name of the company your account will be assigned to: California Business Bureau
How you can obtain an itemized bill from us: Please call 805-648-9553 for an itemized bill
The name and type of health care coverage on record at the time of services or a statement that the hospital does not have that information:
Applications for our Charity Care and Discount Payment Policies: See attached applications.
The date(s) you were originally sent a notice about applying for financial assistance: XX/XX/XXXX
The date(s) you were sent a financial assistance application: XX/XX/XXXX
The date a decision was made on the application: XX/XX/XXXX

Please contact us at (phone number/business office) if you have any questions about this letter, or about your account/bill with us.

Respectfully

VCHCA

For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-382-4357 or online at *www.ftc.gov*. Patients may also contact the Ventura County consumer assistance center toll free at **866-904-9362** or visit the Ventura County Human Services Agency website at ***www.vchsa.org.***

All Revision Dates

5/3/2023, 4/14/2023, 7/30/2019, 8/1/2017

Attachments

Charity Care Application

Approval Signatures

Step Description	Approver	Date
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	5/3/2023
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	5/3/2023
Policy Owner	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	5/3/2023

Status **Active** PolicyStat ID **13566281**

Origination	2/1/2009	Owner	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH
Last Approved	5/3/2023		
Effective	5/3/2023	Policy Area	Administrative - Fiscal
Last Revised	5/3/2023		
Next Review	5/2/2026		

110.032 Discount Payment Policy

PURPOSE:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and hospital campus clinics strive to provide compassionate, quality patient care for the community we serve. This policy demonstrates VCMC and SPH's commitment to our mission and vision by helping meet the needs of low income and uninsured patients in our community.

POLICY:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and hospital campus clinics shall offer a Discount Payment Program for hospital, ambulatory care, urgent care and emergency room services.

PROCEDURE:

Eligibility for Participation in Discount Payment Program

Self-Pay Patients

A patient who does not have third party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal or whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital and hospital clinics. Self-pay patients may include charity care patients.

Insured and Underinsured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by hospital and/or hospital clinic staff may qualify for the Discount Payment Program (for co-pays and deductibles)

if all of the following conditions are met:

- The patient does not receive a discount rate from the hospital because of his or her third party coverage.
- The patient has annual out-of-pocket costs incurred by the patient at the hospital or clinic that exceed the lesser of ten percent (10%) of the patient's current family income or family income in the prior twelve (12) months, or annual out-of-pocket medical expenses that exceed 10 percent (10%) of the patient's family income, if the patient provides documentation of the medical expenses paid by the patient or the patient's family in the prior twelve (12) months.

Hospital and hospital clinic staff shall make reasonable efforts to obtain from the patient, or his or her representative, information about whether private or public health insurance, including eligibility for the California Health Benefit Exchange, may fully or partially cover the charges for care. If the patient does not have proof of third party coverage, hospital staff shall provide the patient with application forms and other information explaining how the patient may be eligible for specified health coverage programs, including, but not limited to, Medi-Cal, California Children's Services, the California Health Benefit Exchange, or other government funded health care programs. The fact that a patient is applying for any of the above described health care coverage, shall not preclude such patient from qualifying for the Discount Payment Program.

Cash Pay Patients

A patient who elects not to complete the Discount Payment Program application shall be eligible for the Discount Payment Program Cash-Pay Patient rate of fifty percent (50%) of billed charges.

Definition of Patient's Family & Determination of Family Income

The "patient's family" means the following:

1. For persons eighteen (18) years of age and older, a spouse, domestic partner and dependent children under twenty-one (21) years of age, whether living at home or not;
2. For persons under eighteen (18) years of age, a parent, caretaker relatives and other children under twenty one (21) years of age of the parent or caretaker relative.

Documentation of family income shall be limited to recent pay stubs or tax returns. The patient's assets or the assets of the patient's family may not be considered when calculating family income.

The measure of the Federal Poverty Level (FPL) shall be made by reference to the most up-to- date Department of Health and Human Services (HHS) poverty guidelines for the number of persons in the patient's family or household. *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines*

For those patients who do not qualify for charity care but qualify to participate in the Discount Payment Program, the amount of the discount is determined by the Discount Payment Rate Schedule. The expected payment for services the hospital provides (to any patient who is eligible under the Discount Payment Program) shall not exceed one hundred percent (100%) of the greatest amount of payment the hospital would receive from Medicare, Medi-Cal, or any other government sponsored health program of health benefits, in which the hospital participates (based on the current fee schedule of such payor). This will be determined on a case-by-case basis.

Emergency Physicians

The hospital's contracted Emergency Department physicians must also offer discounted payment programs. Patients shall be notified of the availability of such programs, as provided in the "Notices" section of this policy.

Extended Payment Plans

Patients who are eligible to participate in the Discount Payment Program shall be permitted to make payments of the discounted amount, over an extended period of time (not to exceed sixty (60) months), with no interest accruing or being charged. Monthly payments pursuant to any repayment plan negotiated with a patient (pursuant to the Discount Payment Program), shall not exceed ten percent (10%) of the patient's income, excluding deductions for essential living expenses.

"Essential living expenses" shall mean expenses incurred by the patient for any of the following:

- Rent or house payments (including maintenance expenses),
- Food and household supplies,
- Utilities and phone,
- Clothing,
- Medical and dental payments,
- Insurance,
- School and child care,
- Child and spousal support,
- Transportation and automobile expenses (including insurance, fuel and repairs),
- Installment payments,
- Laundry and cleaning expenses,
- Other extraordinary expenses.

Hospital staff shall request that the patient provide details supporting the essential living expenses that should be considered in determining a reasonable payment plan for the patient.

Resolution of Disputes

Any disputes regarding a patient's eligibility to participate in the Discount Payment Program, shall be directed to and resolved by the Health Care Agency Chief Financial Officer.

Notices

In order to ensure that patients are aware of the existence of the Discount Payment Program, the following actions shall be taken:

Written Notice to Patients

Each patient who is seen by VCMC, SPH, or hospital clinics, whether admitted or not, shall receive the notice attached hereto as Exhibit 1. The notice shall be provided in the English and non-English languages spoken by a substantial number of the patients served by the hospital.

In addition, the notice attached hereto as Exhibit 1, shall also be clearly and conspicuously posted in locations that are visible to patients in the following areas:

1. Emergency Department;
2. Billing Office;
3. Admissions Office;
4. Other outpatient settings;
5. Prominently displayed on the hospital's internet website with a link to the Discount Payment Policy.

Notice to Accompany Bills to Potentially Eligible Patients

Each bill that is sent to a patient, who has not provided proof of coverage by a third party at the time care is provided or upon discharge, must include a statement of charges for services rendered by VCMC and the notice attached hereto as Exhibit 2. The notice shall be provided in the English and non-English languages spoken by a substantial number of the patients served by the hospital.

Collection Activities

The Health Care Agency may use the services of an external collection agency for the collection of patient debt. No debt shall be assigned for collection until the Health Care Agency Director or his/her designee has reviewed the account, and either 1) the patient has been found to be ineligible for financial assistance, or 2) the patient has not responded to any attempts to bill or offer financial assistance for on hundred eighty (180) days. The notice attached hereto as Exhibit 3, will be provided to the patient prior to an account being assigned to an external collection agency.

The Health Care Agency shall obtain an agreement from each collection agency that it utilizes to collect patient debt that the collection agency shall comply with the requirements of Health & Safety Code, Sections 127425, 127426 and 127430, and the Discount Payment Program.

Neither the Health Care Agency, nor any collection agency utilized by the Health Care Agency, shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to one hundred eighty (180) days after the initial billing period if the patient lacks third party coverage or if the patient provides information that he or she may incur high medical costs. "High medical cost" is defined as: either annual out-of-pocket medical costs incurred by the patient at the hospital or clinic that exceed the lesser of ten percent (10%) of the patient's current family income or family income in the prior twelve (12) months, or annual out-of-pocket medical expenses that exceed ten percent (10%) of the patient's family income.

In addition, if a patient is attempting to qualify for eligibility under the Charity Care Program or Discount Payment Program and is attempting in good faith to settle an outstanding bill with the hospital, by negotiating a reasonable payment plan or making regular partial payments of a reasonable amount, the Health Care Agency shall not send the unpaid bill to any collection agency unless that entity has agreed to comply with Health & Safety Code Sections 127425, 127426 and 127430, and the Discount Payment Program.

Collection agencies shall comply with any payment plan entered into by a patient.

The Health Care Agency shall not, in dealing with patients eligible under the Charity Care Program or Discount Payment Program, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

Exhibit 1

Charity Care & Discounted Payment Program

Patients who lack insurance or have inadequate insurance and meet certain low and moderate income requirements, may qualify for discounted payments or charity care. Patients should contact the Ventura County Health Care Agency at **805-648-9553 or** VCHCA.PatientAssistance@ventura.org to obtain further information. Emergency Department physicians, who are not employees of the hospital, must also provide a discounted payment program. Please contact **626-447-0296** for further information.

There are organizations that will help patients understand the billing and payment process. For assistance, patients may contact the Health Consumer Alliance (*https://healthconsumer.org*.)

For information and eligibility for Covered California, please visit *www.coveredca.com*.

For Medi-Cal eligibility, please visit *www.medi-cal.ca.gov*.

For a list of the hospital's shoppable services, please visit *https://apps.para-hcfs.com/PTT/FinalLinks/Ventura_V3.aspx*.

Exhibit 2

Notice to Accompany Bills to Potentially Eligible Patients

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, or other similar government or non-government programs. If you have such coverage, please contact our office at **805-648-9553** as soon as possible, so the information can be obtained and the appropriate entity billed**.**

If you do not have health insurance coverage, you may be eligible for Medicare, Medi-Cal, the Ventura County Health Care Agency's Discounted Payment Program, or the Charity Care Program. For more information about how to apply for Medicare, Medi-Cal, the California Health Benefit Exchange, or other similar programs, please contact the Ventura County Health Care Agency by telephone at **805-648-9553** or via email at VCHCA.PatientAssistance@ventura.org and speak to a representative who will be able to answer questions and provide you with applications for these programs.

Emergency Department physicians, who are not employees of the hospital, must also provide a discounted payment program. Please contact **626-447-0296** for further information.

For additional assistance, patients may contact the Ventura County consumer assistance center toll free at **866-904-9362** or visit the Ventura County Human Services Agency website at *www.vchsa.org*.

Exhibit 3

Notice of Commencement of Collection Activities

John Doe
123 Main Street
Ventura, CA 93001
Re: Encounter #: 2000000001
Balance: $100.00

Dear Mr. Doe,

State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment.

Before assigning your account to a collection agency, a newly enacted California law requires that we notify you of the following information:

The date or dates of service of this account: XX/XX/XXXX
The name of the company your account will be assigned to: California Business Bureau
How you can obtain an itemized bill from us: Please call 805-648-9553 for an itemized bill
The name and type of health care coverage on record at the time of services or a statement that the hospital does not have that information
Applications for our Charity Care and Discount Payment Policies: See attached applications
The date(s) you were originally sent a notice about applying for financial assistance: XX/XX/XXXX
The date(s) you were sent a financial assistance application: XX/XX/XXXX
The date a decision was made on the application: XX/XX/XXXX

Please contact us at (phone number/business office) if you have any questions about this letter, or about your account/bill with us.

Respectfully

VCHCA

For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-382-4357 or online at *www.ftc.gov*. Patients may also contact the Ventura County consumer assistance center toll free at **866-904-9362** or visit the Ventura County Human Services Agency website at ***www.vchsa.org.***

All Revision Dates

5/3/2023, 4/14/2023, 7/30/2019, 6/6/2019, 8/1/2017

Attachments

Discount Payment Clinic Service Schedule

Discount Payment Policy Rate Schedule

Discount Program Application

Approval Signatures

Step Description	Approver	Date
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	5/3/2023
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	5/3/2023
Policy Owner	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	5/3/2023

Status **Active** PolicyStat ID **13630666**

Origination	5/9/2023
Last Approved	5/9/2023
Effective	5/9/2023
Last Revised	5/9/2023
Next Review	5/8/2026
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.116 Ambient Temperature and Humidity Monitoring Critical Spaces

PURPOSE:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH)Facilities Operations Department supports and participates in the infection control plan. This is achieved by maintaining information regarding temperature, relative humidity and differential pressure in designated critical environment areas and rooms.

POLICY:

It is the policy of the Facilities Operations Department to follow. To ensure a systematic process for implementing parameters for relative humidity and temperature in all Critical Spaces, with respect to promoting patient safety and the care and handling of sterile supplies and equipment as approved by the Environment of Care Committee (EOC) and ANSI/ASHRAE/ASHE Standard 170-2008 Ventilation of Health Care Facilities.

Monitoring is performed in critical environments as a result of a risk assessment wherever variations in temperature, humidity and pressure may impact clinical outcomes including invasive locations. The actual monitoring is performed by Engineering Services building automation and Building Maintenance System (BMS).

Critical Spaces (VCMC)

G410	OR-1	G422	INTERVENTIONAL RADIOLOGY #2
G413	OR-2	G421	INTERVENTIONAL RADIOLOGY #1
G414	OR-3	2427.0	OR C-SECTION

G415	OR-4	G472	STERILE SUPPLY
G416	HYBRID OR	G520	SOILED RECEIVING
G468	OR-6	G520	STERILE STORAGE
G431	OR-7	G521	ISSUING VESTIBULE
G411	CLEAN SUPPLY CORE		

Critical Spaces (SPH)

103	OR-1
102	OR-2
99	OR-3
104	STERILE CORE
97	GI LAB
238	STERILE STORAGE
039	STERILE STORAGE II
069	STERILE SUPPLY

Doors in restricted, semi-restricted, and unrestricted areas will remain closed, except during the entry and exit of patients, staff, equipment, and supplies. When doors are left open, there are greater challenges for the HVAC system to maintain environmental control parameters.

Preventive Maintenance

Facilities Management will implement appropriate preventative maintenance, including regular inspections, changing of filters and monitoring practices to assure the heating/ventilation/air conditioning (HVAC) system is working as designed according to its relevant building code design and as-built age.

Acceptable/Recommended Temperature Ranges:

- Operating room: Recommended temperature 68°F to 75°F.
- Decontamination area: Temperature 60° to 73° F
- Preparation and packing area: Temperature 68° to 73° F
- Sterile storage area: Temperature 60° to 75° F

Temperature/Humidity

1. Temperature and humidity levels are monitored and maintained within the range based on the approved ANSI/ASHRAE/ASHE Standard 170-2008 Ventilation of Health Care Facilities.

2. The room temperature and humidity for operating rooms and Interventional Radiology are set with Low-temperature alarm to High temperature alarm per AAMI/ANSI/AORN standards.
3. If the room temperature of humidity goes above or below the defined parameters, the engineer on duty will make necessary adjustments to correct the alarm. If equipment failure occurs, the engineer will notify the affected department, and a repair technician will be dispatched to assess the problem and make repairs.
4. If Facilities Maintenance is unable to correct the temperature or humidity, the room may be deemed unusable by hospital leadership, until room is brought in too acceptable range.
5. Accommodations for individual cases and/or patient temperature can be addressed pre-, intra-, or post procedure utilizing ambient temperature change or patient warming measures such as forced-air, mat, blanket, fluid warming systems, and by limiting exposure of patient to the minimum required for effecting surgical intervention. Perioperative staff is responsible for the documentation related to these accommodations.

Refer to policy T.01 VCMC Trauma Response Plan

Acceptable/Recommended Relative Humidity (RH) Ranges:

- Operating room: Recommended 20-60%
- Decontamination area: *Not Rated*
- Preparation and packing area: Max 60%
- Sterile storage area: Max 60%

Ventura County Medical Center leadership has approved the categorical waiver to allow relative humidity as low as 20% in anesthetizing locations.

1. If the relative humidity is below 20% or above 60% the responsible monitoring individual of the area will notify the Facilities maintenance department of the environmental condition or the Facilities maintenance departments building maintenance system (BMS) or SmartSense monitoring system will alarm and the stationary engineer will respond immediately to intervene and attempt to bring the HVAC system into compliance. If unsuccessful in maintaining these parameters continuously for more than 8 hours within any 24 hour period, notifications will occur to the appropriate Nursing staff and Medical Leadership, including Infection Prevention and Control.

PROCEDURE:

TEMPERATURE

A. Ventura County Medical Center Facilities Maintenance Department is responsible for oversight and monitoring of the BMS 24 hours a day, 7 days a week in critical space areas.

B. SmartSense by Digi monitoring devices have been installed in area not tracked by the BMS. SmartSense provides real time visibility, monitoring and reporting the Facilities Maintenance Department.

C. Critical Space areas will be observed each day by area staff when in use. Initial observation will be made prior to creating a sterile field so that corrective actions may be taken if needed.

D. When requesting a temperature adjustments below 68 degrees or above 75 degrees F staff shall take into consideration:

- Age Extremes: infant, elderly
- Operating room ambient temperature
- Length and type of surgery
- Amount of body exposure and the temperature of irritants and intravenous fluids
- Preoperative and intraoperative medications
- Anesthetics: General and Regional Anesthesia
- Trauma patient

A member of the perioperative team will notify facilities personnel to request a change in temperature and place a work order.

Unwarranted Temperatures

If unwarranted temperatures remain, the facilities or OR staff will:

A. Place a facilities work order to adjustment temperatures in the affected room.

B. Affected room will not be used until acceptable ranges are met.

RELATIVE HUMIDITY (RH}

A. Relative humidity will be observed each day by clinical staff when areas are in use. Initial observation is made prior to the creation of a sterile field so that corrective actions may be taken if needed.

1. Facilities will be responsible for: Maintaining RH documentation for all perioperative areas, initiating work orders to investigate and pursue corrections to HVAC equipment, and communicating with OR staff.
2. The Operating Room Charge Nurse or team member will be responsible for: Notifying facilities, and perioperative leadership.
3. Ventura County Medical Center and Santa Paula hospital are located in a coastal region where high marine-related humidity is common. HVAC equipment is maintained according to its manufactures recommendations and as-built construction. It is normal for RH to fluctuate based on environmental conditions. Incidental occurrences of RH above 60% do not create immediate risks or conditions of non-compliance. Sustained RH will initiate the steps outlined in B - E below to assess risks and promote patient safety.

B. RH above 60%:

1. Facilities will be responsible for creating a work order upon occurrence.
2. Facilities will monitor Perioperative areas.
3. Charge Nurse or Perioperative leadership will assess environmental surfaces for visible dampness on walls, furniture, equipment, surfaces or supplies, and arrange

for terminal cleaning after the last procedure of the day.

C. RH above 75%:
    1. Facilities will be responsible for creating a work order upon occurrence.
    2. Facilities will monitor Perioperative areas and create work orders.
    3. Charge Nurse or perioperative leadership will assess environmental surfaces for visible dampness on walls, furniture, equipment, surfaces or supplies, and arrange for terminal cleaning after the last procedure of the day.

D. RH uncorrected and sustained for 72 hours above 75%:
    1. Facilities Management will notify Perioperative leadership
    2. Perioperative leadership will:
        a. Notify Infection Prevention & Control to begin assessment and consultative form documentation for inspection and mitigation.
        b. Notify Nursing and Medical leadership.

E. If visible dampness is found on walls, furniture, equipment, surfaces or supplies:
    1. Surgeries/Procedures will be rescheduled to another room unless this would cause a delay that would potentially harm the patient as determined by the appropriate attending physician.
    2. Perioperative leadership will:
        a. Notify Infection Prevention & Control to begin assessment and consultative form documentation for inspection and mitigation.
        b. Notify Nursing and Medical leadership.
    3. Investigation and mitigation:
        a. Each sterile package will be inspected for evidence of dampness or water exposure. If signs of dampness or water exposure are found, the package or container will be immediately opened and the contents cleaned and re-sterilized or, if single-use, discarded.
        b. As soon as safely possible, the area will be assessed by Perioperative leadership, Facilities management and Biomedical Engineering for further repairs and equipment safety checks.
        c. Infection Prevention and Control will provide notification to appropriate medical and nursing leadership including recommendation for returning the room to service.
        d. Terminal cleaning will occur prior to returning the room to service.
    4. All occurrences are to be documented with corrective actions described and reported out via Infection Prevention & Control Committee, Environment of Care Committee, and Patient Safety Committee.

References

ANSI/ASHRAE/ASHE Standard 170-2008/2021,AAMI/ANSI/AORN standards

All Revision Dates

5/9/2023

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	5/9/2023
Infection Prevention	Magdy Asaad: Infection Prevention Manager	5/9/2023
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	5/9/2023
Surgical Services	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/9/2023
Facilities Department	Ian McGraw: Manager Facility Operation	5/9/2023

Status **Active** PolicyStat ID **13643209**

Origination	1/26/2023
Last Approved	5/12/2023
Effective	5/12/2023
Last Revised	5/12/2023
Next Review	5/11/2026
Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services

IS.01 Radiation Safety & Protection Program

Ventura County Medical Center & Santa Paula Hospital

Radiation Safety and Protection Program Guide

REVIEWED (ANNUALLY): Nov 2022

Compiled by: Radiation Safety Committee

VENTURA COUNTY MEDICAL CENTER (VCMC) & SANTA PAULA HOSPITAL (SPH) RADIATION SAFETY and PROTECTION PROGRAM

In California, all radiation sources, either radiation (X-ray) machines or radioactive material, are subject to State laws and regulations. The statutes are found in the Health and Safety Code, Division 104-Environmental Health. The regulations are found in the California Code of Regulations (CCR), Title 17, Div. 1, Chapter 5, Subchapters 4, 4.5, and 4.7. Title 17 CCR 30253 incorporates by reference the federal regulations specified in Title 10, Code of Federal Regulations (CFR), Part 20. Requirements in 10 CFR 20 apply to all registrants.

This medical imaging facility is required to develop, document, and implement a radiation protection program commensurate with the scope and extent of use of X-ray machines and sufficient to ensure compliance with the above regulations. Additionally, the medical imaging facility shall use, to the extent practical, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are **a**s **l**ow **a**s **r**easonably **a**chievable (ALARA). The Radiation Safety Officer will audit the radiation protection program on an annual basis to ensure it remains within the scope and extent of activities required to ensure compliance with the said regulations.

All components of the Radiation Safety and Protection Program do not have to be contained in one consolidated document. However, all components do have to be documented and identified as being part of the Radiation Protection Program and will be duly listed and described. Records of the Radiation Safety and Protection Program content, implementation and audits must be maintained for inspection by the Department.

The regulatory agency for radiation safety is the Radiologic Health Branch of the Department of Public Health and can be contacted at the following addresses and phone number:

Department of Public Health
Radiologic Health Branch
P.O. Box 997414, MS-7610
Sacramento, CA 95899-7414
Email: RHBInfo@cdph.ca.gov
(916) 327-5106
www.cdph.ca.gov

Access to Title 17 is available for all staff through PolicyStat and can be found within the Imaging Services policy section or directly as policy "IS.17 Title 17 California Code of Regulations".

TABLE of CONTENTS

I. Organization and Administration

The delegation and responsibility for each aspect of the radiation program and provisions for ensuring enforcement of radiation safety policies and procedures are as follows:

A. **Facility Radiation Safety Officer, qualifications and responsibilities.**

1. VCMC/SPH's designated Radiation Safety Officer is Miguel Jimenez in partnership with our medical physicist, Therapy Physics Inc.
2. The primary responsibility of the Radiation Safety Officer's (RSO) is implementing the Radiation Safety Program. The RSO shall ensure that radiation safety activities are performed with approved procedures, meeting all regulatory requirements in the daily operation of the licensee's radioactive materials program.
3. The Radiation Safety Officer shall promptly investigate and implement corrective actions as necessary regarding:
    a. Overexposures
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Accidents
    d. Spills
    e. Losses
    f. Thefts
    g. Unauthorized receipts, uses, transfers, and disposals; and
    h. Other deviations from approved radiation safety practice. A written report of these investigations and the corrective actions taken shall be given to management.
4. The Radiation Safety Officer shall implement written policies and procedures to:
    a. Authorize the purchase of radioactive material
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Receive and open packages of radioactive material
    d. Store radioactive material
    e. Keep an inventory record of radioactive material
    f. Use radioactive material safely
    g. Take emergency action if control of radioactive material is lost
    h. Perform periodic radiation surveys
    i. Perform checks of survey instruments and other safety equipment
    j. Dispose of radioactive material
    k. Train personnel who work in or frequent areas where radioactive material is used or stored; and
    l. Keep a copy of all records and reports required by department regulations,

a copy of these regulations, a copy of each licensing request and license including amendments, and the written policies and procedures required by the regulations.

5. The Radiation Safety Officer shall:
    a. Approve radiation safety program changes for medical use not at a medical institution with the consent of management prior to sending to the department for licensing action. assist the radiation safety committee for medical use at a medical institution.
    b. review, sign and date, at least every 3 months the occupational radiation exposure records of all personnel working with radioactive material.

II. ALARA Program

VCMC/SPH uses, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA) and documents procedures addressing this requirement. Staff resources and educational materials are available within PolicyStat and through annual education.

III. Dosimetry Program

All registrants are responsible for the protection of individuals that enter the registrants' controlled areas. The registrant is also responsible for ensuring that the public is protected and that the public dose does not exceed the limits found in 10 CFR 20.

A. Each facility must evaluate whether or not personnel monitoring for occupational exposures is required. If a facility chooses to or is required to monitor, then those who are occupationally exposed to radiation should be instructed in the following:

    1. Types of individual monitoring devices used and exchange frequency.
        - Landauer Film badges (and TLD finger rings for Nuclear Medicine): Monthly

    2. Use of control badges.
        - The use of the control badge is used to maintain a base reading of non-occupational exposure. Control badges are kept in the respective departments until ready to be sent back with appropriate dosimetry badges for reading.

    3. Instructions to employees on proper use of individual monitoring devices, including consequences of deceptive exposure of the device.
        - See Radiation Safety Policy "IS.19 Staff Radiation Safety and Dosimetry Monitoring"

    4. Procedures for ensuring that the combined occupational total effective dose equivalent (TEDE) to any employees receiving occupational exposure at this facility and at other facilities does not exceed 5 rem per year.
        - Employee dosimetry reports are monitored at specified intervals (see #1 above) to ensure their combined occupational total effective dose equivalent does not exceed 5 rem per year. An employee's exposure is investigated further if his/her monthly deep dose equivalent is greater than 125 mrem (ALARA Level 1) or quarterly deep dose equivalent is greater than 375 mrem (ALARA Level 2) in a quarter.

    5. Procedures for obtaining and maintaining employees' concurrent occupational doses during that year.

        Employees are required to self-disclose any and all concurrent occupational doses received during the previous year in January of the subsequent year or upon being

employed. Their doses will be sent to Landauer for inclusion in their dose record. The RSO and designate will investigate in a timely manner the cause(s) of all personnel exposures equaling or exceeding Investigation Level II and, if warranted, will take action. A notice of exposure and a questionnaire will be sent to the affected staff to determine the source of exposure. An acknowledgement letter will be obtained from the affected staff. A report of the investigation and actions taken will be presented to the Radiation Safety Committee at the first Radiation Safety Committee meeting following completion of the investigation. The details of these reports will be recorded in the Radiation Safety Committee minutes.

6. Procedures for ensuring that if minors are employed, their occupational TEDE does not exceed 500 millirem per year
    - N/A. We don't employ nor have any intentions of employing minors.
7. Procedures for addressing a declaration of pregnancy.
    - See policy *IS.56 Radiation Protection*. Declaration by employees and withdrawal is a voluntary process.
8. Procedures for maintaining documentation of dose to the embryo/fetus and associated documentation for the declared pregnant worker.
    - If an employee declares a pregnancy, she will be required to wear a fetal badge at the waist level and her dosimetry badge at the collar level. The fetal badge will be submitted and processed once a month to ensure fetal readings do not exceed the set dose limits. The employee's occupational dosimetry badges will be submitted monthly or quarterly based on the department (see item #1). All dosimetry reports are evaluated by the RSO and/or designate to ensure compliance with state/federal regulations concerning dose limits.

IV. Area Monitoring and Control

A. **Radiation Area Monitoring**

The need for area monitoring shall be evaluated and documented.

- Any area regulated through protective measures and safety provisions is considered a "Controlled Area". Access is restricted to controlled areas with warning signs specified in 17 CCR and incorporated sections of 10 CFR 20.
- Any area accessible to personnel in which there exists radiation at such levels that a major portion of the body (whole body, head and trunk, active blood-forming organs, gonads, or lenses of the eye) could receive in any one hour a dose equivalent in excess of 5 mrem or in 5 consecutive days a dose equivalent in excess of 100 mrem is considered a "Radiation Area"

B. **Instrument Calibration and Maintenance**

Instruments used to verify compliance with regulatory requirements must be appropriate for use and calibrated at required frequencies.

Maintenance of the machine should be addressed. This may be addressed in part by the operator's manual from the manufacturer.

All maintenance and calibration is completed by:

- G.E. Healthcare
- Phillips Healthcare
- Konica
- Siemens Medical
- Hologic
- Varian
- In-house Biomedical Engineering: Contracted to the above vendors for all radiation producing and radiation detection instrumentation on campus. All non-PM based services are coordinated with above vendors and completed by qualified field service engineers to meet current regulatory and manufacturer recommendations.

V. Radiological Controls

A. **Entry and Exit Controls**

Entry and exit from controlled areas must be adequate to ensure radiation safety. Design of emergency escape routes shall comply with applicable building codes. Document procedures addressing this requirement.

- All applicable building codes were followed in the design of emergency escape routes of our facility.

B. **Posting**

1. Areas that are required to be posted should be identified in the Radiation Protection Program, in addition to procedures for ensuring that such areas are properly posted. Also, include procedures for ensuring that areas or rooms containing as the only source of radiation are posted with a sign or signs that read "CAUTION X-RAY". Identify who is responsible for maintaining those signs and/or labels. In addition, certain documents must be posted. This requirement is found in 17 CCR 30255(b).
    a. Entrances to X-ray suites are posted with signs that read "CAUTION X-RAY".
2. Conspicuously post:
    a. A current copy of the 17 CCR, incorporated sections of 10 CFR 20, and a copy of operating and emergency procedures applicable to work with sources of radiation (If posting of documents specified above is not practicable, the registrant may post a notice which describes the document and states where it may be examined.)
        - A current copy of 17 CCR and incorporated sections of 10 CFR 20 can be found on PolicyStat within policy "IS.17 Title 17

California Code of Regulations"

b. A current copy of Department Form RH-2364 (Notice to Employees) in a sufficient number of places to permit individuals working in or frequenting any portion of a restricted area to observe a copy on the way to or from such area.

- A current copy of RH-2364 (Notice to Employees) is posted in each department where ionizing radiation is utilized.

c. Any notice of violation involving radiological working conditions, or any order issued pursuant to the Radiation Control Law and any required response from the registrant.

- Notice of violation and any response will be posted in the cited department.

C. **Disposal of Equipment**

Registrants shall report in writing to the Department the sale, transfer, or discontinuance of use of any reportable source of radiation. See the Guidance for Disposal of X-ray Machines available http://www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx.

D. **Other Controls**

The registrant should evaluate the need for other controls in addition to those mentioned above.

1. The following items should be considered :

a. Types of controls used to reduce or control exposure to radiation, such as positioning aids, gonadal shielding, protective aprons, protective gloves, mobile shields, etc.

- Refer to the "Apron Inventory" listing all of the above in each department utilizing radiation or radiation-producing devices.

b. Procedures for routine inspection/maintenance of such controls.

- Refer to the policy "IS.24 Lead Apron and Glove Survey" on PolicyStat

VI. Emergency Exposure Situations and Radiation Accident Dosimetry

Identify any possible emergency exposure situations or radiation accidents and document procedures to address such, to include dose assessment.

- An established process to address and manage high radiation dose fluoroscopically guided procedures to ensure proper patient follow-up and follow-ups on suspicious readings has been developed and is followed.
- All exposure situations or radiation accidents that have occurred are reported immediately to the RSO and reviewed quarterly by the Radiation Safety Committee for trends and performance

improvement.

VII. Record Keeping and Reporting

All record keeping and reporting requirements are specified in regulations. Document the applicable requirements and commitments to compliance. The facility must also maintain all records of the Radiation Protection Program, including annual program audits and program content review. The following items should also be identified:

The person responsible for maintaining all required records.

- The RSO and/or delegate are responsible for maintaining all required records.

Where the records will be maintained.

- For the most part, all records will be located in Radiology or online.

The format for maintenance of records and documentation.

- Documentation of policies and procedures are online, with a hard copy for specific departments. Film Badge reports are located in their respective departments, and online with Landauer.

Procedures for record keeping regarding additional authorized sites (mobile providers).

- N/A

VIII. Reports to Individuals

The Registrant shall provide reports of individual exposure when requested in accordance with 17 CCR 30255. Document procedures addressing this requirement.

- Employees are provided, free of charge, dosimetry badges throughout the duration of their employment. Dosimetry badges must be submitted on a department specific basis. Monthly badges are available on the first of each month, quarterly badges are due on the 15th of each quarter. The dosimetry pick-up/drop-off container is located in each department utilizing badges. The most current dosimetry report is available through the "myLDR.com" web portal.
- User: VCMCDOSEREPORTS
- Pass: Radiation1
- The RSO or delegate reports Level 1 or higher exposure levels to the Radiation Safety Committee. A termination radiation dosimetry summary report is available to each employee once their employment has ended. Annual summary reports are kept indefinitely, available on-line from Landauer Inc.

IX. Radiation Safety Training

A. **Operating and Safety Procedures**

1. All registrants are required to have a written operating and safety procedure manual. This may be the operating manual that comes with a radiation unit which may

include safety procedures. However, if safety procedures are not included in the manual they must be developed. These safety procedures must be posted on the machine or where the operator can observe them while using the machine.

2. Document all training your employees, both occupationally exposed and non-occupationally exposed workers, are required to have before using radiation machines including continuing education. Also, document other training you provide to your employees or visitors such as radiation safety and protection program review, safety meetings, formal classroom training, etc.
3. Some of these requirements are found in the 17 CCR 30255(b) (1). Specifically, each registrant shall:
    a. Inform all individuals working in or frequenting any portion of a controlled area of the use of radiation in such portions of the controlled area.
    b. All new employees are required to attend a departmental orientation where he/she is orientated to the various components (policies & procedures) of our radiation protection plan.
    c. Instruct such individuals in the health protection problems associated with exposure to radiation, in precautions or procedures to minimize exposure, instruct such individuals in, and instruct them to observe, to the extent within their control, the applicable provisions of Department regulations for the protection of personnel from exposures to radiation occurring in such areas.
        i. This facility has adopted the Radiation Right policies as a guide to effective Radiation Safety.
        ii. Annual Radiation Safety review is mandated for all staff dealing with radiation and/or radiation producing devices.
        iii. Staff meetings are held routinely, and Radiation Safety incidents are reviewed for best practice.
    d. Instruct such individuals of their responsibility to report promptly to the registrant any condition which may lead to or cause a violation of department regulations or unnecessary exposure to radiation, and of the inspection provisions of 17 CCR 30254.
        i. Staff are encouraged to report any causes for concern promptly as it relates to department regulation violations or unnecessary radiation exposure. Excessive Fluoroscopy is reported and documented per policy and procedures.
4. Instruct such individuals in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation and advise such individuals as to the radiation exposure reports which they may request pursuant to 17 CCR 30255.
5. Any unusual occurrence or malfunction involving exposure to radiation will be promptly reported to the Equipment Service Coordinator who notifies the vendor and administration. Excessive radiation exposure reports will be documented and

presented to the Radiation Safety Committee.

X. Quality Assurance Programs

Quality assurance program testing and frequency will conform with CCR Title 17 and accreditation requirements. Examples include but are not limited to:

Radiographic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
AEC	Annual		None	Exposure meter
Collimation	Annual		<2% SID	IR + metal markers
Exposure Linearity	Annual		Greater or less than 10%	Exposure meter or ion chamber
Exposure Reproducibility	Annual		Greater or less than 5%	Exposure meter or ion chamber
Exposure time	Annual		<10 ms, greater or less than 20%	Exposure meter
			>10 ms, greater or less than 5%	
Filtration	Annual		>2.5 mm Al	Aluminum sheets
Focal Spot Size or Spatial Resolution	Annual		± 50% stated FSS - <0.8 mm 40% larger – 0.8 mm – 1.5 mm 30% larger – >1.5mm	Slit/pinhole camera or star pattern phantom
kVp	Annual		Greater or less than 10%kVp	kVp meter

Fluoroscopic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
ABC	Annual		None	Exposure meter
Exposure rate	Annual		<10 rad/min	Exposure meter
Protective apparel	Annual		No cracks or gaps	Fluoroscope, IR
Resolution	Annual		None	Resolution phantom

CT Scanner QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits
Contrast resolution	**Semiannual**		**Resolve 5mm objects at 0.5% contrast**
Linearity	**Annually**		**coefficient correlation between the densities & HU should equal or exceed 0.96%**
CT number Accuracy, Noise	**Daily**	**CT Technologist**	**0 +/- 5HU for CT number of water, Noise is dependent on scan parameter (mAs)**
Slice thickness <5mm	**Semiannual**		**0.5 mm**
Slice thickness >5mm	**Semiannual**		**±1.0 mm**
Spatial resolution	**Annual**		**greater or less than 20%**
Table increment accuracy	**Annually**	**Field Service Engineer (PM)**	**Expected table movement should be within ±2 mm**
Uniformity	**Daily**	**CT Technologist**	**<±10 HU across the image**

Regulations

Maintenance of all applicable regulations is required.

Acceptance testing performed on all newly acquired equipment prior to usage. Acceptance testing performed by qualified medical physicist. All acceptance testing procedures are to meet ACR, TJC, IAC, CDPH and Federal Requirements (i.e. MQSA).

XI. Internal Audit Procedures

The Registrant must audit the Radiation Protection Program on an annual basis. Documentation of the annual audits may be requested during inspection. The following items should be addressed depending on the scope of the radiologic health protection problems:

A. Identification of inspection types and program audits conducted, to include radiation machines, personnel and procedures.
    1. Each piece of radiation producing and or radiation detecting device shall be inspected by a qualified medical physicist on an annual basis. All annual testing shall be performed within the confines of current state regulations.
    2. Notification of failure to pass performance-based testing shall be documented and remedied within the allowable time period as dictated by current state regulations.
    3. In certain circumstances equipment must be retested by a qualified medical physicist. Vendor qualified field service engineers shall remedy all deficiencies noted in testing results, and their remedies shall be communicated to the qualified medical

physicist.

B. Identification of the individual(s) who are responsible for performing inspections and/or audits.
    1. Only qualified medical physicists shall perform inspections/audits. These individuals must meet requirements as outline by the accreditation body (The Joint Commission diagnostic imaging requirements) and be authorized by the State of CA to provide mammography services.
    2. As a Technologist:
        a. If the test indicates that the x-ray equipment is not functioning within specified standards, I will contact the department Director, equipment vendor, or in-house biomedical engineering to ensure that the equipment is repaired as soon as possible.
        b. If other image quality is not satisfactory, I will contact Therapy Physics, Inc (the medical physicist) to evaluate the system and correct the problem as soon as possible.
        c. All corrective actions will be carried out as soon as possible (within regulatory limits).

C. Identification of where and at what intervals the inspections and/or audits are conducted.
    1. The program is to be valid for VCMC/SPH
    2. Intervals of testing are to be annual. Testing in between annual periods will be dictated by equipment purchases, major component changes in particular systems or the movement of fixed equipment into areas that they do not normally occupy. Acceptance testing will be conducted at purchase and prior to clinical use for newly acquired equipment. All acceptance testing is designed to satisfy current CDPH, Federal, TJC, ACR, IAC standards.

D. Procedures for conducting the inspections and/or audits.
    1. We are contracted with qualified field service engineers as well as qualified medical physicists. Their contractual obligations are such that they are to make certain that all equipment is compliant with current state and OEM standards and specifications.
    2. The compliance is dictated by the frequency of visits and the legal mandate for frequency of testing. Deficiencies or fail items resulting from testing are remedied within the time confines of current state regulations.

E. Instructions on identification of proper use of instrumentation if staff performs machine maintenance or fluoroscopic monitoring.
    1. The quality control (QC) technologist is responsible for all quality assurance duties not assigned to the lead interpreting physician or the medical physicist. Normally, he or she is expected to perform these duties, but may also assign other qualified personnel or may train and qualify others to do some or all of the tests. When these duties are assigned to others, the QC technologist retains the responsibility to ensure they are performed in accordance with the regulations.
    2. "Other personnel qualified" means persons with technical training appropriate for the

task(s) assigned to them. Examples include a radiological technologist qualified under state regulations with appropriate training, a technologist who is trained to do the QC test(s) by the QC Technologist, or other persons appropriately trained to do the task(s) and supervised by the QC technologist. A receptionist or a secretary whose sole qualification is to copy documents, type, or answer the phone is not included under "other" qualified personnel.

All Revision Dates

5/12/2023, 1/26/2023

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	5/12/2023
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	5/12/2023
Imaging Services	Matt McGill: Director, Imaging Services	5/11/2023

Status **Active** PolicyStat ID **13674617**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	12/1/2013
Last Approved	5/23/2023
Effective	5/23/2023
Last Revised	5/23/2023
Next Review	5/22/2026
Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services

IS.16 Code Red in the MRI Department

POLICY:

Magnetic Resonance Imaging (MRI) personnel will work in conjunction with other hospital staff to ensure safe procedures are followed throughout the Code Red process. Safe procedures include the evacuation of any patients from the Magnetic Resonance (MR) Scan room (zone IV), assessment of the need to disable electrical power or magnetic field, and proper screening of all responders.

PROCEDURE:

FIRE EMERGENCY (CODE RED)

This procedure includes all fire emergencies in the MR scan room and may also involve patient emergency (code blue). For small fires, local MR-safe extinguishers can be used if the operator is confident and competent of its use. There is no responsibility to fight fires. In addition to patient-emergency rescue procedures, the MR operator is responsible for following these general procedures for Code Red:

A. Rescue the patient
    1. Remove patient from scan room. For medical emergencies, Code Blue procedures should be followed.
        a. For power failures, manual table movement is required.
    2. Move patient to a safe area.
B. Pull the nearest fire alarm.
C. Call the emergency line at x76666.
    1. State the code and appropriate location.
D. Press the “Emergency Power OFF” button.
    1. This will cut all power to MR room and system. Note: MR MAGNET IS STILL ON.
    2. These buttons are located inside and outside the MR scan room. They are distinguished from the MR Quench button.
    3. Note: for large fires that will need professional intervention, magnetic quench will be necessary.
E. Evacuate the MR control room.
F. Prevent emergency fire personnel from entering the MR room with external fire equipment. Local MR-safe fire extinguishers should be used to control confined fires.

1. For large fires in the gantry, MR quench will be necessary. (See MR Quench procedures)

Fire Containing Procedures

Following patient removal and emergency calls, procedures can be followed to extinguish small, controlled fires. However, there is no responsibility to do so. This will require an MR-Safe fire extinguisher. Please note the location of this device in the MR control room. The use of the extinguisher is generalized to the PASS procedures: P – Pull the pin from the MR safe extinguisher; A – Aim at the base of the fire; S – Squeeze the handle; S – Sweep from side to side.

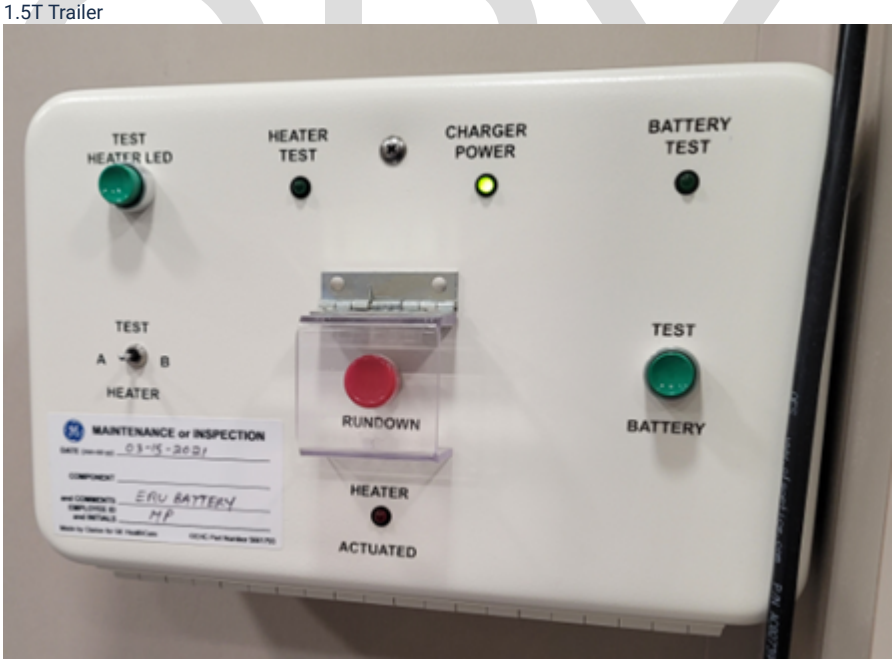
MRI EMERGENCY QUENCH and STOP BUTTONS:

A magnet emergency power off is specific to each scanner and should be known by the MR scanner operator prior to assuming any scanning duties. Use of the magnet emergency stop button should be restricted to extremely emergent conditions, which include:

- Forces attributed to the magnetic field that are causing patient or personnel injury.
- Fire and/or other unexpected occurrences that demand immediate action.

MR personnel should be familiar with the location and difference between the MR quench button and MR emergency power off button.

A. MR Quench button – located inside and outside MR room. Usually protected by plastic shield.
   1. May be used to disable the magnetic field if there is a fire in the scan room (Zone IV) that cannot be contained and/or if first responders must enter the room to contain the fire.
      a. 1.5T Trailer



b. 3T Fixed (North Tower)

B. MR Emergency Power Off – generally a red button with the label “EPO” or “Power OFF”.

1. Should be used to disable electrical power to equipment in the MRI room. It will NOT disable the magnetic field.

QUENCH

An MR “quench” is a release of the helium needed to cool the superconducting magnet. It can be triggered manually or can occur spontaneously. The process of a quench cannot be stopped. There are usually loud noises and the magnet gets very hot. Typically the rapid boil off of helium escapes through a vent, but can be very dangerous if the vent fails, does not function, or bursts. If this occurs, white chilled gas will escape into the room. It is essential that the room be evacuated before this occurs. With the gas present, oxygen will be depleted, and there is a high risk of asphyxiation and frostbite. There also will be an increase in pressure in the room, enough to destroy walls or equipment. All helium may not be dissipated during a quench, so no ferrous material should be allowed in the magnet room, including rescue equipment, until proper clearance is given.

A spontaneous quench can occur due to: fire, large projectiles, natural disasters or weather events, or no particular reasons at all.

A quench results in several days of downtime, and significant financial burden. It should only be activated in true emergencies.

A. When to Quench:

1. Quench only if there is a personal or patient injury risk.

2. A subject is “pinned” within or against magnet.
3. A fire within gantry that cannot be extinguished.

B. Quench is NOT necessary

1. For an isolated projectile in magnet, without patient risk; the service engineer should be called.
2. In an emergency event (i.e. ER code, fire), if the patient can be removed safely.

C. MRI Staff Workflow for Quench

1. Remain calm, and assess the situation. Determine if an emergency event warrants activation of a quench (see criteria above).
    a. If warranted, push quench button.
    b. If spontaneous quench occurs, inform the patient to stay calm, and to remain on the table. Follow the procedures below.
    c. If spontaneous quench occurs due to fire, follow MRI fire procedures.
2. Notify nearby colleagues/staff of the emergency.
    a. If available, other MR staff can initiate notification of appropriate emergency personnel
3. Keep MR door propped open in case of sudden cryogen gas release in the room.
4. Proceed to vacate patient:
    a. Move table out of magnet automatically (if power is still on) or manually with table release (if power is out)
    b. Transport patient out of MR room with dockable table, or magnet-safe stretcher (if table and/or patient is immobile).
    c. For “trapped” patients, a quench will last approximately 2-3 minutes, at which time the ferromagnetic object may become dislodged. Proceed to vacate patient after this time.
5. Transport patient to a safe area, which will be determined by the extent of the quench event, and the nature of patient injury.
6. Notify appropriate emergency personnel, if not already done so.
    a. Determine which codes need to be activated (i.e. fire, ER, etc).
7. Despite a quench event, no ferrous material should be allowed in the MR room (zone 4) until zero magnetic field is confirmed.
    a. If available, other MRI staff members should remain near the entrance of zone 4 to prevent premature entry of emergency personnel.
    b. If available, other MRI staff members should remain near the entrance of zone 3 to direct and inform emergency personnel of the event.
8. Notify manufacturer service engineer and Director of Imaging Services.
9. Document as much of the event as possible.

D. Quench Vent Failure

In some cases, there may be a failure of the vent, and cryogen may leak into the room (cloud of smoke). It is important to remain calm in this situation.

1. Prop the MR door and the hallway door open (to relieve pressure build-up).
    a. If the door does not open after several attempts, it may be necessary to break glass. Some installations also have a small trap door underneath the scanner console to relieve pressure.
2. Proceed to remove the patient as quickly and calmly as possible using the methods described above.
    a. Oxygen is dissipating with a cryogen/helium leak. Oxygen will be highest near the floor, so lowering table may be appropriate.
    b. There is also frostbite risk.
3. Transport patient to a safe place outside of the MR room and MR control room, and ensure emergency personnel is notified if patient requires attention.
    a. The open doors will allow gas/pressure to be released into control room.

4. Evacuate all other patients and personnel from the MR control room (zone 3 and 4) until normal air is restored.
5. Notify external emergency personnel, depending on the emergency event (i.e. fire, spontaneous quench).
6. Notify manufacturer service engineer, MRI director, and MR Physicist.
7. Document as much of the event as possible.

All Revision Dates

5/23/2023, 12/1/2015, 10/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	5/23/2023
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	5/23/2023
Imaging Services	Matt McGill: Director, Imaging Services	5/17/2023

Status **Active** PolicyStat ID **13315503**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	12/1/2001
Last Approved	5/23/2023
Effective	5/23/2023
Last Revised	5/23/2023
Next Review	5/22/2026
Owner	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU
Policy Area	PEDS/PICU

P.02 Hospital Pediatrics Indoor Playroom/Outdoor Play Area and Guidelines for Toy Maintenance and Donations

POLICY:

The purpose of this policy is to define the appropriate use of the outdoor play area, to define the appropriate type and maintenance of toys used in the Pediatrics Department and to set guidelines for toy donations.

PROCEDURE:

A. The play area is open seven days a week from 7:00 am to 4:00 pm and is monitored by either a staff member or a child life volunteer (over 18 years old). Only pediatric patients and their visitors may use the play area.

B. All children and their visitors *(under 18 years old)* must be supervised while in the play area. If a staff member or volunteer is not available, the pediatric patient can be supervised by their parent with the approval of the bedside or charge nurse. The outdoor play area opens at 0900 and closes at dusk.

C. All patients, visitors and staff shall wash their hands using soap and water or hand sanitizing gel before entering the play area.

D. Patients and their visitors must be free of fever, vomiting, diarrhea, and isolation precautions for 24 hours before entering the playroom. Patient visitors may have access to the play area if they are free from illness.

E. Patients on isolation are not approved to use the play area. Isolation-approved toys can be brought to the patient's room.

F. No food or drink is allowed in the play area.

G. No medical procedures are allowed in the play area. This space is designed as a "safe" area

for children to play freely. Child Life Specialist staff may use their discretion regarding a patient's ability to cope with procedures in or out of the indoor play area.

H. The play area may contain locked cabinets accessible only by Nursing or Child Life Specialist.

I. Staff will determine who should be permitted access to the play area (i.e., physicians, nurses, Child Life Specialist).

J. Toys can be borrowed from the play area and used for patients. Once toys are returned, they should be placed in the dirty toy bin or cleaned immediately.

K. Only hard-surfaced toys should be used (i.e., plastic, vinyl, varnished or painted wood or metal). Toys should be thoroughly cleaned with the approved disinfectant and allowed to dry.

L. Stuffed animals that are not washable are to remain with the patient and cannot be shared with other patients or their family members.

M. Crayons and markers should be non-toxic and washable.

N. Cloth and stuffed toys can be used on an individual basis provided the toy is new with all tags attached and has been inspected for patient specificity (no small parts, loose pieces, long strings, etc.).

O. Stored cloth toys shall be kept in sealed plastic bags until given to a patient at which time the plastic will be removed and discarded prior.

P. Toys should be developmentally appropriate. Toys for smaller and young children should not contain parts small enough to be swallowed.

PLAY AREA TOYS

Toys will be checked for obvious contamination and washed and dried, if needed, prior to use. All toys are to be inspected before and after use for safe construction, breakable parts and cleanliness.

GUIDELINES FOR TOY DONATIONS

Donations of toys and gift certificates to Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) are deeply appreciated. At times, certain types of toys are not appropriate for some patients, i.e., immunocompromised or respiratory compromised patients. VCMC retains the right to examine all toys for appropriateness and safety. Due to infection control guidelines and patient confidentiality, toy donors will not be able to deliver donations directly to patient rooms. Toy donations may be left with the Child Life Specialist, charge nurse or Clinical Nurse Manager.

Examples of acceptable new toys are as follows: rattles, teethers, mobiles, lullaby and music tapes, board books, remote control cars, Matchbox cars, balls, dolls, play houses/farms, bubbles, posters, view masters, baby gyms, squeeze toys, crib mirrors, blocks, See-n-Say, Etch-a-Sketch, action figures, water toys, electronic toys, and kaleidoscopes.

Acceptable new crafts:

Play Doh, non-toxic crayons and washable markers, glue, pipe cleaners, coloring books, stickers, glitter, water colors, jewelry making kits, sand art, paint by numbers, fabric, colored pencils, wood projects, beads, leather crafts, snap-together models.

Acceptable new electronics:

Radios, CD players, Game Boys, portable DVD players, video games and movies with appropriate ratings.

Other acceptable new items:

Word searches, color forms, puzzles, cards, teaching toys.

Examples of unacceptable toys:

Used cloth toys or stuffed animals, small toys that may present a choking hazard, violent video games or movies, used items that are broken, damaged, or unable to be cleaned per VCMC/SPH policy.

At certain times of the year, "character" figures visit the PICU/NICU/Peds. During these events, staff will make every attempt to provide a place for these special visitors so that any able patient in the unit will have the opportunity to participate in the event.

All Revision Dates

5/23/2023, 6/9/2020, 11/1/2016, 8/1/2016, 5/1/2011, 4/1/2008, 1/1/2005

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/23/2023
Pediatrics/PICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	5/18/2023

VENTURA COUNTY AMBULATORY CARE

Ventura County Health Care System Oversight Committee
Ambulatory Care Administrative Policies

June 08, 2023

The following administrative policies were reviewed and recommended for approval by appropriate departments and committees.

1. AC.03 Coverage for Medical Emergencies During and After Hours
2. AC.05 Ambulatory Care Back Office Practice Standards Resources
3. AC.07 Ambulatory Care Contracts and Sub-awards
4. AC.16 Ambulatory Care Emergency Facility Closure
5. AC.30 Timeliness of Documentation
6. AC.32 Assessing Patient Experience
7. AC.34 Ambulatory Care Laboratory / Imaging Results Tracking Policy

Status Active PolicyStat ID 13066632

Origination	10/1/2017	Owner	Martin Hahn: Regional Administrative Director, Ambulatory Care
Last Approved	4/3/2023		
Effective	4/3/2023	Policy Area	Ambulatory Care - Administrative
Last Revised	4/3/2023		
Next Review	4/2/2026		

AC.03 Coverage for Medical Emergencies During and After Hours

POLICY:

Ventura County Health Care Agency Ambulatory Care promotes patient health and well-being by providing after-hours access for providers and care team members to address routine, urgent and emergent needs after normal business hours through the health center's extended hour offerings at some locations and through telephone and secure electronic messaging. FQHCs shall provide patients access to after-hours clinical advice when the health center is closed to lessen patient use of the Emergency Department, promote continuity of care, and foster patient-centered care.

Ventura County Health Care Agency (VCHCA) Ambulatory Care, all Federally Qualified Health Centers (FQHC) providers and non-FQHC clinics has established a process for patients to receive clinical advice when the health center is closed, and delegation and monitoring of contractor performance with regard to compliance with HRSA program requirements in accordance with the Bureau of Primary Health Care (BPHC) HRSA Health Center Compliance Manual Chapter 7 and *Section 330(b)(1)(A)(IV) and Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.102(h)(4), 42 CFR 56.102(l)(4), 42 CFR 51c.303(a), and 42 CFR 56.303(a).*

PROCEDURE:

Definitions:

- Health Resources and Services Administration (HRSA) – The primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs.
- Federally Qualified Health Center (FQHC) – Includes all organizations receiving grants under

Section 330 of the Public Health Service Act that qualify for enhanced reimbursement from Medicare and Medicaid.

- Community Health Center (CHC) – The collective primary clinics subject to the HRSA grant requirements.
- FQHC Provider – Licensed Independent Practitioner employed or contracted to provide clinical services at any of the County of Ventura's FQHCs.

Hours of Operation:

1. Extended hours may be offered early a.m., evenings or weekends.
2. Each FQHC location will post the clinic hours and after hours information at the clinic for the public to see.
3. The hours and after hours information for the CHC shall be accessible to the public through posting on the VCHCA website.

Medical Emergencies During Clinic Hours

1. Each FQHC location will offer clearly defined arrangements for promptly responding to patient medical emergencies.
2. All FQHCs have the capability of referring patients to a local urgent care site if medically indicated.

After-Hours Telephone Access:

1. When the health center is closed, phone lines are transferred to a contracted answering service vendor each time a patient calls. FQHC providers are responsible for offering professional after-hours coverage and for ensuring that the contracted vendor has current provider call schedules and current contact information. The Health Care for the Homeless Clinic and some non-FQHCs provide a recorded message after hours directing callers to either urgent care or emergency room locations.
2. When life-threatening emergency situations are identified patients are instructed to call 911 or go to the nearest emergency room. The after hour access answering service and/or the provider on call should make reasonable attempts to find out which hospital the patient is being transported to. Subsequently, a call may be placed to the facility, when appropriate, and report of the emergency situation and disposition is made to their personal clinician the following day.
3. Non-life threatening calls received by the after-hours answering service that are determined appropriate for a provider call back using the triage criteria and decision-support tools should be immediately forwarded to the on call provider. Calls placed to the on call provider should include patient demographic (name, date of birth, telephone number), personal clinician, and clinical symptom information that is necessary to locate the patient's electronic health record for review.
4. On call providers are expected to contact patients within a reasonable time frame after receiving the call to provide clinical advice as needed. Clinical advice provided is documented in the clinical record at the time of the call.
5. The answering service records the time each call is received, the time the call is closed, and

the disposition of the call (e.g., instructed to go the ER or time the provider was contacted, etc.). Each FQHC has access to documentation of after-hours calls and provides any necessary follow-up resulting from such calls for the purposes of continuity of care.

CHC Board Approval: 02/23/2023

All Revision Dates

4/3/2023, 10/1/2017

Approval Signatures

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/3/2023
Ambulatory Care	Martin Hahn: Regional Administrative Director, Ambulatory Care	3/21/2023

Status Active PolicyStat ID 11722953

VENTURA COUNTY HEALTH CARE AGENCY

Origination	6/1/2015
Last Approved	2/28/2023
Effective	2/28/2023
Last Revised	2/28/2023
Next Review	2/27/2026
Owner	Lizeth Barretto: Chief Operating Officer, Ambulatory Care
Policy Area	Ambulatory Care - Administrative

AC.05 Ambulatory Care Back Office Practice Standards Resources

POLICY:

To facilitate back office patient flow in a cost-effective manner, to improve/maintain health outcomes in the Ambulatory Care clinics.

PROCEDURE:

DEFINITIONS:

- Scope of Practice: Actions, procedures, etc. that are permitted by law for a specific profession. It outlines restrictions to what the law allows, based on specific experience and educational qualifications.
- Resource: A source of information or expertise.

Clinics may maintain policies in areas designated as higher acuity (example: Pediatric Oncology), and provide approved specialty-specific resources.

Responsibilities:

- All back office staff are responsible for the knowledge of their individual scope of practice and regulatory limitations.
- The Clinic Administrator, Clinical Nurse Manager, assigned super-user, and/or designee will inform/inservice clinic back office staff based on scope of practice.
- Documentation of staff training will be maintained by the trainer/educator and/or Manager as appropriate.

Available Staff References:

- Nursing reference book(s) will be available in all clinics to be utilized as a guide for those clinical nursing skills identified as “Standard Nursing Practice." Each clinic will provide the most up-to-date version of the selected reference book(s).
- Any of the reference materials/websites listed below can be utilized:
    - Clinical Nursing Skills and Techniques; Mosby, Inc.
    - Fundamentals of Nursing; Lippincott, Williams, and Wilkins.
    - Lippincott Nursing Drug Guide; Wolters Kluwer Health.
    - Davis’ Drug Guide for Nurses; F. A. Davis Company.
    - Pearson Nurse’s Drug Guide (current year); Prentice Hall.
    - Mosby’s (current year) Nursing Drug Reference; Elsevier, Inc.
    - Epocrates® Online Medical Reference: https://online.epocrates.com
    - UpTo Date: https://www.uptodate.com/login
    - Electronic Health Record – Cerner: http://cernerapps/Prod/auth/login.aspx
    - Micromedix 2.0.
    - California Department for Public Health Immunization Branch, Vaccines for Children website: http://eziz.org
    - Immunization Action Coalition website for health professionals: www.immunize.org
    - Immunization Action Coalition website for public educational use: www.vaccineinformation.org
    - Centers for Disease Control and Preventions website for vaccines and immunization information use: www.cdc.gov/vaccines
    - Epidemiology and Prevention of Vaccine-preventable Diseases; The Pink Book; Centers for Disease Control and Prevention; Public Health Foundation.
    - Lippincott Procedures (VCMC intranet): https://procedures.lww.com/lnp/home.do
- Clinics may have additional department-specific standards manual/reference books available based on the types of patients they care for (for example, oncology). Each clinic shall provide the most up-to-date version of selected reference book(s).
- Any of the reference book listed below can be utilized:
    - Wong’s Nursing Care of Infants and Children; Mosby, Inc.
    - Chemotherapy and Biotherapy Guidelines and Recommendations for Practice; Oncology Nursing Society.
    - Infusion Nurses Society Infusion Nursing: An Evidence-based Approach; Elsevier Health Sciences.
    - Policies and Procedures for Infusion Nursing; Infusion Nurses Society; Infusion Nurses Society, Inc.
    - Oncology Nursing Drug Handbook; Jones and Bartlett Learning LLC.
- All clinics shall also have access to manufacturer equipment manuals for specialized, unit-

specific equipment (for example, cryogen, infusion pump).

All Revision Dates

2/28/2023, 7/29/2019, 7/1/2016

Approval Signatures

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	2/28/2023
Ambulatory Care	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	2/28/2023
Ambulatory Care	Martin Hahn: Regional Administrative Director, Ambulatory Care	1/4/2023

Status Active PolicyStat ID 11722942

Origination	8/1/2017	Owner	Lizeth Barretto: Chief Operating Officer, Ambulatory Care
Last Approved	4/27/2023		
Effective	4/27/2023	Policy Area	Ambulatory Care - Administrative
Last Revised	4/27/2023		
Next Review	4/26/2026		

AC.07 Ambulatory Care Contracts and Sub-awards

POLICY:

To establish a process for Ventura County Health Care Agency (HCA) Ambulatory Care to monitor and track Ambulatory Care clinic and FQHC provider contractor performance. In compliance with HRSA program requirements in accordance with **45 CFR Part 75 – Subpart D Post Federal Award Requirements:** The recipient's performance should be measured in a way that will help the HHS awarding agency and other non-Federal entities to improve program outcomes, share lessons learned, and spread the adoption of promising practices. The HHS awarding agency should provide recipients with clear performance goals, indicators, and milestones as described in §75.210.

PROCEDURE:

Definitions:

- Health Resources and Services Administration (HRSA) – The primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs.
- Federally Qualified Health Center (FQHC) – Includes all organizations receiving grants under Section 330 of the Public Health Service Act that qualify for enhanced reimbursement from Medicare and Medicaid.
- Community Health Center (CHC) – The collective primary clinics subject to the HRSA grant requirements.
- Environment of care (EOC) rounds – Mock survey event to ensure regulatory compliance and readiness.
- Uniform Data System (UDS) –. A standardized reporting system that provides consistent information about health centers. This report is submitted annually to HRSA by the CHC.

All FQHC staff will participate in regular training to ensure compliance with HRSA program requirements. Contractor performance will be monitored through regular EOC rounds, regular review and analysis of UDS measures, and review of required monthly productivity reports.

CHC Board Approval: September 24, 2020

All Revision Dates

4/27/2023, 8/1/2017

Approval Signatures

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/27/2023
Ambulatory Care	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	4/26/2023
Ambulatory Care	Martin Hahn: Regional Administrative Director, Ambulatory Care	9/14/2022

Status Active PolicyStat ID 8623668

VENTURA COUNTY HEALTH CARE AGENCY

Origination	7/22/2008
Last Approved	12/13/2022
Effective	12/13/2022
Last Revised	12/13/2022
Next Review	12/12/2025
Owner	Martin Hahn: Regional Administrative Director, Ambulatory Care
Policy Area	Ambulatory Care - Administrative

AC.16 Ambulatory Care Emergency Facility Closure

POLICY:

To ensure that adequate policies, procedures, and practices are in place for a safe operational response for the need of emergency closure of Ventura County Ambulatory Care clinics.

PROCEDURE:

If an event occurs that results in an Ambulatory Care clinic being unfit to provide medical services, Ambulatory Care clinic staff shall adhere to the following guidelines:

1. If the event occurs during operating hours and there is danger to the patients and staff:
    a. Evacuate patients/visitors/staff as soon as possible to designated rally points.
    b. Notify Ambulatory Care Administration.
    c. Follow up with a Notification Form to document the events for review and an After Action Report.
2. If the event occurs during operating hours, but there is no danger to the patients and staff:
    a. Patients shall be asked to leave the clinic in an orderly fashion.
    b. The staff member in charge shall provide direction to other clinic staff as to their duties.
    c. The staff members in charge of the office shall be:
        - The Medical Director.
        - In absence of the Medical Director, it shall be the Clinic Manager.
        - In absence of the Medical Director and Clinic Manager, it shall be the office Nurse Manager or designee.

d. If the power is out, move to downtime operations for patient discharge and final patient charting.

e. Notify Ambulatory Care Administration.

f. Document events with a Notification Form and After Action Report.

3. If the event occurs during after-hours:

    a. The Medical Director or office manager shall:

        - Notify Ambulatory Care Administration.
        - Activate the clinic staff phone tree.

    b. Document events with a Notification Form and After Action Report.

FOR ALL EVENTS:

1. If the clinic has been determined to be safe to enter, but is not able to provide services:

    a. Patients shall be notified of the closure and where they can receive alternate services, and, if possible, when the clinic will be open. A notice of closure shall be placed on the door of the clinic. If the closure is expected to last longer than one day, notice of closure will be placed on County website.

    b. Arrangements shall be made for long-term security and disposition of:

        - Patient records and Protected Health Information.
        - Medications and vaccines - If there is a loss of electrical services, follow the Emergency Medication and Vaccine Retrieval and Storage Plan for Power Outage.
        - Immunizations.
        - Hazardous materials.
        - Other office contents.

2. If the clinic facility is damaged and unfit to provide services for an extended period of time, contact the Facilities Maintenance Department to assess if the building is safe to enter. If needed, contact the appropriate authorities (Fire Department, Engineering, County, etc.) to inspect the structure and determine if the facility is safe for entry. The contents of the building - particularly confidential patient records - will be protected from access by unauthorized individuals.

All Revision Dates

12/13/2022, 8/1/2017

Approval Signatures

Step Description	Approver	Date

Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	12/13/2022
Ambulatory Care	Martin Hahn: Regional Administrative Director, Ambulatory Care	12/13/2022

Status **Active** PolicyStat ID **13108519**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	10/11/2021
Last Approved	5/8/2023
Effective	5/8/2023
Last Revised	5/8/2023
Next Review	10/10/2024
Owner	Lizeth Barretto: Chief Operating Officer, Ambulatory Care
Policy Area	Ambulatory Care - Administrative

AC.30 Timeliness of Documentation

I. **SCOPE:**
To define the expectation for completion of ambulatory care clinic medical records and establish a procedure to support a member of the Medical Staff, including Licensed Independent Practitioners (LIP) and healthcare workers who provide direct services to patients, has either incomplete medical records or is delinquent in completion of medical records.

II. **PURPOSE:**
Timely completion of visit documentation is necessary to provide safe and effective care to our patients. Incomplete or untimely documentation creates delays in care and negatively impacts patients.

III. **DEFINITIONS:**

EHR- Electronic Health Record.

LIP- Any Licensed Independent Provider who can provide a visit, including but not limited to; doctor, nurse practitioner, physician assistant, psychologist, licensed clinical social worker and registered dietician.

Healthcare Workers- Any professional who provides documentable direct service to patients including LIPs.

Medical Staff Member- Any LIP who is a member of the Medical Staff.

Clinic Administration- Program or clinic managers responsible for the oversight of clinic operations.

Medical Director- Clinic Medical Director.

Day- Calendar Day

Day 0- Day of clinic encounter

Incomplete Record- A medical record that has not been completed more than three (3) days (i.e. 72 hours) after the patient encounter.

Delinquent Record- A medical record that has not been completed fourteen (14) or more days after the patient encounter.

IV. POLICY:

A. The patient's clinic medical record should be completed and signed electronically in the Electronic Health Record (EHR) or signed legibly in ink during EHR down-time by those providers involved in the patient's care within 3 days after each encounter. The 3-day (or 72 hour) period is consecutive (inclusive of weekdays, weekends and holidays) and will commence at 11:59 PM PST on the day of the encounter. Clinic Administration will monitor progress and provide support, including but not limited to, sending email notifications of deadlines for the submission of encounter records in accordance with section V of this policy in order to reach the submission timelines, as defined in this document, if encounters are not closed at 14 days.

B. The ambulatory clinic record should include the following elements if applicable to the practitioner's scope of practice and the nature of the visit:

1. Updated demographic data.
2. Clinical documentation, including the dates and time of the visit, with the patient’s history, physical examination, and all information necessary to support a well-informed assessment and treatment plan.
3. Treatment recommendation should include any notation of prescriptions and/or diet instructions given, if applicable and self-care instructions.
4. Updated summary list, as appropriate, including chronic medical problems, medications, and allergy documentation.
5. Consultation reports.
6. Reports of all ancillary services, including laboratory tests, medical imaging examinations and pathology reports.
7. If a procedure was performed, a well-documented note summarizing the essential details of the procedure, including the techniques used, the findings and tissue removed or altered, as appropriate, and medications given.
8. Referral information from other providers.
9. Consent forms.
10. Resident physician documentation associated with the encounter.
11. Telemedicine encounters and electronic consults.
12. Billing and charges applicable to the visit.

C. Clinic Administration will utilize report for determining incomplete medical records, and for documentation requirements.

D. A failure to complete records shall not be cause for administrative suspension if the member is unavailable due to an unexpected emergency and the member notifies Clinic Administration of the absence in advance, and completes the medical record(s) in question within fourteen (14) days of his/her return.

V. PROCEDURE:

A. Medical records are expected to be completed within 3 days/72 hours after the encounter to facilitate care coordination as defined in IV(A).

B. All healthcare workers shall be responsible for completion of the medical record documentation for the clinic visit, entering all documentation, including progress notes and ambulatory clinic procedure notes, into the EHR. During down time, handwritten notes shall be completed using an approved clinic form and scanned into the EHR. All billing and charges must be supported by the appropriate documentation of services.

C. For each patient encounter, clinic documentation is expected to be in the record, signed and submitted, within 3 days after the encounter. Clinic notes forwarded for an attending physician's co-signature are expected to also be completed, signed and submitted within 3 days after the encounter.

D. If at any time the practitioner contests the incomplete or delinquent medical record, it is the responsibility of the practitioner to contact Clinic Administrator promptly. Clinic Administrator, with the Medical Director's support, will investigate the practitioners claim, taking into consideration any mitigating circumstances to make a final determination. The timeline for any pending action against the practitioner will be stopped immediately after written/emailed submission of his/her contestation, until such determination is made by Clinic Administrator in writing via email response, thereafter the timeline for pending disciplinary action will resume from when it was stopped.

E. When clinic documentation is not completed within 3 days after the encounter, the process will proceed as follows:

1. Time = Day 4 after patient encounter: Clinic Administrator will inform provider and Medical Director of the incomplete documentation. The notification shall be via email and shall include the date of potential suspension. If the documentation is not completed, the process continues as below.

2. Time = Day 7: The Clinic Administrator will evaluate the incomplete medical record(s) to confirm responsibility and will establish formal contact with the provider via email. The Clinic administrator may utilize text messaging or phone call in addition to email to contact the provider, but these methods are not required and shall not replace formal contact via email. The clinic administrator shall inform the Medical Director of the incomplete medical record(s) and potential for suspension if the medical record is not completed within the next 7 days.

3. Time = Day 12: Clinic Administrator notifies Medical Director, Regional Administrative Director (RAD) and Ambulatory Care Chief Medical Officer (CMO) of provider's incomplete record(s). Medical director informs provider of potential suspension. The notification shall be in writing via email and shall include the date of potential suspension, if the record(s) become delinquent.
4. Time = Day 14: If the subject medical record(s) is/are still incomplete, they are now considered delinquent. Clinic Administrator will notify the provider, Medical Director, RAD, Ambulatory Care CMO, and/or their designee of the imminent administrative suspension. If the record is not immediately completed, the Clinic Administrator will notify the Medical Staff Office of administrative suspension of privileges.
5. Notification shall be provided to providers timely, taking into consideration weekends, holidays, and approved employee time off.

F. Once the suspension of privileges for delinquent medical records has been initiated, the Ambulatory Care CMO or designee will:
    1. Contact the provider via phone call.
    2. Forward a suspension letter to the provider via email (See Suspension Letter Template).
    3. Send a certified copy of the suspension letter to the provider via USPS.
    4. Notify the providers Department Chair.
    5. Notify the clinic Medical Director.
    6. Notify the Ambulatory Care CEO

G. Patients who require care will be referred to the medical director to triage their care needs until the physician's privileges are restored. Scheduled clinic time that is disrupted due to suspension will still count towards work hours but with zero productivity for patient care encounters.

H. While under suspension of privileges for delinquent medical records, no new non emergent procedures or clinic days will be allowed.

I. The Clinic Medical Director may, on an individual basis, decide to withhold suspension for delinquent records in emergent situations as necessary. No suspension shall compromise patient safety. Providers shall have the right to request an extension for completing medical records in the event of an emergency to the Clinic Medical Director in order to withhold suspension, and shall not be unreasonably denied.

J. The practitioner will remain on suspension until the practitioner has completed all delinquent medical records.

K. Upon completion of all delinquent records, the Ambulatory Care CMO and/or their designee will notify the provider and personnel listed in section V.F.1-6 via email, text messaging, or phone call, of immediate reinstatement. In addition, reinstatement of privileges shall be confirmed with formal contact with email to the provider. The

provider shall also have the right to request immediate reinstatement after completion of documentation.

L. Exceptions may be made by the Ambulatory Care CMO for providers with delinquent medical records who are ill, on vacation, or out of town for an extended period of time, depending on the exigent circumstances. In the provider's absence, the delinquent medical records shall be reassigned to the Ambulatory Care CMO for administrative closure.

M. Monitoring- The Clinic Administrator shall conduct a monthly review encompassing all clinical services to determine chart completion compliance. Results shall be reported to the Medical Executive Committee for further action as appropriate.

N. Instances of incomplete documentation shall not be included in the employee's Personnel Files if all documentation is completed prior to Day 7. Employees who complete all incomplete documentation prior to Day 7 shall still be considered to be in "good standing" and "satisfactory" within County's policies and regulations.

All Revision Dates

5/8/2023, 10/11/2021

Approval Signatures

Step Description	Approver	Date
Health Information Management Committee	Mary Jane Green: HIM Manager	5/8/2023
Ambulatory Care	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/14/2023

Status **Active** PolicyStat ID **13312831**

Origination	5/10/2023	Owner	Rachel Stern: Chief Medical Quality Officer
Last Approved	5/10/2023	Policy Area	Ambulatory Care - Administrative
Effective	5/10/2023		
Last Revised	5/10/2023		
Next Review	5/9/2026		

AC.32 Assessing Patient Experience

POLICY STATEMENT:

It is the policy of Ventura County Ambulatory Care (VCAC) to seek formal feedback from patients and families about their experience with their care at our medical clinics in order to identify potential opportunity to improve care. VCAC uses both qualitative and quantitative data to assess patient experience. Data sources include the patient experience survey and patient complaints and grievances.

RESPONSIBILITY:

The Chief Medical Quality Officer (CMQO) and quality team are responsible for the development and updating of this policy. The VCAC executive team and local clinic leadership are responsible for ensuring compliance with the policy. The Community Health Center (CHC) Board has ultimate authority, the Chief Medical Quality Officer has overall accountability, and the provisions of the policy are delegated to the local clinic leadership or designee for oversight and day to day operations.

PROCEDURE(S):

VCAC contracts with a vendor to distribute patient experience surveys. The survey questions are specific to the type of visit the patient had, meets the needs of Ventura County Ambulatory Care's various funding entities and provides useful information from VCAC patients about their care. The survey is conducted to assess the experience of patients and their families with VCAC.

The patient experience survey evaluates the following elements:

- Ease or difficulty of assessing healthcare services
- Patient communication with VCAC providers and staff. This includes patient reports of feeling respected, listened to and able to get answers to questions.
- Overall rating of provider and facility.

- Other topics may be selected for patient experience surveys when the need arises.

The patient experience survey is sent out by automated phone call or email after routine ambulatory visits no less frequently than weekly. Some patients are randomly selected to receive the full Agency for Healthcare Research and Quality (AHRQ) Clinician and Group Survey Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey. VCAC's quality team reviews quantitative data and patient comments at no less frequently than weekly. Clinic leaders also review their site-specfic data on a regular basis and transmit that information to relevant team members. If a serious patient safety or care quality issue is identified through the patient experience survey, the quality team will address it as per Policy 100.005 Patient Complaint Advocacy.

To assess the disparities of care, VCAC obtains feedback on the experiences of its vulnerable patient population. VCAC stratifies patient experience data by race and ethnicity to look for disparities in care.

Data obtained from the patient experience surveys and qualitative mechanisms are calculated and summarized, and the information is reported to the CMQO, who reviews that information ad hoc with the Ambulatory Care Performance Improvement Coordinating Council (AC PICC) and CHC Board. The AC PICC reviews complaints and grievances data quarterly. They may include a patient experience metric among their key quality metrics, such as overall rating of provider at their discretion and the discretion of the CHC Board.

The Chief Executive Officer (CEO), CMQO and CMO shall ensure that the patient is not discriminated or retaliated against for expressing negative information (if any).

IMPLEMENTATION

The CMQO in conjunction with the Chief Operating Officer and the local clinic leadership are responsible for the training and compliance of the policy.

All Revision Dates

5/10/2023

Approval Signatures

Step Description	Approver	Date
MEC/Oversight	Tracy Chapman: VCMC - Med Staff	5/10/2023
AC Chief Executive Officer	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/17/2023

AC Chief Medical Quality Officer	Rachel Stern: Chief Medical Quality Officer	4/17/2023
AC Quality Improvement Manager	Rachel Stern: Chief Medical Quality Officer	4/17/2023
AC Quality Improvement Manager	Michelle Meissner: AC Quality Improvement Manager	3/14/2023

Status Active PolicyStat ID 13400768

Origination	4/19/2023	Owner	Allison Blaze: Chief Medical Officer, Ambulatory Care
Last Approved	4/19/2023		
Effective	4/19/2023	Policy Area	Ambulatory Care - Patient Care Services
Last Revised	4/19/2023		
Next Review	4/18/2026		

AC.34 Ambulatory Care Laboratory / Imaging Results Tracking Policy

POLICY:

To provide and ensure timely communication and reviewing results from studies of lab/image ordered to patients, and are documented in the Electronic Health Record (EHR), which is essential for ensuring safe and effective quality patient-centered care.

POLICY STATEMENT:

It is the policy of Ventura County Ambulatory Care to track the orders for tests, as well as the notification of the results for patients and to follow up in a systematic process for all overdue results.

PROCEDURE(S):

A. Ventura County Ambulatory Care strives to electronically communicate with testing facilities, including laboratories and imaging facilities. The communication includes both ordering tests and retrieving results.

B. Ventura County Ambulatory Care uses an electronic medical records (EMR) system that has bi-directional interface capabilities with certain reference laboratories, such as Quest Diagnostics.

C. Providers are trained and educated on the process for placing orders and receiving results via the EMR. Components of training include:

1. The process of ordering labs.
2. Electronically submitting orders and printing orders for the patient.
3. Reviewing results by tasks that are created for electronic review and provider signature.

4. Forwarding result notes to clinical staff for patient outreach to discuss results with patient as directed by the provider.

D. Management of Abnormal Lab Results

1. Receipt of abnormal lab results through the EMR.
    i. Critical Labs are called to either the ordering provider, nurse, or on-call provider if after hours. See Policy 100.030 Critical Tests and Critical Results.
    ii. Abnormal Labs are assigned high priority and are flagged red in the EMR system. These flags alert the provider of the abnormal results to ensure timely follow-up with the patient.
2. Receipt and management of abnormal in-office lab results.
    i. In-house laboratory tests are performed during the patient's office visit.
    ii. Results are entered into the patients' medical record by the clinical staff performing the test and the provider has the capability to pull the result(s) into their progress note.
    iii. Provider will review, manage and discuss the result(s) with patient, parent or guardian.

E. Communication of abnormal results, per the provider's orders and documentation:

1. Abnormal result is interpreted by physician prior to clinical staff notifying patient, parent or guardian.
2. Provider will provide clear expectation for follow up results and care plan for the clinical staff member when handling abnormal results. Documentation is entered in the EMR and is consistent with medical and legal prudence.
3. A clinical staff member will attempt to contact the patient/parent/guardian by:
    i. Telephone call: If unsuccessful, after a minimum of three attempts, or telephone number is disconnected or no other emergency contact number documented in EMR, proceed to next step.
    ii. A clinical staff member will create a letter or certified (depending on result type) in EMR addressed to the patient, parent or guardian, providing one of the following and letter will be translated in the patient's appropriate language prior to mailing:
        1. Instructions for follow-up care.
        2. Instructions to call staff to discuss the results.
        3. Instructions to call to schedule an appointment with provider. Telephone call: If unsuccessful, after a minimum of three attempts, or telephone number is disconnected.

F. Communication of Normal Lab Results:

1. Normal result is interpreted by physician prior to clinical staff notifying patient, parent or guardian.

2. Communication of normal results will occur by one of the following methods:
    i. Provider or designated clinical staff member will outreach to patient, parent or guardian via phone call or patient portal to discuss normal result.
    ii. Provider or clinical staff member will create a normal result letter in EMR, and designated staff member will mail letter to the patient, parent or guardian. Letter will be translated in the patient's appropriate language prior to mailing.

G. Tracking Overdue Lab Results:
    1. When provider places an order for lab(s), a time frame is noted on the lab order for provider to select completion date.
    2. The Overdue Results are flagged in the patients EHR and is reviewed in a timely manner by the provider and will contain orders that do not have results within seven (7) days and any STAT orders within two (2) business days.
    3. Overdue Results Report includes Lab Collect orders that do not have a result within fourteen (14) business days after the expected completion date and laboratory orders that have expired, one year after the order date.
    4. Each business day, a designated staff member will monitor and manage the overdue results for management of overdue stat and clinic collect orders.
        i. Staff member will check if there is no final result for the test. If there is a result, the duplicate order will be canceled.
        ii. If no result is found for the test, staff member will create a telephone encounter with reason for call "test reminder" and will contact the patient via telephone to verify if the test was completed. If there is no phone number on file, contact patient's emergency contact.
        iii. If the patient had the test done at an outside facility, request results and scan according to the scanning workflow.
        iv. If the test was not done, ask when the test is scheduled and document. Note: not all tests require an appointment.
        v. If the patient does not have the test scheduled, offer to assist the patient with making the appointment and document.
        vi. If the patient does not answer the phone, leave a message to return call, or place a message on the patient's portal (refer to patient communication consent form). Leave encounter open and route to the ordering provider as well as verbal notification to the provider or designee as assigned.
        vii. If the patient does not respond, contact again in one business day and document in the encounter. A total of three (3) telephone attempts will occur within three (3) business days.
        viii. If the patient does not respond after the third phone call, send an overdue letter to the patient.
        ix. Send letter to the patient via mail and enclose order slip(s).
        x. If the patient does not respond or refuses the test, notify the provider so

there can be further discussion with the patient or the order can be canceled per the provider.

5. On a quarterly basis, a designated staff member will "work" the overdue results report.

IMPLEMENTATION:

The Clinic Medical Directors in conjunction with the Clinic Managers, are responsible for the training and compliance of the policy.

QUALITY CONTROL:

Ventura County Ambulatory Care shall monitor the policy and procedure in the following manner:

1. Designated clinic staff will monitor the "Orders Tab" daily and review with the clinical support staff.
2. If one type of result is deemed to be untimely in notification, the Chief Medical Officer shall review the situation to determine if an alternate testing facility will be used.
3. Reports will be run weekly on critical results, and reviewed in Clinical Operations to ensure results are being reviewed in a timely manner with patients.

All Revision Dates

4/19/2023

Approval Signatures

Step Description	Approver	Date
AC Chief Executive Officer	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/19/2023
Chief Medical Officer, Ambulatory Care	Allison Blaze: Chief Medical Officer, Ambulatory Care	4/18/2023

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Document Approvals

May 11, 2023

a. Medical Staff Forms

The following were reviewed and recommended for approval by the appropriate Departments, Committees, and the Medical Executive Committee

1.	Department/Division Medical Director Job Description	page 1
2.	Anesthesiology Privilege Checklist	page 2-3
3.	Bariatric Surgery Privilege Checklist	page 4-5

b. Policies & Procedures / Forms / Orders

The following were reviewed and recommended for approval by the appropriate Departments, Committees, and the Medical Executive Committee

4.	100.004 Patient Rights	page 6-12
5.	100.007 Admission Criteria to the NICU	page 13-15
6.	100.025 Medications: Ordering, Administration and Documentation	page 16-23
7.	100.028 Fetal Demise	page 24-27
8.	100.076 Pain Assessment, Management and Documentation	page 28-35
9.	100.112 Code White – Pediatric Medical Emergency	page 36-40
10.	100.267 Naloxone Overdose Rescue Kit	page 41-42
11.	106.029 Aerosol Transmissible Disease Exposure Control Plan	page 43-46
12.	106.037 Methicillin Resistant Staphylococcus Aureus (MRSA) Admission Screening	page 47-48
13.	106.039 Disaster/Emergency Volunteer Health Professionals	page 49-51
14.	107.072 Disclosure Policy/Communication After A Harm Event	page 52-57
15.	108.035 Patient Throughput (Intrafacility Admissions and Transfers)	page 58-59
16.	108.044 Clinical Implementation Guide for: Electrocardiogram Guided Tip Confirmation System During Peripherally Inserted Central Catheter Placement	page 60-63
17.	108.048 Midline Intravenous Catheter Placement	page 64-68
18.	Centralized Telemetry Monitoring	page 69-77
19.	AC.24 Retinal Imaging Systems	page 78-81
20.	AC.25 Terminating Patient-Provider Relationship	page 82-84
21.	AC.31 Ambulatory Care Standards of Care and Use of Clinical Practice Guidelines in the Clinics	page 85-87
22.	AC.33- Referral Tracking for Non-Clinical Services	page 88-89
23.	DM.001 Adult Inpatient Diabetes and Hyperglycemia Management	page 90-94
24.	ER.11 Emergency Obstetrical (OB) Patients	page 95-96
25.	ER.22 Standards of Care in the Emergency Department	page 97-99
26.	ER.24 Volunteers in the Emergency Department	page 100-101
27.	ER.51 Medical Legal Examinations	page 102-103
28.	IS.38 MRI Pre-Screening Process	page 104-105
29.	IS.56 Radiation Protection	page 106-108
30.	IS.57 Computerized Tomography Enterography	page 109-110
31.	RS.13 Outpatient Rehab Services Use of Dexamethasone	page 111-112
32.	S.94 Operating Room Admixture Preparation	page 113-115
33.	UR.05 Provision of Non-Urgent/Emergent Transportation	page 116-117
34.	MS.102.018 Peer Review	page 118-120
35.	PH.48 Medication Error Reduction Plan (MERP)	page 121-124
36.	PH.61 Automatic Stop Orders	page 125-126
37.	MCH.05 Car Seat Tolerance Screening	page 127-129
38.	MCH.12 Neonatal and Pediatric Physiologic Monitoring, Hygiene and Comfort Management Protocol	page 130-134
39.	MCH.19 OB/PEDS Access and Egress of Soiled Utility Room	page 135
40.	MCH.22 Resuscitation of the Neonate	page 136-142

VENTURA COUNTY MEDICAL CENTER
SANTA PAULA HOSPITAL
A Division of Ventura County Health Care Agency

Department/Division Medical Director Job Description

Qualifications

The Medical Director of each department/division at Ventura County Medical Center will hold current certification in their respective specialty, have a minimum of 5 years clinical experience, and demonstrated leadership qualities.

Responsibilities

1. The Medical Director is responsible for ensuring compliance with the Medical Staff bylaws, Rules, Department Rules and Regulations, Medical Staff and Hospital policies and procedures within the department/division.

2. Supervising the quality and appropriateness of care within the department/division.

3. Attend (or assign a designee to attend) any assigned Hospital and/or Medical Staff Committees.

4. Recommending to Hospital Administration and/or the Medical Staff requirements for equipment, personnel and medications relevant to the department/division.

5. Facilitating regular department/division meetings.

6. Providing and/or recommending ongoing continuing education to staff/practitioners in the department/division.

7. Participating in the development of department/division policies and procedures, and clinical practice guidelines.

8. Work in collaboration with the Chief Medical Officer and the hospitals Quality Assessment/Performance Improvement (QAPI) team to meet any department/division quality measures or regulatory reporting requirements as well as any contract specific requirements.

9. Oversight and completion of required department/division specific, Medical Staff, and agency-wide trainings and certifications.

Name: _____ (please print)

Signature: _____ Date: _____

Department/Division: _____

Delineation Of Privileges

Anesthesiology 2023 Draft

Name:

Privilege	Requested	Granted	Deferred	Suspended

Basic Criteria:
a. Completion of an ACGME or AOA-accredited residency program in Anesthesiology
b. Current board certification by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology **OR**;
c. Active participation in the examination process leading to certification within 5 years of completion of training

Evaluation Criteria:
A minimum of 5 cases reviewed (first cases/concurrent review)

Renewal Criteria:
a. A minimum equivalent of 1 full shift per month during the previous 24 months
b. Ongoing participation in Anesthesia case reviews

CORE PRIVILEGES IN ANESTHESIOLOGY:

General Anesthesia: ___ ___ ___ ___
Preoperative assessment, including interpreting laboratory studies, diagnostic studies, and treatment plans
Techniques of rendering a patient insensible to pain during medical diagnostic interventions or surgical procedures
Support of life functions and management of unconscious patients during anesthesia and surgery
Treatment of fluid electrolyte and metabolic disturbances.

Local and Conductive Anesthesia Included in the Core Privileges:
(Indicate in the comment section below, any portion of the core privileges not being requested)

Peripheral/Neuro-Axial Nerve Block
Subarachnoid Block
Epidural Block
Caudal Block
Intravenous Regional (Bier) Block

Procedures Included in the Core Privileges*:
(Indicate in the comment section below, any portion of the core privileges not being requested)

Direct Arterial Line
Central Venous Pressure Line
Swan-Ganz Catheters
Hypotensive/Hypertensive Technique
Respiratory Care, Nebulizer Therapy
Temporary Transvenous Pacing
Intrapleural Catheters
Fiberoptic Bronchoscopy
Ventilator Initiation/Management
Management of Patient Controlled Analgesia (PCA) Devices

Additional evaluation criteria may apply at the discretion of the Anesthesia Medical Director or Department Chief

NON-CORE PROCEDURES:
(must also meet core criteria)

Delineation Of Privileges

Anesthesiology 2023 Draft

Name:

Privilege	Requested	Granted	Deferred	Suspended
Transesophageal Echocardiogram (TEE)	___	___	___	___

Initial and Renewal Criteria:
a. Documentation of training through residency or fellowship **OR** certification from a nationally recognized training program in TEE
b. Core Anesthesia privileges
c. Documentation of 25 prior studies as primary operator during previous 24 mos
(If volume criteria not met, first 5 cases evaluated)

Evaluation Criteria:
Concurrent evaluation of first case

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 Surgery Date

Delineation Of Privileges

Bariatric Surgery

Name:

Privilege	Requested	Granted	Deferred	Suspended

GENERAL CREDENTIALING REQUIREMENTS*

1. Document that the surgeon is working within an integrated program for the care of the morbidly obese patient that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training, and psychological assistance as needed. Document methods of patient selection.

2. Document that the surgeon has a program in place to prevent, monitor and manage short-term and long-term complications.

3. Document that there is a system in place to provide and encourage follow-up for all patients. Follow-up visits should either be directly supervised by the bariatric surgeon of record or other healthcare professionals who are appropriately trained in the perioperative management of bariatric patients and part of an integrated program. When applicants cannot guarantee patient compliance with follow-up recommendations, they should demonstrate evidence of adequate patient education regarding the importance of follow-up as well as adequate access to follow-up.

4. Privileges to perform investigational bariatric procedures will be limited to those individuals with privileges to perform core bariatric procedures. All patients undergoing investigational procedures must be entered into the MBSAQIP database at the participating accredited center.

5. Bariatric Surgeons at the accredited center must maintain a minimum of 8 hours of Category I Continuing Medical Education credits per year or 24 hours of Category I Continuing Medical Education credits every 3 years relating to bariatrics/obesity.
Covering nonbariatric privileged surgeons must maintain a minimum of 12 Category I Continuing Medical Education credits every 3 years relating to bariatrics/obesity.

**Source: American Society for bariatric Surgery, "Guidelines for Granting Privileges in Bariatric Surgery"*

LAPAROSCOPIC BARIATRIC PRIVILEGES

BASIC CRITERIA: Successful completion of an approved residency training program in general surgery, with completion and maintenance of the American Board of Surgery certification (or eligibility for new graduates pending examination), **AND** at least **one** of the following:

a. Successful completion of an advanced laparoscopic fellowship, with a specialty focus on bariatric surgery **OR**;

b. Documentation of at least 25 bariatric surgery cases in the past two years, excluding gastric banding surgery.

INITIAL APPLICANTS: Must submit documentation of fellowship or case log as noted above.

EVALUATION CRITERIA/FPPE: 3 concurrent cases

REAPPOINTMENT CRITERIA: 25 cases per year.

Laparoscopic Bariatric Surgery: (includes privileges to admit, treat and perform history and physical exams) Gastric Bypass Sleeve Gastrectomy Adjustable Gastric Banding	___	___	___	___

OPEN BARIATRIC SURGERY

Delineation Of Privileges

Bariatric Surgery

Name:

Privilege	Requested	Granted	Deferred	Suspended

BASIC CRITERIA: Meet the basic criteria for laparoscopic bariatric privileges, the general credentialing criteria, **AND** at least **one** of the following:

a. Document operative experiences of 15 open bariatric procedures (or subtotal gastric resection with reconstruction) with satisfactory outcomes during either general surgery residency or post-residency training supervised by an experienced bariatric surgeon **OR**;

b. Surgeons who primarily perform laparoscopic bariatric surgery may obtain open bariatric surgery privileges after documentation of 50 laparoscopic cases and at least 10 open cases supervised by an experienced bariatric surgeon.

INITIAL APPLICANTS: Must submit case log(s) as noted above.

EVALUATION CRITERIA/FPPE: Open cases are considered rare/unplanned emergent events and not subject to FPPE requirements unless deemed appropriate by the Bariatric Medical Director or Department of Surgery Committee.

REAPPOINTMENTS: 15 cases per year **or** maintenance of laparoscopic bariatric privileges.

Open Bariatric Surgery: Involving stapling or division of the gastrointestinal tract *(includes privileges to admit, treat and perform history and physical exam)*	___	___	___	___

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 Surgery Date

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/1983*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/12/2020*
Next Review:	*3 years after approval*
Owner:	*Alicia Casapao: Director of Quality and Performance Improvement*
Policy Area:	*Administrative - Patient Care*
References:	

100.004 Patient Rights

POLICY:

The patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) and affiliated clinics have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial and spiritual values. VCMC/SPH and clinic staff members recognize that these values often influence the patient's perception of care and illness.

PROCEDURE:

This Patient Rights document incorporates the requirements of the The Joint Commission; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13 (Medicare Conditions of Participation).

Upon admission, in accordance with CMS-Condition's of Participation (Section 482.13); each patient, or when appropriate, the patient's representative will be informed of their patient's rights. These rights will be presented to them in a written brochure. The informational brochure is available in English and Spanish. The Patient Advocate will be contacted to provide assistance for patients with the different languages, assistive devices or difficulty understanding written material.

In accordance with Section 70707 of title 22, Division 5 of the California Administrative Code, Ventura County Medical Center/Santa Paula Hospital and clinic staff adopt the following list of patient's rights and responsibilities. This list shall be posted in both Spanish and English in the following areas:

A. Admitting
B. Emergency Room
C. Every clinic
D. Acute Psychiatric Unit (VCMC)

Patient Rights brochures (English and Spanish) are available to be distributed to patients. These may be ordered through forms management services.

Staff members of the Ventura County Health Care Agency are pledged to provide quality, respectful care to our patients; and support their right to be informed about their condition and right to make decisions that affect their well-being. Staff will deliver medical care in accordance with the statements of rights listed below.

All hospital personnel are instructed to observe and comply with each of the following patient's rights.

OUR PATIENTS HAVE THE RIGHT TO:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and nonphysicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or nontreatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital.

You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:

- No visitors are allowed.
- The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
- You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to sex, economic status, educational background, race, color,religion, ancestry, national origin, sexual orientation, gender identity/expression , disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling *(name, address and phone number of hospital)*: Ventura County Medical Center, Patient Advocate, 300 Hillmont Avenue, Ventura, CA, 93003 at 1-(805) 652-6691. The grievance committee will review each grievance and provide you with a written response within seven (7) days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).

23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is: *(local address and phone number of CDPH):*

Ventura District Office
1889 North Rice Avenue, Suite 200
Oxnard, CA 93030.

NOTE: Accreditation organizations, such as The Joint Commission, may also require that the hospital post a notice informing patients how they may file a complaint with the accreditation organization. Hospitals should check with their accreditation organizations and revise this Appendix accordingly.

PATIENT RESPONSIBILITIES

You (and your family, as applicable) also have the responsibility to:

1. Keep appointments or call ahead if you cannot keep your appointment.
2. Provide, to the best of your knowledge, accurate information about present complaints, past illnesses, medication, (including prescribed, non-prescribed, and herbal medicates), allergies, hospitalization, unexpected changes in your condition, possible risks in your care, and any other matters relating to your health; and provide us with feedback about your needs and expectations.
3. Bring immunization records for your child if the appointment or hospitalization is for your child.
4. Follow instructions; ask questions to make sure you are fully informed about your treatment and understand the plan for care. Be honest with us about instructions you receive; let us know if you do not understand them or feel that you cannot follow them.
5. Accept consequences for the outcomes if you do not follow your doctor's care, treatment, or service plan.
6. Follow the rules and regulations of the hospital, including the no-smoking policy, cell phone restrictions, and visitation guidelines.
7. Show respect and consideration for the safety and property of other patients and staff; keep information about others confidential; help maintain a quiet atmosphere; see that your visitors do the same.
8. Be prompt about the payment of bills, to give us information necessary for insurance processing of bills and to ask any questions you may have concerning your bills.

In accordance with Title 22 Section 70577, and Welfare and Institution Code Section 5325, patients' rights for the **VENTURA COUNTY MEDICAL CENTER, INPATIENT PSYCHIATRIC UNIT** will also include the right to:

1. Wear their own clothes.
2. Keep and use personal articles.
3. Keep and be allowed to spend a reasonable sum of their own money for expenses and small purchases.

4. Have access to individual storage space for private use.
5. See visitors each day.
6. Have reasonable access to telephones to both make and receive confidential calls.
7. Have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
8. Refuse shock treatment.
9. Refuse lobotomy.
10. Be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially.
11. Receive a copy of the State Department of Mental Health Patient's Rights Handbook.
12. Treatment services which promote the potential of the person to function independently.
13. Dignity, privacy, and humane care.
14. Be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect.
15. Medication shall not be used as punishment, for the convenience of staff, as a substitute program, or in quantities that interfere with the treatment program.
16. Prompt medical care and treatment.
17. Religious freedom and practice.
18. Physical exercise and recreational opportunities.
19. Be free from hazardous procedures.

To ensure that these rights are denied only for good cause, the Director of Mental Health shall adopt regulations specifying the conditions under which they may be denied. Denial of a person's rights shall, in all cases, be entered in the person's treatment record.

EMERGENCY MEDICAL SCREENING – COBRA, EMTALA (refer to Administrative Policy 100.068).

In accordance with the mission of Ventura County Medical Center/Santa Paula Hospital and under Section 1867 of the COBRA Act our patients have the right to:

1. A medical screening examination to determine whether or not an emergency medical condition exists, regardless of diagnosis, financial status, race, color, national origin, handicap, or payment source.
2. Necessary stabilizing treatment for emergency medical conditions, (including women in labor).
3. A safe transfer to another hospital when appropriate or when needing a higher level of care.
4. No delay in medical screening and/or stabilizing treatment in order to inquire about payment status.

AVAILABILITY OF INTERPRETER SERVICES

In order to meet the needs of our patients we realize the necessity to ensure adequate and speedy communication to our patients with language or communication barriers. In accordance with the Health and Safety Code Section 1259 and Title 22 – Department of Health Services, VCMC/SPH provides interpreter services upon request. The following interpreter services are available immediately on site: Spanish

There are other interpreters available by arrangement. To request an interpreter, please let your nurse or

doctor know and they will arrange access to the Health Care Interpreter Network (HCIN) System (Refer to Administrative Patient Care Policy #100.064). A family or friend may interpret if you choose.

UNIFORM STANDARDS FOR OBSTETRICAL CARE

It is the mission of Ventura County Medical Center/Santa Paula Hospital to "ensure the provision of care to persons, regardless of race, creed, color, or economic status, especially those persons who have difficulty obtaining care elsewhere." In keeping with the VCMC/SPH mission and Health and Safety Code Section 1256.2, we will provide one standard of obstetrical care to our OB patients. We will not deny pain management services based on the patient's ability to pay.

PAIN MANAGEMENT

We are committed to our patient's comfort. We will not deny pain management based on financial status or ability to pay. You have the right to have your pain or discomfort assessed and treated. We encourage you to participate actively in the planning and treatment of your care, including pain management. Please help us by asking questions and letting us know what we can do to assist you to be more comfortable.

ETHICS COMMITTEE

During an illness, difficult decisions must be made about treatment or stopping treatment, for you or your family member. The Hospital has specially trained staff to discuss and assist you with difficult medical decisions. To access this team, please speak with your nurse or doctor, or contact the Medical Staff Office at 652-6062.

CONCERNS OR COMPLAINTS

Complaints or concerns (including discrimination, auxiliary aids, and interpreter services) can be made to:

Ventura County Medical Center
Patient Advocate
300 Hillmont Avenue
Ventura, CA 93003
1-805-652-6691
1-800-735-2929 – TTY
1-805-652-6075 – VCMC Nursing Supervisor
1-805-933-8600 – SPH Nursing Supervisor

OR

Ventura County Behavioral Health
Patients' Rights Advocate
300 North Hillmont Avenue
Ventura, CA 93003
1-805-477-5731

OR

California Department of Health Services

1889 N. Rice Avenue, Suite 200
Oxnard, CA 93030
(805) 604-2926
(800) 735-2929 - TTY
(800) 735-2929 - TDD
(800) 735-2922 - Voice

OR

The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
(630) 792-5000
www.jointcommission.org

All revision dates: 2/12/2020, 9/1/2016, 6/1/2010, 5/1/2006, 1/1/2005, 11/1/2004, 7/1/2001, 2/1/2001, 8/1/1999, 11/1/1998, 7/1/1990, 7/1/1989, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/17/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/13/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/13/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/13/2023
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	2/13/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/28/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*Administrative - Patient Care*
References:	

100.007 Admission Criteria to the NICU

POLICY:

To identify neonates that are eligible for admission to the Neonatal Intensive Care Unit (NICU) by meeting established standards and to define the process of providing special observation and/or monitoring during the transition phase.

PROCEDURE:

NICU admissions may originate from Couplet Care, Labor & Delivery, Pediatrics, Operating Room, Emergency Room and through Transport for acute or convalescent care from other facilities. All neonates who meet the admission criteria may be admitted to the NICU.

All neonates requiring intensive care, including those with California Children's Services (CCS) eligible conditions admitted to the NICU, will be under the direct supervision of the NICU Medical Director or CCS-paneled neonatologist. The physician shall have evidence of successful completion of NRP course by the AAP or AHA. The physician shall be in the hospital or be no more than 30 minutes away from the NICU at any time, shall be on call for no more than one hospital at the same time, and shall be notified of new admissions and adverse changes in the status of neonates in a timely manner. Infants requiring intensive care provided by a Neonatal Nurse Practitioner (NNP) shall have daily review, evaluation and documentation of care by a CCS-paneled neonatologist. A CCS-paneled pediatrician with NICU privileges, in consultation with a neonatologist, may provide care to infants requiring intermediate or continuing care. Neonatology consultation will be initiated when consultation criteria are met (please refer to NICU policy N.56, *NICU Scope of Service*). A CCS-paneled neonatologist and pediatrician shall review, evaluate and document the clinical management of each infant, on-site, at least on a daily basis. It shall be the responsibility of the CCS-paneled neonatologist to ensure that information is provided on an ongoing basis to referring physicians regarding their patients.

Infants requiring special observation and/or monitoring during transition will be cared for in the Transition Care Nursery.

EXCEPTIONS

Admission through the Emergency Department, from home, or physician office may occur only with the approval of the NICU Medical Director or designee. All admissions coming through the Emergency Department, home, or a physician's office must have a negative Respiratory Synctial Virus (RSV) screen prior

to entering the NICU, and will be admitted to an isolation room.

RESPONSIBILITIES

A. Admission to the NICU is arranged by contacting the NICU Charge Nurse and notification of the appropriate pediatrician/neonatologist/neonatal nurse practitioner (NNP). At any time a question arises as to the appropriateness of an admission to the NICU, the Charge Nurse will contact the on-call attending Neonatologist and the NICU Clinical Manager and/or Nursing Supervisor.

B. The following clinical conditions warrant immediate transfer to the NICU for admission/observation:

1. Any infant requiring IV fluid and/or IV medications.
2. Any infant with feeding difficulties.
3. Any infant requiring supplemental oxygen.
4. Infants less than 36 weeks gestation.
5. Infants weighing less than 2,300 grams at birth.
6. Infants with respiratory distress.
7. Infants with apnea and bradycardia.
8. Infants with cardiovascular/congenital heart disease with clinically compromised hemodynamic status.
9. Infants with birth depression/perinatal asphyxia and/or 5 minute APGAR score 5 or less.
10. Infants requiring exchange transfusion.
11. Infants with unstable physiologic vital signs, including hypothermia.
12. Persistent or symptomatic hypoglycemia following the Hypoglycemic Algorithm.
13. Neonatal abstinence syndrome (NAS) requiring observation and treatment.
14. Any infant at the discretion of the Neonatologist/NNP/NICU Resource Nurse.

C. Older infants (less than 10 kg and less than 1 month post-natal age) who require intensive care and isolation because of infection, may be admitted to the NICU after consulting with the Neonatology Service. Precautions will be implemented according to VCMC Infection Control Policy. Exception may apply to graduates of the NICU upon discretion of the Neonatologist.

D. Infants meeting the above criteria will be admitted to an isolation room. Precautions will be implemented according to VCMC Infection Control Policy.

PATIENT FLOW

A. Those infants meeting the above criteria will be transferred directly to the NICU with immediate notification of the NNP and/or pediatrician/neonatologist by the nursing staff.

B. Infants who require more acute neonatal intensive care will be transferred to a regional NICU as indicated within the Transfer Guidelines.

C. Patient overflow for times of high census: please refer to policy NOBP.10, *Transfer Criteria of Stable Neonates*.

D. All patients in NICU will have an acuity assigned.

E. Upon admission, nurses will be required to complete a system assessment. The EHR form "NICU Basic Admission Information" will be documented within 12 hours of admission.

F. The EHR form "Admission History Neonatal ICU" which provides information on maternal history and anticipated discharge teaching of caregivers will be initiated within 12 hours. This form can be reviewed and updated as needed in the Form Browser. The Activities and Intervention portion of EHR, will fire this task within 10 hours of admission and will be marked overdue after 12 hours.

G. The NICU Charge Nurse will assist in chart audit during patient rounds, to ensure that this task does not continue to be Overdue.

PHYSICIAN/NNP RESPONSIBILITIES

A. The attending physician/NNP is responsible for the admission to the NICU.

B. Notify the Charge Nurse of any pending admissions.

C. Examine and evaluate the condition of the infant on admission.

D. Write an admission note, history and clinical findings within hospital guidelines. Dictate H&P D/C summary.

E. Write the admission orders to include medication orders, lab orders, IV fluid orders, treatments, and respiratory support.

F. Update parents/guardians regarding the infant's condition; obtain informed consent for procedures/care and place subsequent documentation in the medical record.

References

California Children's Services Department of Health Care Services, www.dhcs.ca.gov/services/ccs/Pages/default.aspx

MCH.14 Hypoglycemia in the Newborn

All revision dates: 3/28/2023, 11/20/2017, 1/1/2013, 1/1/2010

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/15/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/15/2023
Policy Owner	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/15/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1991*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/14/2023*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

100.025 Medications: Ordering, Administration and Documentation

Policy:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU) and ambulatory care clinics maintain processes for the safe and timely prescribing, administration, and documentation of medications to patients.

Definitions:

Licensed ~~Independent~~ Practitioner (~~LIP~~LP): physicians or mid-level practitioners contracted with the Health Care Agency to provide patient care.

Health Care Professional (HCP): licensed individuals such as registered nurses and respiratory therapists who are authorized to administer medications.

Procedure:

I. Medication Order Prescribing

A. All medications administered at VCMC, SPH, IPU, CSU, and ambulatory care clinics shall be ordered by a licensed ~~independent~~ practitioner (~~LIP~~LP) and noted by a health care professional (HCP) as approved in the Medical Staff bylaws.

B. A current Medical Staff Roster shall be maintained by the Medical Staff Office. A listing of all Medical Staff members recognized as having the privilege to prescribe medications within the facility shall be available to the Department of Pharmacy Services.

C. The Medical Staff Office shall maintain a log documenting Medical Staff and their Drug Enforcement Administration (DEA) numbers.

D. Medication orders to non-providers can be found on policy 100.220 Electronic Order Management.

E. Pharmacy approved prescriptive authority can be found on policy 100.216 Electronic Pharmacy Prescriptive Order Entry Authority.

F. Abbreviations used in medication orders can be found policy 107.005 Medical Abbreviations.

II. Medication Order

A. Medication orders shall be entered into the electronic health record (EHR) and shall include the

following:

1. Medication name
2. Dosage
    i. Dosage should be expressed in the metric system except in instances where dosage must be expressed otherwise (e.g. units).
    ii. For pediatric patients, dosage should be based on weight or body surface area (e.g. milligrams/kilogram [mg/kg] or milligram/meter squared [mg/m^2]).
    iii. Dose ranges are not acceptable (e.g. hydrocodone/acetaminophen 1-2 tablets every [q] 4 hours As Needed for [PRN] pain).
3. Frequency of administration
    i. Interval ranges are not acceptable (e.g. hydrocodone/acetaminophen 1 tablet q 4-6 hours PRN pain)
4. Route of administration
5. Indication for use for the following:
    i. All PRN medications
        a. Indication ranges are acceptable if the order does not create therapeutic duplication(e.g. hydrocodone/acetaminophen 1 tablet every 6 hours PRN mild-moderate pain).
        b. Topical medication orders shall describe the specific location of application.
        c. Acetaminophen and ibuprofen orders must be clarified to describe the specific indication for use (e.g. fever versus [vs] headache or pain). If fever is selected, the actual temperature must also be included.
    ii. Antimicrobial orders
    iii. Anticoagulant orders
6. The date and time of the order
7. The identity of the ordering ~~LIP~~LP

B. Titratable Intravenous (IV) medication orders shall also include the following
    1. Concentration in units/milliliter (mL) such as mg/mL
    2. Initial rate of infusion
    3. Loading and/or bolus doses, if applicable
    4. Titration parameters
        i. Incremental dose
        ii. Titration rate with increase and/or decrease instructions for nurse administration.
        iii. Maximum dose or specified time
        iv. Titration goal, end point, or desired patient response
    5. Notify provider parameters

C. All medications orders shall follow Automatic Stop-Orders (see PH.61 Automatic Stop Orders).

III. Medication Order Review and Verification

A. All medication orders are routed to Pharmacy and reviewed by a licensed Pharmacist.

1. See policy PH.55 Medication Order Management
2. See policy PH.19 After Hours Pharmacy Services at Santa Paula Hospital

B. Appropriate HCPs shall review medication orders prior to administration.

IV. 0.0.0.1. Medication Distribution

A. Medications shall be available in the automatic dispensing cabinet (ADC); however, in the event the medication is not supplied in the ADC, Pharmacy shall send the medication to the nursing unit

1. Medications not readily available in the ADC should be placed in the patient's cassette.
2. Any discrepancies noted in the medications or labels should be brought to the attention of a Pharmacist.
3. At no time shall a medication be "borrowed" from one patient for the use of another.

B. When a patient is transferred from unit to unit, the patient's IV solutions, IV antibiotics and medications not stocked in the ADC such as insulin are to be delivered to the new unit by the nurse responsible for the patient.

C. Missing medications shall be requested through the EHR by the appropriate HCP.

a. Intravenous continuous infusions for Intensive Care Unit (ICU), Definitive Observation Unit (DOU) and Pediatric Intensive Care Unit (PICU) patients shall be electronically requested by through the electronic health record (EHR) by the appropriate HCP no later than three hours prior to the time the medication is expected to run out or time of drip change.

D. Medications for Emergency Department (ED) Hold patients

1. HCPs caring for ED Hold patients may request scheduled medications to be dispensed from the pharmacy by submitting a request through the EHR. Any scheduled medication that is not administered immediately shall be stored in a secure location.
2. Controlled substances, immediate (STAT), NOW, and PRN medication should be obtained from the ADCs in the ED.

E. When a patient is discharged, expires, or leaves the hospital Against Medical Advice (AMA), the medications remaining in the cassette are returned to Pharmacy. The label on the outside of the patient cassette is removed and placed with the medications. The medications should be returned to Pharmacy immediately or placed in the Pharmacy "out" box.

F. Pharmacy policies related to medication distribution

1. See policy PH.46 Medication Storage and Security
2. See policy PH.52 Medication Handling
3. See policy PH.55 Medication Order Management
4. See policy PH.88 Controlled Substances
5. See policy PH.92 Automated Dispensing Cabinet Usage and Documentation
6. See policy PH.96 Medication Override from Automated Dispensing Cabinets

V. Medication Administration and Documentation

A. Medication Administration Privileges

1. See policy PH.72 Staff Authorized to Administer Medications
2. Medications are administered only on the order of a member of the Medical Staff, a practitioner who has been granted temporary privileges by the Chief Executive Officer or designee, a pharmacist or nurse who is practicing under the auspices of an approved protocol, or a physician's assistant who is practicing within the context of his/her Medical Staff-supervising physician.

B. Standard Administration Times

1. Scheduled medications shall be given up to one (1) hour before or one (1) hour after the scheduled time.
    i. Initial emergency department (ED) orders placed prior to nursing assignment are to be given within one hour of a nurse being assigned to the patient. Antibiotics, anticoagulants, and insulin are considered time critical and need to be administered within 30 minutes after nurse is assigned to patient.
2. Time critical medications are identified as medications that require administration within 30 minutes before or after the scheduled dosing time. These medications include:
    i. Antibiotics
    ii. Anticoagulants
    iii. Insulin
3. Medications should be given during standard administration times (see Attachment A).
4. Pharmacists may adjust the frequency to comply with standard administration times taking care to ensure the first dose is initiated as originally ordered (see Attachment B - Standard Administration Dosing Matrix).
5. Around the clock (ATC) medications should be limited to intravenous antibiotics & intravenous diuretics and will automatically default to every # hours from the time of the order with initiation or first dose priority per the LIP's order.
6. HCPs can adjust the first administration time. HCPs shall notify pharmacy via electronic change request, if subsequent doses requires adjusting.
7. Administration times may change based on patient care needs.

C. Non-standard Administration Times

1. For medications available from the ADC, all STAT orders shall be given within 15 minutes of order, NOW or ASAP orders shall be given within 20 minutes of order, and PRN shall be given within 30 minutes of order or patient request.
2. For medications NOT available from the ADC, the order shall be verified by pharmacy and processed as follows:
    i. STAT order shall be processed and delivered to nursing units within 30 minutes.
    ii. NOW and ASAP orders within 60 minutes
    iii. Regularly scheduled medications and PRNs within two (2) hours.

D. Seven Rights of Safe Medication Administration

1. The Seven Rights shall be followed: right DRUG, right Patient, right DOSE, right TIME, right ROUTE, right INDICATION, and with the right DOCUMENTATION.
2. Medications are prepared one patient at a time.
3. The HCP shall verify that the medication dispensed is what was ordered by checking the medication label with the provider's order on the medication administration record (MAR). All aspects of the order (patient, medication, name, route, dose, frequency) must be correct.
4. When administering an unfamiliar medication, a known resource shall be used as a reference to determine the correct dose, correct administration technique, indications, contraindications, compatibility, signs/symptoms to monitor, and necessary post administration monitoring requirements
5. The patient's identity shall be verified verbally by the HCP asking the patient to state their name and date of birth and then comparing and scanning that with their identification (ID) band and the MAR each time a medication is administered or blood is taken or given.
6. Non-verbal patient and neonatal and pediatric patient identities shall be verified by the HCP checking the ID band or medication record for name, date of birth, ID band number and/or medical record number. Such identifying information shall also be checked with the MAR.
7. The HCP administering medications takes the medication to the patient's bedside or just outside the room, prepares and verifies the medications to be administered.
8. The HCP shall verify the MAR summary including allergies, scan the patient's ID band and the medication barcode before immediately administering the medication.
    i. Upon confirmation that the dose was administered, the HCP shall complete the MAR documentation.
    ii. Record patient response to medications in the medical record including PRNs and all new medications.
    iii. If a pain medication is administered, the patient's response must be assessed and documented as per policy 100.076 Pain Assessment, Management and Documentation.
    iv. The HCP shall immediately contact pharmacy if a medication is found to be incorrect, beyond its expiration or beyond use date.
9. The HCP should adequately assess a patient for adverse reactions following medication administration.
10. Due to logistical issues at the present time, Ambulatory Care clinics and the Emergency Departments at VCMC and at SPH are exempt from barcode scanning.
11. Crushed and/or partial dose medications
    i. Medications requiring crushing or splitting are scanned prior to opening at the bedside and then ~~crushed with the facility approved~~manipulated using a patient specific pill crusher ~~at bedside~~/splitter for immediate administration.

    ~~Medications requiring cutting are scanned prior to opening at the bedside and then cut on the scored portion using a patient specific pill splitter for immediate administration.~~

E. IV Medication Administration and Documentation

1. See Attachment C - Adult IV Administration Guidelines
2. See Attachment D - Pediatric/PICU IV Push Drug References
3. Intravenous infusions shall be administered using an infusion pump with the medication guardrail parameters in place.
4. The basic infusion setting may only be used in the event the medication to be administered is not contained in the infusion pump library.
5. When an infusion is held or stopped, the nurse must document a zero (0) rate in the IV drip section of the MAR.
6. Documentation at shift change between the hours of 0600-0659 and 1800-1859 is the responsibility of both the ongoing nurse and incoming nurse.
    i. Incoming nurse shall verify rates and document volumes of infusions from 0600-0659 and 1800-1859 at 0705 and 1905, respectively.
    ii. Outgoing nurse shall document infusion rate changes and any titrations.

F. IV Medication Titration (see policy CC.23 IV Medication Titration in Critical Care Areas)

G. Standardized Drug Concentrations for IV Infusions
    i. The Pharmacy Department shall maintain guidelines for the administration and compounding of IV infusions.

H. Neonatal Intensive Care Unit (NICU) oral medications shall be administered by syringe through a nipple, gavage tube or buccal cavity as tolerated
    i. Follow bitter tasting medication with 5 mL of breast milk or formula.
    ii. Flush gavage tube with 2-3 mL of sterile water post medication.

I. Medications ordered to be given on a sliding scale such as insulin, are documented in the same manner as other medications, except that the dose given (e.g. units, mg) shall also be documented.

J. Waste documentation is not required for non-controlled substances. See policy 106.35 for more information on how to properly dispose of pharmaceutical waste.

VI. Holding Medications

a. If a medication is temporarily held because the patient is to have nothing by mouth (NPO) for a test or was unavailable at the scheduled administration time, the dose may be given later. HCPs can reschedule one (1) dose but then must consult pharmacy if further adjustments are needed.

b. If a medication cannot be given, the HCP shall notify the ~~LIP~~LP. The HCP shall document on the MAR that the dose was held, the reason the dose was not given and that the ~~LIP~~LP was notified. If the LIP decides to discontinue the medication, then an order to discontinue the medication shall be entered into the EHR.

c. If a medication has a hold parameter and is held twice, the HCP shall notify the ~~LIP~~LP.

d. See Attachment E - Automatic Hold Parameters

e. See Attachment F - Held medication workflow

VII. Documentation of medication errors

a. If a medication is given in error, the medication, name, dose, route, and time must be documented.

b. To this the following steps are followed

i. If the error involved a medication listed on the MAR, document the time that the dose was given. Notify the patient's LIP to determine if the next scheduled dose should be held.

ii. For errors involving medications, routes or dosages not listed on the MAR, do not write "Medication error" or "error." Follow VCMC/SPH procedure for notification of LIP and completion of notification and medication error forms.

VIII. Keep vein open (KVO) Nursing Protocol

i. Nurses may order 0.9% sodium chloride KVO orders or flushes per protocol in order to document volumes used during intermittent infusions or flushes

1. Nurse to enter order into EHR using "KVO adult" or "KVO pediatrics."
2. Nurse to sign order using "Protocol/Standardize Procedure – co-sign" as the communication type.

ii. Approved KVO rates or flushes

1. Adults: 0.9% sodium chloride IV at 10 mL/hour (hr)
2. Pediatrics: 0.9% sodium chloride IV at 3 mL/hr
3. Neonates: requires an order from the provider

IX. High risk medications

a. Special consideration will be taken for high risk medications and certain high risk medications require an independent double check by two HCPs. See policy PH.70 High Alert Medications for complete list and considerations.

b. All weight-based neonatal and pediatric drug dosages and drug calculations should be double checked by another HCP prior to administration.

c. Radiopaque IV push medications for neonatal or pediatric patients shall be given by a ~~LIP~~LP.

d. Patient controlled analgesia (PCA) settings and amount administered are to be checked every 4 hours by the nurse and documented in the patient's EHR in the Interactive View (See policy 100.235 Patient-Controlled Analgesia).

All revision dates: 2/14/2023, 1/12/2022, 8/10/2021, 10/14/2020, 3/4/2020, 5/15/2019, 3/21/2019, 11/26/2018, 10/3/2017, 10/1/2016, 11/1/2015, 2/1/2015, 8/1/2013, 8/1/2012, 2/1/2012, 7/1/2011, 5/1/2006, 5/1/2005, 12/1/2004, 7/1/2004

Attachments

Attachment A - Standard Administration Times
Attachment B - Standard Administration Times Dosing Matrix
Attachment C - Intravenous Administration Guidelines for Adults
Attachment D - Pediatric/PICU IV Push Drug Reference
Attachment E - Automatic Hold Parameters
Attachment F - Held Medication 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	2/14/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/14/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/14/2023
Policy Owner	Sara Pendleton: Medication Safety Officer	2/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/1981*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/27/2018*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Administrative - Patient Care*
References:	

100.028 Fetal Demise

POLICY:

It is the intent of this policy to clarify between fetal deaths, stillborn infants and infant deaths at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), and to establish the recommended guidelines to be followed for each.

PROCEDURE:

Fetal Death

A. A Fetal Death means a death prior to the complete expulsion from its mother or a product of conception (irrespective of the duration of pregancy). The death is indicated by the fact that after separation from the mother, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles.

   1. If the gestational age is considered to be less than 20 weeks, the conceptus is referred to as an abortus.
   2. If length of gestation is undetermined and fetus is over 400 grams (13 1/2 ounces) or greater and the length from heel to crown is 28 centimeters or greater this is considered a fetal demise.

B. Nursing Supervisor must be notified of all fetal demise

   1. Notify Nursing Supervisor and Social Services of fetal death and disposition of remains :
      a. The abortus will be sent to Histology as a surgical specimen. Specimen is to be placed in formalin and properly labeled.
      b. A fetal demise will be placed in the VCMC morgue by nursing supervisor and security. If an autopsy is to be performed, routine autopsy procedures will be followed.

C. All Fetal Demise must be registered with Public Health Vital Records and recorded in appropriate VCMC/ SPH records.

   1. The nursing staff will notify Nursing Supervisor of the date and time of expulsion, sex of the stillborn, mother's name and chart number and physician.
   2. At the time Nursing Staff become aware of any potential pregnancy loss or fetal demise, an order will be places for Social Service Consult.
   3. Spiritual Support will be offered, and

4. Nursing will record the weight and length and gestational age in Electronic Health Record.(EHR).
5. Nursing staff will record delivery information on the delivery log as follows:
    a. Mother's name
    b. Date/time of delivery
    c. Chart number
    d. Gestation
    e. Sex
    f. Weight
6. A Birth Certificate clerk in the Admitting Department will prepare the Fetal Death Certificate, which must be signed by the attending physician within 15 hours of pronouncement of legal death.

D. Social Services

1. Notify Social Services of any fetal or infant death to better provide emotional support to the family and discuss options of disposition of remains. If after hours, the on-call social worker should be contacted or leave a message at 805-652-3280. Social Services will consult with the parent(s) of the Fetal Demise or abortus to determine if they would like to make arrangements with a mortuary for burial or cremation.
2. Based on the decision of the parent(s), Social Services will arrange for disposition of the abortus or Fetal Demise as follows:
    a. Abortus **(Less than 20 weeks gestation)**
        i. If the parents request that VCMC/SPH handle disposition of the abortus, they will sign the VCMC/SPH **Release of Stillborn/Abortus form** (VCMC-546-022). If the father is not present, the **Maternal Statement form** (VCMC-546-018) must be signed by the mother. Histology will follow appropriate departmental procedures for disposal. Copies of all forms must remain with mother's chart.
        ii. If the parents want to retain the remains of the abortus, they will sign the **Release of Body to the Funeral Director form (VCMC-546-042**) and designate the mortuary of their choice. Social Services will notify Histology that the remains of the abortus must be retained. Copies of all forms must remain with mother's chart.
        iii. Place Placenta in container and label. Send placenta to laboratory. Assure physician has placed orders in EHR.
        iv. The mortuary of the parent(s) choice will pick up the abortus from Histology anytime during the business hours of 9:00 a.m. to 4:00 p.m., Monday through Friday.
        v. Nursing Supervisor will take the VCMC/SPH **Release of Body to the Funeral Director form (VCMC-546-042**) With this form will escort mortuary service to Histology.
    b. Fetal Demise **(Greater than 20 weeks gestation)**
        i. Fetal Demise will be placed in the VCMC morgue by Nursing Supervisor and Security. This information will be noted by the Security Officer and the Deceased Log which is located in the Nursing Supervisor office.
        ii. Nursing will notify Birth Certificate Clerk at **805-652-3244** to make them aware of the Fetal Demise and a death certificate can be prepared.

iii. If the parent(s) request VCMC/SPH to handle disposition of the stillborn, they will sign the VCMC/SPH **Release of Stillborn/Abortus form** (VCMC-546-022). If the father is not present, **the Maternal Statement** form **(VCMC-546-018)** must be signed by the mother. Copies of all forms must remain in mother's chart.

iv. Place Placenta in container and label. Send Placenta to laboratory. Assure physician has placed order in EHR.

v. If the parent(s) want to retain the remains of the Fetal Demise, Social Services will offer them a list of local mortuaries. The parent(s) will sign the **Release of Body to the Funeral Director form (VCMC-546-042**) and designate the mortuary of their choice. The mortuary of the parent(s) choice will pick up the stillborn from the VCMC morgue. Nursing Supervisor and Security will escort the mortuary service to the morgue. Copies of all forms must remain in mother's chart.

E. Legal Issue

If the fetus is in any way involved in a legal issue, a chain of evidence/custody will be maintained and the appropriate law enforcement agency will be notified.

Infant Death (Live Birth)

A. Live births are distinguished from fetal deaths by regulation as follows:

1. The complete expulsion or extraction from its mother of the products of conception, irrespective of the duration of pregnancy which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
2. If a fetus shows any post-delivery life signs, no matter how transient, it is a live birth, regardless of the length of gestation.
    a. Routine procedures for live births will be followed (e.g., notifying the Admitting Department of birth, establishing a chart number, adding to the census, birth certificate, etc).
    b. Place the placenta in container and label. Send to laboratory. Assure physician has placed orders in EHR.
    c. Time of birth and time of death must be determined, and documented in the EHR.

B. If the infant expires, nursing staff will notify Admitting and receive a Medical Record Number. The birth certificate clerk will be notified by nursing staff, and a Birth and Death Certificate will be prepared. If the infant has lived less than 72 hours and the parents wish to donate the remains of the infant to the Hospital, they may sign the "Contribution of Remains" consent, and related procedures described in the proceeding section should be followed. Copies of all forms must remain in mother's chart.

Also see Administrative policy 100.031, *Processing a Death*.

All revision dates: 9/27/2018, 5/1/2010, 3/1/2009, 5/1/2006, 8/1/2001, 12/1/1998, 3/1/1991, 11/1/1990, 10/1/1986, 5/1/1983

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/14/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/3/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	3/2/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2001*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/23/2022*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.076 Pain Assessment, Management and Documentation

POLICY:

To ensure that patients have their pain assessed and managed, and that they are involved in decisions regarding treatment of their pain consistent with the scope of care, treatment, and services provided by Ventura County Medical Center, Santa Paula Hospital and Ambulatory Care clinics in various care settings. The goal of pain management is to incorporate non-pharmacological and pharmacological interventions to ease or lighten pain which may not include the elimination of pain. Pain assessment and pain management is an organizational priority.

PROCEDURE:

Patients have the right to pain management which is determined through discussion with their providers and care team members. Management of pain is focused on easing the patient's pain using non-pharmacological and pharmacological interventions. The health care workers of the Ventura County Health Care Agency (HCA) shall do the following in accordance with staff scope of practice:

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and services provided in the specific care setting in accordance with staff scope of practice. All assessments and reassessments for prn and scheduled pain medication shall be documented on the Medication Administration Record (MAR).
2. Require that methods used to assess a patient's pain are consistent with the patient's age, condition, and comprehension. (Refer to attachments for pain scales used throughout the Ventura County Health Care Agency.)
3. Assess the patient's response to care, treatment, and service implemented to address pain.
4. If the patient does not achieve their pain goal or if the pain is not reduced to a tolerable state, the care team member should notify the physician and follow the chain of command to advocate on behalf of the patient:
    1. Ambulatory Care: Medical Assistant or Clinical Assistant shall report to nurse (registered nurse (RN) or licensed vocational nurse (LVN)), then to Nursing Supervisor, then to Clinic Medical Director and Chief Nursing Officer. Clinic Medical Director may report to Chief Medical Officer.
    2. Hospitals: Nursing Supervisor and/or Clinical Nurse Manager, then Associate Chief Nursing Officer, then Chief Nursing Officer and/or resident, then attending physician, then Chief Medical Officer.

5. Consider non-pharmacological measures as well as medication therapy, taking into account the patient's stated preferences for pain management.
6. Treat the patient's pain or refer the patient for treatment.
7. Ensure the patient's comprehensive care plan reflects the patient's pain management preferences and responses to interventions. Update the care plan as needed to reflect changes in the patient's pain management.
8. Assess and manage the patient's pain and minimize the risks associated with treatment.
9. Identify physical, social and psychological consequences of unrelieved pain.

PAIN SCALES

To ensure an age-appropriate, clinical condition assessment of pain occurs, multiple pain scales are approved for use within the organization. These scales are:

- Universal Pain Assessment Tool (Numeric Pain scale with Intensity)-Eight (8) years of age and older and who are able to self report)
- Critical Care Pain Observation Tool (CPOT) - paralyzed and sedated
- FLACC- Children two (2) months through three (3) years of age
- The revised (r) FLACC Scale (face, legs, activity, crying and consolability) - Developmental Delay/ Cognitive Impairment
- ~~N-PASS scale~~N-PASS scale - Preterm and infant two (2) months of age (48 weeks gestation)
- Finnegan Neonatal Abstinence Scoring System
- ~~Faces Pain Scale~~Faces Pain Scale - Children four (4) years through seven (7) years of age

See Attachments A through F.

INPATIENT CARE SETTINGS

Upon Admission and with Change in Pain Characteristic

Patients admitted to an inpatient care setting shall receive an initial screen at the time of admission to identify the presence and severity of pain. Initial assessment of the patient should include, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools
- The character of pain, quality, onset, location, radiation, duration and frequency
- The patient's tolerance to pain and acceptable intensity of pain (pain goal)
- The patient's history of analgesic use or abuse
- The patient's respiratory risk factors
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain

Communication about Pain

Communication with the patient should include, but is not limited to, assisting them in understanding that some pain is to be expected and it may be unrealistic to expect to be completely pain-free following their procedure. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan; involve family as appropriate when discussing the plan of care and anticipate pain goals.

Treatment of Pain

In general, inpatients shall receive treatment for any active acute or chronic pain when intensity or severity exceeds an acceptable level. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, and potential risk of dependency, addiction and abuse (if applicable); and realistic expectations with measurable goals and the evaluation process. The same pain scale shall be consistently used as the patient's clinical condition permits.

Paralysis Considerations

Paralysis prevents the assessment of behavioral cues for pain. Increases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

1. Analgesics should be administered continuously by drip or around-the-clock dosing.
2. Opioid doses should be evaluated as tolerance can occur without symptoms of inadequate pain relief.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications; for other routes of pain medications, standards of practice shall be implemented. In addition, the patient's pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

Emergency Department

Treatment of Pain

In general, ED patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in the ED to treat chronic pain conditions. Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If no pain issues were identified during the initial assessment, then no routine reassessment is required. If at any time during the patient's stay in the ED pain issues are identified, the process of assessment/reassment should be initiated. If acute pain issues were identified, then the patient should be reassessed at least at time of discharge or transfer. At a minimum, this reassessment shall consist of noting the intensity and severity of the patient's pain.

OPERATIVE AND INVASIVE PROCEDURE SETTINGS

Pre-Procedure Assessment

Patients seen in operative and invasive procedural settings shall be assessed prior to surgery or procedure to identify the presence and severity of pain. If this is an initial assessment of the patient (i.e., the patient is being seen as an outpatient or will be admitted following the procedure) the assessment should include, but is not limited to:

- Understanding the patient's perception of the procedure and their expectations about the extent of pain and its management.
- The intensity of pain using age or condition and ability to understand appropriate assessment tools.
- The character of pain, quality, onset, location, radiation, duration and frequency.
- The patient's history of analgesic use or abuse.
- The patient's respiratory risk factors.
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain.

It is recommended that the patient's tolerance to pain and acceptable intensity of pain (pain goal) be ascertained so that this information can be used to address the post-procedure care needs of the patient.

Post-Procedure Assessment

Patients shall receive an assessment following the operative or invasive procedure to determine the presence of pain that may have resulted from the procedure. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition appropriate assessment tools
- The location and nature of pain

Treatment of Pain

In general, these patients shall receive treatment for acute pain related for their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic condition.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

PEDIATRIC INPATIENT SETTING

Definitions

- Pain is defined as an unpleasant sensory and emotional experience associated with actual or resembling that associated with, actual or potential tissues damage (IASP 2020). Pain is an inherently subjective multi factorial experience and should be addressed and treated as such.

Principles

- All pediatric patients will be assessed for pain using a validated developmentally appropriate pain assessment tool
- The pediatric pain experience involves the interaction of physiologic, psychologic, behavioral, developmental, and situational factors.
- Every child and family is informed that the child has the right to the best pain relief possible and is entitled to optimal pain management.
- All healthcare members have a responsibility to advocate for effective pain management on the patients behalf, to promote the child's and family's learning about pain and its management and to actively involve the child and family in the decision making process related to pain assessment, management and evaluation
- All healthcare team members are responsible for ongoing communication with other members of the healthcare term regarding pain management outcomes.

Treatment of Pain

All heathcare team members have a responsibility to recognize and accept that the childs reports of pain reflect their real experiences of pain. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Pain relief interventions will be tailored to the individual patient. Shared decision making between nursing/medical staff and parents should be employed to optimize the care of pain in children.

Paralysis Considerations(PICU)

Paralysis prevents the assessment of behavioral cues for pain. Increases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

- Analgesics should be administered continuously by drip or around-the-clock dosing.
- Opioid doses should be evaluated as tolerance can occur without symptoms of inadequate pain relief.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications; for other routes of pain medications, standards of practice shall be implemented. In addition, the patient's pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

NEONATAL INPATIENT SETTING

Initial Assessment

Patients seen in the Neonatal period (0-28d or 0-28d Corrected Gestational Age) shall receive a screen during the initial assessment process to identify the presence of pain using the Neonatal Pain Agitation and Sedation Scale (N-PASS) to identify the presence of pain. If the screen is positive, then the patient shall receive an assessment to gather further sufficient information to identify the pain. The Neonatal Nurse Practitioner (NNP) or Neonatologist will be notified of any N-PASS score >4/10 or any time current nursing

interventions and/or pain medications are not effective in lowering the patient's N-PASS score.

AMBULATORY CARE CLINICS

Initial Assessment

Patients seen in outpatient care settings shall receive a pain assessment on establishment of care to identify the presence of pain. If the patient is in pain or reports a history of persistent pain, a more in-depth assessment shall be conducted. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools (refer to attachment A)
- The character of pain, quality, onset, location, radiation, duration and frequency
- The patient's goal for pain management
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain
- The patient's history of analgesic use or abuse
- The patient's risk level for adverse outcomes related to opioid treatment (e.g., acute psychiatric instability or high suicide risk, cognitive impairment, sleep apnea, advanced age, COPD, etc.)

Communication about Pain

Communication with the patient should include but is not limited to assisting them to understand that some pain is to be expected and it may be unrealistic to expect to be completely pain free following procedures. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan; involve family as appropriate when discussing the plan of care and anticipate pain goals.

Treatment of Pain

In general, Ambulatory Care patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic, designated primary care and specialty care clinics). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided during the care visit, then the response to that intervention must be assessed to include progress toward pain goal and side effects. Reassessment is recommended to occur within 60 minutes following treatment (depending on the type of intervention). However, by policy, this reassessment must occur at least at the conclusion of the care visit. If treatment consists of prescribing medications (or other modalities) that will be taken after the care visit, then no reassessment is required.

PATIENT/FAMILY EDUCATION

1. All education should be documented in the patient's electronic health record (EHR).
2. Patients will be taught that effective pain management will be part of their treatment.
3. Patients will be instructed to keep the nurse informed about their pain so that pain interventions may be provided as ordered. Medication may not rid the patient of all of their pain. Pain medication can reduce pain so that the patient can participate in activities to improve their health.
4. The patient and the family/significant other(s) should receive information regarding:
    a. The use of pain scales.
    b. Pain control options.
    c. Appropriate expectations for pain control.
    d. Potential limitations of pain management.
    e. How and when to communicate the effectiveness/ineffectiveness of pain interventions.
    f. Potential/actual side effects of pain medications/treatments.
    g. The risks of addiction and overdose, especially with prolonged use.
    h. Safe storage of medications.
5. A patient/family pain education brochure is available to support patient teaching on pain management.

During Treatment

When pain medications are prescribed, patients IN ALL SETTINGS shall receive education on pain management, the risks and benefits of medication treatment, and safe use of opioid and non-opioid medications. This information will be documented in the patient's EHR.

At Discharge

The patient/family shall receive education at discharge on the following:

- Pain management plan of care
- Side effects of the pain management treatment
- Activities that may exacerbate or reduce the effectiveness of the pain management care plan
- The risks of addiction and overdose
- Safe use, storage and disposal of opioids
- The use of controlled substances may cause the patient to be less alert resulting in increased risks when driving a car or operating machinery

PATIENT REFUSAL OF PAIN MANAGEMENT

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient's EHR.

DECISION NOT TO TREAT PAIN

If a decision is made to not treat a patient's pain and/or refer the patient for treatment, then the clinical justification for that decision should be documented in the patient's EHR.

REFERENCES:

Department of Health and Human Services, Centers for Medicare & Medicaid Services, Publication 100-07 State Operations Provider Certification, Transmittal 37, October 17, 2018, Section 482.23 Nursing Care.

Center for Improvement in Healthcare Quality - Standard QS.2, E-mail inquiry and reply to Traci Curtis, RCP, HACP, Executive Director Survey Operations, Center for Improvement in Healthcare Quality, March 28, 1980.

The Joint Commission Standards: LD.0403.13, MS.05.01.01, PC.01.02.07, PI.01.01.01, PI.02.01.01.

R3 Report, Requirement, Rationale, Reference, A publication of The Joint Commission, Issue 11, August 29, 2017.

VCMC Performance Improvement Project - Addiction Medicine

CURES (2018) - Controlled Substance Utilization Review and Evaluation System

All revision dates:	11/23/2022, 11/10/2021, 12/8/2020, 11/26/2018, 7/26/2017, 10/1/2011, 3/1/2011, 4/1/2008, 5/1/2006, 3/1/2004, 2/1/2002

Attachments

- Attachment A - Universal Pain Assessment Tool.pdf
- Attachment B - Finnegan Neonatal Abstinence Scoring Tool (FNAST).pdf
- Attachment D - Faces Pain Scale.pdf
- Attachment E - FLACC.pdf
- Attachment F - NPASS.pdf
- Attachment G - FLACC_R.pdf

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/13/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/29/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/29/2022
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/29/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/14/2020*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/22/2022*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.112 Code White - Pediatric Medical Emergency

POLICY:

The rapid application of Cardiopulmonary Resuscitation (CPR) is essential to patient survival in the event of respiratory or cardiac failure. For "DO NOT RESUSCITATE" orders, see Administrative policy 100.013 Do Not Resuscitate (DNR) Orders.

PROCEDURE:

HOSPITAL refers to Ventura County Medical Center (VCMC), including the Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU), and Santa Paula Hospital (SPH). ***See Section I below.***

CLINIC refers to Ventura County Health Care Agency Ambulatory Care (AC) Clinics. ***See Section II below.***

Section I - Hospital:

A. **Cardiopulmonary Resuscitation (CPR) – Preliminary Steps**:

1. Follow Basic Life Support (BLS) guidelines.
2. In the event of patient respiratory or cardiac failure, call for help by dialing x7-6666 at VCMC or x7-8666 at SPH. Communicate the patient's location and whether an adult or child. If in on a nursing unit, also press the "CODE" button at head of the patient's bed. “CODE WHITE” shall be used for a medical emergency resulting in pulseless arrest or near pulseless arrest in a patient less than 18 years old.
3. Telephone Operator: Shall announce "CODE WHITE" on the paging system.
4. State the patient location and repeat this information two (2) times.
5. In the event of patient respiratory or cardiac failure in the NICU (Neonatal intensive care unit) the patient will be internally managed and a "CODE WHITE" will not be paged.

B. **Code White Response Team:**

1. VCMC members are Pediatric Advance Life Support (PALS) certified.
   a. Pediatric Intensive Care Unit (PICU) Attending Physician or designee.
   b. Residents On call Intensive Care Unit, Medicine, and Surgical residents.

c. PICU Nurse
d. Respiratory Therapist
e. Laboratory
f. Radiology
g. House Supervisor

2. SPH
   a. Hospitalist or Emergency Department (ED) attending
   b. ED or Intensive Care Registered Nurse (RN)
   c. House Supervisor
   d. Respiratory Therapist
   e. Laboratory
   f. Radiology

C. **Personnel Duties:**

1. First on the scene:
   a. Assess airway, breathing and circulation.
   b. Initiate "Code White" by: Dialing x7-6666 at VCMC or x7-8666 at SPH. Communicate the patient's location and whether an adult or child. If in on a nursing unit, also press the "CODE" button at the head of the patient's bed.
   c. Do not leave the patient alone.
   d. Begin CPR.
   e. Participate in the debrief session.
2. First responding physician (and any additional physicians):
   a. Assume the role of team leader; may transfer responsibility of team leader to attending physician or ED physician.
   b. Assign roles to code participants.
   c. Provide a report to the patient's primary physician, if the physician has not attended the code.
   d. Initiate and facilitate the debrief session.
   e. Ensure accuracy of code documentation (code sheet).
3. Departmental personnel (personnel from the department, calling the code):
   a. Obtain a crash cart and bring it to the patient's location.
   b. Attach monitor leads and defibrillation pads to the patient.
   c. Ensure that end tidal carbon dioxide (CO_2) capnography is in place.
   d. Assist with CPR as needed.
   e. Participate in the debrief session.
   f. Exchange the used crash cart (refer to policy 100.113 Crash Cart Check and Restocking for process roles and responsibilities).

4. Nurse assigned to care for the patient:
    a. Provide a report to the Code Team, including but not limited to:
        i. pertinent history;
        ii. vital signs;
        iii. events leading to the arrest; and
        iv. medication allergies.
    b. Remain with the patient during the code.
    c. Assist with CPR as needed.
    d. Participate in the debrief session.
5. Critical Care or Emergency Department nurse:
    a. Bring the emergency medication box and refrigerated medications to the patient's location.
    b. Ensure placement of monitor leads and defibrillation pads.
    c. Ensure that end tidal CO_2 capnography is in place.
    d. Ensure venous access.
    e. Administer medications as directed.
    f. At SPH the ED or Intensive Care RN will assist in the administration of medications as directed.
    g. Ensure the code record accurately reflects the medications administered.
    h. Assist with CPR as needed.
    i. Participate in the debrief session.
6. Scribe:
    a. Complete the Cardiopulmonary Resuscitation Record.
    b. Ensure that the yellow carbon copy is provided to the Quality Assessment Performance Improvement (QAPI) department and the pink carbon copy is provided to the Pharmacy department.
    c. Complete the Code Debrief Form.
    d. Complete the Electronic Notification Form.
    e. Obtain the team leader's signature on the Cardiopulmonary Resuscitation Record.
    f. At SPH the Medical Surgical nurse responding will act as the Scribe
    g. Participate in the debrief session.
7. Respiratory Therapist:
    a. Bring the airway kit to the bedside, for ventilatory aspects of the procedure.
    b. Manage oxygenation and ventilation with the team leader and identified support physicians.
    c. Assist with oxygen set-up and ventilation, using ambu-bag and oxygen.
    d. Ensure that end tidal CO_2 is monitored.
    e. Provide CPR as needed.
    f. Participate in the debrief session.

8. House Supervisor:
    a. Assist with obtaining a bed if the patient is to be transferred to another unit.
    b. Arrange family support.
    c. At **SPH** the House Supervisor will act as the central point of communication. Will contact VCMC Neonatal Intensive Care Unit (NICU) at 805-652-6130 if needed.
    d. Participate in the debrief session.
    e. Collect the Debrief Forms and send them to the QAPI department.
9. Pharmacy:
    a. Obtain and transport medications as needed.
    b. Add the medication tray to the newly obtained crash cart.
    c. Verify medications in the replacement tray have not expired.
10. Nursing Assistant:
    a. Bring the 12 lead electrocardiogram (EKG) machine to the patient.
    b. Stand by to act as runner.
    c. Participate in the debrief session.
    d. At SPH this role is not applicable.
11. Central Supply:
    a. Ensure that the replacement cart is available and that equipment and supplies are not expired (refer to policy 100.113 Crash Cart Check and Restocking for process roles and responsibilities).

D. **Magnetic Resonance Imaging (MRI)**

See Policy 100.055 Code Blue Adult - Medical Emergency for process.

Section II - Clinic:

A. The Ambulatory Care clinics do not house crash carts. The clinics maintain Emergency Response Equipment (refer to Ambulatory Care Policy AC.001 Emergency Response Equipment).

B. In the event of an emergency, clinic staff shall call 911.

CPR certified clinic staff shall initiate CPR if needed, apply the Automated External Defibrillator (AED), maintain an open airway and administer oxygen. Non-CPR certified staff shall **only** call 911 and stay with the patient until help arrives.

Cardiopulmonary Resuscitation Outside of Hospital Buildings:

~~Initiate BLS protocol and call 911.~~

Initiate BLS protocol and call 911. Staff to attend codes on Hospital Campus in accordance with Policy 100.224 Emergency Medical Treatment and Labor Act (EMTALA) Guidelines.

ATTACHMENTS:

A. 2015 American Heart Association, Summary of High Quality CPR Components for BLS Providers

B. Cardiopulmonary Resuscitation Record

C. NICU Cardiopulmonary Resuscitation Record

All revision dates: 12/22/2022, 8/10/2022, 1/14/2020

Attachments

Attachment A- BLS-CPR 2015 American Heart Association Guidelines.pdf
Attachment B- Cardiopulmonary Resuscitation Record.pdf
Attachment C- NICU Cardiopulmonary Resuscitation Record.pdf

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/22/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/22/2022
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/22/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.267 Naloxone Overdose Rescue Kit

PURPOSE

To make naloxone available to patients ~~at risk of an opioid-related overdose in the emergency department~~seen in the Emergency Department (ED) who are determined to be at risk of an opioid- related overdose.

DEFINITION

Overdose rescue kit: One bag containing naloxone nasal sprays, breathing shield, and instructional card, Fentanyl Risk education card, and "Safe Choices" resource card.

POLICY

Dispense life-saving medication, naloxone in the form of a rescue kit, to patients at risk of opioid overdose pursuant of licensed independent practitioner's (LIP) order or otherwise ordered by a trained staff.

PROCEDURE

1. Training of staff, other than LIP, will be completed by the Substance Use Services (SUS) Prevention Team.
    a. Staff member may include substance use navigators (SUNs) and/or registered nurses.
    b. Trained staff will be required to take a refresher training every 2 years to dispense overdose rescue kits.
2. Issuance, delivery, distribution, maintenance of inventory in ED, and collection of required data will be managed by the SUNs with the use of the Program's Inventory Binder. This maintenance shall include checking of expired medications and managing of medication recalls if applicable. Refer to the following forms.
    a. Site Inventory Tracking Log (Attachment A)
    b. Overdose Rescue Kit Participant - Initial Form (Attachment B)
    c. Overdose Rescue Kit Participant - Refill Form (Attachment C)
3. Overdose rescue ~~kit~~kits will be stored in locked cabinet in the ED with the Program Inventory Binder.
    a. Trained staff member will document required elements on the dispensing log, remove one rescue kit

from locked, secured cabinet.

   b. Educate the patient regarding the use of rescue kit in the patients preferred language.

   c. Document necessary information for record keeping including progress note in electronic health record (EHR) as necessary.

4. Overdose rescue ~~kit~~kits will be dispense by SUNs pursuant of the attached standing order. (Attachment D)

5. Substance Use Services (SUS) Prevention Team can be reached at 805-667-6333 (No Over Dose)

All revision dates:

Attachments

Attachment A: Site Inventory Tracking Log
Attachment B: Overdose Rescue Kit Participant - Initial Form
Attachment C: Overdose Rescue Kit Participant - Refill Form
Attachment D: Standing Order Naloxone VCBH 2021

Approval Signatures

Step Description	Approver	Date
ED Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	1/25/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/4/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/4/2023
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	1/4/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*3/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/10/2023*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.029 Aerosol Transmissible Disease Exposure Control Plan

POLICY:

The aerosol (airborne) transmitted disease exposure control plan, mandated by the California's Occupational Safety and Health Administration (OSHA Section 5199. Aerosol Transmissible Diseases), describes the management of aerosol transmissible diseases in the Healthcare organization. (This policy addresses and replaces policy *106.019 Tuberculosis Exposure Control Plan.*)

Applicability:
Ventura County Medical Center, Santa Paula Hospital, Ambulatory Care Clinics, the Behavioral Health Department

This policy includes all employees who could "reasonably anticipate" that by performing their job duties they may come into contact with suspected or known patients to be infected with an aerosol-transmissible pathogen or a novel/unknown pathogen for which there is no evidence to rule out airborne transmission.

PROCEDURE:

Responsibility:
Employees must know and follow the requirements of the standard as described in this policy.

The Infection Prevention and Control Manager is responsible for administering the aerosol transmissible plan. Authorship, implementation, and administration of the plan will be accomplished in collaboration with Administration, Infection Prevention and Control Committee, Employee Health Services, and Human Resources.

Engineering and Work Place Controls:

1. Supplies include: NIOSH-approved N95 mask/respirators, splash shield surgical masks, gowns, goggles, and gloves. These should be supplied by Central Supply. The Product Evaluation Committee will be responsible for leading and organizing the selection of alternate products when needed. In the event of a shortage of NIOSH-approved N95 masks and/or respirators, the local public health officer will be asked to release NIOSH-approved N95 respirator/masks from local stockpiles.
2. Maintenance, repair, and employee education regarding use of Powered Air Purifying Respirators (PAPRs) will be done by Respiratory Therapy. Users will clean respirators after each use. Hoods, which are personal use only, are either kept or processed.

3. Isolation signs: Infection Prevention and Control will supply isolation signs. Nursing will post the appropriate sign. When the patient is discharged, environmental services personnel will remove the sign to signal that the room has been terminally cleaned.
4. Negative pressure patient rooms are identified and managed by Facilities Management (see policy *F.76 Isolation Rooms*).
5. Isolation Policy and Procedure: Follow the directives in policy *106.028 Isolation Precautions Guidelines*.
6. Policy and Procedure: *106.018 Infection Control Standard Precautions* is applicable to all patients.
7. Respiratory etiquette is practiced in all settings by all employees in accordance with policy *106.018 Infection Control Standard Precautions*.
8. Facilities will maintain the alarm system and air pressure system for the airborne isolation patient rooms.
9. Environmental Services: The cleaning and decontamination of the hospital environment is done according to the Environmental Services Department policies and procedures.
10. In the event of a surge of patients with an aerosol transmitted disease, the Emergency Management Plan will be put into effect. Supplies may be accessed through the disaster stockpiles via the Public Health Department.

Aerosol Generating Procedures:

1. All health care workers shall wear an N95 mask/respirator and eye protection as appropriate for level of exposure.
2. Procedures that may generate an aerosol include, but are not limited to:

    - Bronchoscopy
    - Intubation
    - Sputum Collection including sputum induction
    - Nasopharyngeal swab specimen collection
    - Nasal wash specimen collection
    - Suctioning

Patient Placement:

1. Patients who are identified as needing a negative pressure room (per Administrative policy 106.028, Isolation Precautions Guidelines*)* are classified as needing Airborne Isolation. In addition, the Aerosol Transmissible Disease Exposure Control Plan has included "novel and unknown pathogens" and "any other disease for which public health guidelines recommend airborne infection isolation" as needing Airborne Isolation.
2. **Patients must be placed in a functioning negative air pressure room within five (5) hours of identification**.
3. If there is no negative air pressure isolation room available, the patient must be transferred to another facility with a functioning negative air pressure room available. When no transfer possible, the local public health officer must be notified before the end of the five hour period and every 24 hours thereafter. The following information must be reported:

    - Date, time, and name of the local public health employee informed of the occurrence.
    - Lack of availability of negative air pressure rooms in the jurisdiction.
    - That reasonable efforts have been made to contact establishments outside the jurisdiction.

- All applicable measures recommended by the local health officer, the Infection Control Committee Chairperson, or the Hospital Infectious Disease Physician.
- All employees entering the room are in compliance with the appropriate Isolation Precautions.
- The attending physician may determine that the transfer may be detrimental to the patient and therefore the patient cannot be transferred to another facility for an airborne isolation room. This shall be documented in the patient's chart and a summary provided to the Plan Administrator. This summary shall include the name of the physician making the determination to not transfer the patient, the date and time of the initial decision, and the date and time of the person who performed the daily review. The summary record shall be kept for three (3) years.

Occupational Health:

1. A pre-employment health assessment will be done by Employee Health Services in accordance with Administrative policy 101.012 Pre-employment and Ongoing Staff Health Requirements .
2. Management of exposures to communicable diseases is addressed in Administrative policy 100.020 Occupational Exposure to Communicable Diseases Other than Bloodborne Pathogens .

Training:

1. Education regarding infection prevention and control practices is conducted during New Employee Orientation.
2. Mandatory annual updates are accomplished via the electronic educational system.
3. Upon employment, NIOSH-approved N95 respirator Fit Testing is conducted and employees are taught the appropriate way to apply the mask/respirator. Employees should request refitting if they experience changes in body weight. **Employee Health and unit managers will be responsible for tracking their employee's size and what brand the employee was fit tested on**.
4. Employees may obtain a copy of the Aerosol Transmissible Disease Standard (California Occupational Safety and Health Standards Title 8 Section 4) from the Infection Prevention and Control Office. See Attachment B.
5. Mask/Respirator fit-testing and competency training will be performed by Employee Health/Respiratory Therapy annually.
6. Just in time training will be used for PAPRs or alternate NIOSH-approved N95 masks as required and competency will be documented.
7. PAPRs will be available throughout the hospital. Employees must complete training to prior to use.

Record Keeping:

1. Orientation attendance will be kept by Human Resources.
2. Mandatory annual updates are accomplished via the electronic educational system.
3. Competency of fit testing: the initial competency is maintained in the employee's medical record in Employee Health Services. Subsequent fit testing competencies will be sent to Employee Health and retained in the employee's file.
4. Facilities Management will maintain records on testing of negative air pressure rooms. The records will be kept for a minimum of five (5) years and will include the name and affiliation of the person performing the test, inspection and maintenance, the date, and any significant findings and actions taken.

REFERENCES:

California Code of Regulations Title 8 Section 5199 Aerosol Transmissible Disease Standard (8/09) (rev 10/2013)
Isolation Precautions: Centers for Disease Control (CDC)
Standard Precautions: Centers for Disease Control (CDC)

All revision dates: 1/10/2023, 6/13/2019, 5/1/2016, 11/1/2013, 9/1/2009, 5/1/2006

Attachments

106.029 Attachment A-Roles and Responsibilities of Team Members Caring for Patients Confirmed or Suspected of Having Mycobacterium Tuberculosis.pdf
Attachment B - Cal/Osha's Aerosol Transmissible Disease Standards and Local Health Departments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	3/17/2023
Policy Owner	Magdy Asaad: Infection Prevention Manager	3/17/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/2009*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/4/2023*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.037 Methicillin Resistant Staphylococcus Aureus (MRSA) Admission Screening

Policy:

To describe the actions that will be taken to comply with the requirements for Methicillin Resistant Staphylococcus Aureus (MRSA) admission screening mandated by California Senate Bill 1058.

Procedure:

A. On admission, within 24 hours, a culture of the anterior nares will be performed on qualifying patients according to Senate Bill 1058.

B. The electronic health record may automatically order MRSA screening in accordance with Senate Bill 1058, otherwise, the nurse performing the admission assessment on the nursing unit will enter the order and collect the specimen. No separate physician order is necessary.

C. Minimum requirements identifying patient risk groups that necessitates MRSA Admission Screen:

1. Nasal Swabs for the following sources of patients:
    a. Patients readmitted within 30 days of discharge from any acute care hospital.
    b. Patients received from Skilled Nursing Facility or Rehab facility
    c. Patients admitted to Intensive Care Units.
    d. Patients scheduled for inpatient surgery and have documented medical condition that would increase susceptibility to infection.
    e. Patient receives inpatient dialysis treatment.
2. Note: Patients undergoing hip and knee arthroplasty have MRSA screening done in Orthopedic Clinic at the preoperative visit.
3. Attending physician shall discuss the positive results with patient or patient's representative as soon as
practically possible.
4. Patient shall be given oral and written information as an educational tool at the time results are discussed or prior to discharge.
5. Contact precautions is only necessary when the infected site of the MRSA cannot be contained, such as an open draining wound, abscess at IV site, or multiple secondary sites.

6. Nasal carriage on its own is not sufficient to require contact precautions.
7. ~~Patient tested negative for MRSA who will be discharged with central line in place shall be retested for MRSA prior to discharge from the facility. If the results are positive, the patient will be informed through the hospital system or their doctor's office.~~Patients with a negative MRSA swab whom the licensed provider (LP) feels are at increased risk of invasive MRSA should be retested for MRSA prior to discharge.

REFERENCES:

A. California Senate Bill 1058, Chapter 296.

All revision dates: 4/4/2023, 2/14/2023, 9/27/2018, 5/1/2016, 3/1/2014, 3/1/2011

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	4/4/2023
Policy Owner	Magdy Asaad: Infection Prevention Manager	4/4/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/2007*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/4/2023*
Next Review:	*1 year after approval*
Owner:	*Fernando Medina: Director, Support Services*
Policy Area:	*Administrative - Environment of Care*
References:	

106.039 Disaster/Emergency Volunteer Health Professionals

POLICY:

During disasters, healthcare professionals who are not employed, contracted or do not possess privileges at Ventura County Medical Center (VCMC) or Santa Paula Hospital (SPH) may be accepted to work in the hospital when the Emergency Operations Plan (EOP) has been activated. A disaster (an officially declared local, state or national emergency) due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions. The organization recognizes, even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained: 1.) Verification of identification and licensure, certification, or registration required to practice a profession. 2.) Oversight of the care, treatment, and services provided.

PROCEDURE:

1. If it has been determined by the Hospital Incident Command Center (HICC) that there is a hospital need for additional healthcare professionals, the Hospital Incident Commander or his/her designee may approve a disaster status for those who wish to volunteer their services. A request for Medical Reserve Corps (MRC) volunteers is made through the Emergency Medical Service (EMS) Agency Disaster Operation Center (DOC) or Medical Health Operational Area Coordinator (MHOAC). The EMS Agency credentials the MRC through the Disaster Health Care Volunteer System (DHV).
2. During a disaster, the Medical Staff office oversees the performance of each volunteer licensed practitioner (LP), Physician Assistant (PA) and Nurse Practitioner (NP) through direct observation by being paired with an existing member of the VCMC/SPH staff in the same specialty or department for proctoring and/or supervision as appropriate. The Chief Nurse Executive (CNE) will oversee the performance of the volunteer practitioner.
3. The individual must present a professional license or certification valid in California, a photo identification (for example, driver's license, passport), and any other information requested by the Hospital Incident Commander or his/her designees.
4. Licensed practitioners (LPs), PAs and NPs wishing to obtain ***disaster privileges*** will be directed to Medical Staff personnel at the labor pool for credentialing.
5. Volunteer practitioners who are not LPs, such as Registered Nurses (RN), Emergency Medical

Technicians (EMT), and Paramedics, who wish to be assigned ***disaster responsibilities***, will be directed to the Nursing Administration staff at the labor pool for verification of certification and licensing.

6. Any volunteers who are not licensed or certified, will not be accepted to work in the hospital.
7. Before a volunteer practitioner is considered eligible to function as a volunteer licensed practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following (If practical, the appended form should be used to collect this information):
    - A current picture identification card from a health care organization that clearly identifies professional designation.
    - A current license to practice.
    - Primary source verification of licensure.
    - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
    - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
    - Confirmation by a LP currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a LP during a disaster.
8. During a disaster, the medical staff oversees the performance of each volunteer licensed practitioner. Based on its oversight of each volunteer licensed practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue, and reevaluated every 10 days thereafter.
9. Absent the ability to immediately perform the primary source verifications indicated below, the Hospital Incident Commander or his/her designee may choose to visually inspect the items listed above and approve disaster/emergency volunteer status.
10. Information regarding individuals approved for disaster/emergency volunteer status (including each individual's name and contact information) will be maintained and provided to the Labor Pool Unit Leader.
11. As soon as the immediate situation is under control or within 72 hours from the time the volunteer LP or volunteer practitioner presents to the hospital, the Labor Pool Unit Leader or designee will initiate primary source verification of the credentials including (see Attachments A through C):
    - current licensure
    - Relevant training and experience
    - Current competence
    - Primary hospital status in good standing and current privileges.
    - National Practitioner Data Bank query
12. Disaster/emergency volunteer status will terminate immediately upon determination that any information received through the verification process indicates any adverse information or suggests the health care professional is not capable of rendering services in a disaster or emergency.
13. If primary source verification of a volunteer LP or practitioner cannot be completed within 72 hours of

volunteer arrival due to extraordinary circumstances, the hospital will document the following and will perform verification as soon as possible,

1. Reason it could not be performed
2. Evidence of the LP or practitioner demonstrated ability to continue to provide adequate care, treatment and services.
3. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

14. The duration of disaster/emergency volunteer status will be for the period of the emergency only.
15. Individuals who are granted disaster/emergency volunteer status will be issued temporary badges or another form of identification to distinguish them as disaster volunteers.
16. Individuals who are granted disaster volunteer status, along with the effective dates, will be reported to the applicable department, administration and Governance.

**Primary source verification of licensure, certification, or registration is not required if the volunteer LP or practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.*

All revision dates: 4/4/2023, 1/13/2021, 2/12/2019, 10/1/2016

Attachments

A: Disaster Volunteer Privileges/Information Release Form
B: Disaster Volunteer Log
C: Source Verification
D. Disaster-Emergency Volunteer LP Evaluation Form

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/14/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/1/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/1/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/1/2023
Emergency Management Committee	Fernando Medina: Director, Support Services	3/1/2023
Policy Owner	Fernando Medina: Director, Support Services	3/1/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*8/24/2017*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/26/2023*
Next Review:	*3 years after approval*
Owner:	*Alicia Casapao: Director of Quality and Performance Improvement*
Policy Area:	*Administrative - Operating Policies*
References:	

107.072 Disclosure Policy/Communication After A Harm Event

PURPOSE:

The purpose of this policy is to provide structure and guidelines for communication with patients and families after harm, unanticipated or adverse medical outcomes. The goal is to provide a coordinated process for promoting timely, transparent, empathic communication with patients and families. It is recognized that communicating with patients and families is a process rather than one conversation in time, with additional information being shared as it is learned and understood.

DEFINITIONS:

A. Harm Event: Any measurable amount of physical, psychological, or financial injury.

B. Patient Communication Consult (Resource) Service: A service within an organization that can be summoned 24/7 to provide advice, coaching, or direct communication for a patient or family who is upset or dissatisfied, which may or may not be related to inappropriate care. This is often most helpful to have in place immediately after serious harm events, when the facts related to the event are unknown and the appropriateness of care may not have been determined.

C. Communication: The process of conveying information verbally or in writing to a patient/family member or other designee, after a healthcare related event. Types of communication in the context of BETA HEART^{SM} (Healing, Empathy, Accountability, Resolution & Trust) include:

Empathic Communication	One that expresses a concern and curiosity about the impact of a harm event on a patient and their loved ones.
Apology	An empathic communication that includes the expression of sorrow to the patient or family for inappropriate care that caused harm. This is done with an eye toward potential early financial and other forms of resolution such as promise for process improvement.
Disclosure of Medical Error	Telling the patient or family the facts of what happened and the way in which mistakes or errors caused the healthcare related harm (disclosure is not an isolated conversation; rather it is a series of conversations).

D. Empathy: The ability to share in another's emotions, thoughts or feelings.

E. Leadership: ~~Members of the Board of Directors,~~ Hospital Administration and Medical Staff.

F. Timely: Timely is defined as appropriately responsive to the circumstances and as soon as possible following actual knowledge of the harm event.

POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) to ensure all patients and /or their family members receive timely, empathic communication from the patient's healthcare team or other designated organizational representatives related to all relevant aspects of their care including information about patient related harm events and/or unanticipated or adverse medical outcomes of their diagnostic tests, medical treatment and surgical intervention. When harm is related to care or treatment, the hospital personnel and medical staff will strive to follow the procedure below in communicating to patients/ families. Patients/families should be fully informed about unanticipated or adverse medical outcomes, which include events related to a medical error, as well as other complications of care or patient care issues, which resulted in a negative and/or adverse patient and family outcome or experience.

Adverse events, medical errors and complications can cause emotional stress and fear with providers, patients and families. This fear may prohibit communication and transparency, which may cause mistrust; all of which may interfere with communication. Therefore, it is essential that the patient/family receive consistent, coherent and accurate information about the event, complication or issues with patient care process, in a timely fashion.

It is the responsibility of the care providers to assure communication of the harm event with the patient/family, occurs in a timely, coordinated, consistent and accurate manner. Every effort will be made to begin the communication process with the patient/family within sixty minutes of the harm event.

At the time of the initial communication about a harm event, the patient/family should be informed about when they can expect follow-up communication about the event. This is not a disclosure communication but acknowledging the harm event and offering an apology. Please see the procedure below for further instructions and detail.

PROCEDURE:

Communication of Patient Harm Events to Patients/Families:

1. Communication huddle prior to speaking with the patient/family. The initial communication huddle should include the following:

a. Identification of who shall participate in the pre-communication discussion and when and where the communication discussion should occur.

   i. Who should participate in the discussion with family; who has the most trusted relationship with the family and can they be present for the conversation?

b. Review the message which shall take place during the planned communication and, if possible, rehearse with participants at least once prior to patient/family meeting. (See BETA HEART[SM] The Power of the Huddle (Questions to Consider While Preparing for A Conversation After Unexpected Harm).

   i. What emotion should be anticipated and how will you validate and respond to them?

c. Identify clinical support staff which may be needed, ie. social services, interpreter services, chaplain, patient family advisory council member, other.

d. Determine family's concrete needs, e.g. cultural services, food and parking assistance, family accommodations, travel, other.

e. Review the goals of this specific interaction.

f. When you should reach out further with the patient/family (set a date/time) and who the contact person is for the patient/family.

g. How you will open the conversation and what you will say.

h. What information is known and can be shared and discussed.

i. What questions can you anticipate from the patient/family.

    i. What emotions do you expect and how will you identify and validate them.

j. Who takes the lead in responding to the patient/family as more information becomes available.

k. How do you respond to and support your caregivers.

l. Notify attending physician of communication plans if he/she is not the individual carrying out the initial communication.

m. An interpreter shall be used if the preferred language is other than English or the patient and family do not speak or understand English (follow the interpreter service policy of the organization - Administrative - Patient Care Policy 100.064 Interpreter Services).

n. The cultural aspects of the patients/family are to be considered as well. (See BETA HEART^{SM} ~~Toolkit for sample cultural communication guides,~~Power of the Huddle (Questions to Consider) as well as the Administrative - Patient Care Policy 100.053 Cultural Competence).

2. The initial communication shall occur in accordance with the following guidelines:

a. ~~All efforts will be taken to initiate communication with the patient and family as soon as appropriately possible given circumstances, with a goal of within an hour of knowledge of the harm event.~~Initial communication is encouraged within 60 minutes of actual knowledge of harm event.

b. The initial patient/family communication contact around harm events checklist should be utilized as a guide to ensure all aspects of the communication process are considered (see BETA HEART^{SM} Communication and Transparency Toolkit for sample initial communication checklist).

c. The harm event will be acknowledged to the patient/family. This is not an admission of guilt; rather it acknowledges that a harm event occurred while the patient was under the organizations care.

d. The first priority is to take care of the patient and meet their healthcare, social and emotional needs.

e. Patients and families should be reassured that the harm event will be investigated with the goal of learning what contributed to the event, so that the organization can take steps to prevent recurrence. The patient/family should also be reassured that they will be given more information as it becomes available.

f. The initial communication should include the nature of the harm event, what is known about the potential impact of the event on the patient's health and what is being done to mitigate any effects on the patient's health.

g. Avoid speculation and conjecture. Communicate facts that are known at the time. If the facts are not known, then state, "At this time we do not know but will look into and get back to you within a specific agreed upon time frame, or in the next communication."

h. Avoid expressions of blame or fault.

i. The communication should not include information on errors or so called “near-misses,” which at the time of the event did not appear to have affected the patient’s medical condition or outcome.

j. Ask the patient and family if there are any immediate needs that have not been addressed. Offer support services such as a social worker, chaplain, patient advocate, interpreter etc., as needed.

k. Patients and families should be reassured that the hospital clinical staff and physicians will continue to provide ongoing care, including the management of the harm event.

l. It is always appropriate to express empathetic regret for an adverse event or a medical error and apologize to the patient and/or family affected by the event.

3. How to communicate and empathize:

a. Be honest and truthful while acknowledging the event

b. Explain what happened slowly and show empathy such as, “this must be very difficult”. “I can’t even imagine how difficult this must be right now for your family.” “Is there anything you need right now?”

c. Apologize – To express empathy.

d. Avoid the use of technical language.

e. Pause and allow ample time for questions, to ensure the patient/family understand the communication.

f. Inform the patient/family that an investigation and analysis will be completed, so they can understand what occurred and that results will be shared.

g. Designate an organizational contact person and notify the patient/family who will reach out to them within an agreed upon time period and that the patient/family can contact the designated person with questions.

h. Ensure the patient/family has written contact information of the organizational contact person, such as a business card.

4. Activation of the communication team once a harm event is identified:

a. Activation of the communication team, at a minimum, should be considered for:

   1. Events that fall under California Health and Safety Code Section 1279.1 (Reportable Adverse Events to the California Department of Public Health);
   2. Any instance of serious bodily harm or death; or
   3. Any instance where a patient or family is extremely upset or angry regarding the care received or an adverse event.

b. Once a harm event is identified, the employee will notify a communication team member for guidance by contacting the Nursing Supervisor, Administrator on Duty, and completing a notification in the Notification System (desktop icon).

c. The communication team member on call will guide the clinician in the initial sixty-minute communication with the patient/family.

d. If a communication team member is present on campus, they will come to the area of the organization where the clinicians are present and guide the clinicians in the conversation.

e. If there are no communications team members physically on campus, the on-call communication team member will guide the clinicians on the phone in the communication process.

5. Who shall communicate the harm event to patients/families:

a. It is the responsibility of the attending physician or designee and the organizational leaders, to assure communication of the harm event with the patient/family and that that communication occurs in a timely, coordinated, consistent and accurate manner.

b. Upon knowledge of a harm event, the communication team shall be notified and the lead on the team, or designee, will guide the clinician(s) in communication of the harm event. A communication team member will also be present if possible, for the actual discussion with the providers communicating the harm event with the patient.

6. Documentation of the conversation:

a. The communication lead shall document the conversation in the patient's Electronic Health Record (EHR). The record note must not state conjecture or opinions, but rather the facts of the conversation.

b. The note shall include the date, time and place of the discussion and the names, titles and relationships of those present. Information provided and plan of care, going forward, will be noted. Offers of assistance to the patient/family, as well as the patients/families response, shall be documented. The documentation shall also include any referrals/consults initiated as a result of the harm event.

7. Follow-up communication:

a. As more facts become known throughout the continual investigation, the contact person will inform the patient/family.

b. The organizational contact person will ensure the patient/family has written contact information, such as their business card, for further communication and any questions the patient/family may have.

c. The contact person will arrange specific dates and times for follow-up at regular intervals.

8. Debriefing the effectiveness of the communication:

a. There will be a debriefing of the team members involved in the communication, after the meeting, to discuss what went well and to identify any opportunities for improvement (See BETA HEART^{SM} Communication and Transparency Toolkit ~~for Communication Debrief Tool~~). The results of the debrief will be communicated to leadership as well.

REFERENCES:

1. California Health and Safety Code 1279.1
2. Title 22, California Code of Regulations § 70737
3. Agency for Healthcare Research and Quality (AHRQ) Communication and Optimal Resolution (CANDOR) Toolkit.
4. The Joint Commission Sentinel Event Policy and Procedures.
5. AHRQ TeamSTEPPS Pocket Guide.

All revision dates: 1/26/2023, 4/17/2020

Attachments

BETA HEART - HEART Huddle Questions

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	3/13/2023
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/1/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/26/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/26/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/26/2023
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	1/26/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/21/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/9/2023*
Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.035 Patient Throughput (Intrafacility Admissions and Transfers)

POLICY:

To transition the patient through the care continuum within Ventura County Medical Center/Santa Paula Hospital, with the goal of ensuring the patient is placed in the appropriate care area within one hour of bed availability.

PROCEDURE:

Prior to the start of each shift the Unit Charge RN shall predetermine the admission flow and assign order of admission with nursing staff. Bed availability is defined as an unoccupied room with a clean bed and an RN to staff.

1. When an inpatient bed need is identified, the unit Charge RN communicates with the House Supervisor to convey the need for admission or change in level of care.
2. The House Supervisor communicates with the receiving unit's Charge RN to determine bed availability and status of the room.
3. The House Supervisor assigns only clean and ready bed assignments, noting assigned RN's name.
    - If no clean bed is ready and available, the House Supervisor will notify the EVS Supervisor.
    - The EVS Supervisor will notify the House Supervisor when a room has been cleaned and is ready to receive a patient.

~~The primary RN of the sending unit completes an SBAR (see Attachment B) and verifies with the sending unit Charge RN. The Charge RN of the sending unit then sends the completed SBAR to receiving unit via the tube system within 15 minutes of bed assignment. The copy of the completed SBAR that is sent will be provided as a courtesy, not a requirement prior to transfer.~~

- ~~Some exceptions may apply, for example the tube system is out of service.~~
- ~~This practice will be the exception, not the norm and the physical SBAR will be provided upon patient transfer.~~

4. ~~Within 30~~The primary RN of the sending unit is responsible for calling report to the receiving unit within 15 minutes of notification of ready, clean bed. A paper SBAR will be filled out and sent within 15 minutes of bed assignment~~, the receiving unit RN will have reviewed the SBAR and called the sending RN to request that the patient be sent to the room where bedside handoff shall be completed by the sending RN~~ for IPU

and with dialysis patients only. ~~Both the sending RN and receiving RN are responsible for this communication.~~t

- Patient transfer is expected to occur within 30 minutes of notification of a clean and ready bed.
- ~~Some exceptions may apply, for example primary~~The gold standard is a telephonic handoff to notify the receiving unit that the patient is coming followed by a bedside handoff between sending and receiving RN ~~is unable to leave unit due to staffing ratio, at which time a phone report will be acceptable~~. Both the sending RN and receiving RN are responsible for this communication.
  - Some exceptions may apply, for example primary RN is unable to leave unit due to staffing ratio, at which time a phone report will be acceptable.

~~One (1) patient per receiving RN per unit every 30 minutes shall be understood as the standard of care and shall occur at any time during shift.~~

5. If limited/unusual circumstances occur which may cause a delay, immediate communication shall occur between the House Supervisor and the receiving unit's Charge RN. Delay of transfer should not exceed a maximum of 30 minutes.

ATTACHMENTS:

- Attachment A - Patient Throughput Algorithm
  ~~Attachment B - SBAR~~
  ~~Attachment C - SBAR Second page~~

All revision dates: 2/9/2023, 3/21/2019

Attachments

108.035 Attachment A - Transfer Flowchart.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/9/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/9/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Nursing*
References:	

108.044 Clinical Implementation Guide for: Electrocardiogram Guided Tip Confirmation System During Peripherally Inserted Central Catheter Placement

POLICY:

To provide guidelines to facilitate standardization of practice for insertion by Registered Nurses (RN) of Peripherally Inserted Central Catheter (PICC) using Electrocardiogram (ECG) Guided catheter tip confirmation.

SCOPE:

1. This applies to RNs at Ventura County Medical Center who have successfully completed population appropriate training and demonstrated competency in Vascular Access device insertion, care and maintenance, patient/caregiver education across the care continuum.
2. RNs must also have completed the online education course on the ECG guided tip confirmation system (TCS) and yearly ECG PICC competency checkoff.

DEFINITION(S):

The ECG guided TCS is indicated for guidance and positioning of the PICC. The ECG TCS provides real-time catheter tip location information by using the patient's cardiac electrical activity. ECG TCS is indicated for use as an alternative method to chest x-ray and fluoroscopy for PICC tip placement confirmation in adult patients. Limiting but not contraindicated situations for this technique are in the patients where alterations of cardiac rhythm change the presentation of the P-wave as in atrial fibrillation, atrial flutter, severe tachycardia, and pacemaker driven rhythms. In such patients, who are easily identifiable prior to PICC insertion, the use of an additional method is required to confirm catheter tip location.

EQUIPMENT:

1. Sherlock 3CG Tip Confirmation System
2. Site Right Portable Ultrasound Machine
3. PICC Catheter with Sherlock 3CG Tip Positioning System (TPS) Stylet

PROCEDURE(S):

1. **Prepare ECG Sensor:**
    a. Enter patient identification information (name, medical record number, date of birth).
    b. Slide the fin assembly onto the sensor until fully seated and place the sensor in protective cover. Do not use excessive force when connecting or disconnecting the fin assembly to or from the sensor or equipment damage may occur.
    c. Position sensor on patient's chest with the top of sensor above the sternal notch and centered on the sternum. Place sensor as flat as possible for best result.
    d. Prepare and attach the external ECG electrodes to the lead wires. Ensure electrode locations are oil-free, completely dry, and on intact skin (e.g., not over open wounds, lesions, infected, or inflamed areas. Discontinue electrode use immediately if skin irritation occurs.
    e. Attach electrodes to all the lead wires. Remove backing and press firmly onto skin at the specified locations:
        - Place BLACK electrode lead wire on patient's lower right shoulder
        - Place RED electrode lead wire on lower left side, inferior to the umbilicus and laterally along the mid-axillary line. CAUTION: Placement of the red lead wire outside of this region may result in reduced ECG performance.
2. **Evaluate baseline ECGs:**
    a. Turn on TCS and note external waveform.
    b. Verify that P-wave is present and identifiable and consistent on the main screen.
    c. If no persistent or regular P-wave is identified, continue with procedure utilizing magnetic tracking and external measurements followed by tip confirmation via alternative method (i.e., x-ray or fluoroscopy).
    d. Adjust ECG scale as needed to endure that entire ECG waveforms are visible in the ECG window throughout the insertion procedure.
3. **Catheter Tip Guidance and Positioning**
    a. Follow Tip Locating System (TLS) "Instructions for Use" for magnetic navigation.
    b. Insert catheter until the magnetic navigation shows stylet icon (Sherlock Spyglass) moving consistently downward.
    c. Continue to slowly advance the catheter until the catheter is inserted to the external measurement determined prior to insertion and/or negative P-wave deflection is noted. Do not rely on ECG signal detection for catheter tip positioning when there are no observable changes in the intravascular P-wave. In this case, rely on magnetic tracking and external measurement for tip positioning and use chest X-ray or fluoroscopy to confirm catheter tip location as per policy and clinical judgement.
    d. Press the FREEZE button on TCS. This will save the current waveform on the right-side reference screen for later comparison. Repeat as needed.
    e. SLOWLY adjust catheter tip position until the maximum P-wave amplitude is reached. Compare main screen waveform to reference screen waveform while closely monitoring for negative P-wave deflection.

f. If negative deflection prior to P wave present, adjust catheter tip position to maximum P-wave amplitude with no negative deflection

g. Advance or retract catheter from maximum P-wave to place tip in desired location (the cavoatrial junction of the superior vena cava).

h. Note catheter exit site marking (centimeters from exit site to hub) and document on TCS screen.

i. To record waveforms at the final catheter tip position, press FREEZE button on TCS. Press the "PRINT" button to save image

4. PICC RN/ Vascular Access Specialist inserting the catheter will notify the RN/ provider for authorization of line use. The PICC RN/ Vascular Access Specialist may order radiograph at his or her discretion when clinically indicated. PICC RN/Vascular Access Specialist will place an order to use the vascular access device.

5. TCS Documentation: Upon successful insertion and TCS confirmation, the PICC RN/ Vascular Access Specialist will follow Ventura County Medical Center process to ensure the ECG waveform determining optimal tip position will be entered into the medical record.

6. When ECG TCS is used to determine optimal PICC tip placement in the SVC, no radiographic confirmation is required. ECG technology has been proven to be a more accurate determination of tip placement than radiographs (per INS Standards). If there is a discrepancy between tip confirmation with ECG TCS and chest X-ray (CXR) read, ECG TCS is considered to be the more accurate of the two technologies. The Vascular Access Specialist inserting the catheter may approve use of the line per policy when the appropriate change in the P wave is noted. At the time of placement, the external catheter measurement will be documented.

REFERENCES:

a. Infusion Nurses Society (2016). Policies and Procedures for Infusion Nursing, (4th Ed.) Norwood, MA: Author

b. BARD Access Systems (2013). Sherlock 3CG Tip Confirmation System, www.bardaccess.com

c. Appl Health Econ Health Policy (2016). Sherlock 3CG Tip Confirmation System for Placement of Peripherally Inserted Central Catheters: A NICE Medical Technology Guidance, Megan D. www.springerlink.com

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medcine & Medicine	Tracy Chapman: VCMC - Med Staff	pending

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/13/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/13/2022
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/13/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Nursing*
References:	

108.048 Midline Intravenous Catheter Placement

POLICY:

To provide guidelines for the proper insertion of midline catheters by trained Registered Nurses (RN's). RN's trained in midline insertion shall show competency prior to independent practice. Competency shall be maintained by successful insertion of three midlines per calendar year.

DEFINITIONS:

Midline Catheter: A peripheral venous access devices inserted above the antecubital fossa and threaded into the basilic, median cubital, cephalic, or brachial vein. A midline terminates distal to the axilla. They are typically 8 to 10cm in length. Midline catheters DO NOT enter the central circulation. "Midline" is clearly marked on the hub of the catheter.

PROVISIONS:

I. Catheter Selection Criteria:

1. Early assessment in the admission process is recommended to determine the appropriate vascular access device.
2. A midline catheter may be selected when the duration of intravenous therapy will last no longer than 28 days.
3. A midline catheter can replace the need for multiple peripheral catheter insertions; however, it should not be regarded as a substitute for a central venous catheter.
    a. Some midline catheters are compatible with power injection for delivery of contrast media; compatibility must be verified before injecting contrast media.
    b. Midline catheters are not appropriate for therapies that include:
        - Any intravenous therapy lasting >4 weeks
        - When the infusate is a vesicant (refer to VCMC's "Irritants and Vesicants Guide to Intravenous Administration")
        - Infusions of extreme pH and osmolarity
        - Vasopressors
        - Total parenteral nutrition (TPN)/chemotherapy
        - >10% dextrose

1. Midline catheters may be placed routinely for any physician-ordered peripheral IV infusion if the above criteria are met, and only after consultation with the covering physician to ensure appropriateness. A physician order is required for placement of a midline.

I. Contraindications:

1. Midline catheter placement should not occur on the ipsilateral side of a mastectomy with node resection, radial artery surgery, fistula or shunt.
2. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs.
   a. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of midline.
      - Primary physician will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.
      - Any discussions with physicians should be documented by the midline nurse.
   b. For patients with stage 4 or 5 chronic kidney disease, midline placement may occur only in the patient's dominant arm, preserving the non-dominant arm for future vascular access.
   c. For patients who already have a fistula or graft, midline placement may be considered only on the contralateral side, and only with the approval of the patient's primary nephrologist.
3. Midline catheters are contraindicated in patients with a history of thrombosis, hypercoagulability, or reduced venous flow in the extremities.
4. Midline catheters should not be placed in areas where a patient experiences pain on palpation, areas near open wounds, areas on an extremity with infection, veins that are compromised (for example, bruised, infiltrated, phlebitis, sclerosed, corded, or engorged), and areas of planned procedures.

PROCESS:

A. Check the physician's order

B. Gather equipment:

1. Powerglide full catheter kit
2. Hair cover
3. Ultrasound
4. Needleless connector cap

C. Powerglide full catheter kit to include:

1. Midline catheter
2. Absorbent towel
3. Surgical tape
4. ChloraPrep™ solution
5. Bedside sign with measuring tape
6. Mask
7. Adhesive dressing

8. Biopatch™ disk
9. 70% isopropyl alcohol wipe
10. 4x4 gauze
11. Extension set
12. Tourniquet
13. Sterile gloves
14. Absorbent drape
15. Fenestrated drape
16. 48" probe cover, elastic bands, and conductive gel
17. StatLock® stabilization device and skin prep pad
18. 10ml 0.9% sterile saline syringe

PROCEDURE:

A. Confirm the patient's identity using at least two (2) patient identifiers.

B. Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs, including the reason for catheter insertion, device benefits, expected dwell time, care and maintenance of the device, and signs and symptoms of complications to report.

C. Don mask and a cap, perform hand hygiene.

D. Open kit to produce a sterile field.

E. Drop items onto sterile field that are not within the kit.

F. Place sterile drape under patient's arm.

G. Place tourniquet on patient.

H. Perform hand hygiene.

I. Don Sterile Gloves.

J. Prep insertion site with Chloraprep™ (30 seconds scrub, 2-minute dry).

K. Prime extension tubing while prep dries.

L. Place fenestrated drape over insertion site.

M. Insert ultrasound probe into sterile cover and place onto sterile drape.

N. Insert Powerglide needle:

1. Be sure to check that that needle bevel is facing up and that the wire or catheter is not exposed.
2. Insert needle into the vein under ultrasound guidance.
3. Slowly advance the guide wire by stabilizing the device and pushing the top slide forward.
4. Deploy the catheter by holding the rear piece of the device stationary then slowly and gently pushing the side wings forward towards the vein. Be careful not to kink the catheter during this phase. Holding skin traction distal to the insertion site will help. If the catheter kinks it will not function properly and a new device will have to be used.
5. Remove the tourniquet.

6. Remove the device applicator and cap.
7. Screw the primed extension set and needleless connector onto the catheter hub and aspirate for for blood return.
8. Flush catheter with 10ml normal saline (NS).

O. Place stabilization device over hub of catheter.

P. Apply antimicrobial patch on the insertion site (i.e. Biopatch™). Align the slit of the patch with the midline catheter.

Q. Cover the insertion site, Biopatch™, and stabilization device with sterile transparent dressing.

R. Place an antimicrobial cap on the needleless connector.

COMPLICATIONS:

A. The most common (but not usually significant) complication of midline catheter insertion is hematoma formation at the insertion site. Other complications include phlebitis, infiltration, infection, air, clot, or particle embolus, nerve damage, compromised distal circulation, fluid overload, inadvertent arterial insertion, and pain and stress from multiple attempts.

SPECIAL CONSIDERATIONS:

A. Monitor the insertion site regularly for signs of phlebitis (including pain, erythema, swelling, warmth, palpable cord, and purulence), infiltration and extravasation (including edema, leakage at the site, resistance with flushing, and coolness of the skin around the insertion site), and infection (including erythema, edema, induration, and drainage at the insertion site).

B. Communicate with all other staff members the need to avoid measuring blood pressure, administering injections, and performing venipuncture on the extremity with the midline catheter. Consider placing a sign at the patient's bed as a reminder to other staff members.

DOCUMENTATION:

A. Document in the electronic medical record:

1. Nursing note: include date, time, staff performing procedure and how patient tolerated procedure.
2. Nursing IV section: catheter type, IV site, laterality, and catheter gauge.

CONTINUING CARE:

A. Do not use Cathflo/Alteplase/Heparin for catheter clearance with this catheter.

B. Flush with 10mL of 0.9% NS after each use and every 8 hours PRN.

C. Routine sterile dressing changes are every 7 days and PRN if soiled. Antimicrobial patch, PIV securement device, and transparent dressing must be changed.

D. Change needleless connectors with dressings.

REFERENCES:

- Bard Access Systems, Inc. (2014). "PowerGlide® Catheter" [Online]. Accessed July 2017 via the Web at http://www.bardaccess.com/assets/literature/0738242_PowerGlide_IFU_web.pdf

- Centers for Disease Control and Prevention. (2011). "Guidelines for the prevention of intravascular catheter-related infections" [Online]. Accessed July 2017 via the Web at http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf (Level I)
- Standard 61. Administration set change. Infusion therapy standards of practice. (2016). *Journal of Infusion Nursing, 39,* S133–S135

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/6/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/6/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	3/6/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

Centralized Telemetry Monitoring

PURPOSE:

To identify the process for continuous monitoring of heart rate and rhythm of patients to ensure life-threatening rhythms can be detected and treated. Centralized telemetry monitoring ensures redundancy of monitoring both at the department level and in the centralized telemetry station. The centralized telemetry station is located in DOU and is responsible for the remote monitoring of patients ~~in the following areas: Med Surg 1, DOU and Telemetry~~within the adult critical care and medical surgical patient populations at VCMC only.

POLICY:

The nursing personnel covered in this policy include telemetry technicians, nurses and anyone covering these roles. Under the direction of nursing directors, these individuals are accountable for the quality of care of the patients and are accountable through nursing administration. The telemetry technicians assigned to the central telemetry station are responsible for maintaining accurate patient information on the system and notifying the nursing staff of any changes.

Qualified personnel to perform the telemetry monitoring function are those individuals who have received training for telemetry monitoring. Qualified staff must demonstrate competency in evaluating of life-threatening arrhythmias.

~~Qualified personnel to perform the telemetry monitoring function are those individuals who have received training for telemetry monitoring. Qualified staff must demonstrate competency in evaluating of life-threatening arrhythmias.~~

PROCEDURE:

~~I. Utilization~~

~~A. A provider's order must be present for all patients receiving continuous cardiac monitoring, except in the ICU where this is the standard of care.~~

~~B. Common indications for cardiac monitoring include: primary cardiac diagnosis, stroke, syncope, chest pain or arrhythmias, patients with significant electrolyte imbalances.~~

~~II. Management of the Patient~~

A. When the nurse receives an order for cardiac monitoring for a patient, the RN applying the telemetry box (or hard wires) will call the telemetry technician to validate two patient identifiers, as well as that the monitor is on. They will identify the telemetry box number and identify the patient's baseline rhythm.

B. The telemetry technician and nurse will set the gain to achieve a QRS amplitude large enough to be detected by the monitor and assure that a clear tracing is visible on the monitor for at least two leads.

C. The telemetry technician and nurse will select the appropriate lead based on the goals of monitoring and the patient's clinical situation.

1. For Arrhythmia diagnosis or Wide QRS tachycardia, V1 is the best lead with V6 as second choice.

2. If a true V1 or V6 is not a lead option, MCL 1 and MCL6 can substitute.

3. Dual lead monitoring is superior to single lead monitoring, making V1 + Lead 3 a good option.

4.Note: if other leads in use, justification required and documented.

D. The assigned nurse will notify the telemetry technician when the telemetry box is being taken off for bathing or discharge. They must also call at the beginning of a dialysis treatment and when it is completed, transporting to a procedure or having physical therapy.

E. Physicians shall be notified in the event of any changes in cardiac rhythm or vital signs.

F. The attending physician must re-evaluate the need for utilization of cardiac monitoring daily. Every effort should be made to discontinue telemetry once the patient becomes stable.

G. The nurse will educate the patient about the need for telemetry and not to remove the wires or box. Patients cannot shower with telemetry wires or the telemetry box.

III. Alarm Management

A. Keep alarms on at all times.

B. Default heart rate alarm settings are standardized for range 50-130 bpm.

C. Certain dysrhythmia alarms (e.g.: irregular rhythms) may be changed by the registered nurse on the basis of the patient's clinical situation, current heart rate, rhythm, and treatment plan. Changing the heart rate standard alarm limits requires an order from the provider. The nurse shall document the clinical justification for altering the alarm limits and dysrhythmia alarms in the patient's medical record. The physician/care team is to be notified of changes from the default settings made by the Registered Nurse. Heart rate alarm limits, different from the default settings, may also be ordered by the physician. Alarm limits can only be adjusted with provider order.

IV. Frequency of Cardiac Rhythm Interpretation

A. The nurse is responsible for strip interpretation.

B. Strip documentation is to be done at the following times.

1. Upon admission or transfer into unit.

2. Every four hours for ICU patients and every shift or with changes for DOU and telemetry patients

3. For any changes in rhythm or rate, change in vital signs, or in mental status; the patient experiences chest pain; change in lead placement; and when evaluating effects of anti-dysrhythmic agents.

4. For Code Blue (continuous).

5. Document on each recorded rhythm strip the two patient identifiers, interval measurements and interpretation (Telemetry: monitor tech or primary RN).

6. Telemetry tech will send all saved telemetry rhythm strips to the patient's primary nurse at intervals mentioned above.

7. For specific procedures such as cardioversion or TEE.

8. During any rapid response event.

C. The registered nurse will document on each rhythm strip the rhythm, and measurements (PR, QRS, QT). Nurse will date, time and initial each strip.

V. Dysrhythmia Notification

A. In the event of a change in rhythm, the telemetry tech will immediately notify the assigned nurse. Notification will be done via department phone. The person receiving the call will collect the name and employee number of the recipient and document that in the medical record.

B. For any arrhythmia with pauses, second degree AV block or delayed ventricular response > 3 seconds, consider placing defibrillator and pacer pads at bedside for potential pacing.

C. The telemetry technician will notify the assigned nurse immediately for any dysrhythmia alarms or changes to baseline rhythm or rate.

D. The telemetry technician will review alarms at least hourly and will notify the assigned nurse of any alarms not previously reported.

E. The nurse will notify the provider when rhythm changes occur causing an alteration of condition or status, for life threatening arrhythmias or as ordered.

F. The nurse will implement and document interventions as ordered.

G. Call Rapid Response or Code Blue as appropriate for any clinical deterioration.

VI. Escalation Pathway

A. For any asystole, cessation of visible rhythm or lethal dysrhythmias, the telemetry tech will do the following.

1. Call assigned RN immediately.

2. If no response, call unit charge nurse where patient is located.

3. If no response, call house supervisor.

4. If no response, call Code Blue.

VII. Discontinuation of Cardiac Monitoring

A. A provider order is required to discontinue cardiac monitoring.

B. Nurse should call provider to inquire about discontinuation when patient has been clinically stable with no arrhythmias for the last 12 hours. Criteria can include heart rate 50-110, systolic blood pressure 90-180.

C. Assigned nurse will notify centralized telemetry when monitoring is discontinued for a patient. Telemetry technician and nurse will use two patient identifiers to ensure the correct patient is having monitored removed.

~~D. Department staff will return telemetry box to the centralized telemetry room.~~

~~E. Nurse will educate patient that monitoring is being discontinued.~~

~~VIII. Handoff~~

~~A. Any changes to cardiac monitoring orders require handoff between providers using SBAR format.~~

~~B. Handoffs must also occur between telemetry technicians and must include alarm volumes, alarm limits (if not standard), basic rhythms and arrhythmias of any patients being monitored.~~

~~C. Telemetry box log book will be maintained and updated by telemetry technicians.~~

~~IX. Downtime~~

~~A. If downtime occurs, the telemetry technician will immediately notify the house supervisor to contact BioMed and department charge nurses. House supervisor will call AOD if downtime extends > 10 minutes.~~

~~B. When department monitoring stations are down, the department charge nurse will notify the centralized telemetry room.~~

~~C. If any monitoring is down in the centralized telemetry room, the house supervisor will place patients on alternative monitoring, call BioMed and call the AOD.~~

~~D. Once downtime resolves, conduct a debrief to understood root causes and mitigate future risk.~~

I. Utilization

A. A provider's order must be obtained for all patients receiving continuous cardiac monitoring (CCM) when it is not the standard of care for all patients on the unit. A provider's order must be obtained for all patients receiving continuous pulse oximetry monitoring.

B. Orders for continuous cardiac monitoring must be re-evaluated every 24 hours or sooner if the patient condition meets criteria per CPG. 50

C. IV access is required on all patients who are receiving CCM.

II. Management of the Patient

A. When the nurse receives an order for cardiac monitoring for a patient, the RN applying the telemetry box (or hard wires) will call the telemetry technician to validate two patient identifiers, as well as that the monitor is on. They will identify the telemetry box number and identify the patient's baseline rhythm.

B. The telemetry technician and nurse will set the gain to achieve a QRS amplitude large enough to be detected by the monitor and assure that a clear tracing is visible on the monitor for at least two leads.

C. The telemetry technician and nurse will select the appropriate lead based on the goals of monitoring and the patient's clinical situation.

1. For Arrhythmia diagnosis or Wide QRS tachycardia, V1 is the best lead with V6 as second choice.

2. If a true V1 or V6 is not a lead option, MCL 1 and MCL6 can substitute.

3. Dual lead monitoring is superior to single lead monitoring, making V1 + Lead 3 a good option.

4. Note: if other leads in use, justification required and documented.

D. The assigned nurse will notify the telemetry technician when the telemetry box is being taken off for bathing or discharge. They must also call at the beginning of a dialysis treatment and when it is completed, transporting to a procedure or having physical therapy.

E. Physicians shall be notified in the event of any changes in cardiac rhythm or vital signs.

F. The attending physician must re-evaluate the need for utilization of cardiac monitoring daily. Every effort should be made to discontinue telemetry once the patient becomes stable.

G. The nurse will educate the patient about the need for telemetry and not to remove the wires or box. Patients cannot shower with telemetry wires or the telemetry box.

III. Equipment/Parameter alarms

A. All telemetry equipment including SPO2 probes and cables will be kept in the telemetry monitoring room.

B. All requests for equipment will be through the monitor tech and returned to the telemetry monitoring room when the patient's monitoring is discontinued.

C. All nursing units are required to clean equipment with germicidal agent before returning equipment.

D. Cleaned equipment will be placed in a designated basket at the nursing station and delivered to and/or picked up by staff to the telemetry monitoring room.

E. Initial set up for alarms is established by using patient's baseline settings. A specific physician order for parameters would supersede using baseline settings.

F. The parameters can be individualized for any patient by a RN or monitor tech. When the monitor tech adjusts parameters it will be in collaboration with the nursing and/ or medical staff.

G. Parameters should be based upon the patient baseline average if there are no specific orders from the provider. Default alarm parameters are standardized for a range between 50-130 bpm.

H. Volume alarms should never be set below 50%.

I. Certain dysrhythmia alarms (e.g.: irregular rhythms) may be changed by the registered nurse on the basis of the patient's clinical situation, current heart rate, rhythm, and treatment plan. Changing the heart rate standard alarm limits requires an order from the provider. The nurse shall document the clinical justification for altering the alarm limits and dysrhythmia alarms in the patient's medical record. The physician/care team is to be notified of changes from the default settings made by the Registered Nurse. Heart rate alarm limits, different from the default settings, may also be ordered by the physician. Alarm limits can only be adjusted with provider order.

J. Other parameters that are monitored via the central monitoring station are blood pressure, O2 saturation, and respirations.

- *Blood Pressure: Within 20% of patient initial BP unless otherwise directed by medical provider*
- *O2 Saturation: Between 90-100% unless otherwise directed by medical provider*
- Respiratory Rate: Within 10 of baseline unless otherwise directed by medical provider. Low rate should NEVER be less than 10.

IV. Frequency of Cardiac Rhythm Interpretation

A. The nurse is responsible for strip interpretation.

B. Strip documentation is to be done at the following times.

1. Upon admission or transfer into unit.
2. Every four hours for ICU patients and every shift or with changes for DOU and telemetry patients
3. For any changes in rhythm or rate, change in vital signs, or in mental status; the patient experiences chest pain; change in lead placement; and when evaluating effects of anti-dysrhythmic agents.
4. For Code Blue (continuous).
5. Document on each recorded rhythm strip the two patient identifiers, interval measurements and interpretation (Telemetry: monitor tech or primary RN**).**
6. Telemetry tech will send all saved telemetry rhythm strips to the patient's primary nurse at intervals mentioned above.
7. For specific procedures such as cardioversion or TEE.
8. During any rapid response event.

C. The registered nurse will document on each rhythm strip the rhythm, and measurements (PR, QRS, QT). Nurse will date, time and initial each strip.

V. Communication: Nurse and Telemetry Technician

A. The Nurse and Monitor Tech should communicate the following information to each other:

- Request for equipment to include two patient identifiers one of which cannot be room number
- Initiation of monitoring
- Discontinuation of monitoring
- Interruption of monitoring
- Chest physiotherapy
- Transfer to another room
- Pacemaker or AICD
- Transporting for diagnostic testing and/or procedure

B. The nurse should call the Monitor Tech to inform of any specific orders received.

C. Nursing assignment sheets will be sent to the Central Telemetry Room within 30 minutes of the start of the shift. Additional changes to assignments must be communicated to include change in mid-shift assignments, patient admissions, and/or transfers and discharges.

VI. Dysrhythmia Notification

A. Follow the Alarm Intervention Flowchart for any changes in patient condition, rhythm changes and/or lethal dysrhythmias

1. Lethal Dysrhythmias
    a. Asystole
    b. Ventricular tachycardia
    c. Ventricular fibrillation
2. Warning Alarms
    a. Bradycardia (patient's low HR parameter)
    b. Non-sustained ventricular tachycardia > 2 beats
    c. Accelerated ventricular rate
    d. Heart rate greater than patient's high parameter, such as SVT or PAT
    e. pause or any dysrhythmia not addressed as a lethal alarm
    f. new onset of atrial fibrillation
3. Message Alarms
    a. Bigeminy
    b. Couplets
    c. Trigeminy
    d. PVC
    e. ST alarms

B. Escalation pathway: all telemetry alarms are to be called to the unit immediately. If no response, the charge nurse will be notified via walkie talkie. If no response from the charge nurse, the central telemetry staff will active a telemetry alert to trigger an overhead page.

C. Telemetry alerts are also to be called immediately for any lethal dysrhythmia.

VII. Telemetry Tech Responsibilities

A. Communicates battery change alarm

B. Creates copies of the telemetry strips for each nurse to review. The Charge Nurse will pick up the strips from the Central Telemetry room when the strips are ready

C. Notifies Bio-Medical Engineering of faulty equipment and takes equipment our of service

D. Admits patient to the CIC in coordination with the RN, including patient data and initial rhythm strip

E. Sets parameters and re-checks parameter every 12 hours

F. Monitors patients continuously via central station

G. Reviews prior alarm history and clears out artifact related alarms

H. The monitor tech will follow the "Alarm Intervention Flowsheet" to escalate any lethal dysrhythmias, warning alarms and/or messages

I. The monitor tech will document all notifications to nurse (In cerner? Or on a paper log?)

J. The monitor tech will label each telemetry strip with the following information:

1. patient's name and MRN
2. Patient's room number

3. Time and Date
4. Measured parameters

VIII. Specific Nursing Responsibilities

A. Patients on telemetry monitoring who require transport for testing will be transported without a nurse to the department, unless otherwise ordered by the provider. The patient will be continuously monitored by telemetry by the monitor tech. In those areas where telemetry is not monitored or telemetry is not transmitted, the nurse will accompany the patient.

B. Electrodes are changes prn and at least every 72 hours. Do not use tape to affix to a patient's body

C. Telemetry ECG strips are to be placed in the chart and the RN signature confirms the monitor tech's interpretation.

D. Broken or faulty equipment should be returned to the CIC. The monitor tech's will be responsible for notifying bio-medical engineering and ensuring the equipment is repaired and returned.

E. The RN will promptly notify the monitor tech when the patient's telemetry is discontinued, the patient leaves the floor, and/or the unit is taken off for any reason.

F. The Charge nurse or designee will pick up the monitor strips from the CIC. The RN will validate the interpretation of the strip and place in the medical record.

G. In the event of an arrythmia, the nurse will:

a. verify the patient by name and MRN

b. Go immediately to check on the patient

c. Nursing assessment will include:

1. Airway, Breathing, Circulation
2. Heart rate and rhythm regularity to include a full set of VS
3. Assess for presence of chest pain
4. Skin color

H. Communicate patient status to monitor tech

I. Call rapid response and notify provider for all symptomatic rhythms.

IX. Handoff

A. Any changes to cardiac monitoring orders require handoff between providers using SBAR format.

B. Handoffs must also occur between telemetry technicians and must include alarm volumes, alarm limits (if not standard), basic rhythms and arrhythmias of any patients being monitored.

C. Telemetry box log book will be maintained and updated by telemetry technicians.

X. Downtime

A. If downtime occurs, the telemetry technician will immediately notify the house supervisor to contact BioMed and department charge nurses. House supervisor will call AOD if downtime extends > 10 minutes.

B. When department monitoring stations are down, the department charge nurse will notify the centralized telemetry room.

C. If any monitoring is down in the centralized telemetry room, the house supervisor will place patients

on alternative monitoring, call BioMed and call the AOD.

D. Once downtime resolves, conduct a debrief to understood root causes and mitigate future risk.

REFERENCE(S):

AACN Procedure Manual for High Acuity, Progressive and Critical Care. (2017). 7th ed.

Alarm Management- American Association of Critical Care Nurses.

procedures.lww.com/lnp/view.do?pId=3378804&hits=telemetry&a=false&ad=false&q=telemetry

All revision dates:

Attachments

Alarm Intervention Flowchart (1).docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/14/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/1/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/28/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/28/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/28/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/12/2020*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/12/2020*
Next Review:	*3 years after approval*
Owner:	*Colleen Rusin: Ambulatory Care RN II*
Policy Area:	*Ambulatory Care - Patient Care Services*
References:	

AC.24 Retinal Imaging Systems

POLICY:

Ventura County Health Care Agency (VCHCA) Ambulatory Care (AC) clinics use retinal imaging systems for obtaining images of the eye, to aid clinicians in the evaluation and diagnosis of eye disease. The following policy is in place to ensure safe use of retinal imaging systems in the Ambulatory Care Clinics.

PROCEDURE:

Indications for Use:

1. Retinal imaging is intended to provide images of the eye as an aid to clinicians in the diagnosis of diabetic retinopathy.
2. Other conditions such as age related macular degeneration, glaucoma and cataracts may be detected as well, however, the sensitivity of detecting these conditions is not sufficient for diabetic retinopathy screening to take the place of a regular eye exam.
3. Retinal imaging systems provide images only and do not provide any diagnostic or pathological analysis or conclusions.
4. Screening with retinal imaging cannot replace clinical judgment and is intended to be used only in conjunction with other clinical tools considered to be the standard of care for measurement and diagnosis of the eye. The purpose of the screening is timely identification of patients with sight-threatening diabetic complications and is not intended to take the place of patients seeking regular eye care.

Performed By:

1. Retinal imaging systems should only be operated by qualified personnel who have received proper training.
2. When dilating drops will be used, the exam may only be performed by a qualified medical professional such as a licensed vocational nurse (LVN), registered nurse (RN), nurse practitioner (NP), or physician (MD/DO). Certified Medical Assistants may also administer dilating drops under direct supervision by a physician or nurse. A written order that includes the medication name, dosage, and specific instructions for administration must be provided and the medication and dosage verified by a licensed nurse or physician prior to being administered.
3. Operation of any retinal imaging system should always be supervised by a physician.

4. The clinic manager or a qualified designee will ensure that staff receive appropriate training and complete certification requirements for the specific instrumentation and operating system being used. Retraining and/or recertification will be required when retinal images fail to meet minimum quality standards, or when retinal imaging is performed only infrequently.
5. Documentation of all training activities will be documented and maintained by the clinic manager or designee, as a part of the employee record.

Guidelines:

1. Retinal imaging will only be performed when ordered by a medical provider.
2. It is recommended that screening be performed according to the American Diabetes Association screening guidelines:
    a. Adults with type 1 diabetes mellitus- Retinal screening should be performed within five (5) years of being diagnosed and at least once every year after that.
    b. Adults with type 2 diabetes mellitus- Retinal screening should be performed at the time of the initial diagnosis and at least once every year after that.
    c. Adults with type 1 or type 2 diabetes mellitus- If there is no evidence of retinopathy for one or more annual eye exams, then exams every 2-3 years may be considered. If retinopathy is progressing or sight-threatening, then examinations will be required more frequently.
    d. Diabetes in Pregnancy- Pregnant women with pre-existing type 1 or type 2 diabetes mellitus require screening within the first three (3) months of pregnancy and should then be monitored every trimester and for one (1) year postpartum, as indicated by the degree of retinopathy. Women who develop gestational diabetes mellitus do not require an eye examination during pregnancy and do not appear to be at increased risk of developing diabetic retinopathy during pregnancy.
3. Follow the manufacturer's guidelines for operation of all system components, including:
    a. Equipment set-up;
    b. Patient preparation and positioning;
    c. Internal and/or external image capturing;
    d. Image uploading for interpretation;
    e. Troubleshooting problems.
4. If retinal images are insufficient quality for interpretation, pupillary dilation may be needed for better images.
5. Prior to pupillary dilation, a qualified health professional will determine that the patient:
    a. Does not have a personal history of glaucoma;
    b. Does not have significant redness, irritation, or discharge from an eye;
    c. Is not pregnant;
    d. Is not wearing contact lenses;
    e. Has not had a previous adverse reaction to pupillary dilation.
6. The patient will be informed that dilating drops will be used and this will increase their pupil size. They will

be advised that the drops may temporarily cause blurred vision and light sensitivity, and that caution should be taken when driving or performing other potentially dangerous activities.

7. The patient will be provided with plastic sun shields before leaving the clinic, when pupillary dilation is performed.
8. Following transmission of the images for interpretation, the staff member will ensure results have been received and will forward a scanned copy to the ordering physician for review and signature.
9. The staff member will document the results in the Electronic Health Record (EHR) in the “Diabetes Eye Exam Ad Hoc Form."
10. Patients with abnormal exams will be referred to an ophthalmologist, who is knowledgeable and experienced in the management and treatment of diabetic retinopathy.

Equipment & Materials:

1. User Manual and/or Manufacturer’s Instructions for Use.
2. Retinal Imaging System for image capture, transmission and review.
3. A darkened room is needed to prevent excessive light from causing pupillary constriction, which affects image quality.
4. A pharmacologic dilating agent may be required for patients who have small pupils, cataracts, or other abnormalities.

Maintenance & Storage:

1. Visually inspect all instrument components prior to use.
2. Power OFF the instrument, place the cap over the lens, and drape the dust cover over the instrument when not in use.
3. Always follow the manufacturer’s guidelines for operation, performance monitoring, and maintenance of equipment.

Infection Control & Prevention:

1. Always observe Standard Precautions according to Policy 106.018- Infection Control Standard Precautions.
2. Wipe the forehead rest and chin rest with a manufacturer recommended, hospital approved disinfecting wipe between patient uses. If chinrest paper is used, remove and replace after one time use.
3. Refer to the manufacturer’s instructions for specific recommendations on cleaning/disinfection of the ocular lens, touchscreen, and other system components.
4. Refer to Policy 106.061- Cleaning & Disinfection of Patient Care Equipment for proper handling, cleaning, disinfecting, and sterilization of reusable instruments and devices.

Documentation:

1. Results of retinal imaging will be documented in the EHR on the "Diabetic Eye Exam Ad Hoc Form."
2. Administration of dilating agents will be recorded on the Medication Administration Record in the EHR.

REFERENCES:

1. CrystalVue Auto FundusVus (NFC-700) User Manual.
2. Cannon Digital Retinal Camera (CR-1) Operation Manual.
3. EyePACS Picture Archive Photographer Manual.
4. Welch Allyn Vision Screener VS100, Software Version 3.1XX User Manual.
5. American Diabetic Association (ADA) Standards of Medical Care in Diabetes. 2019.

All revision dates: 2/12/2020

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	2/13/2023
Ambulatory Care	Theresa Cho: Chief Executive Officer, Ambulatory Care	12/6/2022
Ambulatory Care	Colleen Rusin: Ambulatory Care RN II	11/29/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*10/14/2020*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/2/2023*
Next Review:	*3 years after approval*
Owner:	*Michelle Meissner: AC Quality Improvement Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.25 Terminating Patient-Provider Relationship

POLICY:

As a Safety Net System, it is the goal of the Ventura County Health Care Agency to provide the best possible care to all patients. The patient-provider relationship is recognized as an important component of care that is critical for achieving positive health outcomes. When it is unsafe, or when attempts to maintain an effective relationship have been ineffective, it may be necessary to terminate the patient-provider relationship.

PROCEDURE:

The following steps should be considered to determine when a patient-provider relationship should be terminated and to ensure a safe and timely termination when it is deemed necessary.

Step 1: Assess for the presence of concerning patient behavior that may warrant immediate termination.

- Threatening or abusive behavior towards providers, clinic staff, or other patients.
- Physically assaulting a provider, clinic staff, or other patients. In this instance, a police report must be filed.
- Obstructing the ability of the provider to deliver safe or effective care.
- Interfering with a safe working environment.

Step 2: Determine whether the patient-provider relationship can and should be maintained.

- Unless a single incident irreparably damaged the relationship with a patient, all efforts at resolution should be exhausted before deciding on termination.
- When safety is not a concern, the clinic manager and/or administrator should meet with the patient to discuss their concerns.
- Attempt to identify and remove the barriers that resulted in a strained patient-provider relationship.
- Ensure patients are aware of their rights and responsibilities.
- Set clear expectations and provide direct statements about what constitutes appropriate behavior. Advise patients of potential consequences to address inappropriate behaviors prior to termination.
- Consider a patient behavior agreement.
- Consider situations that warrant delay of relationship termination:

a. If the patient is in an acute phase of treatment or testing, terminations should be delayed until the acute phase has passed.

b. If the provider is the only source of medical care within a reasonable driving distance or other barriers to care exist, consider delay until other arrangements can be made.

c. If the provider is the only source of a specific type of specialized care, they are obligated to continue care until the patient can be safely transferred to another provider who can provide treatment and follow-up.

Step 3: Identify the patterns of behavior that resulted in the relationship termination.

- The treating provider along with the clinic medical director should be the one who makes the determination to terminate the patient-provider relationship.
- Details describing the incident(s) and steps taken to address the behavior should be well documented in the patient's chart.

Step 4: Provide appropriate notice of relationship termination.

- Notify the patient in writing that care will be terminated by certified letter, return receipt requested.
- The letter should include:

a. Reason for the termination.

b. Effective date of termination which allows the patient a reasonable amount of time to establish care with another provider, typically a minimum of 30 days unless unsafe to do so.

c. Patient-specific insurance contact information for establishing care with a new provider.

d. Notification that follow-up and continued medical care elsewhere are now the patient's responsibility.

e. Include a copy of the Health Care Agency Release of Information form with an offer to send the patient's medical records to their new provider.

- Scan the letter into the patient chart under "Disciplinary Action."
- Maintain a copy of the letter for your records. If the letter was sent back undelivered, keep the unopened letter.

Step 5: Provide staff support and education.

- Inform all clinic staff of the termination and date range of continued care, especially the scheduler. Cancel appointments at the clinic patient is being discharged from, after the date of discharge.
- Advise staff how to respond if the patient attempts to schedule an appointment or seek care with the terminating provider.
- Notify the patient's insurer.

Gold Coast Health Plan

- The provider must notify Gold Coast Health Plan's (GCHP) Provider Relations Department in writing the provider's intent to discharge the patient. Documentation regarding the nature of the problem must be included.
- Send patient termination letter to GCHP for follow-up and assistance with patient reassignment: ProviderRelations@goldchp.org

Ventura County Health Plan

- Send patient termination letter to Ventura County Health Plan for follow-up and patient assistance with reassignment: VCHCP.Memberservices@ventura.org

Valley Care Select

- Contact the Provider Relations Representative at the member's IPA for health plan specific requirements.
- Send patient termination letter to Valley Care Select IPA for follow-up and patient assistance with reassignment: ProviderRelations@IdentityMSO.com

Attachments

- De-Escalation Tip Sheet
- Primary Care- Sample Clinic Discharge Letter
- Specialty Care- Sample Clinic Discharge Letter

CHC Board Approval: 02/23/2023

All revision dates: 3/2/2023, 10/14/2020

Attachments

De-Escalation Tip Sheet.pdf
Primary Care -Sample Clinic Discharge Letter.pdf
Specialty Care- Sample Clinic Discharge Letter.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	3/7/2023
AC Chief Medical Quality Officer	Rachel Stern: Chief Medical Quality Officer	3/7/2023
AC Quality Improvement Manager	Michelle Meissner: AC Quality Improvement Manager	3/3/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Allison Blaze: Chief Medical Officer, Ambulatory Care*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.31- Ambulatory Care Standards of Care and Use of Clinical Practice Guidelines in the Clinics

Policy:

The Ambulatory Care Clinics under the Health Care Agency of Ventura County utilizes sound medical policy derived from literature based and supported by Clinical Practice Guidelines (CPG), nationally recognized utilization and technology assessment guidelines, industry established standards and academically published clinical guidelines. All medically necessary determinations will follow State and Federal guidelines.

The CPG will act as a guideline for treatment in conjunction with careful clinical assessment of clinical conditions.

Definitions:

Standards of Care and Practice: The standards of care and practice describe a competent level of medical care as demonstrated by the critical thinking model in medicine. This process includes the components of assessment, diagnosis, outcomes identification, planning, documentation, implementation, and evaluation.

Clinical Practice Guidelines (CPG): Tools that describe a specific procedure or processes found through clinical trials or consensus opinion of experts, to be the most effective in evaluating and/or treating patients who have a specific symptom, condition, or diagnosis. These are evidence based clinical guidelines in peer reviewed medical journals and publications. CPG are reviewed and approved internally by the HCA.

Protocol: Often used as a synonym for a clinical practice guideline, a protocol is generally a reference to a pre-approved clinical process to standardize and optimize treatment and care.

Procedure:

Standards of Care and Practice:

The process encompasses significant actions taken by medical professionals and forms the foundation of the provider's decision-making.

1. **Assessment:** The medical professional collects pertinent data and information relative to the healthcare consumer's health or situation.
2. **Diagnosis:** The medical professional analyzes the assessment data to determine actual or potential diagnoses, problems, and issues.

3. **Outcomes Identification:** The medical professional identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.
4. **Planning:** The medical professional develops a plan that prescribes strategies to attain expected, measurable outcomes.
5. **Documentation:** The medical professional will document the actions taken to uphold standards of care in the patient chart and clinic notes, in accordance with the Timeliness of Documentation Policy.
6. **Implementation:** The medical professional implements the identified plan.
7. **Coordination of Care:** The medical professional coordinates care delivery.
8. **Health Teaching and Health Promotion:** The medical professional employs strategies to promote health and a safe environment.
9. **Evaluation:** The medical professional evaluates progress toward attainment of goals and outcomes.

Acceptable CPG resources include the following:

1. CPGs will be published by consortiums of medical organizations and are generally accepted as industry standard.
2. All CPGs will be based on evidence based clinical guidelines published in peer reviewed medical journals and publications with proven favorable clinical outcomes.
3. All CPGs will be written with references such as, but are not limited to, nationally recognized panels and agencies, Centers for Disease Control, National Institute of Health, Agency for Health Care Research and Quality, National Comprehensive Cancer Network. CPGs will be reviewed and approved by the HCA review process every 3 years and will be made readily available to Ambulatory Care providers.
4. The use of CPGs to support medical decision making shall be documented in the EHR.
5. Specialty and Sub-specialty published guidelines, including but not limited to those listed below:
    a. Family Medicine: Clinical Practice Guidelines | AAFP
    b. Internal Medicine: Clinical Practice Guidelines and Recommendations | ACP (acponline.org)
    c. Pediatrics: Patient Care (aap.org)
    d. Dentistry: Clinical Practice Guidelines and Evidence | American Dental Association (ada.org)
    e. OB/GYN: Clinical Practice Guideline | ACOG
    f. Endocrinology and Diabetes: 2022 AACE Diabetes Guideline Update | American Association of Clinical Endocrinology and Practice Guidelines Resources | American Diabetes Association
    g. Infectious Disease: IDSA Practice Guidelines (idsociety.org)
    h. Neurology: Clinical Practice Guidelines for Neurologists | AAN
    i. Dermatology: Clinical guidelines (aad.org)
    j. Gastroenterology: Guidelines - American College of Gastroenterology (gi.org)
    k. Rheumatology: Clinical Practice Guidelines (rheumatology.org)
    l. Pulmonology: Statements, Guidelines & Reports (thoracic.org) and Clinical Pulmonary | Guidelines - American College of Chest Physicians (chestnet.org)

CHC Board Approval: 02/23/2023

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Tracy Chapman: VCMC - Med Staff	pending
	Theresa Cho: Chief Executive Officer, Ambulatory Care	3/7/2023
	Allison Blaze: Chief Medical Officer, Ambulatory Care	3/7/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Navid Papehn: Regional Administrative Director, Ambulatory Care*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.33- Referral Tracking for Non-Clinical Services

POLICY:

At times, the health center may need to use external resources to meet a patient's needs, thus has established service agreements for non-clinical services. The health center may engage service providers of non-clinical services, as outlined in Exhibit A, to facilitate access to care. Non-clinical services covered by this policy are provided free of charge for the patient.

PROCEDURE(S):

Ventura County Ambulatory Care (VCAC) engages in service agreements for non-clinical services that facilitate access to care. In the case that a patient requires a service that is outlined in Exhibit A, the procedure to ensure care continuity is as follows:

A. VCAC staff or patient identifies the need and creates a referral for a non-clinical service that facilitates a patient's access to care.

B. If needed, VCAC staff request and secure the patient's permission to engage providers of non-clinical services.

C. VCAC calls the service provider to arrange for the service.

D. VCAC staff document the service in the patient's health center record for future reference and/or follow-up, if needed.

When appropriate:

A. VCAC will monitor contract performance annually by reviewing invoices and records, as well as any reports from staff regarding contractor activities. Periodic and comprehensive evaluations will include review of terms, conditions, and specifications of the contract to ensure that all deliverables are being met/were met during the term of the contract and that contractors comply with applicable federal requirements, including financial and programmatic reporting requirements.

B. VCAC is responsible for retaining records as approved by the respective board policy.

C. VCAC is responsible for conducting regular audits and monitoring to ensure that records are retained, securely maintained, archived or destroyed appropriately.

Exhibit A

Ventura County Ambulatory Care may engage providers of non-clinical services for:

- Translation
- Transportation
- Coverage for Emergencies During and After Hours

CHC Approal 2/23/23

All revision dates:

Attachments

No Attachments

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	4/3/2023
AC Chief Operating Officer	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	3/21/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/2014*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/13/2022*
Next Review:	*3 years after approval*
Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Diabetes Management*
References:	

DM.001 Adult Inpatient Diabetes and Hyperglycemia Management

POLICY:

This policy reviews the importance of glucose management of adult hospital inpatients. Glycemic control results in lower rates of hospital complications. Glycemic targets can be reached safely and reliably through the use of clinical practice guidelines and policies.

PROCEDURE:

I. Definitions

A. Hyperglycemia is defined as blood glucose (BG) over 180 mg/dL.

B. Severe hyperglycemia is defined as blood glucose > 300mg/dL.

C. Hypoglycemia is defined as blood glucose <70 mg/dL.

D. Critical hypoglycemia is defined as blood glucose <40 mg/dL.

II. Multi-disciplinary Diabetes Management Team

A. The Diabetes Management Team, led by the Director of Diabetes Management, includes physicians, nurses, dietitians, certified diabetes educators, pharmacists, Laboratory staff, and case managers.

B. This team shall monitor patients with diabetes who are managed according to this policy when admitted to our hospitals.

C. Audits of insulin use are conducted by the Diabetes Management Team.

III. Glycemic monitoring in the hospital

A. Adult patients will have laboratory blood glucose testing upon admission, including those without a prior history of diabetes.

B. Patients with persistent hyperglycemia (BG > 180 mg/dL x 2) or known diabetes should have point-of-care (POC) blood glucose monitoring at least 4 times a day for at least 24 hours with appropriate therapeutic intervention.

C. ~~The provider should order a~~A HbA1c should be ordered on admission for patients with hyperglycemia or with known diabetes~~,~~ if one has not been performed in the preceding 2-3 months.

D. Patients receiving high-dose steroids, parenteral nutrition, octreotide, or immunosuppressive

medications should be monitored with POC BG testing 4 times a day for at least 24 hours.

IV. Transition from home to hospital

A. ~~Provider discontinues~~Discontinue oral diabetes medications on admission for most patients with type 2 diabetes.

B. ~~Provider should review~~Review home oral and injectable diabetes medications, HbA1c, renal function, and co-morbidities prior to ordering insulin in the hospital.

C. ~~Provider should consider~~Consider reducing the outpatient basal insulin dose by 20% upon admission to avoid inpatient hypoglycemia.

V. Glycemic management for patients in non-critical care setting

A. Nursing staff shall perform POC BG ~~testing shall be performed by nursing staff~~ according to the following ~~schedules~~schedule:

1. Patients who are eating or receiving bolus enteral feeds: before meals and at bedtime or with each feeding bolus.

2. Patients who are NPO, receiving continuous enteral feeds, or TPN: ~~every 6 hours~~four times daily, QID.

B. Coordination of insulin administration and meal delivery:

1. Nursing staff (Registered Nurses, Licensed Vocational Nurses, and Nursing Assistants) checks BG prior to each meal.

2. Meal tray is delivered to the patient per Dietary Department schedule.

3. Nursing staff assesses mealtime carbohydrate intake.

4. Nurse administers rapid-acting analog insulin to cover carbohydrates and to correct pre-meal hyperglycemia per ~~provider~~Licensed Independent Practitioner (LIP) and/or resident orders.

VI. Glycemic management in the critical care setting

A. Critical care patients with hyperglycemia can be managed with subcutaneous insulin if hemodynamically stable, without need for pressor agents, and if they remain well-controlled.

B. Critical care patients with ~~diabetic ketoacidosis~~hyperglycemic crisis or persistent hyperglycemia (BG > 180 mg/dL x 2) should be managed with continuous intravenous insulin infusion.

VII. Subcutaneous insulin use

A. ~~Providers should use~~Use approved subcutaneous insulin electronic order-set in the Electronic Health Record (EHR).

B. ~~Basal~~Use basal-bolus insulin therapy ~~is used~~ for inpatient diabetes treatment, rather than exclusively using a "sliding scale" method.

C. Scheduled subcutaneous insulin therapy consists of basal insulin given once or twice a day in combination with rapid-acting insulin administered with meals.

D. Mealtime rapid-acting insulin dose is based on observed carbohydrate intake.

VIII. IV insulin infusion use: refer to policy DM.004

IX. Insulin pump use in the hospital: refer to policy DM.006

X. Prevention and management of hypoglycemia

A. ~~Provider reevaluates POC~~BG will be evaluated daily and insulin regimen adjusted as needed to maintain BGs ~~daily and adjusts insulin regimen as needed to maintain BGs~~ in the target range.

B. ~~Provider~~LIP and/or resident should consider modifying therapy when BG values fall below 90 mg/dL.

C. ~~Provider~~LIP and/or resident should modify therapy when BG values fall below 70 mg/dL.

D. Nurses will treat hypoglycemia per VCMC/SPH administration policy 100.095 or per IV Insulin software program.

E. Blood glucose data will be routinely tracked by the Diabetes Management Team, with intervention and communication with the ~~provider~~LIP and/or resident if patient is hypoglycemic without a change in management.

F. Critical hypoglycemia cases (BG<40 mg/dL) and severe hyperglycemia cases (BG>300 mg/dL) are reported to the Diabetes Committee and the Medication Safety Officer for review.

XI. Nutrition Therapy

A. Medical nutrition therapy (MNT) is provided for patients with diabetes and hyperglycemia.

B. ~~Provider~~LIP and/or resident orders MNT (for example modified carbohydrate, renal, and/or heart healthy diet) providing consistent-carbohydrate meals for patients with diabetes.

C. Registered Dietician and/or the Certified Diabetes Nurse Educator assesses appropriateness of and provides education for MNT ~~per dietary protocol~~.

XII. Special situations for consultation with Diabetes Management Team

A. Consider consultation ~~required~~ for patients who use an insulin pump at home, whether or not the insulin pump is continued in the hospital.

B. Consider consultation ~~required~~ for conversion for patients who use U-500 concentrated regular insulin at home.

C. Consultation is highly recommended for patients admitted for hypoglycemia (typically BG<70 mg/dL resulting in altered sensorium, trauma, and/or need for external assistance).

XIII. Perioperative hyperglycemia management

A. Blood glucose should be monitored and controlled at the time of surgery.

B. Nursing staff shall check BG in all patients over 18 years in the Pre-Operative Unit, and will notify anesthesiologist, attending surgeon, and Diabetes Management Team if glucose is >180mg/dL.

C. Patients with hyperglycemia will have BG rechecked hourly in Pre-Op and in the OR.

D. Patients with hyperglycemia will receive appropriate corrective insulin therapy, typically SQ insulin for short, minor cases (< 1 hour) and IV insulin drip for longer, major cases (>1 hour).

E. Anesthesia and ~~surgery staff~~surgeon should consider canceling elective cases when the BG is excessively high, i.e. >180. Elective surgical cases should be rescheduled or delayed until hyperglycemia responds to corrective doses of insulin. See administrative policy #100.202.

F. Post-operative management of hyperglycemia for NPO patients includes IV insulin infusion, basal SQ insulin, or insulin pump for basal insulin coverage.

G. Post-operative management of hyperglycemia for PO patients includes IV insulin infusion with meal bolus, basal/bolus SQ insulin, or insulin pump for basal and bolus insulin coverage.

XIV. Patient discharge

A. Transition from hospital to home

1. Patients with previously well-controlled diabetes may resume pre-hospital diabetes medications, as long as no contraindications exist.
2. Patients with suboptimal control prior to admission will be discharged with an intensified diabetes medication regimen, barring history of treatment non-adherence, or will have appropriate outpatient follow-up arranged to improve glycemic control as an outpatient.
3. Initiation of insulin administration, when clinically appropriate, shall begin at least one day before discharge to allow assessment of efficacy and safety, and to provide patient education.

B. Diabetes self-management education and nutrition education shall be provided to patients with diabetes, particularly patients who are newly-diagnosed or not optimally controlled.

C. Physicians, nurses, registered dietitians, and nurse educators should provide clear instructions regarding diabetes management, including insulin, prior to discharge.

D. ~~Follow~~Hospital staff will make a follow-up appointment ~~is made prior to~~. The Diabetes Management Team or the LIP and/or resident shall communicate the diabetes management plan with the outpatient provider at the time of discharge. ~~The Diabetes Management Team or the inpatient hospitalist team shall communicate the diabetes management plan with the outpatient provider at the time of discharge.~~

Guidelines:

1. Glycemic targets in non-critical care setting are as follows:
   A. Fasting BG target is 90-140 mg/dL
   B. Random BG target is <180 mg/dL
2. Glycemic target in the critical care setting
   A. Target BG 120-180 mg/dL.
   B. Intravenous insulin infusion will be initiated if BG>180 mg/dL x 2 consecutive checks.
3. Modified Carbohydrate Diet consists of 45-60 grams of carbohydrates per meal.
4. Perioperative hyperglycemia management
   A. For elective surgery, goal preoperative HbA1c is < 8%.
   B. BG goal at time of surgery is < 180mg/dL.
   C. Patients with BG > 180 mg/dL will receive appropriate corrective insulin therapy.
5. Patient discharge
   A. For the purpose of discharge management, HbA1c < 8% is considered well-controlled.

REFERENCES:

American Diabetes Association. Standards of Medical Care in Diabetes 2018. *Diabetes Care* 41: Supplement 1, S144-S151, January 2018.

Cobaugh DJ, Maynard G, Cooper L, et al.Enhancing insulin-use safety in hospitals: practical recommendations from an ASHP Foundation expert consensus panel. Am J Health Syst Pharm 2013;70:1404–1413

Guidelines for the Use of an Insulin Infusion for the Management of Hyperglycemia in Critically Ill Patients. *Critical Care Medicine* 40: 12, 3251-3276, 2012.

Lansang MC, Umpierrez GE. Inpatient hyperglycemia management: a practical review for primary medical and surgical teams. Cleve Clin J Med 2016;83(Suppl. 1):S34–S43

Umpierrez G, Korytkowski M. Diabetic emergencies--ketoacidosis, hyperglycaemic hyperosmolar state and hypoglycaemia. Nat Rev Endocrinol 2016;12:222–232

All revision dates: 9/13/2022, 5/15/2019, 12/1/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & Medicine	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	9/19/2022
Nursing Administration	Sherri Block: Interim Chief Nursing Officer	9/15/2022
Diabetes Management	Hugo Ortiz: Diabetes Nurse Educator	9/15/2022
Diabetes Management	Anthony Walls: MD	9/13/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/28/2020*
Next Review:	*3 years after approval*
Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.11 Emergent Obstetrical (OB) Patients

POLICY:

To safely care for any term or preterm OB patient in the Emergency Department (ED) when they cannot be directly admitted to OB. These patients include:

1. Any OB patient presenting to the ED with uterine contractions, pain with feeling of a need to "bear down" or urge to push (imminent delivery).
2. Any OB patient needing to be held in ED prior to admission to OB (e.g., waiting for available bed).
3. Any OB patient presenting with an emergent condition requiring immediate intervention before going to OB (e.g., prolapsed cord, shock due to vaginal bleeding, etc.)

PROCEDURE:

EQUIPMENT

A. Gestational Wheel
B. Fetal Doppler
C. Blood Pressure (BP) Cuff
D. Vaginal Speculum
E. Sterile Gloves
F. Water Soluble Lubricant
G. Nitrazine Tape
H. Born out of asepsis (B.O.A.) Pack
I. Bedside Ultrasound (US) Machine

A. Each OB patient needs to be evaluated to determine:
    1. Last menstrual period (LMP), expected date of confinement (EDC), Gravida and Parity.
    2. Rupture of membranes (ROM) and/or any vaginal bleeding.
    3. Vital signs (VS) including fetal heart tones (FHT) and Fetal Movement should be assessed upon

arrival and every half hour while in the ED.

4. Transabdominal ultrasound evaluation by Emergency Physician, Resident, or Advanced Practice Practitioner.

B. Monitor all patients for uterine contractions to determine frequency and duration.

C. Palpation of abdomen may be necessary.

D. Perform vaginal exam to determine effacement and dilation. This procedure is to be performed by trained personnel only.

E. If necessary, delivery will be done in the ED. (Refer to Delivery Procedure in Lippincott.)

F. Emergent Conditions – Intervene as necessary:

1. Prolapsed cord – Registered Nurse/Physician to insert gloved hand into vagina to keep pressure off cord. Maintain until baby is safely delivered or until relieved by OB or Surgery staff. Place patient in Trendelenberg position.
2. Vaginal bleeding/shock - Establish intravenous access, intervene as needed to stabilize patient. Monitor VS, including FHT.

DOCUMENTATION:

Chart dates, times of all patient information and essential data observed or obtained during the procedure in the patient's electronic health record (EHR).

Document any procedures performed and patient's response to procedures in the patient's EHR.

In the event of an emergent delivery in the ED, an EHR should be completed for the mother and each delivered infant. A Notification Form is to be completed as well.

All revision dates: 1/28/2020, 12/1/2013, 3/1/2011, 12/1/2004, 11/1/2001, 3/1/1998, 6/1/1995, 10/1/1992, 12/1/1989

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/18/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/18/2022
Policy Owner	Kathie Jones: Interim Clinical Nurse Manager, Emergency Services	11/18/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/4/2020*
Next Review:	*3 years after approval*
Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.22 Standards of Care in the Emergency Department

POLICY:

The purpose of the Emergency Department (ED) at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) is to provide adequate evaluation and treatment to any patient with an illness or injury who presents to the Department. The patient is entitled to a clean, organized therapeutic environment. All team members must cooperate and strive to maintain the ED to meet these standards.

PROCEDURE :

All nursing staff in the ED report directly to the ED Clinical Nurse Manager. There will be a Charge Nurse appointed for each shift. Charge Nurse duties are listed under the section entitled "Charge Nurse."

1. Nursing and Medical Personnel will collaborate to formulate a plan of care for the patient.
2. In the case of death or serious injury, the Registered Nurse (RN) and the physician will communicate with the family.
3. Each family is entitled to receive periodic information by the nursing staff regarding the general status of the patient.
4. To adequately care for patients, a comprehensive report will be given to the on-coming shift.
5. An RN and/or physician will accompany every critically ill patient to the floor. Resuscitation equipment, monitor and defibrillator will be taken when the condition of the patient deems it necessary.
6. Referral to resources within the Ventura County Health Care Agency (VCHCA) and the community will be made available to patients as needed.
7. The ED clerical and nursing staff will cooperate to provide an efficient and professional environment for the patient and family.
8. To ensure patient privacy, only the first three (3) letters of the last name will be entered on the tracking board.
9. To ensure patient safety, all medication orders must be entered into the electronic health record (EHR) prior to administration except in a true emergency.
10. Safety precautions must be followed at all times.
11. Patients presenting themselves to the ED will be triaged according to the policies set down in the

admission of patients to the ED.

12. All patients will have an ED record completed and will be seen by a physician on duty, or Advanced Practice Provider, in the ED or by their private physician. Nursing staff will complete a nursing assessment appropriate for the patient's problem.
13. Any patient receiving medication which could possibly produce an untoward response, will be observed for a minimum of 20 minutes prior to discharge.
14. All patients admitted with a wound or laceration will be evaluated for tetanus immunization status. Documentation of such will be noted in the EHR.
15. Patients receiving sedatives and/or narcotics will be observed for a minimum of 20 minutes after the drug is given. Patients must have someone to drive them home prior to receiving the medication, and must be instructed not to drive.
16. All reportable conditions or injuries such as dog bites, venereal disease, child abuse, adult abuse, domestic violence, etc. will be reported per hospital policy.
17. All treated patients will be given printed aftercare instructions in their language of choice. These aftercare instructions will be explained to the patient by the nurse or physician prior to discharge. Vital signs will also be documented upon discharge in the EHR.
18. Any treatment or medication given to the patient will be documented in the EHR.
19. Report will be given to the receiving nurse on all admitted and transferred patients and nurse's notes will be completed (see ED policy ER.A.14, *Admission to the Hospital from the Emergency Department*).
20. No patient will be transferred from the ED until his/her medical condition is stabilized to a degree that allows for safety during transport. No patient will be transferred arbitrarily. No patient will be transferred without acceptance by the receiving facility of physician. See section on "Transfers."
21. Consideration will be given to patients who are in the custody of a law enforcement officer, Mental Health, or CYA so that treatment is expedited and those staff may return to their duties.
22. "Doctor's First Report of Injury" form will be completed on all industrial accidents.
23. All surgical specimens will be sent to Pathology, except those specimens removed for legal examinations, which will be given to law enforcement agents.
24. Vital signs and weight will be recorded on all patients upon admission and as often as needed and/or ordered. Fetal heart tones will be attempted on all pregnant females beyond 12 weeks and results documented in the EHR. Head circumference will be measured on all patients under two (2) years of age with a soft anterior fontanel, whenever medical condition warrants.
25. If medications are administered in the ED, name, dosage, route of administration, site of administration, time given, and results shall all be documented in the EHR.
26. Pain assessment will be noted with each set of vital signs within 60 minutes after intervention/medication.
27. Nursing care shall be delivered consistent with Hospital policy, scope of practice and as directly related to the needs of the patient.

All revision dates: 3/4/2020, 9/1/2016, 12/1/2013, 8/1/2011, 5/1/2006, 12/1/2004, 11/1/2001, 12/1/1998, 1/1/1995, 10/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/14/2022
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/14/2022
Policy Owner	Kathie Jones: Interim Clinical Nurse Manager, Emergency Services	12/14/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*8/30/2022*
Next Review:	*3 years after approval*
Owner:	*Stephanie Nelson: Manager, Auxiliary Services*
Policy Area:	*Emergency Services*
References:	

ER.24 Volunteers in the Emergency Department

POLICY:

To provide information to the Emergency Department (ED) staff regarding appropriate activities for ED auxiliary volunteers.

PROCEDURE:

A. The ED Clinical Nurse Manager and the Volunteer Service Manager will plan, supervise and evaluate the services performed by volunteers to ensure the safety of volunteers, patients, and staff. The Clinical Nurse Manager and Volunteer Services Manager will orient volunteers and confirm their understanding of service functions as well as provide necessary resources and supervision.

B. Selection of volunteers:

1. Must be 18 years of age or older.
2. All volunteers are screened and selected by the Emergency Department (ED) Clinical Nurse Manager and the Volunteer Services Manager.
3. Volunteers should exhibit a professional, caring demeanor with conservative, simple dress, make-up, hairstyle and jewelry.
    I. Volunteers shall wear a blue designated smock, long pants, a plain shirt, and closed toe shoes.
    II. Name tag will be provided by the Hospital and must be worn at all times while on duty.

C. Hygiene and Safety

1. Volunteers should perform hand hygiene before and after each patient contact.
2. Use of personal protective equipment (PPE) appropriate to the assigned task, and when handling contaminated materials (e.g., when cleaning wheelchairs or waiting area tabletops).
3. Report any injury, needle stick, etc. to the ED Charge Nurse immediately and the Volunteer Services Manager .
4. If you feel sick, do not report to your volunteer shift, instead call out to the ED Charge Nurse and/or ED Clinical Nurse Manager.

D. General Guidelines

1. Acceptance of assignments as a volunteer implies that the volunteer agrees **not** to perform tasks or procedures that he/she is not authorized to perform. Exceptions are allowed only in acute

emergencies as directed by the ED staff, and must be documented in writing and submitted to the Clinical Nurse Manager.

2. Hospital insurance coverage places strict limitations on the duties volunteers may perform. Volunteers performing unauthorized tasks or procedures may be leaving themselves and the hospital open to possible legal action.
3. If asked or told by a staff member to do any unauthorized tasks or procedures, the volunteer should immediately advise the staff member that he/she is unable to comply with the request.

E. Volunteers **May Not:**

1. Perform any clinical or professional tasks.

F. Volunteers **MAY** :

1. Provide reassurance and comfort to patients and their families.
2. Monitor and assist patients and their families in the waiting room.
3. Assist in helping ED staff with patient experience initiatives.
4. Think "kindness and courtesy."
5. Keep a positive and constructive outlook.
6. Monitor stock of supplies such as pillows, basins, etc. Call Central Supply or Housekeeping as appropriate for re-stock of supplies.

G. Grievances and Volunteer Concerns

1. If a patient expresses their wish to file a formal grievance, the ED Charge Nurse and/or ED Clinical Nurse Manager should be notified so that they may help facilitate that process.
2. Should a concern arise while volunteering, volunteers should contact the ED Charge Nurse and/or ED Clinical Nurse Manager and the Volunteer Services Manager, to talk over the concern and seek a resolution.

All revision dates: 8/30/2022, 1/28/2020, 5/1/2006, 12/1/2004, 7/1/2001, 6/1/1995, 10/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Interim Chief Nursing Officer	8/30/2022
Policy Owner	Stephanie Nelson: Manager, Auxiliary Services	8/30/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/18/2022*
Next Review:	*3 years after approval*
Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.51 Medical Legal Examinations

POLICY:

For Emergency Department (ED) patients, to facilitate referral of victims to the proper facility for evidence collection and documentation.

PROCEDURE:

A. Medical Legal Exams will be done at Safe Harbor/Family Justice Center by a Sexual Assault Nurse Examiner (SANE).

B. In the event the victim has a medical emergency condition, the medical needs will first be addressed and then appropriate referrals made to law enforcement and Safe Harbor.

C. Child physical abuse exams are performed in the Pediatric Clinic or by staff physicians in the ED or at Safe Harbor/Family Justice Center.

GUIDELINES:

A. As mandated reporters, registered nurses are required to report any suspected or confirmed abuse to law enforcement. Any patients presenting to the Emergency department for abuse or assault must undergo medical screening exam and be referred to law enforcement.

B. If law enforcement calls to request a Medical Legal Exam, refer the officer to Safe Harbor/Family Justice Center at: (805) 641-4430.

C. Medical Legal Examinations are only performed by Sexual Assault Nurse Examiners after extensive training. The chain of evidence will be maintained between the SANE and the requesting agency.

D. Referrals for further care of victims of abuse are available from SAFE Harbor.

E. When a patient arrives at the ED with symptoms of possible sexual abuse, establish jurisdiction of where the alleged crime occurred.

F. Place the patient in a quiet room and notify the proper law enforcement agency.

G. The patient is not to be registered into the ED unless an emergent condition exists.

H. After law enforcement interviews the patient, they will escort them to Safe Harbor/Family Justice Center for a Medical Legal exam if patient is willing.

I. The law enforcement officer will determine whether a medical legal exam can occur. If it is determined

that a patient will not receive a medical legal exam, the patient may request to be seen by a physician, or advanced practice practitioner, for treatment. If law enforcement authorizes the exam and the victim refuses, the victim can also choose to leave without being seen.

J. The registered nurse can also contact the Coalition for Family Harmony (https://thecoalition.org) for support with counselors who can respond to the hospital and provide support for the victim.

DOCUMENTATION

A. The nurse shall document all referrals made for patients treated in the ED in the Electronic Health Record (EHR).

All revision dates: 11/18/2022, 1/28/2020, 11/1/2016, 12/1/2013, 12/1/2004, 10/1/2001, 12/1/1998, 6/1/1995, 10/1/1992, 12/1/1989

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/21/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/21/2022
Policy Owner	Kathie Jones: Interim Clinical Nurse Manager, Emergency Services	11/21/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/2013*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/8/2022*
Next Review:	*3 years after approval*
Owner:	*Matt McGill: Director, Imaging Services*
Policy Area:	*Imaging Services*
References:	

IS.38 MRI Pre-Screening Process

POLICY:

To ensure patient safety, all patients that are scheduled for an Magnetic Resonance Imaging (MRI) exam shall be pre-screened for any metallic devices that will contraindicate the patient entering the MRI magnet room, Zone IV and for any issues related to claustrophobia or anxiety.

PROCEDURE:

All initial screenings should ~~be performed~~begin at the ordering physician's office and/or at the time of scheduling the MRI exam appointment. Patients with contraindications shall not be scheduled. Patients with claustrophobia and/or anxiety can review options for management with their ordering physician as necessary.

Contraindications

Contraindications may include, but are not limited to the following:

- Cardiac pacemaker
- **Individual devices may be cleared through the website: www.mrisafety.com**
- Implanted cardioverter device (ICD)
- Electronic implant or device, neurostimulator device, aneurysm clip
- Magnetically activated implant or device
- Internal electrodes or wires
- Bone growth stimulator
- Cochlear or other ear implant
- Implanted insulin pump
- Any metallic fragment or foreign body
- EKG/cardiac monitoring electrodes that are not MRI approved

A positive response to any item on the pre-screening form must be checked and approved by the Radiologist or MRI Technologist before the MRI can be done.

Patients shall be screened upon arrival at VCMC for their scan. Each patient shall have a complete MRI Patient History and Screening Form (see ~~Attachments A and B~~Attachment A).

If applicable, patients will be asked if they feel their claustrophobia or anxiety has been appropriately managed prior to bringing them into the MRI scan room.

~~in~~In addition to the screening form, a pre-MRI TIMEOUT Form will be completed by the MRI Technologist

before any MRI exam is performed (see Attachment ~~C~~B). ~~This form will be scanned into the patient's electronic health record.~~

The pre-screening form shall be reviewed by the MRI Technologist with the patient before the patient is allowed to enter the MRI scan room.

Patients who are unconscious or unable to answer questions shall be screened through one of the following ways:

- A family member, surrogate, or physician who is familiar with the patient's medical record
- Review of the patient's medical history and medical record
- Use of plain film radiography
- Visual inspection looking for scars, deformities or devices

If the patient cannot be screened to the satisfaction of the technologist, the technologist shall consult with the Radiologist. If the Radiologist is unavailable, the MRI exam shall be canceled and rescheduled.

The pre-screening form shall be scanned into the electronic health record and become part of the patient's permanent medical record.

All revision dates: 11/8/2022, 9/17/2019, 10/1/2015

Attachments

Attachment A.pdf
Attachment B - Pre-MRI Time Out Form.xlsx

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/15/2022
Imaging Services	Matt McGill: Director, Imaging Services	11/8/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/2005*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/14/2022*
Next Review:	*3 years after approval*
Owner:	*Matt McGill: Director, Imaging Services*
Policy Area:	*Imaging Services*
References:	

IS.56 Radiation Protection

POLICY

It is the policy of the Radiology Department to obtain satisfactory diagnostic radiographs. This must be done with the minimum amount of exposure to the patient at all times. Technique charts are posted in each room provided annually by a Radiologic Health Physicist.

PROCEDURE

1. Patient identification will be made by verifying name and date of birth on every neonate, pediatric, adolescent and adult patient by checking the identification band and verbally to patient and/or patients' nurse.
2. Verification of physicians order in the patients' CERNER Powerchart for accuracy of order and reason for exam.
3. In general, the relatives and friends of patients being examined are to be kept out of the diagnostic room.
4. When absolutely necessary, the parent, friend, nurse, etc., may be used to help hold the patient being examined. Pregnant women should not be used in this capacity.
5. When applicable, such individuals will be given appropriate protection equipment to use, i.e., lead aprons~~, lead gloves, etc.~~
6. Special restraints for neonates, pediatric and adolescent patients are expected to be used as the patient's condition allows, such as sandbags, lead aprons or an appropriate pediatric immobilizer/positioner.
7. Lead Aprons ~~and gloves~~ are to be used where indicated.

SHIELDING

POLICY:

To provide maximum measures of radiation protection, and to establish procedure in the interest of protecting the patients and the hospital. Maximum efforts should be made to minimize radiation received by all patients and personnel.

PATIENT PROTECTION: Utilization of various coning devices, collimation devices, and lead shielding devices should be practiced at all times and extreme care should be utilized as to not obscure or compromise clinical information in the area of interest. PRODUCTIVE AGE GROUP: To include, but not limited to,

neonates, pediatric gonads, a 0.5mm of lead shielding is to be placed between the patient and the primary beam, taking care not to obscure clinical information.

GENERAL RULES: Personnel operating various X-ray equipment are to use all means available to enhance detail and reduce radiation.

1. Restrict beam size to the size of the image receptor.
2. Utilize cones.
3. Utilize fluoroscopy field limiting devices, exposing only areas with good fluoroscopy practice.
4. Exposure switches are to be located as not to allow operation beyond the primary protective field.

RADIATION PROTECTION FOR PERSONNEL WORKING IN RADIOLOGY

Per Title 17, section 30308 (b.)(l.): No individual occupationally exposed to radiation shall be permitted to hold patients during exposures except during emergencies, nor shall any individual be regularly used for this service. If the patient must be held by an individual, that individual shall be protected with appropriate shielding devices such as protective gloves and apron and shall be so positioned that no body part will be struck by the useful beam.
Only those persons required to perform fluoroscopy procedures are allowed beyond the primary protections barrier. These individuals are to utilize proper procedures at all times.

1. Utilize lead fluoroshield.
2. Wear lead aprons.

   ~~Wear lead gloves.~~

PROPER PLACEMENT OF RADIATION MONITORING DEVICE
During fluoroscopy, the radiation dosimeter badge is to be worn as close to the individual's eyes as conditions permit. Preferably on the collar next to the clavicle.

PREGNANT EMPLOYEES:

All staff members that become pregnant will fill out and sign a Declaration of Pregnancy form letter. This letter will be signed by the Radiation Safety Officer. The pregnant employee will be given information related to radiation safety for pregnant employees.
The pregnant employee will also fill out a pregnancy policy acknowledgement. This form contains the acknowledgement of radiation risk during pregnancy and the ability to withdraw the declaration of pregnancy.

Every effort must be taken to minimize exposures for pregnant employees. Under no circumstances should a pregnant employee be allowed to hold a patient during an X-ray exposure. Job assignments within the radiology department will incorporate minimal radiation risk to the employee. Normal daily job assignments will be altered in order to minimize and reduce the risk of an accidental overexposure.

The following job assignments will not be assigned:

1. Surgery assignments involving use of the C-arm
2. Fluoroscopy assignments

A second film badge shall be ordered for the employee and shall be worn at belt level to monitor the fetal dose.

RADIATION PROTECTION FOR EMPLOYEES OUTSIDE RADIOLOGY DEPARTMENT

The following areas/individuals are provided with radiation dosimeter badges and rotated on a routine/monthly basis. The records are retained in with the records for the Radiology Department.

At present, the following areas are monitored:

1. Same Day Surgery Staff
2. Surgery-nursing and physicians
3. Doctors who perform ERCP's

All revision dates: 10/14/2022, 9/17/2019, 12/1/2015, 4/1/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/3/2022
Imaging Services	Matt McGill: Director, Imaging Services	10/14/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Matt McGill: Director, Imaging Services*
Policy Area:	*Imaging Services*
References:	

IS.57 Computerized Tomography Enterography

POLICY:

~~POLICY: To provide~~ Nursing staff will be provided with guidelines and dosing instructions for the administration of oral contrast, Barium Sulfate 0.1% oral suspension with the order of CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST.

~~Renaissance Imaging Medical Associates (RIMA) Radiology Group are responsible for the directions in this Clinical Practice Guideline.~~

PROCEDURE:

~~PROCEDURE:~~ Upon receiving a order for a CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST examination for an inpatient at Ventura County Medical Center (VCMC ~~or~~) or Santa Paula Hospital (SPH ~~hospitals~~), a specific time frame for the administration of the the Barium Sulfate 0.1 % oral suspension ~~will have to~~shall be followed by the Registered Nurse (RN) providing the daily care of the patient. In addition, Computerized Tomography (CT) staff and ~~Nursing~~nursing staff will need to be in communication with each other to properly time the administration of the oral contrast and the performance of the CT exam following the administration of the oral contrast to the patient.

When the order for CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST is entered, a ~~Pharmacy~~pharmacy order will automatically ~~order~~generate for the Barium Sulfate 0.1% oral suspension. There will be four orders for the different amounts of Barium Sulfate and the time frames that the oral contrast needs to be taken orally by the patient.

The oral contrast will need to be given to the patient at the following dose amounts and time frames.

~~450 ml of Barium Sulfate, 0.1% oral suspension at 60 minutes prior to scanning.~~

~~450 ml of Barium Sulfate, 0.1% oral suspension at 40 minutes prior to scanning.~~

~~225 ml of Barium Sulfate, 0.1% oral suspension at 20 minutes prior to scanning.~~

~~225 ml of Barium Sulfate, 0.1% oral suspension at 10 minutes prior to scanning.~~

1. 450 mL of Barium Sulfate, 0.1% oral suspension at 60 minutes prior to scanning.
2. 450 mL of Barium Sulfate, 0.1% oral suspension at 40 minutes prior to scanning.
3. 225 mL of Barium Sulfate, 0.1% oral suspension at 20 minutes prior to scanning.

4. 225 mL of Barium Sulfate, 0.1% oral suspension at 10 minutes prior to scanning.

After the final dose of oral contrast is given to and consumed by the patient, patient will be transported to the CT department where the CT scan will be completed. Nursing staff and CT Technologists will be in communication to coordinate the time of the exam.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	11/22/2022
Imaging Services	Matt McGill: Director, Imaging Services	10/14/2022
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	5/17/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/2009*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/17/2020*
Next Review:	*3 years after approval*
Owner:	*Christian Gallagher: Physical Therapy*
Policy Area:	*Rehab Services*
References:	

RS.13 Outpatient Rehab Services Use of Dexamethasone

POLICY:

Dexamethasone is a water soluble corticosteroid used by Outpatient Rehab Services clinical staff for topical application under the orders of an attending physician in conjunction with the iontophoresis system or ultrasound for treatment of acute and subacute inflammation of bursae, tendons and joints. It is also used over scar tissue that needs softening.

PROCEDURE:

Contraindications:

- Allergy to medication or excessive susceptibility to Dexamethasone.
- Do not use over skin with any damage.
- Avoid use when infections are present.

Iontophoresis application:

1. Fill a syringe with 1.5 mL to 3.5 mL of dexamethasone depending on electrode size.
2. Hydrate entire electrode pad.
3. Have patient wash area to be treated.
4. Prep electrode sites on patient's skin, with alcohol prep. Allow skin to dry. Do not apply electrode to damaged skin, skin with ingrown hairs, pimples, razor nicks or open wounds as excessive irritation or burns may occur.
5. Apply hydrated drug electrode on the selected treatment site and secure by pressing on the adhesive border only.
6. Attach twin leads, black to the drug electrode, red to the dispersive pad.
7. Begin treatment, setting parameters on unit per protocol (see instructions with electrode packet).
8. If patient experiences discomfort, lower current and lengthen treatment period proportionally.
9. At end of treatment, turn off machine, disconnect leads, remove electrodes.
10. Check skin for excessive redness or blisters.

Storage:

Medication(s) shall be stored in accordance to PH.24 Clinic Medications.

All revision dates: 3/17/2020, 10/1/2016

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	3/23/2023
Rehab Services	Christian Gallagher: Physical Therapy	2/8/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

S.94 Operating Room Admixture Preparation

PURPOSE:

POLICY:

Operating Room (OR) Nursing at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) may prepare approved admixture products with short stability for immediate use in the OR.

DEFINITION(S):

1. Aseptic technique is a set of methods used to keep objects and areas free of micro-organisms and thereby minimize infection risk to patients. It is accomplished through practices that maintain the microbe count to an irreducible minimum.

2. Beyond-use-date (BUD) is the date or date and time after which administration of a compounded drug preparation shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored.

3. Compounding is the process of combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug or bulk drug substance to create a sterile medication.

4. Compounded sterile preparation (CSP) is a preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging or otherwise altering a drug product or bulk drug substance.

4. Reconstitution is the process of adding a diluent to a conventionally manufactured products to prepare a sterile solution or suspension.

PROCEDURE(S):

A. All admixtures prepared in OR shall be in compliance with policy S.22 Medication and Fluid Transfer to the Sterile Field.

B. Only trained OR circulator nurses may prepare approved admixture products in the OR for immediate use by OR staff.

C. OR Nursing preparation of admixture products is restricted to the following:

   1. Approved admixture products (see Attachment A - Master Recipes for Approved OR Admixture

Products).

a. Simple transfers of not more than 3 (three) commercially manufactured, sterile, non-hazardous medications and/or components from a manufacturer's original container.

b. No more than 2 (two) entries into one container in either the IV bag or the vial.

2. Nursing shall not compound chemotherapy, hazardous medications, parental nutrition, and concentrated electrolytes such as potassium chloride repletion.

D. Preparation of the admixture product shall include the following process:

1. Medication orders must be reviewed for completeness (see policy 100.025 Medication Ordering, Administration, and Documentation).
2. The standard admixture recipe shall be utilized (See Attachment A – Master Recipes for Approved OR Admixture Products).
3. Preparation of the admixture product shall occur in a dedicated, clean, uncluttered space.
4. All medications and supplies shall be gathered before initiating the process.
5. The admixture product shall be prepared using aseptic technique.
6. A second nurse is required to complete a verification double check

E. The Nursing prepared admixture product shall be labeled as per policy 100.080 labeling Medications On and Off the Sterile Field.

F. Documentation

1. All medication administration is documented in a timely manner in the electronic health record and medication administration record.
2. Nurse admixture products will not scan due to the lack of a pharmacy generated IV label with proper barcodes.

G. OR Circulator Nurses shall be trained and demonstrate annual competency on the following:

1. Proper hand hygiene (see policy 106.055 Hand Hygiene)
2. Pharmaceutical calculations and terminology
3. Aseptic technique
4. Standard admixture recipes
5. Quality assurance procedures
6. Labeling

REFERENCE(S):

United States Pharmacopeia 797 - Sterile Preparations 2008

All revision dates:

Attachments

Attachment A: Master Recipes for Approved OR Admixture Products

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	3/23/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/23/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	3/23/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/17/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/24/2023*
Next Review:	*3 years after approval*
Owner:	*Laura Zarate: Clinical Nurse Manager, Case Management*
Policy Area:	*Utilization Review*
References:	

UR.05 Provision of Non-Urgent/Emergent Transportation

POLICY:

Non-emergent transportation may be provided by ~~the~~ Ventura County Medical Center ~~(VCMC) and/or~~and Santa Paula Hospital ~~(SPH)~~ to assist patients who have been discharged from the acute care setting and are in need of transport to the next, lower level of care. Non-emergent transportation includes bus ~~tokens and/or tickets~~, taxi ~~vouchers~~, ride share service, wheelchair ~~vans~~van and gurney ~~vans~~van and will only be ordered by the medical centers ~~if/~~when all other ~~forms of~~options for transportation have been exhausted. Transportation will not be provided on a regular or repetitive basis for the same patient(s) and/or family member(s). Case Management/Social Services will make every effort to locate alternative means of transport for those patients who demonstrate a frequent or consistent need for non-emergent transportation

PROCEDURE:

1. Any team member may identify a transportation need. Once the transportation need has been identified, the team will refer the patient to Case Management/Social Services Monday-Sunday, and the House ~~Supervisors~~Supervisor after hours. Case Management/Social Services will exhaust all of the following prior to requesting hospital-provided transport:
    a. Family members and/or friends – team member should make attempts to contact family/friends with patient's permission~~;~~. Attempts should be documented in the Electronic Health Record (EHR).
    b. Inquire with patient/family re: all means of private pay, e.g. Credit or debit card, cash, payment app, etc. Attempts should be documented in the EHR.
2. When all other options for transportation and means of payment for transportation have been exhausted, the Social Worker, Case Manager ~~and/~~or House Supervisor will ~~provide or order~~arrange transportation as appropriate~~. All orders for hospital provided transportation must be accompanied by a Transportation Checklist (see attached)~~ via one of the following:
    a. Bus ~~Token;~~
    b. Taxi ~~voucher;~~
    c. Ride Share Service
    d. Ambulatory Transport, ie Door to Door*;
    e. Wheelchair Van (Standard and Bariatric)*;

f. Gurney Van (Standard and Bariatric).*

*Items "~~e~~b" through "~~e~~f" will be ordered via approved non-emergency transportation vendors.

3. Ambulance transport shall not be used for Non-Urgent/Non-Emergent transport, unless approved by one of the following individuals:
    1. The ~~Clinical Nurse~~Director or Manager~~,~~ of Case Management/Social Services~~, and/~~ or designee;
    2. The acting House Supervisor~~, and/~~ or the Administrator on Duty ~~(AOD)~~.
4. Staff shall only escalate for ambulance transport when all other means, to include approved non-emergency transportation vendors, have been exhausted.
5. The tracking and trending of the use of approved non-emergency transportation vendors will be reviewed by the UM Committee.

All revision dates: 2/24/2023, 9/13/2022, 9/17/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Utilization Management Committee	Cheryl Lambing: Medical Director, Utilization Management	3/17/2023
Utilization Management Committee	Laura Zarate: Clinical Nurse Manager, Case Management	2/24/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/24/2023
Case Management	Laura Zarate: Clinical Nurse Manager, Case Management	2/24/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*5/12/2020*
Next Review:	*3 years after approval*
Owner:	*Tracy Chapman: VCMC - Med Staff*
Policy Area:	*Administration - Medical Staff*
References:	

MS.102.018 Peer Review

POLICY:

Peer review is an ongoing evaluation of the performance of clinical privileges at Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU) and the Ambulatory and Behavioral Health Clinics. The goals of the peer review process are:

1. Preserve and continuously improve the safety and quality of patient care;
2. Provide ongoing review and evaluation of care provided by practitioners exercising privileges in the hospital and/or clinic setting;
3. Identify significant trends by analyzing aggregate data that may impact the safety and quality of patient care;
4. Provide recommendations and specific feedback to practitioners;
5. Identify opportunities for process and systems improvements;
6. Identify educational opportunities / Continuing Medical Education (CME) recommendations;
7. Improve completeness and quality of the medical record.

PROCEDURE:

A. Peer review is a case-based evaluation of a practitioner's performance of clinical privileges, directed towards issues which impact patient safety and the quality of patient care. Peer review is performed by individuals from the same discipline (e.g., physician to physician, dentist to dentist, etc…) with similar qualifications, experience and training. Review shall be designed to evaluate whether a practitioner's patient care falls within acceptable standards of safety and professional practice as defined by the Medical Staff.

B. At the discretion of the Department Chief, a Quality Medical Director or a Medical Director, peer review may be performed when any of the following is identified involving a member of the Medical Staff or Allied Health Practitioner (AHP) exercising clinical privileges in the hospital or clinics:

   1. Occurrences which meet Medical Staff Department approved peer review quality indicators;
   2. Statistical analysis and aggregate data reflecting levels of performance, utilization or patient outcomes which varies significantly and undesirably from professional standards;
   3. Significant adverse patient events and/or safety risks with the potential for patient harm;

4. Risk Management concerns involving quality of care;
5. Reports by Medical Staff or AHP Staff members, Hospital healthcare team, or patient/family involving a quality of care issue which may indicate a substantial deviation from the standard of care;
6. Notices from regulatory bodies, accreditation agencies or third party payors involving quality of care.

C. Code of conduct issues, physician health and well-being, and issues related to professional behavior are not part of the peer review process, unless they directly impact patient care. These issues shall be directed to the Chief of Staff, Chief Medical Officer or any Medical Staff Officer including Department Chiefs for management as specified in the Medical Staff Bylaws.

D. All activities related to peer review are protected by California Evidence Code §1157 and will remain confidential. All documentation will be maintained within the Medical Staff Services Department to maintain confidentiality in accordance with the Medical Staff Bylaws.

E. Actions taken according to this policy are not considered a formal investigation and do not invoke section 805 reporting requirements if a member withdraws requests for privileges or terminates membership or privileges. If the Medical Executive Committee (MEC) concludes that corrective action may be warranted, a formal investigation shall be initiated pursuant to Article 13 of the Medical Staff Bylaws.

F. Practitioner specific peer review results will be considered during the credentialing and privileging recommendations and, as appropriate, may be utilized in the organization's performance activities.

G. Notwithstanding the terms and provisions of this policy and procedure, corrective action or disciplinary action, including but not limited to summary suspension, may be instituted at any time in accordance with the Medical Staff Bylaws.

H. Each clinical department shall establish and approve peer review indicators which will be tracked in order to identify potential problems with patient care.

I. The Quality Assurance Performance Improvement Department (QAPI) shall screen Hospital cases utilizing these peer review indicators and notify the Medical Staff Services Department to initiate the peer review process.

J. Practitioners providing care solely in an Ambulatory or Behavioral Clinic are subject to the same quality standards and care concerns identified will be assigned for review through the electronic peer review process, and reviewed by the appropriate Medical Staff Department in which the practitioner holds clinical privileges.

K. Reviewers shall be notified by the Medical Staff Services Department of the charts assigned for review and their responsibility to participate in peer review activities.

L. A reviewer may be recused and another reviewer assigned if:
1. The reviewer was involved in the care or treatment of the patient(s); or
2. A conflict of interest exists which may compromise the reviewer's objectivity.

M. Practitioners being reviewed will be given an opportunity to provide additional information or feedback, whenever reasonably possible, regarding the case reviewed, which may include an invitation to attend the Department meeting in which the case will be discussed.

N. Peer review shall be conducted as soon as reasonably possible. In general, the medical record shall be completed prior to the case being assigned for peer review. It is the goal of the Medical Staff to have peer review finalized within 120 days from the date the occurrence was identified for peer review, although this time frame may be extended for good cause.

O. Practitioners will be notified by the Department Chief or his/her designee in writing of all peer review findings that were found to deviate from the standards of care and given an opportunity to respond, request additional review or provide information not available at the time of review that may have relevance on the peer review rating.

P. All cases not meeting the standards of care will be trended for Ongoing Professional Practice Evaluation (OPPE) and recredentialing. Practice trends towards substandard patient care may, at the discretion of the Department Chief, invoke Focused Professional Practice Evaluation (FPPE) as described in the Medical Staff Bylaws.

Q. Circumstances which may require external peer review include but are not limited to:

1. There is insufficient local expertise to adequately and objectively review the practitioner's care. This would include situations in which the only peers on the Medical Staff are partners, associates or direct competitors of the practitioner under review and the potential for conflict of interest exists.
2. There is a known conflict among practitioners which would impact the objectivity and fairness of the review.
3. When there are conflicting recommendations from internal reviewers or Medical Staff committees.
4. As requested by the Medical Executive Committee or Governing Board.

All revision dates: 5/12/2020, 1/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	4/4/2023
Policy Owner	Tracy Chapman: VCMC - Med Staff	3/28/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/2003*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/10/2021*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

PH.48 Medication Error Reduction Plan (MERP)

POLICY:

To have an established plan and multidisciplinary process for identifying, reporting and evaluating medication errors with the ultimate goal of reducing the incidence and/or the severity of medication errors.

Definitions[1]:

Adverse Drug Event (ADE): An injury resulting from medical intervention related to a drug. This could include medication errors or adverse drug reactions

Adverse Drug Reaction (ADR): Any response to a drug which is noxious and unintended which occurs at doses normally used in humans for prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function.

Harm: Impairment of the physical, emotional, or psychological function or structure of the body and pain or injury resulting therefrom

Just Culture: See policy 107.082 Just Culture - Response to Safety Events

Medication error: "Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use."

PROCEDURE:

Medication Error Reduction Plan (MERP)

The Medication Error Reduction Plan (MERP) is a formal plan that includes the evaluation, assessment and methodology by which weaknesses and deficiencies in the medication process are identified and addressed. The medication process includes prescribing, prescription order communication, drug product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, and monitoring, and use. This is a practical approach to address processes that could contribute to medication errors in the administration of medications.

The plan shall incorporate technology solutions for reducing medication errors. In addition, the MERP plan shall incorporate prospective and retrospective review of clinical care such as med pass audits and chart

reviews. Effort shall be made to incorporate external medication related error alerts thus providing the initiative for modifying susceptible processes and systems.

The MERP plan is reviewed annually for effectiveness allowing for modifications when warranted for further reduction of medication errors.

Medication Error Notification System

Medication Error Notification System is a process by which medication errors can be reported and data collected for assessment, dissemination, education, collaborative corrective measures, and medication error trends. It is a way to identify in real time, medication errors that have the potential to or have caused patient harm. If warranted, it allows the hospital to address the medication safety issues quickly and efficiently.

The effectiveness of the medication error notification system is dependent upon the amount and quality of the data collected. A robust reporting system allows the hospital to assess opportunities to improve its medication use process. A just culture supports a robust reporting system.

Medication Error Reporting:

1. Medication errors shall be reported electronically through the completion of an electronic medication notification form. Access to the notification form is available on all healthcare agency desktops.
2. All medication errors should be reported, regardless of whether the error resulted in a "near miss," caused harm, did not cause harm, or resulted in an adverse drug event.
3. Medication errors shall be ideally reported at the time of discovery.
4. The prescriber and patient shall be notified immediately of the error if indicated. If the prescriber who ordered the medication is not available, the error shall be reported to the attending prescriber or another responsible prescriber.
5. Any medication administered in error or omitted in error and the action taken shall be properly recorded in the patient's medical record. The entry in the patient's medical record need not indicate that an error occurred.
6. If a medication error resulted in an adverse drug reaction, both a medication error notification and an adverse drug reaction report shall be completed.
7. Records of the medication error review shall be retained by the Medication Safety Officer for at least three (3) years from the date the record was created.
8. Important information to include in the medication error notification form
    a. Patient information
        i. Name, age, gender, weight (if pertinent to error)
        ii. Medical record number (MRN) or financial number (FIN)
    b. Event inform
        i. Date/time of event
        ii. Date of initial report
        iii. Setting/Location
        iv. Description of event:
        v. Did the error reach the patient?

c. Relevant information
    i. Laboratory data or tests, including dates/times
    ii. Relevant history (e.g. pre-existing medical conditions, allergies)
    iii. Concomitant therapy
    iv. Dates of therapy
    v. Diagnosis/indication for use
    vi. Medical intervention(s) following the error
    vii. Actions taken and recommendation for prevention
d. Possible Cause(s) of medication error if known
    i. Identify the most common cause of the medication error
    ii. Describe known and potential contributing factors

Medication Error Analysis:

Once the medication error notification is filed, the notification shall be routed to the Medication Safety Officer (MSO) who shall review and investigate as soon as reasonably possible. The notification may be forwarded to the appropriate department manager for further review and/or administration for notification, event analysis, and/or peer review. It is important that medication error information be collected and reported as soon as possible. It is understood that the eventual patient outcome may change from the time when the medication error initially occurred.

Medication Error Severity Assignment (attachment 1): The MSO shall initially assign the severity of the medication errors with Medical Staff consultation if warranted. In addition, Patient Safety Committee and/or MERIT (Medication Error Reduction Improvement Team) subcommittees shall review medication errors and committee members/attendees have the ability to request a reassessment and/or change in severity assignment.

All medication errors that may have contributed to or resulted in harm to the patient and required initial or prolonged hospitalization may be reported to the California Department of Public Health (CDPH) as per Policy 107.023 Adverse Events, Sentinel Events, and Unusual Occurrences.

Patient Safety Committee and MERIT Subcommittee

Patient Safety Committee is a multidisciplinary committee that meets at least quarterly to review the MERP plan and the medication errors that were reported through the medication error notification system. Patient Safety Committee composed of various hospital department representatives, and a quorum for Patient Safety Committee shall include Administration, Medical Staff, Nursing, and Pharmacy representatives.

At minimum, Patient Safety Committee and/or MERIT subcommittee shall review and analyze those medication errors that 1) reached the patient and required monitoring to confirm no harm was done and 2) those medication errors that caused patient harm. Patient Safety Committee and/or the MERIT subcommittee shall confer on policy, procedural and system change solutions in order to reduce the incidence and severity of the medication errors discussed. If warranted, the committees may recommend further follow-up and analysis of the medication errors (e.g. change in severity coding, event analysis, peer review).

Medication Safety generated summaries, data and action plans shall be reported to the following committees

A. Performance Improvement Coordinating Council (PICC)/Patient Safety Committee

B. Pharmacy and Therapeutics Committee (P&T)

C. Medical Executive Committee (MEC)

References:

1. National Coordinating Council for Medication Error Reporting and Prevention. www.nccmerp.org. Accessed 10/1/2018.

2. California Health and Safety Code Section 1339.63

All revision dates: 11/10/2021, 11/26/2018, 1/1/2014

Attachments

PH.48 Medication Error Reduction Plan 2023 Summary.pdf

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	3/23/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/23/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	3/23/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/23/2023*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

PH.61 Automatic Stop Orders

POLICY:

Medication orders shall have defined automatic stops, which may vary in duration depending on the medication.

DEFINITIONS: Definitions of automatic stop types for medication orders:

A. Hard stop: A type of automatic stop where the order will automatically discontinue after the order has expired. Hard stop order types are not renewable.

B. Physician stop: A type of hard stop where the duration of therapy is defined by the provider. The order will automatically discontinue after the order has expired.

C. Soft stop: A type of automatic stop where the order will persist on the medication administration record (MAR) after the order has expired. Soft stop types are renewable, and shall be renewed or discontinued upon expiration of the order.

PROCEDURE:

A. Automatic hard stop orders:

1. ~~One day (24 hours) expiration:~~

   ~~a. Sodium Polystyrene Sulfonate solution~~

   One day (24 hours) expiration:

   a. Sodium polystyrene sulfonate (Kayexalate) oral solution

   b. Sodium zirconium cyclosilicate (Lokelma) powder for suspension

      i. This restriction only applies for treatment of emergent hyperkalemia.

2. Three-day (72 hours) expiration:

   a. Methocarbamol injection

3. Five-day (120 hours) expiration:

   a. Ketorolac injection

B. Automatic soft stop orders:

1. One day (24 hours) expiration

   a. Amiodarone drip

2. Three day expiration:
    a. Baclofen (oral), methocarbamol (oral), cyclobenzaprine (oral)
3. Fourteen day expiration:
    a. Antibiotics, oral and injectables
4. Twenty-one day expiration:
    a. Antifungals and antivirals, oral and injectables
5. Ninety-day (90 day) expiration:
    a. All other medications not listed in this policy

C. Start and Stop dates are noted in the order details and MAR in the electronic health record (EHR).
1. Renewal notice icons will automatically populate the order details and MAR for soft stop orders 48 hours prior to expiration of the order. The renewal icon will persist until the order is renewed or discontinued.

D. Renewal of Medication Orders:
1. Medication orders can be renewed by a provider by selecting the renew function for the order in the EHR.

E. Discontinuation of Medications:
1. Hard stop orders will automatically discontinue upon expiration of the order. This includes physician stop orders.
2. Soft stop orders will not automatically discontinue upon expiration of the order. The provider has the option to discontinue or renew the order.

All revision dates: 3/23/2023, 10/11/2022, 11/10/2021, 1/13/2021, 3/17/2020, 2/15/2018, 3/1/2015, 12/1/2013, 2/1/2011, 8/1/2008, 6/1/2006, 9/1/2002, 6/1/2000, 11/1/1998, 8/1/1994, 3/1/1991

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	3/23/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/23/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/2001*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/28/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.05 Car Seat Tolerance Screening

POLICY:

As part of the discharge process, premature and compromised infants will be assessed for ability to sit in a car seat for ~~60~~ 90-120minutes without evidencing respiratory compromise,.

PROCEDURE:

A. All infants meeting one of the following criteria at time of discharge will receive a Car Seat ~~Challenge~~Tolerance Screening (~~CSC~~CSTS) after 24 hours of life, and within 24-72 hours of discharge:

1. Gestational age < 37 weeks ~~at time of discharge~~.
2. Birth weight less than 2500 grams at discharge.
3. Requiring oxygen supplementation.
4. Other medical conditions, which place the infant at high risk for apnea, bradycardia, or oxygen desaturation (i.e. ~~hydrocephaly~~neuromuscular disorders, hypotonia, etc.).
5. Home apnea monitor.
6. Clinically significant heart disease

B. ~~CSC~~CSTS will be performed by an RN/LVN ~~when preparing for~~within 72 hours of discharge.

C. ~~CSC~~CSTS Flow Sheet (see attached) will be used to record patient data.

D. Data will be collected and recorded by an RN/LVN.

E. Infant will be monitored in the family-owned car seat. Brand of car seat will be recorded on the ~~CSC~~form. Baby's weight should be appropriate for car seat being used. Label car seat with patient's name. Parents who do not own a car seat and will be traveling by public transportation will not be expected to participate.

F. Infant will be positioned in car seat using blanket rolls on either side of body to prevent lateral slouching of head (prevent airway obstruction). Remind parents to bring two receiving blankets and cloth diaper at discharge for this positioning. Parents will receive instructions regarding positioning of infant in car seat. This can be done during the ~~CSC~~CSTS. Nothing should be added beneath the harness straps. Questions regarding the use of the car seat in the automobile may be referred to the California Highway Patrol or a member of SafetyBeltSafe.

G. The car seat retainer clip should be positioned according to the manufacturer's recommendations.

H. The infant should recline at a 45° angle when positioned in the car seat.

I. Begin CSTS when baby is in a quiet alert or sleep state.

J. The infant will be placed on a cardiorespiratory monitor and pulse oximeter and studied for ~~60~~90 minutes to 120 minutes or the duration of travel, whichever is longer while positioned in the car seat.

K. The infant's heart rate, respiratory rate, O_2 saturation, and assessment parameters will be recorded when first positioned in the car seat and every ~~10~~15 minutes thereafter.
The values recorded will be taken from the monitor readings.

L. The infant's skin color, respiratory effort and activity level will be visually assessed by the RN/LVN and recorded when first positioned in the car seat and every ~~10~~15 minutes thereafter on the CSTS flow sheet. A check mark (√) should be placed in the appropriate patient parameter box.

M. Infant's diagnoses, age, weight, medication regime, time and mode of the last feeding will be recorded on the ~~CSC~~CSTS. If oxygen is in use, check the appropriate space.

N. Infant will be returned to the crib at the conclusion of study. Encourage parents to take car seat home at conclusion of study or the following day.

O. ~~CSC~~CSTS will be discontinued/assessed as FAILED with the following infant parameters:

1. ~~Heart rate drop of 30 beats below baseline for ≥20 seconds~~Bradycardia <80 BPM for >10 seconds
2. Apnea (lack of respirations for >20 seconds)
3. Persistent labored respirations.
4. Dusky colored skin accompanied by pulse oximetry readings of ~~less than~~ ≤90% for ~~≥20~~>10 seconds.

P. In the event of apnea, bradycardia, and/or oxygen desaturation – clinical stimulation, repositioning, oxygen and other appropriate interventions should be performed and documented on the ~~CSC~~CSTS form under "Interventions" to be placed in the chart.

Q. The RN/LVN will indicate with a check mark (√) whether infant has passed or failed challenge and then sign the ~~CSC~~CSTS in designated space. All failures must be reported to infant's physician/~~CNP~~nurse practitioner (NP).

R. Unless there is a "~~definitive~~significant" change in the patient's condition/stability, the ~~CSC~~CSTS does not need to be repeated even though the discharge date may be extended.

S. When failure occurs, the patient ~~is either~~remains in the hospital and retested within 24-48 hours or may be discharged in a car bed following a discussion with the attending physician/~~CNP, or remains in the hospital and is re-tested in a few days~~NP.

T. Physician/~~CNP~~NP should counsel parents regarding the restrictions of associated activities (i.e., infants cannot be placed in swings, etc., where upright sitting positions are required).

U. The completed ~~CSC~~CSTS Flow Sheet will be placed in patient's medical record at the bedside.

REFERENCES:

~~N.O.E.P., 2007~~
American Academy of Pediatrics ~~Policy Statement on~~: Safe Transportation of ~~Newborns~~Preterm and Low Birth Weight Infants at Hospital Discharge, ~~Pediatrics~~Pediatrics, ~~1999~~2009; ~~104: 986-987~~123; 1424-1429

All revision dates: 3/28/2023, 2/1/2010, 6/1/2008, 11/1/2004, 3/1/2001

Attachments

A: Car Seat Challenge Flow Sheet
B: Car Seat Challenge Guidelines

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/1/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/1/2023
Policy Owner	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/1/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/28/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.12 Neonatal and Pediatric Physiologic Monitoring, Hygiene and Comfort Management Protocol

POLICY:

To define the routine nursing management of neonatal and pediatric patients in relation to physiologic monitoring, hygiene and comfort measures. This protocol will be initiated on all patients in the Neonatal Intensive Care Unit (NICU) and Pediatrics (PEDS) Department at Ventura County Medical Center.

PROCEDURE:

A. **Orient** parents/primary care giver to the unit:
   1. Visiting hours
   2. Layout
   3. Telephone numbers
   4. Video monitoring (when indicated).

B. **Assess** vital signs, including pain assessment, on admission and as directed by the physician orders.

C. **Place** ID band.

D. Take axillary temperatures until the child is old enough to comply with oral methods. **Obtain** a rectal temperature on admission and when specifically ordered by the physician. No rectal temps on patients without a physician order.

E. Take apical pulses on all patients (count the HR for 1 full minute).

F. Take respiration count immediately after pulse count (count the RR for 1 full minute).

G. Perform Blood Pressure (BP) measurements as follows:
   1. Use appropriate size pediatric cuff and non-invasive BP monitor on upper or lower extremity
   2. Use arterial line with transducer cable if available (NICU only).

H. Obtain BP and/or pulse readings prior to any medication known to alter these (i.e. diuretics, antihypertensives).

I. **Obtain** an ECG monitor strip every shift and PRN for patients with diagnosed cardiac disease, rhythm

disturbances, or on medications known to alter the cardiac rhythm, i.e., Digoxin (PEDS only).

J. **Perform** baseline neuro checks every shift and then PRN as applicable to the diagnosis or as directed by physician order.

K. **Rigidly adhere** to the 7 Rights of Medication Administration Safety. Validate the patient's identification using the wrist or ankle ID bands.

L. **Validate** allergies on all patients via an intact allergy wrist or ankle band.

M. Obtain the patient's weight on admission and every 24 hours except when contraindicated due to unstable condition:

1. Use the same scale each time if possible
2. Record patient's weight in kilograms (kg) in PEDS and grams (gms) in NICU.

   ~~Plot on growth chart on admission.~~

N. Obtain the patient's height using the standing stadiometer for ambulatory patients or the recumbent stadiometer for non-ambulatory patients. ~~Plot on growth chart on admission.~~

1. If < 36 months of age, obtain head circumference, upon admission and as ordered. Plot on growth chart.

O. **Reposition** the non-ambulatory/non-mobile patient at least every two (2) hours (for patients less than 1 year refer to MCH.20 Infant Positioning and Safe Sleeping policy):

1. Position prone, supine, or lateral ~~sidelying~~side-lying as tolerated
2. Use blanket rolls and/~~diaper rolls~~or positioning aids to enhance proper body alignment
3. Maintain the patient in a state of physiologic flexion when positioning
4. Swaddle infants with their arms crossed over their chest, or use blanket rolls and/~~diaper rolls~~or positioning aids and form a nest around the infant for comfort.

P. Provide personal hygiene as needed:

1. Complete or partial bath (face/chest/arms/axilla/back/genitals/legs/feet)
2. Shampoo hair
3. Complete or partial linen change
4. Oral care daily or Q4 3-6 hrs when NPO
5. Perineal care following diaper change/toileting.

Q. Keep patient clean and dry at all times.

R. Keep the patient's room or area free of noxious odors/sites.

S. Check IV site ~~qlh~~q 1h & prn.

T. Control the noise level and lighting on unit to provide for day-night orientation and rest.

U. Provide age appropriate visual and auditory stimulation as tolerated (also see Pediatric Development Protocol):

1. Visual stimulation:
   a. Newborn – 3 months: black/white geometric patterns, mirrors
   b. Infants – toddlers: mobiles, stuffed toys, activity bars

c. Preschool – school age: videos, television, pictures/posters

d. Adolescents: books, ~~books on tape~~audiobooks, ~~Nintendo~~video games, school homework, videos.

2. Auditory Stimulation:

a. Infants: soothing music, lullabies, musical toys, tapes of their parents' voices, crib cuddle.

b. Toddler/preschool/school age: children's music tapes or ~~books on tape~~audiobooks.

V. Utilize the infant swing, infant seat, stroller, wagon, or wheelchair as appropriate per age and level of care.

W. Assess the patient daily for bowel regularity. In the event of constipation/diarrhea, notify the physician.

X. Maintain strict record of enteral and parenteral intake and urine output (weigh diapers/measure urine) for patients on IV fluids or diuretic therapy. Monitor urine and stool output via "diaper check" or stool/void check for all other patients unless ordered by physician.

Y. Do not leave infant unattended on a scale, exam table, isolette with the door open or radiant warmer when the side panels are down. Crib side rails to be raised at all times unless maintaining direct contact with patient.

Z. Do not disable or deactivate monitor alarms unless directly providing care for the patient, unless ordered by physician.

AA. Do not leave infants/small children unattended in a bathtub.

AB. Validate the resuscitation equipment is present and functioning at all times and includes:

1. Resuscitation bag/valve/mask set up
2. Suction apparatus/tubing
3. Oxygen and air source
4. Bulb syringe (infants ≤ 1 yr only)
5. Emergency drug sheet for current weight.

AC. Validate that ~~K-pads, saran wrap and~~ heat lamps are a safe distance from the patient's skin, when in use. ~~Isolettes and radiant~~Radiant warmers must have temperature skin probe in place.

AD. Validate monitor alarms are set appropriately for blood pressure as follows:

1. Set a low mean BP and/or low CVP alarm for any neonate with an umbilical or peripheral arterial line or an umbilical venous catheter (NICU)
2. Calculate alarm limits for mean BP based on this formula for average mean BP: Wt (kg) x 10 + 20 (NICU and infants < 1 yr)
3. Set a low systolic and/or low CVP alarm for any child (age 1-10 yrs) with an arterial or central venous line
4. Calculate systolic low alarm limits for children age 1-10 years using this formula: 70mm Hg + (2 x child's age in years)
5. Calculate systolic low alarm limit for neonates at 60 mm Hg and infants ≤ 1 yr at 70 mm Hg.

AE. Validate monitor alarms for high/low heart rate and high/low respiratory rate are active and set appropriately for age:

1. Heart rate high/low Beats per minute (BPM)
    a. ≥ 200 bpm or ≤ 100 preterm/newborn
    b. ≥ 180 bpm or ≤ 90 bpm infant
    c. ≥ 140 bpm or ≤ 80 bpm toddler
    d. ≥ 130 bpm or ≤ 60 bpm preschool
    e. ≥ 100 bpm or ≤ 50 bpm school age
2. Respiratory rate high/low
    a. ≥ 60 breaths/min or ≤ 10 breaths/min infant
    b. ≥ 30 breaths/min or ≤ 10 breaths/min toddler
    c. ≥ 30 breaths/min or ≤ 10 breaths/min preschool/school age
3. Oxygen saturation high/low
    a. ≥ 100 % high or ≤ 90 % low (neonate, infant or child)
    b. Or as ordered by physician
4. Apnea alarm limit set at ~~20~~15 seconds (neonate, infant ~~or~~ child)

AF. Assess the family's needs for spiritual support and provide appropriate religious resources as requested.

AG. Identify yourself by name and title to the parents/primary caregiver. Ask the parents/caregivers how they wish to be addressed by the staff and update white board every shift.

REFERENCES:

AWHONN: NOEP 3rd edition, 2015

All revision dates: 3/28/2023, 7/1/2015, 3/1/2013, 3/1/2010, 2/1/2007, 4/1/2004

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/6/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/2/2023
Policy Owner	Enriqueta Coronado: Clinical Nurse Manager, NICU [MK]	2/2/2023
Nursing Administration	Michelle Sayre: Chief Nursing Officer	11/10/2020
Nursing Administration	Sherri Block: Associate Chief Nursing Officer	11/10/2020

Step Description	Approver	Date
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/10/2020

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*5/12/2020*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Maternal Child Health*
References:	

MCH.19 OB/PEDS Access and Egress of Soiled Utility Room

POLICY:

To avoid the incorrect pathway of travel between the shared soiled utility room and the Obstetrics and Pediatric departments.

PROCEDURE:

All staff will follow the correct pathway of travel through the Obstetric and Pediatric departments to access and egress the common soiled utility room.

Staff working in Obstetrics will access and egress the soiled utility room from the Obstetrics Department hallway. Staff working in Pediatrics will access and egress the soiled utility room from the Pediatrics Department hallway.

All revision dates: 5/12/2020, 7/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/21/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/21/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	2/21/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/1999*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/1/2022*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.22 Resuscitation of the Neonate

POLICY:

To define the guidelines for the Neonatal Intensive Care Unit (NICU) and OB Registered Nurse who provides cardiopulmonary resuscitation to a neonate, including:

A. Establishing the airway, initiating breathing and restoring circulation.

B. Assigning Apgar scores as needed.

C. Administering emergency medications.

PROCEDURE:

A. All NICU and Perinatal Services staff are Neonatal Resuscitation Program (NRP) ~~providers~~certified, re-testing every two (2) years to maintain competency.

B. All neonatal resuscitation is conducted following the NRP protocol.

1. At Ventura County Medical Center (VCMC), the Neonatologist or Neonatal Nurse Practitioner (NNP) is in charge of the resuscitation team. The NICU RN is in charge of the resuscitation team in the absence of the Neonatologist or Neonatal Nurse Practitioner (NNP).
2. At Santa Paula Hospital (SPH), the delivering physician is in charge of the resuscitation team.

C. The resuscitation team administers oxygen and medications according to the NRP protocols in the absence of medical orders.

D. The RN is responsible for assigning Apgar scores in the absence of the Neonatologist or NNP.

E. Neonatal Emergency Medication Administration sheets are to be posted at each NICU/ Intermediate Care Nursery (INT ~~nursery~~) and infant's bedside, with appropriate weight category circled.

- ~~All sheets are updated/re-posted every Sunday NOC shift based on specific infant's current weight. (Resource nurse responsible for completion of such.)~~
- ~~If an infant's weight falls between listed weight categories, "round up" and utilize those specific weight dosage/administration guidelines (refer to Appendix B below).~~

1. All sheets are updated and re-posted every Sunday night by the night shift based on specific infant's current weight. Resource nurse responsible for completion of such.
2. If an infant's weight falls between listed weight categories, "round up" and utilize those specific weight dosage/administration guidelines.

3. See Attachment A for the Neonatal Emergency Medication Administration (VCMC-306-038)

EQUIPMENT

~~All medications, supplies and equipment required by the NRP protocol are available in the Labor & Delivery area and the NICU (refer to Appendix A below).~~

A. All medications, supplies and equipment required by the NRP protocol are available in the Labor & Delivery area and the NICU.

B. Refer to policy 100.113 Crash Cart Checks and Restocking Process for the following

1. Crash Cart and Defibrillator Locations
2. Neonatal Crash Cart Supply List
3. Neonatal Crash Cart Medications
4. Neonatal Crash Cart Checklist

C. Refer to policy PH.115 Emergency Medication Boxes and Kits for contents and location of Neonatal Resuscitation Box

GUIDELINES

~~The Resuscitation team members are determined at the beginning of each shift. An alternative team is identified when needed by coinciding resuscitations.~~

A. The ~~Labor and Delivery Nurse is available for all deliveries~~Resuscitation team members are determined as per NRP guidelines. ~~The NICU RN and Respiratory Therapist (RT) attend all known high-risk deliveries such as meconium staining, prematurity and fetal heart rate abnormalities. The NNP attends known high-risk deliveries such as fetal bradycardia, premature babies less than 35 weeks, multiple gestation and malformations. The Neonatologist attends deliveries with questionable viability and at any other time based on his/her discretion.~~

1. The Labor and Delivery Nurse is available for all deliveries.
2. The NICU RN and Respiratory Therapist (RT) attend all known high-risk deliveries.
3. The NNP attends known high-risk deliveries such as premature babies less than 35 weeks, multiple gestation and malformations.
4. The Neonatologist attends deliveries with questionable viability and at any other time based on his/her discretion.

B. Resuscitation efforts must be continued until a medical order is given to discontinue.

DOCUMENTATION

A. Electronic Health Record (EHR~~–~~) - times, treatments, procedures, personnel, vital signs, outcome.

B. EHR– narrative summary of the event.

C. EHR – medications, times, routes.

D. All documentation relating to a Code should occur on the Code Sheet.

Attachments:

APPENDIX A: Neonatal Crash Cart supplies
APPENDIX B: Neonatal Emergency Medication Administration sheet

Appendix A

NEONATAL CRASH CART

Top of Cart		
Defibrillator Pediatric Paddles Conductive Jel	Adult Self-inflating Ambu Bag	Adult Intubation Tray EKG Electrodes (snap-on) Neonatal Self-inflating Ambu Bag
FIRST DRAWER	**FOURTH DRAWER**	
(2) Laryngoscope Handles (1) Blade Miller, #00, #0, #1 (1) Blade Mac curved # 1 (2) Battery C / 2 AA (6) Blade Light Bulb (2) Stylet 6 Fr. (2) E/T Tube: 2.5, 3.0, 3.5, 4.0, 4.5 (2) Steri Strip ¼ x 3 (2) Tincture of Benzoin (1) Elastoplast 1" (2) Hy-Tape ½ (1) Silk Tape ½ (1) Disposable Scissor (1 each) Feeding Tube: 6 Fr., 8 Fr. (1) Oxygen Tubing (1) Breathing Bag (1 each) Infant Mask #1, #2, #3 (1) Oxisensor N-25 (1) Oxisensor 1-20	(1) ICN Pneumothorax Tray-Fr (2 each) Trocar 10 fr, 12, fr, 16 fr (1 each) angiocatheter: 14 ga, 16 ga, 18 ga (2) Stopcock 3-Way (2) Steri-Strip 1/8 x 3 (1) Silk Tape 1" (2) Large Safety Pins (2) Vaseline Gauze 1x8 inch (4) Op-Site: 2 small, 2 medium (2) Silk Suture: 2-0, 4-0 (2) Syringe Catheter Tip 60 mls (2) Secure-All Tube Hold (3) Connector 5-in-1 (1 each) Pig tail chest tubes: 6 fr, 8 fr.	
SECOND DRAWER	**SIXTH DRAWER**	
(2) Connecting Tube (2 each) Suction Catheter 6 fr, 8 fr, 10 fr (1) Bulb Syringe 2 oz.	**IV Fluids** (1) Dextrose, 10% 250 mls (1) Dextrose, 5% 250 mls (1) NS 0.9% 250 mls	

Top of Cart	
Normal Saline bombs for Inhalation 3 ml	(6) Med. Labels **(1) Med tray:** (1) Atropine 1mg/10ml PFS (2) Calcium Gluconate 10% (2) Epinephrine : 10,000 10 ml PFS (2) Naloxone 1 mg/ml 2ml PFS (3) Sodium Bicarbonate 4.2% 10ml PFS (6) Sodium Chloride Inj. 10ml Vials Vi Lane: Sterile omphalocele bag
THIRD DRAWER	
(1) Umbilical Insertion Tray (2) Umbilical Catheter: 3.5 fr, 5.0 fr (2) Dual Lumen catheter: 3.5 fr 5 fr (4) Limb Restraint (2) Stopcock 3-way (1) Betadine Bottle (2) Surgical Nurse Hat (2 each) Sterile Gloves 6.0, 6.5, 7.0, 7.5, 8.0 (2) Surgeon Mask (1) Gown XL (1) Sterile Towel 4/PK (3) Syringes: 3 ml (1) Umbilical Cord Clamp (1) Tube Clamp Disposable (1) Foley Catheter: 6fr Rush (2) Paul Saver Micron 0.2 filter (2) IV Pump Burette	
FIFTH DRAWER	
(2) Posiflow cap (blue) (1 bx) Alcohol Wipes (1 bx) Betadine Wipes (2) Rubber Band (1) Penrose ¼ (1) Razor (1) Armboard each: Blue, Pink	

Top of Cart	
(1 each) Tape silk 1", ½" (1) Cotton Balls T-Connector Luer lock (2 each) Protective. Angiocatheter: 24 and 22 gauge (2) Luer Lock Cannula (3 each) Butterfly Needle: 21x1, 23x1, 25x5/8 (3 each) Butterfly needles: 21x1, 23x1, 25x3/8 (3) Syringe each: 1 ml, 3 ml, 10 ml, 20 ml, 30 ml (2) Syringe 60 ml (2) Microbore Extension.Tubing: 0.2 mls (2) Microbore Extension tubing: 2.0 mls (1) Tape Clear	

APPENDIX B

VCMC / SPH

EMERGENCY MEDICATION ADMINISTRATION

Addressograph:						
MEDICATION	**EPINEPHRINE IV**	**EPINEPHRINE ET**	**VOLUME EXPANDERS**	**SODIUM BICARBONATE**	**NALOXONE**	**DEXTROSE 10%**
Source Concentration	1:10,000 or (1 mg/10 ml) Syringe	1:10,000 or (1mg/10 ml)	Whole Blood NS, LR 5% Albumin	4.2% or 0.5 mEq/ml Syringe	1 mg/ml 2 ml Syringe	25 gm/250 ml IV Solution
Dosage	0.1 – 0.3 ml/kg	0.3-1 ml/kg	10 ml/kg	2 meq/kg	0.1 mg/kg	2 ml/kg
Amount to prepare	1 ml	4 ml	50 ml	20 ml	1 ml	
Instructions	Give Rapidly IV, IT	Give rapidly via ETT	Give IV over 5-10 minutes	Give IV slowly over at least 2 minutes	Give IV, IT SQ, IM rapidly	Give IV rapidly
Weight (Grams)	**ml/kg**	**ml/kg**			Dosage for 1.0 mg/ml Concentration	
0.1	0.2	0.3	0.3- 1			

MEDICATION	EPINEPHRINE IV	EPINEPHRINE ET	VOLUME EXPANDERS	SODIUM BICARBONATE	NALOXONE	DEXTROSE 10%		
	Amount in mls	Amount in mls	Amount in mls	Amount in mls	Amount in mls	Amount in mls		
500 gms	0.05	0.10	0.15	0.15–0.5	5	2	0.05	1
600 gms	0.06	0.12	0.18	0.18–0.6	6	2.4	0.06	1.2
700 gms	0.07	0.14	0.21	0.21–0.7	7	2.8	0.07	1.4
800 gms	0.08	0.16	0.24	0.24–0.8	8	3.2	0.08	1.6
900 gms	0.09	0.18	0.27	0.27–0.9	9	3.6	0.09	1.8
1000 gms	0.10	0.20	0.30	0.3–1	10	4	0.10	2
1100 gms	0.11	0.22	0.33	0.33–1.1	11	4.4	0.11	2.2
1200 gms	0.12	0.24	0.36	0.36–1.2	12	4.8	0.12	2.4
1300 gms	0.13	0.26	0.39	0.39–1.3	13	5.2	0.13	2.6
1400 gms	0.14	0.28	0.42	0.42–1.4	14	5.6	0.14	2.8
1500 gms	0.15	0.30	0.45	0.45–1.5	15	6	0.15	3
1600 gms	0.16	0.32	0.48	0.48–1.6	16	6.4	0.16	3.2
1700 gms	0.17	0.34	0.51	0.51–1.7	17	6.8	0.17	3.4
1800 gms	0.18	0.36	0.54	0.54–1.8	18	7.2	0.18	3.6
1900 gms	0.19	0.38	0.57	0.57–1.9	19	7.6	0.19	3.8
2000 gms	0.20	0.40	0.60	0.6–2	20	8	0.20	4
2250 gms	0.23	0.46	0.69	0.675–2.25	23	9	0.23	4.5
2500 gms	0.25	0.50	0.75	0.75–2.5	25	10	0.25	5
2750 gms	0.28	0.56	0.84	0.825–2.75	28	11	0.28	5.5
3000 gms	0.30	0.60	0.90	0.9–3	30	12	0.30	6
3250 gms	0.33	0.66	0.99	0.975–3.25	33	13	0.33	6.5
3500 gms	0.35	0.70	1.05	1.05–3.5	35	14	0.35	7
3750 gms	0.38	0.76	1.14	1.125–3.75	38	15	0.38	7.5
4000 gms	0.4	0.80	1.20	1.2–4	40	16	0.40	8
4250 gms	0.43	0.86	1.29	1.275–4.25	43	17	0.43	8.5
4500 gms	0.45	0.90	1.35	1.35–4.5	45	18	0.45	9
4750 gms	0.48	0.96	1.44	1.425–4.75	48	19	0.48	9.5
5000 gms	0.50	1.00	1.50	1.5–5	50	20	0.50	10

All revision dates: 11/1/2022, 11/1/2013, 3/1/2010, 6/1/2006, 5/1/2005, 3/1/2003

Attachments

Attachment A Neonatal Emergency Medication Administration (VCMC-306-038)

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Officer	3/21/2022
Policy Owner	Enriqueta Coronado: Clinical Nurse Manager, NICU	3/17/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/9/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/9/2022*
Next Review:	*1 year after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Maternal Child Health*
References:	

MCH.28 Substance Use in Pregnancy

POLICY:

It is the goal of Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), and the Ambulatory Care (AC) Clinics to universally screen pregnant women who are admitted to perinatal services for exposure to drugs and alcohol.

PURPOSE:

To appropriately manage the care of women suffering from substance use disorders and their exposed infants in a compassionate, non-judgmental manner using best practices. Efforts are directed at identification, treatment, parental education/counseling, and appropriate referrals for treatment and services as indicated.

SCOPE:

Obstetrical and Family Medicine providers, Nursing, and Social Services.

DEFINITIONS:

A. Addiction – a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

B. Substance Use Disorder (SUD) - a complex medical condition in which there is uncontrolled use of a substance despite harmful consequence and is defined by the DSM-V.Substance Use Disorder (SUD) - a complex medical condition in which there is uncontrolled use of a substance despite harmful consequence and is defined by the DSM-V.

   1. Specific substances have specific DSM-V diagnoses, such as:
      - Opiate Use Disorder (OUD)
      - Alcohol Use Disorder (AUD)
      - Stimulant Use Disorder (StUD)
      - And more

C. Drug and/or Alcohol Screening- the process of using a standardized and validated tool to inquire about a

patient's history and present use or interactions with substances and alcohol in an attempt to ascertain if a SUD is present. It is important to remember that use of a substance is not synonymous with addiction/ SUD nor does it correlate to parenting capability.

1. The 4Ps plus is recommended at our institution as a validated screening tool.

D. Toxicology testing – a qualitative test done on a biological specimen to indicate the presence or absence of a substance in the blood, urine or tissue.

E. Confirmatory Testing – a specific laboratory test which detects metabolites confirming the presence of a substance in the blood, urine or tissue. Confirmatory tests are done as a send out lab to a reference laboratory and may be used for legal purposes if chain of custody of the sample is followed.

INDICATORS SUGGESTIVE OF MATERNAL SUBSTANCE ABUSE:

A. Obtunded or unconscious

B. Patient who is falling asleep mid-sentence, shows other evidence of being intoxicated

C. Patient who smells of alcohol or has alcohol on her breath

D. Patient with recent physical evidence of injection use (e.g. "track marks")

E. Patients with acute clinical complications such as placental abruption or unexplained severe hypertension (cocaine, amphetamine)

F. Patient with unexplained soft tissue infections or endocarditis

G. At the time of delivery in a patient previously identified as having used certain illicit drugs or inappropriately used prescription medications, at any point in the pregnancy

H. Patient with no prenatal care at the time of delivery

INDICATORS SUGGESTIVE OF DRUG AND ALCOHOL EXPOSURE IN THE NEONATE

A. Tremors (when disturbed or undisturbed)

B. Poor feeding (uncoordinated suck and swallow)

C. Frantic sucking

D. High-pitched cry

E. Seizures

F. Poor sleeping or excessive wakefulness irritability, increase muscle tone, exaggerated Moro reflex

G. Lethargy

H. Loose/watery stools or dehydration

I. Projective vomiting

J. Frequent yawning and sneezing

K. Hyperthermia or sweating

L. Premature or small for gestational age

M. Fever

N. Difficult to arouse

O. Tachypnea or tachycardia

PROCEDURE:

Please refer to policy *OB.48 Testing for Prenatal Drug Exposure* for details on toxicology testing.

A. Pain Management

1. All patients should be offered adequate pain control.
2. Pain management options should include analgesic and non-analgesic mediation as well as other adjunctive, non-pharmacologic approaches (ice, heat, local anesthetic, relaxation techniques) with the goal of achieving a function recovery rather than a specific pain score. Pain scores can be used to judge pain level but should not be the goal of treatment with the goal being functional recovery.
3. Neuraxial anesthesia (epidual or combine epidural/spinal) should be encouraged for pain management in laboring women with OUD in early labor or as soon as contractions are perceived to be uncomfortable.
4. Pain management among opioid-dependent women.
    a. Opioid-dependent women may experience more severe pain in the immediate postpartum period compared with women without opioid dependence due to high tolerance combined with opioid-dependent hyperalgesia (an increased sensitivity to feeling pain and an extreme response to pain.
5. Women on Medication Assisted Therapy (MAT)
    a. MAT should be continued during and after the pregnancy and the patient maintained on her baseline dosage.
    b. Some women benefit from receiving their usual daily dosage in divided doses because the half-life for analgesia is much shorter than for opioid withdrawal.
    c. Some patients, especially those on buprenorphine or methadone maintenance, may require more opioid pain medication than the opioid–naïve patient and may need analgesia with a full agonist with strong affinity for the mu receptor, such as fentanyl or hydromorphone, for 24 hours or more if oxycodone does not suffice.

B. Breast Feeding and OUD

Exposure	Effect	Recommend Breastfeeding?
Methadone/ Buprenorphine	Reduces severity of NAS in the breastfeeding infant. Unlikely to have negative effects on the infant but monitor for sedation and appropriate weight gain.	Yes
Other opioids	Monitor infant for sedation and appropriate weight gain.	Yes, but drug specific variances exist. CAUTION with codeine due to CYP2D6 ultra-rapid metabolizers.
Cannabis	Monitor for infant sedation.	Recommend minimizing or stopping

	Long term effects unknown but concern for neurocognitive development in some studies.	cannabis use during lactation.
Alcohol	Interferes with milk ejection reflex and may lead to inadequate emptying	Limit maternal exposure to 8 ounces of wine or two beers and waiting 2 hours after drinking to breastfeed.
Tobacco	Combustible/vaped tobacco and second hand smoke increases the risk of Sudden Infant Death Syndrome (SIDS). Data is unclear if nicotine replacement products also increase this risk.	Yes. Consider smoking cessation products and nicotine replacement. Recommend NRT for partners and others to avoid second hand smoke exposure.
Cocaine and methamphetamine being abused	Metabolites are excreted in breast milk. No clear data but case reports demonstrate fetal intoxication. Large doses will reduce milk supply.	Avoid breastfeeding.
Prescription amphetamines	Long-term infant effects are not well studied. Large doses will reduce milk supply.	Yes, but consider non-amphetamine alternatives.
Benzodiazepines	No long-term effects noted. Observe for sedation.	Yes, but drug specific variances exist. Ideal choices are short-acting agents with no active metabolite such as lorazepam. Avoid long-acting agents with active metabolites such as diazepam.
Naltrexone/ Naloxone	No long-term effects noted due to limited data.	Yes
HIV	Virus does excrete in breast milk.	No, per the Centers for Disease Control and American Academy of Pediatrics, in resource-rich settings such as the United States, due to adequate access to clean water and infant formula.
Hepatitis B or C	Blood-borne but does NOT excrete in breast milk.	Yes, unless cracked/bloody nipples present. In that case, wait for nipples to heal before resuming breastfeeding.

C. Discharge Planning

1. The Social Worker, in collaboration with nursing and the patient's providers, will coordinate a safe discharge plan for the Infant and Mother prior to discharge.
2. The Discharge Plan developed by the Health Care Team shall:
    a. Identify services needed by the Infant/Parent/Family and specify referrals.

b. Be developed in conjunction with all team members.

3. Primary team should offer women evidence based and patient-centric post-partum birth control options, harm reduction (needle exchange, HIV pre-exposure prophylaxis, etc), and safe disposition including to local residential treatment centers, outpatient programs, or other safe living facilities.

All revision dates: 2/9/2022

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/23/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/21/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/21/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	2/21/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/1/2005*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.19 NICU Staff Orientation and Responsibilities

POLICY

The care of the high-risk infant requires an understanding of normal physiology, disease processes and medical management of the neonate in order to give competent skilled nursing care. The neonatal critical care nurse must be able to demonstrate knowledge and skill in the following aspects of neonatal care.

PROCEDURE

A. Identify antenatal and intrapartal maternal factors predisposing to a high-risk newborn.

B. Demonstrate an understanding of assessment tools utilized to evaluate fetal maturation and well-being.

C. Demonstrate an understand of the Apgar score:

1. Must be able to correlate Apgar score with appropriate resuscitative measure.
2. Understands relationship between Apgar score, weight, gestational age and neonatal mortality and morbidity.

D. Characteristics of the newborn and be able to assess gestational age and identify normal physical characteristics.

E. Identify the high risk neonates requiring intensive care.

F. Newborn Resuscitation:

1. Must be able to demonstrate understanding of the principles of neonatal resuscitation.
2. Initiates cardiopulmonary resuscitation unless contraindicated by Unit Director or a "no-code" designation is written in the physicians order sheet as well as other required information.
3. Must demonstrate knowledge of drugs used: action, side effects, indications and dosage.
4. Nurses do not defibrillate neonatal patients.

G. Adaption to extrauterine life:

1. Demonstrate understanding of the physiologic changes, interdependent adaptive and compensatory mechanisms experienced by the newborn during fetal, transitional and neonatal periods.
2. Dynamics of and factors responsible in the limitations of the first breath of life.
3. Differentiate fetal from neonatal circulation and indicate the sites for anatomical shunting.
4. Understand changes that occur in the cardiopulmonary system at birth.

H. Understand the pathophysiology, clinical manifestations, treatment, and nursing approaches for the newborn in metabolic adaptation.

I. Demonstrate knowledge of the principles of the thermoregulation of the newborn:
   1. Mechanism of heat loss.
   2. Be able to relate neutral thermal environment to oxygen consumption, and metabolic rate.
   3. Understand consequences of heat and cold stress.
   4. Demonstrate ability to maintain neonate in neutral-thermal environment.

J. Neonatal heart rate monitoring:
   1. Understand biophysical basis on neonatal monitoring.
   2. Understand concepts of instantaneous heart rate monitoring and cardiac variability.
   3. Correlate monitored parameters with progressive changes in newborn's condition and response to treatments and nursing care.
   4. Know life threatening arrhythmias and notifies primary care physician.

K. Identify normal wave forms and values for arterial blood pressure, and central venous pressure.

L. Umbilical catheters
   1. Identify proper placement of all umbilical catheters by use of x-ray.
   2. Demonstrate knowledge in the use of umbilical catheters:
      a. Interventions to prevent complications.
      b. Equipment preparation and assistance with insertion of catheters.
      c. Safe maintenance of lines.

M. Respiratory System:
   1. Identify basic anatomical structures, physiologic and commonly encountered pathophysiologic processes of the respiratory system, pleural dynamics, lung function, ventilation, oxygenation and perfusion.
   2. Identify pertinent developmental, anatomical, and physiologic differences in premature infants, neonates, or children to adults, which alters common therapeutic interventions.
   3. Demonstrate understanding of the parameters of ventilation and oxygenation.
   4. Be able to perform systematic nursing assessments of respiratory status; interpretation of blood gas and acid-base status; inspection of respiratory patterns, auscultation of normal, abnormal and adventitious breath sounds, and nursing assessment of x-rays.
   5. Demonstrate knowledge of pathophysiology, clinical manifestations and management of the following respiratory conditions.
      a. RDS
      b. Broncho-pulmonary dysplasia
      c. Meconium aspiration
      d. Pulmonary hemorrhage
      e. Pneumothorax

6. Demonstrate knowledge of the indications for assisted ventilation of correlate ventilator settings with changes in the neonate's condition.
7. Be able to relate the use of emergency needle aspiration of the chest, the insertion of chest tubes and the maintenance of various closed chest drainage apparatus commonly encountered in patho-physiologic pulmonary dynamics.
8. Understanding of use of the transcutaneous O2 and CO2 monitors, and O2 saturation monitor.

N. Cardiovascular System

1. Understand perinatal circulatory structures and patterns in terms of the interrelationship of flows, pressures and resistance.
2. Identify the three (3) fetal shunts, describe their normal mechanisms of closure. Understand causes and clinical consequences of persisting fetal circulatory patterns.
3. Identify causes and effects of achieving or failing to achieve postnatal pulmonary vasodilation.
4. Be able to identify the most common disease entities which cause neonatal cardio-respiratory distress, congenital heart malformations, systemic conditions affecting the myomardium and non-myocardiac conditions which cause cyanosis and respiratory distress.
5. Be able to identify infants who are going into congestive heart failure and appropriate nursing intervention.

O. Drug addiction

1. Be able to recognize the clinical manifestations of drug withdrawal in the newborn infant.
2. Demonstrate understanding of the therapeutic, preventative and supportive role of the nurse in the care of the family and newborn of the drug addicted mother.
3. Demonstrate ability to use abstinence scoring sheet for neonates.
4. Assist with application and maintenance care off nasal prongs.
5. Provide maintenance care of a tracheostomy.
6. Provide chest physiotherapy.
7. Use approved suctioning procedures; be able to suction the following airways:
    a. Oropharynx.
    b. Endotracheal tube with and without use of suction adapter.
    c. Nares
    d. Tracheostomy tube.
8. Monitor oxygen concentration, airway temperatures and humidity.
    a. Hood
    b. Ventilator
9. Maintain mode of oxygen administration
    a. Bag and mask
    b. Hood
    c. Pneumogard

d. Sechrist ventilator

e. Transcutaneous PaO2, PcCo2, and O2 saturation.

10. Assist with insertion of chest tubes

a. Maintain chest tubes

b. Maintain water seal drainage system and suction and/or pleura vac chest drainage system.

P. Monitor and administer intravenous fluids.

1. Mix intravenous fluids.
2. Understand and operate IV infusion pumps
3. Start peripheral IV's according to protocol.
4. Monitor infants receiving hyperosmotic IV solutions.
5. Administer IV, medications as ordered by physician and approved for RN's to administer per policy and procedure.

Q. Draw blood for lab work from peripheral veins, heel sticks, umbilical catheters and peripheral arterial lines.

R. Draw arterial blood gases (peripheral arteries, peripheral arterial lines and umbilical catheters).

S. Prepare for and assist with exchange transfusion.

T. Document cardiac arrthmias.

U. Request diagnostic procedures, HcT, EKG, blood chemistries, blood gases, and chest x-rays without written order if a change in the patient's condition warrants these procedures.

REFERENCES

N.O.E.P. 2005

All revision dates: 1/1/2005, 6/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/17/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/16/2023
NICU	Enriqueta Coronado: Clinical Nurse Manager, NICU [MK]	2/16/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1986*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/1/2010*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.23 Chest Tube Use in the NICU

POLICY:

When a pneumothorax in the NICU occurs, immediate treatment may be required. Immediate treatment in the severely compromised infant consists of needle aspiration. Definitive treatment consists of thoracotomy and placement of a drainage tube connected to a chest drainage device. These guidelines are intended to provide safe, consistent and effective care for an infant/child who requires a chest tube (CT) to drain fluids or air (pneumothorax) from the chest cavity, re-expand a collapsed lung, or re-establish correct pressures in the thoracic cavity.

PROCEDURE:

A. Needle aspiration is accomplished for removal of air/fluid in the pleural cavity by the physician/NNP.

B. Chest tubes are placed in the pleural or mediastinal space by a physician/NNP.

C. The chest tube collection system consists of the following three chambers:

1. **Drainage collection chamber**: fluid drained from the thoracic cavity is collected and measured here.
2. **Water seal chamber**: prevents back flow of fluid or air into the thoracic cavity. The level of water in this chamber normally fluctuates with respiration. Bubbling in this chamber indicates an air leak which needs correction (unless CT was placed for pneumothorax).
3. **Suction control chamber**: determines the amount of suction to be applied to the system in centimeters of water pressure.
    a. Water level, not the setting on the suction regulator, determines the amount of suction to the chest.
    b. With **dry suction** device, the amount of suction is determined by a dial on the collection system, not the wall regulator.

EQUIPMENT

Equipment for Chest Tube Insertion

- Argyle chest tube #8 ,10, 12
- Chest tube tray
- Sterile towels
- Betadine

- Kelly clamp
- Gloves
- Thoracic or regular suction gauge
- Underwater drainage system kit (PLEUR-EVAC®)
- Sterile H_20
- Tape
- Suture
- Toomey syringe
- Polysporin ointment, sterile 2x2
- Tegaderm/transparent dressing
- ½ % Xylocaine
- Morphine/Fentanyl on hand

Equipment for Needle Aspiration

- 23 or 25 gauge butterfly, or
- 14-16 gauge angio catheter
- Gloves
- Three-way stopcock
- 10-20 ml syringe
- Betadine/alcohol
- Sterile H_20

PROCEDURE

A. The transilluminator is often used for diagnosis. CXR is done prior to insertion of chest tube whenever possible.

B. Insertion of a chest tube and/or needle aspiration is an invasive procedure that requires sterile technique. Insertion of chest tubes is performed by the physician/ NNP.

C. RN should position infant so that side with pneumothorax is at an upright angle or flat with head of bed (HOB) elevated, and with restrained extremities. For older children, the seated position with arms folded on a bedside table and the head resting on the arms may be preferred. Infants should have an HR/apnea monitor in use with an audible QRS and pulse oximeter should be on and functioning while procedure is performed. Also a BP cuff should be in place in order to check BP readings.

D. Prepare parents for procedure, as appropriate.

E. Assure informed consent is documented by physician and placed in chart.

F. Obtain signed consent for the procedure.

G. Utilize Time Out Procedure (see Administrative policy 100.062).

H. The drainage system (PLEUR-EVAC®) should be set up according to package insert instructions:

1. Fill Water Seal Chamber through short suction tube to the "FILL TO HERE" line on the water seal pressure scale (approximately 70 ml). This is the 2 cm water level.
    a. A funnel is provided to facilitate filling. To fill, attach the funnel to the connector of the suction tubing, hold the funnel so that it is below the level of the top of the PLEUR-EVAC and the suction tubing is crimped.
    b. Fill with sterile water or saline to fill line.

c. Then raise the funnel above the PLEUR-EVAC and release the crimp in the tubing; water will enter the water seal chamber to the level of the dotted line.

d. Once filled, the water seal will turn blue.

2. The end of tubing from the collection chamber should be connected to a universal adapter and remain sterile. It will be connected to the chest tube as soon as inserted.

3. Connect the short suction tubing to suction source.

4. Fill Suction Control Chamber—remove atmospheric vent cover (muffler) and fill through atmospheric vent to 20cm level or as prescribed. Once filled, water in the suction control chamber will turn blue. Replace atmospheric vent cover (muffler) after filling. The muffler, when in place, allows air to enter suction control chamber. It reduces evaporation in the suction control chamber and dampens the noise of bubbling.

5. Turn on Suction and increase until the gentle bubbling appears in the suction control chamber. The height of the water in the suction control chamber determines the approximate amount of suction imposed *regardless* of the degree of bubbling. Gentle bubbling is all that is needed.

6. For Water Seal Drainage Only—Disconnect system from suction source and leave open. Do not clamp off.

7. When dry suction is being utilized, check the dial to ensure that appropriate suction is set and the orange ball is visible in the clear window.

I. **Maintaining patency of the system**:

1. The tubing should be positioned so there are not dependent loops where drainage would have to flow up against gravity. The tubing should also be stabilized and secured to promote function, comfort and prevent accidental removal. Connections should be taped.

2. Check tubing for twisting or kinking every two (2) hours.

3. Any drainage should be marked in the white area of the collection chamber and amount should be documented under the 'output" section on the Nursing Flow Sheet.

a. If drainage is present in chest tube and tubing, gently pinch or tap—DO NOT "strip" or "milk" chest tubes (negative pressure generated by stripping the tube may damage the lung).

b. Tenacious clots may be broken up by pinching tubing at clot site.

4. The dressing (use a clear transparent type) should be airtight: therefore routine dressing changes are not recommended. The site should be evaluated for signs of infection. Dressing should be changed if infection is suspected, or if the dressing becomes wet and drainage occurs. Remove old dressing carefully to prevent dislodgement of chest tube. Label dressing with the date and time it was placed on the infant.

5. Keep Kelly clamp or Toomey syringe at beside at all times while chest tube is in place.

6. Clamping has been proven to be of minimal clinical value; therefore, if it is necessary to transport an infant with a chest tube, the chest tube may be placed to water seal. The one justification for clamping a chest tube is to simulate tube removal to determine patient tolerance.

7. Following the insertion of a chest tube, a CXR, blood gas and vital signs should be obtained (per physician/NNP). Breath sounds should be evaluation prior to and following the procedure. After insertion, the infant should have HOB increased to 30-45° to assist in draining of air.

J. **Assessment of the Chest Tube set-up:**

1. Check H_2O level at beginning of shift and with each documentation of output.
2. Keep the suction control chamber at level ordered by physician/NNP.
3. If water seal level is above 2cm the negative pressure is too high and may cause tissue damage. The tube should be vented.
    a. To vent the tube, thus lowering the amount of negative pressure, scrub a small area of the rubber drainage tubing with alcohol swab for 30 seconds and insert small bore needle (25g or 23 g). When the H_2O level in the water seal chamber returns to the proper level (this takes a few seconds), remove the needle (the tubing is self-sealing). Ensure the patient is on suction during the procedure.
    b. Use negative pressure release button to relieve negative pressure.
4. Check for air leaks in the system. If an air leak is suspected, the following steps should be initiated:
    a. Interrupt suction and look for bubbling in the water seal chamber—may indicate patient air leak.
    b. If bubbling is present and not treating a pneumothorax, the following steps should be initiated:
    *Check all connections to make sure they are tight.
    *Clamp the tubing using the toothless clamp. Begin clamping closest to the patient and work towards the drainage system, moving the clamp away from the patient until the leak is found. It is important to clamp proximally and distally to the drainage system connection to determine site of air leak.
    c. If the chest tube or tubing is not leaking, change the drainage system.

K. **Changing the Drainage Collection System**:
1. Prepare a replacement drainage system (see instructions on packaging).
2. Clamp the chest tube close to the patient. When on positive pressure ventilation it is not necessary to clamp, just disconnect and reconnect quickly.
    a. Aseptic technique is used. Clean end of chest tube with betadine prior to attaching new chest tube connection.
    b. Maintain sterility of chest tube connection.
    c. *If child—instruct to exhale and hold his/her breath. Allows for maximum positive pressure in pleural space.
3. Remove the old drainage system and attach the new one. Remove chest tube clamp.
4. Attach to suction as ordered.

L. **Specimen Collection:**
1. Possible sites are rubber ports in collection chamber of drainage system or drainage tubing.
2. To obtain specimen from rubber port--clean port with alcohol swab, insert needle attached to syringe, and withdraw specimen.
3. To obtain specimen from drainage tubing—form dependent loop to collect fluid, clean tubing with alcohol swab, insert needle attached to syringe, and withdrawn.

M. **Removal of Chest Tube**:
1. Obtain order for pre-medication to prevent pain associated with procedure.
2. Follow Pain Policy P.1.0 for monitoring guidelines.

3. After chest tube removal, place occlusive (petroleum) dressing (as ordered by physician/NNP) over site and tape securely.
4. Dressing is checked for signs of drainage/infection.

N. **Documentation (upon insertion and every shift):**

1. Location/size of the chest tube and amount of suction in cm of water.
2. Amount and characteristics of drainage.
3. Appearance of insertion site and dressing changes
4. Assessment findings.
5. Pain Management (tool, score, adequate management)
6. Interventions and patient response.

REFERENCES:

Bowden, V. & Greenberg Smith, C. Pediatric Nursing Procedures, J.B. Lippincott Co., Philadelphia, 2003.

Carlsm, K., Lyna-McHale, D. (Eds.) AACN Procedure Manual for Critical Care 4th Ed.
W.B. Saunders, Philadelphia, 2001.

Genzyme Corporation. PLEUR-EVAC® Infant Single Use Chest Drainage Unit Package Instructions, Fall River, MA, 2004.

Levin, D.L., & Morris, F.D. (Eds). Essentials of Pediatric Intensive Care, St. Louis, Quality Medical Publishing, Inc., 1990.

National Association of Neonatal Nurses—Neonatal Nursing Policies and Procedures, 1999.

Walsh-Sukys, M., & Krug, S. Procedures in Infants and Children, WB Saunders, Philadelphia, 1997.

All revision dates: 2/1/2010, 4/1/2008, 11/1/2004, 1/1/2002, 4/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/1/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/1/2023
NICU	Enriqueta Coronado: Clinical Nurse Manager, NICU [MK]	2/1/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/14/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.25 Defibrillator Use and Cardioversion in the NICU

POLICY:

To describe nursing activities involved with the use of the defibrillator in neonates.

~~PROCEDURE:~~

CONSIDERATIONS:

A. The use of the defibrillator in neonates requires the presence of the NNP/physician.

B. A skilled RN must be available for assisting when the defibrillator is used.

C. Competency regarding the defibrillator will be assessed on a regular basis.

D. The defibrillator will be included in the Crash Cart check.

E. The defibrillator is not considered an emergency application in neonates, as the most common conditions requiring its use are tachyarrhythmias. The RN is responsible for identifying the dysrhythmias and for notifying the physician/NNP promptly. ~~Physiologic methods such as vagal stimulation and thermal stimulation are attempted first followed by use of medication.~~

1. probable SVT: vague and nonspecific compatible history, absent or abnormal P waves, unvarying heart rate greater than 220 bpm at rest
2. possible ventricular tachycardia with a pulse: wide-complex tachycardia (more than 0.08 s)

F. Physiologic methods such as vagal stimulation (e.g. stimulate a gag or suction the nasopharynx) or thermal stimulation (apply ice pack to nose and forehead area) are attempted first followed by use of medication (adenosine).

EQUIPMENT

A. Defibrillator

B. Neonatal Pads

C. or Neonatal paddles

D. Monitor leads (~~2~~3)

E. Conduction gel

PROCEDURE

~~A. Keep the defibrillator plugged into the wall outlet at all times. Check the defibrillator for battery charged status. Press the ON button to activate the monitor.~~

~~B. At the request of the physician/NNP, apply the defibrillator leads to the neonate's chest in the left and right axillary areas and over the lower abdomen. When the defibrillator monitor is accurately displaying the ECG waveform, remove the patient monitor lead wires and cable from the patient's bed.~~

~~C. Remove the paddles from the holder by pulling up and out. Attach the neonatal paddles by sliding them over the clean/dry adult paddles. Check for a secure, snug fit. Apply defibrillation gel to the neonatal paddle electrodes.~~

~~D. Set the Joules to the dose ordered by the physician/NNP, usually 0.5 to 1 joule per kilogram.~~

~~E. Press the SYNC mode button and check for SYNC recognition of the ECG.~~

~~F. Turn off and unplug the isolette or radiant warmer. Ensure that all electrical cords or monitor wires are removed from the bed. IV tubing, ventilator tubing and chest tubes will not be affected by the shock.~~

~~G. Medicate the neonate for pain as ordered.~~

~~H. Keep clear of the neonatal bed during the cardioversion.~~

~~I. Plug in and turn on the isolette or radiant warmer.~~

~~J. Check for cardiac rhythm and rate.~~

A. Prepare Patient

1. With 12-lead ECG verify SVT
2. Place infant in the supine position with chest bared
3. Maintain infant on cardiorespiratory monitor with printout capability before, during and immediately after procedure

B. Medicate the neonate for pain as ordered.

C. Prepare equipment for synchronized cardioversion.
Unplug crash-cart and bring to room and bedside.
** The defibrillator is battery operated and does not need to be plugged-in to use.

D. At the request of the physician/NNP, apply the defibrillator leads to the neonate's chest in the left and right axillary areas and over the lower abdomen. When the defibrillator monitor is accurately displaying the ECG waveform, remove the patient monitor lead wires and cable from the patient's bed.

E. Turn off and unplug the incubator or radiant warmer. Ensure that all electrical cords or monitor wires are removed from the bed. IV tubing, ventilator tubing and chest tubes will not be affected by the shock.

1. If using hands-free defibrillation (recommended):
   a. Ensure OneStep™ cable is connected to OneStep™ CPR Complete pads.
   b. Remove OneStep™ cable BLACK connector from the back of the defibrillator and connect ZOLL 3-lead cable to the defibrillator.
   c. Place cardiac lead patches on patient.
   d. Connect ZOLL 3-lead cable to the patient.

e. Open OneStep™ Pediatric CPR pads from sealed envelope.

f. Connect OneStep™ Pediatric CPR pads to the patient.

g. Position OneStep™ Pediatric CPR anterior pad on the patients lower left-anterior chest with the CPR feedback device placed on the sternum. Place posterior pad on the patient's back per ZOLL recommendations.

h. Connect patient to defibrillator.

2. If using paddles:

a. Remove OneStep™ cable BLACK connector from the back of the defibrillator and connect ZOLL 3-lead cable to the defibrillator.

b. Place cardiac lead patches to the ends of the red, black and white leads of the ZOLL 3-lead cable.

c. Connect ZOLL 3-lead cable now attached to the defibrillator to the patient.

d. Connect OneStep™ cable to the paddles.

e. For neonatal patients, remove the adult conduction plates from paddles revealing underlying pediatric conduction plates.

f. Place one disposable conductive pad over sternum and one in left-lateral chest position. Conductive gel may be used if pads are unavailable.

g. Remove paddles from the defibrillator and place the paddles over sternal pad and left lateral chest pad, press firmly.

F. Turn switch to DEFIB.

G. Press the "Sync On/Off" soft key on the screen and observe white arrows synchronizing with the R-waves.

H. Adjust the ENERGY SELECT on the paddles or defibrillator to joule delivery desired. Neonatal Synchronized Cardioversion J/kg, 1-2 J/kg

I. Press CHARGE button on the paddles or defibrillator and allow defibrillator to charge fully.

1. Verbally and loudly notify all personnel to stand clear

J. Push *SHOCK* on the paddles or defibrillator and allow defibrillator to charge fully. ** Do not touch bed, patient, or any equipment attached to patient during synchronized cardioversion.

K. Check cardiac rhythm, check pulse, initiate CPR if necessary.

L. If repeat synchronized cardioversion is required, resync the defibrillator before attempting the synchronized cardioversion.

M. After use, return to storage place and plug in to maintain battery charge.

N. Plug in and turn on the incubator or radiant warmer.

O. Assess and support airway, oxygenation, and ventilation.

P. Assess and maintain adequate blood pressure and perfusion.

Q. Continue to monitor cardiac rhythm and rate.

DOCUMENTATION

A. Nursing notes – time, dose, staff involved, patient's response. Include printouts of abnormal rhythms, associated clinical signs, interventions, and follow-up rhythm.

B. MAR – pain medication.

REFERENCES:

~~AWHONN: NOEP 3rd edition, 2015.~~

Sundquist Beauman, S. & Bowles, S. (2019). Policies, Procedures, and Competencies for Neonatal Nursing Care. 6th ed. National Association of Neonatal Nurses.

All revision dates: 3/14/2023, 7/1/2015, 8/1/2004, 1/1/2002, 12/1/2001

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/16/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/14/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/28/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.28 NICU Discharge Planning

POLICY:

To ensure careful and complete discharge planning for patients in the NICU. Discharge planning utilizes a continuous multidisciplinary approach and systematic process which ensures patient outcome in a timely, supportive and cost effective manner.

PROCEDURE:

Discharge planning of NICU patients includes the following components:

A. Expected length of stay shall be predicted when possible and discussed with the parents.

B. A multidisciplinary team composed of the clinical care coordinator, discharge planning coordinator, neonatologist, medical social worker, dietician, respiratory care therapist, developmental physical therapist, and other support staff, shall assess patient and parental readiness for home care.

C. All appropriate neonatal screening examinations shall be completed and their results discussed with parents. Immunizations shall be initiated when appropriate.

D. Follow-up appointments with the pediatrician, specialists and community resources shall be made.

E. A multidisciplinary pre-discharge conference shall be conducted weekly and when necessary to review the infant's clinical course in the hospital and to provide the opportunity for parental questions.

F. For complicated cases, when at all possible, the parents/primary caretaker shall be encouraged to spend one or two nights rooming in within the hospital so that they can become acquainted with providing 24-hour care to their infant within a safe and supportive environment. ~~The parent room will be reserved the week prior to discharge (see *Visiting* policy).~~

G. A written discharge summary shall be sent to the infant's community physician. This will be noted in the Discharge Summary. If the family has not identified a Primary Care Provider, a physician will be assigned within the VCMC clinic system.

   Written home care instructions shall be provided to parents on the Discharge Instruction Form. Discharge materials and information will be culturally and linguistically appropriate and can be provided in various formats:

   1. Written Materials
   2. Video

3. Demonstration/return demonstration

H. A home health agency referral shall be made when indicated, based on parent and/or infant needs. Referrals to community agencies and services shall be made when indicated. This includes:

   a. Public Health Nurse

   b. Home Health Agency

   c. Tri Counties Regional Center

   d. Durable Medical Equipment Vendor

   e. High Risk Infant Follow-Up Program

I. Clinical Nurse Specialist (CNS)/~~NIC~~NICU Discharge Planner ensures the implementation of a coordinated and effective discharge planning program.

GUIDELINES

A. Discharge Planning care coordinator is a staff nurse (with BSN) responsible for coordinating care of the patient from admission through discharge utilizing a multidisciplinary approach, answering concerns, providing for patient-family involvement, and monitoring appropriate use of patient care resources.

B. Assignment priority for each patient will be given to ~~resource nurse/HNS II's. This provides the best~~ensure continuity of care ~~because coordination of each case is~~ from admission through discharge.

C. In addition to daily patient care rounds by the Neonatologist and medical and nursing team, weekly multidisciplinary care and discharge planning rounds shall be held with the entire NICU team to discuss plans and progress for each infant in the NICU. The ~~Children's Services~~ Discharge Planner, Neonatologists and NNPs will make referrals for follow-up appointments weekly. Documentation will occur on the multi-disciplinary planning worksheet (attached).

D. Time frames for discharge planning and teaching include:

   1. Simple discharge: plan documented and majority of teaching completed at least 48 hours prior to discharge. Simple discharges include infants with well-child care needs, oral medications, incision care. Infant may or may not have been home prior to hospitalization in NICU.

   2. Moderately complex discharge: plan documented and majority of teaching completed at least 1 week prior to discharge. Moderately complex discharges include infants requiring home apnea monitoring, in home oxygen, aerosol
   treatments, medications, external feeding tube care, special formulas, stoma care, trach care, non-English speaking caretakers, PICC lines and infants that have never been home.

   3. Complex discharge: plan documented and majority of teaching completed at least 1 to 2 weeks prior to discharge. Complex discharges include infants requiring home ventilation.

   4. The plan of care for infants in the NICU frequently requires modification, therefore an adequate time frame for teaching allows for changes to be incorporated into the plan.

   5. Optimally, no new teaching should be done on the day of discharge.

   6. Documented information regarding mandatory law on car seats should be given to all parents.

   7. Hearing screen results on chart prior to discharge.

   8. The following list includes some examples of infants that should be referred to the discharge planner assigned to NICU:

a. Those requiring other methods of feeding, such as PEG or gavage feeding.
b. Those being discharged on oxygen or with a home apnea monitor.
c. Those requiring DME or home health supplies (i.e., ostomy supplies).
d. Those requiring special formula.
e. Those being discharged to hospice or requiring home health nursing services.
f. Those being discharged to a caregiver other than the parents (i.e., foster care) or being discharged to an extended care facility.

~~DISCHARGE PLANNING DOCUMENTATION~~

DISCHARGE PLANNING DOCUMENTATION

A. Documentation should include:
   1. Plan of care utilizing multidisciplinary approach.
   2. Family involvement with planning care.
   3. Outcome achievement and evaluation.
   4. Discharge planning and teaching.
   5. Parental response to discharge planning and teaching.

B. Time frames for documentation include:
   1. Note by care coordinator within 24 hours of signing on the case.
   2. Weekly documentation by care coordinator or associate team member.
   3. Post-conference notes must be written by nurse attending the conference within 24 hours. The note should include a specific plan of care with measurable outcomes for each problem discussed by team.

~~DISCHARGE STUDIES AND CRITERIA FOR TESTING~~

DISCHARGE STUDIES AND CRITERIA FOR TESTING

A. Discharge Studies:

   All infants treated in the NICU will require some or all of the following studies prior to discharge:
   1. Developmental assessment (OT/PT evaluation) per criteria.
   2. Ophthalmology assessment (per criteria).
   3. Hearing assessment (all babies).
   4. Newborn (PKU) screen (all babies).
   5. Car seat evaluation ~~if less than 37 weeks gestation at birth~~(per criteria).

B. Development assessment:
   1. The Neonatal Assessment Behavioral Assessment Scale (Brazelton) is an examination that is

intended as a **behavioral** rather than neurological examination. It is performed by physical and occupational therapists trained in this assessment.

2. The examination allows evaluation of the infant's ability to interact with external stimuli and is also a gauge of how quickly the infant will become irritable or will quiet with intervention. The examination does not, as yet, have value as a predictor of future behavior. It is useful as an educational tool for parents and suggests ways for effective interaction.
3. All infants who have been critically ill or have neurological impairment shall have a developmental examination prior to discharge. This will aid in determining appropriate referrals and to educate the parents regarding their baby.
4. OT/PT evaluation can be performed on an infant up to three months corrected age. Beyond this age, a Bailey Developmental Exam is performed.

C. Ophthalmology:

1. An **ophthalmologic assessment**, performed by a CCS-approved ophthalmologist with experience and expertise in the retinal examination of the preterm infant. The assessments are to be done in accordance with the American Academy of Pediatrics policy statement, "*Screening Examination of ~~Preterm~~Premature Infants for Retinopathy of Prematurity*," *Pediatrics*, Vol ~~117~~142: Number ~~2~~6, ~~February 2006~~December 2018, ~~P.572-576,~~ and until the ophthalmologist determines the child is no longer at risk for developing retinopathy of prematurity.
2. Criteria for testing:
   a. Infants with a birth weight if <1500gm

      ~~S/P ECMO~~
   b. Gestational age <30 weeks
   c. ~~Any infant at high risk, per neonatologist's order~~Any infant at high risk, per neonatologist's order (ie infants with hypotension requiring inotropic support, infants who received oxygen therapy for more than a few days, or infants who received oxygen without saturation monitoring)

D. Hearing Assessment: All NICU infants shall have a hearing screen examination just prior to discharge and follow-up recommendations provided (see ~~*Newborn Hearing Screen*~~ policy *NOBP.13 Newborn Hearing Screen*). Factors which place infants **at risk** for hearing impairment include:

1. Family history of childhood hearing impairment.
2. Congenital perinatal infections (e.g. cytomegalovirus, rubella, herpes, toxoplasmosis, syphilis).
3. Anatomic malformations involving the head or neck.
4. Birth weight less than 1500 grams.
5. Hyperbilirubinemia at levels ~~exceeding~~nearing indications for exchange transfusion.
6. Bacterial meningitis.
7. Severe asphyxia, which may include infants with Apgar Scores of 0 to 3.
8. Infants treated with aminoglycosides and/or lasix.

~~Pneumogram:~~

~~A pneumogram is a magnetic tape recording of respiratory and/or cardiac rates usually collected over a 12-24 hour period. This study can provide useful clinical information regarding an infant's respiratory and/or cardiac pattern over a given period of time. However, it is limited in its predictive ability. A negative (i.e.~~

~~normal) evaluation does not always predict a low-risk situation. The infant's clinical history and current behavior must be considered in determining the need for home monitoring. Infants with an abnormal pneumogram require home monitoring. However, certain clinical diagnoses regardless of the pneumogram results may require home monitoring, based on the neonatologist's assessments.~~

E. Hospice Care:

Hospice Care is an alternative to the acute hospital setting, available to parents of a dying infant and can be provided in the parents' home or in foster care. Aid is provided the family regarding infant care, comfort measure, and pain management. Emotional, psychological, and spiritual services are also offered the family of the dying infant. These infants will be referred to the discharge planner or social services to initiate referral.

~~REFERENCES:~~

~~AWHONN: NOEP 3rd edition, 2015~~

REFERENCES:

AWHONN: NOEP 3rd edition, 2015

American Academy of Pediatrics, December 2018. Screening Examination of Premature Infants for Retinopathy of Prematurity. *Pediatrics,*142 (6): e20183061. 10.1542/peds.2018-3061. Screening Examination of Premature Infants for Retinopathy of Prematurity | Pediatrics | American Academy of Pediatrics (aap.org)

All revision dates: 3/28/2023, 7/1/2015, 2/1/2010, 4/1/2007, 4/1/2006

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/15/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/14/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*4/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/1/2010*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.30 Medical Social Workers in the NICU

POLICY:

NICU social work services are provided by the assigned medical social worker, who holds a master's degree in social work (MSW) and is CCS-paneled. The social worker applies knowledge and expertise in assessing the psychosocial issues affecting families of seriously ill infants.

PROCEDURE:

Social work services are rendered within the first 48 hours of a patient's admission whenever possible (according to a patient's/family's ability to engage in services) and include but are not limited to:

A. The ability and freedom to case find.

B. The application of social work interventions during the inpatient hospital stay.

C. The inclusion of social work assessments in the patient's medical records.

The ratio for MSW coverage for community NICU does not exceed 1:15. In the event that the NICU census exceeds 15 patients, a second MSW will assist. The community NICU MSW works within the parameters of the written job description for Medical Social Worker II Hospital Services.

GUIDELINES:

Under general direction of Medical Social Services Supervisor, the MSW provides medical social work service in a multicultural environment through the use of individual, family or group therapy, case management, interagency collaboration, and community organization, and performs related work as required, including the following:

A. Evaluates social, physical and mental functioning of patients through bedside patient interviews, record reviews and/or consultation with applicable service agencies, family and friends.

B. Determines extent of patients' needs, coordinates specific tangible social services available, develops treatment and discharge plans and follows through with case management of services, which are appropriate to the situation.

C. Interprets diagnoses and prognoses to patients and their families to insure best adjustment to hospitalization and/or medical condition.

D. Counsels patients and their families on rehabilitation, placement and employment programs.

E. Makes arrangements for recipients' hospital discharge and follow-up care.

F. Investigates nursing homes and other placement options and arranges patient placement.

G. Performs assessments, individual therapy, and psychosocial case management for patients and their families in collaboration with other members of the treatment team.

H. Documents patient assessments, interventions and discharge planning.

I. Participates in treatment and discharge rounds as needed.

J. Coordinates community support services with the treatment and discharge plan.

K. Collaborates with community health, education, social services, juvenile or criminal justice agencies, or other services to assist the client and/or family member.

L. Available to the High Risk Infant Follow-up Clinic during scheduled patient visits.

M. May have other duties as assigned.

All revision dates: 1/1/2010

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/10/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/10/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/10/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/1998*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/14/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.33 Insulin Administration in the NICU

POLICY:

To describe NICU nursing considerations in administering insulin to infants. Insulin is used to reduce hyperglycemia in infants with persistent glucose intolerance. Insulin may also used to treat hyperkalemia.

PROCEDURE:

The NICU RN will administer insulin per medical order. Calculations and dose must be double-checked by a second staff person.

EQUIPMENT

A. Insulin – regular only

B. Syringe, extension tubing

C. Syringe pump

PROCEDURE

A. Check medical order for dose in units per kg per hour.

B. Check compatibility with other fluids or medications currently infusing.

C. ~~Mix~~Prime tubing with ~~normal saline. Purge tubing with~~ 10 ml over ~~5~~20 minutes ~~or 2 ml over 20 minutes~~ to saturate plastic binding sites. Infuse at prescribed rate.

D. Check blood glucose every 15 to 30 minutes after starting infusion and after any rate change until stable. Check blood glucose per medical order when stable glucose level achieved.

E. Monitor potassium concentrations closely when treating hyperkalemia.

DOCUMENTATION

A. MAR – dose, time and route, signature.

B. Nursing notes – patient tolerance, complications.

C. Nursing flowsheet – blood glucose values.

REFERENCES:

~~AWHONN: NOEP 3rd edition, 2015~~

Fuloria, M., Friedberg, M. A., DuRant, R. H., & Aschner, J. L. (1998). Effect of flow rate and insulin priming on the recovery of insulin from microbore infusion tubing. *Pediatrics*, *102*(6), 1401–1406. https://doi.org/10.1542/peds.102.6.1401

All revision dates: 3/14/2023, 7/1/2015, 2/1/2010, 12/1/2001, 7/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/16/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/14/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1982*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/14/2023*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.41 Orientation and Training of the NICU RN

POLICY:

All NICU Registered Nurses (RN's) undergo hospital and Nursing Orientation through the Ventura County Medical Center Education Services. NICU orientation is accomplished under the immediate supervision of the Clinical Nurse Manager and designated clinical preceptors. The orientation includes basic concepts in neonatal critical care, common neonatal pathology, and skills necessary in the care of critically ill newborns.

PROCEDURE:

All RN's assigned to the NICU will be trained in the care of the critically ill newborn. Upon completion of this training, the RN demonstrates competence in the following:

1. Recognition, interpretation, and reporting signs and symptoms of patients, particularly those signs and symptoms that require notification and/or intervention of the physician.
2. Initiation of cardio-pulmonary resuscitation.
3. Parenteral administration of electrolytes, fluids, blood and blood components, and medications.
4. Effective and safe use of electrical and electronic life support, and other equipment in the unit.
5. Prevention of contamination and transfer of infection.
6. Recognition of and attention to the psychological and social needs of patients and their families.
7. Included in the basic orientation for all registered nurses is a basic orientation to the care of the ventilator patient.

A. Skill ~~checklist~~checklists will be completed by the orientee prior to regular assignment in the NICU. The orientee has the responsibility to complete and seek out needed skills.

B. At least annually, all NICU ~~RN's~~nurses will be assessed for clinical competence.

C. Neonatal Resuscitation ~~Certification~~Program (NRP) certification as well as ~~BCLS~~BLS must remain valid.

D. Refer to Orientation and Skills checklists.

All revision dates: 3/14/2023, 6/1/2013, 3/1/2010, 12/1/2004, 9/1/1992, 1/1/1992, 1/1/1991, 11/1/1990, 11/1/1989, 11/1/1988

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/15/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/14/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1982*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/1/2015*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.42 Philosophy, Functions and Goals of the NICU

POLICY:

The Ventura County Medical Center NICU nursing staff believe in providing the type of therapeutic milieu that will allow for optimal care of the neonate and family. This care may be preventative, curative, supportive, rehabilitative, restorative or palliative. It will be comprehensive in nature and will include provisions for life threatening situations.

We believe that every infant and family has the right to receive this type of health care. To ensure that this is accomplished, each patient's and family's needs will be individually assessed, a plan of care developed and implemented, and the effectiveness of care evaluated.

We believe that this approach involves other medical departments and staff. These departments will be kept appraised of patients' needs and plans of care and the plans of care will reflect this holistic approach.

PROCEDURE:

Functions of the NICU:

1. In order to understand deviations from normal there must be understanding of normal growth and development of the fetus, the birth process and hemodynamic postnatal changes.
2. The staff will provide the highest level of care to patients and families and will be specially trained in the care of neonates, both critically ill and healthy newborns.
3. State of the art equipment will be utilized and maintained.
4. Transport services will be provided for neonates in the area whenever possible.
5. Individualized patient care plans will be utilized in order to meet changing needs of patient and family.
6. Family interaction will be promoted by involvement of the parents or surrogate in the infant's care at the earliest possible moment.
7. The family will be supported by counseling and referral.
8. The family will be educated regarding the physical condition of the infant, possible sequelae, emergency procedures and developmental follow-up.

NICU Goals:

1. Early identification of developmental delay or neurological impairment.
2. Appropriate home programming and parent education to prevent or ameliorate minimal problems.
3. Referral to appropriate community agencies in consultation with primary physician as indicated.
4. Data collection to assist neonatologists at Ventura County Medical Center in monitoring clinical outcomes and program evaluations.
5. Assist parents in the transition from hospital to home care of their infants.

REFERENCES:

AWHONN: NOEP, 3rd edition, 2015

All revision dates: 7/1/2015, 5/1/2004, 6/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/6/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/5/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/5/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/25/2014*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/25/2014*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.43 Guidelines for Quilts, Hats and Clothing Brought to the NICU

POLICY:

To state the requirements for quilts, hats and infant clothing brought to the Ventura County Medical Center Neonatal Intensive Care Unit (NICU).

PROCEDURE:

All quilts, hats and infant clothing brought in to the NICU from outside will have fire-retardant treatment/labels prior to use. These items will be laundered by the hospital services and returned to the NICU in covered carts.

All revision dates: 2/25/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/14/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/14/2023
NICU	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	3/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/2014*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/1/2014*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*NICU*
References:	

N.54 Neonatal Whole Body Cooling

POLICY:

To describe the nursing responsibilities in the care of the newborn requiring whole body cooling.
Neonatal hypoxic ischemic encephalopathy (HIE) is a major cause of death and neurodevelopmental disability in term infants. The patient care guideline has been developed to define therapeutic hypothermia by whole body cooling to 33.5° - 34.5° C (92.3° F – 94.1° F) for 72 hours with the Blanketrol III for patients in the Neonatal Intensive Care Unit (NICU). Therapeutic hypothermia safely and carefully lowers the infant's body temperature by whole body cooling, the metabolic processes slow down, thereby decreasing the severity and extent of brain injury. Studies have shown that when therapeutic hypothermia is initiated within 6 hours of birth, the incidence of death or severe disability is reduced. This procedure outlines the care of infants ≥ 36 weeks who meet the criteria for therapeutic hypothermia with Moderate to Severe Hypoxic Ischemic Encephalopathy (HIE).

It is the policy of Ventura County Medical Center to ensure that all infants ≥36 weeks gestation admitted to the NICU with an admitting diagnosis of neonatal depression, acute perinatal asphyxia or encephalopathy will be evaluated for the potential treatment of total body cooling.

PROCEDURE:

Determination of eligibility for whole body cooling must be met by both physiologic and neurologic criteria:

(Clinical and Biochemical)

Eligibility criteria to be considered for cooling:

Must fulfill all three criteria

I.	Infants ≥ 36 weeks gestational age ≤ 6 hours after birth at initiation of cooling. >1800 gms Infants must meet both physiologic and neurologic criteria. See attached Body Cooling Algorithm.
II.	Physiologic criteria (Blood gas is defined as (A) a cord gas, or (B) any blood gas within the first hour of life.) 1. Blood gas pH <7 or base deficit of >16, then proceed to neurologic criteria.

	2. No blood gas **or** blood gas pH 7-7.15 or base deficit of 10-15.9 with an acute perinatal event (abruption placenta, cord prolapse, severe FHR abnormality: variable or late decels), **plus** either a or b. then proceed to neurologic criteria. a. A 10 minute apgar less than 5. b. A continued need for ventilation initiated at birth and continued for at least 10 minutes.	
III.	Neurologic Criteria 1. The presence of seizures is automatic inclusion. 2. Physical exam consistent with moderate to severe encephalopathy in 3 of the 6 categories.	
Neuro Exam	**Moderate Encephalopathy**	**Severe Encephalopathy**
1. Level of Consciousness	Lethargic	Stupor or Coma
2. Spontaneous activity	Decreased activity	No Activity
3. Posture	Distal Flexion	Decerebrate
4. Tone	Hypotonic (focal, general)	Flaccid
5. Primitive reflexes • Suck • Moro	 Weak Incomplete	 Absent Absent
6. Autonomic System: • Pupils • Heart Rate • Respiration	 Constricted Bradycardia Periodic breathing	 Dilated, nonreactive Variable Apnea

A. **Procedure – Transport**

Upon the Transport team's arrival at referring facility, evaluate baby for signs of encephalopathy and the stated inclusion/exclusion criteria. The eligible infants must have at least moderate encephalopathy for cooling measures to be initiated.

Equipment

Rectal temperature probe – (9 fr)
Passive Cooling – to be started at referring hospital

1. Turn off radiant warmer or transport isolette heater or turn down to lowest setting *apply servo probe set to 34°

2. Lubricate and insert rectal temperature probe to 5 cm depth and secure with duoderm/tegaderm combo to buttocks or thigh
3. In the absence of esophageal or rectal probe during transport, rectal temp should be checked every 15 minutes.
4. Infants can cool very rapidly on transport – strict attention should be paid to monitoring core temperature (target core temperature 33.5° C/92.3° F)
   ►Safety Point: Cooled babies have depressed metabolism, so they generate less heat. If baby has never been warmed, they are easily overcooled
5. Once core temperature falls to 34° C (93.2° F) have external heat source available
6. If core temp falls <33° C (<91.4° F) turn on heat source to lowest settings
   a. Slowly adjust heat source as needed to achieve target temperature
   b. Continue close monitoring to prevent rapid rewarming
7. If core temp rises >34° C (>93.2° F), open isolette portholes
8. Record time of commencement of passive cooling and record temperature every 15 minutes

Vascular Access

1. Cooling causes peripheral vasoconstriction, therefore, vascular access should be established early
   a. Umbilical catheters (UAC and UVC) – preferable
   b. Peripheral access – avoid scalp IV (EEG leads will need to be placed)

Sedation

1. Maintain adequate sedation. Do NOT let patient shiver.

Monitoring

1. Obtain baseline vital signs and temperature.
2. All clinical decisions will be made using esophageal temperature. Skin temperature is used as continuous back-up monitoring in case of esophageal probe failure.
3. Document skin temp readings every 15 minutes-record the initiation time of both passive and active cooling.
   If goal core temperature of 33.5° C is met during the transport phase, be sure to note the time as this marks the beginning of the 72 hour cooling period.
4. Lab
   a. ABG (Patient temperature at time of draw should be entered into analyzer)
   b. Blood cultures
   c. Lactate (if available)
   d. CBC with Differential
   e. PT/PTT/Fibrinogen/D.Dimer
   f. Blood Glucose

B. **Exclusion Criteria for Cooling:**

- <36 weeks gestation age
- BW <1800gms

- Severe PPHN (at discretion of Attending Physician)
- Severe hemodynamic compromise / perfusion sensitive states (sepsis)
- Coagulopathy with active bleeding
- Need for transfer for possible ECMO
- Severe congenital anomalies / syndromes / known metabolic disorders
- Confirmed Sino-venous thrombosis
- Inability to initiate cooling by 6 hours of age

C. **Identification of Infants**

Eligible infants may be identified by Labor & Delivery (Transitional Nursery, NICU or Pediatric staff/ referring hospital) at the time of resuscitation or based on cord blood gases and/or initial newborn blood gases. Eligible infants should be identified and discussed with Neonatologist for possible cooling therapy as soon as possible after birth due to the narrow window of six (6) hours after birth initiate therapeutic hypothermia.

*** As soon as infant qualifies, cooling should be initiated. Studies demonstrate the sooner cooling is initiated: the amount of neuronal cell lost is decreased.**

Body Cooling Protocol Please See Attachment:

D. **Qualified/Applicable Staff**

RN must be a NICU RN who has completed training in caring for infants undergoing therapeutic hypothermia therapy and setting up the Blanketrol III System.

* **Circumstances under which RN/Qualified Individual (s) may perform the functions (s)**

1. Setting
   Therapeutic hypothermia may be performed on the critical care area of the NICU.
2. Supervision
   Under the supervision of the neonatologist or neonatal nurse practitioner (physician or Nurse Practitioner will write orders).

E. **Definition of Hypothermia**

Hypothermia occurs when an infant's core (esophageal or rectal) body temperature drops below 36° C (96.8° F) or axillary temperature below 34.9° C (94.8° F).

F. **Procedure-Initiation of Cooling upon admission to the NICU**
(cooling period to last for total of 72 hours from the time target core temperature is first reached)

Labs:

1. ABG (patient temperature at time of draw should be entered into analyzer every 24 hours or more)
2. Blood Cultures (if not already obtained)
3. Lactate

4. PT/PTT/Fibrinogen/D.Dimer at 0 (zero) hours and Q24 hours x 2 and PRN.
5. CBC© Differential Q 24° & PRN
6. Blood Glucose
7. ALT, AST, total protein, ALB, Total and direct bilirubin, ALK PHOS, GGT and ABG at zero hours.

Equipment

1. CSZ Blanketrol III Unit with connecting hoses
2. CSZ Kool-Kit ® Neonate/950 which includes:
   a. Maxi-Therm lite Blanket
   b. Mittens & Booties
   c. Esophageal/Rectal Temperature Probe
3. 2 Gallons distilled water (for initial set-up)
4. Infant Warmer or Giraffe
5. Pillow Case or thin receiving blanket
6. Lubricating Jelly
7. Duoderm/Tegaderm to secure temperature probe
8. Measuring tape
9. Tape

Setting up Blanketrol III (Set up Only)*

1. Gather equipment
2. Check the water fill opening to be sure there is water at the top of the drain. If water level is not visible, gradually pour approximately enough to have water visible (maximum is 2 gallons if empty) in the reservoir. Stop pouring when the water reaches the drain visible at the bottom of the water fill opening. **Do Not** overfill. Add distilled water as needed.
3. Open the Kool Kit and remove contents.
4. Make sure unit is "Off" prior to connecting to electrical outlet.
5. Connect the blanket to the unit by attaching the quick disconnect female coupling of the connecting hose to a male outlet coupling (bottom row) of the unit. There are three outlet couplings—you may use any one of these.
6. Make sure that the connections are secure and the clamps are open. Hoses should not be twisted or kinked. The blanket should be flat.
7. Prepare bed by placing the cooling blanket on the warmer or scale if infant is currently on the warmer. Do not turn bed warmer on. The warmer will remain off until cooling phase is over.
8. Turn the power switch "On". Water will be circulated into the blanket. Check that there are no leaks in the blanket.
9. Place pillowcase or thin receiving blanket on the cooling blanket. Only one thin receiving blanket or pillowcase can be between the patient and the cooling blanket to prevent soiling.

10. Set the Celsius/Fahrenheit switch, so that "Celsius" will be displayed.
11. Pre-cool the blanket in the manual mode at 5 degrees C.
    A. Press the "Temp Set" switch
    B. Press the DOWN arrow to change the "Set Point" display to 5C
    C. Press the Manual Control switch (Allow about 15 minutes to pre-cool the blanket prior to use. Temp does not need to reach 5C before placing infant or blanket).

    * Blanketrol Technical help
    1-800-989-7373
    1-513-772-8810

Brain Monitoring

Implement bedside brain monitoring via Olympic Brainz Monitor. Please follow Manufacturer's "Quick Start Guide" to initiate such (Attachment A: CFM Olympic Brainz Monitor Quick Start Guide.)

Placement of Esophageal Probe

1. Soften the probe prior to insertion by placing in warm water for a few minutes
2. Measure distance (with measuring tape) from nares to the ear to the xyphoid process (then minus 2 cm) and then mark the distance with a small piece of tape around tube. This should position the temp probe in the lower third of the esophagus. Nasal placement is preferred
3. Lubricate the tube (first 5 cm) and carefully insert to desired length.
4. Secure the probe by taping to infant's cheek. Appropriate Temp probe placement may be confirmed with x-ray.
5. Insert the "s" probe into the probe jack on right side of the cooling unit.

Initiation of Hypothermia (when infant is on the blanket)

During cooling therapy, the infant should be cared for on an open warmer (heat off) as the cooling blanket should be flat and the connecting hoses should remain un-kinked. (Make sure the heater output is not inadvertently turned on during body cooling).

1. Position the pre-cooled 25" x 33" blanket fully unfolded under the infant. Lay the infant supine with occiput resting on the blanket.
2. Operate the unit in GRADIENT VARIABLE
    a. Press TEMP SET switch
    b. Press the UP arrow to SETPOINT display to 33.5° C. This will be the set point for the next 72 hours.
    c. Press the GRADIENT VARIABLE button.
    d. Set the desired gradient variable offset to 6-10° C or as ordered, and press the GRADIENT VARIABLE button again.
    e. Then press smart button.
3. The infant's esophageal temperature will begin to decrease soon after the initiation of the cooling therapy. Within the first 30-45 minutes on the blanket, it is expected for infant's esophageal temperature to drop below the eventual desired temperature of 33.5° C (target range of 33-34°). The cooling blanket system

adjusts quickly and will warm the blanket water to raise the infant's temperature to 33.5° C by approximately 90-120 minutes from initiation of cooling therapy. Once stable at 33.5° C, some esophageal temperature fluctuation around the set point is to be expected, but should not be greater than ± 0.5° C.

4. Upon initiation of cooling, with the exception of the diaper worn by the infant, it is optimal not to have any material between the infant and the blanket since interposed surfaces may alter the desired cooling. Once the infant's esophageal temperature has reached the set point of 33.5° C, a single layer such as a thin receiving blanket or pillow case may be placed between the infant and the cooling blanket to prevent soiling of the cooling blanket. Rolled cloth blankets and other positioning aids maybe used but should be placed under the cooling blanket. Booties and mittens may be placed on infant for aesthetic purposes. Encourage parents to touch covered hands and feet.
5. Set Nebulizer temp to 34° (Enter patients actual temp on ABG Machine for accurate Co2 results.)

Re-warming Procedure

1. Re-warming is done gradually over minimum of 6 hours after completion of the 72-hour period of cooling.
2. Core body temperature is slowly increased at the rate of 0.5 C per hour over a 6 hour period.
    - Each hour increase the cooling blanket SETPOINT temperature by 0.5° C (to maximum SETPOINT of 36.5° C).
3. Cooling blanket is maintained at **GRADIENT VARIABLE**
    - Press the TEMPERATURE SET switch; use the up arrow to increase the SETPOINT by 0.5° C.
    - Press the GRADIENT VARIABLE button.
    - Set the desired gradient variable offset to 6-10° C or as ordered, and press the GRADIENT VARIABLE button again.
4. At the end of the 6-hour re-warming period, the infant's thermoregulation will be returned to the overhead warmer and temperature maintenance as per NICU protocol.
5. Esophageal, cooling blanket temperature; vital signs are performed frequently, as outlined in the "Initiating hypothermia" section.
6. Monitor closely during re-warming, then at least 24 hours afterwards for:
    - Seizures
    - Rebound hyperthermia
    - Acidosis
    - Hypocalcemia
    - Hypoglycemia
    - Hyperkalemia
    - Hypermagnesemia
    - Diuresis/oliguria
    - Vasodilatation and hypotension

Conclusion of Hypothermia Therapy

1. Turn off cooling blanket. Keep the blanket and hose to connect to the unit for about 10 minutes.
2. Remove the esophageal probe from the patient and the esophageal cable from the probe jack.
3. Disconnect the power cord from the power source, loosely coil it and attach it to the back panel using nylon strap
4. Disconnect the connecting hose from the unit. Remove the blanket.
5. Needs to go to Biomed every 90 days to drain H2O.

Monitoring/Documentation

1. Esophageal, blanket/water temperatures, Heart Rate, Respiration, Blood Pressure and Oxygen Saturation are to be monitored/documented as follows:
   a. Q 15 minutes for the first 2 hours (hours 0-2)
   b. Q 30 minutes for the next 2 hours (hours 2-4)
   c. Q 1 hour for the next 68 hours (hours 4-72)

   *Frequent Vital Sign Form may need to be used during the first 6 hours
2. Labs: Frequent labs will be ordered per physician/NNP during cooling and will be documented per policy.
3. EEG Via a cerebral function monitor/see Olympic Brainz Monitor Quick Start Guide
4. All other documentation per VCMC NICU policy.

SPECIAL PRECAUTIONS

1. During cooling expect:
   a. Decreased Heart Rate. Lower limit of HR monitor to 80 bpm as the HR of the infant being cooled will be in the low 100's or below 100. Heart rates in the 70's may be tolerated as long as the infant has a normal sinus rhythm, stable BP and saturation.
   b. Increased blood pressure initially due to increases in peripheral vasoconstriction
   c. Increase in urine output initially due to shunting of blood to the internal organs, cold and diuresis
   d. Decrease in serum calcium, phosphorus and potassium.
   e. Labile glucose due to relative insulin resistance, decreased metabolic rate and shivering. Shivering is not unusual in these infants.
2. During re-warming expect:
   a. Increase in Heart Rate
   b. Decrease in blood pressure due to decrease in peripheral vascular resistance.
   c. Decrease in urine output due to increases in third spacing and shunting of blood to the periphery.
   d. Electrolyte shifts, as renal and liver clearance rates change.
3. Keep blanket dry and away from sharp objects.
4. Infant can be positioned and turned normally while maintaining full contact with cooling blanket. Check

every two hours for skin breakdown-adjusting position to avoid pressure points.

5. Notify physician/NNP if:
    a. Temperature falls below 31° C
    b. 02 Sats < 85%
    c. Heart Rate<80 bpm and > 180 bpm
    d. Mean arterial pressures <40 mmHg
    e. Urine output <1 ml/kg/hour
    f. Blood glucose <60 and > 180 mg/dl
    g. Bleeding
    h. Evidence of skin breakdown
6. If power outage, Blanketrol defaults to 37°

All revision dates: 7/1/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/30/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/30/2023
NICU	Enriqueta Coronado: Clinical Nurse Manager, NICU [MK]	1/30/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/9/2019*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.06 Santa Paula Hospital Obstetrical Guidelines

POLICY:

The Santa Paula Hospital Obstetrical unit is especially well suited to women with low-risk pregnancies who desire a more intimate delivery environment. Women who deliver at Santa Paula Hospital will have the opportunity to deliver in a spacious, well-equipped Labor and Delivery room. Private post-partum rooms are also available at Santa Paula Hospital.

PROCEDURE:

Pregnancies with medical conditions which place the mother or fetus at high risk should be delivered at Ventura County Medical Center (VCMC). The following lists, though not complete, are meant to serve as guidelines in determining whether an obstetrical patient is a candidate for delivery at Santa Paula Hospital:

1. Pregnant patients with medical conditions which may place the mother or fetus at high risk should be delivered at VCMC. Such conditions include:
    a. Severe asthma/pulmonary disorders
    b. Maternal cardiovascular disease
    c. Maternal renal disease
    d. Pre-gestational diabetes
    e. Gestational diabetes mellitus that is not well controlled; A 1c greater than or equal to 6.5% at 36 weeks gestation or after.
    f. BMI equal to or greater than 40.
2. Pregnant patients with complications of pregnancy which may place the mother or fetus at high risk should be delivered at VCMC. Such conditions include:
    a. Preterm delivery (<37 weeks gestational age)
    b. Preterm premature rupture of membranes
    c. IUGR
    d. Multiple gestation with the exception of planned twin C-Section at term
    e. Placenta previa

f. Suspected chorioamnionitis if identified in early labor

g. Preeclampsia which is identified prior to labor or at initial presentation in labor.

h. Isoimmunization

i. Three (3) or more previous C-Sections.

j. Trial of labor after caesarian.

k. BMI greater than or equal to 40.

3. 2 nd Trimester Pregnancy termination

Please contact the on-call Obstetrician with any questions about the management of an individual patient.

All revision dates: 10/9/2019, 10/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/12/2022
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	10/12/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2009*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.51 Criteria for Pathological Examination of the Placenta

POLICY:

Examination of the placenta can yield information that may be important in the management of the mother and the infant. Information obtained from the examination and pathology of a placenta may be essential for protecting the attending physician in the event of an adverse maternal or fetal outcome.

PROCEDURE:

An examination of all placentas shall be performed in the delivery room. The findings of this assessment should be documented on the delivery records. All placentas should be labeled and saved for at least 3 days past delivery.

GUIDELINES:

A. During the examination, the size, shape, consistency and completeness of the placenta should be determined and the presence of accessory lobes, placental infarcts, hemorrhage, tumors and nodules should be noted.

B. The umbilical cord should be assessed for length, insertion, number of vessels, thromboses, knots and the presence of Wharton's jelly.

C. The color, luster and odor should be evaluated and the membranes should be examined for the presence of large (velamentous) vessels.

D. The placenta should be submitted to Pathology if an abnormality is detected or if certain indications are present.

E. Nursing sends the placenta in special sealed containers to which formalin is added. The specimen is labeled with patient's label and the date and time is handwritten on the label. A Laboratory Tissue Request order is placed in EHR that includes the clinical information of the pregnancy, i.e. weeks of gestation, number of fetuses and the reason for the exam.

Criteria for Sending a Placenta to Pathology when ordered by LIP:

A. Placenta has gross abnormalities

1. Inconsistent size

2. Hemorrhage
3. Umbilical cord with abnormal insertion
4. Umbilical cord has single artery
5. Membranes have velamentous vessels present

B. Maternal conditions
1. Diabetes
2. Oligohydramnious
3. Infection
4. Repetitive bleeding episodes
5. Maternal history of reproductive failure
6. Abruptio placenta
7. Hypertension
8. Fever
9. Substance abuse

C. Fetal and Neonatal conditions
1. Stillbirth
2. Multiple births
3. Prematurity
4. Hydrops
5. Fetal growth retardation
6. Admission to the NICU
7. Apgar score of 3 or less at 5 minutes
8. Depressed 1 minute Apgar score
9. Neurological problems, including seizures
10. Suspected infection
11. Perinatal deaths
12. Congenital anomalies
13. Post maturity
14. Thick meconium

All revision dates: 10/17/2022, 5/15/2019, 1/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Tracy Chapman: VCMC - Med Staff	pending
Laboratory Services	Erlinda Roxas: Director Laboratory Services	10/23/2022
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	10/22/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/17/2022
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2022
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	10/17/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/1986*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/12/2023*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.59 Assisting with Spinal Anesthesia in OB

POLICY:

To assist the physician with spinal anesthesia and early detection of possible complications in the OB Department.

PROCEDURE:

Spinal anesthesia is used to block all sensations from the lumbar area down and is sometimes used with a forceps delivery or manual removal of the placenta.

A. Preparation of equipment:

1. Assemble and organize in the delivery room/explain procedure to patient.
2. After placing patient on delivery room table, open the IV fluids so that 500 – 1000 ml IV solution is infused.
3. Patient may be positioned:
    a. Sitting on side of bed with feet on stool, shoulders slumped, hands on knees, chin on chest and back rounded toward anesthesiologist.
    b. Sitting upright on delivery table, shoulders slumped, arms on bedside table, chin on chest, and back rounded toward anesthesiologist.
    c. Lying on side in curled position, chin on chest, knees pulled up to abdomen, and back rounded toward anesthesiologist.
4. Adjust overhead light to patient's lumbar area
5. Reassure patient throughout entire procedure.
6. Place patient in position of choice as described above.
7. Place BP cuff on arm and take initial BP. Place O_2 Sat. monitor on finger and monitor continuously.
8. Hold patient still during the entire procedure; reassure patient.
9. Immediately after spinal, take BP and then take again when patient lies down (30 - 90 seconds later).
10. Obtain BP every minute x 3, then every 2 minutes x 10 - 15 minutes.
11. Obtain BP once every 5 minutes throughout delivery and record. If signs of shock, take every 1 minute.

12. A wedge or pillow may be placed under the right lumbar area to displace the uterus to the left and prevent the vena cava from partial occlusion causing hypotension.
13. Patient to remain flat throughout procedure.
14. Document vital signs, level of anesthesia, ability to move legs in Fetal Monitoring System, q 5 min x3, then every 15 minutes until criteria is met to be discharged from the OB Recovery Room.
15. Patient may transfered to Postpartum when able to move lower extremities, vitals are stable and meets discharge from Recovery Room criteria found in Cerner EHR.

EQUIPMENT

A. Spinal tray
B. Sterile gloves
C. Electronic Health Record (EHR) Fetal Monitoring System
D. Two (2) pillows or sandbag
E. Stool and/or bedside table
F. Anesthesia record for physician
G. Intravenous line/infusion pump

DOCUMENTATION

A. Power Chart Maternity EHR
B. Follow PACU documentation flow sheet
C. MAR

KEY POINTS

A. Observe Universal Precautions
B. The OB patient is particularly susceptible to high levels of subarachnoid or epidural block because of increased cerebrospinal fluid pressure during uterine contractions and voluntary expulsive effort, and decreased size of subarachnoid space.
C. Total spinal block produced anxiety, respiratory arrest, unconsciousness, cardiovascular collapse, resulting from generalized vasodilatation compounded by blockage of sympathetic cardioaccelerator fibers. All muscles are paralyzed except those of the face and neck innervated by cranial nerves.

REFERENCES:

Pac Lac Prenatal and Intrapartum Guidelines of Care, 2009.

All revision dates: 1/12/2023, 3/21/2019, 11/1/2013, 8/1/2010, 1/1/2008, 1/1/2005, 12/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: OB & Surgery	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/1/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/1/2022
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/1/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.76 Maternal Sepsis

Purpose:

~~**Purpose:**~~ Maternal Sepsis occurs in about 0.004 % of deliveries and is a leading cause of maternal death (12.7-23.0%). Most cases 63% of maternal death from sepsis are likely to have been preventable. For each maternal death from sepsis, there are 50 women who experience life-threatening morbidity from sepsis. Prompt recognition and rapid treatment of maternal sepsis is key to improving outcomes. ~~This two-step approach will first screen using vital signs adjusted for pregnancy and the most recent white blood cell WBC count (within 24 hours). The second diagnostic step uses evaluation for end organ injury with laboratory values adjusted for pregancy when needed.~~

~~I. Definitions~~

Policy:

A two-step approach shall be followed for maternal sepsis. The first step will be a screen using vital signs adjusted for pregnancy and the most recent white blood cell WBC count (within 24 hours). The second diagnostic step uses evaluation for end organ injury with laboratory values adjusted for pregnancy when needed.

Definitions:

A. ~~Inatraamniotic~~Intraamniotic **(CHORI) Infection:** Infection with inflammation of any combination of the amniotic fluid, placenta, fetus or decidua.

B. **SIRS (Systemic Inflammatory Response Syndrome):** A clinical manifestation resulting from insult, infection, or trauma that includes a body-wide activation of immune and inflammatory cascades.

C. **Septic Shock:** MAP <65 mm Hg (sustained for 15 minutes after 30 mL/kg fluid load in setting of infection.

D. **Time ZERO:** ~~Any 2~~The specific date and time at which the patient was known to have any two signs indicative of (SIRS) AND physician confirms positive Sepsis Screen.

~~II. OB SIRS Criteria Step 1: Initial Sepsis Screen (*Positive if any of 2 of 4 criteria met)~~

~~A. Oral temperature Less than <96.8 OR Greater >100.4~~

B. ~~White Blood Cell Count: Greater than 15,000 OR Less than 4,000~~

C. ~~Heart Rate-Greater than >110~~

D. ~~Respiratory Rate-greater than 24~~

E. ~~*If sepsis criteria is met, Cerner will fire an alert for the nurse and physician or midwive providing care. OB Septic Shock will appear. A red sepsis icon will appear on the tracking shell.~~

~~III. Confirmation of Sepsis Evaluation Step 2: (Confirmed if 1 or more criteria met)~~

A. ~~Respiratory: New need for mechanical ventilation or Pa02/Fi02 <300~~

B. ~~Coagulation: Platelets <100 x109/L OR INR >1.5 or PTT >60 secs~~

C. ~~Liver: Bilirubin >2 mg/dl~~

D. ~~Cardiovascular: SBP <85 mm Hg or MAP < 65 mm Hg or >40 mm Hg decrease in SPB (after fluids)~~

E. ~~Renal: Creatinine > 1.2 mg/dl or doubling of creatinine or urine output , 0.5 mL/kg/hr x2 hrs~~

F. ~~Mental Status: Agitated, confused, or unresponsive~~

G. ~~Lactic Acid: >2 mmol/L in absence of labor~~

~~IV. Ob Department Personnel Duties~~

Procedure:

A. OB SIRS Criteria Step 1: Initial Sepsis Screen **(*Positive if any of 2 of 4 criteria met)**

1. Oral temperature Less than <96.8ºF OR Greater >100.4ºF.
2. White Blood Cell Count: Greater than 15,000 OR Less than 4,000.
3. Heart Rate-Greater than >110 beats per minute.
4. Respiratory Rate-greater than 24 breaths per minute.
5. *If sepsis criteria is met, Cerner will fire an alert for the nurse and physician or midwife providing care. OB Septic Shock will appear. A red sepsis icon will appear on the tracking shell.

B. Confirmation of Sepsis Evaluation Step 2: (Confirmed if 1 or more criteria met)

1. Respiratory: New need for mechanical ventilation or Pa02/Fi02 <300.
2. Coagulation: Platelets <100 x109/L OR INR >1.5 or PTT >60 secs.
3. Liver: Bilirubin >2 mg/dL.
4. Cardiovascular: Systolic blood pressure (SBP) <85 mm Hg or MAP < 65 mm Hg or >40 mm Hg decrease in SBP (after 30 ml/kg of fluids or lesser volume with physician documentation of reasoning/requirement for reduced volume).
5. Renal: Creatinine > 1.2 mg/dl or doubling of creatinine from patient's previous baseline, or decreased urine output of < 0.5 mL/kg/hr x2 hrs.
6. Mental Status: Change from patient's baseline mental status, including agitation, confusion, or unresponsive.

7. Lactic Acid: >2 mmol/L in absence of labor.

C. ~~Ob Triage or Primary Nurse~~OB Department Personnel Duties

~~Assess the patient for as part of the Ob triage intake process. Determine if patient meets Initial Sepsis screen criteria as listed in Step 1 Initial Sepsis Screen.~~

~~If it is a positive Sepsis Screen, RN is to notify primary care provider immediatetly.~~

~~The primary care provider will determine if source-directed antibiotics and 1-2 L of IV fluids will be started. Increase monitoring and surveillance.~~

~~The primary care provider will move to Step 2 Confirmation of Sepsis Evaluation, and initiate the 'OBGYN Sepsis" Power Plan if indicated by confirmed sepsis screen and 1 or more criteria met in Step 2 Confirmation of Sepsis Evaluation. The following will be started by 1 hour of time Zero.~~

1. ~~The nurse will page a silent page~~ OB ~~Code Sepsis, rapid response nurse will be notified for additional support, and the following actions will be performed;~~Triage or Primary Nurse

~~Start source-directed antibiotics if not done so, broad spectrum antibiotics if source unclear; increase fluids to 30 ml/kg within 3 hours; collect blood cultures if not already obtained, maintain close surveillance; RRT and draw initial lactate. Repeat in 4-6 hours if indicated.~~

a. Assess the patient for sepsis as part of the OB triage intake process. Determine if patient meets Initial Sepsis screen criteria as listed in Step 1 Initial Sepsis Screen.

b. If Sepsis Screen positive, RN is to notify primary care provider immediately.

c. The primary care provider will determine if source-directed antibiotics and IV fluids are indicated, and orders will be provided (1-2 liter IV fluid bolus initially will be considered). Increase monitoring and surveillance will be initiated.

d. The primary care provider will perform Step 2 Confirmation of Sepsis Evaluation, and initiate the 'OBGYN Sepsis" Power Plan if indicated by confirmed sepsis screen and 1 or more criteria met in Step 2 Confirmation of Sepsis Evaluation. In the initial hour following "Time Zero", the following actions and procedures will be initiated.

e. ~~For septic shock defined by MAP <65 mmHg (sustained for 15 minutes). Follow steps listed above for~~The nurse will page a silent page OB Code Sepsis, ~~consider admission to ICU. If hypotension persists for after 30 mL/kg fluid load, assess hemodynamic status and consider vasopressor use. If a higher level of care is needed, the nursing supervisor~~The following departments will be ~~notified. The physician will contact ICU attending to transfer care.~~paged

- Rapid Response Nurse
- Lab Personnel
- Ob attending
  - ***Collect Blood Cultures should be collected prior to starting source-directed antibiotics.***
  - Start source-directed antibiotics if not done so, broad spectrum antibiotics if source unclear; administer additional fluids to complete a total of 30 ml/kg within 3 hours; or a lesser volume with documentation from the provider, with reasoning. Draw initial lactate. Automated lactate orders will be repeated if elevated.
  - For septic shock: Follow steps listed above for Sepsis, consider admission to ICU. If hypotension persists after 30 mL/kg fluid load, assess hemodynamic status and

consider vasopressor use. If vasopressors or a higher level of care is needed, the nursing supervisor will be notified. The physician will contact ICU attending to transfer care.

- For elevated lactate ONLY in laboring patients without evidence to suggest bacterial sepsis: Maintain close surveillance, consider additional fluids; lactate orders for monitoring will be automatically repeated if elevated every 4-6 hours as indicated.

~~For elevated lactate ONLY in Labor. Maintain close surveillance, consider additional fluids to reduce lactic acid level; repeat lactate every 4-6 hours as indicated.~~

2. For all inpatient antepartum, intrapartum and post-partum patients:
   a. The nurse will assess the patient each shift, and follow the guidelines listed above.
   b. If Sepsis Screen is positive, the primary RN will notify primary care provider, who will respond with any necessary orders and the nurse will follow actions listed under Ob Department Personnel Duties.

~~For all inpatient antepartum, intrapartum and post-partum patients~~

1. ~~The nurse will assess the patient each shift, and follow the guidelines listed above.~~
2. ~~If positive Sepsis Screen the primary RN to notify primary care provider for orders and the nurse will follow actions listed under Ob Department Personnel Duties.~~

~~V. Refernces~~

~~•Barton, J. R. & Sibai, B. M. (2012). Severe sepsis and septic shock in pregnancy. *Obstetrics & Gynecology, 120*(3), 689-706. •Levy, M. M., et al. (2003). 2001 SCCM/ESICM/ACCP/ATS/SIS International sepsis definitions conference. *Intensive Care Medicine, 29*, 530-538. doi 10.1007/s00134-003-1662 •Levy, M. M., et al. (2010). The surviving sepsis campaign: Results of an international guideline-based performance improvement program targeting severe sepsis. *Critical Care Medicine, 38*, 367-374. •Levy, M. M., et al. (2003). 2001 SCCM/ESICM/ACCP/ATS/SIS International sepsis definitions conference. *Intensive Care Medicine, 29*, 530-538. doi 10.1007/s00134-003-1662-x •Levy, M. M., et al. (2010). The surviving sepsis campaign: Results of an international guideline-based performance improvement program targeting severe sepsis. *Critical Care Medicine, 38*, 367-374.~~

References:

A. Barton, J. R. & Sibai, B. M. (2012). Severe sepsis and septic shock in pregnancy. *Obstetrics & Gynecology, 120*(3), 689-706.

B. Levy, M. M., et al. (2003). 2001 SCCM/ESICM/ACCP/ATS/SIS International sepsis definitions conference. *Intensive Care Medicine, 29*, 530-538. doi 10.1007/s00134-003-1662.

C. Levy, M. M., et al. (2010). The surviving sepsis campaign: Results of an international guideline-based performance improvement program targeting severe sepsis. *Critical Care Medicine, 38*, 367-374.

D. Levy, M. M., et al. (2003). 2001 SCCM/ESICM/ACCP/ATS/SIS International sepsis definitions conference. *Intensive Care Medicine, 29*, 530-538. doi 10.1007/s00134-003-1662-x.

E. Levy, M. M., et al. (2010). The surviving sepsis campaign: Results of an international guideline-based performance improvement program targeting severe sepsis. *Critical Care Medicine, 38*, 367-374.

All revision dates:

Attachments

Lactation Sepsis Medications
Maternal Sepsis Evaluation Flow Chart

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	10/21/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/17/2022
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2022
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	10/17/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*8/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/18/2020*
Next Review:	*3 years after approval*
Owner:	*Maura Krell: Clinical Nurse Manager, Pediatrics/PICU*
Policy Area:	*PEDS/PICU*
References:	

P.04 Pediatric Treatment Room

POLICY:

To define the rationale behind using treatment rooms for pediatric patients.

PROCEDURE:

Painful and invasive procedures can greatly affect a patient's ability to cope as well as their psychosocial well-being. Due to a potential increase in anxiety and distress, pediatric pain specialists recommend the use of a treatment room as an alternative option to performing procedures in the patient room. The rationale is to allow the patient's room to remain a safe place, relieving patients of constant fear of the occurrence of painful procedures at bedside. The use of the treatment room is designed to remove painful procedures from the bedside. All patients react differently to pain and procedures, so a multidisciplinary team approach should be taken to decide if use of a treatment room will aid in a patient's coping.

- The treatment room will be used by the multidisciplinary team members (nursing, physicians, child life specialist).
- Use of the treatment room should be considered whenever a painful or invasive procedure needs to take place.
- Procedures can include, but are not limited to:
  - Blood draws (even if blood is being drawn off an IV or peripherally inserted central catheter (PICC) line).
  - Nasogastric (NG) tube placement or removal.
  - Gastrostomy (G-tube) changes and cleanings.
  - PICC line care, including but not limited to: cleaning, dressing changes and removal.
  - Tracheostomy (Trach.) changes, cleaning, care and removal.
  - Wound care: cleaning, removal of bandages and application of bandages.
  - Any other procedure that has the potential to be traumatizing to a patient. Even "simple procedures" can have negative effects on a patient's psychosocial well-being.
- Physician and nursing staff should contact the child life specialist prior to the procedure.
- The child life specialist will prepare the patient for the procedure and discuss coping techniques with the patient and their family.
- Siblings should not be present in the treatment room during procedures.
- For school age children, a choice can be given to use the treatment room or have the procedure done in their room. Caregivers should be collaborated with about this choice as well.

All revision dates: 2/18/2020, 8/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/21/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/21/2023
Pediatrics	Andrei Bobrow: Medical Director, Pediatrics	2/21/2023
Pediatrics	Maura Krell: Clinical Nurse Manager, Pediatrics/PICU	12/6/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1989*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/14/2023*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Pharmacy Services*
References:	

PH.42 Adverse Drug Reaction Reporting System

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) responds to actual or adverse events and significant adverse drug reactions (ADR). The ADR reporting system raises awareness of the risks associated with adverse drug reactions, identify ADRs that have occurred, and reduce their risk of associated harm.

Background:

A robust ADR reporting system involves different types of surveillance to identify ADRs.[1]

A. Prospective surveillance system for high-risk medications and/or patients at high risk for ADRs.

B. Ongoing and concurrent surveillance based on reporting suspected ADRs by Pharmacists, Licensed ~~Independent~~ Practitioners (~~LIP~~LP), nurses, other caregivers, and patients.

C. Retrospective surveillance that includes identifying orders for the use of trigger medications that are used to treat common ADRs (e.g. NOW orders for anti-histamines, epinephrine, etc.).

The ultimate goals of a robust ADR reporting system[1] are to

A. Improve patient care and decrease length of stay by ensuring safer use of drugs and appropriate follow-up.

B. Educating health care professionals and patients about drug effects and increasing their level of awareness regarding ADRs.

C. Providing an indirect measure of the quality of drug therapy through identification of potential ADRs and anticipatory surveillance for high-risk drugs or high-risk patients.

D. Assess the safety of drug therapies.

E. Providing quality-assurance screening to identify opportunities for medication-use evaluation or other performance improvement initiatives.

F. Characterize ADR incidence.

Definition:

A. **Adverse Drug Event (ADE)[1-2]:** Harm resulting from medical intervention involving a drug. Adverse drug events may be preventable (i.e, medication errors) or non-preventable (i.e., adverse drug reactions). All

ADEs are associated with harm.

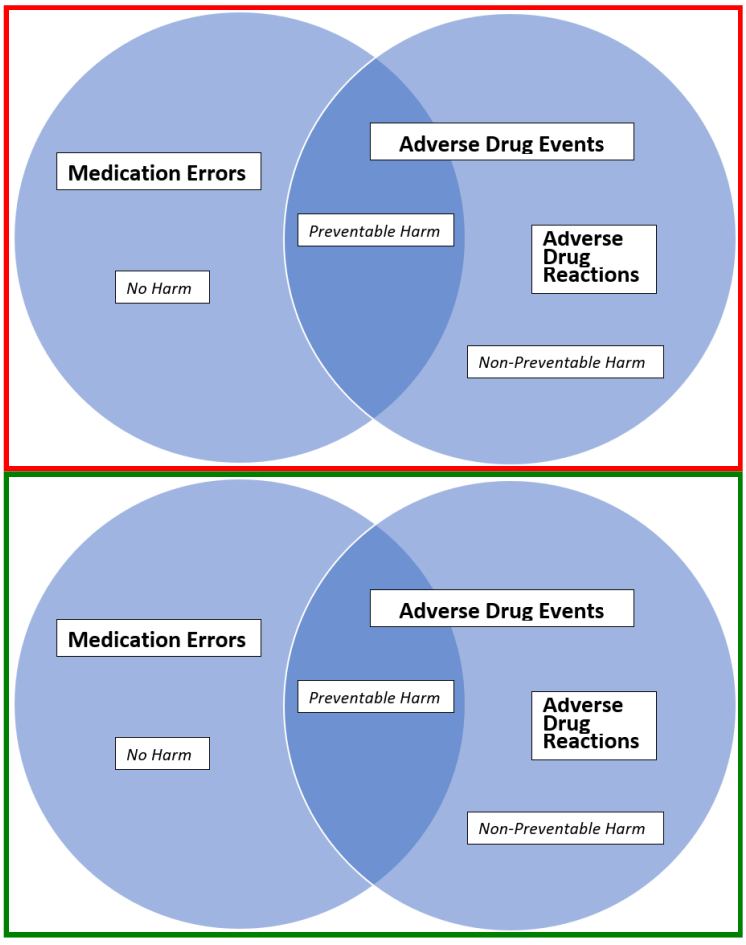
B. **Adverse Drug Reaction (ADR)[2]:** Any response to a drug which is noxious and unintended which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function.

   1. Side effect is a a popular term typically used to describe ADRs that are known to occur with a medication with varying degrees of associated harm.
   2. Drug withdrawal, drug-abuse syndromes, accidental poisoning, and drug-overdose complications should not be defined as ADRs.

C. **Harm[3]:** Impairment of the physical, emotional, or psychological function or structure of the body and pain or injury resulting therefrom.

D. **Medication Error[3]:** A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. For more information on medication errors, see policy PH.48 Medication Error Reduction Plan (MERP)

Relationship between medication errors and adverse drug events and adverse drug reactions[3-4]



Procedure:

Adverse Drug Reaction Reporting

A. ADRs should be reported electronically through the electronic notification system. Access to the notification system is available on all healthcare agency desktops. For more information on safety events, assistance, and escalation, see policy 107.082 Just Culture - Response to Safety Events

B. If an ADR is identified during ongoing/concurrent drug therapy, the Licensed Independent Practitioner (LIP) shall be notified immediately.

C. If an ADR is determined to have caused preventable harm (e.g., a medication error), both a medication error notification and an adverse drug reaction report should be completed.

D. Records of the adverse drug reaction review shall be retained by the Medication Safety Officer (MSO) for at least three (3) years from the date the event occurred.

E. The following information is important for initiating an ADR assessment (minimal information in **bold**):

1. **Patient information (i.e., two patient identifiers)**
2. **Date/time of onset**
3. **Description of suspected ADR including the suspected drug(s).** *See Table 1 for affected body system.*
4. Reaction Type. *See Table 2 for classification of adverse drug reactions.*
5. Management and Treatment
    a. No action taken
    b. Supportive treatment
    c. Drug(s) discontinued
    d. Antidote/antagonist used
    e. Drug dose decreased
    f. Other
6. Outcome
    a. No harm/discharged home
    b. Required intervention to prevent permenant impairment/damage
    c. Hospitalization
    d. Life threatening
    e. Disability/permanent damage
    f. Death
7. Severity
    a. Severe: Caused death or was life threatening
    b. Significant: Caused or contributed to hospitalization, or prolonged length of stay (LOS) by 1 day or more
    c. Moderate: Did not prolong LOS, but required antidote/antagonist and/or discontinuation of

suspected drug(s)

d. Mild: Required no antidote/antagonisht or drug discontinuation. Drug dosage may have been reduced.

8. Probability. *See Table 3 for Naranjo Adverse Drug Reaction Probability Scale.*

Adverse Drug Reaction Analysis

Once the adverse drug reaction notification is filed, the notification shall be routed to the Medication Safety Officer (MSO) or designee who shall review and investigate as soon as reasonably possible. The ADR may be forwarded to the appropriate department for further review and analysis, including Root Cause Analysis (RCA) and/or peer review referral if indicated.

The MSO or designee shall initially assign ADR metrics (e.g., severity and probability) with Medical Staff consultation if warranted. Pharmacy and Therapeutics Committee shall review and evaluate ADRs and ADR metrics quarterly. The Pharmacy and Therapeutics (P&T) committee members/attendees can request re-assessment and/or change in severity assignment. Likewise, for any ADRs that are reviewed during RCAs.

Findings from ADR interdisciplinary discussion may be incorporated into ongoing quality improvement activities. This may include preventative and corrective interventions, monitoring for future ADRs, education, and promoting the awareness of the consequences of ADRs.

Medication Safety generated summaries, data, and action plans shall be reported to the following committees:

A. Pharmacy and Therapeutics Committee

B. Medical Executive Committee

External Reporting

Voluntary reporting to external reporting systems helps identify unknown risks and trends. Serious or unexpected ADRs should be reported to the medication manufacturer and/or the Food and Drug Administration (FDA).

~~A. FDA Medwatch. MedWatch: The FDA Safety Information and Adverse Event Reporting Program | FDA~~

~~B. VAERs (Vaccine Adverse Event Reporting System) for vaccines causing adverse reactions. Reporting can be made online by visiting https://vaers.hhs.gov/reportevent.html.~~

A. FDA Medwatch for observed or suspected adverse events for human medicinal products (e.g., medications, equipment, and ancillary supplies). Reporting can be made online by visiting The FDA Safety Information and Adverse Event Reporting Program | FDA

B. Vaccine Adverse Events (see Attachment B - VAERS and VERP)

1. VAERs (Vaccine Adverse Event Reporting System) for vaccines causing adverse reactions.

   a. Report all COVID-19 vaccine administration errors to VAERs regardless of whether an adverse event occurred.

   b. Reporting can be made on line by visiting https://vaers.hhs.gov/reportevent.html.

2. VERP (Vaccine Error Report Progam) for preventable vaccine administration errors. Reporting can be made on-line by visiting ismp.org/form/verp-form

3. CAIR (California Immunization Registry) documentation should be corrected if indicated.

4. myCAvax for reporting COVID vaccine shipment incidents (e.g., damaged/missing shippers or packages, missing or surplus vaccine, missing kit supplies, and temperature excursions in transit).
5. California Department of Public Health (CDPH) should be contacted to report any deficiencies or defects related to the ancillary supply kits . Reporting can be made online by visting myCAvax under Vaccine Inventory.

Analysis Tools

Table 1 Affected Body System(s)		
Cardiovascular	Gastrointestinal	Neurological
Dermatological	Generalized	Renal
Electrolyte homeostasis	Hematological	Respiratory
Endocrine/metabolic	Hepatic	
ENT/oral	Musculoskeletal	

Table 1 Affected Body System(s)		
Cardiovascular	Gastrointestinal	Neurological
Dermatological	Generalized	Renal
Electrolyte homeostasis	Hematological	Respiratory
Endocrine/metabolic	Hepatic	
ENT/oral	Musculoskeletal	

Table 2 Classification of Adverse Drug Reactions[5]			
Type of Reaction (mnemonic)	**Features**	**Examples**	**Management**
A: Dose related (augmented)	- Common - Related to the pharmacologic actin of the drug – exaggerated pharmacologic response - Predictable - Low mortality	- Dry mouth with tricyclic anti-depressants - Respiratory depression with opioids - Bleeding from warfarin - Serotonin syndrome with SSRIs - Digoxin toxicity	- Reduce dose or withhold drug - Consider effects of concomitant therapy
B: Non-dose related (bizarre)	- Uncommon - Not related to the pharmacologic action of the drug - Unpredictable - High mortality	- Immunologic reactions: anaphylaxis to penicillin - Idiosyncratic reactions: malignant hyperthermia with general anesthetics	- Withhold and avoid in the future
C: Dose related and time related (chronic)	- Uncommon - Related to the cumulative dose	- Hypothalamic pituitary adrenal axis suppression on corticosteroids - Osteonecrosis of the jaw with bisphosphonates	- Reduce dose or withhold - Withdrawal may have to be prolonged
D: Time related (delayed)	- Uncommon - Usually, dose related - Occurs or becomes apparent sometime after use of the drug	- Carcinogenesis - Tardive dyskinesia - Teratogenesis - Leucopenia with lomustine	- Often intractable
E: Withdrawal (end of use)	- Uncommon - Occurs soon after withdrawal of the drug	- Withdrawal symptoms with opiates or benzodiazepines (e.g., insomnia, anxiety)	- Re-introduce drug and withdraw slowly
F: Unexpected failure of therapy (failure)	- Common - Dose related - Often caused by drug interactions	- Inadequate dosage of an oral contraceptive when used with an enzyme inducer - Resistance to antimicrobial agents	- Increase dosage - Consider effects of concomitant therapy

Table 2 Classification of Adverse Drug Reactions[5]			
Type of Reaction (mnemonic)	**Features**	**Examples**	**Management**
A: Dose related (augmented)	- Common - Related to the pharmacologic actin of the drug – exaggerated pharmacologic response - Predictable - Low mortality	- Dry mouth with tricyclic anti-depressants - Respiratory depression with opioids - Bleeding from warfarin - Serotonin syndrome with SSRIs - Digoxin toxicity	- Reduce dose or withhold drug - Consider effects of concomitant therapy
B: Non-dose related (bizarre)	- Uncommon - Not related to the pharmacologic action of the drug - Unpredictable - High mortality	- Immunologic reactions: anaphylaxis to penicillin - Idiosyncratic reactions: malignant hyperthermia with general anesthetics	- Withhold and avoid in the future
C: Dose related and time related (chronic)	- Uncommon - Related to the cumulative dose	- Hypothalamic pituitary adrenal axis suppression on corticosteroids - Osteonecrosis of the jaw with bisphosphonates	- Reduce dose or withhold - Withdrawal may have to be prolonged
D: Time related (delayed)	- Uncommon - Usually, dose related - Occurs or becomes apparent sometime after use of the drug	- Carcinogenesis - Tardive dyskinesia - Teratogenesis - Leucopenia with lomustine	- Often intractable
E: Withdrawal (end of use)	- Uncommon - Occurs soon after withdrawal of the drug	- Withdrawal symptoms with opiates or benzodiazepines (e.g., insomnia, anxiety)	- Re-introduce drug and withdraw slowly
F: Unexpected failure of therapy (failure)	- Common - Dose related - Often caused by drug interactions	- Inadequate dosage of an oral contraceptive when used with an enzyme inducer - Resistance to antimicrobial agents	- Increase dosage - Consider effects of concomitant therapy

Table 3 Naranjo ADR Probability Scale[6]				
Question	**Yes**	**No**	**UNK**	**Score**
1. Are there previous conclusive reports on this reaction?	+1	0	0	
2. Did the adverse event appear after the suspected drug was administered?	+2	-1	0	
3. Did the adverse reaction improve when the drug was discontinued, or a specific antagonist was administered?	+1	0	0	
4. Did the adverse event appear when the drug was readministered?	+2	-1	0	
5. Are there alternative causes (other than the drug) that, on their own, could have caused the reaction?	-1	+2	0	
6. Did the reaction reappear when a placebo was given?	-1	+1	0	
7. Was the drug detected in the blood (or other fluids) in concentration known to be toxic?	+1	0	0	
8. Was the reaction more severe when the dose was increased or less severe when the dose was decreased?	+1	0	0	
9. Did the patient have a similar reaction to the same or similar drugs in any previous exposure?	+1	0	0	
10. Was the adverse event confirmed by any objective evidence?	+1	0	0	
Total Score: 9=high probable; 5-8=probable; 1-4=possible; 0=Doubtful				UNK=unknown

References

1. ASHP Guidelines on Adverse Drug Reaction Monitoring and Reporting. AM J HEALTH-SYST PHARM.

2021.

2. Safety Monitoring of Medicinal Products. Guidelines for setting up and running a Pharmacovigilance Centre. Uppsala Monitoring Cen tre - WHO Collaborating Centre for International Drug Monitoring, EQUUS, London, 2000.
3. National Coordinating Council for Medication Error Reporting and Prevention. Contemporary review of medication-related harm. A new paradigm. Accessed March, 21, 2022. https://www.nccmerp.org/sites/default/files/nccmerp_fact_sheet_2015-02-v91.pdf
4. Morimoto T, Gandhi TK, Seger AC, et al. Adverse drug events and medication errors: detection and classification methods. Qual Safe Health Care 2004; 13:306-314.
5. Edwards IR, Aronson JK. Adverse drug reactions: definitions, diagnosis, and management. Lancet. 2000; 356: 1255-9.
6. Naranjo CA, Busto U, Sellers EM, et al. A method for estimating the probability of adverse drug reactions. Clin Pharmacol Ther. 1981; 30:239-245.

All revision dates:	2/14/2023, 6/21/2022, 11/26/2018, 8/1/2015, 6/1/2011, 6/1/2008, 12/1/2004, 7/1/2001, 11/1/1998, 1/1/1996, 11/1/1991

Attachments

Attachment A - Adverse Drug Reaction Report Form (VCHCA-345-008).pdf

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	2/14/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/14/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	2/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1986*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/4/2020*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Operating Policies*
References:	

PH.55 Medication Order Management

POLICY:

The Department of Pharmacy Services maintains processes for the safe and timely prescribing and administration of medication to patients at Ventura County Medical Center and Santa Paula Hospital.

PROCEDURE:

I. Medication order review and verification

A. The Pharmacist reviews the appropriateness of all medication orders for medications dispensed within the hospital. See policy PH.96 Medication Override from Automated Dispensing Cabinets for exceptions.

B. Medication orders entered and submitted in the electronic health record (EHR) are immediately routed to the Pharmacy order verification application for Pharmacist review with an electronic signature generated upon completion.

C. The Pharmacist shall screen all orders indicating which orders need first priority.

1. "STAT" orders shall be processed and delivered within 30 minutes of receipt.
2. "NOW" and "ASAP" orders shall be processed and delivered within one (1) hour of receipt.
3. Routine and "PRN" medications shall be processed and delivered within two (2) hours of receipt.
4. All other orders shall be processed by patient status acuity; Emergency Department (ED), Intensive Care Unit (ICU), Neonatal Intensive Care Unit (NICU), and Pediatric Intensive Care Unit (PICU) shall have priority.
5. Turn-around-time for new total parenteral nutrition (TPN) orders for premature infants should be anticipated to be approximately two (2) hours.

D. The Pharmacist shall review the patient's profile and medication order for the following: allergies, weight, diagnosis, interactions, contra-indications, appropriate-ness of the medication (e.g. dose, frequency, and route), pertinent labs, and for therapeutic duplication.

1. The Pharmacist shall not dispense any medication without documentation of weight and allergy on the medication profile.
2. The Pharmacist receiving the order is responsible for clarifying any identified issues with the medication order. All medication order clarifications shall be resolved prior to the end of the

shift.

3. If the Pharmacist is unable to resolve the order, chain of command is initiated and all unresolved problem orders shall be reported to the Pharmacy Supervisor (see Procedure II. Medication Orders in Conflict with Standard of Practice).
4. The Pharmacist shall document all clinical interventions in the EHR.

E. Therapeutic duplication is the practice of prescribing multiple medications for the same indication without clear distinction of when one agent should be administered over another.

a. Pharmacists shall review all medication orders for therapeutic duplication when verifying any new medication orders(s) for patients.
b. Orders which specify a range of doses without explicit parameters for use shall be rejected. All such orders shall be clarified by the pharmacist prior to review and processing.
c. Multiple "PRN" medication orders for medications in similar classes or similar indications shall be clarified by the pharmacist.
d. Orders for multiple routes of administration for the same medication shall be clarified by the provider as to which route is the preferred route and the situation necessitating a change from one route to another. The pharmacist shall contact the provider for a clarification if this information is not provided.

F. For pediatric orders, the Pharmacist shall confirm pediatric doses in a pediatric drug reference.

1. Pediatric medication orders should be based on weight or body surface area (e.g. mg/kg or mg/m^2) up to the maximum adult dose. Maximum adult doses may be exceeded in special circumstances.
2. Pediatric doses should be re-calculated prior to dispensing.
3. Patient specific doses shall be dispensed whenever possible.

G. The metric system should be used for all medication orders except where dosages must be expressed otherwise (e.g. units for insulin). Conversion charts shall be available to all health care professionals (HCPs).

H. Generic drugs shall be selected unless the licensed independent practitioner (LIP) specifies "Do Not Substitute" on the medication order.

I. Orders for "PRN" medication shall not be reviewed or processed without documentation of the indication for use.

J. Orders for topical agents shall not be reviewed or processed without documentation of location for where the medication is to be applied.

K. Complex orders, medication orders requiring patient monitoring for assessment, or orders which need additional information to ensure safe administration must provide additional information (i.e., monitoring parameters). Examples of medication orders that require monitoring parameters include insulin and NORepinephrine. Incomplete orders for such medications shall not be reviewed or processed. The pharmacist shall contact the LIP directly for order clarification.

L. Titration orders for medication must be specified on the orders (see policy CC.23 Intravenous Medication Titration in Critical Care Areas).

M. All medication orders shall be stored for three (3) years and be available for review, if required, within two (2) business days.

II. Medication Orders in Conflict with Standard of Practice

A. If the pharmacist finds the use of a medication prescribed by a LIP inconsistent with the approved standard of practice, the pharmacist shall intervene.

B. The pharmacist shall contact the LIP directly to discuss the therapeutic issue(s) and contact the primary care HCP regarding the possible delay in therapy.

C. The pharmacist shall record and document such clinical interventions in the EHR.

D. If the situation cannot be resolved and is deemed to pose a serious risk to the patient, the pharmacist shall contact the Director of Pharmacy Services, who shall then contact the Chair of the Pharmacy & Therapeutics (P&T) Committee. The Chair shall contact the LIP. Once resolved, the Chair will notify the pharmacist of the decision, who will proceed accordingly.

E. If the Chair of the P&T Committee cannot resolve the problem, the Chair shall then refer the matter to the Chief Medical Officer (CMO).

F. The pharmacist and HCP shall maintain complete documentation. The pharmacist or HCP shall complete and submit a Notification Form.

G. A report of any issue referred to the CMO shall be presented at the following P&T Committee.

III. Medication Distribution and Dispensing Procedure

A. The preparation and dispensing of medications are consistent with applicable law or regulation governing professional licensure, operation of the Pharmacy and professional standards of pharmacy practice.

1. No person other than a pharmacist or an individual under the direct supervision of a pharmacist shall distribute or dispense medications, make label changes or transfer medication. This includes floor stock medications, crash cart medications and medications brought in by patients.

2. The duties and responsibilities of non-pharmacist staff are consistent with their training and experience. Non-pharmacist staff may not be assigned duties that by law must be performed only by licensed staff.

B. Pharmacy provides medications in the most ready to administer form whenever possible (see Procedure IV. Medication Packaging, Preparation and Labeling).

C. Medications are stored in the designated Automated Dispensing Cabinet (ADC), in the medication rooms, or in the medication carts. Each patient has an assigned cassette (drawer) for storage of any medications not in the ADC.

D. If the medication is not available in the ADC, Pharmacy shall dispense the first dose(s) after which a 24 hour supply shall be filled and delivered to the nursing unit between 1500 and 1630 every day.

1. Parental nutrition and lipids are delivered directly to the nurse with signed receipt.

2. For controlled substances deliveries see policy PH.88 Controlled Substances.

3. Intravenous continuous drips for the ICU, DOU, and PICU shall be requested by the nurse no later than three hours prior to expected drip change.

E. Missing Medications

a. When a patient is transferred from one nursing unit to another, it is the responsibility of the sending nurse to place all medications for the patient in a bag and send them with the patient to the receiving destination.

b. When missing medications are encountered, the HCP shall request the missing medication through the EHR.

F. Medications for ED Hold Patients

a. HCPs caring for ED Hold patients may request scheduled medications to be dispensed from the pharmacy by submitting a request through the EHR. Any scheduled medication that is not administered immediately shall be stored in a secure location.

b. Controlled substances, "STAT", "NOW", and "PRN" medications should be obtained from the ADCs in the Emergency Department.

IV. Medication Packaging, Preparation and Labeling

A. A label shall be generated and affixed to all pharmacy dispensed medications.

1. The pharmacy technician or a pharmacist shall fill the medication based on the label and document this process with their initial on the label.

2. The pharmacist shall double check that the medication was prepared appropriately and document this process with their initials on the label.

3. The medication shall be placed in a plastic bag whenever possible and shall be delivered to the nursing units.

B. For compounded sterile products, refer to policy PH.26.04 Sterile Drug Preparation, Labeling, End Product Evaluation and Record Keeping.

C. For unit dose medication packaging, refer to policy PH.31 Drug Packaging.

D. Bulk pharmacy items and topical medications shall be directly labeled on the container.

E. Liquid medications

a. For adult patients, liquid medications shall be dispensed in manufactured unit dose containers whenever possible. In the event a medication is not available in unit dose containers, the Pharmacy shall pre-package and label the medication into a unit dose container.

b. For pediatric and neonatal patients, liquid medications shall be drawn into dose specific oral syringes whenever possible.

c. The Pharmacy shall maintain documentation of the manufacturer, lot number, and expiration date of source container, initials of preparing pharmacy technician, and initials of checking pharmacist.

F. Pill splitting: Pharmacy may split and pre-package standard unit dose partial tablets. Non-standard partial tablets are split by the nurse prior to administration. Nursing shall use a patient specific pill splitting device obtained from Central supply.

G. Pill crushing: For those medications that can be crushed, pharmacy and nursing shall use the approved pill crusher.

V. Cleaning Agents, Solvents, Chemicals and Poisons

A. Labeling of repackaged products shall contain the name of the chemical, detergent, solvent, strength of the solution, the amount, lot number and expiration date when applicable. Additionally, any cautionary labels or warnings shall be affixed to the container when applicable.

B. The Pharmacy Department designee shall be an active member of the Infection Prevention Committee and shall be consulted on proper methods for prepackaging and labeling. The

pharmacist shall also verify that disinfectants are dispensed pre-mixed in the required concentrations, to ensure that staff are utilizing an effective product.

VI. Discharge medications

1. Discharge medications are not routinely dispensed to patients at time of discharge and are only provided in hardship situations (examples: self-pay, no insurance, undocumented status).
2. Discharge medication dispensed to inpatient or outpatients at the time of discharge shall have the following label information:
    a. Name, address and telephone number of the hospital Pharmacy
    b. Date and prescription number
    c. Name of the drug, strength and quantity dispensed
    d. The directions to the patient for use of the medication
    e. The name of the prescriber
    f. The initials of the dispensing Pharmacist
    g. Any required or other pertinent accessory cautionary labels
    h. Expiration date of the drug
3. When medications are dispensed at time of discharge, the following information shall be provided to the patient by a pharmacist or discharging nurse.
    1. Name of drug.
    2. Indication for the drug.
    3. Instruction on how to use the medication.
    4. Storage instructions.
    5. Common side effects of the medication.
    6. Patient drug information.
    7. Provide consultation on the medication.

All revision dates:	3/4/2020, 5/15/2019, 3/21/2019, 5/31/2017, 3/1/2014, 12/1/2011, 3/1/2011, 6/1/2006, 9/1/2003, 11/1/1998, 6/1/1995, 10/1/1992

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	2/15/2023

Step Description	Approver	Date
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/15/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	2/15/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2006*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/14/2023*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

PH.70 High Alert Medications

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) shall maintain a list of high alert medications in order to increase patient safety by identifying and implementing strategies to avoid preventable injuries.

While the Institute of Safe Medication Practices (ISMP) does not recommend independent double checks for all high alert medications, Pharmacy and Nursing staff shall complete independent double checks for select high risk medications, prior to medication dispensing and administration.

DEFINITIONS:

1. High Alert medications are those drugs that have been identified as potentially causing significant harm if administered incorrectly.

2. Independent double check (IDC) is a manual process requiring two licensed practitioners separately, checking each component of the work process and comparing the results. By conducting this double check independently of each other, the risk of bias is reduced, as two practitioners are less likely to make the same mistake.

3. Verification double check is the process where two licensed practitioners are simultaneously checking a portion of the work process.

4. Required witness cosign refers to the required Medication Administration Record (MAR) documentation by another licensed practitioner before the medication can be dispensed and/or administered.

5. The "seven rights" of safe medication administration includes verification of the following:

- Right patient,
- Right drug,
- Right dose,
- Right route,
- Right time,
- Right indication, and
- Right documentation.

PROCEDURE:

A. The Pharmacy and Therapeutics Committee, in conjunction with pharmacy and nursing services, shall review the list of "High Alert" medications every three (3) years or as indicated, addressing those high alert medications that have been identified from internal adverse drug events (medication errors and adverse drug reactions), Institute for Safe Medication Practices (ISMP), the U.S. Food and Drug Administration (FDA), and The Joint Commission (TJC). See Attachment A.

B. The "High Alert" medication list shall be made available in all patient care areas, for reference, and shall describe each medication or class of medication from the time of procurement, storage, ordering, preparing, administration, and monitoring.

C. Automated double check is a computerized system safeguard (e.g. bar code scanning) and should be used to compliment, not substitute, the 7 Rights of Safe Medication Administration.

D. Pharmacists shall perform independent double checks on chemotherapy/antineoplastic orders and intrathecal compounded sterile products

E. Pharmacists shall perform verification double checks on the following prior to dispensing:

1. Compounded high alert medications that are normally supplied premixed.
2. Pediatric, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) parenteral infusions
3. Parenteral nutrition (peripheral parenteral nutrition (PPN), total parenteral nutrition (TPN))
4. Cisatracurium infusions
5. Amphotericin infusions.
6. Continuous Renal Replacement Therapy (CRRT) fluids
7. In the event there is no second pharmacist available for a verification double check, a pharmacy technician shall perform the verification double check.

F. Nursing shall perform IDCs with required witness cosign on the following:

1. Anticoagulants (intravenous)
    a. Alteplase for stroke - bolus and start of infusion
    b. Argatroban infusion - start of infusion, rate changes, and bag changes
    c. Heparin infusions - bolus, start of infusion, rate changes, and bag changes
2. Chemotherapy/antineoplastics - before administration with two competent, licensed ~~healthcare~~health care providers
3. Hypertonic saline - start of infusion
4. Insulin intravenous (IV) infusion - before administration, rate changes, and bag changes
5. Magnesium 20 gm/500 mL - start of infusion (see policy OB.47 Magnesium Sulfate for Pre-Eclampsia and Tocolytic Therapy
6. Oxytocin for labor induction/augmentation - start of infusion and bag changes (see policy OB.30 Oxytocin use for Labor Induction/Augmentation)
7. Patient Controlled Analgesia (PCAs) - initial set up, reprogramming the pump, and with syringe changes (see policy 100.235 Patient-Controlled Analgesia (PCA)

G. Nursing ~~shall~~should perform ~~an IDC on~~ the following~~, but does not require witness cosign~~:

~~Titratable drips -- start of infusion and bag changes~~

~~Pressor dose medications (e.g. EPINEPHrine 10 mcg/mL and PHENYLephrine 100 mcg/mL)~~

1. ~~Pump~~Independent double check at pump change (e.g., between an Alaris pump and an ~~Iradimed~~ MRI pump)
2. ~~It is best practice for nurses to complete a beside~~Bedside review of all infusions at start of shift.

H. ~~Nursing~~The licensed health care provider shall perform verification double checks, with required witness cosign on the following medications:

1. Emergency Department (ED) administration of ALL pediatric, NICU, and PICU parenteral medications - before administration.
2. ~~Inhaled~~Respiratory Therapist administration of inhaled epoprostenol ~~with Respiratory Therapist~~ - start of therapy (see policy R.96 Inhaled Epoprostenol (Flolan))

Independent Double Check Procedure

Prior to medication administration, two licensed health care providers shall independently go through the steps in the double check procedure below and arrive at the same conclusion. IDC must be performed before the start of the infusion/before administration of the medication.

A. Identify the patient using two patient identifiers (name and date of birth). See policy 100.088 Patient Identification

B. Review allergies and sensitivities

C. Compare the most current prescriber order or medication administration record to the medication label to verify:

1. Right patient name
2. Right drug
   a. Right diluent if applicable
   b. Right concentration if applicable
3. Right dose
   a. Right weight based dosing if applicable
   b. Right rate of administration
4. Right frequency and time of administration
5. Right route
6. Right indication
7. Right documentation

D. Ensure the pharmacy label matches the manufacturer label (if appropriate).

E. Review expiration and/or beyond use date of the medication.

F. Perform any necessary calculations.

G. Review medication protocols when or if applicable (e.g. heparin protocol or TPN order)

H. Check the patient's relevant lab values and/or diagnostic results

I. Program the IV pump and review the settings. Confirm the rate and trace the lines.

J. If discrepancies exist, the two health care providers shall repeat the IDC process. If discrepancies remain, the health care provider shall clarify the medication order(s) with the provider.

K. If the IDC verifies the medication and process to be correct, both health care providers shall document that an IDC has been completed and the medication can be dispensed and/or administered.

L. Re-identify the patient (name and date of birth) immediately prior to administration.

All revision dates: 2/14/2023, 10/12/2021, 3/9/2021, 2/12/2020, 5/2/2019, 6/1/2008

Attachments

Attachment A - High Alert Medication List.pdf

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	2/14/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/14/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	2/14/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/1/2006*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/30/2022*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

PH.96 Medication Override from Automated Dispensing Cabinets

POLICY:

To define the use of the override function on ~~Pyxis~~automatic dispensing cabinet (ADC) system, Pyxis ES, and identify the best practices associated with its use.

PROCEDURE:

Override medications are medications that can be accessed by nursing staff before review of an order by the pharmacist. The purpose of the override function is to allow for quick administration of medications in emergency and immediate (STAT) situations. The Joint Commission (TJC) standard MM.05.01.01 requires all medication orders be reviewed by a pharmacist prior to dispensing of the drug. There are two allowable exceptions:

1. A licensed independent practitioner controls the ordering, preparation, and administration of the drug, such as in the Operating Room, Gastroenterology Lab (GI Lab), Emergency Department and the Radiology Department.
2. Emergencies, when time does not permit the pharmacist to review the medication order, such as in a STAT situation when patient harm could result from delay in administration of a medication.

Accessing, "first dose" medications prior to pharmacist review in "routine situations" violates the TJC Medication Use Standards, therefore the following guidelines have been established.

Guidelines:

1. The automated dispensing cabinets (ADC), ~~Pyxis,~~ are interfaced with the electronic health record (EHR) such that all new orders must be reviewed and verified by a pharmacist before a nurse is able to access the medication in the dispensing machine.
2. The Pharmacy & Therapeutics Committee shall review the list of approved override medications ~~annually~~periodically (see Attachment A). The override list shall be developed by nursing leadership and the Pharmacy Department. Override medications in general shall only be utilized to access medications in emergency situations. Other non-emergency medications may be approved by the Pharmacy & Therapeutics Committee to be added to the override list if they have strong safety profiles.
    1. Institute of Safe Medication Practices (ISMP) recommends the override function for the following

circumstances:

a. Antidotes, rescue agents, and reversal agents

b. Life-sustaining medications

c. Urgent comfort measure medications (e.g., to manage acute pain or intractable nausea and vomiting)

3. Set up and control of the ~~Pyxis~~ADC override function is restricted to the System Administrators designated by the Pharmacy Director ~~of Pharmacy, Pharmacy Supervisor, and/or designee~~. See policy ~~PH.94 Pyxis Medstation Inventory Management.~~PH.92 Automated Dispensing Cabinet (ADC) Usage and Documentation
4. Prior to administration of a medication that has been removed by the override function, the following should be reviewed for appropriateness prior to administration.
   a. Drug, dose, frequency, and route of administration
   b. Therapeutic duplication
   c. Real or potential allergic reactions
   d. Real or potential drug - drug interactions or drug - food interactions, and laboratory values
   e. Other contraindications
   f. Variations from the organizational criteria for use
   g. Other relevant medication related issues or concerns
5. Patient safety should be considered in all decisions involving override medications.
6. Medications removed using the override function shall be reviewed by the Pharmacy Department on a weekly basis.

All revision dates: 12/30/2022, 3/4/2020, 3/21/2019, 2/1/2016, 10/1/2014, 8/1/2012, 4/1/2012, 8/1/2011, 3/1/2011, 9/1/2008

Attachments

Attachment A - Medication Override List.pdf

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	2/13/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	1/31/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	12/30/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/2012*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2023*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

PH.102 Pyxis Anesthesia System

POLICY:

The Pyxis Anesthesia System provides Ventura County Medical Center & Santa Paula Hospital with secure and identifiable access of medications to anesthesiologists and other staff in the Operating Room. The Pyxis Anesthesia System shall be maintained by the Pharmacy Department.

PROCEDURE:

Authorized Privileges for Access

A. ID/Password

1. Users shall include anesthesiologists, Operating Room (OR) nurses, OR technicians, Obstetrics (OB) nurse, pharmacists, and pharmacy technicians.
2. Security levels vary between users and may include access to only supplies and non-narcotics, or may include narcotics if within the individual's scope of practice.
3. Access to the Pyxis Anesthesia System (P-AS) shall be provided according to PH.92 Automated Dispensing Cabinet Usage and Documentation.

B. BioID scanning technology should be used in place of password whenever possible.

C. Users shall change their password as required.

D. Users shall exit the P-AS when leaving the OR suite. Anyone discovering a P-AS that has not been logged off shall document the incident into the notification system and notify management.

E. Access Privileges

1. Anesthesiologist, OR nurses, and pharmacy staff shall be able to access P-AS for removing, returning and refilling medications.
2. OB nurses shall be able to access P-AS for witness of controlled substance waste.
3. OR technicians shall be able to access P-AS for restocking supplies.
4. No other Pyxis users shall have access to P-AS.

F. Inactivate Users

1. Director of Surgical Services, Human Resources or the Medical Staff office shall notify the ~~Pharmacy Department~~Information Technology (IT) department of any employment or contract terminations.

2. The ~~Pharmacy Department~~IT department shall remove the terminated users from the Active Directory. Removal from Active Directory will remove user from Pyxis system.

G. Education/Training

1. All staff responsible for administering or handling medications shall receive training prior to use of the P-AS.
2. Training consists of the following:
   a. Self-guided tutorial completion.
   b. Review the P-AS system with a pharmacist, anesthesiologist or other certified trainer.
3. An annual review of the policies and procedures associated with P-AS shall be required with Director of Pharmacy Services or their designee.

H. Pyxis Anesthesia System Medications

1. Medications stored in P-AS are limited to those approved by the Department of Surgery under the Anesthesia Section Chairman, ~~Chief Medical Officer~~Director of Pharmacy Services, ~~Director of~~and the Pharmacy ~~Services and the Pharmacy~~ & Therapeutics Committee.

I. Medication Access

1. The P-AS shall contain medications used frequently in the OR and shall charge for these medications as they are removed from the station.
2. Controlled substances are contained in mini-drawers and dispensed one at a time.
3. Non-controlled substances are contained in drawers that unlock and remain unlocked while the anesthesiologist is using the P-AS.
4. Emergency drugs are available outside the P-AS.
5. Non-medication supplies shall be maintained in the P-AS by OR technicians.

J. Identification of Patient on the P-AS and Medication Removal

1. Whenever possible, a patient should be identified in the system and medication removal utilizing the patient's name, financial identification number (FIN), or medical record number (MRN).
2. If a patient does not appear on the P-AS census screen, the patient can be added using the Add Temporary Patient function.
3. In case of emergency where no account number is available, the patient's date of birth (DOB) or trauma number can be used as the account number.
4. Removing medications for multiple patient use is **not permitted**.

K. Returned Medications

1. Medications in the original, unopened package and charged but not administered to a patient may be returned using the Return Medication function and placed in the External Return Bin.
2. Return Medication function will allow all unused medications to be credited back to the patient.
3. Return Bin activity is a function and duty of the Pharmacy.
4. Refrigerated items returned in the Return Bin shall be destroyed by Pharmacy.

L. Waste Medications

1. All controlled substances removed from P-AS whether opened, partially used, or compromised in

terms of tamper resistance, shall be wasted and documented in the P-AS and physically disposed in the Controlled Substance RX (CSRX) waste bin.

2. Pharmacy staff shall routinely monitor the content of controlled substance returns with the use of return and waste report.

M. Transfer of Medications From One Patient to Another

1. Medications removed from one patient shall not be transferred and used on another patient.
2. Medication shall be returned using the return medication function. If the medication has been removed and prepared in a syringe, it shall be wasted.

N. Controlled Substance Documentation

1. ~~An All Station Activities report~~It is ~~generated when necessary to document disposition or discrepancy of each controlled substance removed from the P-AS. It is~~ the anesthesiologist's responsibility to accurately document the medication administered and to document any waste or return in the P-AS software.
2. A pharmacist shall complete and document physical inventory of all schedule II controlled substance medications quarterly in all P-AS units.
3. Pharmacy department will conduct routine surveillance of controlled substance use and documentation. If discrepancies in removal of medication from Pyxis or documentation on the electronic health record (EHR) is found, pharmacy will notify the individual anesthesiologist within 7 days of case completion. The anesthesiologist must respond to the inquiry within 2 business days of the initial notification.

O. System Management and Maintenance

1. P-AS Inventory
   a. The Pharmacy Department shall be responsible for maintaining inventory including, loading, restocking, emptying the return bin, unloading and removing outdates.
   b. The P-AS shall be refilled **at least once daily**.
   c. Outdates shall be tracked by P-AS, and shall be routinely checked.
   d. Outdates shall be removed from the P-AS and returned back to the Pharmacy Department.
2. Clinical personnel, including anesthesiologists and nurses, shall be responsible for administering medications per hospital policy (100.025 Medications: Ordering, Administration, and Documentation), properly identifying/selecting patients, removing, wasting and returning medications appropriately.
3. Pharmacy shall be called when the P-AS cannot be recovered by the clinical staff in the OR.

P. Downtime Procedures/Disaster Plan

1. All P-AS are connected to emergency power and have a battery that will keep the system functional for up to 15 minutes between power switches.
2. In the event of emergency power failure, the Pharmacy shall be contacted to bring keys to open any P-AS drawers that are unopened.
3. Medications removed from P-AS during a downtime is logged on a paper anesthesia record.
4. Pharmacy shall have custody of the PA-S keys at all times and the keys shall be stored in a secure place for manual access of the P-AS.

5. Power to the P-AS is never turned off unless instructed to do so by the Pharmacy Department or Pyxis Support.

Q. Paper Replacement

1. Pharmacy technicians shall check paper daily during the routine refilling of the P-AS and change paper when empty. ~~Paper shall also be stored within the P-AS for immediate replacement.~~

R. Reports

1. Reports used to ensure the P-AS is utilized according to policy.
   a. Daily Refill report for controlled substances ~~and non-controlled substances ran daily~~.
   b. Charge and Credit Report.
   c. Return and Waste Report.
   d. Controlled Substance Discrepancy Report.

All revision dates: 3/7/2023, 5/11/2022, 4/14/2020, 6/1/2012

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Surgery Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/30/2022
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	12/30/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/1985*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/16/2023*
Next Review:	*3 years after approval*
Owner:	*Jessica Rodriguez: Manager-Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.97 Handheld Resuscitation Bag and Mask Use

POLICY:

To provide ventilation and oxygenation to patients whose respirations are inadequate or absent, to pre-oxygenate patients before intubation, and to oxygenate patients during procedures, transport, cardiac arrest and/or mechanical failure.

EQUIPMENT

A. ~~Ambu~~Hand-held resuscitation bag with face mask and connection tubing

B. ~~Oxygen flowmeter and 0 $_2$ source~~Oxygen

1. Flow Meter
2. Oxygen Cylinder

C. Oral airway (if immediately available)

D. Suction equipment

PROCEDURE:

A. ~~Attach ambu bag's oxygen tubing to flowmeter.~~Attach resuscitation bag's connection tubing to oxygen source available.

B. Set flow rate at a minimum of 15 liter per minute.

C. Quickly suction mouth or nasopharynx, if necessary, to clear airway.

D. Open patient's airway by using the head tilt/jawlift technique or hyperextend head and insert oral airway. This prevents the tongue from falling back and occluding airway. (**Caution** : if the possibility of cervical spine injury exists,use jaw thrust technique and DO NOT hyperextend head.)

E. Ventilation via face mask:

1. Standing at head of bed, apply face mask to patient's face, with rounded cushion between lower lip and chin and narrow cushion high on bridge of nose.
2. With dominant hand, hold mask with thumb and forefinger (forming a "C") over mask to ensure seal. Use the other 3 fingers of that hand to hold up patient's mandible ("E" fingers). Avoid excessive downward pressure on patient's face.
3. With non-dominant hand, squeeze the ~~Ambu~~resuscitation bag to deliver enough air to make the

patient's chest visibly rise.

4. Keep head and neck hyperextended, mandible forward and shoulders slightly elevated. This position elevates base of tongue from pharynx and keeps airway open.
5. Preferred is the 2-person technique: 1 st person stands at head of bed using both hands, fingers in "C" and "E" positions to make seal and lift mandible while 2 nd person squeezes bag.

F. Ventilation via intubation tube:

1. Remove face mask from ~~ambu~~resuscitation bag.
2. Connect ~~ambu bag~~ directly to endotracheal or tracheostomy tube **with cuff inflated** .
3. If patient is on a ventilator and has a cardiac arrest, take him/her off and ventilate with ~~Ambu~~resuscitation bag. Neither adequate lung volume nor proper timing can be achieved with a patient on a ventilator while external cardiac massage is being performed.

G. Squeeze bag and watch for chest expansion. Release to allow patient to exhale. ~~(Adult rate: 8-12/min. or every 5 sec; Child/Infant rate: 12-20/min. or every 3-5 seconds.)~~

H. If no chest expansion is observed:

1. check fit of mask.
2. check oral airway placement.
3. check hyperextension of head and neck.
4. listen for breath sounds

I. When Spontaneous Respirations are present, coincide bag inflation with patient's inspiratory effort. If patient has gasping, shallow or less than12 respirations per minute, supplementary inflations may be required.

J. Oxygenation level should be monitored by $Sp0_2$ (Oxygen Saturation level) device. Ventilation status should should be monitored by end-tidal $C0_2$ (Carbon Dioxide) device if available.

K. Care of equipment:

1. Store at bedside. Single patient use. Dispose of and replace if soiled with emesis, blood or thick secretions.
2. Disposable ~~ambu bags~~resuscitation bag are available from Central Supply in adult and/or child/Infant sizes.

DOCUMENTATION:

A. Electronic Health Record (EHR) intervention

B. Cardiopulmonary Resuscitation Form (for Code Blues)

All revision dates: 2/16/2023, 10/1/2016, 12/1/2013, 11/1/2012, 11/1/2009, 5/1/2008, 12/1/2004, 10/1/2001, 6/1/1998, 6/1/1995, 6/1/1992, 6/1/1991, 6/1/1990, 6/1/1989, 6/1/1988, 6/1/1987, 6/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine and Pediatrics	Tracy Chapman: VCMC - Med Staff	pending
Respiratory Care	Jessica Rodriguez: Manager-Cardiopulmonary Services	12/6/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1999*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/21/2022*
Next Review:	*3 years after approval*
Owner:	*Jessica Rodriguez: Manager-Cardiopulmonary Services*
Policy Area:	*Respiratory-NICU/PICU*
References:	

R.NP.01 Aerosolized Medications in the NICU

POLICY:

~~The lungs have more potential surface area for molecular exchange with blood than any other organ. Aerosolizing medications is a rapid means of achieving blood levels of particular drugs. Some medications are aerosolized for bronchodilating effects or to decrease tracheal swelling.~~

~~PROCEDURE:~~

~~LEVEL:~~

~~Dependent – The Neonatologist and/or NNP orders the appropriate medication via the Electronic Health Record. The respiratory therapist delivers the aerosolized treatments as ordered by the physician/NNP.~~

~~SUPPORTIVE DATA:~~

1. ~~Indications:~~
    i. ~~Albuterol: changes smooth muscle tone, dilates airways and relieves and prevents bronchospasm.~~
    ii. ~~Normal saline: used as a diluent and liquefies secretions.~~
    iii. ~~Racemic epinephrine: for stridor following extubation, decreases laryngeal swelling.~~
    iv. ~~Considerations:~~
        a. ~~The respiratory therapist will evaluate the appropriateness of using a HHN (hand held nebulizer) by monitoring the patient's breath sounds, heart rate, color and respiratory effort.~~
        b. ~~Treatments may be:~~
            1. ~~Hand bagged~~
            2. ~~In line with the ventilator for high flow set up~~
            3. ~~If patient needs deeper breaths than is spontaneously breathing~~
            4. ~~Blow-by, preferably with mask~~

To define the indications, procedure, method and documentation of aerosolized medication

EQUIPMENT:

1. Nebulizer
   a. Hand Held Nebulizer (HHN)
   b. Aerogen Nebulizer with appropriate adapters
2. Blender ~~–~~with pressurized gas source, set at patient's $FiO_{~~2~~}2$ or slightly higher
3. Flow meter with nipple adaptor

   ~~HHN kit~~
4. Resuscitation bag if treatment to be bagged in or masked continuous positive airway pressure (MCPAP)
5. Appropriate Personal Protective Equipment (PPE)

PROCEDURE – FREE FLOW:

1. Verify order written, in the electronic health record (EHR), by the Neonatologist or Neonatal Nurse Practitioner (NNP).
2. Wash hands before giving HHN treatment.
3. Don appropriate PPE.
4. Assemble HHN and get medications.
5. Verify patient identification using two identifiers.
6. Verify dosage and expiration date of medication.
7. Explain procedure to parents if applicable.
8. Assess patient for respiratory rate (RR), heart rate (HR) , breath sounds, work of breathing (WOB), and patient condition.
9. Assemble equipment. Place patient label on nebulizer, date and initial.
10. Check medication in the EHR and documents on the Medication Administration Record (MAR). Add prescribed medication to nebulizer cup. ~~Check medication in the EHR and documents on the Medication Administration Record.~~ Position patient properly.
11. Turn on flow generator to 6 – ~~7~~8 liters per minute.
12. With nebulizer in place, allow the patient to breathe at normal tidal volume until treatment is completed.
13. Perform chest physiotherapy treatment (CPT) if applicable and if ordered.
14. Suction if appropriate.
15. Assess patient as in #6.
16. Clean nebulizer and place in patient's bedside equipment bag.
17. Return patient to previous status of comfort and safety.
18. Wash hands.
19. Document procedure in EHR.

PROCEDURE – INTUBATED AND ON VENTILATOR:

1. ~~Assemble equipment.~~
2. ~~Attach nebulizer in line with ventilator set up at patient "Y".~~
3. ~~Attach drive line to flow meter with blender – utilizing same FiO_2 as patient is receiving on ventilator. Turn on flow generator to 5 – 6 liters per minute. Remember to remove the flow transducer prior to initiation of therapy.~~
    i. ~~Duration of treatment is until medication is consumed. Remember to replace the flow transducer after the treatment is completed.~~
4. ~~Add prescribed medication to the nebulizer cup. Check medication and document in the EHR and MAR.~~
1. Assemble equipment.
2. Assess patient for RR, HR, breath sounds, work of breathing (WOB) and patient condition
3. Make sure Aerogen controller and alternating current (AC) adapter are plugged in.
    i. Duration of treatment is until medication is consumed.
4. Check medication and document in the EHR and MAR. Add prescribed medication to the nebulizer cup.

PROCEDURE - HEATED HIGH-FLOW NASAL CANNULA:

1. Assemble equipment
2. Assess patient for RR, HR, breath sounds, WOB, and patient condition.
3. Attach Aerogen nebulizer to dry side of heater.
4. Make sure Aerogen controller and AC adapter are plugged in.
5. Verify dosage and expiration date of medicine.
6. Check medication and document in the EHR and MAR. Add prescribed medication to the nebulizer cup.

PROCEDURE - MCPAP AND PPV

1. Assemble equipment.
2. Assess patient for RR, HR, breath sounds, WOB, and patient condition.
3. Attach nebulizer to flow-inflating bag. Ensure appropriate level of continuous positive airway pressure (CPAP) on flow-inflating bag per physician's order.
4. Verify dosage and expiration date of medicine.
5. If giving MCPAP, apply with ordered level of CPAP. Give positive pressure ventilation (PPV) breaths only if ordered by physician.
6. Check medication and document in the EHR and MAR. Add prescribed medication to the nebulizer cup.

STORAGE AND HANDLING OF MEDICATIONS:

Medications are stored and distributed by pharmacy department. Respiratory therapy will document administration in the patient's MAR and in the EHR.

DOCUMENTATION:

1. Time and date
2. Heart rate – before and after

   ~~FiO_2~~
3. Respiratory rate – before and after
4. Fraction of inspired oxygen (FiO_2)
5. Medication and diluent
6. Method of delivery – bagged/PPV, MCPAP, blow-by, in line with ventilator, or in line with high -flow nasal cannula (if on a Servo-I medication cannot be given in line)
7. Breath sounds
8. Effects of therapy and adverse reactions

COMPLICATIONS:

The major complication which can develop during a treatment is an adverse reaction to the medication by the patient. If this occurs, the therapist should discontinue the treatment, notify the Neonatologist and the NNP. Common adverse reactions are tachycardia and hyperactivity. If giving in line with ventilator, breaking the circuit may cause desaturations. Additionally, increasing flow on the ventilator may cause increased volume and increased peak inspiratory pressures (PIPs).

~~DOSAGE:~~

1. ~~Albuterol: 0.1 – 0.5 mg diluted to a total volume of 2 – 3 ml with normal saline~~
2. ~~Racemic epinephrine: 0.15 – 0.25 ml diluted to a total volume of 2 – 3 ml with normal saline~~
3. ~~Xopenex: 0.63 mg diluted to a total volume of 2 – 3 ml with normal saline~~
4. ~~Atrovent: 0.5 mg diluted to a total volume of 2 – 3 ml with normal saline~~
5. ~~Occasional use of Tobramycin: 10 mg diluted to a total volume of 2 – 3 ml with normal saline~~

All revision dates: 11/21/2022, 11/1/2013, 3/1/2010, 1/1/2006, 1/1/2004, 6/1/2001, 1/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics	Sul Jung: Associate Director of Pharmacy Services	2/13/2023

Step Description	Approver	Date
Committee		
Respiratory Care	Jessica Rodriguez: Manager-Cardiopulmonary Services	12/6/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/2009*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2023*
Next Review:	*3 years after approval*
Owner:	*Christian Gallagher: Physical Therapy*
Policy Area:	*Rehab Services*
References:	

RS.09 Outpatient Rehab Services Pediatric Infectious Disease Management

POLICY:

To provide guidelines for reducing the spread of common pediatric infectious diseases in the Outpatient Rehab Services Department.

PROCEDURE:

Children who have had exposure to the common infectious diseases shall be required to discontinue therapy until the likelihood of spreading the disease is reduced or eliminated.

Guidelines:

- Fever greater than 100.5°: Discontinue therapy until fever is resolved.
- Chicken pox:
  - If a child has been exposed, discontinue therapy from the 10th day through the 21st day after exposure, even if no lesions occur.
  - Active disease: Discontinue therapy for six (6) days after the last lesion has crusted over and the child is non-febrile.
- Head Lice: Discontinue therapy until all lice have been treated and visual inspection reveals no ~~gnats~~nits or eggs.
- Scabies:
  - Discontinue therapy until all mites and eggs are destroyed by treatment.
  - Obtain a signed release from the physician or nurse prior to resuming care.
- Ringworm: Discontinue therapy until all lesions have healed.
- Pink Eye/Conjunctivitis: Discontinue therapy until all symptoms have cleared, including eye drainage.

All revision dates: 3/7/2023, 2/26/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	6/28/2022
Rehab Services	Christian Gallagher: Physical Therapy	12/2/2021

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/2017*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/11/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

CSU.04 Crisis Stabilization Unit (CSU) Operation and Patient Flow

POLICY:

The Ventura County Medical Center (VCMC) Crisis Stabilization Unit (CSU) identifies and treats members of the community that are in need of outpatient mental health services.

PROCEDURE:

1. Initiation
    a. For patients that present to the CSU voluntarily, follow Administrative policy 100.203, *Patient Transport/Escort to and From the Inpatient Psychiatric Unit (IPU) and (CSU), the Emergency Department (ED) and Inpatient Acute Care Units.*
    b. Any patient that presents to the CSU:
        1. Will have the following skin assessment/contraband check. This assessment/check will include the patient taking off all of their clothes in one of the quiet rooms, including undergarments and socks. Two ~~same gender~~ staff, one of whom is licensed, will assist the patient. Belongings will be separated and searched for contraband. The staff will politely check the back of the person, and then, respectfully and briefly, check the front to ensure that no contraband is present on the person, and that the skin is intact. Once the assessment/check has been completed, the patient may have their searched clothes returned or offered pajamas.
        2. Should a patient decline to turn over their belongings or comply with the skin assessment check, he or she will be placed on a 1:1 observation immediately in the hallway. The 1:1 observation will continue until the patient cooperates with the skin assessment/contraband check.
        3. Contraband will be stored in a locked secure area.
        4. Medications that are to be stored or brought in from home, please follow policy *PH.46 Storage and Security of Medication*s.
    c. Each patient will be assessed by a licensed nurse upon admission. A history of high-risk behaviors, factors that may increase risk, current symptoms and behaviors will be identified and documented. All acute medical needs will be identified and reported to a physician.
    d. An initial treatment plan will be initiated based on the nursing assessment.
    e. Patient location and activity will be documented on a fixed interval of every 10 minutes and a variable

ratio check within the 10 minutes. Licensed nursing staff will document patient location and activity every hour.

f. No patient is to be discharged from the CSU without a physician order.

g. Patients that are determined to need inpatient services will be provided those services as soon as possible. Should a patient have insurance that contracts with a specific inpatient service, the patient should be sent to that contracted facility. If it is determined by a physician the patient is in an acute psychiatric emergency, the VCMC inpatient psychiatric unit (IPU) may be utilized.

h. A transfer order will be obtained when a patient is transferred to an outside inpatient psychiatric unit.

i. A milieu monitor will be in the hallways at all times to address patients needs.

j. Nursing staff-to-patient ratio will be at a maximum of 1:4. RNs must make up at least 50% of the ratio. For example, a census of 1 to 4 has to have one (1) RN. A census of 5 to 8 shall have one (1) RN and one (1) LVN/LPT. A census of 9 to 12, shall have two (2) RNs and one (1) LPT/LVN.

k. Outlying emergency departments can send patients to the CSU after the following conditions have been met:

   I. A medical screening exam (MSE) has been performed

   II. A psychiatrist has accepted the patient

   III. A bed is available

   IV. Nursing is staffed to the appropriate nurse-to-patient ratio

l. Potential patients in outlying emergency departments will be placed on the "outlier board" in the order the calls are received.

m. Patients on the outlier board will be addressed for potential transfer to the CSU at least twice daily, once on the day shift and once on the night shift. Outlying emergency departments will be updated in regard to the status of the potential transfer at least once per shift as well.

n. All patients that connect to the IPU lobby or back door will be logged into a log book.

All revision dates: 1/11/2023, 6/13/2019, 1/1/2017

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee, Medical Executive & Oversight Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

Step Description	Approver	Date
Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/11/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/1/2009*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.02 Advance Healthcare Directives in the IPU

POLICY:

Advance Healthcare Directives is a document that provides a mechanism for patients to direct their own health care decisions such as agreeing to or refusing certain treatment when they are unable to provide informed consent, (e.g. comatose state, impaired mental status, inability to communicate). Patients may use Advance Healthcare Directives to: (1) Appoint a Health Care Agent to make health care decisions on their behalf and/or (2) To establish individual Healthcare Instructions. Patients may choose to complete either one or both of these options. Each part alone is legally binding.

Ventura County Medical Center (VCMC) informs patients of their right to formulate an Advance Directive and honors established directives or decisions specified by an authorized Agent within the limits of the law and within VCMC's mission, philosophy and capabilities (see VCMC Administrative policy 100.0490). Any patient over 18 years of age who has "capacity" may complete an Advance Directive. "Capacity" means that the patient understands the nature and consequences of the proposed health care, including the risks and benefits, and is able to make or communicate his/her health care decisions.

California Probate Code Section 4600 now allows for the provisions of Mental Health Instructions, sometimes referred to as Psychiatric Advance Directives. Instructions may not include decisions for placement into an acute psychiatric facility, convulsive treatment, psychosurgery, elective sterilization, or abortion.

PROCEDURE:

1. During the admission process, the admitting nurse (team LNS) will supply the patient (over the age of 18 years) with an Advance Directive Brochure (see attached sample) and sign the Advance Directive Inquiry Form (ADIF) to indicate patient receipt of the brochure. **NOTE:** In many instances, the patients will be unable to receive the brochure (e.g. acute altered mental status or combative). In these cases the information will be given to the family members, if available or at a later point when the patient is ready.

   Healthcare provider's responsibilities include:

   - The hospital determines whether a patient has or wishes to make an Advance Directive and honors Directives within the limits of the capabilities (TJC Standard RI. 1.2.4).
   - Comply with the individual healthcare instructions or decisions made by the healthcare agent. Failure to follow an Advance Directive may result in liability for damages (Cal. Probate Code 4742).
   - Maintaining Advance Directives in the patient medical record (Cal. Probate Code 4731 (a)).

- Notifying the designated healthcare agent that the patient lacks capacity (Cal. Probate Code 4732).
- Providing the designated agent access to the patient's medical record (Cal. Probate Code 4678).
- May not require or prohibit the execution or revocation of an Advance Directive as a condition of admission or providing health care (Cal. Probate Code 4677).

2. The LNS will ask if the patient would like additional information regarding Advance Directives and document accordingly on the ADIF. Patients who request more information will be referred to the Team Social Worker or Director of Social Services. The Team Social Worker will provide additional information as requested and document accordingly on the ADIF. **NOTE:** Social Services Staff will maintain competency on the provision of information and the assistance in development of Advance Directives and locating established Advanced Directives for filing in the medical record.
3. If the patient indicates that he/she has an Advance Directive that is filed in the medical record (soft chart), the LNS should access the chart through Health Information Management, communicate the content to the Treatment Team, and document accordingly on the ADIF. If the Advance Directive is not in the medical record, Team LNS will attempt to make arrangements for access of a copy for the medical record.
4. The Advance Directive must contain all of the following elements to be considered legally valid:
   - Statement of the patient's intent to create an Advance Directive
   - Signature of the patient and date of signature
   - Signatures of two (2) witnesses or a Notary Public and official stamp
5. Patients who wish to formulate an Advance Directive need to have approval by the Attending Physician to insure that they have present "capacity." If the Team physician is determined that the patient has the requisite capacity, he/she should document on the Physician Assessment form. Patients approved for this process will be referred to the Team Social Worker who will assist the patient if formulating an Advance Directive.
6. For patients who have an established Advance Directive not in the medical record, Social Services will attempt to locate a copy of the Advance Directive and place in patient's medical record. **NOTE:**
7. Advance Directives filed in the patient's old record (soft chart) are still valid unless they have passed their expiration date.
8. An Advance Directive is activated if a patient lacks "capacity" to give informed consent. The Attending Physician will make the determination if the patient lacks "capacity". **NOTE:** The fact that a patient has been admitted to a mental health facility, does not, in itself, mean that the patient lacks capacity. An Advance Directive is no longer in effect as soon as the person regains the capacity to make health care decisions. The patient's primary physician will make the determination when the patient's capacity is restored and document accordingly.
9. If a patient has an Advance Directive specifying mental health instructions, every effort will be made to comply with the instructions within the scope of the law, department policy and procedures, and the patient's treatment plan.
   a. A healthcare agent cannot authorize any treatment that the patient objects to, even though the patient is deemed to lack capacity by the primary physician.
   b. A healthcare provider may decline to comply with a healthcare instruction that requires medically ineffective health care or health care that is contrary to generally accepted health care standards.

c. LPS law supersedes Advance Directives. 5150's, Certifications, and Riese proceedings shall continue as needed.

d. Administration of emergency medications and other emergency procedures such as use of Seclusion or Restraint may be utilized even though they may not be authorized by the Advance Directive.

10. Patients having capacity may revoke the designation of an agent and may revoke or modify any and all part of an Advance Directive in writing or by personally informing a healthcare provider. Advance Directives do not expire unless a specific expiration date is stated in the document.

11. Any question regarding the compliance of a Mental Health Advance Directive will be routed to the Administrator.

All revision dates: 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 10/1/2001, 2/1/2000, 9/1/1998, 12/1/1997, 5/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/1995*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.06 Psychological Testing in the IPU

POLICY:

Psychological testing is available for Inpatient Psychiatric Unit (IPU) patients when the results are needed for a diagnosis and/or to establish a plan of treatment during acute care hospitalization, to help with discharge placement decisions or for legal purposes. The attending psychiatrist can request psychological testing for their patient upon approval of the IPU Medical Director.

PROCEDURE:

~~ACUTE CARE~~ PSYCHIATRIST:

Send completed consultation form to the IPU Medical Director.

IPU MEDICAL DIRECTOR:

1. Along with the attending psychiatrist, determine whether to proceed with the request for psychological testing.
    a. If the decision is approved, the IPU Medical Director or attending psychiatrist will write the order for psychological testing.
    b. It is recommended that the order be written to allow the psychologist to determine the type of tests and the time of testing.

In case an order is written:

LICENSED NURSING STAFF:

1. Route a request for psychological testing to the IPU ~~Operations Officer~~Manager for approval. If the IPU ~~Operations Officer~~Manager is absent, contact the IPU Shift Supervisor/Charge Nurse and/or the Administrator on Duty.
2. Arrange for the psychologist to complete testing. The IPU may contract with a private psychologist or contact the Behavioral Health Director to request a psychologist.
3. Report on the testing arrangements to the Shift Supervisor/Charge Nurse. Normal processing of the aforementioned should be completed with 24 hours. Special arrangements may require more time.

~~SHIFT SUPERVISOR/CLINICAL NURSE MANAGER:~~

IPU STAFF:

Ensure that the arrangements for testing are documented in the ~~patient~~Electronic Health record ~~and in the patient appointment schedule book~~.

All revision dates: 10/17/2022, 5/14/2018, 3/1/2009, 8/1/2008, 3/1/2008, 10/1/2004, 6/1/2000, 2/1/2000, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	12/10/2021

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1998*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/18/2020*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.07 Medical Treatment of Patients in the In-Patient Psychiatric Unit (IPU)

POLICY:

Treatment for physical/medical conditions is important for the well-being of the acute psychiatric patient in the Inpatient Unit (IPU) at Ventura County Medical Center. It is therefore policy that appropriate medical treatment and procedures be carried out in a timely manner.

PROCEDURE:

Nursing Staff:

1. Assess patient's condition and response to treatment
2. Complete treatment as ordered
3. Treatment times in the IPU:

Daily:	09:30
BID:	09:30 and 17:30
TID:	09:30,13:30 and 17:30
QID:	09:30, 13:30, 17:30 and 21:30

4. Documentation:
   a. Record in Nursing Progress Note treatment given and patient response.
   b. Document completion of the treatment in the electronic health record (EHR).

All revision dates: 2/18/2020, 1/1/2015, 6/1/2014, 4/1/2011, 9/1/2009, 3/1/2009, 8/1/2008, 10/1/2006, 10/1/2004, 2/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/3/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/1991*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/12/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.09 IPU Patient Safety Precautions

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) identifies patients at risk for ~~Absent without leave (AWOL)~~Elopement, assault, self-harm, suicidal behaviors, damage to property, or infringement on the rights of others and, while protecting patients' rights, provides special levels of observation and intervention in order to maximize the safety of patients, visitors, and staff. These observations and interventions are documented in the patient record.

PROCEDURE:

1. Initiation
    a. All patients admitted to the IPU:
        1. Will have a skin assessment/contraband check. Assessment/contraband check entails the patient removing all clothing in a quiet room, including undergarments and socks, and donning a ~~paper~~ gown. Two same-gender staff(when available), one of whom is licensed, will assist the patient. Once the patient has donned the ~~paper~~ gown, the patient's belongings will be separated and searched for contraband. Staff will politely check the back of the patient's body with the gown covering the front, and then, respectfully and briefly, check the front of the patient's body without the gown to ensure that no contraband is present on the person and that the patient's skin is intact. Once the assessment/check has been completed, the patient may have their searched clothes returned or they can be offered pajamas.
        2. Should a patient decline to turn over their belongings or don the ~~paper~~ gown for the assessment/check, he or she will be immediately placed on 1:1 observation in the admission hallway. 1:1 observation will continue until the patient cooperates with the skin assessment/ contraband check.
    b. Physicians will assess each patient and identify those at risk during the initial Psychiatric Evaluation and on a daily basis using the current version of "Physician Progress Note." Based on the physician's assessment, the appropriate precaution and level will be ordered.
    c. Each patient will be assessed by an RN upon admission. Based on a history of high-risk behaviors, any pertinent factors that may increase risk, and the patient's current symptoms and behaviors, a recommendation will be ordered.
    d. All patients admitted without a face-to-face evaluation by a psychiatrist will be placed on routine

precautions at minimum until seen by a psychiatrist.

2. Levels of Intervention
   Please refer to the Adult Inpatient Psychiatric Clinical Practice Policy.
   a. **Routine Precaution:** All patients will be placed on routine precautions while they are hospitalized in the IPU.
      1. Advise patient of the precaution level and procedure involved.
      2. Observe patient every **15 minutes.**
      3. Observe patient on separate hallway variable rounds in between the 15 minutes.
      4. Assigned licensed nursing staff will assess the patient every shift.
   b. **1:2 Precaution**
      1. Patients may be admitted that require a higher level of observation and assessment. The physician may order a 1:2 staff-to-patient ratio. The observer is either located in the hallway ~~or observed via audio/visual monitor~~ where he/she can observe both patients concurrently.
      2. Advise patient of precaution level and procedure involved.
      3. Initiate Patient Observation Record
      4. Search patient room, locker, and bathroom for contraband.
      5. Notify the Shift Supervisor(SS)/Charge Nurse(CN).
      6. Patient is observed continuously, and has additional every 15 minute observation and variable rounds as part of routine precaution checks.
      7. The observer will document patient behavior and any signs of injury on a progress note. Documentation is encouraged hourly, however is not required to be performed concurrently.
      8. Reassessments are performed by an RN every four (4) hours and as needed according to the patient's condition with documentation of the outcome of the assessment in the Nursing Progress Notes required at least once per shift (concurrent documentation of reassessments is not required). The Progress note includes an assessment of the patient's behavioral health condition and is annotated in the "ABC" format. This format is based on clinical staff's observation, assessment, intervention and evaluation of the patient.
      9. Physician will reassess daily, during treatment team meetings, to determine level of risk and will continue or discontinue precautions and document in the Progress Record.
      10. If patient's condition has deteriorated, notify team or on-call physician for order to change level.
      11. Duration: A physician order for a 1:2 precautions will remain in place until the behavior or circumstance no longer requires the use of 1:2 observation. Order must be renewed each calendar day.
      12. Accompany patient to bathroom/shower. The door shall be kept slightly open with all suicidal patients to monitor and ensure safety and attempt to provide same gender staff. Staff will stand within close proximity.
   c. **1:1 Precautions**
      1. Patients may be admitted that require a higher level of observation and assessment. The physician may order a 1:1 staff-to-patient ratio. The observer is either located in the hallway ~~or observed via audio/visual monitor~~ where he/she can observe ~~both patients concurrently~~patient.

2. Advise patient of precaution and procedure involved.
3. Initiate Patient Observation Record.
4. Begin **1:1 constant observation** immediately. Physician **may** specify the maximum distance between patient and 1:1 staff.
5. Notify the SS/CN and the physician.
6. Search patient room, locker and bathroom.
7. Initiate hourly documentation.
8. Patient to be attended at all times.
9. Escort patient to all meals and activities.
10. Accompany patient to bathroom/shower. The door shall be kept slightly open with all suicidal patients to monitor and ensure safety and attempt to provide same gender staff. Staff will stand within close proximity.
11. Patient is observed continuously, and has additional every 15 minute observation and variable rounds as part of routine precaution checks.
12. The observer will document patient behavior and any signs of injury on a progress note. Documentation is encouraged hourly, however is not required to be performed concurrently.
13. Reassessments are performed by an RN every four (4) hours and as needed according to the patient's condition with documentation of the outcome of the assessment in the Nursing Progress Notes required at least once per shift (concurrent documentation of reassessments is not required). The Progress note includes an assessment of the patient's behavioral health condition and is annotated in the "ABC" format. This format is based on clinical staff's observation, assessment, intervention and evaluation of the patient.
14. Physician will reassess daily during treatment team meetings, to determine level of risk and will continue or discontinue precautions and document in the Progress Record.
15. Duration: A physician order for a 1:1 precautions will remain in place until the behavior or circumstance no longer requires the use of 1:1 observation. Order must be renewed each calendar day.

All revision dates:	1/12/2023, 12/12/2019, 7/26/2017, 7/1/2015, 2/1/2014, 3/1/2009, 8/1/2008, 9/1/2007, 10/1/2004, 7/1/2003, 3/1/2003, 11/1/2002, 6/1/2002, 1/1/2002, 3/1/2001, 6/1/2000, 4/1/1999, 11/1/1998, 4/1/1996, 2/1/1996, 7/1/1995, 5/1/1995, 2/1/1995, 1/1/1994

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/12/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/2002*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.11 Nicotine Replacement Therapy in the IPU

POLICY:

In an effort to further enhance the health of patients, the Ventura County Medical Center Inpatient Psychiatric Unit (IPU) offers a smoking cessation program. Transdermal Nicotine Replacement Therapy (NRT) is available as part of this program.

PROCEDURE:

On admission, the physician and nursing staff will assess nicotine use with the following parameters:

a. Number of cigarettes smoked per day (24-hour period)
b. Desire to quit
c. Desire to use nicotine replacement therapy

If the patient is unable to provide pertinent history upon admission, reassess as soon as clinical condition allows.

a. RN should document patient response on the Nursing Assessment Form.
b. RN is to inform physician of patient response and request order for NRT, if applicable.

If indicated, the physician writing the Admission Orders will check off the appropriate order on the "Admission Orders" sheet for the smoking cessation program and then use a standard physician order form to write an order for NRT. The physician should discuss side effects of the smoking patch with the patient.

a. NRT can be ordered as a 7 mg, 14 mg, or 21 mg patch
    1. A cigarette provides the equivalent of 1 mg of nicotine
    2. Do not cut a patch into smaller pieces

The patch will be initially applied or replaced every day at 8:30 A.M.

a. The patient may refuse the patch.
b. Wash hands after application.
c. Dispose of adhesive from patch in medical waste container
d. Patient should be instructed that smoking is prohibited while on the patch, and that the patch will be discontinued if they smoke while on the unit.

e. Nursing staff will provide the patient with verbal and written information regarding the nicotine patch, as appropriate.

f. The physician may specify an alternative time of day for application. If written as "daily," the patch will be applied at 8:30 A.M.

Once initiated, a new patch will be applied every 24 hours. If the patch falls off, the same mg dosage patch will be reapplied immediately. The patch will be removed daily at 10:00 P.M. or at patient's request.

The patient will not have a patch on overnight, unless ordered by the physician.

a. When disposing of a patch, fold the sticky ends of the patch together before disposal.

b. Dispose of used patches in the medical waste container.

Any patient found smoking during their stay will have their patch discontinued for the duration of their current hospital stay.

a. Nursing will track the patients currently on nicotine replacement.

If a patient wishes to continue or initiate smoking cessation after discharge, they will receive verbal and written information regarding smoking cessation, including the use of the patch, if appropriate.

a. The patient will be instructed not to smoke when on the patch.

b. Nursing will provide the patient with information regarding resources for nicotine cessation programs and continuation of the patch, if appropriate.

c. Ambulatory care appointments for follow-up NRT will be provided for patients who wish to continue smoking cessation after discharge.

All revision dates: 10/17/2022, 3/8/2018, 2/1/2015, 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2006, 10/1/2004, 10/1/2003, 7/1/2002

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/1/2016*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.12 Urine Drug Screens in the IPU

POLICY:

To obtain a urine drug screen on all consenting patients admitted to our facility. It is our expectation that these specimens will be obtained at the time of admission or within 24 hours of admission. The collection of the specimen will be documented on the Urine Collection Record and kept in the patient record.

PROCEDURE:

URINE PREGNANCY (WHEN APPROPRIATE) and DRUG SCREEN

A. Initiate the collection record at the time of admission.

B. Attempt collection at the time of admission or any time during the process.

   1. Drug abuse screen can be run so long as urine has been refrigerated.
      Urinalysis can be run up to six (6) hours post collection, if refrigerated. Drug screens have no time limit.

C. Attempt every shift until obtained.

   1. Team RN is responsible to assign.

D. Document all attempts on the collection record.

   1. Keep collection record in lab collection book until obtained. Once obtained, place record in chart.

E. Inform the oncoming shift if unable to obtain.

   1. Team RN giving report is responsible to notify.

F. Patient has right to refuse lab.

All revision dates: 2/1/2016, 3/1/2009, 2/1/2007, 9/1/2004, 2/1/2000, 2/1/1998

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/12/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/9/2023*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.13 Patient Room Assignments in the IPU

POLICY:

Assignment of patients to rooms in the Inpatient Psychiatric Unit (IPU) is done to promote compatibility and to enhance safety of the patients and staff. Procedure identifies risk responsibilities for communication and documentation.

PROCEDURE:

ROOM/BED ASSIGNMENT

A. Shift Supervisor (SS) /Charge Nurse (CN)

1. Identify bed availability.
2. Assess for clinically appropriate compatibility and safety.
   Clinical assessment should take into consideration factors such as known risks and alerts as well as the patient's psychiatric status. For example, an individual who is a danger to self may be more suitable for a semi-private room and conversely, an assault risk patient to a private room.
3. Assign to semi-private room with same gender or to a private room.
4. Assess and provide for special needs of individual patients.
   These needs may be known at admission or later in the hospitalization and include but not be limited to:
   - Medical needs (i.e., seizures)
   - Activities of Daily Living (ADL'S) (ex: incontinence)
   - Visual/Hearing Impairment
   - ~~D.D. (~~Developmentally Disabled~~)~~

   ~~Provide for assistive devices as needed.~~
   ~~Careful assessment must be made related to assistive devices to determine if additional risks are posed and managed accordingly. Assessment must also include whether such devices are for medical necessity or for behavioral restraint. Refer to Policy and Procedure, *Seclusion and Restraint*.~~

   ~~Patients requiring a bed with bedrails should also be evaluated for requiring side rail padding.~~
   ~~*Assess for risk of potential strangulation due to altered mental status, seizures or sedation.*~~

B. Make room changes ASAP when indicated to maintain safety of patients, staff, visitors and environment.

C. Room Assignments are made at the discretion of the SS/CN , and are designed with the safety and dignity of the patient in mind.

D. Best efforts will be made to separate male and female patients to designated hallways until full.

E. Communicate bed change to clinical and clerical staff.

1. ~~Medical and LNS~~Nursing staff will:

   a. Enter room change into electronic health record

      ~~Call Pharmacy~~

   b. Change bed list

   c. Change "master"

~~Clerical staff will:~~

~~a. Enter bed change into Avatar~~

~~b. Change bed list~~

~~c. Change "master"~~

~~d. Call Admitting~~

~~Room assignments are made at the discretion of the SS/CN, and are designated as follows:~~

~~1. All female patients are to be assigned to Hallway A until all beds are full~~

~~2. All male patients are to be assigned to Hallway C until all beds are full~~

~~3. Bed assignments to Hallway B are to be made only as overflow~~

~~a. Any female patients will be assigned to the even numbered beds~~

~~b. Any male patients will be assigned to the odd numbered beds~~

~~4. When patients are assigned to Hallway B overflow beds, every effort will be made to move them to the appropriate hallway as soon as a bed is available.~~

All revision dates: 2/9/2023, 1/1/2015, 3/1/2010, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 3/1/2003, 7/1/2002, 3/1/2001, 9/1/2000, 2/1/2000, 6/1/1998, 2/1/1998, 10/1/1997, 5/1/1997, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/3/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/3/2023

Step Description	Approver	Date
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/3/2023
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/9/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/23/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.15 Notification of Patient Elopement

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) will notify the appropriate authorities of involuntary patients who ~~are absent without leave (AWOL)~~have Eloped from the unit.

PROCEDURE:

1. Determine if patient is missing from the unit.
    a. Notify Shift Supervisor/Charge Nurse (SS/CN) - May review camera footage covering the facility exits to confirm if patient exited the building and the time of the exit.
    b. Page the patient on "All Call" three (3) times within five (5) minutes (after 06:00 or before 23:00).
    c. Search the unit and surrounding areas.
2. Notify the following:
    a. IPU Medical Director, Operations Officer and Clinical Nurse Manager.
    b. VCMC Security - (805) 652-6283.
    c. Ventura Police Department - (805) 339-4400.
    d. Sheriff's Department: Camarillo (805) 388-5100, Fillmore (805) 524-2233, Moorpark (805) 532-2700, Ojai (805) 646-1414, Thousand Oaks (805) 494-8200.
    e. Law enforcement in the city of patient's residence.
    f. Physician on duty.
    g. Crisis Team: Oxnard (866) 998-2243, Thousand Oaks (805) 494-8253.
    h. Next of kin/significant other.
    If release of information on chart or if disclosure is necessary for the protection of the patient or others, without Release (Sec. 5328.3 WIC).
    i. Public Guardian/Conservator, as appropriate. Leave message if after hours. Public Guardian: (805) 654-3141.
    j. Board and care, if residence prior to admission.
    k. Administratively discharge patient at 23:59 if not returned ~~from AWOL~~. Obtain physician order.

DOCUMENTATION

1. Document in Progress Note:
    a. Time patient noted to be missing from the unit.
    b. Actions taken to locate the patient.
    c. List separately name of each individual/agency notified of patient ~~AWOL~~Elopement.
2. Complete Notification Form. Include how patient left the unit, if known.

DISPOSITION

Complete a second Notification Form to document the final disposition. Report that the patient was either discharged at 23:59 hours or report the time the patient returned to the unit.

All revision dates:	1/23/2023, 12/12/2019, 4/1/2011, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 2/1/2000, 5/1/1997, 2/1/1997, 6/1/1996, 6/1/1995, 3/1/1995

Attachments

Elopement by Patient

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/23/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/1990*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/12/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.18 Consent for Voluntary Inpatient Treatment

POLICY:

To provide an effective and legal admission to the Inpatient Psychiatric Unit (IPU) . All admitted patients will be screened to determine their capacity to give informed consent for treatment.

PROCEDURE:

~~The ACUTE CARE~~ PSYCHIATRIST or MENTAL HEALTH EVALUATOR will:

1. Use the following criteria to determine capacity to give informed consent:
    a. Patient is aware of his/her situation and condition.
    b. Patient is able to understand the benefits and risks of, as well as, alternatives to the proposed medication.
    c. Patient is able to rationally participate in his own treatment decisions and is capable of providing needed information.
2. Have the patient read the form or read it to him/her (Spanish is on the reverse side).
3. Answer any questions the patient may have.
4. Ask the patient to sign the form.
5. Sign as a witness to the patient's signature and date the form.
6. Give the patient a copy of the signed voluntary form.
7. Place the original in the legal section of the medical record.

~~ACUTE CARE~~ PSYCHIATRIST

~~1. Order "Admit to Inpatient Mental Health Voluntary Status" on Admission order sheet.~~

~~2. Provide order for change to Voluntary Status during course of hospitalization.~~

~~MEDICATION LNS:~~

1. Enter legal status in Cerner.

Inpatient Psychiatric Unit Personnel :

1. Enter legal status in Avatar.

All revision dates:	1/12/2023, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 2/1/2000, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/12/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*10/1/1993*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.19 Contraband and Dangerous Articles in the IPU

POLICY:

VCMC Psychiatric Unit (IPU) will provide a safe and secure environment for patients and staff. One aspect of this requires control of dangerous articles. Staff will identify, remove from patient access, inventory, secure and return dangerous articles to the patient upon discharge.

PROCEDURE:

A. DANGEROUS ARTICLES

1. Razors, including electric razors, nail clippers.
2. Knives
3. Guns and sling shots
4. Sharps including scissors, pins, safety pins, paper clips, and all objects with sharp edges or points. Plastic pre-school scissors are acceptable under supervision during activity based therapies.
5. Chemicals that may be ingested and can be toxic include but are not limited to: shampoos, lotions, any cleaning chemicals including hand sanitizers.
6. Medications
7. Matches, lighters and all flammable liquids.
8. Drug paraphernalia and all illegal substances.
9. Alcoholic beverages.
10. Needles, crochet hooks, knitting needles and other craft items.
11. Knives, forks and spoons. Nursing staff must account for utensils given to patients.
12. Soft drink aluminum cans, plastic serving cups and glass containers of all kinds.
13. Manicure items: nail files, nail clippers, hair barrettes, combs and brushes with sharp handles.
14. Mirrors and all glass objects.
15. All jewelry and watches
16. Metallic toothpaste tubes, hard plastic items that can be reduced to sharps such as spiral notebooks,

objects that can be torn or cut resulting in sharps, wire coat hangers.

17. Stainless steel and plastic are considered equally dangerous..
18. Plastic bags, saran wrap, foil, and anything that can cut off air supply
19. Keys
20. Electrical appliances.
21. Any other item that is determined by staff to be harmful. Document in the progress notes the item and the rationale for determining that it is dangerous and report to charge nurse.
22. If a dangerous article is lost and cannot be accounted for, search the entire patient occupied areas.
23. For example, if a razor given to a patient is not returned or if scissors are missing from OT, a search of the entire Unit may be necessary.
24. Should a patient decline to turn over their belongings or change into the paper gown for the assessment/check, he or she will be placed on 1:1 observation immediately on the admission hallway. The 1:1 observation will continue until the patient cooperates with the skin assessment/ contraband check. Use of the portable metal detector/wand may assist in this search.
25. Patients refusing a contraband check will be placed on the "Contraband Check Refusal Log" to differentiate them from other 1:1 patients. The charge nurse will notify the Clinical Nurse Manager or AOD immediately of any patients placed on the log.

B. Over the counter and prescription medications must be secured. Controlled drugs must be counted and co-signed by licensed nursing staff on the inventory sheet and sent to the VCMC pharmacy.

C. Illegal substances shall be reported to police department.

All revision dates: 10/17/2022, 4/24/2018, 7/26/2017, 5/1/2014, 9/1/2009, 3/1/2009, 8/1/2008, 10/1/2006, 6/1/2004, 8/1/2002, 2/1/2000, 2/1/1997, 2/1/1996, 1/1/1996, 8/1/1994

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	7/13/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/2/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.20 Court Procedures in the In-Patient Psychiatric Unit (IPU)

POLICY:

To assist patients, the Public Defender and the Patient's Rights Advocates in the exercise of due process of law regarding detention for involuntary treatment. Accuracy in the preparation of reports to the court and timely handling of the legal documents and attention to the necessary procedures of the court are given our highest priority. TERMS: Welfare and Institution Code sections are referred to by the section number only. For example, W&I Code Section 5150 will be referred to as 5150 legal status.

PROCEDURE:

COURT INTERPRETER

1. A Certified Court Interpreter is required for any court procedure requiring patient translation services. The existing list of Certified Court Interpreters is accessed through notification to Mental Health Court (MHC) of the impending court procedure along with the request for specific translation services. See Translator/ Interpreter Services Policy and Procedure for specific instructions on ordering a Court Interpreter.

ACUTE CARE PSYCHIATRIST:

2. Determine the need for or change of involuntary legal status.
3. Complete the documentation as required by the court
   a. 5250
   b. 5260
   c. 5270
   d. 5300
   e. 5353
   f. Capacity for Medication Consent (Riese)

SHIFT SUPERVISOR/CHARGE NURSE (SS/CN)

4. Stay abreast of the changes in legal status anticipated on each shift and ensure nursing staff follows through.

5. Oversee the nursing and clerical staff for accuracy and timeliness in completion of the court documents. Group all document copies for one patient together. The court clerks will distribute them after stamped.

   ~~Schedule cases in "COURT" book.~~

6. Review Court Cases from email sent from Courts.
7. ~~Assign a registered nurse (RN) to deliver~~Clerk faxes documents to the appropriate court ~~or location~~ for processing. Documents must be delivered at 1500 hours by the day prior to the court hearing. Conservator papers may be entered prior to 1700.
8. ~~Complete~~Charge Nurse Completes Notification Form for any errors resulting in lapse in legal status.
9. On the day of court in the IPU:
   a. Assign a trained ~~RN~~staff as bailiff. Regular court days are Monday, Tuesday, Thursday and Friday.
   b. Arrange for back-up coverage for the bailiff during the time special court duties are carried out.
   c. Prepare court office for on-line Court Hearing during Covid. Ensure ~~the~~ availability ~~and order of the large conference~~of Conference room ~~for court~~post pandemic. Find out the name of the patient and the type of hearing scheduled.
   d. As early as possible in the shift, confirm the court calendar and:
      1. Notify the team psychiatrist and tell them the time the documentation is due to the nursing clerk/ bailiff. Psychiatric evaluations for 5250 hearings are required to be done on the day of the hearing. Conservatorships (5353, 5358) may be done earlier.
      2. Notify the ~~RN~~staff designated as bailiff.
      3. Arrange for notification of the team RN.
   e. Requests for additional cases to be placed on the calendar may be made, such as a capacity hearing. The judge makes the decision when to calendar the item.

   ~~TEAM~~Charge RN

10. Assign appropriate staff to prepare the patient as appropriate for the event. Whenever possible, the patient should wear his/her own clothing rather than hospital clothing.

    BAILIFF

11. Prior to court session:
    a. Gather charts and reports and remind psychiatrists whose reports are late.
    b. Make copies as needed.
    c. Assist the Public Defender to find and interview patients on the calendar.
    d. Assist in notifying the psychiatrist to appear when needed.
    e. Distribute authenticated copies of 5250/5260 RIESE. Documentation of 5353/5358 is via Court Clerk list placed in court notebook, until formal letters arrive within three (3) business days.

    SHIFT SUPERVISOR/CHARGE NURSE

12. Obtain from the court, the Public Defender, a Patient's Rights Advocate, or the Public Conservator, the disposition for every case heard by the court. Input from the bailiff may also be useful, but may not be

considered official communication of the results of the hearing. May call Court Clerk for verification.

a. Place in "Court" book the original listing of hearings and their disposition.

~~Give a "yellow patient copy" of each patient's certification disposition to the Team RN.~~

TEAM RN/designated LNS:

13. Give patient appropriate copy.
14. File the Medical Record copy in the legal section of the chart.
15. Complete the Firearms Prohibition when necessary. See Firearms Prohibition Policy and Procedure.

All revision dates: 3/2/2023, 2/18/2020, 3/1/2009, 9/1/2008, 8/1/2008, 2/1/2007, 10/1/2006, 7/1/2004, 7/1/2002, 2/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/3/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.27 IPU Nursing Documentation

POLICY:

Inpatient Psychiatric Unit (IPU) patients will be assessed with a plan of care/treatment based on assessed needs. ~~Documentation of assessment and reassessment outcomes will be contained in the Nursing Progress note.~~

PROCEDURE:

1. The initial nursing assessment will be performed by the Registered Nurse and completed within 24 hours after the patient's admission with this information contained in the Adult Admission Assessment.
2. ~~Reassessments performed and documented in the~~ Nursing Progress Notes are annotated in the "ABC" format. This format is based on clinical staffs observation, assessment, intervention and evaluation of the patient.
3. The ABC format includes:
    a. A - Appearance - discusses ~~the nurse's assessment of~~ the patient's physiological condition and physical presentation.
    b. B - Behavior - discusses ~~the nurse's assessment of~~ the patient's behavior (e.g., behaviors exhibited by the patient and any resultant impact of this behavior on the patient's progress).
    c. C - Content - discusses the patient's thought processes, cognition and mental functioning.
4. ~~Assessments~~Progress Notes are performed as appropriate to patient condition and treatment and standards of care and consider other data available to the licensed nurse (such as patient intake and output, participation in activities and therapies, vital signs, laboratory values), however, documentation of ~~assessment~~ outcomes are required once per shift. The healthcare provider may document more frequently (such as when a significant event occurs, if the patient leaves the unit, if the patient is evaluated in the Emergency Department), however a solid, clinically relevant nursing note is required once per shift.
5. Care plans will be updated ~~after an incident~~daily and with ~~staff or another patient that has a negative effect on them~~a change of condition.
6. Multidisciplinary Treatment Planning: See "Multidisciplinary Treatment Plan Policy."

All revision dates: 1/20/2023, 12/12/2019, 7/1/2015, 3/1/2010, 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2006, 8/1/2004, 2/1/2000, 2/1/1997, 12/1/1993, 11/1/1993, 10/1/1993

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1990*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.28 IPU Nursing Admission Assessment Documentation

POLICY:

An Inpatient Psychiatric Unit (IPU) Registered Nurse (RN) is to complete a Nursing Assessment within 24 hours of admission. The purpose of the policy is to ensure safety, to establish the baseline level of the patient's need for physical and psychiatric care, and to comply with the California Nurse Practice Act, Title 22 Regulations, and The Joint Commission Standards.

PROCEDURE:

SHIFT SUPERVISOR:

1. Assign responsibility for completion of the nursing assessment to RN at the time of admission of the patient on the Ventura County Medical Center (VCMC) Inpatient Psychiatric Unit (~~the Unit~~IPU). Use the approved Nursing Assessment Form.

RN:

1. Collect the data or supervise and countersign the collection of data by an LPT/LVN. An RN must establish the nursing diagnosis and institute the initial plan of care.
2. Obtain information from medical records, family, case manager, and any other available source when possible. Document the source whenever it is not directly from the patient.
3. If the patient is unable to cooperate with the assessment process, document in the Progress Notes what is preventing completion of the assessment.
4. Regardless of the condition of the patient, the RN must assess the patient for safety risks and recommend precautions if appropriate. Complete the assessment as able within 24 hours, even if the information from patient and all other sources is sparse. Pass on in report that assessment is incomplete for next shift until complete.
5. Following the data collection, establish the nursing diagnosis. Focus on 1-3 significant problem areas, which can realistically be addressed in the acute care setting. Also see Precaution Policy.
6. Institute an initial plan of care based upon the nursing diagnosis. Needs which can be addressed at other levels of care may be part of the discharge plan. This may be done ~~on the Nursing Assessment Form or in~~In the Electronic Health Record (EHR).

7. Assesses patient response to treatment plan and reports directly to the Team RN.
8. Assessment is completed by RN.
9. Admitting RN assigns patient acuity.

~~RN/~~LPT/LVN

1. Provides direct care, maintaining therapeutic milieu.
2. Implements the treatment plan and accomplishes treatment.

   ~~Assesses patient response to treatment plan and reports directly to the Team RN.~~
3. Transcribes and audits orders, including medication.
4. Administers scheduled and PRN medication.
5. Documents on MAR and Progress Notes as appropriate administration of medication and patient response.
6. May perform medical treatments if within scope of practice and qualifications/competence.
7. Documents daily Progress Notes as assigned by the Team RN. Assists with admissions and discharges.

   ~~Assessment is completed by RN.~~

   ~~Admitting RN assigns patient acuity.~~

Health Technician:

1. Provides nursing support services.
2. Maintains accurate documentation on vital signs, locations for precautions, rounds, and percentage of meals eaten as assigned by the Team RN.
3. Provides ancillary services such as patient or legal document transport, court bailiff, Laboratory or Pharmacy errands, etc.
4. Provides rudimentary clerical support services for nursing unit such as phones, filing, forms, photocopying, list pats., etc.

All revision dates:	1/20/2023, 3/1/2009, 8/1/2008, 7/1/2008, 10/1/2006, 9/1/2004, 2/1/2000, 2/1/1997, 2/1/1996, 1/1/1993, 5/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023

Step Description	Approver	Date
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1990*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.36 IPU Admission, Stabilization and Discharge Plan

POLICY:

The Ventura County Medical Center (VCMC) Inpatient Psychiatric Unit (~~the Unit~~IPU) will complete patient admissions in a legal, safe, and expeditious manner and will initiate treatment, stabilization and a discharge plan.

PROCEDURE:

In order to ensure patient safety, the order in which each of the following steps is completed may vary.

ACUTE CARE PSYCHIATRIST AND SHIFT SUPERVISOR/CHARGE NURSE (SS/CN)

1. Notify the SS/CN that patient is to be admitted (see also Admission, General, for details about required documentation of legal status).
2. Review original legal status document
   a. Ensure documentation is complete
   b. Confirm that patient advisement is completed. If not, assign LNS (Licensed Nursing Staff) to complete advisement.

SS/CN

3. Assist referring personnel as needed. Peace Officers ~~may keep~~must lock their ~~weapon when admitting a patient to the Unit only in the seclusion~~firearm in the designated lock box. Staff to sequester all other patients to secure areas prior to letting police in the admissions hallway. ~~Staff to sequester all other patients to secure areas on the milieu prior to letting police in the seclusion hallway.~~
4. Assign LNS accountable for completion of admission process individually or by supervision of any nursing staff. Arrange for as many staff as needed to accept patient without injury to patient or staff.
5. Notify Public Conservator of admission if patient is a conservatee. Call 1-805-654-3141 during business hours. After hours, call ~~1-805-854-3141~~1-800-684-7681.

ACUTE CARE PSYCHIATRIST

6. Complete Psychiatric Assessment per policy within 24 hours of the admission of the patient.

~~Complete Mental Status Checklist/Risk Assessment Checklist (see *Z.09 Patient Safety Precautions*).~~

~~Complete Drug History Form per policies and procedures.~~

7. Inform and educate the patient if medications are ordered and, except in emergency, obtain written consent.
8. Write or provide telephone orders for admission. All orders must be legible, contain no banned abbreviations, and comply with policies and procedures.

   ~~Complete Psychiatric Evaluation within 12 hours of the admission and file in chart.~~
9. Communicate with LNS any information needed for initial plan of care.

   ~~Meet with family, if they are present.~~

~~LICENSED NURSING STAFF~~

~~Introduce self to the patient.~~

~~Ensure immediate safety status of patient. See *Z.19 Contraband and Dangerous Articles in the IPU* and *Z.09 Patient Safety Precautions*.~~

~~Patient to provide contraband articles for safekeeping.~~

~~Secure patient's articles and valuables~~

1. ~~Document description and disposition of each item~~
2. ~~Arrange for secure placement of valuables in safe or locked storage. See *Z.44 IPU Patient Belongings*.~~

~~Constantly observe, listen, and assess throughout the admission process for risk of danger to self, others or AWOL.~~

~~Request physician to evaluate the patient for special precautions for safety, if indicated.~~

~~Continue assessment, initial interventions and orientation of patient to the Unit.~~

a. ~~Administer NOW orders, if any, for medication. Determine patient's drug allergies. See *100.206 Electronic Documentation of Allergies*.~~
b. ~~Inform patient of his/her rights and provide patient rights written materials.~~
c. ~~Obtain signature of patient and one LNS signature, or obtain two staff signatures if patient refuses to sign for receipt of the materials about patient's rights.~~
d. ~~Provide copies of all legal documents as required by law or policies and procedures..~~
e. ~~Take photo ID. Obtain consent. If patient refuses, attempt daily.~~
f. ~~Orient patient to room and Unit. Include the following:~~
   - ~~Show room, bed, bathroom, pay phones, and locker.~~
   - ~~Give schedule and patient information brochure.~~
   - ~~Inform about next meal.~~
   - ~~If patient smokes, orient to smoking procedures.~~
g. ~~Complete the Patient Identification Form (VCMC 516-33) ASAP and provide to clerical staff.~~
h. ~~Obtain urine for diagnostic tests as ordered.~~

i. ~~Document allergies, drug reactions on bracelet, physician's order sheet, and Medication Administration Record (MAR).~~

j. ~~Place identification bracelet on patient's wrist and explain its necessity. Bracelet must include allergy information.~~

k. ~~Complete "Nursing Assessment" and document initial plan of care per policy. This must be done by an registered nurse. Any identified medical problems must have a plan of care.~~

l. ~~Complete Firearms Prohibition, if applicable.~~

m. ~~Complete other forms as required.~~

n. ~~Identify patients at risk by accessing Cerner screen and search for "Patient Alerts." Note, if "other" is listed, refer to patient's medical record.~~

CLERICAL STAFF:

~~Obtain completed Patient Information Form from nursing staff~~

a. ~~FAX patient information to the VCMC Admitting Department, then call the Admitting Department and inform them a fax is on its way.~~

Call the Admitting Department with any follow-up information as necessary.

~~Post admission information in:~~

a. ~~Admission log~~

b. ~~Bed list~~

c. ~~Census sheet~~

d. ~~Computer~~

~~Go to VCMC to pick up:~~

a. ~~Patient face sheet~~

b. ~~Chart from previous admissions, if applicable~~

~~CLINICAL STAFF~~

1. ~~Implement Initial Plan of Care pending further review or change in needs of patient. Initial plan of care is directed at safety and medical needs.~~
2. ~~Complete history and physical per policy~~
3. ~~Complete psychosocial history per policy~~
4. ~~Establish initial Discharge Plan per policy~~

LICENSED NURSING STAFF

1. Introduce self to the patient.
2. Ensure immediate safety status of patient. See *Z.19 Contraband and Dangerous Articles in the IPU* and *Z.09 Patient Safety Precautions*.
3. Patient to provide contraband articles for safekeeping.
4. Secure patient's articles and valuables

1. Document description and disposition of each item
2. Arrange for secure placement of valuables in safe or locked storage. See *Z.44 IPU Patient Belongings*.

5. Constantly observe, listen, and assess throughout the admission process for risk of danger to self, others or elopement.
6. Request physician to evaluate the patient for special precautions for safety, if indicated.
7. Continue assessment, initial interventions and orientation of patient to the Unit.
   a. Administer STAT/NOW orders, if any, for medication. Determine patient's drug allergies. See *100.206 Electronic Documentation of Allergies*.
   b. Inform patient of his/her rights and provide patient rights written materials.
   c. Obtain signature of patient and one LNS signature, or obtain two staff signatures if patient refuses to sign for receipt of the materials about patient's rights.
   d. Provide copies of all legal documents as required by law or policies and procedures..
   e. Obtain consent. If patient refuses, attempt daily.
   f. Orient patient to room and Unit. Include the following:
      - Show room, bed, bathroom.
      - Orient to unit schedule and provide patient information brochure.
      - Inform about next meal.
      - If patient smokes, advise regarding nicotine replacement options.
   g. Complete the Patient Identification Form (VCMC 516-33) ASAP and provide to clerical staff.
   h. Obtain urine for diagnostic tests as ordered. For refusals of pregnancy tests, the physician is to be notified.
   i. Document allergies, drug reactions on bracelet, physician's order sheet, and Medication Administration Record (MAR).
   j. Place identification bracelet on patient's wrist and explain its necessity. Bracelet must include allergy information.
   k. Complete "Nursing Assessment" and document initial plan(s) of care per policy. See Z.28 *IPU Nursing Admission Assessment Documentation*.
   l. Complete Firearms Prohibition, if applicable.
   m. Complete other forms as required.

CLERICAL STAFF:

8. Obtain completed Patient Information Form from nursing staff
   a. FAX patient information to the VCMC Admitting Department, then call the Admitting Department and inform them a fax is on its way.

Call the Admitting Department with any follow-up information as necessary.

9. Post admission information in:

a. Bed list

b. Census sheet

c. Computer

All revision dates: 10/17/2022, 7/20/2018, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 7/1/2002, 3/1/2001, 2/1/2000, 2/1/1998, 5/1/1997, 2/1/1997, 1/1/1996

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	12/8/2021

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.37 IPU/CSU Patient Amnesia

POLICY:

After exhausting all attempts to treat amnesia and/or to confirm the identity of a patient in the IPU/CSU without identification, the clinical team may request the psychiatric social worker to utilize the news media and other public organizations to assist the patient.

PROCEDURE:

ALL CLINICAL STAFF - Examine patient's belongings for clues to identify them or their family, friends or employers.

PSYCHIATRIC SOCIAL WORKERS

1. Call the Emergency Shelter Program - 651-4460 (Emergency Shelter is seasonal)
2. Contact other are social service agencies:
    a. Homeless Program - (805) 981-4200.
    b. Tri-Counties Regional Center if patient is suspected to be D.D. - (805) 485-3177 (Tri-Counties serves only San Luis Obispo, San Bernardino and Ventura Counties).
    c. Social Security Office - They can complete a search based on the patient's place of birth, age and parents' names.
    d. Other similar social service agencies who may be of assistance.
    e. If patient could be an undocumented alien, call:
        1. El Concilio - (805) 486-9777
        2. Migrant Education - (805) 388-4416, Fax: (805) 388-4385
3. Call related social service agencies:
    a. Missing Persons Reports with Ventura P.D. - 399-4400 (they utilize a state and national missing persons network
    b. Fingerprints - if brought in by law enforcement, call the watch commander of the agency that brought patient in. If not, call the crime lab at (805) 654-2370.
4. Consult with the Social Services Supervisor and acute care psychiatrist, and consult with representatives from Adult Residential Services (ARS) team and members of other departmental units who could help.

5. Obtain signed release of information filed in chart, which specifically states that the VCMC Inpatient Psychiatric Unit (IPU) or Crisis Stabilization Unit has permission to take and publish photographs of the patient.

As a last resort, contact local news organizations to run the patient's story, and include photos if authorized by patient. Contact Hospital Administration at ext. 6058 for a list of media outlets.

All revision dates: 6/13/2019, 3/1/2009, 8/1/2008, 10/1/2006, 8/1/2004, 2/1/2000, 11/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/1/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.38 IPU Patient Bedroom Access

POLICY:

To encourage patients to use the common living areas in order to develop and improve social skills and to ensure a safe environment for patients and staff. Vacant patient bedrooms will be locked.

PROCEDURE:

A. When bedrooms are not assigned to a patient:

1. Inspect the bedroom and bathroom
   a. Ensure room is empty

      ~~Inspect drawers and cabinets~~

   b. Remove any items left in the room and report them to the Shift Supervisor/Charge Nurse (SS/CN) in order to attempt to return them to their owner
   c. Make sure the room is clean and ready for the next patient
2. Turn off all lights
3. Lock the door
4. Patient bedrooms must be kept unlocked whenever a patient is assigned to a bed in the room with one exception. A physician may place an order for a patient to be locked out of their room for brief periods of time as part of a treatment plan. The clinical justification will be delineated in the physician note and reflected in a communication order. The reason for the treatment plan will be communicated by the team to the patient and they will be advised that they may speak with patient rights if they have concerns about the proposed treatment plan. This may not be used as a punishment. Patients may not be locked in their rooms.
5. Patients are allowed only in their assigned rooms.
6. Visitors are not allowed in patient rooms. Visitation is permitted only in designated areas.

All revision dates: 1/20/2023, 12/12/2019, 5/1/2011, 9/1/2009, 8/1/2008, 9/1/2006, 7/1/2004, 2/1/2000, 2/1/1997, 10/1/1996

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1990*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.41 IPU Nurse Staffing Pattern

POLICY:

The VCMC Inpatient Psychiatric Unit (IPU) will establish flexible guidelines to provide safe, quality patient care that is in accordance with:

- Title 22, Title 9, and The Joint Commission Standards
- Standards of Professional Practice as outlined by the Board of Registered Nursing
- California Nurses Association and Service Employees International Union contracts and VCMC Policies and Procedures
- Fiscal accountability
- Safe practice standards necessary to contain an assaultive/combative patient 24 hours a day

Safety requires a minimum number of eight (8) nursing staff in the IPU to safely contain an assaultive patient and manage the remaining patients. Therefore, a minimum of eight (8) nursing staff will be required on duty at all times.

PROCEDURE:

1. Staffing pattern for patient care delivery.
    A. The Shift Supervisor:
        1. Triages admissions
        2. Oversees patient care delivery and unit operations
        3. Accomplishes daily staffing and staff development. In the absence of the Shift Supervisor, a MHN ~~II~~ Charge Nurse with competency will be assigned.
    B. Nursing Care Team
        1. The RN Team Leader:
            a. Responsible for admissions and discharges.
            b. Responsible for daily nursing assessment of all team patients' initial admission nursing assessments, and nursing assessment of seclusion and restraint.
            c. Coordinates, delegates and assigns direct patient care and documentation.
            d. Maintains accurate documentation.
            e. Responsible to notify Team Psychiatrist that legal paperwork is due and when treatment

plans require review and signature.

f. Initiates Nursing Care Plan and is responsible for ensuring that the treatment plan is on the chart, signed, and timed correctly.

g. Participates in the Multidisciplinary Treatment Plan Meeting. In the absence of assigned Social Services Staff, Multidisciplinary Treatment Planning defaults to nursing for all required signatures.

2. The ~~Second~~ License (RN/PT/LVN):

a. Provide direct care and maintain therapeutic milieu.

b. Implement the Treatment Plan and accomplish treatments.

c. Report directly to the Team RN and assess patient response to Treatment Plan.

d. Transcribe and audit orders, including medications.

e. Administer scheduled and PRN medication.

f. Document on MAR and Progress Notes, as appropriate, administration of medication and patient response.

g. May perform medical treatments if within their scope of practice and qualification/ competence.

h. Document daily Progress Notes ~~as assigned by the Team RN~~. Assists with admissions and discharges.

3. Health Technician/LNS:

a. Provide nursing support services, such as rounds and height, weight and vital signs each shift.

b. Maintain accurate documentation on worksheets as assigned by the Team RN.

c. Provide ancillary services such as patient or legal document transport, court bailiff, Laboratory or Pharmacy, errands, etc.

d. Provide clerical support services for nursing unit.

2. Acuity:

A. Team lead to calculate for each patient for the oncoming 12-hour shift. Complete by 0400 and 1400, respectively. Acuity calculations are given to the Charge Nurse prior to 0500 and again prior to 1700 for proper documentation. Per California Health & Safety Code 1276.4, the Charge Nurse makes staffing adjustments accordingly and notifies the Clinical Nurse Manager or AOD for needed approval. Refer to VCMC Patient Classification System Inpatient Psychiatric Unit.

B. Charge Nurse calculates the acuity for the entire shift and adjusts staffing for oncoming shift.

3. Scheduling

A. Utilize 12-hour shift for nursing care delivery.
Establish schedule for regular employees generated.

All revision dates: 10/17/2022, 2/15/2018, 1/1/2015, 3/1/2009, 9/1/2007, 2/1/2007, 10/1/2006, 10/1/2004, 1/1/2002, 9/1/2000, 2/1/2000, 2/1/1998, 2/1/1997, 9/1/1996, 4/1/1996, 2/1/1993, 1/1/1993

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.42 IPU/CSU Patient Accountability System

POLICY:

At a minimum of every 15 minutes, Inpatient Psychiatric Unit (IPU)nursing staff will account for and document on a unit worksheet the location (and if in room, whether asleep or awake) of all patients. In addition, variable rounds will be conducted by a separate staff member(s) in between the 15 minute rounds.

At a minimum of every ~~10~~15 minutes, Crisis Stabilization Unit (CSU) nursing staff will account for and document on a unit worksheet the location (whether asleep or awake) of all patients. In addition, a licensed nursing staff member will document every 60 minutes on each patient.

PROCEDURE:

1. Shift Supervisor/Charge Nurse (SS/CN) or designee will generate the appropriate Patient Accountability Record (PAR) and Hallway Variable Rounds at the beginning of each shift.
2. All precaution levels will be indicated in the column provided.
3. Staff assignments will be indicated on each shift assignment sheet.

A. 1. IPU-During waking hours (0600-2300), Nursing staff (LNS) and / or qualified health tech (HT) will be assigned to do fixed q15 minute rounds. The LNS/HT doing rounds will notify the team nurse of any patient exhibiting bizarre behavior, agitation, pacing, or any behavior that requires intervention to maintain safety of the patient or others.

2. Hallway variable rounds can be either licensed or unlicensed staff.

3. Between the hours of 2300-0600, ~~two~~ staff will be assigned to do fixed rounds either licensed or unlicensed staff.

4. Between the hours of 2300-0600, the ~~two~~ staff members assigned to perform fixed q15 minute rounds will enter each patient's room to determine patients are safe.

B. Each shift will document in the appropriate column, using the legend provided, the patient's location and/ or activity. All patients must be accounted for. If unable to locate a patient, notify the SS/CN and begin ~~AWOL~~Elopement procedure.

C. Each patient will be observed for signs of life (respiration, change of position, snoring) when sleeping.

D. Hours of sleep will be documented in the Electronic Health Record (EHR).

E. Patients getting less than six (6) hours of sleep will have their sleep hours entered onto the AM Report

Sheet.

F. Day Shift LNS will notify the physician of all patients sleeping less than six (6) hours.

G. Initiate q15 minute and variable rounds observation on all patients.

H. Document on Rounds Sheet (use slash with location from legend).

I. Hallway variable rounds will be performed in the IPU in-between the current q15 minute checks (document the time and location of patients from the legend) on the Hallway Rounds Sheet.Variable rounds can be completed by either licensed or unlicensed staff.

All revision dates: 1/20/2023, 12/12/2019, 7/26/2017, 2/1/2016, 3/1/2010, 3/1/2009, 8/1/2008, 10/1/2006, 10/1/2004, 3/1/2003, 11/1/2002, 2/1/2000, 11/1/1997, 2/1/1997, 9/1/1996, 7/1/1995, 10/1/1992, 9/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*8/24/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.43 IPU and CSU Patient and Client Information Brochures and Booklets

POLICY:

The Ventura County Medical Center (VCMC) Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) provides patients and clients with written information about their rights and responsibilities, aspects of treatment, what to anticipate during ~~the inpatient~~their stay, how to make the most out of the experience, and what options may exist for outpatient treatment post-discharge. Medi-Cal booklets are also provided outlining services, service providers and contact numbers for grievances and appeals. The patient information brochures are for patients to read while in the hospital and to take home as reference for additional outpatient referrals.

PROCEDURE:

1. Brochures and patient handouts, explaining unit services, are available to visitors, clients and patients. Contact information for grievances and appeals is provided and accessible to patients. Brochures are available in both English and Spanish.

NURSING STAFF:

1. Upon admission, ~~the patient~~patients shall be given a copy of the brochure ~~entitled~~titled, "Ventura County Medical Center Inpatient Psychiatric Unit - Information for Patients and Their Significant Others."
2. Staff shall review the brochure with the patient to make sure he/she understands it , and answers any questions the patient may have.
3. If the patient cannot read or speaks a language other than English or Spanish, arrange for an interpreter to translate the brochure for the patient, and help answer whatever questions the patient has. Contact the VCMC Nursing Supervisor for access to in-house and contracted interpreters in a variety of languages, or utilize the ATT Language Line for interpretation over the telephone.
4. The following additional topics are covered for ~~the patient's information:~~

~~Things You Need to Know~~
~~You Have the Right~~
~~Daily Schedule~~
~~Orientation to the Activities Therapy~~

~~Occupational Therapy Program~~
~~Seclusion and Restraint Philosophy and Notification of Family~~
~~Ventura County Behavioral Health Consumer Guide~~
~~Summary of Joint Notice of Privacy Practices~~
~~Your Right to Make Decisions about Medical Treatment~~patients admitted to the IPU.

1. Things You Need to Know
2. You Have the Right
3. Daily Schedule
4. Orientation to the Activities Therapy
5. Occupational Therapy Program
6. Seclusion and Restraint Philosophy and Notification of Family
7. Ventura County Behavioral Health Consumer Guide
8. Summary of Joint Notice of Privacy Practices
9. Your Right to Make Decisions about Medical Treatment

5. Contact information will be provided to patients upon admission regarding quality of care concerns Quality Improvement Organization (QIO).

~~*Please refer to the policy on "Patients' Rights, Denial, and Documentation" for more information and additional procedures.*~~

Please refer to the Administrative Patient Care Policy 100.004 Patient Rights for more information and additional procedures. **["Patient Rights, Denial, and Documentation" not found]**

All revision dates: 8/24/2022, 7/5/2018, 9/1/2010, 3/1/2009, 9/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/28/2022
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022
Hospital Administration	Matthew Sandoval: VCMC - Chief Operating Officer	10/15/2019

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*8/24/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.44 IPU/CSU Patient Belongings

POLICY:

To inventory and secure ~~patient~~patients' valuables during admission and valuables delivered during hospitalization to provide for their efficient retrieval, and to ensure their return to the patient or conservator at discharge. To establish a system to keep and account for small sums of money (not greater than $50.00) accessible to patients for incidental purposes during their stay. To provide for the disposition of lost and found items post-patient discharge. To establish a system for disposal of illegal substances and paraphernalia that protects the rights of the patient.

PROCEDURE:

1. GENERAL INSTRUCTIONS

   LICENSED NURSING STAFF (LNS):

   a. Follow these general procedures for all locations and special requirement (listed below) for specific locations. Unlicensed nursing staff that have been trained may assist.

   b. Label each envelope with the patient's name, room number (and chart number, if available) immediately upon admission.

      1. Use one envelope for each location. Locations are listed below in Item #2.
      2. Itemize on each envelope the exact number for each item secured. DO NOT photocopy credit cards or transcribe account numbers.
      3. Obtain two (2) signatures per deposit or withdrawal of belongings. One must be a LNS/HT, the second should be the patient or second LNS/HT if patient is unable/unwilling to sign. Individuals who sign for patient belongings are qualified by virtue of documented training.
      4. Label with patient name, chart number and room number.
      5. File white copy under Discharge section of chart.
      6. Provide NCR receipt to patient.

   c. Clothing not considered contraband shall be listed on the Patient Belongings Inventory (PBI) Sheet and filed under the discharge section of the patient's chart. Itemize each clothing item appropriate for unit on PBI and return to patient. No laces or strings permitted.

2. **LOCATIONS**

a. **VCMC Pharmacy** :

1. Patient's Own Medications (**ALL** medications brought from home shall be stored in VCMC's Pharmacy).
    a. Document patient's name, chart number and location on envelope. List on outside of separate envelopes controlled and non-controlled medications.
    b. Count and document number of tablets.
    c. Two LNS signatures are required for "controlled" drugs.
    d. Transport of "controlled" drugs to or from the Pharmacy requires **LNS**
        i. Pharmacy to sign for acceptance of medications for storage and/or disposal.
        ii. Original document to be filed under "Discharge/Property" in patient chart.
        iii. See "Medication: Patient's Own: Dispensing for Administration" P&P.
        iv. See "Medication: Patient's Own: Disposal at Discharge" P&P.
2. Contraband Lockers:
    a. Nursing admission room lockers for contraband items locked in contraband locker remain there for duration of hospital stay unless SS/CN approves otherwise and so documents. Item(s) shall be kept out of patient care area.
    b. See "Food Storage" P&P
    c. See "Search for Patient Safety" P&P
    d. Team RN's and SS/CN have keys to these lockers
    e. Items that SS/CN approve to leave facility require a signed release. See "Release of Contraband" form.

b. **Under Bed Locker:**
Store items that are non-contraband and of personal value to the patient.

c. **Utility Room:**

1. Use Utility Room for items too large to store in patient's area. List on clothing sheet items are located in the Utility Room or contraband locker.
2. Bags are to be thoroughly searched and procedure for storage of contraband articles shall be strictly adhered to. Contents shall be itemized regardless of storage location.
3. Secure envelope/list to belongings.

d. **Unit Safe:**

1. All cash, credit cards, checkbooks, insurance cards, ID cards, jewelry, etc. will be stored in the unit safe. **DO NOT** photocopy credit or debit cards. Stickers for counter signatures are attached to envelope.
2. Designated individuals can open safe to allow access to cash upon patient's request. In some cases, the amount and use of funds may be established as part of the treatment plan.
3. Withdrawals of cash will be documented on the original valuables form, and cosigned by patient and LNS or two LNS'.

e. **Activity Therapy (AT) areas:**

1. AT staff provide envelope with brief description and location to nursing for appropriate storage and return. Valuables list used for tracking purposes are filed by staff under "Discharge."

3. **ITEMS DELIVERED DURING HOSPITALIZATION**

   LICENSED NURSING STAFF

   a. During office hours, Reception staff will notify SS/CN of items to be delivered. Reception staff will not accept delivery. This is the responsibility of Nursing Staff.
   b. LNS will take delivery of any items delivered to the facility during the patient's hospitalization.
   c. Document these items as outlined in the P&P.

4. **MOVING PATIENT'S BELONGS: (Except Contraband)**

   a. Document all movement of patient's property from a secure area to the patient's possession or from one secure area to another.
   b. Document on the clothing list in the patient's chart. Be sure forms are dated and signed by patient and staff.

5. **RETURN OF PATIENT PROPERTY: (Non-medication)**

   a. Team RN is responsible for ensuring all property is returned at the time of discharge.
   b. Property lists are to be filed in "Discharge" section of the patient's chart.

6. **RETURN OF PATIENT MEDICATION:**

   a. Prior to discharge, the team psychiatrist will determine if it is in the patient's best interest to return the patient's own medications. The safety of the patient will be the primary determining factor.
   b. If the psychiatrist determines that returning the medication is contraindicated, the patient will be given a claim form for reimbursement for the cost of those medications. Directions will accompany the claim form.

7. **LOST PATIENT PROPERTY** :

   a. Follow-up on reports of Lost Patient Property
      1. Provide a copy of the VCMC policy and official VC claim form, which will enable the patient to file a claim and receive reimbursement from the VC Auditor.
      2. Assist the patient, when possible, to:
         i. Complete the forms
         ii. Obtain copies
         iii. Send original to VC Risk Management at the Government Center
         iv. Make a copy and send to Unit Supervisor of Nursing Services
         v. Complete a Notification Form

8. **ITEMS LEFT AFTER DISCHARGE:**

   a. Locked cabinet in Nurse's Station (above) and refrigerator are checked.
   b. Under bed lockers are checked by Housekeepers at time of discharge.
   c. Monthly checks are done by SS/CN of contraband locker, utility room, file cabinet in nurse's station, locked cabinet above, refrigerator and unit safe.

d. An attempt is made to return items to the discharged patient by phone or letter.

e. After 90 days, cash is donated to "Patient General Fund." Personal items are donated to boutique or discarded.

f. VCMC Pharmacy is responsible for medications brought from Pharmacy.

All revision dates: 8/24/2022, 2/13/2019, 8/1/2010, 9/1/2009, 9/1/2008, 5/1/2008, 10/1/2006, 7/1/2004, 3/1/2003, 1/1/2002, 2/1/2000, 4/1/1999, 11/1/1998, 9/1/1998, 6/1/1998, 4/1/1998

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/28/2022
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/1999*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.45 IPU Patient's Request for Another Team Psychiatrist

POLICY:

Requests by an Inpatient Psychiatric Unit (IPU) patient for assignment to another team psychiatrist shall be received and processed with attention to the patient's therapeutic benefit and with appropriate procedures for the psychiatrist.

PROCEDURE:

ANY CLINICAL STAFF MEMBER:

1. Immediately notify the team psychiatrist of a patient request for a different psychiatrist. The notice to the on-duty team psychiatrist may or may not be the psychiatrist the patient is speaking about. In all cases, use this procedure.

   TEAM or ON-CALL PSYCHIATRIST:

   a. Convene the entire clinical team at the earliest possible time:
   b. Notify the IPU Medical Director of the situation and the team's recommendation.
   c. Document the clinical process and outcome in the patient's medical record.
   d. Develop a recommendation to best serve the patient.
   e. Ensure all key clinical staff on duty are involved and informed about this issue.
   f. Discuss the patient's request and the clinical issues involved.

2. MEDICAL DIRECTOR

   a. Evaluate the patient's request and the team's recommendation.
   b. Uphold the recommendation or make another plan of action.
   c. If the psychiatrist with whom the patient no longer wants to work is off duty then no changes will be made, unless an emergency issue has been identified necessitating an immediate change by the IPU Medical Director.

3. If other shifts or work groups are involved, ensure that all those involved in providing clinical services for the patient are informed of the process and outcome.

All revision dates:	12/12/2019, 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2004, 2/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/2001*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.46 Personal Protective Equipment in the IPU

POLICY:

To provide for the safety of IPU staff through the use of appropriate personal protective equipment, which includes an electronic alarm system to summon help. This policy is in addition to any other hospital-wide policies related to dress, protective equipment, and safety. These guidelines are in accordance with standards set by The Joint Commission, HCFA, Title 22, Title 9, and the OSHA General Duty clause.

PROCEDURE:

1. PROFESSIONAL DRESS
   a. Refer to Administrative policy 101.008 General Dress Policy .
   b. Items that can be easily grabbed and present a safety risk are not allowed. This includes items such as non-breakaway neckties, name tags, necklaces, and dangling earrings.
2. SPIT SOX
   Spit sox are available to provide a barrier between staff and patients and shall be used at staff discretion.
3. DURESS ALARMS
   a. Each employee working in patient care areas will be assigned a personal alarm (tag).
   b. The alarm will be programmed to identify the individual.
   c. The Unit Clerk or Nursing Staff, if the clerk is not present in the nurses' station, will call a Code Gray on the overhead paging system in response to the alarm, announcing the location.
   d. Reset the alarm after safety is ensured.
   e. In the event of a known or unforeseen malfunction (Note: Refer to Duress Alarm System in the Psychiatric Unit Orientation Sheet):
      1. Clerical or Nursing Staff will call a Code Gray when notified, announcing the location over the PA System, using the "all call" button.
      2. The buddy system will be initiated immediately upon notification that the system is not functioning.
         Two (2) Staff members must be present at all times when entering a patient room or any area that prevents line of sight.
      3. All group functions require a minimum of two (2) staff to be present at all times, including, but

	not limited to OT, chemical dependency groups and nutrition groups.
All revision dates:	12/12/2019, 2/1/2016, 2/1/2015, 8/1/2010, 3/1/2010, 9/1/2009, 3/1/2009, 8/1/2008, 2/1/2007, 8/1/2004, 6/1/2004, 12/1/2003

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	11/29/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.47 IPU/CSU Tarasoff Reporting

POLICY:

The VCMC Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) will ensure compliance with the California Supreme Court Tarasoff decision. IPU and CSU staff have a legal/ethical obligation to protect others when a patient threatens bodily harm to a specific identified victim(s). This duty to warn overrides confidentiality requirements.

PROCEDURE:

All Staff:

1. When a patient verbalizes a threat to do bodily harm against a reasonably identifiable person, licensed staff will report it immediately, and in the following order:
    - Ventura County Police Department and Sheriff s Department
    - Police Department in the area where the victim resides
    - Intended victim
    - Charge Nurse and Shift Supervisor
    - Administrator on Duty (AOD)
    - Medical Director and Weekday Staff Physician
    - Social Services Staff
2. When an unlicensed staff member, including administrative support staff, hears a plan to carry out a threat, he/she will immediately report it to a licensed staff member.
3. Should Housekeeping staff hear a threat, he/she will report it immediately to the Shift Supervisor or Charge Nurse.
4. Every reasonable attempt must be made to inform the intended victim and all attempts must be documented.

DOCUMENTATION

1. Documentation includes completion of:
    a. Tarasoff Reporting Form and file in medical record.

b. Daily assessment of the patient's homicidal ideation should be entered in the Progress Notes and the Mental Status Exam.

INTERVENTIONS/PRECAUTIONS

2. Precautions shall be instituted at the appropriate level and staff should consider ordering hospital clothing to assist in maintaining the patient in the IPU/CSU until it is determined by assessment that the patient no longer poses a threat.
3. The Nursing Care Plan and/or Treatment Plan must address the patient's homicidality. Reviews and updates should reflect the patient's status toward the elimination of homicidal intent.
4. Should a threatening patient ~~AWOL~~Elope during the interview process, Licensed nursing staff shall follow the notification procedure and complete the Tarasoff process.

All revision dates:	1/20/2023, 12/12/2019, 5/1/2015, 3/1/2009, 9/1/2007, 2/1/2007, 9/1/2004, 2/1/2000, 2/1/1998, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/1999*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.49 IPU Patient Referral to Board and Care Facilities

POLICY:

The required Board and Care (B&C) forms must be completed prior to placement of a Ventura County Medical Center inpatient psychiatric unit (IPU) patient in a licensed board and care facility. The forms must accompany the patient to the facility at the time of discharge or the facility will not accept the patient for placement. The Social Services staff will coordinate the completion and delivery of these forms as they are an essential part of Discharge Planning to Board and Care placements. However, they are NOT exclusively Social Services forms.

PROCEDURE:

A. TEAM PSYCHIATRIC SOCIAL WORKER (PSW) - (PSW designation includes under-fills)

1. Complete the address and length of stay section on LIC 602 Form, the Physician's Report for Community Case Facilities form (the PSW Section includes the first 13 boxes plus "Length of Stay" box and "In Your Opinion" box).

B. REGISTERED NURSES:

1. Complete the personal care sections and the section on Tuberculosis (TB) status - eight sections under "Patient's Diagnosis."

C. TEAM PHYSICIAN:

1. Complete the "Diagnosis" section, the sections on "Medication Management," "Substance Abuse," and "Cognitive Ability."
2. List the current medications being taken.
3. Review the entire form and make any corrections or changes.
4. Sign the form and route to the Team PSW.

D. COMMUNITY SERVICES COORDINATOR

1. Complete the Pre-Placement Appraisal Information (LIC 603). The community services coordinator may request that the Team Social Services staff assist with and/or complete the form.
2. Complete Functional Capacity Assessment Form (LIC 9172) - Same as #1 above.
3. Complete Appraisal/Needs Services Plan (LIC 625) - Same as #1 above.

All revision dates:	12/12/2019, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 2/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/2000*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.50 The IPU Utilization Review Subcommittee

POLICY:

The Utilization Review Subcommittee performs, directs, and delegates utilization review activities and processes for the Inpatient Psychiatric Unit (IPU) at Ventura County Medical Center (VCMC). It functions in conformity with the VCMC Utilization Review Committee, the VCMC Medical Director, the Behavioral Health Director, and the State Department of Mental Health regulations for acute Short/Doyle Medi-cal (SD/MC) hospital standards.

PROCEDURE:

Unit Utilization Review Subcommittee members shall consist of the following members:

- ~~IPU~~ Utilization Review Clinical Nurse Manager
- IPU Medical Director
- A second physician appointed by the IPU Medical Director
  ~~IPU Operations Officer~~
- IPU Supervisory Nursing Services
- IPU ~~Director~~Lead of Social services
- VCMC Administration Representative
- Ex-officio members include VCMC Associate Administrator and VCMC Medical Director
- The UR Committee may not include any individual who is directly responsible for the care of the patient under review or who has a financial interest in any psychiatric facility (42 CFR 456.206 (3)(d).
- The Committee Chair is the IPU Medical Director assisted by the Utilization Review Nurse who may serve as Co-Chair.
- The Subcommittee functions shall consist of the following:

  1. Review summary reports of utilization trends, patient demographics, MCE studies, and other performance improvement activities.
  2. Review and audit medical records according to relevant to medical necessity criteria for admission and continued stay (use UR audit worksheet).
  3. Review plan of care, plan for discharge, and referrals and coordination with other agencies including, but not limited to, substance abuse treatment, education, medical, housing, vocational rehab and tri-counties regional center.
  4. Educate physicians and clinicians regarding matters relevant to level of care and documentation requirements based on results of UR audits.

5. Participate in review of the findings of IPU performance improvement processes, Medical Care Evaluation studies and equivalents, and VCMC-wide Performance Improvement activities.
6. Review relevant policies and procedures including but not limited to interpreter services, MHP cultural competency, and treatment planning.
7. Review selected case(s) of patients with long stays, multiple hospital stays, and/or with complex treatment plans. Long stays are defined as 10 or more hospital days. Multiple stays are defined as two (2) or more admissions in 30 days.
8. Review current compliance issues and oversight regulations/audits.
9. Reviews cases of physicians whose patterns of care are frequently found to be questionable. The outcome of such reviews will be forwarded to the Medical Director to develop an individual plan of correction.
10. Minutes to be maintained and forwarded to the VCMC Utilization Review Committee.
11. Perform, direct, and delegate Utilization Review activities in the IPU.
12. The Subcommittee shall meet at least quarterly.
13. All Subcommittee records and reports are maintained in such a way as to maximize the confidentiality of all patient, clinician, and hospital information.
14. All Medical Care Evaluations studies will be discussed, reviewed and approved by the UR Committee prior to implementation. Results from MCE studies will be shared at UR Committee meetings and with the QAPI department.
15. Any quality of care or physician-related concerns will be directed to the Medical Staff Office for peer review.

All revision dates:	1/20/2023, 12/12/2019, 3/1/2009, 8/1/2008, 1/1/2006, 9/1/2004, 3/1/2003, 2/1/2003, 12/1/2002, 6/1/2002

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*11/1/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/1/2015*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.51 Therapeutic Boundaries in the IPU

POLICY:

It is the responsibility of Ventura County Medical Center Inpatient Psychiatric Unit (IPU) employees to exercise appropriate judgment and conduct themselves with patients in a manner that reflects use of common sense. The following general guidelines are for the information and guidance of all IPU staff. These guidelines are not all inclusive.

PROCEDURE:

1. Staff members are to render care in a manner that respects the personal dignity and rights of each patient. Any form of patient abuse and/or neglect will not be tolerated and staff members are to support facility policy and procedures in this regard.
2. Counseling of a patient outside the realm dictated by the physician in treatment/care plan sessions is discouraged.
3. Patients are to be dealt with equally and fairly at all times. The selection of "favorites" is not beneficial to the therapeutic milieu or the patient population.
4. Staff members may not:
    a. Be alone in a patient room with a patient with the door closed.
    b. Escort a patient from the grounds alone without prior approval.
5. Befriending patients outside of the facility is not acceptable.
6. Befriending patients after they have been discharged from the facility is not acceptable.
7. Any sexual relations between staff and patients will result in termination of employment and shall further result in all applicable professional and legal sanctions against such employee.
8. Staff members are not to reveal unnecessary personal information about themselves (such as home address, telephone number, e-mail address) to patients or patient family members. Staff members are not to engage patients via social media including but not limited to Twitter, Facebook, LinkedIn or texting.
9. Staff members who have reason to believe a co-worker is committing a boundary violation are obligated, for the sake of patient safety, to bring such concerns to a supervisor.
10. Staff are to notify their supervisor if a pre-existing relationship/acquaintance exists with a patient.
11. Staff members who are licensed or certified in any profession shall follow all applicable rules of conduct.

12. Significant or repeated violations of therapeutic boundaries may be grounds for disciplinary action, up to and including immediate termination.

All revision dates: 11/1/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2011*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.52 Timely Medical Treatment of Ventura County Public Guardian Conservatees in the IPU

POLICY:

The conservatee is legally under the jurisdiction of the Ventura County Public Guardian (VCPG). Every VCPG conservatee assessed and determined to meet medical necessity for psychiatric treatment shall receive psychotherapeutic medications according to the Order Appointing Conservator with Authority to Consent to Administration of Psychotropic Medication. The VCPG has authorized the dispensing of FDA approved medications under the guidelines found in the following protocol. *This policy ensures VCPG clients receive timely treatment.*

PROCEDURE:

A. **EVALUATING ~~OPOS~~ CLINICIAN**

1. Weekly, VCPG will provide an updated conservatee list of LPS conserved clients assigned to/under the care of the Ventura County Public Administrator. This will aid in the timely administering of medication.
2. Upon verification, ~~OPOS~~Inpatient Psychiatric Unit (IPU) / Crisis Stabilization Unit (CSU) will immediately contact VCPG and request the "Letter to Treat"; include in the chart a copy of the "Letter of Conservatorship" with the Assessment and, if received, the "Letter to Treat."

   Contact the VCPG at:
   Days: (805) 654-3141-AOD Line - (805) 650-1344 FAX
   Nights: (800) 684-7681-AOD Line - (805) ~~256-4614-AOD Line - (805)~~ 658-4531
3. Once notified, the VCPG agrees to provide the IPU/~~OPOS~~CSU with "Letters to Treat" within 24 hours (or the next business day). VCPG may provide verbal authorization to admit for treatment. ~~However, the~~The *Informed Consent for Psychotropic Medications for Conservatees* form must be signed by the treating psychiatrist and the VCPG'S office ~~prior to psychotropic medications being prescribed~~. After hours, verbal authorization is sufficient. Written informed consent will be obtained as soon as possible.
4. If the prescribing psychiatrist is not on the unit, the patient may receive emergency medications per unit protocol until formal *Informed Consent* signed by the VCPG'S office forms are in place.
5. Notify the receiving IPU/~~OPOS~~CSU team that patient is under legal guardianship of Ventura County

and that legal documents have been requested. Assigned ~~IU Staff~~IPU/~~Social Services~~CSU staff will follow up to ensure timely receipt of required legal forms.

6. If the conservatee does not meet medical necessity for an acute level of care, notify the VCPG and discuss arrangements for further care.

B. ~~**AFTER HOURS IN A&R:**~~

~~1. Review active list and verify all conservatees of VCPG.~~

~~2. Call the VCPG-AOD (see after hours contact number) and request "Letters to Treat."~~

~~If the prescribing psychiatrist is not on the unit, the patient may receive emergency medications per unit protocol until formal *Informed Consent* signed by the VCPG'S office forms are in place.~~

~~3. Notify the receiving IPU/OPOS Team that patient is under legal guardianship of Ventura County and that the legal documents have been requested.~~

~~Every effort should be made at the point of entry (IPU/OPOS) to complete the *Informed Consent for Psychotropic Medications for Conservatees* and forward to the office of the VCPG to expedite administering medications and stabilizing the patient.~~

AFTER HOURS:

1. Identify and verify all conservatees of VCPG.
2. Call the VCPG-AOD (see after hours contact number) and request "Letters to Treat."

C. **PRESCRIBING PSYCHIATRIST:**

1. Complete both the VCPG'S *Informed Consent for Psychotropic Medications for Conservatees and* the **Patient Notification for Psychotropic Medications.**

~~Only the acute care~~Medication consent is completed by the psychiatrist ~~may sign the medication consent form~~, except when using the 3-way telephone procedure (including a signature of a second licensed staff member as a witness). ~~Include a signature of a second licensed staff member as a witness.~~

~~All VCPG patients will be informed about their medication and provided a "Patient Notification" form to sign, indicating medications have been reviewed. The psychiatrist will document patient response to medications. It is therapeutic to include the patient even when the patient cannot legally give direct consent.~~

~~Care will be exercised in dispensing medications that are not medically contraindicated.~~

2. ~~Educate~~When appropriate, educate the patient of the following:
    a. Rights under conservatorship.
    b. The nature of the patient's mental condition.
    c. The reason(s) for recommending medication.
    d. The likelihood of improving or not improving without such medication.
    e. Reasonable alternative treatments available, if any.
    f. The name, type, frequency and amount, route of administration, and expected duration of treatment with medication.

g. Any dosage exceeding the usual daily dose - additional approval must be ~~obtayined~~obtained from VCPG.

h. Explanation of long acting injectable medications.

i. Side effects known to commonly occur, including symptoms of Tardive Dyskinesia or Neuroleptic Malignant Syndrome, if indicated.

j. Any side effects or food/drug interactions likely to occur with the particular patient.

k. Document patient response and place in the chart.

3. The team psychiatrist then completes and signs the *Informed Consent for Psychotropic Medications for Conservatees form;* only the acute care psychiatrist may sign. (Rare exception is when there is a three-way telephone procedure.)

4. The completed/signed forms are faxed to the VCPG's office for the authorized legal guardian's signature.

   During business hours, the *Informed Consent to Treat* form will be returned by the VCPG ~~within one (1) hour~~.

5. If medications are added to the list of medications on the *Informed Consent for Psychotropic Medications for Conservatees* later in the course of treatment, a new form must be filled out, faxed to the VCPG's office for signature, and the signed copy included in the chart.

   ~~This VCPG informed Consent for Psychotropic Medications for Conservatees is under the outlined protocol, valid for the duration of the hospital stay, i.e., if new medications are prescribed, added a new form must be completed as explained above.~~

6. Request a dietary consult if additional patient education is indicated for food/drug interactions. ~~Include copies or list the handouts used for patient education in the patient record.~~

   ~~Team may refer to the "VCMC/SPH Dietary Manual" for additional dietary information. Manuals are located in the RN station, Shift Supervisors' Office and/or IPU/OPOS.~~

All revision dates: 10/17/2022, 2/1/2016, 12/1/2011, 10/1/2011

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

Step Description	Approver	Date
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	12/8/2021

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/2000*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.54 The IPU Utilization Management Plan

POLICY:

The Utilization Management Plan provides for the Quality Care/Utilization Management (QC/UM) Department to direct, perform, and delegate QC/UM activities as prescribed under the mental health plan (MHP) and processes on the Inpatient Psychiatric Unit (IPU). This plan provides for a standardized process to manage the medical necessity and clinical justification for each patient admission and their continued stay in the IPU.

Table of Authorities:
California Code of Regulations (CCR) Title 9, Chapter 11, Section 1820.205, 1820.225 and sections following. Department of Mental Health (DMH) letters Ventura County Behavioral Health Department Mental Health Plan Code of Federal Regulations Title 42, Subchapter C, Subpart D, Sections 456 and following.

PROCEDURE:

1. Prior to authorization of payment, a physician will complete a medical evaluation on each presenting patient to provide written clinical justification for admission into an acute psychiatric hospital.
2. Clinical documentation will be in descriptive, behavioral and observable language and will describe the patient's functional impairments. Physicians are encouraged to avoid the use of psychiatric terminology and jargon. When psychiatric terminology is used, the author needs to define how symptoms are manifested in behavioral terms and the effect on the patient's functional status.
3. Quality Care/Utilization Management nurse to review each patient's medical record and appropriate need for admission. Document justification for admission and appropriate level of care in the QC/UM record.
4. Documentation and Review Activities:
    a. All UM chart activities to have oversight by the power of attorney (POA) representative. Use the QC/UM audit worksheet which incorporates the highest standard of criteria across all regulatory agencies.
    b. Use the QC/UM audit worksheet which incorporates the highest standard of criteria across all regulatory agencies. It incorporates CCR Title 9, Chapter 11, Section 1820.205, 42 CFR 456, The Joint Commission HAS IM.7 and 1820.225.
    c. Prepare an individualized file for each hospital stay under review. Each recipient's QC/UM record shall contain all the required elements as follows:
        1. Identification of the recipient.

2. The name of the recipient's physician.
3. The date of admission.
4. The plan of care as required under CFR 456.180. NOTE: Utilization Management Plan and Procedures revised 5/1/12 to Quality Care/Utilization Management (Short Doyle Medi-Cal) to include the procedures for ensuring each recipient's UM Record contains all required elements, in accordance with the requirements of CFR Title 42, subchapter C, Subpart D, Section 456.211 (a-g); CCR, Title 9, Chapter 11, Section 1820.210, 1820.220, 1820.225.
5. Progress Notes.
6. Maintain records by month for each fiscal year.

d. Initial and subsequent continued stay, if the attending physician believes continued stay in necessary under CFR 456.233 and 456.234. Determination of need for continued stay shall be based on chart documentation that includes but is not limited to the following:
   1. Documentation of danger to self, others and grave disability.
   2. Documentation of behavioral indicators that warrant acute psychiatric level of care.
   3. Documentation of risk factors prohibiting patient's ability to be managed at a lower level of care.
   4. Physician's certification of hospital stay.
   5. Continued presence of indications that meet the medical necessity criteria.

e. The Quality of Care Management Worksheet shall be used to manage each recipients continued stay in the IPU to:
   1. Determine need for continued stay.
   2. Evaluate criteria for continued stay.
   3. Initial continued stay review.
   4. Subsequent continued stay review dates.
   5. Describe methods and criteria for continued stay review dates; length of stay modifications with supporting orders for Seclusion; Restraints; CSP; SSP; GSP; AWOL Risk; Riese; Labs; 1:1; Assault; Emergency Meds; H&P; Medical Complications, etc.
   6. Continued stay review process
   7. Notification of adverse decisions

f. Review all records, including 5150, Legal Status, Physician's diagnosis, each business day following admission. ("Use Quality Care Worksheet.") For each continued stay that does not meet the acute criteria, notify attending physician to give him/her an opportunity to provide an explanation before issuing a final determination on continued stay.

g. All QC/UM Department activities are to be monitored by the POA and/or physician.
If the physician **does not** provide additional information for the justification of continued stay, the adverse decision is final. If the physician chooses to appeal the decision by written communication, two physicians from the QC/UM committee to review the need for continued stay and issue a decision.

h. Give notice of adverse decision to physician/Medical Director within 7 business days of the review date or within 7 business days of the final decision, whichever is sooner.

i. All Inpatient psychiatrists will receive a PowerPoint training annually along with all necessary attachments regarding the plan of correction from the Short/Doyle Audit during April 2018. Additionally, all new inpatient psychiatrists will receive the same PowerPoint training and all necessary attachments. Documentation of required attendance will be kept to verify that trainings have occurred.

All revision dates: 12/12/2019, 2/15/2018, 5/1/2012, 2/1/2010, 9/1/2009, 3/1/2009, 8/1/2008, 2/1/2007, 1/1/2006, 9/1/2004, 3/1/2003, 2/1/2003, 12/1/2002, 6/1/2002, 9/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.55 IPU Psychiatric Services

POLICY:

The VCMC IPU Admission Psychiatrist will provide on-site psychiatric admission assessments as well as psychiatric consult services. The psychiatrist will be available in-house Monday through Sunday from 0700 to ~~2300~~1900. After hours there is a psychiatrist on-call for phone consultations and admission orders.

PROCEDURE:

A. All patients presenting for assessment to the VCMC ~~Outpatient Psychiatric Observation Service~~Crisis Stabilization Unit (~~OPOS~~CSU) will be assessed by a licensed mental health professional. The ~~OPOS~~CSU is staffed with Mental Health Nurses and other Mental Health Professionals.

B. If it is determined that the patient meets medical necessity, the information will be presented to the psychiatrist on duty.

C. The psychiatrist will verify medical necessity and complete the Admission Psychiatric Assessment. This assessment must be completed within 24 hours of admission.

D. The psychiatrist will complete the admission orders in the electronic health record (EHR). The psychiatrist will also order medications for psychiatric conditions and may order medications for medical conditions ~~and psychiatric medications~~unless done by physician completing medical History and Physical.

E. The psychiatrist will complete the "Reise" Petition for any patient that is determined to need medication consent. "Petition for Hearing to Determine Capacity to Give Informed Consent to Antipsychotic Medication."

F. The psychiatrist will initiate ~~a~~ precautions level (routine, 1:1, or 1:2) as needed.

G. After hours, the on-call psychiatrist will be responsible for giving admission orders.

   a. The on-call psychiatrist will use a three-way call with the patient and the admitting nurse to obtain medication consent for psychiatric medications. Orders for medications the patient is taking for medical problems will also be ordered at this time.

H. Patients admitted after hours will be seen by the team psychiatrist within 24 hours of admission and the Admission Psychiatric Assessment will be completed.

All revision dates: 10/17/2022, 2/1/2016, 4/1/2012, 8/1/2010, 3/1/2009, 10/1/2007, 9/1/2007

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/1/1991*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/2/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.57 Treatment of High Risk Behavior Patients in the IPU

POLICY:

The Ventura County Medical Center (VCMC) Inpatient Psychiatric Unit identifies patients at risk for ~~AWOL~~Elopement, assault, self-harm, suicidal behaviors, damage to property, or infringement on the rights of others and provides special levels of observation and intervention in order to maximize the safety of patients, visitors, and staff. These are documented in the patient record. The patients' rights will be protected.

PROCEDURE:

1. Initiation
    a. Any patient admitted to the unit.
        1. Will have the following skin assessment/contraband check. This assessment/check will include the patient taking off all of their clothes in one of the quiet rooms, including undergarments and socks, and putting on a ~~paper~~ gown. Two ~~same gender~~ staff~~,~~ will be attained one of whom is licensed~~,~~ and will assist the patient. Once the patient has put on the ~~paper~~ gown, belongings will be separated and searched for contraband. The staff will politely check the back of the person while the gown covers the front, and then, respectfully and briefly, check the front without the gown to ensure that no contraband is present on the person, and that the skin is intact. Once the assessment/check has been completed, the patient may have their searched clothes returned or offered pajamas.
        2. Should a patient decline to turn over their belongings or change into the ~~paper~~ gown for the assessment/check, he or she will be placed on 1:1 observation immediately in the admission hallway. The 1:1 observation will continue until the patient cooperates with the skin assessment/ contraband check.
    b. Physicians will assess each patient and identify those at risk during the initial Psychiatric Evaluation and on a daily basis using the current version of "Physician Progress Note." Based on their assessment and judgment, the appropriate precaution and level will be ordered.
    c. Each patient will be assessed by an ~~RN~~Registered Nurse upon admission. A history of high-risk behaviors, factors that may increase risk and current symptoms and behaviors will be identified and a recommendation will be ordered.
    d. All patients admitted without a face-to-face evaluation by a psychiatrist will be placed on routine

precautions at minimum, until seen by a psychiatrist.

2. Levels of Intervention
   Please refer to the Adult Inpatient Psychiatric Clinical Practice Policy.

   a. **Routine Precaution-** All patients will be on Routine precautions while they are hospitalized on the Inpatient Unit.

      1. Advise patient of the precaution level and procedure involved.
      2. Observe patient every 15 **minutes.**
      3. Observe patient on separate hallway variable rounds in between the 15 minutes.
      4. Assigned Licensed Nurse Staff will assess every shift.

   b. **1:2 Precaution**

      1. Patients may be admitted that require a higher level of observation and assessment. The physician may order a 1:2 staff to patient ratio. ~~The observer is either located in the hallway or observes via audio/visual monitor where he/she can observe both patients concurrently.~~
      2. Advise patient of precaution level and procedure involved.
      3. Initiate Patient Observation Record.
      4. Search patient room, locker, and bathroom for contraband.
      5. Notify the Shift Supervisor/Charge Nurse.
      6. Patient is observed continuously, and has additional every 15 minute observation as part of routine precaution checks.
      7. The observer will document patient behavior and any signs of injury on a progress note. Documentation is encouraged hourly, however is not required to be performed concurrently.
      8. Reassessments are performed by an RN every four (4) hours and as needed according to the patient's condition with documentation of the outcome of the assessment in the Nursing Progress Notes required at least once per shift (concurrent documentation of reassessments is not required). The Progress note includes an assessment of the patient's behavioral health condition and is annotated in the "ABC" format. This format is based on clinical staff's observation, assessment, intervention and evaluation of the patient.
      9. Physician will reassess daily, during treatment team meetings, to determine level of risk and will continue or discontinue precautions and document in the Progress Record. A physician's order for 1:2 precautions will remain in place until the behavior or circumstance no longer requires the use of 1:2 observation. Order must be renewed each calendar day.
      10. If patient's condition has deteriorated, notify team or on-call physician for order to change level.

      ~~Duration: A physician order for 1:2 precautions will remain in place until the behavior or circumstance no longer requires the use of 1:2 observation. Order must be renewed each calendar day.~~

   c. **1:1 Precautions**

      1. Patients may be admitted that require a higher level of observation and assessment. The Physician may order a 1:1 staff to patient ratio. ~~The observer is either located in the hallway or observes via audio/visual monitor where he/she can observe both patients concurrently.~~
      2. Advise patient of precaution and procedure involved.

3. Initiate Patient Observation Record.
4. Begin 1:1 **constant observation** immediately. Physician **may** specify the maximum distance between patient and 1:1 staff.
5. ~~Notify the SS/CN and the physician.~~Notify the Charge Nurse.
6. Search patient room, locker and bathroom.
7. Initiate hourly documentation.
8. Patient to be attended at all times.
9. Escort patient to all meals and activities.
10. Accompany patient to bathroom, stall door to be open with all suicidal patients~~, attempt to provide same gender staff~~.
11. Patient is observed continuously, and has additional every 15 minute observation as part of routine precaution checks.
12. The observer will document patient behavior and any signs of injury on a progress note. Documentation is encouraged hourly, however is not required to be performed concurrently.
13. Reassessments are performed by an RN every four (4) hours and as needed according to the patient's condition with documentation of the outcome of the assessment in the Nursing Progress Notes required at least once per shift (concurrent documentation of reassessments is not required). The Progress note includes an assessment of the patient's behavioral health condition and is annotated in the "ABC" format. This format is based on clinical staff's observation, assessment, intervention and evaluation of the patient.
14. Physician will reassess daily during treatment team meetings, to determine level of risk and will continue or discontinue precautions and document in the Progress Record.
15. Duration: A physician order for a 1:1 precaution will remain in place until the behavior or circumstance no longer requires its use. The order must be renewed each calendar day.

All revision dates: 3/2/2023, 2/12/2020, 7/1/2015, 2/1/2014, 3/1/2009, 8/1/2008, 9/1/2007, 10/1/2004, 7/1/2003, 3/1/2003, 11/1/2002, 6/1/2002, 1/1/2002, 3/1/2001, 6/1/2000, 4/1/1999, 11/1/1998, 4/1/1996, 2/1/1996, 7/1/1995, 5/1/1995, 2/1/1995, 1/1/1994

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/3/2023

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*7/1/2003*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/1/2009*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.58 IPU Patient Consent to be Photographed

POLICY:

Patients may be photographed for identification purposes or to capture evidence of suspected child, elder, dependent adult, or domestic abuse. It is the policy of the Inpatient Psychiatric Unit (IPU) at Ventura County Medical Center to obtain proper consent whenever a photograph of a patient, or any part of the patient's body, is taken for purposes not directly related to medical treatment.

PROCEDURE:

1. Nursing staff will photograph patients at admission for identification purposes. The Joint Commission National Patient Safety Goals require two forms of patient identification prior to medication administration, the taking of blood samples or other specimens for clinical testing, or prior to completion of any high-risk procedure.
2. Patients who have injuries as a result of suspected abuse may also be photographed (see VCMC Administrative policy 100.010, *Photographing of Patients*).
3. Nursing staff are to explain the purpose of the photograph to the patient and obtain proper consent using the "Consent to Photograph" form.
    a. Patient or legal representative should sign and date the form.
    b. The signature should also be witnessed and the witness should sign on the space provided on the form.
    c. Any limitation on the use of the photographs should be noted on the consent form.
    d. The original form should be placed in the patient's medical record and a copy given to the patient.
4. Photographs are **not** to be used for other purposes without obtaining the written consent of the patient or the patient's legal representative. A separate consent form is needed to authorize the use of the photograph for any other purposes.
5. At discharge, patient photographs should be sent with the rest of the chart to Health Information Management.

All revision dates: 3/1/2009, 7/1/2008, 2/1/2007, 10/1/2006, 9/1/2004

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1990*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/1/2009*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.61 History and Physicals in the IPU

POLICY:

To establish guidelines to ensure timely completion of the patient History and Physical (H & P) in the Inpatient Psychiatric Unit (IPU) at Ventura County Medical Center consistent with regulatory guidelines.

PROCEDURE:

Physician:

1. Review labs, chart, and consult with team physician as indicated.
2. Perform H & P within 24 hours of admission.
3. If for any reason the H & P cannot be completed within 24 hours, the physician will document:
    a. Document refusals, etc. on a daily basis
    b. Gross physical observations
    c. Vital signs if patient allows
    d. Presence or absence of pain
    e. Review chart from prior admissions and address prior diagnoses
    f. Note absence or presence of signs or symptoms of alcohol and/or drug withdrawal
    g. Record absence or presence of physical complaints
4. May request that SS/CN assign staff to accompany patient to and from the exam room and to provide chaperone during H & P as appropriate.
5. Provide list of completed H & P to clerk to note as completed in electronic health record at end of shift.

All revision dates: 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2006, 9/1/2004, 7/1/2003, 6/1/2001, 4/1/2001, 1/1/2000, 11/1/1998, 1/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	12/21/2021

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/1/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.62 Use of Electronic Lift in the IPU

POLICY:

To provide guidelines for Inpatient Psychiatric Unit (IPU) staff and vendors at Ventura County Medical Center in the proper use of the electronic lift to ensure their safety and to prevent the ~~AWOL~~Elopement of patients.

PROCEDURE:

1. The roll-up door is unlocked with the ~~137~~ **AA1** key. Turn key to "ON" position and follow operating procedures (#5 below).
   a. Lock must remain in "OFF" position when lift is not in use.
   b. Report loss of ~~137~~ **AA1** key immediately to the Shift Supervisor/Charge Nurse.
2. Use lift only for heavy items such as food carts, laundry carts, trash carts, shipping and receiving.
3. IPU staff should stay with any vendors, VCMC staff, or other non-IPU staff during operation of the lift to ensure that these procedures are followed.
4. Laundry, Housekeeping and Facilities Maintenance operate the lift without supervision.
5. Operating procedures:
   a. Open the roll door.
   b. Remove the chains.
   c. Step on the lift.
   d. Load carts onto the lift.
   e. Fasten chains. Never leave chains lying on the platform.
   f. Keep feet at least six (6) inches away from the edge of the platform. Do not rest hand on platform pole at doorway opening
   g. Push UP Control Button
   h. Remove chains.
   i. Unload cart.
   j. Step back on lift.
   k. Replace chains

l. Push DOWN control button
m. Step off lift
n. Fasten chains
o. Close roll door
p. Lock roll-up door by switching key to "OFF" position

6. Prior to use of the lift, all staff/vendors, etc. must sign the form agreeing to follow the above procedure.
7. The form is kept on file in the IPU.

All revision dates: 10/17/2022, 7/26/2017, 3/1/2009, 8/1/2008, 10/1/2006, 9/1/2004, 12/1/2001, 2/1/2000, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	10/20/2021

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/26/2017*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.63 IPU Census and Capacity

POLICY:

Ventura County is required to evaluate and provide, or arrange for the provision of, acute psychiatric care for all adults who meet criteria for admission, but cannot receive services elsewhere while maintaining a census at or below the number of 43 beds licensed by the California Department of Public Health (CDPH). Management of patient capacity in the Inpatient Psychiatric Unit (IPU) shall follow the procedure below, with the understanding that bed capacity may be more restricted on weekends, holidays, or other times when patient admissions or discharges do not occur or do not occur in even distribution.

PROCEDURE:

ACUTE CARE PSYCHIATRIST/SHIFT SUPERVISOR/CHARGE NURSE (SS/CN):

1. Admission to the IPU is based on bed availability and the number of qualified staff to safely treat the patient.
2. When the patient census reaches a point where the current staffing pattern would not be able to manage additional admissions, the SS/CN shall contact the IPU Clinical Nurse Manager or AOD to request diversion of potential patients to other facilities. *Diversion may be due to increased census, decreased staffing or environment of care problems.*
3. Any admission over our licensed capacity of 43 must be reported to Hospital Administration.
4. If census exceeds capacity at any time, or the IPU is on diversion status, the following notifications must take place:
    a. SHIFT SUPERVISOR/CHARGE NURSE
        1. Contacts the IPU Clinical Nurse Manager and notifies the following:
        By phone:
        IPU AOD
        VCMC Nursing Supervisor
        By email:
        IPU Medical Director
        VCMC Medical Director
        VCMC Administration
        VCMC Chief of Operations
        VCMC Chief Nurse Executive

2. Report information about the census, including:
    a. Additional staff called in
    b. Intra-facility admissions and transfers denied
    c. Crisis Team notified
    d. Current patient assessments
    e. Problems/reasons patients unable to be discharged
3. Call in necessary additional staff as census/acuity dictate.
4. Work with the Crisis Team and Outpatient Teams to screen admissions carefully on a case-by-case basis. Legal status and clinical status are two different things.

    It is not as simple as saying that only patients on a Legal Hold may be admitted. Patients may be dangerous yet willing to be admitted on a Voluntary Legal status.
5. Discuss any questionable admission with the on-call AOD.

b. IPU ADMINISTRATION:

1. Complete the "Over Capacity Report."
2. Telephone CDPH to report the census. State that the full written report will be faxed as indicated in the steps below:
   CDPH Contact Number:
   (805) 604-2925 Monday through Friday
   (800) 547-8267 Weekends
3. Fax the report to CDPH immediately, if during normal business hours.
    a. Fax the report to CDPH on the next business day, if this occurs on the weekend or a holiday.
4. Provide a copy of the written report to VCMC Hospital Administration by fax or email.

All revision dates:	7/26/2017, 1/1/2014, 3/1/2009, 7/1/2008, 2/1/2008, 9/1/2007, 7/1/2004, 5/1/2001, 2/1/2000, 4/1/1999, 5/1/1997, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/1/2010*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.64 Breathalyzer Screening - Alco-Sensor FST®

POLICY:

Licensed Nursing Staff in the Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) at Ventura County Medical Center may perform alcohol breathalyzer screening to obtain result values for diagnostic purposes and subsequent treatment.

PROCEDURE:

1. Client/patient must voluntarily consent to undergo screening.
2. Explain the procedure to the client/patient.
   Follow manufacturer guidelines for proper administration for diagnostic and treatment only purposes. (See Alco-Sensor FST® Operator's Manual.) FOR ACCURACY OF TEST, THERE MUST BE A 15 MINUTE PERIOD OF NO FOREIGN SUBSTANCES IN THE MOUTH.
3. Depress ON button for one (1) second – *To illuminate the display, hold the ON button down for an extra second or two.*
   If the battery is low, the display will indicate BAT or it will not turn on.
   If it displays **BLN**, it is performing a blank test. A successful test is indicated with an **"O."** An unsuccessful test is indicated by **"E11."**
4. Attach a clean, unused mouthpiece. Insert the long, closed end of the mouthpiece into the mouthpiece channel. Rotate the mouthpiece downwards, attaching the mouthpiece to the two ports.
5. When **"BLO"** appears on the display, ask the client/patient to take a deep breath, hold it and then blow steadily through the mouthpiece as long as possible
   The client/patient should blow a steady, continuous sample. **The breathalyzer will power down if the sample is not obtained in 30 seconds.**
6. The sensor will display the percentage of alcohol in the breath.
   After testing, remove the mouthpiece and dispose of it.
7. Document breathalyzer screening results on the assessment form/progress notes and in the log.
8. Notify appropriate clinical staff of the screening results.
9. **Calibration:**

   Manufacturer's Instrument Manual Calibration shall be completed according to the manufacturer's guidelines by the Biomedical Department.

10. **Competency:**

IPU and CSU orientation will include the two (2) step competency:

Staff is required to complete competency training by adhering to the following two (2) step process:

a. Online competency certification (one-time only) at the following website: www.training.intox.com/asfst. The serial number is 038917; and

b. Demonstrate annual competency with sign-off by supervisor.

NOTE: Abnormal vital signs and/or abnormal values greater than 200 require medical review with physician for determination of medical clearance.

TESTING SHALL BE PERFORMED TO AID IN THE INITIAL ASSESSMENT OF CLIENTS/ PATIENTS PRESENTING IN IPU/CSU WHO ARE SUSPECTED OF BEING UNDER THE INFLUENCE OF ALCOHOL.

MANUAL AND PASSIVE SAMPLING WILL NOT BE PERFORMED.

SCREENING RESULTS SHALL NOT BE USED FOR FORENSIC PURPOSES.

Equipment use: Single-use disposable breathalyzer mouthpiece will be used in conjunction with the ALCO-SENSOR FST® by Intoximeters, Inc. (314-429-4000).

CLIENTS/PATIENTS MAY REFUSE TO UNDERGO THE SCREENING.

All revision dates: 6/13/2019, 1/1/2015, 11/1/2010

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2014*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.65 IPU Patient Admission Flow

POLICY:

The VCMC Inpatient Psychiatric Unit (IPU) will complete patient admissions in a legal, safe, and expeditious manner and will initiate treatment, stabilization, and discharge planning under the direction of the team Psychiatrist.

PROCEDURE:

A. The Shift Supervisor/Charge Nurse will assign staff from the patient's assigned team to complete the admission.

B. Assigned IPU staff will receive report from ~~OPOS~~CSU staff or designated staff from patient referral source in the case of direct admission to IPU (bypassing ~~OPOS~~the CSU).

C. Once the admitting psychiatrist writes the admission orders, the assigned nursing staff member shall complete the admission process within 2 hours on the same day the orders were written to ensure a timely admission.

D. Assigned staff will retrieve the patient's belongings/paperwork and escort the patient to the admission hallway.

E. Patients will have the following skin assessment/contraband check:

- The patient will remove their clothing in one of the quiet rooms, including undergarments and socks, and don a paper gown. Two same gender staff as the patient, one of whom is licensed, will assist the patient. Once the patient has donned the paper gown, their belongings will be separated and searched for contraband. The staff will politely check the back of the person while the gown covers the front, and then respectfully and briefly check the front without the gown to ensure that no contraband is present on the person and that the patient's skin is intact. Once the assessment/check has been completed, the patient may have their searched clothes returned or they may be offered pajamas.

F. Should a patient decline to turn over their belongings or don the paper gown for the assessment/check, he or she will immediately be placed on 1:1 observation in the admission hallway. The 1:1 observation will continue until the patient cooperates with the skin assessment/contraband check.

G. In extraordinary circumstances not covered by this policy, by physician order, which justifies the exception to the policy.

H. Patient's belongings will be searched and inventoried prior to returning them to the patient.

I. Any items identified as contraband will be removed from the patient, inventoried by nursing staff, documented and stored in the contraband locker.

J. Valuables will be inventoried, documented, and stored in the safe.

K. The patient will be advised of their legal status both verbally and in writing. They will be given the original of the advisement form and a copy will be placed in their chart.

L. The patient will be provided with a copy of the 5150 document, if applicable, or the signed "Consent for Voluntary Treatment" form.

M. Patient's rights will be reviewed with the patient verbally, and the patient will be provided a copy.

N. The patient will be asked to sign a "Consent to Obtain or Release Confidential Information" form if they wish the IPU to obtain information from or release information to whomever they specify.

O. The patient will be asked to sign a "Consent to be Photographed" form for identification and safety purposes.

P. The patient will be provided handouts on topics which may make their stay more rewarding and beneficial. They will be asked to sign for receipt of these materials and will be given a copy.

Q. The assigned Mental Health Nurse shall complete a comprehensive admission intake assessment, which will include both psychiatric and medical information within 2 hours on the same day from the time the admitting psychiatrist wrote the admission orders.

R. The Nurse will complete an "Admission Risk Assessment for Seclusion/Restraint."

S. The Nurse will complete a "Behavioral Risk Assessment". If the patient scores greater than 3, a behavior plan will be written by the RN

T. The patient will be asked for a urine sample, if ordered.

U. The patient will be given orientation to the unit and their assigned bed.

All revision dates: 10/17/2022, 2/15/2018, 3/1/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*2/1/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/19/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.66 In-Patient Psychiatric Unit (IPU)/Crisis Stabilization Unit (CSU) Staff Duty to Warn Others -Tarasoff

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) will ensure compliance with the California Supreme Court Tarasoff decision. Staff has a legal/ethical obligation to protect others when a patient threatens bodily harm to a specific identified victim(s). This duty to warn overrides confidentiality requirements.

PROCEDURE:

All Staff:

1. When a patient verbalizes a threat to do bodily harm against a reasonably identifiable person, licensed staff will report it immediately and in the following order:
    - Ventura County Police Department and Sheriff's Department
    - Police Department in the area where the victim resides
    - Intended victim
    - Charge Nurse and Shift Supervisor
    - Administrator On Duty (AOD)
    - Medical Director and Weekday Staff Physician
    - Social Services Staff
2. When unlicensed staff, including administrative support staff, overhear a plan to carry out a threat, he/she will immediately report it to a licensed staff member.
3. Should Housekeeping staff hear a threat, he/she will report it immediately to the Shift Supervisor or Charge Nurse.
4. Every reasonable attempt must be made to inform the intended victim and all attempts must be documented.

DOCUMENTATION

Documentation includes:

a. Completion of Tarasoff Reporting Form and file in medical record.

b. Daily assessment of the patient's homicidal ideation which shall be entered in the Progress Notes and the Mental Status Exam.

INTERVENTIONS/PRECAUTIONS

Precautions shall be instituted at the appropriate level and staff should consider ordering hospital clothing to assist in maintaining the patient on the Unit until it is determined through assessment that the patient no longer poses a threat.

The Nursing Care Plan and/or Treatment Plan must address the patient's homicidality/violent ideation toward others.

Reviews and updates should reflect the patient's status toward the elimination of homicidal/threatening harm toward others intent.

Should a threatening patient ~~absent without leave (AWOL)~~Elope during the interview process, Licensed Nursing Staff shall follow the notification procedure and complete the Tarasoff process.

All revision dates: 1/19/2023, 2/18/2020, 3/1/2009, 9/1/2007, 2/1/2007, 9/1/2004, 2/1/2000, 2/1/1998, 2/1/1997

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/19/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2000*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.68 Vendor Access to IPU Patient Care Areas

POLICY:

To ensure that Ventura County Medical Center Inpatient Psychiatric Unit (IPU) ~~treatment team~~ consultants are appropriately identified before entering any IPU patient care area ~~as~~. This provides an ongoing effort to ensure a safe and secure environment for patients and staff.

PROCEDURE:

Guidelines For Reception, Nursing and Clerical Staff:

1. When someone presents to the IPU, request to see proper County identification.
2. If someone does not have identification, you may verify the identity of the individual with another employee who knows them. All guests **must** have some form of a badge. If their official one is missing, they are to be given a visitor badge. Visitor badges will be issued to all visitors with the exception of those with appropriate photo identification badges, i.e. County employees from another department. *Non-County employees/visitors/vendors with access to patient care areas should sign confidentiality forms.*
3. All guests, visitors, vendors, and representatives from outside agencies will be required to sign in and out with reception. All guests, before being allowed access to the IPU~~,~~ will need to provide their name, agency or team, purpose of visit, and time in.
4. All guests will be assigned a host while on the unit. The host will be an IPU staff member who will provide them oversight during visit.
5. A temporary key may be assigned by the shift supervisor, if needed. Upon leaving, all guests will return any temporary key that ~~may have been~~was assigned.
6. ~~Go to~~See the Shift Supervisor/Charge Nurse to obtain assistance, if needed.

LOCKED DOORS

a. Be sure that no one is given permission to go through a locked Unit Team door behind you unless you know him or her or they can display identification. Otherwise, inform them that you will have to find someone who can verify their identity.

b. ~~Page~~Contact the Administrator on Duty (AOD) if needed.

All revision dates: 10/17/2022, 7/26/2017, 5/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/1/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.69 IPU Floor Monitors

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) identifies the need for staff presence within the milieu environment. The goal of the Milieu Monitor Policy is to increase staff presence within the milieu environment by specifically assigning staff members for one (1) hour intervals to the IPU floor. Furthermore, the goal will be for staff to be present in the milieu to interact, engage and meet patients' needs.

PROCEDURE:

Initiation

a. Charge Nurse / Shift Supervisor will divide up staff members for one (1) hour or more intervals throughout each shift to be present ~~on~~in the milieu. These schedules will be printed and distributed on the shift assignment sheets.
b. ~~Schedule~~Schedules will be posted and distributed by the Charge Nurse/Shift Supervisor shortly after the start of each shift.
c. Milieu Monitors can include Health Techs, Psych Techs, ~~Med Nurses,~~ Registry staff, RN's,Social Services, OT, and the charge nurses/shift supervisors as well.
d. Milieu Monitors will be assigned to remain in the Milieu to attend to patients' needs.
e. The Milieu Monitors will remain in the milieu outside the nurse's station throughout the entire interval of their assignment.
f. There will be at least one to three staff members acting as the Milieu Monitors at all times in the milieu.
g. While assigned, Milieu Monitors will not be pulled aside for other duties.
h. Milieu Monitors will not be assigned to do rounds (AKA Patient Accountability Record) unless otherwise approved by the AOD.
i. RN's will be assigned as Milieu Monitors during the first half of their shift.

All revision dates: 10/17/2022, 7/26/2017, 12/1/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.72 5250 and 5260 Certification in the Inpatient Psychiatric Unit (IPU)

POLICY:

~~VCMC~~The Ventura County Medical Center Inpatient Psychiatric ~~Hospital~~Unit (IPU) recognizes the need to establish clear guidelines for all involuntary holds. This policy outlines excerpts from the California Mental Health Law ~~regrading~~regarding 5250 certifications.

PROCEDURE:

Section 5250 - ~~Fourteen~~14 Day Certification

- ~~-~~If a patient has been held on a 72-hour detention, he or she may be ~~additionally~~ held for an additional 14 ~~-~~days of intensive treatment only if all of the following apply:

~~1. The professional staff of the designated facility has found that the patient meets the criteria of being dangerous to others, self, and/ or gravely disabled due to a mental disorder; and~~

~~2. The facility providing the intensive treatment is designated by the county and agrees to admit the patient; and~~

~~3. The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. (§5250)~~

A. The professional staff of the designated facility has found that the patient meets the criteria of being dangerous to others, self, and/ or gravely disabled due to a mental disorder; and

B. The facility providing the intensive treatment is designated by the county and agrees to admit the patient; and

C. The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis (§5250).

- ~~-~~**The Notice of Certification must be signed by two (2) people:**

~~(a) The professional person in charge of the facility, or a physician or licensed psychologist (with five years postgraduate experience) who has been designated by the professional person in charge.~~

~~(b) A physician (a board-certified psychiatrist if possible) or a licensed psychologist (with five years postgraduate mental health experience) who has participated in the evaluation. If the physician or~~

~~psychologist designee in the above (a) is the person who performed the medical evaluation, then the second signatory may be another physician or psychologist or, if one is not available, a social worker or registered nurse who participated in the evaluation. (§5251)~~

A. 5251. (a) For a person to be certified under this article, a notice of certification shall be signed by two people.
(1) The first person shall be the professional person, or his or her designee, in charge of the agency or facility providing evaluation services. A designee of the professional person in charge of the agency or facility shall be a physician or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

B. (2) The second person shall be a physician or psychologist who participated in the evaluation. The physician shall be, if possible, a board certified psychiatrist. The psychologist shall be licensed and have at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

C. (b) If the professional person in charge, or his or her designee, is the physician who performed the medical evaluation or a psychologist, the second person to sign may be another physician or psychologist unless one is not available, in which case a licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, or registered nurse who participated in the evaluation shall sign the notice of certification.

• A copy of the certification must be given to the person certified and to anyone else the person designates, and to the person's attorney or advocate representing the person at the "probable cause" hearing~~.~~ (§5253).

• The person certified must be informed that he or she has a right to a certification review and to a judicial hearing and to the assistance of a patients' rights advocate or attorney~~.~~ (§5254).

• Nothing in the law prohibits the patient from being allowed out on a pass provided the professional person in charge of the facility or designee allows it (§5259).

~~(§5259)~~

• The patient may not be further detained on an involuntary basis once he or she no longer meets the involuntary detention criteria~~.~~ (§5257).

• If a patient's family or conservator expresses a preference for a particular designated treatment facility, the person initiating the certification shall try, if administratively possible, to comply with that preference. (§5259.4)

~~•~~ **At the conclusion of the 14-day period, a patient must be either:**

~~1. Released; or~~

~~2. Referred for further care and treatment on a voluntary basis; or~~

~~3. Placed on an additional 14-day detention for suicidal persons; or~~

~~4. Placed on 180-day detention for demonstrably dangerous persons; or~~

~~5. Placed on 30-day intensive treatment for grave disability; or~~

~~6. Placed on temporary LPS conservatorship. (§5257)~~

A. 1. Released; or

B. Referred for further care and treatment on a voluntary basis; or

C. Placed on an additional 14-day detention for suicidal persons; or

D. Placed on 180-day detention for demonstrably dangerous persons; or

E. Placed on 30-day intensive treatment for grave disability; or

F. Placed on temporary LPS conservatorship (§5257).

• The law permits a patient to obtain civil damages from any person who knowingly and willfully detains them in violation of these provisions. (§5259.1).

C. Section 5260 - Second Fourteen 14-Day Certification - Additional Treatment of Suicidal Persons

• At the expiration of the 14-day certification, a patient may be detained for a maximum of 14 additional calendar days only if all of the following apply:

1. The patient, as a result of a mental disorder, either threatened or attempted to commit suicide during the 72-hour or 14-day certification period or was detained originally for that reason.

2. The patient continues to present an imminent threat of suicide as determined by the professional staff of the designated facility.

3. The facility providing additional intensive treatment is equipped and staffed to provide treatment, and is designated by the county, and agrees to admit the person.

4. The person has been advised of, but has not accepted voluntary treatment. (§5260)

A. The patient, as a result of a mental disorder, either threatened or attempted to commit suicide during the 72-hour or 14-day certification period or was detained originally for that reason.

B. The patient continues to present an imminent threat of suicide as determined by the professional staff of the designated facility.

C. The facility providing additional intensive treatment is equipped and staffed to provide treatment, and is designated by the county, and agrees to admit the person.

D. The person has been advised of, but has not accepted, voluntary treatment (§5260).

• All of the provisions for the initial 14-day certification must be followed (see subsection B above), except that a certification review hearing is not required (§5260-5268).

(§5260-5268) The patient may request a writ. (§5275).

• Any person who knowingly and willfully detains a patient beyond the legal

Here is an example of a 5150 and 5250 certification:

A patient has a hold written on NovNovember 1st at 11:00 am. The 5150 hold expires after 72 hours (i.e., the expiration is on NovNovember 4th at 11:00 am).

If a 5250 certification is placed on the patient on NovNovember 4th at 11:00 am, then the 5250 will expire on NovNovember 18th at 11:00 am.

Between a 5150 and a 5250, there is a total of 17 days thea patient can be held.

When a patient enters the facility on a voluntary status.

Patients who enter the facility on a voluntary status and are then placed on a 5150 and then a 5250, will have

their voluntary time count towards their entire 17 -day stay.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	10/19/2021

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.73 Ankle Restraint Application for Patients Being Transported Between the CSU, VCMC and Other Facilities

POLICY:

Ventura County Medical Center (VCMC) ensures safe transport of patients being transported to and from VCMC campus buildings ~~and the~~, Crisis Stabilization Unit (CSU) and off-site facilities including The Hall of Administration. At times, ankle restraints may be necessary to ensure safe patient transport.

PROCEDURE:

A. Initiation:

1. The physician determines the need for ankle restraints during transport and places an order in the electronic health record (EHR).
2. Nursing staff shall apply the restraints to each ankle, leaving at list one finger width between the restraint and the patient's skin.
3. The patient is transported by either wheelchair or gurney.
4. To ensure privacy, a blanket is used to cover the restraint.
5. After the patient has arrived at his/her destination, the restraints shall be removed by nursing staff as soon as safely possible.
6. Nursing staff shall document in the EHR the exact time the restraints were applied.
7. Nursing staff shall document in the EHR the exact time the restraints were removed.
8. Nursing staff shall document the color, motion and sensitivity of the patient's skin prior to application and post-application of the restraint.

All revision dates: 10/17/2022, 6/13/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/16/2022
Approver	Daniel Powell: IPU	12/26/2019

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.75 IPU Nurse's Role in Patient's Legal Status Change From 6000 or 5150 to 5250

~~VCMC Inpatient Psychiatric Hospital recognizes the need to have a policy regarding patients placed on a 5250 (additional 14 day hold). The purpose of the policy is to establish clear guidelines regarding nursings' role for patients placed on a 5250 and to comply with California Welfare and Institutions Code.~~

POLICY:

The Inpatient Psychiatric Unit (IPU) at Ventura County Medical Center shall establish clear guidelines for nurses regarding patients placed on a 5250 (additional 14 day hold).

Any patient ~~that has~~on a certified 5250 hold can ~~have~~be held in the IPU for a total of 17 days (14 days after the expiration of a 5150)~~ held in the hospital~~.

~~Procedure:~~

PROCEDURE:

A. ~~Make sure~~Ensure that the following parts of the legal status form ~~is~~are filled out ~~in its entierty. This includes:~~including; Demographics, Patient's name, Address, Marital Status, Date of Birth and Sex of the Patient.

B. ~~One of the following~~The psychiatrist is responsible for checking the appropriate boxes ~~must be checked~~for the reason for the commitment (DTS, DTO, GD)~~. Use one~~, and using a line to mark -through the boxes that have ~~**NOT**~~not been checked.

   ~~Make sure that the assessment is completed and written in after, "above as follows:"~~

   ~~Make sure that, "Inpatient psychiatric hospitalization" is written in after, "accept referral to, the following services:"~~

C. The psychiatrist is responsible for filling out the "specific facts" section.

D. The psychiatrist is responsible for completing the section following "accept referral to, the following services:"

E. Where the form begins, "We", the "We" means the person ~~writing~~completing the form (~~which is usually~~ the psychiatrist) and person attesting that they (usually the nurse) concur with the assessment. Date and place will be listed as "~~Hillmont Psychiatric Center~~VCMC IPU." The physician's signature, printed name and title and the nurse's signature, name and title needs to be written.

F. After the section that starts, “I hereby”, the person providing the copy of the form must ~~sign~~ print their **name, title and sign** at the bottom. It does **NOT** have to be the same person that concurs with the assessment, but it does have to be signed **BEFORE** the copy is provided to the patient. If the patient has an unsigned copy of the form and presents it to the court, the patient will automatically win the case.

~~**Examples of how to correctly count the additional 14 day hold:**~~

~~A. A patient is brought in on a 5150 on Nov 1st at 10:05am. The 5150 hold will expire on Nov 4th at 10:05am (a total of 72 hours).~~

~~B. If the patient's psychiatrist writes a 5250 (an additional 14 day hold) the patient's hold will expire midnight (12:00 am) on Nov 18th.~~

Examples of how to correctly count the additional 14 day hold:

A. A patient is brought in on a 5150 that was initiated on November 1st at 10:05am. The 5150 hold will expire on November 4th at 10:05 am (a total of 72 hours).

B. If the patient's psychiatrist completes a 5250 (an additional 14 day hold), the 14 days will still begin on the day of 5150 expiration. For example, if a 5150 is written November 1st at 0200 am and the 5250 is written November 3rd at noon, then the 5250 would still expire at midnight on Nov 18th.

C. After an involuntary hold is initiated, the total period of detention including intervening periods of voluntary treatment, must not exceed the total maximum period during which the person could have been detained if the person had been detained if the person had been detained continuously on an involuntary basis from the time of the initial involuntary commitment. Thus, if a patient is admitted as a voluntary patient and subsequently detained on an involuntary basis,the maximum period of time is counted from the first date of involuntary commitment rather than from the date the person was admitted to the hospital. [Welfare and Institutions Code Section 5258.]

D. Example A: Voluntary following 5150, then placed on 5250. If a patient signs for voluntary status following the expiration of the 5150, and is subsequently placed on a 5250 during **that same hospitalization**, the maximum time for a total hold remains 17 days, **including** time as a voluntary patient. As an example; the 5150 was placed November 1st 10:05 AM. The patient signs on a voluntary basis on November 4th at 10:00 AM. On November 7th at 10:00 AM, the patient requests to leave during the interview with the psychiatrist. The psychiatrist then places the 5250. In order to protect the patient's rights, the maximum hold is November 18th at midnight, as calculated 17 days from the original 5150.

E. Example B: Admitted Voluntary, then placed on 5150 and 5250. If a patient is admitted voluntarily, and then placed on a 5150 (which runs for 72 hours) and subsequently placed on a 5250, **the maximum hold period is 17 days from the time that the 5150 was placed**. For instance, the patient is admitted voluntarily on November 1st at 10:05 AM. Three days later in treatment team on November 4th at 10:05 AM, the psychiatrist places a 5150 (expires November 7th at 10:05 AM), and prior to expiration of the 5150 a 5250 is completed and filed. **The maximum hold then is November 21st at midnight, as calculated 17 days from the original involuntary hold, not the time of admission.**

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/3/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	3/3/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/12/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.79 CSU Patient Assessment Referrals from Outside Facilities

POLICY:

Ventura County Medical Center's Psychiatric Crisis Stabilization Unit (CSU) shall accept all referrals for review. Referrals shall be accepted based on clinical appropriateness and bed availability. Patients shall be accepted if they are medically screened (or medically cleared when clinically indicated), stable for transport, alert and able to participate in the assessment process. Language is not considered a barrier for assessment. Patients shall be evaluated on an individual basis. The appropriate and least restrictive level of care shall be determined in accordance with current W & I code.

PROCEDURE:

1. Staff in the CSU shall take calls from outside facilities referring patients for assessment. Staff shall complete an initial review to determine clinical appropriateness for CSU services.
2. Medical screening shall be completed prior to acceptance to the CSU.The CSU physician, on call physician, or medical director shall review the case to determine if medical screening is complete and medical clearance is not indicated. If medical clearance indicated (as determined by referring entity or requested by our medical staff), the medical clearance evaluation will be reviewed by the CSU physician, on call physician, or medical director.
3. CSU staff shall advise all callers that patients being referred for assessment must be ambulatory or able to safely transfer self from wheelchair to toilet/bed and back.
4. The CSU is not equipped to provide oxygen or IV administration.
5. The following information may be requested from the referring facility:
    a. Demographics - Must be received and reviewed prior to acceptance of the patient for assessment.
    b. Lab values, including Blood Alcohol Level (BAL) drug screen including, if applicable:
        - Acetaminophen level – Two levels
        - Tricyclic level – Two levels
        - Other relevant level(s)
    c. Current pregnancy tests on patients of child-bearing age.
    d. Studies/imaging studies which may include EKG, X-rays, CT Scan, MRI results or other clinically

relevant tests.

e. Treatment, vital signs, and physician's statement of medical clearance from the referring facility.

f. Current and complete legal status (i.e., 5150, LPS conservatorship, etc.).

6. Once medical screening (or clearance) has been established, CSU staff shall notify the referring facility that the patient has been accepted for further evaluation and assessment.

7. It is the responsibility of the sending hospital to arrange transport for the patient to the CSU.

All revision dates: 12/12/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	11/29/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/20/2023*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.80 Patient Flow in the CSU

POLICY:

All patients brought into the Crisis Stabilization Unit (CSU) at Ventura County Medical Center shall follow a standardized patient flow.

PROCEDURE:

Upon arrival of a patient to the CSU, staff shall take the following steps:

Initial Presentation:

Prior to admission to the CSU assessment room:

~~1. Nursing staff shall wand the patient with a metal detector to search for contraband.~~

~~2. If the patient arrives with law enforcement and no patient rooms are available, law enforcement may elect to wait with the patient in the law enforcement office or go to the Emergency Department until a CSU bed is available.~~

~~3. Register the patient in the electronic health record (EHR).~~

1. Register the patient in the electronic health record (EHR).
2. Nursing staff shall search for contraband.

Initial Assessment:

1. A Medical Screening Exam (MSE) must be conducted on all patients prior to entering the CSU Assessment Room.
2. The patient shall be assessed by a qualified professional as defined in the Medical Staff Bylaws.
3. A head to toe skin assessment for contraband conducted by two staff members shall be completed. At least one RN shall be present during the assessment.
4. Staff shall refer any questions or concerns about the patient's condition to the psychiatrist (onsite or on call).
5. Staff shall attempt to obtain a breathalyzer sample when indicated with results documented in the EHR.
6. Staff shall notify the psychiatrist of the breathalyzer results, if indicated.
7. Staff shall medicate patients per physician's orders when appropriate prior to entering the assessment

room.

Restroom:

1. Staff (including Health Techs, Psych Techs, Mental Health Associates, Nurses, etc...) shall escort and monitor all CSU patients while using the restroom. Restroom doors will be slightly left open to ensure patient safety. Security will remain in the hallway and assist as needed.
2. Staff shall provide a hospital gown to the patient.
3. When indicated, staff shall obtain a urine sample for drug toxicology/pregnancy screening per physician's order.

   ~~Staff shall place a patient label on the urine sample and note date, time and staff Cerner ID.~~

   ~~Staff shall transport the sample to the Lab. If the sample cannot be immediately transported to the Lab, the sample shall e stored in the designated refrigerator.~~
4. Patients may use the restroom/shower as needed with staff escort for safety.

Storage Room:

1. Staff shall document all stored patient valuables, clothing and money over $100.00 in the EHR in Ad Hoc under “valuables."
2. Staff shall ~~lock and~~ store valuables ~~and clothing in the storage room~~in the safe.
3. Clothing will be logged and stored in the CSU belongings storage room.

Contraband:

1. Staff shall remove all contraband items from patients and secure them in a locked patient belonging area.
2. All items considered dangerous to self or others during the disposition process shall be reviewed with the physician. Contraband may be withheld from the patient on discharge by physician order.
3. Staff shall contact the Ventura Police Department when weapons (i.e., firearms, large knifes, etc.) are discovered.

Patient Assessment Room:

1. Staff shall escort the patient from the bathroom to the Assessment Room. Patients shall not be segregated or left in the hallway alone.
2. ~~Two staff~~Staff members shall be present in the Assessment Room at all times while patients are ~~present~~being interviewed.

All revision dates: 1/20/2023, 12/12/2019, 6/13/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee, Medical Executive & Oversight Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/12/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.82 Alcohol Detoxification--Clinical Institute Withdrawal Alcohol (CIWA)

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) are dedicated to the delivery of safe, quality patient care. Patient alcohol withdrawal may be treated in the Emergency Department (ED), hospital inpatient units, Crisis Stabilization Unit (CSU), Inpatient Psychiatric Unit (IPU) using the Clinical Institute Withdrawal Alcohol (CIWA) protocol.

PROCEDURE:

HOSPITAL refers to Ventura County Medical Center (VCMC), including the Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU), and Santa Paula Hospital (SPH). ***See Section I below.***

SECTION I – HOSPITAL

All locations/departments:

Licensed nursing staff shall:

- Assess the patient as soon as possible using the CIWA scale, once ordered.
- Document the assessment on the CIWA scale.
- Medicate the patient based on the CIWA alcohol detoxification orders and the findings of the CIWA scale.
- Document in the electronic health record (EHR).

Emergency Department (ED):

Staff shall:

- Identify the patient as at risk for alcohol withdrawal.
- Assess for coexisting mental illness
- Notify the provider on duty regarding the patient's condition.

Crisis Stabilization Unit (CSU):

Staff shall:

- Identify the patient as at risk for alcohol withdrawal.
- Assess for coexisting mental illness.
- Notify the psychiatrist on duty regarding patient's condition.

The CSU psychiatrist shall:

- Evaluate the patient for appropriateness of management in the CSU.
- If indicated, order CIWA protocol.

Licensed nursing staff shall:

- Assess the patient as soon as possible using the CIWA scale, once ordered.
- Document the assessment on the CIWA scale.
- Medicate the patient based on the CIWA alcohol detoxification orders and the findings of the CIWA scale.
- Document in the electronic health record (EHR).

All revision dates: 12/12/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee, Medical Executive & Oversight Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.83 Consent for Voluntary Evaluation in the Crisis Stabilization Unit (CSU)

POLICY:

All patients shall have a current legal status (either voluntary or involuntary) while in the Crisis Stabilization Unit (CSU). Upon the patient's arrival to the CSU, an evaluation shall be completed to assess whether the patient in “good faith” is able and willing to provide voluntary consent to CSU services.

PROCEDURE:

The Licensed Mental Health Professional may:

1. Use the following criteria to determine the patient's capacity to give informed consent:
    a. Determine if the patient is aware of his/her situation and condition.
    b. Determine if the patient is able to understand the benefits and risks of, as well as alternatives to, the proposed evaluation.
    c. Determine if the patient is able to rationally participate in his own treatment decisions and is capable of providing needed information.
2. Have the patient read the Crisis Stabilization Unit Voluntary Consent for Treatment form (see Attachment A) or read it to him/her (Spanish is on the reverse side). Translation services shall be provided for the patient.
3. Answer any questions the patient may have.
4. Ask the patient to sign the form. If the patient refuses to sign, they shall be evaluated for the appropriateness of a 5150.
5. Sign as a witness to the patient’s signature and date the form.
6. Give the patient a copy of the signed voluntary form.
7. Place the original of the form in the legal section of the patient's medical record.

All revision dates: 6/13/2019

Attachments

Attachment A - Crisis Stabilization Unit Voluntary Consent for Treatment

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/28/2022
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.84 Crisis Stabilization Unit (CSU) Patient Transportation Services

POLICY:

The Crisis Stabilization Unit (CSU) at Ventura County Medical Center shall appropriately and safely transport patients to their next destination after disposition from the Crisis Stabilization Unit. Taxi, bus transportation and Greyhound transportation services may be utilized if the patient has no other means of transportation.

PROCEDURE:

- After it has been determined that a patient will be dispositioned from the CSU, staff shall have the patient first request a ride from family members or friends.
- If a patient does not have transportation to their next destination, CSU staff may contact a local taxi company or provide the patient with bus tokens or a Greyhound voucher to take the patient to their next destination (i.e. home, physician appointment, group home, shelter).
- If a patient chooses to walk to their next destination or refuses any transportation assistance, CSU staff shall document in the patient's electronic health record (EHR) that efforts were made to offer the patient transportation services.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023

Step Description	Approver	Date
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*12/12/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.85 Medicating Patients in the Crisis Stabilization Unit (CSU)

POLICY:

The Crisis Stabilization Unit (CSU) at Ventura County Medical Center may utilize medication(s) to manage psychiatric symptoms. When indicated, non-psychiatric medications may be continued or indicated as clinically appropriate.

PROCEDURE:

The physician shall be responsible for:

- Determining need for medication
- Documenting orders for medications in the electronic health record (EHR)
- Obtaining signed medication consent during the hours of 0700-1900
- After hours, the on-call psychiatrist may use a three-way call with the patient and the nurse to obtain medication consent for psychotropic medications. Medications for other medical conditions may also be ordered at this time, if necessary.

Licensed Nursing Staff shall be responsible for:

- Noting the order
- Verifying the medication consent
- Checking for patient allergies
- Removing the medication from the Pyxis
- Verifying the patient's identity using at least two (2) forms of patient identifiers
- Medicating the patient
- Documenting the patient medication administration in the EHR
- Monitoring the patient's response to the medication
- Documenting the patient's response in the EHR

All revision dates: 12/12/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	11/29/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/17/2022*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.86 Crisis Stabilization Unit (CSU) Patient Service Delivery

POLICY:

~~Initial screening or intake procedures in the Crisis Stabilization Unit (CSU) at Ventura County Medical Center determine a patient's eligibility and readiness for admission. Patients are referred to the CSU from multiple sources. The initial intake assessment is performed by a trained registered nurse (RN) and documented into the electronic health record (EHR). Information obtained is according to the current intake form in Cerner. If the CSU criteria for admission are met, the psychiatrist shall be notified and make a decision based on the information obtained during the intake screening process. Upon decision to admit to the CSU, the psychiatrist shall provide admission orders.~~

Patients are referred to the CSU from multiple sources.Initial screening or intake procedures in the Crisis Stabilization Unit (CSU) at Ventura County Medical Center determine a patient's eligibility and appropriateness for admission. Based on the information obtained during the intake screening process,the Physician will make a decision to admit to the CSU. Admission orders will be provided or input directly into the electronic health record (EHR).

PROCEDURE:

Admission:

~~Within 24 hours of admission, an RN shall complete the patient assessment which shall include at a minimum:~~

The following Patient Assessment Components are to be started within 2 hours (to include the Columbia Suicide Severity Rating Scale C-SSRS) and be completed and documented within twelve hours of admission.

A. Description of presenting problem
B. General appearance, behavior, mental status exam
C. Home medication list
D. Substance use including alcohol, drugs and smoking
E. Nutritional and functional needs

   ~~Suicide risk screening and suicide assessment, if indicated~~

F. Falls risk assessment

G. Skin assessment for abnormalities (wounds, bruises, rashes, etc.).

H. Assess for any risks for restraint or seclusion

~~If it is determined that the patient meets criteria for CSU services, the information will be presented to the psychiatrist on duty.~~

I. Psychiatric assessments and psychiatric diagnosis will be conducted by the psychiatrist and documented in the EHR. A physician shall provide a psychiatric assessment within 24 hours. The psychiatrist shall be available in-house Monday through Sunday from 0700 to 1900. An on call psychiatrist is available after hours from 1900 to 0700.

J. The psychiatrist shall complete orders in the electronic health record (EHR) when indicated. This may include orders for medications for medical conditions and psychiatric medications. Physician assessments shall be documented on a daily basis in the EHR.

K. The social worker shall engage the patient and family member(s) or other designated persons (with the patient's consent), in the assessment and discharge planning processes.

L. Assessments by other disciplines such as nutrition, social services, occupational therapy, and chemical dependency counselors may be performed as needed.

Therapeutic Activities

While in the CSU, patients may receive therapeutic activities such as group and individual therapy based on their assessment and treatment needs. Staff shall encourage patients to attend these activities and the patient's response to these activities shall be documented in the medical record as indicated.

Patient Safety and Observation

- All patients shall be monitored by staff and the staff assigned to the patient shall document their observations in the EHR or unit approved form.
- Any changes in a patient's condition, such as escalating behavior, injury to themselves or others or change in physiological status, shall immediately be reported to ~~an~~ a registered nurse (RN) and psychiatrist for further assessment.
- Reassessments are performed by an RN as needed according to the patient's condition and documented in the ~~Nursing Progress Notes at least once per shift~~EHR.

Discharge Planning

- Staff determines what services/resources the patient needs post-discharge and are responsible for arranging those services. The patient or conservator, and if applicable patient's surrogate, as appropriate, are involved in the discharge planning process.
- Staff shall address placement and aftercare.
- Discharge planning begins on admission to the CSU and may be updated throughout the patient's stay due to changing variables. Disposition needs may be discussed with the Ventura County Behavioral Health case manager.
- Staff arrange all post-hospitalization appointments and services. The Alcohol and Drug Program require that the patient make the initial contact~~; the Program shall not schedule an appointment for the patient through the social worker~~.

All revision dates: 10/17/2022, 6/13/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee, Medical Executive & Oversight Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	1/12/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.87 Crisis Stabilization Unit (CSU) Continuum of Care

POLICY:

The Crisis Stabilization Unit (CSU) at Ventura County Medical Center views provision of patient care as part of an integrated system of settings, services, health care practitioners and care levels, beginning with pre-admission through post-disposition. While in the CSU, patients receive a range of care from multiple providers. Patients entering the CSU have the benefit of disposition planning as part of their comprehensive patient care. Disposition planning is a process, which begins with the initial encounter, continues throughout the CSU stay to disposition and follow-up.

Patient discharge planning in the CSU is a multidisciplinary process involving the patient, physician, nurse, social worker and other staff members. When CSU staff begin work on disposition planning and referrals as soon as the patient is admitted to the CSU, the patient may develop a more positive attitude toward their recovery resulting in a significantly reduced length of stay and decreased likelihood of additional crisis stabilization.

Effective disposition and discharge planning improves patient care by ensuring a smooth transition of the patient from one level of care to another through the use of appropriate community agencies and services and ensuring community responsibility on the part of Ventura County Medical Center and the Ventura County Behavioral Health Department.

PROCEDURE:

Disposition coordinators are registered nurses, social workers or other qualified staff who ensure that every possible effort has been directed toward the best possible continuity of care for the patient.

Disposition Planning Evaluation:

- Staff shall provide a disposition planning evaluation to patients who require assistance with disposition planning upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
- A registered nurse, social worker, or other appropriately qualified staff member shall develop or supervise the development of the evaluation.
- The disposition planning evaluation shall include an evaluation of the likelihood of a patient needing additional services and the availability of such services.

- Staff shall complete the evaluation on a timely basis so that appropriate arrangements for post-CSU care are made during disposition and to avoid unnecessary delays in disposition.
- Staff shall include the disposition planning evaluation in the patient's medical record for use in establishing an appropriate disposition plan and shall discuss the results of the evaluation with the patient or individual acting on their behalf.

REFERRAL PROCESS:

During disposition, outside agencies such as public social services agencies or Ventura County Behavioral Health are contacted by staff. Follow-up care may be provided by Ventura County Health Care Agency Ambulatory Care, Ventura County Behavioral Health or other appropriate entities or referral sources.

All revision dates: 6/13/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee, Medical Executive & Oversight Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/13/2019*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.92 IPU 5250 Certifications

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) has established clear guidelines regarding patients placed on a 5250 (an additional 14 day hold) in compliance with California Welfare and Institutions code.

PROCEDURE:

Any patient that has a certified 5250 can be held in the IPU for a total of 17 days (14 days after the expiration of a 5150).

Section 5250- Fourteen Day Certification

If a patient has been held on a 72-hour detention, they may be held for an additional 14 days of intensive treatment only if all of the following apply:

1. The professional staff of the designated facility has found that the patient meets the criteria of being dangerous to others, self, and/ or gravely disabled due to a mental disorder; and
2. The facility providing the intensive treatment is designated by the county and agrees to admit the patient; and
3. The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis (§5250).

The Notice of Certification must be signed by two (2) people:

1. The professional person in charge of the facility, or a physician or licensed psychologist (with five years postgraduate experience) who has been designated by the professional person in charge.
2. A physician (a board-certified psychiatrist, if possible) who has participated in the evaluation. If the physician in #1 above is the person who performed the medical evaluation, then the second signatory may be another physician or, if one is not available, a social worker or registered nurse who participated in the evaluation (§5251).

A copy of the certification must be given to the person certified and to anyone else the person designates, and to the person's attorney or advocate representing the person at the "probable cause" hearing. (§5253)

The person certified must be informed that he or she has a right to a certification review and to a judicial hearing and to the assistance of a patients' rights advocate or attorney. (§5254)

If a patient's family or conservator expresses a preference for a particular designated treatment facility, the person initiating the certification shall try, if administratively possible, to comply with that preference. (§5259.4)

At the conclusion of the 14-day period, a patient must be either:

- Released; or
- Referred for further care and treatment on a voluntary basis; or
- Placed on an additional 14-day detention for suicidal persons; 5260.
- Placed on 180-day detention for demonstrably dangerous persons; or
- Placed on 30-day intensive treatment for grave disability; or
- Placed on temporary LPS conservatorship. (§5257)

The law permits a patient to obtain civil damages from any person who knowingly and willfully detains them in violation of these provisions. (§5259.1)

Section 5260-Second Fourteen Day Certification - Additional Treatment of Suicidal Persons

At the expiration of the 14-day certification, a patient may be detained for a maximum of 14 additional calendar days only if all of the following apply:

1. The patient, as a result of a mental disorder, either threatened or attempted to commit suicide during the 72-hour or 14-day certification period or was detained originally for that reason.
2. The patient continues to present an imminent threat of suicide as determined by the professional staff of the designated facility.
3. The facility providing additional intensive treatment is equipped and staffed to provide treatment, and is designated by the county, and agrees to admit the person.
4. The person has been advised of, but has not accepted voluntary treatment. (§5260)

All of the provisions for the initial 14-day certification must be followed (see above), except that a certification review hearing is not required. (§5260-5268) The patient may request a writ. (§5275)

Examples of how to correctly count the additional 14-day hold:

- A patient is brought in on a 5150 on November 1st at 10:05 am. The 5150 hold will expire on November 4th at 10:05 am (a total of 72 hours).

If the patient's psychiatrist writes a 5250 (an additional 14-day hold), the patient's hold will expire midnight (12:00 am) on November 18th. If the 14-day hold is initiated on November 3rd in this example, then the additional 14-day hold would expire November 17th at midnight (i.e., if the 5150 was written November 1st at 0200, the 5250 evaluation would likely take place November 3rd).

All revision dates: 6/13/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Jason Cooper: Medical Director, IPU	3/2/2023
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU	9/28/2022