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

Ventura County Health Care System Oversight Committee
Administrative Policies

December 14, 2023

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

1. 107.064 Critical Incident Stress Management
2. PH.13 Drug Supply Chain Security Act (DSCSA)

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Summary of Changes

#	Title	Summary of Changes	Review Period
1	107.064 Critical Incident Stress Management	Change in policy owner and added additional reviewers. No changes made to policy content.	Triennial
2	PH.13 Drug Supply Chain Security Act (DSCSA)	Review and update for Drug Supply Chain Security Act (DSCSA) law.	Triennial

Status **Active** PolicyStat ID **14104004**

Origination	4/1/2017	Owner	Alicia Casapao: Director of Quality and Performance Improvement
Last Approved	10/31/2023		
Effective	10/31/2023	Policy Area	Administrative - Operating Policies
Last Revised	10/31/2023		
Next Review	10/30/2026		

107.064 Critical Incident Stress Management

POLICY:

Critical incident stress management (**CISM**) is an adaptive process that provides psychological care for the care giver involved in potentially stressful events. Through huddles and debriefings, trained individuals will provide support for care givers involved in critical events by means of pre-incident preparedness, acute crisis management and/or post-crisis follow-up. To improve the well-being and longevity of the staff at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), a CISM task force was formed in 2017.

Critical Incident Stress Management (CISM) is a comprehensive, integrated, systematic and multi-component crisis intervention program. CISM support is available for any VCMC/SPH staff where events occur which overwhelm the resources of personnel, causing traumatic stress and reducing the individual's ability to function. The effects of traumatic stress are best prevented and mitigated through the use of Critical Incident Stress Management (CISM).

The "classic" CISM model was developed by Dr. Jeffrey Mitchell of the University of Maryland for use with emergency services personnel. Although it was not called CISM until the mid-1980s, critical incident stress management concepts were introduced into the emergency services field in 1974. They were first developed to assist emergency operations personnel, such as firefighters, paramedics and police officers. Over the last three decades CISM support services and the Mitchell Model have extended well beyond their original intended target populations and now include use in natural disasters, school-based incidents, and a variety of other settings, including, in recent years, the U.S. military, hospitals, church groups, and businesses.

The use of CISM increases productivity, health, morale, and enjoyment of life. It may decrease post-traumatic stress disorder, acute stress disorder, workman's compensation claims, fatalities, injuries, and suicide. CISM will help those who were involved in critical cases know that they are having **A NORMAL**

RESPONSE TO AN ABNORMAL SITUATION.

PROCEDURE:

I. **PLAN IMPLEMENTATION**

a. **This plan is to be implemented when a critical case is identified which may include code blues, traumas, decompensation of patients, CPS cases, difficult pediatric cases or any other clinical scenarios in which one or more members of the care team desire more information or support.**

b. Attachment A is an algorithm that provides direction to the individual requesting either personal support, a group debriefing or case follow-up after a critical case.

c. Attachment B is the CISM Huddle Form which provides definitions for huddle types, step by step instructions to notify the CISM task force, contact information for Fire Communications Center (FCC), and a CISM call back log. The information provided on this form will be reviewed by the CISM task force and used to improve the program as it develops.

II. **Definitions**

Assessment: A review of the circumstances of a critical incident, staff involvement and subsequent support needs to determine an appropriate response and follow-up.

CISM Huddle Forms: Are to be completed and placed in the CISM Huddle Form file to help the CISM committee track critical incidents. Please find out where the file location is in your department.

Critical Incident Stress Debriefing (CISD): A structured group meeting that emphasizes emotional reactions to a critical incident. It also emphasizes educational and informational elements which are helpful to employees in understanding and dealing with the stress generated by the event. Debriefings generally occur at least 24-72 hours after the critical incident.

Critical Incident Stress Management Task Force: Resources activated by the CISM Leads to respond to a critical incident. The CISM Team members consist of co-workers and a variety of hospital-based professionals trained and certified in CISM in Ventura County. Training for peer team members will be ongoing.

Critical Incident: Any event which has a stressful impact sufficient enough to overwhelm the effective coping skills of an individual or group. Critical incidents are typically sudden, powerful events which are outside the range of ordinary experiences. Examples of critical incidents include, but are not limited to, code blues, severe traumas, pediatric codes or patient decompensation.

Critical Incident Stress Management (CISM): A wide range of programs and services designed to prevent and mitigate the effects of traumatic stress.

Defusing (CISD)/ CISM Huddles: Two (2) minute CISM huddles (hot or warm) will happen immediately after a critical incident. CISM huddles will be led by the primary physician on the case and the charge nurse, who will stand by. The main purpose of a defusing is to stabilize and assist with immediate needs of the affected personnel so that they can return to work if necessary or they may go home without unusual stress. Defusing allows for initial venting of reactions to the incident and provides stress-related information to affected personnel. A defusing may eliminate the need for a formal CISD. Participants in the huddles will be reminded that they may not begin to show signs and symptoms for 24 to 48 hours after the incident or sometimes even longer, depending on the individual.

Fire Communications Center (FCC): The communication center handling 911 fire and medical calls throughout Ventura County.

Hot Huddle is a defusing process done immediately after a critical case**.**

Warm Huddle is a defusing process done minutes to hours after a critical case.

Individual Crisis Debriefing: One-on-one private assistance by peers who are trained to listen without judgment and who are trained in positive coping strategies.

Peer Team Members: Personnel trained (once certified) to assist their fellow employees with stress, and to help others validate their thoughts and emotions about an overwhelming trauma or loss. Peer team members have the same or similar work backgrounds as the affected personnel. All members will complete a minimum of a two (2) day CISM training course approved for certification in Ventura County. Members will be encouraged to participate in ongoing training and work with the lead CISM Agency, Ventura County Emergency Medical Services (VCEMS), to help improve their skills and abilities.

III. **Privacy and Confidentiality**

a. **Confidentiality.** Confidentiality is the foundation on which the CISM program rests. CISM principles require that confidentiality and privacy of responders be respected. Confidentiality applies to information received during a debriefing or individual session. Program members have a primary obligation and take responsible precautions to respect the confidentiality rights of those with whom they work.

b. **Discussing the Limits of Confidentiality.** Unless it is not foreseeable or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant**.**

c. **Minimizing Intrusion on Privacy.** Members discuss confidential information obtained from program related contacts only for CISM professional purposes and only with persons clearly concerned with such matters.

d. **Maintenance of Records.** Members maintain appropriate confidentiality when creating, storing, accessing, transferring and disposing of records under their control, whether these are written, automated or in any other medium. Program members maintain and dispose of records in accordance with the law in a manner that permits compliance with the requirements of VCMC/SPH.

e. **Disclosures**. Program members disclose confidential information without the

consent of the individual only for a valid purpose, such as (1) to provide needed professional services to an individual, (2) to obtain appropriate professional consultations, or (3) to protect the responder or others from harm.

Program members do not share confidential information which reasonably could lead to the identification of a responder, agency or organization with whom they have had a debriefing relationship unless they (1) obtain the prior consent of the person, agency or organization or (2) the disclosure cannot be avoided. Information is shared only to the extent necessary to achieve the purpose of the consultation.

f. **Use of Confidential information for Teaching or Other Purposes**. Program members do not disclose in their writing, lectures or other public media, confidential, personally identifiable information concerning the responders or agencies for whom they have provided a stress management session, unless the person or agency has consented in writing or unless there is an ethical or legal obligation for doing so.

In scientific and professional presentations, members shall disguise confidential information concerning persons or organizations so they are not individually identifiable to others and so discussions do not cause harm to persons who might identify themselves.

IV. **CISM Deployment Responsibilities**

i. An algorithm will be developed to help those needing to activate CISM.

ii. Requesting CISM can be done by calling Paging and sending a group page to the CISM group.

iii. The CISM Peer Members on call will then come in. One member will be designated to come in to relieve primary nurse while the designated CISM lead for the event notifies the to help deploy a team that is appropriate given the critical incident. Peer Members will stay no longer than 4 hours.

V. **Critical Incident Stress Management Team Member Duties**

A. **CISM Leads**

1. Administers and coordinates the critical incident stress management (CISM) program.
2. Serves as primary point of contact for requests for CISM Peer Team support. Activates CISM Peer Team members and assigns a CISM leader to respond to the incident.
3. Updates CISM protocols and operational procedures with VCMC/SPH annually.
4. Recruits personnel who are interested in becoming a peer support member. Once individuals show interest they will then be interviewed through an EMS third party to determine if they will be appropriate as a peer support member, CISM Leads will not be responsible for appointing peer support members.
5. Coordinates with VCMC/SPH CISM Committee to provide training for new

recruits and continuous education for group members. Stays up-to-date of new developments and innovations in the field of crisis intervention.

6. Provides stress education and support programs for personnel.
7. Maintains current list of peer support team members. Provides list to VCMC.
8. Maintains records of all trained CISM members.
9. Ensures that distressed group members receive the appropriate help (i.e. debrief the debriefers).
10. In conjunction with the VCMC/SPH CISM committee, reviews activities to address quality issues to improve service.
11. Provides outreach to inform agency administrators and employees of CISM services.

B. **CISM Huddle Leader**

Major Duties (When called in for an incident)

1. Responsible for delegating to other peer team member to cover primary nurse of critical incident.
2. Responsible for CISM team activities after deployment.
3. Provide private crisis intervention services as needed (i.e. defusings, debriefings).
   Working within the level of competence and makes appropriate referrals.
4. Communicates ongoing information to CISM Leads after deployment of team.

C. **Peer Support Members**

Major Duties:

1. Cover patients of primary nurse of critical incident if needed.
2. Help maintain the flow of the primary department (i.e. Emergency Department, Critical Care Unit).
3. Attends CISM training to maintain skills and abilities.
4. Updates peer support information form on annual basis to reflect current experience, education and training in crisis management.

REFERENCES:

American Academy of Experts in Traumatic Stress and Clinical Professor of Emergency Health Services University of Maryland
Nebraska Critical Incident Stress Management (CISM) Program
Northern Rockies Critical Incident Stress Management

ATTACHMENTS

Attachment A – CISM Flow Sheet
Attachment B – CISM Huddle Form

All Revision Dates

10/31/2023, 4/1/2017

Attachments

A: Critical Incident Stress Management (CISM): Flowsheet

B: Critical Incident Stress Management (CISM) Huddle Form

Approval Signatures

Step Description	Approver	Date
Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	10/31/2023
Medical Staff	Minako Watabe: Chief Medical Officer, VCMC & SPH	10/30/2023
Nursing Leadership	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/8/2023

Status **Active** PolicyStat ID **14624631**

Origination	7/1/2015	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	10/30/2023		
Effective	10/30/2023	Policy Area	Pharmacy Services
Last Revised	10/30/2023		
Next Review	10/29/2026		

PH.13 Drug Supply Chain Security Act (DSCSA)

Policy:

The Department of Pharmacy Services shall only accept pharmaceutical products from authorized sources. The Department of Pharmacy Services shall develop processes to identify, quarantine, and investigate pharmaceutical products suspected to be illegitimate. Transaction information for each drug product shall be retained for six years from the date of transaction.

Background:

The Drug Quality and Security Act (DQSA), was signed into law by President Obama on November 27, 2013. Title II of DQSA, the Drug Supply Chain Security Act, outlines critical steps to build an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the United States.

Procedure:

A. The Department of Pharmacy Services shall verify sources of pharmaceutical products either from the U.S. Food and Drug Administration (FDA) registration database http://accessdata.fda.gov/scripts/cder/drls/ or from the California State Board of Pharmacy web site http://www.pharmacy.ca.gov/online/verify_lic.shtml.

B. Transaction history statements in paper or electronic form for each prior transaction going back to the manufacturer of the product shall be maintained for six years from the date of transaction.

C. The transaction information required includes:

    1. Proprietary name of the product
    2. Strength and dosage form

3. NDC number
4. Container size
5. Number of containers
6. Lot number
7. Date of transaction
8. Date of shipment, if more than 24 hours after the date of the transaction
9. Business name and address from where the product is transferred.
10. Business name and address to where the product is transferred.

D. A transaction statement in paper or electronic from shall be included that states the entity transferring the product:
    1. is authorized (licensed) as required
    2. Received the product from an authorized source
    3. Received transaction information and a transaction statement from the prior owner
    4. Did not knowingly ship a suspect or illegitimate product
    5. Had systems in place to comply with verification requirements
    6. Did not knowingly provide false transaction information
    7. Did not knowingly alter the transaction history

Excluded Products from the DSCSA:

1. Blood or blood components for transfusion
2. Radioactive drugs or radioactive biological products
3. Imaging Drugs
4. Medical gases
5. Compounded drugs
6. Dialysis solutions
7. Irrigation solutions
8. Sterile water (irrigation or injectable)
9. IV products intended for replenishment of fluids, electrolytes or calories

Excluded Transactions

1. Intercompany distributions
2. Distribution among hospitals under common control
3. Public health emergencies
4. Dispensed pursuant to a prescription
5. Product sample distribution

6. Blood and blood components for transfusion
7. Minimal quantities by a licensed pharmacy to a licensed practitioner
8. Charitable organizations
9. Distributions pursuant to a merger or sale
10. Certain combination products
11. Certain medical kits
12. Medical gas distribution
13. Approved animal drugs

E. Pharmacy shall notify FDA and all appropriate immediate trading partners within 24 hours after determining product is illegitimate by completing FDA Form 3911. Visit https://www.fda.gov/drugs/drug-supply-chain-security-act-dscsa/notify-fda-illegitimate-products.
    1. Illegitimate product: Counterfeit, diverted, stolen, intentionally adulterated such that the product would result in serious adverse health consequence or death to humans, subject of fraudulent transaction, or appears otherwise unfit for distribution such that the product would be reasonably likely to result in serious adverse health consequences or death to humans.

F. Pharmacy shall notify California Board of Pharmacy within 72 hours of obtaining knowledge of or has cause to believe drugs in its possession is counterfeit or the subject of a fraudulent transaction. [California Board of Pharmacy Law: 4107.5]

All Revision Dates

10/30/2023, 9/20/2021, 7/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/30/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	10/30/2023

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

December 2023

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

b. Medical Staff Forms

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Medical Executive Committee Document Approvals

December 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.	100.006 Patient Valuables	No changes	Triennial	2-4
2.	100.038 Discharge Requirements	Updated sections related to patients being transferred and discharge order documentation requirements	Triennial	5-7
3.	100.055 Code Blue – Adult Medical Emergency	Minor terminology changes to reflect current responders during the code including the new rapid response nurse role, and hyperlinking reference policies,	Triennial	8-13
4.	100.064 Interpreter Services	Updated terminology and updated the section regarding ASL via the Language Line in lieu of TDD,	Triennial	14-17
5.	100.207 Electronic Orders Management of Boarding Patients	No changes	Triennial	18-19
6.	100.271 Violent Disruptive Behavior	Updated section regarding verbal abuse, added security rounds, staff to notify, added alerts in the EMR, engaging families, noncompliant patients, removed section regarding administrative discharge and spelled out abbreviations	Triennial	20-25
7.	101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements	Added American Red Cross to approved courses, and clarified which BLS courses should be taken and removed the CEU statement.	Triennial	26-28
8.	107.060 The Promotion of Medication by Pharmaceutical Representatives	Minor clarification to drug promotional/educational activities	Triennial	29-30
9.	108.047 Centralized Telemetry Monitoring	Minor changes to arrhythmia diagnosis, monitoring, and frequency	Triennial	31-36
10.	108.048 Midline Intravenous Catheter Placement	Added abbreviation (RN) and the use of Tegaderm, allergy reference under Biopatch disk, corrected abbreviations and added language regarding dressing changes.	Triennial	37-41
11.	108.053 Contraband Guidelines for Acute Detoxification	New	Triennial	42-43
12.	ICU.03 Adult Intensive Care Unit Visitation	Updated policy statement, visitation time limits and added family members encouraged to participate in bedside shift report when approved	Triennial	44-45
13.	MCH.23 Neonatal Evacuation Jacket	Removed references to NNPs (no longer used in the NICU) and spelled out abbreviations	Triennial	46-47
14.	MST.70 Admission to and Discharge from 3 Fainer South Tower (3FST)	New	Triennial	48-52
15.	OB.52 Preterm Labor	Complete policy revision	Triennial	53-58
16.	OB.69 Administration of Rho Immune Globulin for Prophylaxis	No changes	Triennial	59-61
17.	PH.24 Clinic Medications and Samples	Added hyperlink to reference documents, terminology updates, added a section regarding Patient Assistance Program Medications, and updated the expired medication section and the section regarding the disposition of clinic medications	Triennial	62-71

18.	PH.40.05 Investigational Drugs – Patient's Own Medications	No changes	Triennial	72-73
19.	PH.78 Boxed Warning Drugs	Complete policy revision per Title 21	Triennial	74-76
20.	Central Venous Access Device (CVAD or "Central Line") Care and Maintenance for Adult Patients	New	Triennial	76-86
21.	Critical Care Electrolyte Protocol	New	Triennial	87-92

b. Medical Staff Forms

1.	Addiction Medicine Privilege Checklist (Approved by Dept of Family Medicine and MEC)	New privilege list for the inpatient detox unit	93-94
2.	Initial and Reappointment Application Attestation Questions (Approved by Credentials Committee and MEC)	Revised the initial and reappointment application attestation questions for compliance with revisions to the NCQA standard requirements, consistency between the two applications and added HLB recommended questions to address legislative changes to 805.8 of the Business & Professions Code	95-98

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Medical Executive Committee Document Approvals

December 2023

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

1.	100.070 Moderate and Deep Sedation	page	2-8
2.	100.098 Pneumococcal and Influenza Vaccine Screening and Administration	page	9-10
3.	100.220 Electronic Order Management - **Tabled**	page	11-13
4.	108.050 Patient Safety Attendant Care	page	14-18
5.	N.06 Formula Preparation and Feeding Guidelines	page	19-20
6.	N.36 Gavage/Enteral Gastric Tube Feeding in the NICU	page	21-24
7.	N.39 Role of the NICU Charge Nurse	page	25-27
8.	N.53 Venipuncture in Neonates	page	28-30
9.	P.32 PICU, NICU, and PEDS Visiting Policy	page	31-34
10.	PH.27.00 Hazardous Drug Overview	page	35-36
11.	PH.27.01 Hazardous Drug Training and Safety Program	page	37-40
12.	PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport	page	41-44
13.	PH.27.03 Hazardous Drug Garbing, and Compounding	page	45-48
14.	PH.27.04 Decontamination, Spill, and Waste Management	page	49-51
15.	PH.40 Investigational Drug Use	page	52-53
16.	PH.79 Multiple Dose Vials	page	54-55
17.	PH.88 Controlled Substances	page	56-61
18.	PH.119 Piperacillin-Tazobactam (Zosyn) Adult Dosing Protocol	page	62-66

b. Medical Staff Forms

1.	Plastic Surgery & Reconstructive Surgery Privilege Checklist (Approved by Dept of Surgery and MEC)	page	67-69

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

#	Title	Summary	Frequency	Page
1.	100.070 Moderate and Deep Sedation	Revised to reflect medical staff privileges language	Triennial	2-8
2.	100.098 Pneumococcal and Influenza Vaccine Screening and Administration	No changes	Triennial	9-10
3.	100.220 Electronic Order Management – **Tabled**	Revised to include entering a diagnosis per protocol, or as instructed by provider	Triennial	11-13
4.	108.050 Patient Safety Attendant Care	Complete policy rewrite	Triennial	14-18
5.	N.06 Formula Preparation and Feeding Guidelines	Spelled out abbreviations	Triennial	19-20
6.	N.36 Gavage/Enteral Gastric Tube Feeding in the NICU	Spelled out abbreviations and added reference to developmental support	Triennial	21-24
7.	N.39 Role of the NICU Charge Nurse	Terminology changes, added updated processes and NICU Steering Committee	Triennial	25-27
8.	N.53 Venipuncture in Neonates	Removed NNP reference and spelled out abbreviations	Triennial	28-30
9.	P.32 PICU, NICU, and PEDS Visiting Policy	Spelled out abbreviations, hyperlinked referenced documents	Triennial	31-34
10.	PH.27.00 Hazardous Drug Overview	Terminology changes	Annual	35-36
11.	PH.27.01 Hazardous Drug Training and Safety Program	Updated to reflect current process and terminology	Annual	37-40
12.	PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport	Updated to reflect current process, added abbreviations and updated terminology	Annual	41-44
13.	PH.27.03 Hazardous Drug Garbing, and Compounding	Hyperlinked reference documents	Annual	45-48
14.	PH.27.04 Decontamination, Spill, and Waste Management	Minor revision to decontamination process and hyperlinked reference documents	Annual	49-51
15.	PH.40 Investigational Drug Use	No change	Triennial	52-53
16.	PH.79 Multiple Dose Vials	Removed 1 medication and hyperlinked reference documents	Triennial	54-55
17.	PH.88 Controlled Substances	Minor revisions related to nursing staff by adding a second nurse to the inventory process and hyperlinked reference documents	Triennial	56-61
18.	PH.119 Piperacillin-Tazobactam (Zosyn) Adult Dosing Protocol	No changes	Triennial	62-66

b. Medical Staff Forms

1.	Plastic Surgery & Reconstructive Surgery Privilege Checklist (Approved by Dept of Surgery and MEC)	New specialty specific privilege list – Privileges previously requested on multiple lists	67-69

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3.	100.055 Code Blue – Adult Medical Emergency	page	8-13
4.	100.064 Interpreter Services	page	14-17
5.	100.207 Electronic Orders Management of Boarding Patients	page	18-19
6.	100.271 Violent Disruptive Behavior	page	20-25
7.	101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements	page	26-28
8.	107.060 The Promotion of Medication by Pharmaceutical Representatives	page	29-30
9.	108.047 Centralized Telemetry Monitoring	page	31-36
10.	108.048 Midline Intravenous Catheter Placement	page	37-41
11.	108.053 Contraband Guidelines for Acute Detoxification	page	42-43
12.	ICU.03 Adult Intensive Care Unit Visitation	page	44-45
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19.	PH.78 Boxed Warning Drugs	page	74-76
20.	Central Venous Access Device (CVAD or "Central Line") Care and Maintenance for Adult Patients	page	76-86
21.	Critical Care Electrolyte Protocol	page	87-92

b. Medical Staff Forms

1.	Addiction Medicine Privilege Checklist (Approved by Dept of Family Medicine and MEC)	page	93-94
2.	Initial and Reappointment Application Attestation Questions (Approved by Credentials Committee and MEC)	page	95-98

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/1983*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/1/2013*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.006 Patient Valuables

POLICY:

Ventura County Medical Center/Santa Paula Hospital has a fireproof safe located in the Admitting Department to provide security, care and storage of patient valuables. Patients are nevertheless advised to bring as little personal property with them as possible, and are encouraged to have relatives or friends take any such property home. Patients or their relatives are also advised that the hospital is not responsible for valuables or personal items retained at the bedside.

Information regarding the availability of the safe and limitations of the hospital's liability is contained in the form VCMC-5□6-001, "Consent for Treatment & Conditions of Admission." When consent is obtained, this provision will be brought to the attention of the signer. In addition, there is a "Patient Belongings □ist," form VCMC-5□6-016.

PROCEDURE:

Emergency Department:

Envelopes are available in the Emergency Department for patients to deposit their valuables. This should be done at the time of admission if possible. The Admitting clerk or nursing staff will be responsible for receiving these items from patients, placing them in the envelope, and inventorying all items. It is important that items be described in general terms only, giving no indication of the possible value of any item.

□nce the inventory is complete and the envelope is sealed, the Admitting clerk or nursing staff will sign the inventory sheet on the envelope and ask the patient to sign the sheet. The patient will also be asked to designate someone to whom the envelope and other property in the Hospital's custody can be given.

Inpatient Units:

Inform patient that articles retained in his/her possession or any articles brought to him/her while in the hospital are no longer the responsibility of the hospital if there is loss or breakage.

1. Patient clothing: Upon admission, place identification name tag on clothing bag or mark patient□s name on outside of bag. Place clothing inside bag.
2. Patient valuables: Complete requested information on valuables envelope, on the reverse side of the clothing sheet, and have the patient sign clothing sheet. Place patient valuables in valuables envelope, complete information on front of envelope and take envelope to the Admitting □ffice to be locked in the safe. If possible, send all articles home with family or friend. The patient and the person taking the articles shall both sign.

3. Patient medications: If possible, send home with family or friends. The patient and the person taking the medication shall both sign. If the medication is not taken home, they will be sent to the Pharmacy Department until the patient is discharged. Note this on form and have patient and family member/friend sign if possible.

4. Advise patient and family that patient may keep only a small amount of money (under 5.00) with him/her while in the hospital and that money and valuables will be locked in the safe in the Admitting ffice.

5. Upon discharge, have patient sign back of patient s clothes list marked eceipt for personal articles on discharge," verifying that articles placed in custody of the hospital were received upon discharge.

At the time of discharge, patient or responsible party must go to Admitting to verify the contents of the envelope and sign both the yellow trust slip and the Patient's Valuables Envelope. Envelope shall be routed to Health Information Management for filing in the patient chart.

PATIENT T ANSFE S: Nursing or responsible party must retrieve the patient's valuables from the safe in Admitting prior to patient transfer in order to ensure all valuables are transferred with the patient. At transfer, patient or responsible party representing the patient will sign for release.

UNCLAIMED PATIENT VALUABLES

The Admitting Department will be responsible for review of the contents of the safe every 30 days to determine if patients are still inpatients. If a patient has been discharged, the Admitting Manager will attempt to verbally contact the patient or family to ask them to claim the belongings. If this attempt fails, a written notice will be sent to the patient or family and a copy of such retained. If belongings remain unclaimed following this notice, the belongings will be forwarded to Administration for disposal. A copy of the letter will be placed in the patient's medical record.

PATIENT DEATH:

A. **Non-Coroner's Office**: If the death does not involve the Coroner's ffice, patient's valuables may be released to the next of kin. The same procedure of verification and signature must be followed as for a discharged patient.

B. **Coroner's Office**: If the death involves the Coroner's office, the Coroner's ffice will sign for and take possession of the Trust Envelope to be returned to the next of kin. Admitting will contact Social Services or their designated person when the Coroner's ffice arrives for the Deceased Trust.

ATTACHMENTS

- Attachment A - Consent for Treatment and Conditions of Admission - English (Form VCMC-5 6-001)
- Attachment B - Consent for Treatment and Conditions of Admission - Spanish (Form VCMC-5 6-002)
- Attachment C - Patient Belongings ist (Form VCMC-5 6-016)

All revision dates: 11/1/2013, 1/1/2010, 6/1/2006, 1/1/2005, 7/1/2001, 10/1/1998, 12/1/1986, 5/1/1986

Attachments

Attachment A - Consent for Treatment and Conditions of Admission - English.pdf
Attachment B - Consent for Treatment and Conditions of Admission - Spanish.pdf
Attachment C - Patient Belongings □ist.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical □fficer, VCMC & SPH	10/30/2023
Hospital Administration	Diana □enner: Chief □perating □fficer, VCMC & SPH	9/25/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/22/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/22/2023
Policy □wner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/22/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.038 Discharge Requirements

POLICY:

The following steps will be followed when discharging patients from Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

A. Prior to discharge, a physician order and / or prescriptions shall be written for:

1. Discharge
2. Medications
3. Follow-up care (i.e., clinic appointments)
4. Medical transportation (if necessary)
5. Durable medical equipment (if necessary)
6. Home health services (if necessary)

~~Transfer form (if patient is to be transferred to another facility)~~

B. A Transfer Summary with physician signature shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital.

1. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan.
2. A copy of the transfer summary shall be given to the patient and patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

C. A Discharge Summary shall be dictated by the discharge physician within ~~2~~ 8 hours post-discharge for patient stays greater than 8 hours. The Discharge Note must include the diagnoses, procedures, complications, outcome of hospitalization, discharge disposition, and provisions for follow up care.

1. A dictated ~~discharge summary~~Discharge Summary is not required for patient stays less than 8 hours, routine obstetrical deliveries, and uncomplicated newborn hospitalizations. The note on the day of discharge must include discharge diagnosis, discharge disposition and provisions for follow up care.

~~A Discharge □rder shall be completed by the discharge physician, prior to discharge~~

D. Discharge medication reconciliation ~~should~~must be completed by the discharging physician/provider, per policy *100.082 Medication Reconciliation*.

E. ~~Instruct~~The patient, family, or significant others ~~using diagnosis~~must be instructed on care post-~~related "Patient Teaching" forms~~hospitalization, take home prescriptions, home instructions, and follow-up appointments.

F. Community □~~esources~~resources with appropriate contact numbers and expected arrival times for nurses, equipment, etc. ~~is~~must be documented.

~~Have patient and nurse sign patient teaching form and Discharge Summary (one copy of each to patient and one copy of each for chart).~~

~~Check clothing list. Have patient sign for belongings (see Clothing Sheet Procedure).~~

~~□eturn valuables and have patient sign for them.~~

G. When a discharge order has been entered, the nurse will receive a task to discharge the patient. Clicking on this task will lead the nurse to complete the discharge summary form, which is provided to the patient along with other discharge documents (instructions, appointment information, prescriptions, etc).

H. The Patient Belongings Inventory Form should be checked. The patient must sign for belongings per policy ***100.256 Patient Belongings*.**

I. The Admitting Department safe should be checked and any deposits returned to the patient.

J. ~~Check for deposits in the Admitting Department safe~~Valuables should be returned to the patient and the patient must sign for them.

K. ~~Nursing enters discharge~~Discharge date, time and disposition are to be entered into ~~hospital computer system~~the EH□ by Nursing.

Note: In the event of patient death, the Nursing unit notifies admitting office by telephone. ~~Discharge~~The discharge order is entered into the ~~hospital computer system~~EH□ by nursing unit staff. Nursing enters discharge date, time and disposition.

~~All paper documents must be sent to Health Information Management (HIM) the following day to be scanned into the electronic health record.~~

□. All patients are to be discharged via wheelchair or ambulance gurney.

M. All patients are to be accompanied by hospital staff to vehicle.

N. All paper documents must be sent to Health Information Management (HIM) the following day to be scanned into the EH□.

□. HIM will review the chart for deficiency analysis and coding ~~unless the patient is readmitted~~.

All revision dates: 9/26/2023, 11/10/2021, 1/1/2017, 2/1/2013, □/1/2012, 10/1/2011, 5/1/2006, 3/1/2006, 1/1/2005, 11/1/1998, 7/1/1992, 10/1/1986, 5/1/1983

Attachments

No Attachments

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Hospital Administration	Minako Watabe: Chief Medical □fficer, VCMC & SPH	10/30/2023
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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/26/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/26/2023
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References:	

100.055 Code Blue - Adult Medical Emergency

POLICY:

The rapid application of Cardiopulmonary □esuscitation (CP□) is essential to patient survival in the event of respiratory or cardiac failure. For "D□ N□T □ESUSCITATE" orders, see Administrative policy 100.013 Do Not □esuscitate (DN□) □rders.

PROCEDURE:

HOSPITAL refers to Ventura County Medical Center (VCMC), including the Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU), and Santa Paula Hospital (SPH). ***See Section I below.***

CLINIC refers to Ventura County Health Care Agency Ambulatory Care (AC) Clinics. ***See Section II below.***

Section I - Hospital

A. **Cardiopulmonary Resuscitation (CPR) – Preliminary Steps**:

1. Follow Basic □ife Support (B□S) and Advance Cardiovascular □ife Support (AC□S) guidelines. (Algorithms □American Heart Association CP□ & First Aid)
2. In the event of patient respiratory or cardiac failure, call for help by dialing x7-6666 at VCMC or x7-8666 at SPH. Communicate the patient's location and whether it's an adult or child. If in on a nursing unit, also press the "C□DE" button at head of the patient's bed. "C□DE B□UE" shall be used for a medical emergency resulting in pulseless arrest or near pulseless arrest in a patient 18 years and older.
3. Telephone □perator: Shall announce "C□DE B□UE" on the paging system.
4. State the patient location and repeat this information two (2) times.

B. **Code Blue Response Team**:

1. VCMC members are Advanced Cardiovascular □ife Support (AC□S) certified:
   a. □n call Attending and Intensive Care Unit (ICU), Medicine, and Surgical □esidents□
   b. ~~ICU □N~~ □apid □esponse Nurse (□N). If one is not available, use the designated critical care □N□
   c. □espiratory Therapist□
   d. □aboratory□

e. □adiology□

f. House Supervisor.

g. Certified Nursing Assistant (CNA)

2. SPH:

a. Hospitalist or Emergency Department (ED) Attending□

b. ~~ED or ICU □N□~~Designated critical care □N□

c. House Supervisor□

d. □espiratory Therapist□

e. □aboratory□

f. □adiology.

C. **Personnel Duties:**

1. First on the scene:

a. Assess airway, breathing and circulation.

b. Initiate Code Blue by: Dialing x7-6666 at VCMC or x7-8666 at SPH.

c. Communicate the patient's location and whether an adult or child. ~~If in on a nursing unit, also press the "C□DE" button at head of the patient's bed.~~

i. If in on a nursing unit, also press the "C□DE" button at head of the patient's bed.

ii. If the patient is less than 18 years of age, staff must call admitting to clarify it is a Code White.

d. Do not leave the patient alone.

e. Begin CP□.

f. Participate in the debrief session.

2. First responding ~~physician~~□icensed Provider (□P) and any additional ~~physicians):~~□Ps.

a. Follow all AHA B□S and AC□S guidelines

b. Assume the role of team leader~~□~~and may transfer responsibility of team leader to attending ~~physician~~□P or ED ~~physician~~□P.

~~Assign roles to code participants.~~

c. Provide a report to the patient's primary ~~physician if the physician~~□P if the □P has not attended the code.

d. Initiate and facilitate the debrief session.

e. Ensure accuracy of code documentation (i.e., code sheet).

3. Departmental personnel (e.g., personnel from the department calling the code):

a. □btain a crash cart and bring to the patient's location.

b. Attach monitor leads and defibrillation pads to the patient.

c. Ensure that end tidal C□2 capnography is in place.

d. Assist with CP□ as needed.

e. Participate in the debrief session.

f. Exchange the used crash cart (refer to policy ~~100.112 Crash Cart Check and □estocking~~100.112 Crash Cart Check and □estocking for process roles and responsibilities).

□. Nurse assigned to care for the patient:

a. Provide a report to the Code Team, including but not limited to:

i. ~~pertinent~~Pertinent history□

ii. ~~vital~~Vital signs□

iii. ~~events~~Events leading to the arrest□and

iv. ~~medication~~Medication allergies.

b. □emain with the patient during the code.

c. Assist with CP□ as needed.

d. Participate in the debrief session.

5. ~~Intensive Care Unit (ICU) or Emergency Department (ED) nurse:~~

~~a. Bring the emergency medication box and refrigerated medications to the patient's location.~~

~~b. Ensure placement of the monitor leads and defibrillation pads.~~

~~c. Ensure end tidal C□2 capnography is in place.~~

~~d. Ensure venous access.~~

~~e. Administer medications as directed.~~

~~f. Ensure the code record accurately reflects the medications administered.~~

~~g. Assist with CP□ as needed.~~

~~h. Participate in the debrief session.~~

□apid □esponse and designated critical care □N:

a. Follow all AHA B□S and AC□S guidelines

b. Assign roles to code participants.

c. Participate in the debrief session.

6. Scribe:

a. Complete the Cardiopulmonary □esuscitation □ecord.

b. Ensure the yellow carbon copy is provided to the □uality Assessment Performance Improvement (□API) department and the pink carbon copy is provided to the Pharmacy department. White copy should be placed in the patient chart.

c. Complete the Code Debrief Form.

d. Complete the Electronic Notification Form.

e. □btain a team leader's signature on the Cardiopulmonary □esuscitation □ecord.

f. Participate in the debrief session.

7. □espiratory Therapist:

a. Bring airway kit to bedside for ventilatory aspects of the procedure.

b. Manage oxygenation and ventilation with the team leader and identified support physicians.
c. Assist with oxygen set-up and ventilation, using ambu-bag and oxygen.
d. Ensure end tidal C□2 is monitored.
e. Provide CP□ as needed.
f. Participate in the debrief session.

8. House Supervisor:
   a. Assist with obtaining a bed, if the patient is to be transferred to another unit.
   b. Arrange family support.
   c. Participate in the debrief session.
   d. Collect Debrief Forms and send them to the □API department.
9. Pharmacy:
   a. □btain and transport medications as needed.
   b. Add the medication tray to the newly obtained crash cart.
   c. Verify that medications in the replacement tray have not expired.
10. Certified Nursing Assistant:
    a. Bring a 12 lead electrocardiogram (EKG) machine to the patient.
    b. Stand by to act as a runner.
    c. Participate in the debrief session.
11. ICU Charge □N delegates department personnel to bring the □ucas device to the patient.
12. Central Supply:
    a. Ensure that the replacement cart is available and that equipment and supplies are not expired.~~D. Magnetic □esonance Imaging (M□I)~~

D. Magnetic Resonance Imaging (MRI)

1. In the event of a Code Blue/White or □apid □esponse in the M□I Magnet □oom, M□I Technologist Number 1 will remove the patient from the M□I Magnet □oom (□one □).

2. Technologist Number 1 will move the patient into the Patient Waiting Area (□one 3).

3. M□I Technologist Number 2 will activate the Code Blue/□apid □esponse and retrieve the crash cart□ see Section I, A. above.

□. When the patient is in Patient Waiting Area (□one 3):

- M□I Technologist Number 1 will initiate CP□.
- M□I Technologist Number 1 will continue CP□ until Code Blue/□apid □esponse team arrive.

5. All emergency medical procedures will be performed in the M□I Patient Waiting Area (□one 3).

6. No resuscitative efforts will be performed in the M□I Magnet room (□one □).

7. M□I Technologist Number 2 will secure the M□I Magnet □oom door (□one □).

8. No staff members or ~~Physicians~~□Ps are allowed to enter the M□I Magnet □oom (□one □) without being

screened even in the event of an emergency.

9. Special caution must be used in the M□I □oom (□one □) due to the strong magnetic field that is always active. No personnel, patients or emergency responders can enter the M□I Magnet room without being pre-screened.

Section II - Clinic

A. The Ambulatory Care clinics do not house crash carts. The clinics maintain Emergency □esponse Equipment. (refer to Ambulatory Care Policy AC.001 Emergency □esponse Equipment for process and responsibilities*).*

B. In the event of an emergency, clinic staff shall call 911.

CP□ certified clinic staff shall initiate CP□ if needed, apply automated external defibrillator (AED), maintain an open airway and administer oxygen. Non-CP□ certified staff shall **ONLY** call 911 and stay with the patient until help arrives.

Cardiopulmonary Resuscitation Outside of Hospital Buildings

~~Initiate B□S protocol and call 911.~~

Initiate B□S protocol and call 911. Staff to attend codes on Hospital Campus in accordance with Policy 100.22□ Emergency Medical Treatment and □abor Act (EMTA□A) Guidelines.

ATTACHMENTS:

~~2015 American Heart Association, Summary of High □uality CP□ Components for B□S Providers~~

1. Cardiopulmonary □esuscitation □ecord

All revision dates: 5/□/2023, 9/10/2020, 12/12/2019, 8/13/2019, 2/15/2018, 7/21/2017, 3/1/2015, □/1/2012, 5/1/2006, 2/1/2005, □/1/2002, 12/1/2001, 11/1/2001, 7/1/2001, 11/1/1998, 3/1/1995

Attachments

Attachment A- B□S-CP□ 2015 American Heart Association Guidelines.pdf
Attachment B- Cardiopulmonary □esuscitation □ecord.pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED & Medicine	Tracy Chapman: VCMC - Med Staff	pending
Code Blue Committee	Ashley Vasquez: Senior □N	5/23/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/8/2023

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/□/2023
Policy □wner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/23/2023

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Policy Area:	*Administrative - Patient Care*
References:	

100.064 Interpreter Services

POLICY:

Ventura County Medical Center/Santa Paula Hospital (VCMH/SPH) and the Ambulatory Care clinics will take reasonable steps to ensure that persons with □imited English Proficiency (□EP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of VCMC/SPH/Ambulatory Care is to ensure meaningful communication with □EP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/ clients and their families will be informed of the availability of such assistance free of charge.

□anguage assistance will be provided through use of *competent* certified bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with □EP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

VCMC/SPH and the Ambulatory Care clinics will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURE:

IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

VCMC/SPH and Ambulatory Care Health Care Providers will promptly identify the language and communication needs of the □EP person, and will document in Cerner the name of interpreter and/or use of □anguage □ine when used. In addition, when records are kept of past interactions with patients or family members, the language used to communicate with the □EP person will be included as part of the record.

INTERPRETERS

□anguage ~~translation~~interpretation is required when the care provider is unable to communicate with the patient in his/her primary language. General guidelines are:

1. When available, qualified employees will be used as first-line ~~translators~~interpreters.
2. VCMC/SPH will maintain a current list of available interpreters and dialects/languages spoken.
3. Contract services are to be used if ~~translation~~interpretation is not available by employees.
4. Certification will be provided to VCMC/SPH by contractors.
5. Employees used as interpreters will be certified by Ventura County Human Resources or be an approved contractor.
6. Patient family members are to be used in urgent/emergent situations only until a designated interpreter arrives.
7. The health care provider will document the following in the EHR:
    a. Name of the interpreter
    b. Date
    c. Time

ARRANGING INTERPRETATION

A. **Accessing the Language Line system at VCMC/SPH and Ambulatory Care Clinics**

1. Mobile video units with direct access to Language Line are available throughout designated areas of hospital and clinic system. Any phone can be used to make a call to Language Line for over the phone interpreter services by calling the below toll free numbers:
    a. VCMC and SPH: Dial 1-833-789-0397
    b. Ambulatory Care: Dial 1-833-99-2320
2. Language Line staff will help identify the patient's language if the VCMC/SPH/Ambulatory Care staff cannot.
3. ~~Infom~~Inform the interpreter that confidential health information will be discussed.

B. **Accessing American Sign Language (ASL) at VCMC/SPH and Ambulatory Care Clinic**

1. Interpretation can also be performed through video conferencing interpreting at **VCMC/SPH** via Language Line. Select American Sign Language and you will then be immediately directed to a sign language interpreter. In person, ASL interpreting may be ordered from Interpreting Services, and may require a 2-72 hour notice of arrangement.

~~**Telecommunications Device for the Deaf (TDD)**~~

~~1. **VCMC/SPH** makes available TDD (also known as TTY) machines (special text telephone devices that allow people who are deaf, hearing-impaired, or speech-impaired, to use the telephone to communicate).~~

~~a. iPads are available—contact the Nursing Supervisor.~~

~~b. TTY machine located in VCMC.~~

~~c. TTY users can contact the Relay Center, where an operator/interpreter can help them communicate with individuals who do not use a TTY.~~

~~i. TTY English: 1-877-735-2929~~

~~ii. TTY Spanish: 1-888-877-5381~~

d. Voice users can contact a □elay Service operator who can facilitate communication with a person's TT□ machine.

i. Voice English: 1-800-735-2922 or 1-888-877-5379□

ii. Voice Spanish: 1-800-855-3000 or 1-888-877-5379.

C. **Gold Coast Cultural and Linguistic Services**

1. Dial 1-866-□21-3□63 if you are a provider and enter your access code.

D. A list of VCMC/SPH bilingual Spanish-speaking staff is updated monthly from Human □esources and can be obtained from:

1. The Nursing □ffice (652-6001) or the Nursing Supervisor (page at 652-6075)

Some □EP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the □EP person will not be used as interpreters unless specifically requested by that individual and after the □EP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the □EP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the □EP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

PROVIDING WRITTEN TRANSLATIONS

VCMC/SPH will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for □EP individuals.

PROVIDING NOTICE TO LEP PERSONS

All patients are informed of the availability of Interpreter Services and TT□ in the Patients' □ights and □esponsibilities Brochure and by signs posted in the Emergency Department, Admitting area and waiting areas.

Patients are not required to use friends or family members as interpreters, but they may choose to do so. VCMC/SPH must offer to arrange interpreter services as a matter of routine course if direct care providers are not fluent in the patient's language. □eliance on family or friends as interpreters can result in confidentiality breaches, shame and embarrassment on the part of the patient, reluctance to share crucial information, incorrect information translated due to lack of understanding of medical terminology, or interpreter personal bias.

MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

□n an ongoing basis, VCMH/SPH will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures annually. In addition, VCMH/SPH will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by □EP persons, feedback from patients and community organizations, etc.

CONCERNS OR COMPLAINTS

Patients with concerns regarding interpreters may call the Patient Advocate or Nursing Supervisor. Patients with complaints may also contact the following:

Ventura County ADA Coordinator

County of Ventura

800 S. Victoria Avenue

Ventura, CA 93009

Phone: (805) 65□-286□

Email: CountyExecutive□ffice□ ventura.org

REFERENCES:

Title VI of the Civil □ights Act of 196□: □5 CF□ Part 80

California Health and Safety Code 1259

CMS Condition of Participation □82.13(a)(1)

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Attachments

No Attachments

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Ambulatory Care Administration	□izeth Barretto: Chief □perating □fficer, Ambulatory Care	10/18/2023
Ambulatory Care Administration	Allison Blaze: Chief Medical □fficer, Ambulatory Care	8/2/2023
Hospital Administration	Minako Watabe: Chief Medical □fficer, VCMC & SPH	2/17/2023
Hospital Administration	Diana □enner: Chief □perating □fficer, VCMC & SPH	2/13/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/9/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/9/2023
Policy □wner	Stephanie Nelson: Manager, Auxiliary Services	2/9/2023

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100.207 Electronic Orders Management of Boarding Patients

POLICY:

To describe electronic orders management for patients boarding during periods of increased census.

PROCEDURE:

Electronic Admission □rders (Powerplans) will be initiated no longer than four (□) hours after received.

Definition: A Powerplan is a grouping of orders. Powerplans can be entered by a provider and left in a planned state, to be initiated when appropriate. Powerplans can have multiple phases, or groups of orders. The component orders of Powerplans become active when that phase of the Powerplan is initiated at the appropriate time/location.

Individual orders from planned/pending PowerPlans, such as Admission □rders, cannot be selectively initiated. Each phase of the PowerPlan must be initiated in its entirety, or remain in a planned/pending state. In cases where there are bed availability challenges, orders intended for the next phase of care will be initiated no later than four (□) hours. For example, a patient with inpatient orders in a planned state is in the PACU for more than four (□) hours. The PACU □N will initiate the inpatient orders phase(s) and discontinue the PACU orders.

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Attachments

No Attachments

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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 □wner	Aimee Brecht-Doscher: Physician	8/10/2023

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Policy Area:	*Administrative - Patient Care*
References:	

100.271 Violent Disruptive Behavior

PURPOSE:

Provide Ventura County Medical Center and Santa Paula Hospital with a means of addressing workplace violence. Aims to reduce or eliminate caregiver exposure to violent conditions that lead to injury by implementing proactive security measures, work practices, systems, procedures, and training. The policy provides action guidelines in the event of a workplace violence incident, and reference to additional policies and procedures for consideration.

POLICY:

Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH) is committed to providing a safe, therapeutic environment for patients, visitors and staff members. This policy sets forth guidelines for patients, visitors, and/or caregivers who engage in disruptive behavior that may adversely impact patient, visitor and staff safety. VCMC/SPH has zero tolerance of violent or aggressive patient and/or visitor behavior toward caregivers and other bystanders.

For violent disruptive behavior in the Inpatient Psychiatric Unit and Crisis Stabilization Unit, please refer to policy *Z.88 Crimes Committed in the Inpatient Psychiatric Unit/Crisis Stabilization Unit (IPU/CSU)*.

DEFINITIONS:

"Disruptive behavior" is any inappropriate behavior by a patient and/or visitor(s) that may be disruptive to the patient's own care□the care of other patients□the safety of patients, visitors or caregivers□or the general operation of the hospital ~~or clinic~~. These situations can include the following:

Intentional Assault: An act with intent to cause harm by a person in control of their faculties. Includes intentional damage to property.

Non-Intentional Assault: An act without intent to cause harm or by one who does not have control of faculties (i.e., head injury/combative, medication/sedation, disease process).

Verbal Abuse: The use of language ~~and~~, communication ~~that causes~~, or gestures intended to demean, frighten, intimidate, humiliate, blame or threaten harm to another ~~to feel emotional pain, distress or fear~~individual.

Non-Intentional Verbal Disruption: Causing disruption without intent to do so or by one who does not have control of faculties (dementia, developmentally delayed pts., etc.).

Threat of Harm: A statement of intent to inflict harm by one who has the ability to formulate the intent to commit an act. Threat of harm can be received via telephone, written form, and other modalities.

PROCEDURE:

Physical Disruption

A. **Intentional Assault** *An act with intent to cause harm by a person in control of their faculties. Includes intentional damage to property.*

1. emove yourself and others from immediate harm.
2. Provide clear direct commands.
3. Press emergency duress button (where applicable) to alert security.
4. Call a Code ~~Gray~~Grey dial x76666 for Ventura County Medical Center (VCMC) or x78666 for Santa Paula Hospital (SPH) and give the operator the location. See policy *106.059 Code ~~Gray~~Grey* for more information.
5. Document in patient's electronic health record, if applicable.
6. Security to document incident in security log.
7. Notify Director of Security if additional security rounds are needed.
8. Notify the Charge Nurse, Department Director and/or Nursing Supervisor.
9. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
10. Submit a notification form into Datix.
11. If caregiver injury occurred, notify the Manager/Supervisor/Nursing Supervisor/Department Director and complete a First eport of Injury (M-75) form.
12. If behavior continues, a huddle should be called with the Primary Nurse, Charge Nurse, Department Director or Nursing Supervisor, Director of Security, and Provider (if available) to determine next steps and a safe discharge plan (see *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
    a. Safety fficer and Social Worker to attend as needed.
13. If patient requests to leave against medical advice, refer to policy *100.223 Discharge Against Medical Advice*.
14. If incident involves a visitor, notify ~~Security~~security.

B. **Non-Intentional Assault** *An act without intent to cause harm or by one who does not have control of faculties (i.e., head injury/combative, medication/sedation, disease process).*

1. emove yourself and others from immediate harm.
2. Provide clear direct commands.
3. Call a Code ~~Gray~~Grey dial x76666 for Ventura County Medical Center (VCMC) or x78666 for Santa Paula Hospital (SPH) and give the operator the location. See policy *106.059 Code ~~Gray~~Grey* for more information.
4. If any restraints are to be considered, refer to policy *100.075 Restraint and Seclusion*.
5. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
6. Document in patient's electronic health record, if applicable.

7. Submit a notification form in □□Datix.
8. If caregiver injury occurred, notify the Manager/Supervisor/Nursing Supervisor/Department Director and complete a First □eport of Injury (□M-75) form.

Verbal Disruption

A. **Intentional Verbal Disruption – Threat of Harm** □*A statement of intent to inflict harm by one who has the ability to formulate the intent to commit an act. Threat of harm can be received via telephone, written form, and other modalities.*

1. Call a Code ~~Gray~~Grey dial x76666 for Ventura County Medical Center (VCMC) or x78666 for Santa Paula Hospital (SPH) and give the operator the location. See policy *106.059 Code ~~Gray~~Grey* for more information.
2. Notify the Charge Nurse, Department Director and/or Nursing Supervisor.
3. Document in patient's electronic health record, if applicable.
4. Patient alert may be placed in patient's electronic health record, if applicable.
5. Submit a notification form in □□Datix.
6. If incident involves a visitor, notify ~~Security~~security.

B. **Non-Intentional Verbal Disruption** □*Causing disruption without intent to do so or by one who does not have control of faculties (dementia, developmentally delayed pts., etc.).*

1. Provide clear direct commands.
2. Document in patient's electronic health record, if applicable.
3. Continue providing care to patient while attempting to minimize auditory disruptions for other patients.
4. Consider engaging with family/visitors to assist with reorientation of patient.

C. **Verbal Interference with Health Care Operations** □*to willfully or recklessly interfere with access to or from a health care facility or willfully or recklessly disrupt the normal functioning of such facility.*

1. Call a Code ~~Gray~~Grey dial x76666 for Ventura County Medical Center (VCMC) or x78666 for Santa Paula Hospital (SPH) and give the operator the location. See policy *106.059 Code ~~Gray~~Grey* for more information.
2. Notify the Charge Nurse, Department Director ~~and/or~~, and Nursing Supervisor.
3. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
4. Document in patient's electronic health record, if applicable.
5. Submit a notification form in □□Datix.
6. If behavior continues, a huddle should be called with Primary Nurse, Charge Nurse, Department Director or Nursing Supervisor, Director of Security, and Attending Physician (if available) to determine next steps and safe discharge plan.
    a. Safety □fficer and Social Worker to attend as needed.
7. If incident involves a visitor, notify ~~Security~~security.

Documentation

A. Patient care staff are to document the disruptive behavior (including the date and time), as well as record that the patient was informed that such behavior is inappropriate and must cease.

B. Instances of inappropriate or persistent non-compliant conduct should be documented to establish a pattern of repetitive disruptive behavior or non-compliance or otherwise inappropriate conduct.

C. Document all efforts to establish and maintain a satisfactory hospital/patient ~~or clinic/patient~~ relationship.

D. Incidents of patient disruptive behavior must be submitted in □□Datix. The incident report must include an accurate description of the situation, quotes (if possible), and actions taken.

E. If caregiver injury occurred, notify the Manager/Supervisor/Nursing Supervisor/Department Director and complete a First □eport of Injury (□M-75) form.

F. For patients with repeated non-compliance to this policy, Department leaders will notify the Administrator on Duty (A□D). A□D to consider consulting additional resources, including □isk Management.

~~Administrative Discharge~~

~~A. The patient's repeated unacceptable behavior may be considered evidence that the patient's intent is to terminate the hospital/patient relationship. In these circumstances, the hospital may consider an administrative discharge if a patient refuses to cooperate or exhibits continued unacceptable behavior, and the patient's medical condition permits such discharge.~~

~~1. □isk Management must be involved in the decision to administratively discharge a patient along with attending physician.~~

~~2. Submit a notification form in □□Datix.~~

~~3. Administrative discharge may be pursued only if there is documentation of the patient's disruptive behavior and the attempts of hospital staff to counsel the patient about his/her behavior.~~

~~□. The attending or treating physician must determine and document that based on their clinical judgment, the patient's medical condition is such that discharge is not likely to result in serious physical harm to the patient.~~

~~a. The attending physician must document the patient's physical and mental condition prior to discharge.~~

~~b. The attending physician must explain to the patient that the patient's repeated behavior evidences the patient's intent to terminate the hospital/patient relationship. The physician must explain the patient's current medical condition, the type of care which should be sought by the patient, and the time frame within which such care should be obtained.~~

~~c. Although the current hospital/patient relationship may be terminated, the patient must be advised that he/she will not be denied emergency medical care in the future.~~

Additional Considerations for Patient and Staff Safety

A. Efforts should be made to achieve compliance from the patient and/or visitor in order to protect the safety to all patients and staff. All efforts to de-escalate and/or achieve compliance should be documented in the medical record.

1. A team huddle may be organized and conducted to develop a Patient Safety Plan. The team may

include, but is not limited to the Primary Nurse, Charge Nurse, Director of Security, Department Director or Nursing Supervisor, Attending Physician, Safety □fficer, and Social Worker.

2. Patients will be provided with a copy of policy *100.004 Patient Rights and Responsibilities*.
3. At least two (2) members from the team should meet with the patient. The patient, his/her family or others involved in the patient's care are counseled. The counseling focus is on the patient's responsibilities, the Safety Plan for the patient, the need for compliance and the consequences of continued inappropriate behavior. If needed, provide behavioral contract (see Attachment B Behavioral Agreement) and place within the medical record.

□. If incident involves a visitor, notify security and consider disallowing visitors.

B. Any caregiver can identify a patient and/or visitor as a possible risk to staff or other patients.

1. History of violence toward staff/patients.
2. Credible verbal threat of harm.
3. Possession of weapon or objects used as weapons.

C. Violent disruptive behavior by patients and/or visitors should be communicated in accordance with policy *100.228 Chain of Command*.

D. **Denying Patient Visitors:** A patient has a right to receive visitors or have a visitor accompany them but this right may be limited or restricted when it interferes with the patient's own care, the care of other patients, or the safety of patients, visitors or ~~VCMS~~Ventura County Medical Center and Santa Paula Hospital caregivers.

1. ~~VCMS~~Ventura County Medical Center and Santa Paula Hospital may exclude a visitor if the visitor engages in disruptive, threatening or violent behavior of any kind.
2. ~~VCMS~~Ventura County Medical Center and Santa Paula Hospital may exclude a visitor if the visitor is providing, or there is reasonable suspicion that he/she is providing, a patient with alcohol or illegal drugs.
    a. Security will ask the visitor to leave the hospital. If needed, ~~Security~~security may contact local law enforcement at their discretion.

All revision dates:

Attachments

Attachment A Violent Disruptive Patient Safety Plan Checklist
Attachment B Behavioral Agreement

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Diana □enner: Chief □perating □fficer, VCMC & SPH	11/2/2023
Hospital Administration	Minako Watabe: Chief Medical □fficer, VCMC & SPH	11/2/2023

Step Description	Approver	Date
Hospital Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/1/2023
Safety Committee	Fernando Medina: Director, Support Services	11/1/2023
Policy □wner	Fernando Medina: Director, Support Services	11/1/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements

POLICY:

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

PROCEDURE:

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

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

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

- Resident physicians
- Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
  - Post-Anesthesia Care Unit (PACU)
  - Preoperative Care Unit
  - Emergency Department (ED)
  - Definitive Observation Unit (DOU)

        - Telemetry (TELE)
        - Intensive Care Unit (ICU)
        - RNs and LVNs assigned monitoring for moderate sedation
    - Respiratory Therapist
    - ACLS/ALS is strongly recommended for RNs and LVNs who work in the perioperative and medical-surgical (Med-Surg) setting.

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

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

E. Medical staff members shall comply with the requirements specified in the Medical Staff bylaws, rules and regulations, or department privileging requirements regarding BLS, ACLS/ALS, PALS and NRP certification/recertification.

Course Offerings:

- All courses shall be taught according to the standards of, and approved/accredited by, the American Heart Association (AHA) or the American Red Cross (ARC) or the American Academy of Pediatrics (AAP).
- Cardiopulmonary Resuscitation (CPR) recertification courses (BLS Provider) shall be offered at least monthly.
- ACLS/ALS, NRP and PALS certification/recertification courses shall be offered at least biannually.
- Scheduling of AHA courses is the responsibility of the VCMC Nursing Education Department's AHA Training Center Coordinator.

- Maintaining required certification and scheduling of employees for courses is ultimately the responsibility of the individual employee (in conjunction with each department manager).

All revision dates: 11/15/2023, 5/12/2023, 3/16/2023, 12/5/2022, 7/18/2022, 2/12/2019, 5/1/2006, 12/1/2004, 9/1/2001, 11/1/1998, 3/1/1995, 8/1/1992, 11/1/1989, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	11/15/2023
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	10/30/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	7/5/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/4/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/3/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/3/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

107.060 The Promotion of Medication by Pharmaceutical Representatives

POLICY:

The purpose of this policy is to establish guidelines for pharmaceutical manufacturer representatives' medication promotional activities at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and the Ambulatory Care clinics.

Compliance with these guidelines is mandatory. Promotional activities at VCMC/SPH and the Ambulatory Care clinics are to be considered a privilege and not a right of the manufacturer representatives and representatives who continually violate these guidelines will be barred from all promotional activities.

PROCEDURE:

Pharmaceutical Representative Registration and Sign In:

- Front-Desk staff at the main entries shall direct all pharmaceutical representatives to the Pharmacy Department for initial registration.
- Initial registration: All pharmaceutical representatives shall register with the Pharmacy Department to establish their identity and the manufacturer they represent. The Pharmacy Department shall provide a copy of this policy to the pharmaceutical representative. The representative shall complete the Pharmaceutical □epresentative □egistration form (see Attachment A), provide a business card and document receipt of this policy before undertaking any drug promotion at Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) or the Ambulatory Care clinics.
- Upon arrival, all pharmaceutical representatives shall log in to VendorMate at VCMC or sign-in at SPH or Ambulatory Care clinics prior to any drug promotion activity. See also policy F.2 Vendor Access and □egistration. Sign-ins shall take place using the Pharmaceutical □epresentative Sign-In Sheet (see Attachment B). The representative shall wear their company identification name tag at all times. The representative shall also be identified with a VendorMate-generated badge at VCMC or a vendor wrist band at Santa Paula Hospital.

Drug Promotion Guidelines

1. Pharmaceutical representatives may not provide drug promotional/educational activities either in person or online unless requested by the Pharmacy Department or physician/designee.
2. Promotional/educational activities are not to take place in any patient care areas. Appropriate areas for promotional/educational activities are staff offices or lounges and are by invitation and/or appointment

only.

3. Establishing contact with Medical Staff may be accomplished through the Pharmacy Department.
4. All product in-servicing must be submitted to the Pharmacy Department for approval prior to training at any location.
5. epresentatives shall refrain from distribution of unsolicited company literature and promotional items to Medical and nursing staff mailboxes.
6. uestions or comments concerning these guidelines may be directed to the Ventura County Medical Center Pharmacy Department at (805) 652-6220.

All revision dates: /28/2023, 5/18/2020, 5/1/201, 1/1/201, 7/1/2001, 11/1/1998, 12/1/1989

Attachments

Attachment A: Pharmaceutical epresentative egistration
Attachment B: Pharmaceutical epresentative Sign-in Sheet

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/31/2023
Ambulatory Care Administration	izeth Barretto: Chief perating fficer, Ambulatory Care	10/18/2023
Ambulatory Care Administration	Allison Blaze: Chief Medical fficer, Ambulatory Care	8/2/2023
Hospital Administration	Minako Watabe: Chief Medical fficer, VCMC & SPH	5/17/2023
Hospital Administration	Diana enner: Chief perating fficer, VCMC & SPH	5/2/2023
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	5/2/2023
Department of Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	/28/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.047 Centralized Telemetry Monitoring

PURPOSE:

To identify the process for continuous monitoring of heart rate and rhythm of patients to ensure life-threatening rhythms can be detected and treated. Centralized telemetry monitoring ensures redundancy of monitoring both at the department level and in the centralized telemetry station. The centralized telemetry station is located in the direct observation unit (DOU) and is responsible for the remote monitoring of patients within the adult critical care and medical surgical patient populations at Ventura County Medical Center (VCMC) only.

POLICY:

The nursing personnel covered in this policy include telemetry technicians, nurses and anyone covering these roles. Under the direction of nursing directors, these individuals are accountable for the quality of care of the patients and are accountable through nursing administration. The telemetry technicians assigned to the central telemetry station are responsible for maintaining accurate patient information on the system and notifying the nursing staff of any changes.

Qualified personnel to perform the telemetry monitoring function are those individuals who have received training for telemetry monitoring. Qualified staff must demonstrate competency in evaluating of life-threatening arrhythmias.

PROCEDURE:

I. Utilization

A. A provider's order must be obtained for all patients receiving continuous cardiac monitoring (CCM) when it is not the standard of care for all patients on the unit. A provider's order must be obtained for all patients receiving continuous pulse oximetry monitoring.

B. Orders for continuous cardiac monitoring must be re-evaluated every 24 hours or sooner.

C. Intravenous (IV) access is required on all patients who are receiving CCM.

II. Management of the Patient

A. When the nurse receives an order for cardiac monitoring for a patient, the registered nurse (RN) applying the telemetry box (or hard wires) will call the telemetry technician to validate two patient

identifiers, as well as that the monitor is on. They will identify the telemetry box number and identify the patient's baseline rhythm.

B. The telemetry technician and nurse will set the gain to achieve a QRS amplitude large enough to be detected by the monitor and assure that a clear tracing is visible on the monitor for at least two leads.

C. The telemetry technician and nurse will select the appropriate lead based on the goals of monitoring and the patient's clinical situation.

1. For Arrhythmia diagnosis or Wide ORS tachycardia, V1 (RSB, 4th intercostal space) is the best lead with V6 as second choice.
2. If a true V1 or V6 is not a lead option, MCL 1 and MCL6 can substitute.
3. Dual lead monitoring is superior to single lead monitoring~~, making~~- lead II and V1~~ + Lead 3 a good option~~.
4. Note: if other leads in use, justification required and documented.

D. The assigned nurse will notify the telemetry technician when the telemetry box is being taken off for bathing or discharge. They must also call at the beginning of a dialysis treatment and when it is completed, transporting to a procedure or having physical therapy.

E. Physicians shall be notified in the event of any changes in cardiac rhythm or vital signs.

F. The attending physician must re-evaluate the need for utilization of cardiac monitoring daily. Every effort should be made to discontinue telemetry once the patient becomes stable.

G. The nurse will educate the patient about the need for telemetry and not to remove the wires or box. Patients cannot shower with telemetry wires or the telemetry box.

III. Equipment/Parameter alarms

A. All telemetry equipment including pulse oximetry (SPO2) probes and cables will be kept in the telemetry monitoring room.

B. All requests for equipment will be through the monitor tech and returned to the telemetry monitoring room when the patient’s monitoring is discontinued.

C. All nursing units are required to clean equipment with germicidal agent before returning equipment.

D. Cleaned equipment will be placed in a designated basket at the nursing station and delivered to and/ or picked up by staff to the telemetry monitoring room.

E. Initial set up for alarms is established by using patient’s baseline settings. A specific physician order for parameters would supersede using baseline settings.

F. The parameters can be individualized for any patient by a RN or monitor tech. When the monitor tech adjusts parameters it will be in collaboration with the nursing and/ or medical staff.

G. Parameters should be based upon the patient baseline average if there are no specific orders from the provider. Default alarm parameters are standardized for a range between 50-130 bpm.

H. Volume alarms should never be set below 50%.

I. Certain dysrhythmia alarms (e.g.: irregular rhythms) may be changed by the registered nurse on the basis of the patient's clinical situation, current heart rate, rhythm, and treatment plan. Changing the

heart rate standard alarm limits requires an order from the provider. The nurse shall document the clinical justification for altering the alarm limits and dysrhythmia alarms in the patient's medical record. The physician/care team is to be notified of changes from the default settings made by the Registered Nurse. Heart rate alarm limits, different from the default settings, may also be ordered by the physician. Alarm limits can only be adjusted with provider order.

J. Other parameters that are monitored via the central monitoring station are blood pressure, O2 saturation, and respirations.

- *Blood Pressure: Within 20% of patient initial BP unless otherwise directed by medical provider*
- *O2 Saturation: Between 90-100% unless otherwise directed by medical provider*
- Respiratory Rate: Within 10 of baseline unless otherwise directed by medical provider. Low rate should NEVER be less than 10.

IV. Frequency of Cardiac Rhythm Interpretation

A. The nurse is responsible for strip interpretation.

B. Strip documentation is to be done at the following times.

1. Upon admission or transfer into unit.
2. Every ~~four hours for~~ shift or with changes for DOU and telemetry patients (ICU patients ~~and every shift or with changes for DOU and telemetry patients~~will be monitored by primary nurses)
3. For any changes in rhythm or rate, change in vital signs, or in mental status; the patient experiences chest pain; change in lead placement; and when evaluating effects of anti-dysrhythmic agents.
4. For Code Blue (continuous).
5. Document on each recorded rhythm strip the two patient identifiers, interval measurements and interpretation (Telemetry: monitor tech or primary RN**).**
6. Telemetry tech will send all saved telemetry rhythm strips to the patient's primary nurse at intervals mentioned above.
7. For specific procedures such as cardioversion or trans-esophageal echocardiogram (TEE).
8. During any rapid response event.

C. The registered nurse will document on each rhythm strip the rhythm, and measurements (PR, QRS, QT). Nurse will date, time and initial each strip.

V. Communication: Nurse and Telemetry Technician

A. The Nurse and Monitor Tech should communicate the following information to each other:

- Request for equipment to include two patient identifiers one of which cannot be room number
- Initiation of monitoring
- Discontinuation of monitoring
- Interruption of monitoring
- Chest physiotherapy

- Transfer to another room
- Pacemaker or automatic implantable cardiac defibrillator (AICD)
- Transporting for diagnostic testing and/or procedure

B. The nurse should call the Monitor Tech to inform of any specific orders received.

C. Nursing assignment sheets will be sent to the Central Telemetry Room within 30 minutes of the start of the shift. Additional changes to assignments must be communicated to include change in mid-shift assignments, patient admissions, and/or transfers and discharges.

VI. Dysrhythmia Notification

A. Follow the Alarm Intervention Flowchart for any changes in patient condition, rhythm changes and/or lethal dysrhythmias

1. Lethal Dysrhythmias
    a. Asystole
    b. Ventricular tachycardia
    c. Ventricular fibrillation
2. Warning Alarms
    a. Bradycardia (patient's low heart rate (HR) parameter)
    b. Non-sustained ventricular tachycardia > 2 beats
    c. Accelerated ventricular rate
    d. Heart rate greater than patient's high parameter, such as supraventricular tachycardia (SVT) or paroxysmal atrial tachycardia (PAT)
    e. pause or any dysrhythmia not addressed as a lethal alarm
    f. new onset of atrial fibrillation
3. Message Alarms
    a. Bigeminy
    b. Couplets
    c. Trigeminy
    d. Premature ventricular contraction (PVC)
    e. Sinus tachycardia (ST) alarms

B. Escalation pathway: all telemetry alarms are to be called to the unit immediately. If no response, the charge nurse will be notified via walkie talkie. If no response from the charge nurse, the central telemetry staff will active a telemetry alert to trigger an overhead page.

C. Telemetry alerts are also to be called immediately for any lethal dysrhythmia.

VII. Telemetry Tech Responsibilities

A. Communicates battery change alarm

B. Creates copies of the telemetry strips for each nurse to review. The Charge Nurse will pick up the strips from the Central Telemetry room when the strips are ready

C. Notifies Bio-Medical Engineering of faulty equipment and takes equipment our of service

D. Admits patient to the Central Telemetry Monitor in coordination with the RN, including patient data and initial rhythm strip

E. Sets parameters and re-checks parameter every 12 hours

F. Monitors patients continuously via central station

G. Reviews prior alarm history and clears out artifact related alarms

H. The monitor tech will follow the “Alarm Intervention Flowsheet” to escalate any lethal dysrhythmias, warning alarms and/or messages

I. The monitor tech will document all notifications to nurse (In cerner? Or on a paper log?)

J. The monitor tech will label each telemetry strip with the following information:

1. patient’s name and MRN
2. Patient’s room number
3. Time and Date
4. Measured parameters

VIII. Specific Nursing Responsibilities

A. Patients on telemetry monitoring who require transport for testing will be transported without a nurse to the department, unless otherwise ordered by the provider. The patient will be continuously monitored by telemetry by the monitor tech. In those areas where telemetry is not monitored or telemetry is not transmitted, the nurse will accompany the patient.

B. Electrodes are changes prn and at least every 72 hours. Do not use tape to affix to a patient’s body

C. Telemetry ECG strips are to be placed in the chart and the RN signature confirms the monitor tech’s interpretation.

D. Broken or faulty equipment should be returned to the Central Telemetry Monitor. The monitor tech’s will be responsible for notifying bio-medical engineering and ensuring the equipment is repaired and returned.

E. The RN will promptly notify the monitor tech when the patient’s telemetry is discontinued, the patient leaves the floor, and/or the unit is taken off for any reason.

F. The Charge nurse or designee will pick up the monitor strips from the Central Telemetry Monitor. The RN will validate the interpretation of the strip and place in the medical record.

G. In the event of an arrhythmia, the nurse will:

a. verify the patient by name and MRN

b. Go immediately to check on the patient

c. Nursing assessment will include:

1. Airway, Breathing, Circulation
2. Heart rate and rhythm regularity to include a full set of vital signs (VS)
3. Assess for presence of chest pain
4. Skin color

H. Communicate patient status to monitor tech

I. Call rapid response and notify provider for all symptomatic rhythms.

IX. Handoff

A. Any changes to cardiac monitoring orders require handoff between providers using SBAR format.

B. Handoffs must also occur between telemetry technicians and must include alarm volumes, alarm limits (if not standard), basic rhythms and arrhythmias of any patients being monitored.

C. Telemetry box log book will be maintained and updated by telemetry technicians.

X. Downtime

A. If downtime occurs, the telemetry technician will immediately notify the house supervisor to contact BioMed and department charge nurses. House supervisor will call AOD if downtime extends > 10 minutes.

B. When department monitoring stations are down, the department charge nurse will notify the centralized telemetry room.

C. If any monitoring is down in the centralized telemetry room, the house supervisor will place patients on alternative monitoring, call BioMed and call the AOD.

D. Once downtime resolves, conduct a debrief to understood root causes and mitigate future risk.

REFERENCE(S):

AACN Procedure Manual for High Acuity, Progressive and Critical Care. (2017). 7th ed.

Alarm Management- American Association of Critical Care Nurses.

procedures.lww.com/lnp/view.do?pId=3378804&hits=telemetry&a=false&ad=false&q=telemetry

All revision dates: 9/5/2023, 6/14/2023, 4/12/2023

Attachments

Alarm Intervention Flowchart (1).docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	10/30/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	9/20/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/5/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/5/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/5/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

108.048 Midline Intravenous Catheter Placement

POLICY:

To provide guidelines for the proper insertion of midline catheters by trained Registered Nurses (~~RN's~~RNs). ~~RN's~~RNs trained in midline insertion shall show competency prior to independent practice. Competency shall be maintained by successful insertion of three midlines per calendar year.

DEFINITIONS:

Midline Catheter: A peripheral venous access devices inserted above the antecubital fossa and threaded into the basilic, median cubital, cephalic, or brachial vein. A midline terminates distal to the axilla. They are typically 8 to 10cm in length. Midline catheters DO NOT enter the central circulation. "Midline" is clearly marked on the hub of the catheter.

PROVISIONS:

I. Catheter Selection Criteria:

1. Early assessment in the admission process is recommended to determine the appropriate vascular access device.
2. A midline catheter may be selected when the duration of intravenous therapy will last no longer than 28 days.
3. A midline catheter can replace the need for multiple peripheral catheter insertions; however, it should not be regarded as a substitute for a central venous catheter.
    a. Some midline catheters are compatible with power injection for delivery of contrast media; compatibility must be verified before injecting contrast media.
    b. Midline catheters are ~~not~~**not** appropriate for therapies that include:

- Any intravenous therapy lasting >4 weeks.
- When the infusate is a vesicant (refer to VCMC's "Irritants and Vesicants Guide to Intravenous Administration").
- Infusions of extreme pH and osmolarity.
- Vasopressors.
- Total parenteral nutrition (TPN)/chemotherapy.
- >10% dextrose.

1. Midline catheters may be placed routinely for any physician-ordered peripheral IV infusion if the above criteria are met, and only after consultation with the covering physician to ensure appropriateness. A physician order is required for placement of a midline.

I. Contraindications:

1. Midline catheter placement should not occur on the ipsilateral side of a mastectomy with node resection, radial artery surgery, fistula or shunt.
2. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs.
    a. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of midline.
        - Primary physician will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.
        - Any discussions with physicians should be documented by the midline nurse.
    b. For patients with stage 4 or 5 chronic kidney disease, midline placement may occur only in the patient's dominant arm, preserving the non-dominant arm for future vascular access.
    c. For patients who already have a fistula or graft, midline placement may be considered only on the contralateral side, and only with the approval of the patient's primary nephrologist.
3. Midline catheters are contraindicated in patients with a history of thrombosis, hypercoagulability, or reduced venous flow in the extremities.
4. Midline catheters should not be placed in areas where a patient experiences pain on palpation, areas near open wounds, areas on an extremity with infection, veins that are compromised (for example, bruised, infiltrated, phlebitis, sclerosed, corded, or engorged), and areas of planned procedures.

PROCESS:

A. Check the physician's order

B. Gather equipment:

1. Powerglide full catheter kit.
2. Hair cover.
3. Ultrasound.
4. Needleless connector cap.
5. 3M™ Tegaderm™ CHG Chlorhexidine Gluconate I.V. Securement Dressing.

C. Powerglide full catheter kit to include:

1. Midline catheter.
2. Absorbent towel.
3. Surgical tape.
4. ChloraPrep™ solution.
5. Bedside sign with measuring tape.
6. Mask.

7. Adhesive dressing.
8. ~~Biopatch™ disk~~Biopatch™ disk.
    a. For patients with CHG allergy, use an antimicrobial silver disk such as the Silverlon® Livesaver™Ag.
9. 70% isopropyl alcohol wipe.
10. 4x4 gauze.
11. Extension set.
12. Tourniquet.
13. Sterile gloves.
14. Absorbent drape.
15. Fenestrated drape.
16. 48" probe cover, elastic bands, and conductive gel.
17. StatLock® stabilization device and skin prep pad.
18. 10~~ml~~ mL 0.9% sterile saline syringe.

PROCEDURE:

A. Confirm the patient's identity using at least two (2) patient identifiers.
B. Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs, including the reason for catheter insertion, device benefits, expected dwell time, care and maintenance of the device, and signs and symptoms of complications to report.
C. Don mask and a cap, perform hand hygiene.
D. Open kit to produce a sterile field.
E. Drop items onto sterile field that are not within the kit.
F. Place sterile drape under patient's arm.
G. Place tourniquet on patient.
H. Perform hand hygiene.
I. Don Sterile Gloves.
J. Prep insertion site with Chloraprep™ (30 seconds scrub, 2-minute dry).
K. Prime extension tubing while prep dries.
L. Place fenestrated drape over insertion site.
M. Insert ultrasound probe into sterile cover and place onto sterile drape.
N. Insert Powerglide needle:
    1. Be sure to check that that needle bevel is facing up and that the wire or catheter is not exposed.
    2. Insert needle into the vein under ultrasound guidance.
    3. Slowly advance the guide wire by stabilizing the device and pushing the top slide forward.
    4. Deploy the catheter by holding the rear piece of the device stationary then slowly and gently pushing

the side wings forward towards the vein. Be careful not to kink the catheter during this phase. Holding skin traction distal to the insertion site will help. If the catheter kinks it will not function properly and a new device will have to be used.

5. Remove the tourniquet.
6. Remove the device applicator and cap.
7. Screw the primed extension set and needleless connector onto the catheter hub and aspirate for for blood return.
8. Flush catheter with 10~~ml~~mL normal saline (NS).

O. Place stabilization device over hub of catheter.

~~Apply antimicrobial patch on the insertion site (i.e. Biopatch™). Align the slit of the patch with the midline catheter.~~

~~Cover the insertion site, Biopatch™, and stabilization device with sterile transparent dressing.~~

P. Apply CHG-impregnated antimicrobial patch (unless using a CHG Chlorhexidine Gluconate Gel Securement Dressing, which is an engineered stabilization device (ESD) plus antimicrobial (CHG) dressing).

1. If applying antimicrobial patch (i.e. Biopatch™) on insertion site , align slit of patch with midline catheter.

Q. Apply occlusive transparent dressing, completely covering insertion site, catheter wings, and separate ESD (if used).

R. Apply detachable closure piece (aka "pants") of the transparent dressing to seal the area where the catheter lumen exits the dressing.

S. Label dressing with date, time, and initials of primary person who performed the dressing change.

T. Place ~~an antimicrobial cap~~a disinfecting port protector on the needleless connector.

COMPLICATIONS:

A. The most common (but not usually significant) complication of midline catheter insertion is hematoma formation at the insertion site. Other complications include phlebitis, infiltration, infection, air, clot, or particle embolus, nerve damage, compromised distal circulation, fluid overload, inadvertent arterial insertion, and pain and stress from multiple attempts.

SPECIAL CONSIDERATIONS:

A. Monitor the insertion site regularly for signs of phlebitis (including pain, erythema, swelling, warmth, palpable cord, and purulence), infiltration and extravasation (including edema, leakage at the site, resistance with flushing, and coolness of the skin around the insertion site), and infection (including erythema, edema, induration, and drainage at the insertion site).

B. Communicate with all other staff members the need to avoid measuring blood pressure, administering injections, and performing venipuncture on the extremity with the midline catheter. Consider placing a sign at the patient's bed as a reminder to other staff members.

DOCUMENTATION:

A. Document in the electronic medical record:

1. Nursing note: include date, time, staff performing procedure and how patient tolerated procedure.
2. Nursing IV section: catheter type, IV site, laterality, and catheter gauge.

CONTINUING CARE:

A. Do not use Cathflo/Alteplase/Heparin for catheter clearance with this catheter.

B. Flush with 10 mL of 0.9% NS after each use and every 8 hours PRN.

C. Routine sterile dressing changes are every 7 days and PRN if soiled. Antimicrobial patch, PIV securement device, and transparent dressing must be changed.

D. Change needleless connectors with dressings.

REFERENCES:

- Bard Access Systems, Inc. (2014). "PowerGlide® Catheter" [Online]. Accessed July 2017 via the Web at http://www.bardaccess.com/assets/literature/0738242_PowerGlide_IFU_web.pdf
- Centers for Disease Control and Prevention. (2011). "Guidelines for the prevention of intravascular catheter-related infections" [Online]. Accessed July 2017 via the Web at http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf (Level I)
- Standard 61. Administration set change. Infusion therapy standards of practice. (2016). *Journal of Infusion Nursing, 39,* S133–S135

All revision dates: 8/21/2023, 3/14/2023

Attachments

CHG Gel Dressing by 3M.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/20/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/20/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	10/20/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.053 Contraband Guidelines for Acute Detoxification

Scope

Patients undergoing acute detoxification need to be in a safe environment. This policy outlines the procedure for any contraband for patients undergoing medical detoxification. Contraband items are not permitted for this population. Patients and visitors to either area will be subject to search and any contraband items will be collected upon patient discharge 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
- □utside 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 □T, 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.
- □ver 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.

□ther 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.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/25/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/25/2023
Policy □wner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/25/2023

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Next Review:	*3 years after approval*
Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
Policy Area:	*Intensive Care Unit*
References:	

ICU.03 Adult Intensive Care Unit Visitation

POLICY:

~~Because people are a major source of pathogenic organisms and the chance of infection increases wherever and whenever people congregate, traffic control and visitor regulation within the Intensive Care Unit (ICU) must be monitored and controlled. Maintenance of a calm and therapeutically conducive patient environment is also accomplished with controlled traffic patterns within the ICU. To provide each patient with privacy and confidentiality while minimizing exposure to pathogenic organisms and risk of infection~~

***ICU visitation that includes family member support of the critically ill patient is an evidence-based practice that has been shown to improve patient outcomes. While unrestricted access of critically ill patients to a chosen support person (eg, family member, friend, or trusted individual) is integral to the provision of emotional and social support 24 hours a day, according to the patient's preferences*, there are times that patient safety, the rights of others, and patient condition warrant a more restrictive guideline for visitation. This policy outlines the general guidelines for visitation in the adult intensive care unit.**

PROCEDURE:

A. The following guidelines shall be adhered to:

~~Visiting hours are limited to ten (10) minutes every hour on the hour, and limited to immediate family members/ significant others. Special arrangements may be made by speaking with the □N assigned to the patient.~~

1. All hospital staff shall enter the ICU only on official business.
2. No children under the age of 13 will be permitted to visit except under special circumstances.
3. Attorneys and investigators of any type are not permitted to interview patients unless approval by the attending physician has been given and patient is agreeable to said visitation.
4. □nly two (2) visitors are to be at the bedside at any one time or at the discretion of the nurse.
5. ~~Visiting should be limited at change of shift and during ICU rounds to ensure confidentiality of patient information.~~Family members are encouraged to participate in bedside shift report with the approval of the patient.
6. □nly staff involved in patient care and authorized visitors will have access to the ICU.

7. Public restrooms are available in the immediate waiting area~~.~~

   ~~Security guards are on duty 2□ hours a day and make regular rounds.~~

8. Visitors are to remain in designated waiting areas. This will allow emergency traffic access to hallways.

All revision dates: 9/22/2023, 1/1/2017, 12/1/2013, 6/1/2012, 12/1/2009, 5/1/2006, 5/1/200□, 6/1/2001, 5/1/1998, 2/1/1996, 1/1/1992, 3/1/1991, 11/1/1990, 12/1/1989, 11/1/1988, 12/1/1986, 12/1/198□, 12/1/1982

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/22/2023
Policy □wner	Kelly Johnson: Director, ICU/D□U/Telemetry	9/22/2023

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Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.23 Neonatal Evacuation Jacket

POLICY:

To provide the ~~NICU~~Neonatal Intensive Care Unit nurse with a guideline for safe patient transport out of the ~~NICU~~Neonatal Intensive Care Unit in case of emergency.

PROCEDURE:

In the event of a disaster requiring evacuation of ~~NICU~~Neonatal Intensive Care Unit patients to a safer area, the neonate will be transported safely out of the unit accompanied by a registered nurse~~, NNP~~ or physician. The evacuation jacket is to be used when it is not feasible to move isolettes or cribs to the safe area. □efer to the Disaster Evacuation Plan in the ~~VCMC~~Ventura County Medical Center Safety Manual.

EQUIPMENT

- Evacuation jacket
- Blankets for swaddling
- □arge (adult) bath blankets

GUIDELINES

A. Staff member obtains six bath blankets from the □B Department. The blankets are to be placed under the infants in the safe area.

B. Nurse dons evacuation jacket, opening in front. Cinch front of jacket with D-ring closure.

C. With two nurses working together, place one swaddled infant, ID band secure in each of four pockets, attempting to evenly balance the weight.

D. Nurse wearing the jacket carries a bath blanket and proceeds to safe area.

DOCUMENTATION

Nurse's notes □Document date, time, patient tolerance, unusual events occurring.

REFERENCES:

AWH□NN: N□EP 3rd edition, 2015

All revision dates: 10/12/2023, 7/1/2015, 2/1/2010, 8/1/200□, □/1/2003,

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Attachments

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Medical Staff Committees: Family Medicine, □B, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/12/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/12/2023
Policy □wner	Jennifer Ferrick: Director, Peds/PICU & NICU	10/12/2023

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Policy Area:	*Med/Surg/TELE*
References:	

MST.70 Admission to and Discharge from 3 Fainer South Tower (3FST)

POLICY:

To orient the 3 Fainer South Tower (3FST) patient to Ventura County Medical Center (VCMC) and the department specifically and to outline the admission criteria, discharge criteria, and process. 3FST is a licensed medical surgical unit providing care to patients undergoing detoxification services at a medical/ surgical level of care. The unit includes patient admissions for inpatient or □bservation status. All admissions to 3FST require physician orders to admit to VCMC. VCMC/SPH does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, religion, creed, ancestry, national origin, gender, sexual orientation or on the basis of disability, age or source of payment in admission to, participation in, or receipt of the services and benefits of any of its programs and activities, whether carried out by VCMC/ SPH or through a contractor or any other entity with whom VCMC/SPH arranges to carry out its programs and activities.

PROCEDURE:

Admission to 3 Fainer South Tower

I. **Criteria for Admission**
A patient is considered a candidate for 3FST admission if they are a patient experiencing acute or potentially acute substance withdrawal or intoxication requiring high level medical management by an Addiction Medicine specialist, in the absence of any additional acute condition requiring intensive treatment and/or exacerbation of a chronic condition requiring intensive treatment. This unit is not designed for critically ill patients.

A. Inclusion Criteria

1. Hemodynamically stable (Sp□2 □92, free of cardiac dysrhythmia)
2. No indication for continuous cardiac monitoring or pulse oximetry.
3. □equirement of high level Addiction Medicine specialty management to safely undergo detox, withdrawal or induction in an inpatient setting.

B. Exclusion Criteria

1. Hemodynamic instability and/or need for invasive hemodynamic monitoring or pressor agents.

2. Patients with active suicidal or homicidal ideation.
3. □espiratory compromise or failure requiring supplemental oxygen, noninvasive or invasive positive pressure ventilation and/or pulse oximetry Sp02 saturation monitoring. Patients requiring CPAP at night may be considered.
4. Cardiac arrhythmia or abnormality requiring telemetry for optimal monitoring (ex. SVT, Type II 2nd or 3rd degree AV block, dynamic ST segment changes on EKG)
5. □equirement of an insulin drip.
6. Severe alcohol withdrawal (with or without delirium tremens) requiring high doses of benzodiazepines.
7. Antepartum patients at 30 weeks of gestation or later.

C. Types of Admissions

1. Direct Admissions: Patients referred by the outside provider and accepted by the ~~admitting detox~~ unit specific attending physician□case management should be notified of all direct admissions.
2. Emergency Department Admissions: Patient assessed in the Emergency Department and referred and approved by the ~~admitting detox~~ unit specific physician for admission. The ~~detox~~ unit attending physician is responsible for the admitting orders to ~~the Med/Surg Detox Unit~~3FST.
3. □bservation Status: Patients admitted for monitoring and observation with discharge or an acute admission expected within 23 hours (or less than two midnights for Medicare).
4. Inpatient Status: Patients admitted for □2□hrs (or greater than two midnights for Medicare). If a patient previously admitted under observation status suffers condition worsening warranting a longer stay, the attending physician must change the order status to reflect an inpatient admission.

II. **Admission Process**

1. Standard procedures for admissions will be followed depending upon point of origin as Emergency or direct admit.
2. Inform patient of hospital and unit routine: visitor policy, location of bathrooms, location of common areas, use of privacy curtain, use of call light, telephone and TV, and procedure for medications brought in from home using Teach-back method to assure patient understanding. (Teach-back is a way to confirm what was explained to the patient or what they need to know in a manner that the patient understands. Patient understanding is confirmed when they explain it back to you).
3. Complete the nursing admission assessments, including medical history, social history, physical assessment, skin assessment, risk screens and fall assessment on the electronic health record (EH□) within 12 hours of admission.
4. Based on assessment findings, identify nursing problems and document in electronic health record (EH□). Develop nursing Plan of Care and Age Appropriate Care as soon as possible but no more than 12 hours after admission. The individualized patient care plan will be based upon nursing diagnosis standards and tailored by the registered nurse (□N) for each individual patient as necessary. The nursing care plan will address the patient's problem both actual and potential with appropriate goals/expected outcomes and nursing interventions to reach the stated goals. The care plan will be updated as often as necessary, but at least every 12 hours, and updated as appropriate to the individual patient's changing condition and/or needs.

5. Apply patient identification and allergy bands if not already applied. Apply Fall □isk wrist band and room sign if patient has been assessed at risk for falls.
6. □eview, verify and initiate orders in the EH□.
7. Inventory the patient's belongings and securing the patient valuables (including their medications). Witness patient signature on any consents or forms as needed.
8. Notify other departments as indicated (i.e., □aboratory, □adiology, etc.)

Discharge From 3 Fainer South Tower

I. **Criteria for Discharge from ~~the Med/Surg Detox Unit~~3FST:**
Patient is determined to be medically ready for discharge by the health care team lead by the attending physician. This discharge plan should include the most appropriate care setting for ongoing care after time of discharge based on the medical, functional, and social aspects of the patient's illness. In order for the patient to be deemed safe and ready for discharge to home or to a non-acute environment (rehabilitative, transitional or residential care), the provider must take into account a number of factors beyond the medical determinants. This decision may involve the patient, family, case manager, nurse, physician, physical and occupational therapist, social worker, and insurer.

II. ~~Discharge Considerations~~ **Discharge Considerations**

1. Patient cognitive status, activity level and functional status
2. The nature of the patient's disposition and suitability for the patient's conditions (eg, presence of stairways, cleanliness)
3. Availability of family or companion support
4. Ability to obtain medications and services
5. Availability of transportation from hospital to home and for follow-up visits
6. Availability of services in the community to assist the patient with ongoing care
7. Follow up appointments made at ADM clinic or/and other appropriate clinic. If unable to schedule directly due to weekend/holiday discharge, information should be provided to the patient & a message sent to the clinic to ensure coordination of said appointment on the next business day.
8. At the time of discharge home, patients, with help from family or other caregivers if available, should be able to:
    a. □btain and self-administer medications.
    b. Perform self-care activities.
    c. Eat an appropriate diet or otherwise manage nutritional needs.
    d. Follow up with designated providers.
9. Continued inpatient stay is generally needed until acceptable patient status for next level of care is achieved and A□□ of the following are present:
    a. Hemodynamic stability
    b. Cardiovascular status acceptable
    c. □espiratory status acceptable
    d. Stable chest findings

e. Airway status acceptable
f. Neurologic status acceptable
g. Pain and nausea absent or adequately managed
h. Abdominal status acceptable
i. Hepatic and biliary abnormalities absent or acceptable
j. □enal function acceptable
k. Urinary status acceptable
l. Temperature status acceptable
m. Vascular, soft tissue and wound status acceptable to next level of care
n. Infection status acceptable
o. Physiologic disorders absent or status acceptable
p. Electrolyte status acceptable
q. No blood loss or problem resolved
r. Behavioral health status acceptable
s. No chest tube (unless cleared by cardiothoracic surgeon)
t. Activity level appropriate for next level of care
u. Intake acceptable
v. No inpatient interventions needed
w. No central venous catheter (unless tunneled or peripheral intravascular central catheter)
x. Follow up with an outpatient Addiction Medicine or Transitions Clinic has been coordinated.

Documentation

I. Nursing Admission Assessment in EH□.
II. Nurses' notes in EH□.
III. Nursing Plan of Care in EH□.
IV. Initiate Educational Assessment in EH□.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees:	Tracy Chapman: VCMC - Med Staff	pending

Step Description	Approver	Date
Family Medicine & Medicine		
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/23/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/23/2023
Policy □wner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/23/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*OB Nursing*
References:	

OB.52 Preterm Labor

POLICY:

~~It is the goal to maintain the maternal-fetal unit as long as possible when patients present to a clinic or the Emergency Department with uterine contractions/cramping at less than 37 weeks gestation. Possible causes of such symptoms may be multiple births, infection, poor nutrition, and a history of high risk pregnancy.~~

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) have established criteria for the early detection and effective management of patients presenting with signs and symptoms of preterm labor in order to reduce the risk of preterm delivery.

PROCEDURE:

~~A. Preparation of equipment~~

~~1. Fetal monitor~~

~~2. Fetal fibronectin swab and vial.~~

~~3. Sterile speculum, light, glass slide, sterile swab, and nitrizine paper.~~

~~B. Preparation of patient~~

~~1. FFN must be done prior to vaginal exam or 12-2□ hours after SVE, and between 2□ to 3□ 6/7 weeks gestation.~~

~~2. Explanation to patient by physician or □N.~~

~~3. Patient placed in Semi-Fowler or side-lying position.~~

~~□. □uestion possibility of blood or fluid leakage per vagina.~~

~~5. Prepare for possible fetal fibronectin testing.~~

~~6. Prepare for vaginal or speculum exam by physician or vaginal exam by □N.~~

~~C. Method~~

~~1. Upon arrival to maternity unit, admit patient to Electronic Health □ecord (EH□) Monitoring System and place patient on external fetal monitor (see protocol for application), both toco transducer for uterine contraction and ultrasound device for FHT's.~~

~~2. Patient to be placed in Semi-Fowlers position or side-lying position.~~

~~3. View and report uterine contractions to the physician.~~

~~□. If unable to determine uterine contractions with fetal monitor □palpation of abdomen by nurse may be necessary.~~

~~5. Vaginal exam to be done by physician or nurse to determine effacement/dilation if patient:~~

~~a. Does not have ruptured membranes~~

~~b. Is not bleeding significantly~~

~~c. Fetal fibronectin specimen has been collected.~~

~~DOCUMENTATION~~

~~A. Initiate labor observation record.~~

~~B. Document palpation of uterine contractions on EH□ Monitor System.~~

~~C. Describe disposition and plan for follow up, if discharged, on EH□.~~

~~KEY POINTS~~

~~A. □bserve Universal Precautions~~

~~B. Monitor all patients for uterine contractions to determine frequency and duration.~~

~~C. Palpation of abdomen may be necessary.~~

~~D. Test for fetal fibronectin appropriately (see policy □B.36).~~

~~REFERENCES:~~

~~AWH□NN: Perinatal Nursing, □th edition, 2013.~~

Preterm labor is characterized by regular uterine contractions occurring at less than 37 weeks of gestation that result in cervical change.

Active management to prevent preterm delivery (e.g., tocolytics) is generally not indicated before neonatal viability.

These guidelines are designed for general application in order to provide a consistent and evidence-based approach. They do not replace the individual clinical judgment of medical professionals in treating individual patients.

I. Assessment of patients presenting for evaluation related to preterm labor include, but are not limited to:

A. History and □isk Factors

1. Signs and symptoms of uterine contractions, low back pain, abdominal cramping, pelvic pressure, premature rupture of membranes (□eference ***CPG.34 Preterm Premature Rupture of Membranes PPROM***)

2. Increased vaginal discharge, bloody show

3. History of preterm birth

□. Hypertensive disorder of pregnancy

5. Inadequate diabetes control

6. Dehydration

7. Infection or genital colonization in pregnancy
8. Uterine anomaly (e.g., fibroids, congenital, surgical)
9. Multiple gestation
10. □ligohydramnios, polyhydramnios
11. Shortened cervical length (□2.0 cm if no history of spontaneous preterm birth□□2.5 cm if history of preterm birth

B. Physical Findings

1. Uterine contractions that are palpable or evident on the external monitor
2. Cervical change
3. Engagement of fetal presenting part
4. □ Signs or symptoms of infection (e.g., maternal or fetal tachycardia, elevated maternal temperature, costovertebral angle □CVA□tenderness, lab results)
5. Placental hemorrhage
6. Fetal anomalies

II. General recommended initial testing and management may include, but not limited to:

A. Continuous electronic fetal heart rate monitoring and uterine contraction monitoring until labor is established or ruled out.

B. Fetal fibronectin- FFN must be done prior to vaginal exam or 12-2□ hours after Sterile Vaginal Exam (SVE), and between 2□ to 3□ $^{6}/_{7}$ weeks gestation.

C. Cervical length through transvaginal ultrasound

D. Magnesium Sulfate for neuro-protection

E. Antibiotics

F. Intravenous (IV) fluid therapy and hydration

G. Monitoring input and output

H. □aboratory testing (e.g., complete blood count)

I. Ultrasound (gestational age, fluid volume, placenta location and appearance, anatomy, position, etc.)

J. Urinalysis, urine culture, and sensitivity

K. Cervical culture (e.g., Group B Steptococcus)

L. □ Evaluation of chlamydia, gonorrhea, bacterial vaginosis, and trichomonas vaginalis

M. Neonatal Intensive Care Unit (NICU) consult

III. The use of tocolytics for patients presenting with symptoms of preterm labor should be limited to those patients who are likely to give birth and for which delay of □8 hours in delivery would provide benefit to the newborn.

A. Tocolytic therapy is contraindicated in cases where maternal and fetal risk of prolonging pregnancy is greater than the risks associated with preterm birth or use of the medications and may include, but not limited:

1. Intrauterine fetal demise
2. □ethal fetal anomaly
3. Severe preeclampsia or eclampsia
4. □. Non-reassuring fetal status
5. Maternal bleeding hemodynamic instability

B. Tocolytic therapy may include the following (doses can vary□not to exceed □8 hours)

1. Nifedipine I□ (immediate release)
   i. □oading dose: 10 mg orally (P□) x 1 dose□may repeat loading dose every (q) 20 minutes up to a total of four (□) doses.[6]
   ii. Then 10 or 20 mg P□ q□ to 6 hours.[5]
   iii. For automatic hold parameters, see policy 100.025 Medications: □rdering, Administration, and Documentation
2. Indomethacin[7]
   i. □oading dose: 50-100 mg P□ or rectally (P□) x 1 dose
   ii. Then 25 mg P□ q6 hours (not to exceed 200 mg/day)
3. Terbutaline 0.25mg subcutaneously every 20 minutes x 3 doses total

IV. Antenatal corticosteroids are recommended for pregnant women between 2□ and 3□ weeks of gestation who are at high risk for delivery.

A. The following should be considered for women who are at risk for delivery within 7 days:

1. A single course starting at 23 weeks gestation for pregnant women.
2. Women in late preterm gestation (3□0/7 weeks to 36 6/7 weeks) who have not previously received corticosteroids.
3. During previable gestation at family□s request related to decision regarding resuscitation
4. □. A single repeat dose for less than 3□ weeks gestation whose prior course of antenatal corticosteroids was administered more than 1□ day prior

B. Antenatal corticosteroid therapy options

a. Betamethasone 12 mg intramuscularly (IM) q12-2□ hours x 2 doses □□
b. Dexamethasone 6 mg IM q12 hours x □ doses.

Preterm Premature Rupture of Membranes (PPROM)

I. PP□□M □2□ weeks:

A. Patient should have consultation with Maternal Fetal Medicine and NICU for assistance with periviability counseling.

B. Counsel regarding risks and benefits of expectant management vs immediate delivery. Immediate delivery with comfort care measures is appropriate and should be offered as an option. Nurse should plan appropriately.

C. If patient chooses expectant management and there is no evidence of infection, outpatient management may be considered.

1. Instruct patient to monitor for evidence of bleeding, labor or infection for which immediate return to the hospital is strongly recommended.
2. Advise patient return to hospital as instructed by primary care provider for betamethasone and latency antibiotic administration.
3. Collect Group b Streptococcus (GBS) culture prior to discharge.

II. PP□□M 2□-3□weeks:

A. □ecommend admission until delivery

B. □equest NICU consultation

C. Administer antenatal corticosteroids (see dosing above)

D. If evidence of labor during betamethasone window, consider tocolysis:

1. Indomethacin
   i. See dosing above
   ii. Contra-indications: peptic ulcer disease, hemolytic disease, kidney or liver disease, ductal dependent fetal cardiac defects, and severe intrauterine growth retardation (IUG□).
2. Nifedipine I□ if indomethacin is contraindicated. See dosing above.
3. There is no evidence for tocolysis in PP□□M beyond betamethasone window.

E. Administer both antibiotics as ordered:

1. Azithromycin 1 gm P□ as a single dose
2. Ampicillin 2 gm IV q 6 hours for □8 hrs followed by Amoxicillin 500 mg P□ q 8 hours to complete a seven-day course. For penicillin allergies, consider Cefazolin IV/Cephalexin P□ for non-anaphylaxis cases and Vancomycin IV/Clindamycin P□ for anaphylaxis patients.

F. Magnesium Sulfate □gm IVPB as a single dose for neuro-protection. May consider re-dosing at time of delivery if □32 weeks and □2□hours since last dose.

G. Culture for group B Strep (GBS) on admission and treatment for positive GBS (or unknown GBS status) at the time of labor.

III. PP□□M 3□weeks or greater: Deliver

IV. For patients with preterm pregnancy who are admitted and not in active labor, please refer to policy □B.75 Admission Criteria and Standards of Care: Antepartum

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Advisory Council: □eadership, Advocacy and Consultation.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & □B	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/1/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/1/2023
Policy □wner	Kristina Swaim: Clinical Nurse Manager, □B	5/1/2023

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References:	

OB.69 Administration of Rho Immune Globulin for Prophylaxis

POLICY:

To reduce the incidence of D alloimmunization. Since the introduction of human □ho Immune Globulin in 1968, the incidence of D alloimmunization has had a marked decline. See also policy *MST.18 Blood and Blood Component Administration*.

PROCEDURE:

Candidates for □ho Immune Globulin (□hophylac, □hoGAM) administration are □h negative women, with negative antibody screens who have:

A. delivered □h positive babies
B. had ectopic pregnancies
C. had spontaneous or induced abortions
D. undergone chronic villus sampling (CVS)
E. undergone amniocentesis
F. undergone fetal manipulation such as external cephalic version (ECV) or an attempted ECV
G. undergone cordcentesis
H. experienced an antepartum hemorrhage
I. suffered antepartum trauma or fetal death
J. undergone any event which could have resulted in fetal-maternal hemorrhage.

DETERMINATION OF THE Rh

□n the initial prenatal visit all patients should be tested for AB□-□h type and have an antibody screening done. If the patient is determined to be □h negative and the antibody screen is negative, she should be retested at 28 weeks and if the screen remains negative will be given a prenatal dose of □ho Immune Globulin. If there has been no prenatal care, the AB□-□h and antibody testing should be done on admission to obstetrics.

If the antibody screen on any OB patient is positive, an antibody identification must be done

immediately and the attending physician notified STAT. Maternal antibodies can and do cross the placenta and can cause grave problems for the fetus.

At the time of delivery, cord blood will be obtained in the delivery room and sent to the Blood Bank for an HDN (Hemolytic Disease of the Newborn) work-up. The HDN work-up includes an AB□-□h typing and a Direct Coombs test. If the test shows the baby is □h positive, the mother is a candidate for the administration of another dose of □h Immune Globulin. If the baby is □h negative □ho Immune Globulin administration to the mother is unnecessary. (AABB Technical Manual, 2008)

GUIDELINES:

After a determination has been made that the baby is □h positive, the mother will be asked to sign an Informed Consent to □eceive □ho Immune Globulin Form (Attachment A). After the Consent is signed, the mother's blood will be drawn for a □ho Immune Globulin work-up (a physician's order for the □ab work and the □ho Immune Globulin injection must be written in the chart by the patient's physician, then ordered in the computer). The □ho Immune Globulin work-up, in addition to an AB□-□h type (to ensure that the mother is indeed □h negative) and screen involves an initial qualitative screening test for D positive fetal red blood cells. If this test is positive then a Kleihauer-Betke test will be run to determine how many additional doses of □ho Immune Globulin are needed. **Rho Immune Globulin must be administered within 72 hours of delivery.**

A. Administration of □ho Immune Globulin:

1. The □ho Immune Globulin will be picked up from the □aboratory by a nursing staff member or Medical Staff member who will verify, along with a Clinical □aboratory Scientist, the name of the patient, the patient chart number, the □ho Immune Globulin lot number and the expiration date.
2. Two licensed nurses (one must be an □N) will again verify this information at the patient's bedside as well as the signed patient consent form and the attending physician's order. All of the checks will be documented on the Unit Issue Form (UIF), which accompanies the □ho Immune Globulin.
3. □bserve Standard Precautions when administering the □ho Immune Globulin.
4. The □ho Immune Globulin is administered by ***intramuscular*** injection.
5. The yellow copy of UIF is placed in the patient's chart and the pink copy of the UIF is returned to the Blood Bank.
6. ***Do not*** administer □ho Immune Globulin intravenously.
7. ***Do not administer Rho Immune Globulin to the baby.***
8. Give the patient the □ho Immune Globulin card on which you have entered our hospital name and date of injection.

DOCUMENTATION

Document injection time, site and lot number on MA□. □ecords patient's response in Nurses Notes, as appropriate.

All revision dates: 10/1□/2020, 8/1/2010, 5/1/200□

Attachments

A: Consent to □eceive □ho Immune Globulin Form

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & □B	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	8/2□/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/2□/2023
Policy □wner	Kristina Swaim: Clinical Nurse Manager, □B	8/2□/2023

VENTURA COUNTY
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References:	

PH.24 Clinic Medications and Samples

POLICY:

This policy addresses medication management in the Ambulatory Care clinics and its affiliated clinics. The following aspects of medication management are described:

- Formulary Control of Clinic Medications
- Procurement of Clinic Medications
- Controlled Substances
- Medication Samples
- Clinic Medication Storage
- □emoval of □utdated Clinic Medications
- Clinic Medication Drug □ecalls
- Disposal of Patient Medications at Clinics

PROCEDURE:

Formulary Control of Clinic Medications

All medications allowed in the clinics, with the exception of medication samples, are approved by the Pharmacy and Therapeutics (P&T) Committee or its representatives. This policy is intended to control medication inventory and assist in the drug recall process.

Drugs in the following categories are permitted in the clinics.

- Formulary medications
- Approved non-formulary medications
- Medication samples
- Controlled substances
- Investigational drugs
- Patient Assistance Program medications
- Patient's own medications

Definitions:

Formulary medications: Medications approved for use by the P&T Committee.
Approved non-formulary medications: Medications not on the VCMC drug formulary, which have been

approved by the P&T Committee for use in the clinics.
Controlled substances: Medications identified as having potential for abuse. These medications are categorized by the DEA as schedule II through V.
Investigational drugs: New medications that have not yet been approved by the FDA or approved drugs that have not yet been approved for a new use, and are in the process of being tested for safety and efficacy.
Medication Samples: Medications provided at no cost by pharmaceutical companies.
Patient's own medication: Medication labeled and dispensed by a pharmacy or provided by a pharmaceutical manufacturer for a specific client which are stored at the clinic.

Formulary Medications:

The P&T Committee has the responsibility of developing and maintaining the drug formulary ~~(see Pharmacy policy PH.35, *Drug Formulary Policy Statement*).~~ □equests for revisions or additions to the drug formulary may be submitted to the P&T for review using a formulary addition request form. ~~(~~See Pharmacy policy ~~7170.37, *Formulary Addition Requests*).~~PH.35, Drug Formulary

Approved Non-formulary Medications:

~~Approval for the use of non-formulary drugs must be obtained from the P&T Committee. The P&T Committee will review requests for addition to the approved non-formulary clinic medication lists.~~

For non-formulary medication approval, see policy PH.35 Drug Formulary.

Controlled Substances:

Schedule II controlled substances shall not be used in the clinics.

Investigational Drugs:

Investigational drugs must ~~have been~~be approved by the Institutional □eview Board (I□B) and the P&T Committee prior to use in the clinics. ~~(~~See Pharmacy ~~Policy PH~~Policy PH.□0 Investigational Drug Use.~~□0 Investigational Drug Use).~~

Procurement of Clinic Medications

A. Clinic staff shall request medications from the Pharmacy department through the requisition application in the electronic health record (EH□) or paper requisition if the EH□ is unavailable.
B. The Pharmacy department shall order all clinic medications at 3□0B discounted prices for clinics registered as 3□0B covered entities.
    1. Exceptions are vaccines and IV solutions.
    2. Clinics that are not registered as a 3□0B covered entity, are not eligible ~~to~~and shall not receive 3□0B discounted ~~medications and shall not receive 3□0B discounted~~ medications. These clinics shall receive group purchasing organization contracted medications.
C. The Pharmacy department will submit an order for the requested medications on the appropriate clinic wholesaler account. Medications may be shipped directly to the clinics from the drug wholesaler~~, or they may be~~.
D. For medications shipped directly to the clinics:

1. ~~Clinic~~□icensed staff shall receive the medications from the drug wholesaler or manufacturer.
2. ~~Clinic~~□icensed staff shall reconcile the packing slip/invoice with the products received immediately after delivery.
    a. ~~Staff~~□icensed staff shall circle the shipped quantity on the packing slip for each line item upon confirming the actual count of the products delivered.
    b. Upon completion of reconciliation, the packing slip/invoice shall be signed and dated by the staff member performing this function.
    c. Any discrepancies shall be reported to the Pharmacy immediately.
3. ~~Clinic~~□icensed staff shall put away the medications in the appropriate storage area(s).
□. A copy of the packing slip/invoice shall be faxed to the Pharmacy department. The faxed packing slip/invoice shall be kept by Pharmacy for three years.
5. A copy of the packing slip/invoice shall be kept on site at the clinic for three years.
6. If a controlled substance is received, the controlled substance shall be logged onto the Controlled Substance Inventory □og (Attachment A). See the section in this policy titled Controlled Substances.
7. Any medications that need to be returned shall be coordinated with the Pharmacy and the drug wholesaler or manufacturer.

E. For medications shipped to VCMC Pharmacy:
1. The Pharmacy department will receive the medications from the drug wholesaler or manufacturer. The medications shall be packaged according to the clinic requisition for medications.
2. A pharmacist shall ~~double-~~check the clinic medications and initial the clinic requisition sheet ~~upon completion of the double-check~~.
3. A delivery invoice shall be packaged with the clinic medications.
□. The medications shall be delivered to the clinics by courier.
5. Upon receipt of the medications at the clinics, the ~~receiving nurse~~licensed staff shall verify that the contents of the medication shipment was accurately packaged.
6. The receiving ~~nurse~~licensed staff shall mark the lot number and expiration on the delivery invoice for each medication.
7. The receiving ~~nurse~~licensed staff shall sign off on the delivery invoice to confirm receipt of medications.
8. A copy of the delivery invoice shall be faxed to the Pharmacy.
9. The delivery invoice shall be kept on site at the clinic for three years.
10. The faxed copy of the delivery invoice shall be kept by Pharmacy for three years.
11. □efrigerated medications and vaccines shall be transported according to ~~PH~~PH.116 Transporting □efrigerated Medications and Vaccines.~~116 Transporting □efrigerated Medications and Vaccines.~~
12. If a controlled substance is received, the controlled substance shall be logged onto the Controlled Substance Inventory □og (Attachment A). See the section in this policy titled Controlled Substances.

F. Patients Assistance Program (PAP) Medications
1. VCMC Pharmacy will deliver patient medications ready for dispensation to the Clinic.

2. Medications received are accepted by licensed clinic staff.
3. The patient shall be contacted to pick up medications at the Clinic with transport storage procedures addressed.
4. Licensed clinic staff shall review progress notes in patient's EHR to ensure medications are accurately labeled for the correct patient.
5. Licensed clinic staff shall document the following information in the progress note in the EHR
    a. Name of Medication and strength
    b. Lot number, Expiration date, Manufacturer and national drug code (NDC) number
    c. Route of administration, injection site if appropriate
    d. Frequency
    e. Indication or reason for use if applicable
    f. Patient education provided, questions or concerns addressed
6. Patient at time of pickup patient signs PAP-sheet supplied by PAP Coordinator.
7. The signed PAP documents are email/faxed to the PAP Coordinator.
8. Final documentation in progress note includes date patient picked up medications, education provided, and that the Provider was notified.
9. All medications within the Clinic are securely stored per manufacturer's recommendations and are inspected for outdates monthly.
10. All expired medications shall be pulled from inventory immediately.

G. Patients Own Medications from Outpatient Pharmacies

1. Licensed staff may accept medications brought in by the patient dispensed from outpatient pharmacies for administration by licensed clinic staff or community outreach programs. This must be verified and logged into the Patient's Own Medication Inventory Log (Attachment B).
2. Patients may bring medications to the clinic for the following reasons:
    a. Patients may not be able to self-administer.
    b. Patients may not have the capacity to properly store the medications per manufacturer's recommendations.
    c. Patients may require community-based supervision for compliance with self-administered medications due to homelessness or mental health barriers.
3. All medications should be properly labeled per state laws and regulations by the furnishing outpatient pharmacy.
4. All medications shall be stored properly in a secure location within the clinic according to the manufacturer's recommendations.
5. Medications received shall be documented by licensed staff using the Patient's Own Medication Inventory Log (attachment B) and stored with the medication.
6. Clinic staff shall notify the patient and schedule a visit for medication administration.
7. Provider enter medication orders through EHR to be administered as an "in office medication" An administration fee may be charged. There is no additional cost for the medication.

8. Medication is prepped by clinic staff (□N, □VN, MA) per manufacturer□s recommendation.
9. Medication is administered following the □7-rights□ right drug, right patient, right dose, right time, right route, right indication, and right documentation.
10. A Clinic note shall be placed on the patient□s EH□ documenting:
    a. Name of Medication and strength
    b. Date of administration
    c. □ot number, Expiration date, Manufacturer and NDC number
    d. □oute of administration, injection site if appropriate
    e. Frequency
    f. Indication or reason for use
    g. Patient education provided, questions or concerns addressed
11. Any unopened medication shall be returned to the patient with a signature of receipt of such medications on the □Patient□s □wn Medication Inventory □og□if patient is able to use the medication on their own.
12. All medications within the clinic are inspected for outdates monthly.
13. All expired medications shall be pulled from inventory immediately.

Investigational Medications: shall be obtained through individual protocol guidelines. As medication is received, log it into inventory and send a copy of the log to the Pharmacy.

~~**Patient's Own Medications:** as patient's own medications are accepted they must be verified and logged into the Patient's □wn Medication Inventory □og (Attachment B).~~

Controlled Substances

Clinics may use Schedule III through V controlled substances that have been approved by the P&T Committee for use in clinics. Schedule II controlled substances shall not be used in the clinic setting. All activity involving controlled substances shall be recorded on a Controlled Substance Inventory □og (Attachment A). Controlled substances shall be managed according to the following procedure.

Exception: Adult Hematology & Oncology clinic and Pediatric Hematology-Oncology clinic may use any Schedule II through V controlled substance ~~*stored in the automated dispensing cabinet*~~*with a valid prescription. See policy PH.88 Controlled Substances*

Controlled substances approved for use in clinics:
Testosterone cypionate 200 mg/m□ injection solution

A. Each controlled substance shall have its own Controlled Substance Inventory □og.
B. The clinic shall document receipt of the controlled substance on a Controlled Substance Inventory □og upon receiving a controlled substance.
    1. Document "□eceived" in the Action column.
C. A daily count shall be performed and documented on the Controlled Substance Inventory □og.
    1. Document "Inventory" in the Action column.
    2. Notify the Pharmacy immediately upon discovery of any discrepancies.

D. Each dose must be logged out of the Controlled Substance Inventory □og prior to administration of the controlled substance.

1. Document the patient's name and medical record number (M□N) in the Action column.

E. Any waste shall be documented on the Controlled Substance Inventory □og and co-signed by licensed personnel.

1. Document "Waste" in the Action column.

F. Controlled Substance Inventory □ogs shall be kept for ~~three~~seven (~~3~~7) years.

Medication and Non-Medication FDA Approved Product Samples

A. ~~Medication samples shall be approved by each clinic medical director.~~Medication and non-medication FDA approved product samples shall be approved by each clinic medical director. The word Samples in this section of the policy include medication and non-medication.

1. Few examples of non-medication FDA approved product include, but not limited to, continuous glucose monitor and wound skin graft material.

B. A list of ~~medication~~ samples stored at each clinic shall be maintained by the clinic.

C. ~~Medication samples~~Samples shall be stored well-organized ~~and in date~~ in a secure location and must not be expired.

D. □nly providers are authorized to sign for the receipt of ~~sample medications~~samples from the pharmaceutical/manufacturering company representative. The provider who signed for the ~~sample medications~~samples assumes full responsibility for the ~~sample medications, including~~ samples. Clinics will not accept samples of controlled substances.

E. Samples shall be logged on the Medication ~~samples shall be logged on the~~ and Non-Medication FDA Approved Product Sample Inventory □og (Attachment C) upon receipt of the ~~medication~~ samples.

1. The following shall be documented on the Medication and Non-Medication FDA Approved Product Sample Inventory □og:
    a. Clinic name
    b. Date received
    c. ~~Drug~~Sample name
    d. Dosage strength if applicable
    e. □ot ~~#~~number
    f. Expiration date
    g. □uantity received

F. The provider may dispense ~~medication~~or apply samples to the patient.

1. The ~~medication~~ sample shall be provided to the patient in the package provided by the manufacturer~~.~~.
2. No charge shall be made to the patient.
3. Education on the ~~medication~~sample shall be offered to the patient.

□. An appropriate record documenting dispensing activity and patient education shall be recorded in the patient's chart.

5. Dispensed medication samples are recommended to be labeled with the following:
    a. Name of the patient
    b. Date dispensed
    c. Name of the prescriber
    d. Directions for use
6. All dispensing activity shall be documented on the Medication and Non-Medication FDA Approved Product Sample Inventory □og.
7. Medication and Non-Medication FDA Approved Product Sample Inventory □og shall be kept for three (3) years.

G. Pharmaceutical representatives shall comply with Administrative policy ~~107~~107.060 The Promotion of Medication by Pharmaceutical □epresentatives.~~060 *The Promotion of Medication by Pharmaceutical Representatives.*~~

Clinic Medication Storage

A. All medication shall be stored properly according to manufacturer's recommendations.
B. All medications shall be stored in a secure location under direct supervision of clinic personnel.
C. For clinics registered as a 3□0B covered entity, all medications procured from the Pharmacy shall be assumed to have been purchased at 3□0B discounted prices.
    1. Exceptions are vaccines and IV solutions.
D. Controlled substances must be secured under double lock and key.
E. Flammable medications shall be stored in accordance with fire and safety regulations.
F. 3□0B purchased medications shall be stored separately from non-3□0B purchased medications.
    1. Non-3□0B purchased medications include:
        a. Vaccines
        b. IV solutions
        c. Medication samples
        d. Patient Assistance Program medications
G. Vaccine for Children (VFC) supplies shall be stored separately from purchased vaccine supplies.
H. □ral, parenteral, and topical medications should be stored separately.
I. Expired medications shall be pulled from inventory immediately.

Removal of ~~Outdated~~Expired Clinic Medications

A. Medications which have reached their expiration date are considered expired.
    1. For expiration dates that do not state the day on which the medication is to expire, the last day of the

month will be used as the expiration date.

B. □eview of expiration date shall be conducted by clinic staff monthly.

C. Any medication that has expired or will be expiring in the current month or following month shall be removed from inventory. For example, in the month of February, any medication expiring in February, the current month, or March, the following month, shall be removed from inventory.

1. Exceptions include high-cost medications (□ □100/unit) such as vaccines (procured from VFC, Public Health, or VCMC) and intrauterine devices. These medications may be stored until its final expiration date.

2. Pharmacist performing monthly inspection of the clinic will notify clinic staff on site and document the following on inspection form regarding soon to expire high-cost medication.

   a. Name of the high-cost medication to be expiring in the current month.

   b. □uantity of each medication.

   c. Actual expiration date of medication.

   d. Name of the individual the information was reported to.

D. In the event an outdated medication is found by clinic staff, the drug shall be removed from stock and sent back to the Pharmacy by courier.

E. The Pharmacy shall dispose of the outdated medications.

Clinic Medication Drug Recalls

The Pharmacy Department shall notify the clinics of any medication recalls. Medications recalled by the manufacturer shall be removed from the clinics immediately.

A. The Pharmacy receives recall notifications.

B. The Pharmacy shall forward recall notifications to the designated clinic staff member and clinic manager including the Urgent □ecall Notification found in PH.20 □ecall/Discontinued Medication Attachment.

C. The designated clinic staff member shall remove the drug from the clinic medication inventory.

D. The recalled medication shall be returned to the Pharmacy by courier unless otherwise instructed.

E. □nce recalled medications are returned to the Pharmacy, the medications shall be handled as specified in ~~7170~~PH.20 □ecall/Discontinued Medications.~~20 □ecall/Discontinued Medications.~~

F. The removal of the recalled medication shall be documented on the recall notification system.

Disposal of Patient Medications at Clinics

As a general rule, the Ventura County Health Care Agency (VCHCA) clinics should not accept returned or unwanted prescription medications from patients. The patient should be directed to the following websites for instructions on the safe disposal of prescription medications:

http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm
http://www.deadiversion.usdoj.gov/drug□disposal/index.html

In certain circumstances, the physician or nurse may dispose of the patient's prescription medication by following the procedures outlined below.

~~A. Non-Controlled substances may be taken from the patient and disposed of using pharmaceutical waste~~

~~container.~~

~~B. Controlled substances should not be accepted from the patient for disposal. Circumstances that may require the medication be taken from the patient or guardian include: medication has expired, the drug is no longer needed or the patient has expired.~~

~~a. A note from the patient or patient's family documenting the medication is no longer needed and are surrendering the medication voluntarily to the physician or nurse.~~

~~b. Two licensed healthcare professionals inventory each medication and document the patient's name, the drug name, strength and quantity.~~

~~c. The controlled substance must be double locked in an area that is secure to prevent drug theft or diversion.~~

~~d. □eturn the medication with the inventory to the VCMC Pharmacy Department for proper disposal.~~

A. Non-Controlled substances may be taken from the patient and disposed of using pharmaceutical waste container.

B. Controlled substances (class II-V) shall not be accepted from the patient for disposal.

1. Complete list of Drug Enforcement Administration (DEA) defined controlled substance can be found at https://www.deadiversion.usdoj.gov/schedules/

All revision dates: 9/1/2023, 11/13/2019, 5/15/2019, □/1/2016, □/1/2015, 11/1/201□, 2/1/2008, 6/1/1995

Attachments

A: Controlled Substance Inventory □og
B: Patient□s □wn Medication Inventory □og
C: Medication Sample Inventory □og

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/31/2023
Ambulatory Care Administration	□izeth Barretto: Chief □perating □fficer, Ambulatory Care	10/18/2023
Ambulatory Care Administration	Allison Blaze: Chief Medical □fficer, Ambulatory Care	10/11/2023
Ambulatory Care Administration	Martin Hahn: □egional Administrative Director, Ambulatory Care □NP□	10/9/2023

Step Description	Approver	Date
Ambulatory Care Administration	Theresa Cho: Chief Executive □fficer, Ambulatory Care	9/5/2023
Ambulatory Care Administration	Navid Papehn: □egional Administrative Director, Ambulatory Care	9/1/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/1/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

PH.40.05 Investigational Drugs – Patient's Own Medications

Policy:

Patients admitted to Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) taking investigational drugs approved by an Institutional □eview Board (I□B) from another institution may continue to take these investigational drugs as long as the necessary information from the sponsoring institution is provided to the appropriate staff of VCMC or SPH.

Procedure:

A. An order to continue the investigational drug(s) from home is prescribed by the provider.

B. The pharmacist shall contact the Director of Pharmacy or designee.

C. The Director of Pharmacy or designees shall contact the I□B chairperson or designee for approval for the use of the investigational drug(s).

D. □nce approved, the following information must be obtained prior to the dispensing of the investigational drug(s).

   1. A copy of the patient's signed informed consent for the investigational drug study.
   2. A copy of the drug protocol which addresses pharmacology, dosage, route of administration, adverse effects and toxicity.
   3. Copies of both the patient's signed consent and protocol shall be maintained in the pharmacy and in the patient's medical record.
   □. Phone number of study coordinator in the event there is a need to un-blind the study drug.
   5. If the investigational drug protocol is unobtainable (i.e., due to a weekend or holiday), it will be the decision of the provider whether to continue or hold the investigational drug until the drug protocol is available. The provider shall document this decision in the electronic health record.

E. The pharmacy shall receive the investigational drug(s) from the patient.

F. The pharmacist shall develop a brief summary of the investigational drug for educational purposes for the nurses and health care professionals taking care of the patient.

G. The investigational drug shall be dispensed by the pharmacy. Inventory received and dispensed shall be logged on a Controlled Substance Perpetual Inventory form.

H. Upon discharge, the remainder of the investigational drug shall be returned to the patient, with provider approval.

I. A formal report shall be presented to the next P&T Committee for notification.

All revision dates: 5/15/2019, 7/1/200□

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/9/2023
Institutional □eview Board	Sara Pendleton: Medication Safety □fficer	10/9/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/27/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

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 US Food and Drug Administration (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 egulations 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 "WANING" 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 (CP□E), the prescriber will receive an alert for the boxed warning, for the medications listed on the current year Boxed Warning Medication Guidelines - High Priority □ist~~

~~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. □esults of the monitoring shall be documented by the physician in the patient's Electronic Health □ecord (EH□), 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 □icensed 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 □icensed 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 □icensed Practitioners and Clinicians to access drug information include boxed warning recommendations.

All revision dates: 10/10/2023, 9/10/2020, 8/7/2018, 12/1/2016, 1/1/201□

Attachments

No Attachments

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	9/5/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/5/2023
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Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Nursing*
References:	

Central Venous Access Device (CVAD or "Central Line") Care and Maintenance for Adult Patients

PURPOSE:

This policy is intended to promote care standardization, catheter management, and prevention of Central Venous Access Device (CVAD) related complications in order to optimize patient outcomes.

POLICY:

To provide guidelines to facilitate standardization of practice for CVAD catheters. This policy does not apply to catheters being used for hemodialysis.

SCOPE:

This policy applies to all Registered Nurses (RNs) at Ventura County Medical Center (VCMC) involved in the care and maintenance of CVADs who have successfully completed and demonstrated competency in CVAD care, maintenance, and patient/caregiver education and training across the care continuum.

PROVISIONS/POLICY STATEMENTS:

1. Line Necessity must be evaluated daily for inpatients and at each visit in ambulatory settings. Discontinue CVAD when no longer indicated.

2. When a patient is admitted with a CVAD and tip placement documentation is unavailable or unreliable, placement will be verified with a chest X-ray prior to use.

3. Change dressing upon admission to assess the site for signs and symptoms of infection.

4. When adherence to aseptic technique during CVAD placement cannot be ensured, replace the catheter as soon as patient condition allows.

5. Prior to any CVAD care and maintenance procedure, prepare by:

A. Performing hand hygiene.

B. Gathering all necessary CVAD care and maintenance equipment/supplies.

C. Prepare education materials for the patient/caregiver to reinforce teaching as needed.

8. A transient phlebitis may occur in the first 48 hours after insertion. Elevating the extremity and applying warm compresses four (4) times a day may alleviate the symptoms. Consult with provider for assessment and treatment plan if symptom persists.

9. Assess the site for redness, swelling, tenderness, bleeding and/or drainage with initial shift assessment and as needed.

10. If the CVAD comes with a clamp, always clamp the catheter when not in use, and every time the needleless connector is changed to prevent air emboli and bleeding.

11. Showering is permitted with precautions. Apply impermeable cover to reduce the likelihood of introducing organisms into the catheter.

12. Refer to the Ventura County Medical Center pediatric specific CVAD policies for guidelines in the care and maintenance of pediatric/neonatal CVADs.

13. All patients with central access shall receive a daily full-body chlorhexidine gluconate (CHG) bath.

14. Disinfecting port protector caps (i.e. Curos™) shall be applied to all needleless connectors and I.V. tubing ports when not in use.

A. After the removal of a disinfecting port protector and prior to access, the hub of the needleless connector or tubing port must be scrubbed with an alcohol or CHG pad.

PROCEDURE(S):

DRESSING CHANGE

Essential Elements

1. Strict sterile technique shall be used with every dressing change.

2. Occlusive transparent dressings shall be changed every seven (7) days, along with antimicrobial patch, and securement device (i.e. Statlock™).

A. Dressings shall also be changed immediately at any time when wet, loosened/non-occlusive, or soiled.

B. The dressing shall be changed immediately if there is site tenderness, signs/symptoms of infection, or loss of dressing integrity; allowing the opportunity to closely assess, cleanse, and disinfect site. Notify the provider any time this occurs and document.

C. Replace dressings used on CVAD sites at least every seven (7) days for transparent dressings, except in those patients for whom the risk for dislodging the catheter may outweigh the benefit of changing the dressing.

3. Gauze dressings shall be changed at least every 2 days.

A. When gauze is placed under a transparent dressing, it is then considered to be a gauze dressing and

changed every two days.

4. Change needleless connectors with dressings every 7 days.

3. Assess the catheter for patency and breaks. To check for patency, aspirate until brisk blood return is obtained, followed by injecting 20 mL normal saline, noting any resistance or sluggish of flow.

4. Do not use any rolled bandages, with or without elastic properties, to secure any type of VAD.

5. Routine sterile dressing changes are every 7 days and as needed (PRN) if soiled. Antimicrobial patch, securement device (i.e. Statlock™), and transparent dressing must be changed.

A. When gauze is placed under a transparent dressing, it is considered to be a gauze dressing and is changed every two (2) days.

B. If an antimicrobial patch (such as a chlorhexidine gluconate (CHG) impregnated disk) is not applied, the first dressing change shall be performed within two (2) days (or sooner if dressing becomes compromised).

6. Protect VAD when patient is showering or bathing by covering the catheter site with a clear plastic wrap or device designed for this purpose. Cover the connections and protect hub connections from water contamination.

7. For Peripherally Inserted Central Catheters (PICCs), measure the length of the catheter remaining outside the body (external length) and compare to the initial external length assessment as documented in the Electronic Medical Record (EMR).

A. If the external length has changed, notify the Vascular Access specialist and/or provider. If necessary, obtain an order for a chest X-ray to confirm tip placement prior to further use.

8. Measure, document, and trend arm circumference for PICCs if deep vein thrombosis (DVT) is suspected. Take measurement at the location of catheter insertion. Compare to baseline measurement to detect possible catheter-associated venous thrombosis; a 3-cm increase in arm circumference and edema are associated with upper-arm DVT.

Equipment

1. CVAD dressing change kit including:

A. Transparent semipermeable membrane (TSM) dressing.

B. Adhesive tape remover.

C. Antimicrobial patch.

- For patients with CHG allergy, use an antimicrobial silver disk such as the Silverlon® Livesaver™Ag.

D. Sterile drape.

E. CHG swab stick applicators.

F. Iodine swab sticks (for use with patients allergic to CHG).

G. Clean gloves.

H. Sterile gloves.

I. Face masks (for self and patient).

J. Tape measure.

K. Skin prep swabs.

L. Needleless connector(s) (one for each lumen).

M. Disinfecting port protector cap(s).

N. Engineered Stabilization Device (ESD, e.g. Statlock™) to hold CVAD in place.

- ESD may be incorporated into the dressing itself (e.g. 3M™ Tegaderm™ CHG Chlorhexidine Gluconate I.V. Securement Dressing).

O. Normal Saline in 10 mL syringes or larger.

Steps in Dressing Change Procedure

1. Perform patient identification using two (2) patient identifiers (i.e. name and date of birth).

2. Explain procedure to patient/caregiver.

3. Perform hand hygiene before direct contact with the patient and subsequently as required throughout the procedural steps.

A. Hand hygiene should be performed before touching a patient, before a procedure, after a procedure or body fluid exposure risk, after touching a patient, or after touching a patient's surroundings, following Wold Health Organization (WHO) guidelines.

4. Apply face mask to patient.

5. RN shall don clean gloves and mask.

6. Use adhesive remover or alcohol swabs to loosen dressing and ESD. Remove the old dressing by gently lifting it from the skin beginning at the distal end of the catheter toward the insertion site and being careful not to dislodge or pull on the catheter. Discard the old dressing and ESD.

7. Assess the insertion site and track the vein for redness, bleeding, tenderness, edema, and drainage.

8. Remove gloves and perform hand hygiene.

9. Set up central line dressing change kit as a sterile field and don sterile gloves.

10. Scrub site with CHG swab using friction in a back and forth motion 3-4 inches in all directions around insertion site (or area appropriate for patient size) for 30 seconds. Allow solution to dry completely without fanning, wiping, or blowing.

A. If CHG is contraindicated, clean the site using three povidone iodine swabs, using a circular motion from the insertion site outward. The iodine must remain on skin for at least three (3) minutes (or until completely dry). Do not wipe off, blow, or fan site to speed drying.

11. Apply skin prep agent (adhesive or barrier film). Do not apply this solution directly under the chlorhexidine-impregnated sponge or gel component of the dressing.

12. Apply CHG-impregnated antimicrobial patch (unless using a CHG Chlorhexidine Gluconate Gel Securement Dressing, which is an engineered stabilization device (ESD) plus antimicrobial (CHG) dressing).

A. If applying antimicrobial patch (i.e. Biopatch™) on insertion site , align slit of patch with CVAD catheter.

13. Apply new securement device/product.

A. Non-tunneled lines must be stabilized with an ESD or sutured. The ESD may be integrated with the

transparent dressing or may be a separate item if an integrated product is inappropriate for the patient.

14. Apply occlusive transparent dressing, completely covering insertion site, catheter wings, and separate ESD (if used).

15. Apply detachable closure piece (aka "pants") of the transparent dressing to seal the area where the catheter lumen(s) exit the dressing.

16. Label dressing with date, time, and initials of primary person who performed the dressing change.

17. Document dressing change in Electronic Medical Record (EMR).

CVAD FLUSHING

Essential Elements

1. Venous access devices (VADs) must be flushed and aspirated for a blood return prior to each infusion to ensure catheter function and prevent complications.

A. If resistance is met and/or no blood return noted, take further steps (e.g. checking for closed clamps or kinked sets, removing dressing, etc.) to locate an external cause of the obstruction. Internal causes may require diagnostic tests, including, but not limited to, a chest radiograph to confirm tip location and mechanical causes (e.g. pinch-off syndrome), color duplex ultrasound, or fluoroscopy to identify thrombotic causes.

2. VADs are flushed after each infusion to clear the infused medication from the catheter lumen, thereby reducing the risk of contact between incompatible medications.

A. Use a minimum volume equal to twice the internal volume of the catheter system (e.g., catheter plus add-on device).

3. Flush the VAD lumen with preservative-free 0.9% sodium chloride following the administration of an IV push medication at the same rate of injection as the medication. Use an amount of flush solution to adequately clear the medication from the lumen of the administration set and VAD.

4. Use a pulsatile flushing technique. In-vitro studies have shown that 10 short boluses of 1 mL solution interrupted by brief pauses may be more effective at removing solid deposits (e.g. fibrin, drug precipitate, intraluminal bacteria) compared to continuous low-flow techniques.

5. Each CVAD lumen is locked after completion of the final flush to decrease the risk of intraluminal occlusion.

6. Only 10 mL or larger syringes shall be used for all central venous catheter flushes.

5. Do not use anticoagulants routinely for flushing.

6. If CVAD is clotted, notify provider and follow VCMC policy Viewing AC.19 Treatment of Occluded Central Venous Catheters Using Alteplase (policystat.com).

7. For CVADs being used intermittently, flush and lock per manufacturer's recommendations.

8. Flush all CVADs with preservative-free 0.9% sodium chloride. If bacteriostatic 0.9% sodium chloride is used, limit flush volume to no more than 30 mL in a 24-hour period to reduce the possible toxic effects of the

preservative, benzyl alcohol.

Equipment

1. Alcohol or CHG swabs (i.e. Prevantics®).
2. Clean gloves.
3. Preservative-free normal Saline in 10 mL syringes or larger.

Steps in CVAD Flushing Procedure

1. Perform patient identification using two (2) patient identifiers (i.e. name and date of birth).
2. Explain procedure to patient/caregiver.
3. Perform hand hygiene and don clean gloves.
4. Assess site for erythema, edema, and/or drainage.
5. Scrub the hub of the needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to dry completely. Do not wipe off, blow, or fan site to speed drying.
6. Attach 10 mL syringe of 0.9% sodium chloride (or compatible flush solution) and confirm patency by aspiration of blood return and ability to easily flush the VAD, and absence of patient complaints.

   A. Never forcibly flush any VAD with any syringe size. If resistance is met and/or no blood return noted, take further steps (e.g. checking for closed clamps or kinked sets, removing dressing, etc.) to locate an external cause of the obstruction.

   B. Use a pulsatile flushing technique. Flush 1-2 mL, then aspirate for a blood return, observing for the color and consistency of whole blood. Flush the remaining volume into the VAD and disconnect the syringe.

7. If disinfecting port protector caps are in use, discard the old cap and attach a new cap onto the needleless connector.
8. Document the saline flush in the EMR.

NEEDLELESS CONNECTOR CHANGE

Essential Elements

1. Needleless connectors should be changed no more frequently than every 96 hours.
2. Always clamp a non-valved catheter prior to changing a needleless connector.

Change the Needleless Connector

1. Every seven (7) days with dressing changes.
2. Whenever the connector has been removed.
3. If there is blood or debris within the connector.

4. Prior to drawing a **blood culture** sample from the catheter.

5. If the integrity of the connector is compromised.

Equipment

1. Needleless connector(s)- one for each catheter lumen.

2. Face mask.

3. Normal saline flush (one per catheter lumen).

4. CHG (i.e. Prevantics®) or alcohol swabs.

5. Clean gloves.

Steps in Needleless Connector Change

1. Perform patient identification using two (2) patient identifiers (i.e. name and date of birth).

2. Explain procedure to patient/caregiver.

3. Don mask.

4. Perform hand hygiene and don clean gloves.

5. Open needleless connector(s), saline flush and CHG or alcohol swabs.

6. Prime needleless connector device with saline. Leave syringe attached to needleless connector.

7. Scrub the hub of the needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to completely dry. Do not wipe off, blow, or fan site to speed drying.

8. Remove old needleless connector and scrub the end of the line with a new disinfectant pad. Allow to dry completely.

9. Quickly secure the new, primed needleless connector to the catheter using aseptic, no-touch technique.

10. Flush the catheter lumen with the saline syringe attached to the new needleless connector.

11. Attach a new disinfecting port protector cap onto the needleless connector.

12. Document needleless connector change in EMR.

DRAWING BLOOD FROM A CVAD

Essential Elements

1. CVAD blood draws should be avoided when possible to limit the opening of the line and the possibility of contamination, leading to increased risk of central line associated bloodstream infection (CLABSI).

2. Do not obtain blood samples for culture from a CVAD unless intended for diagnosis of a catheter-related bloodstream infection (CR-BSI). Licensed practitioner order is required for blood cultures obtained from a CVAD. See Policy 100.258 "Blood Culture Specimen Collection."

3. Do not routinely use CVADs infusing parenteral nutrition for blood sampling as manipulation may increase the risk for catheter associated bloodstream infection (CABSI).

4. Draw the blood sample from a dedicated lumen not used for administration of the drug being monitored (i.e. total parenteral nutrition), if possible.

5. Do not re-infuse the discard specimen into the VAD after obtaining the sample due to risk of contamination and blood clot formation.

Equipment

1. Clean gloves.

2. CHG (i.e. Prevantics®) or alcohol swabs.

3. Two (2) syringes 3- to 10 mL fill volume as needed for the volume of blood to be aspirated.

4. 10 mL of preservative-free 0.9% sodium chloride.

5. Blood transfer device (i.e. Vacutainer®).

6. Vacuum tubes as appropriate for the ordered laboratory tests.

7. Disinfecting port protector end caps.

CVAD Blood Draw Procedure

1. Verify provider's order for lab work prior to initiating blood draw.

2. Perform patient identification using two (2) patient identifiers (i.e. name and date of birth).

3. Explain procedure to patient/caregiver.

4. Perform hand hygiene before direct contact with the patient and subsequently as required throughout the procedural steps.

A. Hand hygiene should be preformed before touching a patient, before a procedure, after a procedure or body fluid exposure risk, after touching a patient, after touching a patient's surroundings.

5. Don clean gloves.

6. If drawing blood cultures, remove needleless connector and replace with new connector to decrease the risk of false-positive culture results. Licensed Practitioner order required prior to blood culture through CVAD.

7. If necessary (and patient condition allows), discontinue administration of all infusates two (2) minutes prior to obtaining blood samples.

A. Stop all infusions through the catheter, clamping lumens and/or stopping infusions as appropriate. Withdraw blood from most distal lumen, if drawing from staggered multilumen CVAD.

8. Remove passive disinfection cap, if in place.

9. Scrub the hub of the needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to dry completely. Do not wipe off, blow, or fan site to speed drying.

10. Attach an empty syringe to the needleless connector, open CVAD clamp (if present), and aspirate 4 to 5 mL of blood into syringe. Discard into sharps container.

11. Disinfect the needleless connector again by scrubbing with a new disinfectant pad and allowing to dry.

12. Attach an empty syringe and aspirate the needed blood volume. Use a slow, gentle technique to withdraw blood. The flow of blood is improved with a small syringe (e.g. 3 mL) over a large syringe (e.g. 10 mL).

13. Disinfect the needleless connector again by scrubbing with a new disinfectant pad and allowing to dry.

14. Flush the CVAD with 10 mL of preservative-free sodium chloride (using the pulsatile flushing technique), and lock CVAD.

A. Place a new disinfecting port protector cap on the needleless connector.

15. Using a needleless transfer device, fill the appropriate vacuum tubes with the designated volume of blood in the correct sequence (see "Order of Draw" attachment).

16. Document lab specimens obtained in the EMR.

INTRAVENOUS (IV) TUBING CHANGES

1. All IV fluids and tubing shall be replaced when a new CVAD is placed.

2. IV administration tubing with new fluids shall be changed with the following frequency:

A. Primary and secondary continuous: every 96 hours.

B. Blood products: every 4 hours .

C. Propofol and lipids: every 12 hours.

D. Total parenteral nutrition (TPN): every 24 hours.

E. Hemodynamic and arterial pressure monitoring: every 96 hours.

DIAGNOSTIC IMAGING OR SPECIAL PROCEDURE USE

Prior to transporting patient to Diagnostic Imaging or special procedures unit, the primary RN shall:

1. Disconnect any non-essential fluids and/or tubing connected to CVAD to improve CVAD accessibility for Diagnostic Imaging or special procedure use. If unable to make a CVAD lumen available for use, a peripheral IV line shall be inserted by the primary nurse prior to transport.

2. Scrub the hub of the needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to dry completely. Do not wipe off, blow, or fan site to speed drying.

3. Connect a 10 mL preservative-free sodium chloride filled syringe onto needleless connector and flush line to ensure patency.

4. Apply disinfecting port protector cap onto needleless connector.

5. Transport patient to Diagnostic Imaging or special procedures unit.

The Receiving RN in Diagnostic Imaging or special procedure unit shall:

1. Scrub the hub of the CVAD needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to dry completely. Do not wipe off, blow, or fan site to speed drying.

2. Connect a 10 mL preservative-free sodium chloride filled syringe onto needleless connector and flush line to ensure patency.

3. For special procedures: connect CVAD to IV tubing/solution.

4. For Diagnostic Imaging: connect CVAD to contrast media injector tubing.

A. A central line may only be used for power injection if specifically designated as safe for power injection. Otherwise, alternate IV access must be obtained.

Following the imaging or procedure the RN or technologist shall:

1. Disconnect the CVAD lumen from injector or used/completed IV tubing/solution.

2. Scrub the hub of the needleless connector with a Prevantics® swab for 5 seconds or an alcohol swab for 15 seconds and allow to dry completely. Do not wipe off, blow, or fan site to speed drying.

3. Connect a 10 mL preservative-free sodium chloride filled syringe onto needleless connector and flush line to ensure patency.

4. Apply disinfecting port protector cap onto needleless connector.

5. Transport patient back to primary nursing care unit.

REFERENCE(S):

1. Infusion Nurses Society. *Policies and Procedures for Infusion Therapy: Acute Care*. 6th ed. Infusion Nurses Society; 2021.

2. Kaiser Permanente. (2020). Central Venous Access Device (CVAD) Care and Maintenance. Southern California (SCAL): Regional Guideline.

3. Gorski LA, Hadaway L, Hagle ME, et al. Infusion therapy standards of practice. J Infus Nurs. 2021;44(suppl 1):S1-S224. doi:10.1097/NAN.0000000000000396.

All revision dates: 9/25/2023

Attachments

CHG Gel Dressing by 3M.pdf
order-of-draw-guide (1).pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/20/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/20/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	10/20/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Pharmacy Services*
References:	

Critical Care Electrolyte Protocol

Purpose:

An electrolyte repletion protocol is fundamental to the management of critically ill patients in the ICU. It lessens the chance of iatrogenic induced arrhythmias, weakness, polyneuropathy, and ongoing malnutrition.

Note: This protocol does not include electrolyte combination products. If a patient requires more aggressive electrolyte repletion or combination electrolyte products, contact provider.

Exclusions: Crush injuries, hypothermic patients, burns, rhabdomyolysis, tumor lysis syndrome, any type of dialysis (continuous renal replacement therapy, hemodialysis, peritoneal dialysis, ultrafiltration), acute decompensated heart failure, pregnant patients, patient is receiving parenteral nutrition, patient is on fluid restriction for intravenous repletion therapy, hyponatremia (sodium □130 mg/d□), Scr □2 mg/dl, 50□ increase in Scr from baseline, CrC□□ 30 m□/min (using Cockcroft Gault formula), or urine output less than 0.5 m□/kg/hr for previous 3 hours or more, contact provider to discontinue repletion orders.

Procedure:

A. This order set can only be utilized in the ICU at VCMC and SPH in patients with ongoing continuous cardiorespiratory monitoring.

B. These orders will be initiated by a provider but due to the dynamic physiology that occurs throughout a patient□s ICU stay, may be revoked at any time. □efer to exclusions and individual electrolyte sections for holding criteria.

C. □eplace critical values first unless otherwise indicated by provider.

   1. If there are multiple critical values or symptomatic abnormalities (e.g., EKG changes, mental status changes) then contact the provider.
   2. □ral route will be the preferred route of administration. (P□ □oral, FT □feeding tube)

D. Nurse will order post replacement laboratory as described within this protocol.

E. If patient is not responding to replacement as ordered, contact the provider.

   1. Patient□s lab value is not within normal range after 2 rounds of replacement have occurred, contact provider.

F. Notify provider if any of the exclusions criteria develop during hospitalization.

Hypokalemia

Do not initiate or stop current repletion plan in patients who have the following. Contact provider if patients have any of the following:

1. Serum chloride □ 115 mEq/□

Table 1. Potassium enteral repletion as potassium chloride enteral repletion						
Serum □K□□ mEq/□	Medication	□oute	Frequency	Duration	Total dose in mEq	Monitor
3.5 □ □	20 mEq tablet or liquid	P□/ FT	□nce	□nce	20	□outine AM lab
3 □ 3.□		P□/ FT	Every 2 hours	3 doses	60	12 hours after completion of total dose
2.5 □ 2.9 Notify physician	2x20 mEq tablet or □0 mEq liquid	P□/ FT	Every 2 hours	2 doses	80	□ hours after completion of total dose
□ 2.5	Start repletion by using intravenous formulation by using Table 2 or 3.					

Table 2. Potassium intravenous repletion as potassium chloride – PERIPHERAL line						
Serum □K□□mEq/ □	Medication	□oute	□ate	Duration	Total dose in mEq	Monitor
3.5 □ □	20 mEq/250 m□ NS	IV	□ver 2 hours	□nce	20	□outine AM lab
3 □ 3.□		IV	Infuse each bag over 2 hours	2 doses	□0	□ hours after completion of total dose
2.5 □ 2.9 Notify physician	□0 mEq/500 m□ NS	IV	Infuse each bag over □ hours	2 doses	80	2 hours after completion of total dose
□ 2.5	2x20 mEq tablet or □0 mEq liquid UDC	P□/ FT□	□nce	□nce	120	1 hours after completion of total dose
	□0 mEq/500 m□ NS	IV	Infuse each bag over □ hours	2 doses		
	□F oral route is available. If not available, give all three doses as IV potassium chloride to equal 120 mEq total.					

Table 3. Potassium intravenous repletion as potassium chloride – CENTRAL line						
Serum □K□□mEq/ □	Medication	□oute	□ate	Duration	Total dose in mEq	Monitor

3.5 □ □	20 mEq/50 m□ NS	IV	□nce	□nce	20	□outine AM lab
3 □ 3.□		IV	Infuse each bag over 2 hours	2 doses	□0	□ hours after completion of total dose
2.5 □ 2.9 Notify physician	□0 mEq/100 m□ NS	IV	Infuse each bag over □ hours	2 doses	80	2 hours after completion of total dose
□ 2.5	2x20 mEq tablet or □0 mEq liquid UDC	P□/ FT□	□nce	□nce	120	1 hours after completion of total dose
	□0 mEq/100 m□ NS	IV	Infuse each bag over 2 hours	2 doses		
	□F oral route is available. If not available, give all three doses as IV potassium chloride to equal 120 mEq total.					

Hypomagnesemia

Table 4. Magnesium intravenous repletion as magnesium sulfate						
Serum Mg mg/d	Medication	oute	ate	Duration	Total dose in gram	Monitor
1.6 2	2 g/50 m premix	IV	ver 2 hours	nce	2	outine AM lab
1 1.5	g/100 m premix	IV	ver hours	nce		hours after infusion has completed
1 Notify physician	g/100 m premix	IV	Infuse each bag over hours	2 doses	8	2 hour after infusion has completed

Hypophosphatemia

Do not initiate or stop current repletion plan in patients who have the following. Contact provider if patients have any of the following:

A. Serum sodium □ 150 mEq/□

B. Serum calcium □ 10 mg/d□

Table 5. Phosphorus enteral repletion					
Serum □Phos□ mg/d□	Medication	□oute	Frequency	Duration	Monitor
2.6 □3	2 Neutraphos tabs	P□/FT	□nce	1 dose	□outine AM lab
2 □2.5		P□/FT	Every □hours	2 doses	□hours after P□/FT dose
□1.9	Start repletion by using intravenous formulation by using Table 6-8. Notify physician if level □1.5				

Table 6. Phosphorus intravenous repletion as sodium phosphate						
Serum □Phos□mg/d□	Bag size	□oute	□ate	Duration	Total Dose in mMol	Monitor
2 □2.5	15 mMol/ 100 m□NS	IV	Infuse over 3 hours	□nce	15	□outine AM lab
1.5 □1.9		IV	Infuse each bag over 3 hours	2 doses	30	2 hours after total infusion is completed
□1.5 Notify physician		IV	Infuse each bag over 3 hours	3 doses	□5	1 hour after total infusion is completed

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	9/27/2023

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/22/2023
Intensive Care Unit	Kelly Johnson: Director, ICU/D□U/Telemetry	9/22/2023
Intensive Care Unit	Sul Jung: Associate Director of Pharmacy Services	9/6/2023

Delineation Of Privileges

Addiction Medicine

Name:

Privilege	Requested	Granted	Deferred	Suspended

Basic Criteria*:
a. MD/DO meeting the membership/privileging criteria in his/her Department
b. Completion of an accredited Addiction Medicine or Addiction Psychiatry fellowship and/or;
c. Current ABMS board certified in Addiction Medicine or Addiction Psychiatry**
d. Current ACLS
e. Documentation of a minimum of 12 hours of accredited CME related to Addiction Medicine in the previous 24 months
f. Documentation of treatment of a minimum of 25 patients for addiction in the previous 24 months

Evaluation Requirements:
A minimum of 5 cases

Renewal Criteria:
a. A minimum of 20 cases in the previous 24 months
b. Current ACLS
c. Documentation of a minimum of 12 hours of accredited CME related to Addiction Medicine in the previous 24 months

Portions of the basic criteria may be temporarily waived for physicians currently enrolled in the VCMC Addiction Medicine Fellowship Training Program

****** New graduates must be board certified within 2 years from completion of fellowship training***

Addiction Medicine Attending Core Privileges: ___ ___ ___ ___
Admit, evaluate, consult, perform history and physical examination, and treat patients of all ages with problems of addiction and substance-related disorders, including management of severe or complex intoxication, withdrawal, medical complications of addiction, and other substance-related disorders, including drug detoxification.

Addiction Medicine Fellow Core Privileges*: ___ ___ ___ ___
Physicians currently enrolled in the VCMC Addiction Medicine Fellowship may perform the following privileges under the direct supervision and at the direction of the Addiction Medicine Attending:

Admit, evaluate, consult, perform history and physical examination, and treat patients of all ages with problems of addiction and substance-related disorders, including management of severe or complex intoxication, withdrawal, medical complications of addiction, and other substance-related disorders, including drug detoxification**.**

**Fellowship privileges automatically terminate at the completion of training; physicians meeting the basic criteria may request attending core privileges.*

Delineation Of Privileges

Addiction Medicine

Name:

Privilege	Requested	Granted	Deferred	Suspended

ACKNOWLEDGMENT OF PRACTITIONER:
I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital and/or within the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by the hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's electronic signature on file
TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature:

_____ Date: _____

Evaluator Assignment:

_____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

Department Chief's Signature:

_____ Date: _____

Initial Appointment	Reappointment
Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Since your last appointment has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?
Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Since your last appointment have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?
Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Since your last appointment have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?
Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Since your last appointment have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Since your last appointment have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?
Have you ever been denied certification/recertification by a specialty board?	Since your last appointment have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?
Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?	Since your last appointment, have you chosen not to recertify or voluntarily surrender your board certification while under investigation?
Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than an infraction traffic offense? If **_Yes_**, please specify in **_Comments_** if there are any such actions pending.	Since your last appointment, have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than an infraction traffic offense? If **_Yes_**, please specify in **_Comments_** if there are any such actions pending.
Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you dismissed or pending. If **YES**, please complete Addendum B.	Since your last appointment have any judgments been entered against you, or settlements been agreed to by you within the last two (2) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you dismissed or pending. If **YES**, please complete Addendum B.
Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Since your last appointment has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?
Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **_Yes_**, please describe within **_Comments_** any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.	Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **_Yes_**, please describe within **_Comments_** any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.

Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution? If **_Yes_** please specify in **_Comments_** if, in the past seven (7) years, you have been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)?	Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution? If **_Yes_** please specify in **_Comments_** if, in the past two (2) years, you have been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)?
Do you presently use any drugs illegally?	Do you presently use any drugs illegally?
Is your current ability to practice impaired by chemical dependency or the use of any illegal or legal substances?	Is your current ability to practice impaired by chemical dependency or the use of any illegal or legal substances?
Has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	Since your last appointment has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?
Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Since your last appointment has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

6 attestation questions drafted by HLB previously approved by MEC recommended during the bylaws revision project to comply with Section 805.8 of the Business & Professions Code requiring health care facilities such as Ventura County Medical Center (VCMC) to report any allegation of sexual abuse or sexual misconduct (defined to mean inappropriate contact or communication of a sexual nature) made by a patient or the patient's representative against a healing arts licensee who is allowed to practice at the facility or provide care for patients.[1] A Section 805.8 report is required within 15 days of receipt of the written allegation by a patient, and is in addition to, not in lieu of, any Section 805 or 805.01 reports (which, by contrast, are made after a final decision or recommendation regarding disciplinary action).

Have you ever been arrested, charged, or convicted of a sex crime, or an offense involving a child victim?	Have you ever been arrested, charged, or convicted of a sex crime, or an offense involving a child victim?
Since the age of 18, has any allegation of sexual misconduct been substantiated against you through a formal investigation by any educational institution, employer, regulatory or law enforcement agency, or other organization or entity, or through any other administrative or judicial proceeding?	Since the age of 18, has any allegation of sexual misconduct been substantiated against you through a formal investigation by any educational institution, employer, regulatory or law enforcement agency, or other organization or entity, or through any other administrative or judicial proceeding?

Are you now or, since the age of 18, have you been subject to any administrative or disciplinary action (e.g., no-contact order, investigatory leave, reprimand, probation, suspension), dismissal, or voluntary or involuntary separation from a post-secondary educational institution (college, university), medical staff, medical group, or employer related to allegations of sexual misconduct?	Are you now or, since the age of 18, have you been subject to any administrative or disciplinary action (e.g., no-contact order, investigatory leave, reprimand, probation, suspension), dismissal, or voluntary or involuntary separation from a post-secondary educational institution (college, university), medical staff, medical group, or employer related to allegations of sexual misconduct?
Has any health professional licensing authority subjected you to any administrative or disciplinary action (as described above) related to allegations of sexual misconduct?	Has any health professional licensing authority subjected you to any administrative or disciplinary action (as described above) related to allegations of sexual misconduct?
Have you ever been arrested for, convicted of, or pled guilty or nolo contendere to any criminal sexual misconduct offense, or found liable or otherwise responsible, in any civil action that alleged sexual misconduct?	Have you ever been arrested for, convicted of, or pled guilty or nolo contendere to any criminal sexual misconduct offense, or found liable or otherwise responsible, in any civil action that alleged sexual misconduct?
Have you ever been required to be accompanied by a chaperone when examining, diagnosing, or treating patients as a result of an allegation of sexual misconduct made against you (answer No if chaperones were consistently present as a matter of institutional policy and not in response to a specific allegation against you)?	Have you ever been required to be accompanied by a chaperone when examining, diagnosing, or treating patients as a result of an allegation of sexual misconduct made against you (answer No if chaperones were consistently present as a matter of institutional policy and not in response to a specific allegation against you)?

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Document Approvals

December 2023

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

1.	100.070 Moderate and Deep Sedation	page	2-8
2.	100.098 Pneumococcal and Influenza Vaccine Screening and Administration	page	9-10
3.	100.220 Electronic Order Management - **Tabled**	page	11-13
4.	108.050 Patient Safety Attendant Care	page	14-18
5.	N.06 Formula Preparation and Feeding Guidelines	page	19-20
6.	N.36 Gavage/Enteral Gastric Tube Feeding in the NICU	page	21-24
7.	N.39 Role of the NICU Charge Nurse	page	25-27
8.	N.53 Venipuncture in Neonates	page	28-30
9.	P.32 PICU, NICU, and PEDS Visiting Policy	page	31-34
10.	PH.27.00 Hazardous Drug Overview	page	35-36
11.	PH.27.01 Hazardous Drug Training and Safety Program	page	37-40
12.	PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport	page	41-44
13.	PH.27.03 Hazardous Drug Garbing, and Compounding	page	45-48
14.	PH.27.04 Decontamination, Spill, and Waste Management	page	49-51
15.	PH.40 Investigational Drug Use	page	52-53
16.	PH.79 Multiple Dose Vials	page	54-55
17.	PH.88 Controlled Substances	page	56-61
18.	PH.119 Piperacillin-Tazobactam (Zosyn) Adult Dosing Protocol	page	62-66

b. Medical Staff Forms

1.	Plastic Surgery & Reconstructive Surgery Privilege Checklist (Approved by Dept of Surgery and MEC)	page	67-69

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1999*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*8/1/2023*
Next Review:	*3 years after approval*
Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.070 Moderate and Deep Sedation

POLICY:

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

PROCEDURE:

DEFINITIONS

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

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

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

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

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

COROLLARIES

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

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

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

QUALIFIED STAFF AND PHYSICIANS

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

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

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

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

PRE-SEDATION ACTIVITIES

A. ASSESSMENT

1. Within □8 hours prior to the procedure, the physician will complete a pre-sedation assessment in the electronic health record (EH□). Components of the pre-sedation assessment will include:
   a. Patient's diagnosis, planned procedure and location of sedation
   b. □ast solid and liquid intake
   c. Presence of food, drug, latex, or contrast allergies

d. Current medications have been reviewed and documented

e. Patient's pertinent review of systems (presence of any acute illness or chronic condition that may place the patient at higher risk to experience complications during sedation)

f. Presence of previous complications from sedation or anesthesia

g. Patient's weight in kilograms

h. Patient's temperature, blood pressure, heart rate, respiratory rate, pulse oximetry

i. Focused physical exam consisting of the following:

i. Mental status examination

ii. Mallampati Classification (Attachment A)

iii. □espiratory exam

iv. Cardiovascular exam

2. The physician will assign an American Society of Anesthesiologists (ASA) status and document the ASA status in the procedural sedation note. If the patient is ASA class 3 or higher then the physician will consider consultation with anesthesiology (See Attachment B).

3. The physician will document the sedation plan.

□. The physician will perform an informed consent that includes a discussion of all reasonable risks and benefits of sedation, alternatives of sedation, risks and benefits of alternatives, and the monitoring plan.

5. Just prior to the administration of moderate or deep sedation, the physician will perform and document a Pre-Induction Assessment, which should include the following:

a. Vital signs

b. Status of the airway

c. □esponse to any pre-procedure medications

B. VE□IFICATI□N

1. The nurse will verify that an informed consent form is completed.

2. The nurse will verify that current medications have been reviewed and documented.

3. The nurse will verify that the physician orders for medication are completed.

□. The nurse and physician will verify the allergy status of the patient.

5. A time out will occur according to policy 100.062 Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

6. The physician and nurse will assess the patient's NP□ status. The physician will consider the ASA guidelines in proceeding with sedation.

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

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

or emergent situations where complete gastric emptying is not possible.

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

INTRA-PROCEDURE ACTIVITIES

A. M□DE□ATE SEDATI□N: ADMINIST□ATI□N, M□NIT□□ING AND D□CUMENTATI□N

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

B. DEEP SEDATI□N: ADMINIST□ATI□N, M□NIT□□ING AND D□CUMENTATI□N

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

EMERGENCY MANAGEMENT

A. In the event of respiratory depression/compromise, perform the following immediately:
   1. Stop the medication infusions.
   2. Suspend the procedure
   3. Support the airway as needed e.g. suction, position and oral airway.
   4. Administer increased FI_2 as needed to maintain oxygen saturations at pre-procedure levels.
   5. Elevate head of bed (HOB) as permitted and reposition patient's chin, neck, and shoulders.
   6. Monitor vital signs as frequently as needed.
   7. Observe for changes in tissue perfusion.

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

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

POST-PROCEDURE ACTIVITIES

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

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

C. In addition to the above monitoring parameters, the nurse will also monitor the following:
    1. Pain level
    2. Procedure site and dressing as applicable
    3. Ability to follow instructions as appropriate
    4. Patency of peripheral IV site
D. Prolonged or overnight monitoring should be considered for the following:
    1. Full term infant who is less than 56 weeks post-gestation
    2. Pre-term infant who is less than 52 weeks post-gestation
    3. Infants with a history of apnea of prematurity
E. Any patient who has received a reversal agent must be observed for at least two (2) hours from the time of administration of the agent.
F. If procedural sedation was used to facilitate a medical procedure, a procedural sedation note should be documented in the EHR by the physician upon completion of the operation or procedure and before that patient is transferred to the next level of care.

DISCHARGE/TRANSFER ACTIVITIES

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

REFERENCES:

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

Anesthesiology 2018□128: □37-79. American Society of Anesthesiologists: Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology* 2002□96: 100□-1017.
The Joint Commission. Nursing Standard PC.03.01.01
The Joint Commission. Nursing Standard PC.03.01.03
The Joint Commission. Nursing Standard PC.02.01.03
□ale-New Haven Hospital Clinical Administrative Policy and Procedure Manual
The Joint Commission. Standard PC.03.01.05
UC□A Pediatric Anesthesia Manual (http://www.anes.ucla.edu/Peds□esManual.pdf)
The Joint Commission. Nursing Standard PC.03.01.07
Centers for Medicare and Medicaid Services, Pub. 100-07 State □perations Provider Certification,Transmittal 59□May 21, 2010
Goodwin et al: Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department. *Annals of Emergency Medicine* 2005□□5: 177-196
The Society for Pediatric Sedation, "Sedation Provider Course."

All revision dates: 8/1/2023, 1/□/2021, 6/9/2020, 11/17/2017, 5/1/2015, 6/1/2010, 5/1/2006, 2/1/2005, 12/1/200□

Attachments

- Attachment A - Mallampati Classification
- Attachment B - ASA Status
- Attachment C - □ichmond Agitation Sedation Scale (□ASS).pdf
- Attachment D - Procedural Sedation (Adult) Discharge Instructions.pdf
- Attachment E - □ecovery After Procedural Sedation (Child).pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine & Surgery	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	11/17/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/30/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/30/2023
Policy □wner	Minako Watabe: Chief Medical □fficer, VCMC & SPH	10/30/2023

VENTURA COUNTY HEALTH CARE AGENCY

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References:	

100.098 Pneumococcal And Influenza Vaccine Screening And Administration

Policy:

The licensed registered nurse shall screen patients on admission and/or discharge and administer influenza and pneumococcal vaccine for patients meeting criteria.

Procedure:

A. Upon inpatient admission, the admitting clerk enters the patient into the California Immunization □egistry (CAI□) system.

B. All patients are to be screened for potential influenza and pneumococcal vaccination by the licensed nurse on admission. The screening and consent process shall be documented in the electronic health record (EH□).

   1. If the patient is unable to answer screening questions upon admission, the patient shall be re-screened and vaccinated, if indicated, prior to discharge.

C. The vaccine information statement shall be provided to the patient.

D. If patient meets criteria for vaccination, the nurse shall enter an order for the appropriate vaccine(s).

   1. □efer to Attachment A for step-by-step instructions for this step.

E. Pharmacy shall verify the order and dispense the vaccine.

F. Vaccine administration shall be documented in the EH□, including manufacturer, lot number and expiration date. Any untoward events are to be documented in the narrative portions of the nursing notes and on a notification form.

G. Administering nurse shall ensure the Share document icon in the EH□ is completed.

H. Prior to patient□s discharge, the nurse shall ensure screening and/or administration of vaccine(s) was completed. If screening and/or administration of vaccine(s) was not completed, repeat steps B-G.

I. Notify the licensed independent practioner if the patient experiences severe allergic reactions (i.e. hives, difficulty breathing, shock).

All revision dates: 6/9/2020, 7/2□/2017

Attachments

Attachment A: Immunization Screening Nursing Workflow

Approval Signatures

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/9/2023
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VENTURA COUNTY
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References:	

100.220 Electronic Order Management

POLICY:

To describe how an electronic order is communicated and properly handled between providers and non-providers.

PROCEDURE:

1. □rders to non-providers shall be given only by a person lawfully authorized to prescribe or furnish. These orders shall be recorded promptly into the patient's electronic health record, noting the name of the person giving the order and the signature of the person receiving the order
    a. **Medication orders** may be given to the □N, □VN, licensed psych tech, pharmacist, physician (and physician assistant from a supervising physician only), physical therapists (for certain topical medications only), and respiratory therapists when the orders relate specifically to respiratory therapy.
    b. **Non-medication orders** shall be considered acceptable from a licensed independent practitioner to a licensed, registered, or nationally certified health professional if the orders received relate to the area of competence of the individual receiving the order: audiologists, cardiopulmonary technologists/technicians, dietitians (except parental nutrition), laboratory technologists, nurses, occupational therapists, physical therapists, radiological technologists, respiratory therapists, and speech pathologists.
2. □rders entered into the Electronic Health □ecord (EH□) by a non-provider shall include the appropriate communication type that either routes to the ordering provider for signature, as approved by the VCHCA *Clinical Advisory Team,* or has already been signed.
    a. **RN/Staff Initiate/Discontinue – No Cosign:** This is a communication type that nursing or a technician will select when initiating an electronic order set that has been previously created and left in the planned state (signed, but not initiated) by a provider. This also pertains to situations where a nurse discontinues an electronic order set that is no longer applicable.
    b. **Telephone with Read Back Verification – Cosign (TORB-Cosign):** A telephone order shall be considered to be in writing from a licensed independent practitioner when received by telephone. All staff receiving a telephone order shall read back the complete order for verification from the ordering provider. Telephone orders are to be used infrequently and not for the convenience of the ordering provider.

c. **Protocol/Standardized – Cosign:** Non-providers are allowed to initiate certain Protocols/ Standardized Procedures, but need orders routed to the provider for acknowledgement by co-signature.

d. **Written/Fax/Transcribe – No Cosign:** In the rare instance a written paper or faxed order is transcribed into the EH□ by a nurse, pharmacist, technician, or M□A, the orders containing medications will need to be scanned to Pharmacy. Pharmacists may enter Pharmacy and Therapeutics initiatives and billing/dispensing clarifications under this order communication type (see policy 100.216).

e. **Verbal with Read Back Verification – Cosign (VORB – Cosign):** Verbal orders shall only be given by a prescribing provider in the event of an emergent situation or if the provider is unable to obtain access to a computer (e.g. the provider is in a sterile environment). Verbal orders shall be used infrequently and read back verification must be provided. Verbal orders shall not be given for chemo orders nor for non-formulary medications.

f. **Future Orders – No Cosign:** Future orders are routed by choosing *Activate* within PowerChart once the correct encounter has been verified. This type of order does not need a communication type and will not route for co-signature.

3. All orders are active when signed and/or initiated.

□. □rders requiring co-signature shall be routed for signature and shall be authenticated within □8 hours with special attention to change in primary provider hand-off (rotating on/off service, transfer to another service. It is the expectation that all outstanding cosigned orders shall be signed before the provider leaves the service. Compliance shall be monitored with real-time reporting.

5. Any code status order other then "full resuscitation" can only be entered electronically by the provider or as a written order.

6. Any paper orders shall be scanned into the patient's electronic health record.

7. All electronic orders shall be reviewed daily for order accuracy and reconciliation of active orders.

8. If a diagnosis is required for the order, this can be entered as part of a protocol, or communicated by the provider and entered into the EH□ by the non-provider as part of the ordering process.

References:

California Code of □egulations Title 22 Div 5 Chapter 1 Article 3 □70263

Joint Commission. 2019 Hospital Accreditation Standards.

- Medication Management (MM) Standard: MM.0□.01.01
- □ecords of Care, Treatment, and Services (□C) Standard: □C.01.01.01, □C.01.02.01, □C.01.03.01, □C.02.01.01, □C.02.03.07

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Attachments

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/30/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/30/2023
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108.050 Patient Safety Attendant Care

PURPOSE:

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

POLICY:

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

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

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

. Patient's families will be encouraged to partner with VCMC/SPH Hospital staff in order to provide a safe environment for the patient. As families provide a stabilizing emotional support for the patient, they will be asked to participate by staying with the patient to prevent pulling tubes, climbing out of bed, etc. Primary N or Charge Nurse approval required to allow family or other visitor to replace Patient Safety Attendant. The patient's visitor will be instructed to notify the nurse to resume Patient Safety Attendant care when they are leaving the room. Family and visitors may never Family members will not be permitted to provide sitter care for suicidal/homicidal or 5150/5585 patients.

PROCEDURE(S):

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

~~2. Care provided by a Patient Safety Attendant will be delegated and overseen by the assigned bedside nurse. The nurse will retain the responsibility of the nursing process and administration of medications. A~~

~~Patient Safety Attendant will provide physical care, within their scope of practice and training, for the patient for whom they are assigned including the documentation of vital signs and intake and output. Patients who are suicidal/homicidal require every 15 minute documentation on the patient observation log.~~

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

~~□. Verify dietary order specifies no sharp objects and/or finger foods only. No utensils will be given to patient.~~

~~5. The Patient Safety Attendant will accompany the patient for any clinical tests or procedures off the unit unless patient is already accompanied by the bedside nurse. The staff member accompanying the patient will remain within line of sight of the patient unless otherwise directed by the person performing the test or procedure.~~

~~6. The Patient Safety Attendant will remain within direct sight of the patient while patient is using the bathroom or shower. The Patient Safety Attendant will attempt to maintain the patient's dignity and privacy by having same gender assistant assume temporary responsibility of the patient as needed.~~

~~7. While on duty, the Patient Safety Attendant will not leave the patient's room without the bedside nurses' approval and/or relief. If a break is needed, a hand-off to the temporary staff member will occur prior to reporting off the unit.~~

~~8. The Patient Safety Attendant will refer the patient to the nurse or physician to answer any questions regarding the plan of care.~~

A. Assessment of Safety Attendant Usage

1. The nurse will assess the patient□s physical condition, behaviors, and emotional status to determine if constant observation of the patient is required to ensure the patient□s safety.
2. The nurse assesses for the following:
    a. The patient is on suicide precautions, which requires a sitter 1:1.
    b. Patient is on a legal hold.
    c. The patient is confused, disoriented or cognitively impaired and at high risk to injure themselves (either by falling, wandering, etc.).
    d. A confused, disoriented or cognitively impaired patient pulling at medically necessary tubes/ lines and hand mittens have been unsuccessful.
    e. Patient has been placed in restraints due to patient exhibiting a danger to self or others.
3. If the patient meets the above criteria c., d., and e., the nurse will first consider the following alternate options to safety attendant usage. The use of a safety attendant for those criteria should only be considered if no other feasible alternative provides a solution, to include the following interventions with documented ineffectiveness in the medical record.
    a. Can the patient□s family members provide supervision of the patient□ The nurse will approach the family to determine feasibility.
    b. Can the patient be moved closer to the nursing station to provide more frequent observation by nursing staff□

c. Have the medications, electrolytes, and blood gases been reviewed as a reversible cause of confusion/delirium

d. Where appropriate, can the patient be placed in a room with another patient who has a sitter

e. Can current shift assignment be adjusted to utilize scheduled staff to provide adequate supervision

. If the patient meets safety attendant criteria and all alternatives have been unsuccessful and documented, the justification for the need is documented on the 'Patient Safety Attendant Care Justification for the Non-Suicidal Patient' form (Attachment C). The patient's bedside nurse completes the form and submits to the Charge Nurse. If criterion is met, the Charge Nurse will speak to the Nursing Supervisor to arrange a Patient Safety Attendant. All completed forms are submitted to the Unit Nursing Clinical Director. Initiation of patient safety attendant will require review and approval each shift or with a change in condition.

B. General Expectations for all Safety Attendants

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

2. nce Patient Safety Attendant care is initiated, patient will not be left unattended until the nurse notifies the Patient Safety Attendant that the assignment is discontinued. If a patient is in a private room, the safety attendant needs to be in the room with the patient.

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

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

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

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

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

8. While on duty, the Patient Safety Attendant will not leave the patient's room without the bedside

nurses' approval and/or relief. If a break is needed, a hand-off to the temporary staff member will occur prior to reporting off the unit.

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

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

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

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

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

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

d. Verify dietary order specifies no sharp objects and/or finger foods only. No utensils will be given to patient.

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

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

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

~~10. **Patient Safety Attendant: Non-Suicidal/Homicidal/5150/5585 Patient**~~

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

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

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

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

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

~~f. Necessity of a safety attendant for this population must be reassessed every 2□ hours. □eassessment may occur by a licensed provider including the registered nurse (for non suicidal/homicidal patients only).~~

11. **Documentation**

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

b. Patient Safety Attendant will complete the ~~□ine of Sight Documentation Form~~Patient □bservation □og (Attachment ~~A~~B).

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

12. Competency

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

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

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

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

All revision dates: 11/7/2023, 7/12/2023, □/28/2023, □/13/2023, □/11/2023, □/11/2023

Attachments

C.A.S.E. Safety Checklist.pdf
Patient □bservation □ecord.PDF
Patient Safety Attendant Care Justification for the Non-Suicidal Patient.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/7/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/7/2023
Policy □wner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/7/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*NICU*
References:	

N.06 Formula Preparation and Feeding Guidelines

POLICY:

To guide the Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU) and Pediatrics (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. Physician order is required for initial nipple feeding and progression nipple feedings. Consult □ccupational 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, standard flow or orthodontic nipple□or developmental feeding system

C. Breastmilk or ordered formula

D. Sterile water for formula preparation

A. Choose appropriate nipple. Consult with □ccupational 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 □ip 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. □eady to feed formula: Single use sterile formula bottles and clean nipples.
2. Powdered formula shall be prepared in a designated formula preparation room (Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU,) and Pediatrics (PEDS)).
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 2□-hour supply under refrigeration or single use amount □hours at room temperature.
    b. Individual serving is fed using a sterile disposable nurser.
□. Human milk fortifier 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.0□, *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.

DOCUMENTATION

NICU: type of feeding, route of feeding, volume, nipple type, duration of feeding, INFACT score.
PEDS: type of feeding solution, amount taken, any difficulties with feeding.
PICU: type of feeding solution, amount taken, any difficulties with feeding.

All revision dates: 10/11/2023, 10/11/2023, 1/1/2016, 6/1/2013, 5/1/2012, 10/1/2011, 2/1/2010, 12/1/200□

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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 when visibly soiled.

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

1. □ack of bilateral patency of the nares
2. Presence of nasal continuous positive airway pressure (CPAP)
3. □espiratory 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:

INSE□TI□N:

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. □nce 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. □abel the tubing with the date and time of insertion. □eplace every 30 days if a polyurethane tube is used. Alternate nares when tube is replaced.

FEEDING VIA GAST□IC 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

   □. 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-□) 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.

□. A polyurethane feeding tube may be reused per manufacturer's guidelines if accidentally removed. □inse 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). □ippincott Procedures. □etrieved May 17, 2022, https://procedures.lww.com/lnp/view.do□pId□3378732&disciplineId□5770

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

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No Attachments

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Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/12/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/11/2023
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	10/11/2023

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References:	

N.39 Role of the NICU Charge Nurse

POLICY:

To outline the NICU ~~R~~esource~~s~~Charge Nurse shift responsibilities.

PROCEDURE:

Each shift, a ~~R~~esource Nurse~~s~~NICU-trained and experienced registered nurse is assigned as the "in unit" charge nurse, reporting directly to the Clinical Nurse Manager or Nursing Supervisor.

DUTIES

A. At change of shift ~~bedside~~ report begins promptly at 6:~~R~~5 am and ~~7~~6:~~00~~~~R~~5 pm.

B. The ~~R~~esource~~s~~Charge Nurse of the preceding shift reports information to the oncoming ~~R~~esource~~s~~Charge Nurse including, but not limited to:

1. The census
2. Pending deliveries, C-sections, discharges, transports and transfers
3. Patient care issues and shift nursing assignments
4. Special procedures or pertinent events.

C. Maintains the nursing assignment sheet, including scheduled break/meal times (when applicable) for staff, designates a ~~R~~esource or Break ~~R~~elief nurse, transport~~/~~ team, C-section nurse and ~~"first~~ admit~~"~~ nurse.

~~Completes the narcotic count with the preceding shift ~~R~~esource Nurse.~~

D. ~~R~~esponsible for maintaining completion of all unit logs and records each shift, including:

1. Admit ~~L~~ogbook
2. Crash Cart checklist
3. ~~R~~ed and Blue~~s~~Emergency Medication Box
4. Transport Equipment Checklists
5. ~~R~~efrigerator/Freezer ~~L~~ogs.
6. Monthly central line reporting form.

E. ~~R~~eviews patient acuity designations and apprises Clinical Nurse Manager and Staffing Coordinator/

Hospital Supervisor of pertinent changes in a timely manner.

F. Attends daily Patient □ounds with medical multidisciplinary team.

G. Attends weekly multi-disciplinary Discharge Planning □ounds.

~~Answers Perinatal Dispatch call for available beds.~~

H. Attends monthly NICU Steering Committee meeting.

I. Attends all high risk deliveries, and in the absence of the neonatologist and leads the resuscitation team until the neonatologist arrives.

J. Enters available beds on perinatal dispatch website (Perinatal.org)

K. Maintains two admission beds available at all times, complete with:

~~□adiant Warmer~~

~~Isolette~~

1. Incubator
2. Emergency equipment
3. □xygen
4. Suction
5. Servo-control thermoregulation
6. Cardio-respiratory monitoring
7. □xygen saturation monitoring.

□. □esponsible for ensuring relief for staff breaks.

M. □esponsible for □VN, float staff and registry □N supervision.

N. □esponsible for maintaining a neat and orderly NICU, with supplies neatly stocked, and equipment and linen stored in appropriate locations.

□. □esponsible for ensuring the required discharge tests are completed prior to all discharges.

P. Identifies unsafe patient care practices and initiates interventions to decrease risk of iatrogenic injuries.

□. Functions as a mentor to new staff/peers by providing advice and counsel, supports/teaches by example, imparts valuable information, provides feedback on progress and shares a positive attitude regarding work environment and responsibilities (positive role model).

□. Participates in patient care conferences as necessary.

~~□eviews patient care plans to ensure that appropriate care is being rendered with appropriate documentation.~~

S. Serves as a clinical resource liaison.

T. Coordinates unit activities for a given shift. Delegates responsibilities to staff as patient needs warrant, is able to match patient acuity with staff skill level. Identifies and solves unit problems. Presents a positive unit and nursing image when communicating with other departments, nursing units, physicians and supervisors.

U. Assigns admissions on the basis of each staff member's patient load and ~~his /her~~ capabilities to facilitate optimal and safe patient care. Ensures that beds are ready for admission, supplies are stocked, and monitors are clean and in working condition.

V. Shift accountability: handles problems in a positive, mature, reasonable, and professional manner, uses established lines of communication for problems and interpersonal conflict.

W. Seeks guidance when appropriate.

□. □btains report at the end of the shift and gives a brief report to oncoming staff. The status of patients, unit needs, or equipment failure, should be communicated to on-coming resource nurse.

REFERENCES:

~~AWH□NN: N□EP, 3rd edition. 2015~~

All revision dates: 10/3/2023, 7/1/2015, 3/1/2010, 9/1/200□

Attachments

No Attachments

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Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/3/2023
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References:	

N.53 Venipuncture in Neonates

POLICY:

To guide the □egistered Nurse (□N) in performing a neonatal venipuncture to insert an indwelling catheter for fluid infusion heparin lock or to obtain a blood specimen.

PROCEDURE:

A. A skilled ~~□N~~□egistered Nurse, □espiratory Therapist, ~~NNP,~~ physician or phlebotomist may perform a neonatal venipuncture.

B. A venipuncture for blood sampling is indicated for clotting studies, blood cultures and when the required volume of blood is more than 2.5 ~~ml~~milliliters for neonate □1.5 ~~kg~~kilograms and more than 1.5 ~~ml~~milliliters for neonates □1.5 ~~kg~~kilograms. The laboratory technician is consulted regarding the amount of blood required for a specific test (if not included in Attachment A below). Process to □aboratory in a timely manner.

C. Intravenous catheters are placed under clean conditions with antiseptic skin preparation. The catheter is discontinued when no longer needed or if there are signs of infiltration or infection. The remainder of the tubing is changed with each change in solution or a maximum of 96 hours. The exception is tubing used for lipids which is changed every 2□ hours.

D. Venipuncture attempts are generally limited to three (3) per practitioner. The physician~~/NNP~~ is notified if there is insertion difficulty.

E. Standard precautions are observed. Protected sharps are used when available.

EQUIPMENT

A. Gloves

B. Povidone Iodine, alcohol wipes

C. Tourniquet

D. Specimen collecting container

E. Needle, -23, 2□ gauge and 3 or 5 ~~ml~~milliliters syringe

F. Butterfly, -23, 25 gauge

G. Angiocatheter -22, 2□ gauge

H. T connector

I. Syringe (1 ~~ml~~milliliter, 3 ~~ml~~milliliter) with flush solution of normal saline

J. □rdered ~~IV~~intravenous solution

K. ~~Heparin 10 unit/for Heparin lock and needleless port~~Heparin Flush (Heparin 10 unit/milliliter)

□. Tape, arm board, cotton ball, transparent dressing as desired

GUIDELINES

A. Select site for venipuncture. In general:

1. Blood sampling-antecubital space, dorsum of hand vein.
2. ~~IV~~Intravenous catheter-dorsum of hand, forearm, foot, ankle, saphenous, scalp. Save antecubital for possible ~~PICC~~Peripherally Inserted Central Catheter placement.
3. Site should be pulseless to prevent unintentional arterial placement.

B. Prepare supplies. Stabilize patient, swaddle or apply heat lamps. □ffer non -pharmacological pain interventions as needed (see pain policy).

C. Tourniquet may be applied if needed to extremities. Hair may be shaved from scalp. Prep site thoroughly with antiseptic solution (povidone iodine and/or alcohol).

D. Utilizing a second staff person as necessary, insert needle according to the manufacturer's recommendations. Slowly advance needle into the vein until blood is visible in hub.

E. **Blood sample:**

1. Attach syringe to butterfly tubing and withdraw the required amount of blood □□
2. Collect blood through a catheter by allowing the blood to drip into the microtainer.
3. □emove tourniquet, then needle and apply pressure to the site till blood flow stops.

□. Clean visible antiseptic solution from the site using sterile water and apply bandaid.

F. **Indwelling catheter:**

1. Gently withdraw needle while advancing the catheter.
2. □emove tourniquet. Attach prefilled T-connector to catheter and flush with 0.5 to 1 ~~ml~~milliliterl solution to check patency. □esistance, edema or blanching indicate unacceptable placement.
3. Clean visible antiseptic solution from the site using sterile water. Apply transparent sterile dressing tape as needed to secure catheter, ensuring visibility of insertions site and unobstructed blood flow. Arm boards may be secured as needed.

□. Prepare ordered ~~IV~~intravenous solution and connect to tubing and filter. Insert in pump, set rate and attach to T-connector.

5. Heparin □ock: Utilizing a needleless port (injection site cap) flush per related policy/procedure heparin.

DOCUMENTATION

A. Nursing Notes □Procedure, attempts, patient tolerance, premedication as ordered, change in IV site assessment.

B. Nursing Flowsheet □ □abs, blood volume withdrawn, solution administration volumes, IV start/DC sites.

C. Nursing Shift Assessment □ Skin-IV site assessment.

REFERENCES

AWH□NN: N□EP 3rd edition, 2015

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Attachments

A: □ab Draws

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/12/2023
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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 (VCMC) Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Pediatric (PEDS) Departments.

PROCEDURE:

General for PICU/NICU/Pediatrics

A. All visitors will follow ~~the~~policy *100.011 Hospital Visitation*. Visitors will access Ventura County Medical Center (VCMC) and Santa Paula Hospital ~~Visiting Hours and Regulations Policy 100.011. Visitors will access VCMC and Santa Paula Hospital~~ (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~~see *Attachment A: Approved Visitor List for Minor Patient*).

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~~see *Attachment A: Approved Visitor List for Minor Patient*). 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~~Pediatric Intensive Care Unit/~~NICU~~Neonatal Intensive Care Unit/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.

□. 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~~Ventura County Medical Center 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.
□. ~~PICU~~Pediatric Intensive Care Unit/~~NICU~~Neonatal Intensive Care Unit 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

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 identification (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□F thought to be related to gynecological (G□N) or urinary tract problem may visit.

F. □nly siblings over the age of 13 are allowed to visit the ~~NICU~~Neonatal Intensive Care Unit. 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. □ength of sibling visit will be left to the discretion of the parents and nursing staff.
2. □n 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.
□. Siblings with illness or temperature over 100□F are not allowed to visit.

G. If the infant is to be taken outside the ~~NICU~~Neonatal Intensive Care Unit to visit mom on the ~~labor~~□abor & ~~delivery~~Delivery/~~postpartum~~Postpartum Units or other units ~~or other units~~ in the hospital, the following apply:

1. Infant is taken by transport cart if visiting to unit other than ~~labor and delivery~~□abor &

Delivery/~~postpartum units~~Postpartum Units.

2. Before touching or holding infant, encourage mother to wash hands with antiseptic soap.
3. ~~NICU~~Neonatal Intensive Care Unit personnel are present during visitation upon discretion of neonatologist.
4. The number of other visitors in the room should be at the ~~NICU registered nurse~~Neonatal Intensive Care Unit egistered Nurse's (N) 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.

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

I. E CEPTI NA CI CUMSTANCES

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.
    a. Plan is conducted by the parents and bedside nurse in consultation with the ~~NICU~~Neonatal Intensive Care Unit Nurse Manager.

J. D CUMENTATI N

A. Discharge teaching encounter form updated.
B. Parent visitation list (~~Attachment A~~*Attachment A: Approved Visitor List for Minor Patient*) completed on admission or during hospitalization.
C. Sibling screen form completed prior to visit episode.
D. Parent contact in Electronic Health ecord (EH) updated each shift.

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~~Pediatric Intensive Care Unit 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~~Pediatric Intensive Care Unit patient must be present for the sibling/child visitation.
D. The child may not leave the ~~PICU~~Pediatric Intensive Care Unit 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 ~~N~~egistered Nurse, pediatric intensivist, and bedside ~~N~~egistered Nurse may allow a child younger than 13 years old to visit.
3. The charge ~~N~~egistered Nurse, pediatric intensivist, and bedside ~~N~~egistered Nurse may allow more than two people at the bedside.

All revision dates: 11/15/2023, 10/11/2023, 11/10/2021, 12/17/2018, 5/1/201, 2/1/2012, 3/1/2010, 1/1/2005

Attachments

Attachment A: Approved Visitor □ist for Minor Patient
Attachment B: My Family Visited Today□Form

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/12/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/11/2023
Policy □wner	Jennifer Ferrick: Director, Peds/PICU & NICU	10/11/2023

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PH.27.00 Hazardous Drug Overview

Purpose:

The Department of Pharmacy Services is responsible for dispensing of hazardous drugs (HDs) for Ventura County Medical Center, Santa Paula Hospital, and Ambulatory Care Campus Clinics. This policy provides an outline of the policies and procedures that the Department of Pharmacy Services will follow in preparation and compounding of sterile drug preparations. Facilities that handle HDs must incorporate USP □800□ standards into the occupational safety plan. Ventura County Medical Center Pharmacy policies must, at a minimum, include: a list of HDs, facility and engineering controls, competent ~~personnel~~staff, safe work practices, proper use of appropriate personal protective equipment (PPE), and policies for HD waste segregation and hazardous waste disposal.

Policy:

A. The Department of Pharmacy Services shall follow all policies and procedures pertaining to HDs and hazardous drug ~~Compounding~~compounding to ensure patient and worker safety. The policies are as follows:
PH.27.00 Hazardous Drug □verview
PH.27.01 Hazardous Drug Training, and Safety Program
PH.27.02 Hazardous Drug Storage, Handling, □abeling, and Transport
PH.27.03 Hazardous Drug Garbing, and Compounding
PH.27.0□ Decontamination, Spill, and Waste Management

B. Policies, procedures, and forms will be reviewed and revised annually to reflect local, state, and federal regulatory requirements as well as professional practice standards.

C. The Department of Pharmacy Services shall not compound sterile drug preparations from non-sterile ingredients.

D. Hazardous Drug policies shall be reviewed at least annually by the Pharmacy Director and/or designee(s).

E. Any revisions or deletions to hazardous drug policies shall be communicated to all pharmacy ~~personnel~~staff involved in sterile compounding.

F. A list of HDs handled at the pharmacy will be reviewed and revised annually (Attachment A: VCMC-SPH Hazardous Drug □ist). This review includes an assessment of risk to determine containment strategies and work practices (Attachment B: Hazardous Drug Assessment of □isk, Attachment C: Hazardous Medication Administrate Guideline).

Reference Documents

United States Pharmacopeial Convention, Inc. □800□ Hazardous Drugs-Handling in Healthcare Settings. United States Pharmacopeia National Formulary 35. □ockville, MD: US Pharmacopeial Convention, Inc., 2019.

NI□SH. Publication 200□-165. NI□SH Alert: Preventing □ccupational Exposure to Antineoplastic and □ther Hazardous Drugs in Health Care Settings. Sept 200□. https://www.cdc.gov/niosh/docs/200□-165/pdfs/200□-165.pdf□id□10.26616/NI□SHPUB200□165 accessed on 9/30/2019.

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Kiffmeyer TK et al. Vapour pressures, evaporation behavior and airborne concentrations of hazardous drugs: implications for occupational safety. The Pharmaceutical Journal. Vol 268 March 2002. 331-7.

All revision dates: 11/17/2023, 1/10/2023, 11/10/2020, 11/13/2019

Attachments

Attachment A: VCMC-SPH Hazardous Drug □ist
Attachment B: Hazardous Drug Assessment of □isk
Attachment C: Pharmacy Guideline for Handling Hazardous Drugs

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	11/17/2023
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PH.27.01 Hazardous Drug Training and Safety Program

Definition and Purpose

The Hazardous Drug Training and Safety Program ensures employee safety while working with, and around, Hazardous Drugs (HDs), within the pharmacy setting. All pharmacy staff must receive training, and demonstrate competency, based on their job functions, before independently handling HDs. Employee competency will be reassessed annually. Employees must be aware of potential opportunities for exposure to HDs in their daily tasks, and demonstrate competency in the use of pharmacy equipment designated for use with HDs.

Policy

A. Hazardous drugs (HDs) are stored, prepared, labeled, packaged, transported, administered and disposed of under conditions that protect healthcare workers and patients. In addition, ~~an~~a HD safety program ~~that~~ incorporates administrative, engineering, and work practice controls maintained to provide maximum protections to healthcare workers and patients.

B. Any personnel who may come in contact with HDs during the normal course of their job duties will receive training on HD handling that is specific to their job duties.

C. Compounding personnel must complete required training and competencies associated with non-HD compounding prior to completing training and competency requirements associated with ~~hazardous drug~~HD compounding.

D. Non-compounding ~~persons~~personnel performing environmental services in the containment secondary engineering control areas (C-SEC) must receive training in hand hygiene and garbing ~~(~~including competency verification~~)~~.

Procedures - Administrative Controls

A. The ~~Hazardous Drug List~~HD Risk Acknowledgement will be ~~communicated to~~read and signed by staff ~~in training programs~~ (see attachment).

B. Safety Data Sheets (SDS) will be immediately available for every drug on the pharmacy hazardous drug list via the ~~MSDS~~SDS Online icon on each desktop.

~~Prior to HD training, compounding staff must successfully complete:~~

~~1. All non-hazardous training including safe aseptic manipulation practices.~~

~~2. All non-hazardous compounding competency evaluations.~~

3. All required aseptic media fill sampling and gloved fingertip sampling.
4. Competency Assessments on Hand Hygiene and Garbing.
5. Aseptic Technique.
6. Cleaning and Disinfecting.

C. All employees that handle HDs must successfully complete training and competencies annually that include the following:

Overview of HDs including the NIOSH list.

1. Review of the written policies that apply to the employee's job classification.Didactic
   a. Overview of HDs including the NIOSH list.
   b. Review of the written policies that apply to the employee's job classification.
   c. Review of waste disposal procedure.
   d. Review of spill management procedures.

Review of Waste disposal procedure.

Review of Spill management procedures.

2. Observational
   a. Garbing and appropriate HD PPE
   b. HD specific compounding techniques
      i. General compounding practices that are different than or in addition to compounding of non-HDs.
      ii. Negative pressure compounding techniques to be used inside a biological safety cabinet (BSC).
      iii. Proper use of a closed system drug-transfer devices (CSTDs).
   c. Proper HD waste disposal
   d. Spill management

D. Specific Hazardous Drug Sterile Compounding trainingEnvironmental Services (EVS) personnel who enter negative pressure HD buffer rooms to perform either daily or monthly cleaning duties, testing andmust review Policy 106.013 Hazardous Substance Communication Right to Know in addition to completing the EVS pharmacy competency evaluation willfor Hand Hygiene and Garbing, and Cleaning and Disinfection. Competencies to be successfully completed by employees who compound HDsinitially and annually.

1. All pharmacy staff must successfully complete the General Hazardous Drug Competency annually (DOES NOT INCLUDE HD Compounding Competency).
2. Additional HD training must be received by compounding personnel and includes:
   a. General compounding practices that are different than or in addition to compounding of non-HDs.
   b. Negative pressure compounding techniques to be used inside a containment primary engineering control (C-PEC) such as a biologic safety cabinet.
   c. Proper use of closed system drug-transfer devices (CSTDs).

3. ~~Housekeeping personnel who enter negative pressure HD buffer rooms to perform either daily or monthly cleaning duties, must review Policy 106.013 Hazardous Substance Communication □□ight to Know in addition to completing the EVS pharmacy competency for Hand Hygiene and Garbing, and Cleaning and Disinfection. Competencies to be completed initially and annually.~~

E. Alternate Duty - If requested, it is recommended that workers be given the option of alternate duty under the following circumstances:

1. Staff who are pregnant,
2. Staff who are breastfeeding,
3. Staff actively trying to conceive a child.

~~**Hazardous Drug Risk Acknowledgement**~~

~~A. At the completion of General HD training but before actual HD handling/compounding, *All* pharmacy staff who may handle or compound HDs must read and sign the HD □isk Acknowledgement (see attachment).~~

~~B. Alternate Duty - If requested, it is recommended that workers be given the option of alternate duty under the following circumstances:~~

~~1. Females who are pregnant,~~
~~2. Females who are breastfeeding,~~
~~3. Males or Females actively trying to conceive a child.~~

Environmental Surveillance

A. Environmental surveillance of the compounding environment may be considered to evaluate and verify containment and effectiveness of controls.

~~1. If contamination is found, based on the level of contamination, the decision may be made to perform additional cleaning and evaluate potential change to engineering, work practice or administrative controls. This would be followed by resampling to determine effectiveness of actions.~~

B. If contamination is found, based on the level of contamination, the decision may be made to perform additional cleaning and evaluate potential change to engineering, work practice or administrative controls. This would be followed by surface re-sampling to determine effectiveness of actions.

~~**Treatment of** **Employees with Direct Eye or Skin Exposure to Hazardous Drugs**~~

A. Employees will be instructed to call for help.
B. Contaminated clothing must be removed immediately.
C. Supervisor will be contacted immediately.
D. A safety data sheet for the HD will be obtained for instructions on exposure.
E. If the eye(s) are affected, they must be flushed with water or normal saline for at least 15 minutes.
F. If skin is affected, it must be washed with soap and water and rinsed thoroughly.
G. Employee will obtain medical attention.
H. The ~~Supervisor~~supervisor is responsible for completing the □M75 □Injury First □eport (available ~~online~~on desktops). This step is to be completed within 2□hours of injury.

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Attachments

Attachment A: HD □isk Acknowledgment

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	11/17/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	11/17/2023

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PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport

Definition and Purpose

This policy addresses the general aspects of hazardous drug (HD) handling. HD handling includes receiving, storage, labeling, packaging and transport activities that are not directly associated with compounding activities. For the purposes of this policy, HDs are those substances which appear in the NI□SH □ist of Antineoplastic and □ther Hazardous Drugs in Healthcare Settings, 2016 as well as any subsequent updates to the NI□SH HD list as they become official. VCMC Pharmacy may choose to exempt some dosage forms ~~of~~ if an Assessment of □isk (A□□) is performed and documented.

Policy Statements

A. HDs will be received, stored, labeled, packaged and transported using methods that protect employees, the surrounding environment, and others who may encounter them in the healthcare environment.

B. Antineoplastic HDs will be stored separately from non-hazardous drug inventory.

C. HDs not in their final dosage form will be stored in a room that is negative pressure between 0.01 and 0.03 inches of water column relative to all adjacent areas, and the room is vented to the outside with at least 12 air changes per hour (ACPH).

D. Any personnel who may be expected to handle HDs will wear appropriate personal protective equipment (PPE) as defined in policy. Activities include: receiving, distribution, stocking, inventory control, order picking, compounding, packaging for distribution or disposal, and cleaning.

Procedures

General Handling of Hazardous Drugs

A. □efer to policy PH.27.0□ Hazardous Drug Garbing and Compounding for detailed instructions of the use of PPE in compounding situations and policy PH.27.05 Decontamination, Spill and Waste Management for use of PPE in HD Spill Cleanup.

B. When handling antineoplastic HDs during receiving, personnel will don a chemotherapy impervious gown and at least 1 pair of gloves that have been tested to ASTM 6978.

C. Hands must be washed before and after the use of gloves.

Receiving Hazardous Drugs

General receiving procedures:

A. Suppliers and distributors should be sending antineoplastic HDs in a container separate from other drugs and in a plastic covering that is impervious to liquids.

B. HDs will be unpacked from shipping containers in an area that is neutral/normal or negative pressure to the adjacent areas.

C. A spill kit must be accessible in the receiving area.

D. ~~Designate a~~A specific area or counter is designated for antineoplastic HD receiving. ~~A disposable, plastic-backed preparation absorbent mat should be used on which to place the HD containers when they are unpacked from the tote.~~

E. Those receiving deliveries with HDs in them, must first visually inspect the delivery to verify that there are no signs of damage such as visible stains from leaking containers or sounds of broken glass.

F. Upon receipt, antineoplastic HDs shall remain in the sealed transport bag for transport to the negative pressure room.

G. As these drugs are checked into inventory they will be moved directly to the HD storage area.

~~When receipt is complete, fold the disposable plastic-backed preparation mat inward and place in yellow trace waste, then decontaminate the surface of the receiving counter with a designated decontamination / cleaning agent.~~

H. Carefully remove gloves turning them inside out and not touching the contaminated portion and discard in yellow trace waste, then remove the chemo gown by slowly turning inside out and place in the yellow trace waste.

I. Wash hands.

Summary of Requirements for Receiving and Handling Damaged Hazardous Drug Shipping Containers

A. **If the shipping container appears damaged**

1. Notify supervisor.
2. Seal container without opening and contact the supplier
3. If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous"
4. If the supplier declines return, double bag the damaged goods. Dispose of in a black □C□A U-□isted waste container.
5. Perform any required clean up per EVS.39 Management of Chemotherapy Spills.

A. **If a damaged shipping container must be opened**

1. Notify supervisor to determine if there is product in the tote that must be salvaged.
2. Seal the container in an impervious container.
3. Transport it to a C-PEC and place on a plastic-backed preparation mat.
4. □pen the package and remove undamaged items.
5. Wipe the outside of the undamaged items with a disposable wipe.
6. Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous".
7. If the supplier declines return, dispose of as hazardous waste.

8. Deactivate, decontaminate, clean and disinfect the C-PEC (see Deactivating, Decontaminating, Cleaning, and Disinfecting) before returning to any sterile compounding activity.
9. Damaged packages or shipping cartons must be considered spills that must be reported by Notification Form, and managed per policy PH.27.05 Decontamination, Spill and Waste Management.
10. Segregate HDs waiting to be returned to the supplier in a designated negative pressure area.

Storage of Hazardous Drugs

A. Access to areas where HDs may be encountered will be limited to authorized staff only.
B. Specific labels have been adopted by VCMC Pharmacy and are used to designate HDs which will be affixed to shelves, drawers or bins where HD are stored.
C. Bins, drawers or containers used to routinely store HDs will be configured to reduce the risk of breakage and facilitate spill containment.
D. Antineoplastic HDs that require further manipulation (other than counting or repackaging final dosage forms are stored separately from non-HDs. These HDs will be stored in the negative pressure buffer area designated for HD compounding.
E. Non-antineoplastic, reproductive risk only and final dosage forms of antineoplastic drugs may be stored with regular inventory.
F. HDs that require refrigeration will be stored separately from non-HDs in a refrigerator in the negative pressure area dedicated for HD storage.

Packaging Hazardous Drugs

A. VCMC Pharmacy uses strategies to reduce the risk of exposure to HDs during administration which include:
    1. HD labeling,
    2. Appropriate use of PPE,
    3. Proper disposal of waste.
B. VCMC Pharmacy selects and uses packaging containers and materials that have been shown to maintain the physical integrity, and stability.
C. Packaging materials selected also protect the HD from damage during transport.
D. HDs that do not require manipulation other than counting or repackaging final dosage forms may be prepared outside of a C-PEC and C-SEC or C-SCA unless otherwise indicated by the manufacturer or there are visible signs of exposure hazards (e.g., dust) present.
E. HDs that do not require manipulation other than counting or repackaging final dosage forms may be prepared outside of a C-PEC and C-SEC unless there are visible signs of exposure hazards (e.g., dust) present.
F. If HD dosage forms require manipulation such as crushing tablet(s) or opening capsule(s) for a single dose, personnel must don appropriate PPE and use a plastic pouch to contain any dust or particles generated.
G. □abels that have been adopted by the organization to be used to designate HDs will be affixed to the HD compounded sterile product (CSP) container itself. "Caution: Hazardous Drug".

Transport of Hazardous Drugs

A. Compounded HDs in final containers for patient administration will be placed inside a sealed transport bag that is labeled prominently "Caution Chemotherapy". Transport bags will also have labeling to indicate use of safety precautions and safe disposal.

B. HDs are transported in containers that reduce the risk of damage or breakage.

C. Pneumatic tube systems are not used to transport liquid HDs or antineoplastic HDs.

D. Personnel involved in the transport of HDs will be trained in transport and spill procedures.

E. HD spill kits will be affixed to the HD delivery tote used to transport HD CSPs.

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Attachments

No Attachments

Approval Signatures

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	11/17/2023
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PH.27.03 Hazardous Drug Garbing, and Compounding

Definition and Purpose

This policy communicates and establishes work practice requirements that specifically apply to activities associated with garbing and compounding hazardous drugs (HDs). It builds upon policy already established related to USP 797.

Policy Statements

A. Containment Primary Engineering Controls (C-PECs) and Containment Secondary Engineering Controls (C-SECs) will be used to protect and safeguard the sterility of compounded sterile products (CSPs) and the safety of workers handling HDs.

B. Specifically designed Personal Protective Equipment (PPE) must be used during the handling of HDs.

C. Specific compounding techniques are used when compounding HDs to minimize the risk of contamination of the compounding area and CSP final packaging with HDs.

D. nly trained, authorized compounding personnel may perform deactivation, decontamination, cleaning, and disinfection of the inside surfaces of C-PECs.

Procedures - Personal Protective Equipment

A. Use of PPE for preparation of HDs shall include chemo impervious gowns, gloves that shall be sterile and ASTM D6978-05 rated, and double shoe covers in addition to sterile compounding garb. PH.26.0 Sterile Compounding Attire policy must be followed along with the following prior to entering the negative pressure hazardous compounding room in the clean room suite.

1. A chemo impervious gown shall be worn on top of the regular gown. Gowns worn during compounding of HDs must be the type that close in the back, have no seams or sealed seems to prevent accidental contamination of clothes.
    a. Gowns must be changed every 3 hours during continuous compounding and immediately if they become damaged or contaminated.
2. Double shoe covers shall be donned as personnel enters the negative pressure hazardous compounding room from the ante room. uter shoe covers should be made of water resistant materials.
3. Gloved hands shall be cleansed using waterless alcohol based cleanser.

. A second pair of sterile, ASTM D6978-05 rated gloves shall be donned over the cuff of the chemo gown.

5. The process to exit the negative pressure hazardous compounding room in the clean room suite is as follows in order:
    a. □emove the outer pair of sterile chemo gloves and discard in the hazardous waste container.
    b. □emove the chemo impervious gown and discard in the hazardous waste container.
    c. □emove the outer shoe covers while exiting and stepping over the line of demarcation between the negative pressure hazardous compounding room and the ante room. Discard in the hazardous waste container.
    d. Hands must be washed with soap and water after removing gloves.
6. Additional PPE
    a. If there is a possibility of exposure from splashing, then goggles must be worn (eye glasses and safety glasses are not compliant with □SHA requirements)
    b. Certain drugs have been shown to volatilize (forming a vapor) in room air during normal handling: cisplatin, cyclophosphamide, etoposide and fluorouracil (Kiffmeyer, T). □ther drugs may also volatilize however they have not been studied.
    c. □espiratory protection is recommended for staff who perform the following activities where there is potential to be exposed to HD vapors:
        a. Workers trained to perform spill management.
        b. Workers who are responsible for the deactivation, decontamination, cleaning and disinfection of the area under the deck (work surface) of the C-PEC since this requires opening the C-PEC.
7. Staff performing functions that require respiratory protection must be fit-tested and trained in the use of either:
    a. A NI□SH approved, full-face, dual-chamber respirator (with cartridges that filter both particles and vapors)□
    b. A NI□SH approved, half-face, dual chamber respirator (with cartridges that filter both particles and vapors) AND goggles□
    c. A NI□SH approved Powered Air-Purified □espirator (PAP□)
    d. □efer to the policy on Hazardous Drug Decontamination, Spill and Waste Management (PH.27.05 Decontamination, Spill and Waste Management).
8. Material Handling Considerations in C-PECs during HD compounding
    a. Sanitize items needed with sterile 70□ IPA before transferring them into the C-PEC.
    b. Place only *required* items for compounding inside the C-PEC and arrange them in such a manner as not to impede the flow of first air. Sterile plastic backed absorbent pads may be used.
    c. Small Sharps Disposal Units will be kept within the C-PEC for use in HD compounding. They will be positioned in such a way and be of a size as to minimize the disruption of first air and reduce potential turbulence.
    d. Non-sterile HDs that require manipulation will be prepared in the C-PEC. All cleanroom procedures will be followed to maintain the cleanroom environment. The C-PEC must be terminally cleaned prior to being used for compounding sterile preparations.
    e. All items used inside of the C-PEC must be considered contaminated and therefore must be

placed inside of an appropriate container or bag which is sealed and wiped down before it is removed from the C-PEC for disposal with other hazardous waste.

f. A plastic-backed preparation mat should be placed on the work surface of the C-PEC. The mat should be changed immediately if a spill occurs and regularly during use, and should be discarded at the end of the daily compounding activity.

g. Surface decontamination of the work area will be accomplished periodically throughout the day and between batches of different HDs.

h. After decontaminating the deck between batches of different HDs, once dry, the deck must be disinfected with sterile 70□ IPA.

9. Use of Closed System Drug-Transfer Devices (CSTDs)

a. Use of a CSTD in compounding is strongly encouraged by USP Chapter □800□.

b. When CSTDs are used for compounding, they will be used within the IS□ Class 5 environment.

c. CSTDs must be placed on CSPs for HD administration to reduce risk of HD spill at point of care.

d. IV sets will be attached inside the C-PEC in a manner that protects the tubing set from HD contamination.

e. Prime the tubing with the solution before adding the HD to the bag.

f. CSTDs must be placed on CSPs for HD administration to reduce risk of HD spill at point of care.

10. □uality reviews required at each step of preparation:

a. The individual compounding the HD prepares the CSP solution and syringe for pharmacist check before injecting the drug into the solution.

b. Pharmacist checks right solution, right drug, right dose, right tubing with CSTD attached, and confirms tubing is primed with solution.

c. HD is injected into the IV bag. The individual checking the dose inspects final product for clarity, and particulate matter.

d. All intrathecal chemotherapy are prepared with preservative-free drug and diluents and an independent double check is performed.

e. It is recommended that the labeling and final packaging occur immediately outside of the C-PEC. Compounders must only be working on one patient CSP or one batch at a time so the components, labels and containers for other batches must not be present on the work surface.

f. Pharmacist attaches medication label along with any auxiliary labels.

g. CSP is placed in transport bag and sealed.

h. Documentation is completed on dispensing label and compounding worksheet.

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Attachments

No Attachments

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VENTURA COUNTY
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PH.27.04 Decontamination, Spill, and Waste Management

Definition and Purpose

Hazardous Drugs (HDs) may pose serious health risks to employees that handle them. The purpose of this policy is to define the activities necessary to properly decontaminate areas used for hazardous drug (HD) compounding as well as provide instructions on proper spill management and disposal of HDs.

Policy Statements

HD residues are decontaminated prior to cleaning and disinfection on a regular basis as described in this document. For the purposes of this policy, decontamination means the transfer of chemically active or inactive hazardous drug residues from the target surface to a wipe which is subsequently disposed in the appropriate HD trace waste container for disposal.

To obtain an Safety Data Sheet (SDS) for HDs utilize the MSDS Management (vendor name) icon on any desktop computer and enter the name and manufacturer of the drug.

Persons who handle HDs must be knowledgeable of the spill management procedures and have access to the required supplies and equipment to carry out these actions. Spill management is part of an institution-wide safety program and is developed in conjunction with other departments and disciplines.

Procedures

A. Deactivation, Decontamination, Cleaning and Disinfection

1. Deactivation renders HD surface contamination inert or inactive. However, there is no single agent that can chemically deactivate all types of HD residue. The SDS for each HD may specify chemical agents that can be used to deactivate them, such as sodium hypochlorite solution or peracetic acid/ hydrogen peroxide solution.
2. Decontamination focuses on physically removing surface contamination/HD residue with a surfactant agent and transferring it to sterile, lint-free, absorbent, disposable materials.
3. Cleaning focuses on removing contaminants from surfaces using water, detergents, surfactants, and solvents or other chemicals.
4. Disinfection, which is intended to inhibit or destroy microorganisms, must occur in areas that are required to be sterile.
5. Decontamination, cleaning and disinfection of the Containment Primary Engineering Control (C-PEC)

must occur at least daily (when used), any time a spill occurs, after certification, anytime non-sterile HDs are prepared in the C-PEC and if operational interruption of the C-PEC occurs.

6. ~~Decontamination~~Deactivation, decontamination, cleaning and disinfection of the surfaces under the work tray of the C-PEC will be performed at least monthly.
    a. ~~When deactivating, decontaminating, and cleaning the area under the work tray of a C-PEC.~~
7. Decontamination of the floor and high touch areas outside of the C-PEC but inside the Containment Secondary Engineering Control (C-SEC) will occur daily with a detergent cleaning agent.
    a. Decontamination will only occur when compounding is not taking place.
8. All wipes used for cleaning must be placed in a sealed bag prior to being discarded in either:
    a. □ellow trace waste container (all other wipes).
    b. Black □esource Conservation and □ecovery Act (□C□A) container (wipes used for spill cleanup only)

B. HD Spill Management

1. Spill kits must be kept in areas where HD are handled such as inventory receiving area□inventory storage area□controlled compounding environment and patient care areas.
    a. After a Spill Kit is used it will be immediately restocked.
2. The management of the spill (e.g., decontamination, deactivation, and cleaning) may be dependent on the size and type of spill. Please refer to EVS.39 Management of Chemotherapy Spills.
3. All personnel who may be required to clean up a spill of HDs must receive proper training in spill management and the use of personal protective equipment PPE and NI□SH-certified respirators.
4. Spills must be contained and cleaned immediately only by qualified personnel with appropriate PPE. □ualified personnel must be available whenever HDs are being handled.
5. Personnel who are potentially exposed during the spill or spill clean-up or who have direct skin or eye contact with HDs require immediate evaluation.
6. The trained individual who cleans the spill is responsible for completing documentation and notification forms.
7. Surgical masks and N95 and N100 respirators do not provide any protection from vapors. Use of appropriate full-facepiece, chemical cartridge-type or Powered Air Purifying □espirators (PAP□) may be required if there is known or suspected airborne exposure to vapors or gases.
8. Spills occurring inside of a C-PEC.
    a. When notified of a spill, take respiratory/eye protection (PAP□ or full-face respirator) as well as spill kits from their designated locations and bring to the location of the spill.
    b. If the HD is a liquid, place an absorbent towel gently on top of the liquid to prevent splashing of HD liquid.
    c. If HD is a solid or powder, cover and wipe with a low-linting wipe that has been moistened with sterile water.
    d. Place saturated/contaminated wipes into hazardous waste bag contained in spill kit.
    e. Clean up any broken glass fragments and place into the HD sharps container.
    f. Place any contaminated non-sharps supplies into the hazardous waste bag contained in the

spill kit which will be deposited into a □C□A container

g. □nce the visually evident spill has been contained, wipe the area thoroughly with a low-linting wipe moistened with sterile water from the areas of lesser concentration to the areas of highest concentration of HD.

h. Then follow by decontaminating the area with the designated agent.

i. Any wipes used for the spill decontamination along with the spill itself must be disposed in a black □C□A U-□isted container. All other supplies and PPE may be disposed in the trace yellow receptacles.

j. Terminally clean the C-PEC with the designated germicidal detergent/sporicidal solution. Followed by disinfection with sterile alcohol 70□ .

k. Place wipes used in the cleaning process into an sealed bag, then dispose of in yellow trace waste.

C. Disposal of HD Waste

1. All items used in the preparation of HDs are considered contaminated and are discarded in the appropriate hazardous waste container.
2. Hazardous waste containers are labeled with a hazardous waste sticker. □ellow bags and yellow sharps containers are utilized for trace waste whereas black □C□A containers are utilized for HD Bulk waste and spill disposal.
3. Needles and other sharps are discarded in yellow sharps containers only.
□. Empty vials and other non-sharps items used in HD preparation are discarded in yellow sharps container.
5. All PPE used in handling of HDs will be disposed of as trace HD waste.
6. At least one hazardous waste receptacle will be located in each area where HDs.
7. When containers are full, they will be sealed and removed from pharmacy for disposal.
8. Appropriate disposal of HD waste is handled by a contracted HD waste disposal company.

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References:	

PH.40 Investigational Drug Use

POLICY:

To define and clarify policies and procedures relating to the safe handling, dispensing, administration and disposition of investigational drugs.

To ensure that investigational drug studies (and other drug-related research) at Ventura County Medical Center (VCMC)/Santa Paula Hospital are conducted in a safe, effective and efficient manner. This will be achieved by working cooperatively with the sponsors of the investigational drug research, the Medical Staff, the Pharmacy Department and the Nursing Department.

PROCEDURE:

□ualified physicians who are on the Medical Staff at VCMC may prescribe an investigational drug with approval from the I□B and the Pharmacy & Therapeutics Committee. Such drugs shall be used under the supervision of the principal investigator and be responsible for ensuring that informed consent is secured from the patient.

Investigational drugs shall be prepared and dispensed from the Pharmacy Department to the nursing staff or other qualified health care professionals.

Basic information concerning the pharmacology of the drug, indications, dosage form, the route of administration, adverse drug reactions, drug-drug interactions, symptoms of toxicity, etc. shall be available in the Pharmacy Department, in the patient's medical records and on the patient care area.

GUIDELINES:

A. Physicians who request an investigational drug study approved by the I□B must comply with the following requirements:
    1. A written physician's order indicating name of the investigational drug, or protocol number, strength, route of administration, frequency.
    2. The Pharmacy Department shall proceed in obtaining the drug protocol and a copy of the signed consent. No drug shall be prepared or dispensed without proof of a signed consent.
    3. The Pharmacy Department shall be responsible for the proper labeling, storage and distribution of the investigational drug.
    □. Investigational drugs shall be stored separately from the normal Pharmacy inventory.

5. A copy of the drug protocol shall be maintained on file in the Pharmacy Department with the following information:
    a. Pharmacology of the agent
    b. Cautions
    c. Appropriate dosing information
    d. Side effects/toxicity
    e. Drug and Food Interactions
    f. □eference and telephone numbers
6. Patient consent forms (signed) and the investigational drug protocol shall be maintained on all investigational drugs in the Pharmacy (copy) and in the patient's medical record (original).
7. Dispensing records shall be maintained on all investigational drugs.
8. Nursing staff responsible for administration of the investigational drug shall demonstrate basic understanding of the basic properties of the drug including dosing, administration and side effects. This information shall be provided by the Pharmacy Department.
9. When an investigational drug is discontinued or the patient is discharged, the investigational drug shall be returned with any unused drug to the Pharmacy Department.
10. Any supplies of investigational drugs that are no longer used will be returned back to the manufacturer or sponsor according to protocol guidelines.
11. A formal report shall be presented to the next scheduled P&T Committee for review of the investigational drug.

Related Documents:

Administrative policy 100.035, *Investigational Drugs and Devices*
Pharmacy policy PH.□0.05, *Investigational Drugs – Patient's Own Medications*

All revision dates: 7/6/2017, 7/1/200□, 9/1/1992, 12/1/1989

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References:	

PH.79 Multiple Dose Vials

POLICY:

Multiple dose vials (MDVs) are considered single dose vials and shall be used for one patient and discarded immediately after use.

The following MDVs are exceptions to this policy and may be used for multiple use for one patient:

- Insulin vials
  ~~Hydroxyprogesterone caproate (Makena)~~

The following MDVs are exceptions to this policy and may be used for multiple use for more than one patient:

- Tuberculin Purified Protein Derivative (PPD)
- Vaccines

Multiple dose vials used for sterile compounding in the pharmacy department shall be exempt from this policy. See *PH.26.04 Sterile Drug Preparation, Labeling, End Product Evaluation and Record Keeping*.

PROCEDURE:

To minimize the use of MDVs, single unit injectable drugs are purchased when possible including ampules, pre-filled syringes, and single dose vials.

For medications that are exempt from this policy, the following shall apply:

Handling of vials

A. Wash hands thoroughly before handling injectables.

B. Determine if vial has been stored properly.

C. Check all multiple dose vials for evidence of contamination and deterioration. Color, clarity, and presence or absence of precipitate should resemble normal state.

D. Check all multiple dose vials for evidence of particulate matter: coring (residue from rubber diaphragm), floaters, etc.

E. Use appropriate aseptic technique. Swab with alcohol before puncturing.

F. Place bevel of needle at appropriate angle to prevent coring.

G. Use a sterile needle each time a multiple dose vial is entered.

H. If vial is unopened and if vial requires reconstitution, reconstitute according to manufacturer's guidelines. Determine shelf life date according to section below.

I. If vial is unopened and vial does not require reconstitution, determine shelf life according to section below.

J. If vial is opened, determine if it can be reused according to guidelines below.

K. Store properly according to manufacturer's recommendations.

Determining Shelf Life

A. Multiple dose vials shall be discarded when empty, when suspected or visible contamination is present, when deterioration is suspected, or when particulate matter is present.

B. Multiple dose vials shall be discarded within 28 days after initial access provided they are stored according to manufacturer's recommendation.

   1. Exception: If the manufacturer indicates that the multiple dose vial may be used beyond 28 days, the multiple dose vial may be used for the duration specified by the manufacturer.

C. When vials have been accessed, the recalculated expiration date shall be placed on the vial as follows: "Exp mm/dd/yy".

Exceptions

A multiple dose vial taken into the room of a patient is not considered to be available to other patients, should be restricted to that patient and discarded after use.

Multi-Dose Dilating and Other Diagnostic Eye Drops

Unit dose bottles are not available for many eye drops. The smallest available volume bottle should be substituted for larger volume bottles. All bottles shall be discarded immediately after use.

References:

USP Chapter 797 for Multi-Dose Vials

All revision dates: 10/9/2023, 11/10/2020, 9/17/2019, 5/15/2019, 5/1/2016, 3/1/2013, 8/1/2011

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PH.88 Controlled Substances

POLICY:

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

PROCEDURE:

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

Definition of Controlled Substances

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

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

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

I. Procurement of Controlled Substances

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

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

II. Receiving Controlled Substances

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

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

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

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

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

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

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

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

IV. Dispensing Controlled Substances in Areas Without ADC's

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

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

B. Nursing Narcotic Floor Stock Requisition

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

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

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

C. Controlled Substance Administration Records

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

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

- Date
- Time
- Medications added to inventory

D. Drug Administration using the CSAR documentation:

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

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

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

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

V. Dispensing Controlled Substances in Adult Infusion Center

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

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

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

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

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

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

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

VI. Nursing Administration and Documentation

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

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

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

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

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

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

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

c. Epidural infusions locked into the appropriate pump

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

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

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

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

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

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

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

VIII. Nursing: Discontinuation of Controlled Substance Infusion

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

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

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

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

IX. Disposal of Controlled Substances

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

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

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

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

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

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

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

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

A. Documenting Controlled Substance wasted from ADC's:

a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste.

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

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

B. Documenting Controlled Substance waste using CSAR:

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

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

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

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

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

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

XI. Returned Controlled Substances

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

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

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

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

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

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

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

XII. Nursing Inventory of controlled substances

1. ~~Nursing staff~~Two charge nurses shall complete at least weekly inventory count on ADCs of all controlled substance class II to V.
2. ~~Nursing staff~~Two charge nurses shall complete at least weekly inventory count on CSAR for units that do not have ADCs.
3. If charge nurses are unavailable, any licensed nurse (RN) may perform this function.

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

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

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

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

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Attachments

Attachment A - Lockbox and Portless Tubing Workflow

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PH.119 Piperacillin-Tazobactam (Zosyn) Adult Dosing Protocol

Policy

A standardized piperacillin-tazobactam adult dosing protocol shall be used to ensure optimal dosing of this medication to maximize bactericidal activity, minimize toxicity and enhance patient care under the support and surveillance of the Antimicrobial Stewardship Program. This policy promotes the safe and effective use of piperacillin-tazobactam.

Indication and Usage

At Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), the use of pipercillin-tazobactam (Zosyn) should be limited to treat severe infections confirmed or suspected to involve gram negative organisms:

- Severe intra-abdominal infections
- Nosocomial/healthcare-associated (HCAP) pneumonia
- Severe skin and skin structure infections
- Severe diabetic foot infection
- Any infection where Pseudomonas aeruginosa is suspected

Procedure

The following prolonged infusion protocol shall be ordered for all patients receiving piperacillin-tazobactam except as noted below. See Attachment A for IV compatibility list.

Prolonged Infusion Protocol (4 hour infusion)

- For creatinine clearance (CrCl) >20 mL/min: 4.5 grams intravenous (IV) over 4 hours every 8 hours
- For CrCl <20 mL/min or End Stage Renal Disease: 4.5 grams IV over 4 hours every 12 hours
- For hemodialysis (HD) patients, dose should be administered immediately after HD.

First Dose Exception

- First dose as surgical prophylaxis: 4.5 grams IV over 30 minutes
- First dose in Emergency Department: 4.5 grams IV over 30 minutes
- Subsequent doses will be given using the prolonged infusion protocol and started 6 hours after the initial dose.

Intermittent Infusion Protocol (30-minute infusion)

Indicated if the prolonged infusion is not feasible due to IV incompatibilities or insufficient IV access

- For CrCl >40 mL/min: 4.5 grams IV every 6 hours
- For CrCl 20 to 40 mL/min: 3.375 grams IV every 6 hours
- For CrCl <20 mL/min: 2.25 grams IV every 6 hours
- Intermittent hemodialysis 2.25 grams IV every 8 hours
    - Administer scheduled doses after hemodialysis on dialysis days. If next regularly scheduled dose is not due right after dialysis session, administer an additional dose of 0.75 gram after the dialysis session.
- Peritoneal dialysis: 2.25 grams IV every 8 hours

Drug information and Background for Prolonged Infusion

DESCRIPTION

Piperacillin-tazobactam (Zosyn®) is an injectable antibacterial combination product consisting of the semisynthetic antibiotic piperacillin and the beta-lactamase inhibitor tazobactam.

PIPERACILLIN MECHANISM OF ACTION

Piperacillin is classified as an ureidopenicillin. It inhibits cell wall synthesis causing cell lysis. It is similar to ampicillin in activity against gram-positive cocci. It has excellent activity against streptococcal species, Neisseria, Haemophilus and many members of the family Enterobacteriaceae. It also has excellent activity against anaerobic species of both cocci and bacilli.

It inhibits 60 to 90% of Pseudomonas aeruginosa strains at concentration less than 16 mcg/mL.

It is hydrolyzed by class A beta-lactamases. Although it is hydrolyzed by class C beta-lactamases produced by P.aeruginosa and enterobacter species, it is not an inducer which accounts for its activity against the majority of strains of these and related species.

TAZOBACTAM MECHANISM OF ACTION

Tazobactam is a beta-lactamase inhibitor. It is a beta-lactam compound that has weak antibacterial activity but is a potent inhibitor of many class A beta-lactamases. It acts primarily as a suicide substrate that forms a stable intermediate rendering the enzyme inactive. It prevents the hydrolysis of piperacillin by those enzymes.

Tazobactam inhibits Extended Spectrum Beta Lactamase (ESBL). However, the activity of piperacillin-tazobactam against ESBL-producing bacteria is controversial.

Tazobactam does not inhibit other classes of beta-lactamases or Klebsiella Pneumonia carbapenemase (KPC).

DISTRIBUTION & ELIMINATION

Piperacillin and tazobactam are widely distributed into tissues and body fluid including intestinal mucosa, gallbladder, lung, female reproductive tissues, interstitial fluid, and bile. Mean tissue concentration are generally 50% to 100 % of those in plasma. Distribution of piperacillin and tazobactam into cerebrospinal fluid is low in subjects with non- inflamed meninges.

Piperacillin is excreted in the urine (68% as unchanged drug) and feces (10 to 20%). Tazobactam is excreted

in the urine (80% as unchanged drug; remainder as inactive metabolite).

OPTIMAL DOSING OF PIPERACILLIN – TAZOBACTAM

The pharmacodynamics parameter that correlates with optimal activity of piperacillin-tazobactam (and all beta-lactams) is the proportion of the dosing interval that the free drug concentration remains above the minimum inhibitory concentration (MIC) for the infecting organism (%ft > MIC). It is the best predictor of bacterial killing and microbiologic response. For piperacillin-tazobactam, near maximal bactericidal effect is typically observed when the free drug concentration exceeds the MIC for ≥ 50% of the dosing interval.

Most Food and Drug Administration (FDA)-approved regimens for beta-lactams commonly used today were designed prior to our current knowledge of antimicrobial pharmacodynamics. Previous reports have demonstrated that conventional dosing regimens of certain beta-lactams may not reliably achieve the desirable pharmacodynamics targets required to maximize bactericidal activity. Resistance among gram negative pathogens is a major public health problem. In vitro data in an experimental Pseudomonas aeruginosa aortic endocarditis model in rabbits suggested that bacterial resistance to beta-lactams would develop if the antibiotic concentration fell below the MIC during more than half the dosing interval.

With advances in computer technology and mathematical modeling, it is possible to apply pharmacodynamics principles to clinical practice. One frequently used technique is a Monte Carlo simulation. It can be used to determine the probability that an antibiotic dosing regimen achieves the drug exposure target associated with maximal microbiological effect across the range of MIC observed in clinical practice. Those techniques allow the design of antimicrobial regimens that optimize the probability of achieving this target.

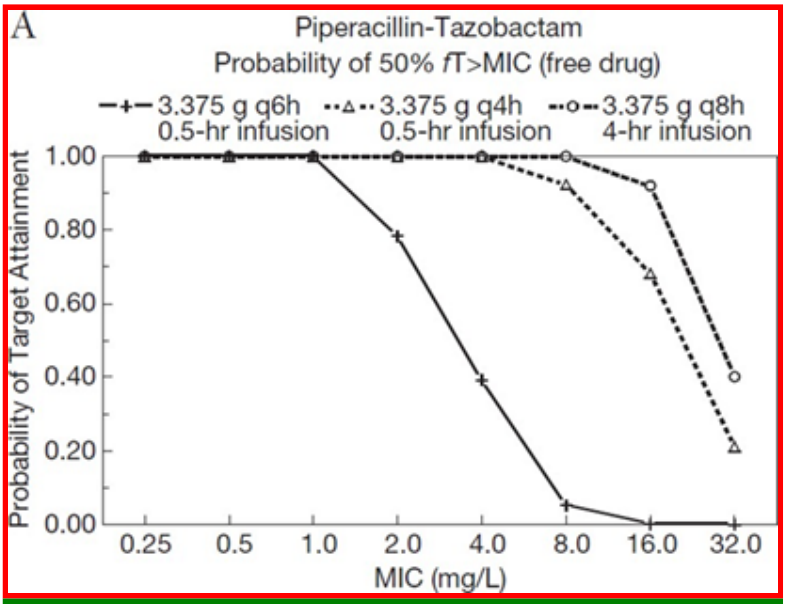
A probability of target attainment (PTA) between 0.9 to 1 correlates with optimal activity. There are several ways to optimize %ft>MIC:

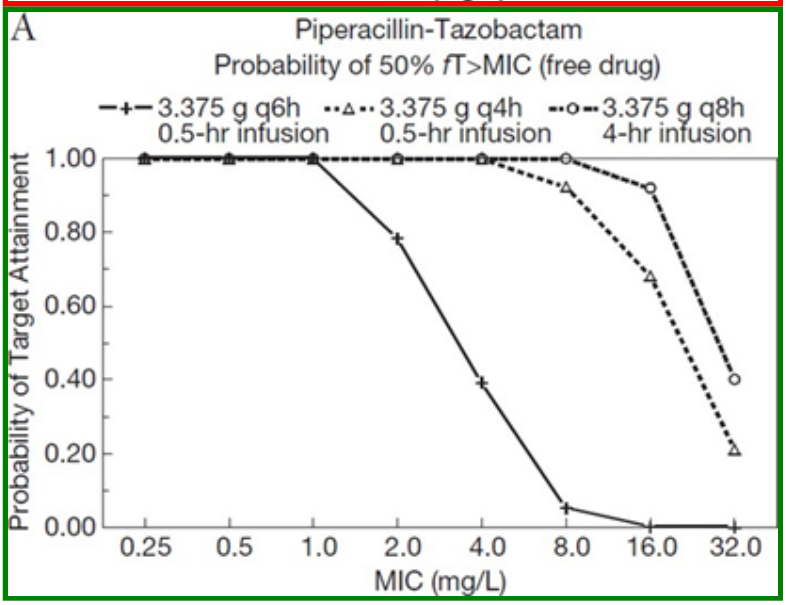
A. INCREASE THE DOSE
    1. A regimen of 4.5 grams IV q6h provides a higher PTA than a regimen of 3.375 grams IV q6h.
    2. This approach is not effective. The higher dosing regimen does not provide an optimal PTA in patients with good renal function and/or infections caused by an organism with MIC ≥ 2 (see Table 1).

B. MORE FREQUENT DOSING
    1. A regimen of 3.375 grams IV q4h provides a higher PTA than a regimen of 3.375 grams IV q6h (see Figure 1).
    2. This approach increases drug cost and risk of toxicity.

C. EXTEND THE INFUSION TIME
    1. Infuse each dose of over 4 hours instead of the traditional 30 minutes to 60 minutes. A dosing regimen of 3.375 grams IV q8h with each dose infused over 4 hours achieves a high PTA.
    2. Resistance rates of Pseudomonas aeruginosa may be reduced.
    3. Improved outcomes may be realized, especially in critically ill patients with Pseudomonas infections.
    4. Drug cost and risk of toxicity are decreased.
    5. This is the most effective way to maximize the PTA (see Figure 1 & Table 1).

D. Figure 1: Probability of target attainment with piperacillin-tazobactam





A. Table 1: Probability of target attainment of various piperacillin-tazobactam regimens stratified by renal function and minimum inhibitory concentration (MIC)

CL_{CR} (ml/min)	Traditional regimen at TZP MIC (mg/liter):								Extended-infusion regimen at TZP MIC (mg/liter):							
	0.25	0.5	1	2	4	8	16	32	0.25	0.5	1	2	4	8	16	32
120	0.96	0.94	0.90	0.83	0.73	0.57	0.36	0.13	0.99	0.99	0.99	0.99	0.99	0.96	0.62	0.11
100	0.98	0.96	0.93	0.88	0.81	0.67	0.46	0.19	0.99	0.99	0.99	0.99	0.99	0.97	0.73	0.17
80	0.99	0.98	0.96	0.93	0.87	0.77	0.58	0.30	0.99	0.99	0.99	0.99	0.99	0.98	0.82	0.27
60	0.99	0.99	0.98	0.96	0.92	0.84	0.70	0.43	0.99	0.99	0.99	0.99	0.99	0.99	0.90	0.43
40	0.99	0.99	0.99	0.98	0.96	0.92	0.84	0.64	0.99	0.99	0.99	0.99	0.99	0.99	0.95	0.62
20	0.99	0.99	0.99	0.99	0.98	0.96	0.91	0.80	0.99	0.99	0.99	0.99	0.99	0.99	0.97	0.81

[a] Traditional regimen, 4.5 g i.v. every 6 h, 30-min infusion; extended-infusion regimen, 3.375 g i.v. every 8 h, 4-h infusion.

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All revision dates: 11/10/2020

Attachments

Attachment A: Piperacillin-tazobactam IV Compatibility

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/9/2023
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	10/9/2023

Delineation Of Privileges

Plastic Surgery & Reconstructive Surgery

Name:

Privilege	Requested	Granted	Deferred	Suspended

Basic Criteria:
a. Successful completion of an ACGME or AOA-accredited residency/fellowship in Plastic Surgery
b. Current board certification by the American Board of Plastic Surgery or the American Osteopathic Board of Plastic Surgery **OR**;
c. Active participation in the examination process leading to certification within 5 years
d. Documentation of a minimum of 100 cases representative of requested privileges within the previous 24 months

Evaluation Requirements: First 5 cases evaluated

Renewal Criteria:
Documentation of a minimum of 100 cases representative of requested privileges within the previous 24 months

PLASTIC SURGERY CORE PRIVILEGES: ___ ___ ___ ___
Please indicate in the drop-down box below any portion of the core privileges not being requested

Admit, evaluate, diagnose, consult, perform history and physician examination, and perform surgical procedures for patients presenting with both congenital and acquired defects or repair due to trauma of the body's soft tissue.

Including but not limited to:
Amputations
Burn management acute/reconstructive
Congenital defects of the head and neck, including clefts of the lip and palate
Cosmetic surgery including liposuction/contouring, face, brow, and neck lifts, rhinoplasty, septoplasty, otoplasty, abdominoplasty, chemicalpeels
Microsurgery including microvascular flaps/grafts, replantation/revascularization of upper/lower extremities/digits, reconstruction of peripheral nerve injuries
Nerve blocks with local anesthetics
Reconstruction by tissue transfer, including flaps/grafts
Reconstruction of congenital and acquired defects of extremities, trunk, and genitalia
Steroid injections
Surgery of benign and malignant lesions of the skin and soft tissue
Surgery of the breast including biopsies, reduction/augmentation, mastectomy, and reconstruction
Treatment/surgery of facial disease and injury including maxillofacial structures
Treatment of skin neoplasia
Wound management

PLASTIC SURGERY PRIVILEGES REQUIRING ADDITIONAL CRITERIA, DOCUMENTATION OR COMPETENCIES:

COMPLEX CRANIOFACIAL SURGERY
a. Documentation of training with special emphasis in this area or fellowship training in craniofacial surgery
b. Documentation of a minimum of 10 cases in the previous 24 months

Evaluation Requirements: First **2** cases evaluated

Renewal Criteria: A minimum of 5 in the previous 24 months

Cranial vault remodeling and related procedures	___	___	___	___
Orthognathic surgery	___	___	___	___

Delineation Of Privileges

Plastic Surgery & Reconstructive Surgery

Name:

Privilege	Requested	Granted	Deferred	Suspended
HAND SURGERY a. Completion of plastic surgery training with documentation of special emphasis in this area or certificate of added qualification in Hand Surgery b. Documentation of a minimum of 20 cases in the previous 24 months **Evaluation Requirements:** First 5 cases evaluated R**enewal Criteria:** A minimum of 10 cases in the previous 24 months				
HAND SURGERY CORE PRIVILEGES: ***Please indicate in the drop-down box below any portion of the core privileges not being requested*** Admit, evaluate, diagnose, consult, perform history and physician examination, and perform surgical procedures for patients presenting with both congenital and acquired defects or repair due to trauma of the hand and forearm **Including but not limited to:** Repair, reconstruction and graft of tendon Peripheral nerve repair and graft Surgery for ganglia, paronychia, infections, cysts or tumors Amputation or revision of amputations Carpal tunnel decompression Skin, nerve and bone grafts pertaining to the hand and upper extremity Repair of laceration Repair of rheumatoid arthritis deformity Repair of open and closed fractures to the hand	___	___	___	___
FLUOROSCOPY Certificate Required	___	___	___	___
LASER SURGERY <u>Initial Criteria</u> a. Documentation of training is required b. Documentation of a minimum of 5 cases in the previous 24 months c. Physician agrees to limit practice to only the specific laser types for which he/she has provided documentation of training/experience <u>Evaluation Requirements:</u> First 2 cases <u>Renewal Criteria:</u> A minimum of 5 cases in the previous 24 months	___	___	___	___
Adult Moderate or Deep Sedation and Analgesia <u>Initial Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) <u>Evaluation Criteria:</u> A minimum of 3 cases evaluated <u>Renewal Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months - If the volume is not met, the next case evaluated	___	___	___	___

Delineation Of Privileges

Plastic Surgery & Reconstructive Surgery

Name:

Privilege	Requested	Granted	Deferred	Suspended
Pediatric Moderate or Deep Sedation and Analgesia Initial Criteria: a. Current PALS b. Completion of Sedation Module (minimum score of 80%) Evaluation Criteria: A minimum of 3 cases evaluated Renewal Criteria: a. Current PALS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months - If the volume is not met, the next case evaluated	___	___	___	___

ACKNOWLEDGMENT OF PRACTITIONER:
I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital and/or within the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by the hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's electronic signature on file
TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature:

_____ Date: _____

Evaluator Assignment:

_____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

Department Chief's Signature:

_____ Date: _____