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 8, 2023

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

1 108.052 Body And Belonging Searches
2 108.053 Contraband Guidelines for Acute Detoxification
3 108.054 Use Of Razors
4 L.BB.01 Direct Antiglobulin Test

Ventura County Health Care System Oversight Committee
Administrative Policies

November 8, 2023

#	Title	Summary of Changes	Review Period
1	108.052 Body And Belonging Searches	Adding policy number. new policy for 3FST. Spelling out 3FST in policy title.	Triennial
2	108.053 Contraband Guidelines for Acute Detoxification	Adding policy number. new policy for 3FST. Spelling out 3FST in policy title.	Triennial
3	108.054 Use Of Razors	Changed nomenclature to reflect acute detox services	Triennial
4	L.BB.01 Direct Antiglobulin Test	Inserting degree symbol.	Triennial

Status **Pending** PolicyStat ID **14650115**

VENTURA COUNTY
HEALTH CARE AGENCY

Origination	8/24/2023	Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH
Last Approved	N/A		
Effective	Upon Approval	Policy Area	Administrative - Nursing
Last Revised	11/2/2023		
Next Review	3 years after approval		

108.052 Body and Belonging Searches

Purpose

To maintain the safety of all patients and staff and to decrease the possibility of any contraband being brought into the hospital, all patient belongings will be thoroughly searched by staff for any patient undergoing acute detoxification services. The unit staff will secure any potentially dangerous items or contraband. This routine search can be completed without a physician's order to assure safety within the unit. The search is completed at time of admission and/or any time new items are received during a patient's continued inpatient stay. This process can also be initiated or repeated by staff at the discretion of said staff members caring for patients undergoing detoxification.

Procedure

1. A search includes asking the patient to remove all items from their pockets and turn out their pockets on all jackets, shirts/sweatshirts and or pants. Patients will remove their shoes and socks to ensure that any contraband or other items are removed.
    a. Explain to the patient what you will do and why
    b. Explain where things will be stored and how the patient may gain access to them
    c. The search should be conducted in a professional manner and maintain the patient's privacy and dignity during the search
    d. Remove all items from pockets, purses, luggage, etc.
    e. Check linings of suitcases and purses for contraband
    f. Clothing and other items should be checked carefully
    g. Clothing is to be unfolded and zippers unzipped; look for belts or drawstrings

h. Clothing with pockets and hems should be checked thoroughly for hidden items

i. Open toiletry containers, cosmetic cases and other items that may contain other objects and check them thoroughly

j. Be aware of mouthwashes, toothpaste, hygiene items with alcohol, check to assure that wells of powders, eye shadows, etc. are secure and do not have hollow bottoms

k. Shoes should be checked inside

l. Belts, shoelaces, hooded sweatshirts and drawstrings will be removed

2. Items deemed as unsafe and not for use in the facility should be sent home with family or secured to be locked in safe storage on the unit. Items deemed as potentially unsafe but appropriate for periodic use for supervised patients should be placed in a container to be locked in the patient belongings area on the unit. All items retained in the facility's possession are to be listed on the Patient Belonging Form.
3. For a list of contraband items, please see the IPU and Acute Detoxification Services contraband policies.
4. Wallets, money, and valuables will be placed in a sealed plastic bag, sealed, stored, and signed off on by Security.
5. Admission belonging checks will be performed and the form will be completed within the shift completing the admission of the patient to the unit and at any time, additional items are received.
6. Luggage, clothes, toiletries are to be checked in the following manner as well as logged on the Patient Belongings Form.
7. Weapons brought into the facility are to be sent home with family or significant other. In the event that the weapon cannot be sent home it will be stored in the unit safe, and Risk Management should be notified that a weapon is on the premise.
8. Patient medications brought from home will be given to the Pharmacy to be processed. The RN will encourage the family or significant other to take medications home.
9. All patients will have a routine patient search conducted by a member of the staff on admission or upon return from emergency medical treatment. The procedure outlined in this policy describes the search/belongings check performed when a patient enters the unit, returns from emergency medical treatment or brings new belongings to the hospital.
10. Searches should be conducted by staff of the same sex, if possible. Two staff will be present during searches if clinically indicated.
11. Any assistive devices including eyewear, dentures, etc. brought from home will be indicated on the form.
12. At the time of discharge, items will be returned to the patient. The units will not be responsible for any belongings left behind.
    a. Belongings left after patient is discharged:
        i. Belongings shall be bagged and marked with patient's information, time, and date.
        ii. Inform patient/representative that they may pick up belongings within

thirty days after discharge

iii. If items are not redeemed within 30 days of discharge, they may be disposed of by hospital staff or donated.

iv. Under rare conditions, hospital may assume responsibility of mailing personal items to discharged patients.

All Revision Dates

11/2/2023, 10/31/2023, 10/25/2023, 10/23/2023, 8/24/2023

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	Pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023

Status **Pending** PolicyStat ID **14650118**

VENTURA COUNTY HEALTH CARE AGENCY

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Effective	Upon Approval	Policy Area	Administrative - Nursing
Last Revised	11/2/2023		
Next Review	3 years after approval		

108.053 Contraband Guidelines for Acute Detoxification

Purpose

To ensure that patients undergoing acute detoxification are in a safely controlled environment, this policy outlines the procedure for any removal of contraband for patients undergoing medical detoxification services. Patients and visitors will be subject to search and removal of any contraband items, which will be collected and returned upon patient discharge or visitor departure if legally permissible.

Procedure

Items considered hazardous or contraband that are **not permitted**:

- Plastic bags
- Cash, Checkbooks, Credit Cards
- Spray cans (aerosols)
- No battery-operated items
- Glass containers, glass objects
- Nail polish and nail polish remover
- Compacts with mirrors & mirrors
- Clothes hangers
- Crochet/sewing needles
- Sharp objects including scissors, knives, metal nail files, knitting needles, tweezers, nail clippers
- Metal combs, hair picks

- Flip flops, shoes without backs, shoelaces
- Any liquid containing alcohol, illegal substances, or any substances that could be abused.
- Weapons
- Car keys
- Hair dryers, curling irons
- Tobacco, electronic cigarettes, lighters, matches
- Tube tops, tank tops, short skirts/shorts, see-through garments, gang related clothing
- Aluminum cans
- Jewelry, except for wedding rings and watches
- Sporting equipment & musical equipment
- Cleaning supplies & laundry detergents
- Purses, luggage, backpacks
- Pillows, stuffed animals, blankets from home
- Flowers/vases
- Outside food/drink/medications
- Any other items deemed potentially dangerous or hazardous by staff.
- Personal assistive devices, rolling walkers, electric scooter/wheelchair
- Any other item that is determined by staff to be harmful. Document in the progress notes the item and the rationale for determining that it is dangerous and report to charge nurse.
- If a dangerous article is lost and cannot be accounted for, search the entire patient occupied areas. For example, if a razor given to a patient is not returned or if scissors are missing from Occupational Therapy, a search of the entire Unit may be necessary.
- Should a patient decline to turn over their belongings or change into the paper gown for the assessment/check, he or she will be placed on 1:1 observation immediately. The 1:1 observation will continue until the patient cooperates with the skin assessment/contraband check. Use of the portable metal detector/wand may assist in this search.
- Patients refusing a contraband check will be declined admission.
- Over the counter and prescription medications must be secured. Controlled drugs must be counted and co-signed by licensed nursing staff on the inventory sheet and sent to the VCMC Pharmacy.
- Illegal substances shall be reported to police department.

Other items not noted above may be restricted on a case-by-case basis.

- Cell phones and other electronic devices will not be permitted during therapy and in other cases at the attending's discretion.

All Revision Dates

11/2/2023, 10/31/2023, 10/25/2023, 10/23/2023, 8/24/2023

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	Pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023

Status **Pending** PolicyStat ID **14650123**

VENTURA COUNTY HEALTH CARE AGENCY

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Last Approved	N/A		
Effective	Upon Approval	Policy Area	Administrative - Nursing
Last Revised	11/2/2023		
Next Review	3 years after approval		

108.054 Use Of Razors

Purpose

To ensure patient safety with the use of razors for patients receiving acute detoxification services.

Procedure:

Patients undergoing acute detoxification services may use electric razors if needed or safety razors under supervision.

1. Inpatient Behavioral Health owns electric razors and safety razors which are available on the unit and hospital approved.
2. Patients may use their own electric razor after it has been inspected for safety through Biomed just as all other electrical appliances brought in by patients.
3. Any patient demonstrating psychosis, confusion, or suicidal ideation is provided 1:1 supervision during shaving and receives hands on assistance as needed.
4. The staff member assisting the patient shaving is responsible for cleaning the electric razor with materials recommended by the infection control department and returning it to the assigned storage.

All Revision Dates

11/2/2023, 10/31/2023, 10/25/2023, 8/24/2023

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	Pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023

Status **Active** PolicyStat ID **11421609**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	7/20/1991	Owner	Michelle Doan-Le: Blood Bank Supervisor
Last Approved	9/29/2023		
Effective	9/29/2023	Policy Area	Blood Bank
Last Revised	9/29/2023		
Next Review	9/28/2025		

L.BB.01 Direct Antiglobulin Test

PRINCIPLE:

The Direct Antiglobulin Test (DAT) is used to detect "in vivo" red blood sensitization. Red blood cell (RBC) sensitization may be due to adsorbed immunoglobulins or complement. Washed red blood cells from the patient are directly tested with antiglobulin.

The Direct Antiglobulin Test (DAT) is used to:

1. Diagnose hemolytic disease of the newborn.
2. Investigate transfusion reactions.
3. Investigate red blood cell sensitization caused by drugs.
4. Diagnose autoimmune hemolytic anemia.

SPECIMEN:

No special preparation of the patient is required prior to specimen collection.,

RBCs from an EDTA-anticoagulated blood sample.

Recommended to be tested within 48 hours of collection. Sample can be stored 1° - 10°C if there is a delay in testing.

REAGENTS:

1. Normal saline.
2. 12 x 75 mm test tubes.
3. Antihuman globulin (AHG) reagents: Polyspecific antiglobulin reagent, anti-IgG, and anti-C3b,C3d.

4. Control reagent (phosphate-buffered saline)
5. Coombs Control cells.
6. Complement Coombs Control cells.

PROCEDURE:

1. Prepare a 3-5% saline cell suspension of the EDTA cells to be tested.
2. Label four (4) tubes with the first 3 letters of the patient's last name and either Poly, IgG, C3 and Ctr.
3. Place one drop of the cell suspension into each of the four-labeled tubes.
4. Wash each of the tubes four times with saline.
5. Add two drops of polyspecific AHG, anti-IgG or anti-C3b,C3d and Control (saline) to the appropriate tubes.
6. Centrifuge for the calibrated time.
7. Re-suspend the cells with gentle agitation and examine for agglutination. Verify negative tests microscopically. Record results.
8. Incubate all the tubes (Poly, IgG, C3, Control) at room temperature for 5 minutes.
9. Centrifuge for the calibrated time.
10. Re-suspend the cells with gentle agitation and examine for agglutination. Verify negative tests microscopically. Record results.
11. To all negative Poly, IgG, Control tubes, add one drop of IgG Coombs Control Cells.
12. To negative C3 tube(s), add one drop of Complement Coombs Control cells. (**NOTE**: The C3 tube must be allowed to sit for five (5) minutes after the control cells are added before it is centrifuged and read)
13. Centrifuge the Poly, IgG and control tubes and examine for agglutination. Record results.
14. At the end of the five (5) minute incubation time in step 12, centrifuge the C3 tube and examine for agglutination. Record results.

RESULTS/INTERPRETATION:

1. The first centrifugation primarily detects IgG antibodies, which may have coated the cells. The second centrifugation has been found to detect Complement and IgA sensitization. Positive reactions due to coating by IgG antibodies will usually become weaker after standing. Therefore, **do not substitute the second reading for the immediate spin reading.**

2. If the direct antiglobulin test (DAT) is negative the testing is complete.

(NOTE: a negative DAT does not necessarily mean that the red cells have no attached globulin molecules. Polyspecific and anti-IgG reagents detect 150 - 500 molecules of IgG per cell, but patients may still experience autoimmune hemolytic anemia when IgG coating is below this level),

3. If the DAT is positive and the saline control is negative, further testing is indicated and the steps in

the Positive DAT Investigation procedure should be followed. Refer to the section on Cord Blood Testing for the uses of the DAT in diagnosis of Hemolytic Disease of the Newborn.

4. **If the DAT and the saline control is positive,** and the presence of a strong cold agglutinin is suspected, manual washing with warm (37oC) saline should resolve reactivity due to cold agglutinin.

PROCEDURE NOTES:

Steps 1 - 14 should be performed without interruption.

Additional washes may be needed when testing cord blood samples contaminated with Wharton's Jelly.

1. Clinically Insignificant DAT's
    a. Clotted blood samples coated with anti-C3.
    b. Silicon gel vacutainer – collected red cells with anti-C3.
    c. Samples from IV lines used for infusion of dextrose-water solutions.
    d. Unwanted agglutinins in the antiglobulin reagent.
    e. Patient with pernicious or megaloblastic anemia.
2. False negative DAT's
    a. Inadequate washing of serum/plasma from the test red cells.
    b. Failure to add antiglobulin serum.
    c. Failure to do the five (5) minute room temperature incubation after the immediate spin negative DAT.
    d. RBC's coated with antibody or complement below the limit of detection in manual DAT testing (100-500 molecules per cell).

REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, Current Edition.
2. Fung, Mark K MD, PhD. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.
3. Current manufacturer's package inserts.

All Revision Dates

9/29/2023, 6/5/2020, 10/3/2017, 3/1/2017, 12/1/2016, 12/1/2013, 10/1/1995

Approval Signatures

Step Description	Approver	Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	9/29/2023
Laboratory Services Department	Erlinda Roxas: Director Laboratory Services	9/29/2023
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/10/2022
Laboratory Services Department	Michelle Doan-Le: Blood Bank Supervisor	10/27/2022

History

Sent for re-approval by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 3/21/2022, 2:56PM EDT

Last Approved by Roxas, Erlinda: Director Laboratory Services on 6/12/2022, 7:03AM EDT

> Reviewed policy, no changes made.

Bulk Last Approved by Adler, MD, Brad: Medical Director, Laboratory Services on 7/21/2022, 5:09PM EDT

Draft saved by Doan-Le, Michelle: Blood Bank Supervisor on 10/27/2022, 6:55PM EDT

Edited by Doan-Le, Michelle: Blood Bank Supervisor on 10/27/2022, 7:02PM EDT

> Add Control tube in Procedure section 1, 3,5,8,11 &13. Revise in Results/Interpretation section 3 & 4. Add 1 reference.

Last Approved by Doan-Le, Michelle: Blood Bank Supervisor on 10/27/2022, 7:02PM EDT

Last Approved by Adler, MD, Brad: Medical Director, Laboratory Services on 11/10/2022, 4:19PM EST

Last Approved by Roxas, Erlinda: Director Laboratory Services on 9/29/2023, 3:24AM EDT

Recurring acknowledgments triggered by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 9/29/2023, 7:03PM EDT

Last Approved by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 9/29/2023, 7:03PM EDT

Activated on 9/29/2023, 7:03PM EDT

Administrator override by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 9/29/2023, 7:04PM EDT

Inserting degree symbol.

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

Consent Agenda

November 2023

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

1.	MCH.10 Neonatal Culture Collection	page	2-5
2.	N.06 Formula Preparation and Feeding Guidelines	page	6-8
3.	N.27 NICU Discharge Criteria	page	9-12
4.	N.36 Gavage/Enteral Gastric Tube Feeding in the NICU	page	13-16
5.	OB.31 Cervical Ripening	page	17-21
6.	OB.43 Hepatitis B Prevention in Newborns	page	22-24
7.	OB.48 Testing for Prenatal Drug Exposure	page	25-30
8.	P.32 PICU, NICU, and PEDS Visiting Policy	page	31-36
9.	PH.19 After Hours Pharmacy Services for Santa Paula Hospital	page	37-38
10.	PH.55 Medication Order Management	page	39-44
11.	PH.78 Boxed Warning Drugs	page	45-46
12.	PH.87 Procurement, Storage, Access, Distribution, Control and Accountability of Radiologic Contrast Media	page	47-49
13.	PH.122 Nonsterile Pharmaceutical Compounding	page	50-56
14.	PH.123 Outpatient Medication Dispensing Procedures	page	57-59
15.	T.09 Structure of the VCMC Trauma Program	page	60-61
16.	T.13 Multiple Casualty Incident (MCI)	page	62-68
17.	T.14 Trauma Department Performance Improvement and Patient Safety Plan (PIPS)	page	69-75

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

November 2023

a. Policies & Procedures / Forms / Orders

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

#	Title	Summary	Frequency	Page
1.	MCH.10 Neonatal Culture Collection	Removed reference to NNPs, no longer using this type of practitioner in the NICU	Triennial	2-5
2.	N.06 Formula Preparation and Feeding Guidelines	Removed NNP, updated to current guidelines	Triennial	6-8
3.	N.27 NICU Discharge Criteria	Removed NNP, hyperlinked reference policies and updated to current guidelines	Triennial	9-12
4.	N.36 Gavage/Enteral Gastric Tube Feeding in the NICU	Removed NNP and updated to reflect the most current guidelines	Triennial	13-16
5.	OB.31 Cervical Ripening	Updated dosing guidelines for Misoprostol	Triennial	17-21
6.	OB.43 Hepatitis B Prevention in Newborns	No changes	Triennial	22-24
7.	OB.48 Testing for Prenatal Drug Exposure	No changes	Triennial	25-30
8.	P.32 PICU, NICU, and PEDS Visiting Policy	Complete policy rewrite	Triennial	31-36
9.	PH.19 After Hours Pharmacy Services for Santa Paula Hospital	Updated to include pharmacy responsibilities related to outpatient medications	Triennial	37-38
10.	PH.55 Medication Order Management	Updated time frame for storing controlled substance orders, medication packaging and labeling requirements, and replaced discharge medication section with a hyperlink to the appropriate policy	Triennial	39-44
11.	PH.78 Boxed Warning Drugs	Updated to reflect Title 21 Code of Federal Regulations, Section 201.57	Triennial	45-46
12.	PH.87 Procurement, Storage, Access, Distribution, Control and Accountability of Radiologic Contrast Media	Updated section related to labeling of oral contract medications and included a final check to ensure accuracy	Triennial	47-49
13.	PH.122 Nonsterile Pharmaceutical Compounding	New policy	Annual	50-56
14.	PH.123 Outpatient Medication Dispensing Procedures	Updated who can dispense, labeling requirements, and the requirements for dispensing of controlled substances	Triennial	57-59
15.	T.09 Structure of the VCMC Trauma Program	Removed SPH reference, policy only applies to VCMC	Triennial	60-61
16.	T.13 Multiple Casualty Incident (MCI)	Minor revisions to terminology and titles, no substantial changes	Triennial	62-68
17.	T.14 Trauma Department Performance Improvement and Patient Safety Plan (PIPS)	No changes, annual review	Annual	69-75

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/1986*
Effective:	*Upon Approval*
Last Approved:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.10 Neonatal Culture Collection

POLICY:

To identify nursing guidelines for collection of neonatal cultures. The specimens covered by this policy are: tracheal aspirate, urine, stool, eye, wound, and nasal pharyngeal.

PROCEDURE:

Cultures may be collected by a skilled RN, LVN, or RT depending on the type of specimen required. A suprapubic tap is collected by a physician~~/NNP~~. Two person technique is used where indicated. A medical order is required for all cultures.
All specimens must be appropriately labeled with the date, time, name and medical record number of the patient, type of specimen and the collector's initials. All specimens must be delivered to the laboratory promptly (maximum allowable delay is 30 minutes for most cultures.) All orders are entered into the Electronic Health Record (EHR) system prior to sending the specimen to the lab.

EQUIPMENT (Universal)

A. Gloves (sterile for tracheal and urine collection)
B. Identification labels
C. Biohazard transport bags
D. Additional supplies specific to procedure.

Tracheal Aspirate Equipment:

E. Sterile suction catheter (size appropriate to ET tube)
F. Wall suction, canister and new tubing
G. Lukens mucus trap
H. Sterile Normal Saline

GUIDELINES

1. Attach tubing to mucus trap and sterile catheter. Using two people, sterile technique, insert catheter to tip of ET tube. Suction 80 – 100 mmHg for 5 seconds while withdrawing catheter. Clear catheter with normal saline as needed.

2. Discard suction catheter. Seal mucus trap by connecting rubber tubing to chimney for delivery to the laboratory.

Urine (straight catheter, suprapubic tab, bag) Equipment:

A. Anti-microbial skin prep

B. Urine collection cup with lid

C. 5 or 6 Fr. Catheter

D. 22 or 23 gauge, 1 to 2 inch needle with 3 – 5 syringe

E. Newborn or Preemie size U Bag

F. PROCEDURE

1. Wait a minimum of 30 minutes from last known void. Position infant supine. Clean site thoroughly including the folds of the labia for females. Collect urine by one of the following:
    a. Apply urine bag and monitor closely for urine. Position infant supine. Clean site thoroughly after neonate voids.
    b. Follow associated policy for urinary catheterization.
    c. Restrain in frog leg position securely. After completion of suprapubic tap, monitor site for bleeding and apply pressure as needed.
2. Remove skin prep with sterile water. Monitor for next void; notify physician~~/NNP~~ for visible blood or delay of void for more than 4 hours.

Stool Equipment:

A. Sterile tongue depressor or swab

B. Urine collection container with lid **or** specialized media tube if recommended by the lab

C. PROCEDURE

1. Contact Microbiology prior to obtaining sample for specific instructions for specimen collection, storage and treatment appropriate to the ordered test.
2. Collect using tongue depressor or swab from recently soiled diaper.

Eye Equipment:

A. Sterile 2X2 moistened with water or saline

B. Culturette tube with swab

C. PROCEDURE

1. Clean eyelid with sterile 2X2. With assistance as needed, swab the lower conjunctival surface with the swab.
2. Replace the swab in the tube carefully. Consider the swab contaminated if it touches anything other than the conjunctiva and restart the procedure.

Wound or Skin Equipment:

A. Culturette tube with swab

B. PROCEDURE

1. If exudate on the skin is to be cultured, the RN may swab the site.
2. If the site has a roof that is to be removed, then the ~~NNP or~~ physician must first prepare the site with an antimicrobial prep and the open the roof. The exudates can then be collected.
3. Note: Herpes Simplex Antigen by EIA or DFA can be done on fluid collected from lesions, vesicles, or ocular surface. Herpes Simplex PCR can only be done on CSF or Amniotic fluid. Herpes Simplex Antibody titers are done on serum.

Nasal Pharyngeal

Chlamydia or viral cultures except for RSV Equipment:

A. Viral (Chlamydial) transport media obtained from Laboratory (Chemistry/Send outs)
B. Mini tip Culturette swab obtained from Central Supply
C. PROCEDURE
   1. Stabilize the neonate's head. Insert swab downward into both nares approximately 1 – 2 cm.
   2. Open media tube and insert swab. Break or cut top of swab and close tube.
   3. Order as Lab – CHLA for non-genital specimen.

DOCUMENTATION

A. Electronic health record entry
B. Nursing flow sheet and progress notes.

REFERENCES:

AWHONN: NOEP, 3rd edition, 2015

All revision dates: 8/10/2023, 7/1/2015, 3/1/2010, 4/1/2008, 1/1/2005, 2/1/2002

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/10/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/10/2023
Policy Owner	Jennifer Ferrick: Director, Peds/PICU & NICU	8/10/2023
Nursing Administration	Michelle Sayre: Chief Nursing Officer	11/10/2020
Nursing Administration	Sherri Block: Associate Chief Nursing Officer	11/10/2020

Step Description	Approver	Date
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/10/2020

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/2001*
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Next Review:	*3 years after approval*
Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*NICU*
References:	

N.06 Formula Preparation and Feeding Guidelines

POLICY:

To guide the NICU, PICU and PEDS nurse in providing the infant with ease of nippling and effective bottle feeding.

PROCEDURE:

The nurse provides nipple feeds and assists the parent to nipple an infant on a regular or demand feeding schedule per physician order. If the infant is not successful with use of the regular infant nipple, gavage feeding is given with physician order. Nursing encourages the parent to breastfeed as appropriate ~~for breastfed patients~~. Physician~~/NNP~~ order is required for initial nipple feeding and progression nipple feedings. Consult Occupational Therapy for difficulties. Formula preparation will take place in a clean area in the food preparation area.

EQUIPMENT

A. Bottle or disposable nurser

B. ~~Slow flow, regular or Nuk nipple~~Slow flow, standard flow or orthodontic nipple; or developmental feeding system

C. Breastmilk or ordered formula

~~Softnets, burp cloth~~

D. Sterile water for formula preparation

A. ~~Choose appropriate nipple. Choices include:~~

~~1. Nuk nipple for breastfed term baby.~~

~~2. Regular infant nipple or Nuk nipple with enlarged hole/slit for the infant with Cleft lip and palate.~~ Choose appropriate nipple. Consult with Occupational Therapist as needed.

B. Hold infant in a sitting position or cradled in arm with head elevated. The small premature may need to be held upright with chin support or side lying position.

C. Frequent burping.

D. Monitor suck, swallow, breathing coordination, apnea and bradycardia.

E. Feeding period should be 30 minutes or less and bottle is discarded at end of time period.

F. Provide parent with feeding instructions and assistance as needed.

G. Cleft Lip and Palate – encourage breastfeeding.

1. If parent chooses bottle, for a unilateral cleft: tip nipple toward non-involved side.
2. More frequent burping is required as infant may swallow increased amounts of air.

H. Formula preparation:

1. Ready to feed formula: Single use sterile formula bottles and clean nipples.
2. ~~All powdered~~Powdered formula shall be prepared in a designated formula preparation ~~kitchen~~room (NICU, PICU, and Pediatrics).

   ~~Ready to feed formula:~~

   ~~a. Single use sterile formula bottles and clean nipples.~~
3. Powdered formula shall be labeled with infant's name and date/time mixed:
   a. Mix according to manufacturer recommendation using sterile water. May keep a 24-hour supply under refrigeration or single use amount 4 hours at room temperature.
   b. Individual serving is fed using a sterile disposable nurser~~ or emptied water bottle~~.

   ~~Don't mix powder formula more than 24 hours ahead.~~
4. Human milk fortifier ~~or Beneprotein powder~~ requires a physician order and is added directly to thawed or fresh breastmilk to add calories and nutrients. Prepare according to package directions to achieve specific calorie count (see policy N.04, *Breastmilk Storage and Collection)*.
5. Preparation of a special formula concentration requires a medical order with guideline for preparation from the dietitian. Use sterile formula (liquid or powder as directed) and/or water bottles.

   ~~NICU, PICU and PEDS RN will perform competency under the dietitian/trainer and prepare in the designated formula preparation kitchen area.~~

DOCUMENTATION

NICU: ~~Nursing flowsheet –~~type of feeding, route of feeding, volume, nipple type, duration of feeding, INFACT score.
PEDS: type of feeding solution, amount taken, ~~nipple type and length of~~any difficulties with feeding.
~~PEDS~~PICU: ~~Nursing flowsheet –~~type of feeding solution, amount taken, any difficulties with~~ feeds.~~
~~PICU: Nursing flowsheet – type of feeding solution, amount taken, any difficulties with~~ feeding.
~~Use In-FACT documents on flow sheet.~~

All revision dates:	8/10/2023, 1/1/2016, 6/1/2013, 5/1/2012, 10/1/2011, 2/1/2010, 12/1/2004

Attachments

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N.27 NICU Discharge Criteria

POLICY:

To identify guidelines for discharge from the Neonatal Intensive Care Unit (NICU).

PROCEDURE:

Infants discharged from the NICU will meet established criteria.

EXCEPTIONS

If the infant's clinical condition precludes normal nipple feeding, the parent/caretaker shall be instructed in an alternate feeding program according to physician's order. ~~The following infants shall be referred to the discharge planner assigned to the NICU:~~

The following infants shall be referred to the discharge planner assigned to the NICU:

1. Those requiring other methods of feeding, such as ~~PEG~~gastrostomy tube (G-tube) or gavage feeding
2. Those being discharged on oxygen or with a home apnea monitor
3. Those requiring DME or home health supplies (i.e., G-tube or ostomy supplies)
4. Those requiring special formula
5. Those being discharged to hospice or requiring home health nursing services
6. Those being discharged to a caregiver other than the parents (i.e., foster care) or being discharged to an extended care facility

GUIDELINES

Discharge orders will be based upon physiologic stability, parental readiness, and a coordinated discharge plan. Criteria for discharge include:

A. Infant:

1. The ability to maintain an axillary temperature of at least 36.5 degrees Celsius in an open crib when the amount of clothing worn and the room temperature are appropriate.
2. The ability to tolerate oral feedings by breast/bottle or tolerating ~~orogastric or gastrostomy~~G-tube feeds; if appropriate, ~~if appropriate~~ parent education and arrangements for supplies have been

made.

3. Gaining weight at an appropriate rate (premature infant).
4. Without apnea or bradycardia requiring intervention for at least five (5) days or discharged home on an apnea monitor and/or ~~Methylxanthine~~Caffeine therapy once stabilized and appropriate education completed and equipment obtained ~~(may not require apnea five (5) inpatient days prior to discharge)~~.
5. Infants with a chronic stable FiO_2 requirement may be discharged home on nasal cannula (NC) oxygen (O2), providing they require <0.3 LPM of ~~O~~O_2. Infants being sent home on NC ~~O~~O_2 must have appropriate arrangements for home oxygen delivery.
6. Able to maintain adequate oxygen saturation in a car seat ~~for one hour~~per MCH. ~~(Infants <36 weeks gestation at birth.) Otherwise~~05 Car Seat Challenge, ~~a car bed must be obtained.~~as indicatated
7. Infant discharged on home monitor/apnea monitor will have teaching on monitor application and maintenance from monitor rep.

B. Parents/Caretakers:

1. Educated about and competent to feed the infant.
2. Competent to give any medications the infant needs. Prescription medications should be obtained prior to discharge.
3. Trained in infant cardiopulmonary resuscitation~~, when applicable (infants <36 weeks gestation or infants in the NICU > 7 days)~~.
4. Demonstrate ability and comfort in providing care for the infant at home (parent teaching of well baby care shall be provided, which includes feeding, bathing, car safety, signs of illness, how to take a temperature, and when to call a doctor.)
5. Given the option to "Room In" (stay overnight) prior to discharge if medically or socially indicated.
6. Parents demonstrate an understanding and agreement with the discharge plan including their infant's need for ophthalmologic follow-up and Synagis prophylaxis as indicated and given necessary follow-up appointment dates.

~~Gastro-care parents: if such caretakers can demonstrate current certification on infant care, cardiopulmonary resuscitation, etc, these discharge activities may be waived at discretion of RN.~~

C. ~~Physicians/NNPs~~Care team:

1. ~~Make sure the~~Ensure the state newborn ~~state~~ screen has been done on all infants.
2. ~~Make sure~~Ensure infants at risk for ROP have had an eye examination.
3. ~~Make sure~~Ensure a hearing screen has been performed.
4. Ensure cyanotic congenitial heart defect (CCHD) screening has been performed.
5. Appropriate immunizations have been administered ~~and immunization card given to parents~~ with instructions for follow-up.
6. Identify whether the infant requires Synagis (RSV prophylaxis). Provide appropriate treatment prior to discharge and/or recommendations for follow up.
7. Nutritional risks have been assessed, and dietary modification instituted, as indicated.
8. Hematologic status has been assessed and appropriate therapy instituted, as indicated.
9. A developmental exam has been performed on infants at risk for developmental delay.

10. Follow-up clinic appointment(s) have been scheduled and discussed with parents/caretakers.
11. Public Health Nurse or Visiting Nurse referral has been made as indicated.
12. Minimum discharge weight is 2000 grams, or at the discretion of the neonatologist.
13. Review of hospital course has been completed, unresolved medical problems identified, and plans for treatment instituted.

D. Written home care instructions shall be provided to parents ~~on the~~. Discharge ~~Instruction Form (see attached). Discharge~~ materials and information will be culturally and linguistically appropriate and can be provided in various formats:
   1. Written Materials
   2. Video
   3. Demonstration/return demonstration

E. Forms/items to be completed prior to discharge:
   1. Newborn Hearing Screening – Infant Reporting Form with Audiology referral arranged if hearing screen failed after two attempts.
   2. Newborn State Screening.
   3. Newborn Discharge Instructions ~~form~~ completed.
   4. Immunization Record.
   5. Multidisciplinary Discharge Planning Worksheet.
   6. Prescriptions – evaluation of caregiver ability to provide/follow prescriptions
   7. Documentation ~~re:~~of follow-up appointments given to caregiver

F. Document patient condition at discharge in nursing notes and parental understanding of discharge instructions; document use of qualified translator, if applicable. Obtain duplicate copy of discharge instructions with mother's signature.

G. ~~NNP~~Physician has completed Discharge Note with copy to parents and follow-up ~~physician~~Primary Care Physician/Pediatrician.

REFERENCES:

AWHONN: NOEP 3rd edition, 2015.

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References:	

N.36 Gavage/Enteral Gastric Tube Feeding in the NICU

POLICY:

To describe the recommended technique of feeding infants in the Neonatal Intensive Care Unit (NICU) who are unable to nipple feed or breastfeed, or who have anomalies of the gastrointestinal tract, impaired swallowing capabilities, severe debilitation, or respiratory distress.

PROCEDURE:

A. Gavage feedings will be ordered by the physician with regard to type of feeding, volume and frequency.

B. The nurse will be responsible for inserting the tube, administering the feeding and monitoring the ability of the infant to advance to oral feedings. Polyurethane tubes may remain a maximum of 30 days per manufacturer's recommendations, or replaced with visibly soiled.

C. The nurse will use the nasal route in all neonates unless the following conditions are identified:

1. Lack of bilateral patency of the nares
2. Presence of nasal continuous positive airway pressure (CPAP)
3. Respiratory distress exacerbated with presence of a nasal tube

D. The nurse will monitor the neonate during a gavage feeding to observe for distress and offer the pacifier, as tolerated.

E. Abdominal girth measurements will be obtained obtained at a minimum of once a shift on all infants receiving gavage feeding, unless otherwise specified.

EQUIPMENT

A. Polyurethane enteral gastric feeding tubes with ENFit-compatible connecting system

1. 5-6 French (Fr.) for infants < 1000 gm
2. 6-8 French (Fr.) for infants > 1000 gm

B. 5 milliliters ENFit-compatible syringe

C. 30 - 60 mililliters ENFit-compatible syringe

D. Water-soluable lubricant or sterile water (for insertion)

E. Prescribed feeding in ENFit-compatible syringe

F. Prescribed medication in ENFit-compatible syringe

G. Stethoscope

H. Tape

I. Pacifier

GUIDELINES:

INSERTION:

A. Prior to a feeding, measure the estimated length of tube to be inserted. Use either:
   1. Tip of nose to earlobe to xyphoid plus 1 centimeter or
   2. Tip of nose to earlobe to halfway between the xyphoid and umbilicus.

B. Provide comfort measure to neonate during procedure. Consider swaddling, as appropriate, use of sucrose oral solution/ Expressed Breast Milk (EBM) with pacifier.

C. Ensure nasal patency prior to insertion, suction nare when indicated. Insert enteral feeding tube gently and swiftly to pre-measured distance. Aspirate gently, if no aspirate is obtained, advance 1 cm more, re-aspirate. Do not push against resistance.

D. Double check placement by pushing 1 milliliter of air while auscultating over the infant's stomach. Note the tube's centimeter marking. Confirm tube placement prior to every use. Once auscultation confirmation completed, remove injected air.

E. Incorrect placement of the tube may be indicated by cyanosis, respiratory distress, low oxygen saturation, coughing or by failure to auscultate air. The tube should be withdrawn. Vagal stimulation may cause bradycardia or distress during insertion. Use tactile stimulation, if distress unresolved, the tube should be withdrawn.

F. Secure tubing with soft tape and/or transparent dressing. If further skin protection is indicated, a hydrocolloid base with a tape overlay may be used.

G. Label the tubing with the date and time of insertion. Replace every 30 days if a polyurethane tube is used. Alternate nares when tube is replaced.

FEEDING VIA GASTRIC TUBE:

A. Prepare feeding as ordered, fill appropriate sized syringe, label syringe with 2 patient identifiers, type of feeding, expiration date and time of feeding.

B. Prior to gavage feedings, aspirate stomach contents, and re-feed.

C. Notify physician of the following, or complications, immediately:
   1. Bile stained, coffee ground or bright red blood in residual
   2. Emesis
   3. Changes in abdominal girth
   4. Presence of bowel loops and/ or abdominal distension

D. If the neonate was breast or bottle fed first, confirm tube placement but complete aspiration is not

necessary.

E. Intermittent feedings may be given by gravity, with the nurse holding the syringe, adjusting the height of the barrel to control flow speed. Infant will be held and provided pacifier, as tolerated.

F. Intermittent feedings be be given via a feeding pump, as ordered. Infant will be held and provided pacifier, as tolerated.

G. Continuous feedings are administered as ordered. Feeding solution, syringe and extension tubing will be changed every three to four (3-4) hours.

H. Provide developmental support for the infant and periodically offer opportunities for non-nutritive sucking. Infant will be held and provided pacifier, as tolerated.

I. Whenever possible, have mother offer non-nutritive breast feeding, as ordered

J. Pacifier may be offered to neonate, as tolerated. **Use Expressed Breast Milk 1-2 drops orally with gavage feeding, as tolerated.

K. The gavage tube must be cleared with approximately 2 milliliters of air after each feeding. Tubing used for feedings should be disconnected and capped, except by order of the physician.

L. A polyurethane feeding tube may be reused per manufacturer's guidelines if accidentally removed. Rinse with sterile water before reinserting.

DOCUMENTATION

A. Feeding: type, volume, route, tube, size, verification of tube placement with method used to confirm placement

B. Abdominal girth, measured in centimeters.

C. Document gastric residual; volume and appearance

D. Non-nutritive breastfeeding, and/or Expressed Breast Milk oral drops

E. Comfort measure(s) provided during enteral tube insertion

REFERENCES:

Enteral Gastric Tube Feedings, Neonatal. (2021, November 19). Lippincott Procedures. Retrieved May 17, 2022, https://procedures.lww.com/lnp/view.do?pId=3378732&disciplineId=5770

Hair, A. (2022). Approach to Enteral Nutrition in the Premature Infant. A. Hoppin (Ed.), *Up to Date*. Retrieved May 16, 2022 from https://www.uptodate.com/contents/approach-to-enteral-nutrition-in-the-premature-infant

Parker, L., Torrazza, R.M., Li, Y., Talaga, E., Shuster, J., & Neu, J. (2015). Aspiration and Evaluation of Gastric Residuals in the NICU: State of the Science. Journal of Perinatal/ Neonatal Nursing, 29 (1), 51-59. Doi: 10.1097/JPN.0000000000000080.

Sunquist Beauman, S. & Bowles, S. (Eds.) 2019. Policies, Procedures, and Competencies for Neonatal Nursing Care, 6th ed. National Association of Neonatal Nurses

All revision dates: 10/11/2023, 10/11/2023, 7/12/2023, 7/1/2015, 6/1/2013, 3/1/2010, 4/1/2008, 2/1/2005, 11/1/2001, 3/1/2001

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
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References:	

OB.31 Cervical Ripening

POLICY:

To ripen the cervix of women who are candidates for induction of labor.

PROCEDURE:

Candidates for Misoprostol, Dinoprostone Vaginal or Cervical Ripening Balloon include:

A. Fetal demise
B. Gestational hypertension
C. Preeclampsia, eclampsia
D. Premature rupture of membranes (except cervical ripening balloon)
E. Post-term pregnancy
F. Maternal medical conditions (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios)
G. May be used with multiple gestation pregnancy
H. Elective induction greater than 39 weeks gestational age

Contraindications:

A. Patient refusal
B. Known hypersensitivity to prostaglandins
C. Women already receiving oxytocin (except cervical ripening balloon)
D. Placenta previa
E. When vaginal delivery is contraindicated
F. Active genital herpes
G. Category III fetal heart rate (FHR) tracing
H. Women with prior cesarean delivery

Essential Steps:

A. Determine vertex presentation with ultrasound.

B. Perform sterile vaginal exam to determine Bishop score. In case of a low (≤6) Bishop score, a cervical ripening agent may be considered.

C. Place patient on an external fetal monitor (EFM). A 20 minute recording of the fetal heart rate and uterine contraction pattern shall be obtained with a Category I fetal strip.

D. Obtain admission orders from licensed independent practitioner (LIP). Carry out orders before administering ripening agent.

E. Have patient void.

F. Continue to monitor patient with the fetal monitor; refer to policy OB.45 OB Management of Fetal Heart Rate Tracing.

G. Re-dosing is withheld if:

1. Tachysystole (5 or more contractions in a 10 minute period) or hypertonus (contraction lasting greater than 120 seconds). The restrictions may be overridden at the discretion of the LIP after clinical evaluation of the patient.
2. Adequate cervical ripening is achieved.
3. The patient enters active labor.
4. Category II tracing must be reviewed by LIP and approved prior to re-dosing.
5. Category III tracing.

Misoprostol:

~~Equipment: 25 or 50 mcg misoprostol tablet, sterile gloves.~~

A. ~~Dose is~~Equipment: 25 or 50 mcg ~~inserted intravaginally every four (4) hours by LIP or registered nurse or 50 mcg orally every four (4) to six (6) hours~~misoprostol tablet, sterile gloves. Dosing can include the following.

1. 25 mcg inserted intravaginally every four (4) hours by LIP or registered nurse
2. 25 mcg orally every two (2) hours
3. 50 mcg orally every four (4) to six (6) hours

B. Keep patient supine for one (1) hour following vaginal insertion.

C. Intermittent Fetal Monitoring may be used according to policy OB.45 OB Management of Fetal Heart Rate Tracing as directed by LIP and risk factors.

D. Maximum number of doses is six (6).

Dinoprostone Vaginal:

A. Equipment: dinoprostone, sterile gloves.

B. Dose is 10 mg in a vaginal insert.

C. Unstable at room temperature, must be refrigerated until use.

D. Inserted by LIP or registered nurse.

E. Keep patient supine for two (2) hours following insertion.

F. Remove after onset of labor or after 12 hours.

G. Assess for removal if tachysystole (5 or more contractions in a 10 minute period) or hypertonus

(contraction lasting greater than 120 seconds).

H. Delay oxytocin for 30 minutes after removal of insert, follow approved policy OB.30 Oxytocin use for Labor Induction/Augmentation.

I. Monitor for 30 minutes after removal.

Cervical Ripening Balloon In-Patient:

A. Equipment: 18F foley catheter, large luer lock syringe, stylet, speculum, long forceps (provider preference).

B. Pass catheter through cervix.

C. Inflate with 30-60 mL of sterile saline.

D. Secure to inner aspect of patient's thigh.

E. Ambulation is appropriate with intermittent EFM per policy OB.45 OB Management of Fetal Heart Rate Tracing and LIP's orders.

F. Continuous traction may be applied to the catheter. Patient may experience a vasovagal response; discontinue traction if this occurs.

G. Notify LIP to deflate or remove balloon, rupture of membranes,fever, bleeding, or uterine tachysystole.

H. May use cervical ripening balloon in conjunction with oxytocin or cervical ripening agent per LIP's orders.

Cervical Ripening Balloon Out-Patient:

Procedure is to be performed by a LIP after review of chart, review of exclusion criteria, obtaining a reactive fetal non-stress test (NST) , after obtaining informed consent from the patient. (Attachment A).

A. LIP should call Labor and Delivery (L&D) Unit to assure appointment can be scheduled for induction of labor the following day, no more than 24 hours after placement of cervical ripening ballon.

B. LIP should review patient's clinical chart and determine that the patient is an appropriate candidate.

1. **Eligibility:** If there are any questions about the patient's candidacy, please call the on-call LIP on L&D.
    a. 39 weeks gestational age or greater at the time of Foley balloon placement by good prenatal dating
    b. Bishop Score less than 6
    c. Intact membranes
    d. Vertex presentation
2. **Exclusions:**
    a. Any contraindications to a vaginal delivery/induction of labor
    b. Severe maternal hypertension (stable chronic and gestational hypertension are okay)
    c. Previous uterine incision
    d. Multiple gestation

C. LIP should review the procedure with the patient and obtain informed consent.

D. Assess vital signs, NST and Deepest Vertical Pocket (DVP) prior to placement of Foley balloon. Patient must have a reactive NST and adequate DVP.

E. Place Foley and inflate with 30 mL to 60 mL of normal saline.

F. Notify LIP of suspected rupture of membranes, fever, abnormal bleeding, non-reassuring fetal heart tones (FHT) or tachysystole.

G. Provide and review the post procedure instructions with the patient.

BISHOP'S SCALE:

SCORE				
CERVICAL STATE:	**0**	**1**	**2**	**3**
Dilation (cm)	Closed	1-2	3-4	5-6
Effacement %	0-30	40-50	60-70	≥80
Station of Head	-3	-2	-1/0	+1/+2
Consistency of Cervix	Firm	Medium	Soft	---
Position of Cervix	Posterior	Midposition	Anterior	---

EQUIPMENT

A. Sterile gloves.

B. Fetal heart monitor.

C. Written order

D. Intravenous infusion pump (with IV use only).

E. Agents used in this facility are misoprostol and dinoprostone vaginal, cervical ripening balloon. The recommended dose for misoprostol is 25 mcg in pill form for intravaginal use or 50 mcg for oral use. The time-release formulation of dinoprostone contains 10 mg of PGE_2.

DOCUMENTATION

A. Document the administration of cervical ripening medication in the Electronic Health Record (EHR) for antepartum care. Include how the patient tolerated the procedure.

B. Document FHR and contraction pattern. Follow policy OB.45 OB Management of Fetal Heart Rate Tracing.

KEY POINTS

A. Observe standard precautions.

B. Apply the external fetal monitor and monitor both FHT and uterine contractions while medication in place.

C. Place the patient in the lithotomy position for the insertion of the cervical ripening medication.

D. Dinoprostone vaginal is to be inserted by the LIP or registered nurse. Misoprostol may be inserted by LIP or registered nurse.

E. Patient may progress to active labor status.

F. The vaginal insert dinoprostone can be easily removed in the event of tachysystole or Category II or Category III FHR tracing.

G. Exercise caution when using in patients with:
    1. Asthma or history of asthma
    2. Glaucoma
H. Oxytocin may be started 4-6 hours after last dose of misoprostol and 30 minutes after removal of dinoprostone vaginal insert.

REFERENCES:

- ACOG Bulletin #143, March 2014
- Rice-Simpson,Kathleen. AWHONN Cervical Ripening and Induction and Augmentation of Labor 2nd Edition
- ACOG Bulletin #107, March 2015
- AAP/ACOG Guidelines for Perinatal Care 6th Ed., p. 150
- ACOG Practice Bulletin Number 107
- AWHONN: Perinatal Nursing, 4TH edition, 2013

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/2/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/12/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/9/2023
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OB.43 Hepatitis B Prevention in Newborns

POLICY:

To prevent chronic hepatitis B in infants born to mother acutely or chronically infected with hepatitis B virus.

Universal hepatitis B vaccine and hepatitis B immunoglobin (HBIG) vaccine will be given, per CDC protocol, to all infants whose mothers are known HB_sAg positive, or when HB_sAg status is unknown (physician's office will be contacted if necessary to obtain this information) and the mother is high risk (victim of sexual assault, drug abuser, history of multiple sex partners, sex partner of an IVDA, liver disease, deferred blood donor, resident of a home for mentally handicapped persons, history of transfusions, hepatitis B viral infections are asymptomatic. To reduce the incidence of perinatal hepatitis B transmission further, all newborn infants with a birth weight of greater than or equal to 2000 grams shall receive hepatitis B vaccine by 24 hours of age.

PROCEDURE:

A. Identify maternal hepatitis B status:
   1. Look up hepatitis B surface antigen (HBsAg) on prenatal records or under current lab results in Electronic Health Record (EHR) system.
   2. Mothers identified as HBsAg positive have babies that require prompt treatment.
   3. Mothers whose status is unknown should have HBsAg testing immediately on admission.
   4. Mothers with no prenatal care shall have HBsAg drawn and shall be identified as HBsAg unknown until lab results are determined.

B. Treat baby according to maternal HBsAg status and weight in grams:
   1. For all infants born to HBsAg positive mothers:
      a. Administer hepatitis B vaccine and HBIG within 12 hours of birth.
      b. Request HBIG from pharmacy
      c. Administer HBIG in the opposite leg from the hepatitis B vaccine
   2. For all infants born to HBsAg-unknown mothers:
      a. Administer hepatitis B vaccine within 12 hours of birth and:
      b. For infants with a birth weight greater than or equal to 2000 grams, administer HBIG by 7 days of age or by hospital discharge (whichever occurs first) if maternal HBsAG status is confirmed positive or remains unknown.

c. For infants with a birth weight less than 2000 grams, administer HBIG by 12 hours of birth unless maternal HBsAG status is confirmed negative by that time.

3. For all infants with a birth weight greater than or equal to 2000 grams born to HBsAg-negative mothers:
   a. Administer hepatitis B vaccine as a universal routine prophylaxis within 24 hours of birth..
   b. For all infants with birth weight less than 2000 grams born to HBsAg-negative mothers, administer hepatitis B vaccine as a universal prophylaxis at one month of age or at hospital discharge (whichever occurs first).

VACCINATION ADMINISTRATION

Standards of administration of hepatitis B vaccine and HBIG vaccine.

A. Obtain physician's order.

B. Obtain signed consent from mother to permit infant to be vaccinated.

C. Identify maternal HBsAg status and infant's weight and gestational age.

D. Determine priority of when to give vaccinations according to this policy and procedure (identified above).
   1. Collect needed materials:
      a. Hepatitis B vaccine from OB medical refrigerator for patients eligible for CHDP/Medi-Cal; for private insurance carriers, vaccine is obtained from the Pharmacy (store at 2°to 8°C).
      b. HBIG is obtained from the Pharmacy (store at 2°to 8°C).
      c. Syringe and needle.
      d. Current vaccination sheets (VIS).

DOCUMENTATION

A. The most current VIS sheets are given to the mother when consents are needed for optional vaccinations. One VIS sheet is given to the mother and a copy is stamped, dated and signed as a written consent, placed on the baby's chart and scanned into the EHR. **Positive maternal HBsAg mandates immediate administration of the hepatitis B vaccine and the HBIG vaccine and does not require written consent.**

B. Document in Cerner under the patient's Immunization Schedule
   1. Fill out requested information completely with baby's identification data.
      Note date, manufacturer and lot #, signature of administrator, site and VIS I.D. under appropriate headings.
   2. HBIG must be documented, if given.

C. Initiate a Public Health referral for positive HBsAg mothers.

D. A copy of the lab result should be kept in both the mother's and infant's EHR.

REFERENCES:

"Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose within 24 hours of Birth" Pediatrics (2017); Volume 140, Number 3

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Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	9/5/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/24/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/24/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	8/24/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/1986*
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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.48 Testing for Prenatal Drug Exposure

POLICY:

The following applies to infants born to mothers with suspected or known substance abuse. Neonatal drug/ alcohol exposure evaluations protect the neonate from possible neglect and child abuse. The birth of a baby to a family with questioned ability to provide appropriate care **must** be reported under the Child Abuse and Neglect Reporting Act (Penal Code, 11164 et seq.). Whenever a toxicology screen is ordered, the physician must document the reason in the patient's medical record, unless provided for under a facility's policy.

PROCEDURE:

A. Neonatal Staff Responsibilities

1. Health care team members should consider notifying the social worker of neonates exposed to potentially harmful drugs.
2. Each case shall be evaluated and the necessary recommendations made, based on input from health care team members. When indicated, additional consultation or follow up should be obtained when child endangerment is suspected.
3. Member of the health care team shall report by:
    a. Making a telephone report of the situation to the Department of Child Family Services (DCFS) as soon as possible by calling 1-805-654-3200 and/or
    b. Completing the California Department of Justice DOJ Form 11166PC, Suspected Child Abuse Report. Fax to 1-805-654-5597.

B. Prenatal Responsibilities

1. When a prenatal patient presents with an acknowledged history of drug/alcohol abuse:
    a. A toxicology screen shall be ordered at the discretion of the physician. (Whenever a toxicology screen is ordered for the mother, the physician must clearly document the reason in the patient's medical record, or comply with facility policy.) Consent must also be obtained per hospital policy.
    b. Confirm that Human Immunodeficiency Virus (HIV) and Hepatitis C screening, counseling, education, and referral have been offered.
    c. Offer the patient a referral for a public health nurse.
2. If the screen is positive for:

a. Alcohol, cannabis, or illegal drugs: Refer the patient to social worker for comprehensive evaluation.

b. Legally available prescribed medications:

i. Prescribed and appropriate use: no further action needs to be taken. Note: some "over the counter" drugs result in a false positive urine toxicology screening and further testing should be sent.

ii. Prescribed but inappropriate: refer patient to social worker.

iii. Illegal use: refer patient to social worker.

3. When the father of the unborn child or the significant other of the pregnant patient is suspected of drug/alcohol abuse, refer the case to a social worker for comprehensive evaluation.

4. Despite positive drug/alcohol screens, only extreme and dangerous situations are reported to DCFS and/or police during the prenatal period.

a. Efforts are directed at counseling the family and making appropriate referrals for treatment.

b. DCFS should be notified if there are children in the home who may be endangered.

c. Public health nurse referral should also be utilized in these situations or when DCFS is not involved but the health care team may have some concern.

C. Intrapartum Responsibilities

1. When a pregnant woman presents with signs and/or symptoms of drug/alcohol abuse:

a. The physician shall consent the patient and order a urine toxicology screen. If clinically indicated consider blood alcohol and blood toxicology.

b. If a pregnant patient presents with an altered mental state, or signs of recent drug and/or alcohol abuse, a urine and/or blood toxicology test can be obtained without a consent to aid in medical decision making, and to provide appropriate medical care.

c. A team member should refer the patient to a social worker.

2. Strong consideration should be given to ordering a toxicology screen if one or more of the following factors are present (if not already done):

a. Clinical evidence of IVDU-track marks.

b. Inappropriate, disruptive behavior.

c. No prenatal care.

d. Preterm labor and/or preterm rupture of membranes.

e. Rule out (R/O) pre-eclampsia/eclampsia.

f. Abruptio placentae.

g. Fetal demise.

h. Patient choice to deliver outside of normal catchment areas without adequate explanation.

i. History of ongoing drug/alcohol abuse.

3. Obtain results of the following screens ASAP: Hepatitis B surface antigen (HBsAG), HIV, and Hepatitis C antibody and syphilis titers. If these have not been done during this pregnancy or there are new risk factors (IV drug use, new sexual partner) these should be repeated.

NEONATAL EVALUATION

The following is meant to serve as a guideline to assist physicians in deciding when to screen neonates for drugs. Health care professionals shall use sound clinical judgment. This guide should not replace training, experience or studying the latest literature and information. It is believed that families of neonates who have been exposed to maternal substance abuse in utero can be helped with identification and appropriate intervention. Parental consent is required for treatment provided to the neonate. An exception should be made if the neonate is exhibiting signs of drug exposure described below.

A. A neonatal sample should be considered if any of the following criteria are met:
    1. All infants born to mothers using illicit drugs or habitual alcohol use during this pregnancy will need:
        a. Cord tissue and urine toxicology sent.
        b. If unable to send tissue then:
            i. Collection of meconium.
        c. Consultation with social worker.
        d. Inform DCFS soon after discovery (do not wait until discharge day).
    2. If mother is on a Methadone or Buprenorphine treatment program or using illicit drug, or if there is a suspicion of ongoing drug abuse:
        a. The infant needs to be evaluated by a qualified provider for neonatal abstinance syndrome (NAS) within 24 hours.
        b. The infant should not breast feed until clarifying the status of use of other drugs, like cocaine, amphetamines, and HIV/Hep C status. In the meantime, assist mom with pumping to maintain breast milk supply.
        c. Some infants may not show signs of withdrawal until 2-3 weeks of age, therefore if the infant is asymptomatic and discharged home, it needs to be closely monitored by the primary care physician for possible late onset signs of withdrawal.
        d. Consider a public health nurse referral to assist with symptom monitoring.
    3. Mothers who have a history of ongoing illicit drug use.
    4. Babies whose mothers have a history of a drug-exposed infant in a previous pregnancy.
    5. Maternal or paternal HIV, gonococcal, chlamydia, hepatitis C, trichomonas, hepatitis B, or syphilitic infection.
    6. Inadequate prenatal care (defined as less than three visits or initiation of care in third trimester).
    7. Abruptio of the placenta.
    8. Unexplained gestational age of less than 37 weeks or birth weight below the tenth percentile for gestational age.
    9. Any one of the following neonatal symptoms, if of unknown cause: jitteriness, seizures, or lethargy.
    10. Neonatal abstinence syndrome.
    11. Vascular disruption syndromes, including (but not limited to) microcephaly, limb deformities, prune belly syndrome, bowel atresia, stroke or urinary tract anomalies.

12. If other risk factors are present, such as meconium in the amniotic fluid, precipitous labor, subarachnoid hemorrhage, or a history of stillbirth or sudden neonate death syndrome (SIDS) in a sibling.

B. Order a drug screen as soon as possible on any neonate demonstrating signs consistent with drug withdrawal. Signs of drug withdrawal can include:

1. High-pitched cry
2. Sleeps less than one (1) hour after feeding
3. Hyperactive Moro Reflex
4. Tremors (when disturbed or undisturbed)
5. Increased muscle tone
6. Generalized seizure
7. Frantic sucking of fists
8. Poor feeding, uncoordinated suck/swallow
9. Regurgitation
10. Projectile vomiting
11. Loose and/or watery stools
12. Dehydration
13. Frequent yawning
14. Sneezing
15. Nasal stuffiness
16. Sweating
17. Mottling
18. Hyperthermia
19. Tachypnea
20. Excoriation of nose, knees, toes and/or chin.

C. The neonatal sample should include umbilical cord tissue as the preferred method. If cord tissue cannot be obtained, meconium can be sent. In addition, a urine toxicology should be ordered for ALL newborns suspected of exposure to drugs in utero.

1. Procedure for cord tissue (preferred testing method)
    a. Cut a 6 to 8 inch segment of umbilical cord in the delivery room.
    b. Rinse the exterior/outside of the specimen with normal saline or sterile water. Important: Prevent the umbilical cord and specimen from coming in contact with ethanol-based liquids or vapors previous to and during the collection process. This includes ethanol-based hand sanitizer and alcohol prep pads.
    c. Squeegee/strip the cord to remove blood and mucous from cord segment.
    d. Pat the specimen dry and place it in the specimen container. The specimen must be dry.
    e. Place the newborn's ID sticker on the specimen container. Place the date, time of collection and

employee ID or Cerner Code on the label.

f. If the newborn sticker is unavailable, write the newborn's name, date of birth and collection time on the specimen cup. Once the sticker is available, place the date, time of collection and the employee ID or Cerner ID on the sticker. Label the specimen cup with the sticker.

g. The nurse who collected the specimen will take it to the Lab in the plastic bag or formally hand off the sample to another nurse or designated staff member and follow standard chain of custody protocol.

h. The nurse or designated staff member will hand carry the sample to the Lab per standard chain of custody protocol.

i. The sample must be handed directly to a licensed clinical laboratory scientist or designee (do not leave the specimen unattended) per standard chain of custody protocol.

j. Every change of custody must be documented on the specimen tracking form. Use the Chain of Custody Form.

k. Physician or nurse will place the following send-out order in Cerner

   i. Name: CordStat 13

   ii. Code: 900924

2. Procedure for meconium testing

   If cord testing was not performed, the provider may order a toxicology test on meconium as follows:

   a. Obtain 1 to 5 grams of meconium from the baby's diaper.

   b. Place the meconium in a specimen cup and label following same steps listed above. Follow standard chain of custody requirements.

DOCUMENTATION

Documentation supporting DCFS referral and/or hold is placed in newborn's medical record. (If a newborn is placed on hold, the hospital should record the name and phone number of the DCFS worker taking custody in the mother's and the newborn's medical records.)

REFERENCES:

A. AWHONN: Perinatal Nursing, 4th edition, 2013.

B. Substance Abuse. Perinatal Guidelines of Care, Seventh Edition, 2012 American Academy of Pediatrics and the American College of Obstetricians & Gynecologists, PP 266-264.

C. PAC-LAC Prenatal and Intrapartum Guidelines of Care, 2009

D. PAC-LAC Neonatal Guidelines of Care, 2013

All revision dates: 10/14/2020, 10/12/2018, 9/27/2018, 1/1/2016, 11/1/2013, 8/1/2010, 10/1/2004, 12/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/24/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/24/2023
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Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*PEDS/PICU*
References:	

P.32 PICU, NICU and PEDS Visiting Policy

POLICY:

In keeping with the philosophy of family centered care, in order to promote and preserve parent-infant/child attachment, and to provide the opportunity for the inclusion of support systems within the family structure and to maintain the quality of care for all patients in the Ventura County Medical Center PICU, NICU ~~and PEDS departments~~, ~~the following visitation policy shall be followed~~Pediatric Departments. ~~Visiting guidelines may be altered at any time due to individual unit activities.~~

PROCEDURE:

~~PEDS UNIT~~

~~A. One parent/visitor is encouraged to stay with the patient at all times. Only one parent/visitor may spend the night.~~

~~B. Parents/visitor may be asked to leave the bedside or unit during procedures or emergencies. and Parents or approved visitors may not linger in the hallways or outside patient rooms. If there are extenuating circumstances, the charge nurse will direct the parents/visitor on where to wait.~~

~~C. At admission, parents will provide the names and relationship of two alternate visitors who have approval to visit their child for the child's entire hospitalization. These named visitors are to remain the same throughout the Childs' stay.~~

~~D. No more than two visitors (including parents) (in addition to one parent) will be allowed at the bedside at one time. The two approved visitors will be able to alternate visitation with the parents. There will be no rotation of visitors in the waiting areas with visitors in the patients' room.~~

~~E. The parents and visitors are instructed to utilize the entry call bell and talk to the Pediatrics staff prior to entering the unit.~~

~~F. All visitors must check in at the nurses' station prior to visiting the patient.~~

~~G. In situations of suspected child abuse or neglect, the staff will contact the social worker if questions exist regarding visitation.~~

~~H. VCMC Pediatric Department practices Family Centered Care, parents and approved visitors may visit at any time.~~

~~I. No visitors are allowed in the nurses' station at change of shift.~~

J. ~~Parents and visitors with known illnesses should not visit until the illness has resolved. All visitors must be free of a history of recent exposure to communicable disease.~~

K. ~~VCMC reserves the right to restrict visitation during times of increased illness or the flu season.~~

L. ~~Children, including siblings, may not visit on the Pediatric floor.~~

M. ~~Exceptions to the above guidelines may be made through consultation with the Charge nurse or the Clinical Nurse Manager.~~

N. ~~Shoes and shirts are required of all visitors.~~

O. ~~Alcohol and tobacco are not allowed on the hospital premises.~~

~~NICU UNIT~~

General for PICU/NICU/Pediatrics

A. All visitors will follow the Hospital Visiting Hours and Regulations Policy 100.011. Visitors will access VCMC and SPH at designated entrances and be provided a visitor wristband upon entering the hospital. The visitor wristband must be always worn when visiting.

B. Parents/Guardians and approved visitors may visit at any time throughout the child's hospitalization (Attachment A).

C. One parent/guardian or visitor is encouraged to stay with the patient at all times.

D. Only one parent/guardian may spend the night with the patient.

E. In respect of confidentiality, only the parent/guardian will be provided patient information.

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

G. Parents/guardians/visitors may be asked to leave the bedside or unit during procedures or emergencies. Parents/guardians/visitors will be asked to wait in the designated waiting area outside of the department.

H. On admission, parents/guardians may indicate up to four approved adults who may visit in their absence (Attachment A). The parents will provide the names and relationship of up to four alternate visitors who have approval to visit their child for the child's entire hospitalization. These named visitors are to remain the same throughout the child's hospitalization.

I. No more than two visitors, including parents/guardians will be allowed at the bedside at one time.

J. Parents/guardians/visitors are instructed to utilize the entry call bell outside PICU/NICU/Pediatrics and talk to the staff prior to entering the department.

K. All visitors must check in at the nurse's station prior to visiting the patient.

L. Parents/guardians and visitors with signs and symptoms of illness, fever, diarrhea, respiratory infection cold sores or signs of any contagious communicable illnesses may not visit until the illness has resolved.

M. VCMC reserves the right to restrict visitation during times of increased illness or the flu season.

N. Children under the age of 13 are not permitted in patient care areas with the exception of siblings.

1. Siblings may visit during regular visiting hours only.
2. Siblings must be accompanied by an adult.
3. The child must be in good health which is determined as necessary by the nurse or physician on the unit.

4. PICU/NICU have more specific visitation guidelines.
5. Exceptions to sibling visitation are made through the consultation of the charge nurse, nursing supervisor and/or manager.
6. Siblings/Children should not be left unattended. Siblings/Children should be accompanied and supervised by a responsible adult whose primary responsibility is to he child and can leave with the child if this becomes necessary.

NEONATAL INTENSIVE CARE UNIT

~~General Guidelines~~

1. ~~Visitors with fever, diarrhea, respiratory infection, or cold sores may not visit.~~
2. ~~Siblings age two (2) and above may visit when accompanied by an adult.~~
3. ~~Children should not be left unattended. All children, including siblings, should be accompanied and supervised by a responsible adult whose primary responsibility is to the child and can leave with the child if this becomes necessary.~~
4. ~~Children of staff and physicians will not be permitted in nursing areas.~~
5. ~~Parents/guardians must be identified by ID band matching or picture identification. Parents may visit at any time. Exceptions depend upon unit activities such as doctors' rounds, procedures, medical emergencies and nursing report (06:30 - 07:30 and 18:30 - 19:30 hours).~~
6. ~~Parent(s) may indicate up to four adults who may visit in their absence (see Attachment A). Parent may also designate another adult who may be given information regarding patient condition.~~

A. Parents/Visitors are to remain at the patient bedside.

B. All visitors will perform a one (1) minute scrub from the fingertips to the elbows with antiseptic soap and follow hand hygiene guidelines.

C. Parents/Guardians must be identified by ID band matching the infant or provide picture identification.

D. Parents/Guardians/Visitors must be free from contagious/communicable illnesses. If a parent's health status is of concern, all questions should be discussed with the Neonatologist.

E. A mother with a temperature less than 102° thought to be related to GYN or urinary tract problem may visit.

F. Only siblings over the age of 13 are allowed to visit the NICU. Siblings under the age of 13 will be allowed to visit on for extenuating circumstances and after a joint conversation with the nursing staff and physician.

1. Length of sibling visit will be left to the discretion of the parents and nursing staff.
2. On every sibling visitation visit, a visitation screening data sheet (Attachment B) must be completed on the chart. Parents must present siblings up to date immunization record. Parent(s) will be asked to sign the sibling visitation form after information is verified by the nurse.
3. Siblings must have had chicken pox or the vaccine more than 30 days prior to visitation.
4. Siblings with illness or temperature over 100°F are not allowed to visit.

G. ~~SPECIFIC GUIDELINES~~If the infant is to be taken outside the NICU to visit mom on the labor & delivery/ postpartum units or other units in the hospital, the following apply:

~~All visitors will perform a one (1) minute scrub to the elbows with antiseptic soap and follow the handwashing policy.~~

~~Three people at a time are permitted at the infant's bedside.~~

~~All visitors, including mothers, should be free from contagious/communicable illnesses. This includes upper respiratory, gastrointestinal and systemic viral infections. If a parent's health status is of concern, all questions should be discussed with the neonatologist or NNP. An infant's mother with temperature less than 102°, thought to be related to GYN or urinary tract problem may visit.~~

~~Parents and their visitors are to remain with their infant while visiting.~~

~~If the infant is to be taken outside the NICU to visit mom on the labor & delivery/postpartum units or other units in the hospital, the following apply:~~

~~a. Infant is taken by transport cart if visiting to unit other than labor and delivery/postpartum units.~~

~~b. Before touching or holding infant, encourage mother to wash hands with antiseptic soap.~~

~~c. NICU personnel are present during visitation upon discretion of neonatologist/NNP.~~

~~d. The number of other visitors in the room should be at the NICU RN's discretion.~~

1. Infant is taken by transport cart if visiting to unit other than labor and delivery/postpartum units.
2. Before touching or holding infant, encourage mother to wash hands with antiseptic soap.
3. NICU personnel are present during visitation upon discretion of neonatologist/NNP.
4. The number of other visitors in the room should be at the NICU RN's discretion.
5. If the parents are not married and concerns are expressed regarding father's visitation, the father has the same visitation rights as the mother, if the mother has acknowledged the man as father of the baby.

~~Parents should be informed that information concerning their infant will only be given to them in respect of confidentiality.~~

~~Parents/guardian may request consultation with any member of the health care team and a parent meeting will be scheduled.~~

H. ~~SIBLING VISITATION GUIDELINES - NICU~~

~~1. On every visit, sibling visitation screening data (see Attachment B) must be completed on the chart. Immunization record must be up-to-date. Parent(s) should sign after verifying information.~~

~~2. Siblings with illness or temperature over 100°F may not visit.~~

~~3. Length of visit by young children will be left to the discretion of the parents and nursing staff.~~

~~4. Siblings should be at least 2 years of age to visit.~~

~~5. Prior to touching/handling the infant, siblings will perform a one (1) minute scrub to the elbows with antiseptic soap and follow the hand washing policy.~~

~~6. Children must have had chicken pox to visit in the NICU or have had the vaccine more than 30 days previously.~~

~~7. Sibling visitation may take place in the NICU or other designated area.~~

Parents/guardian may request consultation with any member of the health care team and a parent meeting will be scheduled.

I. EXCEPTIONAL CIRCUMSTANCES

1. For the dying infant/child, there will be unlimited visitation privileges by parents.
2. Special events, such as birthday parties or holidays, may be planned for long term patients. ~~Plan is conducted by the parents and bedside nurse in consultation with the NICU Nurse Manager.~~
    a. Plan is conducted by the parents and bedside nurse in consultation with the NICU Nurse Manager.

J. DOCUMENTATION

A. Discharge teaching encounter form updated.

B. Parent visitation list (Attachment A) completed on admission or during hospitalization.

C. Sibling screen form completed prior to visit episode.

D. Parent contact in Electronic Health Record (EHR) updated each shift.

~~PICU UNIT~~

~~A. General Guidelines~~

~~1. Two visitors (including parents) are permitted at the child's bedside.~~

~~2. Parents/approved visitors may visit at any time. Only one person may spend the night.~~

~~3. Parent(s) may indicate up to four two approved adults who may visit in their absence. Upon admission, the names of the two approved visitors will be provided to the nurse and will remain the same throughout the child's hospitalization.~~

~~4. The approved persons will alternate visitation with the parents. There will be no rotations of visitors in the waiting room with visitors in the patients' room.~~

~~5. Visitors with fever, diarrhea, respiratory infection, or cold sores may not visit.~~

~~6. No children, sibling or non-siblings, will be allowed to visit in the PICU. For any extenuating circumstance, a joint discussion concerning the risks and benefits of visitation will be had with the charge nurse, the child life specialist and the physician.~~

~~7. All visitors must check in the nurses' station prior to visiting the patient.~~

~~8. All visitors, including parents, should be free of a known illness and any contagious/communicable illnesses.~~

~~9. Parents should be informed that information concerning their infant will only be given to them in respect of confidentiality.~~

~~10. The child may not leave the PICU with any visitor.~~

~~11. Parents should be informed that information concerning their infant will only be given to them in respect of confidentiality.~~

~~B. Extenuating Circumstances~~

~~1. For the dying child, there will be unlimited visitation privileges by parents.~~

~~2. The charge RN, pediatric intensivist, and bedside RN may allow a child younger than 13 years old to visit.~~

~~3. The charge RN, pediatric intensivist, and bedside RN may allow more than two people at the bedside.~~

PEDIATRIC INTENSIVE CARE UNIT

A. Parents/Visitors are to remain at the patient bedside.

B. Siblings and children will not be allowed to visit in the PICU except for extenuating circumstances. For any extenuating circumstances, a joint discussion with nursing staff, physician, and child life specialist to address the risks and benefits of the visitation.

C. The parent of the PICU patient must be present for the sibling/child visitation.

D. The child may not leave the PICU without the supervision of the nursing staff.

E. Extenuating Circumstances

1. For the dying child, there will be unlimited visitation privileges by parents.
2. The charge RN, pediatric intensivist, and bedside RN may allow a child younger than 13 years old to visit.
3. The charge RN, pediatric intensivist, and bedside RN may allow more than two people at the bedside.

All revision dates: 7/17/2023, 11/10/2021, 12/17/2018, 5/1/2014, 2/1/2012, 3/1/2010, 1/1/2005

Attachments

A: Approved Visitor List for Minor Patient
C: My Family Visited Today! Form

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/17/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/17/2023
Policy Owner	Jennifer Ferrick: Director, Peds/PICU & NICU	7/17/2023

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Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Pharmacy Services*
References:	

PH.19 After Hours Pharmacy Services for Santa Paula Hospital

POLICY:

The Ventura County Medical Center Inpatient Pharmacy shall provide pharmacy services to Santa Paula Hospital during the hours the Santa Paula Hospital Inpatient Pharmacy is closed.

PROCEDURE:

A. The Santa Paula Hospital (SPH) Inpatient Pharmacy is open seven days a week from the hours of 08:00 to 16:30.

B. When the SPH Pharmacy is closed, all medication orders shall be reviewed by a pharmacist at Ventura County Medical Center (VCMC).

C. When an order is reviewed and verified, the medication shall be available at the appropriate automated dispensing cabinet (ADC).

D. The pharmacist at VCMC shall be responsible for clarifying any orders, if necessary, with the provider at SPH.

E. If an ordered medication is not available at SPH, the VCMC ~~Pharmacy Staff~~pharmacy staff shall be responsible for locating the medication in a quantity sufficient to maintain the patient for at least 24 hours. Once the medication is located by the pharmacist, SPH nursing shall be notified. A hospital courier shall be contacted for delivery of medications to SPH.

   1. For emergent, first doses of intravenous medications, see policy 100.248 Santa Paula Hospital After Hours Intravenous Medication Preparation.

F. The pharmacist at VCMC shall also be available to assist health care professionals with questions relevant to medications or Pharmacy Services.

G. The pharmacist at SPH shall review all medication orders from the time SPH Pharmacy closed the previous day. Any irregularities in the orders shall be immediately corrected.

H. The nursing supervisor shall have access privileges to all ADCs enabling them to pull medications when the pharmacy is closed.

I. VCMC pharmacist shall be responsible for preparing and dispensing outpatient medication for patients at SPH during after hours. VCMC staff shall follow policy PH.123 Outpatient Medication Dispensing Procedure. The prepared outpatient medication may be delivered to SPH via hospital courier or patients

may pick up the medication at VCMC pharmacy location.

All revision dates:	9/5/2023, 9/10/2020, 5/31/2017, 5/1/2016, 2/1/2014, 6/1/2011, 9/1/2008, 7/1/2006, 6/1/2006, 10/1/2003, 10/1/2002, 4/1/2000, 11/1/1998, 2/1/1996, 6/1/1995

Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
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Pharmacy Services	Sara Pendleton: Medication Safety Officer	9/6/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/5/2023

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References:	

PH.55 Medication Order Management

POLICY:

The Department of Pharmacy Services maintains processes for the safe and timely prescribing and administration of medication to patients at Ventura County Medical Center and Santa Paula Hospital.

PROCEDURE:

I. Medication order review and verification

A. The Pharmacist reviews the appropriateness of all medication orders for medications dispensed within the hospital. See policy PH.96 Medication Override from Automated Dispensing Cabinets for exceptions.

B. Medication orders entered and submitted in the electronic health record (EHR) are immediately routed to the Pharmacy order verification application for Pharmacist review with an electronic signature generated upon completion.

C. The Pharmacist shall screen all orders indicating which orders need first priority.

1. "STAT" orders shall be processed and delivered within 30 minutes of receipt.
2. "NOW" and "ASAP" orders shall be processed and delivered within one (1) hour of receipt.
3. Routine and "PRN" medications shall be processed and delivered within two (2) hours of receipt.
4. All other orders shall be processed by patient status acuity; Emergency Department (ED), Intensive Care Unit (ICU), Neonatal Intensive Care Unit (NICU), and Pediatric Intensive Care Unit (PICU) shall have priority.
5. Turn-around-time for new total parenteral nutrition (TPN) orders for premature infants should be anticipated to be approximately two (2) hours.

D. The Pharmacist shall review the patient's profile and medication order for the following: allergies, weight, diagnosis, interactions, contra-indications, appropriate-ness of the medication (e.g. dose, frequency, and route), pertinent labs, and for therapeutic duplication.

1. The Pharmacist shall not dispense any medication without documentation of weight and allergy on the medication profile.
2. The Pharmacist receiving the order is responsible for clarifying any identified issues with the medication order. All medication order clarifications shall be resolved prior to the end of the

shift.

3. If the Pharmacist is unable to resolve the order, chain of command is initiated and all unresolved problem orders shall be reported to the Pharmacy Supervisor (see Procedure II. Medication Orders in Conflict with Standard of Practice).
4. The Pharmacist shall document all clinical interventions in the EHR.

E. Therapeutic duplication is the practice of prescribing multiple medications for the same indication without clear distinction of when one agent should be administered over another.

a. Pharmacists shall review all medication orders for therapeutic duplication when verifying any new medication orders(s) for patients.
b. Orders which specify a range of doses without explicit parameters for use shall be rejected. All such orders shall be clarified by the pharmacist prior to review and processing.
c. Multiple "PRN" medication orders for medications in similar classes or similar indications shall be clarified by the pharmacist.
d. Orders for multiple routes of administration for the same medication shall be clarified by the provider as to which route is the preferred route and the situation necessitating a change from one route to another. The pharmacist shall contact the provider for a clarification if this information is not provided.

F. For pediatric orders, the Pharmacist shall confirm pediatric doses in a pediatric drug reference.

1. Pediatric medication orders should be based on weight or body surface area (e.g. mg/kg or mg/m^2) up to the maximum adult dose. Maximum adult doses may be exceeded in special circumstances.
2. Pediatric doses should be re-calculated prior to dispensing.
3. Patient specific doses shall be dispensed whenever possible.

G. The metric system should be used for all medication orders except where dosages must be expressed otherwise (e.g. units for insulin). Conversion charts shall be available to all health care professionals (HCPs).

H. Generic drugs shall be selected unless the licensed independent practitioner (LIP) specifies "Do Not Substitute" on the medication order.

I. Orders for "PRN" medication shall not be reviewed or processed without documentation of the indication for use.

J. Orders for topical agents shall not be reviewed or processed without documentation of location for where the medication is to be applied.

K. Complex orders, medication orders requiring patient monitoring for assessment, or orders which need additional information to ensure safe administration must provide additional information (i.e., monitoring parameters). Examples of medication orders that require monitoring parameters include insulin and NORepinephrine. Incomplete orders for such medications shall not be reviewed or processed. The pharmacist shall contact the LIP directly for order clarification.

L. Titration orders for medication must be specified on the orders (see policy CC.23 Intravenous Medication Titration in Critical Care Areas).

M. All medication orders shall be stored for three (3) years and seven (7) years for controlled substance orders and be available for review, if required, within two (2) business days.

II. Medication Orders in Conflict with Standard of Practice

A. If the pharmacist finds the use of a medication prescribed by a LIP inconsistent with the approved standard of practice, the pharmacist shall intervene.

B. The pharmacist shall contact the LIP directly to discuss the therapeutic issue(s) and contact the primary care HCP regarding the possible delay in therapy.

C. The pharmacist shall record and document such clinical interventions in the EHR.

D. If the situation cannot be resolved and is deemed to pose a serious risk to the patient, the pharmacist shall contact the Director of Pharmacy Services, who shall then contact the Chair of the Pharmacy & Therapeutics (P&T) Committee. The Chair shall contact the LIP. Once resolved, the Chair will notify the pharmacist of the decision, who will proceed accordingly.

E. If the Chair of the P&T Committee cannot resolve the problem, the Chair shall then refer the matter to the Chief Medical Officer (CMO).

F. The pharmacist and HCP shall maintain complete documentation. The pharmacist or HCP shall complete and submit a Notification Form.

G. A report of any issue referred to the CMO shall be presented at the following P&T Committee.

III. Medication Distribution and Dispensing Procedure

A. The preparation and dispensing of medications are consistent with applicable law or regulation governing professional licensure, operation of the Pharmacy and professional standards of pharmacy practice.

1. No person other than a pharmacist or an individual under the direct supervision of a pharmacist shall distribute or dispense medications, make label changes or transfer medication. This includes floor stock medications, crash cart medications and medications brought in by patients.

2. The duties and responsibilities of non-pharmacist staff are consistent with their training and experience. Non-pharmacist staff may not be assigned duties that by law must be performed only by licensed staff.

B. Pharmacy provides medications in the most ready to administer form whenever possible (see Procedure IV. Medication Packaging, Preparation and Labeling).

C. Medications are stored in the designated Automated Dispensing Cabinet (ADC), in the medication rooms, or in the medication carts. Each patient has an assigned cassette (drawer) for storage of any medications not in the ADC.

D. If the medication is not available in the ADC, Pharmacy shall dispense the first dose(s) after which a 24 hour supply shall be filled and delivered to the nursing unit between 1500 and 1630 every day.

1. Parental nutrition and lipids are delivered directly to the nurse with signed receipt.

2. For controlled substances deliveries see policy PH.88 Controlled Substances.

3. Intravenous continuous drips for the ICU, DOU, and PICU shall be requested by the nurse no later than three hours prior to expected drip change.

E. Missing Medications

a. When a patient is transferred from one nursing unit to another, it is the responsibility of the sending nurse to place all medications for the patient in a bag and send them with the patient to the receiving destination.

b. When missing medications are encountered, the HCP shall request the missing medication through the EHR.

F. Medications for ED Hold Patients

a. HCPs caring for ED Hold patients may request scheduled medications to be dispensed from the pharmacy by submitting a request through the EHR. Any scheduled medication that is not administered immediately shall be stored in a secure location.

b. Controlled substances, "STAT", "NOW", and "PRN" medications should be obtained from the ADCs in the Emergency Department.

IV. Medication Packaging, Preparation and Labeling

A. A patient specific label shall be generated and affixed to all pharmacy dispensed medications.

1. Label shall include the following

i. Name, address, phone number of the pharmacy

ii. Patient's name and date of birth

iii. Location

iv. Medical Record Number (MRN)

v. Medication name and strength

vi. Dose, Route, Frequency

vii. Date dispensed

viii. Beyond use date (BUD)

ix. Appropriate auxiliary labeling

2. The pharmacy technician or a pharmacist shall fill the medication based on the label and document this process with their initial on the label.

3. The pharmacist shall double check that the medication was prepared appropriately and document this process with their initials on the label.

4. The medication shall be placed in a plastic bag whenever possible and shall be delivered to the nursing units.

B. For compounded sterile products, refer to policy PH.26.04 Sterile Drug Preparation, Labeling, End Product Evaluation and Record Keeping.

C. For unit dose medication packaging, refer to policy PH.31 Drug Packaging.

D. Bulk pharmacy items and topical medications shall be directly labeled on the container.

E. Liquid medications

a. For adult patients, liquid medications shall be dispensed in manufactured unit dose containers whenever possible. In the event a medication is not available in unit dose containers, the Pharmacy shall pre-package and label the medication into a unit dose container.

b. For pediatric and neonatal patients, liquid medications shall be drawn into dose specific oral syringes whenever possible.

c. The Pharmacy shall maintain documentation of the manufacturer, lot number, and expiration date of source container, initials of preparing pharmacy technician, and initials of checking

pharmacist.

F. Pill splitting: Pharmacy may split and pre-package standard unit dose partial tablets. Non-standard partial tablets are split by the nurse prior to administration. Nursing shall use a patient specific pill splitting device obtained from Central supply.

G. Pill crushing: For those medications that can be crushed, pharmacy and nursing shall use the approved pill crusher.

V. Cleaning Agents, Solvents, Chemicals and Poisons

A. Labeling of repackaged products shall contain the name of the chemical, detergent, solvent, strength of the solution, the amount, lot number and expiration date when applicable. Additionally, any cautionary labels or warnings shall be affixed to the container when applicable.

B. The Pharmacy Department designee shall be an active member of the Infection Prevention Committee and shall be consulted on proper methods for prepackaging and labeling. The pharmacist shall also verify that disinfectants are dispensed pre-mixed in the required concentrations, to ensure that staff are utilizing an effective product.

VI. ~~Discharge medications~~

1. ~~Discharge medications are not routinely dispensed to patients at time of discharge and are only provided in hardship situations (examples: self-pay, no insurance, undocumented status).~~
2. ~~Discharge medication dispensed to inpatient or outpatients at the time of discharge shall have the following label information:~~
   a. ~~Name, address and telephone number of the hospital Pharmacy~~
   b. ~~Date and prescription number~~
   c. ~~Name of the drug, strength and quantity dispensed~~
   d. ~~The directions to the patient for use of the medication~~
   e. ~~The name of the prescriber~~
   f. ~~The initials of the dispensing Pharmacist~~
   g. ~~Any required or other pertinent accessory cautionary labels~~
   h. ~~Expiration date of the drug~~
3. ~~When medications are dispensed at time of discharge, the following information shall be provided to the patient by a pharmacist or discharging nurse.~~
   1. ~~Name of drug.~~
   2. ~~Indication for the drug.~~
   3. ~~Instruction on how to use the medication.~~
   4. ~~Storage instructions.~~
   5. ~~Common side effects of the medication.~~
   6. ~~Patient drug information.~~
   7. ~~Provide consultation on the medication.~~

Discharge medications (see Policy PH.123 Outpatient Medication Dispensing Procedures)

All revision dates: 9/5/2023, 3/4/2020, 5/15/2019, 3/21/2019, 5/31/2017, 3/1/2014, 12/1/2011, 3/1/2011, 6/1/2006, 9/1/

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Attachments

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	9/6/2023
Pharmacy Services	Sara Pendleton: Medication Safety Officer	9/6/2023
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VENTURA COUNTY
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PH.78 Boxed Warning Drugs

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) will make drug safety information related to boxed warnings readily available to Licensed Practitioners (LP) and clinicians involved in the medication use process.

The hospital maintains processes for managing high-risk or "high-alert" medications per Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) Pharmacy Department, policy PH.70 High Alert Medications.

BACKGROUND:

~~Ensure that medications that bear a boxed warning are identified and managed according to the guidelines set forth by the U.S. Food and Drug Administration (FDA).~~ In the United States, a boxed warning is a type of warning that appears on prescription drugs that may cause serious adverse effects. A boxed warning means that medical studies indicate that the drug carries ~~a~~ significant risk of serious or even life-threatening adverse effects.

The FDA can require a pharmaceutical company to place a boxed warning on the labeling of a prescription drug, or in literature describing the drug. It is the strongest warning that the FDA requires.

~~The hospital maintains processes for managing high-risk or "high-alert" medications per Ventura County Medical Center/Santa Paula Hpsital (VCMC/SPH) Pharmacy Department, policy PH.70 High Alert Medications.~~

Per Title 21 Code of Federal Regulations section 201.57.15(5)(b)(1),

> *Boxed warning.* Certain contraindications or serious warnings, particularly those that may lead to death or serious injury, may be required by the FDA to be presented in a box. The boxed warning ordinarily must be based on clinical data, but serious animal toxicity may also be the basis of a boxed warning in the absence of clinical data. The box must contain, in uppercase letters, a heading inside the box that includes the word "WARNING" and conveys the general focus of the information in the box. The box must briefly explain the risk and refer to more detailed information in the "Contraindications" or "Warnings and Precautions" section, accompanied by the identifying number for the section or subsection containing the detailed information.

PROCEDURE:

~~a. Medications that bear the boxed warning, that are on formulary, and require monitoring, will be identified upon physician order.~~

~~Currently, the medications that meet these requirements are included on the Boxed Warning Medication Guidelines - High Priority list (see Appendix A).~~

~~b. At the time of order selection, with computerized physician order entry (CPOE), the prescriber will receive an alert for the boxed warning, for the medications listed on the current year Boxed Warning Medication Guidelines - High Priority List~~

~~i. The prescriber shall review the Boxed Warning and take actions to mitigate harm.~~

~~ii. The pharmacist shall aid in the process during order verification and medication review.~~

~~iii. Results of the monitoring shall be documented by the physician in the patient's Electronic Health Record (EHR), for tracking, trending and possible action, as required.~~

~~iv. The pharmacist shall document a Clinical Intervention for all changes that are made.~~

a. Pharmacy and Therapeutics committee (P&T) is responsible for the review of non-formulary drug requests (see policy PH.35 Drug Formulary). If a drug with a boxed warning is approved for formulary, the drug monograph may be disseminated to Licensed Practitioners and Clinicians involved in the medication use process.

b. Formulary medications that bear the boxed warning may include an order comment, "Boxed Warning" viewable to the Licensed Provider at order entry and other Clinicians involved in the medication use process (e.g., Pharmacists at order verification and Nursing at order review).

c. A vetted drug resource is available on all health care agency desktops. This vetted drug resource can be used by Licensed Practitioners and Clinicians to access drug information include boxed warning recommendations.

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PH.87 Procurement, Storage, Access, Distribution, Control and Accountability of Radiographic Contrast Media

Purpose:

To establish a mechanism for the control, storage, and distribution of radiographic contrast agents at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

Policy:

The Pharmacy Department shall be responsible for the procurement, storage, distribution, control and accountability of radiographic contrast agents. Pharmacists may dispense oral contrast to patients according to the *Oral Contrast Dispensing Protocol for Outpatient CT Scans* .

Procedure:

A. Procurement
The Pharmacy Department shall be responsible for the procurement of radiographic contrast agents.

B. Storage
Radiographic contrast agents shall be stored securely in the designated Pharmacy, Radiology and Surgery Departments and stored according to the manufacturer's recommendations.

C. Access
The following staff shall have access to these agents.

1. Pharmacists
2. Pharmacy Technicians
3. Radiology Technologists
4. Radiologists
5. Nurses/Nursing Supervisors

D. Distribution
The Pharmacy Department shall have the responsibility of distributing these agents to the designated departments upon request.

E. Control and Accountability

The Pharmacy and Radiology Departments shall be responsible for the security and control of these agents throughout the organization.

F. Oral Contrast Dispensing Protocol for Outpatient CT Scans
Oral Contrast shall be dispensed by the Pharmacy Department for outpatient CT scans using the following procedure:

1. Pharmacist shall confirm the patient has a scheduled CT scan in the electronic health record (EHR). If there is no scheduled CT scan in the patient's profile, the patient shall be referred back to the ordering provider, and then to the Radiology Department to schedule the desired CT scan.
2. Upon confirmation of a scheduled CT scan, the Pharmacist shall inquire about patient allergies. If the patient is allergic to the contrast agent or any of its components, the Pharmacist shall contact the prescribing provider for further direction.
3. The Pharmacy shall dispense the following:

   For Adult Patients:
   Gastrografin (diatrizoate meglumine-diatrizoate sodium) 3% 1000 mL for CT contrast
   Dispense #1 bottle with Dixie cup (5 oz.)

   Patient Instructions: Drink one cup the night before the CT exam. Two hours before the CT exam, start drinking one cup every 15 minutes. Stop when you have about 1/8 of the bottle of liquid contrast left. Bring the remaining amount to the exam. Drink the remaining contrast right before the CT scan.

   Oral contrast may be refrigerated. ***POWDERED*** *Crystal Light or Kool Aid may be used for flavoring. IT MUST BE POWDERED FLAVORING, NOT LIQUID.*

   DO NOT EAT OR DRINK OTHER FOODS (ONLY ENOUGH WATER TO TAKE YOUR MEDICINES) FOUR HOURS PRIOR TO CT SCAN.

   For Pediatric Patients:
   Gastrografin (diatrizoate meglumine-diatrizoate sodium) 3% for CT contrast
   Dispense #1 bottle with Dixie cup (5 oz.)

Weight of Child (lbs)	Weight of Child (kg)	Amount to Dispense	Contrast Start Time
≥100 lbs	≥45 kg	1000 mL	2 hours prior to CT exam
75-99 lbs	34-44 kg	750 mL	1½ hours prior to CT exam
50-74 lbs	22-33 kg	500 mL	1 hour prior to exam
25-49 lbs	11-21 kg	250 mL	1 hour prior to exam
<25 lbs	<11 kg	100 mL	1 hour prior to exam

   Instructions: Have your child drink one cup every 15 minutes. Please save one cup of the liquid contrast and bring it to the CT exam (Exception: <25 lbs or <11 kg - Have your child drink as much of the oral contrast as possible). Oral contrast may be refrigerated. ***POWDERED*** *Crystal Light or Kool Aid may be used for flavoring. Flavoring products cannot be in liquid form. Do not add ice or other forms of liquid, including water, to the contrast.*

   Do not eat or drink within four hours prior to the exam.

Keep oral contrast out of the reach of other children.

4. ~~The Pharmacist shall label the oral contrast with the name and strength of the oral contrast agent, instructions for use, patient name, date of issue, prescription identifier, quantity dispensed, expiration date of drug, and Pharmacist initials.~~The Pharmacy Technician or Pharmacist shall label the oral contrast according to the labeling requirement per policy PH.123 Outpatient Medication Dispensing Procedures. Pharmacist must conduct final check to ensure medication labeling and medication dispensed is correct and initial the final product.

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PH.122 Nonsterile Pharmaceutical Compounding

Policy

The Department of Pharmacy Services prepares compounded nonsterile preparations (CNSPs) for Ventura County Medical Center and Santa Paula Hospital in accordance with California State Board of Pharmacy laws and regulations and United States Pharmacopeia (USP) <795> Pharmaceutical Compounding - Nonsterile Preparations.

Procedure

Nonsterile Compounding Overview

A. The Department of Pharmacy Services shall follow all policies and procedures pertaining to nonsterile compounding to ensure that high-quality drug preparations are consistently prepared.

B. CNSPs include but are not limited to the following dosage forms:
   1. Solid oral preparations
   2. Liquid oral preparations
   3. Rectal preparations
   4. Topical preparations

C. The following practices are not considered compounding:
   1. Administration: Preparation of a single dose for a single patient when administration will begin within 4 hours of beginning the preparation.
   2. Reconstitution: Reconstitution of a conventionally manufactured nonsterile product in accordance with the directions contained in the manufacturer approved labeling.
   3. Repackaging: Repackaging of conventionally manufactured drug products (refer to PH.31 Drug packaging).
   4. Splitting tablets: Breaking or cutting a tablet into smaller portions.

D. Nonsterile compounding policies shall be reviewed at least annually.

E. Any revisions or deletions to any nonsterile compounding policies shall be communicated to all pharmacy personnel involved in nonsterile compounding.

Training and Evaluation of Staff in Nonsterile Compounding

This section promotes the safe, efficient, and uniform performance of all Pharmacy staff involved in the preparation of CNSPs. The Pharmacy Department shall develop and maintain an initial and ongoing competency evaluation process at least every twelve months for Pharmacy staff involved in nonsterile compounding. All Pharmacy staff involved in nonsterile compounding shall have the skills and training required to perform their assigned nonsterile compounding responsibilities properly and accurately. Pharmacy staff assigned to nonsterile compounding duties shall demonstrate knowledge about processes and procedures used in nonsterile compounding prior to compounding any CNSPs, which may include hazardous drugs.

Training and Process Validation

A. All CNSP compounding staff shall be trained and demonstrate competence on the following:
    1. Nonsterile compounding policies, procedures, and USP Chapter 795
    2. Pharmaceutical calculations and terminology
    3. Master formulation
    4. Nonsterile compounding documentation
    5. Quality assurance procedures
    6. Proper hand hygiene and garbing
    7. General conduct in the compounding area
    8. Cleaning, sanitizing, and maintaining of the equipment and the designated area
    9. Container, equipment, and closure system selection

B. All nonsterile compounding staff working with hazardous drugs shall also complete the following:
    1. Acknowledge notification about the risks of handling hazardous drugs.
    2. Demonstrate competence in handling and compounding hazardous drugs.

C. Evaluation
    1. Training exams are considered passed if 80% of questions are answered correctly. Any results less than 80% shall require additional review and discussion. The failed exams shall be retaken until 80% of questions are answered correctly.
    2. Competency assessment includes the successful demonstration of observed nonsterile compounding procedures under the supervision of a trainer.
    3. Pharmacy staff who fail to pass any training exam or validation process test shall be prohibited from performing any nonsterile compounding until all training exams and validation process tests are successfully completed.

D. Documentation of all training and assessments shall be maintained in the Pharmacy Department for at least three (3) years.

Facilities and Equipment

This section defines the facility and equipment used in preparing CNSPs. The cleaning, sanitizing, and

maintenance of the facility and equipment are described to ensure safe and accurate CNSPs.

Facility

A. The nonsterile compounding area is designated for the preparation of CNSP. This area is situated in the pharmacy to minimize the potential for contamination.

B. The nonsterile compounding area shall be clean, organized, and well-lit.

C. The nonsterile compounding area shall contain equipment and supplies needed for preparation of CNSP.

D. A sink with hot and cold running water shall be easily accessible.

E. Direct compounding area

1. Cleaning of the direct compounding area shall occur with an approved cleaning agent before initiating compounding and after any spills.
    a. Approved cleaning agent include:
        i. PreEMPT Ready-To-Use (RTU) and wipes
        ii. Super Sani-Cloth
2. Direct compounding area shall be sanitized with 70% isopropyl alcohol frequently, including
    a. Daily, prior to compounding activites, after spills, and when surface contamination (e.g., from splashes) is known or suspected.

F. Work surfaces and floors shall be cleaned daily and documented on the corresponding cleaning log.

G. Walls and storage shelving in the nonsterile compounding area shall be cleaned at least every 3 months and documented on the corresponding cleaning log.

H. Ceilings shall be cleaned when visibly soiled and after any unanticipated event that could increase the risk of contamination.

I. Cleaning supplies and equipment used to clean hazardous drug areas shall not be used to clean non-hazardous drug areas to avoid cross-contamination of hazardous materials. Cleaning supplies and equipment used to clean hazardous drug areas shall be identified with a "Hazardous Drug" label.

J. Daily monitoring and documentation of refrigerator and room temperatures shall be stored for a period of three (3) years.

Equipment

A. All equipment used for compounding a CNSP shall be cleaned and sanitized before first use and between each lot and in accordance with the manufacturer, USP, and state and federal requirements.

B. Hazardous nonsterile drug preparations shall be prepared in a negative pressure biological safety cabinet (BSC) (refer to PH.27.03 Hazardous Drug Garbing, and Compounding).

C. Problems with equipment shall immediately be reported to the Designated Person or the Director of Pharmacy Services.

Drug Preparation, Labeling, End-product, and Record Keeping

This section ensures final products are correctly prepared prior to dispensing. The pharmacist has the responsibility and authority to inspect and approve or reject all components, drug product containers, closures, in-process materials, and labeling used during the nonsterile compounding process. The pharmacist

shall review all compounding records for quality assurance. The pharmacists are responsible for the proper maintenance and cleanliness of all equipment used in the nonsterile compounding process.

PROCEDURE:

Nonsterile Drug Preparation

A. Nonsterile drug preparations shall be prepared in the appropriately clean and sanitized designated nonsterile compounding area.

B. A written master formula shall be created prior to compounding a nonsterile drug preparation. Each master formula shall include:

   1. Name, strength or activity, and dosage form of the compounded nonsterile product (CNSP)
   2. Identities and amounts of all components
   3. Equipment to be used
   4. Complete instructions for preparing the CNSP
   5. Physical description of the final CNSP
   6. The beyond use date (BUD) for the preparation with references
   7. Instructions for storage and handling of the CNSP
   8. Quality control (e.g. visual inspection)

C. All drugs and supplies shall be gathered before initiating the compounding process.

D. Each ingredient and container shall be inspected for defects, expiration date, and product integrity prior to use.

E. Expired, inappropriately stored, or defective ingredients shall not be used in preparation of nonsterile products.

F. Calculations shall be performed prior to initiating the nonsterile product preparation process, if applicable.

G. Other activities must not be occurring in the space at the same time as compounding.

H. Materials and equipment used in nonsterile product preparation should be arranged to prevent mix-ups among components, containers, labels, in-process materials, and finished CNSPs.

I. Triturated tablets and solutions of reconstituted powders shall be mixed carefully, ensuring complete dissolution of the drug with appropriate base solution.

J. Terminally clean the BSC after hazardous CNSP is completed prior to commencing sterile compounding.

Labeling

A. All nonsterile products shall be labeled with the following information:

   1. Assigned internal identification number
   2. All active component(s) names, amounts, strength, and concentrations (when applicable)
   3. Dosage form
   4. Date compounded
   5. Total amount or volume in each container

6. Instructions for storage and handling if other than controlled room temperature
7. Beyond use date

B. CNSP labeling should display the following information:

1. Prescribed administration regimen, when appropriate (e.g. route of administration)
2. Appropriate auxiliary labeling (e.g. precautions)
3. Identification of the responsible pharmacist and technician with their initial
4. Name, address, and contact information of the compounding facility

C. The label shall be affixed directly to the final product.

End-product Evaluation

A. The responsible pharmacist shall verify that the CNSP was prepared and labeled correctly. The pharmacist shall complete visual inspection for appearance and container closure integrity.

B. The pharmacist(s) shall initial the label on the final product, which confirms end-product evaluation was performed and the final product was prepared correctly and adhered to proper nonsterile compounding procedures.

Record Keeping

A. Documentation for nonsterile preparations shall include the following:

1. Name, strength or activity, and dosage form of the CNSP
2. The date and time of preparation
3. Pharmacy-assigned lot number of the finished batched product
4. Name, manufacturer, lot number, expiration date, and weight or measurement of each component
5. The package size and the number of units prepared
6. The BUD of the finished product
7. Physical description of the final CNSP
8. Results of quality control procedures (e.g., visual inspections)
9. Initials of the individuals involved in the compounding process and verifying of the final CSNP
10. Master Formulation Record reference for the CNSP

B. Nonsterile compounding logs shall be maintained by the Pharmacy Department for at least three (3) years.

Beyond Use Dates

A. The beyond use date (BUD) shall not exceed the shortest expiration date or BUD of any ingredient in nonsterile compounded drug preparation (CNSP), nor the chemical stability of any one ingredient in the nonsterile compounded drug preparation, nor the chemical stability of the combination of all ingredients in the nonsterile compounded drug preparation.

B. BUD is determined by USP-NF Compounded Preparation Monograph or CNSP-specific stability information with maximum of 180 days. If not available, USP 795 default BUD for non-preserved aqueous dosage form will be 14 days stored in refrigerator (2-8°C).

Quality Assurance Program

Definitions

Integrity: retention of potency until the beyond use date provided on the label, so long as the preparation is stored and handled according to the label directions.

Potency: active ingredient strength within ±10% of labeled amount.

Quality: the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, the absence of active ingredients other than those noted on the label and the absence of inactive ingredients other than those listed on the master formula.

Strength: amount of active ingredient per unit of a compounded drug preparation.

Policy

A. Random samples of compounded sterile products shall be assessed on a quarterly basis for strength and potency.

B. The Pharmacy Supervisor shall regularly review compounding documents for accuracy and completeness.

C. The Medication Safety Officer shall complete quarterly audits on various aspects of nonsterile compounding.

D. All documents shall be available for review for at least three (3) years.

Procedure

A. Integrity of the selected compounded nonsterile product (CNSP) shall be assessed by measuring the potency of the selected CNSP on the date of expiration if integrity data is not available through USP monograph or literature.

B. Potency of the selected CNSP shall be assessed by submitting a sample to a lab for analysis. Potency shall be within +/-10% the listed amount of active ingredient.

C. Quality assurance results shall be kept in the pharmacy's nonsterile compounding document binder with the master formula.

D. Any unacceptable result relating to the potency of the CNSP shall result in the following:

1. Designated Person or Director of Pharmacy shall start an investigation and review:
    a. compounding logs
    b. active ingredients used
    c. master formula
2. The action plan shall include any procedural changes, educational needs, mitigation plan, and monitoring.
3. For unacceptable results relating to potency of labeled strength, staff shall review of pharmaceutical

calculations and nonsterile product compounding technique.

E. Any unacceptable result shall result in a recall of the nonsterile compounded product.

1. If use of or exposure to the recalled drug may cause serious adverse health consequences or death, the recipient pharmacy, prescriber, or patient and the California Board of Pharmacy shall be notified as soon as possible within 12 hours.

All revision dates:

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	9/7/2023
Infection Prevention	Magdy Asaad: Infection Prevention Manager	9/6/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/6/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Operating Policies*
References:	

PH.123 Outpatient Medication Dispensing Procedures

POLICY:

This policy outlines the procedure to follow at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) when supplying medications for outpatient use. Dispensing of medication for outpatient use are not routinely performed and should be reserved for cases deemed necessary for patient care.

PROCEDURE:

I. ~~Medications for outpatient use shall only be dispensed by the hospital Pharmacies.~~

   A. ~~Exception: SPH Emergency Department may dispense medications for outpatient use during the hours that SPH Pharmacy is closed. Quantity dispensed from SPH Emergency Department shall not exceed 72 hours. All dispensing information is recorded and provided to the pharmacy when the pharmacy reopens.~~

   Medications for outpatient use shall only be dispensed by the hospital Pharmacies at both VCMC and SPH.

II. California State Board of Pharmacy regulations specify that the "packaging, labeling, and dispensing of drugs can only be done by licensed physicians or pharmacists, physician assistants, and nurse practitioners."

III. All medications dispensed from VCMC/SPH shall be properly labeled. Proper labeling includes:

   ~~Manufacturer's trade name or generic name and name of manufacturer~~

   ~~Directions for use~~

   A. Name, address, and phone number of dispensing location

   B. Name of patient

   C. Name of prescriber

   D. Date of issue

   ~~Name, address, and phone number of location (hospital, clinic, etc.)~~

   E. Prescription number

   F. Manufacturer's trade name or generic name and name of manufacturer

G. Strength of the drug

H. Directions for use

I. Quantity of the drug

~~Strength of the drug~~

J. Expiration date

K. The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

L. Physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules.

M. Controlled substances shall be dispensed in prescription containers bearing a federal warning label prohibiting transfer of the drugs.

~~Whenever possible, medications are dispensed in a child-resistant containers unless requested by patient.~~

~~Caution labels shall be affixed as necessary.~~

N. ~~When opioids are dispense, note "~~Caution~~: Opioid~~ labels shall be affixed as necessary. ~~Risk of overdose and addiction" on the on the prescription label or adhere auxiliary pre-printed label.~~

a. When opioids are dispense, note "Caution: Opioid. Risk of overdose and addiction" on the on the prescription label or adhere auxiliary pre-printed label.

b. Include on the prescription label or adhere auxiliary pre-printed label to indicate that the drug may impair a person's ability to operate a vehicle or vessel and possible potentiating effects when taken in combination with alcohol when applicable.

O. ~~Include on the prescription label or adhere auxiliary pre-printed label to indicate that the drug may impair a person's ability to operate a vehicle or vessel and possible potentiating effects when taken in combination with alcohol when applicable.~~Initials of the pharmacy technician who prepared the label and medication bottle and/or pharmacist who prepared and completed the final check for dispensing.

IV. Pharmacist must conduct final check to ensure medication labeling and medication dispensed is correct.

V. Whenever possible, medications are dispensed in a child-resistant containers unless requested by patient.

VI. Dispense medication guides for all estrogen medication and medication with Box Warning.

VII. Pharmacist shall be available for medication consultation as needed if not performed by a registered nurse or licensed ~~independent~~ practitioner (~~LIP~~LP).

All revision dates: 9/5/2023, 12/14/2021, 9/28/2018, 2/1/2016, 5/1/2006, 10/1/1998, 3/1/1995, 7/1/1992, 11/1/1989, 10/1/1986

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Policy Area:	*Trauma Services*
References:	

T.09 Structure of the VCMC Trauma Program

POLICY:

To define and outline the structure of the Ventura County Medical Center~~/Santa Paula Hospital~~ Trauma Program. The Trauma Program is an administrative unit that includes the Trauma Service and coordinates all trauma-related activities, including education injury prevention, research, access, acute hospital care, and rehabilitation.

PROCEDURE:

The Trauma Program includes the following:

1. A Trauma Medical Director, Deputy Trauma Medical Director, Trauma Program Manager, Trauma Registrar(s), Trauma Nurse Liaison(s), Trauma Nurse Practitioner(s), and Injury Prevention Coordinator.
2. Multidisciplinary Trauma Team consisting of:
   A. Trauma Surgeon
   B. Emergency Department (ED) Physician
   C. Resident on Surgical Services
   D. Residents on Medicine-Pediatrics
   E. Emergency Department (ED) Trauma Nurses
   F. Trauma Program Manager
   G. Ancillary Services Support to include Respiratory Therapist, Lab Technician, X-Ray Technician, and CT Technician
   H. Operating Room (OR) Team
   I. Nursing Supervisor
   J. Patient Advocate and Social Services
   K. Pediatric Services
   L. Critical Care Services
3. Multidisciplinary Trauma Operational Process Systems Committee
4. Multidisciplinary Trauma Mortality and Morbidity Committee

All revision dates: 7/22/2023, 6/9/2020, 5/1/2012

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No Attachments

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Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	9/28/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	9/20/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/20/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/19/2023
Trauma Services	Gina Ferrer: Manager, Trauma Services	9/19/2023
Trauma Services	Thomas Duncan: Trauma Director	7/22/2023

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References:	

T.13 Multiple Casualty Incident (MCI)

POLICY:

To provide a system-wide hospital plan for receiving and caring for multiple trauma patients.

PROCEDURE:

The Multiple Casualty Incident (MCI) plan may be implemented when the Emergency Department (ED) is to receive three (3) or more trauma patients, regardless of reported level of acuity, which cannot be safely cared for by the ED staff. See definitions for MCI and Code Triage below.

1. Definitions:

- Multiple Casualty Incident is defined as 3 to 14 trauma victims, regardless of acuity.
- A Code Triage is 15 or more patients expected due to traumatic mechanism. The Emergency Department will immediately notify the Administrator on Duty (AOD) on weekdays, and nursing supervisor at all other times. The AOD, nursing supervisor, or Emergency Department Charge Nurse will then notify Paging to announce a Code Triage-External on the overhead paging system.
- Directly involved defined as: ED, operating room (OR), post anesthesia care unit (PACU), ~~critical~~intensive care unit (~~CCU~~ICU), pediatrics, Medical/Surgical units, Admitting, Paging Operator, Nursing Supervisors, computer tomography (CT), Blood Bank, Environmental Services, Respiratory Services, Radiology, Trauma Services, and the Residency Program.
- Indirectly involved includes all other patient care area and ancillary services.
  Refer to Administrative policy 106.034, *Emergency Management Plan,* Section V-Initiation of Code Triage.
  2. Notification:
  Mobile intensive care nurse (MICN)/Charge Nurse to initiate MCI in REDDINET.
- MCI Plan notification is 76666, and the number of patients (paging system)
- Code Triage notification 76666, and number of patients (paging system)

3. Ventura County Emergency Medical Services (VCEMS):
Notification of base station hospital by VCEMS will be through direct communication through base station phone.

PROCEDURE:

1. Trauma Team activation will be initiated to triage and stabilize arriving patients.
2. ED to activate as early as possible for multiple victims.

1. **Nursing documentation is to be done on the** *Trauma Resuscitation Flow Sheet.*
2. Trauma surgical attending will be notified and will respond to the ED (Tier 1 response). It will be the decision of the Attending Trauma surgeon to call the back up on-call trauma surgeon, trauma medical director, and/or additional surgeons.
3. STAT registration will be initiated for all the patients.
4. In the event that the MCI will overwhelm the ED, the ED Saturation plan will be implemented. The ED Charge Nurse or Clinical Nurse Manager, ED Physician, and or Attending Trauma Surgeon will make this decision. All ED patients with assigned beds will be sent to the assigned floor regardless of readiness of bed. It will be the ED's responsibility to obtain basic holding orders including diet, activity, pain and nausea medications. It will be the responsibility of the receiving nursing units to continue the care of these patients, which could include contacting designated attending physicians for orders.
5. Any ED patients awaiting admission without assigned beds will be transported to wherever empty staffed beds are available, upon the direction of the nursing supervisor. The senior resident on the ED service will coordinate the care of patients waiting for admission with the Medical/Surgical Resident, who will assume the care and disposition of these patients.
6. Pediatric patients awaiting admission without assigned beds will be sent to Pediatrics. Any pediatric trauma patients who will need higher level of care will be transferred out to an appropriate accepting facility.
7. The nursing supervisor will report to the ED charge nurse and assist with the deployment of staff from critical care and placement of all ED admits.
8. The following nursing departments are required to send one registered nurse (RN) to the ED once the MCI has been activated.

a. ~~CCU~~ICU and PEDS RN's as determined by ED Charge Nurse and Nursing Supervisor.

b. Assignments to be determined by the ED charge nurse or trauma team.

c. Additional critical care nurse may be requested and every effort will be made to assist the ED when staffing permits.

d. ED Clinical Nurse Manager and Trauma Program Manager are to be called 24/7 and report to the ED if requested.

e. Trauma Medical Director to be called regardless of on call status.

1. Assignments will be made for the ED and overflow areas under the direction of the ED charge RN, rooms, equipment, supplies, and staff.
2. Trauma pagers and cell phones will be activated with MCI indicated and number of trauma victims.
3. Departments indirectly involved will go on stand-by until further notice
4. All members of the trauma team and ancillary services included in the trauma activations page are to report to the ED.

5. Triage and Designation of the trauma patients in the ED will be according to advanced trauma life support (ATLS) American College of Surgeons (ACS) guidelines and will be conducted by the ED physician until the attending trauma surgeon arrives or Trauma or Medical Director or Deputy Trauma Medical Director arrives. Critical factors to be taken into consideration include the number of patients, acuity, location, and available resources.
6. Charge RN or designee will be responsible for entering the patients and pertinent information into the REDDI-NET SYSTEM (this will facilitate communications between hospitals and emergency medical services (EMS).
7. Resuscitation of critical patients will be the shared responsibility of the Trauma Attending(s), ED Physicians, Senior Residents, the responding anesthesiologist(s) and the on-call Pediatrician. The final resuscitation and management decisions will be the responsibility of the trauma surgical attending or his/her designee.
8. The Paging Department is to make every effort to triage calls requesting the ED during this time and only forward the calls when they are unable to assist the caller.
9. ~~OR~~Operating Room (OR) preop and post anesthesia care unit (PACU) will be used if available and additional space is needed to hold or monitor ED patients during this time. This also could include trauma patients awaiting OR and ~~critical~~intensive care unit (~~CCU~~ICU) until ~~CCU~~ICU beds are available. The OR Charge Nurse and Nursing Supervisor will coordinate staffing of these areas.
10. All families and patients waiting in the ED will be informed of the multiple victim activation so that they can anticipate delays. The waiting room may need to be evacuated to accommodate patients.
11. Performance Review will follow as soon as possible for all multiple victim activations.
12. Critical incident stress debriefing will be considered and offered to staff following all multiple victim activations as soon as possible.
13. For 5 or more tier 1 victims potentially requiring surgical intervention, 2 OR teams will respond and 2 OR rooms will be made available until released by the attending trauma surgeon.

a. In the case of treatment of multiply injured patients, all lower extremity long bone fractures should be stabilized as soon as possible in multiply injured patients. Every attempt should be made to stabilize lower extremity long bone fractures once a patient has been determined by the trauma team and neurosurgery team to be stable enough to undergo surgery. The sequence of treatment should be femur first then tibia. Upper extremity long bone fractures should be treated once the patient has been optimized and adequately resuscitated.

14. Family Medicine and Surgery residents will respond according to their current call schedule. Additional back up residents can be activated at the request of Chief Residents and/or Residency Program Directors.

SPECIFIC DUTIES:

All ancillary services presently activated for Tier 1 trauma activations will be activated for MCI's. They are to respond to the ED as per present trauma policy.

Attending Trauma Surgeon:

- Triage/establish priorities of care/overall responsibility for MCI.
- Call in second trauma surgeon and or additional surgical staff.
- Request additional OR teams be called in.
- Release OR teams on standby.

Residents:

- Resuscitation of patients.
- Continuity of care between assigned areas.
- Assist in the OR as assigned by attending trauma surgeon.

ED Physician:

- Request activation of MCI.
- Assist in overall coordination of MCI as requested by attending trauma surgeon.
- Triage and provide destinations for victims until attending trauma surgeon arrives.
- Request additional ED physicians to respond.
- Assist with resuscitation of patients.

ED Charge Nurse:

- Take and communicate radio report.
- Remain on radio or delegate ongoing radio communication.
- Ensure trauma activation page.
- Clear the ED.
- Coordination of ED staff and responding personnel in ED and overflow areas with Nursing Supervisor.
- Assignment of nursing, tech, support personnel to rooms.
- Reddi-net update.
- Notification of ED Clinical Nurse Manager.

Trauma Program Manager:

- Assist trauma team.
- May assist trauma medical director in overall organization of MCI.
- Responsible for the performance improvement (PI) review of all MCI's.
- Responsible for any debriefing requested.
- Responsible for integration and communication with arriving families.

ED RN's:

- Accept assignment from ED charge nurse.
- Assist with immediate clearing of ED.
- Preparation of all rooms to receive trauma patients.
- Accept role of hands on nurse, scribe role to be delegated to arriving critical care nurses.
- Critical care nurse to assume care of patients going to computer tomography (CT).

ED CNA's:

- Accept assignments from ED charge nurse.
- Assist with immediate clearing of ED.

Nursing Supervisor:

- Responds immediately to the ED.
- Calls in OR teams as requested.
- Secures a place for ED admits to be sent if no beds assigned.
- Ensures all directly involved departments respond to the MCI with adequate staff.
- Ensures all involved departments are aware and prepared for response, Lab, respiratory, transport, etc.,

until the Hospital Incident Command (HICS) is activated. Once HICS is activated, all resource requisitions including staff will be directed to the Logistics section.
- Assists with assignments of beds.
- Notifies Administrator on Duty and Activates Hospital Incident Command System as needed, after collaborating with the on call Emergency Department Physician and/or surgeon on call
- Calls in additional Supervisors or Administrative staff as needed.
- Assists Social Worker with management of arriving families.
- Provides on-going communication with the units affected regarding actual victims, number of potential admissions, MCI status.
- Provides information to the media if directed by AOD.

Critical Care Unit:

- Receive communication initiating the MCI via the paging system and/or ED charge nurse call initiating the MCI.
- Critical Care Unit will send one person to the ED to report to the charge nurse for further instruction.
- Critical Care Unit charge nurse will prepare for potential admissions and transfers by making a list of patients who can be transferred either between units or to the Medical/Surgical areas.
- Critical Care Unit charge nurse will receive communication from the Nursing Supervisor regarding the number of potential admissions and placement of MCI victims.
- Critical Care Unit charge nurse will contact the appropriate physicians and services to transfer patients if necessary when directed to do so by the Nursing Supervisor.
- Critical Care Unit charge nurse will call in additional staff if possible to care for MCI victims in the Critical Care area.
- If additional staff is requested in the ED, the charge nurse and nursing supervisor will review patient's safety needs and send additional staff as appropriate to maintain patient care in these areas.
- Critical Care Staff will assess unit supplies and order additional supplies as needed.
- Disaster carts are available from Central Supply.

Pediatric Units:

- Receive specific communication from the shift Supervisor regarding number of potential patients and expected duration of MCI.
- Prepare to receive trauma patients from the ED.
- Prepare to discharge and/or transfer patients as able to home, facilities or to other units.
- Assess supplies and equipment needs and order, as indicated.
- Assess staffing needs and initiate calls for additional staff, as needed.

Medical Surgical Unit:

- Receive specific communication from the shift Supervisor regarding the number of potential victims and expected duration of the MCI.
- Prepare to receive patients from the Emergency Department.
- Prepare to receive existing patients from critical care areas to open beds in these areas.
- Assess supplies and equipment needs and order as indicated.
- Assess staffing needs and initiate calls for additional staff as needed.
- Prepare to send staff to ED to assist with patient care as needed.

OR/PACU

- **Report number of available OR's to nursing supervisor until HICS positions activated.**

- **Assist with triaging of surgery patients under the direction of the surgeon on call.**
- **May be asked to halt elective cases as needed.**
- **Request additional staff as needed.**

ED Radiology techs:

- Call in additional techs.
- Call in attending radiologist to assist with reads.
- Prepare to triage outpatient studies under the direction of the radiologist.

Paging Department

- Initiating emergency notifications per the MICN, nursing supervisor or AOD request.
- Notification of Administrator on Duty.
- Re-directing of incoming calls away from the ED during MCI as needed

ED Registration staff:

- Registration of incoming patients, utilizing Stat registration if needed.
- Call in additional staff if needed.

Social Services:

- Notifying family that the patient is in the ED regardless of whether another agency has done so or says they will do so.
- If unable to find family, contacting the appropriate agency for help such as law enforcement, homeless outreach, mental health outreach, etc.
- Greeting the family members in the ED waiting room and, if the physician thinks it's appropriate, escorting them to the bedside to be with the patient.
- Monitoring family coping mechanisms and provide support, if needed.
- Facilitating communication between family members and ED medical and nursing staff.
- Provide information about community resources and referrals to the family.

In the event of life-threatening injury or fatality:

- Escort the family from the ED waiting room to the Quiet Room.
- Participation in the meeting between the ED physician and family.
- Remain in the Quiet Room with the family after the meeting to answer any questions that arise after the meeting with the physician.
- Provide information about community resources and referrals, including a list of mortuaries, to the family.
- Remain in the Quiet Room with the family to provide emotional support unless they request privacy.
- Document all interventions and assessment of the family's ability to cope in the electronic health record.

Blood Bank-

- Be prepared to activate Massive Transfusion Protocol as needed.
- Communicate the need for additional blood products to local blood bank.

Environmental Services-

- Be prepared to assist in expediting room turn over.
- Request additional staff as needed.

Respiratory Services-

- Be prepared to request additional supplies, particularly ventilators.
- Request additional staff as needed.

Security

- Security Department will be responsible for securing the perimeter of the Emergency Department and assisting with crowd control.
- Will coordinate efforts with local enforcement agencies.

All revision dates: 7/22/2023, 6/9/2020, 7/26/2017

Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	9/28/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	9/20/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/20/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/19/2023
Trauma Services	Gina Ferrer: Manager, Trauma Services	9/19/2023
Trauma Services	Thomas Duncan: Trauma Director	7/22/2023

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T.14 Trauma Department Performance Improvement and Patient Safety Plan (PIPS)

POLICY

The Trauma Department Performance Improvement and Patient Safety Plan (PIPS) is a description of the efforts that are directed towards ensuring the consistent delivery of safe, quality, service-focused, effective health care for the trauma patients we serve at Ventura County Medical Center (VCMC).

We look to achieve this through data assessment, outcomes review, process examination, evidenced based practice research, as well as the identification of opportunities for change and improvement. This is accomplished by systematically assessing patient outcomes and support processes to identify improvement opportunities, and to act on them in a timely manner.

PHILOSOPHY OF THE TRAUMA PROGRAM

Ventura County Medical Center and the Trauma Service are dedicated to providing specialized, effective care to all injured patients brought to this facility.

This requires the ability to critique ourselves and identify issues, develop plans, and correct problems all geared to improve trauma patient care. Our mission is to provide high quality, safe patient care, through physician driven performance evaluation and patient care improvements for the community.

AUTHORITY/SCOPE

Trauma performance improvement is under the direction of the Trauma Medical Director (TMD) as delegated by the Medical Staff and hospital bylaws. The trauma service has the authority to monitor all events that occur during a trauma-related episode of care when admitted to this institution.

CREDENTIALING

All surgeons providing trauma care will be credentialed according to the VCMC Medical Staff bylaws, and the Department of Surgery Policy and Procedures before being scheduled for trauma call.

- Physicians taking trauma call will be credentialed and proctored per Medical Staff bylaws.
- Surgeons and surgical specialists taking trauma call will meet additional credentialing criteria as specified by the Division of Trauma and the Trauma Medical Director.
- Surgeons and Emergency Department (ED) boarded physicians should have taken Advanced Trauma Life Support (ATLS) at least once.
- Continuing education hours in trauma management, attendance at specified committees, is required.

The Trauma Medical Director will do initial and annual review of credentials for the trauma call panel.

Neurosurgery, Orthopedic Surgery, and Emergency Medicine will also undergo annual review of privileges for participation on the trauma Call panel. The Trauma Medical Director in cooperation with the trauma liaisons and department chairs will complete this process.

The Trauma Program Manager in collaboration with the Nurse Managers is responsible for overseeing the credentialing and continuing education of nurses working with trauma patients.

TRAUMA PATIENT POPULATION CRITERIA

A trauma patient is defined by the state trauma plan as a victim of an external cause of injury that results in major or minor tissue damage or destruction. The trauma patient is defined as any patient under National Trauma Data Standard (NTDS) patient inclusion criteria.

- All trauma activated patients
- All trauma related hospital admissions
- All injury-related deaths in the ED or after admissions

DATA COLLECTION AND ANALYSIS

All patients that meet criteria for entry into the trauma registry are monitored for compliance with or adherence of standards of care as established by the Trauma Service and Performance Improvement (PI) Committee.

Process of Care will be reviewed by utilizing audit filter and identifying those cases screened by the filters.

Cases identified through the peer review process will be reviewed through the Trauma PIPS program; information includes:

- occurrence or audit filter based issues
- provider specific issues
- trended data
- system or resource failure problems

Audit results will be shared during the Trauma Operations Performance and Patient Safety (TOPPS) meeting, at the Performance Improvement Council Committee (PICC) meeting and at least quarterly during the Medical Executive Committee (MEC) meeting.

PROCESS FOR MONITORING COMPLIANCE

Standards of Quality Care

All trauma patients that meet criteria for entry into the trauma registry are monitored for compliance with or adhere to the standards of quality patient care as established by the Trauma Service and local, regional and national standards.

Death Reviews

Trauma patient deaths are reviewed as they relate to trauma care and trauma system issues.

Audit Filters /Indicators

Audit Filters/ Indicators as defined by the American College of Surgeons and/or the trauma program and/or the trauma system are monitored

- Complications that occur in the trauma patient are recorded in the Trauma Registry.
- The Trauma Quality Improvement (QI) Committee will review complications from injury or treatment that significantly affect patient outcome.
- The Trauma QI Committee makes appropriate referrals and recommendations
- All complications will be reported on a quarterly basis and monitored for trend analysis.

System Issues

All identified issues that are not provider related are reviewed in the Trauma performance Improvement Committee.

REVIEW PROCESS/LEVELS OF REVIEW

First Level of Review:

The Trauma Program Manager (TPM) or designee will do the initial case review. If the first level of review is completed, affirming that clinical care is appropriate and no provider or systems issues are identified, the case does not require second level or formal committee review. Or, after review of all the pertinent information, the TPM may determine that the issue should be addressed by the TMD and/or the Trauma PI Committee.

Second Level Review:

The second level of review can be done by the TPM and the Trauma Performance Improvement nurse. A case in which a second level review is required is when issues in clinical care, provider or systems issues are evident that require the TMD's expertise and judgment. They may begin further investigation, implement action without formal referral to a peer review or system committee, or decide to send it to the appropriate PI

committee or to a hospital department for further investigation/peer review and ask for help.

Third Level Review:

The Trauma Program Manager and the Trauma Medical Director will perform an initial case review in preparation for the committee meeting identifying all background information, pertinent protocols (or lack) and specifying all individual issues to be discussed. The issue is then formally reviewed by the Trauma PI Committee(s). The Committee may communicate with the individual physicians, other clinical sections or departments to request additional data or give input. Determination of judgments will be made by the committee using the following criteria.

DETERMINATION OF JUDGMENTS

The committee will render a judgment regarding the appropriateness of the issue and all mortalities will be reviewed. Each issue will be placed into one of the following categories:

1. Unanticipated mortality and morbidity with opportunity for improvement (Preventable): An event or complication that is an expected or unexpected sequel of a procedure, disease, illness or injury that could have been prevented or substantially ameliorated.

2. Anticipated mortality and morbidity with opportunity for improvement (Potentially Preventable): An event or complication that is a sequelae of a procedure, disease, illness, or injury that has the potential to be prevented or substantially ameliorated.

3. Anticipated mortality and morbidity without opportunity for improvement (Non-preventable): An event or complication that is a sequelae of a procedure, disease, illness or injury for which reasonable and appropriate preventable steps had been taken.

DOCUMENTATION OF ANALYSIS AND EVALUATION

The Trauma QI issues will be documented on the Trauma Quality Improvement Occurrence Tracking Form. This form tracks all aspects of the case review including the summary of the clinical care, identified issues, reference to discussion/minutes from the Trauma PI Committee(s), judgment, recommendations, actions, and loop closure.

- Identified opportunities for improvement to include interventions that address the opportunity.
- The intervention should include dates, accountability, responsibility and any auditing that may be required.
- The effectiveness of these interventions should be continuously reevaluated to determine if these revisions improved the process or outcomes in care.
- This will assist with tracking and documentation of loop closure.

The Occurrence Tracking Form will be placed into the minutes of the bi-monthly Trauma QI Committee meetings as evidence of case review and discussion and recommendations for corrective action.

Patterns and trends identified will be shared during Trauma Operation Performance and Patient Safety

(TOPPS) meeting.

REFERRAL PROCESS FOR INVESTIGATION OR REVIEW

The cases determined to require further investigation by the first and second level review or a judgment/ rating determination by the Trauma PI Committee may be referred to the appropriate hospital department via appointed liaisons, committee or department chairman for review. The Trauma PI Committee and/or the Trauma Medical Director will then review the response of the referral for follow up.

TRAUMA PI COMMITTEE STRUCTURE

The Trauma Performance Improvement Committee is a multidisciplinary peer review committee functioning under the auspices of the Department of Surgery PI Committee that in turn reports to the Medical Executive Committee.

Recommendations and action plans with associated re-evaluation will be made when areas needing improvement are determined. Membership includes all trauma surgeons, the TPM and representatives from Orthopedic Surgery and Anesthesia, Emergency and Neurosurgery Departments. Additional attendees are invited ad hoc. The Trauma PI Committee provides a bi monthly summary report to the Department of Surgery PI Committee. Committee meets bi monthly with no less than 5 times annually with 50% attendance requirement of peer review representatives.

The charge of the committee is to evaluate the care of a trauma patient from a clinical and systems perspective and to perform interdisciplinary implementation of improvement strategies. It is responsible for establishing objective criteria for identifying issues for review and determining compliance with standard of care. The committee will systematically monitor/analyze data, and improve patient outcomes through improvement opportunities.

OPERATIONAL STAFF RESPONSIBILITY FOR THE TRAUMA PI PROGRAM

The staff responsible for the operational support of the trauma performance:

1. The trauma Medical Director and the Trauma Program Manager maintain the Trauma PI and QI process with data support from the trauma registrar and TPI committee. The Trauma Medical Director monitors this process. Representatives from the other clinical and hospital departments as well as the hospital Performance Improvement Department participate when appropriate. This ensures multidisciplinary collaboration and compliance with the hospital Performance Improvement Plan.

2. The TMD is responsible for chairing the Trauma PI Committee and for initial review of all physician related issues including all deaths and screened complications. The TMD is also responsible for coordination of all performance improvement activity relative to clinical departments/physicians as well as associated remedial action. The TMD may delegate related PI studies.

3. The TPM is responsible for identification of issues and their initial validation, the maintenance of the trauma PI database/ files and protection of their confidentiality, facilitating data trends and analysis, and coordinating surveillance of protocols/ guidelines/clinical paths. The Trauma Register and Trauma PI Nurse (s) will assist the TPM in these activities. The registrar will interface with the TPM and TMD to assist with identification of issues using registry filters, and compilation of reports to support the PI process.

CORRECTIVE ACTION PLANNING

The Trauma Medical Director oversees all corrective action planning and their institution. Structured plans may be created by any Trauma PI team members or committees in an effort to improve sub-optimal performance identified (root cause analysis) through the PI process.

Our goal is to create forward momentum to effect demonstrable outcome change leading to subsequent loop closure.

An evaluation and re-evaluation process will be part of the plan according to instructions action plan methodology of: plan, do, check, act (PDCA). Examples of potential corrective action categories are:

- Organization of Improvement PI Teams
- Education
- Referral to peer group
- Trending
- Focus Audit
- Protocols
- Counseling
- Proctoring/change in privileges or credentials
- External Review
- Enhanced resources or methods of communication

CONFIDENTIALITY PROTECTION

- All performance improvement activities and related documents will be considered confidential and protected as specified in Ventura County Medical Center policies and HIPAA.
- All PI Information will be clearly labeled "Confidential for Peer Review Only. This report is a review function and as such is confidential and shall be used only for the purpose provided by law and shall not be public record and shall not be available for court subpoena".
- Whenever feasible, generic identifiers for patient care providers will be utilized. No PI information will be part of the patient medical record. All PI paper documents and electronic information will be kept in a secure location with limited, controlled access. Any copies distributed at meetings will be counted and collected at the close of the meeting.
- All physicians appointed to Trauma PI activities will have a signed "Physician Peer Review Confidentiality Agreement" on file.

LOOP CLOSURE AND RE-EVALUATION

Any identified issues will be subject to Level 1, 2, or 3 reviews which may result in the formation of an action plan. In order to "close the PI loop", the outcome of the corrective action plan will be monitored for the expected change and re-evaluated. A PI issue will not be considered to be closed until the re-evaluation process demonstrates a measure of performance or change at an acceptable level. "Acceptable level" may be determined by frequency tracking, benchmarking, and variance analysis as decided by the Trauma Medical Director and/or PI committee. Loop closure will be reported to the Trauma PI committee and a determination made regarding periodic or continuous monitoring.

INTEGRATION INTO HOSPITAL PERFORMANCE IMPROVEMENT PROCESS

1. The Trauma PI program practices a multi-disciplinary and multi- departmental approach to reviewing the quality of patient care across all departments and divisions. The Trauma Performance Improvement Committee is integrated with and collaborates with the appropriate performance improvement committees as needed.

2. The Trauma PI program will report all activity through the Department of Surgery and to the Risk Management and Patient Safety hospital committee as specified in the hospital QI plan.

All revision dates: 9/29/2021

Attachments

No Attachments

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	9/28/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	9/20/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/20/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/19/2023
Trauma Services	Gina Ferrer: Manager, Trauma Services	9/19/2023
Trauma Services	Thomas Duncan: Trauma Director	9/11/2023