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

Ventura County Health Care System Oversight Committee
Administrative Policies
March 14, 2024

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

1. 100.011 Hospital Visitation
2. 107.017 Plan of Internal Control
3. 107.034 Additions to the Charge Master
4. IS.01 Radiation Safety & Protection Program
5. IS.47 MRI Magnet Quench
6. OB.42 OB Urinalysis Dipstick Quality Control
7. PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays
8. PH.18.01 340B Drug Pricing Program: Disproportionate Share Hospital
9. R.20 Blood Gas Laboratory RapidPoint 500 Analyzer Quality Control Program
10. R.54 Designees in the Blood Gas Laboratory
11. L.40 Notifiable Laboratory Test Results
12. L.BB.01 Direct Antiglobulin Test
13. L.BB.04 Blood Component Filters
14. L.BB.05 Irradiation of Blood Products
15. L.BB.32 Blood Bank Issue of Blood Products
16. L.BB.33 Sickle Cell Testing - Donor Units

Ventura County Health Care System Oversight Committee
Administrative Policies - March 14, 2024
Summary of Changes

#	Title	Renewal Period	Summary of Changes
1	100.011 Hospital Visitation	Triennial	Added language to policy statement. This change is to comply with new Joint Commision standards.
2	107.017 Plan of Internal Control	Annual	Minor edits to refer to Auditor-Controller rather than Auditor/Controller. Also in 4th paragraph, last sentence of Financial Control, refer to a "financial" audit, not just an audit.
3	107.034 Additions to the Charge Master	Triennial	Modified approvals in procedure section of policy and other edits.
4	IS.01 Radiation Safety & Protection Program	Triennial	Revised policy layout
5	IS.47 MRI Magnet Quench	Triennial	Removed language specific to "life threatening event" and the "cost" if we were to quench the magnet
6	OB.42 OB Urinalysis Dipstick Quality Control	Triennial	Removed keeping logs for 3 years.
7	PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays	Triennial	Add location SPH. Reconcile kit check related boxes and kits
8	PH.18.01 340B Drug Pricing Program: Disproportionate Share Hospital	Annual	Updated patient status to include Outpatient in Bed in Definitions section
9	R.20 Blood Gas Laboratory RapidPoint 500 Analyzer Quality Control Program	Biennial	Additional info added per College of American Pathologists
10	R.54 Designees in the Blood Gas Laboratory	Biennial	Changes per College of American Pathologists
11	L.40 Notifiable Laboratory Test Results	Biennial	Description of HIV result reporting was changed to reflect current practices.
12	L.BB.01 Direct Antiglobulin Test	Biennial	Added date of when paper copy of policy and procedure was last reviewed.
13	L.BB.04 Blood Component Filters	Biennial	Revised filter size from 170 to 150 (Technical Manual, 2023). Added paper copy review date.
14	L.BB.05 Irradiation of Blood Products	Biennial	Revised to include requirements for neonates and pediatric patients, added paper copy review date.
15	L.BB.32 Blood Bank Issue of Blood Products	Biennial	Added "Paper copy reviewed on 12/12/2023 by Janette O'Neill." Revised Procedure section.
16	L.BB.33 Sickle Cell Testing - Donor Units	Biennial	Added "Paper copy reviewed on 12/12/2023 by Janette O'Neill." Reference updated.

Status **Active** PolicyStat ID **15303603**

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Last Revised	2/26/2024
Next Review	2/25/2027
Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices
Policy Area	Administrative - Operating Policies

100.011 Hospital Visitation

POLICY:

In order to ensure the safety and security of patients, employees and volunteers of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), to maintain an orderly environment and assist patients and visitors with finding their destination, there is controlled access to both facilities. Hospital visitation guidelines are available in English and Spanish in the Patient Information Booklet.

At designated entrances only, all guests will be required to check in as either a visitor or a vendor and will then be issued a wrist band or vendor identification (ID) badge.

Hospital visitation will not be restricted, limited or otherwise denied based on age (with the exception of children <13 year old), race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity and expression.

PROCEDURE:

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

HOSPITAL VISITATION GUIDELINES

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

A. Regular visitation hours are from 9:00 a.m. to 9:00 p.m. daily.

B. Patient visits should not exceed two (2) visitors at any given time, unless there is a special circumstance and approved by the Department Manager or House Supervisor.

C. Visitors must be in good health. Visiting is not allowed if the visitor is ill.

D. Visitors are required to comply with all hospital infection control policies.

    1. Visitors of Neonatal Intensive Care Unit (NICU), Pediatrics Unit, Pediatric Intensive Care Unit (PICU), immunocompromised or other high-risk patients may be asked to mask based on community prevalence of respiratory illnesses or at the discretion of the provider or nurse in charge.

E. Service animals will continue to be allowed entrance.

F. No visitors under the age of 13 are permitted in patient care areas unless they are the parents of hospitalized children, the significant other of a laboring person, a brother or sister of a child who is a patient in NICU, Pediatrics Unit, PICU, Obstetrics Unit (OB) or family members of a terminally ill patient. Visitors meeting this criteria may visit under these conditions:

    1. Siblings may visit during regular visitation hours only. They must be accompanied by a responsible adult.
    2. Siblings must be in good health, as determined (when necessary) by a nurse or physician on the unit.

G. Shoes and shirts are required for all visitors.

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

I. No food should be brought in from outside the hospital unless approved by physician and/or nursing staff. Visitors should only eat in patient areas after conferring with nursing staff. Visitors may go to the cafeteria to purchase food.

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

K. Fresh or dried flowers, or potted plants, are not allowed in patient-care areas for immunosuppressed patients.

L. Pediatrics Unit and Pediatric Intensive Care Unit (PICU) - We invite parent participation in the Pediatrics and PICU Unit. One parent may stay with the patient at all times as space allows. Grandparents or other significant adult(s) may visit with a parent, unless otherwise specified. Prior to sibling visitation in the PICU, a joint discussion concerning the risks and benefits of visitation will be had with the charge nurse, Child Life Specialist, physician and parents. See policy *P.32 PICU, NICU and PEDS Visiting Policy* for more information.

M. Neonatal Intensive Care Unit (NICU)-We invite parent participation in the NICU Unit. Parents will be required to wear their identification armband when visiting. One parent may stay with the patient at all time as space allows. Grandparents or other significant adult(s) may visit with a parent unless otherwise specified. See policy *P.32 PICU, NICU and PEDS Visiting Policy* for more information.

N. Emergency Department

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

O. Obstetrics Unit
    1. The support person of the patient may stay in post-partum or ante-partum overnight. A sibling must be accompanied by an adult. The support person will receive an identification bands at the time of delivery.

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

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

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

S. In the event of an infectious disease outbreak, the visitor policy may be adjusted at the recommendation of the Infection Control Committee, the Medical Director of Infection Control and Prevention, or the Hospital Chief Medical Officer. If adjusted, the policy will be reviewed on a monthly basis.

The VCMC entrance will be open daily from 5:00 am until 9:00 pm. The Customer Service desk at VCMC will be staffed by one to two Security Guards 24 hours a day, 7 days a week, as well as a Customer Service employee from 5:00 am to 9:00 pm. At SPH the entrance will be open from Monday through Friday 6:30 am to 9:00 pm and Saturday through Sunday 8:30 am to 6:30 pm. Entrance can be gained through the Emergency Department when the front lobby is closed.

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

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

VCMC Hillmont Surgery Entrance. This entrance will be designated for staff and providers only via badge access. No patients, visitors or vendors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

VCMC Loma Vista MRI Trailer Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff may enter through this entrance 24 hours a day, 7 days a week.

VCMC Radiology Entrance. This entrance is closed to everyone.

VCMC Lab Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

VCMC Boardwalk Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

SPH Staff Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff may enter through this entrance 24 hours a day, 7 days a week.

REFERENCE:

Patient Information Booklet. Ventura County Medical Center and Santa Paula Hospital. [VCHCA-505-050 (01/2020)]

All Revision Dates

2/26/2024, 1/2/2024, 9/18/2023, 7/6/2023, 3/8/2023, 11/22/2017

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/26/2024
Policy Owner	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/23/2024

Status **Active** PolicyStat ID **12335158**

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Effective	2/14/2024		
Last Revised	2/14/2024		
Next Review	2/13/2025		

107.017 Plan of Internal Control

POLICY:

The purpose of this policy is to define methods and procedures necessary to safeguard assets, monitor the accuracy and reliability of accounting data, promote managerial efficiency and encourage adherence to managerial policies.

It is not the purpose of this policy to preempt the ultimate role of responsibility that the County of Ventura Board of Supervisors holds for the Ventura County Medical Center (VCMC) /Santa Paula Hospital (SPH). This policy outlines internal mechanisms of control that have been developed by the VCMC/SPH, the Ventura County Health Care Agency, and the County of Ventura Auditor/Controller, in order to ensure fiscal accountability and managerial effectiveness to the Board of Supervisors. The scope of this policy is general, but references are made to specific documents that provide detailed procedures.

PROCEDURE:

Organization

The organization of the areas of responsibilities within the hospital shall be reviewed at least annually and published in an Organization Chart, which shall be maintained in the front of each Departmental Policy and Procedure Manual (see Attachment A, *VCMC/SPH Organizational Chart*).

The Organizational Chart shall define the reporting mechanisms within VCMC/SPH, the Ventura County Health Care Agency, the Oversight Committee and the Board of Supervisors, which has ultimate responsibility.

Policies and Procedures

Each department within VCMC/SPH shall develop and maintain written policies and procedures necessary for the conduct of its activities, to ensure the quality of its services and to conform to licensing and accreditation requirements applicable to that department. These policies and procedures shall be reviewed every three (3) years and approved by Hospital Administration, Medical Staff and the Health Care Agency Director (by authority delegated by the County Board of Supervisors).

Financial Control

The overall responsibility for financial control rests with the Hospital Chief Executive Officer in conjunction with the Health Care Agency Director and Chief Financial Officer. These individuals shall be accountable for financial control to the County Auditor/ Controller, County Executive Officer and the Board of Supervisors.

VCMC/SPH follows financial accounting guidelines established by the Ventura County Auditor/ Controller's Office, the Office of Statewide Health Planning and Development, and generally accepted accounting principles.

A complete schedule of rates and charges shall be maintained by the HCA Revenue Cycle Department. Inquiries should be directed to the HCA Chief Financial Officer or the Revenue Cycle Director.

A monthly VCMC/SPH financial report is prepared by the VCMC Accounting Department and saved on a common directory of the Hospital server for review by hospital leaders. Internal audits are made periodically by the County Auditor-Controller's staff. These are typically focused reviews on topics such as cash and inventory control and record storage. The County Auditor-Controller's Office arranges for an annual County financial audit, which includes the Ventura County Medical Center, conducted by an independent certified public accounting firm.

Human Resources

The Human Resources Department shall ensure that all personnel actions are conducted according to hospital policies and Memorandums of Agreement (MOA) as established in the Ventura County Personnel Rules and Regulations.

PLAN OF INTERNAL CONTROL DOCUMENTATION

DOCUMENT	RESPONSIBLE PARTY	FILE LOCATION	SCHED. REVIEW
BOARD OF SUPERVISORS:			
County Ordinance	County Government	Government Center	Ongoing
State Government Code	Secretary of State	Government Center	Ongoing
Meeting Minutes	County Government	Government Center	Weekly

DOCUMENT	RESPONSIBLE PARTY	FILE LOCATION	SCHED. REVIEW
Membership	County Government	Government Center	4 Years
***COUNTY GOVERNMENT*:**			
County Administration Manual	County Government	Government Center	Ongoing
***MEDICAL STAFF*:**			
Bylaws	Medical Staff Office	Medical Staff Office	Annual
Organization	Medical Staff Office	Medical Staff Office	Annual
Credentials	Medical Staff Office	Medical Staff Office	Biennial
Committee Minutes	Medical Staff Office	Medical Staff Office	Monthly
***HOSPITAL*:**			
Organization Chart	Hospital Admin	Hospital Admin	Annual
Dept. Manager	Hospital Admin	Hospital Admin	Annual
Administrative Policy	Hospital Admin	Hospital Admin	Triennial
Dept. Functions/ Staffing Responsibilities	Hospital Admin	Hospital Admin	Annual
Dept. Manager Meetings	Hospital Admin	Hospital Admin	Monthly
Reports of Inspection by Agencies & Actions Taken	Hospital Admin	Hospital Admin	As necessary
Annual Report to Grand Jury	Hospital Admin	Hospital Admin	Annual
Hospital License	Hospital Admin	Hospital Admin	Annual
FACILITIES:			
Master Plan	Hospital Admin	Hospital Admin	As necessary
Beds (No. & Type)	Hospital Admin	Hospital Admin	Annual
Statement of Conditions	Hospital Admin	Maintenance	Ongoing
Description & Construction Time-frame	Hospital Admin	Hospital Admin	Biennial
Preventative Maintenance Program	Support Services	Support Services	As necessary
PATIENT CARE:			
Performance Improvement Plan	Administrative Policy Manual		Annual
Review & Evaluation	Patient Care Srvcs	Case Management	Monthly
UR Plan	Administrative Policy Manual		Annual
FISCAL/ACCOUNTING:			

DOCUMENT	RESPONSIBLE PARTY	FILE LOCATION	SCHED. REVIEW
Operating Budget/Capital Budget	Hospital Admin	HCA Accounting	Annual
Schedule of Rates & Charges	Hosp Admin/ HCA Bus. Off.	HCA Business Office	Semi-Annual
Financial Reports	HCA Accounting	HCA Accounting	Monthly
Financial Audit Reports	Auditor-Controller	Auditor-Controller	Annual
Fiscal Intermediary Cost Reports	HCA Accounting	HCA Accounting	Annual
Human Resources:			
Employee Records	HCA Human Resources	HCA Human Resources	Annual
Competency Files	Department Management	VCMC/SPH	Annual
Human Resources Policies	HCA Human Resources	HCA Human Resources	Annual
MOU	HCA Human Resources	Hospital Admin	Biennial
Job & Salary Ordinance	County Human Resources	HCA Human Resources	Annual
Employee Health Program	Occupational Health	Employee Health Services	Annual
Job Description	County Human Resources	HCA Human Resources	Annual
SAFETY/DISASTER:			
Safety Plan	Safety Officer	Hosp. Admin.	Annual
Fire Plan	Fire Safety Chairman	Hosp. Admin.	Annual
Emergency Mangement Plan	Emergency Mgmt Chairman	Hosp. Admin.	Annual
Fire Drills	Fire Safety Committee	EOC Minutes	Quarterly
Disaster Drills	Emergency Mgmt Committee	EOC Minutes	Semi-Annual
Security Management Plan	Security Committee	Security Office	Annual
AUXILIARY:			
Bylaws	Auxiliary	Auxiliary	Annual
Member & Organization	Auxiliary	Auxiliary	Annual
Services	Auxiliary	Auxiliary	Annual
INSURANCE PROGRAM:			

DOCUMENT	RESPONSIBLE PARTY	FILE LOCATION	SCHED. REVIEW
Type Coverage, Exp. Date, Insurer, Policy Co.	County Risk Management	Hosp Admin/ County Risk Mgmt.	Annual
Premium, Payments	County Risk Management	Hosp Admin/HCA Accounting	Annual
DISCHARGE PLANNING/SOCIAL SERVICES:			
Transfer Agreements	Discharge Planning	Hospital Admin	Annual
Home Health Agreements	Case Management	Hospital Admin	Annual
Patients Rights' Policy	Hospital Admin	Admin Manual	Annual
COMMUNITY RELATIONS:			
Media & Press Relations	Hospital Admin	Hospital Admin	Annual
Community Service Programs	Hospital Admin	Hospital Admin	Annual
CONTRACTS:			
Physicians	Hospital Admin	Hospital Admin	Annual
Health Professionals	Hospital Admin	Hospital Admin	Annual
Vendors	County Purchasing	County Purchasing	Annual
Service Contracts	HCA Support Services	Support Services	Annual
Educational Training	Hospital Admin	Hospital Admin	Annual
Third Party Payors	Hospital Admin/HCA Admin	HCA Admin	Annual

All Revision Dates

2/14/2024, 11/16/2021, 9/1/2016, 10/1/2011, 5/1/2006, 12/1/2004, 10/1/1998, 8/1/1992, 8/1/1991, 12/1/1989, 10/1/1986

Attachments

Attachment A: VCMC/SPH Organizational Chart

Approval Signatures

Step Description	Approver	Date

Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	2/14/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/24/2023
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	4/14/2023
Policy Owner	Jill Ward: Chief Financial Officer, VCMC & SPH	4/14/2023

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Effective	2/15/2024	Policy Area	Administrative - Operating Policies
Last Revised	2/15/2024		
Next Review	2/14/2027		

107.034 Additions to the Charge Master

POLICY:

As new medical technology is implemented, it is important to establish appropriate patient charges. Patient charges are listed in the Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) Charge Master which is maintained by the VCMC Business Office.

PROCEDURE:

In order to add a charge to the VCMC Charge Master, the approval of the following are required:

1. Hospital Chief Financial Officer (CFO) for Hospital charges OR Ambulatory Care CFO for Ambulatory Care charges
2. Health Care Agency Director (HCA) OR HCA CFO

A memorandum seeking such approval should be addressed to the above individuals allowing sufficient lead time, prior to introduction of the new service.

Information Needed to Add a Charge to the VCMC Charge Master:

1. Proposed date for initiation of charge;
2. Short descriptive (unique) name of charge;
3. Department(s) in which charge will be generated;
4. Expected annual volume;
5. Current Procedural Terminology code, RVS code, unit values (if known);
6. Proposed price;

7. Narrative justification.

While all VCMC rates are ultimately under the purview of the Board of Supervisors (BOS) and subject to public hearing, the power of approval to change, add, or delete charge master items has been delegated to the HCA Director. However, the complete set of charge master items and rates for any new fiscal year budget is to be included in the BOS budget packet and requires the BOS approval. BOS has delegated such approval power to change, add or delete charge master items throughout the year, to the HCA Director.

All Revision Dates

2/15/2024, 11/1/2019, 7/1/2016, 5/1/2006, 11/1/1998, 8/1/1992, 12/1/1989

Approval Signatures

Step Description	Approver	Date
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	2/15/2024
Finance	Ursula Sutherland: Assistant CFO	11/28/2022
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	11/8/2022
Policy Owner	Michael Taylor: Chief Financial Officer, Health Care Agency	11/8/2022

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Last Revised	3/4/2024
Next Review	3/4/2027
Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services

IS.01 Radiation Safety & Protection Program

POLICY:

In California, all radiation sources, either radiation (X-ray) machines or radioactive material, are subject to State laws and regulations. The statutes are found in the Health and Safety Code, Division 104-Environmental Health. The regulations are found in the California Code of Regulations (CCR), Title 17, Div. 1, Chapter 5, Subchapters 4, 4.5, and 4.7. Title 17 CCR 30253 incorporates by reference the federal regulations specified in Title 10, Code of Federal Regulations (CFR), Part 20. Requirements in 10 CFR 20 apply to all registrants.

This medical imaging facility is required to develop, document, and implement a radiation protection program commensurate with the scope and extent of use of X-ray machines and sufficient to ensure compliance with the above regulations. Additionally, the medical imaging facility shall use, to the extent practical, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are **a**s **l**ow **a**s **r**easonably **a**chievable (ALARA). The Radiation Safety Officer will audit the radiation protection program on an annual basis to ensure it remains within the scope and extent of activities required to ensure compliance with the said regulations.

All components of the Radiation Safety and Protection Program do not have to be contained in one consolidated document. However, all components do have to be documented and identified as being part of the Radiation Protection Program and will be duly listed and described. Records of the Radiation Safety and Protection Program content, implementation and audits must be maintained for inspection by the Department.

The regulatory agency for radiation safety is the Radiologic Health Branch of the Department of Public Health and can be contacted at the following addresses and phone number:

Department of Public Health

Radiologic Health Branch
P.O. Box 997414, MS-7610
Sacramento, CA 95899-7414
Email: RHBInfo@cdph.ca.gov
(916) 327-5106
www.cdph.ca.gov

Access to Title 17 is available for all staff through PolicyStat and can be found within the Imaging Services policy section or directly as policy *IS.17 Title 17 California Code of Regulations*.

PROCEDURE:

Organization and Administration

The delegation and responsibility for each aspect of the radiation program and provisions for ensuring enforcement of radiation safety policies and procedures are as follows:

A. **Facility Radiation Safety Officer, qualifications and responsibilities.**

1. VCMC/SPH's designated Radiation Safety Officer is Miguel Jimenez in partnership with our medical physicist, Therapy Physics Inc.
2. The primary responsibility of the Radiation Safety Officer's (RSO) is implementing the Radiation Safety Program. The RSO shall ensure that radiation safety activities are performed with approved procedures, meeting all regulatory requirements in the daily operation of the licensee's radioactive materials program.
3. The Radiation Safety Officer shall promptly investigate and implement corrective actions as necessary regarding:
    a. Overexposures
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Accidents
    d. Spills
    e. Losses
    f. Thefts
    g. Unauthorized receipts, uses, transfers, and disposals; and
    h. Other deviations from approved radiation safety practice. A written report of these investigations and the corrective actions taken shall be given to management.
4. The Radiation Safety Officer shall implement written policies and procedures to:
    a. Authorize the purchase of radioactive material
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Receive and open packages of radioactive material
    d. Store radioactive material

e. Keep an inventory record of radioactive material
f. Use radioactive material safely
g. Take emergency action if control of radioactive material is lost
h. Perform periodic radiation surveys
i. Perform checks of survey instruments and other safety equipment
j. Dispose of radioactive material
k. Train personnel who work in or frequent areas where radioactive material is used or stored; and
l. Keep a copy of all records and reports required by department regulations, a copy of these regulations, a copy of each licensing request and license including amendments, and the written policies and procedures required by the regulations.

5. The Radiation Safety Officer shall:
    a. Approve radiation safety program changes for medical use not at a medical institution with the consent of management prior to sending to the department for licensing action. assist the radiation safety committee for medical use at a medical institution.
    b. review, sign and date, at least every 3 months the occupational radiation exposure records of all personnel working with radioactive material.

ALARA Program

VCMC/SPH uses, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA) and documents procedures addressing this requirement. Staff resources and educational materials are available within PolicyStat and through annual education.

Dosimetry Program

All registrants are responsible for the protection of individuals that enter the registrants' controlled areas. The registrant is also responsible for ensuring that the public is protected and that the public dose does not exceed the limits found in 10 CFR 20.

A. Each facility must evaluate whether or not personnel monitoring for occupational exposures is required. If a facility chooses to or is required to monitor, then those who are occupationally exposed to radiation should be instructed in the following:
    1. Types of individual monitoring devices used and exchange frequency.
        - Landauer Film badges (and TLD finger rings for Nuclear Medicine): Monthly
    2. Use of control badges.
        - The use of the control badge is used to maintain a base reading of non-occupational exposure. Control badges are kept in the respective

departments until ready to be sent back with appropriate dosimetry badges for reading.

3. Instructions to employees on proper use of individual monitoring devices, including consequences of deceptive exposure of the device.
    - See Radiation Safety Policy "IS.19 Staff Radiation Safety and Dosimetry Monitoring"

4. Procedures for ensuring that the combined occupational total effective dose equivalent (TEDE) to any employees receiving occupational exposure at this facility and at other facilities does not exceed 5 rem per year.
    - Employee dosimetry reports are monitored at specified intervals (see #1 above) to ensure their combined occupational total effective dose equivalent does not exceed 5 rem per year. An employee's exposure is investigated further if his/her monthly deep dose equivalent is greater than 125 mrem (ALARA Level 1) or quarterly deep dose equivalent is greater than 375 mrem (ALARA Level 2) in a quarter.

5. Procedures for obtaining and maintaining employees' concurrent occupational doses during that year.

    Employees are required to self-disclose any and all concurrent occupational doses received during the previous year in January of the subsequent year or upon being employed. Their doses will be sent to Landauer for inclusion in their dose record. The RSO and designate will investigate in a timely manner the cause(s) of all personnel exposures equaling or exceeding Investigation Level II and, if warranted, will take action. A notice of exposure and a questionnaire will be sent to the affected staff to determine the source of exposure. An acknowledgement letter will be obtained from the affected staff. A report of the investigation and actions taken will be presented to the Radiation Safety Committee at the first Radiation Safety Committee meeting following completion of the investigation. The details of these reports will be recorded in the Radiation Safety Committee minutes.

6. Procedures for ensuring that if minors are employed, their occupational TEDE does not exceed 500 millirem per year
    - N/A. We don't employ nor have any intentions of employing minors.

7. Procedures for addressing a declaration of pregnancy.
    - See policy *IS.56 Radiation Protection*. Declaration by employees and withdrawal is a voluntary process.

8. Procedures for maintaining documentation of dose to the embryo/fetus and associated documentation for the declared pregnant worker.
    - If an employee declares a pregnancy, she will be required to wear a fetal badge at the waist level and her dosimetry badge at the collar level. The fetal badge will be submitted and processed once a month to ensure fetal readings do not exceed the set dose limits. The employee's occupational dosimetry badges will be submitted monthly or quarterly based on the

department (see item #1). All dosimetry reports are evaluated by the RSO and/or designate to ensure compliance with state/federal regulations concerning dose limits.

Area Monitoring and Control

A. **Radiation Area Monitoring**

The need for area monitoring shall be evaluated and documented.

- Any area regulated through protective measures and safety provisions is considered a "Controlled Area". Access is restricted to controlled areas with warning signs specified in 17 CCR and incorporated sections of 10 CFR 20.
- Any area accessible to personnel in which there exists radiation at such levels that a major portion of the body (whole body, head and trunk, active blood-forming organs, gonads, or lenses of the eye) could receive in any one hour a dose equivalent in excess of 5 mrem or in 5 consecutive days a dose equivalent in excess of 100 mrem is considered a "Radiation Area"

B. **Instrument Calibration and Maintenance**

Instruments used to verify compliance with regulatory requirements must be appropriate for use and calibrated at required frequencies.

Maintenance of the machine should be addressed. This may be addressed in part by the operator's manual from the manufacturer.

All maintenance and calibration is completed by:

- G.E. Healthcare
- Phillips Healthcare
- Konica
- Siemens Medical
- Hologic
- Varian
- In-house Biomedical Engineering: Contracted to the above vendors for all radiation producing and radiation detection instrumentation on campus. All non-PM based services are coordinated with above vendors and completed by qualified field service engineers to meet current regulatory and manufacturer recommendations.

Radiological Controls

A. **Entry and Exit Controls**

Entry and exit from controlled areas must be adequate to ensure radiation safety. Design of emergency escape routes shall comply with applicable building codes. Document procedures

addressing this requirement.

- All applicable building codes were followed in the design of emergency escape routes of our facility.

B. **Posting**

1. Areas that are required to be posted should be identified in the Radiation Protection Program, in addition to procedures for ensuring that such areas are properly posted. Also, include procedures for ensuring that areas or rooms containing as the only source of radiation are posted with a sign or signs that read "CAUTION X-RAY". Identify who is responsible for maintaining those signs and/or labels. In addition, certain documents must be posted. This requirement is found in 17 CCR 30255(b).
    a. Entrances to X-ray suites are posted with signs that read "CAUTION X-RAY".

2. Conspicuously post:
    a. A current copy of the 17 CCR, incorporated sections of 10 CFR 20, and a copy of operating and emergency procedures applicable to work with sources of radiation (If posting of documents specified above is not practicable, the registrant may post a notice which describes the document and states where it may be examined.)
        - A current copy of 17 CCR and incorporated sections of 10 CFR 20 can be found on PolicyStat within policy "IS.17 Title 17 California Code of Regulations"

    b. A current copy of Department Form RH-2364 (Notice to Employees) in a sufficient number of places to permit individuals working in or frequenting any portion of a restricted area to observe a copy on the way to or from such area.
        - A current copy of RH-2364 (Notice to Employees) is posted in each department where ionizing radiation is utilized.

    c. Any notice of violation involving radiological working conditions, or any order issued pursuant to the Radiation Control Law and any required response from the registrant.
        - Notice of violation and any response will be posted in the cited department.

C. **Disposal of Equipment**

Registrants shall report in writing to the Department the sale, transfer, or discontinuance of use of any reportable source of radiation. See the Guidance for Disposal of X-ray Machines available http://www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx.

D. **Other Controls**

The registrant should evaluate the need for other controls in addition to those mentioned above.

1. The following items should be considered :
    a. Types of controls used to reduce or control exposure to radiation, such as positioning aids, gonadal shielding, protective aprons, protective gloves, mobile shields, etc.
        - Refer to the "Apron Inventory" listing all of the above in each department utilizing radiation or radiation-producing devices.
    b. Procedures for routine inspection/maintenance of such controls.
        - Refer to the policy "IS.24 Lead Apron and Glove Survey" on PolicyStat

Emergency Exposure Situations and Radiation Accident Dosimetry

Identify any possible emergency exposure situations or radiation accidents and document procedures to address such, to include dose assessment.

- An established process to address and manage high radiation dose fluoroscopically guided procedures to ensure proper patient follow-up and follow-ups on suspicious readings has been developed and is followed.
- All exposure situations or radiation accidents that have occurred are reported immediately to the RSO and reviewed quarterly by the Radiation Safety Committee for trends and performance improvement.

Record Keeping and Reporting

All record keeping and reporting requirements are specified in regulations. Document the applicable requirements and commitments to compliance. The facility must also maintain all records of the Radiation Protection Program, including annual program audits and program content review. The following items should also be identified:

The person responsible for maintaining all required records.

- The RSO and/or delegate are responsible for maintaining all required records.

Where the records will be maintained.

- For the most part, all records will be located in Radiology or online.

The format for maintenance of records and documentation.

- Documentation of policies and procedures are online, with a hard copy for specific departments. Film Badge reports are located in their respective departments, and online with Landauer.

Procedures for record keeping regarding additional authorized sites (mobile providers).

- N/A

Reports to Individuals

The Registrant shall provide reports of individual exposure when requested in accordance with 17 CCR 30255. Document procedures addressing this requirement.

- Employees are provided, free of charge, dosimetry badges throughout the duration of their employment. Dosimetry badges must be submitted on a department specific basis. Monthly badges are available on the first of each month, quarterly badges are due on the 15th of each quarter. The dosimetry pick-up/drop-off container is located in each department utilizing badges. The most current dosimetry report is available through the "myLDR.com" web portal.
- User: VCMCDOSEREPORTS
- Pass: Radiation1
- The RSO or delegate reports Level 1 or higher exposure levels to the Radiation Safety Committee. A termination radiation dosimetry summary report is available to each employee once their employment has ended. Annual summary reports are kept indefinitely, available on-line from Landauer Inc.

Radiation Safety Training

A. **Operating and Safety Procedures**

1. All registrants are required to have a written operating and safety procedure manual. This may be the operating manual that comes with a radiation unit which may include safety procedures. However, if safety procedures are not included in the manual they must be developed. These safety procedures must be posted on the machine or where the operator can observe them while using the machine.
2. Document all training your employees, both occupationally exposed and non-occupationally exposed workers, are required to have before using radiation machines including continuing education. Also, document other training you provide to your employees or visitors such as radiation safety and protection program review, safety meetings, formal classroom training, etc.
3. Some of these requirements are found in the 17 CCR 30255(b) (1). Specifically, each registrant shall:
    a. Inform all individuals working in or frequenting any portion of a controlled area of the use of radiation in such portions of the controlled area.
    b. All new employees are required to attend a departmental orientation where he/she is orientated to the various components (policies & procedures) of our radiation protection plan.
    c. Instruct such individuals in the health protection problems associated with exposure to radiation, in precautions or procedures to minimize exposure, instruct such individuals in, and instruct them to observe, to the extent within their control, the applicable provisions of Department regulations for the protection of personnel from exposures to radiation occurring in such areas.

i. This facility has adopted the Radiation Right policies as a guide to effective Radiation Safety.

ii. Annual Radiation Safety review is mandated for all staff dealing with radiation and/or radiation producing devices.

iii. Staff meetings are held routinely, and Radiation Safety incidents are reviewed for best practice.

d. Instruct such individuals of their responsibility to report promptly to the registrant any condition which may lead to or cause a violation of department regulations or unnecessary exposure to radiation, and of the inspection provisions of 17 CCR 30254.

i. Staff are encouraged to report any causes for concern promptly as it relates to department regulation violations or unnecessary radiation exposure. Excessive Fluoroscopy is reported and documented per policy and procedures.

4. Instruct such individuals in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation and advise such individuals as to the radiation exposure reports which they may request pursuant to 17 CCR 30255.

5. Any unusual occurrence or malfunction involving exposure to radiation will be promptly reported to the Equipment Service Coordinator who notifies the vendor and administration. Excessive radiation exposure reports will be documented and presented to the Radiation Safety Committee.

Quality Assurance Programs

Quality assurance program testing and frequency will conform with CCR Title 17 and accreditation requirements. Examples include but are not limited to:

Radiographic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
AEC	**Annual**		**None**	**Exposure meter**
Collimation	**Annual**		**<2% SID**	**IR + metal markers**
Exposure Linearity	**Annual**		**Greater or less than 10%**	**Exposure meter or ion chamber**
Exposure Reproducibility	**Annual**		**Greater or less than 5%**	**Exposure meter or ion chamber**
Exposure time	**Annual**		**<10 ms, greater or less than 20%**	**Exposure meter**
			>10 ms, greater or less than 5%	
Filtration	**Annual**		**>2.5 mm Al**	**Aluminum sheets**

Focal Spot Size or Spatial Resolution	**Annual**		**± 50% stated FSS - <0.8 mm 40% larger – 0.8 mm – 1.5 mm 30% larger – >1.5mm**	**Slit/pinhole camera or star pattern phantom**
kVp	**Annual**		**Greater or less than 10%kVp**	**kVp meter**

Fluoroscopic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
ABC	**Annual**		**None**	**Exposure meter**
Exposure rate	**Annual**		**<10 rad/min**	**Exposure meter**
Protective apparel	**Annual**		**No cracks or gaps**	**Fluoroscope, IR**
Resolution	**Annual**		**None**	**Resolution phantom**

CT Scanner QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits
Contrast resolution	**Semiannual**		**Resolve 5mm objects at 0.5% contrast**
Linearity	**Annually**		**coefficient correlation between the densities & HU should equal or exceed 0.96%**
CT number Accuracy, Noise	**Daily**	**CT Technologist**	**0 +/- 5HU for CT number of water, Noise is dependent on scan parameter (mAs)**
Slice thickness <5mm	**Semiannual**		**0.5 mm**
Slice thickness >5mm	**Semiannual**		**±1.0 mm**
Spatial resolution	**Annual**		**greater or less than 20%**
Table increment accuracy	**Annually**	**Field Service Engineer (PM)**	**Expected table movement should be within ±2 mm**
Uniformity	**Daily**	**CT Technologist**	**<±10 HU across the image**

Regulations

Maintenance of all applicable regulations is required.

Acceptance testing performed on all newly acquired equipment prior to usage. Acceptance testing performed by qualified medical physicist. All acceptance testing procedures are to meet ACR, TJC, IAC, CDPH and Federal Requirements (i.e. MQSA).

Internal Audit Procedures

The Registrant must audit the Radiation Protection Program on an annual basis. Documentation of the annual audits may be requested during inspection. The following items should be addressed depending on the scope of the radiologic health protection problems:

A. Identification of inspection types and program audits conducted, to include radiation machines, personnel and procedures.
    1. Each piece of radiation producing and or radiation detecting device shall be inspected by a qualified medical physicist on an annual basis. All annual testing shall be performed within the confines of current state regulations.
    2. Notification of failure to pass performance-based testing shall be documented and remedied within the allowable time period as dictated by current state regulations.
    3. In certain circumstances equipment must be retested by a qualified medical physicist. Vendor qualified field service engineers shall remedy all deficiencies noted in testing results, and their remedies shall be communicated to the qualified medical physicist.

B. Identification of the individual(s) who are responsible for performing inspections and/or audits.
    1. Only qualified medical physicists shall perform inspections/audits. These individuals must meet requirements as outline by the accreditation body (The Joint Commission diagnostic imaging requirements) and be authorized by the State of CA to provide mammography services.
    2. As a Technologist:
        a. If the test indicates that the x-ray equipment is not functioning within specified standards, I will contact the department Director, equipment vendor, or in-house biomedical engineering to ensure that the equipment is repaired as soon as possible.
        b. If other image quality is not satisfactory, I will contact Therapy Physics, Inc (the medical physicist) to evaluate the system and correct the problem as soon as possible.
        c. All corrective actions will be carried out as soon as possible (within regulatory limits).

C. Identification of where and at what intervals the inspections and/or audits are conducted.
    1. The program is to be valid for VCMC/SPH
    2. Intervals of testing are to be annual. Testing in between annual periods will be dictated by equipment purchases, major component changes in particular systems or the movement of fixed equipment into areas that they do not normally occupy.

Acceptance testing will be conducted at purchase and prior to clinical use for newly acquired equipment. All acceptance testing is designed to satisfy current CDPH, Federal, TJC, ACR, IAC standards.

D. Procedures for conducting the inspections and/or audits.
    1. We are contracted with qualified field service engineers as well as qualified medical physicists. Their contractual obligations are such that they are to make certain that all equipment is compliant with current state and OEM standards and specifications.
    2. The compliance is dictated by the frequency of visits and the legal mandate for frequency of testing. Deficiencies or fail items resulting from testing are remedied within the time confines of current state regulations.

E. Instructions on identification of proper use of instrumentation if staff performs machine maintenance or fluoroscopic monitoring.
    1. The quality control (QC) technologist is responsible for all quality assurance duties not assigned to the lead interpreting physician or the medical physicist. Normally, he or she is expected to perform these duties, but may also assign other qualified personnel or may train and qualify others to do some or all of the tests. When these duties are assigned to others, the QC technologist retains the responsibility to ensure they are performed in accordance with the regulations.
    2. "Other personnel qualified" means persons with technical training appropriate for the task(s) assigned to them. Examples include a radiological technologist qualified under state regulations with appropriate training, a technologist who is trained to do the QC test(s) by the QC Technologist, or other persons appropriately trained to do the task(s) and supervised by the QC technologist. A receptionist or a secretary whose sole qualification is to copy documents, type, or answer the phone is not included under "other" qualified personnel.

All Revision Dates

3/4/2024, 1/23/2024, 5/12/2023, 1/26/2023

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	3/4/2024
Imaging Services	Matt McGill: Director, Imaging Services	3/4/2024

Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/29/2024

Status **Active** PolicyStat ID **14255759**

Origination	12/1/2009
Last Approved	2/6/2024
Effective	2/6/2024
Last Revised	2/6/2024
Next Review	2/5/2027
Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services

IS.47 MRI Magnet Quench

POLICY:

It is the policy of the Imaging Services Department that the MRI magnet will only be quenched in response to a serious safety event impacting a patient, staff, or first responders.

PROCEDURE:

Quenching the magnet is deactivating the magnetic field of the unit.

A magnet quench shall only be initiated if there is a serious safety event which is directly threatening the condition of a patient, staff member, or first responder and there is no other option available due to the impact of the magnetic field on a ferromagnetic object within the scan environment.

The emergency magnet quench button is located in the MRI computer control room. There is a plastic cover over the quench button to prevent accidental activation of the quench.

If you have to quench the magnet due to a serious safety event, lift the plastic cover and push down on the red button. This will initiate the magnet quench.

Remove any patients from the MRI room immediately.

Evacuate any personnel or patients from the MRI area and do not allow anyone to enter the MRI magnet room.

Contact service engineers immediately.

All Revision Dates

2/6/2024, 10/26/2020, 11/17/2017, 4/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/6/2024
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/5/2024
Imaging Services	Matt McGill: Director, Imaging Services	1/23/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Kristina Swaim: Clinical Nurse Manager, OB
Policy Area	OB Nursing

OB.42 OB Urinalysis Dipstick Quality Control

POLICY:

To ensure Quality Control (QC) and accuracy of the urinalysis dipstick procedure in the OB Department.

PROCEDURE:

A. QC is performed daily on the day shift using the urinalysis dipstick control kit called "The Dipper," which includes the urine dipstick control vials for high and low QC. This kit is obtained from Central Supply and is kept refrigerated in the dirty utility rooms in the OB Department at Ventura County Medical Center/Santa Paula Hospital.

B. QC results are recorded on the daily log and must fall within the acceptable high and low ranges.

C. For remedial actions, please refer to the "Remedial Actions" section below.

EQUIPMENT NEEDED:

A. Timing device that measures seconds, i.e. clock, watch, timer.

B. QC testing kit.

C. Gloves.

D. Bayer MULTISTIX 10 SG Reagent Strips for urinalysis.

E. QC log.

QUALITY CONTROL:

A. QC testing kit:

1. "The Dipper" urine dipstick control vials are stored in the specimen refrigerator in OB

at 35.6 - 46°F (2 - 8°C) when not in use. Do not freeze.

2. Must be brought to room temperature for testing QC. 68 - 77°F (20 - 25°C) for at least fifteen (15) minutes.

B. Procedure for QC:
NOTE: Each vial of the **Low Level 1** Control is to be used as a **normal** control for dipsticks. Each vial of the **High Level 2** Control is to be used as an **abnormal** control for dipsticks.

1. Remove the control vials from the refrigerator and allow them to come to room temperature.
2. Immerse the dipstick in the control vial as if it were a patient specimen.
3. Read the dipsticks, visually in accordance with manufacturer's instructions.
4. Record the dipsticks results in the Log, low and high levels.
5. Immediately recap the control vials and return them to 35.6 - 46°F (2 - 8°C) when not in use.
6. QC log documents lot #'s and expiration dates of reagent strips and control vial solutions.

POTENTIAL BIOHAZARDOUS MATERIAL:

1. The QC vial solutions contain human urine. Utilize universal precautions.
2. Dispose of QC vials in the Biohazardous Material Container. The chemical in the solution may form metal azides in plumbing and pose a threat of explosion.

STORAGE AND STABILITY OF CONTROL VIALS:

1. Discard the control if turbid or any evidence of microbial contamination is present.
2. When stored at 35.6 - 46°F (2 - 8°C), the controls are stable until the expiration date stated on the label.
3. After initial use, each vial of control is stable for twenty (20) dipstick immersions or three (3) months, whichever occurs first.

REMEDIAL ACTIONS:

1. If results are not within the acceptable range, then the test should be repeated. Document remedial action on the daily log sheet.
2. If results are still not within the acceptable range after being repeated, then repeat the test using a new bottle of strips and a new vial of controls. The bottle of strips and the control vial not within acceptable range should be discarded.
3. If results are still outside the limits, then notify your supervisor and DO NOT REPORT ANY PATIENT RESULTS UNTIL THE PROBLEM IS RESOLVED.

DOCUMENTATION:

QC Log.

REFERENCES:

Bayer Multistix 10 SG. Product Package. Elkhart, Indiana.

All Revision Dates

2/4/2024, 1/1/2016, 9/1/2006, 2/1/2005

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/4/2024
Laboratory Services	Erlinda Roxas: Director, Laboratory Services	2/4/2024
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	12/2/2022
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/2/2022

Status **Active** PolicyStat ID **15262096**

Origination	9/2/2020	Owner	Sul Jung: Associate Director of Pharmacy Services
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Last Revised	2/20/2024		
Next Review	2/19/2027		

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

POLICY:

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

PROCEDURE:

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

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

C. Responsibility
    1. Pharmacy technician

a. Affix the RFID labels to the medications and maintain adequate inventory levels.

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

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

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

F. Restocking procedure
    1. Used, opened, or expired boxes, kits, or trays must be returned to the pharmacy for replenishment of the content with RFID labeled medications.
        a. Boxes and kits including anesthesiologist medication box: See policy PH.115 Medication Boxes and Kits.
        b. Crash cart: See policy 100.113 Crash Cart Checks and Restocking Process.

c. Anesthesia Pyxis tray and Anesthesia emergency kit exchange process will be performed by a pharmacy technician.

2. The pharmacist shall use the Kit Check technology as outlined in Attachment A to replenish the medications associated with each box, kit, or tray.
3. The pharmacist shall assign a specific location to each box, kit, or tray for tracking purposes (if applicable) and secure it with appropriate locks.
4. The expiration date and name of the earliest expiring medication shall be readily available/visual on the box, kit, or tray.

G. System Management and Maintenance

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

All Revision Dates

2/20/2024, 3/24/2023, 9/13/2022, 9/2/2020

Attachments

Attachment A: Kit Check Procedure Manual

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/20/2024

Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/16/2024

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PH.18.01 340B Drug Pricing Program: Disproportionate Share Hospital

I. Purpose

This policy serves as the basis for the covered entity (CE) Ventura County Medical Center's (VCMC, DSH050159) policy and procedures for the 340B Drug Pricing Program (340B Program), which requires drug manufacturers to provide outpatient drugs to eligible health care organizations, including the covered entity (CE) Ventura County Medical Center [DSH050159], at significantly reduced prices. The CE uses savings from the 340B Program following its intent to reach “more eligible patients and provide more comprehensive services."

II. Background

A. Section 340B of the Public Health Service Act (1992), *(See Reference I)*, requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of the Department of Health and Human Services (DHHS).

   1. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

B. The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

C. Upon registration on 340B Office of Pharmacy Affairs Information System (OPAIS), the CE:

   1. Agrees to abide by specific statutory requirements and prohibitions.
   2. May access 340B drugs.

III. 340B Policy Statements

A. The CE shall comply with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than an eligible patient of the entity.

B. The CEs have systems and internal controls in place to ensure ongoing compliance with all 340B requirements:

    1. Audit Process *(See Section "340B Program Compliance, Monitoring and Reporting")*
    2. Purchasing process *(See Section "Inventory Management")*
    3. Shipping and receiving process *(See Section "Inventory Management")*

C. Registration & Recertification *(See Section "340B Program Enrollment Recertification")*

D. The CEs maintain auditable records demonstrating compliance with the 340B Program.

    1. These records are reviewed by the CE monthly as part of its 340B oversight and program compliance. *(See Section "340B Program Compliance, Monitoring and Reporting")*

E. Policy review, updates, and approval shall be updated and approved by the CEs' Compliance Committee whenever there is a rules clarification, regulations change, or change in guidelines to the 340B Program requirements. Otherwise, the policy shall be reviewed and approved annually by key stakeholders.

IV. Definitions

A. Child Site: An offsite location that is eligible to participate in the 340B Program because it is part of the Covered Entity but is separately registered with the Office of Pharmacy Affairs (OPA) because it has a different street address than the Covered Entity's main facility. A Covered Entity does not need to register outpatient clinics and departments located within the four walls of the entity's main facility. OPA guidance establishes a Medicare cost report test to determine whether an offsite clinic is part of the Covered Entity and, therefore, eligible to use 340B drugs. Under this test, an offsite clinic's costs must be reimbursable on the hospital's Medicare cost report. In implementing this guidance, OPA has taken the position that, to be 340B eligible, an offsite clinic's costs must appear on a reimbursable line of a hospital's most recently filed cost report. A Covered Entity pharmacy is not a Child Site.

B. Covered Entity: The statutory name for facilities and programs eligible to purchase discounted drugs through the 340B Program. Covered entities include federally qualified health center look-alike programs; certain disproportionate share hospitals owned by, or under contract with, State or local governments; and several categories of facilities or programs funded by Federal grant dollars, including federally qualified health centers, AIDS drug assistance programs, hemophilia treatment centers, STD and TB grant recipients, and family planning clinics.

C. Covered Outpatient Drug: The category of drugs for which manufacturers must give 340B discounts to covered entities under the 340B Program. In order for a product to qualify as a Covered Outpatient Drug, it must be FDA-approved, prepared and dispensed pursuant to a

prescription, and used on an outpatient basis. In order for a Covered Outpatient Drug to be paid for by Medicaid or Medicare Part B, a manufacturer must enter into both a Medicaid Drug Rebate Agreement and a Pharmaceutical Pricing Agreement (PPA) that covers the Covered Outpatient Drug. The Medicaid statute includes a limiting provision that excludes from the definition of "Covered Outpatient Drug" any drug, biological product, or insulin that is "provided as part of, or incident to and in the same setting as" certain specified services and paid for by Medicaid as part of payment for those services and not as direct reimbursement for the drug.

D. Disproportionate Share Hospital (DSH): A type of 340B covered entity that receives adjustment payments to provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients. The primary method of qualification is based on the sum of the percentage of Medicare inpatient days and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A. Among other requirements, DSHs must have a DSH Adjustment Percent >11.75% in order to be 340B eligible. VCMC qualified for the 340B Drug Pricing Program as a DSH covered entity.

E. Duplicate Discount: When a manufacturer gives both an up-front 340B discount to a Covered Entity at the time of purchase and a post-purchase discount to a state Medicaid agency after Medicaid pays the Covered Entity for the drug and submits a rebate request to the manufacturer under the Medicaid rebate program. Both the 340B and Medicaid rebate laws protect manufacturers from duplicate discounts. A Covered Entity must comply with the prohibition against duplicate discounts by: (1) billing Medicaid at no more than actual acquisition cost plus a dispensing fee; OR (2) "carving out" Medicaid drugs from its 340B program.

F. Eligible Patient Definition: An individual is a "patient" of a covered entity only if:

    1. The covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; and
    2. The individual receives health care services from a health care professional who is either employed by the covered entity or under contractual or other arrangement such that responsibility for the care provided remains with the covered entity.

G. Parent Site: The main facility of the Covered Entity that becomes eligible to use 340B drugs by virtue of the entity's enrollment in the 340B Program. In contrast, outpatient clinics that have a different street address than the entity's main facility, which are commonly called "child sites," must be separately registered with OPA before they can begin using 340B drugs.

H. Mixed-use setting: A hospital area that serves a mixed patient type of both inpatients and outpatients. Often these are facilities such as surgery centers, cardiac catheter labs, infusion centers, and emergency departments.

    1. Inpatient Status: VCMC determines that patients have an inpatient status if the patient's admit type is one of the following in the electronic health record:
        a. Inpatient
        b. Inpatient Psych
        c. Trauma Inpatient
    2. Outpatient Status: VCMC determines that patients have an outpatient status if the patient's admit type is one of the following in the electronic health record:

a. Clinic
b. Day Surgery
c. ED Telehealth
d. Emergency
e. Observation
f. Outpatient
g. Outpatient Multiday
h. Outpatient in Bed
i. Recurring
j. Telehealth
k. Trauma Emergency
l. Trauma Observation

V. Covered Entity Eligibility

A. **Policy**

1. The CE must meet the requirements of 42 USC §256b(a)(4)(L), *(See Reference II)*, to be eligible for enrollment in, and the purchase of drugs through, the 340B Program.

B. **Purpose**

1. To ensure the CE's eligibility to participate in the 340B Program.

C. **Covered Entity**

1. The CE has locations where it would be appropriate to dispense, administer or prescribe 340B drugs to eligible patients. (*See Reference III*).
2. These locations include the following:
    a. Within the four walls of the parent site; and
    b. Within off-site outpatient locations that are fully integrated in the hospital, reimbursable on the most recently filed Medicare cost report, and registered on 340B OPAIS.

D. **Eligibility Requirements**

1. The CE is owned or operated by a unit of state or local government.
2. The CE has a disproportionate share adjustment percentage greater than 11.75%.
3. The CE does not obtain covered outpatient drugs through a group purchasing organization (GPO) or other group purchasing arrangement for eligible locations, in accordance with GPO Policy Release. (*See Reference IV*)
    a. The CE may define non-covered outpatient drugs: Non-covered outpatient drugs may be purchased on GPO or non-340B contracts.
    b. The CE will maintain a list of all non-covered outpatient drugs. See

Attachment A: List of Non-Covered Outpatient Drugs.

c. CE does not dispense or administer covered outpatient drugs to individuals not meeting the 340B patient definition.

d. If a pharmaceutical manufacturer refuses to sell enough of a 340B priced drug to serve all of the CE's 340B eligible patients, the rest of the quantity needed will be purchased on a non-GPO account. The CE will notify OPA in writing that the manufacturer will not sell the drug at a 340B price. (*See Reference V*)

e. The GPO exclusion does not preclude CE from purchasing covered outpatient drugs through the Prime Vendor Program (PVP). OPA does not consider purchases made through PVP to be a violation of the GPO exclusion

4. The CE maintains a complete roster of 340B, GPO, and non-340B/non-GPO vendor accounts, including segregated GPO accounts for the primary care network.
5. The CE has tracking systems and safeguards in place to prevent GPO violations. *(See Section "340B Program Compliance, Monitoring and Reporting")*
6. The CE ensures that OPAIS is complete, accurate, and correct for all 340B eligible locations including the parent entity, off-site locations, and contract pharmacies. (*See Reference III*)
    a. All off-site locations that use 340B drugs are registered on 340B OPAIS.
    b. All main addresses, billing and shipping addresses, the authorizing official, and the primary contact information are correct and up to date.
    c. The CE regularly reviews its 340B OPAIS records quarterly.
    d. The CE will inform HRSA immediately of any changes to its information by updating the 340B OPAIS and or Medicaid Exclusion File.
    e. The CE will notify HRSA immediately of any changes to The CE's Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage less than 11.75%.
7. The CE annually recertifies information on 340B OPAIS.

E. **GPO Prohibition Exclusion**

1. The CE has identified exclusions to the covered outpatient drug definition.
    a. Drugs that are part of or incident to the service, these drugs are given in the same setting as the service provided, and they are paid (bundled) as part of the service rendered.
    b. Items that do not meet the covered outpatient drug definition are listed in *Attachment A: List of Non-Covered Outpatient Drugs*.
2. An offsite outpatient clinic that is not registered as a child site may purchase drugs using a GPO account as long as the purchase is made on a wholesaler account that is separate from the 340B Program accounts.

VI. 340B Program Enrollment Recertification

A. **Policy**

1. The CE shall maintain the accuracy of 340B OPAIS and be actively registered to participate in the 340B Program.

B. **Purpose**

1. To ensure the CE is appropriately registered and maintains accurate records on 340B OPAIS.
    a. Registration dates:
        i. January 1–January 15 for an effective start date of April 1
        ii. April 1–April 15 for an effective start date of July 1
        iii. July 1–July 15 for an effective start date of October 1
        iv. October 1–October 15 for an effective start date of January 1
    b. 340B Contract Pharmacy Guidelines (https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf).

C. **Enrollment**

1. The CE is eligible to participate in the 340B Program (See Section "*Covered Entity Eligibility*")
2. The CE identifies upcoming registration dates and deadlines.
3. The CE identifies authorizing official and primary contact.
4. The CE has available the required documents:
    a. Medicare cost report:
        i. Worksheet S, S-2, S-3
        ii. Worksheet E, part A, and
        iii. For outpatient facilities: Worksheet C, Worksheet A, and Working trial balance
    b. Certification of ownership status
5. The CE completes registration on 340B OPAIS (https://340bopais.hrsa.gov/).

D. **Recertification Procedure**

1. The CE shall recertify information listed on 340B OPAIS annually.
2. The CE shall verify and confirm cost centers listed on 340B a crosswalk and assure that it matches with the most recently filed Medicare Cost Report.
3. 340B Crosswalk is compared to the OPAIS database to ensure all contact and address information is listed accurately.
4. Any changes or corrections to clinic / contract pharmacy information can be completed during recertification period. However, new clinics cannot be registered at

this time.

5. Ensure there are no clinic termination(s) to be completed.
6. NPI numbers, Primary Contact and Authorizing Official's (AO) contact information is verified and confirmed.
7. Review and verify contract pharmacy name, store #, address listed on the OPA database match the covered entity's contract pharmacy agreement.
8. Ensure all contract pharmacy agreements are current and match the copy of the Third Party Administrators.
    a. Authorizing official completes the annual recertification by following the directions in the recertification email sent from HRSA to the CE prior to the stated deadline.
9. The CE submits specific recertification questions to 340b.recertification@hrsa.gov.

E. **New Outpatient Facilities**

1. The CE will determine that a new outpatient service or facility is eligible to participate in the 340B Program.
    a. The criteria used include that the outpatient service must be fully integrated into hospital, appear as a reimbursable service or clinic on the most recently filed cost report, have outpatient drug use, and have patients who meet the 340B patient definition.
2. The CE's authorizing official completes the online registration process during the registration window.
    a. Submit any updated Medicare cost report information, as required by HRSA: http://www.hrsa.gov/opa/eligibilityandregistration/hospitals/disproportionatesharehospitals/index.html

F. **New Contract Pharmacies**

1. The CE has a signed contract pharmacy services agreement.
    a. The CE's Contracts Division reviews the contract and verifies that all federal, state and local requirements have been met.
2. The CE has contract pharmacy oversight and monitoring policy and procedure developed, approved, and implemented.
3. The CE's authorizing official or designee completes the online registration during one of four registration windows.
    a. Within 15 days from the date of the online registration, the authorizing official certifies online that the contract pharmacy registration request was completed.
4. The CE begins using the contract pharmacy services arrangement only on or after the effective date shown on 340B OPAIS.

G. **Changes to Information in 340B OPAIS**

1. Ventura County Medical Center notifies HRSA immediately of any changes to Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage less than 11.75%.
    a. Ventura County Medical Center will stop the purchase of 340B drugs as soon as Ventura County Medical Center files its cost report with a disproportionate share percentage is less than 11.75%.
    b. Authorizing official will complete the online change request as soon as a change in eligibility is identified.
2. Ventura County Medical Center's registered and eligible clinics that move to new locations can continue with 340B eligibility if only a 'Change Request Form' is submitted with new address. Once approved by Office of Pharmacy Affairs, clinic can continue to be 340B eligible.
3. Clinic expansions and cost centers that are eligible and listed on the current Medicare cost report are registered during the next registration period by the Authorizing Official. 340B drugs shall not be used at the expansion location until clinic is registered and approved by OPA.

VII. 340B Program Roles, Responsibilities and Education

A. **Policy**
    1. The CE participating in the 340B Program must ensure program integrity and compliance with 340B Program requirements. 340B key stakeholders will participate in education and training as needed to ensure that these key stakeholders have the knowledge to guarantee compliant 340B operations.

B. **Purpose**
    1. To identify The CE's key stakeholders and determine their roles, responsibilities and education in maintaining 340B Program integrity and compliance.

C. **Committee Oversight**
    1. The CE will maintain a roster of all key stakeholder's roles, responsibilities and education within the CE's 340B Program.
    2. The CE's Compliance Committee is responsible for the oversight of the 340B Program.
    3. The CE's Compliance Committee:
        a. Meets on a quarterly basis with all key stake holders.
        b. The CE maintains readily retrievable meeting agendas and minutes.
        c. Reviews 340B rules, regulations and guidelines to ensure consistent policies procedures and oversight throughout the entity.
        d. Identifies activities necessary to conduct comprehensive reviews of 340B compliance.

i. Ensure that the organization meets compliance requirements of program eligibility, patient definition, 340B drug diversion and duplicate discounts via ongoing multidisciplinary teamwork.

ii. Integrate departments such as information technology, legal, pharmacy, compliance, and patient financial services to develop standard processes for contract/data review to ensure program compliance.

e. Oversees the review process of compliance activities and audits, as well as taking corrective actions based on findings.

f. The Compliance Committee assesses if the results of audits are indicative of a material breach. (*See Section "340B Material Breach and Noncompliance Disclosure"*)

g. Reviews and approves work group recommendations (process changes, self-monitoring outcomes and resolutions).

4. HRSA Audits:

a. Upon notification of a HRSA audit, all key stakeholders (Pharmacy, Compliance, Finance, Purchasing, Contract Pharmacies, etc.) will be informed of the audit.

b. The CE will comply with any and all requests for information from HRSA during the pre-audit period.

c. During an on-site HRSA audit, all key stakeholders will be involved, and the CE will fully cooperate with the auditor throughout the audit process.

5. Manufacturer Audits

a. The CE will respond to all manufacturer requests for information related to 340B purchases in a timely manner.

b. Upon notification of a manufacturer audit, all key stakeholders will be informed of the audit.

c. The CE will respond to all requests for information from a manufacturer in a timely manner

d. During the on-site manufacturer audit, all key stakeholders will be involved as necessary, and the CE will fully cooperate with the auditor throughout the audit process.

D. **Education and Stakeholder Certification**

1. Education

a. The CE determines any educational requirements for each 340B Program role.

b. Education and training may consist of any of the following:

i. Initial basic training upon hire

ii. On-demand modules on the Apexus website

iii. 340B University
iv. 340B conferences
v. Complete Advance 340B Operations Certification Exam
vi. Participate in HRSA and 340B Health webinars
vii. Participate in statewide 340B workgroup calls
viii. Other 340B related activities

2. The CE provides educational updates and training, as needed.

VIII. Patient Eligibility/Definition

A. **Policy**

1. Per the Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 340B drugs are to be provided only to individuals eligible to receive 340B drugs from covered entities. (*Reference VI*)

B. **Purpose**

1. The CE ensures that 340B drugs are dispensed, administered, and prescribed only to eligible patients.

C. **Patient Eligibility**

1. An individual is a patient CE is 340B eligible only if:
    a. The covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; and
    b. The individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity.
2. The CE recognizes observation patients, registered outpatients, hospital discharge patients and/or any status prior to admission from an eligible location may be eligible to receive 340B Covered Outpatient Drugs.
3. The CE often provides specialty care subsequent to a referral. The prescriptions written for conditions treated by the CE's specialty providers in the outpatient clinics are eligible for 340B prices at the CE's contracted pharmacies with the patient outcomes and follow-up remaining the responsibility of our contracted providers.
4. CE staff are eligible as patients ONLY when they meet all the same criteria required under the patient definition.

IX. 340B Program Compliance, Monitoring and Reporting

A. **Policy**

1. The CE is required to maintain auditable records demonstrating compliance with the 340B Program requirements.

B. **Purpose**

1. To provide an internal monitoring program to ensure comprehensive compliance with the 340B Program.

C. **Diversion and Duplicate Discounts**

1. The CE complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulation, public notices, and guidelines including, but not limited to, selling, giving, or otherwise transferring of covered outpatient drugs purchased under the program to anyone other than a "patient of the covered entity." (See Section "*Patient Eligibility/Definition*".)
2. The CE maintains compliance with 42 USC §256b(a)(5)(A)(i) which prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have mechanisms in place to prevent duplicate discounts.
    a. The CE will append the appropriate modifiers on all claims. Physician Administered Drug claims require a "UD" modifier. The "UD" modifier informs California Department of Health Care Services (DHCS) that a 340B purchased drug was used for the claim. The CE maintains and reviews Medicaid provider numbers and NPI numbers quarterly and assures that they are properly reflected in the Medicaid Exclusion File (MEF).

D. **Medicaid Carve-In**

1. The CE dispenses or administers 340B purchased drugs to Medicaid patients AND subsequently bills Medicaid for those 340B drugs (carve-in) for the mixed-use setting.
2. The CE bills Medicaid per state Medicaid reimbursement requirements. This is audited monthly using internal audits.
3. The CE reviews its 340B OPAIS Medicaid Exclusion File (MEF) records quarterly. Any changes in our MEF information shall be communicated to HRSA immediately by updating 340B OPAIS before the 15th of the month prior to the quarter when the change would take effect.
4. Medicaid reimburses the CE for 340B drugs per state policy and does not seek rebates on drug claims submitted by the CE.
5. All Medicaid prescriptions are excluded from the CE's contract pharmacies. This includes both fee-for-service (FFS) and geographic managed care (GMC) plans.
6. Covered outpatient drugs are only billed to Medicaid for the state of California.

E. **Program Assurance**

1. The designation of all outpatient clinics (340b-eligible or non-340B) are identified when clinics are first created. These clinics are reviewed thereafter on a monthly basis and audited quarterly.
2. The CE voluntarily contracts with an independent consultant to conduct an annual external audit of our program that has been approved by the Compliance Committee.
3. The CE ensures compliance with the GPO Prohibition.
    a. Segregated purchasing accounts are used for non-registered sites
    b. Orders for mixed use are placed through a split billing platform
    c. All orders for clean 340B only sites are placed on separate accounts
4. To demonstrate the ongoing responsibility for health care, the CE shall provide health care to the individual at a registered site of the CE within 15 months of a written prescription.
5. The CE determines outpatient locations and status that meet the following criteria:
    a. Registered hospital-based clinics that provide care to outpatients.
    b. Emergency departments that provide outpatient emergency and primary care to the insured, uninsured and underinsured.
    c. Non-admit patients seen in mixed-use areas (e.g., GI lab, OR, PACU and radiology).
    d. Discharge patients.
    e. Authorized Observation non-admit patients carrying the appropriate outpatient classification. or
    f. Any patient class prior to admission orders being written
6. The CE determines provider eligibility as either employed by the covered entity or provides health care under contractual or other arrangements such that responsibility for the care provided remains with the CE.
7. At no time are prescriptions rewritten solely for the purpose of patient eligibility for 340B prescriptions.
8. Patients treated in the Emergency Department may remain in the Emergency Department for extended periods of time, e.g., awaiting placement to a proper unit or facility, observation status, etc. Once inpatient orders are written for a patient in the Emergency Department, the patient's status shall change to inpatient and they will no longer be eligible to receive 340B drugs.

F. **Program Self Audits & Maintenance**

1. The CE routinely conducts internal monthly reviews of each registered contract pharmacy, mixed use areas and clinics for compliance with 340B Program requirements.
2. The following elements will be reviewed when conducting self-audits:
    a. The prescription shall be written from a site of care that is registered on

340B OPAIS and included as a reimbursed outpatient service cost center on the most recently filed Medicare cost report; and

b. The patient shall have had an eligible encounter in the last 15 months; and

c. The patient shall meet the eligibility defined by HRSA and DHHS; and

d. The provider shall be eligible at the time the prescription is written

3. The CE reviews 340B OPAIS quarterly to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies.
4. The CE reviews the Medicaid Exclusion File (MEF) quarterly to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies.
    a. Twenty randomly selected 340B medications dispensed to Medicaid patients are audited every quarter.
        i. The CE shall confirm that the Medicaid number and/or National Provider Index numbers used to bill Medicaid on the Medicaid Exclusion File are accurate.
5. The CE reconciles purchasing records and dispensing records to ensure that covered outpatient drugs purchased through the 340B Program are dispensed or administered only to patients eligible to receive 340B drugs and that any variances are not the result of diversion.
6. The CE shall maintain its split billing software program by conducing the following:
    a. Weekly review of unknown items.
    b. Quarterly audit of multipliers.
7. The CE reconciles dispensing records to patients' health care records to ensure that all medications dispensed were provided to patients eligible to receive 340B drugs.
    a. Thirty randomly selected dispensed 340B drugs are audited every quarter to confirm that the patients receiving 340B medications were qualified outpatients.
8. The CE will randomly select records from a drug utilization file and perform the audit monthly for all contract pharmacies.
9. The CE reconciles dispensing records and Medicaid billing practices on a monthly basis, to demonstrate compliance with Medicaid billing and duplicate discount.
10. Provider listing is retrieved from reporting on a monthly basis, reviewed for accuracy and is shared with a third party administrator for outpatient contract pharmacy operations.
11. All audit results shall be presented to the Compliance Committee every quarter.

G. **Record Keeping and Data Management**

1. The CE maintains records of 340B-related transactions for a minimum of 7 years in a readily retrievable and auditable format.
    a. This will be stored in a network location and kept up to date on a monthly basis for internal and external audit purposes

2. The CE reviews and maintains data being sent to all third parties as part of its audit and maintenance process
3. The CE maintains complete and auditable records of individual's health care.
4. The CE has an electronic medical records shared between hospital and clinics. No undocumented care is provided under the CE.

X. Inventory Management

A. **Policy**

1. The CE must be able to track and account for all 340B drugs to ensure the prevention of diversion.

B. **Purpose**

1. Ensure the proper procurement and inventory management of 340B drugs.

C. **Background**

1. 340B inventory is procured and managed in the following settings:
    a. In-house pharmacies
    b. Clinic site administration
    c. Contract pharmacies
2. The CE uses both of the following inventory methods:
    a. Physical 340B-only inventory
    b. Virtual mixed-use inventory

D. **Procedure for Purchasing and Logistics**

1. The CE has registered 340B eligible hospital based clinics.
    a. Clinics eligible for 340B pricing are listed on the Health Resources and Services Administration website. (*See Reference III*)
    b. Clinics eligible for 340B pricing shall receive medication using 340B eligible accounts dedicated to 340B-eligible clinics.
    c. Requisitions for 340B pharmaceuticals are submitted in the electronic health record by clinic staff.
    d. When the 340B order arrives at the hospital pharmacy, they are received, quantified and separated by clinic and delivered to the 340B eligible clinic or picked up by the 340B eligible clinic.
    e. Automated dispensing machines located in 340B eligible clinics are refilled with medications that are ordered through 340B accounts dedicated to 340B-eligible clinics.
2. The CE has outpatient GPO eligible clinics.
    a. Outpatient clinics eligible for GPO pricing are located at a different physical address than the parent site and are not registered in 340B

OPAIS.

b. Outpatient clinics eligible for GPO pricing shall receive medication using GPO accounts dedicated to outpatient clinics eligible for GPO pricing.

c. Requisitions for outpatient GPO purchases are are submitted in the electronic health record by clinic staff.

d. When the GPO order arrives at the hospital pharmacy, they are received, quantified and separated by clinic and delivered to the GPO eligible clinic or poicked up by the GPO eligible clinic.

3. Mixed use settings

   a. For the purposes of this policy, all areas within the four walls of Ventura County Medical Center (300 Hillmont Avenue; Ventura, CA 93003) and Santa Paula Hospital (825 North 10th Street; Santa Paula, CA 93060) are mixed use settings.

   b. Designated pharmacy purchasers will ensure all orders are placed appropriately through applicable systems.

   c. Orders for mixed use areas are split to the appropriate account (340B, GPO, non-340B/non-GPO) based on utilization data using an 11-digit NDC match.

   d. All direct non wholesaler vendor orders will be created using split billing software. *See policy PH.17 Direct Ordering Procedure*.

4. Transfers

   a. Transferring between inventories should only be done in the event of an immediate patient need. (e.g. emergency, delay of therapy, and pending discharge.)

   b. At no time should inventory be transferred for convenience or re-stocking purposes.

   c. All transfers should be documented on a Loan-Borrow form, which can be found as Attachment A of policy *PH.16 Pharmaceutical Borrowing and Loaning*.

   d. In the event of inventory transfer, a pharmacist shall sign the form to verify it is needed for immediate patient need.

   e. Inventory transferred from the mixed use areas are replenished at WAC.

   f. Inventory transferred from 340B only shall only be approved by the Director of Pharmacy or designee. Transfers from 340B only areas shall be replaced at WAC or adjusted into accumulation by the 340B team to reconcile the transfer.

5. Returns

   a. Returns shall be processed by inventory management staff and are returned for credit under their corresponding account in a timely manner.

6. Wasted 340B Medication
    a. The CE's mixed use areas use a virtual inventory system and does not define any inventory as 340b for the purpose of waste.
    b. Purchases made in clean 340b only areas have their inventory wasted on site in appropriately labeled medication waste bins without credit..

XI. Contract Pharmacy Operations

A. **Policy**

1. Covered entities are required to provide oversight of their contract pharmacy arrangements to ensure ongoing compliance. The covered entity has full accountability for compliance with all requirements to ensure eligibility and to prevent diversion and duplicate discounts. Auditable records shall be maintained to demonstrate compliance with those requirements.

B. **Purpose**

1. To ensure that the CE remains responsible for all 340B drugs used by its contract pharmacies in accordance with HRSA requirements and guidelines. (*See Reference VII*)

C. **Procedure**

1. The CE maintains regular contact with third party administrators (TPA) to ensure compliance with applicable federal and state policy and legal requirements. This includes at minimum monthly calls with each TPA.
2. The CE contracts with TPAs to facilitate both the design and implementation of the 340B contract pharmacy program.
3. The CE has a written contract in place for each contract pharmacy location that meets HRSA requirements. These contracts follow the suggested 12 essential elements of contract pharmacy agreements. (*See Reference VII*)
    a. Copies of the written contracts for each contract pharmacy location shall be maintained in the Pharmacy Department and shall be made available to HRSA or impacted drug manufacturer upon request.
4. The CE registers each contract pharmacy location on the CE's 340B OPAIS prior to the use of 340B drugs at that site.
5. The CE must notify OPA of any changes to its contract pharmacy program, including when a contract pharmacy relationship has ended.
6. The contract pharmacy may provide other services to the CE or its patients.
7. The CE may not restrict patients to use a contract pharmacy; all patients may use the pharmacy of their choice.
8. Both parties will adhere to all applicable federal, state and local laws.
9. The CE uses a virtual replenishment model using an 11-digit-to-11-digit NDC match for its contract pharmacies.

10. 340B-eligible prescriptions are presented to contract pharmacies via e-prescribing, hard copy, fax and/or phone.
    a. Each prescription is verified by the TPA for patient, prescriber, and outpatient clinic eligibility via encounter data file provided daily and provider file provided monthly.
    b. Updates are may be made to these mechanisms by the CE at minimum monthly intervals or as needed sooner if need be.
11. Contract pharmacies may dispense prescriptions to 340B eligible patients using non-340B drugs.
12. The CE implements a bill-to, ship-to arrangement with the contract pharmacies.
    a. Each individual contract pharmacy orders 340B drugs based on 340B eligible use as determined by the TPA, from CE's contracted wholesalers.
        i. Orders are created by the TPAs or pharmacy and placed using their preferred ordering method.
    b. Invoices are billed and review on a bi-weekly basis to the CE.
13. Contract pharmacy receives shipments directly.
14. Contract pharmacy will verify quantity received with quantity ordered.
    a. Identifies inaccuracies.
    b. Resolves inaccuracies.
    c. Documents resolution of inaccuracies.
15. The CE receives and reviews the invoice for drugs shipped to its contract pharmacies for accuracy on a bi-weekly basis.
16. Contract pharmacies are included in the CE's internal-audit process.
17. Prescriptions that are found to be ineligible in the event of monthly audit shall be submitted to the TPA to process a reversal. These reversal requests are to be tracked to ensure approval of the pharmacy and completion. In the event that a prescription cannot be reversed, it will need to be tracked accordingly and directly with the manufacturer during the next accumulator review.

XII. Material Breach and Non-Compliance Disclosure

A. **Policy**

1. Covered entities are responsible for contacting HRSA as soon as reasonably possible if there is any material breach by the covered entity or any instance of noncompliance with any of the 340B Program requirements. (*See Reference VIII*)

B. **Purpose**

1. To define the CE's material breach of 340B compliance and self-disclosure process.

C. **Non-Compliance**

1. The CE's established threshold of what constitutes a material breach of 340B Program compliance is any error that includes 10% of our total 340B purchases. Any errors less than that shall be reviewed by the Compliance Committee to determine materiality. Any instance of non-compliance that the Compliance Committee decides to consider material shall be reported to HRSA.
    a. The CE ensures that identification of any threshold variations occurs among all its 340B settings, including contract pharmacies during monthly audits.
    b. Such violations require self-disclosure. Violations identified through internal self-audits, independent external audits, or otherwise that exceed this threshold, and that remain non-correctable within a 6 month period from the time of review, shall be immediately reported to HRSA.
2. The CE assesses materiality.
    a. The CE maintains records of materiality assessments.

D. **Disclosure**

1. The CE reports identified material breach immediately to HRSA and applicable manufacturers along with a corrective action plan to address the violation.
    a. The CE will maintain records of material breach violations, including manufacturer resolution correspondence.

References

I. Section 340B of the Public Health Service Act (1992) http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf

II. Title 42 USC 256b(a)(5)(A)(i) https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapII-partD-subpartvii-sec256b.pdf

III. HRSA OPAIS Database https://340bopais.hrsa.gov/

IV. 340B Policy Releases https://www.hrsa.gov/sites/default/files/opa/programrequirements/policyreleases/prohibitionongpoparticipation020713.pdf

V. GPO prohibition entity purchase via GPO https://www.340bpvp.com/content/contentSearch.html?category=content&Ntt=1242&main-submit.

VI. Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/patientandentityeligibility102496.pdf

VII. Notice Regarding Section 602 of the Veterans Health Care Act of 1992; Contract Pharmacy Services https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/contractpharmacyservices082396.pdf

VIII. HRSA Entity Self-Disclosures https://www.hrsa.gov/opa/self-disclosures/self-disclosure.html

All Revision Dates

1/30/2024, 10/16/2023, 5/18/2020, 5/31/2017, 4/1/2016, 11/1/2015, 7/1/2015, 4/1/2015, 1/1/2015

Attachments

Attachment A: List of Non-Covered Outpatient Drugs

Approval Signatures

Step Description	Approver	Date
Authorizing Official	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	1/30/2024
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	1/30/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	1/29/2024
Pharmacy Services	Beatriz Cachu: 340B Program Administrator	12/15/2023

Status **Active** PolicyStat ID **15095932**

Origination	11/28/1989
Last Approved	1/26/2024
Effective	1/26/2024
Last Revised	1/26/2024
Next Review	1/25/2026
Owner	Jessica Rodriguez: Manager, Cardiopulmonary Services
Policy Area	Respiratory Care

R.20 Blood Gas Laboratory RapidPoint 500 Analyzer Quality Control Program

POLICY:

To establish the procedures for the Blood Gas Laboratory RapidPoint 500 Analyzer Quality Control program at Ventura County Medical Center and Santa Paula Hospital.

PROCEDURE:

A. It will be the policy to run a Quality Control program for the RapidPoint 500 analyzers. Much of this program will be in fully computerized and computer managed mode.

1. The RapidPoint 500 analyzers will utilize the Siemens Diagnostics' Automatic Quality Control (AQC) system. This system consists of three (3) replaceable cartridges, one of which is the AQC. The AQC will need to be replaced every 28 days.
2. The AQC system will be set to run all three (3) levels of quality control every eight (8) hours.
3. All staff will have the ability to manually program the analyzer for the QC cycle.
4. New reagent lot/Shipment confirmation of Measurement/Automatic Quality Control Cartridge cartridges: When a new reagent lot or an existing lot from a different shipment is placed into service, that reagent must be compared to the prior lot that is being removed. The new reagent will be compared to the old reagant by using ranges provided by the manufacture. Those ranges will be listed on the report in the Quality Control Corrective Action Log book and can also be located in RapidComm. If the new reagent is within the ranges described, the machine will be ready for use.
5. The Rapidpoint 500 has a measurement cartridge which has a 28 day or set number of sample life span, whichever comes first. Once the measurement cartridge has been replaced and the internal quality control completed, 3 level external Quality

Control testing (using Siemens Rapid QC Complete level 1, 2, and 3) must be performed prior to specimen processing. All printed Quality Control results will be placed into the external Quality Control log book and reviewed and signed off by the Blood Gas Lab Director or designee. External Quality Control results will be uploaded into the RapidComm data management system. The testing material is Siemens Rapid QC Complete level 1, 2, and 3. All internal and external Quality Control test results must be within ranges. Any analyte that fails to fall within Siemens Rapid QC Complete established range is considered out of control and the instrument cannot be utilized for specimen processing. Corrective action must be initiated based upon manufacturer's guidelines found in the Rapidpoint 500 operator's manual. The above outline task for the Rapidpoint 500 measurement cartridge will apply for the Auto Quality Control cartridge as well. All test parameters of the external testing program must pass in order to process blood gas specimens. In the event of a failure immediate on site remedial action must be taken or Siemens Tech-support must be contacted (800-229-3711) to correct the deficiency. All corrective actions taken must be documented in the Quality Control Corrective Action Log book.

B. **AQC Values and Assessments:** Acceptable ranges and means for each analyte on each level will be established and statistical analysis performed, including standard deviations, etc.

1. **Establishing Initial Values:** AQC values were set during installation of the instruments. The Rapidcomm information system has its evaluation system to set "Target Value and Absolute Limits." Siemens Diagnostic has designed the system so that periodic lot changes will not occur. Therefore, the initial values should not require changes over the life of the instruments.
2. **Monitoring and Reassesment of QC Values:** Any AQC failure will be flagged on the display panel of the instrument, and will not allow reporting of results for any analyte (or calculated value based on that analyte) that has sustained AQC failure. In the event of an AQC failure, staff has the ability to manually cycle calibrations. If after repeated calibrations there are still AQC failures, staff should notify a key operator or Siemens Diagnostics technical support.
    a. **Weekly Evaluations:** Key operator staff will review QC data on a weekly basis. This should generally be done on Monday.
    b. **Overriding AQC failures:** It will not be the policy of this Laboratory to allow any AQC failure to be overridden by any operator. The ability to override is inherent in the analyzer software, but is only granted to Level One operators (top level). Level One operations will be assigned to "Key" operators, with the majority of staff assigned as Level Three operators.
3. **DOCUMENTATION**
    A. **Quality Control Logs:**
        1. **Computer records:** Shall be maintained in the Rapidcomm stand-alone computer. All individual data points will be retained by the Rapidcomm information manager.
        2. **Communication Log:** There is a daily report sheet for each shift in the department report room for staff to log procedures that are not covered by the normal Rapidcomm maintenance logs or

to communicate other issues to staff.

All Revision Dates

1/26/2024, 1/18/2024, 8/26/2016, 4/25/2016, 2/10/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	1/26/2024
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	1/26/2024
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	1/25/2024

Status **Active** PolicyStat ID **15192338**

Origination	7/10/2006
Last Approved	2/12/2024
Effective	2/12/2024
Last Revised	2/12/2024
Next Review	2/11/2026
Owner	Jessica Rodriguez: Manager, Cardiopulmonary Services
Policy Area	Respiratory Care

R.54 Designees in the Blood Gas Laboratory

POLICY:

To establish the duties and responsibilities of the Blood Gas Laboratory designees.

PROCEDURE:

I. **DESIGNEES:**

A. **Includes:** The Department Manager and Laboratory Medical Director may assign a qualified Respiratory Therapist to act as Blood Gas Designee. (See attachment of Respiratory Care Blood Gas Designees.)

B. **Examples of Designee Responsibilities:** Designees may, at the Manager's discretion, assume any of the following duties:

1. Management and oversight of Blood Gas Laboratory operations.
2. Development of policies and procedures relevant to Laboratory operations.
3. Oversight of staff activity in the Laboratory, including safe practices.
4. Supervision of Quality Control activities, including Proficiency Studies and Calibration Verification activities.
5. Lead role in the Quality Assessment process.
6. Review of documents produced in the course of Laboratory operations, such as canceled specimen lists, proficiency and Calibration Verification Material (CVM) documents.
7. Review all Blood Gas analysis daily, weekly and monthly reports as required and take any correction actions as may be deemed necessary.
8. Conduct inservice education for staff as may be required.

9. Review maintenance/correction logs maintained for the Blood Gas Laboratory and take corrective action as needed.
10. If the Medical Director is unavailable, the designee is authorized to sign documents for the purpose of timely.

C. The Medical Director will personally document via memo his/her personal, on-site assessment of the adequacy of physical and environmental conditions as well as the adequacy of staffing for Laboratory operations, return of CAP surveys, etc.

D. The Medical Director will evaluate the performance of the technical consultants and designees on a yearly basis.

E. Please see attachment A

All Revision Dates

2/12/2024, 1/9/2024, 12/12/2023, 7/27/2022, 2/13/2019, 10/24/2013

Attachments

R.54 Org Chart 2024.xlsx

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/12/2024
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	2/9/2024
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/9/2024

Status **Active** PolicyStat ID **14649253**

Origination	3/25/2007	Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Last Approved	2/5/2024		
Effective	2/5/2024	Policy Area	Laboratory Services
Last Revised	2/5/2024		
Next Review	2/4/2026		

L.40 Notifiable Laboratory Test Results

POLICY:

The Ventura County Medical Center (VCMC) Laboratory will notify the appropriate physician and/or other authorities of infectious diseases and other reportable test results and will document the notification. The Laboratory Manager will review the state and local regulations and revisions as received.

PROCEDURE:

The State of California lists the reportable disease requirements in Title 17 California Code of Regulations Section 2505 (see attached.) The County of Ventura Public Health Department (VCPHD) has provided a list of the reportable tests and a form on which to report them (see attached). The test results are reported to the VCPHD, the attending physician and the VCMC Infection Control Officer. In most cases, the Public Health Laboratory performs HIV testing, and reports results to the attending physician. In the event that an HIV test is requested by an Emergency Department RN, a rapid assay is performed by Blood Bank personnel and the results are reported to the RN who requested it. Records are maintained in Cerner and in a notebook in the Laboratory's Serology Department.

All Revision Dates

2/5/2024, 11/1/2016

Attachments

A: Confidential Morbidity Report

Title-17-CCR-Section-2505-LabReportableDiseases-Aug-2022.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/5/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/4/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	12/12/2023
Laboratory Services Department	Gayle Haider: Quality Assurance Supervisor, Laboratory Services	11/2/2023

Status **Active** PolicyStat ID **15265049**

Origination	7/20/1991
Last Approved	2/27/2024
Effective	2/27/2024
Last Revised	2/27/2024
Next Review	2/26/2026
Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Laboratory Services - Blood Bank

L.BB.01 Direct Antiglobulin Test

PRINCIPLE:

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

The Direct Antiglobulin Test (DAT) is used to:

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

SPECIMEN:

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

RBCs from an EDTA-anticoagulated blood sample.

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

REAGENTS:

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

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

PROCEDURE:

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

RESULTS/INTERPRETATION:

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

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

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

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

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

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

PROCEDURE NOTES:

Steps 1 - 14 should be performed without interruption.

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

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

REFERENCES:

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

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Paper copy reviewed 12/12/2023
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All Revision Dates

2/27/2024, 9/29/2023, 6/5/2020, 10/3/2017, 3/1/2017, 12/1/2016, 12/1/2013, 10/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/27/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	2/27/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/17/2024

Status **Active** PolicyStat ID **15265063**

Origination	12/10/1993	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	2/27/2024		
Effective	2/27/2024	Policy Area	Laboratory Services - Blood Bank
Last Revised	2/27/2024		
Next Review	2/26/2026		

L.BB.04 Blood Component Filters

PRINCIPLE:

Components must be administered through special IV tubing with a filter designed to remove blood clots and particles potentially harmful to the patient. Standard blood administration tubing has a 150- to 260-micron filter.

All blood and blood components are leukocyte-reduced during production at the blood center therefore not requiring bedside leukocyte reduction.

MATERIALS:

Blood administration sets for the administration of blood and blood components are supplied by Central Supply.

Central supply has two blood administration sets:

- Baxter 4C8723 is a gravity set with a hand pump with a 170 to 260 micro filter.
- Carefusion 72980E is for the Alaris pumps and has a 180 micron filter.

Blood bank supplies a platelet filter for the administration of platelets to pediatric and adult patients.

Platelet filters are not provided for the transfusion of platelets to the neonates. The NICU uses a small filter routinely and should use the same one for platelets.

REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, 2022. 33rd Edition.
2. Cohn et.al. Technical Manual. Bethesda, MD: American Association of Blood Banks, 2023.

21st Edition.

Paper copy reviewed 12/12/2023 by Janette O'Neill, CLS

All Revision Dates

2/27/2024, 8/8/2022, 12/1/2016, 2/1/2012

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/27/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	2/27/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/18/2024

Status **Active** PolicyStat ID **15265073**

Origination	3/11/1993	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	2/27/2024	Policy Area	Laboratory Services - Blood Bank
Effective	2/27/2024		
Last Revised	2/27/2024		
Next Review	2/26/2026		

L.BB.05 Irradiation of Blood Products

PRINCIPLE:

Cellular components are required to be irradiated for certain patient populations to prevent transfusion-associated graft-vs-host disease.

The current gamma irradiation dose recommended to prevent proliferation of donor T lymphocytes in the recipient is a minimum of 25 Gy (2500 cGy/rads) to the central point of the blood container and 15 Gy (1500 cGy/rads) to any other part of the container.

The expiration date of irradiated RBCs is 28 days after irradiation or the original expiration date, whichever date is earliest.

SPECIMEN COLLECTION:

N/A

MATERIALS:

N/A

PROCEDURE:

1. All requests for irradiated blood products must be approved by the pathologist (first request only).
2. Add attribute to patient's "transfusion requirements" and document date and ordering physician in BB comment.
3. Charge "IRR" fee for each irradiated unit ordered.
4. Patients in the following categories should receive irradiated blood products:

a. Patients at risk for graft-versus-host disease (GVHD).
b. Premature neonates weighing less than 1200 g at birth.
c. Recipients of intrauterine transfusions.
d. All neonates.
e. Pediatric patients actively receiving chemotherapy
f. Any patient with:
    - Known or suspected cellular immune deficiency
    - Significant immunosuppression related to chemotherapy or radiation treatment.
g. Any patient receiving:
    - Directed donations from blood relatives
    - HLA-Matched or -crossmatched platelet components
    - Granulocyte transfusion.
h. Patients who are immunodeficient
i. Patients who have bone marrow failure or are status post bone marrow or solid organ transplant.
j. At the discretion of the Attending Physician.
k. All irradiated blood and blood components are special ordered from the blood supplier.

CALIBRATION:

N/A

CALCULATIONS:

N/A

RESULTS:

N/A

LIMITATIONS:

N/A

REFERENCES:

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

2. Cohn, C., et. al. Technical, Manual. Bethesda, MD: American Association of Blood Banks, Current

Edition.

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Paper copy reviewed 12/12/2023 by Janette O'Neill, CLS
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All Revision Dates

2/27/2024, 4/24/2023, 6/5/2020, 12/1/2016, 12/1/2011

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/27/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	2/27/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/18/2024

Status **Active** PolicyStat ID **15265389**

Origination	5/1/1996	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	2/27/2024		
Effective	2/27/2024	Policy Area	Laboratory Services - Blood Bank
Last Revised	2/27/2024		
Next Review	2/26/2026		

L.BB.32 Blood Bank Issue of Blood Products

POLICY:

Anyone who delivers blood or blood products to patient locations at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) must be a member of VCMC/SPH nursing or Medical Staff (i.e., a physician, Nursing Assistant, Medical Office Assistant, Registered Nurse or Licensed Vocational Nurse).

PROCEDURE:

The individual who delivers blood or blood products must present the following to the Blood Bank:

- Patient Identification
- A Blood Pickup Request Form with the patient's name, medical record number, and current vitals.
- Documentation of informed consent

Note: A patient registration label can be presented to the Blood Bank if the Blood Pickup Request Form cannot be printed due to computer down procedure or during an emergency where the patient's treatment would be delayed.

SPECIMEN COLLECTION:

N/A

MATERIALS:

1. Blood Pickup Request Form.
2. Patient registration label (used during computer down time procedures and during emergency dispensing of blood products).

3. Printed Blood Component Tag.

PROCEDURE:

1. The individual (transporter), who will deliver the blood product to the patient location, must present a ***Blood Pick up Request Form*** with the intended recipient's full name and medical record number to the Blood Bank Technologist. This form should also document the current vitals and the documentation of consent forms having been signed.
    a. A patient registration label may be presented during computer down time procedures or during emergency dispensing of blood products.
2. A Blood Bank Technologist will retrieve the proper product for issue by verifying the patient identification on the unit with the identification provided by the transporter.
    a. When multiple units are available for issue, the shortest dated unit will be issued first.
    b. Only one unit of blood will be issued at a time except in an extreme emergency. When more than one unit is issued, it will be transported in a blood transport cooler to the patient's location. (See policy *Supplying Blood in Blood Transport Coolers).*
    c. A transporter can only pick up blood products for one patient recipient at a time.
3. The Blood Bank Technologist will dispense the unit in the Laboratory Information System as follows:

    Health-*e*-Connect:
    a. Open Dispense and Assign Products application.
    b. Choose a location and click <OK>.
    c. Receive the blood pickup request &/or patient registration label from the courier.
    d. Locate the patient's medical record number on the submitted identification form. Enter this medical record number into the medical record number field in the dispense application.
    e. Press the enter/return key.
    f. The patient's demographic information will load. Compare and verify the loaded information is the same as the submitted identification.
    g. Retrieve the appropriate blood product from storage.
    h. Scan the unit Donor Identification Number under product number in product list below.
    i. Press the enter/return key. The product demographics will load.
    j. Click <Save>.
    k. A dispense dialog box will pop up. Enter the following:
        - Physician
        - Patient Location

- Visual Inspection
- Reason for Transfusion
- Courier's user name
- Blood Cooler (if appropriate)
- Blood Recipient wristband number.

l. Click <OK>.

m. An output destination box will appear for printing the Dispense packing form and the Blood Component/Crossmatch/Emergency Tag. Print to default printer for both forms.

4. A visual inspection of the retrieved blood component will be performed as outlined in the policy, *Visual Inspection of Blood Components*.
5. The Blood Bank Technologist, issuing the blood product, will ask the transporter if he/she has performed the blood issue procedure. If the answer is ***no***, the Blood Bank Technologist will explain each step of the procedure and then directly observe their performance of the procedure.
6. The blood product will be handed to the transporter. The Blood Bank Technologist will retain the printed Blood Component/Cross match/Emergency Tag and the read procedure will be performed.
7. The transporter will read all of the following information from the label of the blood product and the Blood Bank staff member will verify that all information read is the same as the information on the printed Blood Component/Cross match/Emergency Tag:
    a. Patient's name and medical record number from the Laboratory label placed on the blood unit.
    b. Patient's Blood Bank wristband number located on the unit. This will be a red or white sticker located next to the Laboratory label. If many units have been dispensed, the wristband number may be written on the Laboratory label because there are no stickers available.
    c. The description of the blood or blood component.
    d. The donor's (unit) 13 digit Identification Number.
    e. The blood type of the donor unit.
    f. The expiration date of the donor unit.
8. The Blood Bank technologist will verify that the compatibility testing has been done and the unit is type specific/type compatible with the patient's blood type.
9. If all the information is correct and complete, the transporter and the Blood Bank Technologist will both sign the Blood Component/Cross match/Emergency Tag using their user name. In addition, the Blood Bank Technologist will:
    a. Document "Yes" next to IRR (Irradiated) if the unit is irradiated.
    b. Document "Neg" next to CMV if the unit is CMV negative, as indicated on the label of the blood unit.

c. Document the hematocrit value next to HCT for red blood cells aliquoted for NICU babies.

10. At the completion of the reading and verification of information, the Blood Bank Technologist will permanently attached the Blood Component/Cross match/Emergency Tag to the donor unit using a plastic "cable tie." This tag must remain attached to the unit for the duration of the transfusion.

CALIBRATION:

N/A

CALCULATIONS:

N/A

QUALITY CONTROL:

See Daily Quality Control SOP 8.1

RESULTS:

N/A

REFERENCES:

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

Cohn, Claudia S., et.al. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.

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Paper copy reviewed on 12/12/2023 by Janette O'Neill.
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All Revision Dates

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Approval Signatures

Step Description	Approver	Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/27/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	2/27/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/18/2024

Status **Active** PolicyStat ID **15265411**

Origination	4/1/2004	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	2/27/2024		
Effective	2/27/2024	Policy Area	Laboratory Services - Blood Bank
Last Revised	2/27/2024		
Next Review	2/26/2026		

L.BB.33 Sickle Cell Testing - Donor Units

PRINCIPLE:

SICKLEDEX is a qualitative solubility test for testing for the presence of sickling hemoglobins in human blood or sickle control material. Deoxygenated Hb-S is insoluble in the presence of a concentrated phosphate buffer solution and forms a turbid suspension that can be easily visualized. Normal Hemoglobin A and other hemoglobins remain in solution under these conditions. These different qualitative outcomes allow for the detection of sickle cell disease and its traits.

SICKLEDEX uses Saponin to lyse the red blood cells. Sodium Hydrosulfite then reduces the released hemoglobin. Reduced Hb-S is insoluble in the concentrated phosphate buffer and forms a cloudy, turbid suspension. Other sickling hemoglobin subtypes may also give a positive result.

CLINICAL SIGNIFICANCE:

Sickle-cell anemia occurs when Hemoglobin S (Hb-S) is present in the homozygous state. When sickle-cell crisis occurs, the patient suffers hemolytic anemia, which effects the spleen, kidneys, lungs, retinas, central nervous system and bones. ***It is extremely important to transfuse such patients with Sickle Cell negative units.***

REAGENTS AND MATERIALS:

STRECK SICKLEDEX KIT

- SICKLEDEX Solubility Buffer
- SICKLEDEX Solubility Reagent Powder
- Dispenser caps for Solubility Buffer
- 12 Polystyrene disposable test tubes (12x75mm)

- 12 20 µL transfer pipettes
- Paperboard test tube rack

STRECK SICKLE-CHEX CONTROL KIT

- Positive control
- Negative control

BLOOD SAMPLE COLLECTION:

1. Fresh blood samples may be collected from a finger puncture.
2. Use anticoagulated whole blood.
3. Blood stored at 2°C to 10°C for up to 45 days may be used for testing.

REAGENT PREPARATION:

The working solubility buffer must be prepared before screening can be performed.

1. Bring buffer and reagent powder to room temperature before mixing.
2. Add the contents of one vial of SICKLEDEX Reagent Powder to one bottle of SICKLEDEX Solubility Buffer.
3. Place a white dispenser cap on the bottle of working solubility buffer. Dissolve the reagent powder completely with vigorous agitation.
4. Record the reconstitution date in the black space provided on the solubility buffer bottle.
5. Store the working solubility buffer tightly capped at 2°C to 10°C when not in use.
6. ***Reconstituted buffer must be used within 45 days.***

CONTROL PREPARATION:

1. Remove the vial of the control from the refrigerator and warm to room temperature (18°-30°C) for 15 minutes before use.
2. To mix: (Do not mix mechanically)
    a. Hold vial horizontally between the palms of the hands and roll the vial back and forth for 20 to 30 seconds.
    b. Mix by rapid inversion to ensure the cells are suspended.
    c. Vials stored for an extended period may require extra mixing.
    d. Gently invert the vials 8 to 10 times immediately before sampling.
3. Refer to the reagent test kit instructions for analyzing control and patient materials.
4. Test kits that require a 20 µL sample should use 1 drop of Sickle-Chex control. Test kits that require a 60 µL sample should use 3 drops of Sickle-Chex control. For accurate delivery volume, the control vial **MUST** be inverted and held vertically directly over the test tube.
5. After sampling, return to refrigeration for maximum open-vial stability. Wipe the threads of

both vial and cap before replacing cap and returning to refrigeration.

6. Storage and Stability: ***Sickle-Chex is stable through the expiration date when stored at 2°-10°C. Open-vial stability is 100 days, based on one opening per day. After opening, Sickle-Chex is stable throughout the open-vial dating when stored at 2°C to 10°C, not to exceed the expiration date stated on the product vial.***

PROCEDURE:

1. Dispense 2.0 mL of cold working SICKLEDEX Solubility Buffer into a 12 x 75 mm disposable polystyrene tubes supplied with 12-test kit. Return working solubility buffer to 2°C to 10°C immediately after use. Allow working solution in test tubes to warm to room temperature (18°C to 30°C). The use of reagents below room temperature can give false results.
2. Add 20 µL of whole blood or 10 µL of packed red cells to the test tube. When running control samples add 20 µL of control.

   Directions for use of plastic pipettes provided with 12-Test Kit:

   Never squeeze the plastic tube while sampling. Filling is automatic.

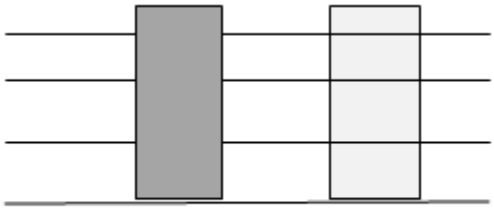
   Step 1: Hold the tube horizontally, and touch the tip of the tube to the sample. Capillary action will automatically draw the sample to the fill line and stop.

   Step 2: To expel the sample, align the tip of the tube with the sample target and squeeze the bulb. If a sample won't expel, hold the tube vertically and slide finger over the vent hole. Then squeeze bulb to deliver sample.

   If the hematocrit is ≤15%, centrifuge the sample for 5-10 minutes at 1200 rpm. Pipet 10 µL of the packed cell volume from the bottom of the tube and add it to the SICKLEDEX Solubility buffer test tube.
3. Mix the contents of the test tube thoroughly by swirling the tube several times. Place the test tube in the test tube rack.
4. Allow the sample to stand at room temperature (18°C to 30°C) for at least six (6) minutes. Observe the sample for turbidity. Results may be observed for up to sixty (60) minutes.

EXPECTED RESULTS:

1. The reaction is read macroscopically by looking through the test tubes at the black lines of the test tube rack.
2. A POSITIVE test for sickling hemoglobin is indicated by a cloudy, turbid suspension through which the black lines are NOT VISIBLE. (Place a Hb-S positive label on the unit)
3. A NEGATIVE test for sickling hemoglobin is indicated by a transparent suspension through which the black lines are CLEARLY VISIBLE.(Place a Hb-S negative label on the unit)



LIMITATIONS:

This procedure will only be used to test donor units of blood and not patient specimens.

REFERENCES:

Streck, 7002 S. 109 Street, Omaha, NE 68128 USA, Product Insert, SICKLEDEX, Current Package Insert.

Streck, 7002 S. 109 Street, Omaha, NE 68128 USA, Product Insert, Sickle-Chex, Current Package Insert.

Cohn, Claudia S., et. al. Technical Manual. Bethesda, MD: American Association of Blood Banks, 2023. 21st Edition.

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Paper copy reviewed on 12/12/2023 by Janette O'Neill.
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All Revision Dates

2/27/2024, 6/5/2020, 12/1/2016, 9/1/2014, 12/1/2011, 1/1/2008

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	2/27/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	2/27/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/18/2024

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

February and March 2024

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Medical Executive Committee Document Approvals

□e□ruary and March 2024

a. Policies & Procedures / Forms / Orders

The follo□ing □ere revie□ed and recommended for approval □y the appropriate Departments□Committees□and the Medical □□ecutive Committee

#	Title	Summary	Frequency	Page
1.	100.02□Continuum of Care/Discharge Planning	Complete policy re□rite	Triennial	3-9
2.	100.200 □npatient Psychiatry Unit □PU□□dmission Criteria	Updated the policy's procedure per the Dept. of Psychiatry Committee	Triennial	10-12
3.	100.240 Suicide Risk □ssessment	Updated the □D licensed practitioner responsi□ilities	Triennial	13-1□
4.	10□032 Blood □lucose Testing □ith the □ova StatStrip □lucose Meter	Updated e□uipment diagrams□and added reference to competency e□am	Triennial	1□-31
5.	10□043 □nteral Tu□e □eeding	Updated process for small □ore feeding tu□es	Triennial	32-40
6.	10□04□Centrali□ed Telemetry Monitoring	Revised to reflect the ne□ telemetry monitoring unit processes	Triennial	41-4□
□	10□04□Midline □ntravenous Catheter Placement	Minor revisions regarding nephrology patients and hand hygiene	Triennial	49-53
□	C□.01 Cancer Program □oals and O□□ectives	Minor terminology change	Triennial	54-55
9.	C□.02 Cancer Registry Case □ligi□ility Criteria	□o changes	Triennial	56-5□
10.	C□.0□Cancer Registry □uality Control Procedures	Updated to reflect current Commission on Cancer Standard 6.1	Triennial	59-60
11.	C□.11 Cancer Registry Policy Statement on Confidentiality	□o changes	Triennial	61-62
12.	C□.16 Cancer Registry □uidelines for Patient Management and Treatment	□o changes	Triennial	63-64
13.	□.3□□emolytic Disease of the □e□□orn □□D□□	Updated per Department of Pediatrics and ne□ □□CU Medical Director	Triennial	65-66
14.	OB.12 La□or and Delivery □dmission and □ssessment	Updated to reflect current documentation re□uirements per current □□ □O□□ Perinatal □ursing guidelines	Triennial	6□-□2
15.	RS.20 □ssessment □Scope of Occupational Therapy □OT□□ssessment□	□o changes	Triennial	□3-□□
16.	□.03 □lcohol □ ithdra□al in the □PU/CSU	Minor revision of documentation re□uirements	Triennial	□□-□9
1□	□.□0 □PU Tu□Room Use	□o changes	Triennial	□0-□1
1□	100.010 Photographing of Patients	□o changes	Triennial	□2-□3
19.	100.03□Discharge Re□uirements	Minor revision regarding PCP and follo□ up	Triennial	□4-□6
20.	100.04□Referral of Potential Organ and Tissue Donors	Revised communication □ith OneLegacy□state la□ re□uirements□ criteria and honor □alk	Triennial	□□-9□
21.	100.0□6 Pain □ssessment□Management and Documentation	Revised pediatric and neonatal sections per Peds Committee	Triennial	99-106
22.	100.0□9 Point of Care Testing□□ aived Tests and Provider-Performed Microscopy □PPM□	Revised □aived testing types/processes □added tests□	Triennial	10□-111
23.	100.223 Discharge □gainst Medical □dvice □□M□□	Revised the afterhours process	Triennial	112-113
24.	100.236 Patient Safety Plan	Minor terminology change/correction	□nnual	114-119
25.	100.250 Management of □□travasation/□nfiltration Due to □on-Chemotherapy Medication □dministration	□o changes	Triennial	120-125
26.	100.26□□alo□one Overdose Rescue □it	Revisions to distri□ution and tracking of kits	Triennial	126-12□

2□	100.2□0 □llocation of Critical Care Resources During a Pu□lic □ealth □mergency	Revised purpose of policy to evaluate cases and allocate resources in the event of resource scarcity due to other medical conditions □eyond □ust COV□D-19	Triennial	12□-13□
2□	100.2□4 □ender □ffirming Care and Care of the Transgender Patient	□e□ policy	Triennial	13□-142
29.	102.015 Medical Staff Code of Conduct	Updated to include additional forms of inappropriate language	Triennial	143-149
30.	10□02□□uality □ssessment and Performance □mprovement Plan □□ith attachment□	□o changes	□nnual	150-165
31.	10□014 Disruption of Services Procedure	□o changes	Triennial	166-16□
32.	10□0□6 □ccessi□ility – □nimals in □ealthcare □acilities	□o changes	Triennial	16□-1□4
33.	10□033 Peripheral □ntravenous □V□□nsertion□□nfusion and Maintenance	Revised maintenance of □V site to adhere to □□S infusion therapy standards of practice	Triennial	1□5-1□9
34.	10□04□Midline □ntravenous Catheter Placement	Minor updates including catheter length□procedure process□and approval process for midline placements in patient	Triennial	1□0-1□4
35.	10□049 Standardi□ed Procedure for Peripherally □nserted Central Catheter □P□CC□Placement	Updated scope of practitioners □ho can perform P□CC placement and added reference to policy regarding additional P□CC care and maintenance standards	Triennial	1□5-20□
36.	C□.02 Cancer Registry Case □ligi□ility Criteria	□dded tumor types that must □e accessioned and a□stracted	Triennial	20□-210
3□	□R.01 □dmitting Patients to the □mergency Department	Revised to include the role of the □reeter R□ and update the role of the admitting clerk	Triennial	211-212
3□	□R.03 □gainst Medical □dvice □□M□□	Updated to include notification process to a provider and role of the □D provider	Triennial	213-214
39.	□R.22 Standards of Care in the □mergency Department	Updated to include additional charge nurse duties regarding communication with patient's primary care/specialist	Triennial	215-21□
40.	□R.46 Treatment of □ail □nmates/Persons on a Legal □old	□o changes	Triennial	21□-219
41.	□CU.22 □dmission Criteria to the Telemetry Units	Revised to define □CU 2 and Med Surg 3 units□criteria for admission□and reassessment to determine continued need for telemetry	Triennial	220-224
42.	□CU.25 □euromuscular Blocking □gents □V □nfusion	Updated to include □est practices for the administration of □MB□s to optimi□e pain control and sedation	Triennial	225-226
43.	□CU.26 □dmission to the DOU	Revised criteria for admission and e□clusion criteria to reference □CU and DOU guidelines. Revised to include testing and training re□uirements for R□s	Triennial	22□-231
44.	□CU.2□Patient Prone Positioning in the □CU	Revised R□ responsi□ilities and manual proning procedure	Triennial	232-235
45.	□S.49 □maging Services □nfection Control Policy	□o changes	Triennial	236-239
46.	MS.102.016 □raduate Medical □ducation Program	Updated to include the addiction medicine fello□ship program. Revised the procedure for visiting residents□supervision of residents□ role of students to adhere to updated □C□M□ institutional re□uirements	Triennial	240-245
4□	MS.102.02□Medical Staff Data□ase Credentialing System Controls and Data□ase User □ccess	Updated to reflect ne□ □C□□ re□uirements for monitoring user data□ase activity for health plan delegation agreements.	Triennial	246-250
4□	P□.01 Department of Pharmacy Purpose□□ccounta□ility□Responsi□ility and Scope of Services	Updated hours of operation of the VCMC infusion center pharmacy	Triennial	251-253
49.	P□.□5 Procuring Drugs for the □ndigent Patient	□o changes	Triennial	254-255

50.	P□.□9 Controlled Su□stances Surveillance	Updated to reference policy to determine reporting re□uirements for loss of controlled su□stances. Updated process □hen discrepancies are identified	Triennial	256-259
51.	T.05 Burn Management □uidelines	Updated to define ho□ □urn percentage is calculated	Triennial	260-261
52.	T.13 Multiple Casualty □ncident □MC□□	Revised to reflect updated □CS Trauma re□uirements/pu□lication	Triennial	262-2□0
53.	T.14 Trauma Department Performance □mprovement and Patient Safety Plan □P□PS□	Revised □udgement categories and structure of the trauma performance improvement committee	□nnual	2□1-2□□
54.	T.16 COV□D-19 Trauma □ctivation Policy	Revised criteria □hen trauma patients receive COV□D-19 antigen test	Triennial	2□□-2□9
55.	T.1□□D Pediatric Performance □mprovement □ Patient Safety Plan	□e□	Triennial	2□0-2□2
56.	T.19 Trauma Mental □ealth Screen and □ssessment Process	□e□	Triennial	2□3-2□4

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/1983*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/13/2023*
Next Review:	*3 years after approval*
Owner:	*Laura Zarate: Clinical Nurse Manager, Case Management*
Policy Area:	*Administrative - Patient Care*
References:	

100.027 Continuum of Care/Discharge Planning

~~POLICY:~~

~~Discharge planning is a multidisciplinary process. Starting Discharge Planning upon admission to Ventura County Medical Center/Santa Paula Hospital positively impacts patient outcomes. The health care team can be alerted to post-discharge needs, allowing time to arrange for those needs and for the patient and family to accept that post-acute care will be required. Early discharge planning also provides patients a positive attitude toward recovery, as well as significantly reducing length of stay and decreasing the likelihood of re-hospitalization. The admitting nurse who first meets the patient starts the assessment and identifies needs. This plan is added to by staff nurses, care management nurses, therapists, physicians, social workers, together with the discharge coordinator. The patient's discharge plan is a hospital-wide plan involving the patient, his or her family, the physician, the pharmacist, the nurse, the dietitian, the social worker and others.~~

~~PROCEDURE:~~

~~The goal of the continuum of care is to define, shape and sequence several processes and activities to maximize coordination of care, matching individual ongoing needs with the appropriate level and type of medical, psychological, health or social services within an organization or across multiple organizations. Patients receive a range of care in multiple settings from multiple providers. A hospital must view provision of patient care as part of an integrated system of settings, services, health care practitioners and care levels, beginning with pre-admission, through admission, hospital stay, pre- and post-discharge. Patients entering Ventura County Medical Center and Santa Paula Hospital have the benefit of Discharge Planning as part of their comprehensive patient care. Recognition of the component of the complex health delivery process, the "total patient care concept" enhances the interdependence and interrelationship of the multidisciplinary team providing care.~~

~~MODEL~~

~~Discharge planning is a process, which begins with the initial encounter, continues throughout hospitalization to discharge and follow-up. Ventura County Medical Center and Santa Paula Hospital utilizes a multi-professional collaboration model, consisting of nursing, physicians, social workers and other health care professionals to provide discharge planning. The process includes planning, based on a comprehensive assessment of needs; teamwork, consisting of the patient, family, physician and other health professionals as needed; contingency plans for unexpected adverse events; responsibility, resting with the attending physician; and communication about the patient, including history and physical, treatment course, diagnostic procedures, medications, etc.~~

~~ROLES~~

~~Discharge coordinators are registered nurses, social workers or other appropriately qualified staff and ensure that every possible effort has been directed toward the best possible continuity of care for the patient.~~

~~***Discharge planning evaluation.***~~

~~**(1)** The discharge coordinator will be responsible to provide a discharge planning evaluation to any patients who require assistance with discharge planning and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the VCMC/SPH nurse or physician.~~

~~**(2)** A registered nurse, social worker, or other appropriately qualified personnel will develop, or supervise the development of, the evaluation.~~

~~**(3)** The discharge planning evaluation will include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.~~

~~**(4)** The discharge planning evaluation will include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.~~

~~**(5)** The discharge coordinator will complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.~~

~~**(6)** The discharge coordinator will include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and will discuss the results of the evaluation with the patient or individual acting on his or her behalf.~~

~~**THE DISCHARGE PLAN:**~~

Policy

Ventura County Medical Center and Santa Paula Hospital have a discharge planning process that ensures a timely, smooth and safe transition to the most appropriate type of setting for post-hospital or rehabilitative care. This process ensures that planning is appropriate to the condition of the patient and that the discharge destination meets the needs and acuity of the patient.

The discharge planning process and the discharge plan must:

A. Be consistent with the patient's goals for care and treatment preferences.

B. Include the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care.

C. Ensure an effective transition of the patient from hospital to post-discharge care.

D. Reduce factors leading to preventable hospital readmissions.

Discharge Planning Process:

Hospital staff will identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and ensure that appropriate arrangements are made prior to discharge. Case Management/Social Service staff shall provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, any member of the multidisciplinary team, or patient's physician/provider.

A. Discharge planning evaluations shall be made timely to ensure that appropriate arrangements for post-hospital care will be made prior to discharge and to avoid unnecessary delays in discharge.

B. Any discharge planning evaluation, coordination of discharge needs, or discharge plan must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

C. Discharge planning evaluations must include the following:

1. A patient's likely need for appropriate post-hospital services including, but not limited to, care at home, care in a skilled nursing or intermediate care facility, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.
2. The patient's capacity for self-care.
3. The ability of the patient to safely return to the environment from which he or she entered the hospital.

D. As part of the discharge planning process, the hospital shall provide each patient who has been admitted as an inpatient with an opportunity to identify one family caregiver/support person who may assist in post-hospital care and shall record this information in the patient's electronic health record (EHR).

1. In the event the patient is unconscious or otherwise incapacitated upon admission, the hospital shall provide the patient or patient's legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity. Hospital staff shall promptly document the attempt in the patient's EHR.
2. In the event the patient or legal guardian declines to designate a caregiver/support person, the declination shall be recorded in the EHR.

E. The patient's designated caregiver/support person shall be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's treating physician/provider. The notification shall be documented in the EHR.

1. In the event hospital staff is unable to contact the designated caregiver/support person, the lack of contact should not interfere with, delay, or otherwise affect the medical care provided the patient or an appropriate discharge of the patient.
2. The attempted notification shall be promptly documented in the patient's EHR.

F. The discharge planning evaluation must be included in the patient's EHR for use in establishing an appropriate discharge plan.

G. The discharge planning evaluation results must be discussed with the patient or the patient's representative (caregiver/support person).

H. Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of the patient's discharge plan.

I. The patient's condition will be re-evaluated regularly to identify changes that require modification of the discharge plan and the discharge plan will be updated, as needed, to reflect these changes.

J. If it is determined that the patient, family members, caregiver(s)/support person(s), or other interested persons need to be counseled to prepare for post-hospital care, hospital staff shall provide that counseling.

K. The hospital will assess its discharge planning process on a regular basis. The assessment shall include a periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that discharge plans are responsive to patient post-discharge needs.

Post-Acute Care Services:

Case Management/Social Service staff must assist patients, their families, or the patient's representative in selecting the following types of post-acute care providers: Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF), and Long Term Acute Care Hospitals (LTCH). Case Management/Social Service staff will share information for these types of post-acute care providers that includes, but is not limited to, data related to quality and resource use measures that are applicable to the patient's goals of care and treatment preferences.

Requirements A, B, and C apply for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services:

~~Patient, family and caregiver if available are assisted in developing a plan of care for ongoing maintenance and improvement of health care, even after acute hospital care. Two aspects of discharge planning are crucial: how accurately needs are assessed and the extent to which patients and families participate in the process. A registered nurse, social worker, or other appropriately qualified personnel will develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.~~

~~In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital will develop a discharge plan for the patient.~~

~~The hospital will arrange for the initial implementation of the patient's discharge plan.~~

~~The hospital will reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.~~

~~As needed, the patient and family members or interested persons will be counseled to prepare them for post-hospital care.~~

~~The hospital will include in the discharge plan a list of Home Health Agencies (HHAs) or Skilled Nursing Facilities (SNFs) with quality rankings that are available to the patient, that are participating in the Medicare/MediCal program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient.~~

~~This list will only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.~~

~~For patients enrolled in managed care organizations, the hospital will indicate the availability of home health and post hospital extended care services through individuals and entities that have a contract with the managed care organizations.~~

~~The hospital will document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.~~

A. The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.

1. This list will only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.
2. For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify which providers are in their managed care organization's network. If the hospital has information regarding which providers are in network with the patient's managed care plan, it must share this information with the patient or the patient's representative.
3. Case Management/Social Service staff must document in the patient's medical record that the list was presented to the patient or the patient's representative.

B. ~~The hospital, as~~As part of the discharge planning process, ~~will~~hospital staff must inform the patient or the patient's ~~family~~representative of their freedom to choose among participating Medicare providers and suppliers of post hospital care services and ~~will~~must, when possible, respect the patient ~~and family~~'s or patient's representative's goals of care and treatment preferences when they are expressed as well as other preferences they express. The hospital will not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

C. The discharge plan will identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

D. ~~Discharge Planning staff shall utilize an automated follow-up discharge call to assist patients who have questions about discharge instructions and health conditions after discharge. Discharge Planning staff shall collaborate with the health care team to provide appropriate care for the patient.~~Every patient anticipated to be in need of long-term care at the time of discharge shall be provided with contact information for at least one public or non-profit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living center, or other information appropriate to the needs and characteristics of the patient.

~~GOALS~~

~~A. To improve patient care primarily utilizing the avenue of the smooth transfer of the patient from one level of care to another whether from hospital to home, to nursing home, or to another acute care or rehabilitation facility, affecting the usage of supportive community agencies and services; thereby implementing the concept of a continuum of care.~~

~~B. To ascertain that the patient is in the right place at the right time at any given stage of his medical involvement.~~

~~C. To develop awareness of non-medical needs for our patient/families as well as medical needs (medical, social, and psychological).~~

~~D. To thoroughly evaluate patient needs and refer to appropriate services available to meet their needs, including meals on wheels, durable medical equipment, long or short term placement, information on community resources.~~

~~E. To recognize the need for patient teaching and ensure its effectiveness, as demonstrated during follow-up care.~~

~~F. To arrange for efficient transfer of medical, nursing, and related information as the patient moves from one facility to another.~~

G. To develop cooperative efforts in geographical service areas involving all agencies that provide patient services.

H. To enhance the value of home health programs.

I. To effect earlier discharge planning of patients, decreasing avoidable hospital days.

J. To fully implement the Utilization Review Plan as approved by the Medical Staff and Administration of Ventura County Medical Center and Santa Paula Hospital.

K. To effect compliance of regulatory mandate and yet maintain humanistic patient care.

L. To display Ventura County Medical Center and Santa Paula Hospital efforts toward community responsibility.

CONSULTATION, IDENTIFICATION AND REFERRAL PROCESS:

A. The initial nursing assessment identifies areas of concern, which are forwarded to the Social Service Department/Care Management Department for further analysis, appropriate intervention and documentation.

B. The Social Worker or Case Manager may case find based upon medical condition, readmission, chronic disease state or other appropriate measures.

C. The physician may make a referral to the Social Services Department or Care Management Department by entering an order in the EHR, or calling the department directly.

D. Nursing personnel or other paramedical personnel may make a referral to Social Services/Care Management. They are requested to discuss the referral with the attending physician; however, if this is not possible, the social worker will inform the physician of the request.

E. The patient, the patient's relatives, and/or the patient's friends may request assistance from Social Services or Case Management. The social worker/case manager will contact the physician with such a referral to ensure his cooperation and assistance in providing future care for the patient.

F. Health care professionals including Social Workers, Care Managers, Alcohol and Drug Treatment Specialists, and Medical Staff attend daily Discharge Planning Meetings to discuss each patient in the hospital and address any discharge planning or social service needs. Changes in the patient's condition are addressed daily at these meetings. Case Mangers and Social Workers also attend Orthopedics, Pediatrics, and Medicine Rounds, and participate in weekly floor rounds with the nursing staff if appropriate. Through these meetings, needs of patients and families are identified for appropriate intervention.

G. Follow-up care may be provided through the Ambulatory Care system of Ventura County Health Care Agency. Inpatients being discharged to one of the clinics are provided with a specific appointment time, or instructions on setting up an appointment, as indicated on the aftercare instructions. Appropriate diagnostic procedures are ordered as necessary, with instructions given to the patient.

H. After discharge, outside agencies, such as Public Social Service Agencies, Home Health Care Agencies, Skilled Nursing Hospitals, and so forth, may be contacted by Social Services/Care Management to address any coordination of care issues.

References

42 C.F.R. § 482.43 Condition of Participation: Discharge Planning Health and Safety Code § 1262.5

All revision dates: 12/13/2023, 1/25/2021, 5/31/2017, 10/1/2011, 5/1/2006, 1/1/2002, 8/1/2001, 11/1/1998, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/16/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	12/14/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/13/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/13/2023
Policy Owner	Laura Zarate: Clinical Nurse Manager, Case Management	12/13/2023

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1990*
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Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Administrative - Patient Care*
References:	

100.200 Inpatient Psychiatric Unit (IPU) Admission Criteria

POLICY:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) admits patients 18 to 64 years of age by order of a Ventura County psychiatrist:

A. For acute psychiatric services as a result of suspected or diagnosed mental disorder, OR

B. For medical necessity

PROCEDURE:

~~A. For admission, the patient must:~~

~~1. Be clear of medical conditions requiring medical/surgical skilled nursing care~~

~~2. Be ambulatory or physically able to perform own Activities of Daily Living (ADL'S) with assistive devices (such as wheelchair, walker, etc.) and;~~

~~3. Have a valid legal status:~~

~~a. Voluntary Admission, or~~

~~b. 5150 or 5250 Certification (must possess original or pink copy)~~

~~c. 5353 or 5358 Form signed by patient's legal Conservator, or~~

~~d. Authorization of Conservator as follows:~~

~~1. *Copy of the Court Order appointing public or private Conservator for the patient*~~

~~2. *The Letters of Conservatorship*~~

~~3. *In the absence of the above, verbal or Fax orders from the Conservator to be*~~

~~4. *Followed by written authorization the next business day*~~

~~5. *Additional consents or reports specific to patient needs*~~

~~6. *A signed consent for psychotherapeutic medication, if applicable*~~

A. For admission, the patient must:

1. Be clear of medical conditions requiring medical/surgical skilled nursing care

2. Be ambulatory or physically able to perform own Activities of Daily Living (ADL'S) with wheelchair.
3. Have a valid legal status:
    a. Voluntary Admission (W&IC 6000), or
    b. Involuntary Admissions, or
        i. If under WI&C 5150, valid 5150 documentation (must at least have a photocopy to admt)
        ii. For admissions/transfers under W&IC 5250, 5260 or 5270, these require valid certification documents (must have at least a photocopy to admit)
    c. W&IC 5353 (Temporary LPS Conservatorship) or W&IC 5358 (Full LPS Conservatorship) Admissions, being admitted with consent of Conservator;
        1. *For patients under the auspices of the Ventura County Public Guardian's Office; may initially be admitted on documented verbal authorization of the Deputy Public Guardian recorded in the electronic medical record, until the next business day, so long as written authorization follows including;*
            a. *Copy of the Court Order appointing public Conservator for the patient and/or*
            b. *The Letters of Conservatorship*
            c. *Authorization for (inpatient) treatment*
            d. *A signed consent for psychotherapeutic medication, if applicable*
            e. *Additional consents or reports specific to the patient's needs*
        2. *For patients who are not under the auspices of the Ventura County Public Guardian's Office, we require written/signed and valid authorization of the Conservator, including legal proof of conservatorship (i.e., letters of LPS conservatorship). Verbal authorization is insufficient.*

All revision dates: 2/5/2024, 8/11/2020, 11/1/2016, 1/1/2014, 1/1/2012, 7/1/2010, 5/1/2008, 3/1/2004, 10/1/2002, 12/1/2001, 11/1/1998, 1/1/1996, 3/1/1994, 1/1/1993, 12/1/1990

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	10/30/2023
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	9/29/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/28/2023

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/28/2023
Policy Owner	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/28/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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

100.240 Suicide Risk Assessment

Purpose:

To provide a guideline for staff to use to identify patients that are at risk for suicide and develop a plan of care with appropriate interventions to keep them safe.

Policy:

Patients who are being evaluated or treated for a behavioral health condition as their primary diagnosis, and those that express suicidal ideation during the course of their care will be screened and assessed for suicidal ideation and risk using a validated tool. To identify and assure safe handling of patients with potential risk for suicide, the assessment will include identification of specific factors that may increase or decrease the risk for suicide on admission and an ongoing basis.

Departments:

All areas of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

Definitions:

1. **Suicide:** Death caused by self-inflicted injurious behavior or endangerment with an intent to die as a result of the behavior.
2. **Suicidal Ideation:** Thinking about, considering, or planning suicide.
3. **Suicide Attempt:** Refers to self-inflicted life-threatening attempt at suicide that did not lead to death.
4. **Suicide Risk Factor**: Factors that can increase the risk for individuals to attempt to harm themselves.
5. **Protective Factors:** Factors that can serve to decrease a patient's suicide risk especially when several are present.
6. **Emotional or Behavioral Disorder**: refers to any DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis or condition, including those related to substance abuse.
7. **Chief Complaint:** Refers to the patient's main reason for seeking treatment that day.

PROCEDURE:

EMERGENCY DEPARTMENT (ED):

1. The Registered Nurse (RN) in the ED will initiate a continuous observation of the patient if the patient's chief complaint is:
    a. Suicidal ideation
    b. Homicidal ideation
    c. Legal Hold Status
2. The RN will complete the Columbia Suicide Severity Rating Scale (C-SSRS) during triage on every patient age 12 and up when the patient's chief complaint is of a behavioral health and /or psychological nature. If the patient is not able to be assessed due to altered mental status, the RN will document that finding in the electronic health record (EHR).
    - If the patient answers "no" on the C-SSRS screening questions 1, 2 and 6, the patient is considered not to be at risk for suicide at this time.
    - If the patient answers "yes" to any of the questions on the C-SSRS then the screening algorithm will be followed, and the correct risk level will be placed based on the Suicide Screening answers.
3. If patient is found to be no, low, or moderate risk of suicide, the RN will re-screen the patient if there is a new occurrence of suicidal behavior, ideation, statement or other noteworthy clinical change.
4. If the patient is found to be at low risk for suicide:
    a. The RN in the ED will:
        - Notify the Licensed Practitioner (LP) and Charge Nurse of the risk level.
        - Consider an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.
        - Document any interventions in the EHR.
    b. The ED LP will ~~assess the patient and document in the EHR:~~
        - ~~Consider addressing suicidality in the treatment and discharge (if applicable) plan. Provide counseling and follow up care upon discharge, as well as suicide prevention information.~~

        consider addressing suicidality in the treatment and discharge (if applicable) plan. Provide counseling and follow up care upon discharge, as well as suicide prevention information.
5. If the patient is found to be at moderate to high suicide risk:
    a. The RN in the ED will:
        - Initiate the continuous level of observation and notify the LP and Charge Nurse of the risk level.
        - Conduct an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.
        - Document any interventions in the EHR.
    b. The ED LP will assess the patient and document in the EHR:
        - Complete suicide assessment and/or consult psychiatry.
        - If assessment confirms patient is moderate to high risk, follow mitigation plan and continue

suicide precautions if indicated.

- If patient meets criteria for safe discharge, directly address suicidality, refer for appropriate level of follow up care and provide suicide prevention information.
- If suicide assessment cannot be completed, the reason and safety plan will be documented in the EHR.

6. When an ED Psychiatric consultation is initiated by the ED LP, the consulting Psychiatric liaison will:
    - Complete and document a Psychiatric evaluation, and Columbia Suicide Severity Rating Scale (C-SSRS) Suicide Assessment (this may take place in the Crisis Stabilization Unit (CSU) or Inpatient Psychiatric Unit (IPU) at the discretion of the covering psychiatrist).
    - If the patient remains in the ED, provide Psychiatric care recommendations including level of observation and ongoing collaboration.

INPATIENT PSYCHIATRIC UNIT (IPU) AND CRISIS STABILIZATION UNIT (CSU):

1. The Registered Nurse (RN) will assess for the presence of Suicide Risk Factors.
    a. Identification of risk factors results in further assessment for presence of a patient's plan and intent.
2. Upon admission, the RN will complete a Columbia Suicide Severity Rating Scale (C-SSRS) full assessment on every patient admitted to the CSU or IPU.
3. After admission the patient will be assessed each shift with the Columbia Suicide full assessment (recent).
4. If there is a change in the patient's condition, a subsequent assessment will be completed by the RN upon readmission to the inpatient Psychiatric Unit or the CSU.
5. If the patient is not able to be assessed due to altered mental status, the RN will document that finding in the EHR.
6. Based on the RN assessment findings, the RN will:
    a. Initiate the level of patient observation.
    b. Obtain LP order for continuous observation if needed and the justification. Enter in the EHR.
    c. Obtain order for Suicide Precautions.

The Psychiatrist will assess the patient within 24 hours of admission to the CSU/IPU for suicidality, and will:

1. Complete and document the Psychiatric Evaluation in the EHR.
2. Document the level of observation required and the justification.
3. Review the Plan of Care and recommend specific interventions to manage patient's risk of harm to self or others.
4. Specific recommendations to manage the patient's risk of harm to self or others will be made.
5. Recommendation(s) will be made to modify the plan as needed based on risk factors.

MEDICAL/HOSPITAL UNITS:

Includes but is not limited to: Intensive Care Unit (ICU), Medical-Surgical, Telemetry, Definitive Observation Unit (DOU), Obstetrics (OB), Pediatrics, and Pediatric Intensive Care Unit (PICU).

1. If a patient presents through the ED, the RN in the medical/hospital unit will continue the level of continuous observation initiated in the ED:
    a. If a patient presents via direct- admission or surgery and the patient's primary complaint is a behavioral health complaint or there is clinical concern for suicidality, the RN will initiate the C-SSRS screen.
2. For patients found to be low risk based on the C-SSRS, the RN will:
    a. Notify the LP and Charge Nurse of the risk level.
    b. Consider an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.
    c. Document any interventions in the EHR.
3. If the patient is found to be low risk for suicide, the Medical Unit LP will assess the patient and document the following in the EHR:
    a. Address suicidality in the treatment and discharge (if applicable) plan. Provide counseling, follow up care and suicide prevention information upon discharge.
4. If the patient is found to be moderate to high suicide risk, the RN will do all of the above (#2 above) plus:
    a. Initiate the continuous level of observation and notify the LP and Charge Nurse of the risk level.
    b. Conduct an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.
    c. Consult psychiatry or LP to complete the suicide assessment.
    d. Document any interventions in the EHR.
5. If the patient is found to be moderate to high risk for suicide, the Medical Unit LP will:
    a. Assess the patient and document the following in the EHR.
    b. Record level of observation required and the justification.
    c. Order for a Psychiatric Consultation if not already completed for further treatment and mitigation plan.
    d. Directly address suicidality in the treatment and discharge (if applicable) plan. Provide counseling, follow up care and suicide prevention information upon discharge.
6. Reassessment
    a. If patient is found to be at no, low, or moderate risk for suicide, the primary RN will re-screen with patient with the C-SSRS if there are any new occurrences of suicidal behavior, ideation, statement, or other noteworthy clinical change.

PATIENT EDUCATION:

All patients who are admitted or treated for Psychiatric, emotional or behavioral disorders/complaints will be given the following information and directions in written form upon discharge.

1. "If you feel unsafe or feel that you might want to harm yourself or others, you can:"
    a. CALL 211 for Mental Health Intervention Services.
    b. Call 1-800-273-8255 or 988 for the National Suicide prevention lifeline.
    c. Call 911 or go to the nearest emergency room.

2. Educational materials on suicide prevention will be included in the EHR discharge instructions.

STAFF EDUCATION/COMPETENCY:

1. All Registered Nursing staff will be educated and evaluated for competency on suicide risk assessment and mitigation upon hire, and when transitioning to another role.
2. Staff who could be assigned to the care of a patient at risk for suicide will be educated and evaluated for competency in suicide risk mitigation yearly.

REFERENCES

The Joint Commission, (2019) https://www .jointcommission.org//media/tjc/documents/standards/national-patient-safety-goals/2020/npsg chapter_bhc_jul2020.pdf.

ENFORCEMENT

Violations of this policy or associated procedure may result in appropriate disciplinary actions and measures in accordance with General rules of conduct and applicable collective bargaining agreements or other applicable county policies or as outlined by any procedures document related to this policy.

All revision dates: 12/26/2023, 1/10/2023, 9/14/2021, 10/19/2020

Attachments

C.A.S.E. Safety Checklist
Columbia Suicide Rating Assessment with SAFE-T
Columbia Suicide Severity Rating Scale
VCMC-SPH Suicide Screen/Assessment Algorithm

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/16/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	12/27/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/26/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/26/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/26/2023

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Administrative - Nursing*
References:	

108.032 Blood Glucose Testing with the Nova StatStrip® Glucose Meter

POLICY:

To evaluate patient whole blood glucose levels using the NOVA BiomedicalStatStrip® Glucose Meter.

The StatStrip® Glucose Meter quantitatively measures glucose in whole blood. Glucose in the blood sample mixes with reagents on the test strip. The reaction produces an electric current. The amount of current that is produced depends on how much glucose is in the blood. The glucose result is displayed on the screen.

PROCEDURE:

Glucose testing may be performed by staff having successfully completed the NOVA StatStrip® Glucose Meter competency training activities and evaluations throughout VCMC/SPH, including RNs, LVNs, and NCAs. The competency of each person to perform the duties assigned must be assessed following training, and at least annually thereafter. Operator performance is monitored continuously through Point-of-Care QA reports and observations. Retraining and reassessment of employee competency must occur when problems are identified with employee's performance.

Supportive Data:

The NOVA StatStrip® Glucose Meter is used to definitively monitor the patient's blood glucose levels.

Reference Ranges:

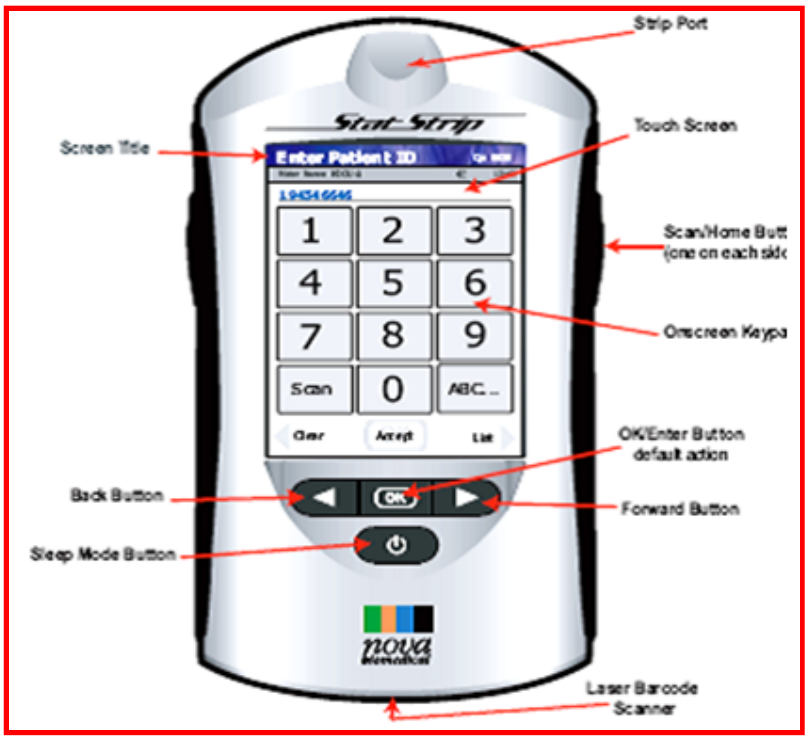
1. Non-fasting reference range: Normal: 70 – 140 mg/dL
   A single up arrow by the result indicates the result is above the normal range.
   A single down arrow by the result indicates the result is below the normal range.
2. Fasting reference ranges:
   Normal: 70 – 99 mg/dL
   Pre-diabetes: 100 – 125 mg/dL
   Diabetes: > 125 mg/dL
3. Manufacturer Measurement Range: 10 mg/dL to 600 mg/dL.
   Results below this range will display as "LO."
   Results above this range will display as "HI."

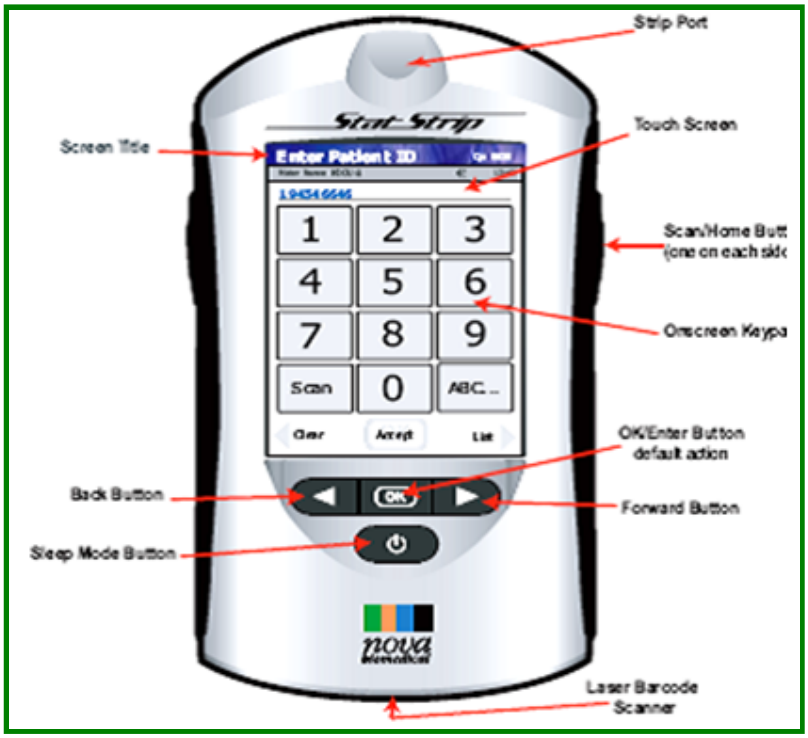
Any HI or LO results should be retested.

4. Alert values:
   < 70 and > 300 mg/dL
   Neonates: < 50 and > 250 mg/dL
   Alert low results display with 2 down arrows.
   Alert high results display with 2 up arrows
5. Alert value protocol: All alert values must be repeated using a fresh sample from a new stick, unless it is consistent with patient's previous result or if the patient has <70 mg/dL and hypoglycemic symptoms. If repeat results are inconsistent, send a specimen to the laboratory for verification.
6. Actions taken must be documented in the meter as described in the "Blood Glucose Patient Testing Procedure". Report to caregiver or provider, and follow his/her recommendations. Alert values obtained by an NCA must be reported immediately to the care nurse for assessment of the patient.

Equipment:

NOVA StatStrip® Glucose Meter





NOVA StatStrip® Glucose Meter

The acceptable temperature range for using the meter is 59-104°F (15-40°C).

Do not place the meter near a heat source. Meter should be held level when applying control or patient samples. Meter can be used at altitudes up to 15,000 feet.

Note: Clean the meter with a hospital approved disinfectant.

CAUTION:
DO NOT immerse the meter or hold the meter under running water.
DO NOT spray the meter with a disinfectant solution.

Materials

StatStrip® Glucose Test Strips, SAP # 343875,
Cardinal Cat. # NB42214DU

NOVA StatStrip ® Control Solutions Level 1 SAP # 342948,
Cardinal Cat # NB41741DU

NOVA StatStrip ® Control Solutions Level 3 SAP # 342949,
Cardinal Cat. #NB41743DU

Fingerstick supplies: disposable lancet device, gloves, alcohol wipes, non-sterile gauze.

Heel warmer (for heat application as necessary)

10 % bleach wipes or 1:10 bleach solution

Reagent Handling

1. NOVA StatStrip® Test strips
   Store the StatStrip® Glucose Test Strips in the tightly closed vial at room temperature (15 to 30° C). The test strips shall be given an open date and a 180 day expiration date from the time of opening. The month, day, and year for both dates shall be documented on each open container.*
2. NOVA StatStrip ® Control Solutions
   Store the StatStrip® Glucose Control Solutions at room temperature (15 to 30° C). The control solutions shall be given a 90 day expiration date from the time of opening. The month, day, and year shall be documented on each open container.*

   **In the event that the manufacturer date comes first, the manufacturer expiration shall be documented as the discard date.*

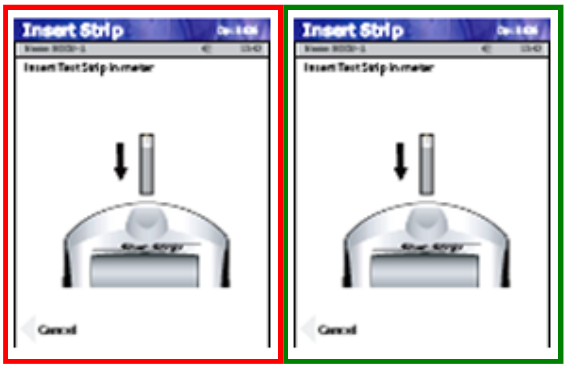
Calibration:
No calibration is necessary. Meter calibration is preset in meter using the strip lot number.

Quality Control Procedure:

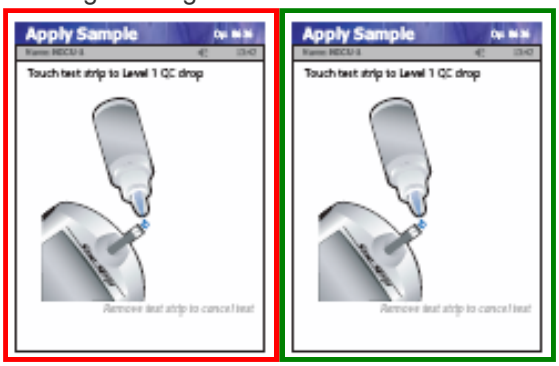
1. Quality control frequency:
   Note: *The meter will lock out testing of patients after 24 hours.*

   Level 1 and Level 3 control testing must be performed every 24 hours that patient testing is performed, or if:.
   a. A vial of strips has been left open or when the test strips have been exposed to extreme heat, humidity, or cold.
   b. The meter is dropped.
   c. When troubleshooting the meter.
   d. When patient test results contradict clinical symptoms.
2. Check the written expiration date on each level of Control solution.
3. Check the written expiration date on the *StatStrip® Glucose Test Strip vial.*
4. When removing the meter from the docking station, wait until the hour glass disappears.
5. Touch <WELCOME> on the screen, or the <OK> button.
6. Touch <LOGIN> on the screen, or the <OK> button.
7. Touch SCAN, or the <OK> button, and scan (or enter) your operator identifier (located on the front of your ID badge).
   Note: *If the meter will not allow you to login, notify the trainer on your unit.*
8. Touch <QC> block at the bottom of the screen.
9. Touch SCAN, or the <OK> button, to scan the barcode on the test strip vial.
10. Touch SCAN, or the <OK> button, to scan the barcode on the control vial being tested.
11. Gently mix control by inverting vial 5 – 10 times, or by rolling the vial between the palms for at least five seconds in two directions.

12. Wipe tip of vial and expel several drops of Control solution to removed dried concentrations of material.
13. Place the strip into the test strip port with the blue side up and the white end exposed, as shown on the screen.



14. With the meter lying flat or pointing downward, touch a drop of the control solution to the end of the strip allowing it to migrate into the test area.



Caution: **Keep the meter flat or pointing downward** while applying sample and during testing to prevent sample from seeping into the test strip insert slot.
Note: *The test strip must fill completely upon touching to the control drop. If the strip does not fill completely,* ***do not touch the strip to the control a second time.*** *Discard the strip and repeat the test with a new strip.*

15. The control solution is drawn into the test strip automatically.
16. Wait for the countdown to end and the result to appear.
17. <PASS> or <FAIL> will appear in 6 seconds.
18. Remove the test strip from the meter and discard before the meter is moved.
Note: *If "Fail" is displayed, touch <COMMENT> and enter up to three comments by touching the appropriate comment display.* Touch <ACCEPT> to finalize the comment(s). *Repeat the test with a new test strip.*
19. When "Pass" is displayed, the test is completed.
20. Touch <ACCEPT>, or the <OK> button to finalize the test.
21. Repeat these steps to perform Level 3.
22. When both quality control test results have displayed "Pass," patient testing may be performed.
23. To prevent others from testing under your name, logout by touching the <Op: XXXX> icon at the top right corner of the screen or <LOGOUT> at the bottom of the screen.

***Note**:* This step prevents others from using your identity to perform testing or reviewing patient information.

The screen times out in 90 seconds if there is no activity, but your identity stays in the meter for 3 minutes.

24. **Return the meter to the docking station.**
***Note:** Meter must remain in the docking station when not in use to allow patient data transmission and maintain a fully charged battery.*
25. Quality control notes:
    a. If a quality control test result displays "Fail," the problem must be corrected before the meter will allow you to proceed. Consider the following factors that may cause a failure of the quality control test:
    b. The test strip vial has been left opened for a period of time.
    c. Procedural error.
    d. The test strip or controls have been exposed to very high or low temperatures.
    e. The test strips are expired.
    f. The control solutions are expired and/or contaminated.
    g. Corrective action must be documented by entering a comment in the meter.
    h. Report two consecutive failures to the Laboratory Point-of-Care Coordinator.

Specimen Collection:

1. Type: Capillary, venous, neonatal (cord blood is not acceptable), and arterial whole blood specimens may be used for testing on the NOVA StatStrip® Glucose Meter.
2. Verify patient ID by using a minimum of two identifiers.
3. Don clean gloves.
4. With the meter flat or pointing downward apply sample.
5. Finger puncture:
    a. Best locations for fingersticks are the 3rd and 4th fingers of the non-dominant hand.
    b. Do not use the top or center of the finger.
    c. Avoid fingers that are cold, cyanotic, swollen, scarred or covered with a rash.
    d. Massage the finger to increase blood flow (gently squeeze the finger from hand to fingertip 5 – 6 times).
    e. Cleanse fingertip with alcohol and wipe dry with clean gauze or cotton ball or allow to air dry (alcohol cause erroneous blood glucose results).
    f. Using a sterile lancet, make a skin puncture just off the center of the finger pad.
    g. Consider wiping away the first drop of blood (which tends to contain excess tissue fluid) and gently apply intermittent pressure to the surrounding tissue until the required blood volume is obtained.
    h. Do NOT squeeze or apply strong repetitive pressure to the site (this may result in hemolysis or increase tissue fluid in the blood). Consider using heat pack using heel warmer.

i. Allow drop of blood to migrate smoothly into the end of the strip.

***Caution**: Do not touch test strip to the patient's finger or apply blood to the top of the strip.*

6. Heel puncture:
    a. Warm the collection site with heel warmer.
    b. Clean the area with alcohol and wipe dry with clean gauze or cotton ball or allow to air dry (alcohol cause erroneous blood glucose results).
    c. Puncture the heel to get free flowing blood.
    d. Consider wiping away the first drop of blood with dry gauze or cotton ball.
7. Apply sample by touching the end of the strip to a drop of the blood allowing it to migrate into the test area.

    ***Note:** Collecting the sample in a heparinized capillary tube is also acceptable.*
    a. *Tilt the tube at a downward angle and allow gravity to draw blood into tube.*
    b. *Mix by gently rolling tube between two fingers.*
    c. *Attach the black transfer bulb to the capillary tube.*
    d. *Squeeze the bulb to transfer sample from the capillary tube to the target area of the test strip.*
8. Venipuncture:
    a. Blood specimens must be performed within 30 minutes of specimen collection to minimize the effect of glycolysis.
    b. Collect the sample only in a Light Green top, heparinized, lab tube.
    c. Mix the collection tube by inverting gently.
    d. Using a syringe and needle, puncture the top of the light green top tube and withdraw a quantity of blood sufficient to dose the testing strip.
    e. Push a drop of blood out of the end of the syringe needle, avoid touching the end of the test strip with the needle.
    f. Apply sample by touching the end of the strip to a drop of the blood allowing it to migrate smoothly into the test area.
9. Syringe collection from a central line or arterial line:
    a. If not using closed inline sampling system, withdraw and discard 5 mL of blood to remove intravenous solution, heparin, or medications that may contaminate the sample.
    b. Collect the sample in a Light Green top lab tube or sodium heparinized syringe and perform glucose testing within 30 minutes.
    c. Mix the collection tube by inverting gently or rolling the syringe between the hands.
    d. Allow a drop of blood to form at the tip of the syringe.
    e. Apply sample by touching the end of the strip to a drop of the blood allowing it to migrate into the test area.

Blood Glucose Patient Testing Procedure:

1. Standard Precautions must be followed when using the NOVA StatStrip® Glucose Meter.

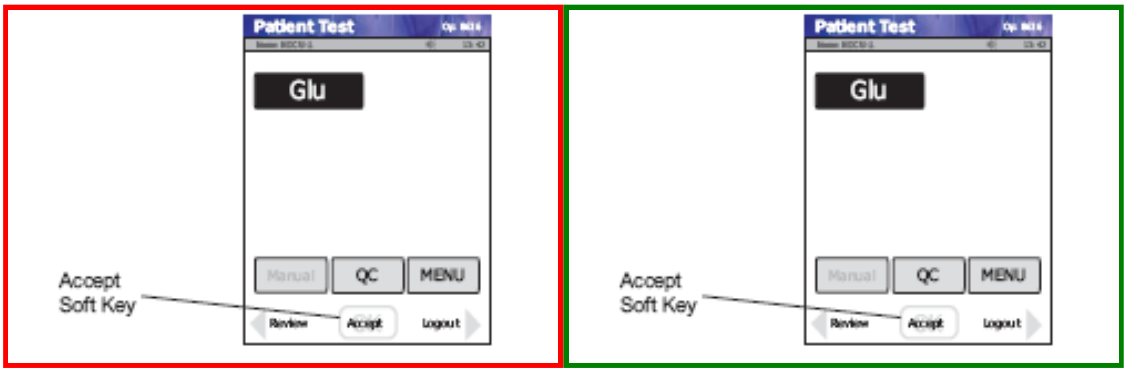
a. This procedure may expose the user to Bloodborne pathogens. To perform this procedure the user must wear gloves.

b. Isolation: To prevent contamination to the patient and/or meter, the meter and vial of test strips may be placed into clear plastic bags prior to testing in isolation and/or high risk blood borne pathogen areas.

- Remove two test strips for testing before entering the isolation room and place the vial in a plastic bag.
- Once in the patient's room, scan the test strip vial through the plastic bag when prompted.

Note: Personal protection equipment and sharps MUST be discarded according to your clinic or unit's infection control policy.

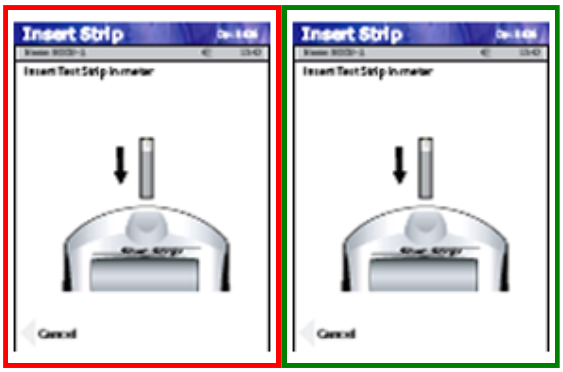
2. Before removing meter from docking station, check to make sure it has completed the download, or you may have to redock it before testing can begin.
3. Check the expiration date on the StatStrip® Glucose Test Strip.
   Note: *When opening a new vial of StatStrip® Glucose Test Strip, write the 6 month expiration date on each vial.*
4. Identify the patient using a minimum of two forms of identification prior to testing.
5. Touch <WELCOME> on the screen, or press the <OK> button, to activate the screen on the meter.
6. Touch <LOGIN> on the screen.
7. Touch SCAN and scan (or enter) your operator identifier (located on the front of your ID badge).
   Note: *If the meter will not allow you to sign in, notify your Clinical Nurse Manager or Superuser on your unit.*
8. Touch the<PATIENT> box.



9. Touch <ACCEPT>, or the <OK> button.
10. Touch SCAN, or the <OK> button, to scan the barcode on the test strip vial.
11. Identify the patient: Ask patient to state name and DOB.
12. Touch SCAN, or the <OK> button, or manually enter the patient's Identification number (6 digit chart number) from the patient's armband.
    Note:
    For neonate before chart number issued: ID # = use date and military time (ex: born on March 5 at 1310, ID# = 051310)
    For ER patient prior to chart number: ID # = 3 digit log number (ex: 003)

    NEVER ENTER A FALSE ID#!!

13. If available, the patient's demographics will appear on the screen.
14. Verify the demographics are correct.
15. Touch <ACCEPT>, or the <OK> button.
    Note: *If the patient's demographics do not appear, recheck the patient ID. If the ID number entered in the meter matches the patient's information, Touch <Downtime Override> and proceed. (There will be no demographics for ER patient or neonate without a chart number)*
16. Place the strip into the test strip port with the blue side up and the white end exposed, as shown on the screen.



17. Don clean gloves.
18. Obtain blood sample.
19. Apply sample by touching the end of the strip to a drop of the blood allowing it to migrate into the test area.

    Caution: Keep the meter flat or pointing downward while applying sample and during testing to prevent sample from seeping into the test strip insert slot.
    Note: *The test strip must fill completely upon touching to the drop of blood. If the strip does not fill completely,* ***do not try to add more blood.*** *Discard the strip and repeat the test with a new strip.*
20. A beep will sound when enough sample has been drawn into the strip.
21. Wait for the countdown to end and the result to appear.
22. Remove strip before moving the meter.
23. Discard strip in biohazard container. Discard the lancet in the sharps container.
24. Perform hand hygiene.
25. If alert value is displayed, *actions must be documented in the meter by touching <COMMENT> and entering up to three comments by touching the appropriate comment display.* Touch <ACCEPT>, to

complete the comments.
Note: *Alert values <70 mg/dl and >300 mg/dL (neonates: <45 mg/dL and >150 mg/dL) must be repeated, using a fresh sample from a new stick, unless the patient has a documented blood glucose >300 within the past 3 hours. Report to caregiver or provider, and follow his/her recommendations. Alert values obtained by any NCA must be reported immediately to the care nurse for assessment of the patient. Results must be verified by the clinical laboratory if requested by the provider.*

26. Touch <ACCEPT>, or the <OK> button, to finalized result and send to the patient's electronic record.
27. Document the blood glucose result (mg/dl), any treatment given, the time, date, and initials of operator in the patient's medical record.
28. To prevent others from testing under your name, logout by touch the <Op: XXXX> icon at the top right corner of the screen or <LOGOUT> at the bottom of the screen.
Note*: The screen will turn off in 90 seconds if there is no activity, but does not log you out for 3 minutes.*
29. Clean the meter between patients and/or prior to docking and PRN by following the cleaning procedure below.
30. Once meter is dry, return to the docking station.
Note: *Meter must remain in the docking station when not in use to allow patient data transmission and maintain a fully charged battery.*

Cleaning and Disinfecting Nova StatStrip Glucose Meter:

A. The meter must be cleaned and disinfected after each patient use to minimize the risk of transmission of blood-borne pathogens between patients and healthcare professionals.
B. Cleaning the meter
    1. Clean the meter using a 10% bleach wipe after donning gloves
    2. Wipe the external surface thoroughly and discard soiled wipe into appropriate container.
C. Disinfecting the meter
    1. Using a new 10% bleach wipe, thoroughly wipe the surface of the meter (top, bottom, left, and right sides) a minimum of 3 times horizontally and 3 times vertically avoiding the bar code scanner and electrical connector.
    2. Gently wipe the surface area of the test strip port making sure that no fluid enters the port.
D. Observe manufacturer’s contact time for germicidal wipe
E. Use clean gauze pad or paper towel to wipe cleaner residue from the scanner window and touch screen, as needed
F. Dispose of used wipe and gloves
G. Wash hands thoroughly with soap and water

WARNING: *Do not allow liquid to enter the strip port connector or allow pooling of liquid on the touch screen. If liquid does get into the strip port or connector, immediately dry the components with a dry cloth or gauze*.

WARNING: *Do not spray the meter with disinfectant solutions; always use a disinfectant wipe*

WARNING: *Do not immerse or hold the meter under running water.*

Limitations and Precautions of the Procedure:

If a significant difference between the bedside and lab results is observed, the patient's glucose should be monitored by the lab.

1. Hematocrit range is 20-65%.
2. Flow errors may occur with extreme high or low Hematocrit; repeat the test with a new strip. If the error code persists, send specimen to lab.
3. Flow errors may occur:
    a. When applying the sample the finger touched the strip, slowing the flow of the sample.
    b. The strip was not filled on the first touch of blood and was applied to the blood again.
4. The following conditions can cause erroneous results:
    a. The test strips were used after the "Use By" date on the vial.
    b. The strips were not stored in the vial with the cap tightly sealed.
    c. The strip was not filled on the first touch of blood and was applied to the blood again.
5. In situations of decreased peripheral blood flow, finger stick blood testing may not be appropriate, as it may not reflect the true physiological state. Examples include, but are not limited to, severe dehydration caused by diabetic ketoacidosis or the hyperglycemic hyperosmolar non-ketotic state, hypotension, shock or peripheral vascular disease.
6. Capillary samples must be obtained from free flowing blood. Excessive milking or squeezing of the puncture site may produce erroneous results.
7. Glucose results <10 mg/dL or >600 mg/dL are outside the linearity range and should not be considered accurate..
8. Test results are best when obtained within an operating relative humidity of 10-90% (non-condensing). Testing outside these ranges may produce inaccurate results.

Troubleshooting:

If for any reason your meter doesn't respond in the appropriate manner (i.e., barcode scanner does not work, meter will not download, unfamiliar error codes, etc.), reboot the meter.

1. Remove the battery from the meter for 10 seconds.
2. Place battery back into the meter, checking to position it correctly.
3. If this does not help, call the lab.

Meter Alert	Explanation	Resolution
Flow Error	May occur in patients with extremely high or low Hematocrit values. Also, when either the strip was not filled or the sample was not applied correctly.	Repeat the test with a new strip. If the error code persists, send specimen to lab. Repeat the test with a new strip.
Low Battery		Place meter in dock to recharge.
Test Strip	Strip removed before test completed. Test	Retest

Meter Alert	Explanation	Resolution
Removed	cancelled.	
Temperature	Meter will only work in temperature range of 59°-104°F (15°-40°C).	Make sure the meter is not near a heat source.
Bad Sample		Insert a new strip and retest.
Strip Rejected		Insert a new strip and retest.
Transfer Failed-Data	Meter cannot connect to the server.	Check that the computer is on. Check that all cables are connected. Call POCT.
Transfer Failed	Meter removed from dock before data transfer complete.	Re-dock the meter.

Maintenance:

Meter, base unit, and carrying case cleaning procedure:

1. Equipment must be cleaned if taken into the patient room using the "Cleaning Procedure," above. Only the meter and the test strip to be used should go into a patient's room. The base unit, carrying case and container with strips should not go into a patient's room.
2. If cleaning solution does get on the connector, dry thoroughly with a cloth or gauze pad before returning the meter to the docking station.

Operator Competency:

1. **Competency Program**
    1. The Laboratory Director, or designee, shall provide orientation and training to, and assess the competency of staff and independent practitioners who perform waived glucose testing.
        a. Clinical Nurse Managers (or those requested by a Clinical Nurse Manager) are determined to be the Superuser after initial training from the Laboratory Point-of-Care Coordinator.
        b. Superusers are required to perform annual competencies.
        c. Documentation of the initial training and annual competencies of the Superusers are kept by the Laboratory Point-of-Care Coordinator.
    2. Initial orientation shall include the safe use and maintenance of the instrument.
    3. Competency is performed initially and annually and includes at least two of the following methods per person per test:
        a. Performance of a test on a blind specimen
        b. Periodic observation of routine work by the supervisor or Superuser
        c. Monitoring of each user's quality control performance
        d. Use of a written test specific to the glucose meter testing.
    4. In addition, Superusers shall have additional training on troubleshooting and training techniques.
2. **Initial Competency:**

The individual unit nursing manager shall ensure that all new RN's and LVN's receive in-servicing on the Nova StatStrip® meter and operating procedure. Initial competency will be documented through the Nova StatStrip® Competency Checklist ~~(Attachment A)~~.

The Nursing Education Department will present this in-servicing content during Nursing Orientation at which time all new operators will complete a Nova StatStrip® competency checklist and will receive an operator ID barcode.

The operator ID consists of the operator's first and last initials and the last four digits of their social security number (i.e., NK3575).

To activate the operator ID, the new operator's competency checklist shall be forwarded to the Laboratory Point-of-Care Coordinator. After activation, the Coordinator will return the checklist to the unit nursing manager for maintenance in the nurse's employee file.

3. **Continuing Competency:**
   Continuing operator competency shall be verified by each activated operator's completion of at least two patient tests and one QC procedure (high and low) every year. Additionally, all users shall verify competency by completion of the Nova StatStrip® ~~Competency Checklist and Blood~~ Glucose ~~Management written test~~Meter competency and Glucometer competency quiz.

   The Laboratory Point-of-Care Coordinator shall generate operator competency reports quarterly and shall forward these reports to each nursing unit manager.

   The Clinical Nurse Manager shall ensure that each operator maintains the minimum competency requirements.

   The Laboratory Point of Care Coordinator shall periodically review and document the review of nursing records of Nova StatStrip® Glucose Meter initial and annual competency assessment.

All revision dates: 1/4/2024, 1/10/2023, 2/11/2019, 8/23/2018, 12/1/2013, 6/1/2010, 12/1/2004, 12/1/2001

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/4/2024
Laboratory Services	Erlinda Roxas: Director, Laboratory Services	2/4/2024

Step Description	Approver	Date
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	1/8/2024
Policy Owner	Hugo Ortiz: Diabetes Nurse Educator	1/5/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/11/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/9/2024*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.043 Enteral Tube Feeding

ENTERAL TUBE FEEDING

1. Purpose

A. To provide consistent best practice guidelines for management of patients receiving enteral tube feeding.

B. To minimize complications associated with enteral tube feeding.

2. Policy

Alerts -

Inadvertent placement in the trachea can lead to severe complication: pleural injury, pneumothorax, tracheobronchial aspiration, pneumonia, and death if fluids or other agents are infused.

The Joint Commission issued a sentinel event alert related to managing risk during transition to new International Organization for Standardization feeding tube standards designed to prevent dangerous feeding tube misconnections, which can lead to serious patient injury and death. Changes to international standards have resulted in the design of the ENFit Connector to help reduce the risk of tube feeding misconnections.

A. Practitioner Order Required:

1. For X-Ray to confirm feeding tube placement prior to use.
2. After confirmation of placement with radiologist, order must be written that feeding tube may be used.
3. To start or discontinue tube feeding.
4. For tube feeding, formula type, volume and flow rate.
5. For flush type and amount, if appropriate.
6. For blood work, as appropriate.
7. For dietician consult for nutrition assessment and feeding recommendations.
8. To give medication via tube.

B. Types of tubes

1. Nasogastric

2. Orogastric
3. Nasogastric small bore feeding tube with stylet for insertion
4. Nasojejunal (NJ)
5. Gastrostomy
6. Jejunostomy
7. Percutaneous endoscopic gastrostomy (PEG)
8. Percutaneous endoscopic gastrostomy with jejunal extension (PEG-J)
9. Percutaneous Gastrostomy (PG)
10. Percutaneous Gastrojejunostomy (PGJ)

C. Method of Administration

1. Continuous: feeding for 24 hours continuously
2. Bolus: feeding is infused over a short time period at specified intervals (less than or equal to 15 minutes)
3. Intermittent: similar technique to that of bolus feeding, but it is infused over a longer duration (greater than or equal to 30-120 minutes)
4. Cyclic: continuous feeding over a specified period (e.g. 8-20 hours per day, night time feeds)

D. Special Considerations

1. Salem Sump tubes are designed for gastric decompression and may be used for tube feeding and medication administration on a short-term basis only. Small bore feeding tubes are preferred for enteral tube feeding administration.
2. Keep the head of the patient's bed elevated at least 30 degrees, unless contraindicated (Reverse Trendelenburg position may be used).
3. If the patient's head of bed must be lowered for a procedure, return to elevated position as soon as able. (Consider length of procedure, patient tolerance of tube feeding, and feeding tube type to ensure risk of aspiration is minimized).
4. Administer tube feeding formula at room temperature.
5. Assess and document gastrointestinal intolerance of tube feedings every 4 hours: abdominal distension, abdominal pain, flatus, monitor stool, emesis. Do not perform routine checks of residuals. Current guidelines from the American Society for Parenteral and Enteral Nutrition (ASPEN) recommend against using Gastric Residual Volumes (GRV) as part of routine care.
6. Jejunal tube feedings should be administered via continuous slow drip.
7. Only use enteral nutrition delivery products when delivering enteral feeds or medications. Trace the feeding tube from the patient to the point of origin.
8. Provide oral care routinely.
9. Consider bowel prep regimen.

E. Medication Administration

1. Medications should be ordered to be administered through the feeding tube

2. When a liquid suspension is not available, medications should be crushed and mixed with sterile water, if approved by Pharmacy.
3. All oral medication; suspensions will be prepared in, delivered and administered in a labeled enteral syringe.
4. Do not give any sublingual, enteric coated or sustained release medication through the feeding tube
5. Medication(s) should be given one at a time with 15 mL flush(es) of sterile water before and after each medication.
6. Medication(s) should not be added directly to an enteral tube feeding formula.
7. Consult pharmacist with continuous tube feeding. Witholding tube feeding medication(s) for at least 30 minutes before and after administration may avoid altered drug bioavailability.
8. Pediatric considerations:

a. Flush feeding tube with lowest volume of sterile water needed to clear it (typically 2-5 mL in children and 1 mL or less in neonates). b. Administer medication with enteral syringe.
c. Flush the feeding tube again with the lowest volume of sterile water needed to clear it.
d. Repeat these steps with the next medication, if prescribed.
e. Flush the feeding tube one final time using the lowest volume of sterile water needed to clear it.

F. Infection Control

1. Tube feeding formula will be labeled with patient name, date, and time opened.
2. Wash hands and wear gloves when accessing tube feeding formula and feeding tube.
3. Maintain clean technique when accessing.
4. Open system: The amount of tube feeding in the bag should not exceed the 4 hour feeding volume.
5. Closed system: closed system containers and tubing must be changed every 24 hours.
6. Change administration sets and any additional administration supplies every 24 hours.

G. Flushing of Feeding Tubes

All Types (NG, OG, NJ, PEG, PEG-J, J-tube, Buttons)

Flushes are provided to maintain feeding tube patency, before and after medication administration, before and after intermittent and bolus tube feeds, before and after adding protein modulars, and when providing additional free water.

1. Flush with 30mLs water every 4 hours (continuous feed) to maintain patency of feeding tube, unless otherwise ordered.
2. Flush with 15mL water before and after each medication.
3. If the patient requires a fluid restriction, consult a pharmacist and dietician to concentrate medications or tube feeds or to decrease water flushes, if appropriate.
4. Pediatric considerations:

a. Flush the feeding tube before and after intermittent tube feedings and at standardized intervals with continuous tube feeds with the smallest volume of sterile water.

b. When using a NJ tube, perform routine flushes as ordered. Use lowest volume needed to clear the

feeding tube (usually 3-5 mL) of sterile water.

H. Confirm Correct placement of Feeding Tube

1. Complete order for X-Ray to confirm initial feeding tube placement.
2. Initial placement: practitioner needs to confirm radiologist confirmation of placement, and write order that the feeding tube may be used.
3. Assess for correct placement of feeding tube prior to each intermittent tube feed, medication administration and at least every 4 hours when patient is receiving a continuous tube feed.
4. See 3. Procedure for methods.

I. Occlusion of Feeding Tube

1. Flush the feeding tube with water, do not force irrigation.
2. Notify practitioner.
3. Pediatric Considerations:

a. Small bore enteral feeding tubes may kink, causing occlusion. Try changing the child's position. Never use a guidewire to reposition the tube.

J. Insertion Site Care

1. PEG, PEG-J, J-tube, Button

a. Follow post-insertion orders

b. Check security of PEG/ PEG-J anchoring device to prevent dislodging.

c. Observe and assess PEG/ PEG-J/ J-tube/ Button insertion site every shift – assess and document skin condition; notify practitioner of redness, swelling, drainage or leaking of gastric contents or tube feed

d. Until healing occurs, clean the exit site daily using a cotton-tipped applicator with normal saline solution, and pat dry using a gauze pad. When exit site healed, wash the skin with soap and water daily, rinse with water and pat dry.

2. NG, OG

a. Assess and document skin at nares, lips and oral mucosa for redness or breakdown.

b. Use protective padding under the feeding tube, if necessary.

c. Keep the skin under the feeding tube clean and dry to prevent skin breakdown.

d. Alternate nares with re-insertion of nasal feeding tube, if possible.

3. PROCEDURE

A. Methods to check feeding tube placement:

1. X-Ray will be ordered to confirm initial feeding tube placement prior to use.

2. Nasogastric (NG) or Orogastric (OG) Tubes:

a. Check external length of feeding tube or incremental marking on the feeding tube, and compare to length

documented in Electronic Health Record (EHR).

b. Review routine chest and abdominal X-Ray reports.

c. Assess patient for signs and symptoms of inadvertent respiratory migration of feeding tube: coughing, choking or cyanosis.

d. Aspirate feeding tube contents with an enteral syringe and inspect visual characteristics of the tube aspirate.

e. Assess for coiling of feeding tube in back of throat.

f. If feeding tube migration is suspected, consult practitioner to check tube and hold tube feed until placement confirmed.

3. Small Bore Feeding Tubes

~~a. Confirm correct placement by measuring external length of feeding tube and compare to length documented in the EHR.~~

~~b. Review routine chest and abdominal X-ray reports~~

~~c. Assess for coiling of tube in back of throat.~~

~~d. If enteral tube migration is suspected, consult practitioner to check tube and hold tube feed until placement confirmed.~~

a. Small bore feeding tubes (remove a. – d.); see policy 'Small Bore Feeding Tube Insertion and Management' Small Bore Feeding Tube Insertion and Management

4. Gastrostomy Tubes (PG, PEG)

a. Confirm correct placement by ensuring gastrostomy flange is flush to the skin

b. PEG: compare the level of which the flange is placed (cm markings on the tubing) to that recorded in the EHR.

c. PG: check for discoloration of the tube shaft; discoloration indicates that the feeding tube may have been pulled out. Consult practitioner to check feeding tube, and hold tube feed until placement confirmed.

5. Jejunostomy (Surgical J-tubes, PGJ)

a. Confirm correct placement by measuring external length of feeding tube and compare to length documented in the EHR.

b. Check for discoloration of the tube shaft; discoloration indicates that the feeding tube may have been pulled out. Consult practitioner to check feeding tube, and hold tube feed until placement confirmed.

B. Administering Tube Feedings

1. Verify the practitioner's order for tube feeding

2. Confirm feeding tube placement has been confirmed prior to starting feeding.

3. Gather equipment

a. Prescribed tube feeding formula.

b. Tube feeding administration set.

c. Enteral syringe, if used.

d. Gloves.

e. Tube feeding pump, if used.

f. Sterile water.

g. Oral care supplies

h. Tape.

4. Compare the tube feeding label to the practitioner order.

5. Check expiration date of tube feeding formula.

6. Perform hand hygiene.

7. confirm patient's identity using two patient identifiers.

8. Explain the procedure to the patient and family.

9. Assess the patient's gastrointestinal status and risk of aspiration.

10. Position the patient with the head of bed elevated to at least 30 degrees, or position the patient upright in a chair. Consider reverse Trendelenburg position, if needed.

11. Perform hand hygiene and put on gloves.

a. Open System

   i. Open tube feeding bag with administration tubing.

   ii. Pour 4 hour volume into tube feeding bag.

b. Closed System

   i. Open tube feeding set tubing.

   ii. Open sterile tube feeding formula bag, and attach to administration set.

12. Attach administration tubing to tube feeding pump and prime.

13. Administration set must be labeled with patient’s name, tube feeding formula type, rate, date, time and initials of the person that hung the tube feeding formula.

14. Verify feeding tube placement using two methods (see 3. Procedure above).

15. If tube migration is suspected, consult practitioner to check tube and hold tube feed until placement confirmed.

16. Flush the feeding tube with at least 30mL of water, or as ordered.

a. Pediatric considerations:

i. Flush the feeding tube with the smallest volume of water needed to clear the tube.

17. Trace the administration set tubing from the patient to its point of origin, and then connect the administration set to the distal end of the feeding tube.

18. Tape the connection.

19. Open the tube feeding administration set clamp, and regulate flow to desired rate. When using a tube feeding pump, set the flow rate; and start the infusion.

20. For a bolus tube feeding through an enteral syringe, attach the syringe to the end of the feeding tube or extension set, and then fill syringe with tube feeding formula. Allow the tube feeding formula to flow, elevating the syringe as necessary, to deliver the tube feeding formula over the prescribed time period, if addressed. Add the tube feeding formula gradually to the syringe until the prescribed volume is infused. Don't allow the syringe to empty completely to prevent air from entering the stomach.

21. Monitor during the tube feeding to recognize complications promptly.

22. When administering a continuous tube feeding, flush the feeding tube every 4 hours with 30 mL of water, or as ordered and tolerated.

23. Monitor the patient's weight and nutritional, fluid, electrolyte and metabolic status, as ordered

24. After the tube feeding, flush the feeding tube with 30 mL of sterile water as ordered and tolerated.

a. Pediatric Consideration: Flush the feeding tube using the lowest volume needed to clear the device (typically 2-5 mL in children, 1 mL or less in neonates), as ordered.

25. Remove and discard gloves; and perform hand hygiene.

26. Document the procedure.

27. Pediatric considerations: Offer an infant a pacifier during tube feedings.

C. Documentation

1. Type of feeding tube being utilized
2. External length of feeding tube prior to initial use and after placement of feeding tube.

a. Continuous enteral feeding: every 4 hours.

b. Intermittent enteral feeding: prior to start of feeding.

3. Date, time, formula type and volume, hourly intake, flush volume, aspirate volume.

4. Symptoms of tube feeding intolerance: vomiting, diarrhea, abdominal distension and/ or pain, large residual volume (if ordered).

5. Feeding tube insertion site assessment and care.

6. Presence and quality of bowel sounds.

7. Color and characteristics of aspirate.

8. Whether gastric residuals (if measured) were returned or discarded.

9. Feeding tube patency, and verification of placement.

4. Resources

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/9/2024

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/9/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/9/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
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, licensed vocational nurses (LVN), registered nurses (RN) and anyone ~~covering~~competent to cover 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 ~~directors, these~~administration. The telemetry technicians assigned to the central telemetry station are responsible for maintaining accurate patient information on the system and notifying the RN staff of any changes.

Qualified personnel to perform the telemetry monitoring function are those individuals ~~are accountable for the quality of care of the patients and are accountable through nursing administration~~who have received training for telemetry monitoring. ~~The telemetry technicians assigned to the central telemetry station are responsible for maintaining accurate patient information on the system and notifying the nursing~~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 at least 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 is placed for cardiac monitoring for a patient, the ~~registered nurse~~RN or surrogate obtain a telemetry box or inform the telemetry technician that a patient has been placed on telemetry via hard-wires. At this time both parties will validate two patient identifiers (~~RN~~name and date of birth) ~~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~~RN 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~~RN 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- lead II and V1.
4. Note: if other leads in use, justification required and documented.

D. The assigned ~~nurse~~RN 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~~transporting the patient to a procedure or while the patient 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.

~~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.~~

F. The RN will re-evaluate the need for utilization of cardiac monitoring daily using the nurse-driven telemetry removal protocol. The RN 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. (VCMC only)

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. (VCMC only)

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. (VCMC only)

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~~RN 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~~RN. 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~~ The other parameter that ~~are~~is 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.~~

K. Frequency of Cardiac Rhythm Interpretation

A. The telemetry technician will do the q shift strip interpretation and will be sent to the primary patient's nurse for validation.

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

1. Upon admission or transfer into unit.
2. Every shift or with changes for DOU and telemetry patients (ICU 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. During any rapid response event.

C. Communication: RN and Telemetry Technician

A. The RN and Telemetry Technician 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 RN should call the Telemetry Technician to inform of any specific orders received.

C. Nursing assignments 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.

~~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 shift or with changes for DOU and telemetry patients (ICU 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.~~

~~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.~~

IV. Dysrhythmia Notification

A. Follow the Alarm Intervention Flowchart (attached) 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. All notifications will be logged

on the telemetry monitoring log.

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

V. Telemetry Tech Responsibilities

A. Communicates battery change alarm

B. Creates copies of the telemetry strips and does the initial interpretation 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~~the telemetry monitoring log~~?)~~

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

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

VI. Specific Nursing Responsibilities

A. Patients on telemetry monitoring who require transport for testing will be transported without a ~~nurse~~RN 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~~RN will accompany the patient. When transporting a patient, the RN must ensure the heart rate alarm is turned on and is audible.

B. Electrodes are changes prn and at least every ~~72~~24 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~~technician's interpretation.

D. Broken or faulty equipment should be returned to the Central Telemetry Monitor. The monitor ~~tech~~technician'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. Telemetry monitoring remains on the patient at all times including ambulation and while toileting.

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~~RN will:
    a. ~~verify~~Verify the patient by name and MRN
    b. ~~Go immediately to~~Immediately 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.
J. Review of need for continuous telemetry monitoring daily. The RN will use the protocol to discontinue telemetry. (Telemetry Discontinuation Worksheet). If telemetry is no longer indicated, the RN will notify the physician to discontinue.

VII. 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.

VIII. Telemetry Discontinuation
A. Every morning (dayshift only), the charge RN in any unit where telemetry is in use at either campus will review all patients on telemetry monitoring.
B. Charge RN will identify any patients on monitoring >48 hours that meet criteria for discontinuation. RN will document in here: Telemetry Discontinuation Worksheet
C. Charge RN will notify primary nurse of their patients where it is no longer indicated.
D. In rounds, primary RN will notify physician that telemetry will be discontinued for those patients identified. Physician can then choose to re-enter order or discontinue it. (Attachment: Nurse-Driven Telemetry Discontinuation Protocol).
E. If patient is continued on telemetry, the process will repeat at Step A above daily until telemetry is discontinued or patient is discharged, whichever is first.

IX. Downtime
A. If downtime occurs, the telemetry technician will immediately notify the house supervisor to contact BioMed and department charge nurses. House supervisor will call AOD if downtime extends > 10 minutes.
B. When department monitoring stations are down, the department charge nurse will notify the centralized telemetry room.
C. If any monitoring is down in the centralized telemetry room, the house supervisor will place patients on alternative monitoring, call BioMed and call the AOD.
D. Once downtime resolves, conduct a debrief to understood root causes and mitigate future risk.

REFERENCE(S):

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All revision dates: 12/27/2023, 11/15/2023, 6/14/2023, 4/12/2023

Attachments

Alarm Intervention Flowchart (1).docx
Tele Removal Workflow.xlsx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/16/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/29/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/29/2023
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	12/29/2023

VENTURA COUNTY HEALTH CARE AGENCY

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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 (RNs). 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~~ 10 to 20cm in length. Midline catheters DO NOT enter the central circulation. "Midline" is clearly marked on the hub of the catheter.

PROVISIONS:

I. Catheter Selection Criteria:

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

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

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

I. Contraindications:

1. Midline catheter placement should not occur on the ipsilateral side of a mastectomy with node resection, radial artery surgery, fistula or shunt.
2. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs.
    a. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of midline.
        - Primary physician will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.
        - Any discussions with physicians should be documented by the midline nurse.
    b. For patients with stage 4 or 5 chronic kidney disease, midline placement may only occur ~~only~~with the approval of the covering nephrologist 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.
    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 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~~allow to dry completely).
K. Prime extension tubing while prep dries.
L. Place fenestrated drape over insertion site.
M. Insert ultrasound probe into sterile cover and place onto sterile drape.
N. Insert Powerglide needle:
    1. Be sure to check that that needle bevel is facing up and that the wire or catheter is not exposed.
    2. Insert needle into the vein under ultrasound guidance.
    3. Slowly advance the guide wire by stabilizing the device and pushing the top slide forward.

4. Deploy the catheter by holding the rear piece of the device stationary then slowly and gently pushing the side wings forward towards the vein. Be careful not to kink the catheter during this phase. Holding skin traction distal to the insertion site will help. If the catheter kinks it will not function properly and a new device will have to be used.
5. Remove the tourniquet.
6. Remove the device applicator and cap.
7. Screw the primed extension set and needleless connector onto the catheter hub and aspirate for for blood return.
8. Flush catheter with 10mL normal saline (NS).

O. Place stabilization device over hub of catheter.

P. Apply 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 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.

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All revision dates: 12/4/2023, 11/15/2023, 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	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/4/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/4/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/4/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.01 Cancer Program Goals and Objectives

POLICY:

The major goal of the Cancer program at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) is to improve its cancer control through use of the following methods:

- Cancer prevention.
- Early diagnosis.
- Evaluation of pre-treatment work-ups
- Accurate staging of the disease.
- Evaluation of treatment against national standards.
- Availability of rehabilitation programs.
- Surveillance of recurrent disease and multiple primaries.
- Enhancement of care for the terminally ill patient.
- Contribute accurate data to the:

1. National Cancer Institue (NCI) Surveillance Epidemiology and End Results (SEER) population-based cancer registry.
2. State of California Cancer Registry.
3. Regional Cancer Surveillance Program Cancer Registry.
4. National Cancer Data Base.
5. American College of Surgeons Commission on Cancer quality of cancer patient care studies and other projects as approved by the Cancer Committee and Hospital Administration.
6. Medical staff and Hospital Administration for statistical studies and reports as requested and approved.

CANCER COMMITTEE OBJECTIVES AND RESPONSIBILITIES:

- Develop and evaluate the annual goals and objectives for the clinical, educational, programmatic activities related to cancer.
- Promote a coordinated, multidisciplinary approach to patient management.
- Ensure that educational and consultative cancer conferences cover all major sites and related issues.
- Assure that an active supportive care system is in place for patients with cancer, their families, and oncology staff.
- Monitor quality management and improvement through completion of quality management studies that

focus on quality, access to care and outcomes.
- Promote clinical research
- Supervise the cancer registry, and ensure accurate and timely abstracting, staging, and follow-up reporting.
- Perform quality control for the cancer registry.
- Encourage data usage and accurate data reporting.
- Cancer Committee analyzes patient outcomes and disseminates the results of the analysis.
- Uphold medical ethical standards.

CANCER REGISTRY OBJECTIVES AND RESPONSIBILITIES:

- Meet and maintain the standards defined in Facility Standards for Oncology Registry Entry(STORE) for collecting and analyzing data on all reportable cancer cases seen at VCMC/SPH.
- Ensure that cancer registry is staffed by personnel who are trained and knowledgeable in cancer registry operations including at least one ~~certified tumor registrar~~oncology data specialist (~~CTR~~ODS)
- Ensure that the maximum abstracting delay is six months and is calculated from the date of initial cancer diagnosis or first cancer admission to the time the data are available for analysis.
- Maintain patient and hospital staff confidentiality as established by the cancer committee and legally required.
- Collect the required data set, and utilize the data definitions and codes in STORE.
- Obtains systematic follow-up information for all analytic patients in the registry and ensure the required follow-up rates are met,
- Submit registry data to the National Cancer Data Base (NCDB) and Cancer Committee approved Commission on Cancer patient care evaluation studies.
- Provide registry data and information to the Medical Staff, Cancer Committee, Administration, other hospital health care professionals in the form of special studies, cancer conference presentations, and quality improvement studies.
- Comply with SEER and State of California Cancer Registry data submission requirements.

Reference:

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

All revision dates: 1/19/2024, 3/9/2021, 3/21/2019, 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	1/19/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.02 Cancer Registry Case Eligibility Criteria

POLICY:

All patients with reportable diagnosed malignancies and/or who received cancer directed care and/or who expired with active cancer at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) must be included in the Cancer Registry database. The Cancer Program Reference Date is 1/1/2015.

PROCEDURE:

Reportable cases are defined as all VCMC/SPH inpatients and outpatients with a clinical or pathological diagnosis of cancer that meets the criteria in the Reportable List. Outpatient departments include Medical oncology, the Gastrointestinal Lab (GI Lab), Outpatient Surgery, and any other hospital operated outpatient clinic providing care to cancer patients. Patients first diagnosed in a staff physician's office and referred to VCMC/SPH for further staging procedures and/or definitive treatment must also be included.

Definitions:

- Reportable Cases:
- The following tumors must be accessioned and abstracted:

1. All carcinomas, sarcomas, melanomas, leukemia, lymphomas and tumors designated with a malignancy behavior code of 2 or higher in the International Classification of Diseases for Oncology (ICDO-3).
2. Basal cell and squamous cell carcinomas originating in mucoepidermoid sites including lip (C00.0-C00.9), anus (C21.0), vulva (C51.0-C51.9), penis (C60.0-C60.9), and scrotum (C63.2).
3. All skin cancers (C44.0) with a histology of 8000-8004, 8010-8045, 8050-8076, 8081-8082, 8090-8110 and at diagnosis, the American Joint Committee on Cancer (AJCC) stage group is II (T2 N0 M0), III (any T N1 M0), or IV (any T and any N and M1).
4. Gastro-intestinal stromal tumors (GIST) and thymomas must be assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.
5. Effective 2015 Carcinoid tumors of the appendix (C18.1) must be coded 8240/3.
6. Any patient with admitted for subsequent treatment for recurrent, persistent, progressive or metastatic cancer which was previously diagnosed and initially treated elsewhere.
7. Any patient with active disease who expires during a VCMC/SPH admission, including those admitted for and/or expiring from unrelated medical conditions.

8. Cases that are not histologically confirmed but are clinically diagnosed by a physician using the following terminology to describe the tumor:
    - apparently (malignant)
    - appears
    - comparable with
    - compatible with (malignancy)
    - consistent with (malignancy)
    - suspect/suspected (malignancy)
    - suspicious (of malignancy)
    - malignant appearing
    - presumed (malignant)
    - probable (malignancy)
    - most likely (malignancy)
    - typical (of malignancy)
    - Neoplasm* beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)
    - Tumor* (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)
    - additional terms for nonmalignant intracranial and CNS tumors only
9. Patients admitted for terminal support care.
10. Patients admitted to the Rehabilitation Program as part of their cancer treatment plan.
11. Non-Reportable Cases:
    The following tumors should not be accessioned and abstracted:
    1. Localized basal and squamous cell carcinomas of the skin except for lesions of the mucous membrane and external genitalia.
    2. Patients seen only in consultation to confirm a diagnosis or treatment plan, or who receive a service not available at the diagnosing or treating facility such as CT and MRI scans, or for placement of venous access devices. Pathology reports that are consultations only must be kept in the "Pathology Report Consultation File" in the Registry office. These reports are filed alphabetically by year.
    3. Patients with a past history of cancer who are clinically free of the disease at the time of their VCMC/SPH admission.
    4. Cases that are not histologically confirmed and the physician uses the following terminology to describe the tumor:
        - Cannot be ruled out
        - Rule out
        - Equivocal
        - Suggests
        - Possible

- Questionable
- Worrisome
- Potentially malignant

5. Patients with precancerous conditions or benign tumors.
6. Patients with prostatic intraepithelial neoplasia.
7. Patients who are diagnosed at a staff physician office and treated at another facility.

Reference:

Standards for Oncology Registry Entry (STORE)

All revision dates: 2/9/2021, 4/24/2018, 4/28/2016

Attachments

No Attachments

Approval Signatures

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Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	1/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.08 Cancer Registry Quality Control Procedures

POLICY:

To ensure compliance with the Commission on Cancer Standard 6.1 as follows:

High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival. Each calendar year, the cancer committee implements a policy and procedure to annually evaluate the quality of cancer registry data and activity, including procedures to monitor and evaluate each required control component.

PROCEDURE:

The Cancer Committee will conduct a quality review of Cancer Registry data by reviewing abstracts with comparison to Medical Records. The Cancer Committee shall designate a physician, physician resident, fellow, advanced practice nurse(APN), physicians assistant (PA) or ~~a certified tumor registrar~~an Oncology Data Specialist (~~CTR~~ODS) to perform Quality Activities of the hospital's analytic cases (Class 10's and 20's). A non-Committee physician can also be involved in Quality Improvement activities depending upon the need.

Accuracy rates:

The accuracy rates have been approved by the Cancer Committee as follows:

CASEFINDING	90%
ACCURACY OF DATA COLLECTION (ABSTRACTING: Class of case, primary site, date of diagnosis, histology, residual tumor, first course of treatment, follow-up information, first recurrence and cancer status, percentage of information coded as unknown)	97%
FOLLOW-UP (The documented follow-up contacts and/or physicians are correct)	100%

Quality review of randomly selected abstracts for the top five (5) sites in the cancer database will be compared to the documentation in the medical record.

A minimum of 10% of analytic cases will be reviewed annually by the designated member of the Cancer Committee.

~~Assessment of Evaluation & Treatment Planning - Evaluate the reviewed cases for appropriate staging and~~

~~evidence based national treatment guidelines. Cancer registry data will be used to identify cases for review.~~

The ~~Cancer Registrar~~cancer registrar randomly selects 10% of the quarterly abstracted cases based on the analytic caseload. ~~For the cases selected, a Quality Control (QC) Form and abstract will be printed. The QC Form and abstract will be provided to the designated reviewer.~~

For the cases selected, a CoC Quality Control (QC) form containing the abstracted data will be printed using CNExT software. The abstract will be provided to the designated reviewer.

REVIEW BY COORDINATOR OF QUALITY OF CANCER REGISTRY DATA:

The Coordinator will conduct periodic quality review of the cases abstracted by the staffed Cancer Registrar and outside consultants.

REPORTING TO CANCER COMMITTEE:

The Coordinator of Cancer Registry Data Quality will report the audit results at least annually to the Cancer Committee.

Reference:

American College of Surgeons, Cancer Program Standards 2020 Edition : Optimal Resources for Cancer Care

All revision dates: 1/19/2024, 3/9/2021, 2/12/2020, 4/28/2016

Attachments

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Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	1/19/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.11 Cancer Registry Policy Statement on Confidentiality

POLICY:

It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) to maintain confidentiality of patient information in compliance with federal, state and local laws governing the release of information, and to ensure that each patient's right to privacy is preserved. Cancer Registry patient data are treated in the same confidential manner as other patient specific information in the Hospital. Other data maintained in the registry database specific to physicians and additional individuals are also treated in this same confidential manner.

PROCEDURE:

The purpose of the cancer data gathering process at VCMC/SPH is to provide information for both internal VCMC/SPH needs and to fulfill reporting standards as required by specific outside agencies.

Definition:

A. Release of data to external organizations must be approved by the Cancer Committee, and is limited to:
    1. The American College of Surgeons Commission on Cancer as needed to meet standards for hospital Cancer Program approval.
    2. The National Cancer Data Base.
    3. State of California Cancer Registry as needed to meet state reporting requirements.
    4. The National Cancer Institue(NCI) Surveillance Epidemiology and End results (SEER) Regional Registry Program as needed to meet regional and NCI reporting requirements.
    5. Legitimate requests for patient follow-up received from other hospital cancer registries that are following the same patients.

B. Any other requests for patient and/or physician specific information must be individually reviewed and approved by the Cancer Committee and Hospital Administration to ensure confidentiality standards are maintained as required by Hospital policy and the law. All requests are documented in the Cancer Registry request log including the date of the request, topic, and study period, source of the request, intent and final use of the data.

C. Any release of data must also follow the confidentiality guidelines as they are defined in the VCMC/SPH

Administrative policies and procedures.

Reference:

Registry Operations and Data Standards

All revision dates: 3/9/2021, 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	1/19/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.16 Cancer Registry Guidelines for Patient Management and Treatment

POLICY:

To ensure compliance with the American College of Surgeons Commission on Cancer 2020 Program Standard 5.1 *Optimal Resources for Cancer Care*, which are guidelines for patient management and treatment that provide an organized approach to quality care.

In addition, Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologists (CAP) cancer protocols, including containing all core data elements within the synoptic format.

Eligible cancer pathology reports are defined as:

- Definitive surgical resection of primary invasive malignancies and ductal carcinoma in situ (DCIS), and
- Definitive surgical resection in patients who have received neoadjuvant therapy AND who have residual tumor

Please refer to the CAP Cancer protocols for specific guidance and examples by primary site.

PROCEDURE:

The Commission on Cancer site reviewer will review the standardized synoptic pathology reports for eligible patients.

All revision dates: 3/9/2021, 3/21/2019, 4/28/2016

Attachments

No Attachments

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Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending

Step Description	Approver	Date
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	1/19/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

N.38 Hemolytic Disease of the Newborn (HDN)

POLICY:

To define nursing responsibility in ~~detecting~~reporting blood incompatibility in neonates admitted to the Neonatal Intensive Care Unit.

PROCEDURE:

The ~~NICU~~Neonatal Intensive Care Unit nurse will be aware of ~~all~~ maternal blood ~~types~~type. A medical order for Hemolytic Disease of the Newborn (HDN) work-up will be obtained for all infants of mothers ~~where the~~whose blood type is unknown or is type O and/or ~~rH~~Rh negative. All infants admitted to the ~~NICU~~Neonatal Intensive Care Unit for prematurity will have a Hemolytic Disease of the Newborn HDN work-up.

EQUIPMENT:

Cord blood.

GUIDELINES:

A. All cord blood and blood obtained during a transport will be sent to Laboratory. The tubes are labeled with the mother's name and ~~chart~~medical record number.

B. If a Hemolytic Disease of the Newborn HDN work-up is indicated, enter an order in the computer: Category **Blood Bank**, procedure ~~**HDN**~~Hemolytic Disease of the Newborn HDN. If the mother has positive antibody screen, the nurse will notify the Blood Bank of the need to do the Hemolytic Disease of the Newborn HDN work-up urgently.

C. The Hemolytic Disease of the Newborn HDN work-up will be drawn from the infant if cord blood is unavailable.

D. The nurse must check for results of Hemolytic Disease of the Newborn HDN work-up (usually available within 4 to 12 hours) and notify the physician~~/NNP~~ if a positive Coombs is obtained or if the infant appears jaundiced within the first 24 hours of life.

E. The nurse ensures that babies with a positive Coombs:

1. Have follow-up bilirubin levels ordered by the physician.
2. Not be discharged prior to 48 hours of age.
3. Have a follow-up evaluation within 24 hours after discharge, if bilirubin has not declined.

4. Have parents understand the importance of and have the means to take the baby to the follow-up visits.

DOCUMENTATION:

~~Nursing Notes –~~Electronic Health Record (EHR) - Notification of the physician~~/NNP~~ of positive Coombs or if infant is jaundiced within the first 24 hours of age. If baby is discharged before 24 hours of age and have declined the bilirubin ~~has declined~~, document parents' understanding and ability to transport the infant to the follow-up visits.

REFERENCES:

~~AWHONN: NOEP, 3rd edition, 2015~~

All revision dates: 2/5/2024, 7/1/2015, 3/1/2010, 4/1/2008, 5/1/2002, 8/1/2001

Attachments

No Attachments

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Step Description	Approver	Date
Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
NICU	Melissa Krebs: Director, NICU	1/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/2/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/2/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	1/2/2024

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.12 Labor and Delivery Admission and Assessment

POLICY:

To provide guidelines for maintaining a consistent standard of care for all patients admitted to Labor and Delivery. A complete nursing assessment will be performed for all patients admitted to Labor and Delivery. Data gathering is accomplished through review of prenatal history, patient and family interview, physical assessment and monitoring and clinical data available.

PROCEDURE:

A. The patient's prenatal record will be in the electronic health record (EHR). For those patients outside our system ~~call the physicians clinic and have it faxed to you~~, identify the primary care provider and request records to be sent to Labor and Delivery Unit.

B. Admission Criteria
   1. Signs and symptoms of labor
   2. Scheduled induction or augmentation of labor
   3. Scheduled, routine, or emergent cesarean section
   4. Born out of asepsis deliveries
   5. Fetal demise labor management
   6. Acute medical obstetrical management, typically 20 weeks gestation or greater.

C. The registered nurse (RN) will review prenatal record for:
   1. Problem list
   2. Lab results: blood type and RH, unusual antibodies, ~~HbsAG~~Hepatitis B Surface AG, GBS, Rubella, VDRL and HIV status
   3. Results of tests, PPD, chest X-ray and therapeutic measures prescribed
   4. Obstetric history, Estimated Date of Conception (EDC)
   5. Ultrasound results
   6. Risk factors, infection or other illness

      ~~Breastfeeding or bottle-feeding.~~

~~Language~~

7. Feeding Plan.
8. Language-Assess for the need of interpretation services
9. Age

D. General Admission Assessment: An admission assessment of the patient will be completed upon admission to the Labor and Delivery Unit. May include, but not limited to.

1. Vital signs – temperature, pulse, respiratory rate, and blood pressure.
2. Urinalysis-as ordered per physician.
3. Neuro: deep tendon reflexes (DTRs) - assess clonus, headache.
4. Skin integrity-edema, varicosities, scars, tattoos, bruises, abrasions, open sores, and rashes.
5. Head, Eyes, Ears, Nose and Throat (HEENT) - Note any possible airway obstruction
6. Allergies
7. Nutrition screen.
8. Education: assess learning needs, barriers to learning and education preferences.

E. Obstetric Assessment:

1. Abdominal exam, fundal height.
2. Physical and psychosocial status
3. Prenatal and medical history by verbal interview and review of prenatal record
4. Vaginal bleeding.
5. Contraction frequency, duration and intensity.
6. Membranes: Intact or ruptured, time, color, amount and odor.
7. Fetal assessment: Continuous electronic fetal monitoring (EFM) to assess fetal well-being and uterine activity
8. Patient's current height and weight should be documented in the ~~EHR~~EMR
9. If there is a history of rupture of membrane, notify physician or resident prior to vaginal exam.
10. Sterile vaginal exam to determine dilation, effacement, station, and presentation if no contraindication to exam.
11. When labor started.
12. Previous Cesarean section (C-section), if any.
13. Pain assessment and management plan.

F. Laboratory:

1. Urine dip for protein/specific gravity/ketones/glucose.
2. Urinealysis (UA) as ordered.
3. Complete Blood Count (CBC) as ordered.
4. : Type and Screen
5. For patients with no prenatal care or unknown prenatal history strongly consider: Prenatal Panel

(including CBC, ABO and RH, ~~HbsAG~~Hepatitis B Surface AG, Rubella, VDRL/RPR) and HIV.

6. Urine drug screen (UDS) with consent.

G. Notify physician/resident and inform him/her of the following:

1. Patient's arrival on unit and reason.
2. Certified Nurse Midwife (CNM) or Registered Nurse (RN) will notify attending physician when a patient of the Santa Hospital Birth Center is in active labor.
3. Estimated date of conception (EDC) – with gestation in weeks.
4. Gravida and Para.
5. Membranes intact or ruptured with time and color.
6. Bloody show or vaginal discharge.
7. Vaginal exam.
8. Fetal Heart Rate (FHR)/Uterine Contraction (UC) Tracing Assessment.
9. Vital signs – significant variation of maternal blood pressure from previously recorded values. Fall or rise of maternal blood pressure of greater than 30/15. Elevated temperatures.
10. Any unusual findings or symptoms.
11. Previous C-section, if any.
12. When labor started.

H. Ongoing assessment:

1. Vital Signs
   a. If patient is not in active labor, routine vital signs including temperature. (Cytotec, Cervadil for Induction of Labor)
   b. Check blood pressure, pulse and respiration hourly (more often, if indicated by any change in condition) during the first stage of labor, and every 30 minutes during the second stage of labor.
2. Check temperature every two hours if ruptured or indicated. Otherwise, check temperature every four hours.
3. Pain should be assessed every hour, or more frequently if indicated by any change in condition.
4. Fetal Heart Tones (FHT) and Uterine Contraction (UC) activity will be assessed per policy guidelines. ***See Ob.45 Management of Fetal Heart Rate Tracing***
5. Document labor activity and all cervical exams.
6. Movement throughout labor will be encouraged as appropriate
7. Continuous Fetal Heart Rate-Uterine Contraction (FHR-UC) monitoring is recommended. Candidates for intermittent FHR-UC monitoring must have a reactive NST and absence of decelerations to be allowed to ambulate. Continuous FHR-UC monitoring must be instituted whenever conditions, maternal or fetal, change to high risk. ***See Ob.45 Management of Fetal Heart Rate Tracing***
8. Oxygen may be available for use with provider's order
9. Nursing management of the newborn and assignment of Apgar scoring will occur immediately post delivery per Neonatal Resuscitation (NRP) guidelines.
10. Notify physician for any unexpected change in patient condition

11. If Auscultation of Fetal Heart Rate (FHR) is used, should be assessed:
    a. At least every 30 minutes in early labor.
    b. At least every 15 minutes in active labor or 5-15 minutes in second stage of labor.
    c. Auscultation should be done following a contraction.
12. The nurse in attendance should have:
    a. Thorough knowledge of principle of FHR and UC physiology and pathophysiology.
    b. Clinical experience and validation of competency in fetal heart rate pattern assessment.
13. Recovery-Maternal
    a. The nurse will perform a recovery assessment immediately following completion of delivery of placenta or vaginal repair, or upon arrival of cesarean delivered patients to the L&D PACU
    b. Assessment and monitoring will be performed on all patients who have had regional (e.g. spinal, epidural) or general anesthesia following "Recovery Room" guidelines.
    c. Continuous cardiac monitoring will be maintained for at least one hour after arrival to the L&D PACU
    d. When both the mother and baby stable, the nurse to ratio may be changed to 1:2
14. Approximately every 15 minutes until transfer to postpartum level of care, the following will be assessed:
    a. Vital Signs (pulse, respiration, blood pressure, oxygen saturation)
    b. Fundal tone, height and location
    c. Lochia amount, color, consistency
    d. Perineal laceration or incision and dressing, if applicable
    e. Abdominal incision and dressing, if applicable
    f. Bladder and urinary elimination status
    g. IV site
    h. Pain level
    i. Mobility Status
    j. Emotional Status
    k. Infant bonding (intial contact and interaction)
    l. Temperature and Intake and Output will be recorded hourly or as needed.
    m. Continue skin to skin through the first feeding
    n. Provide the patient with adequate pain relief as ordered by provider
    o. Assist and encourage ambulation if appropriate. Assist with first void.
    p. Procedure for complications of Maternal Recovery-Notify the obstetrician, anesthesia and, if needed, the Rapid Response Team. For excessive or continued bleeding, initiate "Code Maternity' protocol. ***See Policy OB09 Code Maternity.***
15. Recovery-Newborn
    a. To facilitate the bonding process for both mother and newborn, skin-to-skin contact is strongly

encouraged immediately post delivery and during the recovery process when both mother and newborn are deemed stable. Vital signs and immediate care assessments can be performed on both the mother and newborn while the infant is in the mother's arms and during breastfeeding.

b. A licensed RN competent in newborn assessment will evaluate the immediate condition of the neonate. Abnormal findings will be reported to resident or attending provider.

c. Approximately every 30 minutes until transfer to postpartum level of care assessment will be done according to ***Policy OB65 Admission and Ongoing Care of a Well Newborn.***

d. No later than two (2) hours after birth, a comprehensive newborn assessment will be performed.

IDENTIFICATION SYSTEM

A. Patient is given an identification band with patient's name, chart number and date of birth.

B. The mother will also have an identification band when blood is drawn for blood bank.

C. Allergy to medication is noted on red wrist band.

D. Four Mother/Infant Identification bands are placed on chart upon admission. They will be placed on mother, infant, and significant other in the delivery room, ~~see policy NOBP.06, *Infants Bands and Identification.*~~***see Policy MCHO7 Infant Identification Bands and Security Tag Procedure.***

E. A security tag will be placed on the newborns anckle when admitted to couplet care. ***see Policy MCHO7 Infant Identification Bands and Security Tag Procedure.***

EQUIPMENT

A. Fetal monitoring.

B. Blood pressure cuff, stethoscope.

C. Thermometer.

D. Oxygen (O_2)and Wall suction.

E. Percussion hammer.

DOCUMENTATION

All patient data will be recorded as appropriate in patient's electronic health record:

A. Height, weight obtained and documented with all admission to Labor and Delivery or Antepartum

B. Allergies

C. Patient's obstetrical history.

D. Patient's physical exam.

E. Uterine pattern and strength per policy.

F. Fetal monitoring system for fetal well being per policy.

G. Care plan.

H. Medication Reconciliation.

I. Patient belongings.

J. Patient charges for supplies used in Labor & Delivery.

K. Initial Newborn recovery care and initial assessment

REFERENCES:

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All revision dates: 1/4/2024, 8/19/2021, 10/14/2020, 12/21/2017, 11/20/2017, 2/1/2014, 7/1/2010, 1/1/2008, 11/1/2004, 12/1/2001, 12/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/30/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/30/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/30/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/1983*
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Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.20 Assessment (Scope of Occupational Therapy (OT) Assessment)

Patient Evaluation:

All patients shall have a written evaluation completed at the initial visit by an Occupational Therapist in the Electronic Medical Record (EMR) (See Occupational Therapy (OT) Evaluation Form). The initial assessment is performed to determine the needs of the patient and to provide a database which is utilized in assessing the response to treatment. The initial assessment may include but is not limited to:

- Date of evaluation
- Diagnosis or condition needing referral to OT
- Date of surgery or injury pertinent to diagnosis
- Physician orders for service
- Precautions, limitations or contraindications for treatment, if any
- A brief medical history, obtained from patient, EMR or medical chart
- Previous functional level and living environment
- All testing is done utilizing standardized procedures of one or more of the following:
    a. Muscle Test (gross/specific)
    b. Range of motion (ROM)
    c. Pain
    d. Sensation, proprioception, tone, functional use
    e. Endurance
    f. Coordination
    g. Activities of Daily Living (ADL) assessment for age
    h. Cognition, where appropriate
    i. Perception, where appropriate
- A list of equipment/orthotics currently being used or needed now or in the future to achieve goals.
- Any planned surgical procedure is listed, if known.
- Barriers to learning such as language, attitude and cooperation are noted.
- Problems are identified and prioritized.
- Discharge plan or needs

Treatment Goals:

- Each treatment goal should be functional and measurable with an estimated time frame of achievement. Goals are determined after completion of the evaluation and discussion with the patient/family and/or significant other.
- Examples of functional and/or behavioral goals **may** include:
    a. Able to perform ADLs without pain
    b. Able to don/doff splint
    c. Able to dress with supervision with use of button hook
    d. Able to use right upper extremity (RUE) to brush teeth
    e. Able to pour half gallon of milk without dropping
    f. Able to stand at sink without assist to manage grooming and oral hygiene
- Judgment is made on the potential to achieve the treatment goals (fair, good, excellent).
- Goals are revised as necessary.
- Barriers to goal achievement and factors that will facilitate goal achievements are identified.

Individualized Assessment:

The assessment process will include evaluation of those areas appropriate to the patient's needs based on age, diagnosis, and medical status. In addition to the items on the general occupational therapy evaluation, the following may be addressed as needed for age specifics:

A. Pediatric Tools used for evaluations include but are not limited to:
    1. Gesell Developmental Schedules
    2. First Step, Screening for Evaluating Preschoolers
    3. Beery-Bukterica Developmental Test of Visual Motor Integration
    4. Infant/Toddler Sensory Profile
    5. Beckman Oral-Motor Protocol
    6. Kohlman Evaluation of Living Skills
    7. Primer Paso (Spanish version of First Step)
    8. Sensory Profile
    9. NEPSY: A Developmental Neuropsychological Assessment
B. General description of child and families participation in the assessment.
C. Living situation, including information about the house, multiple families living in the home, other disabled individuals living in the home, etc.
D. Include whether child is in school/ day care or other special programs.
E. Include whether child has been receiving other therapy services or whether child will be referred to other out-patient therapy services or programs.
F. If child has had multiple hospitalizations, include past level of function and whether there has been change in function.

G. List any adaptive equipment child may have and whether any changes will be recommended for equipment.

H. List any behavioral issues/problems and whether family is receiving any services in this regard, or whether child is on any behavioral medications.

I. List whether child has any sensory issues such as visual, tactile, auditory sensitivities which affect the child's ability to participate with therapy.

J. Review of oral motor skills.

Assessment Criteria:

Licensed therapists will perform initial assessments at the following times or under the following conditions:

- Prior to the initial treatment session when physician orders are received for therapy.
- When trigger/screening criteria developed by the services are identified and the physician orders an assessment.

Timely Completion of Assessment:

Inpatient assessments will be completed within the following time frames:
Occupational Therapy (OT)

- Inpatient referrals will be assessed within 24-72 hours of receipt of the order for OT. Refer to policy on response time frames for referrals.
- Acute out-patient referrals will be scheduled within 1-2 weeks of receipt of referral and will be prioritized based upon patient need.

Documentation of the assessment findings will be done following the documentation guidelines for the department.

Inpatient assessment findings will be placed in the EMR immediately following the treatment.

Out-patient assessment documentation will be completed within 72 hours of the completion of the evaluation visit.

Notification of Physician – Significant Findings:

When assessment findings warrant immediate response for inpatients or out-patients, the physician or his office will be notified, and report of the significant findings and discussion documented.

Referrals for Assessment by Other Providers:

A request for assessment/treatment by other services will be made when:

- The therapist identifies any other deficit that requires therapeutic intervention.
- The caregiver identifies a learning need that can best be addressed by another service (i.e. diabetes counseling, nutrition).

Referrals will be made in the following manner:

- For treatment requiring physician's orders, the physician will be contacted for consultation and request of the order. This may be done, at the therapist's discretion, using any of the acceptable communication procedures available (documentation of request in EMR or chart, recommendation on physician progress

statement, phone call, communication through multidisciplinary team meetings, etc.)
- For needs not requiring physician's orders, the caregiver may contact the involved service directly and coordinate the referral process.

Priorities for Care:

As part of the assessment process, the evaluating therapist will identify patient problems, deficits, needs and issues and will establish a priority for addressing those needs based on the following scale:

High Priority	The need, problem, deficit or issue is significant, interferes with the patient's ability to achieve desired outcomes or functional status and must be addressed within the first 3 days of service.
Medium Priority	The need, problem, deficit or issue is moderate, interferes with the patient's ability to achieve the desired discharge outcome to a lesser degree and needs to be addressed during their admission.
Low Priority	The need, problem, deficit or issue is either long-standing and unlikely to respond to short-term interventions or is of a lower significance in affecting the outcome of this patient stay and will not likely be addressed during their admission.

Frequency indicating level of prioritization will be documented on the initial evaluation form.

Ongoing Assessment:

In addition to the formal assessment and reassessments that are performed by therapists based on the above time frames and criteria, the patient is assessed for response to treatment and change in needs at each visit. Objective measurements may include vital signs, strength, range of motion, endurance and other indicators that measure progress or lack of progress. These indicators may be recorded by a occupational therapist assistant. (COTA) and therapy aides involved in the care of the patient, and will report any noted signs, symptoms or subjective data to the therapists responsible for the patient so this data can be included in the overall assessment and care of the patient.

Utilization of Assessment Data:

All assessment data will be documented in the medical record. This data will be utilized to establish priorities for care and develop a plan of care, educational plan and goals for patient treatment. The initial and subsequent measurements will be used to determine progress of the patient and to reevaluate needs during the care process.

Treatment Plan:

- The treatment plan is based on the patient assessment and functional goals. The treatment plan is discussed with the patient, family and/ or caregiver and verbal consent is obtained.
- Procedures utilized may include therapeutic exercise, functional activities, splinting, posture training, endurance training, ADLs, cognitive and perceptual training, and coordination skills as indicated.
- Physical modalities are available for hand rehab patients.
- Training is provided in the proper use of adaptive equipment to maximize function (i.e., sock aide, reacher, rocker knife)
- Various exercise equipment may used to regain strength, motion and function (e.g. free weights, grippers, weight well, theraputty).

- Instruction in a home exercise program with written instructions is a part of treatment plan where applicable. Patient/family education regarding various aspects of the treatment plan is ongoing and may include but is not limited to instruction in edema control, scar management, skin care, use of adaptive equipment, etc.
- Treatment time is planned to optimally provide one-on-one care
- Frequency and estimated duration of treatment plan
- Full signature of the evaluating therapist

Progress Record:

- Therapist records each visit by date.
- List of modalities/procedures utilized by date and total time of treatment.
- Responses to treatment, especially change or progress are documented.
- Home exercise or instructions in splint use, edema controls, etc., to patient/family is noted.

Summary:

- Revision of treatment program is done if goals are not being achieved.
- A discharge summary is performed at the completion of the therapy sessions. It should include:
    a. Diagnosis
    b. Number of treatments and dates of service
    c. Summary of treatment program
    d. A review of functional goals and whether goals were met.
    e. A comments section which may address response to treatment, amount of pain decrease, degree of functional improvement, etc.
    f. Recommendation for further care, discharge or referral if needed
    g. If patient fails to complete the episode of care, the reason for the discontinuation of service will be noted

All revision dates: 12/8/2020, 10/1/2006, 2/1/2006, 9/1/2004, 11/1/2001, 12/1/1998, 10/1/1995, 12/1/1992, 5/1/1990

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	1/22/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.03 Alcohol Withdrawal in the IPU/CSU

POLICY:

Alcohol withdrawal coexisting with mental illness will be treated using the Clinical Institute Withdrawal Alcohol (CIWA) protocol.

PROCEDURE:

A. ADMITTING PSYCHIATRIST

1. Identify the patient as at risk for alcohol withdrawal
2. ~~Complete the CIWA Order Form~~When clinically indicated, complete the CIWA electronic orders in Cerner or the paper Order Form

B. LICENSED NURSING STAFF:

1. Assess the patient as soon as possible using CIWA scale.
2. Document the assessment on the CIWA scale.
3. Medicate the patient based on the CIWA alcohol detoxification orders and the findings of the CIWA scale.

All revision dates: 11/15/2023, 8/11/2020, 11/1/2015, 3/1/2009, 8/1/2008, 10/1/2006, 7/1/2004, 2/1/2000

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/26/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/26/2023

Step Description	Approver	Date
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/26/2023

Current Status: *Pending* **PolicyStat ID:** *13798955*

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.70 IPU Tub Room Use

POLICY:

To state the proper procedure for staff to follow when Inpatient Psychiatric Unit (IPU) patients use the tub room.

PROCEDURE:

1. Tub rooms will remain locked and unoccupied at all times.

2. Tub rooms are not to be used, unless directed by a physician's order.

3. If a physician writes an order, nursing staff must remain with the patient at all times while the patient is in the tub room.

4. Nursing staff must maintain direct line of sight of the patient throughout the duration of the tub room use.

5. Once the patient is finished in the tub room, nursing staff will ensure the tub room is unoccupied and locked.

All revision dates: 5/12/2017

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/26/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/26/2023
Inpatient Psychiatric Unit &	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/26/2023

Step Description	Approver	Date
Crisis Stabilization Unit		

VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised:	*2/9/2021*
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Owner:	*Mary Jane Green: HIM Manager*
Policy Area:	*Administrative - Patient Care*
References:	

100.010 Photographing of Patients

POLICY:

Any photography, videography, audio recording or other capture of images, whether in traditional or digital/ electronic format shall be governed by this policy. For simplification, photography, in this policy, shall refer to all of the above types of recorded images/digital content. There is an important distinction between photography taken in the usual and customary course of medical care, and that which is unrelated to medical care (e.g. public relations, medical research, newborn photographs for sale).

This policy does not apply to, and is not limited to, any security cameras on the premises, medical diagnostic imaging, telemedicine, and/or video translation services.

PROCEDURE:

A. Consent for photography that is **directly related to the medical treatment** of that patient, or part of a patient's body, is covered under the general consent completed by the patient prior to care (see 100.008 Consent for Medical Care). It is recommended that the staff member taking the photograph inform the patient about what will be taken, and how the images will be used (i.e. archived in the medical record, shared with a consulting physician).

B. The *Consent to Photograph and Authorization for Use or Disclosure* form (available in Docushare) is to be completed whenever photographs are taken of a patient or a part of a patient's body, for any reason that is **not directly related to the medical treatment**.

C. In all circumstances of photography, care must be taken to exclude sensitive parts of the body, namely the genitalia, unless there is medical reason why they need to be included.

PHOTOGRAPHS AND THE MEDICAL RECORD

Photographs directly related to medical treatment should be stored in the medical record. For photographs that are printed in hard copy, staff should ensure that at least two patient identifiers are included on the photograph to facilitate placement into the correct patient's medical record. For photographs captured digitally that are intended for the electronic medical record, staff should ensure that the electronic transmission of these photographs into the electronic medical record also follows a double check of patient identification before transmission. An example of this would be the Mobile Capture capability of the Cerner electronic health record that allows the direct transmission of a photograph from a smart phone directly into the electronic chart of a patient.

All revision dates: 2/9/2021, 5/31/2017, 5/1/2014, 12/1/2013, 5/1/2006,

	8/1/2001, 3/1/1995, 5/1/1983

Attachments

- Authorization & Consent to Photograph & Publication
- Authorization & Consent to Photograph & Publication sp
- Consent to Photograph & Authorization for Use sp
- Consent to Photograph and Authorization for Use

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	2/14/2024
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/7/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/8/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/7/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/4/2024
Policy Owner	Mary Jane Green: HIM Manager	1/4/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
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/Primary Care Provider or Specialist/Underimmunized follow-up, etc.)
   4. Medical transportation (if necessary)
   5. Durable medical equipment (if necessary)
   6. Home health services (if necessary)

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 48 hours post-discharge for patient stays greater than 48 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 is not required for patient stays less than 48 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.

D. Discharge medication reconciliation must be completed by the discharging physician/provider, per policy

100.082 Medication Reconciliation.

E. The patient, family, or significant others must be instructed on care post-hospitalization, take home prescriptions, home instructions, and follow-up appointments.

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

G. Communication to occur with the patient's primary care provider, specialist or medical caregiver as needed.

H. 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).

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

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

K. Valuables should be returned to the patient and the patient must sign for them.

L. Discharge date, time and disposition are to be entered into the EHR by Nursing.

Note: In the event of patient death, the Nursing unit notifies admitting office by telephone. The discharge order is entered into the EHR by nursing unit staff. Nursing enters discharge date, time and disposition.

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

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

O. All paper documents must be sent to Health Information Management (HIM) the following day to be scanned into the EHR.

P. HIM will review the chart for deficiency analysis and coding.

All revision dates:	1/16/2024, 11/15/2023, 11/10/2021, 1/1/2017, 2/1/2013, 4/1/2012, 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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/16/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/16/2024

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

100.048 Referral of Potential Organ and Tissue Donors

Policy:

To maintain compliance with the CMS 42 CFR Section 482.45 Conditions of Participation for Hospitals, Senate Bill 2777 and CHSC 7184; Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) shall facilitate organ and tissue donation by recognition of potential donors and report*ing* all deaths to the appropriate Organ and Tissue Procurement Organization (OPO) VCMC) and SPH is OneLegacy.

The hospital's written agreement with the OPO will include criteria for referral, definition of "imminent death", definition of "timely notification; address the OPO's responsibility to determine medical suitability for organ donation; provides for timely notification of each death in accordance with the agreement; ensures designated requestor training offered by the OPO has been developed; permits OPO access to hospital's death records according to designated schedule; hospital is not required to credential /privilege members of the organ recovery team; and the interventions the hospital will utilize to maintain potential organ donor patient so organs remain viable.

To ensure timely communication the following processes will be implemented:

A. All imminent brain deaths and all cardiac deaths must be reported to OneLegacy's 24-hour Donor Referral Line within one (1) hour.

B. The hospitals shall provide a protocol for identifying potential organ and tissue donors:

   1. Refer all patients meeting clinical triggers including cardiac death within one hour to OneLegacy.
   2. All deaths shall be called in to the OneLegacy referral line (800) 338-6112 within one hour of the patient meeting clinical trigger for referral.

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

D. OneLegacy is the organ, tissue and eye procurement agency utilized by VCMC/SPH.

E. ~~The request for donation must be made by a designated requestor. A designated requestor is defined as an individual who has completed a course offered or approved by OneLegacy, and designed in conjunction with the tissue and eye bank community in the methodology of approaching potential donor families and requesting organ and tissue donors. This request for organ donation usually occurs with the knowledge and concurrence of the attending physician.~~To best support the family, Hospital will defer to OneLegacy in raising any discussions regarding the opportunity for donation; in no case should a

Hospital-affiliated physician or other staff member approach a Potential Donor's family directly about the opportunity for donation, or indirectly by mentioning OneLegacy to them, without first conducting a collaborative counsel between Hospital and OneLegacy

F. The hospital will work with OneLegacy to review death records to ensure that potential donors are being identified correctly, and to educate hospital staff regarding donation practices.

Purpose

In accordance with CMS 42 CFR Section 482.45, Senate Bill 2777 and California Health and Safety Code 7184, requiring general acute care facilities to assist organ and tissue procurement agencies in obtaining needed organ and tissue donors.

A. **California Health and Safety Code 7184:**
"Each general acute care hospital shall provide a protocol for identifying potential organ and tissue donors. The protocol shall require that any deceased individual's next-of kin or other individual, as set forth in Section 7151, at or near the time of notification of death be asked whether the deceased was an organ donor or if the family is a donor family. If not, the family shall be informed of the option to donate organs and tissue pursuant to Chapter 3.5 (commencing with section 7150) of Part 1 of Division 7."

B. **Center for Medicare and Medicaid Services {CMS) 42C.FR Section 482.45:**
Medicare Conditions of Participation (COP) : Organ Tissue and Eye Donation, effective August 21, 1998, requires that all deaths be called into the organ procurement agency (OPO) or a third party designated by the OPO; all potential donor families be informed of their option to donate; ensure discretion and sensitivity with all potential donor families; ensure education to hospital staff on donation issues, perform death record reviews, and maintain potential donors while testing and placement of organs, tissues and eyes takes place; maintain written agreements with the OPO and designated Tissues and Eye Bank.

C. **United States Uniform Anatomical Gift Act (UAGA), *Senate Bill 2777*:**
Provides clear and precise legal structure for donation and procurement of organs and tissues for transplantation. This act exempts any person who acts in good faith in accord with the UAGA from liability for damages in a civil action or prosecution in any criminal proceeding.

Definitions

A. **Brain Death**- is *defined as* the complete and irreversible loss of all brain and brainstem (neurological) functions. Brain death is considered to be equivalent to cardiopulmonary death.

B. **Imminent Death**- ventilated patient with a devastating illness or injury with one or more these triggers;

1. A plan to discontinue mechanical/pharmacological support, Do Not Resuscitate (DNR).
2. Loss of one or more brainstem reflexes: pupils fixed, no cough, no gag, no response to painful stimuli, no spontaneous respirations.

C. **Donation after Cardiac Death (DCD)-** is defined as the surgical recovery of organs after pronouncement of death based on the cessation of cardio-respiratory function in patients who have not sustained irreversible cessation of all functions of the entire brain, including brain stem (death by neurological criteria), but who have sustained devastating, irreversible neurological injury and whose families have independently, or in conjunction with the patient's attending physician, chosen to withdraw life- sustaining therapy.

D. **Designated Reguestor-** is defined as an individual who has completed a course offered or approved by the OPO, and designed in conjunction with the tissue and eye bank community in the methodology of

approaching potential donor families and requesting organ and tissue donors.

Potential Organ Donor Evaluation

A. OneLegacy will perform an on-site evaluation of the potential donor to determine medical suitability when appropriate. If the patient is deemed unsuitable then a second call to OneLegacy will be placed within one (1) hour of cardiac death *using the referral number.*

B. It is the responsibility of the physician(s) of record to inform the family of the grave prognosis and imminent death, actual death or cardiac death.

   1. All attempts will be made to have this discussion in the family's primary language.
   2. Family members will be given time to understand their relatives death before the opportunity of donation request is offered. (Hospital staff **MUST NOT** mention organ donation).
   3. Hospital staff will provide emotional support to the family with consideration to their cultural and religious beliefs and their desires.

C. Hospital staff will provide supportive medical management to potential organ donors, maintaining organ function for transplantation. Medical management will continue while OneLegacy determines medical suitability. OneLegacy will provide the hospital with management guidelines as a resource.

D. **Approach and Consent:**

   1. The OneLegacy coordinator will assess the family's readiness to be offered the option of organ donation. The family must be given time to accept the hopelessness of the situation and understand the concept of brain death before the donation option is presented.
   2. The OneLegacy coordinator will facilitate a collaborative approach process with the hospital staff.
   3. The OneLegacy coordinator will inform the available next-of-kin of their option to donate organs and/or tissues. If consent is obtained, the OneLegacy coordinator will conduct a medical/social history review. The family's response and the name of the person who made the request will be documented in the *progress notes* patient's medical record and on the death form.
   4. Notification regarding the option to donate or decline to donate is made by an organ procurement representative.
   5. A copy of the consent form will be included in the patient's medical record.

Donor Registry

OneLegacy will check the California Donor Registry to determine the patient's wishes to donate.

A. The OneLegacy coordinator and hospital staff will facilitate the best strategy for talking with the family about organ and/or tissue donation.

B. The OneLegacy coordinator will inform the family of the donation process for organs and/or tissues. The OneLegacy coordinator will conduct a medical/socialhistory review with the family. The family's response and the name of the person who provided the medical/social history will be documented in the patient's medical record *progress notes*. Approach for tissue donation may be made over the telephone.

C. A copy of OneLegacy's consent form will be included in the patient's medical record.

Donation Process: Brain Death

A. Organ donation may take place when brain death has been declared by two physicians, ventilator and cardiovascular support has been maintained, and consent from the family or Donor Registry has been

obtained. Organs considered for donation include heart, lung(s) liver, pancreas, kidney(s), and small bowel.

B. California law requires that two (2) licensed physicians must examine the patent and declare brain death. Both physicians must document separately in the Physician's Progress Notes that the patient is brain dead and must include the **date and time of each declaration**. The **SECOND** declaration of brain death is the legal time of death and will be made as soon as possible (ideally within two hours; not to exceed twenty-four hours for adults) following the first physician's assessment unless Hospital and OneLegacy agree that, under the circumstances, such a delay is necessary to best serve the interests of the Potential Donor, and/or the donation program in general. Neither physician may assist in the recovery or transplantation of the donated organs. If a clinical exam is included in the brain death note, the patient cannot be declared brain dead until the results are obtained.

C. **Donor Maintenance:**

1. OneLegacy will begin medical management of the donor after consent is obtained from Donor Registry or legal next of kin. Ventilator and cardiovascular systems must be maintained until the organs are recovered by the transplant surgical team(s) in the hospital operating room.
2. The OneLegacy's Transplant coordinator will guide the medical management of the donor in accordance with the OneLegacy donor guidelines.
3. The hospital will provide a trained critical care nurse to continue providing 1:1 care to the donor patient throughout the Critical Care Unit stay.
4. The hospital/physician(s) will provide consultations necessary to ensure suitability of the organs. These may include, but may not be limited to, bronchoscopy, echocardiograms, cardiac catheterization, and chest x-rays.
5. The hospital laboratory will provide OneLegacy with STAT laboratory results for those tests that can be completed by the hospital.
6. For laboratory tests not available at the hospital, OneLegacy will provide outside laboratory services.
7. The OneLegacy coordinator will continue to provide and support communication to the donor family throughout the donation process.
8. The OneLegacy coordinator will facilitate communication with all involved parties, i.e., appropriate hospital staff, donor family members, the coroner, tissue bank, and transplant center personnel.
9. Reasonable efforts should be made to accommodate the family members to gather at bedside prior to discontinuation of mechanical ventilation when possible. Most efforts to gather family should occur within 24 hours. This time may be prolonged at the discretion of the attending physician but should not extend to period of weeks.

Donation Process: After Cardiac Death

A. Donation after cardiac death is defined as the surgical recovery of organs after pronouncement of death based on the cessation of cardio-respiratory function.

B. Organ donation may take place when an individual who has sustained an irrecoverable neurological injury, but does not fulfill the criteria for brain death, to donate organs.

C. **Procedure:**

1. Potential patients shall be identified **AFTER** the decision has been made by the family, in coordination with the physician, to remove the patient from life-sustaining equipment who has met

the following criteria:

~~a. The patient has a non-recoverable illness or severe neurological injury and or other system failure resulting in respiratory dependency such as intracranial hemorrhage, stroke, anoxia, trauma on a ventilator.~~

~~b. The patient is ventilator dependent.~~

~~c. The Glasgow coma scale is less than or equal to 5.~~

~~d. The patient has a Do Not Attempt Resuscitation order.~~

~~e. The patient does not meet brain death criteria.~~

~~f. The patients who request discontinuance of life support in anticipation of death.~~

~~g. The family, in conjunction with the medical staff, has decided to withdraw life sustaining measures.~~

a. That possesses a non-recoverable illness or injury that has caused neurological devastation or other system failure, resulting in ventilator dependency;

b. That does not meet criteria for death by neurological criteria;

c. That does not have an opportunity for meaningful recovery;

d. Whose next of kin initiates a discussion of, or is offered and agrees to, withdrawal of life-sustaining therapies; and

e. Whose next of kin requests discontinuance of ventilatory support in anticipation of death.

2. Notify the attending physician that referral will be made to the organ procurement agency.
3. It is the opinion of the OneLegacy coordinator and the attending physician that cardiopulmonary arrest will occur within sixty (60) minutes following withdrawal of life support.
4. The OneLegacy coordinator shall obtain the consent form entitled "Consent for Organ Donation after Withdrawal of Artificial Life support," which includes a discussion of the following:
    a. The family may change their decision about donation at any time up to the time of actual removal of the organs.
    b. The patient shall be declared dead by the attending physician or his/her designee after the withdrawal of life support and before the removal of organs. There is a potential that the organ recovery may be aborted and the patient may be returned to the nursing unit and allowed to expire.
    c. During the consent process, OneLegacy will request consent for heparin to be administered before transport to the Operating Room (OR). If consented by the legal next of kin, heparin will be ordered by the physician to be administered before transport to the OR.
5. The hospital/physicians will provide consultations necessary to ensure suitability of the organs. These may include, but not be limited to: bronchoscopy, echocardiograms, cardiac catheterization, and x-rays. Attending physician is to maintain organ viability of potential DCD donor.
6. The hospital will provide OneLegacy with STAT laboratory results for those tests that can be completed by the hospital.
7. For laboratory tests not available at the hospital, OneLegacy will provide outside laboratory services.
8. The OneLegacy coordinator will continue to provide support and communication to the donor family

throughout the donation process.

9. The OneLegacy coordinator will facilitate communication with all involved parties, i.e., appropriate hospital staff, donor family members, the coroner, tissue bank, and the transplant center personnel.

Organ Recovery

1. The OneLegacy coordinator will notify the hospital OR as soon as possible after consent is obtained for the potential organ recovery.
2. The hospital will make an OR suite available for the organ/tissue recovery process.
3. The OneLegacy coordinator will schedule the organ recovery with the hospital OR staff.
4. The OneLegacy coordinator will communicate with the transplant centers to facilitate timely arrival of the surgical recovery teams.
5. Hospital OR personnel necessary include: Anesthesiologist to maintain and monitor the donor's intra-operative perfusion and oxygenation until after the aorta is clamped or until released by the recovery surgeons, a circulating nurse and scrub nurse.
6. OneLegacy will continue to facilitate the donation process throughout the organ recovery in the hospital OR.
7. A copy of the entire chart (CD or paper) will be provided to OneLegacy and the Ventura County Medical Examiner's office if a coroner's case.

Procedure for Donation after Cardiac Death (DCD) Patients

1. The OR is notified of the case and the operating time is scheduled.
2. Life support will be discontinued in the OR by the hospital physician. Document the name of the physician who removes the patient from life support, as well as the exact time life support was removed. The physician pronouncing death will **NOT** be associated with the surgical recovery of the organs or tissue. The pronouncing physician must remain in the OR for the entire duration from the moment life support is discontinued through the pronouncement of death.
3. The hospital physician will pronounce the patient dead utilizing the following criteria. The presence of one or more criteria is suitable to pronounce death:
    a. The patient must be apneic and unresponsive to all stimuli.
    b. Five (5) minutes of ventricular fibrillation is sustained.
    c. Five (5) minutes of electrical asystole is sustained.
    d. Five (5) minutes of pulseless electrical activity is sustained.
4. The attending physician or designee will document the pronouncement of death in the medical record.

Abandoning the Recovery Organs

1. The recovery of organs may be abandoned at the transplant team's discretion if the patient does not sustain cardiopulmonary arrest within a reasonable amount of time (usually one-hour) the patient will be returned to appropriate nursing unit.
2. Upon return to the appropriate nursing unit, comfort measures will be maintained by the attending physician/designee. Obtain orders for continued care.

Honor Walk

1. Honor walks are established to provide families of organ donors and medical care teams the chance to honor the generosity of the family. Honor walks occur during transport of the donor from the ICU to the OR. Note: Due to a variety of circumstances that may arise intra-op, not all patients honored through this practice will be able to donate their organs for transplant or research. The Honor Walk honors the decision of the patient and/or family, and their intent to donate.

2. ICU leadership and palliative care collaboratively organize the practice of Honor Walks at VCMC. Honor Walks are optionsal and require family consent. All patients meeting criteria for organ donation where authorization or donor designation has been established are eligible.

3. Procedure

a. When appropriate in the care of a patient deemed eligible for organ donation where authorization/donor designation is present, hospital staff or One Legacy team member will provide education on the Honor Walk and offer the family the opportunity to honor their loved one through this practice.

b. The decision of the family or legal next of kin will be documented in Cerner by the hospital staff and communicated to the nursing and palliative care teams. If the family declines, no further action is necessary. If the family accepts, continue to step 3

c. ICU leadership will communicate the family has affirmed and consented to proceed with an Honor Walk to the palliative care team.

d. Palliative care team (or ICU leadership after hours) will communicate that there will be an Honor Walk to hospital team members. Suggested script is "There will be an Honor Walk at (enter time). Please join us to line the hallways from (name unit) to the elevators to the operating room at that time." Note: delays are common at this critical part of the donation process: One Legacy coordinators will communicate with ICU leadership to update those invited to attend if there are timing or location changes.

e. Hospital staff will gather for the Honor Walk at the established time and location. Hospital employees may not take photos or videos. Donor's family may take photos or videos or request someone to do so on their behalf. Media may only be used by the hospital with written consent from family.

f. It is recommended that a message be read from the hospital when the patient approaches the elevators to surgery. Sample scripting is as follows: "Let us take a moment to pause and honor the life of this patient. He/she was someone who loved and was loved, was someone's family member and friend. In our own way and in silence, let us take a moment to honor this patient." The group would then take 30 seconds of silence. Once this time is completed, speaker will thank all attendees. Family/friends of patient may also choose to speak at this time.

g. Hospital staff will line both sides of hallway from ICU entry doorway to the main elevator down to the OR. If more room is needed, staff may also line both sides of hallway on the ground floor between the elevator and OR main desk.

h. When an Honor Walk has begun, ICU leadership or palliative care team will thank those in attendance for participating and offer opportunity to donor's family to speak if they so choose.

Hospital Reimbursement

1. All OneLegacy directed charges incurred following declaration consent of brain death and consent obtained for organ recovery should be billed to:

OneLegacy
221 S. Figueroa Street, Ste. 500,
Los Angeles, CA 90012
213-229-5600
213-229-5601 (fax)

Coroner Cases

1. The OneLegacy coordinator will notify the Ventura County Medical Examiner before the removal of any organs and/or tissues if the patient is considered a reportable coroner case.
2. Appropriate documentation, which will include a copy of the chart (CD or paper) and a copy of the donation consent form, will be prepared for the Ventura County Medical Examiner.

Tissue/Eye Donation

A. After the legal next-of-kin has been notified by the hospital of the patient's biological cardiac death, the hospital will call the Tissue Donation Hotline (800) 338-6112 (OneLegacy Referral Line) within one (1) hour of death and receive referral number.

   Neither hospital staff nor physician(s) should approach for donation.

B. When calling, preliminary patient identification information will b requested so that a Coordinator can call the referring unit for an extended review of the patient's medical status to determine suitability for tissue donation. The following will be obtained:
   1. Name, age, race, and sex of patient
   2. Medical record number of patient
   3. Date and time of death
   4. Date and time of admission
   5. Admitting diagnosis and possible cause of death
   6. Name of staff member reporting death
   7. Hospital name, unit name, and phone number
   8. Location of body

C. .If, after the above questions have been answered, and it is determined that the patient does not meet the current criteria for donation, a Death Notification Number (DN#) will be given to the hospital staff for documentation in the patient's chart. The body can then be released to the mortuary chosen by the family.

D. .If the patient is a possible donor, the following information will also be needed:
   1. Use of ventilator and date of extubation
   2. WBC count
   3. Temperature
   4. CPR performed and how long
   5. Known past medical history
   6. Legal next-of-kin

7. Phone number where legal next-of-kin can be reached within two (2) hours.

E. If after the extended review the patient is deemed a potential tissue donor, the coordinator will request a hold on the body until the legal next-of-kin is contacted and extend the opportunity for tissue donation by the coordinator. If consent is granted, telephone consent will be obtained and recorded by phone. (Telephone Consent will be recorded per protocol; or, if the request was made prior to calling the Organ and Tissue Donation number and hospital staff obtained consent, a copy must be faxed to the coordinator for their approval).

   The body should be held and refrigerated at the hospital until such time as the option has been offered to the legal next-of-kin and the donation has taken place.

F. The coordinator will obtain consent from the legal next-of-kin or the Donor Registry for each specific tissue. Tissues that may be recovered include corneas, whole eyes, skin, bone, soft tissue (tendons and ligaments), heart valves, pericardium, saphenous veins, dura mater, and vertebral bodies.

Procurement Recovery Process

1. The recovery of tissues will take place in the hospital operating room (if available), the morgue, or the autopsy room. The operating room is preferred as the tissue recovery is performed aseptically.
2. No hospital staff is required to assist with tissue recovery. The tissue recovery team will provide all necessary supplies.
3. The tissue recovery team will clean the area when tissue recovery is completed. If the operating room is used, the hospital will be required to do the "terminal cleaning" per the hospitals' protocol. The morgue or autopsy room will be left in a clean condition.
4. The surgical recovery of tissues is done with respect and minimal disfigurement to the donor. Reconstruction will be performed on all tissue donors. Families may have an open casket service if they wish.
5. The hospital will provide a copy of the entire chart (CD or printed) to OneLegacy and for the *coroner* Ventura County Medical Examiner when a coroner's case.

Post Tissue /Eye Donation

1. After completion of the tissue recovery, the coordinator will notify the designated hospital staff that the body is ready for release to the mortuary.
2. Any charges relating to the tissue recovery are billed directly to OneLegacy.
3. No recovery charge will be billed to the legal next-of-kin.

Scope of Responsibility

1. Physician
2. RN
3. One Legacy
4. Administration

Procedure

A. **Physician's:**

1. Identify the potentially brain dead patient, or patient who meets DCD criteria.
2. Collaborate with OneLegacy to maintain management of the potential donor for the potential donor for maximizing vital organ functions.
3. Inform the family of the patient's grave prognosis. Provide an assessment to the OneLegacy coordinator regarding the family's understanding of brain death/DCD.
4. Document in the physician's progress notes the date and time patient is declared brain dead or meets DCD criteria.
5. Obtain confirmation of brain death by a second physician who shall also document the patient's date and time of brain death (The second declaration is the legal time of death). Neither the physician declaring brain death nor the physician confirming brain death may be a member of a transplant team.
6. ~~Write an order for OneLegacy to begin management of the donor after consent is obtained from the legal next of kin or the Donor Registry.~~ Place PSO Admit to Inpatient Organ Donation Services on the newly created organ donation encounter transferring care to the Organ Donor Service as the Medical Service.

B. **Nursing:**

a. Identify the potentially brain dead patient or patient who meets DCD criteria.
b. Refer the patient to OneLegacy for evaluation, document the call, and have the patient's chart available for evaluation.
c. Inform attending physician of potential suitable organ donor patient.
d. For patents meeting brain death criteria, confirm that the attending or consulting physician has certified in the progress notes that brain death has occurred. (Progress notes must state that the physicians' patient is pronounced brain dead, note must include the date and time, and signed by a licensed physician.)
e. Verify that a second physician has independently confirmed the determination of brain death and note this in the progress notes, including the date, time and signature.
f. Document in the medical record, the physician, date, and time of each brain death declaration.
g. For patients meeting DCD criteria: Document in the medical record the date and time the physician and OneLegacy were notified that the patient met DCD criteria.
h. Ensure that a copy of signed consent form is in the patient's medical chart. The family will receive a copy of the consent form. Nursing staff may be requested by OneLegacy to participate as witnesses to the consent.
i. Provide supportive medical management to the potential organ donor to maintain biological function of organs, order, and obtain lab tests, etc., as requested by the OneLegacy coordinator.
j. Document in the patient's medical record when the patient is transferred to the OR.
k. Send the coroner's case number and form, and all appropriate documentation to the OR with the patient for coroner's cases
l. Maintain the donor on ventilator or resuscitation bag and portable cardiac monitoring during transfer to the hospital OR.
m. Call admitting to create the new organ donation encounter.

C. **OneLegacy:**

1. Respond on-site to a referral in a timely manner whenever possible.
2. Establish medical suitability for donation and contact the assigned eye/tissue agency if the patient is also a potential tissue donor.
3. Check Donor Registry for patient's registry status.
4. Collaborate with the hospital in accordance with all Federal and State laws.
5. Obtain consent from the family and coroner, and provide continued family support, as needed.
6. Coordinate teams consisting of recovery surgeons and transplant coordinators to remove organs suitable for donation.
7. Coordinate the medical management of the patient from the second brain death declaration and after family consent for donation.
8. Notify the coroner when recovery is concluded, when applicable.
9. Inform the family when donation has been completed, at the family's request.

References:

1. The United States Revised Uniform Anatomical Gift Act (UAGS), *Senate Bill 2777*
2. CMS 42 C.F.R Section 482.45
3. California Health and Safety Code 7184
4. HASC Consent Manual
5. The Joint Commission Standards TS O1.01.01-02.01.01
6. OneLegacy (Policy attached)
7. 100.026 Declaration of Brain Death and Apnea Testing

All revision dates: 2/5/2024, 9/17/2019, 8/2/2019, 2/1/2013, 5/1/2006, 9/1/2004, 5/1/2000, 9/1/1998, 4/1/1995, 11/1/1989

Attachments

2023 Donation After Brain Death Policy to Affiliation Agreement .docx
2023 Donation After Cardiac Death Policy to Affiliation Agreement.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/26/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/5/2024

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/5/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/5/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2001*
Effective:	*Upon Approval*
Last Approved:	*N/A*
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.076 Pain Assessment, Management and Documentation

POLICY:

To ensure that patients have their pain assessed and managed, and that they are involved in decisions regarding treatment of their pain consistent with the scope of care, treatment, and services provided by Ventura County Medical Center, Santa Paula Hospital and Ambulatory Care clinics in various care settings. The goal of pain management is to incorporate non-pharmacological and pharmacological interventions to ease or lighten pain which may not include the elimination of pain. Pain assessment and pain management is an organizational priority.

PROCEDURE:

Patients have the right to pain management which is determined through discussion with their providers and care team members. Management of pain is focused on easing the patient's pain using non-pharmacological and pharmacological interventions. The health care workers of the Ventura County Health Care Agency (HCA) shall do the following in accordance with staff scope of practice:

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and services provided in the specific care setting in accordance with staff scope of practice. All assessments and reassessments for prn and scheduled pain medication shall be documented on the Medication Administration Record (MAR).
2. Require that methods used to assess a patient's pain are consistent with the patient's age, condition, and comprehension. (Refer to attachments for pain scales used throughout the Ventura County Health Care Agency.)
3. Assess the patient's response to care, treatment, and service implemented to address pain.
4. If the patient does not achieve their pain goal or if the pain is not reduced to a tolerable state, the care team member should notify the physician and follow the chain of command to advocate on behalf of the patient:
    1. Ambulatory Care: Medical Assistant or Clinical Assistant shall report to nurse (registered nurse (RN) or licensed vocational nurse (LVN)), then to Nursing Supervisor, then to Clinic Medical Director and Chief Nursing Officer. Clinic Medical Director may report to Chief Medical Officer.
    2. Hospitals: Nursing Supervisor and/or Clinical Nurse Manager, then Associate Chief Nursing Officer, then Chief Nursing Officer and/or resident, then attending physician, then Chief Medical Officer.

5. Consider non-pharmacological measures as well as medication therapy, taking into account the patient's stated preferences for pain management.
6. Treat the patient's pain or refer the patient for treatment.
7. Ensure the patient's comprehensive care plan reflects the patient's pain management preferences and responses to interventions. Update the care plan as needed to reflect changes in the patient's pain management.
8. Assess and manage the patient's pain and minimize the risks associated with treatment.
9. Identify physical, social and psychological consequences of unrelieved pain.

PAIN SCALES

To ensure an age-appropriate, clinical condition assessment of pain occurs, multiple pain scales are approved for use within the organization. These scales are:

- Universal Pain Assessment Tool (Numeric Pain scale with Intensity)-Eight (8) years of age and older and who are able to self report)
- Critical Care Pain Observation Tool (CPOT) - paralyzed and sedated
- FLACC- Children two (2) months through three (3) years of age
- The revised (r) FLACC Scale (face, legs, activity, crying and consolability) - Developmental Delay/ Cognitive Impairment
- N-PASS scale - Preterm and infant two (2) months of age (48 weeks gestation) ~~Finnegan Neonatal Abstinence Scoring System~~
- Faces Pain Scale - Children four (4) years through seven (7) years of age

See Attachments A through F.

INPATIENT CARE SETTINGS

Upon Admission and with Change in Pain Characteristic

Patients admitted to an inpatient care setting shall receive an initial screen at the time of admission to identify the presence and severity of pain. Initial assessment of the patient should include, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools
- The character of pain, quality, onset, location, radiation, duration and frequency
- The patient's tolerance to pain and acceptable intensity of pain (pain goal)
- The patient's history of analgesic use or abuse
- The patient's respiratory risk factors
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain

Communication about Pain

Communication with the patient should include, but is not limited to, assisting them in understanding that some pain is to be expected and it may be unrealistic to expect to be completely pain-free following their procedure. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan; involve family as appropriate when discussing the plan of care and anticipate pain goals.

Treatment of Pain

In general, inpatients shall receive treatment for any active acute or chronic pain when intensity or severity exceeds an acceptable level. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, and potential risk of dependency, addiction and abuse (if applicable); and realistic expectations with measurable goals and the evaluation process. The same pain scale shall be consistently used as the patient's clinical condition permits.

Paralysis Considerations

Paralysis prevents the assessment of behavioral cues for pain. Increases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

1. Analgesics should be administered continuously by drip or around-the-clock dosing.
2. Opioid doses should be evaluated as tolerance can occur without symptoms of inadequate pain relief.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications; for other routes of pain medications, standards of practice shall be implemented. In addition, the patient's pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

Emergency Department

Treatment of Pain

In general, ED patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in the ED to treat chronic pain conditions. Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If no pain issues were identified during the initial assessment, then no routine reassessment is required. If at any time during the patient's stay in the ED pain issues are identified, the process of assessment/reassment should be initiated. If acute pain issues were identified, then the patient should be reassessed at least at time of discharge or transfer. At a minimum, this reassessment shall consist of noting the intensity and severity of the patient's pain.

OPERATIVE AND INVASIVE PROCEDURE SETTINGS

Pre-Procedure Assessment

Patients seen in operative and invasive procedural settings shall be assessed prior to surgery or procedure to identify the presence and severity of pain. If this is an initial assessment of the patient (i.e., the patient is being seen as an outpatient or will be admitted following the procedure) the assessment should include, but is not limited to:

- Understanding the patient's perception of the procedure and their expectations about the extent of pain and its management.
- The intensity of pain using age or condition and ability to understand appropriate assessment tools.
- The character of pain, quality, onset, location, radiation, duration and frequency.
- The patient's history of analgesic use or abuse.
- The patient's respiratory risk factors.
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain.

It is recommended that the patient's tolerance to pain and acceptable intensity of pain (pain goal) be ascertained so that this information can be used to address the post-procedure care needs of the patient.

Post-Procedure Assessment

Patients shall receive an assessment following the operative or invasive procedure to determine the presence of pain that may have resulted from the procedure. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition appropriate assessment tools
- The location and nature of pain

Treatment of Pain

In general, these patients shall receive treatment for acute pain related for their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic condition.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

PEDIATRIC INPATIENT SETTING

Definitions

- Pain is defined as an unpleasant sensory and emotional experience associated with actual or resembling that associated with, actual or potential tissues damage (IASP 2020). Pain is an inherently subjective multi factorial experience and should be addressed and treated as such.

Principles

- ~~All pediatric~~Pediatric patients will be assessed for pain using a validated developmentally appropriate pain assessment tool.
- The pediatric pain experience involves the interaction of physiologic, psychologic, behavioral, developmental, and situational factors.
- Every child and family is informed that the child has the right to the best pain relief possible and is entitled to optimal pain management.
- ~~All healthcare~~Healthcare team members have a responsibility to advocate for effective pain management on the patients behalf, to promote the child's and family's learning about pain and its management and to actively involve the child and family in the decision making process related to pain assessment, management and evaluation.
- ~~All~~Healthcare team members are responsible for ongoing communication with other members of the healthcare team ~~members are responsible for ongoing communication with other members of the healthcare term~~ regarding pain management outcomes.

Treatment of Pain

~~All heathcare~~Healthcare team members have a responsibility to recognize and accept that the ~~childs~~child's reports of pain reflect their real experiences of pain. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Pain relief interventions will be tailored to the individual patient. Shared decision making between nursing/medical staff and parents should be employed to optimize the care of pain in children.

Paralysis Considerations(PICU)

Paralysis prevents the assessment of behavioral cues for pain. Increases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

- Analgesics should be administered continuously by drip or around-the-clock dosing.
- Opioid doses should be evaluated as tolerance can occur without symptoms of inadequate pain relief.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications; for other routes of pain medications, standards of practice shall be implemented. In addition, the patient's pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

NEONATAL INPATIENT SETTING

Initial Assessment

Patients seen in the Neonatal period (0-28d or 0-28d Corrected Gestational Age) shall ~~receive a screen during the initial assessment process to identify the presence of pain~~be screened using the Neonatal Pain Agitation and Sedation Scale (N-PASS) to identify the presence of pain. ~~If the screen is positive, then the patient shall receive an assessment to gather further sufficient information to identify the pain. The Neonatal~~

~~Nurse Practitioner (NNP) or~~The Neonatologist/Pediatrician will be notified of any N-PASS score >4/10 or any time current nursing interventions and/or pain medications are not effective in lowering the patient's N-PASS score.

AMBULATORY CARE CLINICS

Initial Assessment

Patients seen in outpatient care settings shall receive a pain assessment on establishment of care to identify the presence of pain. If the patient is in pain or reports a history of persistent pain, a more in-depth assessment shall be conducted. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools (refer to attachment A)
- The character of pain, quality, onset, location, radiation, duration and frequency
- The patient's goal for pain management
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain
- The patient's history of analgesic use or abuse
- The patient's risk level for adverse outcomes related to opioid treatment (e.g., acute psychiatric instability or high suicide risk, cognitive impairment, sleep apnea, advanced age, COPD, etc.)

Communication about Pain

Communication with the patient should include but is not limited to assisting them to understand that some pain is to be expected and it may be unrealistic to expect to be completely pain free following procedures. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan; involve family as appropriate when discussing the plan of care and anticipate pain goals.

Treatment of Pain

In general, Ambulatory Care patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic, designated primary care and specialty care clinics). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided during the care visit, then the response to that intervention must be assessed to include progress toward pain goal and side effects. Reassessment is recommended to occur within 60 minutes following treatment (depending on the type of intervention). However, by policy, this reassessment must occur at least at the conclusion of the care visit. If treatment consists of prescribing

medications (or other modalities) that will be taken after the care visit, then no reassessment is required.

PATIENT/FAMILY EDUCATION

1. All education should be documented in the patient's electronic health record (EHR).
2. Patients will be taught that effective pain management will be part of their treatment.
3. Patients will be instructed to keep the nurse informed about their pain so that pain interventions may be provided as ordered. Medication may not rid the patient of all of their pain. Pain medication can reduce pain so that the patient can participate in activities to improve their health.
4. The patient and the family/significant other(s) should receive information regarding:
    a. The use of pain scales.
    b. Pain control options.
    c. Appropriate expectations for pain control.
    d. Potential limitations of pain management.
    e. How and when to communicate the effectiveness/ineffectiveness of pain interventions.
    f. Potential/actual side effects of pain medications/treatments.
    g. The risks of addiction and overdose, especially with prolonged use.
    h. Safe storage of medications.
5. A patient/family pain education brochure is available to support patient teaching on pain management.

During Treatment

When pain medications are prescribed, patients IN ALL SETTINGS shall receive education on pain management, the risks and benefits of medication treatment, and safe use of opioid and non-opioid medications. This information will be documented in the patient's EHR.

At Discharge

The patient/family shall receive education at discharge on the following:

- Pain management plan of care
- Side effects of the pain management treatment
- Activities that may exacerbate or reduce the effectiveness of the pain management care plan
- The risks of addiction and overdose
- Safe use, storage and disposal of opioids
- The use of controlled substances may cause the patient to be less alert resulting in increased risks when driving a car or operating machinery

PATIENT REFUSAL OF PAIN MANAGEMENT

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient's EHR.

DECISION NOT TO TREAT PAIN

If a decision is made to not treat a patient's pain and/or refer the patient for treatment, then the clinical

justification for that decision should be documented in the patient's EHR.

REFERENCES:

Department of Health and Human Services, Centers for Medicare & Medicaid Services, Publication 100-07 State Operations Provider Certification, Transmittal 37, October 17, 2018, Section 482.23 Nursing Care.

Center for Improvement in Healthcare Quality - Standard QS.2, E-mail inquiry and reply to Traci Curtis, RCP, HACP, Executive Director Survey Operations, Center for Improvement in Healthcare Quality, March 28, 1980.

The Joint Commission Standards: LD.0403.13, MS.05.01.01, PC.01.02.07, PI.01.01.01, PI.02.01.01.

R3 Report, Requirement, Rationale, Reference, A publication of The Joint Commission, Issue 11, August 29, 2017.

VCMC Performance Improvement Project - Addiction Medicine

CURES (2018) - Controlled Substance Utilization Review and Evaluation System

All revision dates:	8/21/2023, 3/14/2023, 11/10/2021, 12/8/2020, 11/26/2018, 7/26/2017, 10/1/2011, 3/1/2011, 4/1/2008, 5/1/2006, 3/1/2004, 2/1/2002

Attachments

- Attachment A - Universal Pain Assessment Tool.pdf
- Attachment E - FLACC.pdf
- Attachment F - NPASS.pdf
- Attachment G - FLACC_R.pdf

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/31/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/21/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/21/2023
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/21/2023

VENTURA COUNTY
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Owner:	*Erlinda Roxas: Director, Laboratory Services*
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References:	

100.089 Point of Care Testing, Waived Tests and Provider-Performed Microscopy (PPM)

POLICY:

A limited number of "bedside" laboratory tests (Point of Care Testing or POCT) have been approved by the Laboratory Director at Ventura County Medical Center/Santa Paula Hospital to be available to clinicians to provide rapid test results in the hospital and to help with treatment decisions in the clinics.

Laboratory procedures that are done at the point of care are performed under the CLIA Laboratory Certificate for Provider-Performed Microscopy Procedures issued by CMS to Ventura County Medical Center/Santa Paula Hospital. Procedures that are approved by the Laboratory Director as Waived Tests or are listed as Provider-Performed Microscopy Procedures (CDC) are the only tests that may be performed at the point of care. Point of care testing sites include bedside and nursing stations in both hospitals, Ambulatory Care clinics, and the Inpatient Psychiatric Unit and clinics.

PROCEDURE:

Overall responsibility for Point of Care Testing lies with the Laboratory Director. The Laboratory Director will designate a Point of Care Testing Coordinator. The Point of Care Testing Coordinator will:

1. Assist in the development of policy and procedures.
2. Review all procedures at least annually.
3. Oversee Quality Control/Quality Assurance.
4. Help educate staff at Point of Care testing sites.
5. Act as a liaison between the VCMC Laboratory and the staff and departments performing Point of Care testing.
6. Validate new tests, new analyzers, and, when required, new reagents.
7. Coordinate, assist, or perform initial competency assessment.
8. Participate at least monthly in departmental reviews of all glucose analyzer testing and of all Inpatient point of care patient tests, quality control and instrument maintenance logs. Ambulatory Care Administration maintains documentation of patient testing, quality control and instrument maintenance logs.
9. Act as a liaison between the POCT sites and the manufacturer should there be analyzer problems or

breakage that cannot be resolved on site by the POCT coordinator.

WAIVED TESTING:

The following waived tests that are performed at Point of Care Testing sites utilize testing instrumentation:

- Blood Glucose by Nova Statstrip method
- Hemoglobin A1c (Glycohemoglobin) by Siemens DCA Vantage
- Hemocue HB201DM for hemoglobin
- HemoCue Hb 801 System for hemoglobin
- Cepheid Gene Xpert COVID-19 Molecular Test for SARS-CoV-2/Flu/RSV
- Cepheid Gene Xpert COVID-19 Molecular Test for SARS-CoV2
- LeadCare II System for blood lead by Magellan Diagnostics

The following waived tests that are performed at Point of Care Testing sites do not utilize any testing instrumentation:

- BinaxNOW Antigen Test Card method for SARS-CoV2
- Dipstick for urinalysis by Multistix 10SG method (10 test pads per strip)
- Dipstick for urine tests by Labstix method (5 test pads per strip)
- Fecal occult blood by Hemoccult Sensa method
- Fecal occult blood by InSureONE method
- First Sign Drug of Abuse Cup Test by Hemosure
- One Step Fentanyl Drug of Abuse Dip Card Test by Hemosure
- Streptococcus A Screen by OSOM Ultra Strep A Test method
- Urine pregnancy test by ICON *25* hCG method
  ~~Streptococcus A Screen by OSOM Ultra Strep A Test method~~
- Urine pregnancy test by Medline hCG Pregnancy Test Cassette method
- Urine pregnancy test by Medline hCG COMBO+ Pregnancy Test Cassette method

Physician privileging for non-instrumentation Waived Testing is coordinated through the Medical Staff Office and the physician credentialing process. Other waived tests may be added only after review by the Point of Care Testing Committee and approved by the Laboratory Director.

PROVIDER-PERFORMED MICROSCOPY (PPM):

A physician or mid-level practitioner may perform Provider-Performed Microscopy Procedures (PPM). Mid-level practitioners include licensed Physicians' Assistants and Nurse Practitioners. The primary instrument used is a microscope and the specimen is considered labile.

The following PPM procedures may be performed:

1. Wet mount for presence or absence of bacteria, fungi, parasites and human cellular elements
2. Potassium hydroxide (KOH) preparations
3. Pinworm examination
4. Fern test
5. Post-coital direct, qualitative examination of vaginal or cervical secretions
6. Urine sediment examinations
7. Nasal smears for granulocytes

8. Fecal leukocyte examinations
9. Qualitative semen analysis (presence or absence of sperm and detection of motility)
10. Initial and annual competency assessment for physicians performing PPM is coordinated through the Medical Staff Office and the physician credentialing process. In addition, the physician may perform Amniotest, pH of vaginal secretions.
11. "When a physician performs waived testing that does not involve an instrument, there is no Joint Commission requirement for documentation of competency assessment when the test is a logical part of his or her specialty and the organization has specifically privileged the physician for that test." Through the medical staff credentialing process, individual physician may be privileged for those specific waived tests appropriate to their scope of practice and no further assessment of skills or documentation of competence would be required. 1

COMPETENCY PROGRAM

A. The Laboratory Director, or a qualified designee, will orient, train and assess the competency of staff and independent practitioners who perform waived testing.
    i. Clinical Nurse Managers (or those requested by a Clinical Nurse Manager, the Mental Health Clinic Coordinator, or Ambulatory Care Administration) are determined to be the "qualified designee/ superuser" after initial training from the Laboratory Point-of-Care Coordinator.
    ii. "Qualified designees/superuser" are required to perform annual competencies.
    iii. Documentation of the initial training and annual competencies of the "qualified designees/ superuser" are kept by the Laboratory Point-of-Care Coordinator.
    iv. Documentation of the initial training and annual competency of staff members (Clinic Assistants, medical assistants, LVN's, RN's, or Nurse Practitioners) are kept by the Clinical Nurse Manager or qualified designee.
B. Initial orientation will include the safe use and maintenance of any instrumentation.
C. Competency is performed initially and annually and includes at least two of the following methods per person per test:
    i. Performance of a test on a blind specimen
    ii. Periodic observation of routine work by the supervisor or qualified designee
    iii. Monitoring of each user's quality control performance
    iv. Use of a written test specific to the testing
D. **Initial and Annual Competency:**

    The "qualified designee" will ensure that all new staff receives instruction of testing devices and operating policies and procedures. Initial and annual competencies will be documented utilizing two (2) methods of competency assessment (see #iii above).

    Competency Assessment and Remedial Action:

    - In the event that an employee fails to demonstrate satisfactory performance on the competency assessment, the deficiency is to be identified on the competency assessment form. Retraining and reassessment of the employee competency must occur when problems are identified with employee

performance. The deficiency will be resolved before the competency assessment is completed. Any deficiency noted for registry or temporary employees will also be reported to their employer.

- Employees who do not pass initial competency evaluation may not perform those functions including patient testing without direct supervision.
- Retraining is provided and competency reassessed and ensured by the section supervisor.
- If the employee does not pass the initial competency during the probation period, the probation period may be extended and further retraining will be provided.
- If the employee still cannot pass the competency after retraining, the Laboratory can exercise probationary termination.
- If the employee does not pass the annual competency, retraining will be provided. The competency will be repeated within 30-60 days. If the employee still cannot successfully complete the competency, disciplinary actions will be taken as recommended by the Human Resources Department.
- Completed competency assessments are to be filed in the employee's personnel file.

Quality Control:
The supervisor or manager of each Point of Care testing site will review and document each review at least monthly Quality Control and patient test results and also any required instrument maintenance. Each testing site is responsible for the performance and reporting of results for waived test Quality Control and patient tests, for instruments used in testing, and for supplies.

PATIENT RESULTS:

Test results for waived testing are documented in the patient's medical record. Quantitative test results in the patient's medical record for waived testing will include documentation of the reference ranges (normal values) for that test and age specific when appropriate.

IT maintains the network components of the NovaBiomedical "Novanet."

WAIVED TESTING OVERSIGHT:

Point of Care Testing Committee:

- Laboratory Director
- Medical Director
- Nursing Administration Representative
- Ambulatory Care Administration Representative
- Point of Care Coordinator

The Point of Care Testing Committee will meet when necessary to discuss adding any new test or new equipment, to resolve compliance problems, or to delete any test.

The Laboratory Point of Care Coordinator will periodically review and document the review of Point of Care initial and annual competency assessment.

REFERENCES:

The Joint Commission Frequently Asked Questions, "*Physician Competency For Waived and P.P.M.P*

Testing," November 24, 2008.

All revision dates: 10/17/2023, 11/26/2018, 6/1/2016, 8/1/2012

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/4/2024
Policy Owner	Erlinda Roxas: Director, Laboratory Services	2/4/2024

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Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.223 Discharge Against Medical Advice (AMA)

POLICY:

This policy is to establish the procedure for discharging a patient Against Medical Advice (AMA).

PROCEDURE:

When a patient does not meet the criteria for a legal hold, is released by the courts or requests to be discharged AMA, the procedure for discharge is as follows:

1. Nursing staff should notify the treating physician of a patient's request to be discharged.
2. The treating physician will meet with the patient to explain the risks involved in failing to continue treatment.
3. If the patient continues to request discharge, staff will begin the process of discharge.
4. All patients will be encouraged to continue with medication regimen and to follow-up with outpatient services upon discharge. Social Services staff or designee will provide resource information or arrange for follow-up appointments if patient consents.
5. Patients will be offered drug prescriptions and medical follow-up appointments. Aftercare Plan and chart will document patient refusal of medications and/or follow-up appointments.
6. Staff will follow discharge procedure according to Administrative policy 100.038.
7. Patients with known reportable infectious diseases or other reportable conditions will be reported to the Public Health Department.

~~**After Hours**~~

After Hours or When Responsible Physician is Not Available

1. Patient will be evaluated for change in legal status by certified unit staff. If patient was not on 5150 hold, initiate 5150 if criteria is met.
2. ~~On Call physician will be notified and an order obtained for release AMA or for change in legal status.~~On call physician will document discussion and outcome in the chart. A Discharge Summary shall be dictated by the responsible physician post discharge for patient stay greater than 48 hours.
3. Patient will be released or notified of change in legal status and detained. Patient will sign AMA form. Patient will be given referrals for follow-up treatment. All belongings will be returned except items kept in the locked unit safe. Patient will be required to return to obtain these items.

All revision dates:	1/2/2024, 1/10/2023, 2/1/2016, 5/1/2014, 3/1/2009, 2/1/2008, 3/1/2007, 10/1/2006

Attachments

No Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/16/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2024
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/16/2024

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Policy Area:	*Administrative - Operating Policies*
References:	

100.236 Patient Safety Plan

POLICY:

This Patient Safety Plan supports and promotes the mission, vision and values of the Ventura County Health Care Agency (HCA) through implementation of a culture that is supportive of safety and reduction of risks for all stakeholders. Recognizing that effective safety improvement and risk reduction requires an integrated and coordinated approach, the following plan relates specifically to a systematic program to minimize physical injury, accidents and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

The Patient Safety Plan is focused on an approach geared towards the avoidance of medical errors and mitigation of hazardous conditions, by utilizing a systematic, coordinated and on-going approach to reducing risk and harm while improving safety. This approach focuses on processes and a proactive approach to reduce real or potential risk, and the integration of patient safety into all aspects of patient care.

The Patient Safety Plan is implemented through the continuous integration and coordination of the patient safety activities performed by members of the medical staff, nursing, ancillary and support services with each member of the healthcare team playing a crucial role to help ensure a safe environment.

The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/healthcare errors; and integrating patient safety priorities into the design and redesign of all relevant organization processes, functions and services.

Leaders focus on establishing a culture of safety that minimizes hazards and patient harm, by focusing on process of care, modeling principles of a Just Culture and integrating patient safety into all functions and services. The framework of a Just Culture ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace.

GOALS:

The goals of the Patient Safety Program include, but are not limited to:

1. Ongoing organizational learning about errors and risk avoidance;
2. Recognition that patient safety is an integral job responsibility;

3. Development of patient safety goals into job specific competencies;
4. Encouraging the recognition and reporting of errors and risks to patient safety without judgment or placement of blame;
5. Involving patients in decisions about their health care and promoting open communication about errors;
6. Collecting and analyzing data to evaluate care processes, to identify opportunities to reduce risk and implement improvement;
7. Communication of safety findings and the actions taken to improve processes and systems, in order to reduce risk.

PROCEDURE:

The procedures for immediate response to medical/health care error are as follows:

A. Staff will obtain required orders to support the patient's clinical condition.
B. Staff will immediately report the event either to the Nursing Manager or the House Supervisor if the event occurs during off-hours.
C. If the event is at the level of a Sentinel Event or acute patient harm has occurred, the Administrator-on-call (AOC) should be notified.
D. Staff will complete the online Notification Form

Authority and Responsibility

The authority to implement this plan is granted by the Oversight Committee. The responsibility of ensuring the tasks and duties described in this document are the responsibility of the Patient Safety Officer/Team. To ensure closed loop communication regarding team activities the Patient Safety Officer or designee will report to the Medical Executive Committee (MEC) and Oversight Committee on a quarterly basis.

Patient Safety Committee

The Patient Safety Committee (PSC) is composed of an interdisciplinary group that meets to review the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The PSC meets no less than four (4) times per year to ensure the maintenance and improvement of patient safety in the establishment of plans, processes and mechanisms involved in the provision of patient care. The chairperson has the discretion to call additional team meetings and to form subgroups to address any outstanding patient safety issues.

A. The scope of the PSC includes review of medical/healthcare errors involving patients of any age, visitors, hospital/medical staff, students and volunteers. Aggregate data from internal reports and external resources will be used for review and analysis in prioritization of improvement efforts, implementation of interventions and follow-up monitoring. The severity categories of medical/health care errors include:
B. **No Harm Error:** an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
C. **Mild to Moderate Adverse Outcome:** any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome.
D. **Hazardous Conditions:** any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome.
E. **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a

significant chance of a serious adverse outcome.

F. **Sentinel Event:** an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

G. The Patient Safety Committee (PSC) will evaluate aggregate data/processes and NOT specific clinical details related to individual occurrences. Clinical details will be reviewed/addressed through the other established processes and committees.

H. The PSC will be chaired by an appointee of the Executive Team.

   1. The responsibilities of the Chair may include but are not limited to:
      a. Compliance with patient safety standards and initiatives;
      b. Evaluation of work performance, as it relates to patient safety;
      c. Reinforcement of the expectations of the Patient Safety Plan; and
      d. Acceptance of accountability, for measurably improving safety and reducing errors.
      e. These duties may include listening to employee and/or patient concerns, and/or interviews with hospital and medical staff to determine what is being done to safeguard against occurrences, and to respond to reports concerning workplace conditions.
   2. Team members include representatives of services involved in providing patient care, i.e., Pharmacy, Laboratory, Infection Prevention, Imaging, Nursing (ED, ICU, Pediatrics, OB, Perioperative and Medical/Surgical), Performance Improvement as well as Executive Team representation. The medical staff representative(s) on the team will be the Medical Director of Inpatient Quality, the Chief Medical Officer (CMO) and at least one resident/ medical student.

I. The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

   1. Reporting of potential (Good Catch) or actual occurrence through the notification system by any employee in every department;
   2. Communication amongst hospital leadership to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment;
   3. Reporting of patient safety and operational safety measurements/activity to the ~~Performance Improvement Coordinating Council~~Patient Safety Committee (~~PICC~~PSC), the MEC and to the Oversight Committee.

As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

A. A non-punitive approach supportive of a Just Culture;

B. Voluntary participation in the Root Cause Analysis/Event Analysis for educational purposes and prevention of further occurrences;

C. Resources such as the Employee Assistance Program (EAP) should the need exist;

D. Regular staff surveys about their willingness to report medical errors.

Methods to assure ongoing in-services, education and training programs for maintenance and improvement of staff competence and support of an interdisciplinary approach to patient care is accomplished by:

A. Providing information about reporting mechanisms to new staff in the initial orientation and during on-going training;

B. Providing ongoing education, including reporting mechanisms, through information presented during annual competency;

C. Testing staff knowledge regarding patient safety during annual competency;

D. Obtaining a confidential assessment of staff's willingness to report medical errors at least bi-annually.

Internal reporting, in order to provide a comprehensive view of both the clinical and operational safety activity of the organization:

A. These quarterly meeting reports will include ongoing activities including data collection, analysis, actions taken, and monitoring for the effectiveness of actions.

B. The minutes/reports of the Patient Safety Committee will be reported to the MEC and the Oversight Committee on a quarterly basis, or more frequently, as indicated.

External Reporting:

A. External reporting will be completed in accordance with all state, federal, and regulatory rules, regulations and requirements.

Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

A. Conversations with patients and families during manager or administrative rounds;

B. Comments from patient satisfaction surveys.

C. Procedures used in communicating with families about the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion, include:

1. Patient's rights statements;
2. Patient responsibilities: A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.;

D. Annual assessment for barriers to effective communication among caregivers.

A proactive component of the program includes the selection of a high-risk or error prone process for concentrated activity through a Proactive Risk Assessment (~~PARA~~PRORA)/Failure Mode Effect Analysis (FMEA) process. The ~~PARA~~PRORA/FMEA selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement activities, infection prevention/ control, research, patient/family suggestions/ expectations or other identified potential high-risk processes.

A. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes).

B. Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.

C. For each failure mode, the possible effects on patients, as well as the seriousness of the effect, will be

identified.

D. The process will be redesigned to minimize the risk of failure modes.

E. The redesigned process will be tested and implemented.

F. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

The Patient Safety Committee (PSC) chairperson will submit a Quality Assessment/Performance Improvement (QAPI) Annual Report to the MEC and to the Oversight Committee which includes review of the hospital's patient safety activities. The report may include, but not be limited to:

A. Definition of the scope of occurrences including Sentinel Events, Event Analysis or a Root Cause Analysis as well as near misses;

B. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process (~~PARA~~PRORA/FMEA) selected for improvement efforts;

C. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis;

D. A description of how the function of process design, which incorporates patient safety, has been carried out using specific examples of process design or redesign that include patient safety principles;

E. The results of the program that assesses and improves staff willingness to report medical/health care errors;

F. A description of the examples of ongoing training and other educational programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Confidentiality

All information related to organizational patient safety performance improvement activities performed by the team members, in accordance with this plan are confidential and are protected. Confidential information may include, but is not limited to; Patient Safety Team minutes, any associated medical staff committee minutes, organizational performance improvement reports, data gathering and reporting, and untoward incident reporting.

Some information may be disseminated, as required, by federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a “need to know."

Evaluation and Approval

The Patient Safety Plan will be evaluated annually or as changes occur, and revised as necessary at the direction of the Executive Team and/or the MEC. The evaluation of the plan’s effectiveness will be documented in a report to the MEC and Oversight Committee.

All revision dates: 2/20/2024, 9/14/2021, 4/14/2020

Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/20/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/20/2024
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	2/20/2024

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.250 Management of Extravasation/Infiltration Due to Non-Chemotherapy Medication Administration

POLICY:

To ensure safe use and monitoring of intravenous catheter (peripheral or central access) when administering medications known to be an irritants or vesicants.

DEFINITIONS:[1]

A. Vesicant drugs can induce the formation of blisters and/or destroy tissue.

B. Extravasation is the accidental leakage of a vesicant.

C. Irritant drugs can cause pain at the injection site with or without an inflammatory reaction.

D. Infiltration is the accidental leakage of an irritant.

PROCEDURE:

Signs and symptoms[2, 3]

A. Peripheral line and midline infiltration/extravasation

1. Burning, stinging pain, tenderness/discomfort, swelling, redness with or without blistering, coolness or blanching at the site of cannula insertion, taut or stretched skin, leakage at the site, inability to obtain blood return

B. Peripherally inserted central line (PICC) and other central line infiltration/extravasation

1. Redness, discomfort, sensitivity, burning or tingling sensation of the chest, shoulders, and/or neck near catheter insertion, discomfort, burning or redness around the catheter, increased resistance in IV line, slow or difficult infusion, inability to obtain blood return, change in infusion flow.

C. Clinical sign of compartment syndrome “6 P rule”[4]

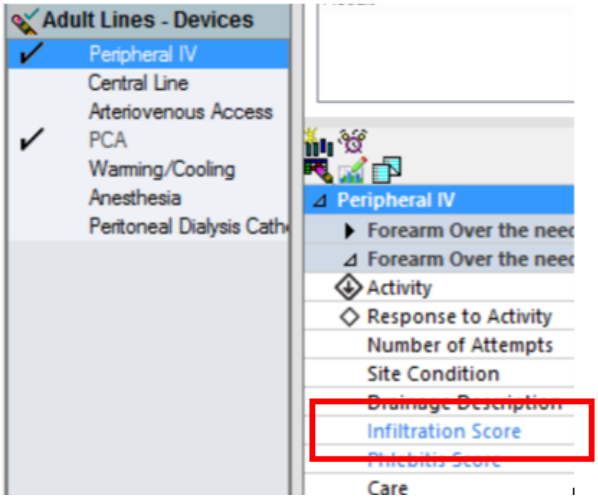
1. **P**ain, **P**allor, **P**aresthesia, **P**ulselessness, **P**ressure, **P**aralysis

Initial management[4, 5]

1. *Stop the infusion. Note the time of occurrence. Do NOT flush the line.*

2. *Evaluate pulses and circulation distal to the infusion site.*
3. *Assess for pain.*
4. *The extent of the extravasation shall be outlined with a felt-tip pen to provide a baseline for monitoring.*
5. *Elevate the extremity above the patient's heart. Avoid heat or cold and other physical modalities (massage, pressure, ultrasound, etc) unless otherwise specified. (See Table 1. below)*
6. Contact licensed independent practitioner (LIP) for orders for antidote if available.
    a. If no antidote is available, aspirate while removing the IV catheter. Do NOT apply pressure to the site.
    b. If antidote is available, leave the needle, aspirate as much as possible. Administer antidote per LIP's order. Do NOT apply pressure to the site.
7. *Photograph* of the extravasation site will be taken and placed in the patient's electronic health record (EHR) at the time of injury and every 2 hours for the first 8 hours. Thereafter, the site shall be examined for tissue injury at least once every 12 hours for the next 48 hours.
8. The IV catheter insertion site should be evaluated every 2 hours for the first 8 hours then once every 12 hours for the next 48 hours. Infiltration score shall be documented on EHR.

a.



b.

Infiltration Score	
Grade	**Clinical Criteria**
0	No symptoms of infiltration
1	Skin blanched, edema is less than1 inch in any direction, cool to touch, with or without pain
2	Skin blanched, edema less than 1-6 inches in any direction, cool to touch, with or without pain
3	Skin blanched or translucent, gross edema greater than 6 inches in any direction, cool to touch, mild to moderate pain, possible numbness
4	Skin blanched or translucent, skin tight, leaking, skin discolored, bruised, swollen, gross edema greater than 6 inches in any direction, deep pitting tissue edema,

	circulatory impairment, moderate to severe pain, infiltration with any amount of blood, irritant, vesicant

9. Surgery consultation is recommended if one of more of the following applies:[4]
    a. Pain in the extravasation area
    b. Osmolarity of the extravasated product is > 1,000 mOsm/L
    c. Symptoms are early
    d. Skin discoloration is present
    e. Extravasated volume is high
10. An Adverse Drug Reaction form shall be completed to be reviewed by the Patient Safety Committee and Pharmacy & Therapeutics Committee.

Documentation

1. Record the date, time, extravasation site, venous access device type and size.
2. Record the drug, amount, and concentration.
3. Record any patient complaints and observed signs of extravasation.
4. Measure and record the dimensions of the tissue affected.
5. Record the time, location, and amount of antidote and other measures applied.
6. Record the names of clinicians notified, and to whom referrals were made if necessary (i.e., plastic surgeon, dermatologist, or rehabilitation).
7. Document instruction given to the patient and/or the caregiver

Medications causing extravasation and treatment options

Table 1. Extravasation agents and treatment options. [4-7]

Hyperosmolar agents	Antidote
Calcium chloride* 10% (V, warm)	Early treatment: Hyaluronidase[6] In severe form of cutaneous calcinosis: Sodium thiosulfate 25%
Calcium gluconate 10% (V, warm)	
Diazepam* (V, warm)	Hyaluronidase
Digoxin (V, warm or cold)	Hyaluronidase
Dextrose* > 10% (V, cold)	Hyaluronidase
Mannitol* > 20% (V, cold)	Hyaluronidase
Phenytoin (also is alkaline, warm) – Purple glove syndrome	Alternate: Nitroglycerin 2% topical ointment. Refractory: Hyaluronidase
Potassium chloride/acetate* > 2 mEq/mL (V, warm or cold[7])	Hyaluronidase[5]
Sodium bicarbonate* > 8.4% (V, warm or cold)	Hyaluronidase[5] In severe form, may use silver sulfadiazine
Sodium chloride* > 10% (V, cold)	May consider use of Hyaluronidase[6]

TPN* (also acidic, V, cold or warm)	Hyaluronidase, Nitroglycerin 2% topical ointment
Contrast agent	See CPG.57
Vasopressors	**Antidote**
Dobutamine (V, warm)	Phentolamine Nitroglycerin 2% topical ointment Alternative: Terbutaline (except for phenylephrine) [6]
Dopamine (V, warm	
Epinephrine (I, warm)	
Methylene blue (V, warm)	
Norepinephrine (V, warm)	
Phenylephrine (V, warm)	
Vasopressin (V, warm)	Nitroglycerin 2% topical ointment

Acidic and basic compounds		**Antidote**
Acyclovir (V, cold)	Gentamicin (V, cold)	No specific pharmacological management is available.
Aminophylline (V, cold or warm)	Metronidazole (V, warm)	
Amiodarone (V, cold or warm)	Nicardipine (I, cold)	
Doxycycline (warm)	Phenobarbital (V, cold or warm)	
Furosemide (V, cold)	Vancomycin (V/I, cold or warm)	
Ganciclovir (V, cold)		

Treatment detail

A. **All cases implement Cold or Warm** packs as suggested above to the affected area and elevate if possible.

B. **Sodium thiosulfate 25%**:

1. First week: 12.5 gram IV over 30 minutes 3 times a week
2. Second week: 18.75 gram IV over 30 minutes 3 times a week
3. Third week: 25 grams IV over 30 minutes 3 times a week

C. **Hyaluronidase**: 150 units/1 mL given as five 0.2 mL intradermal injection around the periphery of the extravasated area.

1. Best if given within the first hour after extravasation.[5]
2. Do not administer if more than 3 hours have passed.[5]
3. Clean site with chlorhexidine.
4. Inject 0.2 mL through the IV catheter before removing it from the extravasation site.
5. Remove IV catheter.
6. Using sterile technique and a ***new*** 25 to 27 gauge needle (hypodermic needles) each time, inject 0.2 mL subcutaneously at the edge of the infiltrate in a circular pattern around the

leading edge of the extravasation.

D. **Nitroglycerine 2% topical ointment**: Apply 1 inch topically to ischemic area. May repeat every 8 hours if necessary

E. **Silver sulfadiazine**: Apply 1/16th inch to the affected area. Application must be done with sterile gloves.

F. **Phentolamine**: Administer 5 - 10 mg given as five to ten separate 0.5 - 1 mL intradermal injection around the periphery of the extravasated area.

1. Do not administer if more than 12 hours have passed.[6]
2. Remove IV catheter.
3. Clean site with chlorhexidine.
4. Reconstitute 5 mg vial with 5 mL of NS to final concentration of 1 mg/mL x 2 vials.[6]
5. Using sterile technique, injected in 0.5 to 1 mL aliquots as separate subcutaneous injections around the leading edge of the extravasation with total of up to 10 mg, using ***new*** 25 to 27 gauge needles (hypodermic needles) for each injection.

G. **Terbutaline**: 1 mg diluted up to 10 mL of NS and administered subcutaneously throughout the extravasation area using ***new*** needles for each injection. [5]

1. The volume (1-10 mL) depend on the size and location of injury.
   a. Small/distal extravasation site (i.e. finger): Dilute to 1 mL
   b. Large extravasation site: Dilute from 3 - 10 mL

Abbreviations: V = vesicant, I = irritant, NS = 0.9% sodium chloride. *Agents with osmolarity > 1,000 mOsm/kg

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All revision dates: 1/13/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/23/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/16/2024
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	2/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.267 Naloxone Overdose Rescue Kit

PURPOSE

To make naloxone available to patients seen in the Emergency Department (ED) who are determined to be at risk of an opioid- related overdose.

DEFINITION

Overdose rescue kit: One bag containing naloxone nasal sprays, breathing shield, and instructional card, Fentanyl Risk education card, and "Safe Choices" resource card.

POLICY

Dispense life-saving medication, naloxone in the form of a rescue kit, to patients at risk of opioid overdose pursuant of licensed practitioner's (LP) order or otherwise ordered by a trained staff.

PROCEDURE

1. Training of staff, other than LP, will be completed by the Substance Use Services (SUS) Prevention Team.
    a. Staff member may include substance use navigators (SUNs) and/or registered nurses or other identified members of the patient care team who have completed training.
    b. Trained staff will be required to take a refresher training every 2 years to dispense overdose rescue kits.
2. Issuance, delivery, distribution, maintenance of inventory in ED, and collection of required data will be managed by the SUNs or other trained staff with the use of the ~~Program's Inventory Binder~~Overdose Rescue Kit Tracking Log. This maintenance shall include checking of expired medications and managing of medication recalls if applicable. Refer to the following forms.
    a. Site Inventory Tracking Log (Attachment A)
    b. Overdose Rescue Kit Participant - Initial Form (Attachment B)
    c. Overdose Rescue Kit Participant - Refill Form (Attachment C)
3. Overdose rescue kits will be stored in locked cabinet in the ED with the Program Inventory Binder.
    a. Trained staff member will document required elements on the dispensing log, remove one rescue kit

from locked, secured cabinet.

b. Educate the patient regarding the use of rescue kit in the patients preferred language.

c. Document necessary information for record keeping including progress note in electronic health record (EHR) as necessary.

4. Overdose rescue kits will be dispense by SUNs or other trained staff pursuant of the attached standing order. If no SUN is available, kits can be dispensed by trained RNs or LPs (Attachment D).

5. Substance Use Services (SUS) Prevention Team can be reached at 805-667-6333 (No Over Dose)

All revision dates: 1/17/2024, 3/14/2023

Attachments

Attachment A: Site Inventory Tracking Log
Attachment B: Overdose Rescue Kit Participant - Initial Form
Attachment C: Overdose Rescue Kit Participant - Refill Form
Attachment D: Standing Order Naloxone VCBH 2021

Approval Signatures

Step Description	Approver	Date
ED Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	1/29/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/5/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/5/2023
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	12/5/2023

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Policy Area:	*Administrative - Patient Care*
References:	

100.270 Allocation Of Critical Care Resources During A Public Health Emergency

INTRODUCTION:

The purpose of this document is to provide guidance for the triage of critically ill patients in the event that a public health emergency creates demand for critical care resources[1] that outstrips the supply. These triage recommendations will be enacted only if: 1) critical care capacity is, or will shortly be, overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients; and 2) a regional authority has declared a public health emergency. This allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. It is consistent with existing recommendations for how to allocate scarce critical care resources during a public health emergency, and has been informed by extensive research of applicable authorities and approaches either taken or contemplated by other medical centers in response to public health emergencies as well as by guidance issued with respect to the COVID-19 pandemic prior to the adoption of this policy by the Medical Staff of Ventura County Medical Center. This policy applies to Ventura County Health Care Agency, including Ventura County Medical Center and Santa Paula Hospital.

During a public health emergency, medical care must shift from ordinary clinical ethics, which focuses on an individual patient, to public health ethics in which the overall welfare of the community becomes central. Like all medical centers, Ventura County Medical Center will be responsible for thoughtfully stewarding the limited resources available to us in ways calculated to result in the best health outcomes for the entire population. Decisions must be based on objective predictions of need and benefit, free of favor, explicit or implicit, linked to patients' wealth, social circumstances, race, ethnicity, or gender. Equal treatment also means using random selection among similarly situated patients. Respect for persons means that patients must be free to decline care that they do not regard as beneficial.

~~This policy is being adopting~~Though originally adopted and implemented to address the COVID-19 pandemic~~. As such~~, ~~the critical~~this policy focuses on public health care ~~resources, treatments, and symptoms contemplated in this Policy focus on the public health care~~ emergency concerns either anticipated or created by the COVID-19 pandemic as well as for any case where an influx of infectious disease patients occurs. However, if appropriate, this policy may be implemented in the future to address other public health emergencies, as necessary and appropriate.

~~The~~While any virus will not reach all communities at the same moment and the pandemic may play out somewhat differently in particular locales, all parts of the medical system across the country - including Ventura County Medical Center may experience a surge of patients in need of critical care that will exceed the

system's capabilities to provide that level of care. When essential resources become scarce and not all patients (whether affected by COVID-19 ~~pandemic has occurred because a novel corona virus emerged for which people have little or no immunity, and for which no vaccine or proven cure yet exists. Although further study is necessary regarding COVID-19, it is apparent that the virus spreads easily from person-to-person. In a very short time, it has made its way around the world and across our country, where the number of confirmed cases increases by the thousands each day. It causes serious respiratory illness and failure which results in a high case-fatality rate especially among older and medically vulnerable patients. While the virus will not reach all communities at the same moment and the pandemic may play out somewhat differently in particular locales, all parts of the~~or some other medical ~~system across the country - including Ventura County Medical Center - can expect a surge in COVID-19 patients in need of critical care that will exceed the system's capabilities to provide that level of care. When essential resources become scarce and not all patients (whether affected by COVID-19 or some other medical~~ condition) can be provided the treatments they may need to survive, the intent of this policy is to set forth an agreed means for the Medical Staff to evaluate cases and allocate resources in an ethically responsible and appropriate manner.

Consistent with accepted standards during public health emergencies, the primary goal of the allocation framework is to maximize benefit to populations of patients, specifically by maximizing survival to hospital discharge and beyond for the greatest number of patients, often expressed as doing the greatest good for the greatest number. It should be noted that this goal is different from the traditional focus of medical ethics, which is centered on promoting the wellbeing of individual patients. The allocation framework described in this document does not categorically exclude any patients who, in usual circumstances, would be eligible for critical care resources. Instead, all patients are treated as eligible to receive critical care resources and receive a priority assignment based on potential to benefit from those resources. The availability of critical care resources determines how many priority groups can receive critical care.

This document describes 1) the creation of triage teams to ensure consistent decision making; 2) allocation criteria for initial allocation of critical care resources; 3) reassessment criteria to determine whether ongoing provision of scarce critical care resources are to be continued for individual patients; and 4) guidance for decisions regarding Cardiopulmonary Resuscitation.

TRIAGE COMMITTEE AND SUPPORT TEAM:

Patients' treating clinicians will not make triage decisions. These decisions are grounded in public health ethics, not clinical ethics, and therefore a triage team with expertise in the allocation framework should make allocation decisions. The separation of the triage role from the clinical role is intended to promote objectivity, avoid conflicts of commitments, and minimize moral distress. This approach permits the treating clinician to remain in the role of patient advocate, while allowing a theoretically objective and preferably interdisciplinary team to handle resource allocation and futility decisions.

A. Triage Committee:

A group of Triage Committee members shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer and members of the Medical Executive Committee, and will be a committee of the Medical Staff dedicated to ensuring the quality of care provided under the constraints associated with a public health emergency. Desirable qualities of Triage Committee members include healthcare clinicians with expertise in the management of critically ill patients, strong leadership ability, and effective communication and conflict resolution skills. These individuals will oversee the triage process, assess all patients, assign a level of priority for each, communicate with treating physicians, and direct attention to the highest-priority patients. The Triage Committee members are expected to make decisions according to the allocation framework described below, which is designed to benefit the greatest number of patients, by maximizing survival to discharge and beyond

for the greatest number of patients, even though these decisions may not necessarily be best for some individual patients. The Triage Committee members have the responsibility and authority to apply the principles and processes of this policy to make decisions about which patients will receive the highest priority for receiving critical care. They are also empowered to make decisions regarding reallocation of critical care resources that have previously been allocated to patients, again using the principles and processes in this policy.

The Triage Committee will be comprised of at least three (3) members per twelve (12) hour shift. To the extent feasible, the Triage Committee members will be comprised of a suitable mixture of disciplines (e.g., Critical care, palliative care, internal medicine, family medicine, obstetrics and gynecology, surgery). A roster of approved Triage Committee members should be maintained that is large enough to ensure that Triage Committee members will be available on short notice at all times, and that they will have sufficient rest periods between shifts.

B. Support Team:

In addition to the Triage Committee, if resources allow, the triage team should also consist of administrative staff member(s) who will conduct data-gathering activities as well as documentation and record keeping. The role of support team members is to provide information to the Triage Committee and to help facilitate and support the decision-making process. A representative from hospital administration should also be linked to the team, in order to assist with ongoing assessments of available critical care resources and to serve as a liaison with hospital leadership.

Communication of triage decisions to patients and families:

Although the authority for triage decisions rests with the Triage Committee, there are several potential strategies to communicate triage decisions to patients and families. Communication or disclosure of such triage decisions to patients and/or their next of kin is a required component of a fair allocation process that provides respect for persons. The Triage Committee member(s) should first inform the affected patient's attending physician about the triage decision. The Triage Committee member(s) and the attending physician should collaboratively determine the best approach to inform the individual patient and family. The best approach will depend on a variety of case-specific factors, including the dynamics of the individual doctor-patient-family relationship and the preferences of the attending physician. If the attending physician is comfortable with disclosing her- or him-self, this approach is useful because the communication regarding triage will bridge naturally to a conveyance of prognosis, which is a responsibility of bedside physicians, and because it may limit the number of clinicians exposed to a circulating pathogen. Regardless of who communicates the decision, it may be useful to explain the medical factors that informed the decision, as well as the factors that were not relevant (e.g., race, ethnicity, gender, insurance status, perceptions of social worth, immigration status, etc). If resources permit, palliative care or behavioral health clinicians should be present or available to provide ongoing emotional support to the patient and family.

Appeals process for individual triage decisions:

It is possible that patients, families, or clinicians will challenge individual triage decisions. Procedural fairness requires the availability of an appeals mechanism to resolve such disputes. On practical grounds, different appeals mechanisms are needed for the initial decision to allocate a scarce resource among individuals, none of whom are currently using the resource, and the decision whether to withdraw a scarce resource from a patient who is not clearly benefiting from that resource. This is because initial triage decisions for patients awaiting the critical care resource will likely be made in highly time-pressured circumstances. Therefore, an appeal will need to be adjudicated in real time to be operationally feasible. For the initial triage decision, the

only permissible appeals are those based on a claim that an error was made by the triage team in the calculation of the priority score or use/non-use of a tiebreaker. The process of evaluating the appeal should include the Triage Committee verifying the accuracy of the priority score calculation by recalculating it. The treating clinician or a Triage Committee member should be prepared to explain the calculation to the patient or family on request.

Appeals based on considerations other than disagreement with the allocation framework should immediately be brought to a Triage Review Committee that is independent of the triage officer/team, and of the patient's care team (see below for recommended composition of this body). The appeals process must occur quickly enough that the appeals process does not harm patients who are in the queue for scarce critical care resources currently being used by the patient who is the subject of the appeal. The decision of the Triage Review Committee will be final.

The Triage Review Committee should be made up of at least three individuals recruited from the following groups or offices: Chief Medical Officer or designee, Chief Nursing Officer or other Nursing leadership, a member of the Medical Staff's Ethics Committee, a member of the Medical Executive Committee and/or an off-duty member of the Triage Committee. Three committee members are needed for a quorum to render a decision, using a simple majority vote. The Triage Review Committee process is to be coordinated with input from legal counsel, who will not vote. The process can happen by telephone or in person, and the outcome will be promptly communicated to whomever brought the appeal.

ALLOCATION CRITERIA FOR ICU ADMISSION VENTILATION:

Consistent with accepted standards during public health emergencies, the primary goal of the allocation framework is to maximize benefit to populations of patients, specifically by maximizing survival to hospital discharge and beyond for as many patients as possible. All patients who meet usual medical indications for ICU beds and services will be assigned a priority score using the criteria set forth in this policy. All patients will be eligible to receive critical care beds and services regardless of their priority score, but available critical care resources may be allocated according to priority score, such that the availability of these services will determine how many patients will receive critical care. Individuals who perform tasks that are vital to the public health response – specifically, those whose work directly supports the provision of acute care to others – will be given heightened priority (e.g., as a tiebreaker between identical priority scores). Patients who are triaged to not receive ICU beds or services will be offered medical care including intensive symptom management and psychosocial support. Where available, specialist palliative care teams will provide additional support and consultation. Patients' interests will be carefully considered. In the event a patient chooses to forgo critical care measures, the patient will not be assigned a priority score. The patient's decision shall be documented in the medical record.

The allocation framework should be used to make initial triage decisions for patients who present with illnesses, that typically require critical care resources (i.e., illnesses that cannot be managed on a hospital ward in that hospital). The scoring system applies to all patients presenting with critical illness, not merely those with the disease or disorders that have caused the public health emergency. For example, in the setting of a severe pandemic, those patients with respiratory failure from illnesses not caused by the pandemic illness will also be subject to the allocation framework. This process involves two steps, detailed below:

1. Calculating each patient's priority score based on the allocation framework;
2. Regular assessment of the critical care resources available to provide patients with access to critical care

interventions.

First responders and bedside clinicians should perform the immediate stabilization of any patient in need of critical care, as they would under normal circumstances. Along with stabilization, temporary ventilatory support may be offered, if available, to allow the Triage Committee member(s) to assess the patient for critical resource allocation. Every effort should be made to complete the initial triage assessment within 90 minutes of the recognition of the likely need for critical care resources.

STEP 1: Calculate each patient's Priority Score using the allocation framework

Each patient's Priority Score will be based on two considerations, a calculation that predicts short term survival and an assessment of likelihood of longer term survival. Patients who are more likely to survive with intensive care are prioritized over patients who are less likely to survive with intensive care. Patients who do not have a severely limited life expectancy are given priority over those who have such advanced conditions that they have a very limited life expectancy even if they survive the acute critical illness.

The presence of conditions that are in such an advanced state that life expectancy is very limited is used to characterize patients' longer –term prognosis. The Triage Committee Members should assess, using validated prognostic tools and their clinical experience patients' pre acute condition life expectancy and assign points as in **Table 1**.

A patient's respective SOFA ("Sequential Organ Failure Assessment") (**Table 2**) or Modified SOFA (**Table 3**) score predicts hospital survival. Modified SOFA is to be used when all laboratory parameters in SOFA are not known. The presence of conditions in such an advanced state that life expectancy is very limited is used to characterize patients' longer-term prognosis. The Priority Score is determining by (1) calculating the SOFA (or, if applicable, Modified SOFA) score; (2) assigning a point value to the determination that a patient has a severely limited life expectancy even if they survived to discharge (suggested point allocations are as follows: two (2) points if life expectancy is predicted to be less than five (5) years, four (4) points for life expectancy less than one (1) year); and (3) the Priority Score is determined by adding these two (2) numbers. Priority Scores should range from 1-8, and persons with the lowest score would be given the highest priority to receive critical care beds and services.

TABLE 1

Specification	Point System*			
	1	2	3	4
Prognosis for short-term survival (SOFA score#)	SOFA score < 6	SOFA score 6-8	SOFA score 9-11	SOFA score ≥12
Prognosis for longer-term survival (medical assessment of prospects for survival after hospital discharge)	…	Life expectancy < 5 years despite successful treatment of acute condition	…	Death likely within 1 year despite successful treatment of acute condition

Specification	Point System*			
	1	2	3	4
Prognosis for short-term survival (SOFA score#)	SOFA score < 6	SOFA score 6-8	SOFA score 9-11	SOFA score ≥12
Prognosis for longer-term survival (medical assessment of prospects for survival after hospital discharge)	…	Life expectancy < 5 years despite successful treatment of acute condition	…	Death likely within 1 year despite successful treatment of acute condition

TABLE 2

Sequential Organ Failure Assessment (SOFA) Score

ORGAN SYSTEM	SCORE = 0	1	2	3	4
RESPIRATORY $Pa0_2/Fi0_2$	> 400	≤ 400	≤ 300	≤ 200 with resp. support	≤ 100 with resp. support
HEMATOLOGIC Platelets	> 150	≤ 150	≤ 100	≤ 50	≤ 20
HEPATIC Bilirubin (mg/dl)	< 1.2	1.2 – 1.9	2.0 – 5.9	6 – 11.9	≥ 12
CARDIOVASCULAR Hypotension	None	Mean Arterial Pressure < 70 mmHg	Dopamine ≤ 5 or any Dobutamine	Dopamine > 5 or Epi < 0.1 or Nor-Epi ≤ 0.1	Dopamine > 15 or Epi > 0.1 or Nor-Epi > 0.1
CENTRAL NERVOUS SYSTEM Glasgow Coma Score	15	13 - 14	10 - 12	6 - 9	<6
RENAL Creatinine	<1.2	1.2 - 1.9	2.0 - 3.4	3.5 - 4.9	≥5.0

ORGAN SYSTEM	SCORE = 0	1	2	3	4
RESPIRATORY $Pa0_2/Fi0_2$	> 400	≤ 400	≤ 300	≤ 200 with resp. support	≤ 100 with resp. support
HEMATOLOGIC Platelets	> 150	≤ 150	≤ 100	≤ 50	≤ 20
HEPATIC Bilirubin (mg/dl)	< 1.2	1.2 – 1.9	2.0 – 5.9	6 – 11.9	≥ 12
CARDIOVASCULAR Hypotension	None	Mean Arterial Pressure < 70 mmHg	Dopamine ≤ 5 or any Dobutamine	Dopamine > 5 or Epi < 0.1 or Nor-Epi ≤ 0.1	Dopamine > 15 or Epi > 0.1 or Nor-Epi > 0.1
CENTRAL NERVOUS SYSTEM Glasgow Coma Score	15	13 - 14	10 - 12	6 - 9	<6
RENAL Creatinine	<1.2	1.2 - 1.9	2.0 - 3.4	3.5 - 4.9	≥5.0

TABLE 3

Modified Sequential Organ Failure Assessment (MSOFA) Score

TABLE 2

Modified Sequential Organ Failure Assessment (MSOFA) Score

Organ System	0	1	2	3	4
Respiratory SpO2/FiO2	>400	≤400	≤315	≤235	≤150
Liver	No scleral icterus or jaundice			Scleral icterus or jaundice	
Cardiovascular, hypotension	No hypo-tension	MAP <70 mm Hg	dopamine≤5 or dobutamine any dose	dopamine>5 epinephrine≤0.1 norepinephrine≤0.1	dopamine>15 epinephrine>0.1 norepinephrine>0.1
CNS, Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal, Creatinine mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0

MAP=mean arterial pressure

dopamine, dobutamine, epinephrine, and norepinephrine doses in micrograms per kilogram per minute

CNS=central nervous system

Table 4 is intended to provide only some examples known to severely limit life expectancy. There are innumerable premorbid clinical scenarios that lead to decreased life expectancy. None should be applied as blanket assessments. Practitioners should use all available prognostic tools, experience, and medical knowledge to assess life expectancy based on premorbid illness.

TABLE 4

Examples of Major and Severely Life Limiting Comorbidities

Examples of conditions likely to result in life expectancy < 5 years	Examples of conditions known to likely result in death within 1 year
• Heart failure – Ejection fraction > 20 % but < 35 %) • Cancers with very poor prognosis that are not known to be metastatic –Small Cell Lung, Pancreatic, Brain • End-stage renal disease in patients < 75 years old	• Advanced Dementia - equivalent to Palliative Performance Scale < 40, OR Functional Assessment Staging Test (FAST) = 7 • Metastatic Solid Organ Cancer being treated without curative intent, OR no cancer treatment • Heart Failure, OR Coronary Artery Disease (CAD)/Angina - New York Heart Association Class IV, OR Ejection Fraction < 20% • Severe Chronic Lung Disease – PAO2 < 55 on Room Air, OR PCO2 > 50 (from chart in last 3 months), OR Global Initiative for Chronic Obstructive Lung Disease (GOLD) Stage 4, OR on continuous home Oxygen (O2)

	• Cirrhosis with Model for End-Stage Liver Disease (MELD) score ≥ 20, OR Childs Pugh Class C • Stage 5 / End-stage renal disease in patients older than 75 years old • Neurologic Dysfunction (e.g. stroke) with Palliative Performance Scale < 40, OR Glasgow Coma Score (GCS) < 6 (non pharmacologically induced)

Considerations for Equal Priority Scores:

Individuals who perform tasks that are vital to the public health response, including all those whose work directly supports the provision of acute care to others, are first to be assigned a Priority Score without consideration of their profession or expertise. This information will be used in connection with "breaking a tie." This category should be broadly construed to include those individuals who play a critical role in the chain of treating patients and maintaining societal order. However, it would not be appropriate to prioritize front-line physicians and not prioritize other front-line clinicians (e.g., nurses and respiratory therapists) and other key personnel (e.g., maintenance staff that disinfects hospital rooms).

If a tie remains after the tie breaker is applied, a lottery (i.e. random allocation) should be used to break the tie. The lottery should be conducted in a fair and confidential manner and, if feasible, occur before a member of the Triage Committee or Triage Review Committee who did not participate in the assigning of the Priority Score for either of the patients at issue. Patient identifiers should be assigned to each of the patients identified for the lottery and a random selection process applied as appropriate under the circumstances and time constraints associated the events that gave rise to the need for the lottery.

STEP 2: Regular determinations of the critical care resources available to provide patients with access to critical care interventions

Hospital leaders and Triage Committee members, with assistance as needed from Support Team members, should make determinations at least daily, or more frequently if needed, about what Priority Scores will result in access to critical care services. These determinations should be based on real-time knowledge of the degree of scarcity of the critical care resources, as well as information about the predicted volume of new cases that will be presenting for care over the near-term (several days). For example, if there is clear evidence that there is imminent shortage of critical care resources (i.e., few ventilators available and large numbers of new patients daily), only patients with the highest priority (lowest scores) should receive scarce critical care resources. As scarcity subsides, patients with progressively lower priority (higher scores) should have access to critical care interventions.

It is important to reiterate that all patients will be eligible to receive critical care beds and services regardless of their priority score. The availability of critical care resources will determine how many eligible patients will receive critical care.

Patients who are not triaged to receive critical care/ventilation will receive medical care that includes intensive symptom management and psychosocial support. They should be reassessed at least daily to determine if changes in resource availability or their clinical status warrant provision of critical care services. Where available, specialist palliative care teams will be available for consultation. Where palliative care specialists are not available, the treating clinical teams should provide primary palliative care.

REASSESSMENT FOR ONGOING PROVISION OF CRITICAL CARE/VENTILATION:

The Triage Committee will conduct periodic reassessments of all patients receiving critical care services during times of crisis (i.e., not merely those initially triaged under the crisis standards). The timing of reassessments should be based on evolving understanding of typical disease trajectories and of the severity of the crisis.

A multidimensional assessment should be used to quantify changes in patients' conditions, such as recalculation of severity of illness scores, appraisal of new complications, and treating clinicians' input. Patients showing improvement will continue with critical care/ventilation until the next assessment. If there are patients in the queue for critical care services, then patients who upon reassessment show substantial clinical deterioration as evidenced by worsening SOFA or Modified SOFA scores or overall clinical judgment should have critical care withdrawn, including discontinuation of mechanical ventilation, after this decision is disclosed to the patient and/or family.

Patients showing substantial clinical deterioration that portends a very low chance for survival may have critical care discontinued based on the then current availability of critical care resources. Patients who are no longer eligible for critical care treatment should receive medical care including intensive symptom management and psychosocial support. Where available, specialist palliative care teams will be available for consultation. Where palliative care specialists are not available, the treating clinical teams should provide primary palliative care. Should a patient elect to discontinue critical care services, this decision shall be documented in the medical record.

GUIDANCE FOR DECISIONS REGARDING CARDIOPULMONARY RESUSCITATION:

While much is still being learned about the COVID-19 pandemic, it is apparent that the virus spreads easily from person-to-person. The risk of exposure is heightened for healthcare providers who are regularly exposed to individuals infected with COVID-19. That risk is further increased for healthcare providers who are tasked with providing Cardiopulmonary Resuscitation ("CPR") to infected patients. It is further recognized and anticipated that personal protective equipment ("PPE"), ventilators, adequately trained personnel or other resources necessary to perform CPR are likely to become rationed as the pandemic continues. This portion of the policy is directed at providing guidance to healthcare providers making decisions regarding CPR.

Attending physicians should consider the following in making determination regarding CPR:

1. CPR should not be performed on patients who have an advanced directive or otherwise communicate that they do not wish to receive CPR. That information should be documented in the medical record.
2. If PPE, ventilators, adequately trained personnel or other necessary resources are rationed, unavailable or otherwise inaccessible, the quality of and the availability of CPR may be compromised.
3. Attending physicians are not obligated to offer or to provide CPR if resuscitative treatment would not be medically appropriate, or of sufficient quality, in light of the critical concerns associated with the COVID-19 pandemic, including the futility of the efforts on improving the health of the patient when considered in connection with the limited availability of resources and equipment necessary to protect the health and safety of healthcare professionals in conducting CPR.
4. For patients with or without COVID-19, a determination that CPR would not be medically appropriate may also be made on the grounds that CPR would not serve a medical purpose because of the patient's prognosis with or without CPR.

Involvement of the Triage Committee:

In addition, for patients with COVID-19, the risks to healthcare providers of performing CPR, coupled with considerations of individual patients' prognoses, may influence a decision of whether to perform CPR. When

possible, attending physicians should seek the input of the Triage Committee regarding the decision of whether to administer CPR, if the patient's clinical condition affords enough time to involve the Triage Committee. If there is insufficient time to involve a Triage Committee member (e.g., if a known COVID-19 patient arrives in the hospital in critical condition and deteriorates rapidly to the point of requiring CPR), the decision for provision of CPR will need to be made by the emergency physician/admitting attending.

If the attending physician and/or the Triage Committee determine that CPR is not medically appropriate under applicable circumstances, or presents an undue risk to healthcare providers when coupled with the individual patients' prognoses and the scarcity of resources, then the primary attending should document this decision in the medical record.

Communication with the patient or patient representative:

Physicians who determine that CPR is not medically appropriate under applicable circumstances should inform the patient or representative of this decision and its rationale, and assure the patient that all other forms of indicated care will continue. This communication should be coordinated, when possible, with the Triage Committee member(s). Patient or representative assent should be sought, but is not required given the constraints faced by healthcare providers during the COVID-19 pandemic and the necessity to allocate limited healthcare resources, including the health and safety of healthcare professionals.

[1] *Throughout this document, the term 'critical care' refers all the essential medical resources that may become 'scarce' (i.e., insufficient to meet demand) in the ICU during a pandemic, such as ventilators, ICU beds, hospital beds, Extra Corporeal Membrane Oxygenation (ECMO), Left Ventricular Assist Device (LVAD), balloon pump, Continuous Renal Replacement Therapy/Hemodialysis (CRRT/HD), pressors, antivirals/ antibiotics, and includes healthcare professionals such as physicians, respiratory therapists, nursing and other crucial staff.*

All revision dates: 10/31/2023, 4/15/2020

Attachments

Attachment A: Addendum to Allocation of Scarce Critical Care Resources During a Public Health Emergency: Fair Allocation of Scarce Medications to Treat COVID-19

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/7/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	11/8/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/2/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/2/2023
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	11/2/2023

VENTURA COUNTY HEALTH CARE AGENCY

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

100.274 Gender Affirming Care and Care of the Transgender Patient

PURPOSE

The purpose of this policy is to ensure that the gender non-~~confirming~~conforming and transgender patient receives the same standard of respect, care and non-discriminatory treatment as any other patient. This policy describes the respective issues and provides guidelines specific to the safe care of this patient population.

POLICY

In accordance with the California state law – The Gender Nondiscrimination Act (2012), OHS Policy 322 – Patients' Bill of Rights, the patient has the right to nondiscriminatory treatment on the basis of gender identity or gender expression. This right is inclusive of privacy and confidentiality during medical treatment or other rendering of care.

The following procedures provide healthcare practitioner guides to safe care:

- Effective interaction with transgender patients
- Patient room assignments
- Access to personal items that assist presentation
- Access to restrooms
- Access to hormone therapy

DEFINITION

The definition of transgender transcends the traditional binary gender identity of Male/Man vs. Female/ Woman. A transgender person identifies with and/or expresses a gender that differs from the one which corresponds to the person's assigned sex at birth.

Gender non-conforming: denotes a person whose behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their gender; also includes individuals identifying as non-binary.

Gender dysphoria is the medical/psychiatric diagnosis (DSM-5) which describes the distress a person experiences as a result of the disparity between the sex and gender they were assigned at birth and their

gender identity.

Transgender woman/Trans-woman/Trans-female: Assigned male at birth and currently identifies as female.

Transgender man/Trans-man/Trans-male: Assigned female at birth and currently identifies as male.

PROCEDURES

Effective Interaction

When transgender or gender non-conforming patients present for health care, they will be addressed and referred to on the basis of their self-identified gender, using their pronouns and name in use, regardless of the patient's appearance, surgical history, legal name, or sex assigned at birth. If the patient's family members suggest that the patient is of a gender different from that with which the patient self-identifies the *patient's* view should be honored.

A patient's pronouns should be determined as follows:

A. If the patient's gender presentation clearly indicates to a reasonable person the gender with which the patient wishes to be identified, the hospital staff member should refer to the patient using pronouns appropriate to that gender.

B. If the hospital staff member determines the patient's pronouns on the basis of the patient's gender presentation, but is the corrected by the patient, the staff member should then use the pronouns associated with the gender identity verbally expressed by the patient.

C. If the patient's gender presentation does not clearly indicate the patient's gender identity, the hospital staff member should discreetly and politely ask the patient for the pronouns the patient uses.

Hospital staff will not use language or tone that a reasonable person would consider to demean, question, or invalidate a patient's actual or perceived gender identity or expression.

A patient should not be asked about transgender status, sex assigned at birth, or transition related procedures unless such information is directly relevant to the patient's care. If it is necessary to the patient's care for a health care provider to inquire about such information, the provider should explain to the patient:

A. Why the requested information is relevant to the patient's care

B. That the information will be kept confidential but some disclosures of the information may be permitted or required

C. That the patient should consult the hospital's HIPAA policy for details concerning permitted disclosures of patient information

Screening and Identification

During the registration process, the admitting team will ask a series of questions to include sexual orientation, gender identify and preferred pronouns. Preferred pronouns will then be reflected on the Banner Bar in Cerner. ~~The registered nurse (RN)~~

Transgender and Gender Non-Conforming Patient Room Assignments

~~Where room assignments are gender-based, transgender patients will be assigned to rooms based on their self-identified gender, regardless of whether this self-identified gender accords with their~~

~~physical appearance, surgical history, genitalia, legal sex, sex assigned at birth, or name and sex as it appears in hospital records.~~ ~~The~~Where room assignments are gender-based, transgender patients will be assigned to rooms based on their self-identified gender, regardless of whether this self-identified gender accords with their physical appearance, surgical history, genitalia, legal sex, sex assigned at birth, or name and sex as it appears in hospital records. The hospital Admissions Office shall determine a patient's self-identified gender prior to assigning the patient a room by reviewing the patient's admitting/registration record. In the event the patient presents in an incapacitated or unconscious state, inference shall be drawn from the patient's presentation and the mode of dress and without examination of genitalia unless clinically indicated. Transgender patients shall be assigned to inpatient rooms in the following order of priority:

1. If a transgender or gender non-conforming patient requests to be assigned to a room with a roommate of the patient's same gender identity and such a room is available, the request should be honored.
2. If a transgender or gender non-conforming patient requests a private room and there is one available, it should be made available to the patient.
3. If a transgender or gender non-conforming patient does not indicate a rooming preference and a private room is available, the private room should be offered to the transgender patient. The offer should be explained to the patient as optional and for the purpose of ensuring the patient's privacy, safety and comfort.
4. If a private room is not available and the transgender or gender non-conforming patient does not wish to share a room with a roommate, the transgender patient should be assigned to an empty double room with the second bed blocked.
5. If there is no private room or empty double room available, the patient should be assigned to a room with a patient of the gender with which the patient identifies.
6. If there is no private or empty double room available and a transgender or gender non-conforming patient does not wish to share a room with other patients, the patient may be moved to make a private room available if doing so would not compromise the health or safety of the patient(s) being moved.
7. If there is no private or empty double room available for admission, and the transgender or gender non-conforming patient refuses to share a room and no other patient can safely be moved to make a private room available, the patient should be allowed to remain in the Emergency Department or ambulatory clinic area until a private room becomes available. NOTE: for IPU only, consider seclusion room as an option.
8. Psychiatric adolescent transgender or gender non-conforming patients will be assigned a single room and on a case-by-case basis. Regarding the rooming of a patient in a female wing or a male wing of a psychiatric ward, psychiatric and nursing leadership will consider and assess the intellectual and emotional safety of the trans youth in question and place the youth in the wing most appropriate. Affirmative consideration must be provided to the patient in order to promote trust, cooperation and a therapeutic milieu.

Complaints from another patient related to a roommate's gender identity or expression do not constitute grounds for an exception to this room assignment protocol, as would be the case for other patients protected by nondiscrimination policy, standards and/or law. Should hospital staff receive such complaints, they should remedy the situation by using curtains or other room dividers to increase the privacy of both patients. A patient making ongoing complaints should be moved to another room as long as relocating the patient would be medically appropriate and safe.

Should a transgender or gender non-conforming patient complain that their roommate is subjecting him or her

to harassment based on the patient's gender identity or expression, a hospital administrator or Patient Relations personnel (preferably trained in cultural competency) should intervene and relocate the roommate if medically safe and appropriate. If the roommate cannot be relocated, the transgender patient should be moved.

Access to Personal Items that Assist Gender Presentation

Transgender and gender-nonconforming patients may have access to personal items that facilitate gender expression (e.g. clothing, makeup) to the same extent that other patients have access to these items, regardless of gender. In addition, transgender and gender-nonconforming patients may also have access to their personal items that assist in their gender presentation, such as those used in binding, padding and tucking (these accessories may be brought from home if not available through hospital supply).

Access to Restrooms

All patients of the hospital may use the restroom that matches their gender identity, regardless of whether they are making a gender transition or appear to be gender non-conforming. Transgender and gender non-conforming patients shall not be required to show identifying documentation in order to gain access to the restroom that corresponds to their gender identity.

Access to Hormone Therapy

The purpose is to ensure that hormone therapy will be provided for transgender patients in a manner consistent with the prevailing standard of care.

Transgender patients that have been receiving hormone therapy prior to admission should have that therapy continued without interruption pending evaluation by a specialist absent urgent medical reasons to the contrary. Health care providers unfamiliar with this aspect of care will consult with providers who have this expertise as well with the patient's prescribing physician if possible.

Explanation – The use of estrogens in individuals assigned male at birth and androgens in individuals assigned female at birth to induce and maintain the physical and psychological characteristics of the sex that matches the individual's gender identity can be a critical and effective treatment for gender dysphoria. Not all transgender people require hormone therapy, but if a transgender patient is admitted to a hospital and is currently taking hormones, that treatment should not stop unless there is a medical indication to do so. Abruptly stopping hormone therapy may result in negative physical and psychological consequences (3).

REFERENCES:

1. The Gender Nondiscrimination Act, California State Law (2012).
2. Diagnostic and Statistical Manual of Mental Disorders, 5th Ed., 2013
3. University of California, San Francisco, Center of Excellence for Transgender Health, Hormone Administration http://www.transhealth.ucsf.edu/trans?page=protocol-hormones.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & Medicine	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/26/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/26/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/26/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Administration - Medical Staff*
References:	

102.015 Medical Staff Code of Conduct

POLICY:

It is the policy that any offensive and/or unprofessional personal behavior by any member of the Medical Staff will not be tolerated. All members of the Medical Staff must treat all persons with courtesy, dignity, and respect and conduct themselves in a professional and cooperative manner. This policy also applies to behavior directed toward any individual associated with the Hospital, including employees, other members of the Medical Staff, colleagues, associates, volunteers, students, patients, families, visitors and others.

This policy outlines collegial and educational activities to be used by Medical Staff leaders to address conduct that does not meet this standard. The objective of these activities is to resolve concerns that have been raised through implementation of appropriate voluntary, responsive actions by the individual violating this policy. If necessary, violations of this policy may result in proceedings through the disciplinary process as outlined in the Medical Staff Bylaws.

In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. However, in the course of carrying out this policy, Medical Staff leaders and Hospital staff will conduct all activities in a manner designed to assure that all rights and privileges of the individual(s) affected are preserved. The rights and privileges are those spelled out in applicable laws and regulations, the Medical Staff Bylaws, Rules, and applicable policies and procedures of the Medical Staff and Hospital.

PROCEDURE:

DEFINITIONS OF INAPPROPRIATE CONDUCT

1. To aid in clarifying the intent and in the enforcement of this policy the following definitions and examples of inappropriate conduct are provided. This list is provided for purposes of illustration. It is not intended to be exhaustive. Medical Staff leaders and Hospital executive staff are responsible for evaluating all reports of behavior that potentially fall within the scope of this policy and for taking appropriate action.
    a. "Appropriate Behavior" includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the Medical Staff, or to engage in professional practice including practice that may be in competition with the Hospital. Appropriate behavior is not subject to discipline under the Medical Staff Bylaws.
    b. "Inappropriate Behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of

harassment and thereby become disruptive, and subject to treatment as "disruptive behavior." Examples of inappropriate behavior include, but are not limited to, the following:

i. Making medical record entries that are inappropriate or inaccurate, that are critical of the quality of care being provided by other members of the Medical Staff or by Hospital employees, or making entries when no care, treatment or services were rendered;

ii. Failure or refusal to comply with Medical Staff or Hospital requirements set forth in the Medical Staff Bylaws, Rules, and applicable policies. Examples of such failures or refusals include, but are not limited to:

1. Refusing to return telephone calls from the facility staff;.
2. Refusal to communicate with responsible persons, or incomplete or ambiguous communications;
3. Refusing on-call assignment or attending to patients, or repeatedly abusing or ignoring scheduling policies, or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in or hurrying of patient care services being rendered to any patient of the facility;
4. Refusing to participate in Medical Staff obligations, as well as quality and Medical Staff leadership assignments;
5. Refusing to provide information or otherwise cooperate in the peer review process (e.g., refusing to meet with responsible committee members or refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the facility);
6. Refusing to provide information necessary to process the facility's or a patient's paperwork; or
7. Violating confidentiality rules (e.g. by inappropriately disclosing confidential peer review information).

iii. Physical contact such as shoving or striking another person that is intended to threaten, intimidate, or harm;

iv. Use of "Inappropriate Language," such as:

1. Making threatening or berating statements;
2. Name-calling, degrading, demeaning, or belittling comments;
3. Using profanity or similarly disrespectful or offensive language while in the Hospital or any of its service locations or licensed space, and/or while speaking with patients, family members or significant others of patients, Hospital staff, volunteers, students or other physicians; or
4. Negative comments regarding the quality of care being provided, the clinical judgment or professional qualifications of other Medical Staff members, or the clinical judgment or professional qualifications of Hospital employees made outside the Medical Staff or Hospital quality management program.
5. *Intentional and persistent failure to use gender pronouns corresponding to the gender identity with which a colleague or patient identifies will not be tolerated.*

c. "Disruptive Behavior" refers to any abusive conduct including sexual or other forms of harassment, other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality

of care or patient safety could be compromised, or any other form of unprofessional conduct reasonably deemed to be disruptive or negatively impactful to patient care and Hospital operations.

d. "Harassment" includes:

   i. Engaging in conduct toward others based on but not limited to their race, religious creed, color, national origin, physical or mental disability, marital status, sex, age, sexual orientation, or veteran status; which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

   ii. Engaging in behavior that constitutes sexual harassment or sexual misconduct. Specific examples of such behaviors include, but are not limited to, the following:

      1. Making sexually suggestive advances, comments, sounds or gestures;
      2. Making sexually graphic commentaries or telling lewd jokes;
      3. Displaying sexually suggestive objects or pictures;
      4. Unwanted physical contact or requesting of sexual favors;
      5. Unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile work environment
      6. Making derogatory comments about an individual or group based on age, sex, sexual orientation, race or ethnic origin;
      7. Verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; or
      8. Threatening harm or other retaliation in response to an individual's negative response to sexual harassment or hostile behavior.

GENERAL GUIDELINES

1. Issues of conduct by members of the Medical Staff will be addressed in accordance with this policy. Issues of employee conduct will be dealt with in accordance with the Health Care Agency's Human Resources policy. As deemed necessary, Medical Staff leadership may collaborate with Hospital leadership to address issues of conduct.
2. This policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken in an attempt to resolve complaints about inappropriate conduct exhibited by practitioners. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and requires initiation of immediate corrective action in accordance with the Medical Staff Bylaws. Nothing in this policy precludes immediate referral to the Executive Committee or the elimination of any particular step in the Policy when dealing with a complaint about inappropriate conduct.
3. The Medical Staff leadership and Health Care Agency Administration shall provide orientation and education to make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy. The Medical Staff Leadership and Health Care Agency Administration shall facilitate prompt reporting of conduct which may violate this Policy and prompt action as appropriate under the circumstances.

REPORTING PROCEDURE

1. Any person may report potentially disruptive conduct on the Hospital, Ambulatory Care or Behavioral Health Notification Form or in accordance with the Medical Staff and Hospital's usual reporting procedures (e.g. to the Department Chair, Clinical Director, Chief Medical Officer, Medical Executive Committee, Confidential Telephone Reporting Line, Hospital Patient Advocate, or Hospital administration). The Medical Staff Office or other appropriate recipient of such a report shall submit a written copy of the report to the Chief of Staff and/or Chief Medical Officer for assessment.

DOCUMENTATION

1. The Chief of Staff and Chief Medical Officer, or designated committee, shall ensure that appropriate documentation of each incident of disruptive conduct is acquired in order to facilitate the assessment process. Such documentation should include:
    a. Date, time and location of the reported questionable behavior;
    b. A factual description of the reported questionable behavior;
    c. The name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
    d. The circumstances that precipitated the incident;
    e. The names of other witnesses to the incident;
    f. Consequences, if any, of the behavior as it relates to patient care, personnel or hospital operations;
    g. Any action taken to intervene in, or remedy, the incident; and
    h. Name and signature of the individual reporting the complaint of inappropriate conduct.

RESPONDING TO REPORTS

Upon receipt of the report of disruptive conduct the following shall occur:

1. Initial Assessment:
    a. The Chief of Staff and Chief Medical Officer shall conduct an initial assessment for each matter reported; alternatively, they may agree to delegate the initial assessment and any action to an appropriate committee.
    b. If the report of inappropriate conduct is anonymous, then, the Chief of Staff and Chief Medical Officer, or designated committee, may exercise discretion as to whether or not to assess the matter.
    c. Through the initial assessment, the Chief of Staff and Chief Medical Officer, or designee, will determine the authenticity and severity of the report. The initial assessment shall be maintained in the member's Medical Staff file with the original report.
    d. Any retaliation against the reporting person, whether the identity is disclosed or not, will be grounds for immediate disciplinary action pursuant to the Medical Staff Bylaws.
2. Actions:
    a. A single, confirmed incident will generally warrant a discussion with the offending practitioner. The Chief of Staff, Chief Medical Officer, or designee shall initiate such discussion and emphasize that such conduct is inappropriate and must cease. The initial meeting should be an attempt to be

educational and helpful to the practitioner. However, there may be certain incidents of misconduct so unacceptable that may warrant initiation of immediate action, including referral to the Medical Executive Committee, and/or summary suspension, as prescribed in the Medical Staff Bylaws.

b. Medical Staff members who are the subject of a report shall be provided a summary of the report and a copy of this Policy in a timely fashion. The subject shall be offered an opportunity to provide a written response to the report, and any such response will be kept in the member's Medical Staff file.

c. After an initial meeting, follow-up meetings may be held or a referral to the Well Being Committee may be made as deemed appropriate by the Chief of Staff, Chief Medical Officer or designee.

d. If it becomes apparent that the actions may represent a pattern of disruptive behavior or if the single incident was sufficiently egregious, the Chief of Staff and Chief Medical Officer, or designee, shall document a plan for addressing the disruptive behavior. The copy of the plan shall be included in the individual's Medical Staff file.

e. As part of the plan to address a member's disruptive behavior, the following actions may be undertaken:

    i. The Chief of Staff and Chief Medical Officer, or designee, may send a letter to the offending individual that describes the inappropriate conduct, explains that the behavior is in violation of the Medical Staff Bylaws and this Policy, and notes any patient care or hospital operations implications, explains why the behavior in question is inappropriate, encourages the individual to be more thoughtful or careful in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of the relevant sections from the Medical Staff Bylaws and this Policy should be included with the letter. Documentation of both the letter and the individual's response should be included in the individual's Medical Staff file.

    ii. The Chief of Staff and Chief Medical Officer or the designated committee, and any other number of appropriate participants from the Medical Staff and Governing Body, may initiate a discussion with the offending individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. A copy of the Medical Staff Bylaws and this Policy, may be delivered to the offending individual and he or she should be advised that the Medical Staff requires compliance with the Medical Staff Bylaws. Each individual or a designated member of a group, (if the group meets with the offending individual), should send a follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform. The offending individual should be invited to respond. This letter and any response will also be included in the individual's Medical Staff file.

f. The plan may incorporate additional components, including, but not limited to:

    i. Warning the offending individual that failure to abide by the terms of the Medical Staff Bylaws and this Policy shall be grounds for disciplinary action including, but not limited to, suspension and/or termination of Medical Staff membership.

    ii. Requiring the offending individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait (i.e., anger management), or requiring the offending individual to sign a behavior modification contract. The Chief of Staff, Chief Medical Officer or designee shall document any corrective action and require the offending individual to sign his or her acceptance of this plan. The plan may clearly delineate the

consequences for the offending individual not successfully completing the agreed upon corrective action.

iii. Referring the matter to the Medical Executive Committee for review and action. The Medical Executive Committee shall be apprised of the previous warnings issued to the practitioner and actions taken to address the concerns and may suggest a course of action. The Medical Executive Committee may adopt the suggested course of action or proceed with further investigation or corrective action pursuant to the Medical Staff Bylaws.

iv. In appropriate circumstances, the suggested courses of action may include a recommendation for immediate suspension and/or termination of Medical Staff membership without need of further warning or counseling.

g. Final Warning:

i. If the Chief of Staff, Chief Medical Officer, or designee determines that the plan has been unsuccessful, the Medical Executive Committee shall be informed in writing of the offending individual's disruptive behavior, including any relevant history regarding this behavior, and advise the Medical Executive Committee to proceed with a final warning.

ii. If the Medical Executive Committee determines that the offending individual deserves a final warning, the Chief of Staff, Chief Medical Officer, or designee shall meet with and advise the offending individual that the disruptive behavior in question is intolerable and must stop.

iii. The Chief of Staff, Chief Medical Officer, or designee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership. This meeting shall not be a discussion, but rather will constitute the offending individual's final warning. The offender will also receive a follow-up letter that reiterates the final warning and the consequence of suspension and possible termination of Medical Staff membership and privileges.

iv. If after the final warning the offending individual engages in disruptive behavior that is deemed to require intervention, the individual's Medical Staff membership and privileges shall be subject to suspension consistent with the terms of the Medical Staff Bylaws and policies and procedures. Additional action may also be taken at this time. Action may be taken to revoke the individual's membership and privileges. The individual may also be found ineligible to reapply to the Medical Staff for a period of at least two years.

All revision dates: 7/13/2023, 3/24/2022, 4/1/2016, 12/1/2013, 4/1/2012, 12/1/2008

Attachments

No Attachments

Approval Signatures

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

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	2/5/2024
Policy Owner	Todd Flosi, MD: Associate Chief Medical Officer, VCMC & SPH	1/18/2024

Status **Pending** PolicyStat ID **14829410**

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Owner	Alicia Casapao: Director of Quality and Performance Improvement
Policy Area	Administrative - Operating Policies

107.027 Quality Assessment and Performance Improvement Plan

POLICY:

The Quality Assessment & Performance Improvement (QAPI) Plan is a description of the efforts that are directed towards ensuring the consistent delivery of safe, quality, service-focused, effective health care for the patients we serve at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and in the licensed hospital, Ambulatory Care (AC) clinics.

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

The intent of the plan is the improvement of key clinical, support and managerial processes that are most important to the health and safety of our patients. Equally important, is our belief that each patient is entitled to quality health care and that every employee is individually obliged to contribute toward the improvement of patient care and safety. To fulfill this obligation, a plan has been developed and the organization shall nurture an environment that is supportive of excellence and learning, and one that is conducive to positive change.

GOALS AND OBJECTIVES:

In an effort to improve performance in clinical processes and outcomes, as well as to sustain performance, once it is improved, the primary goal of the QAPI Plan is to provide a comprehensive performance improvement program that will coordinate and integrate performance improvement

activities across VCMC/SPH and the AC clinics. The approach to performance improvement is the continuous assessment and revision, when required to meet the goal of ensuring that patient outcomes are continually improved and that safe care is provided.

The objectives of the QAPI Plan include, but are not limited to:

1. Establish priorities for review, investigation and implementation of changes. Special consideration will be given to processes with the greatest impact on patient outcomes and those that are of the highest risk to patients.
2. Improve processes utilizing established performance improvement tools and techniques, as well as systems thinking.
3. Maintain a framework for improving performance that includes activities focusing on process design and redesign, while measuring, assessing and improving performance.
4. Identify, assess and implement corrective action plans for urgent situations requiring immediate action, such as processes that involve risks, have the potential for medical error, or may result in patient harm.
5. Conduct intensive analysis when significant undesirable performance is detected or suspected.
6. Ensure that accurate, valid data is available to monitor performance, and is used to identify opportunities for change.
7. Collect data designed to monitor the stability of existing processes, identify opportunities and changes that will lead to improvement, and document areas of sustained improvement.
8. Communicate outcomes of reviews and corrective action plans, to facilitate change.
9. Conduct ongoing and systematic assessment and documentation of hospital-wide issues, which have a direct or indirect impact on patient care.
10. Coordinate medical staff quality improvement activities with others within the organization, and integrate efforts whenever appropriate.
11. Maintain compliance with regulatory standards, which include those outlined in the Conditions of Participation (CoPs), via the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the California Department of Public Health (CDPH): Title XXII.
12. Monitor, trend, communicate and implement interventions to improve the patient's perceptions of care that they received, while hospitalized.

Areas to consider when fostering a culture of improvement includes reducing factors known to contribute to adverse events and poor outcomes. These factors are often predicated on poorly designed systems, unanticipated system failures and failures in processes.

Opportunities to minimize these factors include, but are not limited to:

1. Recognizing and minimizing risks and/or processes that may lead to adverse events.
2. Communication regarding adverse events, in an effort to reduce future events and develop specific process change, to ensure similar events do not reoccur.
3. Focusing on processes and systems while continuing to hold individuals accountable for their personal responsibilities, which includes fostering an environment that supports the principles

of a “Just Culture.”

4. Exploring processes, tasks, equipment and other factors that may have contributed to adverse events.
5. Agreeing that standardized processes will lead to predictable outcomes and that aspiring to become a highly reliable organization requires a deference to operational experience and a predisposition with the fact that failure may occur.

THE PERFORMANCE IMPROVEMENT COORDINATING COUNCIL (PICC):

The Performance Improvement Coordinating Council (PICC) functions as the quality improvement committee for the hospitals and provides a forum for performance improvement (PI) activities, with primary responsibility for the quality assessment and performance improvement (QAPI) programs within the organization, including those related to regulatory compliance.

The PICC membership includes, but is not limited to:

1. Executive leadership
2. Representatives of medical staff
3. Departmental directors and managers and other members of the health care team.

   Every leader and department participates in PI and safety efforts, with the intent of fostering departmental leadership and encouraging staff participation.

The PICC meets no less than 4 times each year, to monitor improvement activities and review quality metrics, in order to identify and prioritize improvement activities. Each meeting includes a review of current and proposed activities within the organization, along with analysis of data, to demonstrate the extent that these activities were successful, in achieving the intended outcomes.

The patient and family are the primary focus of every QAPI activity. The QAPI team shares the task of performance improvement with everyone who works at VCMC/SPH and the AC clinics. The QAPI team operates under a set of guiding principles, which include:

1. Ensuring that data is timely, relevant and valid.
2. Performance improvement efforts are visible throughout the organization.
3. Collaboration, in order to drive efforts to optimize patient outcomes and improve processes, which are the foundation of all QAPI activities and efforts.
4. Serving as subject matter experts who collaborate with others, in order to continually improve patient safety and serve as performance improvement mentors.
5. Ensuring that evidence-based principles of performance improvement are applied to improvement teams, processes and efforts.

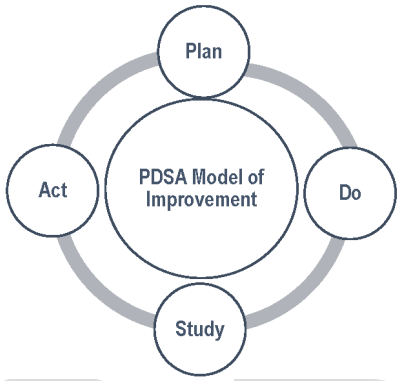
METHODOLOGY AND MODEL OF IMPROVEMENT:

Performance Improvement (PI) methodologies, tools and strategies are integrated into activities to

improve patient outcomes.

The **Plan, Do, Study, Act (PDSA)** is the primary methodology used within the organization:

- **P**lan the improvement and continued data collection
- **D**o Improvement, data collection and analysis
- **S**tudy the results
- **A**ct to correct identified problem areas or improve performance.



Plan

Performance improvement projects are designed or redesigned to monitor expected performance. Projects are developed to measure, assess, improve and maintain process improvements.

Performance goals are established through comparison with other “like” facilities, and benchmarking with national and regional results. Comparative data from the NHSN, CMS, TJC or current/past department performance is utilized as well..

Do

Data collection is the basis of all performance improvement activities and provides a means of measuring performance, through which informed decisions can be made.

Study

Activities are assessed, reviewed and trended, to determine if process changes, interventions, or policies need to be created or revised. Changes that may need to occur may appear as:

1. System(s): Changes in communication channels, changes in organizational structure, adjustments in staffing and changes in equipment or documentation;
2. Knowledge Enhancement: In-service education, continuing education and circulating informational material;
3. Intensive Reviews/Focus Studies: When a medical/health care system, error-related occurrence is identified; proactive risk assessment activities are implemented, including intensive review and/or a focused study. A data collection tool is developed to address processes, functions, and services that can be designed or redesigned to prevent trends that

may have contributed to the problem. Once all charts are reviewed, a summary report is compiled to report conclusions.

4. Root Cause Analysis: An event where a medical/health care error is established as a near miss, a causal analysis is completed to determine the underlying causes of the potential variation and the outline action plan is implemented.
5. Policy Revisions: Policies are developed or revised for significant organizational issues that are either interdepartmental or mandated to be hospital-wide, by accreditation agencies or state/ federal legislation.
6. Proactive Risk Assessment/Failure Mode Effects Analysis: A Proactive Risk Assessment which is commonly referred to as a Failure Mode Effects Analysis (FMEA), will be conducted at least once every 18 months on one high-risk, high/low volume or "error prone" process. Once potential issues have been identified, the organization will establish processes to improve performance and measures to provide follow-up to ensure that improvement is maintained and that the information learned is communicated.

Act

When opportunities for improving performance are identified, a systematic approach is utilized to redesign the involved process, or to design a new process. When a department or service identifies an opportunity for improvement, the department/service will determine if other disciplines or departments will have an impact on the design/redesign of the process. If other disciplines or departments are involved, the opportunity for improvement will be referred to the appropriate department.

The approach to improving performance at VCMC/SPH and the AC clinics is based upon the following three questions:

1. What are we trying to accomplish?
2. What change can we make that will result in improvement?
3. How will we know that a change is an improvement?

Once those questions are answered, VCMC/SPH and the AC clinics examine "best practice" models that can be adopted and implemented. Results are monitored, rapid cycle changes are made, as indicated, and monitoring continues. The performance improvement model provides:

1. A systematic method for the design of a process.
2. Measurement of the level of performance and stability of important processes.
3. Assessment of the dimensions of performance, as relevant to functions, processes and outcomes.
4. Development of a plan for improvement.
5. Implementation of the outcomes.
6. Evaluation for additional opportunities for improvement.

Data Collection:

Each clinical professional discipline (hospital staff and medical staff) participate in the review of patient

care/ services it provides. Results and/or findings and actions are reported through the defined reporting structure.

Information obtained through the performance improvement review are, when indicated, a cause for action and a resource for educational programs with the objective of benefiting the patients, staff, hospital and the community.

Sources of data for PI review activities include, but are not limited to:

1. Review of data related to patient safety events;
2. Performance measures related to accreditation and regulatory agencies, as well as other acceptable databases;
3. Patient throughput;
4. Outcomes measures;
5. Morbidity/mortality review findings;
6. Monitoring activities of the medical staff and hospital departments or committees;
7. Risk management findings;
8. Infection control review: surveillance, prevention, and reporting;
9. Medication use review;
10. Laboratory activities, including blood utilization and autopsy results;
11. Organ procurement activities, including conversion rates;
12. Utilization management review;
13. Staffing effectiveness;
14. Patient and staff satisfaction surveys;
15. Externally generated data received by the hospital;
16. Customer demographics and diagnoses;
17. Information management and medical record reviews;
18. Department specific indicators and PI team activities.
19. Guidance/direction from regulatory agencies, ie., TJC, CMS, CDPH, etc.

Performance measurement data will be collected, aggregated and analyzed, to determine if opportunities are identified, to improve safety and reduce risk. If performance improvement opportunities exist, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified. The data will be utilized to:

1. Assess the intended and actual implementation of the process, to identify the steps in the process where there is, or may be undesirable variation.
2. Identify the possible effects on patients, and how serious those effects could be (criticality of the effect) for each undesirable variation.

3. Conduct a Root Cause Analysis (RCA) for the most critical effects, to determine why the variation led to that result.
4. Redesign the process and/or underlying systems to minimize the risk of that variation, or to protect patients from the effects of that variation.
5. Test and implement the redesigned process.
6. Identify and implement measures for the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.
8. When processes, functions or services are designed or redesigned, patient safety will be considered as part of the planning and implementation process.
9. Opportunities to reduce errors, which reflect the performance of the individual care provider, are addressed as appropriate, through the Medical Staff Peer Review process or through the organization's Human Resource policy(s).

Examples of data collected and employed interventions, to improve related outcomes (not limited to):

1. Operative or other procedures that place patients at disability or death;
2. Discrepancies between pre and post-operative diagnosis;
3. Events associated with sedation;
4. Administration of blood and blood components;
5. Transfusion reactions;
6. Resuscitation efforts;
7. Medication errors;
8. Adverse drug events;
9. Patient thermal injuries;
10. Incidents or injuries related to ferromagnetic objects in the magnetic resonance imaging (MRI) scanner room.

In order to reduce the likelihood of patient incidents and negative outcomes, VCMC/SPH and the licensed AC clinics shall track the frequency and type of medical errors and compile them, in order to learn from and prevent future negative occurrences.

The Information Technology (IT) Department provides hardware and software support for the performance improvement activities of VCMC/SPH and the AC clinics. Data sources include, but are not limited to the following:

Internal Sources

1. Incident Reports from Notification System;
2. Adverse Drug Events and Adverse Drug Reactions;
3. Data from Patient Complaints;
4. Risk Management and Safety Findings;

5. Compliance Findings;
6. QAPI and special study findings i.e. tracer audits centered around areas such as high-level disinfection practices, ligature risk assessments and sterile compounding processes;
7. Infectious Disease Information;
8. Operative/Invasive Procedure, Blood Use, Autopsy, Restraint Reviews;
9. Morbidity/Mortality Review Findings;
10. Departmental Indicators;
11. Staff Surveys (includes perception of risk).

External Sources

1. The Joint Commission (TJC) accreditation standards, TJC Sentinel Event Alerts and TJC FAQs as well as communication related to the National Patient Safety Goals;
2. Core Measures Indicators;
3. Accreditation / Regulatory Deficiencies;
4. Patient Satisfaction Surveys;
5. Other Evidence-Based external sources.

Regulatory Reporting

The VCMC/SPH and the hospital clinics collects, reports and analyzes data for submission to the Centers for Medicare & Medicaid Services (CMS) as well to a variety of other regulatory entities. Data submission includes, but is not limited to:

1. Inpatient Quality Reporting (IQR);
2. Meaningful Use (MU);
3. Electronic Clinical Quality Measures (e-CQM);
4. Hospital Acquired Conditions (HACs);
5. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

Additional Program Activity

Improvement activities may be conducted in partnership with other improvement programs. Every improvement project is driven by measurable performance indicators. Relevant systems and sources of data inform the measurement of improvement. Evidence-based guidelines and current clinical literature provide information to guide improvement focus and measurement. Teams with operational and clinical representation design interventions to achieve targeted outcomes.

Authority, Accountability and Responsibility

The Oversight Committee has the ultimate responsibility for assuring the quality and effectiveness of patient care services provided by VCMC, SPH and the AC clinics. The Oversight Committee holds the medical staff leadership and hospital administration responsible for the establishment and maintenance of an effective Performance Improvement (PI) program. This includes maintenance of safe and effective

care, the provision of PI management, planning PI activities and development of PI policies when indicated. The Oversight Committee has responsibility, either directly or through delegation, for the assessment and recommendations regarding the program's efficiency and effectiveness. The Oversight Committee is provided performance improvement updates on a quarterly basis and/or more frequently as indicated by a regulatory agency's activities.

The Chief Operating Officer (COO) has oversight for Performance Improvement, Quality Assessment and Patient Safety. The COO reports to the Chief Executive Officer (CEO)/Administrator who in turn reports to the Ventura County Health Care Agency Director. The CCO is responsible for the QAPI Department and will provide reports to the Medical Executive Committee and to the Oversight Committee.

Performance Improvement activities are the responsibility of every department and every employee within the organization. In an effort to minimize patient harm, maximize clinical outcomes and sustain improvement momentum, the QAPI Department is responsible for coordinating, communicating, integrating and disseminating performance improvement activities within the organization and to ensure that regulatory compliance is maintained.

Medical Staff

The Medical Staff, through the Medical Executive Committee (MEC), has the responsibility for medical care rendered at VCMC/SPH and the licensed hospital clinics. The Medical Staff departments meet as designated in their rules and regulations to evaluate process and outcomes data. The Department Chair is responsible for reporting, monitoring and evaluating the outcomes and processes of performance improvement activities for the department. Outcomes and processes are reported up to the MEC and to the Oversight Committee as appropriate. The Medical Staff Rules and Regulations describe the scope of Medical Staff departments.

Each service or department develops a performance improvement plan specific to that department and selects or recommends improvement actions. Each department utilizes the pattern of care demonstrated by the results of the performance improvement monitoring and evaluation activities, as criteria for evaluating competence of licensed independent practitioners and allied health professionals. These activities include, but are not limited to, patient care review, generic screening case review, utilization review, infection control review, operative and other invasive/non-invasive procedure review, medical record review, blood and blood component review, medication use review and risk management review.

All information gathered is considered confidential and, as part of the medical staff records, is protected under California Evidence Code 1157. When the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in ongoing professional practice evaluation, focused professional practice evaluation, peer review and/or any other periodic evaluations of licensed independent practitioner's competence.

Plan Evaluation

On an annual basis, or more frequently as indicated, the QAPI Plan will be reviewed, evaluated and revised to incorporate the most current TJC, CMS and CDPH regulatory standards. The review will assess the objectives, scope, organizational effectiveness and appropriateness of the program. The plan will be

modified as needed, based on the results of the evaluation or more frequently if indicated. Individual committees and departments will review, evaluate and revise their performance improvement activities which may be re-prioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, or based upon expectations and needs of patients, staff, or the community. Priorities may be reset by the multidisciplinary Performance Improvement Coordinating Council (PICC) Committee in consultation with senior management, the MEC and/or the Oversight Committee.

Confidentiality

The Ventura County Health Care Agency (VCHCA) ensures the privacy and confidentiality of patient records and other protected information. All information generated within or as a result of the Quality and Performance Improvement Program and all peer review discussions and records are confidential and protected by California Evidence Code §1157.

Patient records and information are safeguarded and protected. Health information is shared in accordance with state and federal laws, statutes and guidelines. VCMC/SPH and AC clinics strive to ensure effective coordination of care with other providers and participates in efforts to legally and appropriately share information with partnering organizations to support integrated, patient-centered care for each person as a whole.

Persons receiving health care services have a right to expect that the confidentiality and privacy of individually identifiable medical information of or derived by health service providers will be reasonably preserved. The VCHCA complies with the Confidentiality of Medical Information Act (1982) and releases information pursuant to HIPAA, Lanterman-Petris-Short Act, Title 22, and other applicable state and federal guidelines, statues and laws.

Policies that ensure privacy and confidentiality and appropriate release of medical records include:

1. An Oath of Confidentiality must be signed by all employees as a condition of employment.
2. Proper logging and control of patient records.
3. Controlled access to electronic medical information.
4. Regular security risk analysis to identify and mitigate risks.

APPENDICES:

1. Appendix A - Quality Assessment & Performance Improvement Plan Measures and Metrics 2019-2020

All Revision Dates

1/10/2023, 11/10/2021, 4/17/2020, 8/1/2015, 9/1/2013, 10/1/2011, 1/1/2011, 5/1/2006, 1/1/2005, 1/1/2004

Attachments

107.027 Appendix A - Quality Assessment & Performance Improvement Plan Measures and Metrics 2023.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration - CMO	Minako Watabe: Chief Medical Officer, VCMC & SPH	Pending
Quality Assessment & Performance Improvement	Alicia Casapao: Director of Quality and Performance Improvement	3/5/2024

VENTURA COUNTY MEDICAL CENTER & SANTA PAULA HOSPITAL
Department Based Performance Measure Summary Matrix
January - December 2024

Department / Performance Measure	Rationale for Measurement			Measurement Purpose		Data Size		Data Frequency			Data Source	Individual Responsible for Collection & Analysis	Reporting Due Dates & Location
	Volume / Risk / Identified Concern	Regulatory Requirement	Organizational Initiative	Stable Process Standard Maintenance	New Process Unstable Process (Variable)	Sample (Number or Percentage)	100%	Monthly	Quarterly	Other			
ORGANIZATIONAL MEASURES													
Team Building			X		X	80%				Bi-annual	Patient Safety Culture Survey	QAPI	
Universal Precautions Being Used			X	X						Weekly	Patient Safety Rounds	Individual Department Manager	PICC & Patient Safety Cmte.
Medical Errors and Adverse Events		X		X						As Reported	Notifications	Regulatory Manager	PICC & Patient Safety Cmte.
Hospital Readmission Rate		X		X				X			Census Data	QAPI	KPI
Hospital Acquired Conditions		X		X					X		Cerner Chart Review	QAPI	PICC & Patient Safety Cmte.
Joint Commission Core Measures		X		X					X		Cerner Chart Review	QAPI	PICC & Patient Safety Cmte.
Joint Commission eCQM Measures		X		X					X		Cerner Chart Review	QAPI	PICC & Patient Safety Cmte.
HCAHPS Survey		X	X	X		< 5% of Patient Population			X		NRC	QAPI	PICC & Patient Safety Cmte.
GACH and CDPH Ad Hoc		X		X		At Least 30 Records		X			Cerner Chart Review	QAPI	PICC & Patient Safety Cmte.
Number and Type of Notifications	X			X			X		X		Notifications	Regulatory Manager	PICC & Patient Safety Cmte.
Findings and Process Improvement Interventions Related to Event Analysis and RCAs	X			X			X		X		Event Analysis and RCAs	QAPI	PICC & Patient Safety Cmte.
Number and Classification of Grievances	X			X			X		X		Grievances	Regulatory Manager	PICC & Patient Safety Cmte.
Patient Flow Throughout the Hospital		X		X			X	X			Cerner Chart Review	QAPI	Throughput Cmte.
Influenza Reporting Compliance and Immunization Rate		X		X			X			Seasonal	Cerner Chart Review	Infection Control Manager	Infection Control Cmte.
Occupational illness and injuries	X	X		X			X		X		Notifications, Employee Injury Reports	Regulatory Manager	PICC & Patient Safety Cmte.
TRAUMA													
ACS POC Compliance	X	X			X	X		X*		*M to Q to A	Cerner Chart Review	Trauma Program Manager (TPM)	Trauma Cmte. PICC & Pt. Safety
Trauma Dashboard	X				X		X		X		Trauma forms	TPM//PI Coordinator	Trauma Cmte. PICC & Pt. Safety
STROKE													
Get With the Guidelines Compliance	X				X		X	X				Stroke Coordinator	Stroke Cmte. PICC & Pt. Safety
Decrease door to intervention times for CT start, CT results, t-PA bolus and infusion, and transfer to another acute care facility.	X				X		X	X				Stroke Coordinator	Stroke Cmte. PICC & Pt. Safety
CLINICAL AND ANCILLARY DEPARTMENTS													
NPSG: Improve the accuracy of patient identification.			X		X					As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
NPSG: Improve the effectiveness of communication among caregivers.			X		X					As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
NPSG: Improve the safety of using medications			X		X					As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
30	NPSG: Reduce patient harm associated with clinical alarm systems			X	X						As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
31	NPSG: Reduce the risk of health care associated infections			X	X						As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
32	NPSG: Identify risk inherent in the patient population.			X	X						As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
33	Number and Location of Cardiac Arrests		X		X			X		X		Cerner Chart Review	Code Blue Chairperson	Code Blue Cmte.
34	Outcomes of Cardiac Arrest Resuscitation		X		X			X		X		Cerner Chart Review	Code Blue Chairperson	Code Blue Cmte.
35	Number and Location of Rapid Responses		X		X			X		X		Cerner Chart Review	Code Blue Chairperson	Code Blue Cmte.
36	Outcomes of Rapid Responses		X		X			X		X		Cerner Chart Review	Code Blue Chairperson	Code Blue Cmte.
37	Crash Carts Checked and Secure										Weekly	Patient Safety Rounds	Departmental Manager	PICC & Patient Safety Cmte.
38	Adverse Events Involving Moderate Sedation	X	X		X			X			As Reported	Notifications	Departmental Manager	PICC & Patient Safety Cmte.
39	Pain Assessment and Pain Management, Including Interventions and Effectiveness	X	X			X	X 30 records per month per dept.		X			Cerner Chart Review	Departmental Manager	PICC & Patient Safety Cmte.
40	Organ Procurement Conversion Rate		X		X			X		X		One Legacy	Trauma Manager	PICC & Patient Safety Cmte.
41	Infection Control :HAI's MDRO, CAUTI, CLABSI and SSI.	X	X		X			X	X			Cerner Chart Review	Infection Control Manager	PICC & Patient Safety Cmte.
42	Hand Hygiene Compliance	X	X	X	X		X		X			Patient Safety Rounds	Infection Control Manager	PICC & Patient Safety Cmte.
43	Patient information is protected.		X		X		X		X			Patient Safety Rounds	Departmental Manager	PICC & Patient Safety Cmte.
44	Point of care testing equipment is maintained and current.	X	X		X		X		X			Patient Safety Rounds	Departmental Manager	PICC & Patient Safety Cmte.
45	Employee food is not stored with patient food.	X	X		X		X		X			Patient Safety Rounds	Departmental Manager	PICC & Patient Safety Cmte.
46	Oxygen cylinders are stored in appropriate holders.	X	X		X		X		X			Patient Safety Rounds	Departmental Manager	PICC & Patient Safety Cmte.
47	**ADMITTING**													
48	CT Scan Days till Next Appointment (VCMC)	X				X		X	X			Admitting records	Patient Access Manager	KPI Dashboard
49	CT Scan Days till Next Appointment (SPH)	X				X		X	X			Admitting records	Patient Access Manager	KPI Dashboard
50	MRI Days till Next Appointment	X				X		X	X			Admitting records	Patient Access Manager	KPI Dashboard
51	**DIETARY**													
52	Open food is labeled with an expiration date.	X				X	X				Weekly	Patient Safety Rounds	Dietary Supervisor	PICC & Patient Safety
53	Team members have hair contained / covered.	X				X	X				Weekly	Patient Safety Rounds	Dietary Supervisor	PICC & Patient Safety
54	**ENVIROMENTAL SERVICES (EVS)**												EVS Supervisor	
55	Room turnover													
56	**HEALTH INFORMATION MANAGEMENT (HIM)**													
57	Medical History and Physical Exam Completion within 30 Days Prior to Admission or within 24 Hours Following Admission		X			X		X	X				HIM Manager	
58	Medical Record Delinquency Rate		X			X		X	X				HIM Manager	
59	Verbal Orders Authenticated by Physician Within 48 Hours		X			X		X	X				HIM Manager	
60	Discharge Summary Within 48 Hours of Discharge		X			X		X	X				HIM Manager	
61	Operative Reports Within 24 Hours of Procedure Date		X			X		X	X				HIM Manager	
62	Scanning TAT Within 48 Hours of Receipt in HIM	X				X		X	X				HIM Manager	
63	**MAINTENANCE / FACILITIES / BIO MED**													
64	Environment of Care Rounds		X		X		Varies			X		Department submission	Facilities Manager /EOC Chair	EOC Cmte.
65	**LABORATORY (VCMC & SPH)**													
66	Blood Culture Contamination Rate	X				X		X	X			Gayle Haider	Lab Director or Designee	Monthly KPI Dashboard
67	Blood Usage and Use of Blood Components		X		X			X		X		Janette O Neil	Lab Director or Designee	Blood, PICC & Pt. Safety Cmte.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
68	Hemolytic Blood Transfusion Reactions		X		X			X		X		Janette O Neil	Lab Director or Designee	Blood, PICC & Pt. Safety Cmte.
69	Discrepancies Between Pre-Operative and Post-Operative Diagnosis in Pathological Findings		X		X			X		X		Erlinda Roxas	Lab Director or Designee	Surgery, PICC & Pt. Safety Cmte.
70	Turn Around Time (TAT) of Stat Labs	X				X		X	X			Gayle Haider	Lab Director or Designee	PICC & Pt. Safety Cmte.
71	Chemical containers are stored appropriately.	X				X	X				Weekly	Patient Safety Rounds	Lab Director or Designee	PICC & Pt. Safety Cmte.
72	**PHARMACY**													
73	Medication Errors and Adverse Drug Reactions		X		X			X			X	Notifications	Medication Safety Officer	Pharmacy, PICC & Pt. Safety Cmte.
74	The Safe Use of Opioids		X		X			X		X		Pyxis Review, Cerner chart review	Medication Safety Officer	Pharmacy, PICC & Pt. Safety Cmte.
75	Antibiotic Stewardship		X		X			X	X			Physician Orders	Medication Safety Officer	Antibiotic Stewardship
76	**THERAPIES**													
77	Mobility-Discharge Scale													
78	**RADIOLOGY**													
79	Thermal Injuries that Occur During MRI		x		X			X	X			Notification	Radiology Manager	PICC & Pt. Safety Cmte.
80	Incidents of Ferromagnetic Objects Entering the MRI Suite		x		X			X	X			Notification	Radiology Manager	PICC & Pt. Safety Cmte.
81	Injuries Resulting From Ferromagnetic Objects Entering the MRI Suite		x		X			X	X			Notification	Radiology Manager	PICC & Pt. Safety Cmte.
82	Incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols.		x		X			X	X			Physicist Review	Radiology Manager	PICC & Pt. Safety Cmte.
83	TAT ED CT Orders Until Start	x			X			X		X		Discern Report	Radiology Manager	Quarterly Dashboard
84	**RESPIRATORY THERAPY**													
85	TAT ABG's	X			X			X		X		ABG documentation	Cardiopulmonary Manager	Regulatory Dashboard
86	**UTILIZATION REVIEW / SOC. SERVICES / CASE MGMT.**												Utilization Review Manager	
87	SBIRT													
88	**NURSING – EMERGENCY DEPARTMENT (VCMC &SPH)**													
89	ED Left Without Being Seen-VCMC		X			X		X	X			ED Reports	ED Manager	Monthly KPI Dashboard
90	ED Door to Room (min)-VCMC		X			X		X	X			ED Reports	ED Manager	Monthly KPI Dashboard
91	ED Door to Doctor (min)-VCMC		X			X		X	X			ED Reports	ED Manager	Monthly KPI Dashboard
92	ED Diversion Hours		X			X		X	X			ED Reports	Thomas Gallegos	Regulatory Dashboard
93	Sepsis													
94	**NURSING – ICU DOU (VCMC)**													
95	Hospital Acquired Pressure Injuries, CAUTI's													
96	**NURSING – ICU, DOU, (SPH)**													
97	Hospital Acquired Pressure Injuries, CAUTI's													
98	**NURSING - GI LAB AND ENDOSCOPY**													
99	Time Outs	X			X		X				Weekly	Patient Safety Rounds	SPD Director	PICC & Pt. Safety Cmte.
100	**NURSING – IPU, CSU**													
101	Restraint Use		X		X		X		X			Patient Safety Rounds	IPU Manager	
102	**NURSING – MED / SURG/Tele (VCMC)**													
103	Hospital Acquired Pressure Injuries, CAUTI's													
104	**NURSING – MED / SURG/Tele (SPH)**													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
105	Hospital Acquired Pressure Injuries, CAUTI's													
106	**NURSING – NICU**													
107	CLABSI													
108	**NURSING – OB. L&D, POST PARTUM (VCMC &SPH)**													
109	Sterile and dirty instruments are in appropriate containers and labeled		X								Weekly	Patient Safety Rounds	Perinatal Services Manager	PICC & Patient Safety
110	3rd & 4th Degree Lacerations - Vaginal			X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
111	3rd & 4th Degree Lacerations - Instrument	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
112	3rd & 4th Degree Lacerations - No Instrument	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
113	<2500 g Rate	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
114	Antenatal Steroids			X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
115	Birth Trauma - Neonate	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
116	Cesarean Birth - Overall			X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
117	C. Birth Primary, Singleton, Vertex			X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
118	Early Elective Delivery	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
119	Exclusive Breast Milk Feeding (PC05)			X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
120	Newborn Bloodstream Infection (PC04)	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
121	Stillbirth	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
122	Transfusions; > 4 RBC Units	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
123	Unexpected Complications in Term Newborns	X		X	X			X		X		CMQCC Database	Perinatal Services Manager	OB Committee
124	**NURSING – PEDS / PICU**													
125	Pain Assessment		0											
126	**NURSING – PERIOPERATIVE SERVICES (VCMC & SPH)**													
127	% of cases done after hours	X				X		X	X			Discern Reports	Perioperative Services Director	Monthly KPI Dashboard
128	Adverse Events Involving Anesthesia		X		X		X				Ad Hoc	Notifications	Perioperative Services Director	Surgery Cmte.
129	Significant discrepancies between preoperative and postoperative diagnoses,		X		X		X				Ad Hoc	Notifications	Perioperative Services Director	Surgery Cmte.
130	Adverse events related to the performance of operative and/or invasive procedures		X		X		X				Ad Hoc	Notifications	Perioperative Services Director	Surgery Cmte.
131	Time Out Prior to Procedure		X		X			X	X				Perioperative Services Director	Surgery Cmte.
132	Pre-Anesthesia assessment within 48 hours prior to surgery	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
133	Pre-anesthesia assessment documentation include airway assessment	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
134	Post procedure note documented by Anesthesiologist (w/in 48 hrs.)	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
135	An Operative note is in the EMR prior to the patient being discharged from the PACU/transferred to an inpatient unit.	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
136	The Operative note include the following elements- The names of Surgeon(s), Assistant(s), procedure performed, estimated blood loss, any specimens removed and post-procedure diagnosis.	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
137	Percentage of normothermia on arrival to PACU	X				X	30 Random Charts		X			Cerner Chart Review	QAPI	Surgery Cmte.
138	**NURSING - EDUCATION/ADMIN**													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
139	Staffing Effectiveness											NDNQI	Nursing Admin/Education Manager	
140														
141														

Current Status: *Pending* **PolicyStat ID:** *15076547*

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Diana Zenner: Chief Operating Officer, VCMC & SPH*
Policy Area:	*Administrative - Operating Policies*
References:	

107.014 Disruption of Services Procedure

POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital to maintain an Emergency Management Plan (see Administrative policy 106.034, *Emergency Management Plan*) for the continuity of hospital services in the event that the provision of services is threatened.

PROCEDURE:

Hospital Administration, or in their absence, the Nursing Supervisor on duty, shall be responsible for putting the Emergency Management Plan into effect. Hospital Administration will notify the California State Department of Health Licensing Office. After hours, the State Department of Emergency Services will be contacted as appropriate.

The Emergency Management Plan is accessible via PolicyStat and is also maintained in the Safety Manual binder, which is located in the Nursing Administration office.

All revision dates: 5/1/2006, 12/1/2004, 7/1/2001

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/7/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/31/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/31/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/31/2024

Step Description	Approver	Date
Policy Owner	Diana Zenner: Chief Operating Officer, VCMC & SPH	1/31/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Stephanie Nelson: Manager, Auxiliary Services*
Policy Area:	*Administrative - Operating Policies*
References:	

107.076 Accessibility - Animals in Healthcare Facilities

PURPOSE:

To establish guidelines for allowing access to animals as required by law as well as provide support for pet visitation to benefit our patients socially, psychologically, and physiologically.

POLICY:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH), and the Ambulatory Care (AC) clinics will reasonably accommodate the use of service animals, as defined by the Americans with Disabilities Act (ADA). Terminal patients or patients whose hospital stay is prolonged will be allowed visits by family pets (to include dogs and cats only). Permission of the Charge Nurse or Infection Prevention and Control Practitioner is **required prior to pet visitation.**

Ventura Police Department canines are permitted anywhere in the hospital except the Nursery, Labor&Delivery C-Section suites, Neonatal Intensive Care Unit (NICU) and restricted areas in the Surgery Department.

Service Animals:

Beginning March 15, 2011, only dogs are recognized as service animals under titles II and III of the ADA.

Service animals are individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual or other mental disability. Examples of work or tasks that may be provided by service animals includes, but not limited to:

- Guide Dog or Seeing Eye Dog - Guiding people who are blind.
- Hearing or Signal Dog - Alerting people who have significant hearing loss or are deaf to the presence of people or sounds providing minimal protection or rescue work.
- SSig Dog (sensory signal dog or social signal dog) - Assist a person with autism.
- Pulling a wheelchair.
- Seizure Response Dog - Alerting and protecting a person who is having a seizure.
- Retrieving medicine or the telephone.
- Picking up dropped items.

- Providing physical support to assist with balance and stability to individuals with mobility disabilities.
- Reminding a person with mental illness to take prescribed medications.
- Psychiatric Service Dog - Calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack.
- Performing other duties directly related to the person's disability or impairment.

Questioning of service animals is limited to two specific questions

- Is the dog a service animal required because of a disability?
- What work or task has the dog been trained to perform?

Comfort or emotional support animals

- Emotional support animals are not considered service animals under the ADA.
- Under the Unruh Civil Rights Act, a denial of accommodation of an emotional support or comfort dog may result in a complaint to the Department of Fair Employment and Housing. That department may investigate for violation of the Unruh Civil Rights Act.
- It does not matter if a person has a note from a doctor that states that the person has a disability and needs to have the animal for emotional support.
- A doctor's letter does not turn an animal into a service animal.
- These support animals provide companionship, relieve loneliness, and sometimes help with depression/ anxiety and certain phobias--but do not have special training to perform tasks that assist people with disabilities.

Service animals are not required to be certified, registered, or professionally trained.

Patient/handler may bring their service animal with them to their appointment, and have their service animal with them during their stay, as long as the animal does not pose a threat to the health or safety of others.

- Although the ADA does not require service animals to wear a vest, ID tag, or specific harness the animal should be under the handler’s control at all times via one of these measures:
    - Leash
    - Harness
    - Tethered
    - Voice, motion or signal control
    - An exception may be granted if the above devices interfere with the service animal's work and/or the person's disability prevents the use to these devices.

Under the ADA the disabled patient/handler is allowed to be accompanied by the service animal in all areas of the facility where the public is allowed to go.

- It is appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

The patient/handler is solely responsible for the health, behavior, well-being, safety, and all aspects of supervision/care and clean up of their service animal.

- If the handler/patient cannot care for the animal they may have a secondary person there to care for the animal.

Reasonable behavior is expected from service animals while on hosptial/clinic property. The owners of disruptive and aggressive service animals may be asked to remove them from the facilities. If the improper behavior happens repeatedly, the owner may be told not to bring the service animal into the facility.

Cleanliness of the service animal is mandatory.

A person with a disability cannot be asked to remove his service animal from the premises unless:

- The service animal is out of control and the patient/handler does not take effective action to control it.
- The service animal is not housebroken.
- The animal is not well groomed has poor hygiene (example-parasites/dirt/stool).
- If the animal is unsafe and poses a direct threat to staff or other patients.
- The animal fundamentally alters the nature of the goods, services, programs, or activities provided to the public.
- When there is a legitimate reason to ask that a service animal be removed, caregivers/staff must offer the person/handler with the disability the opportunity to obtain goods or services without the animal's presence.

Caregivers/staff are not required or permitted to provide care or food for a service animal.

Caregivers/staff cannot:

A. Ask about the persons disability

B. Require medical documentation

C. Require a special identification card or training documentation for the animal.

D. Ask that the animal demonstrate its ability to perform the work or task.

Requests by employees for service animals will be forwarded to HR. HR will work with the employee in this matter. Employees requesting accommodation for a service animal may be asked to provide medical documentation to verify that a service animal is needed, why, and how the service animal will help the employee perform essential job functions.

Employees with service animals will be allowed an additional break every 6 hours to allow their service animal to go outside. Employees must clean up after their service animal.

ADA Requirements:

- The ADA titles II and III require that entities permit service animals to accompany people with disabilities in all areas where members of the public are allowed to go (e.g. patient rooms, clinics, cafeterias, or examination rooms).
- It may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile or healing environment.
- Establishments that sell or prepare food, such as cafeterias/gift shops, must allow service animals in public areas even if state or local health codes prohibit animals on the premise.
- People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals.
- Service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

PETS:

Pets are animals whose sole function is to provide comfort or emotional support. They do not qualify as service animals under the ADA.

Pet visitation to inpatients is discouraged under most circumstances, due to the potential health risk posed to patients, caregivers, and visitors. However, visitation may be arranged after consulting the Charge Nurse or Infection Prevention as mentioned above.

The Charge Nurse or Infection Prevention and Control Practitioner will assess the desire for a pet visit along with the type of care provided to the patient, the likelihood and extent of disruption caused by this visit and any other factor that may cause the pet visit to be unreasonable under the circumstances.

Patients who are immunocompromised must have physician approval prior to pet visitation.

Caregivers, including clinicians, are not allowed to bring their pets into any of the clinics unless the animal is a service animal.

Visitors to the facility are not allowed to bring their pets when accompanying a patient unless the pet qualifies as a service animal.

Requirements of pets and their owners include:

All animals must be immunized against rabies and other diseases common to that type of animal. All vaccinations must be current.

- Animals must wear a license/rabies vaccination tag.
- All dogs must be licensed per state/local ordinance(s). (HSC 121690,17 CCR 2606.4).
- Animals must wear an owner identification tag (which includes the name, phone number, and room number, when applicable, of the owner) at all times.
- Animals must be in good health.
- Animals must be clean.
- Pet must be carried or in a carrier. (To keep hair and other possible contaminates off hospital/ organization buildings floors and furniture)
- Pet must be escorted into and out of facility.
- The owner must be in full control of the animal at all times. The care and supervision of the animal is solely the responsibility of the owner.
- Pets are not to be left alone with the patient.
- The individual bringing in the pet will be responsible for any cleanup of all body excretions.
- All individuals coming into contact with the pet will perform appropriate hand hygiene.
  In addition to the above, the following is required of pets:
  - Pet owners may be asked to remove the pet at any time, with or without notice, failure to follow this directive will prohibit any future visitation.
  - The individual bringing the pet is solely responsible for all cleaning and repairs necessary.
  - The visit will occur in the patient's room, unless there is a roommate with physical allergies etc. to the pet. If needed, the Infection Control Practitioner will be notified and an alternative place will be arranged if possible.
  - Pets are allowed to interact ONLY with the patient.

While we make every effort to allow a service animal into our hospital/clinic facilities, there may be circumstances in which this accommodation will be unavailable.

PET THERAPY PROGRAM:

The program is available to all facilities at VCMC/SPH, administered through the Auxiliary and Volunteer Services and coordinated by the Director of Volunteers.

Therapy dogs are not service dogs and must meet behavioral criteria/requirements of the Therapy Dogs International, Inc. or Love on a Leash. Dogs must be at least one (1) year of age, be housebroken and be owned by the volunteer who will be working with the dog at the hospital.

Guidelines:

1. The program is restricted to canines only.
2. Pet Therapy will be limited to regular visiting hours.
3. Volunteers must submit a completed application for the Pet Therapy Program to Volunteer Services and be accepted to the program by the Pet therapy Coordinator, following a personal interview.
4. Volunteers must complete general volunteer orientation. All general volunteer requirements, policies and privileges pertain to Pet Therapy volunteers.
5. Pet therapy teams must demonstrate special skills in appropriate and sensitive interaction with patients and in accommodating requests and individual needs. This proficiency will be determined by the Pet therapy Coordinator or designed Pet Therapy team member in a hospital-approved evaluation.
6. Dogs must be current in all required vaccinations. A duplicate copy of all dog vaccinations will be kept in the Volunteer Services office.
7. Volunteers and dogs must adhere to all security requirements and wear hospital badges at all times.
8. All dog owners must belong to either "Therapy Dogs International" or "Love on a Leash."
9. Volunteers must observe at least one visitation with an experienced Pet Therapy team in the hospital without their own dog first.
10. The new Pet Therapy team must then be observed by an experienced Pet Therapy team member at least once.

Pet Therapy Visits:

1. ATTIRE: Volunteer and dog will wear ID badges while on duty.
2. PREPARATION: Dogs will be bathed within 24 hours of visit (exceptions will be dogs making more than one visit per week to the hospital). Dogs will be thoroughly brushed prior to every visit to removed loose hair. Nails will be trimmed and filed smooth. Eyes, ears and nose will be free of any matter. Dogs will be free of any parasites and on a flea control program (e.g. fleas, ticks). No flea collars will be worn in the hospital.
3. HANDLING: Dogs will remain on a leash at all times. The volunteer is responsible for the dog's proper behavior and welfare. The volunteer must maintain control of the dog at all times and in all circumstances. At no time will the animal be left under the control of any person other than the Pet Therapy volunteer. A

clean, dry bath towel or sheet (available from the linen care in each unit) will be used if an animal is placed on a bed. That linen will be placed in the soiled linen hamper at end of visit.

4. SCHEDULING: Visitations will be scheduled by the Pet Therapy Coordinator. No visitations will be scheduled during meal times and dogs will be removed from any areas where food is being served. Special requests for visitations outside these hours must be cleared with the charge nurse of the unit involved.
5. HAND HYGIENE: Patients, health care workers, volunteers and animal handlers will perform hand hygiene after animal contact. Hand Hygiene consists of either soap and water hand washing or alcohol-based hand sanitizer. See Administrative policy 106.055, *Hand Hygiene*.
6. ASSIGNMENTS: The Pet Therapy Team will check in at the Auxiliary Office to see if there are any special requests. Requests are located in the Spiritual Care and Services Book. The Pet Therapy team will then proceed to designated and approved areas throughout the hospital. Pet Therapy teams will be assigned units to avoid crossing paths with other teams. Special requests should take precedence over routine assignments.
7. RESTRICTIONS: The Pet Therapy teams will not be allowed in the following areas: Surgery; Emergency Department; Labor & Delivery; Nursery; Neonatal Intensive Care (NICU); endoscopy treatment rooms; or patient rooms where infection control isolation precautions are posted.
8. INTERACTIONS: Visits will be primarily with individual patients, although some small group interactions may occur if appropriate. The volunteer will check at the unit desk to see if there are any individuals that may benefit by a Pet Therapy visit or if there are any rooms which should be avoided.
9. Volunteers will first knock on the patient's door before entering and ask if the patient would be interested in a pet visit. The volunteer will introduce themselves and the dog. The volunteer will inquire about any special precautions (i.e. recent surgery, pain, medical or surgical equipment, etc.).
10. UNUSUAL OCCURRENCES: The volunteer will immediately remove the dog from a visitation if any of the following occurs: improper behavior of the dog (growling, barking, scratching, biting); patient, staff or visitor request; allergic response; medical emergency; animal fatigue. On exiting the situation, the volunteer must report the incident to the charge Nurse on the unit and also to Volunteer Services, where an incident report will be filed.
11. SANITATION: The volunteer is responsible for cleaning up after his/her animal. See Animal Waste Management section. Depending on the circumstance, the visit may be canceled.
12. DEPARTURE: At the conclusion of visits, the volunteer will return to Volunteer Services to complete documentation per requests. The volunteer will then sign out and exit the hospital.

Special Visitation Requests:

1. Special visitation requests by a Pet Therapy team can be made by doctors, nurses, patients or family. They may be directed to the Department of Volunteer Services at 652-6693.

REFERENCES:

Americans with Disabilities Act of 1990 (ADA), Title II regulation, 28 CFR Part 35 (State and local government services); Title III regulation, 28 CFR Part 36. Appendix A (Public accommodations and commercial facilities). Revision published September 15, 2010 and further revised March 11, 2011 (See, http://www.ada.gov/ada_req_ta.htm; ADA Revised Requirements: http://www.ada.gov/service_animals_2010.htm

Duncan, S.R. (2000) APIC State-of-the-Art Report: The Implications of Service Animals in Health Care Setting. American Journal of Infection Control, Vol. 28 No. 2, pages 170-178.

https://adata.org/guide/service-animals-and-emotional-support-animals

https://www.ada.gov/regs2010/service_animal_qa.html

All revision dates: 3/9/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	2/14/2024
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/7/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/2/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/2/2024
Policy Owner	Stephanie Nelson: Manager, Auxiliary Services	2/2/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.033 Peripheral Intravenous (IV) Insertion, Infusion and Maintenance

POLICY:

To establish a route to supply fluids, medications, blood and blood components and to maintain intravenous(IV) access to a patient for treatment or prevention of disease and preoperative and postoperative care. See Lippincott Procedures for IV catheter insertion, Intermittent infusion device insertion, IV administration set priming, IV pump use, for further detailed instructions and guidelines. Vein selection for access by conventional peripheral catheters may not include deep peripheral veins (i.e., a deep cephalic vein in the upper arm).

EQUIPMENT:

1. IV insertion kit
2. IV solution as ordered
3. Arm board as needed
4. IV tubing or IV lock
5. IV tubing expiration stickers (change Q96 hours)

PROCEDURE:

1. Preparation:
    a. Verify Licensed Independent Practitioner's (LIP) order in the medical record.
    b. Review the patient's medical record for allergies and factors affecting peripheral vasculature.
    c. Identify patient with two (2) patient identifiers, inform patient of procedure and purpose, and answer questions
2. Preparation of equipment:
    a. Compare label of solution with LIP's order, check expiration date.
    b. Select IV tubing appropriately for infusion
    c. Prepare IV bag and tubing as appropriate
    d. Prime IV tubing and close roller clamps

3. Method of insertion:
    a. Assemble equipment
    b. Check Patient's ID band and verbally verify patient's ID with two (2) patient identifiers
    c. Perform hand hygiene and follow standard precautions and aseptic technique
4. Applying the Tourniquet
    a. Apply a tourniquet to dilate the veins and assess for an appropriate insertion site. Assess the veins in the extremity, and identify potential sites that are easily seen or palpated. Check for a pulse distal to the tourniquet location. If a pulse isn't present, release the tourniquet and reapply it with less tension.
    b. Release the tourniquet for site preparation.
    c. Perform hand hygiene and don gloves.
5. Preparing the Site
    a. Cleanse skin at proposed insertion site thoroughly with chlorhexidine using a vigorous side-to-side motion for 30 seconds and allow to dry for 30 seconds. (tincture of iodine, povidone-iodine may be used if chlorhexidine is contraindicated).
    b. For providone-iodine solution apply using a swab. Begin at the intended insertion site and move outward in concentric circles. Allow the solution to dry completely (typically at least 2 minutes).
    c. if you must palpate the intended insertion site after cleaning, remove and discard your gloves, perform hand hygiene, and put on sterile gloves to avoid contaminating the insertion site.
    d. Reapply the tourniquet.
6. Inserting the Catheter
    a. Stretch the skin taut below the puncture site using the thumb of your nondominant hand.
    b. Tell the patient that you're about to insert the device.
    c. Place the short peripheral catheter on top of the vein at a 10- to 15-degreeangle to the skin.
    d. Puncture the skin and anterior vein wall, watching for blood to appear in the catheter, flashback chamber, or both.
    e. As you continue to hold the skin taut, use the device's push-off tab to separate the catheter from the needle stylet. Advance the catheter into the vein.
    f. Release the tourniquet.
    g. Activate the device's safety mechanism.
7. Assessing Catheter Patency
    a. Compress the skin above the catheter tip to stop blood flow. Attach extension tubing to catheter carefully, avoiding hub contact with skin.
    b. Scrub the hub of the extension tubing with alcohol-based chlorhexidine wipe (5 second wipe, 5 second dry)
    c. Attach NS syringe, unclamp catheter and slowly aspirate to remove air from the extension set and to assess for a blood return.
    d. Inject NS slowly 2-3 ml into the catheter.
    e. Clamp the catheter

f. Remove and discard NS syringe.
g. Scrub the hub 5 sec with 5 sec dry.
h. Attach primed IV tubing, and trace the tubing from the patient to the point of origin.
i. Unclamp catheter and begin infusion, as prescribed.
j. Monitor for swelling, or patient complaint of discomfort or pain.

8. Dressing the Site
    a. Secure using IV securement device included in IV start kit.
        i. Cover with transparent dressing.
        ii. Secure tubing to the arm with tape, if needed
    b. Label the dressing: date of insertion, time of insertion, and initials (Does not apply to Neonatal Intensive Care and the New Born Nursery).
    c. Secure arm with arm-board, if necessary.
    d. Remove and discard gloves.
    e. Perform hand hygiene.
    f. Document the IV start in the electronic health record (EHR); *see documentation section below.*
9. Discontinuation of IV catheter
    a. Obtain physician order to discontinue IV catheter.
    b. Perform hand hygiene and don gloves
    c. Identify patient with two (2) patient identifiers and explain procedure
    d. Stabilize needle or catheter while carefully removing dressing and tape.
    e. Remove needle/catheter carefully and smoothly keeping it almost flush with the skin.
    f. Quickly press sterile pad over site and hold until bleeding stops to prevent hematoma
    g. Apply small gauze dressing/band-aid.
    h. Observe venipuncture site for redness, swelling or hematoma
    i. Dispose of equipment and gloves, place all sharps into sharps container
    j. Perform hand hygiene
    k. Reassess site
    l. When discontinuing an IV, document the discontinuation in the EHR and inactivate the documentation field

MAINTENANCE OF IV SITE

1. Replace catheter site transparent dressing when the catheter is removed or replaced, or when the dressing becomes damp, loosened or soiled.
2. When the dressing is required to be changed, the documentation on the dressing should reflect the date and time of insertion, needle gauge and the initials of the nurse completing the dressing change.
3. Avoid touch contamination of IV site when dressing is replaced.

4. Change IV site when clinically indicated: insertion site becomes reddened, sore, edematous, phlebitis, infiltration, or venous cord palpable.
5. Evaluate and document IV site at least every 12 hours for site-related complications. ~~For~~According to INS Infusion Therapy Standards of Practice, for the Pediatric population~~, evaluate~~ an assessment and documentation of the site should be done at a minimum of every ~~four (4)~~two hours ~~for site-related complications~~and more frequently for patients receiving vesicant medications. For the Neonatal population an assessment and documentation should be done hourly.
6. Special Considerations
    1. Carefully assess patient for appropriate IV site:
    Use an upper extremity site in preference to one on a lower extremity. Transfer a lower extremity site to an upper extremity site when possible.
    2. Emergent conditions, pre-hospital care or occasions when aseptic technique cannot be ensured: change site as soon as possible and no longer than 48 hours.

MAINTENANCE OF ADMINISTRATION SETS AND INTRAVENOUS FLUIDS

1. The administration sets include the area from the spike of tubing to the hub of the vascular device. However, a short extension tube may be connected to the vascular device and may be considered a portion of the vascular device to facilitate aseptic technique when changing administration sets. The extension tubing may be replaced when the vascular device is replaced.
2. Replace administration sets including secondary sets and add-on devices, no more frequently than at 96 hours intervals, unless catheter related infection is suspected or documented.
3. Clean injection ports with alcohol-based chlorhexidine: (5 sec wipe, 5 sec dry) before accessing system
4. When changing an IV solution, follow steril no-touch technique to reduce the risk of vascular catheter-associated infection.
5. Check expiration dates and visually inspect the solution for particles, discoloration, or other loss of integrity; don't admnister the IV solution if integrity is compromised.
6. Verify that the IV solution is being administered at the proper time, in the prescribed dose, and by the correct route to reduce the risk of medication errors.
7. Label IV bags with date and time hung and initials. On unlabeled bags, may use patient's registration label (change IV fluid bags every 48 hours).
8. Trace the tubing from the patient to the point of origin.

EHR DOCUMENTATION

1. Date and time of insertion
2. Needle gauge
3. Insertion site
4. Patient's response
5. Number of attempts
6. Results of IV site assessment

7. Type of solution and amount administered per shift (I&O)
8. Condition of Catheter tip and IV site upon discontinuation of catheter

AGE SPECIFIC CONCERNS

1. Infants/children and the elderly are at greater risk for circulatory overload if IV fluids are accidentally infused. Volume control sets and IV pumps should be used when possible. For PEDS patients, IV pump fluid limits shall be set every four (4) hours. Accurate I & O should be maintained.
2. Secure IV as appropriate for age, activity level, and skin sensitivity.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/23/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/23/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/23/2024

VENTURA COUNTY HEALTH CARE AGENCY

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108.048 Midline Intravenous Catheter Placement

POLICY:

To provide guidelines for the proper insertion of midline catheters by trained Registered Nurses (RNs). 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~~ 10 to 20cm in length. Midline catheters DO NOT enter the central circulation. "Midline" is clearly marked on the hub of the catheter.

PROVISIONS:

I. Catheter Selection Criteria:

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

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

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

I. Contraindications:

1. Midline catheter placement should not occur on the ipsilateral side of a mastectomy with node resection, radial artery surgery, fistula or shunt.
2. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs.
    a. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of midline.
        - Primary physician will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.
        - Any discussions with physicians should be documented by the midline nurse.
    b. For patients with stage 4 or 5 chronic kidney disease, midline placement may only occur ~~only~~with the approval of the covering nephrologist 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.
    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 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~~allow to dry completely).
K. Prime extension tubing while prep dries.
L. Place fenestrated drape over insertion site.
M. Insert ultrasound probe into sterile cover and place onto sterile drape.
N. Insert Powerglide needle:
    1. Be sure to check that that needle bevel is facing up and that the wire or catheter is not exposed.
    2. Insert needle into the vein under ultrasound guidance.
    3. Slowly advance the guide wire by stabilizing the device and pushing the top slide forward.

4. Deploy the catheter by holding the rear piece of the device stationary then slowly and gently pushing the side wings forward towards the vein. Be careful not to kink the catheter during this phase. Holding skin traction distal to the insertion site will help. If the catheter kinks it will not function properly and a new device will have to be used.
5. Remove the tourniquet.
6. Remove the device applicator and cap.
7. Screw the primed extension set and needleless connector onto the catheter hub and aspirate for for blood return.
8. Flush catheter with 10mL normal saline (NS).

O. Place stabilization device over hub of catheter.

P. Apply 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 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

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Attachments

CHG Gel Dressing by 3M.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/4/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/4/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/4/2023

VENTURA COUNTY
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108.049 Standardized Procedure for Peripherally Inserted Central Catheter (PICC) Placement

~~Policy~~

~~To provide guidelines to facilitate standardization of practice for the insertion of peripherally inserted central catheter (PICC) catheters.~~

~~Purpose~~

~~To provide guidelines to standardize the practice of PICC catheter insertion, in order to minimize the risk of device related complications and optimize patient outcomes.~~

~~Scope~~

~~This applies to Registered Nurses (RNs) who have successfully completed population- appropriate training and demonstrated competency in vascular access device insertion, care and maintenance, and patient/caregiver education across the care continuum.~~

~~Definitions~~

~~**Peripherally Inserted Central Catheter (PICC):** a central vascular access device (CVAD) inserted into a peripheral vein and threaded into the central venous circulation. The tip of the PICC should reside in lower 1/3 of the superior vena cava (cavoatrial junction) for upper-body insertions.~~

~~Provisions~~

~~A. Selection of the appropriate vascular access device (peripheral or central) shall accommodate:~~

~~1. Patient's vascular needs.~~

~~2. Diagnosis.~~

~~3. Type and length of prescribed treatment regimen.~~

~~4. Duration of dwell.~~

~~5. Condition of the vasculature.~~

~~6. Patient/caregiver's preference.~~

7. Ability and resources to care for the device.

B. The vascular access device shall be the smallest gauge and length with the fewest number of lumens and shall be the least invasive device needed to accommodate and manage the prescribed therapy.

1. Select the vein or site that best accommodates the outer diameter and length of the vascular access device (VAD) required for the prescribed therapy.
2. Catheter-to-vein ratio of <45%.
3. VADs shall be accessed with 10ml or larger syringes.
4. Prior to PICC insertion, review patient's history and all pertinent lab results including but not limited to platelet count, international normalized ratio (INR), glomerular filtration rate (GFR), and serum creatinine.
5. In adults, use an upper extremity site for catheter insertion.

C. Radiographic confirmation or other tip location confirmation system (TCS) will be utilized to assess location of catheter tip. Limiting but not contraindicated situations for ECG (electrocardiogram) TCS are in the patients where alterations of cardiac rhythm change the presentation of the P-wave as in atrial fibrillation, atrial flutter, severe tachycardia, and pacemaker driven rhythms. In such patients, who are easily identifiable prior to PICC insertion, the use of an additional method is required to confirm catheter tip location. See policy 108.044 ECG Guided Tip Confirmation System During PICC Placement.

1. When ECG TCS is used to determine optimal PICC tip placement in the superior vena cava (SVC), no radiographic confirmation is required. The Vascular Access Nurse inserting the catheter may approve use of the line per policy when the appropriate change in the P-wave is noted. At the time of placement, the external catheter measurement will be documented.

D. Patients admitted to the hospital with a PICC should have a chest x-ray to verify placement prior to utilization.

Considerations for Vascular Access Device Placement

1. Patient stability.
2. Areas of pain on palpation.
3. Veins previously used or compromised (e.g., bruised, infiltrated, phlebitis, scleroses, corded or with presence of venous thrombosis).
4. Areas near venous valves.
5. Areas where there are planned procedures/veins needed for other purposes
6. Neurological injury
7. Localized edema.
8. Following axillary node dissection.
9. After radiation therapy on the proposed insertion side.
10. Lymphedema at the proposed insertion site.

11. Previous history of CVAD and central occlusion such as SVC Syndrome or stenosis of major upper thoracic vessels.
12. Known or suspected allergy to materials contained in the device.
13. History of medical conditions including cerebrovascular accident (affecting extremity being considered), bleeding disorders, anticoagulation therapy, and any condition that requires crutch walking.
14. Presence of other intravascular devices within the target vessel (e.g., pacemaker, other central lines, A-V shunts for dialysis).
15. Uncontrolled bacteremia, fungemia, or other infections.
16. Thrombocytopenia or coagulopathies.
17. Fracture/orthopedic injury.
18. Decreased venous return.
19. Cardiac malformations
20. Nerve injury affecting insertion site.
21. Local infection, skin breakdown, and/or cellulitis.
22. Patient lab values.
23. Bleeding risk.
24. Areas of flexion.
25. Need for analgesia or sedation.
26. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs such as Chronic Kidney Disease (CKD) stage 4 and above indicated by a Glomerular Filtration Rate (GFR) of 29 or lower.

A. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of PICC.
B. Primary Licensed Practitioner (LP) will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.
C. Any discussions with physicians should be documented by the PICC nurse.

Competency

A. **Completion of BARD PICC Certification Course.**
B. **Initial competency assessment:**
    1. Adult: A minimum of 5 complete PICC insertions (from assessment to tip verification) while being coached by a qualified Vascular Access Nurse, followed by a minimum of 3 successful independent ultrasound guided PICC insertions directly supervised by a qualified Vascular Access Nurse, are required for independent practice.
C. **Annual Competency:** Minimum eight hours of Continuing Education Units (CEUs) related to Vascular Access or current certification such as Certified Registered Nurse Infusion (CRNI), Vascular Access Board Certification (VA-BC), maintained.

1. Adult: A minimum of 10 successful PICC insertions per year.
2. Re-validation for those who do not meet minimum annual requirements will be 1 PICC observed by a qualified Vascular Access Nurse for a skills check-off. If this check- off is not passed, all initial competency requirements must be repeated.

Informed Consent Process

1. Informed consent must be completed by the LP. The clinician shall provide the patient/family with information on the risks, benefits and alternatives and document the informed consent in the Electronic Health Record (EHR).
2. A LP's order is required for PICC insertion.
3. A signed written consent is required prior to PICC insertion.

Device Selection

1. **PICC**: Recommended for irritants or vessicants such as chemotherapeutic agents, total parenteral nutrition (TPN) with a dextrose concentration of greater than 10%, sclerosing agents, and/or patients with poor peripheral access.
2. **Power injectable PICC**: Required for the power injection of intravenous contrast. May also be used for hemodynamic monitoring, high flow rate Intravenous (IV) fluids, and blood administration.

PICC Insertion Barrier Precautions

1. Hair that requires removal for facilitation of catheter placement should be clipped using surgical clippers prior to catheter insertion, not shaved. Shaving may cause micro-abrasions of the skin, allowing access of microorganisms into the body.
2. For PICC placement (including guidewire exchange), the person who inserts the line shall use maximal sterile barrier precautions including:
    - Sterile gloves (2 pairs).
    - Long-sleeved sterile gown.
    - Full sterile body drape with fenestration.
    - Bouffant cap.
    - Fluid shield mask or mask with protective eye wear.
3. Restrict non-essential persons from entering the patient/sterile area (within three feet) during insertion.
4. All persons entering the field and assisting with performing the procedure, shall wear sterile gown, mask, and cap.
5. Place mask on patient, as tolerated.
6. Following thorough hand hygiene, strict sterile technique shall be used throughout catheter insertion, care, maintenance, and removal.
7. The PICC must not be advanced once a post-insertion dressing has been applied.

8. Guidewire exchanges are discouraged and should not be performed unless absolutely necessary (patients having limited access sites, lack of alternative insertion sites, and/or patient is high risk such as having coagulopathy or morbid obesity). Do not use guidewire exchange if a catheter is suspected to be infected.
9. All PICCs shall have a needleless connector attached to the end of the lumen.
10. Suturing of the PICC is not recommended. Use appropriate securement device or application of sterile adhesive dressing to secure the catheter. Dressing should not wrap around the entire circumference of the patient's extremity.

Equipment

1. Procedure kits or carts containing all necessary supplies are to be available for use at the time of PICC insertion and care/maintenance procedures (including those required for dressing change, needleless connector change, and removal).
2. Closed catheter access systems are used preferably over open systems for infusions, medication administration, and blood withdrawal. When an integral in-line administration system is unavailable, specific add-on devices (e.g., extension sets, in-line filters, manifolds, blunt cannulas, or stopcocks) may be required to facilitate delivery of prescribed therapy. The use of these devices should be limited to reduce the risk of contamination from manipulation, mis-connection, or accidental disconnection.
3. Maximum barrier kit as described above.
4. Standard PICC insertion kit that includes all necessary components.
5. Sterile probe cover.

Pre-Procedure

A. **Assessment**
   1. Determine indication for PICC and obtain/verify LP order for PICC placement.
   2. Verify that the informed consent has been completed, and that it is signed and dated.
   3. Review patient's medical history, contraindications and indications for device placement, allergies, coagulation status, and other pertinent labs.
   4. Assess patient's current vascular access.
   5. Assess patient/caregiver readiness.

B. **Planning**
   1. Add PICC pre-procedure order set under ordering LP's name per protocol
   2. The goal is to minimize patient's discomfort during insertion and assure that the patient/caregiver will be informed of the need, purpose, and risks/benefits of PICC placement and signs/symptoms of possible complications.
   3. Gather equipment/supplies.
   4. Provide patient/caregiver education regarding indication for PICC, insertion procedure, and maintenance of the PICC and appropriate infection prevention measures to prevent Central Line Blood Stream Infection (CLABSI).

5. The patient's assigned nurse shall be available to assist the PICC nurse especially if the patient is unable to cooperate during procedure.
6. Close door to room/area and post sign indicating "Sterile Procedure in Progress- Do Not Enter."
7. Note: for pediatric and neonatal patients, additional nursing staff shall be available to assist during the insertion procedure to provide sedation (if indicated), to monitor for signs of patient distress and to assist the RN placing the catheter by holding the patient.

C. **Pre Procedure**

1. Perform patient identification with two appropriate identifiers (e.g., patient's full name, date of birth and/or medical identification number).
2. Explain procedure to patient/caregiver.
3. The person inserting the PICC must perform a time out with an observing Nurse before beginning the procedure and record the timeout in the EHR.
4. Perform hand hygiene and don clean gloves.
5. Conduct visual inspection of potential insertion site(s) to assess for skin integrity, erythema, edema, pain, compromised veins, etc.
6. Place ultrasound machine where ergonomically comfortable for clinician.
7. Examine the vasculature in the chosen extremity using ultrasound.
    - Ensure ultrasound probe has been disinfected with PDI® Super Sani-Cloth Germicidal Disposable Wipes prior to use on patient.
    - Apply a liberal amount of sterile ultrasound gel (from single use packet) to patient's arm.
8. Apply probe to skin: visualize and note the location of veins, arteries, and nerves surrounding the proposed insertion site.
    - Assess veins for vessel size, path, round shape, and compressibility without a tourniquet.
    - Assess depth of intended vessel for venipuncture.
    - Assess for adequacy of vessel size compared to the proposed outer catheter diameter to promote hemodilution and preserve vessel health.
    - Avoid selecting smaller vessels to prevent phlebitis and thrombosis.
    - If marking the level of the proposed insertion site, utilize a single-use disposable skin marker on the outer aspect of the arm to avoid leaving ink under the dressing and to allow for appropriate skin cleansing.
    - Remove the ultrasound gel from the patient's skin.
9. To approximate the desired terminal tip location at the lower one-third of the SVC at the level of the Cavoatrial Junction (CAJ), measure from the proposed insertion site to the clavicular head on the right side and then down to the bottom of the third intercostal space on the right.
10. Remove gloves and discard.
11. Prepare for insertion, collecting necessary insertion supplies and setting up a sterile field.

D. **Procedure**

1. ~~Perform hand hygiene.~~
2. ~~Don head covering and mask.~~
3. ~~Perform hand hygiene.~~
4. ~~Open the insertion tray and PICC kit to create a sterile field and include items in the field using sterile technique as needed.~~
5. ~~Don a pair of sterile gloves.~~
6. ~~Place sterile drape under the extremity of the intended insertion site.~~
7. ~~Prep the skin in the entire area where the dressing will cover. Cleanse insertion site using the preferred skin antiseptic agent of alcohol-based chlorhexidine solution according to the manufacturers' directions for use; allow to dry completely.~~
    - ~~Use an iodophor (e.g., povidone-iodine) or 70% alcohol if chlorhexidine solution is contraindicated.~~
    - ~~Use aqueous chlorhexidine if there is a contraindication to alcohol-based chlorhexidine.~~
8. ~~Apply tourniquet proximal to the insertion site.~~
9. ~~Remove sterile gloves and perform hand hygiene.~~
10. ~~Don sterile gown and a new pair of sterile gloves.~~
11. ~~Inside PICC kit, prime any needed extension set(s) and catheter with 0.9% sodium chloride.~~
12. ~~Use stylet wires according to manufacturers' directions for use.~~
    - ~~Never cut a wire of any kind.~~
    - ~~If the catheter has a manufacturer installed stylet wire, withdraw just past the desired length, bending the stylet wire over the catheter hub or locking in place before trimming the catheter to the premeasured length.~~
    - ~~Stylet wire should not extend beyond the catheter tip.~~
13. ~~Place large, sterile sheet drape with insertion site fenestration over the entire patient; best practice is to cover the patient's face with the large sterile drape. If the patient cannot tolerate having their face covered, the drape can be tented, and the patient can wear a mask or turn the head away from the insertion site.~~
14. ~~Cover the ultrasound with the sterile probe cover and secure.~~
15. ~~Apply sterile ultrasound gel to the skin over the proposed insertion site.~~
16. ~~Relocate the intended vein with the ultrasound probe, verifying it is non-pulsatile and compressible.~~
17. ~~Inject local anesthetic subcutaneously at the insertion site, if needed. Before injection, aspirate for the absence of blood return.~~
18. ~~Apply covered probe to skin, visualize the vessel, and insert the micro introducer needle through the skin and into the vein using a 45° angle. Place the tip of the access needle on the skin at a distance from the probe that will intersect the vein within the plane of the scan field as the catheter is advanced to the intended vein's depth. Move the ultrasound probe toward the catheter to identify the catheter tip. Move the ultrasound probe and needle in the same direction, keeping the needle tip in view on the screen as the catheter approaches and~~

enters the lumen of the intended vessel. Make sure to keep the gel and probe away from the sterile catheter.

19. Align the path of the needle to enter the center most superficial area of the vein wall and observe the needle tip entering the lumen of the vein.
20. Confirm slow venous blood return is the color and consistency of whole blood.
    - If blood return is pulsatile, immediately abort the procedure by removing the needle and tourniquet and applying pressure to the area for 10 minutes or until hemostasis is achieved.
21. Observe for blood return in the micro introducer needle hub and visualize the needle tip in the center of the vein on ultrasound before proceeding.
22. Put the ultrasound probe down on the sterile field.
23. Reduce the angle of the micro introducer needle and stabilize.
24. Insert the floppy-tipped guidewire into the micro introducer needle, threading into the vein. The guidewire should never be inserted into a position beyond the level of the axilla without fluoroscopy guidance.
25. Carefully remove the micro introducer needle from the vein and skin by pulling it back over the guidewire.
    - Do not allow the guidewire to move outward through the micro introducer needle due to risk of severing the guidewire.
26. Secure the guidewire with your nondominant hand to prevent migration in or out of the vein.
27. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
28. Make a skin nick, if needed.
    - Using a scalpel, hold the blade with the blunt side against the wire.
29. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
30. Remove the guidewire.
31. Release the tourniquet, using caution not to break sterile technique.
32. Slowly remove the dilator, leaving the peel-away introducer sheath in the vein.
33. Slowly advance the PICC catheter through the introducer sheath.
34. Continue to advance the catheter slowly to the predetermined measurement.
    - If using a tip-locating device, follow policy 108.044 Clinical Implementation Guide for: ECG Guided Tip Confirmation System During PICC Placement.
    - If tip-location technology is not being used, withdraw the stylet wire from the catheter lumen, using air emboli precautions.
35. Attach sterile 0.9% sodium chloride-filled syringe and aspirate for blood return (the color and consistency of whole blood) from catheter and flush to determine patency.
36. Break the wings and slowly peel away the introducer sheath as it is withdrawn, taking care to allow the catheter to remain in its terminal tip location.

37. Apply a needleless connector to each lumen.
38. Clean excess blood and ultrasound gel from the insertion site using chlorhexidine solution.
    - Ensure there is no oozing of blood from PICC entry site and hold pressure using sterile gauze to achieve hemostasis if necessary.
39. Apply sterile alcohol free skin barrier product around the perimeter of the intended dressing site.
    - Do not apply barrier film/product directly under chlorhexidine-impregnated sponge or gel patch as the solution will block its action at the puncture site.
    - Allow product to completely dry before dressing is applied.
40. Apply chlorohexidine-impregnated sponge (e.g., Biopatch™) or gel and securement device/ product. Then apply Transparent semi-permeable membrane (TSM) dressing (e.g., Tegaderm™).
    a. If applying an antimicrobial patch, align the slit of the patch with the PICC line.
41. Flush each PICC lumen with a minimum of 10ml normal saline in a 10ml syringe.
42. Label dressing with date, time performed, and clinician's initials.
43. Place an alcohol impregnated cap on the needleless connector of each of the PICC lumens.
44. Place a sign above the patient's bed with: "NO VENIPUNCTURE OR BLOOD PRESSURE IN EXTREMITY where PICC has been placed (e.g., arm/leg, Right/Left)."
45. Discard used supplies in appropriate receptacles.
46. Remove personal protective equipment (PPE) and perform hand hygiene.
47. Clean and disinfect ultrasound probe by removing sterile ultrasound cover, wiping away excess gel, and cleansing with PDI® Super Sani-Cloths Wipes.
48. Obtain a chest radiograph to determine tip placement if not using a tip locating confirmation system device and get verification from radiologist of PICC placement in SVC prior to use.

E. **Post Procedure:**

1. After successful PICC placement, educate patient/caregiver regarding care and maintenance of PICC, steps to avoid catheter dislodgement, and daily flushing schedule.
2. Provide education to patient/caregiver as to signs and symptoms of common complications and how and whom to report complications.
3. Measure arm circumference at the site.
4. Add PICC post-procedure order set and "okay to use" order under ordering physician's name per protocol.

Infusion Tubing Configuration

1. Any tubing and fluid/medication bags hooked up to the PICC should be new having not been hooked up to any other peripheral IV (PIV) or central lines, including secondary tubing and bags.
2. The configuration of infusion tubing is integral to the efficient and safe use of the PICC. When assembling the infusion tubing, requirements for all infusates must be considered to ensure the appropriate number of injection ports are available for set-up and to prevent unnecessarily

accessing the catheter later.

3. Infusion tubing connected to the PICC shall be luer locked.
4. To minimize entry into the PICC and decrease the risk of contamination, secondary IV tubing (used for medication administration) shall remain attached to the primary administration set and not removed after each injection.
5. If the secondary (piggyback) IV tubing is not being used or becomes disconnected it shall not be reconnected but replaced with new secondary tubing. This includes situations when a patient is receiving medications that could cause precipitate if administered through the same line. A new secondary tubing set shall be used for each infusion.
6. Eliminate open stopcocks from tubing and instead use needleless connectors, which must be vigorously cleaned with alcohol before entry.

Complications and Nursing Interventions

A. **Immediate Complications:**

1. Excessive bleeding: verify venous placement. Apply direct pressure.
2. Chest pain: Assess and rule out causes. Notify physician.
3. Numbness and tingling of arm or hand for greater than 30 minutes: Catheter must be removed.
4. Catheter Embolism: DO NOT LEAVE THE PATIENT. Immediately place finger over portion of catheter in vein to prevent migration into heart and pulmonary vasculature. For pediatric and adult patients, place tourniquet on uppermost portion of effected extremity. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.
5. Air Embolism: DO NOT LEAVE THE PATIENT. Stop entry of air. If catheter is in place, attempt to aspirate air. Prepare for code blue. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.
6. Nerve irritation/damage: Stop insertion and remove all devices that have been inserted. Insert device in new location.

B. **Unsuccessful Insertion- Notify Provider:**

1. Malposition (if identified before sterile field broken): attempt to reposition catheter by partially withdrawing catheter, repositioning patient, and reinserting catheter.
2. Difficulty advancing the catheter/removing stylet: Stop procedure. If catheter and stylet can easily be removed, remove catheter and notify the provider.
3. Cardiac arrhythmias: Withdraw catheter 1 centimeter (cm) and observe for resolution: if dysrhythmias persist, continue to withdraw catheter.

Delayed Complications

1. Phlebitis: Transient phlebitis may occur in first 48 hours after insertion. Increased range of motion of extremity and applying heat may alleviate the symptoms. Consult with physician before removing catheter.
2. Infection: Swelling or tenderness on the affected side, fever. Notify LP. recommendation for

neutralizing coating.

3. Malposition: Remove catheter.
4. Bleeding/hematoma: Some oozing (a few drops of blood, not a steady ooze) is expected for first 24-48 hours. Apply pressure to site for at least 5 minutes until hemostasis is achieved following insertion: a pressure dressing may be required. Place a small piece of sterile gauze under dressing to wick blood from site. If available, place topical hemostatic agent at insertion site. Investigate potential causes of persistent bleeding.
5. Occluded Catheter: Check line for kinks, constrictive dressing or precipitate from medications. If clotted catheter suspected, notify physician.

Documentation:

1. Document all insertion related elements in Cerner. Additional documentation should include:

- "Time Out" form.
- "CLIP" form.
- PICC supply charge and order for PICC supply charge.
- Post procedure note
- Reason/indication for line (line necessity).
- Hand hygiene performed.
- Maximum sterile precautions used.
- Site prep and if dry prior to access.
- Date, time, and site/vein of PICC insertion.
- Condition of site.
- Use of ultrasound/needle guidance.
- Number of placement attempts.
- Arm circumference.
- Size of PICC, length of PICC, number of lumens, manufacturer's lot number, reference number and expiration date.
- Amount of 1% lidocaine administered (if used).
- Document lidocaine administration in Medication Administration Record (MAR)
- Internal length of catheter inserted and external length from patient to hub.
- Blood return.
- Line securement (dressing).
- Patient response to the procedure.
- Complications during the procedure, and intervention.
- Verify tip location to confirm placement in the lower 1/3 of the Superior Vena Cava (i.e., Cavoatrial Junction).
- Patient education.

Continuing Care

1. Routine sterile dressing changes are every 7 days and as needed (PRN) if soiled. Antimicrobial patch, PIV securement device, and transparent dressing must be changed.
2. All patients with central access shall receive a daily full-body chlorhexidine gluconate (CHG) bath.
3. Arm circumference (at the location of the site) should be checked, documented, and trended if

~~deep vein thrombosis (DVT) is suspected.~~

~~References~~

1. ~~Infusion Nurses Society. *Policies and Procedures for Infusion Therapy: Acute Care*. 6th ed. Infusion Nurses Society; 2021.~~
2. ~~Kaiser Permanente. (2019). Peripherally Inserted Central Catheter (PICC) and Midline Catheter Insertion. Southern California (SCAL): Regional Guideline.~~

Purpose

To provide guidelines to standardize the practice of PICC catheter insertion, in order to minimize the risk of device related complications and optimize patient outcomes.

Policy

To provide guidelines to facilitate standardization of practice for the insertion of peripherally inserted central catheter (PICC) catheters.

Scope

This applies to Registered Nurses (RNs) who have successfully completed population- appropriate training and demonstrated competency in vascular access device insertion, care and maintenance, and patient/ caregiver education across the care continuum. Nurse practitioners (NPs) who have privileges for this procedure are also in scope.

Definitions

Peripherally Inserted Central Catheter (PICC): a central vascular access device (CVAD) inserted into a peripheral vein and threaded into the central venous circulation. The tip of the PICC should reside in lower 1/3 of the superior vena cava (cavoatrial junction) for upper-body insertions.

Provisions

A. Selection of the appropriate vascular access device (peripheral or central) shall accommodate:
   1. Patient's vascular needs.
   2. Diagnosis.
   3. Type and length of prescribed treatment regimen.
   4. Duration of dwell.
   5. Condition of the vasculature.
   6. Patient/caregiver's preference.
   7. Ability and resources to care for the device.

B. The vascular access device shall be the smallest gauge and length with the fewest number of lumens and shall be the least invasive device needed to accommodate and manage the prescribed therapy.
   1. Select the vein or site that best accommodates the outer diameter and length of the vascular access

device (VAD) required for the prescribed therapy.

2. Catheter-to-vein ratio of <45%.
3. VADs shall be accessed with 10ml or larger syringes.
4. Prior to PICC insertion, review patient's history and all pertinent lab results including but not limited to platelet count, international normalized ratio (INR), glomerular filtration rate (GFR), and serum creatinine.
5. In adults, use an upper extremity site for catheter insertion.

C. Radiographic confirmation or other tip location confirmation system (TCS) will be utilized to assess location of catheter tip. Limiting but not contraindicated situations for ECG (electrocardiogram) TCS are in the patients where alterations of cardiac rhythm change the presentation of the P-wave as in atrial fibrillation, atrial flutter, severe tachycardia, and pacemaker driven rhythms. In such patients, who are easily identifiable prior to PICC insertion, the use of an additional method is required to confirm catheter tip location. See policy 108.044 ECG Guided Tip Confirmation System During PICC Placement.

1. When ECG TCS is used to determine optimal PICC tip placement in the superior vena cava (SVC), no radiographic confirmation is required. The Vascular Access Nurse inserting the catheter may approve use of the line per policy when the appropriate change in the P wave is noted. At the time of placement, the external catheter measurement will be documented.

D. Patients admitted to the hospital with a PICC should have a chest x-ray to verify placement prior to utilization.

Considerations for Vascular Access Device Placement

1. Patient stability.
2. Areas of pain on palpation.
3. Veins previously used or compromised (e.g., bruised, infiltrated, phlebitis, scleroses, corded or with presence of venous thrombosis).
4. Areas near venous valves.
5. Areas where there are planned procedures/veins needed for other purposes
6. Neurological injury
7. Localized edema.
8. Following axillary node dissection.
9. After radiation therapy on the proposed insertion side.
10. Lymphedema at the proposed insertion site.
11. Previous history of CVAD and central occlusion such as SVC Syndrome or stenosis of major upper thoracic vessels.
12. Known or suspected allergy to materials contained in the device.
13. History of medical conditions including cerebrovascular accident (affecting extremity being considered), bleeding disorders, anticoagulation therapy, and any condition that requires crutch walking.
14. Presence of other intravascular devices within the target vessel (e.g., pacemaker, other central lines, A-V

shunts for dialysis).

15. Uncontrolled bacteremia, fungemia, or other infections.
16. Thrombocytopenia or coagulopathies.
17. Fracture/orthopedic injury.
18. Decreased venous return.
19. Cardiac malformations
20. Nerve injury affecting insertion site.
21. Local infection, skin breakdown, and/or cellulitis.
22. Patient lab values.
23. Bleeding risk.
24. Areas of flexion.
25. Need for analgesia or sedation.
26. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs such as Chronic Kidney Disease (CKD) stage 4 and above indicated by a Glomerular Filtration Rate (GFR) of 29 or lower.

A. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of PICC.

B. Primary Licensed Practitioner (LP) will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.

C. Any discussions with physicians should be documented by the PICC nurse.

Competency

A. **Completion of an approved PICC Certification Course.**

B. **Initial competency assessment:**

1. Adult: A minimum of 5 complete PICC insertions (from assessment to tip verification) while being coached by a qualified Vascular Access Nurse, followed by a minimum of 3 successful independent ultrasound guided PICC insertions directly supervised by a qualified Vascular Access Nurse, are required for independent practice.

C. **Annual Competency:** Minimum eight hours of Continuing Education Units (CEUs) related to Vascular Access or current certification such as Certified Registered Nurse Infusion (CRNI), Vascular Access Board Certification (VA-BC), maintained.

1. Adult: A minimum of 10 successful PICC insertions per year.
2. Re-validation for those who do not meet minimum annual requirements will be 1 PICC observed by a qualified Vascular Access Nurse for a skills check-off. If this check- off is not passed, all initial competency requirements must be repeated.

Informed Consent Process

1. Informed consent must be completed by the LP. The clinician shall provide the patient/family with information on the risks, benefits and alternatives and document the informed consent in the Electronic

Health Record (EHR).

2. A LP's order is required for PICC insertion.
3. A signed written consent is required prior to PICC insertion.

Device Selection

1. **PICC**: Recommended for irritants or vesicants such as chemotherapeutic agents, total parenteral nutrition (TPN) with a dextrose concentration of greater than 10%, sclerosing agents, and/or patients with poor peripheral access.
2. **Power injectable PICC**: Required for the power injection of intravenous contrast. May also be used for hemodynamic monitoring, high flow rate Intravenous (IV) fluids, and blood administration.

PICC Insertion Barrier Precautions

1. Hair that requires removal for facilitation of catheter placement should be clipped using surgical clippers prior to catheter insertion, not shaved. Shaving may cause micro abrasions of the skin, allowing access of microorganisms into the body.
2. For PICC placement (including guidewire exchange), the person who inserts the line shall use maximal sterile barrier precautions including:
    - Sterile gloves (2 pairs).
    - Long-sleeved sterile gown.
    - Full sterile body drape with fenestration.
    - Bouffant cap.
    - Fluid shield mask or mask with protective eye wear.
3. Restrict non-essential persons from entering the patient/sterile area (within three feet) during insertion.
4. All persons entering the field and assisting with performing the procedure, shall wear sterile gown, mask, and cap.
5. Place mask on patient, as tolerated.
6. Following thorough hand hygiene, strict sterile technique shall be used throughout catheter insertion, care, maintenance, and removal.
7. The PICC must not be advanced once a post-insertion dressing has been applied.
8. Guidewire exchanges are discouraged and should not be performed unless absolutely necessary (patients having limited access sites, lack of alternative insertion sites, and/or patient is high risk such as having coagulopathy or morbid obesity). Do not use guidewire exchange if a catheter is suspected to be infected.
9. All PICCs shall have a needleless connector attached to the end of the lumen.
10. Suturing of the PICC is not recommended. Use appropriate securement device or application of sterile adhesive dressing to secure the catheter. Dressing should not wrap around the entire circumference of the patient's extremity.
11. Clinicians covered by this protocol are expected to comply with measures to mitigate central line associated bloodstream infections. See policy Central Venous Access Device policy- https://vcmc.policystat.com/policy/token_access/5ae53a8b-5087-4633-a053-a1086c21448d/

Equipment

1. Procedure kits or carts containing all necessary supplies are to be available for use at the time of PICC insertion and care/maintenance procedures (including those required for dressing change, needleless connector change, and removal).
2. Closed catheter access systems are used preferably over open systems for infusions, medication administration, and blood withdrawal. When an integral in-line administration system is unavailable, specific add-on devices (e.g., extension sets, in-line filters, manifolds, blunt cannulas, or stopcocks) may be required to facilitate delivery of prescribed therapy. The use of these devices should be limited to reduce the risk of contamination from manipulation, misconnection, or accidental disconnection.
3. Maximum barrier kit as described above.
4. Standard PICC insertion kit that includes all necessary components.
5. Sterile probe cover.

Pre-Procedure

A. **Assessment**

   1. Determine indication for PICC and obtain/verify LP order for PICC placement.
   2. Verify that the informed consent has been completed, and that it is signed and dated.
   3. Review patient's medical history, contraindications and indications for device placement, allergies, coagulation status, and other pertinent labs.
   4. Assess patient's current vascular access.
   5. Assess patient/caregiver readiness.

B. **Planning**

   1. Add PICC pre-procedure order set under ordering LP's name per protocol
   2. The goal is to minimize patient's discomfort during insertion and assure that the patient/caregiver will be informed of the need, purpose, and risks/benefits of PICC placement and signs/symptoms of possible complications.
   3. Gather equipment/supplies.
   4. Provide patient/caregiver education regarding indication for PICC, insertion procedure, and maintenance of the PICC and appropriate infection prevention measures to prevent Central Line Blood Stream Infection (CLABSI).
   5. The patient's assigned nurse shall be available to assist the PICC nurse especially if the patient is unable to cooperate during procedure.
   6. Close door to room/area and post sign indicating "Sterile Procedure in Progress- Do Not Enter."
   7. Note: for pediatric and neonatal patients, additional nursing staff shall be available to assist during the insertion procedure to provide sedation (if indicated), to monitor for signs of patient distress and to assist the RN placing the catheter by holding the patient.

C. **Pre Procedure**

   1. Perform patient identification with two appropriate identifiers (e.g., patient's full name, date of birth and/or medical identification number).

2. Explain procedure to patient/caregiver.
3. The person inserting the PICC must perform a time out with an observing Nurse before beginning the procedure and record the timeout in the EHR.
4. Perform hand hygiene and don clean gloves.
5. Conduct visual inspection of potential insertion site(s) to assess for skin integrity, erythema, edema, pain, compromised veins, etc.
6. Place ultrasound machine where ergonomically comfortable for clinician.
7. Examine the vasculature in the chosen extremity using ultrasound.
    - Ensure ultrasound probe has been disinfected with PDI® Super Sani Cloth Germicidal Disposable Wipes prior to use on patient.
    - Apply a liberal amount of sterile ultrasound gel (from single use packet) to patient's arm.
8. Apply probe to skin: visualize and note the location of veins, arteries, and nerves surrounding the proposed insertion site.
    - Assess veins for vessel size, path, round shape, and compressibility without a tourniquet.
    - Assess depth of intended vessel for venipuncture.
    - Assess for adequacy of vessel size compared to the proposed outer catheter diameter to promote hemodilution and preserve vessel health.
    - Avoid selecting smaller vessels to prevent phlebitis and thrombosis.
    - If marking the level of the proposed insertion site, utilize a single-use disposable skin marker on the outer aspect of the arm to avoid leaving ink under the dressing and to allow for appropriate skin cleansing.
    - Remove the ultrasound gel from the patient's skin.
9. To approximate the desired terminal tip location at the lower one-third of the SVC at the level of the Cavoatrial Junction (CAJ), measure from the proposed insertion site to the clavicular head on the right side and then down to the bottom of the third intercostal space on the right.
10. Remove gloves and discard.
11. Prepare for insertion, collecting necessary insertion supplies and setting up a sterile field.

D. **Procedure**

1. Perform hand hygiene.
2. Don head covering and mask.
3. Perform hand hygiene.
4. Open the insertion tray and PICC kit to create a sterile field and include items in the field using sterile technique as needed.
5. Don a pair of sterile gloves.
6. Place sterile drape under the extremity of the intended insertion site.
7. Prep the skin in the entire area where the dressing will cover. Cleanse insertion site using the preferred skin antiseptic agent of alcohol-based chlorhexidine solution according to the manufacturers' directions for use; allow to dry completely.

- Use an iodophor (e.g., povidone-iodine) or 70% alcohol if chlorhexidine solution is contraindicated.
- Use aqueous chlorhexidine if there is a contraindication to alcohol-based chlorhexidine.

8. Apply tourniquet proximal to the insertion site.
9. Remove sterile gloves and perform hand hygiene.
10. Don sterile gown and a new pair of sterile gloves.
11. Inside PICC kit, prime any needed extension set(s) and catheter with 0.9% sodium chloride.
12. Use stylet wires according to manufacturers' directions for use.
    - Never cut a wire of any kind.
    - If the catheter has a manufacturer-installed stylet wire, withdraw just past the desired length, bending the stylet wire over the catheter hub or locking in place before trimming the catheter to the premeasured length.
    - Stylet wire should not extend beyond the catheter tip.
13. Place large, sterile sheet drape with insertion site fenestration over the entire patient; best practice is to cover the patient's face with the large sterile drape. If the patient cannot tolerate having their face covered, the drape can be tented, and the patient can wear a mask or turn the head away from the insertion site.
14. Cover the ultrasound with the sterile probe cover and secure.
15. Apply sterile ultrasound gel to the skin over the proposed insertion site.
16. Relocate the intended vein with the ultrasound probe, verifying it is non-pulsatile and compressible.
17. Assess whether topical anesthetic agent is needed. NOTE: registered nurses who have demonstrated competency in placing PICC lines as noted above may administer lidocaine prior to the placement of a PICC line as a standardized procedure.
    - Inject local anesthetic subcutaneously at the insertion site, if needed. Before injection, aspirate for the absence of blood return.
18. Apply covered probe to skin, visualize the vessel, and insert the micro introducer needle through the skin and into the vein using a 45° angle. Place the tip of the access needle on the skin at a distance from the probe that will intersect the vein within the plane of the scan field as the catheter is advanced to the intended vein's depth. Move the ultrasound probe toward the catheter to identify the catheter tip. Move the ultrasound probe and needle in the same direction, keeping the needle tip in view on the screen as the catheter approaches and enters the lumen of the intended vessel. Make sure to keep the gel and probe away from the sterile catheter.
19. Align the path of the needle to enter the center most superficial area of the vein wall and observe the needle tip entering the lumen of the vein.
20. Confirm slow venous blood return is the color and consistency of whole blood.
    - If blood return is pulsatile, immediately abort the procedure by removing the needle and tourniquet and applying pressure to the area for 10 minutes or until hemostasis is achieved.
21. Observe for blood return in the micro introducer needle hub and visualize the needle tip in the center of the vein on ultrasound before proceeding.
22. Put the ultrasound probe down on the sterile field.

23. Reduce the angle of the micro introducer needle and stabilize.
24. Insert the floppy-tipped guidewire into the micro introducer needle, threading into the vein. The guidewire should never be inserted into a position beyond the level of the axilla without fluoroscopy guidance.
25. Carefully remove the micro introducer needle from the vein and skin by pulling it back over the guidewire.
    - Do not allow the guidewire to move outward through the micro introducer needle due to risk of severing the guidewire.
26. Secure the guidewire with your nondominant hand to prevent migration in or out of the vein.
27. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
28. Make a skin nick, if needed.
    - Using a scalpel, hold the blade with the blunt side against the wire.
29. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
30. Remove the guidewire.
31. Release the tourniquet, using caution not to break sterile technique.
32. Slowly remove the dilator, leaving the peel-away introducer sheath in the vein.
33. Slowly advance the PICC catheter through the introducer sheath.
34. Continue to advance the catheter slowly to the predetermined measurement.
    - If using a tip-locating device, follow policy 108.044 Clinical Implementation Guide for: ECG Guided Tip Confirmation System During PICC Placement.
    - If tip-location technology is not being used, withdraw the stylet wire from the catheter lumen, using air emboli precautions.
35. Attach sterile 0.9% sodium chloride-filled syringe and aspirate for blood return (the color and consistency of whole blood) from catheter and flush to determine patency.
36. Break the wings and slowly peel away the introducer sheath as it is withdrawn, taking care to allow the catheter to remain in its terminal tip location.
37. Apply a needleless connector to each lumen.
38. Clean excess blood and ultrasound gel from the insertion site using chlorhexidine solution.
    - Ensure there is no oozing of blood from PICC entry site and hold pressure using sterile gauze to achieve hemostasis if necessary.
39. Apply sterile alcohol-free skin barrier product around the perimeter of the intended dressing site.
    - Do not apply barrier film/product directly under chlorhexidine-impregnated sponge or gel patch as the solution will block its action at the puncture site.
    - Allow product to completely dry before dressing is applied.
40. Apply chlorohexidine-impregnated sponge (e.g., Biopatch™) or gel and securement device/product. Then apply Transparent semi-permeable membrane (TSM) dressing (e.g., Tegaderm™).

a. If applying an antimicrobial patch, align the slit of the patch with the PICC line.

41. Flush each PICC lumen with a minimum of 10ml normal saline in a 10ml syringe.
42. Label dressing with date, time performed, and clinician's initials.
43. Place an alcohol impregnated cap on the needleless connector of each of the PICC lumens.
44. Place a sign above the patient's bed with: "NO VENIPUNCTURE OR BLOOD PRESSURE IN UPPER EXTREMITY where PICC has been placed (e.g., Right/Left arm)."
45. Discard used supplies in appropriate receptacles.
46. Remove personal protective equipment (PPE) and perform hand hygiene.
47. Clean and disinfect ultrasound probe by removing sterile ultrasound cover, wiping away excess gel, and cleansing with PDI® Super Sani-Cloths Wipes.
48. Obtain a chest radiograph to determine tip placement if not using a tip locating confirmation system device and get verification from radiologist of PICC placement in SVC prior to use.

E. **Post Procedure:**

1. After successful PICC placement, educate patient/caregiver regarding care and maintenance of PICC, steps to avoid catheter dislodgement, and daily flushing schedule.
2. Provide education to patient/caregiver as to signs and symptoms of common complications and how and whom to report complications.
3. Measure arm circumference at the site.
4. Add PICC post-procedure order set and "okay to use" order under ordering physician's name per protocol.

Infusion Tubing Configuration

1. Any tubing and fluid/medication bags hooked up to the PICC should be new having not been hooked up to any other peripheral IV (PIV) or central lines, including secondary tubing and bags.
2. The configuration of infusion tubing is integral to the efficient and safe use of the PICC. When assembling the infusion tubing, requirements for all infusates must be considered to ensure the appropriate number of injection ports are available for set-up and to prevent unnecessarily accessing the catheter later.
3. Infusion tubing connected to the PICC shall be luer-locked.
4. To minimize entry into the PICC and decrease the risk of contamination, secondary IV tubing (used for medication administration) shall remain attached to the primary administration set and not removed after each injection.
5. If the secondary (piggyback) IV tubing is not being used or becomes disconnected it shall not be reconnected but replaced with new secondary tubing. This includes situations when a patient is receiving medications that could cause precipitate if administered through the same line. A new secondary tubing set shall be used for each infusion.
6. Eliminate open stopcocks from tubing and instead use needleless connectors, which must be vigorously cleaned with alcohol before entry.

Complications and Nursing Interventions

A. **Immediate Complications:**

1. Excessive bleeding: verify venous placement. Apply direct pressure.
2. Chest pain: Assess and rule out causes. Notify physician.
3. Numbness and tingling of arm or hand for greater than 30 minutes: Catheter must be removed.
4. Catheter Embolism: DO NOT LEAVE THE PATIENT. Immediately place finger over portion of catheter in vein to prevent migration into heart and pulmonary vasculature. For pediatric and adult patients, place tourniquet on uppermost portion of effected extremity. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.
5. Air Embolism: DO NOT LEAVE THE PATIENT. Stop entry of air. If catheter is in place, attempt to aspirate air. Prepare for code blue. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.
6. Nerve irritation/damage: Stop insertion and remove all devices that have been inserted. Insert device in new location.

B. **Unsuccessful Insertion- Notify Provider:**

1. Malposition (if identified before sterile field broken): attempt to reposition catheter by partially withdrawing catheter, repositioning patient, and reinserting catheter.
2. Difficulty advancing the catheter/removing stylet: Stop procedure. If catheter and stylet can easily be removed, remove catheter and notify the provider.
3. Cardiac arrhythmias: Withdraw catheter 1 centimeter (cm) and observe for resolution: if dysrhythmias persist, continue to withdraw catheter.

Delayed Complications

1. Phlebitis: Transient phlebitis may occur in first 48 hours after insertion. Increased range of motion of extremity and applying heat may alleviate the symptoms. Consult with physician before removing catheter.
2. Infection: Swelling or tenderness on the affected side, fever. Notify LP. recommendation for neutralizing coating.
3. Malposition: Remove catheter.
4. Bleeding/hematoma: Some oozing (a few drops of blood, not a steady ooze) is expected for first 24-48 hours. Apply pressure to site for at least 5 minutes until hemostasis is achieved following insertion: a pressure dressing may be required. Place a small piece of sterile gauze under dressing to wick blood from site. If available, place topical hemostatic agent at insertion site. Investigate potential causes of persistent bleeding.
5. Occluded Catheter: Check line for kinks, constrictive dressing or precipitate from medications. If clotted catheter suspected, notify physician.

Documentation:

1. Document all insertion related elements in Cerner. Additional documentation should include:

- "Time Out" form.
- "CLIP" form.
- PICC supply charge and order for PICC supply charge.
- Post procedure note
- Reason/indication for line (line necessity).
- Hand hygiene performed.
- Maximum sterile precautions used.
- Site prep and if dry prior to access.
- Date, time, and site/vein of PICC insertion.
- Condition of site.
- Use of ultrasound/needle guidance.
- Number of placement attempts.
- Arm circumference.
- Size of PICC, length of PICC, number of lumens, manufacturer's lot number, reference number and expiration date.
- Amount of 1% lidocaine administered (if used).
- Document lidocaine administration in Medication Administration Record (MAR)
- Internal length of catheter inserted and external length from patient to hub.
- Blood return.
- Line securement (dressing).
- Patient response to the procedure.
- Complications during the procedure, and intervention.
- Verify tip location to confirm placement in the lower 1/3 of the Superior Vena Cava (i.e., Cavoatrial Junction).
- Patient education.

Continuing Care

1. 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.
    - When gauze is placed under a transparent dressing, it is considered to be a gauze dressing and is changed every two (2) days.
    - 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).
2. All patients with central access shall receive a daily full-body chlorhexidine gluconate (CHG) bath.
3. Arm circumference (at the location of the site) should be checked, documented, and trended if deep vein thrombosis (DVT) is suspected.
4. See "108.055 Central Venous Access Device (CVAD or "Central Line") Care and Maintenance for Adult Patients" policy for further PICC care and maintenance standards.

References

1. Infusion Nurses Society. *Policies and Procedures for Infusion Therapy: Acute Care*. 6th ed. Infusion Nurses Society; 2021.
2. Kaiser Permanente. (2019). Peripherally Inserted Central Catheter (PICC) and Midline Catheter

Insertion. Southern California (SCAL): Regional Guideline.

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

Attachments

CHG Gel Dressing by 3M.pdf

Approval Signatures

Step Description	Approver	Date
Interdisciplinary Practice Committee	Tracy Chapman: VCMC - Med Staff	pending
Medicine Committee	Tracy Chapman: VCMC - Med Staff	3/4/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/4/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/4/2023
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/4/2023

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.02 Cancer Registry Case Eligibility Criteria

POLICY:

All patients with reportable diagnosed malignancies and/or who received cancer directed care and/or who expired with active cancer at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) must be included in the Cancer Registry database. The Cancer Program Reference Date is 1/1/2015.

PROCEDURE:

Reportable cases are defined as all VCMC/SPH inpatients and outpatients with a clinical or pathological diagnosis of cancer that meets the criteria in the Reportable List. Outpatient departments include Medical oncology, the Gastrointestinal Lab (GI Lab), Outpatient Surgery, and any other hospital operated outpatient clinic providing care to cancer patients. Patients first diagnosed in a staff physician's office and referred to VCMC/SPH for further staging procedures and/or definitive treatment must also be included.

Definitions:

- Reportable Cases:
- The following tumors must be accessioned and abstracted:

1. All carcinomas, sarcomas, melanomas, leukemia, lymphomas and tumors designated with a malignancy behavior code of 2 or higher in the International Classification of Diseases for Oncology (ICDO-3).
2. Basal cell and squamous cell carcinomas originating in mucoepidermoid sites including lip (C00.0-C00.9), anus (C21.0), vulva (C51.0-C51.9), penis (C60.0-C60.9), and scrotum (C63.2).
3. All skin cancers (C44.0) with a histology of 8000-8004, 8010-8045, 8050-8076, 8081-8082, 8090-8110 and at diagnosis, the American Joint Committee on Cancer (AJCC) stage group is II (T2 N0 M0), III (any T N1 M0), or IV (any T and any N and M1).

   ~~Gastro-intestinal stromal tumors (GIST) and thymomas must be assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.~~

4. Gastro-intestinal stromal tumors (GIST) are reportable with a malignant behavior /3 in ICD-O-3.2, 8936/3, dx 01/01/2021+
5. Thymoma are nearly all reportable, behavior /3 in ICD-O-3.2, dx 01/01/2021+ (Exceptions : Microscopic thymoma or thymoma, benign, 8580/1, Micronodular thymoma with lymphoid stroma, 8580/1, Ectopic hamartomatous thymoma, 8587/0.)

6. Effective 2015 Carcinoid tumors of the appendix (C18.1) must be coded 8240/3.
7. Lymphangioleiomyomatosis, 9173/3, dx 01/01/2023+
8. Malignant perivascular epithelioid cell tumor (PEComa), dx 01/01/2018+
9. Mesothelioma in situ, 9050/2, dx 01/01/2023+
10. Severe or high-grade dysplasia, documented as being synonymous with carcinoma.
11. Any patient with admitted for subsequent treatment for recurrent, persistent, progressive or metastatic cancer which was previously diagnosed and initially treated elsewhere.
12. Any patient with active disease who expires during a VCMC/SPH admission, including those admitted for and/or expiring from unrelated medical conditions.
13. Cases that are not histologically confirmed but are clinically diagnosed by a physician using the following terminology to describe the tumor:
    - apparently (malignant)
    - appears
    - comparable with
    - compatible with (malignancy)
    - consistent with (malignancy)
    - suspect/suspected (malignancy)
    - suspicious (of malignancy)
    - malignant appearing
    - presumed (malignant)
    - probable (malignancy)
    - most likely (malignancy)
    - typical (of malignancy)
    - Neoplasm* beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)
    - Tumor* (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)
    - additional terms for nonmalignant intracranial and CNS tumors only
14. Patients admitted for terminal support care.
15. Patients admitted to the Rehabilitation Program as part of their cancer treatment plan.
16. Non-Reportable Cases:
    The following tumors should not be accessioned and abstracted:
    1. Localized basal and squamous cell carcinomas of the skin except for lesions of the mucous membrane and external genitalia.
    2. Patients seen only in consultation to confirm a diagnosis or treatment plan, or who receive a service not available at the diagnosing or treating facility such as CT and MRI scans, or for placement of venous access devices. Pathology reports that are consultations only must be kept in the "Pathology Report Consultation File" in the Registry office. These reports are filed alphabetically by year.

3. Patients with a past history of cancer who are clinically free of the disease at the time of their VCMC/SPH admission.
4. Cases that are not histologically confirmed and the physician uses the following terminology to describe the tumor:
    - Cannot be ruled out
    - Rule out
    - Equivocal
    - Suggests
    - Possible
    - Questionable
    - Worrisome
    - Potentially malignant
5. Patients with precancerous conditions or benign tumors.
6. Patients with prostatic intraepithelial neoplasia.
7. Patients who are diagnosed at a staff physician office and treated at another facility.

Reference:

Standards for Oncology Registry Entry (STORE)

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Cancer Committee	Tracy Chapman: VCMC - Med Staff	pending
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	2/27/2024

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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.01 Admitting Patients to the Emergency Department

POLICY:

To expedite care of each patient admitted to the Emergency Department (ED) according to the individual patient needs.

PROCEDURE:

A. Patients will be admitted to the ED via walk-in, ambulance, accompanied by inpatient psychiatric unit (IPU) or helicopter transport. Patients will be seen according to the seriousness of the complaint. ~~The~~At VCMC, the Greeter RN will be present in the waiting room to make initial contact with patients to evaluate urgency. Subsequently, the Triage Nurse will ~~respond to the triage area to~~further assess all walk-in patients. ~~The Admitting Clerk~~Santa Paula has a triage RN only. The Greeter RN or the Triage RN will notify the ~~Triage or~~ Charge Nurse ~~of the~~when a patient~~'s arrival~~ needs priority bedding.

B. Patients with the following complaints or symptoms will receive priority in treatment and will be brought into the treatment area before others:

1. Any comatose or semi-comatose patient
2. Any patient with possible syncopal episode or seizure.
3. Any patient complaining of chest pain.
4. Any patient complaining of shortness of breath.
5. Any patient with poisoning or ingestion of potentially dangerous substance.
6. Any patient with an acute burn.
7. Any patient with significant bleeding.
8. Any patient with trauma to the eye, sudden onset of decrease in vision or toxic exposure to the eye.
9. Any newly paralyzed or partially paralyzed patient.
10. Any active GI bleeding or uncontrolled hemorrhage.
11. Any patient with an open fracture or fracture deformity with circulatory compromise.
12. Any patient with major trauma or multiple traumas.
13. Any pregnant patient with vaginal bleeding or severe distress.

14. Any behaviorally disturbed patient/suicidal patient.
15. Any patient with gunshot wound(s) or stab wound(s).
16. Any patient with amputated parts.
17. Any patient who subjectively or objectively requires immediate attention even if not in the above named groups.

C. The Admitting Clerk will complete the demographic information in the Electronic Health Record (EHR) after the patient has been assessed by the Triage Nurse and medically screened by a physician.

~~1. At a minimum the hospital/ED record (EHR) shall contain:~~

~~a. Patient information~~

~~b. Date of visit or admission~~

~~c. Date of notification~~

~~d. Reason for visit, if known~~

~~e. Documentation received~~

~~f. Documentation requested~~

The Admitting Clerk will enter the means of arrival, whether patient wants to be in the directory and the reason for visit.

D. Quality data is monitored by the Healthcare Agency (HCA) and is reported on, at least, an annual basis.

1. Timely sharing of information with admitting hospitals and EDs
2. Data the HCA receives about its patients' hospital/ED visit are scanned into the patient's EHR
3. Adherence to protocols regarding patients transitioning from pediatric to adult care based on a percentage of applicable patients receiving a written care plan.

All revision dates: 11/9/2023, 5/10/2023, 12/1/2013, 9/1/2011, 6/1/2009, 12/1/2004, 11/1/2001, 1/1/1995, 10/1/1992

Attachments

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Step Description	Approver	Date
Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/9/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/9/2023
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	11/9/2023

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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.03 Against Medical Advice (AMA)

POLICY:

To provide information to Emergency Department (ED) staff to facilitate discharge of a patient who has not been deemed medically clear for discharge.

PROCEDURE:

A. The "Against Medical Advice" (AMA) form must be completed when a patient demands to leave after a medical screening exam has been completed, but a physician has not written a discharge order.

B. The "Patient Medical Screening Examination Refusal Form" will be completed when a patient refuses a primary medical screening examination by a physician.

C. The ED nurse, in conjunction with the ED physician, is responsible for completion of the appropriate documentation and/or intervention. The ED nurse is responsible for notifying the provider if the patient wants to leave AMA.

D. ~~Before the patient leaves the hospital, an explanation shall be given to him/her concerning the risk involved.~~The ED provider must provide the patient an explanation concerning risk and potential negative outcomes and alternatives, as well as demonstrate patient capacity. ED provider will also document the following:

1. Patient capacity
2. Reasons for wanting to leave
3. Clear explanation to patient of medical concern and risks of treatment refusal
4. Patient understanding of provider concerns
5. Therapies offered to patient still available after AMA decision
6. Invitation to return for further eval and treatment at any time.

E. Whether the patient will sign the form or not, a copy will be provided to the patient (or parent or guardian) for signature in the presence of two witnesses.

F. If the patient refuses to sign the form, indicate so in the space provided for the patient's signature. Include date, time, explanation, and the nurse's signature.

G. The signature of a witness will complete the form.

H. Charting will be completed in the patient's Electronic Health Record (EHR) and the AMA form should be

placed in the patient's chart with a label to be scanned into the patient's EHR.

All revision dates:	11/9/2023, 1/23/2020, 12/1/2013, 9/1/2011, 7/1/2009, 12/1/1998, 6/1/1995, 12/1/1994, 12/1/1993, 12/1/1992, 10/1/1991

Attachments

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/14/2023
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References:	

ER.22 Standards of Care in the Emergency Department

POLICY:

The purpose of the Emergency Department (ED) at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) is to provide adequate evaluation and treatment to any patient with an illness or injury who presents to the Department. The patient is entitled to a clean, organized therapeutic environment. All team members must cooperate and strive to maintain the ED to meet these standards.

PROCEDURE :

All nursing staff in the ED report directly to the ED Clinical Nurse Manager. There will be a Charge Nurse appointed for each shift. Charge Nurse duties are listed under the section entitled "Charge Nurse."

1. Nursing and Medical Personnel will collaborate to formulate a plan of care for the patient.
2. In the case of death or serious injury, the Registered Nurse (RN) and the physician will communicate with the family.
3. Each family is entitled to receive periodic information by the nursing staff regarding the general status of the patient.
4. To adequately care for patients, a comprehensive report will be given to the on-coming shift.
5. An RN and/or physician will accompany every critically ill patient to the floor. Resuscitation equipment, monitor and defibrillator will be taken when the condition of the patient deems it necessary.
6. Referral to resources within the Ventura County Health Care Agency (VCHCA) and the community will be made available to patients as needed.
7. The ED clerical and nursing staff will cooperate to provide an efficient and professional environment for the patient and family.
8. To ensure patient privacy, only the first three (3) letters of the last name will be entered on the tracking board.
9. To ensure patient safety, all medication orders must be entered into the electronic health record (EHR) prior to administration except in a true emergency.
10. Safety precautions must be followed at all times.
11. Patients presenting themselves to the ED will be triaged according to the policies set down in the

admission of patients to the ED.

12. All patients will have an ED record completed and will be seen by a physician on duty, or Advanced Practice Provider, in the ED or by their private physician. Nursing staff will complete a nursing assessment appropriate for the patient's problem.
13. Any patient receiving medication which could possibly produce an untoward response, will be observed for a minimum of 20 minutes prior to discharge.
14. All patients admitted with a wound or laceration will be evaluated for tetanus immunization status. Documentation of such will be noted in the EHR.
15. Patients receiving sedatives and/or narcotics will be observed for a minimum of 20 minutes after the drug is given. Patients must have someone to drive them home prior to receiving the medication, and must be instructed not to drive.
16. All reportable conditions or injuries such as dog bites, venereal disease, child abuse, adult abuse, domestic violence, etc. will be reported per hospital policy.
17. All treated patients will be given printed aftercare instructions in their language of choice. These aftercare instructions will be explained to the patient by the nurse or physician prior to discharge. Vital signs will also be documented upon discharge in the EHR.
18. Any treatment or medication given to the patient will be documented in the EHR.
19. Report will be given to the receiving nurse on all admitted and transferred patients and nurse's notes will be completed (see ED policy ER.A.14, *Admission to the Hospital from the Emergency Department*).
20. No patient will be transferred from the ED until his/her medical condition is stabilized to a degree that allows for safety during transport. No patient will be transferred arbitrarily. No patient will be transferred without acceptance by the receiving facility of physician. See section on "Transfers."
21. Consideration will be given to patients who are in the custody of a law enforcement officer, Mental Health, or CYA so that treatment is expedited and those staff may return to their duties.
22. "Doctor's First Report of Injury" form will be completed on all industrial accidents.
23. All surgical specimens will be sent to Pathology, except those specimens removed for legal examinations, which will be given to law enforcement agents.
24. Vital signs and weight will be recorded on all patients upon admission and as often as needed and/or ordered. Fetal heart tones will be attempted on all pregnant females beyond 12 weeks and results documented in the EHR. Head circumference will be measured on all patients under two (2) years of age with a soft anterior fontanel, whenever medical condition warrants.
25. If medications are administered in the ED, name, dosage, route of administration, site of administration, time given, and results shall all be documented in the EHR.
26. Pain assessment will be noted with each set of vital signs within 60 minutes after intervention/medication.
27. Nursing care shall be delivered consistent with Hospital policy, scope of practice and as directly related to the needs of the patient.
28. Communication will be conducted with a patient's primary care provider/specialist as needed..

All revision dates: 1/16/2024, 3/4/2020, 9/1/2016, 12/1/2013, 8/1/2011, 5/1/2006, 12/1/2004, 11/1/2001, 12/1/1998, 1/1/1995, 10/1/1992

Attachments

No Attachments

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Emergency Department Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2024
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	1/16/2024

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References:	

ER.46 Treatment of Jail Inmates/Persons on a Legal Hold

POLICY :

To inform Ventura County Medical Center/Santa Paula Hospital Emergency Department (ED) staff of the manner in which to facilitate treatment of jail patients/persons on legal hold.

PROCEDURE:

A. Jail patients or any person under a legal hold accompanied by a law enforcement officer, will have priority in treatment whenever possible.

B. Inmates who are acutely ill and who would normally require inpatient care will be admitted to the hospital. In addition, inmates who require narcotics, intravenous fluids or medications, traction, breathing treatments, oxygen, suctioning, monitoring, hourly vital signs, etc., will be admitted to the hospital and not returned to the jail or jail infirmary. The Sheriff's Office will, when deemed necessary, provide 24-hour security coverage for hospitalized inmates.

C. The decision to place an inmate in the infirmary is usually made by the jail physician or other jail medical staff.

D. Inmates who require no treatment or a low level of treatment will be discharged to the jail after medical clearance

E. All medications will be placed in the custody of the accompanying officer.

F. The accompanying officer on all jail patients treated in the ED will complete a "Legal Hold Form." A copy will be placed on the face sheet.

G. A printed copy of the patient's completed EHR will be placed in a sealed envelope and given to accompanying law enforcement officer when the inmate is returned to the jail or jail infirmary. The officer will sign aftercare instructions.

All revision dates: 11/1/2016, 12/1/2013, 5/1/2006, 4/1/2003, 11/1/2001, 1/1/1995, 10/1/1992

Attachments

No Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/26/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/26/2024
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	1/26/2024

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Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
Policy Area:	*Intensive Care Unit*
References:	

ICU.22 Admission Criteria to the Telemetry Units

POLICY:

The Telemetry Unit provides care for and continuous cardiac monitoring of patients in stable condition and having or suspected of having a cardiac condition or a disease requiring telemetry monitoring, recording, retrieval and display of cardiac electrical signals. ~~This~~ICU 2 is further defined as a specialty unit ~~is further defined as a specialty unit~~ in relation to the specialized chemotherapy and oncological care provided to those patients diagnosed with cancer. Med Surg 3 is an additional unit for patients at telemetry or medical surgical level of care.

PROCEDURE:

Patient transfers from the Intensive Care Unit (ICU), Definitive Observation Unit (DOU), and/or Emergency Department/clinic referrals shall meet criteria for telemetry admission as outlined below.

CRITERIA FOR ADMISSION OF PATIENTS

a. Hemodynamically stable

b. Neurological evaluation limited to every four (4) hours.

c. Chemotherapy infusions (only in the ICU ~~1~~2 unit).

d. One or more appropriate indications for telemetry monitoring outside the ICU/DOU (refer to Attachment A).

e. ~~Respiratory illness requiring continuous oximetry monitoring.~~Continuous pulse oximetry monitoring without telemetry can be managed in Med Surg 1.

EXCLUSION CRITERIA FOR ADMISSION

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

B. Respiratory failure requiring invasive or noninvasive positive pressure ventilation.

C. Patient requiring neurological evaluation more frequently than every four (4) hours.

D. Sustained ventricular tachyarrhythmia.

E. Patients with active, uncontrolled chest pain secondary to an acute coronary syndrome.

F. Type II second-degree or third-degree AV block (symptomatic or asymptomatic).

G. Patients with acute ST segment changes on EKG.

H. Patients requiring insulin drip.

I. Severe alcohol withdrawal (with or without delirium tremens) requiring high doses of benzodiazepines.

Additional Criteria includes:

A. Admission by members of Medical Staff, Residents, Emergency Department physicians.

B. Initiation of telemetry monitoring requires a written physician's order according to telemetry guidelines (refer to Attachment A).

General Discharge Criteria:

APPROPRIATENESS FOR DISCHARGE — The medical necessity of continued hospitalization is primarily determined by the presence of an acute health condition of sufficient severity that ongoing diagnostic or therapeutic intervention, or careful monitoring, is required.

When it has been determined that a patient is medically ready for discharge, the health care team must determine the most appropriate setting for ongoing care. Determinants of the appropriate site of care involve medical, functional, and social aspects of the patient's illness. The patient’s acute and chronic medical conditions, potential for rehabilitation, and decision-making capacity must be taken into account.

Input is needed from multiple sources to determine the most suitable discharge plan. Involved parties often will include the patient, family, case manager, nurse, physician, physical and occupational therapist, social worker, and insurer.

In order for the patient to be deemed safe and ready for discharge to home or to a non-acute environment (rehabilitative, transitional, or chronic care), a provider must take into account a number of factors beyond the medical determinants. These factors include:

- Patient cognitive status
- Patient activity level and functional status
- The nature of the patient's current home and suitability for the patient's conditions (eg, presence of stairways, cleanliness)
- Availability of family or companion support
- Ability to obtain medications and services
- Availability of transportation from hospital to home and for follow-up visits
- Availability of services in the community to assist the patient with ongoing care

At the time of discharge home, patients, with help from family or other caregivers if available, should be able to:

- Obtain and self-administer medications
- Perform self-care activities
- Eat an appropriate diet or otherwise manage nutritional needs
- Follow up with designated providers

Specific insurance benefits and availability of services in the community may also influence whether or not the patient may be safely discharged home. Home services, such as visiting nurses or infusion providers to administer intravenous infusions, may allow selected patients, who would otherwise need non-acute residential care, to manage their care needs at home.

A patient is deemed appropriate for discharge when all the following are present:

- Hemodynamic stability
- Cardiovascular status acceptable
- Respiratory status acceptable
- Stable chest findings
- Airway status acceptable
- Neurologic status acceptable
- Pain and nausea absent or adequately managed
- Abdominal status acceptable
- Hepatic and biliary abnormalities absent or acceptable
- Renal function acceptable
- Urinary status acceptable
- Temperature status acceptable
- Vascular, soft tissue, and wound status acceptable
- No infection, or status acceptable
- Physiologic disorders absent, or status acceptable
- Electrolyte status acceptable
- No blood loss, or problem resolved
- Behavioral health status acceptable
- No chest tube, or status acceptable
- Activity level acceptable
- Intake acceptable
- No inpatient interventions needed

SAFETY PRECAUTIONS

A. Patients meeting one or more of the exclusion criteria above will not be admitted to the Telemetry/ Oncology unit, but rather should be admitted to (or remain in) the DOU or ICU.

B. Each patient on the Telemetry/Oncology unit will be assessed daily by the attending physician or designee.

C. The need for continued telemetry should be reassessed by provider every 24 hours.

D. Appropriate Telemetry/Oncology orders must be completed for all admissions.

E. Telemetry Monitor alarms are "on," without exception.

F. ICU staff will provide overview/monitoring and response.

G. IV infusions and IV push medications allowed on the Telemetry unit are listed on the Intravenous Medication Guidelines for Adults.

PATIENT CARE

~~Care is provided by Registered Nurses or combination skill mix of Registered Nurse and Licensed Vocational Nurse.~~

~~Specialty-trained Registered Nurse will function as Resource Nurse.~~

A. Care is provided by Registered Nurses with support from ancillary staff, including nursing assistants.

B. Trained staff in Telemetry Medical System utilized for cardiac monitoring.

C. Status change reported to appropriate physician.

D. Internal Medicine attending or designee to be available for triage of patients.

~~If telemetry units (Medical Surgical 1 and ICU 1) are at capacity, five (5) beds in the post-anesthesia care unit (PACU) shall be utilized. The patient population that may be permitted to utilize this space shall be:~~

- ~~Postoperative (after recovery period)~~
- ~~Adult (14 years of age or older)~~
- ~~Without need for isolation due to infectious disease~~

~~As soon as bed availability exists on the telemetry unit, patients shall be transferred.~~

EQUIPMENT

A. Medical System Telemetry with monitoring screen ~~in the Telemetry/Oncology unit nurses' stations, DOU, and ICU~~.

B. Alarm System Response: by audible indicator and viewing information center with text information.

DOCUMENTATION

A. An admission assessment documented in electronic health record within six (6) hours of admission.

B. Nursing care plan and psychosocial questionnaire within eight (8) hours of admission.

C. Patient Care Note and Interventions.

D. EKG strip upon admission, every shift and PRN status change.

E. Indication for continuing telemetry monitoring must be documented daily.

KEY POINTS

- Report status changes promptly to physician.
- Unconfirmed dysrhythmia:
  i. Assess patient
  ii. CCU staff backup confirmation
  iii. Physician notification/assessment
- Efforts to protect the neutropenic patient may warrant consideration to prevent infectious exposures by omitting patients requiring isolation.
- This unit does not have capability of direct observation.
- All patients admitted to the Telemetry unit should have functional intravenous access at all times. The IV access is to be placed prior to the patient's admission to the Telemetry unit.
- Discontinuation of telemetry monitoring should be considered as soon as clinically appropriate, as outlined in ~~Attachement~~Attachment A.

All revision dates: 8/8/2023, 11/26/2018, 1/1/2017, 12/1/2004

Attachments

Attachment A - Admission Criteria to the Telemetry Unit

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/23/2024
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	1/23/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
Policy Area:	*Intensive Care Unit*
References:	

ICU.25 Neuromuscular Blocking Agents IV Infusion

POLICY:

Neuromuscular Blocking Agents (NMBAs) are high-alert medications that may be used to provide skeletal muscular relaxation during mechanical ventilation.

PROCEDURE:

NMBAs as a continuous infusion shall only be administered in intensive care areas upon a physician order while the patient is on a cardiac monitor, intubated on mechanical ventilation and adequately sedated. NMBAs shall be monitored using the Train of Four (TOF) method with a peripheral nerve stimulator. NMBAs are administered utilizing an infusion pump and guardrails.

1. NMBAs do not have any analgesic or sedating properties. Optimize pain control and sedation prior to NMBA administration.
    1. It is best practice to achieve a RASS -4 to -5 prior to starting the NMBA infusion.
    2. It is also recommend that patients be comfortable (e.g., CPOT < 3) prior to starting the NMBA infusion.
2. Nursing shall perform an independent double check per Policy PH.70 High Alert Medications.
3. Verify the goal of therapy and desired Train of Four response in the order.
4. Monitoring of neuromuscular blockade:
    a. Monitor NMBAs using the Train of Four method using a peripheral nerve stimulator. See Lippincott's reference for detailed process.
    b. It is best practice to obtain and document a baseline Train of Four prior to starting the NMBA infusion.
    c. Train of Four shall be measured hourly.

The physician shall be notified if the following occurs:

1. Inadequate pain control and/or sedation
2. Hemodynamic changes
3. Unable to obtain goal Train of Four at maximum dose ordered

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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	10/31/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/26/2023
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	10/26/2023

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Policy Area:	*Intensive Care Unit*
References:	

ICU.26 Admission to the DOU

POLICY:

The Ventura County Medical Center/Santa Paula Hospital Definitive Observation Unit (DOU) provides care for and continuous cardiorespiratory monitoring of patients in stable condition who require more intensive monitoring and nursing care than can be provided in the telemetry units (~~see~~ ICU.22 Admission Criteria to the Telemetry Units).

PROCEDURE:

Patient transfers from the Intensive Care Unit (ICU), medical/surgical and telemetry units, and/or Emergency Department/clinical referrals shall meet criteria for DOU admission ~~as outlined below~~.

Criteria for Admission of Patients and Exclusion Criteria:

1. ~~Hemodynamically stable~~
2. ~~Any patient requiring frequent (i.e., more often than q4h) nursing observation/care, vital signs and/or neurological assessments up to q2h in frequency (or q1h with a stop point)~~
3. ~~Hyperglycemia requiring a continuous insulin infusion and/or frequent lab draws (whether patient is in DKA or otherwise)~~
4. ~~Severe alcohol withdrawal necessitating up to 32mg of lorazepam in a 24h period~~
5. ~~Patients with active bleeding (from the GI tract or otherwise), severe sepsis, severe pancreatitis, recent major surgery, or other condition with the potential to cause hemodynamic compromise but who currently remain hemodynamically stable and/or fluid-responsive~~
6. ~~Patients with complex wound/drain management and/or postoperative care needs that cannot be met on the medical/surgical or telemetry units~~
7. ~~Respiratory failure requiring noninvasive positive pressure ventilation and/or close observation due to evidence of compromised gas exchange~~
8. ~~Patients with atrial fibrillation with rapid ventricular response requiring a diltiazem infusion rate > 10mg/hr OR active titration by nursing~~
9. ~~Severe hyponatremia (level ~115-122) requiring frequent monitoring~~
10. ~~Patients with an acute coronary syndrome (ACS) with acute ST-T segment changes on EKG (not including ST elevations) and/or who continue to have intermittent chest pain (insufficient to require a~~

~~nitroglycerin infusion) while awaiting catheterization~~

11. ~~Other downgrades from the ICU who no longer require an ICU level of care but continue to require close monitoring~~
12. ~~DOU may also be considered for placement of patients receiving chemotherapy~~

~~Exclusion Criteria:~~

1. ~~Hemodynamic instability and/or need for invasive hemodynamic monitoring or pressor agents.~~
2. ~~Respiratory failure requiring invasive positive pressure ventilation.~~
3. ~~Patient requires vital signs or neurological evaluations more frequent than q2h (beyond a brief, defined period of q1h).~~
4. ~~Sustained ventricular tachyarrhythmia.~~
5. ~~Patient with ongoing, uncontrolled chest pain due to ACS who require a nitroglycerin drip OR who have ST-segment elevations.~~
6. ~~Hypertensive emergencies (ie with evidence of associated ACS, congestive heart failure, or other end-organ complications), which require treatment with continuous IV antihypertensive medications.~~
7. ~~Symptomatic type II second-degree or third-degree AV block.~~
8. ~~Hyponatremia with serum sodium <115 requiring ICU-level care.~~
9. ~~Diabetic ketoacidosis (DKA) with serum pH < 7.15 and/or severe electrolyte imbalances.~~
10. ~~Severe alcohol withdrawal (with or without delirium tremens) requiring more than 32mg of lorazepam in a 24h period.~~

1. See attachment (Updated ICU and DOU Guidelines)

Additional Criteria Includes:

1. Admission by members of the Medical Staff, Residents, and/or Emergency Department physicians

General Discharge Criteria:

Appropriateness for Discharge - The medical necessity of continued hospitalization is primarily determined by the presence of an acute health condition of sufficient severity that ongoing diagnostic or therapeutic intervention, or careful monitoring, is required.

When it has been determined that a patient is medically ready for discharge, the health care team must determine the most appropriate setting for ongoing care. Determinants of the appropriate site of care involve medical, functional, and social aspects of the patient's illness. The patient's acute and chronic medical conditions, potential for rehabilitation, and decision-making capacity must be taken into account.

Input is needed from multiple sources to determine the most suitable discharge plan. Involved parties often will include the patient, family, case manager, nurse, physician, physical and occupational therapist, social worker, and insurer.

In order for the patient to be deemed safe and ready for discharge to home or to a non-acute environment (rehabilitative, transitional, or chronic care), a provider must take into account a number of factors beyond the medical determinants. These factors include:

- Patient cognitive status
- Patient activity level and functional status
- The nature of the patient's current home and suitability for the patient's conditions (eg, presence of stairways, cleanliness)
- Availability of family or companion support
- Ability to obtain medications and services
- Availability of transportation from hospital to home and for follow-up visits
- Availability of services in the community to assist the patient with ongoing care

At the time of discharge home, patients, with help from family or other caregivers, if available, should be able to:

- Obtain and self-administer medications
- Perform self-care activities
- Eat an appropriate diet or otherwise manage nutritional needs
- Follow up with designated providers

Specific insurance benefits and availability of services in the community may also influence whether or not the patient may be safely discharged home. Home services, such as visiting nurses or infusion providers to administer intravenous infusions, may allow selected patients, who would otherwise need non-acute residential care, to manage their care needs at home.

A patient is deemed appropriate for discharge when all the following are present:

- Hemodynamic stability
- Cardiovascular status acceptable
- Respiratory status acceptable
- Stable chest findings
- Airway status acceptable
- Neurologic status acceptable
- Pain and nausea absent or adequately managed
- Abdominal status acceptable
- Hepatic and biliary abnormalities absent or acceptable
- Renal function acceptable
- Urinary status acceptable
- Temperature status acceptable
- Vascular, soft tissue, and wound status acceptable
- No infection, or status acceptable
- Physiologic disorders absent, or status acceptable
- Electrolyte status acceptable
- No blood loss, or problem resolved
- Behavioral health status acceptable
- No chest tube, or status acceptable
- Activity level acceptable
- Intake acceptable
- No inpatient interventions needed

Safety Precautions:

~~Patients meeting one or more of the exclusion criteria above will not be admitted to the DOU, but rather~~

~~should be admitted to (or remain in) the ICU.~~

1. Each patient on the DOU unit will be assessed daily by the attending physician or designee.
2. Appropriate DOU orders must be completed for all admissions.
3. Telemetry monitor alarms are "on," without exception.

   ~~ICU staff will provide overview/monitoring and response.~~
4. IV infusions and IV push medications allowed on the DOU unit are listed on the "Intravenous Medication Guidelines for Adults."

Patient Care:

1. Care is provided by Registered Nurses with the support of Nursing Assistants. Nurse staffing ratio is 3:1.

   ~~Specialty-trained Registered Nurse will function as Resource Nurse.~~

   ~~Trained staff in Telemetry Medical System utilized for cardiac monitoring.~~
2. Upon hire, all RN staff must take a written ECG test. Passing score = 80%. There are two chances to pass the test.
   Annually, all DOU RNs will attend a class and skills day competencies. Updating and overseeing this content is the responsibility of the unit clinical nurse specialist (CNS).
3. Annually, all DOU RNs will attend a class and skills day competencies. Updating and overseeing this content is the responsibility of the unit clinical nurse specialist (CNS).
4. Status change reported to appropriate physician.
5. Internal Medicine attending or designee to be available for triage of patients.
6. If DOU is at capacity, five (5) beds in the post-anesthesia care unit (PACU) shall be utilized. The patient population that may be permitted to utilize this space shall be:
   - Postoperative (after recovery period)
   - Adult (14 years of age or older)
   - Without need for isolation due to infectious disease

     ~~As soon as bed availability exists on the DOU unit, patients shall be transferred.~~
   - As soon as bed availability exists on the DOU unit, patients shall be transferred.

Equipment:

- Medical System Telemetry with monitoring screen in the Telemetry/Oncology unit nurses' stations, DOU, and ICU.
- Alarm System Response: by audible indicator and viewing information center with text information.

Documentation:

1. An admission assessment documented in electronic health record within two (2) hours of admission.
2. Nursing care plan and psychosocial questionnaire within eight (8) hours of admission.
3. Patient Care Note and Interventions.
4. EKG strip upon admission, every shift and PRN status change.

5. Indication for DOU-level care must be documented daily.

Key Points:

- Report status changes promptly to physician.
- Unconfirmed dysrhythmia:
  - Assess patient
  - ICU staff backup confirmation
  - Physician notification/assessment
- All patients admitted to the DOU should have functional intravenous access at all times. The IV access is to be placed prior to the patient's admission to the DOU.

All revision dates: 11/27/2023, 9/13/2022, 3/21/2019

Attachments

Updated ICU and DOU Guidelines

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/23/2024
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	1/23/2024

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Policy Area:	*Intensive Care Unit*
References:	

ICU.27 Patient Prone Positioning in the ICU

POLICY:

To delineate the process for ~~Respiratory Care staff~~the interdisciplinary team (Physician, Registered Nurse (RN), RCP) when placing a mechanically-ventilated, critical care patient in prone position. Acute respiratory distress syndrome (ARDS) is a syndrome with heterogeneous underlying pathological processes. It represents a common clinical problem in intensive care unit (ICU) patients and is characterized by high mortality. Prone positioning is a supplementary strategy available in managing patients with ARDS. Current evidence strongly supports that prone positioning has beneficial effects on gas exchange, respiratory mechanics, lung protection and hemodynamics as it redistributes transpulmonary pressure, stress and strain throughout the lung and unloads the right ventricle.

PROCEDURE:

I. **Pre-Prone/Pre-Movement**

- **Physician:**
  1. Order for prone position must come from attending level physician
  2. Physician to explain purpose and procedure to family
  3. Endotracheal tube (ET), central line (if applicable), and enteric tube confirmed on chest x-ray
- **Registered Nurse (RN)**~~:~~

  ~~Facilitate ordering of proning bed~~

  - ~~If proning bed is not immediately available, it is at the discretion of the ICU attending physician to manually prone patient.~~

  1. Ensure team, patient, and family have been educated on the process and what to expect
  2. Monitor the following before, during and after positioning:
     - Heart rate and cardiac rhythm

       ~~Cardiac rhythm~~
     - Blood oxygen saturation via pulse oximetry (SpO2)
     - Respiratory rate
     - Richmond Agitation Sedation Score (RASS)

- Blood pressure
- Skin assessment

3. Tube feeding: either hold or trickle while proning, ~~at the discretion~~upon the order of the attending
4. Invasive lines: ensure they are secured, not kinked, and are long enough for the turn
5. Skin: Assess and change any dressing on the anterior body. Empty any drains or ~~ostomies~~ostomy bag

   ~~If patient is on a prone positioning bed, ensure patient is properly secured in the bed and all pieces are locked into place~~

◦ **Respiratory Therapist:**

1. Consult with team before repositioning patient; decide which direction to turn patient; priority shall be given to moving patient towards the ventilator
2. Re-secure the endotracheal tube with cloth tape. Confirm placement
3. Obtain blood gas up to one hour prior to prone position
4. Pre-oxygenate to 100% fraction of inspired oxygen (FIO2)
5. Suction oropharynx and endotracheal tube
6. Ensure reintubation equipment is at beside

II. **Prone Positioning** (during the process both to and from prone):

◦ **Physician:**

- At bedside at time of proning and supination

◦ **Registered Nurse (RN):**

1. Lines and tubes: ensure they are easily accessible and not kinked
2. Tube feeding: resume at prior rate 1 hour after patient is positioned if ordered
3. Body Positioning: Change positioning every two (2) hours placing patient's limbs in alternating positions
4. Document vitals, as listed in section I above

◦ **Respiratory Therapist (RT):**

1. At head of bed monitoring stability and position of endotracheal tube; remain with the patient until members of the team have ensured that the patient is maintaining adequate oxygenation and is hemodynamically stable
2. The endotracheal tube must be easily accessible at all times
3. Document ventilator settings and end-tidal carbon dioxide concentration
4. Perform ventilator checks every two (2) hours while in prone position

III. **Manual Proning Procedure**

1. Perform a time out, review procedure before starting the turn.
2. Move the patient to the appropriate pressure relief bed surface if needed.
3. ~~Consider applying~~Apply protective foam dressings to the anterior pressure area such as the

forehead, knees or iliac crests (see appendix for possible location of pressure ulcer (PU) from the prone position).

4. Place a sheet under the patient to assist with turning.
5. Have RT at the head of the bed to turn the head and ensure that the endotracheal/trachosotmy tube remains in position (will require a minimum of two staff on each side of the bed).

   ~~Perform a time out, review procedure before starting the turn.~~
6. Remove the patient's gown and chest electrocardiogram (ECG) electrodes to prevent pressure areas under the patient.
7. Place pumps and drain collection devices centrally at foot or head of the bed.
8. Pull the patient to the far side of the bed, and gradually turn the patient to the prone position.
9. Apply ECG electrodes to posterior chest or to an area of intact skin (the exact placement is not important). The ECG will not represent true lead placement, however basic electrical components will still be present. If a diagnostic ECG is needed, the patient will have to be repositioned to supine position with appropriate lead placement.
10. Consider placing a regular pillow or body alignment cushion under the upper chest and pelvic area.
    - Key Point: Chest and pelvic pillows allow for better chest excursion and ventilation. Be careful not to place pressure on abdomen which could limit ventilation.
11. Position head to avoid pressure and pooled secretion around the eyes. Use pressure relief devices as necessary (head cushion) and ensure the neck is in an anatomical position. Reposition the head as tolerated every two hours. Verify the ET tube has not moved or been kinked.
12. Be careful that the patient's eyes are not open to avoid scratching the corneas and that no pressure is placed on the eyes. Eye lubrication should be applied as ordered.
13. Position the arms to avoid over rotation of the brachial plexus. ~~Preposition~~Reposition the arms at least every two hours.

IV. Indications Criteria

1. < 48 hours after onset of ARDS and meets all the following criteria:
   - Partial pressure of oxygen (PaO2)/FIO2 ratio < 150mmHg
   - FIO2 > 0.60 mmHG
   - Positive end expiratory pressure (PEEP) > 5cmH2O ~~as per Proseva~~
2. Mean arterial pressure > 65mmHg (with or without medication)

V. ~~Possible~~ Complications

1. Immediate Termination:
   - Cardiac arrest
   - SPO2 <85% or PaO2 < 55mmHg for > 5 minutes
   - Heart rate < 30 beats per minute for > 1 minute
   - Sustained systolic blood pressure < 60 mmHg
2. ~~Relative Complications~~Consider Termination:
   - Airway obstruction/dislodged endotracheal tube

- Hypotension or cardiac arrhythmia
- Loss of venous access or kinking of tubing
- Facial and airway edema
- Increase need for sedation or paralysis
- Pressure Sores

VI. ~~Exclusion Criteria~~Contraindications

1. Absolute:
   - Unstable cervical, thoracic, lumbar, pelvic, skull, or facial fractures
   - Uncontrolled intracranial pressure, cerebral edema or frequent seizures
2. Relative:
   - Unstable pulmonary status determined by the attending physician
   - 2nd or 3rd trimester pregnancy
   - Kyphoscoliosis
   - Advanced arthritis
   - 20% surface area burn
   - Cardiac instability, determined by the attending physician
   - Recent abdominal surgery, abdominal compartment syndrome, or grossly distended abdomen

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Attachments

No Attachments

Approval Signatures

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Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/26/2023
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	10/26/2023

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

IS.49 Imaging Services Infection Control Policy

Policy:

It is the policy of the Radiology Department to prevent cross contamination by patients, visitors, aids or technical staff.

Procedure:

A. Hand washing is the primary method of preventing cross contamination. Wash your hands before and after each patient interaction.

B. Prior to the first scheduled procedure of the day:

   A. Flat surfaces of tables and upright cassette holders must be cleaned with DISPATCH CLEANER or SUPER-SANI-CLOTH GERMICIDAL WIPES. DISPATCH is used to clean when C- DIFF is present.

C. Cleanup and room preparation is necessary between patients:

   1. Sheets, pillow covers and blankets are one-time-use only and are placed in the dirty linen hamper after use.
   2. Disposables are placed in plastic bags or plastic lined trash containers. Sharps are disposed of in red "sharps" containers.
   3. Glass, tins and non-combustibles are disposed of in designated rigid containers.
   4. Areas contaminated by organic debris,such as blood during the course of a procedure, will receive immediate attention by applying cleaning agents approved by the hospital infection control nurses.
   5. Gloves and appropriate PPE will be worn at all times when cleaning up blood and body fluids.

D. Care of equipment that shall be clean, but not necessarily sterile:

   1. Patient emesis basins.
      Emesis basins will be rinsed following use and disposed in the trash containers.
   2. Patient enema bags.
      Disposable single patient enema bags and tips are to be purchased clean from the manufacturer. Following use they are discarded.

E. Barium Preparation:

   1. All employees shall wash their hands before handling barium.
   2. All work areas and equipment are to be kept clean.

3. All barium will be kept covered between the time of preparation and the time of use.
4. Barium will be kept stored to prevent contamination by rodents, insects and moisture.
5. Barium not used by the patient will be discarded.

F. Supplies:

1. Sterile supplies are picked up from Central Service. These items are stored in X-ray in a separate clean supply cabinet. Regular examination of stored packs for integrity and dating is important. As each case is started, these supplies are taken to the appropriate X-ray room.
2. Items from purchasing are brought to X-ray on their cart, transferred and stored in a clean area in X-ray.
3. Linen is brought to X-ray on a laundry cart, transferred and placed in X-ray area.

PARENTERAL INJECTION

I. **Procedure**:

A. The set-up will be properly assembled using surgical aseptic technique and protected from contamination.

B. Sterile solutions are to be drawn up using surgical septic technique.

1. Clean tops of medication and/or diluent vial with alcohol sponge.
2. Aseptically withdraw required amount of diluent and inject into medication vial.
3. Avoid contamination.
4. Shake well and administer dosage as directed.

C. Sterile solutions will be introduced using surgical aseptic technique by the physician.

D. The skin shall be cleaned prior to injection using individually packaged gauze moistened with 70% alcohol.

E. The set-up will be discarded if not used by the person who prepared it.

MINOR SURGICAL PROCEDURES DEMANDING ASEPTIC TECHNIQUE

I. **Procedure**: Surgical aseptic technique shall be followed by personnel involved in performing minor surgical procedures. This includes all of the following:

A. A surgical hand scrub shall be accomplished prior to all minor surgical procedures.

B. Surgical attire shall include cap, mask, gown and gloves.

C. Preparation of patient's skin by the physician shall be accomplished prior to all surgical procedures.

D. The X-ray machine may be required to be draped.

E. The technologist may be required to open the outer wrapping of packs and/or other special equipment.

F. Gloved personnel will open the pack, drape equipment and handle sterile equipment and supplies.

II. **Clean-up between procedures requiring aseptic technique:**

A. Gowns and gloves must be placed in proper receptacles by personnel prior to leaving the X-ray room.

B. Linen from any open packs, whether soiled or not, must be placed in linen hampers for the laundry.

C. Used or soiled non-woven disposable fabrics will be placed in plastic bags for disposal.

D. Soiled waste articles, paper trash, etc., will be discarded in plastic bags.

E. Glass waste materials will be discarded in separate containers.

F. Needles, sharps and disposable syringes will be discarded in the red "sharps" containers.

G. Instruments should be placed by a double-gloved technologist or nurse directly into a basin of water. All hinged instruments must be in the open position for processing. All sharp and delicate instruments should be placed separately into a small basin.

H. Suction units are disconnected by the double-gloved technologist or nurse to eliminate contamination.

I. Suction contents shall be disposed of during the flushing of a hopper.

J. The horizontal surface of furniture and equipment involved in the minor surgical procedure is to be cleaned with DISPATCH CLEANER or SUPER SANI WIPES (this includes the X-ray table, image intensifier, television monitor and the like).

K. Floors are to be damp-mopped with a detergent germicide after minor surgical procedures. Spot cleaning of walls should be done as necessary.

ISOLATION TECHNIQUES AS RELATED TO RADIOGRAPHIC ROOMS:

A. Gowns and masks are to be used only once.

B. Linen shall be placed in a yellow plastic bag.

C. All wastes shall be disposed of in a plastic bag and then terminally placed in a red bag. Sharps should be placed in the red "sharps" container.

D. Housekeeping will be notified to mop floor as needed. On a septic case, after use, the mop will be discarded with the laundry.

E. Transportation of patients will be for essential purposes only. If possible, the patient should be aware of the disease so they can assist in the required bilateral protection.

F. Equipment...

1. Table and pillow shall be draped with sheets.
2. Tables and all used equipment shall be wiped down after each use with DISPATCH or SUPER SANI CLOTHS.
3. Basins and trays will be washed and bagged and taken to Central Service for sterilization.

ISOLATION TECHNIQUE ON NURSING UNITS:

A. On nursing units, follow instructions of the floor nurse and respect patient isolation signage.

B. Portable equipment (X-Ray machines, C-arms, Portable Ultrasound equipment, EEG machines) will be wiped down with an infection control-approved cleaning agent. The date and time of cleaning will be

logged into the equipment's log book before leaving any patient room. Special attention to cleaning of a machine is necessary after leaving a respiratory isolation room.

C. Two people will, when possible, work the isolation case - one to handle the patient - being gowned, masked and gloved as necessary - the other masked and gowned as necessary. The first technologist will handle the machine and film holder.

D. For further information regarding specific types of isolation, consult the VCMC Isolation Manual.

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Attachments

No Attachments

Approval Signatures

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Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	1/4/2024
Imaging Services	Matt McGill: Director, Imaging Services	1/3/2024
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	9/22/2023

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Policy Area:	*Administration - Medical Staff*
References:	

MS.102.016 Graduate Medical Education Program

POLICY:

In ~~hospitals~~healthcare systems participating in a professional graduate medical education program, the organized medical staff must have a defined process for supervision of each member in the program by a licensed independent practitioner with appropriate clinical privileges. This policy is to delineate who may participate in the graduate education program, the elements of supervision by medical staff members, the description of resident and fellow roles, and the role of the Graduate Medical Education Committee.

PROCEDURE:

1. The Family Medicine Residency Program is a ~~3-year~~ training program accredited by the Accreditation Council for Graduate Medical Education (ACGME) ~~and is affiliated with the University of California at Los Angeles, Department of Family and Community Medicine~~.
2. The Addiction Medicine Fellowship Program is a training program accredited by the ACGME. It is open to graduates of an accredited residency program as defined in the Program Requirements for Addiction Medicine of the ACGME.
3. The ACGME Residency Review Committee (RRC) for Family Medicine and the American Board of Family Medicine (ABFM) define the duration of training and required curricular elements for Family Medicine Residency training.
4. Visiting residents from other institutions with an approved Affiliation Agreement between the County of Ventura and that institution, may participate in patient care and training at VCMC and its affiliated clinical sites. These experiences must be approved by the Graduate Medical Education Committee (GMEC) and not hinder the training of the residents/fellows in ACGME-accredited programs where the County of Ventura is the Sponsoring Institution (SI).
5. The Medical Board of California defines the ~~graduate medical education~~ requirements ~~that must be met prior to~~for licensure as a physician in the State of California.

~~Medical Staff Supervision of Resident Staff:~~

Medical Staff Supervision of Resident Staff:

1. The medical staff responsible for the patient care provided by the resident ~~medical~~ staff and the educational curriculum shall be under the direction of the Residency Program Director and the Residency

Program Core Faculty. They shall generally consist of the ~~Family Medicine~~ Residency Program Faculty~~,~~ and those medical staff members who ~~hold~~have accepted teaching ~~appointments in the Department of Family and Community Medicine of the University of California at Los Angeles School of Medicine, and those~~responsibilities for supervising residents and fellows. Participation in the teaching program by medical staff members ~~who have accepted teaching responsibilities for supervising Family Medicine Residents. Participation in the teaching program by medical staff members~~ is voluntary.

2. Evidence of supervisory responsibility for inpatient hospital care shall be documented in the patient's chart by the supervising physician within 24 hours of the patient's admission to the hospital.
3. The Residency Program Director and the Faculty of the Residency Program, in collaboration with the organized medical staff, remain responsible for the supervision and quality of care provided by the resident staff. Evidence of this supervision will include regular evaluations of a residents' performance, and review of medical care provided by the mechanisms of each department's peer review process.
4. Residents shall have the right to challenge disciplinary actions made by Ventura County Medical Center and the Residency Program through the due process procedure as outlined in the Residency Policy and Procedure Manual. The decision reached under this procedure shall be final and binding on both the resident and the residency program. Any discipline of a resident shall be done in accordance with the due process procedure and shall be the responsibility of the Residency Program Director and ~~Core~~ Faculty of the Residency Program.
5. The supervising medical staff member may modify or provide an addendum to a statement in the medical record made by a resident staff member, but it must be dated, timed, and signed by the supervising medical staff. This shall also include modifying or providing an addendum to any electronic chart notation.
6. Resident staff members, under the direction of the supervising medical staff member, may enter patient care orders. Medical staff members may also enter patient care orders on patients admitted to the resident service, as they deem necessary for patient care.

~~Role of First Year Resident:~~

Medical Staff Supervision of Fellow Staff:

1. The medical staff responsible for the patient care provided by the fellow staff in their training role and the educational curriculum shall be under the direction of the Fellowship Program Director and the Fellowship Program Core Faculty. When the fellow is providing medical care under their primary Board Certification role, they shall be subject to peer review in their department as medical staff members. The Fellowship Program Faculty shall generally consist of those medical staff members who have expertise and training in the subject area of the fellowship. Participation in the teaching program by Medical Staff members is voluntary.
2. Evidence of supervisory responsibility shall generally be indicated by a notation made in the patient's chart confirming the faculty member's review and supervision of the fellow's clinical care on a concurrent basis.
3. The Fellowship Program Director and faculty, in collaboration with the organized medical staff, shall remain responsible for the supervision and quality of care provided by the fellow staff. Evidence of this supervision will include regular evaluations of a fellow's performance, and review of medical care provided by the mechanisms of each department's peer review process.
4. Fellows shall have the right to challenge disciplinary actions made by Ventura County Medical Center and the Fellowship Program through the due process procedure as outlined in the Fellowship Policy and

Procedure Manual. The decision reached under this procedure shall be final and biding on both the fellow and the fellowship program. Any discipline of a fellow shall be done in accordance with the due process procedure and shall be the responsibility of the Fellowship Program Director and the Faculty of the Fellowship Program.

Role of First Year Resident:

1. Residents in their first year of training (12 calendar months) ~~shall be practicing medicine under the license of the hospital and residency~~must obtain a Postgraduate Training License (PTL) from the Medical Board of the State of California within 180 days of enrolling in the program.
2. Their scope of practice shall include performing medical examinations, documenting history and physical examinations, entering patient care orders, documenting discharge summaries, and performing medical and surgical procedures under the supervision of teaching medical staff. The level of supervision shall be commensurate with requirements from the ACGME, which delineate that first year residents have Direct Supervision, or Indirect Supervision with Direct Supervision immediately available.
3. Graduation from the first year of training to the second year of training shall be upon the review of the first year resident's performance with adequate evaluations by the teaching staff, and satisfactory completion of all requirements as outlined in the Residency Policy and Procedure Manual.

~~Role of Second Year Resident:~~

~~1. Residents in their second year of training (12 calendar months) must obtain their medical license from the Medical Board of California, if they are graduates of an accredited LCME school in the United States or Canada, which shall occur no later than the end of the 24th month of graduate medical education.~~

~~2. Their scope of practice shall include that of a resident in the first year of training, with additional responsibilities of performing some medical and surgical procedures with limited independence. The teaching medical staff shall remain responsible at all times for the patient care delivered by the resident staff. The residency program director and faculty must delineate these procedures. Second year residents will also provide supervision of more junior residents, medical students, and other trainees, under the direction of the faculty.~~

~~3. Graduation from the second year of training to the third year of training shall be upon the review of the second year resident's performance with adequate evaluations by the teaching staff, and satisfactory completion of all requirements as outlined in the Residency Policy and Procedure Manual.~~

~~Role of Third Year Resident:~~

Role of Second Year Resident:

~~Residents in their third year of training (12 calendar months) shall practice medicine under their license from the Medical Board of California. If they are a graduate of an international medical school, they are required to obtain a medical license from the State of California after the 24th month of training and not later than by the end of their 36th month of graduate medical education.~~

1. Residents in their second year of training (12 calendar months) must have a PTL from the Medical Board of California. For those residents who completed their first year of training outside of the State of California, they must obtain a PTL within 180 days of enrolling in the residency program.
2. Residents in their second year of training who obtained a PTL after January 1, 2022, have up to 15

months (U.S. or Canadian medical school graduates) or 27 months (international medical school) to obtain their unrestricted Physician & Surgeons license from the Medical Board of California.

3. Their scope of practice shall include that of a resident in the first ~~and second~~ year ~~resident~~of training, with additional responsibilities of performing some medical and surgical procedures with limited independence. The teaching medical staff shall remain responsible ~~for~~at all times for the patient care delivered by the resident staff. The residency program director and faculty must delineate these procedures. ~~Third~~Second year residents will also provide supervision of more junior residents, medical students, and other trainees, under the direction of the faculty.
4. ~~Completion and graduation~~Graduation from the ~~residency program~~second year of training to the third year of training shall be upon the review of the second year resident's performance with adequate evaluations by the teaching staff, and satisfactory completion of all ~~rotational and other~~ requirements as outlined in the Residency Policy and Procedure Manual~~, completion of the ACGME and ABFM requirements, and adequate evaluations by the teaching staff~~.

~~Role of Medical Student:~~

Role of Third Year Resident:

1. Residents in their third year of training (12 calendar months) must have a unrestricted Physician & Surgeon license from the Medical Board of California if they obtained their PTL after January 1, 2022.
2. Their scope of practice shall include that of a first and second year resident, with additional responsibilities of performing some medical and surgical procedures with limited independence. The teaching medical staff shall remain responsible for patient care delivered by the resident staff. The residency program director and faculty must delineate these procedures. Third year residents will also provide supervision of more junior residents, medical students, and other trainees, under the direction of faculty.
3. Completion and graduation from the residency program shall be upon satisfactory completion of all rotational and other requirements as outlined in the Residency Policy and Procedure Manual, completion of the ACGME and ABFM requirements, and adequate evaluations by the teaching staff.

Role of Fellow:

1. Fellows will have Board Certification in their primary specialty prior to entering the Fellowship Program. They must have a full and unrestricted license from the Medical Board of California in order to engage in patient care.
2. Their scope of practice shall include all the privileges granted by the Medical Staff in their primary specialty. Their scope of practice shall also include the role of fellow when training in the subject area of the Fellowship Program. When acting as a fellow, their clinical care shall be supervised by the Fellowship Program Faculty commensurate with supervision as defined by the ACGME Fellowship Program Requirements.
3. Completion and graduation from the Fellowship Program shall be upon satisfactory completion of all rotational and other requirements as defined by the Fellowship Program Policy and Procedure Manual, completion of the ACGME and Fellowship Board requirements, and adequate evaluations by the teaching staff.

Role of Visiting Resident:

1. Visiting residents from other teaching institutions with Affiliation Agreements with the County of Ventura must have a license commensurate with the number of years of Postgraduate training they have completed and in compliance with the current Medical Board of California's requirements for licensure.
2. Their scope of practice shall be commensurate with their level of training in their residency program. They shall be supervised by the Medical Staff members responsible for their training as designated by the visiting residents' Sponsoring Institution (SI), in accordance with the ACGME Program Requirements for their specialty. For rotations that take place on a regular basis, there shall be an identified Clinical Site Director as appointed by the visiting residents' Sponsoring Institution.
3. Visiting residents whose clinical care or behavior is deemed below the standards of care at VCMC and its affiliated clinical sites may be removed from patient care duties at the request of the DIO and/or Medical Director of VCMC or the Health Care Agency (HCA). The Clinical Site Director shall be responsible for working with the visiting residents' Sponsoring Institution for any disciplinary action as deemed necessary by that SI.

Role of Medical Student:

1. Medical Students (externs) from Liaison Committee on Graduate Medical Education (LCME) accredited medical schools (allopathic) or American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) accredited medical schools (osteopathic) ~~will~~may do rotations at Ventura County Medical Center. They have no legal standing to engage in the independent practice of medicine. There must be an affiliation agreement between the student's medical school and the County of Ventura at the time of their rotation at VCMC and its affiliated clinical sites.
2. Medical Students will be under the direct supervision of the Medical Staff members responsible for the care of those patients with whom the student is involved. The scope of practice of medical students will be to perform history and physical examinations, documenting history and physicals, progress notes, and proposing orders in the electronic medical record. All notations in the medical record must be co-signed by either a medical staff member or a resident staff member. All orders must be co-signed and verified by the supervising resident or medical staff member before they will be acted upon by the hospital staff.
3. Any procedures performed by medical students must be under direct supervision, i.e., the supervising physician must be physically present with the patient and student.

~~Graduate Medical Education Committee (GMEC)~~

Graduate Medical Education Committee (GMEC)

1. An institution sponsoring (SI) Graduate Medical Education must have a Graduate Medical Education Committee (GMEC). The GMEC reports to the Sponsoring Institution.
2. The frequency of meetings shall be at least quarterly.
3. Written minutes shall be forwarded to the Medical Staff office and the Executive Committee, and shall include information about the quality of care, treatment and services, and educational needs of the Graduate Education Program.

4. A Sponsoring Institution with multiple ACGME-accredited programs must have a GMEC that includes at least the following voting members: Program Directors (minimum of two), Designated Institutional Official, a minimum of two peer-selected residents/fellows from its ACGME-accredited programs, and a Quality Improvement or Patient Safety Officer or designee.
5. ~~A Sponsoring Institution with one program must have a~~Additional voting ~~membership on the GMEC that consists of the~~members may include Residency Program ~~Director, Designated Institutional Official, Residency Program~~ Faculty, designated Administrative representation, representatives with significant GME involvement from the following clinical departments/areas of Obstetrics, Surgery, Medicine, Pediatrics, Emergency Medicine, ~~and the Chief residents who have been chosen by their peers.~~ The voting ~~membership~~members shall also include the Quality Medical Director(s) from both the Hospital and Ambulatory Care, and the Medical Directors from both the Hospital and Ambulatory Care.
6. The GMEC responsibilities include establishing and implementing policies and procedures regarding the quality of education and the work environment for the residents and fellows, and providing oversight to the educational program of the residency and affiliated fellowships.

~~References:~~

REFERENCES:

The Joint Commission Standards

~~The Joint Commission Standards~~
ACGME Institutional Requirements, Effective ~~7/1/2014~~
~~Medical Board of California (MBC)~~7/1/2022

Medical Board of California (MBC)

All revision dates: 3/5/2024, 5/1/2016, 9/1/2015, 12/1/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	pending
Policy Owner	David Araujo: Residency Program Director	3/5/2024
Medical Executive & Oversight Committee	David Araujo: Residency Program Director	5/29/2019

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administration - Medical Staff*
References:	

MS.102.027 Medical Staff Database Credentialing System Controls and Database User Access

This policy applies to the Medical Staff credentialing database system and system modules used to perform credentialing, privileging and ongoing monitoring for practitioners with membership and/or clinical privileges throughout the Health Care Agency (HCA) including Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU), Ambulatory Clinics and Ventura County Behavioral Health Clinics. The credentialing process will be performed in accordance with the Medical Staff Bylaws, Rules & Regulations and Department Rules & Regulations.

Medical Staff Administration is responsible for protecting the integrity of the credentialing information, including but not limited to the credentialing application, practitioner attestation, primary source verifications, verification dates, report dates, credentialing decisions, credentialing dates, signatures/initials of the verifier or reviewer, committee minutes, and credentialing checklists.

I. Electronic and Paper Data Storage

A. The content of the electronic application and confidential credentialing file, including primary source verifications are stored in a secure password protected cloud based system. The vendor's database security policies, security audits and contract are reviewed and on file in the Medical Staff Administration Office.

B. The content of the paper credentialing file is secured in locked file cabinets in the Medical Staff file room with physical access limited to the Medical Staff Administration staff (Chief Medical Officer, Department Manager, Credentialing Coordinators, Peer Review Coordinator, and Administrative Assistant working in Medical Staff Administration).

II. Primary Source Verifications (PSV)

Primary source verifications are defined as verifications obtained directly from the source or an approved entity and may be obtained through an electronic query subscription, web query, direct electronic, faxed or mailed query response. In some circumstances telephone verification may be obtained from a primary source.

A. Verifications may be performed by Medical Staff Administration staff: the Department Manager, Credentialing Coordinators, Peer Review Coordinator, and Administrative Assistant working in Medical Staff Administration.

B. Verifications will be documented and tracked in each practitioner's electronic verification log. Verifications received outside of the database are scanned and attached to the appropriate verification record. A hard copy may also be placed in the confidential credentials file folder.

C. Each database verification entry indicates the type of verification, the method of verification, the date the verification was requested and received, and the identity of the database user obtaining and reviewing the verification.

D. Printed verifications will be initialed and dated by the staff member obtaining and reviewing the verification.

E. File progress is tracked via internal checklists and the database.

III. Database Access

Access to the database is granted and monitored by the Department Manager and limited to the user's individual roles and responsibilities:

A. Prior to accessing the database all users must review and agree to comply with this policy and policy 102.031 Confidentiality of Medical Staff/Allied Health Professional Staff Records (Attachment A). Policy review will be required annually as part of annual database training for all active users.

B. Medical Staff Administration staff will have read and write access to fulfill their roles and responsibilities within the Department and maintain files. ~~This may include other temporarily assigned staff for special projects requiring limited access.~~

C. Medical Staff Committee members will be granted read only access for the purposes of fulfilling their responsibility of reviewing and recommending approval of a practitioner's membership and/or clinical privileges as outlined in the Medical Staff Bylaws. Read access is limited to files subject to review and added to the secure database Virtual Committee module. If paper files are to be reviewed, the review will be conducted in the Medical Staff Administration Office or within the appropriate Medical Staff Committee meeting.

D. Ventura County Health Care Plan and Contracts Management may be granted limited read ~~and/or write~~ access to fulfill their specific roles ~~and responsibilities~~ related ~~to health~~ plan ~~enrollment, health plan rosters and contract~~audits and contracts management.

E. The Enrollment team may be granted limited read/write access to fulfill their roles and responsibilities related to health plan enrollment, health plan rosters and managing the County's malpractice insurance.

F. The County's contracted enrollment vendor may be granted limited read access to the practitioner application information required to complete health plan enrollment applications. View access is limited to practitioners in which the County is responsible for billing/collecting for services.

G. Employee Health Services (EHS) may be granted limited read access to practitioner demographic information and limited write access to the practitioner medical history section of the electronic file to document annual required health screenings.

H. Database vendor support access is granted and tracked through the "Grant Support Access" database feature and limited to the specific technical support case in which access has been granted. Access terminates upon completion of the support ticket and may be revoked if the activity is deemed inappropriate.

IV. Privileging Portal Access

A. Nursing and other ~~clinical~~hospital staff may be granted read only access to the database privileging portal for the purpose of verifying privileges.

B. Hospital Pharmacy staff may be granted read access through the database privileging portal and limited to the necessary information when needed to verify practitioner DEA information, medication orders and

as required for compliance with the Hospital 340B Drug Pricing Program.

V. Tracking and Monitoring User Activity

A. The Department Manager will annually review all users to ensure their access is necessary and at the appropriate level for their roles and responsibilities.

B. The Department Manager monitors user activity through the database ~~login~~security and user activity reports, and through regular file audits.The Manager will audit a minimum of 5% or 50 files (whichever is ~~greater~~less) at least annually and as often as necessary or when concerns arise regarding user activity or file integrity. The audits will include a minimum of 10 initial appointment files and 10 reappointment files.

C. The database security alerts are automatically generated and sent to the Department Manager for inactive user account login attempts and valid user logins from unknown IP addresses.

D. User accounts are suspended automatically if inactive for 30 days and must be reactivated by the Department Manager.

E. Staff is required to report any suspected inappropriate database activity to the Department Manager.

F. When inappropriate activity is identified, an investigation will be initiated by the Department Manager and the user will be notified and counseled. The user's activity will be monitored at least quarterly for a minimum of 3 quarters by the Department Manager and reported on the credentialing systems control oversight report. Continued violations will be reported to the Chief Medical Officer, and Human Resources for disciplinary action.

G. ~~Database~~User access may be ~~temporarily~~adjusted, suspended, or permanently revoked if inappropriate activity is identified.

~~Staff is required to report any suspected inappropriate database activity to the Department Manager.~~

~~The Department Manager will annually review all users to ensure their access is necessary and at the appropriate level for their roles and responsibilities. User access will be adjusted and/or terminated based if inappropriate activity is identified.~~

H. Fraud and misconduct will be reported to the Chief Medical Officer, Compliance Officer, and as required by the delegated credentialing agreements, the National Committee for Quality Assurance.

VI. Modifying or Deleting Database Information

A. Database modifications and deletions are documented in the record by the database and on the user activity reports.

B. Staff with the appropriate level of access may add new or updated information, correct verified inaccurate information or incorrect data entry in the practitioner record, document notes, update required expiring items including but not limited to licensure, certifications, insurance, life support certifications, annual health screenings and contact or practice information.

C. Access to delete database information is limited to Medical Staff Administration staff and is limited to removing an error or inaccurate entries to the record.

D. ~~Deletions to~~Access to delete information in the verification section of the database (verification log) or any primary source verified credentialing data is limited to Medical Staff Administration staff. Deletions are limited to removing files attached in error, deleting a timed out or failed electronic verification ~~attempt~~attempts, and verification errors (example: license verification was ran for the wrong state or license type) or a duplicate verifications.

E. ~~Modifications~~Access to modify/~~corrections made~~correct entries to the primary source verification section

of the database (verification log) is limited to Medical Staff Administration staff and must be documented in the notes section of the record and include the date, user name, the type of modification/correction, and reason for the modification/correction.

F. Modifications/corrections made to the practitioner provided data (example: work history, addresses, affiliations etc...) must be documented in the notes section of the record and include the date, user name, type of modification/correction and when appropriate, who authorized the change and reason for the change. These modifications may be completed by Medical Staff Administration staff and the Enrollment team.

G. Medical Staff ~~with the appropriate level of access~~Administration staff may remove confirmed duplicate entries in the credentialing application and/or database fields.

H. Staff may not alter credentialing approval dates or dates of verifications, unless there was a verified manual entry error. Staff may not modify or white out any portion of a hard copy verification.

I. The following modification are considered inappropriate and will result corrective action:

1. Falsifying dates (credentialing decisions, licensure, verifications, ongoing monitoring)
2. Creating documents/records without completing the required verification/activity
3. Fraudulently altering existing documents, minutes, ongoing monitoring reports
4. Attributing verifications or file review to an individual who did not perform the activity
5. File updates by unauthorized individuals

VII. Database User Accounts and Passwords

A. Account and password activations and terminations are managed by the Department Manager.

B. Each user will have a unique login and required to create a strong password, unique to the database. Passwords must be at least 8 characters and contain alphanumerical characters or symbols, should not be written down and should be changed frequently.

C. Passwords must be changed if requested by staff or if compromised.

D. Sharing account information or allowing non-authorized user's access is strictly prohibited, including inappropriate screen sharing. User's must exit the database or lock their computer screens when stepping away from their workstations and secure physical credentials files when not in use to protect files from unauthorized access.

E. User accounts will be locked after 5 failed login attempts and access will automatically expire after 30 days of inactivity.

F. The Department Manager will promptly remove all user access to the database upon termination or when access is no longer required to perform the user's specific job requirements.

Reference:

National Committee for Quality Assurance (NCQA) Standards CR.1, Factors C.1 through C.5 ~~(2022)~~

Health Industry Collaboration Effort, Inc. (HICE) - Delegated Credentialing Compliance

All revision dates: 3/4/2024, 5/11/2022, 7/16/2020, 7/14/2020

Attachments

Attachment A Confidentiality of Medical Staff and Allied Health Professional Staff Records

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/1/2024
Policy Owner	Tracy Chapman: VCMC - Med Staff	2/27/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Pharmacy Services*
References:	

PH.01 Department of Pharmacy Purpose, Accountability, Responsibility and Scope of Services

POLICY:

The goal of the Department of Pharmacy Services shall be to provide the Medical Staff with a program for the control and accountability of all medications. The Department of Pharmacy Services shall also provide pharmaceutical care in a manner consistent with the highest standards of pharmacy practice and public safety, and as economically as possible.

Pharmaceutical care is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life and include cure of a disease, elimination or reduction of a patient's symptomatology, arresting or slowing of a disease process, or preventing a disease or symptomatology.

PROCEDURE:

A. The Department of Pharmacy Services shall be headed by the Director of Pharmacy Services who is appropriately licensed.
    1. The Director of the Pharmacy Services shall be directly responsible and accountable to the Hospital Chief Executive Officer and Medical Staff.
        i. The Director of Pharmacy Services shall provide to Hospital Administration at least quarterly a report detailing the pharmaceutical services provided by the Department of Pharmacy Services and any recommendations that could improve those services.
        ii. The Director of Pharmacy Services shall be responsible to the Medical Staff by being a member of and attending all meetings of the Pharmacy & Therapeutics (P&T) Committee. The Director of Pharmacy Services shall participate in those aspects of the hospital's patient care evaluation program that relates to drug utilization and effectiveness.
            1. The Director of Pharmacy Services shall enforce all decisions of the P&T Committee regarding the use, procurement, storage, distribution and dispensing of all pharmaceutical products within the hospitals and clinics.
    2. The Director of Pharmacy Services shall be responsible for the following:
        i. Maintaining proper licensure of the Department of Pharmacy Services.

ii. Integration of the department into the primary functions of the hospital.

iii. The coordination and integration of interdepartmental and intra-departmental services.

iv. Continuous assessment and improvement of the quality of care and services provided.

v. Maintenance of quality control programs.

vi. Orientation and continuing education of all persons in the department.

vii. Recommendations for space and other resources needed by the department.

3. The Director of Pharmacy Services, in consultation with other health professionals, shall be responsible for the development, implementation and review of policies and procedures as they relate to the Department of Pharmacy Services. These policies and procedures shall be approved by the P&T Committee, Medical Executive Committee and the Governing Body. The following elements shall be considered when policies and procedures are developed.

   i. Type(s) and age(s) of patients served.

   ii. The scope and complexity of the patient's care needs.

   iii. The extent to which the level of care or services provided will meet the patient's need.

   iv. The appropriateness, clinical necessity, and timeliness of support services provided directly by the organization or through referral contracts.

   v. The availability of necessary staff.

   vi. Recognized standards or guidelines for practice when available.

   vii. Methods that will be used to assess and meet patient's care needs.

4. The Director of Pharmacy Services collaborates with Hospital Administration in developing the department's annual operating budget.

5. The Director of Pharmacy Services collaborates with Hospital Administration in developing the department's capital expenditure plan and monitors the implementation of the plan.

6. The Director of Pharmacy Services assesses and recommends to the relevant hospital authority off-site sources for needed services not provided by the department or the organization.

B. The Department of Pharmacy Services shall be staffed by competent and adequate personnel, in keeping with the size and scope of the services rendered to sufficiently meet the medication needs of the patients, as determined by the Medical Staff and by Hospital Administration.

C. The Department of Pharmacy Services shall operate the following pharmacies:

1. Ventura County Medical Center Infusion Center Pharmacy

   i. Hours of operation: ~~06~~08:00-16:30, Monday through Friday

2. Santa Paula Hospital Inpatient Pharmacy

   i. Hours of operation: 08:00-16:30, Sunday through Saturday

3. Ventura County Medical Center Inpatient Pharmacy

   i. Hours of operation: 24 hours a day, Sunday through Saturday

D. Comprehensive pharmaceutical services are provided to all patients, medical staff, and hospital staff. Services include:

1. Review of medication orders

2. Medication distribution throughout the hospital and clinics
3. Sterile compounding
4. Unit-Based Pharmacy Services for the Intensive Care Unit
5. Unit-Based Pharmacy Services for the Neonatal Intensive Care Unit and Pediatrics Unit
6. Antimicrobial Stewardship Program involvement
7. Oncology Infusion Services
8. Drug Information
9. Drug Monitoring
10. Monitoring and reporting medication errors and adverse drug reactions
11. Medication use evaluations
12. Providing assistance to indigent patients requiring medications

All revision dates: 2/16/2024, 1/1/2017, 5/1/2005

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/16/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1985*
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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Operating Policies*
References:	

PH.85 Procuring Drugs for the Indigent Patient

POLICY:

To obtain medication for medically indigent patients who do not have prescription coverage and/or who meet various financial qualifications. All requests should be made using the Patient Assistance Program (PAP) Enrollment Form. The PAP Enrollment form is available from the PAP office, Ambulatory Care clinics, or on the VCMC Pharmacy Resources webpage. Requests made may require 6 to 12 weeks, depending on the completion of the application process for each pharmaceutical manufacturer.

Procedure:

I. Application Process

A. The PAP Enrollment forms shall be submitted to the PAP office by the patient's referring party.

B. PAP staff shall research/identify pharmaceutical companies that supply each medication requested for the patient.

C. PAP staff shall contact the patient via phone, whenever possible, to check qualifications, confirm demographics, and request financial documents.

D. PAP staff shall obtain and complete the required information on the pertinent application(s).

E. PAP staff shall mail application to the patient for required signature and copies of requested financial documentation.

F. Upon receipt of completed and signed application and financial documents from the patient, PAP staff shall use the Intracounty Mail Courier to send the application to the patient's physician for signature and appropriate prescription, as required by each pharmaceutical company.

G. PAP staff shall fax or mail the completed application with financial documents and prescription, as required, to the appropriate pharmaceutical company.

H. Each patient shall have a chart where copies of the patient's prescription, enrollment forms, applications, and packing slips will be kept for reference. Information shall be kept for three years.

II. Arrival of Medication

A. A log shall be kept of all received medications, both paper and in Indicare. Packing slips shall be kept for three years.

B. If the medication is not labeled from the manufacturer, designated pharmacist shall label each medication based on the physician's prescription as required by applicable State and Federal law.

C. Labeled medications shall be placed in a bag and prepared to either be sent to the patient's clinic for distribution or be prepared for pick up at the VCMC Inpatient Pharmacy.

   a. Clinic Distribution: A form shall be attached to the bag of medication with patient's name and chart number. The clinic shall contact the patient. A signature is required by the patient and the clinic staff. The form shall be returned to the PAP office.

   b. Pick Up at the VCMC Inpatient Pharmacy: A sticker shall be adhered to the bag with date, the patient's name and date of birth. The patient shall be informed that the medication is ready for pick up. The patient shall sign the sticker confirming receipt of medication. The signed stickers shall be kept in the PAP log book.

   c. A log shall be maintained of all PAP medications sent to the clinics for pick up or picked up at VCMC Inpatient Pharmacy for three years.

   d. Some pharmaceutical companies may send PAP medications directly to the patient's home.

D. Consultation/educational information shall be offered to the patient. Consultations shall be provided by a pharmacist.

E. Medications no longer needed by the patient or not picked up within a six (6) month period shall be available for other patients, returned to the pharmaceutical company, or destroyed, depending on the requirements of each pharmaceutical company.

All revision dates: 4/24/2018, 5/1/2015, 9/1/2003, 3/1/1995, 6/1/1991, 11/1/1989, 10/1/1986

Attachments

No Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/16/2024
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PH.89 Controlled Substances Surveillance

Policy:

Ventura County Medical Center/Santa Paula Hospital has processes in place to identify the potential or actual diversion of controlled substances as well as an interdisciplinary plan of action for identifying, evaluating and reporting controlled substance diversion to all regulatory agencies.

PROCEDURE:

Identifying

A. Automated Dispensing Cabinets (ADC)

1. The Pharmacy Department shall run daily reports to identify controlled substance discrepancies involving the ADC's that are unresolved within 24 hours. Discrepancy resolutions shall be reviewed for complete responses.
2. The Pharmacy Department shall run discrepancy reports on demand to identify detailed activities.

B. ControlCheck (BlueSight) Software

1. ControlCheck (BlueSight) software reconciles ADC activity with doses documented in the medication administration record.

C. Carefusion Knowledge Portal

1. Reports shall be run in the event of any suspicious activity identified by pharmacy or nursing.

D. Employees

1. Any suspicious activity or perceived impairment of abilities or inadequate care level for patients shall be reported to a supervisor or Clinical Nurse Manager in a timely fashion during the shift.

Evaluating

A. ControlCheck (BlueSight)

1. All discrepancies identified by ~~BlueSight~~ControlCheck shall be reviewed by the pharmacy department.
2. Any discrepancies that cannot be resolved by the pharmacy department shall be forwarded to the staff member and their manager for further review and investigation.

a. If the pharmacy department does not receive a response within 48 hours, the pharmacy department may inactivate the staff member's access to ADCs. ADC access will be reactivated upon receiving a response.

3. Any concern for diversion shall be discussed with the Chief Nursing Executive (CNE)/Associate Chief Nursing Officer (ACNO).

B. Shift Supervisors/Clinical Nurse Managers

1. Any staff placing patient care at risk or exhibiting untoward behavior shall be removed from the work environment.

Reporting

A. Internal Reporting

1. Any suspicious activity associated with controlled substances shall be reported immediately to the Director of Pharmacy Services and the Clinical Nurse Manager of that unit, as well as the CNE/ ACNO and/or Chief Medical Officer (CMO). An investigation shall also be conducted.
2. A summary of all events and personnel involved shall be prepared at the end of the investigation.
3. The detail of the summary report shall be discussed between the Director of Pharmacy Services, the Clinical Nurse Manager, as well as the CNE/ACNO and/or CMO as soon as it is finalized.

B. Validated Findings

1. Once the summary report of the investigation has been discussed, validated abuse of controlled substances (i.e., witnessed diversion) shall be reported to the California State Board of Pharmacy, Nursing and/or Medicine, the California Department of Public Health and the Drug Enforcement Agency .
2. See also policy ~~*PH.23 Reporting Controlled Substance Loss or Diversion.*~~ PH.23 Reporting Controlled Substance Loss or Diversion.

Auditing Procedures

A. The Director of Pharmacy or designee shall meet regularly with Clinical Nurse Managers to identify any personnel who have had recent changes in behavior or performance.

1. A 30-day User Audit-All Transaction Activity Report shall be run on identified individuals. The User Audit report indicates in detail the following:
   a. Date and time of withdrawal
   b. Area of withdrawal
   c. Description as to override or profile withdrawal
   d. Patient name for whom drug was withdrawn
   e. The patient ID number
   f. Name of the controlled substance
   g. User ID number and user name
   h. Any attached comments (i.e., wasted amount, etc.)
2. Using the Medication Administration Record in the electronic health record (EHR), review the

withdrawal transactions identified in the User Audit report to verify electronic documentation of administration. *(Depending on the number of users and transactions this step could take as much as 8 hours.)*

3. Those events which are not documented in the EHR are fall outs. These shall be identified and sent to the Clinical Nurse Manager for follow up to verify documentation.
4. Any event not documented either because of no order or order without documentation shall be followed up with the nurse.
5. Completed follow up reports shall be returned to the Department of Pharmacy Services for tabulations and storage. *(Steps 3 through 5 should be completed within 24 hours of initial review.)*

B. Pharmacy Internal Audit of Controlled Substance Supply Chain

1. An inventory count of all controlled substances shall take place at least every two years.
2. An inventory count of Schedule II controlled substances shall take place at least every three months.
    a. All acquisitions of Schedule II controlled substances since the previous inventory shall be totaled.
    b. All disposition of Schedule II controlled substances since the previous inventory shall be totaled.
    c. A comparison shall be performed between the difference of the previous two inventories and the difference between the acquisitions and dispositions made between the two inventories.
    d. All records used to compile each inventory reconciliation report shall be maintained in the pharmacy for at least three years in a readily retrievable form.
    e. Any possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.
    f. ~~Any identified losses or known cause shall be reported to the California Board of Pharmacy within 30 days of discovery unless the cause of the loss is theft, diversion, or self-use, in which case the report shall be made within 14 days of discovery.~~
        i. ~~If the cause of the loss is unknown, the pharmacy shall perform further investigation to identify the cause and actions necessary to prevent additional losses of controlled substances.~~

    Use policy PH.23 Reporting Controlled Substance Loss or Diversion to determine reporting requirements for any identified losses of controlled substance.
3. The purchasing and receiving of controlled substances by the Pharmacy Department shall be audited monthly.
    a. The monthly purchase report shall be reconciled with the receiving invoice.
        i. For Schedule II Controlled Substances, the DEA Form 222 shall also be reconciled.
    b. The receiving invoices shall be reconciled with the CII Safe Receive Report or perpetual inventory log.
    c. Any discrepancies shall be reported immediately to the Pharmacy Supervisor or the Director of Pharmacy for further investigation.

C. Anesthesiologist Audit Procedure

1. Quarterly audits of anesthesiologists shall be run by the Pharmacy Department. Results shall be communicated to the Medical Director of Anesthesia and the Medical Staff office.

a. The quarterly audit results shall be presented to the Anesthesia Committee, Pharmacy and Therapeutics Committee, and Medical Executive Committee.

~~All controlled substance activity from Pyxis Anesthesia System shall be reviewed using the Anesthesiologist Audit report every 5 calendar days.~~

~~Using the Anesthesia Record, review the withdrawal transactions identified in the Anesthesiologist Audit report to verify documentation of administration.~~

2. All discrepancies identified by ControlCheck shall be reviewed by the pharmacy department.
3. Any discrepancies identified shall be reported to involved anesthesiologist, Pharmacy Director and ~~medical~~Medical Director of Anesthesia for follow up within 7 days of case completion. The anesthesiologist must respond to the inquiry within 2 business days of the initial notification. See policy PH.102 Pyxis Anesthesia System.
    a. Any unresolved discrepancies will be reported to the Chief Medical Officer.
4. Completed follow up reports shall be returned to the Pharmacy Department for quarterly report.

Controlled Substance Diversion Committee

A. An interdisciplinary team consisting of representatives from Pharmacy, Nursing, Medical Staff, Administration, and Human Resources shall meet regularly to discuss any findings from controlled substance audits or any events involving diversion/theft of controlled substances.

All revision dates: 2/16/2024, 6/21/2022, 1/12/2022, 6/8/2021, 11/10/2020, 5/2/2019, 11/26/2018, 9/1/2016

Attachments

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References:	

T.05 Burn Management Guidelines

POLICY:

To establish guidelines for the care of burn patients at Ventura County Medical Center (VCMC).

PROCEDURE:

A. All patients are to have a thorough Primary Survey with immediate management of any life threatening issues.

B. After completion of the Primary Survey, a complete secondary survey should be performed.

C. Patients who have burns less than 10% of the total body surface area will be admitted to VCMC under the TRAUMA SERVICE.

D. Burn patients who require referral to a burn center will need to be transferred as soon as they are stable.

1. The primary and secondary survey should be performed as usual and life threatening issues should be dealt with immediately.
2. If a burn patient requires an emergent procedure in order to be stabilized, these will be performed prior to transfer.
3. Contact should be made with VCMC's contracted burn centers.
4. During the time awaiting transfer, if necessary, a consultation will be obtained from the Intensive Care Physician on call. The primary lead physician will be the Trauma Surgeon.
5. The Trauma Surgeon will be expected to evaluate and document a patient's stability prior to transfer or emergent surgery by another service.
6. The Rule of Nines is utilized to determine burn percentage.
7. Burn injuries that should be referred to a burn center include the following:
   - Partial-thickness burns of greater than 10% of the total body surface area.
   - Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
   - Third degree burns in any age group.
   - Electrical burns, including lightning injury.
   - Chemical burns.
   - Inhalation injury.

- Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality.
- Children with any of the above burn injuries, or if the severity of the burns exceeds the level of care provided by VCMC or Santa Paula Hospital.
- Burn injury in patients who will require special, social, emotional, rehabilitative intervention

All revision dates: 2/26/2024, 10/11/2019, 5/1/2012

Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	2/27/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/27/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/27/2024
Trauma Services	Thomas Duncan: Trauma Director	2/27/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	2/26/2024

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References:	

T.13 Multiple Casualty Incident (MCI)

POLICY:

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

PROCEDURE:

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

~~1. Definitions:~~

Definitions:

- Multiple Casualty Incident is defined as 3 to 14 trauma victims, regardless of acuity.
- A Code Triage is 15 or more patients expected due to traumatic mechanism. The Emergency Department will immediately notify the Administrator on Duty (AOD) and the ~~nursing supervisor~~Nursing Supervisor. The AOD, ~~nursing supervisor~~Nursing Supervisor, or Emergency Department Charge Nurse will then notify Paging to announce a Code Triage-External on the overhead paging system.
  - Refer to Initiation of Code Triage in policy *106.034 Emergency Management Plan.*
- Directly involved defined as: ED, ~~operating room~~Operating Room (OR), ~~post anesthesia care unit~~Post Anesthesia Care Unit (PACU), ~~intensive care unit~~Intensive Care Unit (ICU), ~~pediatrics~~Pediatrics unit, Medical/Surgical units, Admitting, Paging Operator, Nursing Supervisors, ~~computer tomography~~Computed Tomography (CT), Blood Bank, Environmental Services, Respiratory Services, Radiology, Trauma Services, and the Residency Program.
- Indirectly involved includes all other patient care ~~area~~areas and ancillary services.

~~Refer to Administrative policy 106.034, *Emergency Management Plan,* Section V-Initiation of Code Triage.~~

~~2. Notification:~~

~~Mobile intensive care nurse (MICN)/Charge Nurse to initiate MCI in REDDINET.~~

~~MCI Plan notification is 76666, and the number of patients (paging system)~~

~~Code Triage notification 76666, and number of patients (paging system)~~

~~3. Ventura County Emergency Medical Services (VCEMS):~~

~~Notification of base station hospital by VCEMS will be through direct communication through base station phone.~~

~~**PROCEDURE:**~~

~~1. Trauma Team activation will be initiated to triage and stabilize arriving patients.~~

~~2. ED to activate as early as possible for multiple victims.~~

Notification:

- Mobile Intensive Care Nurse (MICN)/Charge Nurse to initiate MCI in REDDINET.
- MCI Plan notification is 76666, and the number of patients (paging system).
- Code Triage notification 76666, and number of patients (paging system).

Ventura County Emergency Medical Services (VCEMS):

- Notification of base station hospital by VCEMS will be through direct communication through base station phone.

Procedure:

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

11. ICU and PEDS RN's as determined by ED Charge Nurse and Nursing Supervisor.
12. Assignments to be determined by the ED charge nurse or trauma team.
13. Additional critical care nurse may be requested and every effort will be made to assist the ED when staffing permits.
14. ED Clinical Nurse Manager and Trauma Program Manager are to be called 24/7 and report to the ED if requested.
15. Trauma Medical Director to be called regardless of on call status.
16. Assignments will be made for the ED and overflow areas under the direction of the ED charge RN, rooms, equipment, supplies, and staff.
17. Trauma pagers and cell phones will be activated with MCI indicated and number of trauma victims.
18. Departments indirectly involved will go on stand-by until further notice
19. All members of the trauma team and ancillary services included in the trauma activations page are to report to the ED.
20. Triage and Designation of the trauma patients in the ED will be according to advanced trauma life support (ATLS) American College of Surgeons (ACS) guidelines and will be conducted by the ED physician until the attending trauma surgeon arrives or Trauma Medical Director or Deputy Trauma Medical Director arrives. Critical factors to be taken into consideration include the number of patients, acuity, location, and available resources.
21. Charge RN or designee will be responsible for entering the patients and pertinent information into the REDDI-NET SYSTEM (this will facilitate communications between hospitals and emergency medical services (EMS).
22. Resuscitation of critical patients will be the shared responsibility of the Trauma Attending(s), ED Physicians, Senior Residents, the responding anesthesiologist(s) and the on-call Pediatrician. The final resuscitation and management decisions will be the responsibility of the trauma surgical attending or his/her designee.
23. The Paging Department is to make every effort to triage calls requesting the ED during this time and only forward the calls when they are unable to assist the caller.
24. Operating Room (OR) preop and post anesthesia care unit (PACU) will be used if available and additional space is needed to hold or monitor ED patients during this time. This also could include trauma patients awaiting OR and intensive care unit (ICU) until ICU beds are available. The OR Charge Nurse and Nursing Supervisor will coordinate staffing of these areas.
25. All families and patients waiting in the ED will be informed of the multiple victim activation so that they can anticipate delays. The waiting room may need to be evacuated to accommodate patients.
26. Performance Review will follow as soon as possible for all multiple victim activations.
27. Critical incident stress debriefing will be considered and offered to staff following all multiple victim activations as soon as possible.
28. For 5 or more tier 1 victims potentially requiring surgical intervention, 2 OR teams will respond and 2 OR rooms will be made available until released by the attending trauma surgeon.
29. In the case of treatment of multiply injured patients, all lower extremity long bone fractures should be stabilized as soon as possible in multiply injured patients. Every attempt should be made to stabilize lower extremity long bone fractures once a patient has been determined by the trauma team and neurosurgery

team to be stable enough to undergo surgery. The sequence of treatment should be femur first then tibia. Upper extremity long bone fractures should be treated once the patient has been optimized and adequately resuscitated.

30. Any other secondary procedures will be coordinated in collaboration with the Trauma Medical Director and the Orthopedic Trauma Surgery liaison.

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

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

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

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

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

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

~~1. Assignments will be made for the ED and overflow areas under the direction of the ED charge RN, rooms, equipment, supplies, and staff.~~

~~2. Trauma pagers and cell phones will be activated with MCI indicated and number of trauma victims.~~

~~3. Departments indirectly involved will go on stand-by until further notice~~

~~4. All members of the trauma team and ancillary services included in the trauma activations page are to report to the ED.~~

~~5. Triage and Designation of the trauma patients in the ED will be according to advanced trauma life support (ATLS) American College of Surgeons (ACS) guidelines and will be conducted by the ED physician until the attending trauma surgeon arrives or Trauma Medical Director or Deputy Trauma Medical Director arrives. Critical factors to be taken into consideration include the number of patients, acuity, location, and available resources.~~

~~6. Charge RN or designee will be responsible for entering the patients and pertinent information into the REDDI-NET SYSTEM (this will facilitate communications between hospitals and emergency medical services (EMS).~~

~~7. Resuscitation of critical patients will be the shared responsibility of the Trauma Attending(s), ED Physicians, Senior Residents, the responding anesthesiologist(s) and the on-call Pediatrician. The final resuscitation and management decisions will be the responsibility of the trauma surgical attending or his/her designee.~~

~~8. The Paging Department is to make every effort to triage calls requesting the ED during this time and only forward the calls when they are unable to assist the caller.~~

~~9. Operating Room (OR) preop and post anesthesia care unit (PACU) will be used if available and additional space is needed to hold or monitor ED patients during this time. This also could include trauma patients awaiting OR and intensive care unit (ICU) until ICU beds are available. The OR Charge Nurse and Nursing Supervisor will coordinate staffing of these areas.~~

~~10. All families and patients waiting in the ED will be informed of the multiple victim activation so that they can anticipate delays. The waiting room may need to be evacuated to accommodate patients.~~

11. ~~Performance Review will follow as soon as possible for all multiple victim activations.~~
12. ~~Critical incident stress debriefing will be considered and offered to staff following all multiple victim activations as soon as possible.~~
13. ~~For 5 or more tier 1 victims potentially requiring surgical intervention, 2 OR teams will respond and 2 OR rooms will be made available until released by the attending trauma surgeon.~~

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

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

~~**SPECIFIC DUTIES:**~~

Specific Duties:

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

Attending Trauma Surgeon:

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

Residents:

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

ED Physician:

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

ED Charge Nurse:

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

- Reddi-net update.
- Notification of ED Clinical Nurse Manager.

Trauma Program Manager:

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

~~**ED RN's:**~~

ED Registered Nurses:

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

~~**ED CNA's:**~~

ED Certified Nursing Assistants:

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

Nursing Supervisor:

- Responds immediately to the ED.
- Calls in OR teams as requested.
- Secures a place for ED admits to be sent if no beds assigned.
- Ensures all directly involved departments respond to the MCI with adequate staff.
- Ensures all involved departments are aware and prepared for response, Lab, respiratory, transport, etc., until the Hospital Incident Command (HICS) is activated. Once HICS is activated, all resource requisitions including staff will be directed to the Logistics section.
- Assists with assignments of beds.
- Notifies Administrator on Duty and Activates Hospital Incident Command System as needed, after collaborating with the on call Emergency Department Physician and/or surgeon on call
- Calls in additional Supervisors or Administrative staff as needed.
- Assists Social Worker with management of arriving families.
- Provides on-going communication with the units affected regarding actual victims, number of potential admissions, MCI status.
- Provides information to the media if directed by AOD.

~~Critical~~Intensive **Care Unit:**

- Receive communication initiating the MCI via the paging system and/or ED charge nurse call initiating the MCI.
- ~~Critical~~Intensive Care Unit will send one person to the ED to report to the charge nurse for further instruction.
- ~~Critical~~Intensive Care Unit charge nurse will prepare for potential admissions and transfers by making a

list of patients who can be transferred either between units or to the Medical/Surgical areas.

- ~~Critical~~Intensive Care Unit charge nurse will receive communication from the Nursing Supervisor regarding the number of potential admissions and placement of MCI victims.
- ~~Critical~~Intensive Care Unit charge nurse will contact the appropriate physicians and services to transfer patients if necessary when directed to do so by the Nursing Supervisor.
- Intensive Care Unit charge nurse will call in additional staff if possible to care for MCI victims in the Critical Care ~~Unit charge nurse will call in additional staff if possible to care for MCI victims in the Critical Care~~ area.
- If additional staff is requested in the ED, the charge nurse and nursing supervisor will review patient's safety needs and send additional staff as appropriate to maintain patient care in these areas.
- ~~Critical~~Intensive Care Unit Staff will assess unit supplies and order additional supplies as needed.
- Disaster carts are available from Central Supply.

Pediatric ~~Units~~Unit:

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

Medical Surgical Unit:

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

OR/PACU

- ~~**Report number of available OR's to nursing supervisor until HICS positions activated.**~~Report number of available OR's to nursing supervisor until HICS positions activated.
- ~~**Assist with triaging of surgery patients under the direction of the surgeon on call.**~~Assist with triaging of surgery patients under the direction of the surgeon on call.
- ~~**May be asked to halt elective cases as needed.**~~May be asked to halt elective cases as needed.
- ~~**Request additional staff as needed.**~~Request additional staff as needed.

ED Radiology ~~techs~~Techs:

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

~~**Paging Department**~~

~~Initiating emergency notifications per the MICN, nursing supervisor or AOD request.~~

~~Notification of Administrator on Duty.~~

~~Re-directing of incoming calls away from the ED during MCI as needed~~

~~**ED Registration staff:**~~

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

Paging Department:

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

ED Registration Staff:

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

Social Services:

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

In the event of life-threatening injury or fatality:

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

Blood Bank~~-~~:

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

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

Environmental Services:

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

Respiratory Care Services~~-~~:

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

Security:

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

All revision dates: 1/24/2024, 1/12/2024, 10/11/2023, 6/9/2020, 7/26/2017

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	2/27/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/27/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/27/2024
Trauma Services	Thomas Duncan: Trauma Director	2/27/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	2/2/2024

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Owner:	*Gina Ferrer: Manager, Trauma Services*
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References:	

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

POLICY

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

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

PHILOSOPHY OF THE TRAUMA PROGRAM

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

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

AUTHORITY/SCOPE

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

CREDENTIALING

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

- Physicians taking trauma call will be credentialed and proctored per Medical Staff bylaws.
- Surgeons and surgical specialists taking trauma call will meet additional credentialing criteria as specified by the Division of Trauma and the Trauma Medical Director.
- Surgeons and Emergency Department (ED) boarded physicians should have taken Advanced Trauma

Life Support (ATLS) at least once.
~~Continuing education hours in trauma management, attendance at specified committees, is required.~~

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

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

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

TRAUMA PATIENT POPULATION CRITERIA

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

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

DATA COLLECTION AND ANALYSIS

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

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

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

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

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

PROCESS FOR MONITORING COMPLIANCE

Standards of Quality Care

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

Death Reviews

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

Audit Filters /Indicators

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

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

System Issues

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

REVIEW PROCESS/LEVELS OF REVIEW

First Level of Review:

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

Second Level Review:

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

Third Level Review:

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

DETERMINATION OF JUDGMENTS

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

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

2. ~~Anticipated mortality~~Mortality and morbidity ~~with~~without opportunity for improvement (~~Potentially~~

~~Preventable~~Non-preventable): An event or complication that is a sequelae of a procedure, disease, illness~~,~~ or injury ~~that has the potential to be prevented or substantially ameliorated~~for which reasonable and appropriate preventable steps had been taken.

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

DOCUMENTATION OF ANALYSIS AND EVALUATION

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

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

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

Patterns and trends identified will be shared during Trauma Operation Performance and Patient Safety (TOPPS) meeting.

REFERRAL PROCESS FOR INVESTIGATION OR REVIEW

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

TRAUMA PI COMMITTEE STRUCTURE

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

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

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

OPERATIONAL STAFF RESPONSIBILITY FOR THE TRAUMA PI PROGRAM

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

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

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

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

CORRECTIVE ACTION PLANNING

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

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

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

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

CONFIDENTIALITY PROTECTION

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

LOOP CLOSURE AND RE-EVALUATION

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

INTEGRATION INTO HOSPITAL PERFORMANCE IMPROVEMENT PROCESS

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

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

All revision dates: 2/26/2024, 9/29/2021

Attachments

No Attachments

Approval Signatures

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

Step Description	Approver	Date
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	2/27/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	2/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/27/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/27/2024
Trauma Services	Thomas Duncan: Trauma Director	2/27/2024
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VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Gina Ferrer: Manager, Trauma Services*
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References:	

T.16 COVID-19 Trauma Activation Policy

COVID-19 Trauma Activation Considerations and Guidelines

Trauma patient evaluation should *not* be delayed to determine COVID-19 status, however appropriate precautions should be taken. Emergency Medical Services (EMS) personnel may have answers to COVID-19 screening questions prior to arrival to the Emergency Department. If not, all trauma patients should be screened according to policy, and appropriate isolation measures must be taken. Documentation of screening should occur in emergency department (ED) physician and trauma history and physical notes.

Ensure strict use of personal protective equipment (PPE) for ALL trauma patients (hat, gown, mask, gloves, and eye protection).

- If patient is **able** and answers "No" to all COVID-19 screening questions, and has no respiratory symptoms, use usual (Non-COVID-19) PPE**.
- For trauma patients (all tiers) **unable** to be screened, **strict** use of PPE for airborne + contact precautions should be maintained.
- If the patient's airway is clear and patient can tolerate, immediately place a face mask on the patient.
- Obtain COVID-19 antigen test for ~~all~~selective trauma patients who have symptoms (screen positive) or have a high index of suspicion at the time of arrival, and modify subsequent use of PPE based on results.

To minimize the number of personnel at the bedside to only those required for direct patient care, only essential members of the trauma team necessary to ensure proper delivery of timely care will be needed in the trauma bay. All others will remain outside of room and available as needed.

Tier 1 team in room: ED physician, 2 Residents (Resident running code and Airway Resident; additional residents can join if further help is needed), 1 RN, 1 Respiratory Therapist, and 1 Trauma Attending **(6 staff)*** *[Note: Scribe will be close to door, and will not be considered part of main team].*

Tier 2 team in room: ED physician, 1 Resident (Resident running code; added resident(s) can join if further help is needed), 1 RN, 1 Respiratory Therapist and 1 Trauma Attending **(5 staff)***. Same as above for extra staff, as needed.

Tier 3 consult: Emergency physician evaluates patient with / without RN; on-call Trauma Resident is summoned to evaluate patient; on-call Trauma Attending eventually evaluates patient.

**Additional staff may enter and treat patient when COVID-19 screening has been addressed.*

*** Modified PPE may be available – i.e. Garbage bag cut outs for head and arms, as well as surgical sleeves. While modified gowns will be eventually discarded, eye protection and shields can be cleansed with recommended Health Care Agency (HCA) policy wipes, and made available for the next case.*

*****While emphasis has been placed on moving trauma patients quickly, strict adherence to this COVID-19 policy will ultimately add time to the overall initial evaluation of patients.*

All revision dates: 2/29/2024, 10/28/2021, 2/4/2021, 10/27/2020, 4/6/2020

Attachments

No Attachments

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Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	3/5/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/3/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2024
Trauma Services	Thomas Duncan: Trauma Director	3/2/2024
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References:	

T.18 ED Pediatric Performance Improvement & Patient Safety Plan

POLICY

The Ventura County Medical Center (VCMC) Emergency Department (ED) Performance Improvement and Patient Safety Plan (PIPS) is a description of the efforts that are directed towards ensuring the consistent delivery of safe, quality service-focused care. Equally important is that we ensure the care we provide is equitable, patient-centric, efficient as well as effective for the pediatric patients we serve.

We work to achieve this through on-going data assessment, which includes outcomes review, and process examination, as well as identification of opportunities for change and improvement. We utilize evidence-based practice research to identify pediatric-specific metrics to guide us in focusing our efforts on the assessment of the quality of care that is provided, systematically assessing patient outcomes along with the identification of improvement opportunities.

- **Framework for** Quality Improvement (**QI) and Performance Improvement (PI) efforts:** Focus on the effectiveness of structural elements, processes, and clinical outcomes relative to pediatric emergency care.

A. **Components:** Collecting and analyzing data to discover variances, defining a plan for improvement, and evaluating the success of the QI/PI plan with measures that are outcome based. Will facilitate education and training, implementation of targeted system change, measurement of system performance over time until steady, and achievement of high-level performance.

B. **Specific indicators.** Pediatric emergency care metrics. Performance bundles may be used to assess quality of care provided for specific clinical conditions (eg, pediatric septic shock, pediatric asthma, pediatric closed head injury).

- **Performance Measures for Pediatric Emergency Care***

Measures & Description

- Patient triage - Measurement of weight in kilograms and height in centimeters for pediatric patients.
- Measurement of complete vital signs (including Blood pressure).
- Method to identify age-based abnormal pediatric vital signs.
- Infrastructure and personnel - Presence of all recommended pediatric equipment in the emergency department.
- Presence of physician and nurse coordinators for pediatric emergency care.

- Patient-centered care - Patient and/or caregiver understanding of discharge instructions.
- Emergency department flow - Door-to-provider time. Total length of stay.
- Pain management - Pain assessment and reassessment for all children.
- Quality and safety - Number of return visits within 48 hours resulting in hospitalization.
- Medication error rates.

Disease-Specific Measures

- Trauma - Use of head computed tomography (CT) in children with minor head trauma.
- Protocol for suspected child maltreatment.
- Respiratory diseases -Administration of systemic steroids for pediatric asthma exacerbations.
- Use of an evidence-based guideline to manage bronchiolitis.
- Infectious diseases - Use of antibiotics in children with suspected viral illnesses.
- *Based on the work of Alessandrini E, Varadarajan K, Alpern ER, et al. Emergency department quality: an analysis of existing pediatric measures. Acad Emerg Med. 2011;18(5):519-526.

Professional performance, credentialing, continuing education, and clinical competencies, including integration of findings from QI audits and case reviews for pediatric emergency care will be monitored. Resources will be available to assist ED staff with implementing QI/PI activities.

Examples of Pediatric Emergency Care Performance Improvement Activities and Resources:

Clinical Emergency Department Registry (CEDR) https://www.acep.org/ced**r/**

Committee on Quality Transformation, Section on Emergency Medicine

https://www.aap.org/en-us/about-the-aap/Committees-Councils Sections/Section-on-Emergency-Medicine/ Pages/About-Us. aspx

EMS for Children Innovation and Improvement Center. https:// emscimprovement.center.

Emergency Nurses Association https://www.ena.org/#practice-resources Education in Quality Improvement for Pediatric Practice (EQIPP). https:// eqipp.aap.org/

The National Pediatric Readiness Assessment **https://**www.pedsready.org Pedialink, The AAP Online Learning Center **https://pedialink.aap.org/visitor** Pediatric Readiness Toolkit http://www.pediatricreadiness.org

Pediatric Trauma Society http://pediatrictraumasociety.org/

Interfacility Tool Kit for the Pediatric Patient. http://www.traumanurses. org/inter-facility-tool-kit-for-the-pediatric-patient

Pediatric TQIP https://www.facs.org/quality-programs/trauma/tqip/ pediatric-tqip

PECARN guidelines http://www.pecarn.org

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Attachments

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Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	3/5/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/3/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/2/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2024
Trauma Services	Thomas Duncan: Trauma Director	3/2/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	3/2/2024

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References:	

T.19 Trauma Mental Health Screen and Assessment Process

PURPOSE:

To define a process to identify patients at high risk for mental health problems or psychological sequelae w/ subsequent referral to a mental health provider in an inpatient trauma population.

Policy:

Trauma patients at high risk will be screened for mental health problems or psychological sequelae prior to discharge.

BACKGROUND:

Per the American College of Surgeons Verification, Review, and Consultation program Resources for Optimal Care of the Injured Patient (2022 Standards): "All trauma centers must meet the mental health needs of trauma patients by having: A protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required."

PROCEDURE:

- Trauma patients 12years and over will be screened by the unit social worker for risk for mental health problems using the CSSRS (Columbia Suicide Severity Rating Scale) and ITSS (Injured Trauma Survivor Screen) in the electronic health record, whichever tool is appropriate to use. Positive screens will initiate a consultation to the Behavioral Health.
  See Attachment A: ITSS Screening Tool
  See Attachment B: CSSRS Screening Tool.
  - A positive CSSRS will be followed by SAFE-T assessment by a licensed independent practitioner.
  - A positive ITSS screen will be followed by appropriate behavioral health referral.
- Social Services will discuss screening findings with the treating physicians to order appropriate level of behavioral health intervention based on results of screening or clinical determination of need.
- When indicated, the trauma team will put an order for Psychiatrist Consult in the EHR (Electronic Health Record).
- Psychiatrist or Psychologist will conduct a consult and evaluation with the patient. If the patient's condition does not allow for participation in screening or the consultation (Traumatic Brain Injury (TBI), dementia, etc.) this will be documented in the medical record. The patient's condition will be monitored for

improvement and will be contacted when the patient's condition is improved.

- The Behavioral Health consultation and evaluation will determine subsequent intervention which will be documented in the medical record. If the treatment plan requires follow-up after discharge, the plan will be documented.
- Screening results and completion of consult will be recorded in the trauma registry.

References:

1. Resources for Optimal Care of the Injured Patient-American College of Surgeons./fi les/quality-programs/ trauma/tqp/ 022_vrc_injured-patient standards manual final.
2. Hunt J.C., Sapp, M., Walker C., Warren A.M., Brasel. K., & deRoon - Cassini T.A. (2017) Utility of the Injured Trauma Survivor Screen to Predict PTSD and Depression During Hospital Admission. Journal of Trauma and Acute Care Surgery, 82 (1), 93 - 101

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Attachments

Attachment A-CSSRS (Columbia Suicide Severity Rating Scale.docx
Attachment B-ITSS (Injured Trauma Survivor Screen).docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	3/5/2024
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