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

# Ventura County Health Care System Oversight Committee
## Administrative Policies
March 9, 2023

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

1. 101.028 Employee Lockers
2. 106.002 Code Pink/Code Purple - Known/Suspected Infant/Child Abduction
3. 106.013 Hazardous Substance Communication – Right to Know
4. 106.032 Use and Storage of Formaldehyde (Formalin)
5. 106.040 Disaster Pet Care Plan for Employees
6. 106.061 Cleaning and Disinfection of Patient Care Equipment
7. 106.078 Facility Role Under 1135 Waiver Enactment or Request to Support Alternate Care Site
8. PH.31 Drug Packaging

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VENTURA COUNTY HEALTH CARE AGENCY

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| Owner | Ian McGraw: Manager Facility Operation |
| Policy Area | Administrative - Employee |

# 101.028 Employee Lockers



## POLICY:

To state the proper use of employee lockers.

## PROCEDURE:

Lockers are provided for the convenience of staff and to provide a secure location for staff possessions during their work shift.

Management may assign lockers to staff by role (i.e., on-call anesthesiologist). Staff are permitted to place locks on lockers to secure their belongings for the duration of the work shift, but the locks must be removed by staff at the end of their work shift. If locks are not removed from lockers at the end of the shift, the locks may be cut off and the contents of the locker removed.

## All Revision Dates

2/12/2019

## Approval Signatures

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| | | |
|---|---|---|
| Hospital Administration | Diana Zenner: Chief Operating Officer, VCMC & SPH | 3/1/2023 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 2/13/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 2/13/2023 |
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| Owner | Ian McGraw: Manager Facility Operation |
| Policy Area | Administrative - Environment of Care |

# 106.002 Code Pink/Code Purple - Known/Suspected Infant/ Child Abduction



## POLICY:

To have a mechanism to ensure that all Ventura County Medical System (VCMS) staff and appropriate outside agencies are notified of an infant or child abduction, with the goal of locating the infant/child and reuniting it with its legal guardian as quickly as possible.

Policy applies to Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

## PROCEDURE:

A. Sound alarm.

1. Staff will dial emergency number 76666 at VCMC or 78666 at SPH and announce "Code PINK" for infant abduction or "Code PURPLE" for a child abduction along with location.
2. Paging operator will announce overhead "Code PINK/PURPLE – (location)" two (2) times.
3. Paging will dial 911 and report the incident to the dispatcher.

B. Response to alarm.

1. The legal guardian and other significant family member will be moved to a private area and a staff member will remain with them. Any other persons will be escorted to another area and detained. The patient room will be secured.
2. Staff will stop visitors with small infants, large purses, and packages. Empty rooms, bathrooms and dressing rooms will be checked.
3. All available staff will check stairwells, elevators, exits and parking lots.

4. No one will be allowed to enter or leave the hospital until checked for missing infant/child.
5. When the staff hears "Code PINK/CODE PURPLE" announced, they will need to be aware of anyone with small infants and stop those carrying large packages, boxes, purses or backpacks. They will need to station staff at all area exits.
6. Departments which have an assigned CODE PINK radio will turn to channel 1 and cover their assigned exits.
7. Security and maintenance will monitor all exits, monitors, parking lots, stairwells, public restrooms, and clinic areas.
8. Staff will reassure families of their infant/child's safety.
9. The unit supervisor will respond to the location and coordinate activities.
10. The Nursing Supervisor will coordinate all related activities to ensure continuity of care and notify the physician, family and Administrator.
11. Engineering services will assist in securing and searching the facility and adjacent grounds. They will report to their assigned areas.
12. In the event the missing child or infant is not found:
    a. The Chief Operating Officer will notify the California Department of Public Health within 24 hours. He or she will coordinate a debriefing session(s) following the event to ensure complete and comprehensive data relating to the incident has been recorded.
    b. Telecommunications will direct all inquiries to Hospital Administration. No confirmation of the incident or information relating to the incident should be provided.
    c. The Chief Executive Officer or designee coordinates with authorities to determine what information will be released, when the release will be made, and prepares the press release.
    d. The Chief Executive Officer or designee collaborates with community relations and law enforcement officials regarding information released to the media, and addresses administrative decisions that require immediate action.



## KEY POINTS

A. At no time during the early stages of a known/suspected abduction should anyone without a valid need to know be told that an infant/child is missing.
B. No hospital employee or volunteer is to make a public statement concerning this incident.
C. All internal communications regarding the search will be handled by the Safety Officer or designee.

## All Revision Dates

2/27/2023, 6/1/2016, 5/1/2006, 8/1/2005, 11/1/2004, 12/1/2001

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| Step Description | Approver | Date |
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| Hospital Administration | Diana Zenner: Chief Operating Officer, VCMC & SPH | 2/27/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 2/27/2023 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 2/27/2023 |
| Safety Committee | Fernando Medina: Director, Support Services | 2/27/2023 |
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| Owner | Sandro Cruz: Hospital Hazardous Materials Coordinator |
| Policy Area | Administrative - Environment of Care |

# 106.013 Hazardous Substance Communication – Right to Know



## POLICY:

Ventura County Medical Center, Santa Paula Hospital and Ambulatory Care patients and visitors have an absolute "right to know" when they may be exposed to hazardous substances.

## PROCEDURE:

To provide a safe environment for all employees, providers, patients and visitors, the following steps will be taken:

1. A Safety Data Sheet (SDS) will be obtained for all substances which are used at Ventura County Medical Center/Santa Paula Hospital. The SDS gives guidance on hazard identification, PPE, first aid, storage and handling, and spills.
2. SDS is located on every desk-top for easy access (Icon reads: ***MSDS)***
3. All employees will be oriented regarding hazardous substances and their "right to know" during New Employee Orientation and with annual training updates.
4. When a new substance is introduced into the work area, employees will be so informed, and oriented to its potential dangers.
5. Departmental procedures will be written to reflect the safety measures noted on the SDS, when applicable.
6. All SDS' will be available to the employee, their union representative, OSHA representatives, or their personal physician upon request.

# Resource person(s):

Hazmat Coordinator
Safety Officer

## REFERENCE:

29CFR 1910.1200, Subpart Z; Hazard Communication

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| Step Description | Approver | Date |
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| 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 |
| Environment of Care Committee | Ian McGraw: Manager Facility Operation | 2/13/2023 |
| Policy Owner | Sandro Cruz: Hospital Hazardous Materials Coordinator | 12/2/2022 |

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# 106.032 Use and Storage of Formaldehyde (Formalin)



## POLICY:

Ventura County Medical Center, Santa Paula Hospital and the Ambulatory Care Clinics use and store formaldehyde in small quantities for biopsies and other histology/pathology applications. The formaldehyde product used is a 10% buffered Formalin and should be handled with caution and according to OSHA guidelines. To provide a safe environment for staff and to monitor Formalin usage for regulatory compliance.

## PROCEDURE

1. Only individuals who have received training specific to hazardous material recognition may enter the area where Formalin is stored.
2. Protective Equipment: For all tasks which contact with the skin or eyes with liquids containing 10% Formalin or greater is likely, suitable protective clothing shall be worn by employees. This may include, but not be limited to, eye protection, face shields, gloves, gown, etc. Appropriate hand hygiene protocol after removal of PPE should be followed.
3. Work areas where spillage may occur (i.e., areas where fixed specimens or stock Formalin are stored) shall be routinely inspected for leaks or spills.
4. Spill Response: spills and responses are addressed in policy *106.035 Hazardous Materials & Waste Management Plan*.
5. Spill kits and eye wash stations are to be available and adjacent to any Formalin product containers.
6. Medical Surveillance: Individuals exposed to formaldehyde at concentrations exceeding the allowed limit or the short term exposure limits of 2 PPM over 15 minutes must participate in the medical surveillance program through Employee Health Services.
7. Individuals who develop signs and symptoms of formaldehyde exposure and those who are

exposed to Formaldehyde in a spill greater than 200 mL, may participate in the medical surveillance program.

8. Hazards Communication: The hazards of formaldehyde exposure include the potential for cancer, irritation and sensitization of the skin and respiratory system, eye and throat irritation, and acute toxicity.
9. Individuals who develop signs and symptoms of overexposures should report these via the Occurrence Report and immediately consult the Safety Officer.
10. All Formalin containers must be labeled. Manufacturer labels should not be removed from Formalin containers.

## Storage

1. Formalin shall be stored in a ventilated area away from open flames or ignition sources.
2. Formalin shall be stored in small quantities.
3. Safety Data Sheets shall be readily available to all staff in the event of a spill and/or exposure.



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2/13/2023, 12/1/2016

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| 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 |
| Environment of Care Committee | Ian McGraw: Manager Facility Operation | 2/13/2023 |
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VENTURA COUNTY HEALTH CARE AGENCY

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| Owner | Fernando Medina: Director, Support Services |
| Policy Area | Administrative - Environment of Care |

# 106.040 Disaster Pet Care Plan for Employees



## POLICY:

Ventura County Animal Services (VCAS) may provide a plan for the care and shelter of the pets of VCMC employees during a prolonged disaster or internal/external Code Triage. VCAS may provide housing and care for employees' pets so that employees are free to assume their work duties.

## PROCEDURE:

1. **PLAN IMPLEMENTATION**
    a. **This plan is to be implemented ONLY under authority of the VCMC Incident Commander and/or Administrator on Duty (AOD). Employees are encouraged to first seek other options for housing their pets.**
    b. The Incident Commander or AOD will authorize the VCMC Family Care Unit Leader to oversee the implementation of this plan.
    c. Before implementing this plan, first confirm with VCAS the locations of any other County pet shelters that been set up in the area.
2. **PET SHELTER GUIDELINES**
    a. Pets should be sheltered in an area of the campus separate from the general population to avoid exposing people with allergies to animals. The location designated as the Pet Care Area is the grassy area adjacent to the VCMC Laboratory Entrance. If this area is unavailable for use, the Public Health parking lot across Hillmont Avenue should be used.
    b. The Pet Care Area will be staffed VCAS approved personnel.
    c. Pets other than canine that are unable to be house safely at their own residence can be delivered by the owner to the main VCAS facility located in Camarillo for safe

keeping.

d. The relief area should be located near the dog housing area. This may be indoors or out, depending on the weather and other conditions.

e. VCAS will provide clean kennels, a clean area, nutrition and a relief area for pets. Pet owners are highly encouraged to come to the Pet Care Area as often as permitted to visit and care for their pet.

f. If a medical need arises for any animal left in the Pet Care Area, VCAS staff/ volunteer will attempt to make contact with the owner. If unable to reach owner, the animal may be transported for veterinary care.

g. Should an animal begin to exhibit unsafe behavior, VCAS staff/volunteer will attempt to make contact with the owner. If unable to reach owner, the animal may be transported to the main VCAS facility located in Camarillo at the discretion of VCAS staff/volunteer.

3. **DIRECTIONS FOR PET OWNERS:**

1. Upon arrival on campus, pet owners will escort their pets to the designated entry point of the Pet Care Area overseen by VCAS or designee. Pet owners will be instructed to use only the designated entry point on campus to access the Pet Care area.
2. Pets must arrive in an appropriate pet carrier, cage, airline kennel or other suitable habitat and should stay confined in the Pet Care Area overseen by VCAS or designee throughout their time on campus. Pets should arrive in appropriate carriers or on a secure leash.
3. Upon arrival to the Pet Care area, pet owners will complete the Pet Log (Attachment A) for each pet. Pet Logs will be monitored and maintained by VCAS and/or designee in the Pet Care Area.
4. At this time, VCAS Pet Care staff or designee will interview pet owners regarding any special medical needs of the pet. If pets have special dietary requirements, the pet owner will be responsible for providing VCAS Pet Care staff with the special diet. If the animal is on medication, the owner will be responsible for administering said medication.
5. Proof of current feline vaccination (FVRCP, Rabies and Bordetella) and canine vaccination (DHPP, Rabies and Bordetella) should be provided by the pet owner upon entry to the facility. Animals with extended stay at the Pet Care Area or main facility in Camarillo which lack proof of vaccination may be vaccinated at the discretion of VCAS staff in accordance with the American Medical Veterinary Association (AVMA).
6. Employees should be informed that their animals are sheltered at their own risk and will acknowledge such by completing and signing the Ventura County Animal Services Disaster Safekeeping Authorization Form (Attachment B).
7. Both pet owners and their pets will be assigned matching tracking numbers and identification.
8. Unless a pet has special dietary needs (see #4 above), while housed in the Pet Care

Area, VCAS Pet Care staff will provide needed nutrition.

4. **PET OWNER RESPONSIBILITIES**
    a. Pet owners are encouraged to bring the following pet supplies with their pet:
        - Carrier or cage
        - Leash, collar or harness
        - Medications (to be held and administered by pet owner)
        - Food and water dish
        - Pet food
        - Sheets, blankets and towels
        - Toys if available

    b. Pet owners must remain on campus to utilize the services of the hospital pet shelter. Any unaccompanied pets will be deemed to have been abandoned and will be requested to be picked up by VCAS staff.

    c. Visitation Hours: any time the pet owner is available and permitted to visit their pet. During visitation, pet owners are responsible for providing all care for their pet. Pet owners are not allowed to remove their pet from its cage without notification to VCAS staff, a leash and proper identification. Although frequent visits with pets are encouraged, the VCMC Family Unit Care Leader, VCAS staff, or designated Shelter Manager reserves the right to limit visitation to the Pet Care Area at any time for any reason. No children shall be permitted in the Pet Care Area without adult supervision.

    d. VCMC or VCAS staff may close the Pet Care Area at any time, for any reason. When the Pet Care Area is at capacity, VCMC staff will be provided alternative resources.

    e. Medications: Pet owners **MUST** administer medication to their pets. Pet owners **MUST** keep a medication administration record for their pet at the Pet Care Area or whichever location the pet is housed in case of medical emergency. No medications will be kept with the pet.

    f. Sanitation: Pet owners shall be the primary caretakers of the hygiene of their pets. The relief area will be cleaned by VCAS staff after each use.

    g. If any animal-related incident occurs, an event and/or security report shall be completed.

# ATTACHMENTS

Attachment A – Ventura County Medical Center Pet Log
Attachment B – Ventura County Animal Services Disaster Safekeeping Authorization Form

# REFERENCES

The Joint Commission Emergency Management Standards

## All Revision Dates

11/1/2016

## Attachments

A: Ventura County Medical Center Pet Log

B: Ventura County Animal Services Disaster Safekeeping Authorization Form

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| 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 |

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# 106.061 Cleaning and Disinfection of Patient Care Equipment



# POLICY:

Cleaning, disinfection and sterilization of patient care equipment at Ventura County Medical System (Ventura County Medical Center, Santa Paula Hospital, the Inpatient Psychiatric Unit and the Ambulatory Care Clinics) is performed in accordance with published guidelines and criteria. The manufacturer's instructions for cleaning, disinfection and sterilization must be followed. All personnel performing cleaning, disinfection and sterilization of patient care equipment must wear appropriate Personal Protective Equipment (PPE) for the task.

# PROCEDURE:

I. **GENERAL INFORMATION**
**Spaulding Classification of Patient Care Items and Equipment**

A. Critical Items

1. **Must be sterile** because these objects enter sterile tissue or the vascular system.
2. Will be purchased as sterile or sterilized by approved methods as described in Surgery Department policies for Sterile Processing.
    a. **Items purchased as sterile must be used before expiration date, if one is given. Inspect package integrity before use**.
    b. **Shelf life for items sterilized in the hospital is event-related or set date by manufacturer. Sterility is verified by intact wrappers, chemical package indicators, and records of sterilization equipment and parametric monitoring.**

3. Examples include, but are not limited to, surgical instruments, invasive devices and surgical implants.

B. Semi-Critical Items

1. Semi-critical items come in contact with mucous membranes or non-intact skin.
2. Examples include, but are not limited to, endoscopic equipment, cystoscopes, diaphragm fitting rings, respiratory and anesthesia equipment, esophageal pH probes, and vaginal ultrasound probes.
3. Reprocessing by high level disinfection is documented by the clinical area performing the high-level disinfection of equipment.

C. Non-Critical Items

1. Non-critical items come in contact with intact skin, but not mucous membranes.
2. **Must be cleaned and disinfected before and after each patient use**.
3. Examples of non-critical equipment are: blood pressure cuffs, portable pumps, and crutches.
4. Examples of non-critical surfaces are: bed rails, bedside tables, and toys.



II. **Soiled and/or Contaminated Items or Equipment**

1. Critical and semi-critical items or equipment must be cleaned, decontaminated and sterilized in accordance with Surgery policies and procedures.
2. Non-critical items or equipment must be cleaned with an approved hospital intermediate-level disinfectant.
3. Certain types of infections, such as Clostridium difficile, will warrant the use of an approved hospital bleach-based disinfectant for non-critical items or equipment. After drying, any salt residue can be wiped off with a damp cloth.
4. **Respiratory equipment shall be cleaned with intermediate-level disinfectants when used with cystic fibrosis patients**.

III. **Definition of Terms**

A. **Cleaning** is the removal of organic and inorganic material from objects and surfaces. This is normally accomplished by using detergents or enzymatic products. Thorough cleaning is necessary **before** disinfection and sterilization because organic and inorganic materials that remain on the surface of instruments interfere with the effectiveness of these processes.

1. Before placing in the biohazard bin, all forceps, clamps, etc should be placed in the open position.
2. All items should be pretreated with hospital approved enzymatic product until they are thoroughly wet or dripping with cleaner or according to the manufacturer's instructions for use.
3. If the biohazard bin is not picked up within four (4) hours, for locations on

the hospital license or within 72 hours per manufacturer's instructions for use at all other clinics, Sterile Processing should be contacted to retrieve the bin.

B. **Decontamination** is the use of physical or chemical means to remove, inactivate, or destroy microorganisms on a surface or item. The selection and use of cleaning equipment, chemicals and exposure times suggested by the manufacturer should be followed to prevent damage to the items.

C. **Disinfection** is a process that reduces the number of microorganisms (with the exception of bacterial spores) on inanimate objects. This is done most often by use of an approved hospital detergent/disinfectant.

1. **High-level disinfection** destroys all forms of microbial life except for bacterial spores. This is usually performed by chemicals or wet pasteurization. Semi-critical items that touch mucous membranes should receive high-level disinfection, i.e., flexible endoscopes, laryngoscopes and other similar instruments.
2. **Intermediate-level disinfection** utilizes hospital-grade disinfectant, or an EPA-approved tuberculocidal cleaner/disinfectant.
3. **Low-level disinfection** will inactivate most vegetative bacteria, some fungi, and some viruses, but cannot be relied upon to inactivate resistant microorganisms

D. **Sterilization** is the complete destruction of all microbial life. It is accomplished by either a physical or chemical process such as steam under pressure, dry heat, or plasma hydrogen peroxide. All critical items must be sterile.

## IV. GENERAL POLICIES

A. Only clean equipment is stored in the designated clean spaces.

B. Only soiled equipment is stored in the soiled or "dirty" utility room.

C. High-touch surfaces in patient rooms are cleaned at regular intervals, at least daily and upon discharge or transfer of the patient, as directed in the Environmental Services Policy and Procedure Manual.

D. Infant beds and cribs are cleaned on their respective units by Environmental Services according to manufacturer's recommendations and the Environmental Policy and Procedure Manual.

E. Agents and/or procedures used for cleaning, disinfecting, or sterilizing equipment shall be approved by Infection Control Committee.

F. In the event that non-critical items are needed immediately, they may be cleaned on the nursing floor by staff using hospital approved detergent/disinfectants.

G. It is the responsibility of the healthcare worker to make certain that only clean and disinfected equipment will be used between patients.

H. **If it is unclear whether patient care equipment has been cleaned, it must be cleaned before patient use.**

V. **PROCESS**

A. Patient Care Equipment managed by patient care units or services must be wiped with a hospital approved detergent/disinfectant **between** patients and when visibly soiled.

B. Manufacturer's Recommendations should be followed.

C. Use the Infection Control Committee List of Approved Disinfectants.

D. Grossly soiled items (visible blood and body fluids) must be cleaned prior to disinfection.

E. If a re-usable blood pressure is used, it must be disinfected between patients.

F. If a piece of equipment needs repair by the Biomedical Department, the equipment must be cleaned and disinfected prior to being sent to the Biomedical Department.

G. Equipment used by specialty departments in patient care areas must be cleaned by department personnel between patient use, when visibly soiled and before entering patient care areas . These items include but are not limited to:

- portable x-ray machines
- equipment carts
- EEG machines
- EKG machines

H. **Surfaces in Patient Rooms** will be cleaned daily and upon discharge/transfer by Environmental Services according to Environmental Services Policy and Procedure Manual.

I. In the absence of a manufacturer's cleaning and disinfection instructions:

1. Consult Biomedical Department and Infection Prevention and Control
2. Clean non-critical medical equipment surfaces with a mild detergent.
3. Cleaning will be followed by an application of an Infection Control Committee approved EPA registered disinfectant according to disinfectant label instructions.

VI. **HOSPITAL-APPROVED AGENTS FOR CLEANING AND DISINFECTION:**

A. Infection Prevention and Control Committee, Approved List of Disinfectants – see attachment. (Note: For all listed disinfectants, the manufacturer's directions for both the device and the solution must be followed).

B. Environmental Services: See Environmental Services Policy and Procedure Manual

# REFERENCES:


A. CDC Guideline for Disinfection and Sterilization in Healthcare Facilities

B. CDC Guidelines for Environmental Infection Control in Healthcare Facilities

C. Occupational Safety and Health Administration Law

D. Central Supply Services Policy and Procedure Manual

E. Environmental Services Policy and Procedure Manual
F. Hospital Epidemiology and Infection Control, 3rd edition, Mayhall.
G. APIC Text of Infection Control and Epidemiology
H. FDA Approved High Level of Disinfectants. http://www.fda.gov/cdrh/ode/germlab.html

## All Revision Dates

2/7/2023, 3/21/2019, 5/1/2016, 10/1/2013, 10/1/2011

## Attachments

Approved Disinfectants - General.docx

Approved Disinfectants - High-Level.docx

Image 01



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Diana Zenner: Chief Operating Officer, VCMC & SPH | 2/7/2023 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 2/7/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 2/7/2023 |
| Infection Prevention Committee | Magdy Asaad: Infection Prevention Manager | 2/7/2023 |
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| Owner | Fernando Medina: Director, Support Services |
| Policy Area | Administrative - Operating Policies |

# 106.078 Facility Role Under 1135 Waiver Enactment or Request to Support Alternate Care Site



## POLICY:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and the Ambulatory Care (AC) clinics provide medical care and services in good faith, to meet the needs of individuals enrolled in the Social Security Action program and collaborate with local emergency management officials in planning for an organized and systematic response to assure continuity of care. In the event that alternate care sites might be required to provide medical care and services in an emergency, the facility response may include staffing, equipment and supplies.

Under the Social Security Act §1135, Authority To Waive Requirements During National Emergencies, the Secretary ensures, to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1)) - that sufficient health care items and services are available to meet the needs of individuals in such area, enrolled in the programs ie., the Social Security Act under titles XVIII, XIX, and XXI; and that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

This policy shall state the role of VCMC/SPH and the AC clinics, under a waiver declared by the Secretary of Health and Human Services (HHS), during a declared public health emergency, under Section 319 of the Public Health Service Act, or whenever local or state emergency management officials might designate alternate care sites during an emergency.

## DEFINITIONS:

Emergency area; emergency period - An “emergency area” is a geographical area in which, and an

“emergency period” is the period during which, there exists

An emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

A public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

Health care provider - The term “health care provider” means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.

# PROCEDURE:

## SCOPE:

To be activated under Presidential declaration of a major disaster or emergency, under the Stafford Act, or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, or whenever local or state emergency management officials are responding to an emergency situation and determine that alternate sites are required to ensure continuity of care.



Types of waiver requests include, but are not limited to:

1. Conditions of participation or other certification requirements for an individual health care provider or types of providers;
    a. Program participation and similar requirements for an individual health care provider or types of providers;
    b. Pre-approval requirements;
2. Requirements that physicians and other health care professionals be licensed in the state in which they providing such services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state, a part of which is included in the emergency area.
3. Actions under section 1867 (relating to examination and treatment for emergency medical conditions and women in labor) for -Emergency Medical Treatment and Labor Act (EMTALA).
    a. A transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer arises out of the circumstances of the emergency;
    b. The direction or relocation of an individual to receive medical screening in an alternative location
        i. pursuant to an appropriate State emergency preparedness plan; or
4. In the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;
5. Sanctions under section 1877(g) (relating to limitations on physician referral;
6. Deadlines and timetables for performance of required activities, except that such deadlines

and timetables may only be modified, NOT waived;

7. Limitations on payment under section 1851(i) for health care items and services furnished to individuals enrolled in a Medicare Advantage plan by health care professionals or facilities not included under such plan; and
8. Sanctions and penalties that arise from the noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996
    a. Section 164.510 of title 45, Code of Federal Regulations, relating to -
        i. requirements to obtain a patient's agreement to speak with family members or friends; and
    b. Section 164.520 of such title, relating to the requirement to distribute a notice; or
    c. Section 164.522 of such title, relating to
        i. the patient's right to request privacy restrictions; and
        ii. the patient's right to request confidential communications.
9. Support for alternate care sites may include, but not be limited to, the provision of supplies[RL1] , staffing and equipment.

**Note:** A waiver or modification of requirements pursuant to this section 1135 of the Social Security Act terminates upon the termination of the applicable declaration of emergency or disaster; the termination of the applicable declaration of public health emergency **or** the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification. The Secretary may, by notice, provide for an extension of a 60-day period (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification.



**Alternate Care Site Support**

1. Meet with local and state emergency management officials to determine needs;
2. Develop strategies to provide alternate care site with staffing, equipment and supplies via logistical support;
3. Communicate provision of support at alternate care site via the Public Information Officer (PIO) or the Joint Regional Intelligence Center (JRIC);
4. Maintain strict accounting, as resources are provided to the alternate care site;
5. Ensure accurate recordkeeping and cost reconciliation practices are upheld.

**Care and Services under Waiver 1135 designation**

1. Meet with local and state emergency management officials;
2. Develop strategies to ensure waiver requests are clear and documented;
3. Communicate waiver provisions as appropriate;
4. Maintain strict accounting, as resources are provided to care for patients/residents;

5. Ensure accurate record keeping and cost reconciliation practices are upheld.

# REFERENCES:

1. Public Health Service Act Sec. 319. Codified at 42 U.S.C. § 247d
2. United States Code 50 U.S.C. Chapter 34, National Emergencies Act
3. United States Code 42 U.S.C. 5121 et seq., and Related Authorities, Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 93-288, as amended.
4. Social Security Act §1135, Authority To Waive Requirements During National Emergencies.
5. Social Security Act § 1851, Part C – Medicare+ Choice Program, eligibility, election and enrollment.
6. Social Security Act § 1867, Examination and Treatment for Emergency Medical Conditions and Women in Labor.
7. Social Security Act § 1877, Limitation on Certain Physician Referrals.
8. The Health Insurance Portability and Accountability Act of 1996, section 264(c), Recommendations with Respect to Privacy of Certain health Information.
9. Code of Federal Regulations 45 CFR § 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.
10. Code of Federal Regulations 45 CFR § 164.520 Notice of Privacy Practices for Protected Health Information.
11. Code of Federal Regulations 45 CFR § 164.522 Rights to Request Privacy Protection for Protected Health Information.



## All Revision Dates

3/1/2023, 4/17/2020

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| 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 |

Status **Active** PolicyStat ID **13149966**

| | | | |
|---|---|---|---|
| Origination | 2/1/2004 | Owner | Sul Jung: Associate Director of Pharmacy Services |
| Last Approved | 2/15/2023 | | |
| Effective | 2/15/2023 | Policy Area | Pharmacy Services |
| Last Revised | 2/15/2023 | | |
| Next Review | 2/14/2026 | | |

# PH.31 Drug Packaging



# POLICY:

All drug products shall be packaged, labeled and stored in accordance with California State Board of Pharmacy laws and regulations and official guidelines prescribed by the American Society of Health-System Pharmacists and the United States Pharmacopoeia. The packager shall be properly trained and familiar with the unit dosing materials as well as this policy prior to proceeding with the unit-dose process. This policy defines how to prepare and label single unit and unit-dose packages of medications such as oral solid and oral liquid dosage forms.

# PROCEDURE:

## Equipment:

Unit Dose technology shall be used for drug packaging.

## Packaging

A. The Unit-Dose area shall be thoroughly cleaned before and after each packaging of a drug item. Eating and drinking is NOT permitted in the unit-dose area at any time.

B. The packager's hands must be thoroughly washed and dried. Gloves are NOT a substitute for hand washing before starting the unit-dose process.

C. All packaging materials and medication(s) shall be gathered before beginning the unit-dose process. If more than one bulk bottle is used, each should be of the same lot number and expiration date.

D. Enter the product information into the Unit-Dose Software Program.

E. After each individual job is complete, the packaged items, the packaging log and empty bulk

containers will be placed in a segregated area for end-product evaluation by the pharmacist.

## Labeling

A. Labels should not be written by hand, except for in emergency situations.

B. The label must contain the following information:

1. **Facility** (i.e. Ventura County Medical Center, Santa Paula Hospital)
2. **Name:** The generic (non-proprietary) name shall be the most prominent part of the package label. It is NOT necessary to include the brand (proprietary) name.
3. **Strength:** Strength should be stated in accordance with terminology in the American Hospital Formulary Service.
    a. A unit dose package containing a 600 mg dose as two 300 mg tablets shall be labeled: "600 mg (2 x 300 mg)".
    b. A 500 mg dose of a liquid or injections containing 100 mg/mL shall be labeled as "500 mg/5 mL".
4. **Dosage Form:** Special characteristics of the dosage form shall be a part of the label (e.g., extended release). Medication packages shall specify route of administration if other than oral (e.g., topical use).
5. **Barcode:** Upon medication administration to patients, the barcode shall be readable at the patient's bedside.
6. **Internal Lot Number:** Lot number is assigned by the pharmacy. It shall appear both on the label and pharmacy Unit Dose Pre-Packaging Log Book, and serve as a means of complete product identification and packaging history of batch products.
7. **Manufacturer Name and Lot Number:** The original manufacturer name shall appear on both the package label and Unit Dose Pre-Packaging Log.
8. **Packaging Expiration Date:** The expiration date for non-sterile solid and liquid dosage forms packaged in single -unit and unit-dose containers shall be one year or less, unless the stability data or manufacturer's labeling or product indicates otherwise. The date shall be assigned according to the United States Pharmacopoeia guidelines or the manufacturer's expiration date, whichever is less.
    a. Oral Solids: 12 months (unless product expires before 12 months).
    b. Oral Liquids: 12 months (unless product expires before 12 months).
    c. Reconstituted Liquids: See manufacturer's labeling or USP guidelines.
    d. For short-dated products with expiration ≤4 days, the **date** and **time** shall be noted together.

## End-Product Evaluation

A. The pharmacist shall verify that the unit-dose process was performed accurately and all components of the label are correct.

B. The pharmacist shall verify the barcode scans properly in both the automated unit dose

system and the electronic health record.

C. The pharmacist shall initial the Unit-Dose Pre-Packaging Log once the verification process is complete.

## Documentation

A. The Unit-Dose Pre-Packaging Log Book shall be used to document:
    1. Internal Lot Number
    2. Packaging date and time
    3. Packaging expiration date
    4. Drug name, strength, and dosage form
    5. Manufacturer's name and lot number
    6. Manufacturer's expiration date
    7. National Drug Code (NDC)
    8. Barcode
    9. Quantity of Pre-Packaged Number
    10. Technician's Initials
    11. Pharmacist's Initials



# References:

I. California Business and Professions Code, Division 2, Chapter 9, Article 7.6 Centralized Hospital Packaging Pharmacies Section 4128

II. ASHP Technical Assistance Bulletin on Single Unit and Unit Dose Packages of Drugs

## All Revision Dates

2/15/2023, 3/17/2020, 1/1/2014, 9/1/2011

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Jason Arimura: Associate Hospital Administrator-AncillaryServices | 2/15/2023 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 2/14/2023 |

# VENTURA COUNTY MEDICAL CENTER

*Property of the Medical Staff, Privileged and Sensitive Information*

**CONFIDENTIAL**

## Medical Executive Committee Document Approval Report

March 9, 2023

### Document Approval

**Policies & Procedures/Documents**

The following were reviewed and recommended for approval by the appropriate Departments, Committees, and the Medical Executive Committee

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


| | | |
|---|---|---|
| 1. | 100.029 Availability of Auxiliary Devices for Disabled Patients and Visitors | page 1-2 |
| 2. | 106.037 Methicillin Resistant Staphylococcus Aureus (MRSA) Admission Screening | page 3-5 |
| 3. | 106.074 Cleaning of Environmental Dehumidifiers | page 6-7 |
| 4. | 107.085 Ebola Virus Disease Response Plan | page 8-15 |
| 5. | 108.031 Treatment of Hemodialysis Patients | page 16-17 |
| 6. | 108.046 Ultrasound Guided Long Peripheral Intravenous Catheter Insertion | page 18-22 |
| 7. | AC.13 Ambulatory Care – Management of Care | page 23-26 |
| 8. | IS.18 Imaging Services Equipment Cleaning Procedures | page 27-30 |
| 9. | HIM.01 Use of the Copy and Paste Function in the Electronic Health Record | page 31-32 |
| 10. | HIM.02 Health Information Management Coder Continuing Education | page 33-34 |
| 11. | HIM.05 Purpose of the Health Information Management Department | page 35-36 |
| 12. | HIM.06 Health Information Management Scope of Services | page 37-38 |
| 13. | HIM.07 Medical Records Access by Staff/Physicians | page 39-40 |
| 14. | MCH.25 Care of the Infant with Hyperbilirubinemia | page 41-49 |
| 15. | OB.05 Management of Preeclampsia and Hypertension in Pregnancy Disorders | page 50-59 |
| 16. | OB.09 Code Maternity | page 60-63 |
| 17. | OB.22 Newborn Physician Consultations | page 64 |


**b. Medical Staff Forms**


| | | |
|---|---|---|
| 1. | Physician Assistant Practice Agreement (Required by SB 697; replaces Delegated PA Services Agreement) | page 65-66 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *2/1/1983* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *1/3/2023* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Stephanie Nelson: Manager, Auxiliary Services* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.029 Availability of Auxiliary Devices for Disabled Patients and Visitors

## POLICY:

It is the policy of Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and Ambulatory Care (AC) clinics to provide general acute care hospital services to the disabled individuals, in a manner free from discrimination and consistent with the Federal regulations of the Rehabilitation Act of 1973, Section 504. This applies to all persons who shall be afforded access to the Hospital and its clinics.

VCMC/SPH and AC clinics shall operate in a manner that does not unlawfully discriminate against people on the basis of race, color, national origin, religion, sex (including pregnancy) age, sexual orientation (including gender identity and expression), marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law.

## PROCEDURE:

The following VCMC/SPH Auxiliary aids are available and provided without charge to patients and visitors:

| DEVICE | IMPAIRMENT | LOCATION |
|---|---|---|
| 1. iPads<br>~~TTY Telephone Device~~<br>1-805-652-6001<br>1-805-652-6695 | Hearing | Nursing Supervisor<br>Nursing Office<br>Auxiliary Department |
| 2. Language Interpreter Services | Hearing | Nursing Supervisor |
| 3. Patient Rights & Responsibilities<br>Written Pamphlet for Hearing | | Admitting, Emergency Department, Outpatient Clinics |

All revision dates: 1/3/2023, 5/2/2019, 12/1/2013, 5/1/2006, 12/1/2004, 8/1/2001, 10/1/1990, 7/1/1990, 10/1/1986, 4/1/1986

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Tracy Chapman: VCMC - Med Staff | pending |
| Hospital Administration | Diana Zenner: Chief Operating Officer, VCMC & SPH | 1/23/2023 |
| Hospital Administration | Minako Watabe: Chief Medical Officer, VCMC & SPH | 1/17/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 1/9/2023 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 1/3/2023 |
| Policy Owner | Stephanie Nelson: Manager, Auxiliary Services | 1/3/2023 |

**Current Status:** *Pending* **PolicyStat ID:** *10249353*

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
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| **Last Approved:** | *N/A* |
| **Last Revised:** | *2/1/2023* |
| **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:~~

## 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: On admission, within 24 hours, a culture of the anterior nares will be performed on the following patients:~~

I. ~~The nurse performing the admission assessment on the nursing unit will do the culture. No separate physician order is necessary.~~

II. ~~Send the specimen to the laboratory.~~

III. ~~Enter the order into electronic health record (EHR) for "MRSA screen."~~

IV. ~~Minimum requirements identifying patient risk groups that necessitates MRSA Admission Screen:~~

1. ~~1. Nasal Swabs for the following sources of patients:~~
   a. ~~a. Patients readmitted within 30 days of discharge from any acute care hospital.~~
   b. ~~b. Patients received from Skilled Nursing Facility or Rehab facility~~
   ~~c. Patients admitted to Intensive Care Units.~~
   ~~d. Patients requiring surgical procedure during hospitalization 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. ~~2. Attending physician must discuss the positive results with patient or patient's representative.~~
   ~~3. Patient must be given written information as an educational tool at the time results are discussed and prior to discharge.~~
   ~~4. Contact precautions is only necessary when the site of the MRSA cannot be contained, such as~~

~~an open draining wound, abscess at IV site, or multiple secondary sites.~~
~~5. Nasal carriage on its own is not sufficient to require contact precautions.~~
~~6. All care givers with 24/7 responsibility for the patient's care are responsible for monitoring culture results and notifying colleagues of the culture status.~~
~~7. Affirmative documentation in the patient's record is required when positive nasal swab culture results are conveyed to patient and written information provided.~~

~~4.~~

~~**REFERENCES:**~~
~~California Senate Bill 1058, Chapter 296.~~

# 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.

# REFERENCES:

A. California Senate Bill 1058, Chapter 296.

All revision dates: 2/1/2023, 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 | 2/1/2023 |
| Policy Owner | Magdy Asaad: Infection Prevention Manager | 2/1/2023 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *2/12/2019* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *2/12/2019* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Ian McGraw: Manager Facility Operation* |
| **Policy Area:** | *Administrative - Environment of Care* |
| **References:** | |

# 106.074 Cleaning of Environmental Dehumidifiers

# POLICY:

Environmental Services and Facilities Maintenance staff shall clean and sanitize the interior and exterior of dehumidifiers per manufacturer's recommendations and shall adhere to the recommendations for frequency of cleaning.

# PROCEDURE:

## Exterior Cleaning of Dehumidifiers:

Environmental Services staff shall sanitize the exterior of all dehumidifiers in the following manner:

- Dehumidifiers in Surgical Services shall be completely cleaned between each surgical case.
- Unplug dehumidifier prior to cleaning.
- Wipe down the outside surface of the dehumidifier, including the plug, using a microfiber cloth and hospital-approved disinfectant.
- Allow the surface to air dry using hospital-approved disinfecting guidelines.
- If a dehumidifier shows signs of corrosion, immediately notify the Facilities Maintenance Department.
- After each airborne isolation case, alert the Facilities Maintenance Department of the need to replace the air filters on the dehumidifier.

## Interior Cleaning and Maintenance of Dehumidifiers:

### Equipment Needed:

- Philips screwdriver
- 10 mm wrench
- 6 mm hex bit
- ¼ in. nut driver
- Cleaning cloths
- HEPA vacuum cleaner with soft brush nozzle and crevice nozzle

Facilities Maintenance staff shall clean and maintain the interior of dehumidifiers in the following manner:

- Use personal protective equipment (PPE) to include gloves and an N95 mask when completing monthly internal cleaning of the dehumidifier.
- Unplug dehumidifier prior to cleaning.

- Remove outside filter (clean per manufacturer's instructions for use).
- Remove the 4 screws from housing and 2 top screws from the inlet and outlet grills. Then lift off cover.
- Inspect and clean both coils, if excessive dust and debris is present. Then vacuum thoroughly with a HEPA vacuum cleaner using a soft brush nozzle.
- Wipe the inside of the housing unit with a hospital-approved disinfectant on the inside of housing.
- Then replace inlet and outlet grill. Then replace housing cover with use of 4 screws.

## To be performed on "as needed" basis:

**Clean pump check valve and basin -** If the unit displays the message "ER9 PUMP BLOCKED PUMP & HOSE," the pump check valve and pump basin shall be cleaned in the following manner:

- Remove grills and cover.
- Remove screws from pump base and lift out pump.
- Wipe out pump basin with a damp cloth. Inspect the pump base for build-up of debris and clean if needed.
- Un-thread barbed fitting with check valve and rinse fitting and check valve with clean water.
- Reinstall check valve into barbed fitting and install the barbed fitting into pump. Do not over-tighten.
- Reinstall pump on base.
- Reinstall cover and grills.

All revision dates: 2/12/2019

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Tracy Chapman: VCMC - Med Staff | pending |
| Infection Control Committee | Magdy Asaad: Infection Prevention Manager | 2/7/2023 |
| Policy Owner | Ian McGraw: Manager Facility Operation | 12/6/2022 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
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| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *12/22/2022* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Minako Watabe: Chief Medical Officer, VCMC & SPH* |
| **Policy Area:** | *Administrative - Operating Policies* |
| **References:** | |

# 107.085 Ebola Virus Disease Response Plan

# PURPOSE:

The purpose of the policy is to:

- Ensure preparedness in the event of a suspect or confirmed case of Ebola virus disease (EVD) within the facility
- Guide the institutional response through assignment of actions and responsibilities in the event of a suspect or confirmed case of EVD within the facility

# BACKGROUND:

- Ebola is a rare and deadly disease caused by infection with one of four viruses (Ebolavirus genus) that cause disease in humans. Ebola infection is associated with fever of greater than 38.6°C or 101.5°F, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage.
- Ebola is spread through direct contact (through broken skin or mucous membranes) with blood or body fluids (including but not limited to urine, saliva, feces, vomit, sweat, breast milk, and semen) of a person who is sick with Ebola or contact with objects (such as needles and syringes) that have been contaminated with these fluids. Ebola is not spread through the air or water. The main source for spread is human-to-human transmission. Avoiding contact with infected persons (as well as potentially infected corpses) and their blood and body fluids is of paramount importance.
- Persons are not contagious before they are symptomatic. The incubation period (the time from exposure until onset of symptoms) is typically 8-10 days, but can range from 2-21 days.
- Additional information is available at http://www.cdc.gov/vhf/ebola/index.html.

# DEFINITION(S):

Ebola case definitions (CDC, updated May 2021; www.cdc.gov/vhf/ebola/hcp/case-definition.html )

1. Person under investigation (PUI):
    a. Signs and symptoms consistent with Ebola virus infection including but not limited to:
        i. Fever
        ii. Aches and pains, such as severe headache and muscle and joint pain
        iii. Weakness and fatigue

iv. Sore throat
v. Loss of appetite
vi. Gastrointestinal symptoms including abdominal pain, diarrhea, and vomiting
vii. Unexplained hemorrhaging, bleeding or bruising
viii. Other symptoms may include red eyes, skin rash, and hiccups (late-stage).

**AND**

b. Epidemiologic risk factors within the past 21 days before the symptom onset such as:
   i. Blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, amniotic fluid, and semen) of a person who is sick with or has died from Ebola virus disease (EVD).
   ii. Objects (such as clothes, bedding, needles, and medical equipment) contaminated with body fluids from a person who is sick with or has died from EVD.
   iii. Infected fruit bats or nonhuman primates (such as apes and monkeys).
   iv. Semen from a man who recovered from EVD (through oral, vaginal, or anal sex). The virus can remain in certain body fluids (including semen) of a patient who has recovered from EVD, even if they no longer have symptoms of severe illness. There is no evidence that Ebola can be spread through sex or other contact with vaginal fluids from a woman who has had Ebola.
   v. Residence in—or travel to—an area where EVD transmission is active https://www.cdc.gov/vhf/ebola/outbreaks/uganda/2022-sep.html

2. Confirmed case:
   a. A patient with laboratory-confirmed diagnostic evidence of Ebola virus infection

# POLICY:

1. Ebola Response Team
   a. Purpose: to guide the institutional response, and determine roles and responsibilities
   b. The membership of the Ebola Response Team includes, at minimum:
      i. Administrator on Duty (AOD)
      ii. Chief Nurse Executive
      iii. Chief Medical Officer
      iv. Manager of Infection Prevention and Control
      v. Infectious Disease Physician Leader
      vi. Emergency Department Physician Leader
      vii. Emergency Department Manager
      viii. Director Laboratory Services
      ix. Director Support Services
      x. Director Central Supply
   c. The Team will meet to review and coordinate investigative, patient safety, and patient management efforts.

d. Information included in this policy is subject to change based on needs to fit the appropriate response and changing guidance from public health authorities.

2. Infection Prevention takes the lead role to:
    a. Engage the Ebola Response Team
    b. Obtain that the most current EVD guidance from public health authorities and Center for Disease Control
    c. Ensure appropriate controls are in place to prevent EVD transmission within the facility
    d. Provide EVD educational material for staff, patients and visitors.

# PROCEDURE(S):

Overview for any patient evaluated as suspect or confirmed EVD:

1. Signs will be placed outside all entrances to the hospital directing patients to call the emergency room if they have signs and symptoms consistent with Ebola and recent travel to areas with active outbreaks.
2. Patients will be directed to the ambulance bay entrance, given a mask and placed into ER bed ISO 2. This prevents the patient from walking through the emergency department as ISO 2 is adjacent to the ambulance bay. This is also an Airborne Infection Isolation Room (AIIR).
3. ER team will evaluate the patient in more detail to see if they meet PUI or confirmed case criteria (see Definitions above).
4. ER will notify Nursing Supervisor of PUI or confirmed case.
5. Nursing Supervisor will alert the Ebola Response Team.
6. Nursing Supervisor will identify a trained observer or "hygienist" to help with donning and doffing of personal protective equipment.
7. Infection Prevention will notify Ventura County Public Health Department.
8. Nursing Supervisor will contact the Emergency Medical Services (EMS) Agency Duty Officer(s) to arrange for transfer to the designated accepting facility utilizing the High-Risk Transport team.
    1. EMS Agency Duty Officers
        a. Chris Rosa:
            i. Cell: (805) 617-5365
        b. Steve Carroll:
            i. Cell: (805) 981-5305
9. Nursing Supervisor will work in concert with AOD and Infection Prevention Manager to ensure the appropriate Infection Prevention measures are implemented.

## Infection Prevention and Control Measures

CDC guidance: www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html Use Standard, Contact, and Droplet precautions in the care of suspected and confirmed Ebola patients. Health Care Providers (HCP) should wear: gloves, fluid resistant gown or coverall, eye protection (goggles or face shield), and a face mask. Additional personal protective equipment (PPE) might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment),

including but not limited to double gloving, disposable shoe covers, and leg coverings. Avoid aerosol-generating procedures. If clinically essential, PPE for these procedures should include respiratory protection (N95 respirator or PAPR) and be performed in an Airborne Infection Isolation Room (AIIR). In addition hand hygiene should be performed frequently before, during and after patient care using and alcohol based hand sanitizer.

## 1. Patient Placement:

a. Place patient in a single patient room containing a private bathroom or covered commode with the door closed. An Airborne Infection Isolation Room (AIIR) is preferred if available.
    i. Room ISO 2 in the ED has been designated as the safest room as it is adjacent to the ambulance bay entrance so patients can walk in directly from outside.
    ii. At Santa Paula Hospital, a patient will be placed in a tent located outside of the Emergency Department.
b. A log of all persons entering the patient's room will be maintained
c. Limit room entry to only those health care workers essential to the patient's care and restrict non-essential personnel and visitors from the patient care area.
d. Signs to be placed on patient room, PPE storage, donning area and doffing area.

## 2. Personal Protective Equipment (PPE):

Recommended PPE varies based on patients' symptoms. All PPE listed is single-use/disposable and fluid resistant or impermeable except the powered air purifying respirator (PAPR), which should be decontaminated according to manufacturers' instructions.

a. For all patients https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html:
    i. Impermeable garment: gown extending to at least mid-calf or coveralls
        a. Surgical or isolation gown that passes:
            i. ANSI/AAMI PB70 Level 3 requirements or
            ii. EN 13795 high performance surgical gown
        b. Coverall made of fabric that passes:
            i. AATCC 42 ≤ 1 g and AATCC 127 ≥ 50 cm $H_2O$ or EN 20811 ≥ 50 cm $H_2O$ or
            ii. ASTM F1670 (13.8 kPa) or
            iii. ISO 16603 ≥ 3.5 kPa
    ii. Respiratory, head and face protection. (PAPR) is preferred. If not available, an N-95 with surgical hood or face shield may be used.
    iii. Double gloves with extended cuffs
    iv. Boot covers (to mid-calf) with shoe covers over the boot covers
    v. Apron

## 3. Training for Staff

Donning and doffing of PPE must be done slowly and in the proper order to minimize contamination. The

CDC has video training available at: https://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html and staff will be pre-selected from necessary departments to undergo training. Enough staff will be trained such that a trained staff member is available from their department on every shift. Competencies will be obtained, and in addition a trained observer or "hygienist" will be present to ensure correct donning and doffing.

## 4. Patient Care Equipment

a. Use dedicated medical equipment (preferably disposable, when possible) for the provision of patient care.
b. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and hospital policies.

## 5. Patient Care Consideration

Per directions from Ventura County Public Health Department and current guidance from California Department of Public Health, no lab specimens will be obtained from patients who are a PUI or confirmed case of EVD.

a. Limit the use of needles and other sharps as much as possible.
b. Limit phlebotomy, procedures, and laboratory testing to the minimum necessary for essential diagnostic evaluation and medical care.
c. All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers.
d. Avoid aerosol-generating procedures (AGPs).
e. Limit HCP only to those essential for patient care.
f. Maintain a log of persons entering the patient's room.

## 6. Aerosol-generating procedures

a. Aerosol-generating procedures (AGPs) should be reserved for life-saving procedures only. Otherwise avoid AGPs.
b. If performing aerosol-generating procedures, use a combination of measures to reduce exposures from aerosol-generating procedures when performed.
c. Limit the number of HCP present during the procedure to only those essential for patient care and support.
d. Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room (AIIR) when feasible. Room doors should be kept closed during the procedure except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure.
e. HCP should wear PPE listed in procedure 2a "For patients who are clinically unstable, bleeding, vomiting, or have diarrhea".
f. Conduct environmental surface cleaning following procedures (see section below on environmental infection control).
g. If re-usable equipment or PPE (e.g. powered air purifying respirator, elastomeric respirator, etc.) is used, it should be cleaned and disinfected according to manufacturer instructions and hospital policies.
h. Collection and handling of soiled re-usable respirators will be done by trained respiratory therapists using

PPE as described above under procedure 2b “For patients who are NOT clinically unstable, bleeding, vomiting or having diarrhea”.

## 7. Environmental infection control

CDC guidance: www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html Ebola virus is classified as a Category A infectious substance regulated by the U.S. Department of Transportation’s (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, used healthcare products such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets; and used PPE (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning contaminated or suspected of being contaminated with a Category A infectious substance.

a. Staff will be trained in proper PPE use and complete competencies.
b. Use an U.S. Environmental Protection Agency (EPA) registered hospital disinfectant from List L or List Q to disinfect environmental surfaces in rooms of PUIs or patients with confirmed EVD.
c. Avoid contamination of reusable porous surfaces that cannot be made single use:
    i. Use only a mattress and pillow with plastic or other covering that fluids cannot get through.
    ii. Do not place PUIs or patients with confirmed EVD in carpeted rooms.
    iii. Remove all upholstered furniture and decorative curtains from patient rooms before use.
d. Perform routine cleaning and disinfection of the PPE doffing area
e. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, all linens, nonfluid-impermeable pillows or mattresses, and textile privacy curtains will be double bagged and incinerated.
f. Other medical waste will be discarded as Category A infectious substance regulated as a hazardous material under the U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR: 49 CFR, Parts 171-180).
g. Staff will follow the most recent guidelines recommended by Center for Disease Control and Calfornia Department of Public Health.

## 8. Duration of infection control precautions

Determine duration of precautions on a case-by-case basis, in conjunction with the public health authorities.

## 9. Monitoring and management of potentially exposed personnel

a. Persons with percutaneous or mucocutaneous exposures to blood, body fluids, secretions, or excretions from a patient with suspected EVD should
    i. Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with copious amounts of water or eyewash solution
    ii. Immediately contact occupational health/supervisor for assessment and access to postexposure management services for all appropriate pathogens (e.g., human immunodeficiency virus, hepatitis C, etc.)

b. Follow policies for monitoring and management of potentially exposed HCP:
    i. HCP who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD should
        1. Not report to work or should immediately stop working
        2. Notify their supervisor
        3. Seek prompt medical evaluation and testing
        4. Notify Ventura County Public Health Department
        5. Comply with work exclusion until they are deemed no longer infectious to others
    ii. For asymptomatic HCP who had an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with Ebola
        1. Should receive medical evaluation and follow-up care including fever monitoring twice daily for 21 days after the last known exposure.
        2. Ensure twice daily contact with exposed personnel to discuss potential symptoms and document fever checks
        3. HCP may continue to work only in a crisis staffing situation under supervision, while receiving twice daily fever checks, based upon discussion with local, state, and federal public health authorities.

## 10. Visitors

a. Restrict all visitors into the patient's room; exceptions may be considered on a case-by-case basis
b. Maintain a log of all visitors entering the patient's room
c. Visitors should be:
    i. Screened for EVD (e.g., fever and other symptoms) before entering or upon arrival to the hospital
    ii. Instructed (before entry into the patient care area) on hand hygiene, limiting surfaces touched, and use of PPE
    iii. Assessed for ability to comply with infection prevention and control precautions
    iv. Restricted to the patient room and an immediately adjacent waiting area

# REFERENCE(S):


1. Centers for Disease Control and Prevention (CDC) Ebola Virus Disease http://www.cdc.gov/vhf/ebola/index.html
2. CDC EVD Infection Prevention and Control https://www.cdc.gov/vhf/ebola/clinicians/evd/infection-control.html
3. CDC Ebola Virus Disease Information for Healthcare Workers http://www.cdc.gov/vhf/ebola/hcp/index.html
4. CDC Ebola Virus PPE Donning and Doffing Procedures https://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html
5. CDC Ebola Virus Disease Overview

https://www.cdc.gov/vhf/ebola/outbreaks/uganda/2022-sep.html

6. Ebola Virus Disease (EVD) Medical Waste Management – Interim Guidelines Revised October 2022 – Attachment B
7. CDPH Guidance for Health Professionals https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx
8. CDC EVD Case Definitions www.cdc.gov/vhf/ebola/hcp/case-definition.html

All revision dates: 12/22/2022, 12/20/2022

## 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 | 1/31/2023 |
| 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 | Minako Watabe: Chief Medical Officer, VCMC & SPH | 1/4/2023 |

VENTURA COUNTY HEALTH CARE AGENCY

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| **Owner:** | *Sherri Block: Associate Chief Nursing Executive, VCMC & SPH* |
| **Policy Area:** | *Administrative - Nursing* |
| **References:** | |

# 108.031 Treatment of Hemodialysis Patients

## POLICY:

To outline the process of care for patients receiving hemodialysis at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH).

## PROCEDURE:

A. Patients admitted for hemodialysis can be assigned to the following rooms:
   1. At VCMC – all dialysis-equipped rooms
   2. At SPH – all rooms except "001"

B. Staff shall do all pre-dialysis work/SBAR before the arrival of the dialysis nurse and should:
   1. Provide/receive warm hand-off to/from dialysis RN prior to/post procedure.
   2. Check pertinent Lab work and confer with dialysis nurse.
   3. Assist dialysis nurse with weighing the patient, if not already done.
   4. Review consent for dialysis procedure comprehensiveness of completion. For patients in the outpatient setting, informed consent is valid for 30-days as long as the reason for the dialysis remains unchanged.

C. Unit nursing staff is responsible for nursing care medications and any other treatments.

D. No BP's, IV's or NEEDLE STICKS ON SHUNT ARM. Protect arterial/venous access.

E. IN THE EVENT OF A CODE BLUE WHEN ON DIALYSIS:
   1. Dialysis nurse will terminate treatment as quickly as possible.
   2. Dialysis nurse will leave the room with as much equipment as possible.
   3. Code team will assume care.
   4. Continuation of treatment after emergency will be at the discretion of the patient's physician and the nephrologist.

F. ** Prior to any AV shunt placement in an arm or leg, place a sign above the bed stating: DO NOT DRAW BLOOD OR PLACE IV'S (FROM EXTREMITY PLANNED FOR AV SHUNT).

   NOTE: Remember to inform the patient not to allow blood draws or needle sticks to the extremity planned

for AV shunt placement.

G. In the event of an internal/external disaster, treatment will be terminated as soon as possible and hand-pumped, if necessary, by the dialysis nurse.

All revision dates: 7/23/2018, 1/1/2017, 12/1/2013, 6/1/2013, 4/1/2011, 4/1/2008, 6/1/2006, 11/1/2004, 5/1/2004, 10/1/2001, 10/1/1998, 11/1/1995, 7/1/1994, 7/1/1992, 4/1/1991, 11/1/1990

## Attachments

No Attachments

## 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 | 1/13/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 1/13/2023 |
| Policy Owner | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 1/13/2023 |

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| **Owner:** | *Sharon Waechter: Clinical Nurse Manager, Nursing Education* |
| **Policy Area:** | *Administrative - Nursing* |
| **References:** | |

# 108.046 Ultrasound Guided Long Peripheral Intravenous Catheter Insertion

# Purpose:

To outline the policy for the standardized use of a long ultrasound-guided peripheral intravenous (USGPIV) catheter insertion.

## Indications and Considerations for Ultrasound Guidance:

- Patients with difficult venous access are candidates for ultrasound guided peripheral IV starts
- Only Registered Nurses who have been trained and whose competency is validated annually may insert peripheral intravenous (PIV) catheters using the ultrasound (US) guided technique
  - Completion of a didactic training class and practicum with simulators is required prior to insertion with patients
  - A minimum of 5 successful USGPIV insertions observed by a Vascular Access trained preceptor is required to satisfy competency of ultrasound guided peripheral intravenous insertion
    - An Ultrasound Guided Peripheral IV Insertion Competency Form must be completed and submitted to the Education Department to validate competency

# Equipment/Supplies List:

- Portable US machine
- High Frequency Linear Transducer Ultrasound Probe
- Clean gloves
- Sterile ultrasound gel (single use packet)
- Sterile 4x4 gauze
- Intravenous (IV) start kit
  - Transparent sterile dressing (Tegaderm™)
  - Chlorhexidine antiseptic skin prep (Chloraprep™)
  - Alcohol or iodine prep (if patient has a known allergy to Chloraprep™)
  - Tourniquet
- Normal Saline flush
- IV connector tubing
- Needleless connector cap
- PIV catheter with a length of 0.75 to 1.88 inch, 24g for pediatrics

- Ultrasound probe cover
- Single use clippers or scissors for hair removal, if indicated

# Procedure:

I. **Pre-procedure Assessment**

1. Review Patient's Health Record:
    a. Note documented allergies (e.g., antiseptic solution, adhesives, etc.)
    b. Patient age and physical condition
    c. Assess the characteristics of the prescribed infusion therapy and the anticipated length of therapy to determine if a PIV is the most appropriate vascular access device (VAD)
2. Select insertion site:
    a. Assess the skin for dermatologic conditions and avoid sites that are inflamed, edematous and scarred, or have moles and birthmarks
    b. Select vessels in the forearm and avoid upper extremities. The upper cephalic vein may be used only after ruling out chronic kidney disease (CKD) and the need for vein preservation
    c. Discuss arm preference with the patient and the recommendation for use of the nondominant arm to decrease accidental removal
3. Assess Vasculature with Ultrasound Device:
    a. Ensure the ultrasound probe has been disinfected prior to patient use, cleansing with PDI® Super Sani-Cloths® wipes
    b. Perform hand hygiene
    c. Don clean gloves
    d. Apply liberal amount of sterile ultrasound gel to the patient's arm
    e. Apply probe to the skin: visualize and note the location of the veins, arteries, and nerves surrounding the proposed insertion site
        - The "Depth" and "Gain" settings on the ultrasound may need to be adjusted for optimal visualization
        - Apply light downward pressure with ultrasound probe. When compressed, arteries are pulsatile; healthy veins should compress easily. Nerves can appear as echogenic bundles adjacent to veins and arteries, and caution should be used to avoid nerve stimulation
        - Assess veins for vessel size, path, round shape, and compressibility without a tourniquet
        - Assess depth of intended vessel for venipuncture
        - Assess for adequacy of vessel size compared to proposed outer catheter diameter to promote hemodilution and preserve vessel health
            - Measure the catheter-to-vessel ratio and ensure it is <45%
        - Avoid selecting smaller vessels to prevent phlebitis and thrombosis
        - Remove gloves and discard
    f. Longitudinal or transverse views can be used when placing vascular catheters with ultrasound. Note: surrounding structures will not be visible in the longitudinal view.

g. Assessment of vessel depth is critical, because selection of the appropriate length catheter will prevent inadvertent infiltration
    - At least 50% of the catheter should reside in vein at final positioning

II. **Patient Education**

1. Prior to procedure, teach patient and caregiver:
    a. The purpose of PIV insertion and procedure, including risks and benefits
    b. Signs and symptoms of common complications
    c. How and whom to report complications
    d. Rationale for use of ultrasound

III. **Preprocedure Preparation**

1. Perform hand hygiene before direct contact with patient
2. Verify patient's identity using two independent identifiers (i.e., name and date of birth)
3. Obtain and review provider's order for peripheral IV
4. Disinfect work area (i.e., bedside table) with antimicrobial solution and allow it to dry completely
5. Prepare for insertion; collect necessary insertion supplies and place them within reach on work area
    a. Attach the needleless connector cap to IV connector tubing and prime with a Normal Saline flush

IV. **Insertion Procedure**

1. Position Patient for comfort and equipment for visualization of the vasculature
2. Apply sterile ultrasound gel to the end of the probe and cover with sterile probe cover; avoid contamination of the probe cover that will be in contact with the patient's skin
3. Perform hand hygiene and don gloves
4. Prepare insertion site
    a. If visibly soiled, cleanse with antiseptic soap and water
    b. Remove excess hair, if necessary, by clipping
5. Cleanse insertion site for 30 seconds with Chloraprep™ creating friction with a back and forth scrubbing motion. Allow site to air dry for an additional 30 seconds.
    a. Use povidone-iodine or 70% alcohol if chlorhexidine solution is contraindicated.
6. Apply tourniquet at least 3-6 inches proximal to intended insertion site
7. Apply small amount of sterile ultrasound gel to the prepped area
8. Hold the ultrasound probe in the non-dominant hand and the IV catheter in the dominant hand. Relocate the intended vein with the ultrasound probe, verifying it is non-pulsatile and align the selected vein to the center of the screen
    a. The recommended insertion angle is 45-60 degrees. The angle may be adjusted depending on the depth of the vein for a goal of having 50% or more of the catheter residing in the vein
9. Perform venipuncture while watching the ultrasound screen until the tip of the catheter is visualized in the center of the vein.

10. Verify blood return in the catheter reservoir and slowly lower angle of catheter and advance slightly.
11. Advance catheter while withdrawing needle and initiate needle safety device mechanism
    a. Place needle in sharps container
12. Release tourniquet
13. Attach primed IV connector tubing with needleless connector cap
14. Aspirate for brisk blood return and flush with 10ml of Normal Saline
    a. Verify the catheter flushes well without pain, burning, or swelling
    b. Clamp the IV connector tubing
15. Wipe off sterile ultrasound gel with sterile gauze while stabilizing catheter
16. Doff gloves and perform hand hygiene
17. Clean and disinfect ultrasound probe by removing sterile ultrasound cover, wiping away excess gel, and cleansing with PDI® Super Sani-Cloths® wipes

V. **Dressing**

1. Secure catheter using a sterile Tegaderm™ dressing and tape if not contraindicated
2. Label site with date and initials
3. Educate patient about signs and symptoms of infiltration and infection

VI. **Post Insertion**

1. Document the USGPIV appropriately in electronic medical record to include:
    a. Use of ultrasound guidance for PIV insertion
    b. Date and time of insertion, number of attempts, functionality of device, and inserter name/ identification
    c. IV site
    d. Dressing and securement type
    e. Patient response to procedure
    f. Patient education
2. For maintenance and care of PIV, follow Ventura County Medical Center policy *108.033; "Peripheral Intravenous (IV) Insertion, Infusion, and Maintenance"*

# References


- Infusion Nurses Society. *Policies and Procedures for Infusion Therapy: Acute Care*. 6th ed. Infusion Nurses Society; 2021.
- LAC+USC Healthcare Network. (2021). Ultrasound-Guided Peripheral Intravenous (USGPIV) Catheter Insertion Procedure.
- Kaiser Permanente. (2020). Ultrasound-Guided Peripheral Intravenous Catheter. (Procedure Number 6603-04W1). Hawaii Region: Regional Nursing.


All revision dates:

## Attachments

No Attachments

## 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 | 1/13/2023 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 1/13/2023 |
| Policy Owner | Sharon Waechter: Clinical Nurse Manager, Nursing Education | 1/13/2023 |

VENTURA COUNTY
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| **Owner:** | *Matthew Tufte* |
| **Policy Area:** | *Ambulatory Care - Administrative* |
| **References:** | |

# AC.13 Ambulatory Care - Management of Care

# POLICY:

The Ventura County Health Care Agency (HCA) Ambulatory Care Management of Care Program focuses on patients with multiple chronic conditions that are risk-stratified and works toward the prevention of exacerbations and complications. The Program increases focus on patients' and family caregivers' roles, needs and goals by supporting the physician-patient relationship, developing a plan of care, and facilitating health care communication across all settings. The Program requires communication between the Ambulatory Care clinic Care Managers, the Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) Case Management Department and other outside agencies that partner with Ventura County. On an as-needed basis, Clinical Social Workers or Social Services designees, Care Managers, Discharge Planners and/or Respiratory Therapists shall also attend multidisciplinary care meetings.

Ambulatory Care promotes patient health and wellbeing by actively coordinating services for members with multiple or complex chronic conditions, using established care management processes and tools within established professional standards in order to promote quality, cost-effective care. VCMC/SPH Case Management shall be directed by inpatient policies and procedures although performance improvement will be a joint effort between inpatient and outpatient case managers. Operating within HIPAA regulations, eligible members are proactively identified by referral, interdisciplinary team review of urgent/ emergent care cases, claims data, or hospital discharge data. Enrollment is voluntary.

The Care Manager shall strive to be a health care leader and maintain the highest standards of professional practice supported by robust health information technology, education, and training. The value of the Management of Care Program will be evidenced by best practices and quality outcomes that contribute to optimal health, function, safety, and satisfaction of our members.

# PROCEDURE:

**DEFINITIONS:**

Case Management: “Case Management in hospitals and health systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination.” Approved by ACMA Membership, November 2002.

## Patient Identification/Risk Stratification:

Patients are identified based on complexity of their chronic conditions and stratified based on risk for readmission, utilization of services, and/or potential for high utilization of services. Best practices include communication regarding high risk patients between all involved Care Managers.

An event or change in care that has caused a disruption in an otherwise stable situation, patients with multiple chronic illnesses, high utilization medical conditions, complex social situations which can affect medical management, or those that may require extensive use of resources qualify.

## Developing an Individualized Care Plan (through, but not limited to, scheduled and unscheduled interviews, by telephone, or written correspondence):

Every effort will be made to facilitate positive patient outcomes by:

- Coordinating all inpatient and outpatient services required for an organized, multidisciplinary, patient centered care team approach that ensures quality, cost-effective care for the identified patient.
- Managing the course of treatment for patients with providers, nurses, and other staff ensuring quality patient outcomes are achieved within established time frames.
- Conducting initial and ongoing assessments, initiating disease management protocols, determining and managing outcomes, ensuring continuity of care through planning, utilization of resources, and analysis of variances.
- Promoting patient empowerment by providing education through evidence-based intervention, informed choices, and linkage to community resources.
- Functioning as a contact person for the patient, families, health care team member, community resources and employees as necessary.
- Building a trusting partnership with patients through evidence-based intervention.
- Using a comprehensive, holistic approach.
- Promoting self-care management of chronic conditions through evidence based care models.
- Identifying problems/conditions.
- Confirming condition status/severity.
- Establishing goals.
- Choosing appropriate interventions.
- Confirming intensity level.
- Documenting in the electronic health record (EHR).
- Reevaluating and revising the plan of care as necessary.
- Helping meet quality metrics, such as diabetes control, immunizations, blood pressure control and cancer screening

## Care Coordination:

Patient interventions are made in collaboration with the multidisciplinary care team, the patient's family and the patient. Care Managers use the “MacColl Center for Health Care Innovation Chronic Care Model,” (Attachment A) and the associated resources, to provide a continuum of personalized primary and specialty care to patients within its Whole Person Care and Patient-Centered Medical Home initiatives. Outpatient Care Managers and Inpatient Care Managers will communicate during transitions of care, including patient admissions and patient discharges. Outpatient Care managers will assign patients to either level I, II, or III care management as appropriate. Criteria are listed on the “Care Management Complexity Level” workflow.

## Reassessment and Monitoring:

Patients shall be reassessed and monitored as indicated by their Care Management level. All reassessment and changes to Care Management level shall be documented in the EHR, including any modifications/ updates to their Care Plans.

## Outcomes and Evaluation:

Patient and overall program evaluation shall be documented and discussed at least semiannually using program-wide reports on quality metrics including EHR reports, patient satisfaction tools, and utilization analysis.

## Management of Care Program Goals:

- Manage patients with multiple and/or complex medical problems by providing a single point of contact.
- Encourage collaborations with all health care team members during various transitions of care settings.
- Promote prevention by appropriate utilization of routine health maintenance.
- Prevent unnecessary hospitalizations/re-hospitalizations of members.
- Facilitate compliance with requested and/or needed therapeutic services.

## Population:

Target patient populations eligible for active case management include, but are not limited to, members who have had hospital admissions (or readmissions), repetitive Emergency Department or Urgent Care visits for the same diagnosis or chronic disease related issues. Specifically identified chronic disease groups include, but are not limited to, cancer, spinal injuries, serious trauma, acquired immunodeficiency syndrome (AIDS), diabetes mellitus (DM), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), and chronic kidney disease/end stage renal disease (CKD/ ESRD), whole person care and medical home initiative patients. The goals of the Program are to capture those patients at highest risk for complications by either intrinsic or extrinsic factors (e.g. severity of disease, co-morbidities, non-compliance).

## ATTACHMENTS:

- Attachment A - MacColl Center for Health Care Innovation Chronic Care Model

All revision dates: 6/1/2022, 6/13/2019, 5/1/2016

# Attachments

Attachment A - MacColl Chronic Care Model.pdf

# Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee/ Oversight | Tracy Chapman: VCMC - Med Staff | pending |
| AC Chief Executive Officer | Theresa Cho: Chief Executive Officer, Ambulatory Care | 1/31/2023 |
| AC Chief Medical Quality Officer | Rachel Stern: Chief Medical Quality Officer | 1/17/2023 |

| Step Description | Approver | Date |
|---|---|---|
| AC Chief Medical Officer | Allison Blaze: Chief Medical Officer, Ambulatory Care | 12/20/2022 |
| AC Director of Nursing | Cynthia Fenton: AC Director of Nursing | 7/26/2022 |
| AC Director of Nursing | Matthew Tufte | 6/14/2022 |

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| **Owner:** | *Matt McGill: Director, Imaging Services* |
| **Policy Area:** | *Imaging Services* |
| **References:** | |

# IS.18 Imaging Services Equipment Cleaning Procedures

# POLICY:

To provide optimum patient care and minimize the risk of healthcare associated infections within Imaging Services. Imaging Services staff shall adhere to the following procedures and guidelines in handling all imaging equipment in order to maintain clean imaging equipment and ancillary items used in the performance of imaging procedures.

# PROCEDURE:

- Standard precautions shall be used with all patients.
- If a patient or visitor is coughing, he or she shall be given a tissue and/or a mask.
- All technologists shall wash their hands before and after all patient interactions.
- Hospital-approved hand sanitizer is available and can be used when hands are not visibly soiled.
- Linens are stored in a clean, designated area and changed between patients. The exam table shall be cleaned between each procedure with the appropriate hospital-approved disinfectant.

## XRAY:

~~All CR cassettes shall be cleaned on a daily basis. A cleaning log shall be used to date and initial the cleaning.~~

- If a DR/CR cassette is soiled with blood or body fluid, the technologist shall don gloves and clean the cassette with the appropriate hospital- approved cleaner. After cleaning the cassette, the technologist shall wash their hands with soap and water.
- All x-ray room upright bucky's and chin rests shall be cleaned between each patient use with a hospital-approved disinfectant.
- Overhead cables, tube support columns, control boards and panels shall be cleaned on an as needed basis.
- All portable machines (x-ray, ultrasound) shall be cleaned after each portable examination. ~~The date, time and technologist initials shall be entered into the specific machine's cleaning log book.~~
- All C-Arm units shall be cleaned before and after every surgical case. ~~The date, time and technologist initials shall be entered into the specific machine's cleaning logbook.~~
- Lead aprons and shields shall be cleaned after each patient use or once a week ~~using the~~when not in routine use with manufacturer's recommended hydrogen peroxide-based cleaning wipes. ~~If a lead apron~~

~~is soiled during a procedure, the apron shall be immediately cleaned after the exam using the manufacturer's recommended wipes.~~

## CT:

- CT gantries shall be cleaned after each exam.
- CT tables shall be cleaned after each exam.
- Linen shall be replaced after each exam performed in CT.
- The CT power injector shall be cleaned after each use. If contrast material is spilled, the contrast shall be cleaned up as soon as possible to avoid damage to the power injectors.

## MRI:

- The MRI gantry shall be cleaned after each exam.
- The MRI tables shall be cleaned after each patient exam.
- Linens shall be replaced after each patient exam.
- The MRI power injector shall be cleaned after each use. If contrast material is spilled, the contrast shall be cleaned up as soon as possible to avoid damage to the power injectors.

## Ultrasound:

- Linens shall be replaced after each ultrasound exam.
- Ultrasound exam tables shall be cleaned with a hospital-approved cleaning agent after any biopsy, needle-guided procedure or when blood and/or body fluids have spilled on the table.
- Ultrasound machines shall be cleaned after every exam with a hospital-approved disinfectant. The date, time and initials of the technologist who has performed the cleaning shall be entered into the unit's cleaning log book. Each ultrasound machine has their own log book.

### Endovaginal Probe Cleaning *(Per transducer manufacturer's instructions)*

TROPHON EPR is the hospital-approved cleaning system used for vaginal probes at Ventura County Medical Center and Santa Paula Hospital. Cleaning logs, chemical Indicator stickers, and Sonex HL Cartridges will be kept per manufacturer's directions.

- ~~Remove transducer cover/condom and wipe ultrasound gel from endovaginal transducer surface with a clean soft paper towel.~~
- ~~Spray Transeptic Cleaner or use a germicidal disposable wipe directly on the endovaginal transducer, wetting the entire surface. Wipe dry with a clean soft paper towel. Make sure probe is dry and clean of any moisture.~~
- ~~Place transducer into the TROPHON EPR disinfection chamber.~~
- ~~Follow manufacturer's directions on cleaning process.~~
- ~~Follow step by step directions on LCD display on door of Trophon unit.~~
- ~~At the end of the seven (7) minute cycle, the LCD screen states: CYCLE COMPLETE REMOVE AND WIPE PROBE.~~
- ~~Don new gloves and open chamber door.~~
- ~~Remove probe from the TROPHON chamber. Wipe probe dry using a single use towel.~~
- ~~Close TROPHON chamber door. Probe is now ready for use.~~
- ~~Place EV probe into clean probe container.~~

- The tech will don proper PPE at all critical points throughout the process
- Used probes are covered and labeled as biohazard during transport to the Trophon room

- The tech will utilize a Trophon companion cleaning wipe on the probe and cord so that it is free from visible debris, bioburden, or gel prior to placing it into the Trophon unit
- The tech will dry the probe by using a lint free drying wipe to ensure the probe is completely dry
- The tech will load the clean, dry probe into the Trophon unit ensuring it does not touch the sides of the chamber
- The tech will place a new chemical indicator (CI) into the indicator holder with the red side facing up
- The tech will close the chamber door and confirm the probe is clean and dry
- The tech will ensure that the log contains the start time, patient sticker, and that the lot # and exp date on the sheet match the CI box and Sonex HL bottle information
- If any information changes based on using a new box of CI's or if a new Sonex HL bottle is loaded, the tech will start a new log sheet
- Upon completion of high level disinfection (HLD) cycle, the tech will open the chamber door, remove and check the CI against the carton, and ensure the LCD screen indicates a successful cycle. If either indicates a fail, the tech will repeat the cycle
- The tech will remove the probe and use a lint free drying wipe to wipe the probe before placing the probe into a clean pouch for storage
- The Trophon unit will print two stickers, the tech will place one in the logbook, and the other on the clean pouch containing the probe
- As part of the Trophon HLD process the tech will visually reference the temp meter placed in the room to ensure manufacturer recommendations for storage are met. If a reading is out of range the tech will notify their supervisor immediately
- Chemical Indicator range: 59F - 86F
- Sonex HL range: 14F - 77F
- Probe cover range: 41F – 122F
- Regular cleaning will occur no less than weekly on all accessible surfaces of the Trophon unit. Utilize a grey (3 min dwell), red (3 min dwell), or purple (2 min dwell) top Sani Cloth prior to using a lint free wipe (after the appropriate dwell time has been followed).
- ■All staff may utilize the OneSource electronic directory (located on the desktop) to reference materials related to Trophon

## Nuclear Medicine:

- Nuclear Medicine tables shall be cleaned with a hospital-approved cleaning agent after each patient exam.
- Linen shall be replaced after each exam.
- All gamma cameras shall be dusted on a daily basis.
- The hot lab shall be cleaned on a daily basis.

## Cardiology:

- The pink exam chair in the cardiology treadmill room shall be cleaned with a hospital-approved cleaning agent after each patient exam.
- The EKG machines shall be wiped down and cleaned after each EKG exam.
- All holter monitors and electronic leads shall be cleaned when they are returned to the department.
- EEG machines shall be cleaned after each portable exam.
- EEG leads shall be cleaned after each exam.

## Echocardiology:

- The echocardiology machines shall be cleaned with a hospital-approved cleaning agent after each portable exam. The date, time and initials of the technologist cleaning the unit shall be entered into the machines cleaning logbook.
- The echocardiology exam table shall be cleaned with a hospital -pproved cleaning agent after each patient exam.
- Linen will be replaced after each exam.
- The echocardiology probes shall be cleaned after each exam with the manufacturer's recommended cleaning agent.
- The echocardiology technologist shall wash their hands before and after each echocardiology procedure. The echocardiology technologist shall be aware of patient precautions before starting any exam. The technologist shall use the appropriate PPE when performing a portable exam.

~~Hospital-approved cleaning agents are:~~

## Hospital-approved cleaning agents are:

1. Clorox Bleach Germicidal Wipes (blue top)
2. PDI Super Sani-Cloths (purple top)
3. PDI Sani Cloths (grey top)
4. Clorox Healthcare Hydrogen peroxide Wipes (green top)

All revision dates: 1/25/2023, 8/10/2021, 1/5/2016

## 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 | 1/31/2023 |
| Imaging Services | Michael Hepfer: Medical Director, Imaging Services | 1/25/2023 |
| Imaging Services | Matt McGill: Director, Imaging Services | 1/25/2023 |

VENTURA COUNTY
HEALTH CARE AGENCY

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| **Next Review:** | *3 years after approval* |
| **Owner:** | *Mary Jane Green: HIM Manager* |
| **Policy Area:** | *Health Information Management* |
| **References:** | |

# HIM.01 Use of the Copy and Paste Function in the Electronic Health Record

## POLICY:

The purpose of this policy is to provide guidelines for the use of Copy and Paste function within the electronic health records used in the Agency. As recommended by the American Health Information Management Association, the use of copy/paste functionality in Electronic Health Records (EHRs) should be only permitted in the presence of strong technical and administrative controls which include organizational policies and procedures, requirements for participation in user training and ongoing education, and continuous monitoring. When used appropriately, copy/paste functionality can be a valuable, time-saving tool. However, it is up to the user to weigh the efficiency and time-savings benefit of copy/paste functionality against the potential for creating inaccurate, fraudulent, or unwieldy documentation. This also includes the use of pre-documented or saved "auto-text" information in the electronic health record.

Copied and pasted notes may interfere with or compromise communication among care team member. There may be implications for the quality and safety of patient care and/or medical errors resulting from inaccurate or outdated clinical information. The medico-legal integrity of the health record may be jeopardized due to inconsistency of information, lack of actual current details, or excess of information causing other clinicians to miss information vital to the care of the patient. Copy/pasted information may facilitate or appear to facilitate attempts to create fraudulent healthcare claims. "Tag" functionality exists, which places footnote notation at the end of the document when providers copy information from source text and paste into new documentation.

## PROCEDURE:

Medical ~~Providers~~Physicians using any electronic method of documentation in the patient record shall exercise their best judgment and discretion when using copy/paste functionality to prevent the following issues:

1. Inaccurate or outdated information
2. Redundant information leading to difficulty in distinguishing current information in the record
3. Inability to identify the author or intent of the documentation
4. Inability to identify when a document was first created
5. Propagation of false information

6. Internally inconsistent progress notes (e.g. subjective does not agree with objective or vice versa)
7. Unnecessarily lengthy progress notes

Medical ~~Providers~~Physicians SHALL:

1. Make every effort to review all information in the medical record BEFORE attempting to SIGN AND SAVE the document.
2. Review the created document for any inconsistencies (e.g. outdated information, elements of history or physical that did not happen or that the clinician did not perform, superfluous information not relevant to the "care at the time" of the patient).
3. Verify the source and destination of any information prior to use of the copy/paste function.
4. Edit any copied information to include only data relevant to the care of the patient at the time of the document creation.
5. Edit information to include only elements of the history, physical, or plan that were performed or discussed with the patient, prior to submission of billing to prevent the appearance of fraudulent healthcare claim submission.
6. Stay current with any changes to EHR documentation functionality through continuous and ongoing education.
7. Use "Tag" functionality within the EHR to notate the original source of copied information.

## Source :

American Health Information Management Association. (2014, March 17). Appropriate Use of the Copy and Paste Functionality in Electronic Health Records. Retrieved from AHIMA: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050621.pdf

All revision dates: 1/11/2023, 2/12/2019, 5/1/2015

## Attachments

No Attachments

## Approval Signatures

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|---|---|---|
| Medical Executive Committee | Tracy Chapman: VCMC - Med Staff | pending |
| Health Information Management Committee | Mary Jane Green: HIM Manager | 1/11/2023 |
| Health Information Management | Mary Jane Green: HIM Manager | 1/11/2023 |

VENTURA COUNTY
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| **Owner:** | *Mary Jane Green: HIM Manager* |
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| **References:** | |

# HIM.02 Health Information Management Coder Continuing Education

# POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital to ensure that all staff involved in the performance of coding or auditing of coding processes are aware of the coding requirements and changes which may impact complete, accurate and consistent coding. The coding staff will also be provided with adequate coding training and/or the access to attend coding seminars in order to maintain and continually enhance their coding skills.

# PROCEDURE:

## ~~THE QUERY PROCESS~~

1. All coding staff must receive regular training to maintain and develop their coding skills, regardless of experience and length of service.
2. Each person involved in the performance of coding or auditing of coding processes must complete all of the following continuing education units (CEU)

   ~~During the term of the IA, a minimum of ten (10) hours of compliance continuing education per year comprised of two (2) hours of general compliance training, four (4) hours of reimbursement training, and four (4) hours of provider training.~~

   a. If a coder has a professional certification from the American Health Information Management (AHIMA) or American Academy of Professional Coders (AAPC), it is the responsibility of the coder to maintain the CEU requirements for his or her certification. CDI Specialists are required to have a RN license and are responsible for maintaining their CEU requirements for their license.

   b. All mandated Department-specific training on billing and coding, including annual review of Department Policies and Procedures and reading of internal and external updates, bulletins and other publications on coding as designated by the Department Manager or Unit Supervisor.
3. Each coder's direct supervisor will maintain an education file for each coder
   a. The education file must be reviewed semi-annually by the coder's direct supervisor to evaluate individual coder education needs.
   b. The education file must minimally contain:

1. copies of credential certification (where applicable)
2. copies of CEU forms
3. copies of attendance forms from exit conferences; and
4. Acknowledgement of annual review or re-review of all county polices and procedures.

# References:

AHIMA CEU Requirements
RHIA 30 hours per two-year cycle
RHIT 20 hours per two-year cycle
CCS 20 hours per two-year cycle
CCA 20 hours per two-year cycle
CCS-P 20 hours per two-year cycle
CPC 36 hours per two-year cycle
CPC-H 36 hours per two-year cycle
CPC-P 36 hours per two-year cycle

All revision dates: 1/11/2023, 1/1/2015, 4/1/2010, 5/25/2006

## Attachments

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| Medical Executive Committee | Tracy Chapman: VCMC - Med Staff | pending |
| Health Information Management Committee | Mary Jane Green: HIM Manager | 1/11/2023 |
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| **Owner:** | *Mary Jane Green: HIM Manager* |
| **Policy Area:** | *Health Information Management* |
| **References:** | |

# HIM.05 Purpose of the Health Information Management Department

# POLICY:

The purpose of the Health Information Management (HIM) Department is to provide a central location for medical record/health information that documents the course of the patient's illness and treatment during a particular episode as an inpatient or outpatient. An adequate record serves as a basis for planning patient care, evaluating care and providing a means of communication between the physician and other professional groups in contributing to the patient's care. A secondary purpose is to protect the legal interests of the ~~hospital and the physician~~hospitals and the physicians and to provide clinical data of interest to those who may wish to do research in a particular field.

The contents of the medical records shall be in accordance with The Joint Commission, Federal Regulations, California State Regulation, and Ventura County Medical Center Rules and Regulations.

# PROCEDURE:

## Responsibility:

1. A qualified individual who is a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT) shall be responsible for the supervision of the HIM Department.
2. The primary responsibility of the HIM Department is to ensure that an adequate medical record is maintained for every patient in our ~~hospital and in the campus~~hospitals and in the clinics.
    a. The patient's medical record shall include all significant clinical information pertaining to the patient, in order that the purpose stated above may be fulfilled.
    b. All entries in the record are to be dated and authenticated.
    c. Each medical record must contain sufficient information to identify the patient, to justify the diagnosis, to delineate the plan of treatment and to document the results accurately.
    d. The medical record must be appropriately documented to meet the standards of licensing and surveying agencies, as well as the hospital Bylaws and Rules and Regulations.
    e. The medical records of the ~~hospital~~hospitals are held confidential and information may be released only in accordance with the law.
    f. There are to be approved methods for processing, analyzing, indexing and filing of all records.

~~The filing system for paper records is in accordance with the California state regulations.~~

g. Diagnosis shall be recorded in the standard nomenclature of International Classification of Disease, Clinical Modification (ICD-~~9~~10-CM) and/or Current Procedural Terminology (CPT) and/or International Classification of Disease, Clinical Modification and Procedure Classification System (ICD-10-CM/PCS).

h. The HIM Department must maintain a close working relationship with the medical and hospital staff.

i. A continuing ongoing in-service program is to be conducted for HIM staff by the manager of the department. Other in-service programs inside and, when available, outside the hospital are made available to HIM staff. All in-services will be documented and all evaluations shall be dated and signed by the reviewer.

All revision dates: 1/11/2023, 4/1/2010, 7/5/2006, 5/31/2006, 4/29/2005, 12/26/2000, 9/13/2000

## Attachments

No Attachments

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|---|---|---|
| Medical Executive Committee | Tracy Chapman: VCMC - Med Staff | pending |
| Health Information Management Committee | Mary Jane Green: HIM Manager | 1/11/2023 |
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| **Owner:** | *Mary Jane Green: HIM Manager* |
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| **References:** | |

# HIM.06 Health Information Management Scope of Services

## POLICY:

The Health Information Management (HIM) Department is responsible for overseeing the timely processing, completeness and retrieval of all patient medical records.

The scope of services provided by the HIM Department is based upon collaboration and information-sharing to enhance patient care. HIM services are provided to all areas of the hospital~~, satellite and campus~~ and clinics as appropriate to need and security levels.

## PROCEDURE:

1. HIM services include provision of an accurate patient record, with emphasis on the following:
    a. Record processing
    b. Record abstracting, analysis and coding
    c. Physician incomplete and delinquent records management and suspension
    d. Correspondence/Release of information in accordance with laws and regulations
    e. Record retrieval, filing and storage
    f. Death certificate function

    ~~Core Measure quality abstracting and data reporting~~
    g. OSHPD data reporting
2. The scope of services encompasses efforts made to provide:
    a. Timelier and easier access to complete information throughout the organization;
    b. Improved data accuracy;
    c. Demonstrated balance of proper levels of security versus ease of access;
    d. Use of aggregate data, available through computerized reporting in the HIM Department, to assist all healthcare ~~providers~~physicians with information that allows for identification of opportunities to improve performance;
    e. Accessibility of the medical record at all times to those authorized persons requesting their use for

patient care;;

f. HIM Hours of Operation is Monday thru Friday 8am to 4:30pm. Closed on the weekends and holidays.

All revision dates: 1/11/2023, 2/13/2019, 1/1/2015, 4/1/2010, 5/31/2006, 5/11/2004

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| Health Information Management Committee | Mary Jane Green: HIM Manager | 1/11/2023 |
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| **References:** | |

# HIM.07 Medical Records Access by Staff/ Physicians

# POLICY:

It is the policy of the Health Information Management (HIM) Department of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) that the medical records are maintained in such a way that they are readily accessible to all those who are authorized to review them, but are also secure from unauthorized persons.

Please refer to HIM policy, *Retrieval of Medical Records,* as well as Administrative policy 109.047, *Unauthorized Use, Access and Disclosure of Protected Health Information (PHI) Breach*.

# PROCEDURE:

1. The HIM Department is responsible for issuing the electronic and paper-based medical records to those authorized persons requesting the use of the medical record.
2. The HIM Department will make records available to staff to review for treatment, payment, and healthcare operations (this includes administrative, medical, legal, and financial purposes) upon request of the appropriate hospital staff.
3. Specific procedures for requesting paper records will be arranged for those individuals in the areas of Patient Affairs, Risk Management, the Center for Clinical Improvement, Financial Management, etc. at VCMC/SPH who routinely have a need to access paper patient records.
4. Paper records may be signed out for medical staff reviews, billing audits, trauma reviews, or to Hospital Administration in cases of legal action and returned within a 24 hour time frame. See HIM policy, *Retrieval of Medical Records*.
5. Any physician, nurse, or other caregiver who is on the staff of VCMC/SPH or one of the ~~satellite~~ clinics may have access to any previous paper record of a patient ~~he or she~~his or her is caring for, other than his own or his family member's record. Requests for Protected Health Information (PHI) for treatment purposes are not subject to the HIPAA "Minimum Necessary Rule." Request for payment and hospital operations shall be subject to the Minimum Necessary Rule. Please refer to Administrative policy 109.0407, *Unauthorized Use, Access and Disclosure of Protected health Information (PHI) Breach*.

## TELEPHONE RELEASE

1. DO NOT RELEASE any information over the phone to a patient or patient's representative.
2. Any release of patient information over the phone will be for continuity of care purposes only and will only be released to an internal requestor. The internal requestor must ask for information by patient name, date of birth, social security number etc.
3. INTERNAL REQUESTORS
    a. County Coroner's office, state or county health departments, VCMC/SPH ~~satellite~~ clinics and VCMC/SPH staff and departments with authorized access.
    b. If you are unable to verify the identity of the internal requestor, ask them to fax over an authorization and/or fax cover sheet to verify identity.
    c. Physician Office requests for patient information will be handled via fax.

## AUDITS EVALUATIONS AND INSPECTION

1. Regardless of whether the request is an audit, evaluation, inspection, or any examination of patient records which is carried out for the purpose of or as an aid to ascertaining the accuracy or adequacy of a program's financial, administrative or medical management or adherence to financial, legal, medical, administrative or other standards must meet certain requirements.
2. Access will be allowed as prescribed by law.
3. An HIM designee will be present at all times during the inspection of the medical record to ensure that the record is not tampered with.
4. If the healthcare professional needs to correct documentation within the medical record, a late entry will be documented in the record along with the date, time, and initials of the person making the late entry.

All revision dates: 1/11/2023, 1/2/2015, 4/1/2010, 5/26/2006, 2/1/2006, 9/15/2001

## Attachments

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| Health Information Management Committee | Mary Jane Green: HIM Manager | 1/11/2023 |
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| **Owner:** | *Kristina Swaim: Clinical Nurse Manager, OB* |
| **Policy Area:** | *Maternal Child Health* |
| **References:** | |

# MCH.25 Care of the Infant with Hyperbilirubinemia

# POLICY:

To describe Neonatal Intensive Care Unit (NICU), Obstetrics (OB) and Pediatrics (PEDS) nursing responsibilities for the care of the newborn with hyperbilirubinemia at Ventura County Medical Center (VCMC).

# PROCEDURE:

The nurse will evaluate and identify those newborns/neonates at high risk for hyperbilirubinemia and acute bilirubin encephalopathy.

Patients with hyperbilirubinemia may be a "direct" admit to PEDS or NICU once initial communication has occurred between the Primary Care Provider and the Pediatric hospitalist or Neonatologist at Ventura County Medical Center.

The nurse will document findings on the shift assessment and/or patient care flow sheet and report any abnormal findings to the Neonatal Nurse Practitioner (NNP)/physician.

A NNP/physician order is required to obtain serum bilirubin level, initiate phototherapy, and for exchange transfusion. Parental consent is required for exchange transfusion.

## Risk Factors for Hyperbilirubinemia

A. Jaundice* observed in the first 24 hours.

B. Previous jaundiced sibling who received phototherapy.

C. Gestation <37 weeks.

D. Exclusive breastfeeding with excessive weight loss.

E. Mediterranean or Asian descent.

F. Significant bruising and/or cephalohematoma

G. Maternal/fetal blood incompatibility

* Jaundice is a yellowing of the skin and subcutaneous tissue that progresses in a cephalocaudal direction (from head to the trunk).

# GUIDELINES:

A. Assess the infant every four (4) hours for the following:
   1. Color of skin, sclera, or mucosa for degree of jaundice
   2. Weigh diapers and check for urine color/concentration
   3. Feeding pattern/volume
   4. Apnea
   5. Temperature instability
   6. Muscle tone
   7. Amount, color, and consistency of stool

B. Assessment for signs and symptoms of Acute Bilirubin encephalopathy
   1. Vomiting
   2. Lethargy
   3. High-pitched cry
   4. Hypotonia/hypertonia
   5. Opisthotonos
   6. Apnea
   7. Seizures
   8. Deafness

C. Measure TCB every 12 hours in infants greater than 35 weeks gestation for jaundice by using the Transcutaneous Bili Meter (TCB) (JM-103 or JM-105). This is to be done at 0800 and 2000 in the couplet care units.

D. Validate cord blood work up for type/RH if mother's blood type is 0, RH negative, or unknown.

E. **Cord Bilirubin Management**
   1. <1.5 mg/dL= Check serum bilirubin at twelve (12) hours of life notify primary physician
   2. 1.5-2.4 mg/dL=Check serum bilirubin at eight (8) hours of life notify primary physician
   3. 2.5-3.4 mg/dL=Check serum bilirubin at six (6) hours of life notify primary physician
   4. >3.5 mg/dL=Check serum bilirubin immediately, notify primary physician and consult with NICU NNP

F. Draw blood sample for serum bilirubin as ordered by physician/NNP.

G. Managing Bilirubin on the Bhutani Curve (nomogram)
   1. Each TCB measurment is to be plotted on the nomogram according to the age of the infant (in hours)
   2. If at any time the TCB measurement falls into the high intermediate or high risk zone, consult with physician to have a total bilirubin level drawn.
   3. Plot the serum total bilirubin level on the nomogram according to the age of the infant (in hours).
   4. ***When the risk level falls in the high intermediate or high-risk zone. Serum total bilirubin levels plotted in the high-risk zone are considered a "critical value".***

H. If serum total bilirubin risk level is in the high intermediate zone, consider an order for phototherapy and/or neonatal consult for potential NICU transfer.

I. Collaborate with physician regarding:

1. Increasing frequency and/or amount of feeding
2. Request Lactation Consultation
3. Breast feeding with supplementation as needed

J. Report to physician/NNP when jaundice is noted, especially in conjunction with:

1. Dark colored, concentrated urine
2. Poor oral feedings
3. Lethargy, hypotonia
4. Delay in meconium passage or infrequent stools
5. Positive Coombs' tests on cord blood (with or without a blood total bilirubin)
6. Elevated and/or rising Total Serum Bilirubin results

# Use of the transcutaneous bilimeter (JM-105 Jaundice Meter)

A. Indications for Use

1. Jaundice meter is to be used on infants >35 weeks gestation pre-phototherapy.
2. Jaundice meter is **not** to be used on infants for whom phototherapy treatments have been initiated or that have undergone an exchange transfusion.

**Note**
The JM-103 and the JM-105 are intended to be a "sequential use" screening device seeking to offer measurement of TCB changes occurring to the infant as hyperbilirubinemia progresses. Documentation of these consecutive readings provides a trend of what is happening with the infant.

B. Procedure

1. See manufacturer's instructions on the use and calibration checker of the transcutaneous bilimeter.

C. Set-Up

1. The JM-105 allows the Clinician to perform either a single measurement or to take an average reading from 1-5 samples (meter is set for 3 consecutive readings).
2. For a single measurement, no setup is required and upon power up the screen will read N-1. VCMC/SPH will do a measurement every 12 hours.

D. Operation

1. A TCB measurement will be done at 0800 and 2000 on all newborns over the age of 12 hours.
2. The sternum is the preferred site used for obtaining all measurements.

**Note**

The JM -105 measurement displayed is a "calculated" bilirubin concentration. It may be different from a total

serum lab analysis (TSB). Statistical data has shown that the JM-105 is usually within ± 1 standard deviation (1.5 mg/dl) and 80-90% of the time within 2 standard deviations of the TSB value.

E. Cleaning

1. Between each infant, wipe down the measuring probe with Sani-wipes.
2. The calibration checker should also be cleaned with Sani-wipes.

# PHOTOTHERAPY:

A. Collaborate with physician/NNP regarding the need for phototherapy if Total Bili is >6 mg/dL in the first 12-24 hours or > 12-15 mg/dL any time after 24-48 hours. Physician/NNP order required for phototherapy.

B. Four types of phototherapy are currently available: overhead bank lights, the spotlight, the bili-blanket and the bili-bed. The type of light to be chosen is dependent on the needs of the infant and the availability of the unit. The nurse may consult with the physician/NNP or use the following general guidelines to determine the type of light:

1. **Bili-bed** to be used only in an open crib with infants over 1800 grams. May be used in mother's room. Eye protection is provided via special bunting.
2. **Bili-blanket** may be used in any type bed. Often chosen as the second light when increased phototherapy intensity is needed. May be used in mother's room. Must be used with eye protectors unless swaddled within infant's blankets.
3. **Spotlight** (portable or attached to radiant warmer) used with isolette or warmer isolation or in combination with other modalities of phototherapy. Must be used with eye protection.
4. **Overhead bank bili-lights** may be used in any bed. If used in open crib, infant must weigh over 3 kgs and be able to maintain stable temperature. Must be used with eye protection. Position lights 12-18 inches above infant. Use all lights as outlined in the manufacturer's equipment manual.

C. Prepare infant as follows:

1. **Undress** and position infant with maximum light exposure to trunk. Diapers/bikini (paper masks with nose guards removed) are optional but should be removed if serum bilirubin near exchange level. Place diaper or chux under buttocks.
2. **Cover** eyes with bili mask/shield; close eyelids prior to applying mask and ensure proper fit to prevent occlusion of nares.
3. **Place** in isolette or open crib under bili light.
4. **Validate** that at least 12-18 inches is between infant and either bank light or spotlight. Ensure that all phototherapy lights are present and working.
5. If using an incubator, there should be a minimum space of 2 inches between the incubator and the lamp to minimize overheating of the incubator.
6. **Apply** skin temperature probe to infant as needed to regulate isolette temperature while under phototherapy.

D. **Assess** axillary temperature every 2–3 hours.

E. **Assess** the following every 3-4 hours while phototherapy is in progress:

1. Pulse, respiration

2. Input/output
3. Stool color/consistency
4. Skin/pressure points for presence of rash, lesions, or redness
5. Eye irritation, inflammation, discharge, excessive pressure on lids, or corneal irritation.

F. **Assess** bili light irradiance intensity every shift as follows:
   1. Intensive phototherapy should have irradiance ≥ 30 μw/cm² per nm (per AAP guidelines)

G. **Monitor** serum Total Bilirubin as ordered by physician/NNP. Turn bili lights off when obtaining blood specimen.

H. **Collaborate** with the physician/NNP regarding lab results and continued phototherapy.

I. **Turn** and **reposition** every 2-3 hours.

J. **Change** linen promptly if soiled.

K. **Wash** peri-anal area as needed and **pat dry** to prevent skin irritation. **Do not use** oils or creams on the infant's skin while under phototherapy lights.

L. **Rinse** eyes as needed every 8 hours with normal saline soaked cotton balls.

M. **Remove** infant from phototherapy for feedings, unless otherwise indicated by physician. Turn off phototherapy lights and **remove** eye patches for 20 minutes.

N. **Maintain** infant's skin/axillary temperature between 96.8° F and 98.6° F.

O. **Explain** procedure and equipment to parents. Assist parents to **identify** and express concerns and questions about hyperbilirubinemia and phototherapy.

P. **Encourage** parents to visit and care for infant as much as possible, including:
   A. Feeding the infant
   B. Holding, touching and cuddling the infant
   C. Diapering, bathing and applying eye protection.

Q. **Report** the following promptly to the physician/NNP:
   1. Total bilirubin level results
   2. Poor feeding, vomiting/regurgitation
   3. Excessively loose stools or absence of bowel movements
   4. Eye irritation/inflammation (redness, swelling, discharge)
   5. Signs of dehydration (poor skin turgor, depressed fontanels, dark concentrated urine)
   6. Lethargy, irritability, or high pitched cry

# EXCHANGE TRANSFUSION:

Exchange transfusion is indicated when bilirubin levels are approaching levels commonly associated with Bilirubin encephalopathy despite phototherapy or when there is evidence of Hemolytic Disease of the Newborn (HDN). Coordinate with NNP/physician and blood bank for exchange transfusion. Red cells and plasm are combined to make "reconstituted whole blood." Blood products for neonates are O packed red blood cells that is CMV negative and irradiated and AB plasma without any requirements. These blood types avoid any additional hemolysis.

The following criteria are used to help determine the need and timing of exchange transfusion:

A. Cord blood indirect bilirubin level > 4mg/dL
B. Hgb < 8 g/dL and bilirubin > 6 mg/dL within one hour of delivery of a term infant
C. Hgb < 11.5g/dL and bilirubin > 3.5 mg/dL within one hour of delivery of a preterm infant
D. Increase of bilirubin levels by 0.5 mg/dL per hour despite phototherapy
E. Bilirubin levels > 20 mg/dL by 24-48 hours of age in a term infant and 17-18 mg/dL in a compromised or high risk preterm infant.

## PRE-TRANSFUSION PREPARATION/ASSESSMENT:

A. **Coordinate with** NNP/physician and blood bank with total volume of ~~reconstitued~~reconstituted product and hematocrit
    1. Verify NNP/physician order for the exchange transfusion
    2. Obtain blood bank and other lab samples as ordered
    3. Specific blood product desired (i.e., PRBC, FFP).
    4. Single exchange volume calculated as follows: 70-90 mL/kg for term infants and 85-110 mL/kg for preterm infants
    5. Verify parental consent for procedure and transfusion
    6. Verify that the "A patients guide to blood transfusions"(Paul Gann) brochure, has been received by family. Answer any questions.
    7. Notify blood bank technician of the procedure being done. Communicate with the technician that the series of labs that will be sent, need to be resulted in the EMR, at the time that is printed on the lab tube.
    8. Perform Time-Out procedure.
    9. Request physician to order Calcium Gluconate 10% to be prepared, and available at bedside.
B. **Prepare the infant**
    1. Ensure infant is NPO 4 hours before exchange, during exchange and for 4 hours after exchange.
        a. If the infant has been fed in the last 2 hours (review with provider) insert a nasogastric tube to empty stomach.
    2. Place the infant on a cardiorespiratory monitor and a pulse oximeter with the alarms set appropriately.
    3. Restrain the infant for the procedure with four limb restraints, as needed Attempt to maintain a position of physiological flexion, if possible.
C. Gather equipment:
    1. Exchange Transfusion Tray
    2. Umbilical Catheterization Tray
    3. Umbilical Catheters (per NNP/~~MD~~Physician's request)
    4. Blood Warmer and blood warming coil

5. Sterile gown, gloves, cap and mask
6. Four limb restraints
7. Additional syringes (for Lab work or ABG's)
8. ~~Exhange~~Exchange transfusion log

D. **Prepare for Emergency**

1. Validate that the resuscitation equipment is at the bedside and function properly including bag/mask, suction equipment, and an oxygen source.
2. Have ~~resuscitaion~~resuscitation fluids as ordered by ~~practioner~~practitioner available (for example Albumin 5% ~~Albumin~~ and Normal Saline 0.9%).
3. Have prepared syringes or 2 vials of Calcium Gluconate 10% at bedside. Dilute Calcium Gluconate 10% to 50mg/ml.

E. **Double check** the blood product with another RN or physician as outlined in the Blood transfusions and Blood Bank regulations Administrative policy.

1. Utilize the blood warmer per the equipment product manual. Attach blood to blood filter and warming ~~coil and~~cassette, hang from blood warmer. ~~Set warmer to 36.5° C.~~ Ensure discard tubing is secured in discard bag.

## DURING THE EXCHANGE TRANSFUSION:

A. **Monitor** the infant's vital signs as follows:

1. Prior to transfusion
2. Every 5-10 minutes or as designated on the Exchange Transfusion Log Sheet or ordered by the NNP/physician
3. Notify the NNP/physician immediately if signs and symptoms of hypocalcemia are present such as: change in the QT interval, ~~agitaion~~agitation, tachycardia, or muscle twitching.

B. **Gently agitate** the blood bag every 15 minutes to prevent red blood cell sedimentation.

C. **Record** the blood volume in and out, the vital signs, the $SpO_2$ , and any ~~Lab~~lab work done on the Exchange Transfusion Log during procedure.

1. The blood ~~volue~~volume infused and phlebotomized
2. The vital signs and Sp02
3. Lab work sent
4. Lab results
5. Medications given

D. **Collaborate** with the NNP/physician every 30 minutes during the exchange regarding the need for blood glucose, electrolytes or ABG sampling.

E. ~~**Notify** the NNP/physician immediately if signs and symptoms of hypocalcemia are present such as: change in the QT interval, agitation, tachycardia, or muscle twitching.~~Provide pacifier and oral sucrose for comfort and pain management.

## EMERGENCY MANAGEMENT:

A. **Administer** Calcium Gluconate 10% 100 mg/kg diluted to 50mg/ml, slow IVP as ordered for hypocalcemia while monitoring the infant's heart rate and ECG.

B. In the event of respiratory arrest or severe bradycardia, implement neonatal resuscitation measures as outlined by the AHA/AAP.

## POST-TRANSFUSION:

A. Maintain the infant NPO for 4 hours minimum and as ordered by practioner

B. Remove restraints, reposition and comfort infant.

C. **Monitor** the vital signs, $SpO_2$ , ECG, blood glucose, and urine output every hour for a minimum of four hours post Exchange Transfusion.

D. **Monitor** the blood gases, Hgb, Total and Direct Bilirubin as ordered ~~bthe~~by the NNP/physician.

E. **Document** all patient changes/status, vital signs, oxygen saturation, blood glucose, and urine output pre and post transfusion in the EMR, and on the ~~NICU flow~~Exchange Transfusion Log sheet ~~and~~ during the ~~transfusion on the Exchange Transfusion Log sheet~~procedure as mentioned above.

F. **Document** all response to care delivered as mentioned previously.

G. **Place** discard blood bag in a red biohazard bag and discard in appropriate waste receptacle. ~~Return the Transfusion Form to Blood Bank with signatures..~~

H. **Complete** Crossmatch Tranfusion Tag form, and make a copy. Return original form to the Blood Bank with signatures.

# Documentation

A. Record all assessment data

B. Record all implementation of phototherapy

C. Record evaluation of effectiveness of care in relation to

1. Stability/instability of infant undergoing phototherapy (thermoregulation, GI function etc.)
2. Improvement/worsening of hyperbilirubinemia
3. Presence/absence of complications from condition or treatments
4. If exchange transfusion was done document all the above mentioned in post transfusion, as well as Time-Out, and CLIP form if applicable, total intake and output of blood in EMR and procedure note.
5. Maternal/family coping of mechanisms/participation in care, education/understanding of therapy.

# REFERENCES:

Atlas of Procedures in Neonatology, 6th Ed., MacDonald and Ramasethu, 2019.
Handbook of Neonatal Intensive Care, 9th Ed., Merenstein and Gardner, 2017.
Essentials of Pediatric Nursing, 10th Ed., Whaley and Wong, CR 2017.
American Academy of Pediatrics ***Management of hyperbilirubinemia in the newborn 35 or more weeks of gestation, 2004;114;297.***

All revision dates: 11/18/2022, 8/11/2020, 6/1/2011, 3/1/2010, 1/1/

| | |
|---|---|
| | 2008, 4/1/2007, 12/1/2003, 3/1/2003, 1/1/2002, 11/1/2001 |

## Attachments

Attachment A: Bhutani Curve

## 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 | 11/18/2022 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 11/18/2022 |
| Policy Owner | Kristina Swaim: Clinical Nurse Manager, OB | 11/18/2022 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *9/1/2016* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *1/4/2023* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Kristina Swaim: Clinical Nurse Manager, OB* |
| **Policy Area:** | *OB Nursing* |
| **References:** | |

# OB.05 Management of Preeclampsia and Hypertension in Pregnancy Disorders

## POLICY:

~~To outline the nursing management of inpatients who have preeclampsia or hypertensive emergency, including special considerations for management of patients on magnesium sulfate, patients on antihypertensive medications and management of eclampsia.~~

## ~~PROCEDURE:~~

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) provides safe and effective management of patients with preeclampsia or hypertensive emergencies. The scope of this policy and procedure is to outline patient care and management with the following goals:

A. Early recognition of severe or worsening preeclampsia or development of eclampsia.

B. Prolongation of pregnancy to optimize fetal maturation must be weighed against risks of pregnancy continuation.

## BACKGROUND:

Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage, which may impact the cardiovascular, renal, hematological, neurologic, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology. Preeclampsia is characterized by new onset of hypertension and proteinuria after 20 weeks gestation in a previously normotensive woman.

~~A. **Blood Pressure:** Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks gestation in a woman with previously normal blood pressure.~~

- ~~Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within short interval(minutes) to facilitate timely antihypertensive treatment.~~

~~B. **Proteinuria:** Greater than or equal to 300 mg per 24 hour urine collection(or this amount extrapolated from a timed collection) **OR**~~

- ~~Protein/creatinine ratio greater than or equal to 0.3~~
- ~~Dipstick reading of 1+ (used only if other quantitative methods are not available)~~

**Diagnostic Criteria**

I. **Blood Pressure:** Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks gestation OR pregnant in the last 6 weeks in a woman with previously normal blood pressure.
   - Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within short interval (minutes) to facilitate timely antihypertensive treatment.

II. **Proteinuria:** Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection) **OR**
   - Protein/creatinine ratio greater than or equal to 0.3
   - Dipstick reading of 2+ (used only if other quantitative methods are not available.

~~OR in the absence of proteinuria, new-onset hypertension with the new onset of any of the following:~~**OR in the absence of proteinuria, new-onset hypertension with the new onset of any of the following:**

- ~~**Thrombocytopenia:**~~ Thrombocytopenia: Platelet count less than ~~1000~~100,000 platelets/microliter
- ~~**Renal insufficiency:**~~ Renal insufficiency: Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease
- ~~**Impaired liver function:**~~Impaired liver function: Elevated blood concentrations of liver transaminases to twice normal concentration
- ~~**Pulmonary edema**~~Pulmonary edema
  ~~**Cerebral or vision symptoms**~~
- Cerebral:New-onset headache unresponsive to medication and not accounted for by alternative diagnosis
- Visual Disturbances: Blurry vision, floaters

## ~~REPORTABLE CONDITIONS~~

~~Notify provider for:~~

~~A. Repeated blood pressure greater than 160 systolic OR greater than 105 diastolic (taken at least 15 minutes apart). If patient has two consecutive blood pressure readings of greater than or equal to 160/105 taken 15 minutes apart, the hypertensive emergency algorithm (Attachment A) should be followed. Treatment of patient should occur within 30-60 minutes of onset as ordered by physician. Primary nurse will submit Significant Event Debrief Form.~~

~~B. New or worsening complaint of any of the following:~~

~~1. Headache~~

~~2. Visual changes~~

~~3. Right Upper Quadrant (RUQ) or epigastric pain~~

~~C. Abnormal lab values~~

~~D. **Urine output less than 30 ml/hour**~~

## ~~ADMISSION~~

~~A. Assess for absence or presence of:~~

~~1. Headache~~

~~2. Visual changes~~

3. Right upper quadrant or epigastric pain
4. Nausea/vomiting
5. General malaise.

B. Assess upper or lower deep tendon reflexes.

C. Auscultate for lung sounds, noting any presence of rales, rhonchi, wheezing, etc.

D. Assess for generalized edema and significant, rapid weight gain.

E. Assess blood pressure using an appropriately sized blood pressure cuff with patient sitting or in the upright position with the patient's arm at the level of the heart. Do not reposition the patient to her left side and retake blood pressure. It will give a false lower reading.

F. Apply external fetal monitor (if viable fetus).

G. Prepare to obtain IV access as ordered by provider.

H. Prepare to administer medications to lower blood pressure and prevent seizure activity.

I. Prepare to monitor intake and output.

J. Maintain activity as ordered by provider. If on bedrest, maintain side-lying position as much as possible, avoiding supine position, and change position every two hours or more often as needed.

K. Provide emotional support and opportunity for patient family to verbalize questions, concerns and/or fears.

L. Assess maternal vital signs including: blood pressure as described above, respiratory rate, heart rate, temperature, and oxygen saturation.

M. Prepare to assess lab values as ordered.

N. Ensure oxygen and suction equipment are present and functioning.

O. Implement measures to decrease stress level, such as provision of a quiet environment and low lighting.

P. Monitor temperature per department protocol.

Q. Assess intake and output (I&O)

## ANTEPARTUM ONGOING ASSESSMENT

A. Goals of patient management are:

1. Early recognition of severe or worsening preeclampsia or development of eclampsia.
2. Prolongation of pregnancy to optimize fetal maturation must be weighed against risks of pregnancy continuation.

B. Preeclampsia without severe features (mild): **NOT on Magnesium Sulfate**

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 4 hours.
2. Assess lung sounds every **4** hours.
3. Assess urine output every **1** hour with totals every 8 and 24 hours.
4. Assess deep tendon reflexes (DTRs), Clonus, edema, level of consciousness (LOC), headache (HA), visual disturbances, epigastric pain every 8 hours.
5. Obtain Non Stress Test (NST) or monitor Fetal Heart Rate (FHR) with uterine activity for 30 minutes every shift or as condition warrants.

6. Assess fetal movement every shift.

Severe Preeclampsia:

Obtain blood pressure, pulse, respirations, and oxygen saturation every 5 minutes during loading dose and q30 minutes during maintenance of magnesium sulfate infusion.

May change to every 60 minutes if any one or more of the following criteria are met:

Preeclampsia without severe features (mild)

BP stable without increases for a minimum of 2 hours

No antihypertensives within last 6 hours

Antepartum patient

## INTRAPARTUM ONGOING ASSESSMENT

A. Preeclampsia without severe features (mild): **NOT on Magnesium Sulfate**

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes.
2. Assess lung sounds every 4 hours.
3. Assess urine output every **1** hour with totals every 8 and 24 hours
4. Assess deep tendon reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA), visual disturbances, epigastric pain every 8 hours.
5. Monitor FHR and uterine activity continuously.

B. Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 5 minutes during loading dose and q30 minutes during maintenance of magnesium sulfate infusion.
2. May change to every 60 minutes if any one or more of the following criteria are met:
   - Preeclampsia without severe features (mild)
   - BP stable without increases for a minimum of 2 hours
   - No antihypertensives within last 6 hours
   - Antepartum patient
   - Latent phase of labor
1. Assess lung sounds every 2 hours.
2. IV solutioins and medication drips should all be on a pump, with total hourly intake of less than or equal to 125 ml/hr.
3. Assess urine output every **1** hour, end of shift and 24 hour total.
4. Assess Deep Tendon Reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA), visual disturbances, epigastric pain every 4 hours.
5. Continous SaO2 during magnesium infusion
6. Patient should be NPO with ice chips or as permitted by practioner.
7. Monitor FHR and uterine activity continuously.

**Note:** If patient is taken for cesarean section magnesium sulfate should be continued at ordered rate. Do not discontinue while patient is in the OR.

## ~~POST PARTUM TO DISCHARGE ONGOING ASSESSMENT~~

A. ~~Preeclampsia without severe features (mild):~~

1. ~~Obtain blood pressure, pulse, respirations, and oxygen saturation every 4 hours.~~
2. ~~Assess lung sounds every 4 hours.~~
3. ~~Assess deep tendon reflexes (DTRs), Clonus, edema, level of consciousness (LOC), headache (HA), visual disturbances, epigastric pain every 8 hours.~~

~~Severe Preeclampsia:~~

1. ~~Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes for first 24 hours after delivery then every 4 hours. More frequent if needed.~~
2. ~~SaO2 checked each time with vital signs~~
3. ~~Assess lung sounds every 2 hours~~
4. ~~Assess urine output every 1 hour, end of shift and 24 hour total.~~
5. ~~Assess deep tendon reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA), visual disturbances, epigastric pain every 4 hours.~~

## ~~Post Eclamptic Seizure and Magnesium Sulfate Toxicity~~

A. ~~BP, Pulse Respiration q5 min until stable~~

B. ~~O2 Sat and LOC Every 15 min for a minium of 1 hour~~

C. ~~Continous Fetal Assessment and uterine activity~~

## ~~REFERENCES:~~


- ~~Sibai, BM. Diagnosis and management of gestational hypertension and preeclampsia. Obstet Gynecol. Jul 2003; 102 (1):181-192.~~
- ~~Turner J. Diagnosis and management of pre-eclmapsia: an update. International Journal of Women's Health. 2010;2:327-337.~~
- ~~The Joint Commission. Preventing Maternal Death. Sentinal Event Alert. Issue 44.2010.~~
- ~~Eggleston N, Trojano N, Harvey C, Chez B. Clinical Care guidelines. Philidelphia:Wolters Kluwer/ Lippincott Williams &Williams &Wilkins; 2013.~~
- ~~CMQCC Preeclampsia Care Guidelines; 2013~~


# PROCEDURE:

I. **Admission Nursing Assessment**

A. Assess for absence or presence of:

1. Headache (HA)
2. Visual changes
3. Right upper quadrant or epigastric pain
4. Nausea/vomiting
5. General malaise.

B. Assess upper or lower deep tendon reflexes (DTR).

C. Auscultate for lung sounds, noting any presence of rales, rhonchi, wheezing, etc.

D. Assess for generalized edema and significant, rapid weight gain.

E. Assess blood pressure (BP) using an appropriately sized blood pressure cuff with patient sitting or in the upright position with the patient's arm at the level of the heart. Do not reposition the patient to her left side and retake blood pressure. It will give a false lower reading.

F. Apply external fetal monitor (if viable fetus).

G. Prepare to obtain intravenous (IV) access as ordered by Licensed Independent Practitioner (LIP).

H. Prepare to administer medications to lower blood pressure and prevent seizure activity (See Attachment A).

I. Prepare to monitor intake and output (I&O).

J. Maintain activity as ordered by provider. If on bedrest, maintain side-lying position as much as possible, avoiding supine position, and change position every two hours or more often as needed.

K. Provide emotional support and opportunity for patient family to verbalize questions, concerns and/or fears.

L. Assess maternal vital signs including blood pressure, respiratory rate, heart rate, temperature, and oxygen saturation as ordered

M. Prepare to assess lab values as ordered.

N. Ensure oxygen and suction equipment are present and functioning.

O. Implement measures to decrease stress level, such as provision of a quiet environment and low lighting.

P. Monitor temperature per department protocol.

Q. Assess I&O.

II. **Reportable Conditions**

A. Nursing to notify LIP for the following:

1. Repeated blood pressure ≥ 160 systolic **OR** ≥110 diastolic (taken at least 15 minutes apart).
    i. If patient has two consecutive blood pressure readings of ≥ 160/110 taken 15 minutes apart, the hypertensive emergency algorithm (Attachment A) should be followed.
    ii. Treatment of patient should occur within 30-60 minutes of onset as ordered by LIP.
2. New or worsening complaint of any of the following:
    i. Headache, visual complaints
    ii. Altered mental status, seizure, cerebrovascular accident (CVA)
    iii. Shortness of Breath
    iv. Right Upper Quadrant (RUQ) or epigastric pain
3. Abnormal lab values
4. Urine output (UOP) less than 30 mL/hour

B. **If any of the above reportable conditions are present with no other etiology, preeclampsia with severe features is suspected and magnesium sulfate should be considered. See Section Magnesium Treatment**

III. **Antepartum Assessment**

A. Nursing should follow the following monitoring guidelines

| TABLE 1: ANTEPARTUM NURSING ASSESSMENT | |
|---|---|
| **Preeclampsia without severe features (mild) – not on magnesium sulfate** | |
| **Monitoring parameter** | **Monitoring Frequency** |
| BP, Pulse (HR), Respirations, O2 saturations | Every 4 hours or as needed |
| Lung sounds | Every 4 hours |
| UOP | Every 2 hours with totals every 8 and 24 hours |
| DTRs, clonus, edema, level of consciousness (LOC), HA, visual disturbances, and epigastric pain | Every 8 hours |
| Non-stress test or fetal heart rate (FHR) monitor with uterine activity for 30 minutes | Every shift or as condition warrants |
| Fetal movement | Every shift |
| **Severe Preeclampsia** | |
| **Monitoring parameter** | **Monitoring Frequency** |
| BP, HR, Respirations, O2 saturations | Every 2 hour or as ordered |
| UOP | Every 2 hours with totals every 8 and 24 hours |
| Non-stress test or FHR monitor with uterine activity for 30 minutes | Every shift or as condition warrants |
| DTRs, clonus, edema, LOC, HA, visual disturbances, and epigastric pain | Every 2 hours or as ordered |

IV. **Intrapartum Assessment**

A. Patient should be nothing by mouth (NPO) with ice chips or as permitted by LIP.

B. IV solutions and medication drips administered through an infusion pump should have a total hourly intake of less than or equal 125 mL/hr.

C. Nursing should follow the following monitoring guidelines

| TABLE 2: INTRAPARTUM NURSING ASSESSMENT | |
|---|---|
| **Preeclampsia without severe features (mild) – not on magnesium sulfate** | |
| **Monitoring parameter** | **Monitoring Frequency** |
| BP, HR, Respirations, O2 saturations | Every 60 minutes |
| Lung sounds | Every 4 hours |
| UOP | Every 2 hours with totals every 8 and 24 hours |
| DTR, clonus, edema, LOC, HA, visual disturbances, and epigastric pain | Every 2 hours |
| FHR and uterine activity | Continuously |
| **Severe Preeclampsia on magnesium sulfate** | |
| **Monitoring parameter** | **Monitoring Frequency** |
| BP, HR, Respirations, O2 saturations | - Every 5 minutes during magnesium loading dose and every 30 minutes during maintenance dose<br>- May change to every 60 minutes if any one or more of the following are met: Pre-eclampsia without severe features (mild), stable blood pressure without increases for a minimum of 2 hours, no antihypertensives within the last 6 hours, antepartum patient, latent phase of labor |
| Lung sounds | Every 2 hours |
| UOP | Every 2 hours with totals every 8 and 24 hours |
| DTR, clonus, edema, LOC, HA, visual disturbances, and epigastric pain | Every 4 hours |
| Sa02 | Continuous during magnesium infusion |
| FHR and uterine activity | Continuously |

## I. POST PARTUM TO DISCHARGE ASSESSMENT

A. Nursing should follow the following monitoring guidelines

| TABLE 3: POSTPARTUM NURSING ASSESSMENT | |
|---|---|
| **Preeclampsia without severe features (mild)** | |
| **Monitoring parameter** | **Monitoring Frequency** |
| Blood pressure, Pulse, Respirations, O2 saturations | Every 4 hours |
| Lung sounds | Every 4 hours |
| DTRs, clonus, edema, LOC, HA, visual disturbances, and epigastric pain | Every 8 hours |
| **Severe Preeclampsia** | |
| Blood pressure, pulse, respirations, O2 saturations | - Every 2 hours for first 24 hours after delivery, then<br>- Every 4 hours<br>- More frequent as needed |
| Sa02 | Each time with vital signs |
| Lung sounds | Every 2 hours |
| UOP | Every 2 hours with totals every 8 and 24 hours |
| DTRs, clonus, edema, LOC, HA, visual disturbances, and epigastric pain | Every 2 hours |

II. **Magnesium Treatment**

A. The LIP may initiate treatment with IV magnesium for seizure prophylaxis or seizure treatment by using the approved OB Pre-eclampsia PowerPlan.

B. Nursing Monitoring: See "Severe Preeclampsia on magnesium infusion" above for detailed monitoring guidance.

C. If patient is taken for cesarean section, magnesium sulfate should be continued at the ordered rate. Do not discontinue while patient is in the operating room (OR).

D. For recurrent seizures while the patient is on magnesium, it is important to secure the patient's airway. the LIP may initiate treatment with an alternative agent (See Attachment A).

E. Toxicity Monitoring and Treatment

1. Nursing to monitor for signs of magnesium toxicity which include the following: disappearance of deep tendon reflexes, decreased RR, shallow respirations, short of breath, heart block, chest pain, and pulmonary edema.

2. Calcium gluconate or calcium chloride should be readily available for treatment of toxicity

III. **Post Eclamptic Seizure and Magnesium Sulfate Toxicity**

A. Maintain airway and oxygenation.

B. Monitor vital signs, cardiac rhythm/EKG for signs of medication toxicity

C. Consider brain imaging for head trauma, focal neurological findings, other neurologic diagnosis

D. Continuous Fetal Assessment and uterine activity

E. Reassure patient and family with information, offer support

# REFERENCES:

1. Sibai, BM. Diagnosis and management of gestational hypertension and preeclampsia. Obstet Gynecol. Jul 2003; 102 (1):181-192.

2. Turner J. Diagnosis and management of pre-eclampsia: an update. International Journal of Women's Health. 2010;2:327-337.
3. The Joint Commission. Preventing Maternal Death. Sentinel Event Alert. Issue 44.2010.
4. ACOG Practice Bulletin 203, 2019
5. ACOG Practice Bulletin 222, 2020
6. Eggleston N, Trojano N, Harvey C, Chez B. Clinical Care guidelines. Philadelphia: Wolters Kluwer/ Lippincott Williams &Williams &Wilkins; 2013.
7. CMQCC Preeclampsia Care Guidelines; 2021

All revision dates: 1/4/2023, 9/17/2019, 9/1/2016

## Attachments

b64_96ab6b1c-4091-4f2d-b53d-4826f0b55c60
b64_a0ac8935-fefe-4980-b2d1-169c44b7b54d
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HDP_FINAL_Appendix_E_111621.pdf

## 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 | 11/22/2022 |
| 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:** | *9/1/2010* |
| **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.09 Code Maternity

# POLICY:

To provide a rapid, coordinated response to maternal hemorrhage in order to prevent cardiovascular collapse and arrest.

# PROCEDURE:

## STAGE-BASED APPROACH TO OBSTETRIC HEMORRHAGE

A. Stage 0: Focus is on risk management and active management of the third stage of labor.
   1. Assess every woman for risk factors for hemorrhage (Attachment ~~A~~B).
   2. Measured cumulative quantitative blood loss on every birth.
   3. Provide active management of Stage Three Labor, per physician's order ~~(Attachment A)~~.
   4. Blood product readiness:
      a. Perform type and screen on all laboring patients.
      b. Perform type and cross on all patients at high risk for hemorrhage (Attachment A&B).
      c. For patient with positive antibody screen and all high risk for hemorrhage, perform type and cross.
      d. OB hemorrhage cart will be made available in the Labor and Delivery and Post Partum units. (OB hemorrhage cart locked at all times, and checked daily)
      e. At VCMC OB hemorrhage cart is available in the main OR with ~~locked medication refrigerator (meds and temperature checked daily)~~medications available.

B. Stage 1: Blood loss greater than 500 mL at vaginal delivery **OR** greater than 1000 mL at cesarean delivery ~~**OR**~~ with continued bleeding **OR** signs of concealed hemorrhage.
   vital sign ~~changes~~abnormal **OR** trending (~~by >15% or~~ HR~~>~~ >110, BP < 85/45,02 sat <95%, shock index 0.9) **OR** Confusion.
   1. Activate OB Hemorrhage Emergency Management Plan (Attachment ~~A~~B).
   2. Establish IV access if not present, at least 18-gauge.
   3. Increase IV oxytocin rate to 500-1000 mL per hour of 30u/500 mL solution.

4. Fundal/bimanual massage.
5. Administer another uterotonic medication. If no response, consider second uterotonic (~~Attachment~~Attachmet B &C).
6. Empty Bladder with straight foley or place foley with urimeter if not already done.
7. Blood Product readiness:
    a. Convert to High Risk and take appropriate precautions
    b. Consider T&C 2 Units PRBCs where clinically appropriate if not already done

C. Stage 2: Continued bleeding despite stage 1 interventions and less than 1500 mL cumulative blood loss~~.~~ **OR** VS remain abnormal

An OB staff member will activate a "Code Maternity." A physician or OB staff member will call the paging operator and activate a "Code Maternity" including location (e.g., labor and delivery, operating room, postpartum room, etc.).

**At VCMC** the paging operator will call "Code Maternity" overhead and will page or call the following individuals:

- Obstetrician on call
- Nursing Supervisor
- Anesthesiologist on call
- Critical Care Unit resident
- Laboratory technician

**At Santa Paula Hospital** the Paging operator will call "Code Maternity" overhead and then page the Nursing Supervisor. The Paging operator will then page or call the following individuals to the Nursing Supervisor phone at 218-1712:

- SPH physician on call
- VCMC Obstetrician on call
- Anesthesiologist on call
- Hospitalist or ED physician
- Laboratory technician

1. The Obstetrician/physician will respond by coming directly to the location. If the Obstetrician on call cannot respond rapidly, the Charge Nurse or designee will begin calling Obstetricians on the emergency call back list.
2. The Nursing Supervisor will call the OR team.
3. The Anesthesiologist will come to the location. If unable to respond rapidly, the Charge Nurse or designee will call the second call Anesthesiologist.
4. Complete evaluation of vaginal wall, cervix, placenta, uterine cavity
5. AT VCMC: The Rapid Response Nurse and ICU charge nurse will respond to the location. Level One blood transfuser will be located in OB PACU for use.
   AT SPH: The ED charge nurse will respond to the location with Level One blood transfuser.
6. The Laboratory will respond immediately, delivering an iced cooler containing two (2) units of O Negative Blood, and (2) units of thawed AB plasma, within five (5) minutes. If the physician determines that the patient can wait for the completion of compatibility testing of type specific/type compatible red blood cells,

the blood will be returned to the Blood Bank.

7. At SPH the charge nurse will send an available staff member to lab immediately to retrieve and deliver an iced cooler containing two (2) units of O Negative Blood, within five (5) minutes. If the physician determines that the patient can wait for the completion of compatibility testing of type specific/type compatible red blood cells, the blood will be returned to the Blood Bank.
8. ~~STAT CBC/CMP/PT/PTT/fibrinogen plus or minus ABG will be drawn.~~Send Labs, including DIC panel. Plus or minus ABG will be drawn.
9. Consider additional uterotonics.
10. The decision to use tranexamic acid with the Code Maternity protocol shall be made within three (3) hours of incident. The loading dose is available in the OB Pyxis machine. The loading dose of 1 gram (100 mg/mL) of tranexamic acid is given intravenously at an approximate rate of 1 mL per minute. If bleeding continues after 30 minutes or stops and restarts within 24 hours of the first dose, a second dose of 1 g of tranexamic acid is again administered.
11. Establish second large bore IV at least 18-gauge, if not done in Stage 1.
12. Place intrauterine balloon.
13. At VCMC, if it is anticipated that greater than 4 units of blood will be required, the physician or Anesthesiologist may activate the Massive Transfusion Protocol.
14. At SPH, the Blood Bank will contact United Blood Services.
15. Move to Operating Room, if indicated.

D. Stage 3: Cumulative blood loss greater than 1500 mL, continued bleeding, greater than two (2) units given, vital signs unstable or suspicious for DIC:

a. ~~Activate Massive Transfusion Protocol (as above) at VCMC.~~Activate Massive Transfusion Protocol (as above) at VCMC. Refer to Policy ***T.02 Adult Mass Transfusion Protocol***
    1. Activate Massive Transfusion Protocol, transfuse aggressively.
    2. Near 1:1 PRBC, FFP
    3. 1 PLT apheresis pack per 4-6 units PRBC
b. At SPH, the Lab will contact United Blood Services.
c. Move to Operating Room.

All revision dates: 10/17/2022, 10/9/2019, 12/20/2017, 12/20/2017, 11/1/2016

## Attachments

Attachment A Obstetric Hemorrhage Care Guidelines Table Format.pdf
Attachment B Obstetric Hemorrhage Risk Factor Assessment Screen.pdf
Attachment C Medications for Postpartum Hemorrhage.pdf

## 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 | 11/22/2022 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 10/17/2022 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 10/3/2022 |
| Policy Owner | Kristina Swaim: Clinical Nurse Manager, OB | 10/3/2022 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
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| **Last Revised:** | *1/20/2023* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Kristina Swaim: Clinical Nurse Manager, OB* |
| **Policy Area:** | *OB Nursing* |
| **References:** | |

# OB.22 Newborn Physician Consultations

# POLICY:

To provide a physician coverage schedule for normal newborns who do not have an attending assigned while in couplet care.

# PROCEDURE:

A. Please call Pediatric services to notify them of birth of a new baby for their service.

B. Non-well baby evaluation/consultation: Please follow the chain of command (do not by-pass resident or attending in charge of the babies).

C. In emergency situation: Inform NICU team and the primary physicians in charge of the babies simultaneously.

D. If NICU team evaluation is needed for any newborn problem, call the Neonatal Nurse Practitioner (NNP).

E. For consultation with the Neonatologist, the resident or attending may contact the Neonatologist on service.

All revision dates: 1/20/2023, 7/1/2016, 7/1/2010, 7/1/2006

## 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 | 10/12/2022 |
| Policy Owner | Kristina Swaim: Clinical Nurse Manager, OB | 10/12/2022 |

# VENTURA COUNTY MEDICAL CENTER

**Physician Assistant Practice Agreement**
**(Business & Professions Code § 3502.3)**

This Practice Agreement has been developed by and through collaboration among physician(s) and physician assistant(s) affiliated with **Ventura County Health Care Agency**, an Organized Health Care System (as that term is defined in Business & Professions Code ("BPC") § 3501(j)), (the "Practice") for the purpose of defining the medical services that each physician assistant ("PA") whose signature appears below is authorized to perform at the Practice pursuant to BPC § 3502, and to grant approval for physicians on the Practice's medical staff to supervise the PA(s) whose signature(s) appear below.

1. **Medical Services Authorized:** Pursuant to BPC § 3502, the PA is authorized to perform those medical services for which the PA has demonstrated competency through education, training, or experience, under physician supervision as provided in Section 3 of this Practice Agreement. Subject to the foregoing, the PA is further authorized to: (a) perform the medical functions set forth in BPC § 3502.3(b); supervise medical assistants pursuant to BPC § 2069; (c) provide care and sign forms under the workers' compensation program pursuant to Labor Code § 3209.10; and (d) perform any other services or activities authorized under California law.

2. **Ordering and Furnishing of Drugs and Devices:** In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule III through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's education, training, experience, and competency, under physician supervision as provided in Section 3 of this Practice Agreement. The furnishing and ordering of Schedule II drugs shall be only based on a patient-specific order approved by the treating or supervising physician and shall be subject to the PA's completion of one-time course in compliance with sections 1399.610 and 1399.61 of Title 16 of the California Code of Regulations concerning Schedule II controlled substances. The PA may further dispense drugs and devices as provided for in BPC § 4170 and may request, sign, and receive drug samples as provided for in BPC § 4061.

3. **Physician Supervision:** Any physician and surgeon of the Practice who meets the definition of a supervising physician in BPC § 3501(e) may provide supervision of the PA acting under this Practice Agreement. A supervising physician need not be physically present while the PA provides medical services but must be available by telephone or other electronic means at the time the PA is providing medical services at the Practice. Supervision means that a physician oversees and accepts responsibility for the medical services rendered by the PA. If rendering services in a general acute care hospital as defined in Health and Safety Code § 1250, the PA shall identify his or her supervising physician with privileges to practice in said hospital.

4. **Patient Care Policies and Procedure:** The PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

5. **PA Competency and Qualification Evaluation:** Through a peer review process based on the standard of care, the Practice shall regularly evaluate the competency of the PA. The Practice may credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures, and drug and device ordering and furnishing authorized under this Practice Agreement.

6. **Review of Practice Agreement:** This Practice Agreement shall be reviewed on a regular basis and updated by the Practice when warranted by a change in conditions or circumstances.

The physician and PA(s) listed below collaboratively approve this Practice Agreement governing the medical services of PA(s) in the Practice, on behalf of the Practice, and authorize the physicians on the medical staff of the Practice to supervise the PA(s) named below effective as of the date signed by the PA. The physician named below authorizing this Practice Agreement may or may not also serve as a supervising physician of a PA. Signing this Practice Agreement does not mean the named physician below is accepting responsibility for the medical services provided by the PA(s) named below. Rather, any physician of the Practice, including a physician named below, would only accept responsibility for a specific PA if, and only during those times, they are serving as a supervising physician as set forth in Section 3 of this Practice Agreement.

**Authorized Physician:**

Name: _____ *(please print)*

Signature: _____ Date: _____

Name of Clinic/Practice: _____

**Physician Assistant:**

Name: _____ *(please print)*

Signature: _____ Date: _____