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

Ventura County Health Care System Oversight Committee
Hospital Administrative Policies & Procedures

October 3, 2024

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

1. AD.3 OB Admissions
2. AD.4 Newborn Admissions
3. AD.12 Surgery Admissions
4. AD.14 Patient Valuables Safe Keys
5. AD.18 Patient Discharge Procedure
6. AD.21 Patient Insurance Verification
7. AD.22 Medicare Verification
8. AD.23 Insurance Verification
9. EVS.03 Patient Room Cleaning
10. T.20 Guidelines for Care of the Injured Older Adult

Ventura County Health Care System Oversight Committee
Hospital Administrative Policies and Procedures October 3, 2024
Summary of Changes

#	Title	Review Period	Summary of Changes
1	AD.3 OB Admissions	Triennial	Policy was updated to reflect current practices
2	AD.4 Newborn Admissions	Triennial	Policy was updated to reflect current practices
3	AD.12 Surgery Admissions	Triennial	Policy was updated to reflect current practices
4	AD.14 Patient Valuables Safe Keys	Triennial	Policy was updated to reflect current practices
5	AD.18 Patient Discharge Procedure	Triennial	Policy was updated to reflect current practices
6	AD.21 Patient Insurance Verification	Triennial	Policy was updated to reflect current practices
7	AD.22 Medicare Verification	Triennial	Policy was updated to reflect current practices
8	AD.23 Insurance Verification	Triennial	Policy was updated to reflect current practices
9	EVS.03 Patient Room Cleaning	Triennial	Policy was updated to reflect current practices
10	T.20 Guidelines for Care of the Injured Older Adult	Triennial	Paragraph C under Procedure section, revised for clarity

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.3 OB Admissions

POLICY:

To state the process for admitting OB patients to Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

A. ~~OB patient is pre-registered on an OB tour or with a clinic.~~

B. ~~Paperwork is sent to Emergency Department (ED) Admitting where it is kept on file awaiting registration date.~~

C. ~~Patient arrives in ED. Paperwork is pulled from OB file and patient is registered as an OB Monitoring without delay.~~

D. Patient presents to Admitting and/or Emergency Department if after hours.

E. Patient is registered as OB Quick Reg and placed into Outpatient in a Bed Status.

F. OB floor is called ~~with status of~~and advised patient ~~and to inform them of the arrival of~~is awaiting transport to OB unit and picks up patient.

G. ~~If applicable, transport is called and patient is wheeled up with paperwork and notification to the floor with supervision.~~

H. ~~Baby packet is created for the arrival of the baby.~~

I. OB Nursing or unit secretary notifies Admitting Department when physician places an order for an Obstetrics admission.

J. Admitting Department changes the ~~OB Monitoring~~Outpatient in a Bed account to an Obstetrics Admission.

All Revision Dates

8/28/2024, 1/1/2014, 10/1/2011, 5/1/2006, 12/1/2001

Approval Signatures

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Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	8/28/2024
Patient Access	Lisa Prather: Admitting	8/27/2024

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> OB patients are not pre registered.

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Last Approved by Ward, Jill: Chief Financial Officer, VCMC & SPH on 8/28/2024, 10:34PM EDT

> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.4 Newborn Admissions

POLICY:

To state the process for admitting a newborn.

PROCEDURE:

~~OB Nursing calls the Admitting Department with the newborn's information, which includes:~~

OB Nursing registers all newborn admissions.

- Mother's name
- Chart number
- Sex of baby
- Time of birth
- Admitting physician
- Attending physician
- Room number

The ~~Admitting~~OB Department registers the newborn using the Newborn Admission function. Birth Clerks will obtain consents and privacy forms.

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> Admitting no longer registers newborns. This is completed by the OB dept

Last Approved by Prather, Lisa: Admitting on 8/27/2024, 12:11PM EDT

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> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.12 Surgery Admissions

POLICY:

To state the process for surgery admissions.

PROCEDURE:

- The Surgery Department supplies ~~Pre-~~Admitting with the surgery schedule.
- ~~Pre-Admitting~~The Clinic verifies that the surgery has prior authorization.
- ~~Pre-~~The Surgery Department gives the Admitting ~~gives the Admitting~~ Department staff the surgery list and surgery packets.
- Upon arrival of the patient, the Admitting Department verifies demographic information and ~~enters~~ activates the pre-registration.

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> surgery pre-registrations and authorizations are completed by the clinic. Admitting only activates and verifies the demographic information once patient presents for surgery.

Last Approved by Prather, Lisa: Admitting on 8/27/2024, 12:13PM EDT

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> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.14 Patient Valuables Safe Keys

POLICY:

To state the location of the keys used to open the patient valuables safe in the Admitting Department.

PROCEDURE:

The patient valuables safe requires two (2) keys to open. The Admitting Department keeps one key and the Nursing Supervisor keeps the other key.

~~The Admitting clerk on duty has the key with them at all times and passes the key on to the Admitting clerk working the next shift.~~

The second key is kept in the Paging Department for use by Patient Access staff when the safe needs to be opened.

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> the key is not passed on. It is secured in the Paging Dept

Last Approved by Prather, Lisa: Admitting on 8/27/2024, 12:09PM EDT

Last Approved by Ward, Jill: Chief Financial Officer, VCMC & SPH on 8/28/2024, 10:25PM EDT

> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.18 Patient Discharge Procedure

POLICY:

To state the process for discharging patients.

PROCEDURE:

- The discharge order is entered by the physician.
- Nursing or the unit medical office assistant enters the discharge date, time and disposition.
- If a patient has been discharged in error, the Admitting Department must be notified to cancel the discharge.
- Any existing orders will need to be re-entered by the physician and/or nurse if account is discharged in error.

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> if account is discharged in error, all existing orders will be deactivated and need to be re-entered by the physician and/or nurse

Last Approved by Prather, Lisa: Admitting on 8/27/2024, 12:15PM EDT

Last Approved by Ward, Jill: Chief Financial Officer, VCMC & SPH on 8/28/2024, 10:32PM EDT

> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.21 Patient Insurance Verification

POLICY:

To state the Admitting Department process for verifying patient insurance.

PROCEDURE:

An Admitting Clerk or Patient Representative is required to verify all insurances through the online verification tool. If unable to confirm eligibility through the online verification tool then the Admitting Clerk or Patient Representative must call the insurance company to verify eligibility and benefits on all patients admitted with insurance coverage.

~~A Patient Representative also~~Case Management obtains the authorization for hospital stay.

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> case management obtains authorization

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> Reviewed. No changes.

Activated on 8/28/2024, 10:33PM EDT

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.22 Medicare Verification

POLICY:

To state the process for verifying a patient's Medicare eligibility.

PROCEDURE:

A Patient Representative verifies patient Medicare eligibility using the online eligibility system.

If Medicare indicates insurance coverage, the Patient Representative calls the insurance company to verify eligibility and benefits~~, and~~. Case Management provides clinicals and then obtains authorization.

All Revision Dates

8/28/2024, 5/1/2006, 12/1/2001

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> Patient Rep does not obtain authorization for admissions. Case Management does after providing clinical information.

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> Reviewed. No changes.

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Owner	Lisa Prather: Admitting
Policy Area	Admitting

AD.23 Insurance Verification

POLICY:

To state the process for verifying patient insurance.

PROCEDURE:

The Admitting Department Clerk/Patient Representative is required to verify insurance eligibility using the online eligibility system on all patients who present with insurance.

The Patient Representative will call the insurance company to verify benefits and refer information to Case Management to provide clinical information and obtain authorization, if necessary.

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> Patient Reps do not obtain authorization. Case Management does after providing clinical information.

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Owner	Fernando Medina: Director, Support Services
Policy Area	Environmental Services

EVS.03 Patient Room Cleaning

POLICY:

To ensure standardize disinfecting and thorough patient room cleaning, to fight hospital acquired infections. By eliminate dust, and bioburden for the prevention of the spread of infection.

PROCEDURE:

The following steps should be taken when cleaning patient rooms:

1. Enter the patient room and observe the room from ceiling to floor, including the walls. **If the room is occupied, do NOT complete high dusting.**
    A. Remove trash, clean trash receptacle when needed and replace liner.
    B. Refill paper towel, soap, and alcohol-based hand sanitizer dispensers when they are empty or near empty.
    C. Install new batteries each time the refill is changed on the soap and alcohol-based hand sanitizer dispensers.
    D. Dust ceiling to floor with dry duster mop, include vents, walls, corners of room, and baseboards.
    E. Dust light fixtures and television.
    F. Dust window frames and sills. Clean windows as needed.
    G. First dust and then clean furniture with hospital approved cleaner-disinfectant. Allow to air dry.
    H. Check to make sure the furniture matches.
    I. Spot clean walls and wash with hospital approved cleaner-disinfectant. Allow to air dry.

J. Check lights to insure they are working.

K. First dust and then wipe blinds with a hospital approved cleaner, leave in down position.

L. Check patient's curtains for cleanliness and make sure all hooks are attached.

M. Check and clean patient closet.

N. Complete total bed cleaning to include mattress, frame, rails, remote control, head board, foot board and wheels using a hospital approved cleaner-disinfectant.

O. Dust mop floor, then mop with hospital approved cleaner and disinfectant. Leave wet floor sign up until floor is dry.

- Complete daily cleaning of all high touch surfaces to include windows, window sills, counters, hand rails, sinks, shower, toilets, paper towel dispenser, phones, light switch panels, door handles, push plates and bed side tables.
- Multiple cleaning wipes or microfiber towels should be used in the cleaning of each patient room.
- Any malfunctioning equipment such as cracked, broken, split coverings of mattresses and upholstery, plumbing problems in the housekeeping closets must be immediately reported to the Housekeeping Supervisor. The Supervisor will then submit a work order to Facilities Maintenance for repairs and continue to monitor the work orders until they are repaired.
- The Housekeeping Supervisors and leads will conduct surveillance for compliance with Housekeeping policies and procedures.
- Specific instructions/checklists (example - Bed Cleaning) can be obtained in the Department's Binder.

All Revision Dates

9/6/2024, 8/11/2021, 3/1/2013, 11/1/2012, 6/1/2012, 2/1/2009, 12/1/2008, 11/1/1992

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	9/6/2024
Infection Prevention	Magdy Asaad: Infection Prevention Manager	9/5/2024
Housekeeping Manager	Michael Lopez: Supervisor, Environmental Services	9/5/2024

Housekeeping Manager	Fernando Medina: Director, Support Services	9/5/2024

History

Edited by Medina, Fernando: Director, Support Services on 9/5/2024, 3:33PM EDT

> Reformatted and added B & C based on input from the Leapfrog Hand Hygiene Committee.

Last Approved by Medina, Fernando: Director, Support Services on 9/5/2024, 3:33PM EDT

Last Approved by Lopez, Michael: Supervisor, Environmental Services on 9/5/2024, 3:35PM EDT

> no changes. looks good

Last Approved by Asaad, Magdy: Infection Prevention Manager on 9/5/2024, 3:41PM EDT

> Reviewed and approved

Last Approved by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 9/6/2024, 10:56AM EDT

Activated on 9/6/2024, 10:56AM EDT

Administrator override by Arimura, Jason: Associate Hospital Administrator-AncillaryServices on 9/6/2024, 10:58AM EDT

> Fixing typo in title.

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH
Policy Area	Trauma Services

T.20 Guidelines for Care of the Injured Older Adult

PURPOSE:

Traumatic injury in the older adult is prevalent and is associated with higher morbidity and mortality. Optimization of positive outcomes requires an interdisciplinary approach. The goal of the trauma department with this population is to standardize care for the injured older adult, minimize complications and improve clinical outcomes.

POLICY:

This policy identifies the protocols in place to provide care for the injured older adult, defined as any trauma patient ≥ 65 years of age. Certain patient populations (ie ICU) may initially be managed by the trauma team but will ultimately be transferred to the care of the medical service (see Attachment A).

PROCEDURE(S):

Identification of Vulnerable Older Adults: All trauma patients ≥ 65 years of age will be included in this policy. As this population will also benefit from the input of a health care provider with geriatric expertise, all trauma patients ≥ 65 years old will be seen by medicine service attending physicians (see Attachment A).

A. Prevention, Identification and Management of Dementia, Depression and Delirium- refer to CPG.53 Analgosedation in the Intensive Care Unit
    1. Assess every shift for and as needed for delirium (CAM-ICU) and depression (eg ITSS, CSSRS, etc).
    2. Customize plan of care based on score from validated assessments.
    3. Depression screen positive- consult social work and/or psychiatry.
    4. Delirium screen positive

a. Non-pharmacologic options: early mobilization, promote healthy sleep/ wake cycle. For example, keeping the room lit and blinds open during the day; decreasing interruptions at night and ensuring lights off.

b. Pharmacological interventions as ordered: Dexmedetomidine or antipsychotic agents may be considered.

c. Engage with patient in ways to decrease anxiety and confusion (ie speak softly, re-orient the patient, talk about family and friends, decorate room with reminders of home, etc).

B. Process to capture and document what matters to patients (including preferences and goals of care, code status, advanced directives and identification of a proxy decision maker)

1. All patients admitted to the hospital will have a code status order entered- the licensed practitioner (LP) is responsible for discussions with the patient and next of kin to ensure the patient/family wishes are reflected. The patient will also be asked about preferences and goals of care by the LP.

2. The nursing staff is responsible for completing an admission intake on all patients, including older adults. This intake includes identification of a proxy decision maker, and an assessment of whether the patient has an advanced directive.

3. Palliative care consult as needed. This team is available to function as an expert resource to nursing and ancillary personnel without a physician's order for education, advanced care planning and for help in assessing the need for a referral. For older adults with life limiting injuries secondary to trauma, a consult will be ordered by the LP. The palliative care team will assist with symptom management, patient/family support, determination of code status and advanced directive assistance if needed.

4. Social work assessment and continued consults as needed to provide additional support to patient/family and to assist with post-discharge planning.

C. Medication Reconciliation and avoidance of inappropriate medications

1. ~~Patients ≥ 65 years of age meet criteria for pharmacy tech medication reconciliation~~ Medication Reconciliation Policy. ~~When available, a pharmacy technician shall obtain a best possible medical history (BPMH) for emergency department AND admitted patients and document this into the electronic health record (EHR). Registered nursing or LPs shall assist in obtaining and documenting the medication history in the EHR when the pharmacy technician is not available. The admitting medical team shall be responsible for reconciling the patient's home medication list within 48 hours of admission.~~

2. Medication reconciliation must be performed by licensed practitioner (LP) of the admitting medical team within 48 hours of admission.

3. Patients meeting the inclusion criteria should be interviewed by pharmacy technician to obtain best possible medication history list (BPMH) (hyperlink policy 100.082 Medication Reconciliation).

4. Registered nurse or LP shall assist in obtaining and documenting the medication history when pharmacy technician is unable to complete the task before 48 hours of admission

5. Obtaining and documenting the patient's home medication history or list into the EHR (Electronic Health Record) is the collaborative responsibility of providers, nurses, pharmacy staff, and licensed health care personnel involved in the patient's medication management. If a history or list cannot be obtained, the healthcare professional will document this in the EHR.
6. The specific decision of whether a patient should continue or discontinue a specific medications and treatments at various stages of their hospitalization (i.e., upon admission, upon transfer, upon discharge) shall be completed by the LP.
7. Medications that can cause fall risk will be reviewed by LP (eg diuretics, sedatives, analgesics, hypnotics and antihypertensives). Medications that can contribute to other untoward side effects in the older adult should also be reviewed and removed as appropriate.

D. Screening for mobility limitations and assurance of early, frequent, and safe mobility- promote early mobilization for all patients, including those ≥ 65 years of age (see policy 100.260 Early Mobility for more details).
   1. General Guidelines for Early Mobility: 5he established early mobility protocol is representative of general guidelines for treatment by the early mobility team based on a model indicated for mechanically ventilated and critically ill patients able to tolerate a progression of mobility from edge of bed (EOB) sitting through ambulation with or without assistive equipment. Modification to the protocol may be necessary to accommodate patient populations that include, but not limited to, patients presenting with strokes, polytrauma, varying degrees of spinal cord injury, burns, orthopedic issues and neurological impairments.
   2. Forming an Interdisciplinary Culture of Early Mobility- A viable early mobility team should comprise all of the components addressed in this protocol. Interactions will occur between LPs, nurses, respiratory therapists and rehabilitation services personnel to assure appropriateness of functional mobility training and subscribe to a clinically logical and stepwise process to minimize functional decline during hospitalization.
   3. Reassessment for Progression/Modification of Services- Physical Therapists/ Occupational Therapists will coordinate with the LP, nurse and respiratory therapist to discuss medical status, modification or initiation of an early mobility program and discharge planning.
   4. Evaluation by Physical Therapist/Occupational Therapist will Determine Appropriate Level for Initiation of Activity. Based on the clinical expertise and reasoning of the rehab therapist treating the patient ordered for evaluation, the rehab therapist will provide guidance as to what phase of the early mobility protocol to implement upon skilled intervention. Progression of functional mobility, utilization of the early mobility team staff, use of assistive equipment and treatment goals will be individualized to the patient based on level of acuity, overall medical condition, co-morbidities stability, weight bearing status, cognition and prior level of function.
   5. Consider any potential contraindications for mobility and consult LP prior to mobilizing (eg increased intracranial pressure, undersedation, unstable hemodynamics, end of life, active hemorrhage, etc).

6. Mobility assessment will place patient into one of four levels: Level 1 (unconscious), Level 2 (Conscious but non-ambulatory), Level 3 (Conscious with pre-gait activities), Level 4 (Conscious and Ambulatory). The assigned level determines the interventions needed for the patient. (refer to Policy 100.260).

E. Fall Risk Assessment

1. Fall risk is assessed on all patients, including older adults, using a screening tool (~~ie~~i.e., modified MEDFRAT for ED, Morse for adult inpatient, Humpty Dumpty for pediatrics). Interventions to prevent falls in the hospital will be customized based on the patient's fall risk.

    a. Prevention interventions include: keeping bed in low position, call light in reach, locking wheels, providing appropriate footwear and hourly rounding to include proactive toileting.

    b. Medications and symptoms that could contribute to greater fall risk are assessed by the LP, and treatment plan may be adjusted accordingly.

2. When appropriate, the older adult will be referred to the Fall Prevention Program. Goals are to decrease the frequency and severity of fall injuries in the elderly population of Ventura County utilizing prevention strategies. This will be coordinated by the Ventura County Medical Center Department of Trauma Services Injury Prevention Program in conjunction with Ventura County Emergency Medical Services (VCEMS), Ventura County Area Agency on Aging (VCAAA), Ventura County Public Health Department, local hospitals, private physicians, skilled nursing facilities, and ancillary medical professionals in our community by utilizing a screening and intervention process.

F. Implementation of safe transitions to home or other healthcare facility

1. Social work consult or consult to case management as needed for discharge planning.

2. Discharge planning evaluations are completed for all patients. Evaluation for the older adult must include the following:

    a. 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.

    b. The patient's capacity for self-care.

    c. The ability of the patient to safely return to the environment from which he or she entered the hospital.

    d. 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). 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. In the event the patient or legal guardian declines to designate a caregiver/support person, the declination shall be recorded in the EHR.

3. 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.
    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.
    b. As part of the discharge planning process, hospital staff must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post hospital care services and must, when possible, respect the patient'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. 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.

G. Medical needs of the older adult
    1. The trauma team acknowledges that the care of the injured older adult ≥ 65 years old requires additional considerations. Each patient's treatment plan should be individualized to consider potential comorbidities. This may include cardiology, syncope or neurological workup. Additional renal and infectious co-morbidities will also be considered, as well as psychosocial needs.

REFERENCE(S):

- American College of Surgeons Trauma Quality Improvement Program. ACS TQIP Geriatric Trauma Management Guidelines. October 2013. https://www.facs.org/quality-programs/trauma/tqp/center-programs/tqip/best-practice.
- The ABCDEF Bundle: Science and philosophy of how ICU Liberation serves patients and families. Ely, Wesley. 2017, Critical Care Medicine, Vol. 45, pp. 321-330

All Revision Dates

9/4/2024, 6/17/2024

Attachments

T Med Protocol.pdf

Approval Signatures

Step Description	Approver	Date
Trauma Services	Thomas Duncan: Trauma Director	9/4/2024
Trauma Services	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/4/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	9/4/2024

History

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> Pharmacy added C1-3

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Last Approved by Gabele, Danielle: Chief Nursing Executive, VCMC & SPH on 9/4/2024, 4:16PM EDT

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> C4 EHR definition
> E1 i.e.,

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Last Approved by Gabele, Danielle: Chief Nursing Executive, VCMC & SPH on 9/4/2024, 6:54PM EDT

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Activated on 9/4/2024, 7:22PM EDT

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VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

September 2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

100.242 Patient Weights

Policy:

Accurate patient weights are measured in kilograms (kg) for both adults and pediatric patients and grams (gm) for newborn patients. Measured weights shall be documented in the electronic health record (EHR).

Definitions

A. Measured weight is the patient's actual weight obtained from an approved scale.

B. Estimated weight is the patient's reported and/or perceived weight.

C. Dosing weight is the weight value that the EHR uses for calculating weight based medication dosing.

Procedure:

A. Patients are weighed upon intake (e.g., ambulatory clinic visit, admission, ED triage, and preop) unless the patient's condition is unstable. If the patient cannot be weighed, reasons are stated in the medical record. Once stable, the patient must be weighed.

B. Follow-up weights are completed at a minimum frequency as noted below, but may be updated at the discretion of the Licensed ~~Independent~~ Practitioner (~~LIP~~LP).

Nursing Unit	**Frequency of measured weights**
Pediatric, Pediatric Intensive Care Unit (PICU), and Neonatal ICU (NICU)	Daily
Adult ICU (ICU1)	Daily
Adult Step Down (ICU3 or DOU)	Weekly
Medical/Surgical and Telemetry units (~~3W~~STMS, MS, ICU2)	Weekly
Inpatient Psychiatric Unit (IPU)	Weekly
OB and Labor and Delivery	Weekly
Observation	As determined by LIP
Clinical condition	**Frequency of measured weights**
Heart failure	Daily
Renal failure on hemodialysis	Before and after dialysis

Continuous Renal Replacement Therapy (CRRT)	Prior to starting CRRT and daily
Ascites	Before and after therapeutic paracentesis
Parental nutrition or tube feeding	Weekly
Pressure ulcer or wound	Weekly
Significant weight loss of greater than (>) 10% of usual weight	Weekly and consult nutrition services
High nutrition risk	Daily or weekly as deemed appropriate by the LIP. Nutrition service consultation required.
Length of stay > 30 days	Monthly

C. Procedure for obtaining and documenting accurate, measured weights

1. Use the same scale whenever possible.
2. Keep the scale locked on metric units (e.g., kg and gm). See Attachment A - Weight Conversion Chart.
3. Weigh the patient at approximately the same time of day whenever possible.
4. Ask and assist the patient to void before weighing the patient. Empty foley before weighing the patient.
5. Weigh non-ambulatory patients on a bed with a built in scale. See Attachment B - Stryker bed
    a. All ~~bedscales~~bed scales must be zeroed out prior to placing a patient on it.
    b. For adult and pediatric patients, zero the bed with the following minimum items: (1) fitted sheet, (1) flat sheets, (1) draw sheet, (1) heavy absorbent pad, (1) pillow with pillowcase, and (1) bedspread.
    c. Additional items on the bed will be patient and unit specific and must be addressed prior to zeroing the bed. (See Attachment C)
6. Record the weight in the EHR (see Attachment D - How to document a measured weight in Cerner). If a measured weight cannot be obtained, the reason must be documented.

D. Procedure for addressing weight discrepancies

1. Nursing shall address discrepancies between estimated and measured weights.
2. Pharmacy may address dosing weight discrepancies.
    a. Pharmacist may update the dosing weight in the EHR in the event there is a significant discrepancy of 5 percent or more between the measured weight and dosing weight.
    b. The Pharmacist must review medications for weight based adjustments and if indicated will notify the ~~LIP~~LP as per policy PH.55 Medication Order Management.
    c. The Pharmacist should coordinate with the Nurse if any weight based adjustments are also indicated at the infusion pump.

All revision dates: 6/26/2024, 8/10/2021, 7/14/2020

Attachments

Attachment A - Weight Conversion Chart
Attachment B - How to Weigh Patients Using a Bed Scale
Attachment C - Unit specific workflows for zeroing a bed
Attachment D - How to document a measured weight in Cerner

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/14/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/26/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/26/2024
Policy Owner	Sara Pendleton: Medication Safety Officer	6/26/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.035 Medi-Cal Enrollment Validation

POLICY:

This policy applies to the initial credentialing/appointment and re-credentialing/reappointment of practitioners under the County of Ventura's health plan delegation agreement for Medi-Cal payors to meet validation requirements.

PROCEDURE(S):

Initial Credentialing/Appointment Process:

The Medical Staff Office will query the California Department of Health Care Services (DHCS) Ordering, Referring and Prescribing (ORP) Enrollment Validation Lookup at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/orp and Enrolled Medi-Cal Fee-for-Service (FFS) Providers list at https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers/resource/d652b210-ec3d-4a92-b7e0-e55c3dcbc7dc during the initial credentialing process.

Practitioners not enrolled in Medi-Cal will be enrolled by the County's enrollment vendor. Practitioners currently enrolled in Medi-Cal will be linked to the County during the enrollment process.

Re-credentialing/Reappointment Process:

The Medical Staff Office will validate continued enrollment during the re-credentialing/reappointment process.

Documentation:

Validation evidence will be maintained in the electronic practitioner credentialing file. The documentation will include the date and time of the verification, the user name of the team member completing the verification, and must be completed within 180 days of the credentialing/appointment or re-credentialing/reappointment approval date.

REFERENCE(S):

Gold Coast Health Plan Practitioner Credentialing Policy QI-025

DHCS All Plan Letter (APL) 22-013

DHCS All Plan Letter 22-013 FAQ

All revision dates:

Attachments

DHCS All Plan Letter 22-013
DHCS All Plan Letter 22-013 FAQ
Gold Coast Health Plan Practitioner Credentialing Policy QI-025

Approval Signatures

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Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	9/4/2024

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

108.004 Nursing Standards

POLICY:

Nursing Standards are authoritative statements of desired levels of performance against which to evaluate nursing care provided to patients and their families. The nursing department will maintain established *Standards of Care* and *Standards of Practice* to meet the needs of patients, families and visitors.This policy shall define the *Standards of Care* and the *Standards of Practice* for nursing care provided at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

PROCEDURE:

Standards of Care and *Standards of Practice* are developed based on:

- Patient population;
- The scope and complexity of the patient's needs for nursing care;
- The knowledge and skill level of nursing staff members who provide nursing care;
- The nursing process.

Standards of Nursing Practice: are generic standards that apply to nursing, regardless of specialty area. *Standards of Nursing Practice* includes standards of professional performance and standards of nursing care.

Standards of Professional Performance: Describe a competent level of behavior in the professional role – including activities related to quality, performance appraisal, education, congeniality, ethics, collaboration, research and resource utilization.

The *Standards of Nursing Practice* provide measurable criteria necessary to guide quality nursing care. They offer a framework for the development of an optimum working environment, and the efficient use of Hospital resources.

The Registered Nurse shall:

1. Perform a complete nursing assessment within (6) six hours of admission and reassess at least every shift and/or more frequently, if the patient's condition warrants the additional assessment.
2. Formulate an individualized, multidisciplinary plan of care, that is initiated within (12) twelve hours of admission. The patient/family will be included in the planning of care, whenever possible.
3. Formulate and document a nursing diagnosis, through observation of the patient's condition and behavior, and through interpretation of information that is obtained from the patient and others.

4. Evaluate the effectiveness of the care plan, through observation of the patient's condition and behavior, signs and symptoms of illness and reactions to treatment and through communication with the patient and health team members. The plan will be modified as needed.
5. Perform essential skills, explain health treatments to patients and families, and teach the patient/family/caregiver how to care for the patient's health needs, based on their learning needs, abilities, preferences and readiness to learn.
6. Address discharge needs and continuity of care issues at the time of admission, and continuing through to patient discharge.
7. Provide appropriate nursing interventions and/or education based on their changing needs, disease process and nursing diagnosis.
8. Delegate tasks to unlicensed personnel that may assist in patient care, based on scope of practice and competence required. The nurse will effectively supervise nursing care that is given by unlicensed personnel.
9. Act as the patient's advocate, as circumstances require, by initiating action to improve health care or by changing decisions or activities which are against the interests or wishes of the patient; give the patient an opportunity to ask questions and to make informed decisions about their health care.
10. Provide the support needed to promote patient/family psychosocial well-being.
11. Assess and provide adequate pain management.
12. Provide care, with respect for the concept of human dignity, and the uniqueness of the patient; provide care unrestricted by considerations of social or economic status, personal attributes or the nature of health problems.
13. Safeguard the patient's right to privacy.
14. Assume responsibility and accountability for individual nursing judgments and actions.
15. Maintain competence.
16. Exercise informed judgment and use individual competence and qualifications as criteria in seeking consultation, accepting responsibilities and delegating nursing activities to others.
17. Take appropriate action concerning spiritual and emotional needs.
18. Accept the patient's individuality, ethnic and cultural heritage.
19. Prioritize patient care needs for hygiene, monitoring, physiologic alterations, education and emotional support, in collaboration with patient, family and physicians.
20. Evaluate one's own practice in relation to professional practice standards and relevant statutes and regulations.
21. Acquire and maintain current knowledge and competency in nursing practice.

Standards of Patient Service: are practice standards, which affirm our commitment to the highest quality. The standards of patient service further clarify expectation of the nursing service personnel. In providing care to all patients, our staff will be caring and considerate, and present themselves with a professional attitude, appearance and behavior. The Nursing personnel will:

1. Acknowledge patients promptly and courteously with eye contact and a pleasant expression and tone of voice.
2. Use words that express respect, patience and understanding, when talking with patients and/or staff

members.

3. Care for people with kindness and consideration.
4. Address adult patients by their proper title and last name, unless the patient requests otherwise.
5. Display visible picture identification and introduce themselves by name and title when first meeting the patient or family.
6. Answer the phone quickly and courteously. They identify themselves by name and department. They provide callers the opportunity to respond to a request to be placed on hold, and explain where their call is being transferred.
7. Be sensitive to reducing noise levels, odors and chaos in and near patient care areas.
8. Respect patient privacy by knocking before entering a patient's room, if the door is closed, and by refraining from discussing any patient in inappropriate areas.
9. Protect the confidentiality of patients, co-workers and others who use our facility.
10. Make certain that patient modesty is respected.
11. Be attentive to patients and their families, who have been kept waiting for extended periods of time.
12. Consider the effects of what is said and done in the presence of patients. Nurses will refrain from conducting personal (not work related) conversation in front of patients and families.
13. Refrain from discussing other staff members, organizational policies, problems or medical care in public areas, or patient care areas.
14. Maintain and utilize hospital equipment and facilities in an appropriate and cost effective manner.

Nursing Standards Of Patient Care: The Standards of Care for each patient population are in the format of care plans. These care plans are organized by medical groupings, and are written as nursing diagnosis, goals and interventions. These standards are based on nationally recognized standards as appropriate.

Utilization of Nursing Standards of Patient Care will:

- Promote consistent and high quality patient care;
- Be part of a multidisciplinary/collaborative treatment plan;
- Be utilized in directing the patient care activities of the nursing staff;
- Provide a framework to monitor and evaluate the quality of nursing care that is provided;
- Provide a framework for nursing documentation.

All revision dates:	9/14/2021, 11/1/2013, 10/1/2009, 6/1/2006, 1/1/2005, 1/1/1999, 8/1/1994, 9/1/1992, 8/1/1991, 8/1/1990, 11/1/1983, 11/1/1981

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/15/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/29/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/29/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Melody Donate: Stroke Coordinator*
Policy Area:	*Administrative - Nursing*
References:	

108.027 Nursing Swallow Screen

POLICY:

The Nursing Swallow Screen Protocol may be used to screen for impaired swallowing in high risk populations such as stroke, degenerative neurologic disease, head and neck cancer/surgery. The purpose of this policy is to establish a standardized procedure for nursing in assessing a patient's ability to swallow, before providing the oral intake of fluids, food or medication, thereby reducing the risk for aspiration.

It is the policy of VCMC/SPH to conduct swallow screens on patients considered at risk for aspiration. A swallow screen will be utilized and the findings will be documented. Nursing will implement the appropriate physician order in response to the findings of the swallow screen. Should neurological deterioration occur, nursing will perform another swallow screen.

PROCEDURE:

A nurse competent in swallow screening (see Attachment A, *Competency Checklist*) will accurately identify potential patients at risk for aspiration and perform a "Three step swallow screen" (see below). First, the patients' presentation and past medical history will be reviewed to identify the predisposition for aspiration. Secondly, a simple 3 ounce water test will conducted. The nurse will proceed to the third step if the patient tolerates 3 ounces of water. Third, two (2) sips of water will be conducted and a determination will be made for a pass or fail status. The "Three step swallow screen" will be conducted to determine if patients are at risk for clinically significant aspiration or require a speech referral for a definitive swallow evaluation.

NOTE: The 3 ounce water swallow screen is not intended to be a comprehensive dysphagia evaluation, nor does the screen replace a formal speech therapy consultation and evaluation.

Three Step Swallow Screen

Steps	Assessments	Actions
Step 1:	Physical presentation- Signs/symptoms Medical History • Commands- can't follow • Glasgow score less than-13 • Combative or lethargic • Voice- none or gurgles • Drools or can't manage secretions	If patient has any of the findings, **STOP** the swallow screen • Keep the patient NPO and do *not* proceed with the swallow screen. • Document: Patient failed Step 1 of Swallow screen • Keep patient NPO including oral

Steps	Assessments	Actions
	• Cough- weak or absent • Lips-can't close • Severe facial asymmetry • Tongue- asymmetry or can't move • Palate asymmetry • No rise of larynx during swallowing • Feeding tube present Past medical history • Prior stroke and dysphagia • Parkinson's • ALS, Multiple Sclerosis Dementia • Neurodegenerative disease • Cranial neurosurgery • Prior dysphagia • Baseline coughing • Recurrent or current pneumonia	medications If not already addressed, contact the physician for further orders, such as: • formal swallow evaluation by speech • seek order for alternate routes if indicated If patient has none of these conditions listed under physical presentation and past medical history, proceed to Step 2.
Step 2:	Before the "One sip of water (3 ounces of water) test" is started, the nurse ensures the following: • Patient is upright 90 • Suction and towel available • Mouth is moist and clean • Patient is alert • Patient is able to follow simple commands • Patient does not display a facial droop • Patient has understandable speech The patient will be instructed to take **one** sip of water (do not use straws). The nurse will observe for the following: • Water dribbling or drooling from mouth • Swallow multiple times • Immediate cough or within one minute of swallow • Voice Quality is wet or gurgling Note: If patient does not exhibit impairments after 3 ounces of water, proceed to Step 3, "Water-2 - sips ."	If patient has any of the findings in Step 2, **STOP** the swallow screen • Keep the patient NPO including oral medications and do *not* proceed with the swallow screen. • Document failed screen (Step 2) in the medical record. • If not already addressed, contact the physician for orders, such as: ◦ formal swallow evaluation by Speech ◦ orders for strict NPO for all food, fluids meds ◦ seek order for alternate routes if indicated If patient does not exhibit any of the impairments listed, after the one sip of water test, proceed to Step 3.
Step	Before the "two sips of water" test" is started,	If the patient exhibits impairment in any of the

Steps	Assessments	Actions
3	the nurse ensures the following: • Patient is upright 90 • Suction and towel available • Mouth is moist and clean • Patient is Alert • Patient is able to follow simple commands • Patient does not display a facial droop • Patient has understandable speech Instruct patient to take **2 sips** of water (no straws) and observe for: • Water dribbles or drools from mouth • Swallow multiple times • Immediate cough or within one minute • Voice quality becomes is wet or gurgling Note: If patient does not exhibit impairments after 2 sips of water, the screen is completed.	Step 3 assessments, **STOP** and: • Keep the patient NPO including oral medications • Document failed screen (Step 3) • If not already addressed, contact the physician for orders, such as: ◦ formal swallow evaluation by speech ◦ orders for strict NPO for all food, fluids meds ◦ seek physician order for alternate routes of nutrition, fluid and medication if indicated If patient does not exhibit any of the impairments, after the 2 sips water tests ,the screen is completed and the patient passed the swallow screen Follow the physician's prescribed orders for diet and nutrition intake • If not already addressed, contact the physician for a diet and nutrition order.

REFERENCES:

Fedder, W. N. (2017). Review of evidenced-based nursing protocols for dysphagia assessment. *Stroke*, *48*(4), e99-e101

Palli, C., Fandler, S., Doppelhofer, K., Niederkorn, K., Enzinger, C., Vetta, C., ... & Gattringer, T. (2017). Early Dysphagia Screening by Trained Nurses Reduces Pneumonia Rate in Stroke Patients: A Clinical Intervention Study. *Stroke*, *48*(9), 2583-2585.

The Joint Commission. Advanced Primary Stroke Center: Appendix. 2017. Retrieved from www.jointcommission.org

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Attachments

A: Competency Checklist

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/16/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/15/2024
Policy Owner	Melody Donate: Stroke Coordinator	8/14/2024

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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.49 Documentation Standards in the Emergency Department

POLICY:

To establish documentation requirements for Emergency Department (ED) patients at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH).

PROCEDURE:

A. An ED record shall be kept for every patient receiving emergency service in the patient's electronic health record (EHR), which shall be part of the official hospital record. This record shall contain:

1. Adequate patient identification and hospital medical record number, date of birth and consents for treatment. When consents are not available or when unable to obtain, documentation will be made. All the paperwork shall be labeled and scanned into the patient's EHR.
2. Date and time of patient arrival and discharge from the ED.
3. Means of arrival and by whom transported.
4. The patient's chief complaint.
5. Physician Charting Will Include:
    a. History of injury or illness including emergency care given prior to arrival
    b. Physical findings with diagrams of injury, if indicated and vital signs.
    c. Laboratory and radiographic studies ordered and results.
    d. Impressions, diagnosis, treatment orders and the results of the treatment.
    e. Instructions in the language understood by patient for after-care given to the patient or relatives, and appointments in writing for return visits to the ED or to other clinics or physicians. When after-care sheets are given to patients, it shall be noted on the chart, in the patient's EHR.
    f. Disposition, means and condition of the patient on discharge.
6. Nurses Charting to include:
    a. Nursing Assessment to include nursing history (emotional and physical) based on ED "Standards of Care."
    b. ~~Vital signs to include Blood Pressure, Pulse, Temperature, Respiratory Rate, and level of pain~~

~~on admission. Then every four (4) hours or more often as indicated or ordered. Critical patients must be evaluated more frequently, i.e., vital signs every 5 to 15 Min on trauma, chest pain, etc., until patient's status improves. Rectal or axillary temperatures on all pediatric patients under the age of two (2) years depending on chief complaint.~~Vital signs to include blood pressure, pulse, temperature, respiratory rate, oxygen saturation, and level of pain on admission as part of the Emergency Severity Index (ESI) scoring assessment.

i. ESI 1 patients or critical patients including traumas, vital signs should be repeated every 5 to 15 minutes until patient's status stabilizes, then every 2 hours after that.

ii. ESI 2-3 patients vital signs should be repeated every 2 hours.

iii. ESI 4-5 patients with abnormal vital signs should have then repeated every 2 hours until they normalize, then every 4 hours after that.

iv. ESI 4-5 patients with normal vital signs should have vital signs repeated every 4 hours.

v. Rectal or axillary temperatures should be taken on all pediatric patients under the age of two (2) years depending on chief complaint.

vi. Any abnormal vital signs should be promptly reported by the nurse or technician who takes them to the attending physician. (See Attachment A).

c. Weight in kg on all patients, naked weight on all children under one (1) year old.

d. Head circumference on pediatric patients when deemed appropriate by attending physician.

e. Fetal heart tones (FHTs) on all pregnant patients over 12 weeks gestation.

f. Allergies, medications currently used and tetanus immunization status.

g. Medication Reconciliation form on all patients in the ED shall be completed by the RN.

h. Document patient's level of pain initially and any changes in the level or severity as applicable.

i. If medications are administered in the ED, note name, dosage, route of administration, site of administration if parental, time administered and results. Document in the patient's EHR.

j. Any change in patient's condition.

7. Conclusions and documentation if the patient leaves against medical advice, label against medical advice (AMA) form and have scanned into patient's EHR.

8. Patients, patient's relatives, guardians, law enforcement or other responsible person's signature on receipt of discharge instructions.

9. Document in EHR if a patient leaves without being seen or leaves before treatment is completed (per policy 100.211).

10. All patient records are confidential. Refer to Administrative policy 100.018.

11. Patient authorization to release information for follow up care to his or her physician or health care organization is addressed.

B. Trauma Flow Sheet to be used on all Code Yellow Tier I and Tier II patients.

DOCUMENTATION

As above

REFERENCES:

Title 22, California State requirements
The Joint Commission Standards
Emergency Nurses Association - Standards of Care

All revision dates:	7/10/2024, 1/28/2020, 11/1/2016, 12/1/2013, 11/1/2011, 8/1/2011, 1/1/2011, 12/1/1998, 1/1/1995, 10/1/1992

Attachments

ER.49 Attachment A.docx

Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/10/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/10/2024
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	7/10/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.55 MED CODE

~~Policy:~~

Policy:

To facilitate and expedite the care and stabilization of nontrauma patients at high risk for rapid deterioration who present to the Emergency Department.

~~Purpose:~~

Purpose:

A "MED CODE" is called so that the staff needed to care for critically ill nontrauma patients responds rapidly to the Emergency Department (ED). The med code response is to ensure a rapid and orderly assessment of patients with significant physiologic impairments. Patients who fall under the guidelines for a code stroke, code yellow (trauma) or code blue should be called and cared for as per those previously established guidelines and should not be called as a med code.

~~Criteria:~~

Criteria:

1. Hemodynamic instability
    1. Adults with systolic blood pressure <80 mm Hg
    2. Children with age specific hypotension
        1. ≤ 1 year: <60mm Hg
        2. 1-10 years: <70 mmHg + 2X age in years.
2. Respiratory compromise
    1. CPAP in field
    2. Persistent 02 sat < 90% despite oxygen supplementation
3. Patient who is unresponsive to painful stimulus.
4. Judgment of ED Physician/MICN. Examples:
    1. Concern for acute vascular dissection or rupture
    2. Concern for pericardial tamponade

3. Concern for imminent decompensation from severe electrolyte derangement
4. Concern for impending airway disaster

~~Procedure:~~

Procedure:

1. The MICN or designee will notify the Emergency Department charge nurse.
2. The MICN or designee will notify the page operator who will send an alphanumeric page stating "*Med Code ER, adult/peds/infant ETA …minutes"* to all required team members including:
   a. nursing supervisor when available
   b. certified phlebotomy technician
   c. xray technician
   d. respiratory therapist
   e. rapid response nurse
   f. ICU attending if adult, PICU attending for children
3. A med code is called overhead in the ER by the charge nurse or MOA
   a. An overhead page will state, *"Med Code ER, adult/peds/infant ETA …minutes."*
   b. If the patient self presents to the ER via triage the overhead page will state *"Med Code ER, adult/peds/infant Now."*
4. The following people are to arrive immediately to the Resuscitation Room in the ED:
   a. Physicians: Attending ED physician, ED residents
   b. Nurses: Two ED nurses (or more if requested), Nursing Supervisor, Rapid Response Nurse
   c. Ancillary Staff: certified phlebotomy technician, Xray technician, Respiratory therapist, ER technician

All revision dates:

Attachments

No Attachments

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Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	8/28/2024

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

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

POLICY:

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

PROCEDURE:

Admission to 3 Fainer South Tower

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

A. Inclusion Criteria

1. Hemodynamically stable (SpO2 > 92, free of cardiac dysrhythmia)
2. No indication for continuous cardiac monitoring or pulse oximetry.
3. Requirement of high level Addiction Medicine specialty management to safely undergo detox, withdrawal or induction in an inpatient setting.

B. Exclusion Criteria

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

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

C. Types of Admissions

1. Direct Admissions: Patients referred by the outside provider and accepted by the unit specific attending physician; case management should be notified of all direct admissions.
2. Emergency Department Admissions: Patient assessed in the Emergency Department and referred and approved by the unit specific physician for admission. The unit attending physician is responsible for the admitting orders to 3FST.
3. Observation Status: Patients admitted for monitoring and observation with discharge or an acute admission expected within 23 hours (or less than two midnights for Medicare).
4. Inpatient Status: Patients admitted for >24hrs (or greater than two midnights for Medicare). If a patient previously admitted under observation status suffers condition worsening warranting a longer stay, the attending physician must change the order status to reflect an inpatient admission.

II. **Admission Process**

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

5. Apply patient identification and allergy bands if not already applied. Apply Fall Risk wrist band and room sign if patient has been assessed at risk for falls.
6. Review, verify and initiate orders in the EHR.
7. Inventory the patient's belongings and securing the patient valuables (including their medications). Witness patient signature on any consents or forms as needed.
8. Notify other departments as indicated (i.e., Laboratory, Radiology, etc.)
9. Disclosures: Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations and advised that they restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.

Discharge From 3 Fainer South Tower

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

II. **Discharge Considerations**

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

achieved and ALL of the following are present:

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

Documentation

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

All revision dates: 4/16/2024, 11/15/2023

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Family Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/16/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/16/2024

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Nursing Practice Protocols*
References:	

NPP.05 Standardized Nursing Procedures for the Rapid Response Nurse

PURPOSE:

Individuals who ~~present to the Emergency Department (ED) or who~~ decompensate in the nursing units and require a response from a rapid response (RR) nurse will be assessed by an RN competent to determine the patient's presenting complaint. Once the assessment is complete, the ~~triage competent ED~~RR RN ~~or the~~may initiate care according to the following standardized procedures in the adult nursing units only. Only RR ~~RN~~nurses who have demonstrated competency in the role and have received specialized training for this protocol may ~~initiate care according to the following standardized~~activate these procedures in response to rapid response events only. This procedure was written by nursing leadership and is approved via the Interprofessional Practice Committee and approved by medical staff.

The standardized procedures outlined in this policy are established to initiate and expedite care in the ED or in rapid response situations. All standardized procedures are to be documented in the Electronic Health Record (EHR). When additional concerns arise or conditions develop not listed in these procedures, the RN will consult with the ED licensed practitioner (LP). The RN will initiate all interventions in the appropriate protocol. The ED LP will be notified and assume responsibility for reviewing test results and contacting the patient in the event that a patient leaves the hospital prior to completion of test results.

Competency for the procedures listed will be assessed annually and stored in the RR RN personnel files. The procedures herein will be reviewed annually ~~also~~with an interpriofessional team including medical staff. When initiating one of the protocols, the RR RN will order under standardized procedure order type, which requires a co-signature by attending physician.

PROCEDURE(S):

A. **The following procedures may be initiated by the RR RN in response to clinical assessment.**

1. Altered mental status
    a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
    b. Cardiac monitoring and cardiac rhythm interpretation
    c. ER Laboratory Panel
    d. Glucose point of care

e. Alcohol level
f. Urine drug screen
g. Point of care urinalysis with reflex to micro and culture
h. 12 lead EKG
i. Chest x-ray 1 view
j. Blood gas, venous
k. Electrolyte panel
l. Lactate level
m. Notify Licensed Practitioner (LP).
n. Vital signs every 5 minutes until symptoms improve or mental status returns to baseline.

2. Respiratory symptoms- for patients exhibiting any signs of respiratory distress including but not limited to desaturation, dyspnea, tachypnea, shortness of breath, labored breathing and use of accessory muscles
   a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
   b. Cardiac monitoring and cardiac rhythm interpretation
   c. Supplemental oxygen to maintain saturations > or = 90%
   d. Chest x-ray 1 view
   e. Venous blood gas and electrolyte panel.
   f. Notify LP.
   g. Page respiratory therapist.
   h. Vital signs every 5 minutes until symptoms improve.
3. Chest pain- for patients exhibiting new onset of substernal chest pain and/or pain radiating to the neck, back, jaw or arms
   a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
   b. 12 lead EKG
   c. Supplemental oxygen via nasal cannula for saturations > or = 90%
   d. Cardiac monitoring and cardiac rhythm interpretation
   e. ER Laboratory Panel
   f. Chest x-ray 1 view
   g. Troponin-I High Sensitivity now and in 2 hours
   h. Notify LP.
   i. Vital signs every 5 minutes until symptoms improve.
4. Cardiac symptoms- for patients exhibiting signs and symptoms of symptomatic hypotension, arrhythmia or new onset of chest pain
   a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
   b. Immediately notify LP.

c. Cardiac monitoring and cardiac rhythm interpretation
d. 12 lead EKG
e. Chest x-ray, 1 view
f. ER Laboratory Panel
g. Troponin-I High Sensitivity now and in 2 hours
h. Blood gas, venous
i. Electrolyte panel
j. Lactate Level
k. Vital signs every 5 minutes until symptoms improve or BP returns to baseline.

5. 2+ Systemic Inflammatory Response Syndrome (SIRS): Temperature less than 96.8ºF or greater than 100.9ºF; HR greater than 90; RR greater than 20; WBC less than 4,000 or greater than 12,000 or Bands greater than 10% with suspected or confirmed infection (Adult)
   a. Adults: Initiate ED Triage Sepsis Adult power plan
   b. Lab ER panel
   c. Venous Blood Gas with lytes and lactate
   d. Blood cultures x 2
   e. Urinalysis with micro reflex to culture
   f. O2 via nasal cannula to keep O2 sat greater than 94%
   g. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
   h. Chest x-ray 1 view
   i. Notify LP.
   j. Vital signs every 5 minutes until symptoms improve or BP returns to baseline.
   k. Discuss presence of existing urinary catheter with provider for further instructions.

B. **Documentation**

1. **The ~~ED or~~ RR RN is responsible for ensuring complete documentation on all interventions selected from these standardized procedures in the EHR.**

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	pending

Step Description	Approver	Date
Protocol Author	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/28/2024

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

OB.09 Code Maternity

POLICY:

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

PROCEDURE:

STAGE-BASED APPROACH TO OBSTETRIC HEMORRHAGE

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

B. Stage 1: Blood loss greater than 500 mL at vaginal delivery **OR**
   greater than 1000 mL at cesarean delivery with continued bleeding **OR** signs of concealed hemorrhage. vital sign abnormal **OR** trending (HR ≥110, BP < 85/45,02 sat <95%, shock index 0.9) **OR** Confusion.
   1. Activate OB Hemorrhage Emergency Management Plan (Attachment B).
   2. Establish IV access if not present, at least 18-gauge.
   3. Increase IV oxytocin rate to 500-1000 mL per hour of 30u/500 mL solution.
   4. Fundal/bimanual massage.
   5. Administer another uterotonic medication. If no response, consider second uterotonic (Attachment B

&C).

6. Empty Bladder with straight foley or place foley with urimeter if not already done.
7. When using second uterotonic strongly consider inserting JADA or uterine balloon tamponade
    a. Contraindications to JADA use include
        i. ongoing intrauterine pregnancy
        ii. Untreated uterine rupture
        iii. Unresolved uterine inversion
        iv. Current cervical cancer
        v. Known Uterine anomaly
        vi. Current purulent infection of vagina, cervix or uterus
        vii. For Cesarean Sections:Cervix <3cm dilated before use of JAD
        viii. JADA system or Uterine balloon tamponade should not be left within the uterus for more than 24 hours.
8. Blood Product readiness:
    a. Modify Hemorrhage Risk to "High" if not already classified as High Risk, and take appropriate precautions
    b. Consider T&C 2 Units PRBCs where clinically appropriate if not already done

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

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

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

- Obstetrician on call
- Nursing Supervisor
- Anesthesiologist on call
- ~~Critical Care Unit resident~~Rapid Response Nurse
- Laboratory technician

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

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

1. The Obstetrician/physician will respond by coming directly to the location. If the Obstetrician on call cannot respond rapidly, the Charge Nurse or designee will begin calling Obstetricians on the emergency

call back list.

2. The Nursing Supervisor will call the OR team.
3. The Anesthesiologist will come to the location. If unable to respond rapidly, the Charge Nurse or designee will call the second call Anesthesiologist.
4. Complete evaluation of vaginal wall, cervix, placenta, uterine cavity
5. AT VCMC: The Rapid Response Nurse and ICU charge nurse will respond to the location. Level One blood transfuser will be located in OB PACU for use.
   AT SPH: The ED charge nurse will respond to the location with Level One blood transfuser.
6. The Laboratory will respond immediately, delivering an iced cooler containing two (2) units of O Negative Blood, and (2) units of thawed AB plasma, within five (5) minutes. If the physician determines that the patient can wait for the completion of compatibility testing of type specific/type compatible red blood cells, the blood will be returned to the Blood Bank.
7. At SPH the charge nurse will send an available staff member to lab immediately to retrieve and deliver an iced cooler containing two (2) units of O Negative Blood, within five (5) minutes. If the physician determines that the patient can wait for the completion of compatibility testing of type specific/type compatible red blood cells, the blood will be returned to the Blood Bank.
8. Send Labs, including DIC panel. Plus or minus ABG will be drawn.
9. Consider additional uterotonics, or uterine tamponode device.
10. The decision to use tranexamic acid with the Code Maternity protocol shall be made within three (3) hours of incident. The loading dose is available in the OB Pyxis machine. The loading dose of 1 gram (100 mg/mL) of tranexamic acid is given intravenously at an approximate rate of 1 mL per minute. If bleeding continues after 30 minutes or stops and restarts within 24 hours of the first dose, a second dose of 1 g of tranexamic acid is again administered.
11. Establish second large bore IV at least 18-gauge, if not done in Stage 1.
12. Place intrauterine balloon.
13. At VCMC, if it is anticipated that greater than 4 units of blood will be required, the physician or Anesthesiologist may activate the Massive Transfusion Protocol.
14. At SPH, the Blood Bank will contact Vitalant.
15. Move to Operating Room, if indicated.

D. Stage 3: Cumulative blood loss greater than 1500 mL, continued bleeding, greater than two (2) units given, vital signs unstable or suspicious for DIC: Activate Code Maternity, if not yet done.

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

All revision dates: 6/12/2024, 5/1/2023, 2/17/2023, 10/9/2019, 12/20/

2017, 12/20/2017, 11/1/2016

Attachments

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

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	7/2/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/12/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/12/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	6/12/2024

VENTURA COUNTY
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References:	

PH.26.00 Sterile Compounding Overview

Purpose:

The Department of Pharmacy Services is responsible for preparation ~~and compounding of~~of compounded sterile ~~drug~~ preparations (CSPs) for Ventura County Medical Center, Santa Paula Hospital, and Ambulatory Care Campus Clinics. This policy provides an outline of the policies and procedures that the Department of Pharmacy Services will follow in preparation and compounding of sterile drug preparations.

Policy:

A. The Department of Pharmacy Services shall follow all policies and procedures pertaining to Sterile Compounding to ensure that high-quality ~~sterile drug preparations~~CSPs are consistently prepared. The policies are as follows:
PH.26.01 Training and Evaluation of Staff
PH.26.02 Facilities and Equipment
PH.26.03 Sterile Compounding Attire
PH.26.04 Sterile Drug Preparation, Labeling, End Product Evaluation and Record Keeping
PH.26.05 Beyond Use Dates
PH.26.06 Sterile Compounding Quality Assurance Program

B. The Department of Pharmacy Services shall not compound ~~sterile drug preparations~~CSPs under high-risk conditions, which includes compounding ~~sterile drug preparations~~CSPs from non-sterile ingredients.

C. Sterile Compounding policies shall be reviewed at least annually.

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

References:

A. USP Chapter <797>, Pharmaceutical Compounding – Sterile Preparations

B. California Code of Regulations Title 16 Articles 4.5, 7 and 7.5.

All revision dates: 8/15/2024, 11/5/2019, 10/3/2017, 7/1/2016, 4/1/2016, 2/1/2014

Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/15/2024
Infection Prevention	Magdy Asaad: Infection Prevention Manager	8/15/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	8/15/2024

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Policy Area:	*Pharmacy Services*
References:	

PH.26.01 Training and Evaluation of Pharmacy Staff in Sterile Drug Preparation

POLICY:

This policy promotes the safe, efficient and uniform performance of all Pharmacy staff involved in the preparation ~~and compounding of~~of compounded sterile ~~drug~~ preparations (CSPs).

- The Pharmacy Department shall develop and maintain an initial and ongoing competency evaluation process for Pharmacy staff involved in sterile compounding.
- All Pharmacy staff involved in sterile compounding shall have the skills and training required to properly and accurately perform their assigned sterile compounding responsibilities.
- Training shall also include support staff whose jobs are related to the sterile compounding process.
- Pharmacy staff assigned to sterile compounding duties shall demonstrate knowledge about processes and procedures used in sterile compounding prior to compounding any sterile drug preparation, which may include hazardous drugs (HD).

PROCEDURE:

Training and Process Validation

A. All sterile compounding staff shall be trained and demonstrate competence on the following:
   1. Sterile compounding policies and procedures.
   2. Aseptic technique.
   3. Pharmaceutical calculations and terminology.
   4. Documentation of compounding processes (e.g., master formula and compounding records)
   5. Quality assurance procedures.
   6. Proper hand hygiene and garbing.
   7. General conduct within the compounding area.
   8. Cleaning, disinfection and maintaining of the equipment and the controlled area.
      a. Principles of movement of materials and personnel.
      b. Maintaining sterility.

c. Principles of high-efficiency particulate air (HEPA)-filtered unidirectional airflow within the ISO class 5 area.

9. Use of equipment.

B. All sterile compounding staff working with HDs shall also complete HD training and competency (see policy PH.27.00 Hazardous Drug Overview)

C. Proficiency and continuing training needs shall be reassessed at least every twelve months for each individual involved in sterile compounding.

D. Training and Evaluation

1. Hand hygiene and garbing competency
    a. Gloved fingertip and thumb (GFT) sampling shall be successfully completed at least three separate times before initially being allowed to compound ~~sterile drug preparations~~CSPs.
    b. Subsequent gloved fingertip testing shall be successfully completed at least once every 6 months.
    c. Completed samples shall be incubated at 30-35ºC for no less than 48 hours and then at 20-25ºC for no less than 5 additional days.
        i. No growth (0 colony-forming unit or CFU) denotes a pass.
        ii. Any growth (≥1 CFU) denotes a failure.
2. Aseptic technique competency shall be successfully completed initially and once every 6 months in the following sequence
    a. Medium risk media fill test
        i. Completed medium samples shall be incubated at 20-25ºC and 30-35ºC for a minimum of 7 days at each temperature band
            a. A clear solution denotes a pass
            b. A turbid solution or presence of precipitate denotes a failure.
        ii. Manufacturer, lot number, and expiration date of the media fill test shall be documented
    b. GFT sampling after media fill testing
        i. Completed samples shall be incubated at 30-35ºC for no less than 48 hours and then at 20-25ºC for no less than 5 additional days.
            a. No growth or growth of ≤3 CFU for both gloves (not per hand) denotes a pass.
            b. Growth of >3 CFU for both gloves (not per hand) denotes a failure.
    c. Surface sampling of the direct compounding area after GFT sampling
        i. Completed samples shall be incubated at 30-35ºC for no less than 48 hours and then at 20-25ºC for no less than 5 additional days.
            a. No growth or growth of ≤3 CFU denotes a pass.
            b. Growth of >3 CFU denotes a failure.
3. Didactic portion of sterile compounding competency shall be repeated at least every twelve months for each individual involved in sterile compounding.
    a. Training exams are considered passed if 80% of questions are answered correctly.

b. Any results less than 80% shall require additional review and discussion.

c. The failed exams shall be retaken until 80% of questions are answered correctly.

E. Response to failure

1. Pharmacy staff who fail to pass any training exam or evaluation shall be assessed for staff remediation. If deemed appropriate, staff will be prohibited from performing any sterile compounding until all training exams and validation process tests are successfully completed. See Policy PH.26.06 Sterile Compounding Quality Assurance Program.

2. ~~For~~An attempt must be made to identify any microorganism recovered to the genus level for surface sampling growth failures~~, an attempt must be made to identify any microorganism recovered to the genus~~ when growth exceeds USP 797 action level.

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

References:

A. USP Chapter <797>, Pharmaceutical Compounding - Sterile Preparations

B. California Code of Regulations Title 16 Article 4, 5, and 7

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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PH.26.02 Facility and Equipment - Sterile Compounding

POLICY:

This policy defines the facility and equipment used in preparing compounded sterile ~~drug~~ preparations (CSPs). The cleaning, disinfecting and maintenance of the facility and equipment are described to ensure safe and accurate compounding of ~~sterile drug preparations~~CSPs.

Definitions:

Ante Area: An area with ISO Class 7 or better air quality where personnel hand hygiene and garbing procedures, staging of components, and other high-particulate generating activities are performed, that is adjacent to the area designated for sterile compounding. It is a transition area that begins the systematic reduction of particles, prevents large fluctuations in air temperature and pressures in the cleanroom, and maintains air flows from clean to dirty areas.

Biological Safety Cabinet (BSC): A ventilated cabinet for compounding sterile drug preparations, having an open front with inward airflow for personnel protection, downward high-efficiency particulate air (HEPA)-filtered laminar airflow for product protection, and HEPA-filtered exhausted air for environmental protection.

Cleanroom/Clean Area/Buffer Area: A room or area with HEPA-filtered air that provides ISO Class 7 or better air quality where the primary engineering control is physically located.

Compounding Aseptic Isolator (CAI): A form of isolator specifically designed for non-hazardous compounding of pharmaceutical ingredients or preparations while bathed with unidirectional HEPA-filtered air.

Primary Engineering Control (PEC): A device that provides an ISO Class 5 or better environment through the use of non-turbulent, unidirectional HEPA-filtered first air for compounding sterile preparations.

Secondary Engineering Control (SEC): Controlled environments in which PECs are placed, such as anterooms and clean rooms.

Segregated Compounding Area (SCA): A designated space for sterile-to-sterile compounding where a PEC is located within either a demarcated area or in a separate room.

Procedure:

Facility

A. The sterile compounding area is designed for the preparation of ~~sterile drug preparations~~CSPs. This area is a restricted location where traffic has no impact on the performance of PEC(s) to minimize the potential for contamination. Access to the sterile compounding area shall be restricted to sterile compounding personnel and trained environmental services staff for cleaning purposes. All other personnel shall be accompanied by a trained pharmacy staff member.

B. The sterile compounding area shall contain equipment and supplies needed for preparation of sterile drug preparations.

C. A sink with hot and cold running water shall be in close proximity for hand washing.

D. The sterile compounding area shall be clean, organized, well-lit and of sufficient size to support a comfortable environment for sterile compounding activities. ~~Room temperature shall be maintained at 20 to 25 ºC.~~

   1. Sterile compounding area should be maintained at a temperature of 20ºC or cooler and a relative humidity of 60% or below.
   2. Results of the temperature and humidity readings must be documented at least once daily or stored in the continuous recording device and retrievable.

E. Clean rooms, clean areas, or buffer areas used for nonhazardous compounding shall have at least 30 air changes per hour of HEPA-filtered supply air and a positive pressure differential of 0.02 to 0.05 inch water column relative to all adjacent spaces.

   1. Anytime pressures and/or air exchanges are not within these specified ranges for the clean room, the clean room shall be designated as a segregated compounding area until pressure and/or air exchange issues are resolved.
   2. During this time, a more conservative beyond use dating shall be applied to compounded sterile products.

      ~~a. 12 hour room temperature or refrigerated (USP 797 – 2012 version)~~

      ~~b. 12 hour room temperature or 24 hour refrigerated (*USP 797 – 2022 version)~~

         ~~i. *Note: Pending USP 797 – 2022 version adaptation into California Board of Pharmacy Law~~

      a. 12 hour room temperature or 24 hour refrigerated

   3. Unclassified segregated compounding areas (SCAs) are exempt from air exchange requirements.

F. Cleaning Procedure

   1. Active work surfaces and counter tops shall be disinfected with sterile 70% isopropyl alcohol throughout each shift.
   2. Cleaning shall occur from the cleanest area to the dirtiest area of the sterile compounding area to avoid contamination.
   3. Daily Cleaning

      a. All PECs, horizontal work table surfaces, carts, counters, pass-throughs, sinks and floors shall be cleaned daily with a ready to use (RTU) disinfectant cleaner (PreEMPT RTU).

b. PEC cleaning agent must be sterile (Contec TB1-3300 (sterile)).

c. Daily cleaning shall be documented on the corresponding cleaning log.

d. Cleaning shall also occur after any unanticipated event that could increase the risk of contamination.

e. Note: The VCMC Infusion Pharmacy is open Monday through Friday and closed on weekends and holidays. The VCMC Infusion Pharmacy sterile compounding area will not be cleaned on days the VCMC Infusion Pharmacy is closed. The VCMC Infusion Pharmacy sterile compounding area shall be cleaned and disinfected at the end of the day every day the pharmacy is operating. The ISO Class 5 and ISO Class 7 environments shall remain in an uninterrupted clean state on days the pharmacy is closed.

4. Monthly Cleaning

a. All ~~PEC~~PECs including exterior, all surfaces of the work table surfaces~~,~~ and carts, counters, pass-throughs, sinks, floors, walls, ceilings, storage shelving, bins, ladders, chairs, and stools shall be cleaned monthly with a RTU sporicidal agent (Peridox RTU or bleach).

b. PEC sporicidal agent must be sterile (Periodox RTU (sterile)).

c. Monthly cleaning must be documented on the corresponding cleaning log.

G. Control capabilities shall be maintained for refrigeration, freezing, ventilation, and room temperature required for appropriate storage of ingredients, supplies, and pharmacy-prepared compounded sterile products in accordance with manufacturer, USP, and state or federal requirements.

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

I. Each ISO environment shall be certified at least every six (6) months by a qualified technician.

J. Cleaning logs, ISO environment certifications, refrigerator and freezer temperature logs shall be stored for a period of three years.

Equipment

A. Any equipment used to compound ~~sterile drug preparations~~CSPs shall be stored, maintained, disinfected and cleaned in accordance with manufacturers' specifications (see One Source desk icon).

B. All pharmacy areas shall have ISO Class 5 PECs.

1. Baker SS400 (Santa Paula Pharmacy)
2. Baker EdgeGARD Laminar Flow Bench EG-6252 (VCMC Pharmacy)
3. Baker BCG 401 Class II, Type B2 (VCMC Pharmacy, Infusion Pharmacy)
4. Baker BCG 601 Class II, Type B2 (Infusion Pharmacy)
5. Baker EGVF 501 Vertical Laminar Flow Clean Bench (Infusion Pharmacy)

C. PECs must remain on at all times. If the PEC is turned off, when the PEC is turned back on, it shall be on for at least 3 minutes and disinfected prior to use.

D. All ISO Class 5 PEC surfaces shall be cleaned with an approved cleaning agent.

1. Approved cleaning agent include:

~~PreEMPT RTU~~

i. Contec TB1-3300 (sterile) ~~or Cyquanol (sterile)~~

2. Approved cleaning agents with sporicidal activity include:

i. Periodox RTU (sterile)

~~Bleach~~

E. Disinfection using sterile isopropyl 70% alcohol shall occur on all surfaces including gloves in the ISO Class 5 primary engineering control (PEC) frequently, including:

1. Immediately before compounding
2. At least every 30 minutes or before each lot.
3. After each spill
4. When surface contamination is known or suspected.

F. Sterile gloves shall be donned over the sterile CAI isolator gloves immediately before compounding. These sterile gloves shall be changed by each individual whenever continuous compounding is ceased and before compounding starts again.

G. The integrity of the filtering system shall be tested and certified by a qualified technician at least every six months or when the PEC is relocated. This testing shall include viable and non-viable sampling.

1. Certificates shall be kept on file in the Biomedical Engineering and Pharmacy Departments for three (3) years.

H. Viable air sampling shall be done at least once every six months and viable surface sampling shall be done at least monthly by a qualified individual who is familiar with the methods and procedures for surface testing and air sampling. Viable air and viable surface sampling shall be performed under dynamic conditions that simulate actual production.

1. Selected sampling site testing should include locations within each ISO Class 5 environment, ISO 7 and 8 areas, and in the segregated compounding areas (SCA).
2. A minimum of 1,000 liters of air shall be tested at each location.
3. The following are considered actionable findings:

Environment	Viable Air Sample	Viable Surface Sample
ISO Class 5	>1 CFU	>3 CFU
ISO Class 7	>10 CFU	>5 CFU
ISO Class 8 or worse	>100 CFU	>50 CFU

4. ~~Any growth of a highly pathogenic microorganism shall also be considered actionable. Highly pathogenic microorganisms may include, but are not limited to, gram-negative rods, coagulase positive staphylococcus, molds and yeasts.~~ If levels measured during air sampling or surface sampling exceed the actionable levels on table under section H.3., an attempt must be made to identify any microorganism recovered to the genus level.
5. Any actionable finding shall result in the following:

a. Immediate reassessment of the conditions of the engineering controls in consultation with the Infection Control Preventionist.

b. Development of an action plan in consultation with the Infection Control Preventionist which

shall address assignment of appropriate beyond use dating, remediation, ~~and~~ training, and recalls (if applicable).

i. Beyond Use Dating shall be one of the following

a. SEC associated finding:

i. 12 hours room temperature or 24 hour refrigerated BUD ~~(USP 797 - 2012 version)~~

~~12 hours room temperature or 24 hour refrigerated BUD (*USP 797 - 2022 version)~~

b. PEC associated finding:

i. ~~1~~4 hour immediate use BUD ~~(USP 797 - 2012 version)~~for CSP prepared by pharmacy department

~~4 hour immediate use BUD (*USP 797 - 2022 version) for CSP prepared by pharmacy department~~

ii. Remediation shall include cleaning and disinfection of the affected PEC(s) and/or SEC(s).

iii. Response shall include retraining of pertinent staff on cleaning and disinfection of affected PEC(s) and/or SEC(s).

iv. CSP recalls are initiated based on the severity of risk of serious or life-threatening patient harm associated with product quality-related issues, with special consideration given to risk assessment of high-risk patient populations and routes of administration.

c. Once remediation is completed, viable air and surface sampling shall be repeated to confirm results are below actionable levels.

I. The outer sleeves of the CAI shall be changed every six months according to manufacturer's instructions for use (see One Source on all desktops) or sooner depending on the condition of the sleeves. The date of the change will be documented.

J. The prefilters of the LAFW and CAI shall be changed every six months or sooner depending on the condition of the prefilters. The date of the change shall be documented.

K. Problems with equipment shall immediately be reported to the Designated Person (DP) or the Director of Pharmacy Services.

L. Refer to PEC operational manual(s) for further details.

Transport of drugs and supplies into the sterile compounding area

A. All ~~cartoned~~ supplies are ~~decontaminated~~wiped prior to being introduced into the sterile compounding area by removing them from shipping cartons ~~and wiping them~~ with ~~a~~an EPA-registered sporicidal disinfectant, EPA-registered cleaning disinfectant, or sterile 70% isopropyl alcohol (IPA) while they are being transferred to a clean and properly disinfected or other conveyance for introduction into the buffer area.

1. Handling of hazardous drugs shall require donning of appropriate personal protective equipment. Upon receipt, antineoplastic HDs shall remain in the sealed transport bag for transport to the negative pressure room. See policy PH.27.02 Hazardous Drug Storage, Handling, Labeling, and

Transport

2. No corrugated or uncoated cardboard shall be allowed into the sterile compounding area.

B. Supplies that are required frequently or otherwise needed close at hand but not necessarily needed for the scheduled operations of the shift are decontaminated and stored on shelving in the appropriate area.

C. Carts used to bring supplies from the store-room cannot be rolled beyond the demarcation line.

D. Supplies required for the scheduled operations of the shift are wiped down with an appropriate disinfecting agent and brought into the buffer area. Supplies that are required for back-up or general support of operations may be stored on the designated shelving in the buffer area, but excessive amounts of supplies are to be avoided.

E. Nonessential objects that shed particles shall not be brought into the buffer area such as pencils.

References

A. California Code of Regulations, Division 17, Title 16, Section 1751

B. USP Chapter <797>, Pharmaceutical Compounding – Sterile Preparations~~; 2012, 2022~~

C. BCG 401 Class II, Type B2 Operator's Manual, The Baker Company

D. BCG 601 Class II, Type B2 Operator's Manual, The Baker Company

E. EdgeGARD Laminar Flow Bench EG-8252 Operator's Manual, The Baker Company

F. EdgeGARD VF Operator's Manual Model 501, The Baker Company

G. SterilSHIELD® Operator's Manual Model SS400, The Baker Company

H. SterilSHIELD® Operator's Manual Model SS600, The Baker Company

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/15/2024
Infection Prevention	Magdy Asaad: Infection Prevention Manager	8/15/2024
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PH.26.03 Sterile Compounding Attire

Policy:

Personnel engaged in the sterile compounding area shall wear appropriate garb as defined in the procedure below.

Procedure:

A. Individuals experiencing exposed rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections or other communicable disease, or those wearing cosmetics, any lash extension, nail polish or artificial nails shall be excluded from the International Organization for Standardization (ISO) Class 5 and ISO Class 7 compounding areas until their conditions are remedied.

B. ~~No chewing gum~~Food (including mints, ~~candy or food items may be brought~~gums, etc) and drinks must not enter into the sterile compounding area. Compounding personnel shall not bring any headphones, earbuds, or personal electronic device into any sterile compounding area. Additionally, coats, purses, jewelry, watches, and other personal items shall be stored in lockers or employee ~~breakroom~~break room.

   1. Eyeglasses are permitted but must be cleaned prior to donning any sterile compounding attire.

C. Hand hygiene ~~is required routinely throughout the day. Hand washing shall be done with soap and water using the sink. Debris from underneath fingernails shall also be removed using a nail cleaner under running warm water for the initial handwashing. Pharmacy personnel shall wet hands with water, apply a sufficient amount of soap and rub hands together vigorously for at least 30 seconds covering all surfaces of hands, fingers, and arms up to elbows. Rinse hands with water and dry thoroughly with a disposable, low-lint towel.~~ and garbing procedure upon entering the secondary engineering control (SEC):

   1. Put on clean, non-shedding uniform comments in the following order: Face mask, scalp hair and facial hair covers, shoe covers as personnel crosses the demarcation line.
   2. Hand washing shall be done with soap and water using the sink. Debris from underneath fingernails shall also be removed using a nail cleaner under running warm water for the initial handwashing. Pharmacy personnel shall wet hands with water, apply a sufficient amount of soap and rub hands together vigorously for at least 30 seconds covering all surfaces of hands, fingers, and arms up to elbows. Rinse hands with water and dry thoroughly with a disposable, low-lint towel.
   3. Don a clean, non-shedding coverall.
   4. Hand sanitizing shall be performed using a waterless, persistent, alcohol-based cleanser.
   5. Don gloves. Gloved hands shall be sanitized using sterile 70% IPA.

6. For the Segregated Compounding Area (SCA) only
    a. Don a clean, non-shedding gown.
    b. The Compounding Aseptic Isolator (CAI) shall have sterile gloves mounted to the sleeve (gauntlet).
    c. In the CAI, a pair of sterile gloves shall be donned over the sterile gauntlet gloves.

~~Personnel working in a Secondary Engineering Control (SEC) shall properly put on clean, non-shedding uniform components in the following order:~~

~~1. Put on clean, non-shedding uniform components in the following order: face mask, scalp hair and facial hair covers, shoe covers as personnel enters the SEC.~~
~~2. Wash hands and forearms up to the elbows for 30 seconds with soap and water.~~
~~3. Don a non-shedding gown.~~
~~4. Hand sanitizing shall be performed using a waterless, persistent, alcohol-based cleanser.~~
~~5. Don gloves. Gloved hands shall be sanitized using sterile 70% IPA.~~
~~6. For the Segregated Compounding Area (SCA) only~~
    ~~a. The Compounding Aseptic Isolator (CAI) shall have sterile gloves mounted to the sleeve (gauntlet).~~
    ~~b. In the CAI, a pair of sterile gloves shall be donned over the sterile gauntlet gloves.~~

D. Sterile gloves are to be routinely disinfected with sterile 70% IPA before entering or re-entering the primary engineering control and after contact with non-sterile objects.

E. Sterile gloves shall also be routinely inspected for holes, punctures, or tears, and replaced immediately if such are detected.

F. Exiting the sterile compounding area:
    1. Temporary exits and exiting for the end of the shift/day: All items must be removed and discarded past the demarcation line.

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PH.26.04 Sterile Drug Preparation, Labeling, End Product Evaluation and Record Keeping

POLICY:

To provide and maintain the sterility of prepared products and to ensure final products are correctly prepared prior to dispensing. The pharmacist has the responsibility and authority to inspect and approve or reject all components, drug product containers, closures, in-process materials, labeling used during the sterile compounding process. The pharmacist shall review all compounding records to assure that no errors have occurred in the compounding process. The pharmacists are also responsible for the proper maintenance, cleanliness, and use of all equipment used in prescription compounding practice.

PROCEDURE:

~~Sterile Drug Preparation~~

Compounded Sterile Drug Preparations (CSPs)

A. ~~Sterile drug preparations~~CSPs shall be prepared under ISO Class 5 conditions.

B. Any equipment placed in or adjacent to the critical work area shall be cleaned, disinfected, and placed to avoid contamination or disruption of the unidirectional airflow between the high-efficiency particulate air (HEPA) filter and sterile surfaces.

C. A written master formula shall be created prior to compounding a ~~sterile drug preparation~~CSPs. Each master formula shall include:

1. Active ingredients to be used.
2. Equipment to be used.
3. The maximum allowable beyond use date (BUD) for the preparation, and the rationale or reference source justifying the determination.
4. Inactive ingredients to be used
5. Specific and essential compounding steps used to prepare the drug.
6. Quality reviews required at each step in preparation of the drug including physical description of the completed CSP. ~~This may include final description of completed Compounded Sterile Product (CSP).~~
7. Post-compounding processor procedures required, if any.

8. Instructions for storage and handling of the ~~compounded drug preparation~~CSP.

D. All drugs and supplies shall be gathered before initiating the compounding process. Articles shall be placed into the primary engineering control (PEC) only after they have been ~~removed from the outer cartons and decontaminated by wiping the outer surface~~wiped with sterile 70% isopropyl alcohol.

E. Containers shall be checked for cracks, punctures, and clarity before the ~~sterile drug preparation~~CSP process begins.

F. Ingredients used for ~~sterile product preparation~~CSPs should be determined to be stable, compatible, and appropriate for the final product to be prepared, according to manufacturer guidelines, United States Pharmacopeia (USP) guidelines or appropriate scientific references.

1. Each ingredient and container shall be inspected for defects, expiration date, and product integrity prior to use. Expired, inappropriately stored, or defective ingredients shall not be used in preparation of ~~sterile products~~CSPs.

2. The final product shall meet physiological norms for solution osmolarity and pH, as appropriate for the intended route of administration.

G. Non-essential material (e.g., labels, calculators, pens, pencils, etc.) shall not be placed inside the PEC.

H. Mathematical calculations shall be performed prior ~~to initiating the sterile product preparation process~~compounding the CSPs.

I. Employees shall not cough, sneeze, or talk during the sterile product preparation process.

J. The number of items being prepared in the PEC shall be consistent with the amount of critical work space available.

K. Materials used in ~~sterile product preparation~~compounding the CSP should be arranged in the critical work area of the PEC in a manner that prevents interruption of the unidirectional airflow between the HEPA filter and critical sites of needles, vials, ampules, containers, and transfer sets.

L. The surfaces of ampules, vials, and container closures (e.g., vial stoppers) shall be disinfected by swabbing with sterile 70% isopropyl alcohol. Surfaces shall be dry prior to use.

M. The sterile areas of the syringe (e.g., plunger, shaft, tip or needle) shall not be touch contaminated.

N. HEPA filters shall not be contaminated with liquid, glass ampule particles, or other means during the sterile product preparation process.

O. Solutions from ampules shall be properly filtered to remove glass particles.

P. Solutions of reconstituted powders shall be mixed carefully, ensuring complete dissolution of the drug with appropriate diluent.

1. The diluent, the volume of diluent, final concentration, date and time of reconstitution, and technician initials shall be recorded on the vials of reconstituted powders, if contents are not entirely used.

Q. Needle entry into vials with rubber stoppers should be done cautiously to avoid the creation of rubber core particles.

R. ~~Single~~A conventionally manufactured single-dose ~~vials~~container entered or punctured in an ISO Class 5 air may be used ~~in the compounding aseptic isolator~~for up to 12 hours (~~CAI~~or shorter manufacturer BUD) ~~may be used for up to six hours~~ after initial ~~needle~~entry or puncture. ~~Date~~The date and time ~~vial~~when container was initially ~~used and~~punctured and the beyond use date (and time, when applicable) shall be documented on the ~~vial~~container. The manufacturer labeled storage requirements during that 12-hour period will be maintained.

S. Multi-dose vials may be used for 28 days or shorter based on manufacturer's recommendation or reference expiration date. Date and time vial was initially used and beyond use date (and time, when applicable) shall be documented on the vial.

T. Multiple containers shall be processed in a consistent direction (i.e., left to right) to avoid confusion.

U. Syringe plungers shall be pulled back to indicate the volume of solution used in the sterile product preparation process.

    1. Exceptions: Hazardous drugs, pediatric doses ~~and~~, total parenteral nutrition (TPN) solutions, and high alert mendications are the exception. See PH.70 High Alert Medications. Drawn syringes shall be checked by a pharmacist prior to admixture.

V. The product label shall be initialed to indicate who prepared the sterile product.

Labeling

A. All sterile products shall be labeled with at least the following information:

    1. For patient specific products: the patient's name and date of birth.
    2. For batch-prepared products: facility specific lot number and expiration date.
    3. All solutions and ingredient names, amounts, strength, and concentrations (when applicable).
    4. Beyond-use date (and time, when applicable).
    5. Prescribed administration regimen, when appropriate (including rate and route of administration).
    6. Appropriate auxiliary labeling (including precautions).
    7. Instructions for storage and handling.
    8. Identification of the responsible pharmacist and/or technician with their initial.
    9. Device-specific instructions, when appropriate.
    10. Name of compounding, dispensing pharmacy
    11. The date compounded
    12. Any additional information, in accordance with state or federal requirements.

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

End Product Evaluation

A. The responsible pharmacist shall verify that the sterile product was prepared correctly. The pharmacist shall check the following:

    1. Correct ingredients
    2. Correct amount of ingredients
    3. Expiration dates of ingredients
    4. Visual check for particulate matter, precipitate, or haziness in the solution.
    5. Double-check calculations
    6. Auxiliary labels
    7. Beyond use date (BUD)

8. Storage conditions

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

Record Keeping

A. A sterile compounding log shall be maintained and shall include the following:

1. The "IV Worksheet" label that prints with each label for sterile compounded product.
2. Date and time of preparation and ~~beyond use date~~BUD of final product.
3. Manufacturer, lot number and expiration date of each component.
4. Initials of the compounding staff.
5. Initials of the pharmacist(s) performing end product evaluation.
6. Results of quality control (e.g., visual inspection)
7. Santa Paula Hospital Pharmacy only: CAI purge time.

B. Documentation for ~~sterile batch preparations~~CSPs shall include the above and the following:

1. Pharmacy-assigned batch identification number of the ~~finished product~~CSP.
2. The package size and the number of units prepared.

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

References

A. USP Chapter <797>, Pharmaceutical Compounding – Sterile Preparations

B. California Code of Regulations Title 16 Article 4, 5, and 7

All revision dates: 8/15/2024, 9/13/2023, 8/16/2022, 9/10/2020, 11/5/2019, 7/1/2016, 5/1/2014, 1/1/2014

Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/15/2024
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References:	

PH.26.05 Beyond Use Dates

POLICY:

This policy defines beyond-use dating for Pharmacy-prepared compounded sterile preparations (CSP).

PROCEDURE:

Beyond Use Date (BUD): The date, or date and time, after which administration of a compounded drug preparation shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).

Controlled cold temperature: 2 degrees to 8 degrees Celsius (C).

Controlled freezer temperature: -25 degrees to -10 degrees C or at a range otherwise specified by the pharmaceutical manufacturer(s) for that product.

Controlled room temperature: 20 degrees to 25 degrees C.

All staff involved in compounding, filling, and labeling of ~~compounded sterile preparations~~CSPs shall read this policy and comply with its requirements.

Beyond Use Dates~~ – USP 797 2012~~

~~A. The beyond-use date shall not exceed the shortest expiration date or beyond-use date of any ingredient in sterile compounded drug preparation, nor the chemical stability of any one ingredient in the sterile compounded drug preparation, nor the chemical stability of the combination of all ingredients in the sterile compounded drug preparation.~~

~~B. In the absence of passing additional sterility testing, the beyond-use dates shall not exceed the following time periods before administration. Unless specified differently by the manufacturer or references, beyond-use dates are assigned according to the risk of contamination and storage conditions as outlined in the following table:~~

~~Compounding Conditions~~	~~Room Temperature (15 to 30° C)~~	~~Refrigeration (2 to 8° C)~~	~~Frozen (-25° to -10° C)~~
~~Low Risk Conditions~~	~~≤ 48 hours~~	~~≤ 14 days~~	~~≤ 45 days~~
~~Medium Risk~~	~~≤ 30 hours~~	~~≤ 9 days~~	~~≤ 45 days~~

Conditions			
High Risk Conditions	Compounding under High Risk conditions is not performed.		

C. Compounded sterile drug preparations prepared under all of the following conditions are at a **LOW RISK** of contamination:

1. Sterile drug preprations are compounded with aseptic manipulations entirely within ISO Class 5 or better air quality using only sterile ingredients, products, components, and devices.
2. The compounding involves only transfer, measuring, and mixing manipulations with not more than three commercially manufactured packages of sterile products and not more than two entries into any one sterile container or package (e.g., bag or vial) of sterile product or administration container or device to prepare the sterile drug preparation.
3. Manipulations are limited to aseptically opening ampules, penetrating disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile products, and containers for storage and dispensing.
4. Examples of LOW RISK conditions include:
    a. Single-volume transfers of sterile dosage forms from ampules, bottles, bags, and vials using sterile syringes with sterile needles, other administration devices, and other sterile containers. The solution content of ampules should be passed through a sterile filter to remove any particles.
    b. Simple aseptic measuring and transferring with not more than three packages of manufactured sterile products, including an infusion or diluent solution to compound drug admixtures and nutritional solutions.

D. Compounded sterile preparations prepared under all of the following conditions are at a **MEDIUM RISK** of contamination:

1. Multiple individual or small doses of sterile products are combined or pooled to prepare a sterile drug preparation that will be administered either to multiple patients or to one patient on multiple occasions.
2. The compounding process includes complex aseptic manipulations other than the single volume transfer.
3. The compounding process requires unusually long duration, such as that required to complete dissolution or homogeneous mixing.
4. Examples of MEDIUM RISK conditions include:
    a. TPN using manual or automated devices during which there are multiple injections, detachments, and attachments of nutrient source products to the device or machine to deliver all nutritional components to a final sterile container.
    b. Filling reservoirs of injection and infusion devices with more than three sterile drug products and evacuation of air from those reservoirs before the filled device is dispensed.
    c. Transfer of volumes from multiple ampules or vials into one or more final sterile containers.

E. Compounded sterile drug preparations shall **NOT** be prepared under HIGH RISK conditions.

~~Beyond Use Dates - *USP 797 2022~~

~~*Note: Pending USP 797 - 2022 version adaptation into California Board of Pharmacy Law~~

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

B. In the absence of passing additional sterility testing, the BUD shall not exceed the following time periods before administration. Unless specified differently by the manufacturer or references, beyond-use dates ~~shall not exceed~~are assigned according to the risk of contamination and storage conditions as outlined in the following ~~time periods before administration. Unless specified differently by the manufacturer or references, beyond-use dates are assigned according to the risk of contamination and storage conditions as outlined in the following~~ table:

Compounding Category	**Conditions**	**Controlled Room Temperature (20 to 25° C)**	**Refrigeration (2 to 8° C)**
Category 1	Prepared in a PEC in a SCA	≤ 12 hours	≤ 24 hours
Category 2	Prepared from only sterile starting components	4 days	10 days

C. Category 1 and Category 2 ~~compounded sterile preparations~~CSPs are distinguished primarily based on the conditions under which they are made, the probability of microbial growth and the time period within which they must be used

1. Category 1 CSPs are typically prepared in an unclassified Segregated Compounding Area (SCA) and have shorter BUDs.
2. Category 2 CSPs are prepared in a clean room suite and have longer BUDs.

D. Category 3 CSPs shall **NOT** be prepared.

References

A. California Code of Regulations, Division 17, Title 16, Article 7~~, Section 1751~~.

B. USP Chapter 797, Pharmaceutical Compounding -- Sterile Preparations.

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References:	

PH.26.06 Sterile Compounding Quality Assurance Program

Purpose:

This policy defines the quality assurance program for sterile compounding.

Definitions:

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

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

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

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

Policy:

A. Random samples of compounded sterile preparations (CSPs) shall be assessed on a quarterly basis for integrity, potency, quality, and labeled strength.

B. The Pharmacy Supervisor or designee(s) shall regularly review sterile compounding documents for accuracy and completeness.

C. The Medication Safety Officer or designee(s) shall complete quarterly audits on various aspects of sterile compounding.

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

Procedure:

A. Integrity of the selected ~~compounded sterile product (~~CSP~~)~~ shall be assessed by measuring the potency of the selected CSPs ~~on the date of expiration~~.

B. Potency of the selected CSP shall be assessed by submitting a sample to a lab for analysis.

   1. The resulting value shall be within ±10% the listed amount of active ingredient.

C. Quality of the selected CSP shall be assessed by submitting a sample of the CSP to a lab for bacterial and fungal growth testing.

D. Quality assurance results shall be kept in the pharmacy's sterile compounding document binder with master formula and compounding record. This record shall be kept in the pharmacy for three (3) years.

E. Complete Quality Assurance Sampling Action Report (Attachment A)

F. Any unacceptable result relating to the potency, labeled strength, quality or sterility of the CSP shall result in the following:

1. Designated Person or Pharmacist in charge shall start an investigation and review.
2. The action plan shall include any procedural changes, educational needs, mitigation plan, and monitoring.
3. Staff Remediation (see policy PH.26.01 Training and Evaluation of Pharmacy Staff in Sterile Drug Preparation)
    a. For unacceptable results relating to potency and labeled strength, staff shall review of pharmaceutical calculations and syringe measurements.
    b. For unacceptable result relating to the quality and sterility, staff shall complete a revalidation process on aseptic technique and aseptic area practices.
4. If use of or exposure to the recalled drug may cause serious adverse health consequences or death, the recipient pharmacy, prescriber, or patient and the California Board of Pharmacy shall be notified as soon as possible within 12 hours.

~~Any unacceptable result shall result in a recall of the CSP.~~

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

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Ph.26.06 Quality Assurance Sampling Action Report

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PH.92 Automated Dispensing Cabinet (ADC) Usage and Documentation

POLICY:

This document is directed to all Ventura County Medical Center/Santa Paula Hospital staff using the automated drug cabinet system for documentation and medication administration.

Definition:

Pyxis ES Medstation System: A computerized storage and dispensing device which is utilized for dispensing controlled substances and floor stock medication. The Pyxis ES Medstations work in coordination with the electronic health record (EHR) and the Pharmacy Healthsight Viewer to allow for efficient dispensing of medications and monitoring of all transactions. Procedures are designed to provide safe and accurate provision of medication, secure storage, accurate accountability for controlled substances and other drugs, accurate patient billing, and compliance with State and Federal regulations.

PROCEDURE:

I. Access to the Pyxis ES Medstation:

A. Nurses (RN, LVN, Psychiatric technician, student), respiratory therapists, licensed independent practitioner (LIP), pharmacist, pharmacy technicians, radiology technicians, and contract staff may be granted access to Pyxis ES Medstation.

B. Department manager/Clinical Nurse Manager (CNM) or their designee shall request permanent Logon identification (ID) creation through the Information Technology (IT) department for hospital wide Active Directory. Contract staff or student must have contract end date submitted to IT. Once ID is created by IT, the user must complete the online tutorial via hospital learning software platform and complete "Pharmacy Pyxis ES Medstation Assignment Statement" form (see Attachment A) to be submitted to the pharmacy department.

C. The department manager/CNM or their designee shall review, sign, and submit the completed form to the Pharmacy Department for proper assignment of roles and access.

D. Upon first logon to Pyxis ES Medstation, the system will prompt the user to scan their fingerprint, which shall serve as the user's biometric identification (BioID) password. If the biometric identification scan is not successful, the employee shall use a password instead.

E. In the event the password is forgotten or lost, the user shall call the IT department (Helpdesk

support: 805-677-5119) to request a password reset. If there is no existing user account, steps A-D in this section must be completed.

F. Upon termination of the user, the department manager/CNM or Human Resources shall notify the IT department for removal from AD.

G. If the user does not log off the Medstation upon completion of the transaction, the Medstation will log off the user after 30 seconds.

II. Pyxis ES Medstation Medication Stock:

A. Non-profile Pyxis ES Medstations list medications available within the device for removal. Non-profile stations are limited to the Emergency Department, GI Lab, Operating Rooms, Post-Anesthesia Care Unit, Nuclear Med, Interventional Radiology, Adult and Pediatric Oncology, and the Crisis Stabilization Unit.

B. Profile Pyxis ES Medstations operate on an interface with the EHR to display the list of ordered medications for each patient.

1. Inventory may be modified to accommodate active medication orders for patients residing in that patient care unit. This requires ongoing loading and unloading of medications as patient's therapy changes or that patient care unit's patient population changes. Par levels are set according to reasonable doses dispensed.

2. As new orders are initiated, Pharmacy staff will verify the needed medication is available in the Medstation that services that patient's location. If the medication is not loaded in that Medstation, the Pharmacy will send doses for administration.

3. The following medications will be handled through the Medstation: Injectable drugs, limited pre-mixed solutions, capsules, tablets, suppositories, and controlled drugs.

C. The Pharmacy Department is responsible for loading, unloading, and refilling all medications within the devices. The outdate tracking function shall be utilized to manage drug expiration dates. Items close to expiration shall be replaced.

D. Assigning, Loading or Unloading a Medication to Pyxis Medstation Inventory

a. Assignment of a new medication to a Pyxis Medstation's inventory shall only be done by the Pyxis System Administrators designated by the Pharmacy Director.

b. Pharmacy technicians and pharmacist may load and unload medication.
Use BD Pyxis Medication ES Station Quick Reference Guide* for full details.

E. Stock Replenishment

a. Refills reports shall be printed at least once daily for Pyxis Medstations.

b. Gather medications based on the delivery portion of the report, which list all medications and quantities needed to restock each unit specific Pyxis Medstation.

i. Do not overfill above assigned maximum quantity to prevent jamming of cubies.

c. Package medications for each Pyxis Medstation in a separate bag.

d. To provide a double check, the pharmacy technician shall pull the medications to refill the Pyxis Medstation and a pharmacist shall check the medications and quantity pulled against the delivery report before the technician delivers the medications to the Pyxis Medstations.

e. For CardinalASSIST medications, pharmacists shall double check prior to delivery of

CardinalASSIST to Pyxis Medstations.

f. Deliver medications and refill the Pyxis Medstation*.

i. Use the barcode for medication refilling process.

ii. If the medication barcode is unreadable, return medication to pharmacy, where a pharmacist shall enter the new barcode into the Pyxis Healthsight Viewer.

III. Patients and Temporary Patients:

A. Patient information for the Pyxis ES Medstation is obtained via an interface with the EHR. If the patient is not listed in the Pyxis ES Medstation, contact the Admitting Department to ensure the admission or transfer function is complete.

B. A temporary patient may be added to the system.

1. To enter a temporary patient, go to "All available patients" tab and select "Add temporary patient." The user shall accurately enter the patient's last name, first name, and the financial identification number (FIN) or medical record number (MRN).

2. Temporary patients will be kept on the system for 2 hours.

3. If the patient was transferred from another inpatient location, the orders shall display within 2-5 minutes.

4. Patients entered as John or Jane Doe will be added as temporary patient

C. Pharmacy will reconcile temporary patients.

IV. Removing Medications:

A. Remove medications for only one patient at a time.

B. Accuracy of the recorded quantity of medications removed from the Medstation is required for accurate patient billing and accurate inventory count of the medication.

C. Removal of controlled substances shall require the user to complete an inventory count and record the count in the Medstation prior to removal of the controlled substance. This is also known as a "Blind Count." If the count is inaccurate, the Medstation will fire a red "Please Recount" alert. A second blind count shall be performed. If the inventory count is inaccurate a second time, a discrepancy is created (see Section VIII, Resolution of Controlled Substance Discrepancies).

D. At the time of medication removal, ensure the medication is not expired prior to adminstration.

E. If the drawer/door opens and no medications are available in the pocket for removal, cancel the transaction and notify the Pharmacy Department.

F. Never remove items from the Medstation to dispense to patients as discharge medications. All discharge medications require a prescription and shall be dispensed according to State Regulations.

V. Override Medications (Profile Stations Only):
See policy PH.96 Medication Override from Automated Dispensing Cabinets.

VI. Returning Medications:

A. Unused medications will be returned to the return bin located in each Medstation within one (1) hour from the time of removal. Scanning of medication is required. Bulky items may be returned to the original pockets. Unused refrigerated medications shall be returned to the pharmacy via external return bin.

B. Witness will not be required for return of non-controlled substance medication into the return bin.

C. Do not return opened patient controlled analgesia (PCA) syringes, used multi-dose containers, or any medication taken out of its original container. These must be discarded; controlled substance waste shall be documented in the Medstation (See Section VII, Wasting Controlled Substances).

D. A witness and scanning of medication are needed for return transactions involving controlled substances. A witness must be a licensed health care professional with an existing user account.

E. The pharmacy technicians shall remove the medications from the Return Bin daily and either replaced back into Medstation inventory if usable (via scanning) or returned back to the pharmacy if unusable.

   a. Pharmacy technician shall verify the quantity of each item in the Return Bin and document quantity found.

   b. For controlled substances, when the expected count and actual count do not match, it will create a discrepancy. Notify supervisor or controlled substance surveillance personnel as soon as possible.

VII. Wasting Controlled Substances:

1. See Policy PH.88 Controlled Substances

VIII. Resolution of Controlled Substances Discrepancies:
See policy PH.98 Automated Dispensing Cabinet Controlled Substance Discrepancy Resolution.

IX. System Maintenance:

A. Medstations shall be plugged in to outlets with emergency power or an uninterruptable power supply device.

B. Inventory Quantities

1. Ideal inventory quantity for each Medstation is a three (3) day minimum inventory.

C. Refill

1. Medstations shall be refilled at least once daily by the Pharmacy Department.
2. Pharmacists are responsible for checking all medications from Pyxis refill lists and CardinalASSIST prior to refilling medications into Medstations.
3. Stock out bulletin/stock low bulletin shall be managed by the Pharmacy Department.

D. Load/Unload Medications

1. Only system administrators will have privileges to assign both non-controlled and controlled substance medications.
2. Authorization to change medications from the Medstation shall be done by the system administrators.
3. Nursing or LIP staff may request changes in the inventory quantity and medication changes by writing to the Director of Pharmacy or Pharmacy Supervisor.
4. Pharmacy staff shall remove and handle expired medications at least once daily and return expired medications to the Pharmacy Department.
5. Outdated tracking will be used for all medications.

E. Management of recalled medication

1. Pharmacy should block the use of medication at the Pyxis Medstation in the event of a medication recall.
2. Any recalled medication may be removed by using the Inventory function.

F. Reports

1. See policy PH.93 Pyxis Reports for more information.

G. Failed Drawer

1. The most common type of Medstation failure occurs when one of the drawers fails to close completely because the medication package extends above the pockets. A Failed Drawer icon will appear on the Medstation screen.
2. Attempt to recover the drawer by selecting "More" from the main screen then select "Recover Storage Space" option and follow the on screen prompts. At the completion of the procedure, the system will state if the drawer is functional.
3. If the "Recover Storage Space" procedure does not correct the problem, the system will state the drawer needs maintenance. Contact the Pharmacy Department for further assistance.

H. Pyxis activity data shall be kept for at least three (3) years on BD Knowledge Portal.

I. Interface Outage

1. In the event of the EHR-Pyxis interface is out for more than 30 minutes, all medications stored in the Medstations shall be accessible as override medications. This is known as Pyxis Critical Override.
2. The Pharmacy Department shall notify the CNM or the nursing supervisor in the event of a Pyxis Critical Override.
3. The Medstation patient profiles will not be updated during interface outages.
4. Nurses must use caution when selecting drugs for removal from this expanded override list to ensure they have the correct drug, dose, and dosage form.
5. Once the EHR-Pyxis interface is restored, the Pharmacy staff shall turn off the Pyxis Critical Override.

J. Troubleshooting Problems

1. A "BD Pyxis Medstation ES System Quick Reference Guide." is available for viewing on the Main home page under "Help" icon.
2. In the event the problem cannot be resolved, the user should contact the Pharmacy Department.
3. The Pharmacy Department is responsible for contacting Pyxis service personnel.
4. Pyxis Medstations utilize emergency power outlets and uninterrupted power supply devices. In the event a Pyxis Medstation cannot be accessed during a power outage, contact the Pharmacy Department.

K. Care of the Touchscreen and BioID

1. Clean the touchscreen and BioID with an alcohol pad and allow to air-dry.
2. If the touchscreen requires recalibration, contact the Pharmacy Department.

L. Help/Support

1. For more information regarding the operation of the Pyxis ES Medstation, refer to the "BD Pyxis Medstation ES System Quick Reference Guide."
2. If further assistance is required, contact the Pharmacy Department at 805-652-6220 (VCMC) or 805-933-8636 (SPH).

X. Location of ADS - Attachment B

All revision dates: 7/11/2024, 8/8/2023, 1/10/2023, 2/9/2022, 3/4/2020, 2/15/2018, 3/1/2015, 10/1/2008

Attachments

Attachment A: Pyxis ES Medstation Assignment Statement Form
Attachment B: Location of Automated Dispensing Cabinet.pdf

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	8/14/2024
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PH.123 Biosimilar Drug Use

PURPOSE

To provide pharmacy department with a protocol for expedited addition of biosimilars to the facility drug formulary and describe pharmacist driven protocol for therapeutic substitution replacing reference product with biosimilar.

POLICY STATEMENT

Biosimilars are biological products that are considered highly similar to an existing FDA-approved reference product, with no clinically meaningful differences in terms of safety, purity, and potency. As these agents undergo a rigorous scientific approval process through the FDA, they are considered as safe and effective as the individual reference product. The addition of these agents to formulary will provide cost savings realized through reductions in direct drug acquisition cost for the organization as well as for the patient. To expedite biosimilar adoption and remove redundant work of reviewing biosimilar data, the Pharmacy and Therapeutics Committee will allow for new biosimilars to be added to formulary based on the procedure and criteria outlined below.

PROCEDURE

Criteria for Expedited Formulary Addition

A. The reference product has undergone Pharmacy and Therapeutics review and is already on formulary.

B. The biosimilar product is an FDA approved biosimilar according to the Purple Book, demonstrating bio-similarity to reference product through FDA biosimilar pathway.

C. The biosimilar product will provide cost-savings to the patient and institution.

Exclusions

A. The biosimilar product does not have corresponding reference product on formulary.

B. If the reference product is not in the formulary, the biosimilar product must undergo the usual P&T approval process.

Procedure Formulary Addition

A. When a biosimilar product is FDA-approved and in distribution, an assigned pharmacist will submit a

Formulary Request to P&T.

B. When multiple biosimilars are available on the market, the decision to add a specific biosimilar to formulary will be based on approved indications, payor coverage, estimated acquisition cost per dose, and product availability.

C. The designated pharmacist will provide P&T with a summary of the biosimilar medication and a rational for replacing the reference or non-preferred product. There is no need to provide a complete review of the biosimilar if the reference product is already on formulary.

D. Once a biosimilar product is added to formulary, a therapeutic interchange will be created directing use to the preferred biological agent.

E. Biosimilar medication will be added to the electronic health record (EHR) drug database. Non-preferred biologic products will be inactivated.

F. Pharmacy will develop new order templates and ordersets that specify the preferred biologic product.

G. Adoption of biosimilar formulary change and any restrictions or unique criteria for use will be communicated to all pharmacy staff, nurses, licensed practitioner (LP).

H. A three-month crossover period will be allowed to convert patients to preferred biologic, to obtain necessary insurance authorizations and exhaust inventory of non-preferred product.

Procedure Therapeutic Interchange

A. Therapeutic interchange of biological products applies to biologics that will be administered in Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) or Infusion Center. Pharmacy staff will use the therapeutic interchange to automatically select the preferred formulary biological product or biological product mandated by insurance. LP will only be contacted regarding a product substitution if LP has specified an exemption “do not substitute” from the therapeutic interchange when placing the medication order.

B. Infusion center pharmacy: When a biosimilar product is available for use, the pharmacist will evaluate patient for appropriateness of biosimilar replacement as part of the routine workup.

   1. To safeguard financial viability, insurance coverage for biosimilar medication will be confirmed via communication with the Prior Authorization team.
   2. If covered by insurance, biosimilar orders will be entered and orders for the reference product will be discontinued.
   3. The therapeutic interchange does not apply if a specific biological product is necessary based on prior authorization outcome or other financial evaluation (e.g., patient assistance program).
   4. When documented on the medication order by the prescriber, other exemptions from use of the therapeutic interchange are:
      a. The patient has a history of intolerance, contraindication, or adverse event to the formulary preferred product.
      b. The patient is already receiving a non-preferred biological product AND additional duration of therapy is not expected to exceed 3 months, during the cross-over period.
   5. For orders where biosimilar therapeutic interchange is applied, the pharmacist must document the change on the pharmacy paper chart as well as in the EHR.
      a. Documentation in pharmacy paper chart: Wording should be as follows - “Biosimilar therapeutic

interchange: (biosimilar drug name, dose and frequency) substitution for (reference product drug name, dose and frequency) per biosimilar therapeutic interchange policy. Sign and date."

b. Give a copy of the order to the nursing supervisor so it may be added to the patient's chart.

c. Documentation in EHR: When entering the dose, document biosimilar change by clicking the "Comments" button, then entering in the information under the "Special Instructions" field. Wording should be as follows: "Biosimilar therapeutic interchange: (biosimilar drug name) substitution for (reference product drug name)."

d. Patients who are switched from reference product to biosimilar will be notified and will receive information regarding biosimilar medications (FDA Biosimilar Handout) https://www.fda.gov/media/166334/download.

C. Inpatient pharmacy: Biosimilar will be given for all approved indications.

1. Exclusion: Patients in the neonatal intensive care unit (NICU), LP designate "do not substitute" for the reference product or patient has documented history of intolerance, allergic reaction, or other adverse drug events to the biosimilar product.

2. Documentation on EHR for automatic therapeutic substitution:

a. Enter information under the "Special Instructions" field - "Biosimilar therapeutic interchange: (biosimilar drug name) substitution for (reference product drug name)."

b. Complete order as "Protocol/Standardize Procedures - cosign" and submit.

All revision dates:

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R.60 Respiratory Care Mini-BAL Induction

POLICY:

Mini bronchoalveolar lavage (mini BAL) is a blind, non bronchoscopic procedure, used to obtain samples from the lower respiratory tract from patients on mechanical ventilation (MV). The purpose of mini-BAL induction is to obtain distal lung fluid specimens for diagnosis by Respiratory Care staff.

Procedure:

1. Licensed Independent Practitioner to enter orders into the Electronic Medical Record (EMR)
2. Respiratory Therapist to be notified of the order, verify order and bring appropriate equipment to the bedside.
3. Equipment
   A. Can be obtained in the Respiratory Therapy Department
   B. Mini-BAL catheter, 13 French (Fr).
   C. Sterile Gloves
   D. Non-sterile gloves
   E. 3-20ml syringes
   F. Labels for syringes
   G. 18 gauge (g) Needle x 1-1/2 blunt
   H. 50ml non-bacteriostatic saline
   I. Double swivel connector
   J. Basin
   K. Specimen container and labels, including patient identification
   L. Suction kit or in-line catheter
   M. Suction tubing
4. Performing the Procedure
   A. The procedure will be performed by a Respiratory Therapist
   B. Physicians

C. Residents who have completed the mini-BAL competency

5. Preparing Patient
   A. Identify the patient using two patient identifiers
   B. Explain the procedure to the patient and/or family at bedside.
   C. Place patient on 100% oxygen
   D. ~~Observe standard precautions~~Perform Hand Hygiene and adhere to precaution standards per patient orders
   E. Ensure the patient is adequately sedated for the procedure
   F. Aspirate two syringes
      1. 2-20 ml non-bacteriostatic saline; and
      2. 1-20ml syringe with 10 ml non-bacteriostatic saline and 10 ml of air
      3. Label appropriately
   G. Place the airway adaptor between the artificial airway and the ventilator circuit
   H. Suction patient prior to procedure
   I. Remove white covered container from package
   J. Using sterile technique, don sterile gloves
      1. Place the sterile white towel on the patient's chest while only contacting the corners of the towel
   K. The person assisting will open the catheter package
      1. Using sterile technique, remove catheter and place on the towel, still in the sheath
   L. Advance the catheter out of the protective sheath at the opened end (end with red plug) and introduce catheter into the artificial airway
      1. As a guide, note the black line depth markings
      2. The 40-cm marking on the catheter at the opening of the airway adapter is approximately positioned at the end of the endotracheal tube
      3. Gently advance the catheter
      4. If resistance is met stop and reposition catheter
      5. Never force the catheter further into airway
      6. Continue advancing catheter until you again meet resistance (at approximately 56 cm depth at the airway adapter)
      7. At the appropriate catheter depth (the 56 cm mark) you should have advanced past the opening of the airway adaptor
      8. If resistance is met before the appropriate depth, pull the catheter back 1 cm, twist the catheter and continue to advance catheter to appropriate depth
   M. Pull the catheter out approximately 3 cm to allow room for the inner catheter to be advanced.
      1. Remove the white plastic protective spacer that separates the inner and outer catheters.
      2. Gently advance the inner catheter and connect it to the outer catheter by slightly twisting it into the outer connector

3. As the inner catheter advances it will dislodge the absorbable polyethylene glycol plug at the distal end of the catheter

N. Flush with 2 syringes of 20 ml non-bacteriostatic saline.
   1. Follow by 20ml syringe with 10 ml non-bacteriostatic saline and 10 ml air

O. Aspirate lavage sample using the same (last) syringe while maintaining catheter position.
   1. Initially during aspiration, a small amount (<10ml) of air will be aspirated prior to lavage return
   2. Continue to aspirate until several mls of saline lavage sample are obtained
   3. Place the sample into specimen container, tightly secure the lid and label the container with:
      a. "mini-BAL"
      b. Initials
      c. Time
      d. Date
      e. Patient identification
   4. Place container in specimen bag, seal it and send it to the Laboratory

P. Assess patient's oxygen status and return to the previous oxygen settings

6. Relative Contraindications
   A. Absolute contraindications
      1. Severe refractory hypoxemia
      2. Low platelet count, less than 30,000
      3. Recent lung surgeries
      4. Unstable hemodynamically
   B. Relative contraindications
      1. High peep/FiO2
      2. Hemoptysis
      3. Partial tracheal obstruction
      4. Moderate hypoxemia
      5. Unstable pulmonary hypertension
      6. Lung abscess
      7. Obstruction of the superior vena cava
      8. Recent head injury
      9. Inability to sedate
7. Documentation
   A. Respiratory Therapist will document the following:
      1. Time of procedure
      2. Amount of saline lavage given

3. Amount of return specimen obtained
4. Any adverse reaction of patient

B. Respiratory Therapist will ensure all Laboratory orders are in the electronic health record
1. Specimens are to be labeled
2. Delivered to Laboratory

All revision dates: 7/8/2024, 5/11/2022, 7/1/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/8/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*7/12/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/3/2024*
Next Review:	*3 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.101 Inhaled Continuous Albuterol

PURPOSE:

To standardize the use of continuous aerosol therapy as a modality used for the rescue of patients with severe bronchospastic disease who do not respond to conventional therapy. This is not a replacement for routine, periodic treatment.

POLICY:

Inhaled continuous albuterol shall be administered via high performance vibrating mesh drug delivery device (e.g., Aerogen Solo) with syringe pump by a Respiratory Therapist via a dedicated line (e.g., Blue Aerogen Solo respiratory tubing for continuous inhalation).

Patients must be monitored continuously either in the intensive care setting or in the Emergency Department. Further, they must be monitored with a cardiorespiratory monitor and pulse oximetry.

BACKGROUND:

A. **Indication** - Severe reactive airway disease and/or impending respiratory failure non-responsive to standard therapy of systemic steroid administration and intermittent beta agonist aerosol therapy.

B. **Contraindication** - Drug hypersensitivity

C. **Precautions**

1. Given the possibility for adverse cardiovascular events, heart rate, blood pressure, and electrocardiogram (ECG) tracing should be closely monitored.
2. Albuterol sulfate inhalation can produce paradoxical bronchospasms, which may be life threatening. If paradoxical bronchospasm occur, albuterol sulfate inhalation solution should be discontinued immediately, and alternative therapy instituted. It should be recognized that paradoxical bronchospasm, when associated with inhaled formulations, frequently occurs with the first use of a new cannister or vial.
3. Albuterol sulfate inhalation solution contains the preservative benzalkonium chloride. Bezalkonium chloride has been associated with bronchospasm in a dose-dependent manner. In patients who receive high doses (e.g, continuous nebulization) of albuterol sulfate inhalation solution and bronchospasm does not resolve, consider a trial of short-acting bronchodilator that does not contain the preservative benzalkonium chloride.

D. **Potential Risks** - Malfunction of device and/or improper technique may result in under dosing or overdosing.

E. **Side Effects**

1. Sensitivity to the drug and/or adverse side-effects may include:
    a. Tachycardia
    b. Dizziness
    c. Nausea and /or vomiting
    d. Tremors
    e. Palpitations
2. Intracellular movement of potassium with albuterol
3. ST changes in electrocardiogram

F. **Assessment of Outcome**

1. The effectiveness of continuous aerosol treatment will be assessed on how well it accomplishes the stated clinical goals.
2. Observation of the following should be noted by the Respiratory Therapist in the patient's Electronic Health Record (EHR):
    a. Sputum - color, amount, consistency.
    b. Auscultation - comparison of pre- and post-treatment breath sounds; breath sounds improved.
    c. Pulse oximetry and/or arterial blood gas measurement
    d. Work of breathing (WOB)- evaluating the ventilatory pattern, use of accessory muscles; decreased WOB.
    e. Change in heart rate
    f. Patients' subjective response ("breathing easier")
    g. Peak flow improvement

PROCEDURE(S):

A. **Equipment**

1. Designated infusion syringe pump (e.g., Alaris syringe pump)
2. Aerogen Solo control module with cable
3. Aerogen Solo nebulizer cup (disposable)
4. Aerogen Solo Blue 60 mL syringe, tubing, blue Luer cap
5. Aerogen Tee shaped adaptor (i.e., T-piece)
6. 3 mL saline unit doses
7. Auxiliary medication label
8. Albuterol 0.5% 5 mg/mL solution prepared by the Pharmacy department in the Aerogen Solo Blue 60 mL syringe

B. **Special Considerations**

1. The nebulizer cup should be labeled with set up date.
2. The medication syringe should be replaced every 48 hours.
3. For continuous use, the life of the Aerogen Solo nebulizer and the continuous nebulization tube set have been qualified for use for a maximum of 7 days.
4. For intermittent use, the duration of use is limited to a max of 28 days.
5. DO NOT use a syringe with a needle to fill the nebulizer with medication. The needle will damage the port.
6. The maximum capacity of the nebulizer unit is 6 mL.
    a. NOTE: It is best practice to introduce 1 mL of sterile water or isotonic sterile saline into the nebulizer after aerosol is complete but before the nebulizer dries out to rinse out any remaining medication.
7. If the syringe needs to be replaced for any reason including when empty, always disconnect the Solo end first. Failure to do so may result in the flow of medication, already in the syringe tubing, into the Aerogen solo.
8. To avoid spillage of medication when changing the syringe tubing, keep both ends of the tubing at the same height.

C. **Functional Test**

1. Perform a functional test with the initial use of Aerogen Solo prior to inserting into the circuit or accessory or at any time to verify proper operation.
2. Pour 2 mL of 0.9% normal saline into the Aerogen Solo and turn on the power.
3. Visually check that aerosol is produced.
    a. NOTE: Rising fluid level in the aerosol cup indicates that the fill rate has exceeded the output rate of the Aerogen Solo.

Roles and Responsibilities

Licensed Practitioner (LP)

A. Inhaled Continuous Albuterol treatment is restricted to the nursing units with 1:1 or 1:2 Acuity (e.g., Emergency Department, Pediatric Intensive Care Unit, Adult Intensive Care Unit, and Direct Observation Unit).

B. The written Licensed Practitioner's order must include the following:

1. Type of solution/medication
2. Amount/dose to be delivered
3. Frequency/duration

Pharmacy

A. Pharmacy will prepare the Albuterol syringes for nebulization

B. Pharmacy shall prepare and dispense 1 syringe upon therapy initiation.

C. At the time of dispensing, the Aerogen syringes of albuterol must be labeled with the patient specific EHR

label, a beyond use date, and a "For Inhalation Only" label

Respiratory Therapist (RT)

Setup

A. The RT will obtain the necessary parts listed under the EQUIPMENT section.

B. The RT will obtain and manage dedicated syringe infusion pump.

C. The RT will assemble Aerogen Solo nebulizer and infusion pump set-up per manufacturer's instructions for use.

1. For non-intubated patient, connect the infusion tubing to the Luer lock connector on the Aerogen nebulizer cup that is in line with the circuit on the dry side.
2. For intubated and on ventilator patient, attach nebulizer in line with the ventilator set up the dry side of the heater chamber.

D. The RT will place labels "ALBUTEROL" on the syringe and Aerogen Solo blue tubing.

E. The RT will prime the tubing and connect the prefilled syringe with the standard concentration of albuterol obtained from pharmacy to the syringe infusion pump.

F. Set the pump to deliver the ordered dose using Dose Error Reduction Software (DERs) and set the "volume to be infused" on the pump to the total amount of volume.

Administration

A. Drop by Drop (Volumetric) Dosing

1. Infusion Rate Pump = Solo Output = Desired Dosage (mg/hr)/Medication Concentration (mg/mL)
2. Dosing based on albuterol concentration

Albuterol Sulfate 0.5% (using 5 mg/mL 20 mL bottle or 2.5 mg/0.5 mL unit dose vials)		
Dose Ordered (mg/hr)	**Volume to be delivered (mL/hr)**	**Duration of 30 mL in a 60 mL syringe (hours)**
5 mg	1 mL	30 hours
10 mg	2 mL	15 hours
15 mg	3 mL	10 hours
20 mg	4 mL	7.5 hours
Albuterol Sulfate 0.083% (using 2.5 mg/3 mL unit dose vials)		
Dose Ordered (mg/hr)	**Volume to be delivered (mL/hr)**	**Duration of 60 mL in a 60 mL syringe (hours)**
5 mg	6 mL	10 hours
10 mg	12 mL	5 hours
15 mg	18 mL	3.5 hours

Albuterol Sulfate 0.5% (using 5 mg/mL 20 mL bottle or 2.5 mg/0.5 mL unit dose vials)		
20 mg	24 mL	2.5 hours

B. Albuterol syringe change will be based on the rate of administration.

C. RT must request new syringe from pharmacy at least 1 hour prior to change time.

D. Hand off report will be given at bedside - verifying medication, dosage, and change of the syringe time.

E. The RT will change the Aerogen Solo continuous tubing with every new syringe. Otherwise, the tubing must be changed every 7 days, when the medication has been changed, and as needed.

F. Scan both patient's wristband bar code~~,~~ and medication bar code~~, and infusion pump bar code~~ to ensure medication safety redundancy~~ and correct use of DERs~~.

Documentation

A. RT shall document every 30 minutes for the first 2 hours, then every 2 hours thereafter:

1. Aerosol delivery device
2. Aerosol treatment route
3. Medication delivered
4. Work of breathing
5. Shortness of breath
6. Respiratory treatment response
7. Heart rate
8. Respiratory rate
9. Breath sounds
10. Cough/suction/sputum
11. Adverse reactions
12. Position

B. RT shall document syringe and dose change on the Medication Administration Record (MAR).

Weaning and Discontinuation

A. The medication will be weaned or discontinued per LP order.

B. Review the LP's order.

C. Explain change in therapy to patient.

D. Discard all disposable equipment.

E. Document the date and time the therapy was discontinued on the EHR.

Cleaning the Control Module

A. See Manufacturer's Instructions for Use.

B. Wipe with a hospital approved disposable cleaning disinfectant wipe.

C. Ensure that no liquid enter the control module case.

D. Dispose of all single patient use supplies.

REFERENCE(S):

1. Aerogen-solo http://www.aerogen.com/products/aerogen-solo/ Accessed 2/8/2023
2. Aerogen Continuous Nebulisation Tube Set. http://www.aerogen.com/products/aerogen--continuous-nebulisation-tube-set Accessed 2/8/2023.
3. Albuterol Package Insert. Accessed 2/8/2023

All revision dates: 7/3/2024, 7/12/2023

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	7/3/2024
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/3/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*2/1/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/19/2018*
Next Review:	*3 years after approval*
Owner:	*Gina Ferrer: Manager, Trauma Services*
Policy Area:	*Trauma Services*
References:	

T.04 Fall Prevention Program

POLICY:

Provide guidance to Ventura County Medical Center/Santa Paula Hospital staff in regard to the Fall Prevention Program. The goals of the program are to decrease the frequency and severity of fall injuries in the elderly population of Ventura County utilizing prevention strategies. This will be coordinated by the Ventura County Medical Center Department of Trauma Services Injury Prevention Program in conjunction with Ventura County Emergency Medical Services (VCEMS), Ventura County Area Agency on Aging (VCAAA), Ventura County Public Health Department, local hospitals, private physicians, skilled nursing facilities, and ancillary medical professionals in our community by utilizing a screening and intervention process.

PROCEDURE:

A. Patients who have fallen will be identified by VCEMS personnel as high risk for repeated falls utilizing screening criteria in the electronic pre-hospital care report.

B. Upon transport to the hospital, VCMC staff will report identified patients to the VCAAA Fall Prevention Coordinator utilizing the Ventura County Fall Form. After obtaining the patient's consent, the Fall Coordinator will refer him/her to a home health agency, Ventura County Public Health or other community resources as appropriate.

C. Patients who have fallen will be provided with Fall Prevention Program educational materials with information on fall prevention strategies and community resources, if such materials were not provided in the field by pre-hospital personnel.

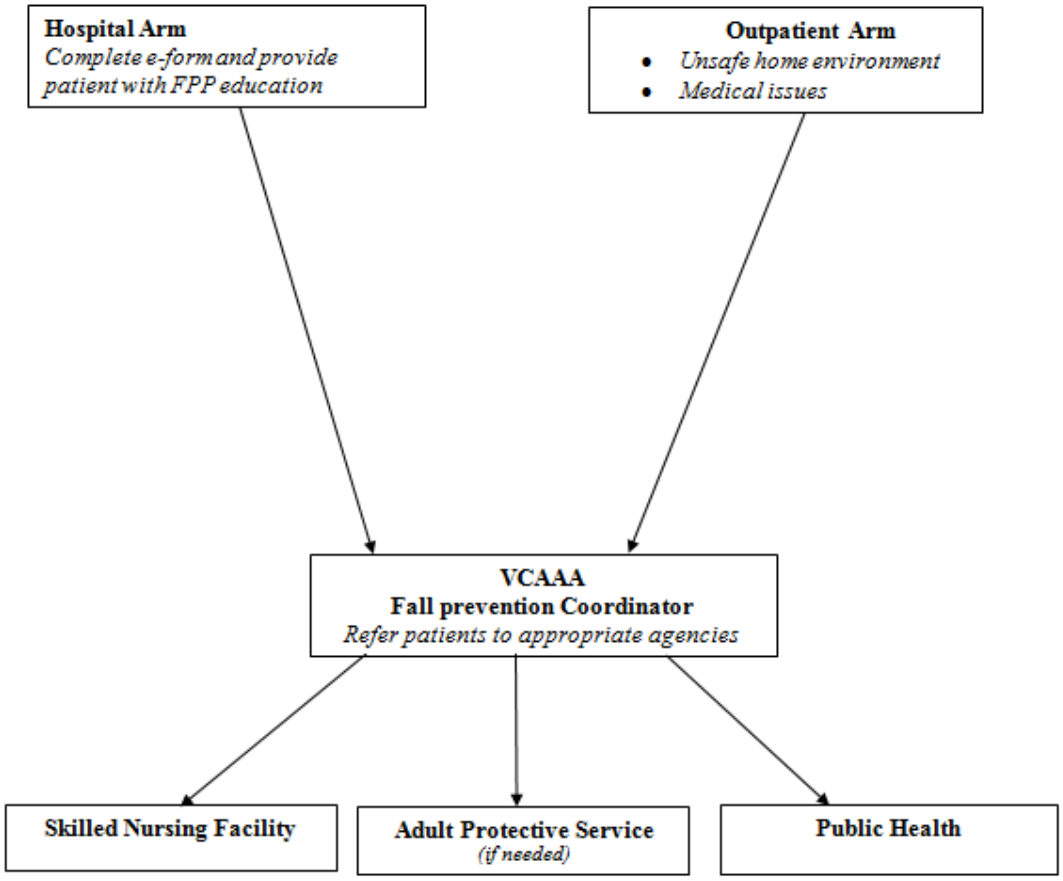
D. Patients that are admitted to the hospital will have a social service consult, with the goal of ensuring patients receive the proper referral to services post-discharge as well as durable medical equipment as needed.

DOCUMENTATION

E. Electronic Fall Prevention Form

F. Cerner Electronic Health Record

Algorithm for Referral to the Fall Prevention Program



All revision dates: 7/19/2018, 7/1/2015

Attachments

Algorithm for Referral to the Fall Prevention Program

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	8/27/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/27/2024

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/27/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	8/27/2024
Trauma Services	Thomas Duncan: Trauma Director	8/7/2024

Contractor Name	Terms and Scope of Service Provide	Term Dates	Physician	Notes
Andrei Bobrow, M.D., Inc., DBA Channel Islands Inpatient Pediatrics	Medical Director, Attending Physicians, Inpatient Pediatric Hospitalist Services	7/1/23-6/30/24	BB 6.11.24	Hospitalist Services"; AGR remain in effect through September 30, 2024, Exhibit A, replaced in its entirety, Attachment I, Responsibility of CONTRACTOR replaced in its entirety, Attachment II, Compensation of
Central Coast Men's Health	Attending Physician, Urology Services	7/1/23-6/30/24	BB 6.11.24	in its entirety Amend 2 eff 1/1/24 Article 7 Section 16 shall be replaced in its entirety; Agreement extended through 12/31/24; Attachment I
Children's Hospital Los Angeles Medical Group (CHLAMG) - Patel, Abbas	Pediatric Gastroenterology Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 11/1/23 Agreement shall continue in effect through October 31, 2024; Exhibit A, Participating Physicians, shall be replaced in its entirety; Attachment I shall be replaced in its entirety; Attachment II replaced in its entirety
Children's Hospital Los Angeles Medical Group - Freed	Medical Director, Pediatric Neurology Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 2/6/24 Section 5. I Insurance Requirements is deleted and replaced in its entirety; Attachment I, Responsibilities of CONTRACTOR, is deleted and replaced in its entirety; Attachment II, Compensation of CONTRACTOR, is deleted and replaced in its entirety
Children's Hospital Los Angeles Medical Group - Shirleen Loloyan Kohn, M.D.	Pediatric Pulmonology Services	7/1/23-6/30/24	BB 6.11.24	New AGR eff 8/1/23
Coastal Vascular Center	Vascular Surgery Medical Director and Attending Physicians, Vascular Surgery Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 7/1/23 Attachment II, Compensation of CONTRACTOR, is deleted and replaced in its entirety Amend 2 eff 7/1/23 Attachment II, Compensation of CONTRACTOR, paragraph 2 is deleted and replaced in its entirety
Critical Care Associates	Director and Attending Physicians, Critical Care Department Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 1/1/24 Exhibit A, Participating Physicians, shall be replaced in its entirety; Attachment I shall be replaced in its entirety; Attachment II shall be replaced in its entirety
Golden State Imaging Associates	Medical Director and Attending Physicians Radiology Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 2/1/24 Section 3.f.i. of Attachment I, Responsibilities of CONTRACTOR regarding Quality Metrics, shall be replaced in its entirety; Section 6.a. of Attachment II, Compensation of CONTRACTOR, regarding Quality Metrics shall be
Institute for Head & Neck Surgery Medical Group	Medical Director and Attending Physicians, Otolaryngology Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 6/4/24 Exhibit A, Participating Physicians, shall be replaced in its entirety; Attachment I shall be replaced in its entirety; Attachment II shall be replaced in its entirety
Island View Gastroenterology Associates	Attending Physicians, Gastroenterology Call Services	7/1/23-6/30/24	BB 6.11.24	entirety; Attachment I, Responsibilities of Contractor, shall be replaced in its entirety; Attachment II, Compensation of Contractor, shall be replaced in its entirety
Nikkee and Suraj, P.C.	Pediatric Neurology Services	10/1/23-6/30/25	BB 6.11.24	New AGR eff 11/1/23
North Star Gastroenterology and Hepatology	Attending Physician, Gastroenterology Services	7/1/23-6/30/24	BB 6.11.24	New AGR eff 1/1/24
Pediatrix Medical Group of California	MEDICAL DIRECTOR AND PROFESSIONAL SERVICES VCMC NEONATAL INTENSIVE CARE UNIT (NICU)	7/1/23-6/30/24	BB 6.11.24	New AGR eff 9/1/23
Pediatrix Medical Group of California	MEDICAL DIRECTOR AND PROFESSIONAL SERVICES VCMC PEDIATRIC INTENSIVE CARE UNIT (PICU)	7/1/23-6/30/24	BB 6.11.24	New AGR eff 7/1/23
Renal Consultants of Ventura County	Ventura County Health Care Agency Agreement for Nephrology Services	7/1/23-6/30/24	BB 6.11.24	Amend 2 eff 10/1/23 Exhibit A shall be replaced in its entirety; Attachment I shall be replaced in its entirety; Attachment II shall be replaced in its entirety
Salutem	Health Care for the Homeless Program Services	7/1/23-6/30/24	BB 6.11.24	New AGR eff 7/1/23
Traditions Psychiatry Group, P.C.	INPATIENT BEHAVIORAL HEALTH AND PSYCHIATRIC MEDICAL SERVICES	7/1/23-6/30/24	BB 6.11.24	New AGR eff 7/1/23
Ventura County Hospitalists	and SPH Director and Attending Physicians, Hospitals and Critical Care Services	7/1/23-6/30/24	BB 6.11.24	Amend 3 eff 7/1/24 Exhibit A shall be replaced in its entirety; Agreement is hereby extended to remain in effect through December 31, 2024; Attachment II shall be replaced in its entirety
Ventura County Surgical Associates	Bariatric Surgery, Trauma, Thoracic Surgery, Robotic Surgery and Quality Improvement Services	7/1/23-6/30/24	BB 6.11.24	Amend 1 eff 7/1/23 Exhibit A, shall be replaced in its entirety; Attachment I, Responsibilities of Contractor, shall be replaced in its entirety; Attachment II, Compensation of Contractor, shall be replaced in its entirety
Ventura County Women's Health Specialists Medical Group	Obstetrics and Gynecology Services, Director, Perinatology Services, and Certified Nurse Midwives Services, and Additional	7/1/23-6/30/24	BB 6.11.24	Participating Providers, shall be replaced in its entirety; Attachment I, Responsibility of CONTRACTOR, shall be replaced in its entirety;
Ventura Faculty Associates	Medicine Center, Urgent Care, Palliative Care Services Obstetrics and Gynecology Fellowship, Ventura Faculty	7/1/23-6/30/24	BB 6.11.24	shall be replaced in its entirety; Attachment I, Responsibility of CONTRACTOR, shall be replaced in its entirety; Attachment II, Compensation of CONTRACTOR, shall be replaced in its entirety
Zarrinkelk and Siavash Dental Partnership	Oral & Maxillofacial Surgery Services	7/1/23-6/30/24	BB 6.11.24	New AGR eff 9/1/23
TERMED/CXL'D/REPLACED VENDORS				
Gold Coast Neonatal Services	Neonatal Services	7/1/22-6/30/23	BB 6.11.24	Term eff 7/1/2023