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

Ventura County Health Care System Oversight Committee
Administrative Policies
November 29, 2022

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

1. 108.006 Nurse Staffing and Scheduling
2. 108.025 Nurse Call System
3. IS.17 Title 17 California Code of Regulations
4. L.05 Laboratory Document Control
5. L.37 Laboratory Data Verification and Validation
6. L.38 Laboratory Proficiency Testing
7. L.42 Preservation of Laboratory Records and Specimens

Status **Active** PolicyStat ID **12681983**

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Last Revised	11/14/2022	Policy Area	Administrative - Nursing
Next Review	11/13/2025		

108.006 Nurse Staffing and Scheduling

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

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

Holidays: Refer to the appropriate union contract.

Vacation:

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

latest).

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

PROCEDURE

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

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

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

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

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

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

Changes in Schedule/Special Requests:

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

Schedules:

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

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

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

Daily Staffing:

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

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

Acuity and Staffing

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

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

Patient Classification System

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

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

A method for the formulation of staffing determinations, including:

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

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

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

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

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

The Nursing Supervisor/Clinical Nurse Manager will take into consideration the reported acuity values of each unit when making staffing decisions for the next shift.

A. Assignment of Patient Care

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

B. Staffing Plan

   As part of this obligation, the Nursing Department has developed a master staffing plan to

meet the needs of each unit in the most efficient manner. Census staffing plans, maintained in the Nursing Office, are based on average acuity assessments and state staffing requirements.

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

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

Weekend Commitment:

1. Each full-time (F/T), part-time (P/T) and Per Diem staff member may be scheduled to work a minimum of two (2) weekends out of four (4), as needed by the unit.
2. All Staff: Weekend absences:
    a. One (1) weekend absence allowed every calendar year.
    b. All others are subject to make up the time, i.e., automatically scheduled by the Clinical Nurse Manager for an extra weekend as needed by unit.

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

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

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

Assignment of Nursing Care of Patients

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

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

1. Assign an alternate assignment for extra personnel on duty.
2. Request a regular part-time person to come in.
3. Request a per diem person to come in.
4. Request on-duty staff to work overtime.
5. Request off-duty staff to work overtime.
6. Request Registry personnel to come in.
7. Reassign on-duty staff for optimum coverage.

8. Mandate overtime (requires approval by a Nurse Executive or their designee).

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

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

Unscheduled Leave:

1. It is the expectation that unscheduled leave will be minimal for a 12-hour shift program.
2. The accepted hospital standard is average of 2.2 hours of unscheduled leave per pay period for F/T employees.
3. P/T employees are assessed on a prorated basis.
4. Consistently exceeding accepted standards may be cause for termination of the employee's 12-hour schedule, and/or disciplinary action.
5. When it is necessary to use unscheduled leave, the 06:45 to 19:15 shift employee will notify the night shift supervisor by 05:00. The 1900 to 0700 shift employee shift will notify the day shift supervisor by 1700 hours (5:00 P.M.).

Scheduled Leave:

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

Overtime:

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

Guidelines:

1. An Employee anticipated need includes:
    a. Anticipated need for overtime must be communicated to the Clinical Nurse Manager/Nursing Supervisor;
    b. When possible, give a two (2) hour notice;
    c. If notice is given in less than two (2) hours before the end of shift, give notice as

soon as possible (ASAP);

- The Clinical Nurse Manager or Nursing Supervisor will decide on a course of action, which may include:
  - Authorize overtime
  - Provide assistance to eliminate the need for overtime
  - Another action, as appropriate

d. Failure to notify in advance of overtime hours, may be grounds for disciplinary action.

2. The Clinical Nurse Manager/Staffing Personnel/Nursing Supervisor anticipated need includes:
   a. Anticipated needs for overtime in an existing or upcoming shift, is identified;
   b. The Clinical Nurse Manager or Nursing Supervisor will make telephone calls to off-duty staff and/or Registry and offer overtime, etc., to meet patient care needs.

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

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

REFERENCES

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

All Revision Dates

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

Attachments

Nurse Acuity MedSurgTele.xlsx

Nurse Acuity NICU

NurseAcuity ICU.docx

NurseAcuity L&D.docx

NurseAcuity PICU.docx

NurseAcuity PP.docx

VCMC IPU Patient Acuity.docx

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/14/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/14/2022
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/14/2022

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Next Review	11/17/2025		

108.025 Nurse Call System

POLICY:

To improve staff responsiveness to patient-initiated call lights by establishing guidelines to answering patient-initiated calls including a team approach and adhering to expected call light response times. Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) are committed to answering every patient's visual and audible call light as soon as possible through collaborative measure by clinical and non-clinical staff as a standard of practice in our inpatient facilities.

A call system shall be maintained in operating order in all nursing units. A call station(s) providing a pillow speaker to each patient bed will be provided for each patient room. These pillow speaker shall be readily accessible to patients. A visible signal in the corridor above the door of each patient room will be maintained. An audible signal and light indicating the room from which the call originates shall be located at the nurses' stations. The call system shall be provided in each patient's toilet room, bathroom and shower room in locations easily accessible to the patients. Electric shock hazard shall be eliminated by grounding or by an equally effective method. The call systems shall be designed to require resetting at the calling station unless a two-way voice communication component is included in the system.

PROCEDURE:

1. Upon admission to the nursing unit, the admitting or primary nurse will familiarize the patient to the room including use of the call light system. Each patient room is equipped with a nurse call device attached to a call station on the headwall and a pillow speaker. The patient will in return demonstrate the use of the call light system to the nurse.
2. At the beginning of each shift, nursing staff will document on the patient communication board the name of the primary care nurse, nursing assistant, and respective phone numbers at the start of the shift.
3. When the patient call light signal goes on, staff (Registered Nurse (RN), Nurses' Aide (NA) or

Medical Office Assistant (MOA)) will answer the call light within two (2) minutes. After two minutes the call system will escalate the call to the designated back-up, and after the next 23 minutes the call system will escalate to the charge RN.

4. Most nurse call lights will be answered by the MOA manning the nurse call station. The MOA will direct nurse calls to the most appropriate person, i.e. RN or NA. However, any staff member in the vicinity who sees/hears a call light alarm is expected to enter the room and engage the patient to address the patient's needs.
5. If the patient requires immediate assistance, the staff person will immediately contact the primary care nurse or charge nurse.
6. The nurse call lights are color coded and located above the patient room door to visually alert responders to the nature of the call. An audible alarm will accompany all color coded lights. *See Table A below for alarm schedule for the North and South Towers at VCMC only.*
7. Nursing staff will complete training and a competency assessment for the nurse call system.

REFERENCES:

California Code of Regulations Title 22 Division 5 section §70859

TABLE A

Call Type	Escalation Sequence	Call activated from...	Default Call Text Displayed	Requested Call Text Displayed (Max 14 Char.)	Corridor Light & Icon Color	Corridor Light Flash Rate
Calls						
Patient Call	Routine - Patient	Nurse Call Button on patient pendant & bed side rail and gray "Call" button on patient station faceplate	Patient	Patient	White	Steady
Staff Call	Routine - Staff	Gray "Call" button on staff station faceplate	Staff	Staff	White	Steady
Cord Out	Priority	Disconnecting patient pendant cord and aux station cord	Cord Out	Cord Out	White	Flashing
Bed Cord Out	Priority	Disconnecting bed communications cord	Bed Cord	Bed Cord	White	Flashing
Aux A	Aux.	Alarm state of equipment connected to Aux Jack A	Aux A	Aux A	White	Flashing
Aux B	Aux.	Alarm state of equipment connected to Aux Jack B	Aux B	Aux B	White	Flashing
Aux C	Aux.	Alarm state of equipment connected to Aux Jack C	Aux C	Aux C	White	Flashing

Call Type	Escalation Sequence	Call activated from…	Default Call Text Displayed	Requested Call Text Displayed (Max 14 Char.)	Corridor Light & Icon Color	Corridor Light Flash Rate
Aux D	Aux.	Alarm state of equipment connected to Aux Jack D	Aux D	Aux D	White	Flashing
Fall Prevention	Fall Prevention	Alarm state of bed Fall Prevention system.	Bed Exit	Bed Exit	White	Flashing
Staff Emergency	Staff Emergency	Red "Emer" button on patient & staff station faceplate or red slide button (without pullcord)	Emergency	Staff Emerg	White	Triple Flash
Bath	Patient Emergency	Red slide button with pullcord located near toilet.	Toilet	Toilet	White	Flashing
Shower	Patient Emergency	Red slide button with pullcord located in shower area.	Shower	Shower	White	Flashing
Code Blue	Code Adult	Code Blue slide button.	Code Blue	Code Blue	Blue	Fast Flash
Smoke Alarm	Fire	Smoke Detector	Smoke Alarm	Smoke Alarm	Red	Fast Flash
Presence & Service Request						
RN Presence	N/A	Activated when presence button in room is pressed.	N/A	N/A	Green	Steady
RN Request	N/A	Activated from nursing station	N/A	N/A	Green	Flashing
Aide Presence	N/A	Activated when presence button in room is pressed.	N/A	N/A	Yellow	Steady
Aide Request	N/A	Activated from nursing station	N/A	N/A	Yellow	Flashing
Faults						
System Faults	Fault	Activated when system or component failure detected.	Fault	N/A	White	Slow Flash

All Revision Dates

11/18/2022, 1/28/2020, 2/1/2017

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/18/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/18/2022
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/18/2022

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VENTURA COUNTY HEALTH CARE AGENCY

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Next Review	11/2/2025
Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services
References	Title 17, California Code of Regulations (17 CCR)

IS.17 Title 17 California Code of Regulations

PURPOSE:

To provide an up to date reference for Imaging Services staff to the regulations established by the California Department of Public Health Radiologic Health Branch.

POLICY:

It is the policy of the Imaging Services department to provide accessibility to Title 17 for all staff.

PROCEDURE(S):

Imaging Services staff may utilize the web links below to access Title 17.

Title 17: Public Health Main Page

Title 17: Public Health

Title 17. Chapter 5, Sub-chapter 4: Radiation

SC4: Radiation

Title 17. Chapter 5, Sub-chapter 4.5: Radiologic Technology

SC4.5: Radiologic Technology

Title 17. Chapter 5, Sub-chapter 4.7: Nuclear Medicine Technology

SC4.7: Nuclear Medicine Technology

REFERENCE(S):

Title 17, California Code of Regulations (17 CCR)

All Revision Dates

11/3/2022

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/3/2022
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/3/2022
Imaging Services	Matt McGill: Director, Imaging Services	11/3/2022

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Owner	Gayle Haider: Quality Assurance Supervisor, Laboratory Services
Policy Area	Laboratory Services

L.05 Laboratory Document Control

POLICY:

The Ventura County Medical Center/Santa Paula Hospital Laboratory has a document management system to ensure that all written policies and procedures are current. All staff will read those policies and procedures pertinent to their positions and will document on the proper form. All new and revised policies and procedures will be reviewed and approved by the Laboratory Medical Director before implementation and all existing policies and procedures will be reviewed biennially by the Laboratory Medical Director or designee. All retired policies and procedures will be retained for three (3) years after discontinuation.

It is the responsibility of the Clinical Laboratory Scientist III (CLS III), Safety Officer, Laboratory Information System (LIS) Coordinator, and Performance Improvement/Quality Assurance Coordinator to maintain the policies and procedures for their areas of responsibilities. The Director of Laboratory Services is responsible for the administrative policies and procedures. The Laboratory Medical Director, along with the associate pathologists and histologists, are responsible for the pathology policies and procedures.

PROCEDURE:

1. All written administrative policies, procedures and forms will be reviewed by the Director of Laboratory Services or designee at least every two years to ensure that they are current with accrediting and licensing agency requirements and standards.
2. All staff must read the policies and procedures relevant to their job duties. Staff will read and document within 30 days of implementation and as changes occur. A sign-off sheet or electronic acknowledgement of review in PolicyStat will serve as documentation.
3. The Laboratory Medical Director will sign and approve each revision of current policy/

procedure, or new policy or procedure before implementation.

4. The Laboratory Medical Director or designee will sign/acknowledge the biennial review of each existing policy or procedure.
5. All discontinued policies, procedures and forms will be retained for three (3) years. Electronic copies will be retained in the sub-folder for retired policies and procedures in the laboratory shared drive.
6. An electronic copy of all policies and procedures will be kept on the Laboratory shared drive.
7. All policies and procedures will include the effective date, review and revision dates, and date when retired.

FORMAT

A. Paper forms that are manually completed by staff or that may involve specialized computer software programs that generate hard copies as necessary.

B. Most records are organized and stored in a chronological, numerical, or alphabetical system.

RECORDS RETENTION (Refer to L.42 Preservation of Laboratory Records and Specimens)

The standards for record keeping and the length of time records must be retained are established by relevant certification agencies.

A. Federal guidelines should be considered minimum standards and are superseded by the standards established by the state or other certification agencies.

B. Agencies include the following.

   a. Clinical Laboratory Improvement Amendments (CLIA) of 1967
   b. CLIA of 1988 & 1990
   c. State of California Code of Regulations Title 17 and Title 22
   d. Code of Federal Regulations
   e. College of American Pathologists (CAP)
   f. Joint Commission
   g. American Association of Blood Banks

Records must be readily available for review.

REFERENCES:

Garcia, Lynne S., **Clinical Microbiology Procedures Handbook**, 2nd edition, 2007, ASM, Washington, D.C. p. 14.3.1-14.3.6.

Wagar, Elizabeth A., **Laboratory Administration for Pathologists,** CAP Press, Northfield, Illinois, 2011,

pp121-127.

Section 1053 - Clinical Laboratory Improvement Amendments (CLIA) Record Retention Regulations Determined to be Less Stringent than California Law, Cal. Code Regs. tit. 17 § 1053 | Casetext Search + Citator. Retrieved October 1, 2022.

Law Section (ca.gov). Retrieved October 1, 2022.

All Revision Dates

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/25/2022
Laboratory Services Department	Gayle Haider: Quality Assurance Supervisor, Laboratory Services	10/25/2022
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	10/11/2022
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	10/11/2022

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Owner	Gayle Haider: Quality Assurance Supervisor, Laboratory Services
Policy Area	Laboratory Services

L.37 Laboratory Data Verification and Validation

POLICY:

The purpose of laboratory method validation is to characterize system performance, to assess the potential for error, to identify method-to-method differences and to meet regulatory (CLIA 88 and CAP) guidelines. Method validation is done when placing a new system into service, at regular intervals to assess ongoing system performance, after the replacement of a component of the sytem, as advised by the manufacturer, and when troubleshooting system performance.

PROCEDURE:

Consult manufacturer's package inserts, evaluation protocol, manuals and supplemental protocols.

BASIC COMPONENTS OF METHOD VALIDATION STUDIES:

For unmodified FDA cleared or approved tests, the Laboratory may use data from manufacturer's information or published reports, but the Laboratory must verify outside data on accuracy, precision and reportable range.

ACCURACY (Measure of Bias, % Recovery)

1. Method to method studies comparing similar instruments
2. Minimum of 20 samples for statistical accuracy
3. Good distribution of sample values ranging from low to high

4. Measures systematic error of an analytical method
5. Limits: Endpoint assays should be within 10% of the standard's stated value or peer group comparison value, but at a minimum, manufacturer's stated tolerance limits should be met.

PRECISION (Measure of Spread, Standard Deviation, Coefficient of Variation)

1. Characterizes the reproducibility of a test system
2. Performed by repetitive testing of the same sample

Measures random error of an analysis:

Formula:

$s = \sqrt{\frac{\sum (X - \bar{x})^2}{n - 1}}$ s = sample standard deviation

$\sum$ = sum of…
X = each value
$\bar{x}$ = sample mean
n = number of values in the sample

- Around 68% of scores are within 1 standard deviation of the mean,
- Around 95% of scores are within 2 standard deviations of the mean,
- Around 99.7% of scores are within 3 standard deviations of the mean.
- Limits: Coefficient of Variation, which is a measure of precision, and is the standard deviation expressed as a percentage of the mean, ideally should also be less than 10%, or at a minimum, remain within the threshold of the manufacturer's stated acceptable performance.

- **REPORTABLE RANGE: LIMIT OF DETECTION**

Validation of Reportable Range, Analytical Measurement Range, Reference Range, Critical Limits and Calibration Verification (CAP POC July 2003 Checklist, Page 34 Commentary) can all be accomplished through the same protocol if the range of testing spans the broadest range.

Materials must be "matrix appropriate" such as: Split blood samples, linearity/calibration verification materials supplied by manufacturer or other vendor.

Verification of the Analytical Measurable Range may not apply to certain assays (for example, in immunology)

1. Reportable Range- The range of results for which a system has been proven to yield numerically accurate results.

2. Critical Limits- Low and high result limits which, when exceeded, require follow up action.
3. Analytical Measurement Range-The range of results through which a method yields numerical values
4. Calibration Verification/Linearity-The process of verifying that a system is properly calibrated.
5. Reference Range Studies

SENSITIVITY

1. Analytic Sensitivity (Low end). Note: For FDA cleared/approved tests, documentation may consist of data from manufacturer's or the published literature.

SPECIFICITY

1. CAP requires assessment of analytical interference

REFERENCE RANGE

1. CAP Requires verification of reference range

REFERENCES

CAP, COM.30980-40000, 08-17-2016

All Revision Dates

11/14/2022, 2/1/2017

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/14/2022
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/10/2022

Laboratory Services Department	Gayle Haider: Quality Assurance Supervisor, Laboratory Services	11/10/2022
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	11/10/2022

Status **Active** PolicyStat ID **12518406**

Origination	3/1/2004
Last Approved	10/25/2022
Last Revised	10/25/2022
Next Review	10/24/2024
Owner	Gayle Haider: Quality Assurance Supervisor, Laboratory Services
Policy Area	Laboratory Services

L.38 Laboratory Proficiency Testing

POLICY:

It is the policy of the Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) Laboratory to assess, by external and internal proficiency testing (PT), the accuracy and reliability of all testing methodologies.

PROCEDURE:

All sections of the Laboratory participate in proficiency testing programs of the College of American Pathologists (CAP) appropriate to the level of service and degree of sophistication of testing in the section. The results of these surveys are reviewed within 30 days of receipt of the evaluation report, by the Section Supervisor, Director Laboratory Services, and/or the Laboratory Medical Director. *Corrective actions are taken for all unacceptable results cited on the survey reports.* CLSs are involved in the documentation of follow up activities related to unacceptable results.

GENERAL INSTRUCTIONS:

1. There is to be no communication between the VCMC Laboratory and other laboratories regarding proficiency testing samples, prior to the deadline of submission of the data to the proficiency testing provider. ***Many VCMC/SPH Clinical Laboratory Scientists (CLSs) are employed at other laboratories, and it is appropriate to ask whether those participating in the survey have already run it at another facility. The CLS will excuse himself/herself from performing the survey if they have performed it elsewhere***.
2. Should proficiency testing (PT) samples be received in the laboratory, as soon as specimens are identified as proficiency testing samples,
    - Immediately sequester samples. ***DO NOT ACCESSION OR TEST SAMPLES***.

- Notify supervisor or PI/QA Coordinator. Following CMS, state, and CAP guidelines, the PI/QA coordinator will notify appropriate inspecting agency (CAP) that PT samples have been received from another laboratory.
- PI/QA Coordinator will notify the Laboratory Medical Director of the incident.

3. For tests performed within the Laboratory, proficiency testing must be performed within the Laboratory. It is strictly prohibited to refer proficiency testing specimens to another laboratory.
    - Do not send VCMC PT samples to Santa Paula or vice versa.
4. Testing personnel shall adhere to general and specific instructions provided with the survey material.
5. Survey samples are handled and analyzed in the same manner that a clinical specimen is tested. This consists of integration of all proficiency testing samples within the routine workload, using the same primary methods systems used for patient/client samples by personnel who routinely test patient/client samples.

    Notes:

    a. Group review and consensus identifications are permitted only for those unknown samples that would ordinarily be reviewed by more than one person in an actual patient sample.

    b. Any CAP survey slide can be used as part of competency assessment and will be performed *after* the deadline of submission of the data to the proficiency testing provider.

6. The system of assuring analytic results on patient samples for which no external proficiency testing program is documented in the specific testing protocol for that assay; accuracy and reliability are measured at least semiannually, and the results from the system are recorded and reviewed by the Section Supervisor of that section of the Laboratory, as well as the Laboratory Director, or their designee.
7. All corrective action is taken and documented, utilizing the PT Exception Investigation Worksheet.
8. Trending or bias is evaluated during result review and follow up/corrective action is documented on the survey result sheets.
9. PT challenges that were not graded because of lack of consensus or because the Laboratory submitted its results after the cut-off date for receipt, failed to submit results, or made an error in completing the result form are processed using the mechanism outlined in #5 and #6 and are documented on the survey result sheet or exception response form. Referee results are evaluated for non-graded PT challenges and compared to submitted results.
10. Transfusion Service Surveys are retained for 3 years. All others are retained for two (2) years.
11. PT records must include worksheets, instrument tapes, reporting forms, evaluation reports, participant summaries, and documentation of follow-up, as applicable.

ALTERNATE PROFICIENCY TESTING Procedure:

Proficiency testing for analytes, not challenged by available external proficiency surveys, will be

performed at least semiannually by an alternate procedure including one of the following methods:

1. Split samples sent to an accredited Reference Laboratory.
2. The same sample tested by a second CLS.
3. Results evaluated and correlated by the Laboratory Director right after results from the reference laboratory are received.

The results review process is identical to the proficiency testing process. Alternate Proficiency Testing results are retained with Proficiency Testing records.

PROFICIENCY TESTING Procedure:

A. Receipt Of Survey
    1. CAP survey specimens are received in the Laboratory and delivered to the Performance Improvement/Quality Assurance Supervisor or designee.
    2. The Performance Improvement/Quality Assurance (PI/QA) Supervisor accessions the PT specimens into Cerner and orders the required tests for each one.
    3. Assignment of a CLS to run each PT specimen is made by the PI/QA Supervisor with input from the Section Supervisor.

B. Testing Completed
    1. Results are checked by 2 people (clerical check only).
    2. The attestation form (paper) is signed by all testing personnel.
    3. Laboratory Medical Director or designee signs the attestation form (paper). For transfusion service proficiency testing surveys, the Laboratory Medical Director signs the attestation form (this function cannot be designated to another person).
    4. The PI/QA Supervisor ***sends*** results electronically to CAP.
    5. All CAP paperwork (instructions), result printouts, and quality control printouts for the day of testing are retained together and filed.

C. Evaluation Received From CAP
    Note: Results may be shared with testing personnel formally or informally
    1. CAP survey results are received in the Laboratory and delivered to the PI/QA Supervisor.
    2. The PI/QA Supervisor marks the date the evaluation was received on the Participant Summary page and the Original Evaluation, and forwards them to the Section Supervisor.
    3. In the event that CAP deems that performance of a survey was unsatisfactory, they will send a letter notifying the PI/QA Supervisor vial email.
    4. The Section CLS III or designee reviews the results and determines if follow up is necessary. If a letter of unsatisfactory performance has been received, the Section CLS III will document (PT Exception Investigation Worksheet) and investigate any exceptions noted.

5. Results and the PT Exception Investigation Worksheet are routed to Laboratory Director for review and signature.
6. Results and Exception Investigation reports are routed to the Quality Assurance Supervisor for filing.

D. PT Exception Investigation Worksheet

1. The Section CLS III initiates the PT Exception Investigation Worksheet form (Attachment A) by entering identifying and other relevant information for the unacceptable result(s). and fills out the checklist on the form. If there are five samples and four out of the five are acceptable and without bias, AND all samples are acceptable in the previous survey, also without bias, the first step would be to repeat the unacceptable sample. If the repeated result is acceptable, no further investigation is needed.
2. **Note:** There are two ways to determine if bias is present. a) Examine SDI (standard deviation indexes) results. If all results are greater than 1.5 or all results are greater than -1.5, then bias may be present and further investigation is required. b) If the difference between any 2 results exceeds 4 times the peer group SD, bias may be present and further investigation may be warranted. (Archives of Pathology & Laboratory Medicine, Volume 129, Issue 8) (See Troubleshooting Guide for Proficiency Testing Data).
3. Review results, worksheets, and printouts to determine if a clerical error is responsible for the exception.
    a. If a clerical error is responsible for the exception, then complete the form and forward to the Laboratory Medical Director and Laboratory Services Director for review and signatures
4. Continue filling out the PT Exception Investigation worksheet to determine the cause of the exception, and follow the recommendations on the form.
5. Write a conclusion/summary of the event and its resolution.
6. Document any corrective action to be taken.
7. Determine whether patient results were affected by 1) assessing the magnitude of any observed bias and 2) comparing the distribution of patient results during this time period with the distribution from another time (when PT results were not in question).
    a. If patient results were affected in such a manner as to cause an Adverse Event, work with Risk Management to determine the appropriate follow up.
8. Complete the appropriate sections on the form and forward to the Laboratory Medical Director and Laboratory Services Director for review and signatures.

REFERENCE

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/CLIAbrochure8.pdf

All Revision Dates

10/25/2022, 10/7/2022, 7/26/2022, 6/5/2020, 2/13/2019, 11/1/2016, 1/1/2009, 10/1/2008

Attachments

5.5.1 PT Exception Investigation Worksheet.pdf

clerical_errors_troubleshooting.pdf

coag_troubleshooting.pdf

Perfoming-Self-Evaluation.pdf

pt_troubleshooting_guide.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/25/2022
Laboratory Services Department	Gayle Haider: Quality Assurance Supervisor, Laboratory Services	10/25/2022
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	10/12/2022
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	10/12/2022

Status **Active** PolicyStat ID **12518458**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	12/6/2001
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Owner	Gayle Haider: Quality Assurance Supervisor, Laboratory Services
Policy Area	Laboratory Services

L.42 Preservation of Laboratory Records and Specimens

POLICY:

To establish guidelines for the retention of Laboratory documents and specimens which comply with California Title 17 and Title 22, CLIA '88, College of American Pathologists (CAP), AABB (formerly Association of Blood Banks), and The Joint Commission requirements, and to maintain a system by which these items are available within a reasonable period of time.

Should the facility or laboratory cease operations, the laboratory ensures that all records and, as applicable, slides, blocks, and tissue are retained and available for the time frames specified in the table below.

PROCEDURE:

Laboratory specimens and documents are frequently needed for retesting or review beyond the initial period of time in which they were obtained and reported. The documentation of test results of patients and quality control specimens must be filed and stored in an organized fashion for an appropriate period of time.

RECORDS			
GENERAL			CALIFORNIA LAW
Instrument Maintenance, Test System Performance Specifications	3	Years	CBPC §1265(j)(2)
Instrument Printouts			
Manual Entry Worksheets	2	Years	
Patient Reports	20	Years**	CBPC §1265(j)(2)
Patient Test Records	3	Years	CBPC §1265(j)(2)
Performance Improvement, Quality Management Systems Assessment Records	3	Years	CBPC §1265(j)(2)
Proficiency Testing Records	2	Years	CLIA 2003
Quality Control Records	3	Years	CBPC §1265(j)(2)
Test Requisitions and Authorizations Records	3	Years	CBPC §1265(j)(2)
Signature List	Forever		
Job Descriptions and Personnel Records	5	Years	
Test Procedure Records/Manuals	3	Years	CBPC §1265(j)(2)

RECORDS			
Test Procedure - Discontinued	3	Years from retired date	
BLOOD BANK (Related Policy: L.BB.11 Blood Bank Record Management)			
Product - Source, Disposition	Forever		
Immunohematology Test Reports and Transfusion Records	10	Years	CLIA 2003
Quality Control Records	10	Years	
Work Sheets	10	Years	
Testing Procedure - Discontinued	5	Years from retired date	
**Retained in Laboratory Information System (LIS)			
CYTOLOGY			
Quality Control Records	3	Years	
Work Sheets	3	Years	
PATHOLOGY			
Accession Records	3	Years	
Quality Control Records	3	Years	
Work Sheets	2	Years	
SPECIMENS			
BLOOD BANK			
Cord Blood	14	Days	
Crossmatch	14	Days	
Product Segments (Red Blood Cells)	14	Days	
Sera, Unusual Antibody	1	Year	
Type, Antibody Screen	14	Days	
Type and Hold	14	Days (7 days post transfusion)	
CLINICAL LAB:			
Chemistry	7	Days	
Coagulation	6	Hours	
Hematology			
Slides	7	Days	
Specimens	2	Days	
Microbiology			
Culture – AFB	2	Months	
Culture – Blood	9	Days	
Culture – Body Fluid	3	Days	
Culture – Fungal	2	Months after final report	
Culture – Plates	2	Days after final report	
Culture – Thiol Broth	3	Weeks	
Isolates – AFB		Sent to Public Health Department	

RECORDS			
Isolates – Blood, Fluid, Surgical	2	Months	
Slides	6	Months	
Specimens	2	Days	
Serology	7	Days	
Urinalysis	2	Days	
CYTOLOGY			
Slides - Negative/Positive	5	Years	
Blocks	5	Years	
PATHOLOGY			
Histopathology Slides	10	Years	
Paraffin Block	10	Years	
Pathology Test Reports	10	Years	CLIA 2003
Slides	10	Years	
Tissue - Autopsy	3	Months after final report	
Tissue - Surgical	2	Weeks after final report	

All Revision Dates

10/25/2022, 8/8/2022, 6/5/2020, 12/1/2016, 2/1/2009

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/25/2022
Laboratory Services Department	Gayle Haider: Quality Assurance Supervisor, Laboratory Services	10/25/2022
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	10/12/2022
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	10/12/2022

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Report to the Oversight Committee

□ovember 2□□2022

Document Approval

Policies & Procedures

□he follo□ing □ere revie□ed and recommended for approval by the appropriate □epartments□Committees □and the Medical □□ecutive Committee.

a. Policies & Procedures

1. 100.103 □levator □se for □ransport of Patients□Linen□□ood□□rash and Supplies
2. 102.020 Provider Preventable Conditions/Patient Safety □ndicators Revie□
3. 10□005 □iseases and Conditions Reportable to the Ventura County Public □ealth □epartment
4. 10□015 □loodborne Pathogen Post□□□posure □valuation and Management
5. 10□023 □nfection Control Plan
6. 10□030 □loodborne Pathogen □□posure Control Plan
7. 10□0□1 Reprocessing Reusable Laryngoscope □lades and □andles
8. 10□0□□Principles of Cleaning and □isinfecting □nvironmental Surfaces □ouse□eeping Surfaces
9. □R.0□ □eath of Patient in the □mergency □epartment
10. □R.45 □elephone Medical □dvise in the □mergency □epartment
11. P□.□2 Staff □uthori□ed to □dminister Medications
12. L.□□.42 Reconstitution of □lood for □□change □ransfusions
13. C□.1□Cancer Registry Clinical Research
14. □.10 Violence □ntervention Program: □mergency □ntry to □□it □V□P□□□□□

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*3/1/2014*
Last Approved:	*N/A*
Last Revised:	*8/1/2017*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - EOC - Infection Control*
References:	

100.103 Elevator Use for Transport of Patients, Linen, Food, Trash and Supplies

POLICY:

Separation of clean and soiled materials or carts will be employed by all departments in the hospital. Infection Prevention and Control principles and practices must be applied in the management and use of elevators. Transportation of patients will take precedence over the transportation of materials or personnel. Carts, regardless of content, will be removed from an elevator to allow patient transport and another elevator summoned.

PROCEDURE:

Infection prevention and control requires the separation of clean, sterile and dirty (soiled or contaminated) items. The transportation and storage of materials is managed in such a manner to maintain spatial separation of clean and soiled items. Separation of clean and dirty supplies applies to the storage of materials as well.

Cleanliness of the elevators must be maintained. In addition, elevator hoist ways and pits will be kept free from dust, water, waste, oil and dirt.

A. All linens, food, trash, biohazard waste and supplies requiring transportation on elevators will only use the designated service elevator or the staff elevators.

B. Patient transportation throughout the facility takes precedence. Staff transporting carts of linen, food or supplies will vacate the elevator and call the next one if a patient needs to access the elevator. No patient will ride the elevator with any cart.

C. Environmental Services carts, carts carrying dirty linen, dirty food carts, carts carrying trash or biohazard waste or any other type of dirty cart will be covered with a secure cover and may not be on the elevator at the same time as clean linen, clean/sterile supplies, food carts intended for patient areas or patients themselves.

D. All elevators throughout the facility will be mon and cleaned daily by Housekeepers. Documentation of daily cleaning will be maintained by the Hou oing Department.

E. All hoist ways and pits will be cleaned by the e maintenance vendor on an as needed basis. Dirt, dust and debris will not be allowed to accumul he elevator pits or hoist ways.

F. All clean and/or sterile supplies and food going ients will be transported in a clean, disinfected cart

with a secure cover.

G. Elevators will be designated for clean versus dirty use.

H. Soiled laundry will be placed in designated laundry bags and deposited in laundry chute for laundering.

All revision dates: 8/1/2017, 3/1/2014

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Leah Kory: Medical Director, Inpatient Quality	10/7/2022
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	8/23/2022
Policy Owner	Magdy Asaad: Infection Prevention Manager	7/12/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/2016*
Last Approved:	*N/A*
Last Revised:	*8/9/2022*
Next Review:	*3 years after approval*
Owner:	*Alicia Casapao: Director of Quality and Performance Improvement*
Policy Area:	*Administration - Medical Staff*
References:	

102.020 Provider Preventable Conditions/Patient Safety Indicators Review

POLICY:

Provider Preventable Conditions (PPCs) consist of healthcare-acquired conditions (HCACs) when they occur in an acute inpatient hospital setting and other provider-preventable conditions (OPPCs) when they occur in any healthcare setting.

Patient Safety Indicators (~~PSI~~PSIs) ~~or Provider Preventable Conditions (PPC)~~ are a set of indicators ~~chosen~~developed by the Agency for Healthcare Research and Quality (AHRQ) to provide information on potentially avoidable safety events that ~~provide information~~represent opportunities for improvement in the delivery of care. PSIs focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. Approximately 25-30 PSIs are specified each year by AHRQ and include, but are not limited to, complications such as iatrogenic pneumothorax, accidental puncture or laceration during procedure, postoperative wound dehiscence, postoperative sepsis, postoperative DVT/PE, hospital acquired pressure ulcer, central line associated blood stream infection and postoperative hip fracture.

Each PCC and PSI identified at Ventura County Medical Center and Santa Paula Hospital will be reviewed by the surgical and hospital quality teams and analysis will be used to reduce future occurrences of these events.

PROCEDURE:

GOALS:

1. To ensure that PPCs and PSIs are documented and reported accurately.
2. To identify potential adverse events that might need further study.
3. To evaluate and provide feedback on individual provider performance for PPC and PSI.

DEFINITIONS:

~~Provider Preventable Conditions (PCC)~~**Provider Preventable Conditions (PCCs)** are defined by the Centers for Medicare/Medicaid Services (CMS) as ~~health care acquired conditions~~**health care acquired conditions (HCACs) or Other Provider Preventable Conditions (OPPCs)** which include, but may not be limited to:

HCACs

- Air embolism
- Blood incompatibility

- Catheter-associated urinary tract infection
- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
- Falls/trauma that result in the following:
    - Fracture
    - Dislocation
    - Intracranial injury
    - Crushing injury
    - Burn
    - Electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Stage III or IV pressure ulcers
- Surgical site infection
    - Mediastinitis following coronary artery bypass graft (CABG)
    - Surgical site infections following:
        - Bariatric surgery
            - Laparoscopic gastric bypass
            - Gastroenterostomy
            - Laparoscopic gastric restrict surgery
        - Orthopedic procedures for spine, neck, shoulder, and elbow
- Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

OPPCs - also known as *"never events"* and Serious Reportable Events under Medicare. Providers must report these three OPPCs when these occur in any health setting. "Invasive procedure" refers to a surgical procedure. For Medi-Cal, OPPCs are defined as follows:

- Wrong surgery/invasive procedure
- Surgery/invasive procedure performed on the wrong patient
- Surgery/invasive procedure performed on the wrong body part

Level 1 Review

- All patients with PPC or PSI diagnoses identified through safety notifications, EHR reports or by coders will be reported, as they are identified, to the QAPI Department and to the appropriate departments for their review.
- The following information will be included in the report:
  Medical Record Number
  Date of Procedure (if applicable)
  Diagnosis Code for PSI or PPC
- Report will be emailed to:

Quality and Performance Improvement (QAPI ~~Clinical Nurse Manager~~) Director
Inpatient Quality Medical Director~~, Inpatient Quality~~

Level 2 Review

- Cases will be reviewed by the QAPI ~~Clinical Nurse Manager~~Director, Inpatient Quality Medical Director and the appropriate department staff.
- QAPI and/or the appropriate assigned/designated staff will prepare documents to support assignment of diagnosis.

Level 3 Review

- ~~The~~ QAPI and appropriate departmental staff will discuss cases with the Inpatient Quality Medical Director and when applicable, ~~Inpatient Quality, and when applicable~~with the appropriate medical director thus creating a Peer Review process. The physicians will approve assignment of diagnosis and will determine action plan.
- Updated PSI list will be forwarded to Medical Records (coders) for revision as necessary.
- The Inpatient Quality Medical Director~~, Inpatient Quality~~ will use established peer review processes (refer to MS.102.018 Peer Review) to give provider feedback and address safety concerns.
- The Inpatient Quality Medical Director~~, Inpatient Quality~~ will analyze PPC and PSI diagnoses to determine trends and need for further study and/or improvement efforts. If there is a question regarding further follow-up, the case will be referred to the Chief Medical Officer (CMO).
- Serious safety concerns will be addressed through a root cause analysis (refer to 107.024 Root Cause Analysis).

References

https://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx

AHRQ QI: Patient Safety Indicators Overview

All revision dates: 8/9/2022, 8/13/2019, 1/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	10/17/2022
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	10/4/2022
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	8/9/2022

Current Status: *Pending*

PolicyStat ID: *11421501*

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/1983*
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Last Revised:	*5/1/2016*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.005 Diseases and Conditions Reportable to the Ventura County Public Health Department

POLICY:

To comply with the California Code of Regulations, Title 17 Section 2500 and The Joint Commission Hospital Accreditation Standards regarding reporting diseases and conditions to the Ventura County Public Health Department.

PROCEDURE:

RESPONSIBILITY for reporting includes, but is not limited to:

Physicians
Infection Control Practitioners
Physician's Assistants
Nurse Practitioners
Nurses

Laboratory Staff

Anyone having knowledge of a reportable condition

There are two methods of reporting to the Ventura County Public Health Department. The first is the Confidential Morbidity Report (Attachment A), Communicable Diseases other than Tuberculosis and AIDS. The preferred method of reporting is by using the CalRedie electronic reporting program. A login can be obtained by contacting the Communicable Disease office of the Ventura County Public Health Department.

The list of diseases, conditions and the required form for reporting is attached to this policy. A diagnosis or a suspected case of any of the diseases or conditions listed on Attachment B must be reported to the Ventura County Public Health Department within the designated time frame.

Tuberculosis reporting requires a separate form (Attachment C). "The Legal Aspects of TB Reporting" information is included as Attachment D. These forms can also be found on the Ventura County Public Health Department website at: www.vchca.org/ph. Click on Communicable Disease Reporting and select the appropriate form.

Severe Influenza Case History form must be completed for any patient with influenza who is in the Ventura County Medical Center/Santa Paula Hospital ICU or any patient aged 0 to 64 who has succumbed to the

disease.

The Severe Influenza Case History and the Tuberculosis Report are faxed to the respective numbers at the Ventura County Public Health Department. The fax numbers are on the forms.

The regular CMR's should be entered into CalRedie. In lieu of this, the form may be faxed to Ventura County Public Health at the number on the form.

AIDS cases are telephoned to the AIDS office. The telephone number is located on the front of the CMR

All reports faxed/sent to the Ventura County Public Health Department must also be faxed to the Infection Control Office at (805) 652-3273.

Reference:

California Code of Regulations Title 17 Section 2500
The Joint Commission Hospital Accreditation Standards

Attachments:

A. Confidential Morbidity Report Fax form
B. Confidential Morbidity Report Instructions
C. TB Suspect/Case Report and Plan Form
D. Legal Aspects of TB Reporting information

All revision dates: 5/1/2016, 11/1/2013, 9/1/2006, 3/1/2004

Attachments

A: Confidential Morbidity Report Form
B: Confidential Morbidity Report Instructions
C: TB Suspect/Case Report and Plan Form
D: Legal Aspects of TB Reporting Information

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Control Committee	Leah Kory: Medical Director, Inpatient Quality	10/7/2022
Infection Control Committee	Magdy Asaad: Infection Prevention Manager	9/26/2022
Policy Owner	Magdy Asaad: Infection Prevention Manager	9/26/2022

VENTURA COUNTY
HEALTH CARE AGENCY

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Last Revised:	*5/1/2012*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.015 Bloodborne Pathogen Post-Exposure Evaluation and Management

POLICY:

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

PROCEDURE:

Definition of a Health Care Worker (HCW) occupational exposure to bloodborne pathogen:

A. Percutaneous injury

B. Mucous membrane

C. Non-intact skin contact

with potentially infectious (HCV, HBV, HIV, etc.) body fluid (blood or bloody body fluid, tissue) or concentrated pathogen.

Procedure for HCW following exposure:

A. Treatment of an exposure site: wash wound, skin, or mucous membrane.

B. Report to manager/supervisor immediately.

C. Report within (</= 2 HOURS) to Emergency Department.

D. Obtain and complete the Employer's Report of Occupational and Injury or Illness Form (GSA 75B) and Doctor's First Report of Injury Form.

E. Identify and document the source individual if possible and obtain permission for source blood work.

F. Meet with Health Professional to complete documentation, obtain counseling and medications (if indicated) and receive follow-up instructions from Employee Health.

G. Provide informational packet to the HCW regarding bloodborne pathogen.

Employee Health Staff to provide exposed HCW with:

A. The results of pending blood work and provide appropriate future testing, follow-up visits, and immunizations per current (CDC) guidelines.

B. Infectious Diseases consultation, if indicated.

C. Prescriptions for medications, if indicated.

Attachment A – Bloodborne Pathogen Exposure Checklist

All revision dates: 5/1/2012, 9/1/2009, 5/1/2006, 10/1/2004, 9/1/2001, 11/1/1989

Attachments

A: Bloodborne Pathogen Exposure Checklist

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Control Committee	Leah Kory: Medical Director, Inpatient Quality	10/7/2022
Infection Control Committee	Magdy Asaad: Infection Prevention Manager	9/26/2022
Policy Owner	Magdy Asaad: Infection Prevention Manager	8/16/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*9/1/1969*
Last Approved:	*N/A*
Last Revised:	*8/18/2022*
Next Review:	*1 year after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.023 Infection Control Plan

Purpose:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and the Ambulatory Clinics plan processes around the identification, control, and prevention of infection to ensure that the Healthcare Agency has a functioning coordinated process in place, to reduce and minimize the risks of endemic (common cause) and epidemic (special cause) Healthcare Associated Infections (HAIs) in patients, visitors and healthcare workers and to optimize use of resources through a strong preventive program.

Goals:

The goals of the infection prevention and control program in a broad context include, but are not limited to:

1. Minimizing Healthcare-Associated Infection (HAI) by:

- Limiting unprotected exposure to pathogens throughout the hospital and clinics
- Minimizing the risk of transmitting infections with the use of procedures, medical equipment, medical devices and other procedures focused on risk mitigation.
- Promotion of effective hand hygiene
- Maintain a sanitary environment to avoid sources and transmissions of infections and communicable diseases.
- Utilization of data to help guide us in our planning and changing performance.

2. Establishing a reliable surveillance program by:

- Comprehensive risk-assessment to be conducted on an ongoing basis and at least annually to guide the surveillance activities and goals
- An active surveillance program to identify risks of infection
- Concurrent surveillance with feedback to the clinicians
- Analyzing HAI rates with methodical root cause analysis
- Establishing annual goals with achievable measures of success
- Evaluation of the program's success and revising techniques as needed.

3. Developing a system for identifying, reporting, investigating, and controlling infections, and communicable diseases in patients, healthcare personnel (HCP) and physicians

4. Training and educating healthcare workers through:

- General new hire orientation program

- Annual education
- Departmental education programs
- Special education events
- Ongoing education: verbal, printed and electronic
- Compliance monitoring

5. Ensuring that the hospital-wide performance programs address problems identified by infection control personnel and others, and that subsequent corrective actions plans are successfully implemented and sustained.

6. Development of specific goals and objectives based on the annual risk assessment

Objectives:

A. Monitoring and evaluation of all possible hospital associated infections (HAI) with emphasis on key performance aspects of infection control surveillance, prevention and management such as:
    - Healthcare-Associated infections in high-risk areas such as Intensive Care Unit (ICU), Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU)
    - Post-operative wound infections
    - Device-related infections:
        - Catheter-related bloodstream infections
        - Catheter-associated Urinary Tract Infections and
        - Ventilator-associated pneumonia
        - Invasive Device-Associated Skin Infection
    - Antibiotics-resistant organisms
    - Other communicable diseases
    - Occupational Health
        - Employee health trends
        - Disease exposure control plan including blood exposure in compliance with The Division of Occupational Safety and Health (DOSH) also known as CAL/OSHA regulations that require annual review.
        - Aerosol Transmissible Diseases Control Plan including Tuberculosis (TB) Control with ongoing surveillance for TB infection on all hospital employees with annual screening and testing (and semi-annual if needed) based on risk assessment.
        - Compliance with the Hepatitis B (Hep-B) vaccine program.
    - Drug utilization surveillance conducted by the clinical pharmacist to include reports on intravenous to oral switch, review of antibiotics for formulary and restricted use, and other epidemiologically significant areas of concern. An active multidisciplinary Antibiotic Stewardship program
    - Laboratory surveillance reporting on susceptibility patterns of organisms.

B. Utilizing sound epidemiologic principles and HAI research from recognized authoritative agencies

C. Continuously collecting and/or screening data to identify isolated incidents or potential infectious outbreaks

D. Interacting with and reporting to governmental agencies, Centers for Disease Control (CDC)-National Healthcare Safety Network (NHSN) reporting for risk-stratification and benchmark generation thought NHSN Standardized Infection Ratio (SIR) system.

Infection Control Program (ICP)

A. The VCMC/SPH Infection Control Program incorporates the following in a continuing cycle:
   - Surveillance, prevention and control of infections throughout the organization
   - Development of alternative techniques to address the real and potential exposures
   - Selection and implementation of the best techniques to minimize adverse outcomes
   - Evaluation and monitoring of results and revision of techniques as indicated

B. The program is guided and influenced by sound principles and current information mainly from the following organizations, which include but are not limited to:
   - American Hospital Association (AHA) and its Advisory Committee
   - Association for Professionals in Infection Control and Epidemiology (APIC)
   - Centers for Disease Control and Prevention (CDC)
   - Centers for Medicare & Medicaid Services (CMS)
   - Certification Board of Infection Control and Epidemiology (CBIC)
   - Food and Drug Administration (FDA)
   - Department of Health and Human Services (HHS)
   - Institute for Healthcare Improvement (IHI)
   - The Joint Commission (TJC)
   - National Institute for Occupational Safety and Health (NIOSH)
   - Occupational Safety and Health Administration (OSHA)
   - Society for Healthcare Epidemiology of America (SHEA)

C. The activities of the Infection Control Program fall under the umbrella and auspices of the organization's performance improvement program.

- Active participation in an organizational proactive education program, in a coordinated effort to reduce and control spread of infection.
- To facilitate a multidisciplinary approach to the prevention and control of infections.
- Integrating outcomes from surveillance and control activities throughout the facilities to allow for internal comparison for trend analysis.
- Assuring the implementation of infection control policies and procedures throughout the hospital(s).
- Communication of infection.

Reporting Structure:

The Infection Control Practitioner (ICP) and the Infection Control/Prevention Committee provide regular updates of information related to program interventions and outcomes as well as the risk assessment and quality improvement projects to the Hospital Administration, the Medical Staff, and other management team members. Appropriate reports of surveillance data are sent to department managers to share with staff. Infection Prevention Committee meeting minutes and reports go to the Performance Improvement and Coordinating Council (PICC). The ICP Committee reports are addressed at the Medical Executive

Committee and the Oversight Committee meetings.

Infection Control Practitioner (ICP) Responsibilities:

The responsibilities of the ICP include, but are not limited to:

1. Develop and implement policies governing the prevention and control of infections and communicable diseases.
2. Develop, implement and evaluate systems and measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare–associated infections and community-acquired infections.
3. Identify and implement the necessary steps to prevent or control the acquisition and transmission of infectious agents
4. Coordinate all infection and control activities within the hospital and clinics
5. Facilitate ongoing monitoring of the effectiveness of prevention and/or control activities

6. Collect and analyze infection data, maintain a log of incidents related to infections and communicable diseases.

7. Participate actively in healthcare worker and patient/family education

8. Evaluation of products and procedures related to disinfection practices.

9. Staffing is based upon guidelines promoted by APIC as well as other regulatory agencies and prevailing community practice.

Infection Control Reporting:

The hospital reports infection control and prevention data to the requisite regulatory and government agencies as well as other entities as required. Required reporting includes but is not limited to the following:

1. ~~Outbreaks or unusual incidence of infectious or parasitic disease or infestation, whether or not listed in Title 17, California Code of Regulations (CCR), §2500~~
2. ~~Occurrence of unusual diseases, rare or a newly apparent or emerging disease or syndromes of uncertain etiology which a health- care provider has reason to believe could possibly be caused by a transmissible infectious agent or microbial toxin~~
3. ~~Transfer or discharge of patients with communicable diseases from healthcare facilities~~
4. ~~Emergency response employees (ERE) personnel should be included in the follow-up contact investigations of patients with infectious TB disease~~
5. ~~Reporting of potential bioterrorism agents~~
6. ~~Reportable diseases and conditions outlined in Title 17, California Code of Regulations (CCR), § 2500~~
7. ~~Mandatory annual report per CA State SB 739~~
8. ~~All CDC-NHSN required reports~~

~~Monthly data reporting elements may include:~~

- Outbreaks or unusual incidence of infectious or parasitic disease or infestation, whether or not listed in Title 17, California Code of Regulations (CCR), §2500
- Occurrence of unusual diseases, rare or a newly apparent or emerging disease or syndromes of uncertain etiology which a health- care provider has reason to believe could possibly be caused by a

transmissible infectious agent or microbial toxin
- Transfer or discharge of patients with communicable diseases from healthcare facilities
- Emergency response employees (ERE) personnel should be included in the follow-up contact investigations of patients with infectious TB disease
- Reporting of potential bioterrorism agents
- Reportable diseases and conditions outlined in Title 17, California Code of Regulations (CCR), § 2500
- Mandatory annual report per CA State SB 739
- All CDC-NHSN required reports
- Monkeypox cases and all suspects are reported through CalREDIE virtual CMR

Weekly

- **Patient level discharge information for each hospitalized person** who tests positive for COVID-19 reported to CDPH in compliance with AFL 21-25
- NHSN COVID-19 Vaccination for Healthcare Personnel

Monthly data reporting elements may include:

- Device-Associated Reporting:
  - Central Line Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infections (CAUTI)
  - Ventilator-Associated Events (optional)
    ~~Central Line Insertion Practice (CLIP) in intensive care units~~
- Surgical Site Infections reporting within 30 Days of inpatient procedure:
  - Abdominal aortic aneurysm repair
  - Limb amputation
  - Appendix surgery
  - Shunt for dialysis
  - Bile duct, liver or pancreatic surgery
  - Carotid endarterectomy
  - Gallbladder surgery
  - Colon surgery
  - Cesarean section
  - Gastric surgery
  - Abdominal hysterectomy
  - Kidney transplant
  - Laminectomy
  - Neck surgery
  - Kidney surgery
  - Ovarian surgery
  - Prostate surgery
  - Rectal surgery
  - Small bowel surgery
  - Spleen surgery
  - Thoracic surgery
  - Thyroid and/or parathyroid surgery
  - Vaginal hysterectomy
  - Exploratory Laparotomy
- Surgical Site Infections reporting within 90 Days of inpatient procedure

- Cardiac surgery
- Coronary artery bypass graft with both chest and donor site incisions
- Coronary artery bypass graft with chest incision only
- Craniotomy
- Spinal fusion
- Open reduction of fracture
- Herniorrhaphy
- Hip prosthesis
- Knee prosthesis
- Pacemaker surgery
- Peripheral vascular bypass surgery
- Ventricular shunt

- Multi-Drug Resistant Organisms (LabID-based):
  - Methicillin/Oxacillin- Resistant Staphylococcus Aureus (MRSA) bloodstream infections
  - Vancomycin-Resistant Enterococcus (VRE) Bloodstream infections
  - Carbapenem-resistant Enterobacteriaceae (CRE)
  - Clostridium Difficile Infections.
- Influenza Vaccination Summary
  - Influenza Vaccination Survey
- Monthly Summary Data

~~Annual NHSN survey~~

Annual NHSN survey

- The hospital confers NHSN rights to California Department of Public Health (CDPH) for access of mandated data.

~~A regular review of effective methods for achieving implementation of water management programs (WMPs) intended to reduce Legionella growth and transmission in buildings at increased risk.~~

COVID-19 Related reporting

- **Patient level discharge information for each hospitalized person** who tests positive for COVID-19 reported to CDPH in compliance with AFL 21-25
- **MIS-C (Multisystem Inflammatory Syndrome in Children) Reported to CDPH** Per Monice Wong request
- **EMS Survey for each inpatient admission, update, and discharge**
- **HHS Daily Tracking**
- **CalREDIE** Reporting Inpatient and Outpatients COVID-19
- **NHSN COVID-19 Vaccination for Healthcare Personnel**

Infection Control Surveillance:

Active surveillance consists of both targeted surveillance of selected patient populations or procedures, as well as organization-wide surveillance designed to identify infectious risks or communicable disease issues in any department or care setting.

A. Total House Surveillance:
All HAIs are monitored in the entire population of the facility. The main benefit of total (or whole) house surveillance is to assist in the comprehensive risk-assessment to identify real and potential infection risks

that would guide the targeted surveillance.
While using total house surveillance, infection rates are calculated for specific HAIs in defined populations in the facility, such as CLABSIs per department or surgical site infections (SSIs) related to a specific operative procedure. An overall facility infection rate is not preferred and may only be calculated for self-comparison over time, it is not to be used for target performance improvement activities as crude overall rates are not sensitive enough to identify potential problems.

B. Targeted Surveillance:
In addition to total house surveillance, targeted focused surveillance narrows the focus on particular care units (e.g., a nursery or ICU), infections related to medical devices (e.g., intravascular and urinary catheters), invasive procedures (e.g., surgery), and organisms of epidemiological significance.
As well, targeted surveillance usually focuses on high-risk, high-volume procedures and on those HAIs and adverse outcomes that are potentially preventable.

C. Surveillance Timing:

Concurrent or prospective surveillance is initiated while the patient is under the care of the organization and includes active surveillance during the post-discharge period specially when patients present to emergency room with a possible surgical site infection.

Post-discharge surveillance methods have been used with varying degrees of success for different procedures include:

- Patient surveys by mail or telephone.
- Surgeon survey by mail.
- Direct reporting from associated clinics, or physicians' offices following examination of patients' wounds during follow-up visits.
- Review of admission diagnosis of all emergency room patients as well as other hospital out-patient services.
- Review of all surgical site infections flagging ICD-10 codes as per the post-discharge surveillance.
- Communication with local hospitals and medical centers to refer and receive post- operative information.

A regular review of effective methods for achieving implementation of water management programs (WMPs) intended to reduce Legionella growth and transmission in buildings at increased risk.

Data Collection:

Examples of data elements that are used for infection surveillance include the following:

1. Demographics: name, identification number, age, sex, location in facility, admission date, underlying diseases or diagnoses
2. Clinical information about infection: signs or symptoms specific to infection definition, with date(s) of onset (date of first sign or symptom)
3. Laboratory data: culture results related to site infection, sensitivity reports, colony counts, titers, and other laboratory findings as related to infection definitions and dates of tests
4. Risk factors: Current surveillance strategies make use of risk stratification when it is appropriate. Most risk data are recorded for all of the population, not just for the cases that develop the outcome being studied. Examples include the following:

- Host-specific risk elements: age, diabetes, obesity, underlying disease, and other intrinsic risk factors.
- Risk related to therapy and procedures: surgical procedures, IV lines, indwelling catheters, and ventilator

use. This factor might include some accounting of days of device use.
- Interventions: antibiotics, other treatment started, corrective procedures and devices removed.
- Additional data: response to treatment, length of stay, other statistical date, and costs of care.

Case Definition:

1. The hospital adheres to the latest Center for Disease Control and Prevention (CDC) National Healthcare and Safety Network (NHSN) Surveillance Definitions for all published specific types of infections.
2. The ICP tracks updated criteria and definitions as soon as they are released.

Benchmarking:

1. The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare-associated infections (HAIs). SIR) is a summary measure used to track hospital acquired infections (HAI) at the hospital level over time. The NHSN adjusts SIR adjusts for our facility and for our patient-level factors that contribute to HAI risk within the facility based on the data submitted to NHSN on a regular basis.
2. In HAI data analysis, the SIR compares the actual number of HAIs reported to what would be predicted/ expected, given the standard population, adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence for example, the duration of a surgical procedure and patient morbidity and wound classification of our patient population. For this reason, the NHSN is no longer issuing HAI rates or pooled means as they cannot reflect differences in risk between populations. Based on that, the hospital uses the NHSN SIR for benchmarking.
3. The Standardized Utilization Ratio (SUR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to compare device utilization at the national, state, or facility level by tracking central line, urinary catheter, and ventilator use.

Infection Control Risk-Assessment:

The organization monitors high-volume, high-risk events in a specific population, events that have the potential to provide information that can be used to improve outcomes and infection prevention practices.

Examples of outcome events to be monitored include, but are not limited to:

1. Hospital acquired infections HAIs (e.g., bloodstream, urinary tract, pneumonia, surgical site, conjunctivitis, upper respiratory tract, or local intravenous site).
2. Infection or colonization with a specific organism (e.g., C. difficile, CRE, MRSA, VRE, ESBL, Respiratory Syncytial Virus [RSV] or Rotavirus).
3. Phlebitis related to peripheral intravascular therapy.
4. Pyrogenic reaction or pus, redness, or increased swelling at a dialysis vascular access site in hemodialysis patients.
5. Sharps injuries and communicable disease or blood/body fluid exposures in healthcare personnel.
6. QuantiFERON-TB Gold or Tuberculin skin test conversion rates in healthcare personnel.
7. Influenza immunization rates in personnel, medical staff, or patients.
8. Hepatitis B immunization rates in personnel.

Examples of process events include, but are not limited to:

A. Personnel compliance with infection prevention protocols, such as:

- Standard precautions
- Transmission-Based precautions
- Central line insertion, maintenance, and removal
- Urinary catheter insertion, care, and removal
- Safe injection and medication handling practices
- QuantiFERON-TB Gold or Tuberculin skin testing
- Hand hygiene
- Instrument processing
- Sterilization quality assurance testing
- Environmental cleaning and disinfection
- Communicable disease reporting
- Antimicrobial prescribing and administration
- Installing and maintaining barriers during construction and renovation project

B. Results of quality a quality assurance testing, such as:

- Monitoring of negative airflow in airborne infection isolation rooms
- Biological monitoring of sterilizers
- Testing of high-level disinfectants.

3. Admission of a patient or resident known to be infected or colonized with a multidrug resistant organisms (MDRO).

Examples of other events of significance to be monitored include, but are not limited to:

1. Occurrence of reportable diseases and conditions.
2. Communicable and potentially communicable diseases in personnel.
3. Organisms or syndromes indicative of a bioterrorism event.

Risk Mitigation:

Practices to Decrease the Risk of Transmission.

A. Monitoring compliance with and the effectiveness of the facility's infection prevention and control policies and procedures.

B. Monitoring compliance with and the effectiveness of the facility's infection prevention and control policies and procedures.

C. Adherence to appropriate infection prevention measures (e.g., hand hygiene, barrier precautions, aseptic techniques.

D. Adherence to CDC guidelines and toolkits which include but are not limited to:

- Disinfection and sterilization
- Environmental infection control
- Hand hygiene

- Isolation precautions specially Category IA, Category IB and Category IC
- Multidrug-resistant organisms (MDRO)
- Catheter-associated urinary tract infections (CAUTI)
- Intravascular catheter-related infection (BSI)
- Surgical site infection (SSI)
- Disease and Organism-specific guidelines

E. Adherence to Institute for Healthcare Improvement (IHI) device-specific bundles including:
   - Prevent Central Line-Associated Bloodstream Infection Bundle
   - Prevent Obstetrical Adverse Events Bundle
   - Prevent Ventilator-Associated Pneumonia Bundle

   ~~Severe Sepsis Bundles~~

F. Measures for the early identification of patients who require isolation in accordance with CDC guidelines.

G. Appropriate use of personal protective equipment including gowns, gloves, masks and eye protection devices.

H. Use and techniques for "isolation" precautions as per by the CDC.

I. Implementing appropriate prophylaxis to prevent surgical site infection (SSI), such as a protocol to assure that antibiotic prophylaxis to prevent surgical site infection for appropriate procedures is administered at the appropriate time, done with an appropriate antibiotic, and discontinued appropriately after surgery.

J. Addressing aseptic technique practices used in surgery and during invasive procedures performed outside the operating room which includes instrument/equipment sterilization.

Program Evaluation:

Evaluation of the Infection Control Program includes, but is not limited to:

1. The organization formally evaluates and revises the Infection Control Risk-Assessment at least annually or more frequently based upon goals and program (or portions of the program) on ongoing basis and/or whenever risks significantly change.
2. The evaluation addresses emerging and re-emerging problems in the health care community that potentially affect the hospital.
3. The evaluation addresses changes in the scope and the results of the program.
4. The evaluation addresses the assessment of the success or failure of interventions for preventing and controlling infection.
5. The evaluation addresses responses to concerns raised by leadership and others within the organization.
6. The evaluation addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus
7. The Infection Control Manager facilitates the program evaluation and submits the evaluation to the Infection Control Committee for review and approval.
8. When aggregate data for any indicator is different from the expected benchmark, analysis of patterns, trends, or problems will be done to determine whether an opportunity to improve the quality of patient

care or provide safer work environment for employees exists. This analysis will include, as applicable, review of the total process involving all departments and or services which has an input into the aspect of care being evaluated. Lines of communication are maintained with all services and departments involved. Information is also presented to the Infection Control Committee and the Performance Improvement Coordinating Council.

9. If an opportunity for improvement of the quality of patient care is determined, or a problem area is identified, a plan of corrective action will be initiated. This corrective action will identify the person, condition or activity that is expected to change, the person responsible for implementing action, the appropriate action in view of the effect on patient care, cause, scope, and severity and when change is expected to occur. Action is implemented through existing channels of the department, administration, or medical staff organization. Every activity will be documented, and conclusions, changes, and reevaluation will be reported.
10. Monitoring and evaluation does not end when actions are taken. Further evaluation of the important aspects of care or service should continue to evaluate the effectiveness of the actions taken, to assure that performance improvements are maintained and to further improve the quality of care and service given. If ongoing monitoring indicates that actions did not result in improving care, further evaluations and further actions should be taken. Ongoing and follow-up monitoring should ultimately show that meaningful improvement has taken place and is maintained.
11. Monitoring and evaluation data, conclusions, recommendations actions and follow-up will be communicated and disseminated through established channels to individuals and groups who are involved and affected by the information including:

- The department(s) concerned.
- The Infection Control Committee
- The Performance Improvement Coordinating Council
- The Medical Executive Committee
- The Oversight Committee (Board)

List of Attached ~~Addendums Are~~Addendum:

1. ~~NHSN HAI Risk Factors~~
2. ~~VCMC Risk Assessment - Demographics~~
3. ~~SPH Risk Assessment - Demographics~~
4. ~~Risk Assessment - HAIs~~
5. ~~VCMC Risk Assessment - SSIs~~
6. ~~SPH Risk Assessment - SSIs~~
7. ~~Risk Assessment - Precautions~~
8. ~~Risk Assessment - Environment~~
9. ~~NHSN Surgical Risk Factors~~
10. ~~Tuberculosis Annual Risk Assessment (CDC)~~
11. ~~2020 Goals 1-3~~
12. ~~2020 Goals 4-7~~
13. ~~NHSN Reporting Plan - 2019~~

14. ~~Standardized Infection Ratio (SIR)~~

1. Previous year annual report

COVID-19 Surveillance and Protocol:

1. ~~VCMC_SPH_COVID_Interim_Management_Guidelines~~
2. ~~Transport_of_COVID_suspected_or_infected~~
3. ~~COVID_19_Checklist~~
4. ~~COVID LABOR AND DELIVERY~~
5. ~~VCMC_COVID_C-section Protocol~~
6. ~~Visitation During COVID-19 Pandemic (PolicyStat ID: 7808604)~~
7. ~~Compiled Resources Google Docs: https://docs.google.com/document/d/149cSAUSj6VAOfdJYSqRLEXszV1VHhQ9Glv8cdGmcFAU/edit~~
8. ~~Daily to HHS (template: Reporting_covid19NewEntry)~~
9. ~~Daily to NHSN module (replaced by FEMA/HHS reporting portal as of 4/21/2020~~

- ~~covid19hcw~~
- ~~covid19patient~~
- ~~covid19supp~~

10. ~~Ongoing reporting to Public Health, all positive and Suspected COVID Cases emailed to vcph-id@ventura.org~~

1. Allocation Of Critical Care Resources During A Public Health Emergency
2. Cardiopulmonary Arrest Protocol During COVID-19 Pandemic
3. Care Of the COVID-19 Positive Mother and Her Newborn
4. Convalescent Plasma as Exploratory Treatment for COVID-19
5. COVID-19 Screening of Healthcare Personnel
6. COVID-19 Trauma Activation Policy
7. CPG.73 Acute Management of Anaphylaxis
8. Discontinuation of Transmission-Based Precautions for Patients with COVID-19
9. Guidelines for Respiratory Therapy During COVID-19 Pandemic
10. Hygienist Role During COVID-19 Pandemic
11. Initiating Medication Therapy to Treat COVID-19 Infections
12. Medication Management Protocols During COVID-19 Pandemic
13. Operative Management Of COVID positive and COVID unknown patients during COVID-19 Pandemic
14. Pandemic Respirators
15. Reprocessing N95 Respirators During COVID-19 Pandemic
16. Standardized Procedure for Ordering COVID-19 Testing
17. Swabbing Asymptomatic Patients for COVID-19

References:

Joint Commission Hospital Accreditation Standards

CMS Conditions of Participation for Acute Care Hospitals, §482.42

APIC Text, ~~2019~~2021

~~CDC COVID Updates~~

~~WHO COVID Updates~~

~~CDPH COVID Updates~~

CDC COVID Updates https://www.cdc.gov/socialmedia/syndication/405380/404364.html

CDC guidelines as updated:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

All Facilities Letters (AFLs) ad published by California Department of Public health at
https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx

All revision dates: 8/18/2022, 6/9/2020, 3/21/2019, 5/1/2016, 5/1/2015, 5/1/2014, 10/1/2012, 10/1/2010, 4/1/2009, 5/1/2008, 6/1/2006, 3/1/2006, 8/1/2004, 6/1/2004, 1/1/2003, 1/1/1999, 1/1/1995

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Leah Kory: Medical Director, Inpatient Quality	10/7/2022
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	8/18/2022
Policy Owner	Magdy Asaad: Infection Prevention Manager	8/18/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*2/1/2004*
Last Approved:	*N/A*
Last Revised:	*10/7/2022*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.030 Bloodborne Pathogen Exposure Control Plan

POLICY:

Ventura County Medical Center/Santa Paula Hospital and Ambulatory Care Administration ~~rrecognizes~~recognizes bloodborne pathogen exposure (BPE) as an important health risk for many employees. The ~~bloodborne pathogen exposure plan~~Bloodborne Pathogen Exposure Control Plan (~~BPEP~~BPECP) has been put in place to protect the health of employees.

Applicability:
Agency/Department employee job classifications are categorized by exposure determination into three categories listed below. Category 1 and 2 job classifications are required to follow all aspects of this plan. Category 3 job classifications need to be aware of the BPECP. Managers/Supervisors must coordinate with Risk Management on any changes in exposure levels or job tasks.

- *Category 1* – those with high potential for exposure to blood or Other Potentially Infectious Materials (OPIM), i.e., those doing regularly assigned duties (e.g. first aid, cardiopulmonary resuscitation (CPR), collecting blood specimens, providing direct patient care, clean-up of bloody spills, etc.) that are exposed to blood, body fluids, or tissues.
- *Category 2* – those with moderate potential for exposure to blood or OPIM, i.e. those whose normal work tasks do not involve routine exposure to blood, body fluids, or tissues, but exposure may occur as a condition of employment based on specific job tasks with BPE risk potential (collecting or handling bloody evidence, controlling an assaultive client, assisting someone injured, clean-up of a bloody spill, etc.).
- *Category 3* – those with very low potential for exposure to blood or OPIM, i.e., those whose normal work tasks do not involve routine exposure to blood, body fluids, or tissues, and exposure is not required as a condition of employment.

Responsibilities:

Program Administrator

The Program Administrator has authority and overall responsibility for the design, implementation, interpretation, and revision of the BPECP. Duties include:

a. Direct and plan an effective BPECP program for the Ventura County Health Care Agency (VCHCA).

b. Coordinate BPE control needs by providing appropriate professional and technical resources.

c. Approve all aspects of this BPECP and any changes hereto.

d. Recommend engineering and administrative controls as needed and determine which job classifications and job tasks are to be included in this BPECP.

e. Ensure the Licensed Health Care Professional (LHCP) has a copy of this BPECP, and after an exposure incident provide LHCP: (1) a description of the exposed employee's duties allied with the incident; (2) documentation of the routes of exposure and circumstances under which exposure occurred; (3) the source person's blood testing results, if known, or a contact to request same; and (4) all employee health records relevant to the appropriate treatment of the employee including vaccination status that are the employer's responsibility to maintain.

f. Obtain and provide the employee a copy of the LHCP's written opinion within 15 days of the completion of the exposure evaluation.

g. Arrange for and/or conduct initial training within 10 days of hire/transfer. Annual training is conducted via the electronic education system per Administrative policy 101.025.

h. Evaluate the BPECP's overall quality and effectiveness by reviewing policies yearly and making recommendations for revisions if necessary.

i. Maintain required records.

Health Care Management

LHCPs authorized and/or administered by the Program Administrator provide services for health maintenance, medical surveillance, and exposure care. The Program Administrator shall use resources from the *County of Ventura Authorized Medical Panel* of providers and Workers' Compensation consultants along with VCHCA/Employee Health Services (EHS) to:

a. Provide Hepatitis B vaccination for employees in identified risk job classifications.

b. Validate agency/department verification of occupational occurrences and exposure incidents and provide initial and follow-up exposure care (after initial exposure evaluation and medical care, follow-up care will be managed and completed by EHS unless employee refuses per item c of this section) based on established protocols per the U.S. Department of Health and Human Services Centers of Disease Control and Prevention.

c. Advise employees following an exposure incident that she/he/they may refuse post-exposure evaluation and follow-up from County's chosen healthcare professional. If consent is refused, notify Risk Management and make immediately available to the exposed employee(s) a confidential medical evaluation and follow-up from a LHCP other than from the County's Employee Health Service or one connected with their Agency/Department for post-exposure follow-up care.

d. Provide a written opinion 15 days after an exposure incident to the Program Administrator to include: (1) for hepatitis B vaccination the opinion shall be limited to whether hepatitis B vaccination is indicated, and if the employee has received such vaccination, and (2) for post-exposure evaluation and follow-up, the opinion shall be limited to whether the employee has been told about any medical conditions resulting from exposure to blood or OPIM that requires further evaluation or treatment. All other findings or diagnoses shall remain confidential and shall not be included in the written opinion.

e. Maintain medical evaluations, exposure data, and related BPECP documentation in medical records per CCR Title 8 §5193 (h)(1) ensuring appropriate notification and documentation of vaccination, declination of vaccination, exposure medical evaluation (including test results),limitations and counseling.

f. Keep a log of verified occupational occurrences sending same to HCA/EHS.

g. Maintain the Sharps Injury Log.

h. Coordinate with the Program Administrator for hazard evaluations or training deficiencies noted.

Management

Management is responsible for ensuring the BPECP has an approved budget to meet the needs of the agency/department/clinic. Duties of management include:

a. Identify at risk job classifications and tasks;

b. Coordinate with LHCPs for hepatitis B vaccination, medical evaluations, and exposure care;

c. Implement BPECP and submit annually to the Program Administrator for review any changes in exposure risk potential or job tasks or specific methods of compliance.

d. Assess the BPECP yearly for overall effectiveness by evaluating Agency/Department program against all aspects of this BPECP.

e. Follow-up and take corrective action after all occupational occurrences or exposure incidents especially sharps incidents resolving deficiencies promptly.

Managers and Supervisors

Managers/supervisors shall ensure that this BPECP is implemented in their areas. In addition to being knowledgeable about the BPECP for their own protection, supervisors must ensure that the BPECP is understood and followed by those in their charge. Duties include:

a. Ensuring work activities within area of responsibility have been surveyed for BPE exposure potential and identified by job classification (hazard evaluation), and exposure history.

b. Continually monitoring job tasks to identify new or unrecognized BPE hazards.

c. Being knowledgeable about BPE and how this issue impacts employees (i.e., know exposure incident trends and injury rates).

d. Using resources and programs available within the County and through the Program Administrator to address bloodborne pathogen concerns or needs.

e. Ensuring they and those they direct follow this BPECP, receive and document BPECP training and vaccination prior (i.e., within 10 days of hire or transfer) to carrying out work tasks with BPE potential.

f. Reviewing and verifying all reported occupational occurrences and exposure incidents along with taking action to prevent reoccurrence.

g. Processing, based on verification, either a Bloodborne Pathogen Employer's Report of Injury or an Occupational Occurrence Incident Form and a Sharps Injury Log per applicable incident.

h. Ensuring prompt medical evaluation is provided for employees involved in an exposure incident, and that each involved employee contacts EHS at 654-3813 the next duty day after an exposure incident for further follow-up.

i. Providing budgetary resources to ensure information/training and control measures are available to those they direct.

j. Conduct monthly inspections of engineering and work practice controls to ensure use as intended and re-evaluate annually for effectiveness, efficiency and cost.

k. Completing a Manager/Supervisor evaluation semi-annually or as otherwise required.

Employees

Employees are responsible for using the control measures, wearing PPE, and following the *Methods of Compliance* (IDCP §2.5 below) when and where required and in the manner in which they were trained. Duties include:

a. Understanding and participating fully in the BPECP.

b. Using engineering/administrative controls established and reporting problems to managers/supervisors.

c. Using all PPE as outlined in established procedures.

d. Participating in initial (within 10 days of hire or transfer) and annual BPECP training.

e. Reporting all occupational occurrences and exposure incidents immediately to their managers/ supervisors.

f. Contact EHS at 654-3813 the following duty day after an exposure incident for further follow-up.

g. Evaluating their BPECP participation, use and effectiveness of control measures semi-annually via checklist or as required by the Program Administrator.

Methods of Compliance

The following controls and work practices will be adhered to when BPE potential has been determined based on job classification, hazard evaluation (exposure determination), and exposure history. Other engineering or administrative controls and personal protective equipment (PPE) will be implemented as needed per Program Administrator review and approval.

Standard Precautions: please see Administrative policy *106.018 Infection Control Standard Precautions*.

Engineering and Work Practice Controls -- General Requirements

Engineering and work practice controls shall be used to eliminate or minimize BPE. Examine these controls for use, maintenance, and/or replacement monthly to ensure their effectiveness and re-evaluated annually for effectiveness and efficiency. All procedures involving blood or OPIM must be done in a manner that minimizes the splashing, spraying, spattering, and generation of droplets of these substances.

Engineering and Work Practice Controls -- Specific Requirements

a. *Rules for Needleless Systems, Needle Devices, and non-Needle Sharps.*
Needleless systems shall be used for: (a) withdrawal of body fluids after initial venous or arterial access is established, (b) administration of medications or fluids, and (c) any other procedure involving the potential for an exposure incident for which a needleless system is available as an alternative to the use of needle devices.

   1. Needle devices with engineered sharps injury protection shall be used if needleless systems are not used for: (a) withdrawal of body fluids, (b) accessing a vein or artery, (c) administration of medications or fluids, and (d) any other procedure involving BPE potential for which a needle device with engineered sharps injury protection is available.
   2. Non-Needle Sharps shall include engineered sharps injury protection.
   3. The following exceptions apply to the engineering controls required by §5193:
      a. If the control is unavailable in the marketplace;
      b. If a LHCP involved in a patient's care reasonably determines, which is to be documented per

§5193(c)(1)(B)6, that use of the control will jeopardize the patient's safety or the success of a medical, dental or nursing procedure involving the patient;

c. If the agency/department/clinic can demonstrate by objective criteria that the control is not more effective in preventing BPE incidents than that used by the agency/department/clinic; or

d. If the agency/department/clinic can demonstrate that reasonably specific and reliable information is unavailable on the safety performance of the control for the subject procedure, and that the agency/department/clinic is actively determining by objective criteria whether use of the control will reduce the risk of BPE incidents occurring in the subject workplace.

b. *Prohibited Practices*

1. Shearing or breaking of contaminated needles and other contaminated sharps.
2. Bending, recapping or removing contaminated sharps from protective devices (***exception***: contaminated sharps may be bent, recapped, or removed from devices if done using a mechanical device or a one-handed technique, and the agency/department/clinic can show that no alternative is feasible or that such action is required by a specific medical or dental procedure);
3. Storing or processing sharps contaminated with blood or OPIM in a way that requires reaching by hand into the containers where these sharps have been placed.
4. Reusing disposable sharps.
5. Directly using hands to pick up sharp objects that may be contaminated.
6. Accessing the contents of sharps containers unless properly reprocessed or decontaminated.
7. Opening, emptying, or cleaning manually sharps containers or in any other manner that would cause expose to the risk of sharps injury.
8. Pipetting/suctioning by mouth of blood or OPIM.
9. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses in work areas where there is a reasonable likelihood of BPE.
10. Keeping food and drink in refrigerators, freezers, shelves, and cabinets or on countertops or bench tops where blood or OPIM are present.

c. *Handling Contaminated Sharps, Broken Glassware or Sharp Objects.*

1. All procedures involving sharps in connection with patient care shall:
   a. be done using effective patient-handling techniques and other methods designed to minimize the risk of a sharps injury;
   b. put contaminated sharps in containers per §5193(d)(3)(D) as applicable immediately or as soon as possible after use; and
   c. use containers for contaminated sharps that are: (1) easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries); (2) maintained upright throughout use, where feasible; and (c) replaced when 2/3 full.
2. Pickup broken glassware potentially contaminated with blood or OPIM using tongs, a broom and dustpan, or a HEPA vacuum (not the hands) and disposed of into a sharps container if regulated waste or bagged and containerized to prevent any further contact or injury.
3. Other sharp objects potentially contaminated with blood or OPIM if to be repaired are to be cleaned

and disinfected first per §2.5.3.i. Don't pick up the object directly with the hands. Use tongs, shovel, or other extended tool to lift and transport via a cart in another container. Clean and disinfect all equipment used per §2.5.3.i. Other broken or unusable sharp objects potentially contaminated with blood or OPIM to be discarded are to be put in a sharps container if regulated waste, or bagged and containerized as regulated waste, or bagged and containerized to prevent any further direct contact or injury.

d. *Sharps Containers for Contaminated Sharps*

   1. All containers for contaminated sharps shall be: (a) rigid, (b) puncture resistant, (c) leak-proof on the sides and bottom, (d) portable if necessary to ensure easy access by the user per §5193(d), and (e) labeled per §5193(g).

   2. If discarded sharps are not to be reused, the container shall be closeable and sealable so that when sealed, the container is leak resistant and can be reopened only with great difficulty.

e. *Cardiopulmonary Resuscitation Precautions.* To minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, pocket masks, or other such device shall be used. Such devices will be supplied to individuals for their use and stored in designated kits or cabinet locations.

f. *Regulated Waste*

   1. Handling, storage, treatment, and disposal of regulated waste shall be per Health and Safety Code Chap. 6.1, §117600 through §118360, other applicable regulations, and the *Ventura County Medical Waste Management: A Guide to Compliance for Medical Waste Generators.*

   2. When any container of contaminated sharps is moved from the area for disposal, it shall be: (a) closed prior to removal to prevent spillage or protrusion of contents during handling, storage, or transport; and (b) if leakage is possible, put in a secondary container that is: closeable, made to prevent leakage during handling, storage, or transport; and labeled per §5193(g).

   3. Regulated waste not consisting of sharps shall be disposed of in containers that are: (a) closeable and made to prevent leakage, spillage, or protrusion of contents during handling, storage, or transport; (b) labeled and color-coded per §5193(g); and (c) closed prior to removal.

   4. If outside contamination of a regulated waste container occurs, put it in a second container that is: (a) closeable and made to prevent leakage, spillage, or content protrusion during handling, storage, or transport; (b) labeled and color-coded per §5193(g), and (c) closed prior to removal.

g. *Handling Specimens of Blood or OPIM.* Specimens of blood or OPIM shall be put in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping.

   1. The container shall be labeled or color-coded per §5193(g), and closed prior to being stored, transported, or shipped. When a facility uses Standard Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens and they remain within the facility. Labeling or color-coding per§5193(g) is required when such specimens/ containers leave the facility.

   2. If the specimen could puncture the primary container, it shall be put within a secondary container that is puncture-resistant in addition to the above characteristics.

h. *Servicing or Shipping Contaminated Equipment.* Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the Agency/Department can demonstrate that decontamination of such equipment or portions of such equipment is not feasible. In such cases:

1. A readily observable label per §5193(g) shall be attached to the equipment stating which portions remain contaminated; and
2. Information concerning all remaining contamination shall be conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

i. *Cleaning and Decontamination of the Worksite*.

1. General Requirements.
    a. Managers/supervisors shall ensure that the worksite is maintained in a clean and sanitary condition via, at minimum, a written schedule for cleaning and decontamination.
    b. The cleaning or decontamination method used shall be effective and appropriate for the location and type of surface or equipment to be treated, the type of contamination present, and the tasks or procedures performed in the area.
    c. All equipment, environmental, and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below.
2. Specific Requirements.
   Contaminated work surfaces and equipment (brooms, mops, clean-up tools, etc.) shall be cleaned and decontaminated immediately or as soon as possible when: (i) item becomes overtly contaminated; (ii) there is a blood or OPIM spill; (iii) procedures are done; and (iv) at the end of the work shift if the item has become contaminated since the last cleaning.

Spill Response Procedures

- Stop all operations.
- Alert personnel via the telephone/overhead paging system.
- Remove all potential sources of ignition and chemical interaction (incompatibles).
- Apprise the Safety Officer or designee of the situation.
- Immediately enact spill response procedures under the direction of the Safety Officer or designee.
- Consult *3E FAX-ON-DEMAND to obtain SDS*
- Block all possible routes of spreading:
    - dike floor drains, sanitary sewer manholes, storm sewer drains and manholes
    - surround spill area with absorbent material

    The following spill kits are available throughout the facilities:
    - Mercury Spill Kit
    - Chemo-therapy spill kit
    - General Spill kit
    - Large Spill kit
    - Cytotoxic spill kit
    - Acid Spill Kit

- Base Spill Kit
- Solvent Adsorb
- Absorbent pad
- Large kit in 10 gallon trash can

In the event of a spill, leakage or release of any hazardous material, proper DISPOSAL of the hazardous substance(s) is an integral part of the waste management system. By following the outline below, proper disposal can be assured:

DISPOSAL SEQUENCE

A. Carry out general or specific spill procedure.

B. Notify the Facilities Maintenance Supervisor who will arrange for the appropriate packaging and disposal of the hazardous material spill waste with Ventura County Risk Management.

C. State law required EPA shipping number, an approved hauler and a hauler's permit number.

D. Non-spilled hazardous waste will be disposed of by placing compatible materials in a clearly marked hazardous materials drum.

   a. **DO NOT MIX** recovered material with any other materials.

   b. All receptacles (bins, pails, cans, and the like) intended for reuse that have a reasonable likelihood for becoming contaminated with blood or OPIM shall be inspected weekly and cleaned and decontaminated immediately or as soon as possible upon visible contamination. Clean as for "Small spills" noted above.

   c. Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible after use, when they become overtly contaminated, at the end of a specific procedure, or at the end of the work shift.

j. *Hygiene.*

   1. Agencies/departments/clinics shall provide handwashing facilities readily accessible to employees.

   2. When the provision of handwashing facilities is not feasible, the agencies/departments/clinics shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

   3. Managers/supervisors shall ensure that employees wash their hands immediately or as soon as possible after removal of gloves or other PPE.

   4. Managers/supervisors shall ensure that employees wash hands and any other skin area with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or OPIM.

k. *Laundry*

   1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.

      a. Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

b. Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded per §5193(g). When a facility uses Standard Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring Standard Precautions.

c. through or leakage from the bag or container, the laundry shall be placed and transported in bags or containers, which prevent soak-through and/or leakage of fluids to the exterior.

2. The manager/supervisor shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate PPE.

3. When contaminated laundry is sent off-site to a second facility that does not use Standard Precautions in the handling of all laundry, the facility generating the subject laundry must place such laundry in bags or containers that are labeled or color-coded per §5193(g).

Personal Protective Equipment (PPE)

a. *Provision.* Where occupational exposure remains after applying engineering and administrative controls, the agency/department/clinic shall provide, at no cost to the employee, appropriate PPE (gloves, gowns, face shields, eye protection, mouthpieces, resuscitation bags, pocket masks, etc.). PPE is "appropriate" only if it does not permit blood or OPIM to pass through to or reach the worker's clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the time that the PPE is used. For fire fighters, these requirements are in addition to and consistent with those in CCR Title 8 §3401-3411.

b. *Use.* The manager/supervisor shall ensure that the employee uses appropriate PPE unless the manager/supervisor shows that the employee temporarily and briefly declined to use PPE when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the issue shall be investigated and documented to determine if changes can be made to prevent such occurrences in the future. The manager/supervisor shall encourage employees to report all such instances without fear of reprisal per CCR Title 8 §3203.

c. *Accessibility.* The agency/department/clinic shall ensure that appropriate PPE in the appropriate sizes is readily accessible at the worksite or is issued to employees.

d. *Maintenance.* The agency/department shall clean, launder, and dispose of PPE required per §5193 at no cost to the employee. The Agency/Department shall also repair or replace PPE as needed to maintain its effectiveness at no cost to the employee.

e. *Removal.* Employees will remove PPE as follows:

1. If a garment(s) is penetrated by blood OPIM, it shall be removed in a manner to not contaminate self or others as trained as soon as safe to do so.

2. All PPE shall be removed in a manner to not contaminate self or others as trained prior to leaving the work area.

3. When PPE is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

f. *Gloves.* Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, OPIM, mucous membranes, and non-intact skin; when performing vascular access procedures except as specified in §5193(d); and when handling or touching contaminated items or

surfaces. These requirements are in addition to those in CCR Title 8 §3384.

1. Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.
2. Disposable (single use) gloves shall not be washed or decontaminated for re-use.
3. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, torn, punctured, or show other signs of deterioration or when their ability to function as a barrier is compromised.
4. Unless the Agency/Department can demonstrate by objective criteria to the contrary, gloving is required for all phlebotomies.
5. Hypoallergenic gloves, glove liners, powder-less gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

g. *Masks, Eye Protection, Face Shields, and Respirators.*

1. Masks in combination with eye protection devices shall be worn whenever splashes, spray, spatter, or droplets of blood/OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated. These rules are in addition to those in CCR Title 8 §3382.
2. Disposable (single use) protection shall be replaced as soon as practical when contaminated or as soon as possible if they are scratched over 25% of the visual field, cracked, punctured, or when their ability to function as a barrier is compromised.
3. Disposable (single use) protection shall not be washed or decontaminated for re-use.
4. Re-usable protection may be decontaminated for re-use if the integrity of it is not compromised. However, they must be discarded if they are scratched over 25% of the visual field, cracked, torn, punctured, or when their ability to function as a barrier is compromised.
5. Where respiratory protection is used, the provisions of the County's Respiratory Protection Program and CCR Title 8 §5144 and 5147 shall apply. (Note: surgical masks are not respirators.)

h. *Gowns, Aprons, and Other Protective Body Clothing.*

1. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, or similar outer garments shall be worn in occupational exposure situations (e.g., tasks likely to generate bloody fluid splashes). The type and characteristics will depend upon the degree of exposure anticipated. These requirements are in addition to those in CCR Title 8 §3383.
2. Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (autopsies, orthopedic surgery, evidence collection, etc.). These requirements are in addition to those in CCR Title 8 §3383.
3. Protective clothing is to be changed when soiled or before leaving the work area.
4. If disposable, protective clothing will be discarded as regulated waste (see §2.5.3.f) or, if possible, as regular trash.
5. Non-disposable protective clothing will be laundered as contaminated/non-contaminated through the Agency/Department. At no time will protective clothing be laundered at home or outside of internal County/County contracted facilities.

Hepatitis B Vaccination

Employees with potential BPE based on identified job classifications, hazard evaluation and exposure history will be offered the hepatitis B vaccine after receiving training per CCT Title 8 §5193 and within 10 working days of hire or transfer unless the employee: (1) has completed the hepatitis B vaccine series, (2) is positive for hepatitis B carriage or immunity, or (3) has a medical contraindication.

Employees must have received training concerning bloodborne pathogens prior to receiving the vaccination. Employees must acknowledge, in writing, if declining the vaccine at that time with the understanding that it can be given at a later date if requested. Employees who have not received the vaccination and have an occupational occurrence incident will be offered the hepatitis B vaccine at the time of incident reporting (Note: the hepatitis B vaccine will be given as soon as possible, preferably within 24 hours), and must acknowledge in writing if they decline understanding the vaccination can be given by request at a later date.

Routine Booster: Booster doses of hepatitis B are not necessary. If the U.S. Public Health Service recommends a routine booster of hepatitis B vaccine at a future date, such booster(s) shall be made available in accordance with CCR Title 8 §5193(f)(1)(B).

POST-EXPOSURE EVALUATION AND FOLLOW-UP - See Administrative policy *106.015 Bloodborne Pathogen Post-Exposure Evaluation and Management.*

All revision dates: 10/7/2022, 5/1/2016, 5/1/2014, 7/1/2009, 5/1/2006

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Control Committee	Leah Kory: Medical Director, Inpatient Quality	10/10/2022
Infection Control Committee	Magdy Asaad: Infection Prevention Manager	9/26/2022
Policy Owner	Magdy Asaad: Infection Prevention Manager	7/12/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/22/2009*
Last Approved:	*N/A*
Last Revised:	*5/1/2016*
Next Review:	*3 years after approval*
Owner:	*Marco Bautista: Sterile Processing Director*
Policy Area:	*Administrative - Environment of Care*
References:	

106.071 Reprocessing Reusable Laryngoscope Blades and Handles

POLICY:

All reusable laryngoscopes blades and handles including, but not limited to, fiber optic and video laryngoscopes, rigid and flexible laryngoscopes, and any device used for direct or indirect intubation or view of a patient's larynx, will be cleaned, disinfected with a high-level disinfectant or sterilized in accordance with manufacturer's instructions, AAMI Standards and State of California guidelines as outlined in the All Facility Letter 07-09, April 30, 2007.

These devices are classified as **semi-critical** devices and will be cleaned and subjected to high-level disinfection or sterilization regardless of whether or not a sheath was used. Any laryngoscope should be examined prior to use and immediately taken out of service if damage is observed or suspected. Proper Personal Protective Equipment must be used when handling and cleaning this equipment.

PROCEDURE:

1. Transportation
   After use, the blade and handle will be sprayed with enzymatic cleaner according to product instructions and will then be covered and promptly transported for reprocessing.
2. Disassembly
   The blade and light bulb, if applicable, should be disconnected from the handle and disassembled according to the manufacturer's reprocessing instructions.
3. Cleaning
   The blade and handle will be cleaned according to manufacturer's instructions and inspected for damage. Any broken equipment must be reported to the Supervisor or Manager who will ensure it is given to the proper department and/or vendor for repair.
4. Sterilization or High-Level Disinfection

   The blade and handle should then be wrapped and sterilized or high-level disinfected in accordance with manufacturer's instructions. The fully processed laryngoscope will be bagged, packaged or tagged to indicate reprocessing has taken place.
5. Transportation, Storage, Handling and Care
   If the laryngoscope is thoroughly dry, it may be returned to storage using care to avoid contaminating the

instrument. The laryngoscope will be stored and transported in such a manner to signify that reprocessing has occurred.

REFERENCES:

California Department of Public Health AFL 07-09
Association for the Advancement of Medical Instrumentation (AAMI)

All revision dates: 5/1/2016, 1/1/2014

Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
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Policy Owner	Marco Bautista: Sterile Processing Director	1/11/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Fernando Medina: Manager, Hospital Support Services*
Policy Area:	*Administrative - Environment of Care*
References:	

106.076 Principles of Cleaning and Disinfecting Environmental Surfaces – Housekeeping Surfaces

POLICY:

Cleaning and disinfection of environmental surfaces at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and Ambulatory Care (AC) clinics is done in accordance with published guidelines and criteria; and is fundamental in reducing their potential contribution to the incidence of healthcare-associated infections. The principles of cleaning and disinfecting environmental surfaces take into account the intended use of the surface or item in patient care.

DEFINITIONS:

A. Cleaning – the necessary first step of any sterilization or disinfection process. Cleaning is a form of decontamination that renders the environmental surface safe to handle or use by removing organic matter, salts, and visible oils, all of which interfere with microbial inactivation.

B. Manufacturer's Instructions for Use (MIFU): maintenance and care instruction specific to a piece of equipment or product.

C. Housekeeping Surfaces: Including but not limited to flooring, walls, tabletops, window blinds, patient privacy curtains, side-chairs, beds, heating and air vents, etc.

D. Safety Data Sheets (SDS): The SDS includes information such as the properties of each chemical; the physical, health, and environmental health hazards; protective measures; and safety precautions for handling, storing, and transporting the chemical.

PROCEDURE:

A. Housekeeping surfaces require regular cleaning and removal of soil and dust. Dry conditions favor the persistence of gram-positive cocci (e.g., coagulase-negative *Staphylococcus)* in dust and on surfaces, whereas moist, soiled environments favor the growth and persistence of gram-negative bacilli.

B. Most environmental surfaces need to cleaned/disinfected depending on the nature of the surface and the

type and degree of contamination using a product from the VCMC Approved Hospital Disinfectant list which is approved by the Infection Control Committee.

C. Cleaning and disinfection schedules and methods vary according to the area of the hospital or clinic.

D. If using a proprietary detergent/disinfectant, the manufacturer's instructions for appropriate use of the product/agent should be followed.

E. Refer to a products' safety data sheets (SDS) to determine appropriate precautions to prevent hazardous conditions during product application. Personal protective equipment (PPE) used during cleaning and housekeeping procedures should be appropriate to the task.

F. Housekeeping/Environmental surfaces can be divided into two groups—those with minimal hand-contact (e.g., floors, and ceilings) and those with frequent hand-contact ("high touch surfaces").

G. High-touch housekeeping surfaces in patient-care areas (e.g., doorknobs, bedrails, light switches, wall areas around the toilet in the patient's room and the edges of privacy curtains) should be cleaned and/or disinfected more frequently than surfaces with minimal hand contact.

H. The methods, thoroughness, and frequency of cleaning and the products used are determined by the health-care facility in collaboration with EVS and Infection Control.

I. Hospital-approved cleaning/disinfecting products, buckets, mops, paper supplies, signs should be secured in a locked area--maintained off the floor in a dry environment to minimize contamination of solutions and tools.

J. Cleaning/disinfecting special care areas such as operating rooms, isolation areas, rooms housing immunosuppressed patients will be done in accordance with published guidelines.

K. Cleaning should occur High-to-Low, Outside-to-Inside, Clean-to-Dirty.

L. Use of tacky mats inside the entry ways of cordoned-off construction areas inside the health-care facility; these mats help minimize the intrusion of dust into patient-care areas.

REFERENCES:

A. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) - Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC) 2003, Updated: July 2019.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Control Committee	Leah Kory: Medical Director, Inpatient Quality	10/7/2022
Infection Control Committee	Magdy Asaad: Infection Prevention Manager	9/26/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/1989*
Last Approved:	*N/A*
Last Revised:	*10/5/2022*
Next Review:	*3 years after approval*
Owner:	*Kathie Jones: Interim Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.07 Death of Patient in the Emergency Department

POLICY:

To facilitate proper care of deceased patients and their families and to assist the Coroner's office with collection of appropriate data.

PROCEDURE:

All deaths in the Emergency Department (ED), whether the death occurred in the ED or the patient was dead on arrival (DOA), are under the Coroner's jurisdiction. ED staff will immediately notify the Coroner's office. The patient's physician will give report to the Coroner.

In the case of a DOA, the patient is not to be undressed nor is this person to be searched for identification until arrival of the Coroner's representative.

No medical devices inserted during resuscitation will be removed unless directed by the Coroner.

It is the responsibility of the Coroner to collect any possible evidence, to notify the next of kin, to make arrangements for autopsy as indicated or for a funeral home to pick-up of the body, and to dispose of the patient's valuables and personal effects. If the patient is not a Coroner's case, these arrangements will be made by the Nursing Supervisor and/or Patient Advocate and family.

Relatives will be asked to remain in the appropriate waiting area until interviewed by the Coroner.

When immediate pick-up cannot be arranged, the ED is busy or the Coroner releases the body, the body may be identified by placing a tag with the patient's name and chart number, if available, on right ankle and taken to the Morgue located in the Hospital basement.

The Nursing Office, the Coroner's office and the Admitting office will be notified of any DOA or death occurring in the ED.

~~Within one hour of patient death, staff should contact One Legacy at (800) 338-6112.~~

All imminent brain deaths and all cardiac deaths must be reported to One Legacy's 24-hour Donor Referral Line within one (1) hour. **One Legacy: 800-338-6112**

All deaths shall be called in to the One Legacy referral line within (1) hour of death or (1) hour of the patient meeting clinical triggers for referral. **One Legacy: 800-338-6112**

All patients meeting **CLINICAL TRIGGERS**, including cardiac death, must be reported within one hour to One Legacy.

Clinical Triggers - include ANY Ventilator Dependent patient with a non-survivable injury, **and** either 1 of the below instances:

- Loss of one or more brainstem reflexes (fixed & dilated pupils, no cough, no gag, no involuntary blinking of the eyelids elicited by stimulation of the cornea, doll's eyes reflex, etc.)
- Or an anticipated discussion of DNR, withdrawal of life-sustaining therapies, or withdrawal of ventilator.

Referrals to One Legacy must be documented in the patient's Progress Notes, and noted directly in the patient's medical record; the One Legacy Referral Number becomes part of the permanent record.

All Cardiac deaths MUST be reported to One Legacy for tissue donation evaluation. Even if the patient was previously ruled out for organ donation, as they may still be eligible for tissue and/or cornea donation.

Provide post-mortem eye care per hospital policy to preserve the opportunity for cornea donation.

Admitting will be notified of patient's name, time of death and name of physician. The ED chart will be completed via Electronic Health Record (EHR).

A Notification form must be filled out by RN.

All deaths within the ED or within 48 hours of admission to the Hospital through the ED will be reviewed on a periodic basis.

All revision dates: 10/5/2022, 11/13/2019, 5/1/2009, 5/1/2006, 1/1/2005, 11/1/2001, 1/1/1995, 10/1/1992, 12/1/1989

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/5/2022
Policy Owner	Kathie Jones: Interim Clinical Nurse Manager, Emergency Services	10/5/2022

Current Status: *Pending* **PolicyStat ID:** *12274063*

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/1989*
Last Approved:	*N/A*
Last Revised:	*10/4/2022*
Next Review:	*3 years after approval*
Owner:	*Kathie Jones: Interim Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.45 Telephone Medical Advice in the Emergency Department

POLICY:

To inform Emergency Department staff of the rules and regulations for giving medical advice to callers by telephone.

PROCEDURE:

~~It is~~Nursing and Ancillary Staff will not ~~recommended that staff~~ give medical advice to callers over the telephone. It is neither legally nor medically safe to give specific information via the telephone, except under unusual circumstances. Staff can instead inform callers that, "We cannot diagnose over the telephone" or "We are available to see you 24 hours a day."

When speaking to callers, staff should identify themselves by name and title, identify the patient's problem to the best of their ability, and then refer the patient to seek appropriate medical care by calling 911, visiting the nearest Emergency Department or visiting their primary care physician.

All revision dates: 10/4/2022, 12/1/2004, 11/1/2001, 1/1/1995, 10/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/4/2022
Policy Owner	Kathie Jones: Interim Clinical Nurse Manager, Emergency Services	10/4/2022

Current Status: *Pending* **PolicyStat ID:** *12552118*

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*11/1/1986*
Last Approved:	*N/A*
Last Revised:	*10/19/2022*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Pharmacy Services*
References:	

PH.72 Staff Authorized to Administer Medications

POLICY:

To state which Ventura County Medical Center/Santa Paula staff have authority to administer medications.

PROCEDURE:

I. All medications are to be administered by appropriate licensed staff or by non-licensed staff under the supervision of licensed staff as stated by applicable state and federal laws, regulations and policies related to medication administration, in conjunction with approved Medical Staff rules and regulations.

II. Administration of specific medications may be restricted to specific areas or staff as determined by the Pharmacy & Therapeutics Committee.

III. Before administering medications, the health care professional approved for medication administration shall adhere to Policy 100.025 Medications: Ordering, Administration and Documentation.

IV. Staff shall be evaluated and deemed competent to administer medications.

V. Current medication administration privileges are as follows:

A. Licensed Vocational Nurses - all medications except intravenous medications

B. Nuclear Medicine Technologists - isotopes

C. Registered Nurses - all medications

D. Respiratory Therapists - inhalation medications

E. Physical Therapists - limited topical medications

F. ~~Physicians~~Licensed Independent Practitioners - all medications

G. Physician Assistants - all medications

H. Psychiatric Technicians - all medications except intravenous medications

I. Radiologic Specialists - contrast agents

J. Radiologic Technicians - oral contrast media

All revision dates: 10/19/2022, 11/26/2018, 8/1/2015, 11/1/1998, 12/1/1989, 11/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/20/2022
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	10/20/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/1984*
Last Approved:	*N/A*
Last Revised:	*10/21/2022*
Next Review:	*2 years after approval*
Owner:	*Michelle Doan-Le: Blood Bank Supervisor*
Policy Area:	*Blood Bank*
References:	

L.BB.42 Reconstitution of Blood for Exchange Transfusions

PRINCIPLE:

Blood for exchange should have a hematocrit, which approximates that of the neonate. The hematocrit level and volume required depends on gestational age and clinical condition of the baby and will be specified by the Neonatologist. The following formula allows the technologist to calculate the amount of Fresh Frozen Plasma (FFP) needed to achieve the desired hematocrit in the reconstituted blood.

W (FFP) = [(**Hct RBC**) – 1] x W (RBC)
Hct RB

1. **Hct RBC =** Hct of Donor Cells
2. **W(FFP) =** Vol of FFP needed
3. **Hct RB =** Hct of Reconstituted Blood
4. **W(RBC) =** weight of RBC Donor Unit

REAGENTS, MATERIALS, AND SPECIAL EQUIPMENT

1. Dietary Scale
2. Plasma Transfer set
3. Hematron Sealer
4. 600 mL transfer bags
5. Donor Cells (see below for criteria)
6. AB Fresh Frozen Plasma, Thawed

DONOR CELL CRITERIA

1. Use donor blood no older than 5 days (excess potassium consideration). If donor blood, less than 5 days old, is not available, have the blood supplier wash the freshest baby unit they have.
2. NOTE: In grave situation when the baby is subjected to bilirubin encephalopathy and kernicterus, the physician may waive the need to obtain less than 5 days old RBC unit or washed unit (which would avoid

the complications of hyperkalemic cardiac arrythmias) and accept the available product on hand (CMV Neg, Irradiated, Hgb S negative O Negative RBC) for the exchange transfusion. The Blood Bank CLS will fill out a Deviation from Standard Operating Procedure form, have the pathologist approve it after he discussed with the Ordering physician and the Ordering physician acknowledges his awareness of possible complications of hyperkalemic cardiac arrythmias from such waiver listed above.

3. Donor blood must be compatible with the Mom:
   a. If the mom has an antibody, the donor unit must be negative for the corresponding antigen.
   b. Crossmatch the unit (s) with the Mom's plasma. If the Mom's plasma is not available, crossmatch the donor unit with the baby's plasma.
4. Donor blood should be CMV Neg, Irradiated and Hgb S negative ~~(see "*Sickle Cell Testing – Donor Units*")~~.

PROCEDURE

1. Mix donor cells well. Express a small amount of the blood into a small satellite bag and perform a hematocrit. The hematocrit of the donor unit should be between 60%-70%.
2. Weigh the parent donor bag. Subtract 55 grams for the weight of the empty bag or tare the scale accordingly.
3. Do the calculations to determine the volume of Fresh Frozen Plasma needed to achieve the desired Hematocrit.
4. **If the total volume of the reconstituted blood is significantly less than the Doctor ordered, it will be necessary to prepare a second bag for transfusions. This will be the case if a double exchange is being done.**

   EXAMPLE:

   The Physician requests an exchange with a Hct of 55%. The RBC donor unit weights 300 grams.

   W (FFP) = 70 – 1 x (300)

   55
   W (FFP) = (1.27-1) x 300 or .27 x 300

   W (FFP) = 81 mL

   TV – 300 RBC + 81 FFP

   TV = 381 mL
5. The calculated amount of Fresh Frozen Plasma is added to the cells using a Plasma Transfer Set (PTS). Any excess Fresh Frozen Plasma is discarded. After the addition of the Fresh Frozen Plasma, seal the PTS line using the Hematron Sealer. Separate the line at the seal and tape the PTS spike into the red cell unit port.
6. If the volume of the reconstituted blood is significantly greater than that requested by the Physician, transfer the excess volume into as many pediatric satellite bags as necessary and label each satellite

bag. These will be kept in case another exchange is necessary.

7. ***Remember that the expiration date of the reconstituted unit (and all aliquots) is just 24 hours from when the donor red cell unit was first entered.***

REFERENCES:

1. Sotelo-Avila, Brovillette, Gould "The Hematocrit of Reconstituted Blood for Exchange Transfusion in Newborn Infants". **The Journal of Pediatrics**, June 1982, pp. 393-398.
2. Funk, Mark K MD, PhD. *Technical Manual.* Bethesda, Maryland: American Association of Blood Banks, Current Edition
3. *Standards for Blood Banks and Transfusion Services*, Bethesda, Maryland: American Association of Blood Banks, Current Edition.

All revision dates: 10/21/2022, 6/5/2020, 12/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Blood Usage Committee	Michelle Doan-Le: Blood Bank Supervisor	10/25/2022
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	10/23/2022
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	10/22/2022
Laboratory Services Department	Michelle Doan-Le: Blood Bank Supervisor	10/21/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/2012*
Last Approved:	*N/A*
Last Revised:	*11/1/2022*
Next Review:	*3 years after approval*
Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.17 Cancer Registry Clinical Research

POLICY:

To promote advancement in cancer treatment through the provision of clinical trial information and patient accrual to cancer-related clinical trials to facilitate advancement of evidence-based medicine. Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) understand the importance of the use of data gathered through clinical research to promote the advancement of evidence-based cancer treatment modalities and cancer prevention, to study economics of care, and to assess patient quality of life. The Cancer Program at VCMC/SPH has developed a list of resources to educate patients and provide easy access to information related to the benefits and availability of clinical trials.

PROCEDURE:

- Prior to presentation at the cancer conferences each patient on the agenda will be evaluated by a pharmacist for possible enrollment in local open clinical trials identified through review of the website www.clinicaltrials.gov . The information will be discussed at the appropriate Tumor Board meeting, and the patient will be referred to the participating facility through either their Medical Oncologist or Surgeon.
- The pharmacist presents patient-specific clinical trial information during the case discussion at the cancer conference.
- Patients identified within the clinic system and hospitals that fall within the category of on-site approved IRB clinical studies will be referred to the physician conducting the study for evaluation and possible inclusion.
- Participating physician obtains patient consent prior to participation in IRB approved on-site research studies.
- Physicians will refer patients to facilities known to participate in clinical trials appropriate to the patients' needs. The referring physician will notify the clinical trials representative of all patients referred for evaluation of inclusion in an open study.

MOST COMMON REFERRAL SITES FOR RESEARCH STUDIES/CLINICAL TRIALS:

- Angeles Clinic - Los Angeles, California
- USC - Los Angeles, California
- UCLA - Los Angeles, California
- Children's Hospital Los Angeles - Los Angeles, California
- City Of Hope, Duarte, California

- The Clinical Research Coordinator will report activity to the VCMC/SPH Cancer Committee on an annual

basis. The Cancer Committee will evaluate the effectiveness of the clinical trial program and make suggestions for modifications in processes and procedures as necessary.

REFERENCE:

American College of Surgeons, Commission on Cancer Standards: Optimal Resources for Cancer Care 2020 ~~Standards~~

All revision dates: 11/1/2022, 1/31/2020, 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	11/1/2022

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*11/1/2014*
Last Approved:	*N/A*
Last Revised:	*6/13/2019*
Next Review:	*3 years after approval*
Owner:	*Gina Ferrer: Manager, Trauma Services*
Policy Area:	*Trauma Services*
References:	

T.10 Violence Intervention Program: Emergency Entry to Exit (VIP-EEE)

POLICY:

To provide a collaborative, multidisciplinary program to reduce violent gang activity through the use of evidence-based prevention, intervention and suppression activities for at-risk/high-risk youth residing in Ventura County.

To promote positive alternatives to violence in order to reduce retaliation, criminal involvement and re-injury among youth injured by violence

PROGRAM GOAL

- Reduce risk factors and increase protective factors for violence
- Reduce recidivism, promote positive alternatives to violence

Protective factors include:

- Peer groups, schools, and communities that emphasize positive social norms;
- Warm, supportive relationships and bonding with adults;
- Opportunities to become involved in positive activities;
- Recognition and support for participating in positive activities; and
- Cognitive, social, and emotional competence.

PROCEDURE:

A. Target population: Patients of any age who are identified as at-risk/high-risk for violent crime.

B. Identification/criteria of activation: All patients who are victims of violent crime will be offered services.

C. Once the patient is identified as a VIP-EEE candidate, he/she will be informed about the program at any point in their treatment which allows for such intervention. The following language will be utilized in the initial brief interaction: "Are you willing to receive a visit from someone to talk about what happened and refer you to services that may help you?"

D. To initiate the VIP-EEE process, the Trauma Team shall refer the patient to community partners.

E. The clinicians from the Trauma Department shall call the community partners. A Community Outreach Worker shall respond to VCMC to discuss the VIP-EEE Program services with the patient. If the patient

wants to participate in the program, the patient will be asked to sign an Assent Form (see Attachment B).

F. Those who enroll will be followed by a VCMC Volunteer Community Outreach Worker.

G. If a patient declines, nothing further will be done.

H. The Community Outreach Worker responding to the referral signs in and out in the VIP-EEE log located at the Security kiosk in the VCMC lobby. An access badge will be released by a member of the Security team. The badge will need to be returned after the patient evaluation is completed.

I. Clinicians from the Trauma Department shall document the referral in the patient's EHR.

J. In order to protect the identity of victims of violence, the trauma nurse or Medical Office Assistant in the Emergency Department will notify the admitting supervisor that the patient's information needs to be flagged as confidential in the EHR, so that the patient will not show up on the information desk census.

K. Outreach organizations shall report to the VCMC Trauma Services for feedback and program evaluation.

ATTACHMENTS:

Attachment A - Schema of the VIP-EEE program
Attachment B - Assent Form in English and Spanish

All revision dates: 6/13/2019, 11/1/2014

Attachments

A: Schema of the VIP: EEE Program
B: Assent form for Emergency Entry to Exit Program (Violence Intervention Program)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	10/17/2022
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	10/17/2022
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2022
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/17/2022
Trauma Services	Thomas Duncan: Trauma Director	4/26/2022
Trauma Services	Gina Ferrer: Trauma Program Manager	4/18/2022