VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

October 2024

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VENTURA COUNTY HEALTH CARE AGENCY

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100.007 Admission Criteria to the NICU

POLICY:

To identify neonates that are eligible for admission to the Neonatal Intensive Care Unit (NICU) by meeting established standards and to define the process of providing special observation and/or monitoring during the transition phase.

PROCEDURE:

NICU admissions may originate from Couplet Care, Labor & Delivery, Pediatrics, Operating Room, Emergency Room and through Transport for acute or convalescent care from other facilities. All neonates who meet the admission criteria may be admitted to the NICU.

All neonates requiring intensive care, including those with California Children's Services (CCS) eligible conditions admitted to the NICU, will be under the direct supervision of the NICU Medical Director or CCS-paneled ~~neonatologist~~Neonatologist. The physician shall have evidence of successful completion of Neonatal Resuscitation Provider (NRP) course by the American Academy of Pediatrics (AAP ~~or~~) or American Heart Association (AHA). The physician shall be in the hospital or be no more than 30 minutes away from the NICU at any time, shall be on call for no more than one hospital at the same time, and shall be notified of new admissions and adverse changes in the status of neonates in a timely manner. ~~Infants requiring intensive care provided by a Neonatal Nurse Practitioner (NNP) shall have daily review, evaluation and documentation of care by a~~A CCS-paneled ~~neonatologist~~Pediatrician with NICU privileges, in consultation with a Neonatologist, may provide care to infants requiring intermediate or continuing care. Neonatology consultation will be initiated when consultation criteria are met (please refer to NICU policy N.56, *NICU Scope of Service*). A CCS-paneled ~~pediatrician with NICU privileges~~Neonatologist and Pediatrician shall review, ~~in consultation with a neonatologist~~evaluate and document the clinical management of each infant, ~~may provide care to infants requiring intermediate or continuing care~~on-site, at least on a daily basis. ~~Neonatology consultation will~~It shall be ~~initiated when consultation criteria are met (please refer to NICU policy N.56, *NICU Scope of Service*). A~~the responsibility of the CCS-paneled ~~neonatologist and pediatrician shall review, evaluate and document the clinical management of each infant,~~Neonatologist to ensure that information is provided on~~-site, at least on a daily~~ an ongoing basis~~. It shall be the responsibility of the CCS-paneled neonatologist to ensure that information is provided on an ongoing basis~~ to referring physicians regarding their patients.

Infants requiring special observation and/or monitoring during transition will be cared for ~~in the Transition Care~~by the Nursery Registered Nurse (RN).

EXCEPTIONS

Admission through the Emergency Department, from home, or physician office may occur only with the approval of the NICU Medical Director or designee. All admissions coming through the Emergency Department, home, or a physician's office ~~must have a negative Respiratory Synctial Virus (RSV) screen prior to entering the NICU, and~~ will be admitted to an isolation room.

RESPONSIBILITIES

A. Admission to the NICU is arranged by contacting the NICU Charge Nurse and notification of the appropriate ~~pediatrician~~Pediatrician/~~neonatologist/neonatal nurse practitioner (NNP)~~Neonatologist. At any time a question arises as to the appropriateness of an admission to the NICU, the Charge Nurse will contact the on-call attending Neonatologist and the NICU Clinical Manager and/or Nursing Supervisor.

B. The following clinical conditions may warrant ~~immediate~~ transfer to the NICU for admission/observation, when inappropriate for admission to the Pediatric Unit:

~~Any infant requiring IV fluid and/or IV medications.~~

~~Any infant with feeding difficulties.~~

~~Any infant requiring supplemental oxygen.~~

1. Infants less than 36 weeks gestation.
2. Infants weighing less than ~~2,300~~2200 grams at birth.
3. Infants requiring IV fluid and/or IV medications.
4. Infants with feeding difficulties.
5. Infants requiring supplemental oxygen.
6. Infants with birth depression/perinatal asphyxia and/or 5 minute APGAR score 5 or less.
7. Infants requiring exchange transfusion.
8. Infants with respiratory distress.
9. Infants with apnea and bradycardia.
10. Infants with cardiovascular/congenital heart disease with clinically compromised hemodynamic status.

~~Infants with birth depression/perinatal asphyxia and/or 5 minute APGAR score 5 or less.~~

~~Infants requiring exchange transfusion.~~

11. Infants with persistent or symptomatic hypoglycemia following the Hypoglycemic Algorithm.
12. Infants with unstable physiologic vital signs, including hypothermia.

~~Persistent or symptomatic hypoglycemia following the Hypoglycemic Algorithm.~~

13. Infants with Neonatal ~~abstinence syndrome~~Abstinence Syndrome (NAS) requiring observation and treatment.
14. Any infant at the discretion of the Neonatologist/~~NNP/~~NICU ~~Resource~~Charge Nurse.

C. Older infants (less than 10 kg and less than 1 month post-natal age) who require intensive care ~~and isolation because of infection,~~ may be admitted to the NICU after consulting with the Neonatology Service. ~~Precautions will be implemented according to VCMC Infection Control Policy.~~ Exception may

apply to graduates of the NICU upon discretion of the Neonatologist.

D. Infants meeting the above criteria will be admitted to an isolation room. Precautions will be implemented according to Ventura County Medical Center (VCMC) Infection Control Policy.

PATIENT FLOW

A. Those infants meeting the above criteria will be transferred directly to the NICU with immediate notification of the ~~NNP and~~Neonatologist/~~or pediatrician/neonatologist~~Pediatrician by the nursing staff.

B. Infants who require more acute neonatal intensive care will be transferred to a regional NICU as indicated within the Transfer Guidelines.

C. Patient overflow for times of high census: please refer to policy ~~NOBP~~MCH.~~10~~11, *Transfer Criteria of Stable Neonates*.

D. All patients in NICU will have an acuity assigned.

E. Upon admission, nurses will be required to complete a system assessment. The Electronic Health Record (EHR) form "NICU Basic Admission Information" will be documented within ~~12~~4 hours of admission.

F. The EHR form "Admission History Neonatal ICU" which provides information on maternal history and anticipated discharge teaching of caregivers will be initiated within 12 hours. This form can be reviewed and updated as needed in the Form Browser. The Activities and Intervention portion of EHR, will fire this task within 10 hours of admission and will be marked overdue after 12 hours.

1. The NICU Charge Nurse will assist in chart audit during patient rounds, to ensure that this task does not continue to be Overdue.

~~The NICU Charge Nurse will assist in chart audit during patient rounds, to ensure that this task does not continue to be Overdue.~~

PHYSICIAN~~/NNP~~ RESPONSIBILITIES

A. The Charge Nurse will notify the attending Neonatologist of any pending admissions. The attending physician~~/NNP~~ is responsible for the admission to the NICU.

~~Notify the Charge Nurse of any pending admissions.~~

B. Examine and evaluate the condition of the infant on admission.

C. Write an admission note, history and clinical findings within hospital guidelines. Dictate H&P D/C summary.

D. Write the admission orders to include medication orders, lab orders, IV fluid orders, treatments, and respiratory support.

E. Update parents/guardians regarding the infant's condition; obtain informed consent for procedures/care and place subsequent documentation in the medical record.

References

California Children's Services Department of Health Care Services, www.dhcs.ca.gov/services/ccs/Pages/default.aspx

MCH.14 Hypoglycemia in the Newborn

MCH.11 Transfer Criteria of Stable Neonates

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
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100.047 Transfusion of Blood and Blood Products

POLICY:

Blood and blood products are introduced into the circulation to improve oxygen delivery, restore circulating blood volume, control hemorrhage and prevent bleeding. All blood products (red blood cells (RBC), whole blood (WB), platelets, fresh frozen plasma (FFP), liquid plasma, and cryoprecipitate) ~~and Rhesus (Rh) immune globulin,~~ must be ordered through ~~the~~ Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) Laboratory Blood Banks. ~~All blood~~Clotting factor components (i.e., von Willebrand factor, prothrombin complex concentrates, etc.) are obtained and ordered from pharmacy and are governed by policy *100.241 The Use of Blood Clotting Factors*. Blood products used at VCMC and SPH are obtained from the local blood supplier, Vitalant, located at 2223 Eastman Avenue, Ventura, California. The available supply of blood products at VCMC and SPH, as well as the reserve at Vitalant, is limited due to the nature of ~~the~~ expiration ~~date~~dating (~~35-42~~7-42 days from the time the blood is drawn from the donor). ~~Early and exact ordering of blood products will enable the needs of patients and physicians to be met in an efficient and economic manner.~~

PROCEDURE:

~~**TO REQUISITION BLOOD**~~

The following procedures regulating blood transfusion at VCMC and SPH and Ambulatory Care Infusion Centers are designed to minimize the ~~Blood Bank workload and the financial burden of the~~risk to patient.

~~A.~~ ~~**TYPE AND CROSS-MATCH**~~

~~When it is highly probable that a blood transfusion will be required, an appropriate number of units should be ordered as "type and cross-match." This procedure includes an ABO and Rh type, an antibody screen, the major cross-match, and product order. The ordered number of compatible units will be held in reserve for three (3) days. If problems exist in obtaining the ordered number of cross-match compatible units, the Blood Bank technologist will immediately notify the ordering physician.~~

~~For elective surgeries, if more than two (2) units of red blood cells are ordered as "cross-match" the Blood Bank will cross-match two (2) units of the ordered red blood cells, and the remainder will be available ("type and screen") and supplied to the surgery suite as needed.~~

~~1. **NOTE:** *All transfusion recipients shall have their ABO group verified on a second sample collected at a separate phlebotomy prior to transfusion. The blood bank will perform a history check in the*~~

blood bank system to determine if the patient has had a prior ABO group performed at VCMC or SPH. If there is no history, the patient must have a second confirmatory blood type performed prior to the transfusion of the first unit of red blood cells. If a second sample cannot be collected prior to the transfusion, the patient will be provided with cross-matched O-Negative red blood cells until a second sample can be collected.

B. **TYPE AND SCREEN**

There are multiple surgical procedures, including many elective surgeries, that rarely require blood transfusion. For these procedures blood must be ordered as **"Type and Screen," not as "Type and Cross-match."** The type and screen includes the ABO/Rh typing and the serum screened for unexpected antibodies (including all antibodies known to be associated with significant transfusion reaction). Blood of the appropriate type is then **made available for immediate cross-matching** up to three (3) days later for this patient. If the patient has not been transfused and/or pregnant in the prior 3 months, type and screen samples can be extended to 7 days with the day of draw day 0.

In it becomes necessary during the surgery to transfuse blood for such a patient, an immediate spin cross-match to confirm ABO compatibility can be performed in five to ten (5 to 10) minutes. Uncross-matched blood can be requested and made immediately available. The release of uncross-matched blood will require a qualified physician sign the waiver on the emergency transfusion tag attached to the unit of blood. The signed transfusion tag is scanned into the patient's chart for documentation.

If a patient with a "type and screen" suddenly requires a blood transfusion, the blood bank must be immediately requested to begin the cross-match. If a patient requires a blood transfusion before the cross-match is complete, the release of uncross-matched red blood cells will be made immediately available and a qualified physician must sign the waiver on the emergency transfusion tag attached to the unit.

ELECTIVE SURGERIES

Please refer to Section XI for information regarding autologous or directed donation transfusions. These patients must present themselves in the Laboratory along with their Laboratory request form within seven (7) days of the proposed surgery, but not later than 1:00 p.m. on the day prior to surgery. Those with orders for Type and Screen, and for Type and Cross-match will have their blood ABO and Rh typed and screened for unexpected antibodies prior to admission. It should **rarely** be necessary for elective surgery patients to appear for this work after 1:00 p.m. on the day prior to surgery. Note that patients who have been transfused or pregnant in the past three (3) months must have the type and screen type and cross-match done within three (3) days of surgery.

EMERGENCY USE OF UNCROSS-MATCHED O-POSITIVE OR O-NEGATIVE RED BLOOD CELLS

The emergency use of uncross-matched donor blood (O-Negative or O-Positive) may be a dangerous procedure. The medical staff is urged to seriously weigh the hazard inherent in using blood that has not been cross-matched to insure compatibility against the gravity of the emergency which calls for use of such blood. Uncross-matched O-Negative or O-Positive red blood cells may be dispensed immediately. It is imperative for the blood bank to receive a patient sample as soon as possible to cross-match red blood cells that are type-specific/type-compatible should additional units of blood be required.

The **cross-match** (with O-Negative or O-Positive) takes five to ten (5 to 10) minutes to complete. If an antibody screen has not been done on the patient, it will take 45-60 minutes to complete. Blood is cross-

matched following the procedures of the American Association of Blood Banks.

POLICY FOR RELEASE OF UNCROSS MATCHED BLOOD

Under emergency situations, O Negative or O Positive red blood cells may be issued uncross-matched. Depending upon the circumstances, the recipient's blood may have been previously screened for unexpected antibodies (Type and Screen).

When blood is requested for a patient who had only a "type and screen" ordered, an immediate spin cross-match will be done prior to release of the blood if there is time to do so. Under more emergent conditions, when the patient's blood has not been screened for unexpected antibodies, or when Blood Bank must release uncross-matched blood ordered prior to receipt of recipient blood, the immediate spin cross-match will be performed after dispensing.

In those circumstances when blood is issued with any phase of the type and cross-match incomplete, the ordering physician will sign the Emergency Release waiver on the emergency transfusion tag attached to the dispensed product. The transfusion tag will be scanned into the patient's chart for documentation.

A. The Laboratory will dispense the required number of blood products in the computer. The patient's name or medical record number will be on the emergency transfuse tag as well as the date and time of issue.

B. Segment(s) with the donor number(s) attached must be removed from the blood bag(s) before release.

C. A technologist or phlebotomist may deliver the blood to the unit/patient location.

D. The blood will be cross-matched. When completed, the Laboratory will notify the requesting physician that the cross-matches are complete and compatible (or incompatible).

E. Cross-match information will be entered into the computer.

F.

RELEASE OF BLOOD ORDERED AS TYPE AND SCREEN

For blood that has been ordered as type and screen, the following procedure will be followed:

1. The physician/provider or unit personnel will notify the Laboratory Blood Bank of the need for blood to be infused. The Laboratory technologist will inform the caller of his/her two options, depending upon the urgency of the need for blood.
    a. If blood is needed STAT and must be transfused before the cross-match is complete (5 - 10 minutes), the blood bank will release uncross-matched O Negative or O Positive RBCs. The physician must sign the waiver on the emergency transfusion tag that comes attached to the blood bag. The emergency transfusion tag will be scanned into the patient's chart when documentation has been completed.
    b. If time is not critical, an immediate spin cross-match will be performed, and blood made available approximately in 5-10 minutes.

G. **USE OF TYPE-SPECIFIC COMPATIBLE BLOOD AFTER TRANSFUSION OF NON-TYPE-SPECIFIC BLOOD**

Type-specific blood may be transfused if a check for anti A/anti B in a fresh patient sample is negative using reagent A and B cells through Immunoglobulin G (IgG).

MULTIPLE TRANSFUSIONS

When intervals exceeding three (3) days between transfusions elapse, a new type and screen and cross-match of blood with a freshly drawn sample of recipient's blood must be performed. In such instances formerly compatible blood being held in reserve must be re-cross-matched with a fresh sample of the recipient's blood before it is given.

FRESH FROZEN PLASMA

ABO compatible plasma will be used.

PLATELET PHERESIS

ABO group specific platelets are not required. Rh negative patients will receive Rh negative platelets, if they are available. If Rh negative platelets are not available for an Rh negative patient, and he/she receives Rh positive platelets, Rh Immune Globulin may be recommended to prevent sensitization.

AUTOLOGOUS AND/OR DIRECTED DONOR TRANSFUSION

The patient's physician must inform the patient undergoing elective surgery about the option of autologous and/or directed donor transfusion, discussing the potential risks, benefits and timing. The physician must note in the progress notes in the patient's chart that this discussion took place.

The State Department of Health Services publishes a standardized written summary which identifies the positive and negative aspects of receiving autologous blood, directed and non-directed homologous to blood from volunteers. This information will be given to the patient and a signed copy entered into the patients' medical record.

H. **PROCEDURE FOR OBTAINING AUTOLOGOUS OR DONOR DIRECTED UNITS**

1. Vitalant can provide information and packets for Autologous and Directed Donations.
2. The patient's physician must order the autologous or directed donation unit(s) and complete the forms contained in the packet.
3. Units are drawn at Vitalant, located at 2223 Eastman Avenue, Ventura, CA. Patients may call for an appointment at (805) 654-1600. Hours are 10:15 a.m. to 7:30 p.m., depending on the day.
4. Vitalant requires three (3) working days to complete the testing required by law to ensure that the blood donated is safe and free of infectious agents. Vitalant prefers patients to schedule autologous donations 3-4 weeks prior to surgery. Directed donations require five (5) working days to complete the testing.

I. **LEUKOREDUCED BLOOD PRODUCTS**

1. Filtration to leuokoreduce blood at the site of collection is standard community practice . Thus, volunteer donated blood components are likely to be leukoreduced. The resultant components of volunteer, non-autologous donation, are safe for administration to all patients. Autologous units may not be leukoreduced. The use of blood components that are leukocyto-reduced at the bedside may cause unexpected severe hypotension in some recipients, particularly those on Angiotensin

Converting Enzyme (ACE) inhibitor medication.

J. **IRRADIATED BLOOD PRODUCTS**

Patients in the following categories should receive irradiated blood products:

1. Patients at risk for Graft-Verses-Host-Disease (GVHD).
2. Directed Donations from blood relatives.
3. All neonates
4. Pediatric patients who are actively receiving chemotherapy
5. Pediatric patients who have active malignancy
6. Patients who are immunodeficient
7. Patients who have bone marrow failure or are status post bone marrow or solid organ transplant
8. At the discretion of the Attending physician.

K. **ADDITION OF THERAPEUTIC AGENTS TO BLOOD**

UNDER NO CIRCUMSTANCES ARE THERAPEUTIC AGENTS OR FLUIDS OTHER THAN 0.9% SALINE to be administered through the same tubing simultaneously with blood or blood components. Units that have been entered into, but not infused, will not be accepted in the Blood Bank, nor given to another patient.

L. **STORAGE OF BLOOD**

Federal Drug Administration (FDA) regulations require that blood held in reserve is to be stored only in refrigerators specifically ordained for this purpose in the Blood Bank. Variations in the temperature range of the unmonitored ordinary refrigerator (frequently entered) is detrimental to blood, and renders it unsafe for transfusion.

NOTE: Unused blood must be returned to the blood bank **WITHIN ONE HALF (1/2) HOUR** from the time of being dispensed and meet the return temperature qualification requirements of 1-10°C. All units that do not meet these requirements will be destroyed.

WITHDRAWAL OF BLOOD OR BLOOD PRODUCTS FROM THE LABORATORY BLOOD BANK

The individual who is to transport the blood products from the Blood Bank must be a member of the VCMC/SPH nursing or medical staff. All persons retrieving blood products must present recipient identification to the blood bank staff. A "Blood Pick-up Request" shall be printed with the recipient's complete name, medical record number, and documentation of current vitals and signed consents. Alternately, in emergent situations, a patient registration label, which has been stamped with the recipient's name and medical record number, can be presented to the blood bank staff. The Laboratory Blood Bank technologist retrieves the appropriate blood product for that patient from storage and inspects its color and appearance. All products are dispensed from the laboratory information system.

Every time a blood component is picked up from the blood bank, the blood bank technologist will verify the transporter's competency by asking if they have performed the process. If not, the blood bank technologist will provide instruction as the following steps in the process are performed:

1. The blood product will be handed to the transporter at which time a verbal read will be performed by

the transporter as the blood bank technologist reads and confirms the transfusion tag information.

2. A check will be made to ensure that the blood type of the patient is compatible with the type of the unit to be transfused. The patient's ABO group and Rh factor are recorded on the transfusion tag and in the computer. The ABO group and Rh factor of the unit are recorded on the blood bag and the unit issue tag.
3. The unit number of the blood bag should be compared with that written on the transfusion tag and in the computer. They must be the same, and the expiration date must be checked to make sure that the unit has not expired.
4. The patient's complete name, medical record number, and blood bank recipient wristband identification number must be the same on the unit as on the transfusion tag.
5. Cross-match compatibility must be verified by examining the results recorded on the transfusion tag. The preceding checks must indicate that:
    a. The unit to be transfused is compatible with the patient's blood
    b. The unit in question is the one cross-matched with the patient.
6. The Laboratory technologist will sign the transfusion tag as the issuer. The person retrieving the blood will also sign the transfusion tag as the transporter.
7. The unit transfusion tag will be attached to the unit of blood. The transporter will take the blood component to the nurse in charge of the patient.
8. NOTE: The blood product transfusion tag will remain attached to the blood bag until the administration of the unit has been completed.

M. NEONATAL TRANSFUSIONS

Because of the complexity in transfusing neonates, residents and attending staff shall confer with the Director(s) of Pediatric/Neonatal Service for the required procedures in transfusing neonates. For specific advice, resident staff, attending physicians, and nursing staff should confer with the Director of the department.

1. **Transfusions of infants in the first four (4) months of life**

    For transfusions of small amounts of blood, all babies will be given O Negative or O Positive red blood cells (depending on whether they are Rh positive or Rh negative).

    a. If fresh frozen plasma is required, blood group AB will be used. FFP is supplied in pediatric units by Vitalant, and not screened for CMV.
    b. All cellular products must be irradiated, Cytomegalovirus (CMV) negative, and less than 10 days old.
    c. All red blood cells and platelet products are sterile docked with bags for producing small volumes.
    d. Pre-transfusion testing in neonates born at VCMC is known as a HDN (Hemolytic Disease of the Newborn) workup, which includes ABO/Rh typing and a direct antiglobulin test. The mother's screen will be checked for the identification of any clinically significant antibodies. If the mother's screen is positive and clinically significant antibodies have been identified, antigen negative red blood cells of group O Negative or O Positive (depending on whether they are Rh positive or Rh negative) will be provided for the neonate. Compatibility testing will be performed

using the mother's banded sample.

e. All neonates/infants (less than 4 months of age) born outside VCMC or neonates/infants (less than 4 months of age) discharged and re-admitted to VCMC, will have a sample collected for a type and crossmatch. O Negative or O Positive (depending on whether they are Rh positive or Rh negative), CMV negative, irradiated red blood cells will be provided.

2. **Exchange transfusions**

In the event of an exchange transfusion, group O Rh negative, irradiated, CMV negative, Hemoglobin S (HgS) negative red blood cells will be mixed with group AB fresh frozen plasma for administration. The red blood cells must be no more than five (5) days old. A specific hematocrit for the unit to be transfused may be requested by the neonatal department. Check with Blood Bank.

BLOOD STORAGE AND TRANSPORTATION

N. **REFRIGERATION**

1. The Blood Bank refrigerator should contain only blood components..
2. The temperature in the refrigerator must be maintained in all areas of the refrigerator between 1-6°C.
3. The temperature in the plasma freezers must be maintained at equal to or below -18°C.
4. All platelet products are stored between 20-24° Centigrade with gentle agitation. The maximum time without agitation is 24 hours.
5. All temperature charts from the seven (7) day mechanical recorder will be changed weekly and dated inclusively. Any temperature variation from normal must be documented in writing on the chart beside the tracing.
6. The visible and audible alarm should be activated when the temperature falls outside the acceptable range. The electrical source for the alarm system should be separate from that of the storage unit.
7. If the temperature limits are exceeded, Blood Bank will initiate corrective action. Products will be moved to alternate monitored storage areas or returned to the blood supplier. If the continuous recorder is not functional, all storage areas will be monitored and temperatures documented every four hours.

TRANSPORTATION

A. When issued for transfusion, blood must not be allowed to stand unnecessarily at room temperature. Blood will exceed 10° C very quickly at room temperature and should be returned if there is a delay in administration of the unit.

B. **Policy**: Unused blood will only be released to Vitalant personnel in person. When unused blood is released to Vitalant, be sure to:

a. Remove all VCMC/SPH labels/blood unit tags.

b. Have the Vitalant courier sign the consignment papers for the units released and retain a copy signed by you.

c. Blood is transported with the patient only when blood is to be given in transit. The blood is signed out and transfusion tags are attached to the blood as per above. Blood is not to be transported with the patient outside the County unless used in transit.

BLOOD TRANSFUSION ORDERS

A. **ORDERS**

Electronic Transfusion orders are linked and grouped as several are required for transfusion. The ABO and Rh type and antibody screen, (Type and screen) are sufficient for majority of patients with modest risk of requiring transfusion. Blood bank orders could include an ABO and Rh type, an antibody screen, the major cross-match, and product type(s). The nursing blood product order indicates how the component(s) are administered. Location (ICU, ED) and age specific (PICU, PEDS) order sets are modified for stat and volume/rates respectively.

1. **LABORATORY ORDERS -** Type, Antibody Screen, product(s) and Computer Cross match for Red Blood Cells.
    a. Orders shall specify the following:
        i. Patient's name, birthdate, and medical record number.
        ii. Indication/Reason.
        iii. The components are ordered individually (e.g., RBC, Platelets, FFP, Cryoprecipitate).
        iv. Any special requirements (irradiated, CMV negative, Type Specific, Hgb S negative). Other special requirements such as antigen matched, washed.
        v. Number of units to be reserved or transfused.
        vi. The date to give the transfusion.
    b. If antibody screen is positive, blood bank will anticipate per standard operating procedure, 2 units of crossmatch compatible RBC on hold for patient.
    c. Many elective surgeries and other procedures do not routinely necessitate transfusion. Type and screen is recommended order.
    d. Volume order would prompt an aliquoted unit. This is routine in neonates but not other pediatrics. Would be necessary in volume sensitive patient that requires slow infusion rate.
    e. Before ABO type specific red blood cells are issued, standards require a confirmation of ABO/Rh. Confirmation may be historical or require a separate blood draw (retype).
2. **NURSING TRANSFUSION ORDERS**
    a. Confirm and transfuse necessary blood product. Select blood product (example RBC) and number of units to transfuse now.
    b. Reason for transfusion.
    c. Special Requirements. Important to match the Product Requirements
    d. The date to transfuse.
    e. The initial transfusion rate and final transfusion rate.
    f. Warming of blood components would be entered as order comment.
    g. Pre-medications as designated. Post transfusion hemoglobin/hematocrit are recommended
        i. PEDS/PICU order sets filter the initial and final transfusion rates for each 10 kg range in weight for ease of ordering. A rate for exact weight can be entered
        ii. Volume order would limit the portion of dispensed unit. This is required for RBC in most

pediatrics.

3. Reserving Blood Products
    a. For most products, the ordered component will be held in reserve for three (3) days.
    b. After three (3) days (on the 4th midnight), a new type and screen and cross-match of blood is required for RBC. RBC units held in reserve must be re-cross-matched. For plasma products, after seven (7) days, a new type and screen is required.
    c. For elective surgeries, RBC of the appropriate blood group are made available for up to seven days from specimen draw. These patients must present themselves in the Laboratory draw station within seven (7) days of the proposed surgery, but not later than 1:00 p.m. on the day prior to surgery.
    Patients who have been transfused or pregnant in the past three (3) months must have the type and screen type and cross-match done within three (3) days of surgery.
    d. All transfusion recipients shall have their ABO group verified with a separate lab draw prior to transfusion of red blood cells. The blood bank will perform a history check for a prior ABO/Rh performed at VCMC or SPH. If there is no history, the patient must have a second confirmatory blood type performed prior to the transfusion of **red blood cells**. If transfusion is emergency and a second sample cannot be collected prior to the transfusion, the patient will be provided with **emergency release** cross-matched O red blood cells.
        i. **Exception**: Neonates less than 4 months of age will receive only group O packed red blood cells and group AB plasma. No second sample is required.
4. **Massive Transfusion Protocol (MTP)** is activated by physician order in accordance with policy *T.02 Massive Transfusion Protocol*. Mutiple blood components are prepared and dispensed for rapid administration.

BLOOD CONSENT

A. Consent is detailed in policy *100.233 Informed Consent and Blood Transfusion*. The patient's physician must inform the patient that their condition, planned medical or surgical procedure may necessitate transfusion. The ordering practitioner or physician responsible for the patient's care shall review the positive and negative aspects of the following (1) autologous blood (includes pre-donation, hemodilution, and intraoperative autologous) (2) directed donor blood and (3) non-directed donor blood from volunteers. California law stipulates adequate pre-donation time shall be offered if it is safe to do so.
    1. The standardized written summary published by the State Department of Health Services will be given to the patient by the physician responsible for the patient's care.
    2. A signed informed consent/declination for blood transfusion with provider attestation shall be completed and scanned into the electronic chart.

BLOOD PRODUCT PICK-UP FROM THE LABORATORY BLOOD BANK

A. Only VCMC, SPH, Ambulatory Care nursing or medical staff (RN, LVN, CNA, MOA, ORT, ER EMT, MD, DO, NP) may pick-up blood products.
    1. Lab technicians may deliver blood during Tier 1 activations (see T.01) or Massive Transfusions (T.02)

B. Print a "***Blood Pick-up Request*** " form from the EHR and bring to Blood Bank.

1. During computer down time procedures and MTP activations, a patient registration label can be presented to the Blood Bank for blood product pick-up.

C. At the time of issue, a clerical check of the transfusion tag with the component label will be verified. The Blood Bank **Technologist** will verify the following WITH the **transporter**. The transporter will use their user name as a signature.

1. The intended recipient's name, date of birth and medical record number
2. The Blood Bank recipient wrist band number
3. The donor unit identification number
4. The donor unit's ABO group and Rh type
5. The intended recipient's ABO group and Rh type. The unit to be transfused is compatible with the patient's blood.
6. Expiration date and time
7. Description of component. Special product requirements
8. The Laboratory Technologist and transporter will sign the transfusion tag.
9. The unit transfusion tag will be attached to the unit of blood. The transporter will take the blood component to the nurse in charge of the patient.
10. The blood product transfusion tag will remain attached to the blood bag until the administration of the unit has been completed.

TRANSFUSION

A. Bedside transfusion patient preparation:

1. Explain procedure.
2. Verify informed consent has been documented. unless unable due to clinical status.
3. Obtain blood transfusion consent (bar coded form).
4. Check "misc. nurse task", confirm availability of blood with Blood Bank.
5. Verify patent IV site.
6. Obtain and document baseline vital signs (including temperature) in the EHR and component tag.
7. Pre-medicate patient if so ordered.
8. Use Y-type blood administration set.
9. Blood sets should not be piggybacked.

B. Preparation to start transfusion:

1. Wash hands and maintain standard precautions and sterile technique.
2. Open Y-type blood administration set and clamp both rollers completely.
3. Spike 0.9% NaCl and prime drip chamber and tubing.
4. Check the appearance of the unit: Units should be returned if there is discoloration, foaming, or bubbles in the component; abnormal cloudiness; presence of clots or clumps; or loss of integrity of

the bag.

5. Check the physician's written order, verify the retrieved blood component is the one requested on the order, including any special processing.

C. Identification of the patient and correlation with blood recipient wrist band ID, hospital band ID and unit tag at the bedside: IDENTIFICATION MUST BE VERIFIED BY TWO LICENSED PERSONNEL (one must be a Registered Nurse) OR ONE PHYSICIAN/LICENSED PRACTITIONER AND AN RN and must include:

1. Patient's complete name, birthdate, and medical record number and Blood Bank recipient wristband number must match blood component tag.
2. ABO/Rh on blood component tag must match ABO/Rh on donor unit label.
3. Unit ABO/Rh is compatible with patient's ABO/Rh.
4. Product number on blood component tag must match product number on donor unit label.
5. Expiration date is acceptable.
6. Send blood component back to the Blood Bank if infusion will not start within 30 minutes. **DO NOT store ANY blood component in ANY refrigerator on the unit floor. Blood components can only be stored in the Blood Bank refrigerator located in the lab.**

D. Start transfusion. Transfusions must be started within 30 minutes or the blood component must be returned to the Blood Bank. **Blood may be hung only by physicians, licensed practitioners and Registered Nurses. Two licensed personnel must be at patient's bedside when blood transfusion is started.**

1. Verify orders transfusion rate including comments on initial transfusion (routinely 120ml/hr) and goal infusion rate.
2. Spike blood component with second spike (keep roller clamp shut). Units that have been entered into, but not infused, will be destroyed by Blood Bank, not given to another patient.
3. Blood tubing should be attached to the port closest to patient. Do not mix other medications with blood components.
4. Close clamp to 0.9% sodium chloride and open clamp to blood component. Open roller clamp below the drip chamber and begin transfusion. With the exception of rapid infusions in OR and emergent situations, the transfusion flow rate should be slower during the first 15 minutes.
5. **Direct observation of the patient must occur during the first 15 minutes.** A complete set of vital signs will be taken after the first 15 minutes, assessing for a transfusion reaction, which might be: **intense pain at the infusion site, chills, fever, back pain, headache, nausea/vomiting, tachycardia, hypotension, tachypnea, shortness of breath or skin rash** . Details for identification and management of transfusion reaction are below.
6. After the first 15 minutes and if there has been no change in the patient's condition, the flow rate should be increased according to the physician's order and as tolerated by the patient. The transfusion should be concluded in **less than 4 hours for all products** (1-2 hours for Red cells, and 30-60 minutes for platelet pheresis and plasma). For patient safety, order aliquoted red cell units if duration of the transfusion would exceed 4 hours (see A.1). Tubing may be used for up to two (2) units. Tubing should be changed if additional transfusion will go past 4 hours total **(tubing life is a maximum of 4 hours).**

7. No medications will be added to the blood component(s) or administered through the administration tubing set.
   If medication must be administered while blood components are infusing and a separate line is not available, stop the transfusion. Flush the line, administer the medication, flush the line again and then restart the transfusion.
8. At the completion of the transfusion flush line with normal saline.
9. Obtain post-transfusion set of vital signs.
   a. An increase in the patient's temp of 1 degree Celsius or 2 degrees Fahrenheit should be reported to the physician and transfusion reaction plan implemented.

E. Upon completion of transfusion:
1. Continue to assess patient closely for 1 hour after the transfusion.
2. Complete all required blood administration documentation in the EHR.
3. Complete blood administration documentation on the blood component tag. All required signatures must be documented.
4. Detach blood component tag and place in the urgent scan file.
   a. During computer down time procedures and Massive Transfusion (MTP) activations, the blood component tag will be used for documentation of blood administration.
5. If no blood product is left in the unit, it may be disposed of in regular trash. Otherwise, dispose of unit bag in biohazard waste container.

Transfusion Reaction Diagnoses and Management

A. A transfusion reaction is any unfavorable event that occurs in a patient during or after transfusion of blood or a blood component that can be related to that transfusion.
1. Reactions range from sentinel events of blood incompatibility, serious complications like pulmonary edema, and minor reactions like hives.
2. Initial signs and symptoms of serious and non-serious reactions overlap, diagnostics are often needed to confirm a suspected reaction

B. During or after blood product transfusion, health care providers should consider any adverse change in the patient's condition a possible symptom of a transfusion reaction and evaluate the patient promptly to prevent further complications
1. **Febrile**: Fever, chills/rigors
2. **Allergic**: Rashes, hives, swelling, itching, urticaria, flushing
3. **Respiratory**: Tachypnea, dyspnea, hypoxemia, respiratory failure, bilateral pulmonary edema,
4. **Cardiovascular**: Hypo/hypertension , tachycardia
5. **IV site**: Heat and intense pain at site of infusion or along vein
6. **Constitutional**: Headache, apprehension, diaphoresis
7. **Gastrointestinal**: Nausea and vomiting
8. **Renal**: Urine color changes (burgundy), low back pain

C. **Immediate action:**

1. STOP the transfusion immediately. Obtain and monitor vital signs
2. Prime and begin new normal saline IV line.
3. Nursing shall notify the physician/provider immediately and then Blood Bank.

D. Evaluation

1. All transfusion reaction clinical information should be charted on the Ad Hoc Blood Transfusion Reaction form.
2. Perform a clerical check at the bedside to include: patient identification, blood unit labels, and all pre-reaction records.
3. Send remainder of blood, tubing and labels to Blood Bank
4. In the EHR, place a Laboratory order for "***Transfusion Reaction Initial***." Once the order is initiated, the following reflex orders will be initiated:
    a. Post-transfusion blood sample – STAT ABO/Rh Typing and Direct Antiglobulin Test – EDTA pink top collected by phlebotomist.
    b. Post-transfusion urine – STAT urine to be collected by Nursing and submitted to the laboratory.
    c. Post-transfusion bilirubin–STAT bilirubin 5 hours post reaction – Green top tube collected by phlebotomist
5. Document in EHR the transfusion reaction (Ad Hoc Blood Transfusion Reaction Form).
6. Complete a Notification Form electronically.

E. Management by Predominant Symptom

1. Hives
    a. Urticaria alone (hives, rash, itch) needs only symptomatic management with antihistamine. There is no laboratory or radiologic evaluation indicated.Transfusion can proceed once symptoms are controlled.
        i. Angioedema, hypotension are concerning for rare anaphylaxis and the transfusion is aborted.
2. Fever Chills
    a. Fever may be expected component of patient's underlying illness and so clinical decision making about likelihood of reaction is warranted.
    b. Acute hemolytic transfusion reaction (AHTR) has fever together with hemoglobinuria, hyperbilirubinemia and sometimes new crossmatch incompatibility. "***Transfusion Reaction Initial***." will complete those tests.
        i. If AHTR diagnosed, is a sentinel event. Transfusion is aborted. New specimen for crossmatching is required prior to new transfusion.
    c. Transfusion Associated Lung Injury (TRALI) has fever with dyspnea, hypoxia and abnormal chest radiograph.
    d. Sepsis from the product would have fever with other signs of infection: hypotension, shock. Transfusion is aborted. Culture from patient and blood unit are diagnostic
    e. Febrile non-hemolytic transfusion reaction (FHNTR) is a diagnosis of exclusion, when hemolysis is EXCLUDED, TRALI not apparent and sepsis unlikely. A transfusion may proceed

after a FNHTR.

3. Respiratory Distress
    a. TRALI occurs during or shortly after transfusion and may have fever or hypotension associated.
        i. Acute hypoxemia and x-ray changes and NO evidence of fluid overload.
        ii. Not responsive to diuretics. Respiratory support as indicated
    b. Transfusion Associated Circulatory Overload (TACO) occurs when cardiorespiratory circulation cannot handle the new volume. Often in the elderly or pre-existing cardiac or renal disease. Recent large transfusion (often of plasma) is common risk.
        i. In addition to abnormal chest radiograph, jugulovenous distension, positive fluid balance, increased pulmonary wedge pressure and brain natriuretic peptide support the diagnosis.
        ii. TACO is responsive to diuretics. Diuretics can be considered empirically in at risk transfusions.
    c. Anaphylaxis is a rare reaction with wheezing, and possible angioedema or hives.
4. Hypotension
    a. May be a component of patients underlying condition, specifically hemorrhage or medication. Clinical decision making about likelihood of reaction is warranted. That is transfusion *may* continue.
    b. May indicate TRALI (see 3a)
    c. May indicate septic shock as in 2d
    d. May indicate AHTR, transfusion should be held until resolved or excluded
    e. Hypotension is uncommon but recognized transfusion reaction

AGE CONSIDERATIONS

A. **NEONATAL TRANSFUSIONS**

1. **Transfusions of infants in the first four (4) months of life**
   All babies will be given O-Negative or O-Positive red blood cells (depending on whether they and mother are Rh positive or Rh negative).
    a. If fresh frozen plasma is required, blood group AB will be used. FFP is supplied with capacity to aliquot by Vitalant, and not screened for Cytomegalovirus (CMV).
    b. All cellular products (RBC, platelets) must be irradiated, CMV negative, and less than 10 days old.
    c. Red blood cells and platelet products may be sterile docked with bags for producing small volumes. Lab order should include aliquot volume requested (see A.1)
    d. Pre-transfusion testing in neonates born at VCMC is known as a HDN (Hemolytic Disease of the Newborn) workup, which includes ABO/Rh typing and a direct antiglobulin test. The mother's screen will be checked for the identification of any clinically significant antibodies. If the mother's screen is positive and clinically significant antibodies have been identified, antigen negative red blood cells of group O-Negative or O-Positive (depending on whether they are Rh positive or Rh negative) will be provided for the neonate. Compatibility testing will be performed using the mother's banded sample.

e. All neonates/infants (less than 4 months of age) born outside VCMC or neonates/infants (less than 4 months of age) discharged and re-admitted to VCMC, will have a sample collected for a type and crossmatch. O-Negative or O-Positive (depending on whether they are Rh positive or Rh negative), CMV negative, irradiated red blood cells will be provided.

2. **Exchange transfusions**
   In the event of an exchange transfusion, group O Rh negative, irradiated, CMV negative, Hemoglobin S (HgS) negative red blood cells will be mixed with group AB fresh frozen plasma for administration. The red blood cells must be no more than five (5) days old. A specific hematocrit for the unit to be transfused may be requested by the neonatal department. Check with Blood Bank.

3. Because of the complexity in transfusing neonates, residents and attending staff shall confer with the Director(s) of Pediatric/Neonatal Service for the required procedures in transfusing neonates. For specific advice, resident staff, attending physicians, and nursing staff should confer with the Director of the department.

B. **PEDIATRIC TRANSFUSIONS**

1. Pediatric specific order sets (PEDS, PICU) are encouraged to match volume, rate, and drug dose parameters.
2. Consent from parent/legal representative with provider attestation. *100.233 Informed Consent and Blood Transfusion*.
3. Volume order on product would prompt an aliquotted unit. This is NOT routine in pediatrics.
4. Nursing Transfusion order
   a. The initial transfusion rate and final transfusion rate are weight based. RBC Initial rate meant to give small volume of blood with close monitoring for reaction. Approximately 2 mL/kg/hr not to exceed 120 mL/hr.
   b. Final rate based on patient condition. Typical is 5 mL/kg/hr which has low incidence of volume overload and will have early physiologic improvement. Rates higher than 5 mL/kg/hr may have volume overload, rates less than 2 mL/kg/hr run the risk of reaching 4 hour limit prior to completion.
   c. Volume to transfuse is recommended on pediatric order set and especially in children less 30 kg.
      i. RBC typical volume is 10 mL/kg, 4mL/kg will raise 1 g of hemoglobin. Therefore 10 mL/kg would raise 2.5 g.
      ii. Platelet volume is 10-15 mL/kg.
      iii. Plasma volume 10-15 mL/kg.
      iv. Cryoprecipitate typical is 1 unit/5 kg of body weight up to 5 units. 5 units pooled into one pooled uni are available in blood bank.
      v. A unit with remaining volume is disposed in biohazard waste
   d. Indications for transfusion, the blood component, special requirements, and date of transfusion as before
   e. Pre-medications if designated are weight based.
   f. Post transfusion hemoglobin/hematocrit as recommended. Coordinate with other labs, depending on clinical status.

EMERGENCY USE OF UNCROSSMATCHED BLOOD

A. Under emergency situations, Group O Rh Negative red blood cells (RBCs), Group O Rh Positive RBCs , or Group O Postive Whole Blood may be issued without cross-match. See *L.BB.65 Release of Uncrossmatched Blood* for blood bank procedures.

1. The records must contain a signed statement ("WAIVER") from the physician indicating the clinical urgency to require release of blood before completion of compatibility testing.
2. **GROUP O Rh Negative RBCs**
    a. RBCs for Children Age <18 years and Females 18-55 years (child bearing age)
3. **GROUP O Rh Positive RBCs**
    a. RBCs for Females >55 years and Males ≥18 years.
    b. Whole Blood for all patients ≥18 years.

B. The common emergency is traumatic hemorrhage and policy *T.01 VCMC Trauma Response Plan* includes plans for transfusion of emergency release blood products (whole blood, plasma, and RBC).

1. Group O Rh Positive Whole Blood has survival benefits for severe traumatic hemorrhage. Those outweigh Rh antibody risk. Indications (age, sex) for O positive whole blood are detailed in *T.01 VCMC Trauma Response Plan*.

C. *T.02 Adult Massive Transfusion Protocol* and *T.15 Pediatric Massive Transfusion Protocol* govern the ongoing use of blood products during massive transfusion. Some of those will be uncross-matched before dispense.

D. Maternal hemorrhage (see policy *OB.09 Code Maternity*) and some other surgical and medical patients (e.g. gastrointestinal hemorrhage) may require transfusion before antibody screen and cross match are complete. Group O Rh Negative RBCs are indicated.

E. When blood is transfused with any phase of the type and cross-match incomplete, the ordering physician will submit an order for emergency release blood products and attest that the clinical situation was sufficiently urgent to require the release of blood products before completion of blood type or compatibility testing. The transfusion tag will be scanned into the patient's chart for documentation.

1. All emergency red cell and whole blood units will have a crossmatch completed and entered into the computer.
2. Any positive antibody screen or crossmatch incompatible units will be reported to requesting physician.

F. Type AB plasma is universal donor as it has no antibodies. Type AB is preferred for children <18 years and pregnant persons. Type A plasma may be used if not pregnant and ≥18 years.

BLOOD COMPONENTS

Red blood cells are the most common transfused component, but several other components are in common use. No blood component can have medication added. Never mix with anything other than 0.9% sodium chloride. Each component vary greatly on typical volume, standard transfusion rates, compatibility and need for cross matching.

A. Packed red blood cells:

1. ABO/Rh type specific/type compatible given.
2. Cross matching required.
3. 350 mL/unit approximately.
4. Most contain additive which will not need to be diluted, or without additive and needing dilution with 0.9% sodium chloride.
5. Transfuse through blood transfusion set.
6. Infused to adults over 100-300 mL/hr (pediatrics 2-5 mL/kg/hour), maximum of 4 hours.

B. Fresh frozen plasma/Thawed plasma/Liquid Plasma

1. Cross matching not performed, but ABO compatible plasma should be given. Rh is generally not considered.
    a. Neonates given AB plasma.
    b. A patient with type A blood can accept plasma from donors who are type A (identical) or type AB (compatible).
    c. A patient with type B blood can accept plasma from donors who are type B (identical) or type AB (compatible).
    d. A patient with type O blood can accept plasma from donors who are type O (identical) or types A, B, or AB (compatible).
    e. A patient with type AB blood can only accept plasma from donors who are type AB (identical).
2. Fresh frozen plasma thawing procedure requires 30-45 minutes. Anticipate 45 minutes before picking up thawed plasma.
3. Blood bank has limited supply of Type A liquid never frozen plasma. Intended for emergency release, but may be used for other O or A recipients. Liquid plasma benefits are rapid availability and longer shelf live (21 days). It is not leukofiltered and would have risk of CMV transmission, and may have RBC contamination.
4. Fresh frozen plasma not transfused within 24 hours of thawing must be relabeled as Thawed Plasma. Thawed plasma has 5 days expiration.
5. 1 unit = 200 to 300 mL. Usual effective dose is 10-15 mL/kg which for a ~70 kg adult would be 3-4 units.
6. Prepare transfusion through blood transfusion set.
7. Transfuse as fast as possible (e.g 2-3 mL/kg/hr) in bleeding patient or ordered rate. Volume is commonly rate limiting.
8. Normal saline is used to flush the tubing before and after transfusion.

C. Platelets Pheresis:

1. Cross-matching is not performed, but ABO compatible platelets are preferred. Rh negative platelets should be given to Rh negative females.
    a. Platelet compatibility is the same as plasma above (B.1.). Incompatible platelets may be given with attending physician notification and approval.
    b. If Rh negative platelets are not available for Rh negative females, and they receive Rh positive platelets, intravenous Rh Immune Globulin is recommended to prevent sensitization.

2. VCMC maintains only platelets obtained from apheresis. 1 unit = 200 to 300 mL and would raise platelet count in adult by 30K-60K/m^3.
3. Prepare IV tubing with normal saline using attached **platelet tubing and filter** from Blood Bank.
4. Administer by gravity as fast as tolerated by the patient.
    a. Platelet tubing is not compatible with infusion pumps. Infusion pumps are avoided.
5. 0.9% sodium chloride is used to flush the tubing before and after transfusion.

D. Cryoprecipitates:

1. ABO compatible is preferred but not required and Rh need not be considered.
2. Volume is 10-15 mL.
    a. A pool of 5 units is readily available. 1-2 pools (=5 or 10 individual units) is typical dosing for adults.
3. Prepare blood transfusion set with 0.9% sodium chloride.
4. If pooled into one bag, run in as fast as possible and flush tubing with 0.9% sodium chloride. If not pooled, add saline to individual bags and flush tubing after infusion. Run in as fast as possible.

E. Whole blood:

1. Group O Rh positive available and pre-selected for low anti-A and anti-B titer. Supply is severely limited.
2. Group O whole blood has anti-A and anti-B antibodies which may cause hemolysis. Rh sensitization is a risk.
    a. Whole blood units are reserved for trauma patients anticipating Massive Transfusion Protocol. (See T.02)
    b. Patients age ≥18 years can receive.
    c. Volume approximately 450 mL.
    d. Transfuse through blood transfusion set.
    e. As is emergency, given by rapid infusion through blood warmer if available.
3. Emergency release before type and cross is complete.
    a. Back Cross matching is performed and reported.

PROCEDURE FOR OBTAINING AUTOLOGOUS OR DONOR DIRECTED UNITS

A. Vitalant can provide information and packets for Autologous and Directed Donations.

B. The patient's physician must order the autologous or directed donation unit(s) and complete the forms contained in the packet.

C. Units are drawn at Vitalant, located at 2223 Eastman Avenue, Ventura, CA. Patients may call for an appointment at (805) 654-1600.

D. Vitalant requires three (3) working days to complete the testing required. Vitalant prefers patients to schedule autologous donations 3-4 weeks prior to surgery. Directed donations require five (5) working days to complete the testing.

SPECIAL REQUIREMENTS

A. **Filtration** to leuokoreduce blood at the site of collection is standard Vitalant practice. volunteer donated blood components from any source are likely to be leukoreduced. By removing white blood cells, risk of cytomegalovirus (CMV) transmission is greatly reduced. The resultant components of volunteer, non-autologous donation, are safe for administration to all patients. Autologous units may not be leukoreduced. Liquid plasma is not leukoreduced. The use of blood components that are leukoreduced at the bedside may cause unexpected severe hypotension in some recipients, particularly those on Angiotensin Converting Enzyme (ACE) inhibitor medication.

B. **Irradiation** to inhibit donor lymphocyte proliferation is performed at Vitalant. An O positive and an O negative RBC unit is stored at VCMC blood bank. Other products (Group A RBC, pheresis platelets) will be requested from Vitalant by VCMC blood bank. Patients in the following categories should receive irradiated blood products:

   1. Patients at risk for Graft-Verses-Host-Disease (GVHD).
   2. Directed Donations from blood relatives.
   3. All neonates less than 4 months.
   4. Pediatric patients who are actively receiving chemotherapy.
   5. Pediatric patients who have active malignancy.
   6. Patients who are immunodeficient.
   7. Patients who have bone marrow failure or are status post bone marrow or solid organ transplant.
   8. At the discretion of the Attending physician.

C. Other special requirements: Physician/LP may order additional requirements for blood products. Including:

   1. CMV titer negative RBC or platelets for those at high risk. Thawed plasma, leukoreduced RBC, leukoreduced platelets, and cryoprecipitate are CMV-safe. Liquid Plasma is not CMV safe.
   2. Sickle negative RBC for patients with sickle cell anemia and those undergoing exchange transfusion.
   3. "Washed" RBC removes suspected allergens (eg immunoglobulin A) from the product.
   4. Antigen matched RBC for those with a known antibody or chronic transfusions.

DO NOT MIX THERAPEUTIC AGENTS WITH BLOOD

A. ***UNDER NO CIRCUMSTANCES ARE THERAPEUTIC AGENTS OR FLUIDS OTHER THAN 0.9% SODIUM CHLORIDE*** shall be administered through the same tubing simultaneously with blood or blood components.

B. Only 0.9% sodium chloride should be used for priming and administering blood component(s).

C. Never use Lactated Ringers Solution for blood administration.

D. Do not piggyback blood components.

E. Do not infuse blood components into lines also infusing medications or IV fluids.

F. No medications will be added to the blood component(s) or administered through the administration tubing set.

1. If medication must be administered while blood components are infusing and a separate line is not available, stop the transfusion. Flush the line, administer the medication, flush the line again and then restart the transfusion.

STORAGE OF BLOOD

A. Federal Drug Administration (FDA) regulations require that blood held in reserve is to be stored only in refrigerators specifically ordained for this purpose in the Blood Bank. Variations in the temperature range of the unmonitored ordinary refrigerator (frequently entered) is detrimental to blood, and renders it unsafe for transfusion.

   1. Unused blood must be returned to the blood bank **WITHIN ONE 30 MINUTES** from the time of being dispensed
   2. Units must meet the return temperature qualification requirements of **1-10°C.**
   3. All RBC/WB units that do not meet these requirements will be destroyed

B. When issued for transfusion, blood should stay in closed transport cooler. RBC must not be allowed to stand unnecessarily at room temperature. Red Blood Cells will exceed 10° C very quickly at room temperature and should be returned if there is a delay in administration of the unit. Platelets are kept at 20-24**°C**

C. Blood is transported with the patient only when blood is to be given in transit.

   1. The blood is signed out and transfusion tags are attached to the blood as per above.
   2. Blood is not to be transported with the patient outside the County unless used in transit. [change to Blood may be transported with the patient only if to be completed during ambulance transit]

REFERENCES:

Roback, John D. **American Association of Blood Banks**. Technical Manual, Current Edition.
Standards for Blood Banks and Transfusion Services. Current Edition.

~~**Blood Transfusions: Autologous Donations and Donor Directed Units**. Former Administrative policy 100.072.~~

~~*Blood and Blood Component Administration*, VCMC Nursing Policy MST.18.~~

All revision dates: 6/26/2024, 6/9/2020, 12/1/2016, 4/1/2012, 2/1/2012, 5/1/2010, 5/1/2006, 10/1/2004, 10/1/2003, 8/1/2001, 11/1/1998, 7/1/1995, 8/1/1993, 7/1/1992, 7/1/1991, 7/1/1990, 12/1/1989, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Blood Usage Committee	Erlinda Roxas: Director, Laboratory Services	9/17/2024
Blood Usage Committee	Francisco Bracho: MD	6/10/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/5/2024
Policy Owner	Erlinda Roxas: Director, Laboratory Services	6/5/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*9/2/2021*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/24/2024*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.256 Patient Belongings

POLICY:

Patients are advised to bring as little personal property with them as possible and are encouraged to have relatives or friends take the patient's personal property home. Patients or their relatives are also advised that the hospital is not responsible for valuables or personal items retained at the bedside. Patient Valuables Envelopes (Attachment A) are available in the ED/OR/Inpatient Units for patients to deposit their valuables as necessary. Ventura County Medical Center has a fireproof safe located in the Admitting Department to provide security, care, and storage of patient valuables. Santa Paula Hospital has a safe in the Nursing Supervisor Office

Information regarding the availability of the safe and limitations of the hospital 's liability is contained in the form VCMC-546-001, "Consent for Treatment & Conditions of Admission" (Attachment B). When consent is obtained, this provision will be brought to the attention of the signer. In addition, there is a "Patient Belongings Inventory Form," form VCMC-546-016 (Attachment C). Staff are encouraged to use the electronic version of the form, only using the paper form in downtime.

PROCEDURE:

Patient Valuables:

Complete information on the front of the Patient Valuables Envelope. Place patient valuable(s) in the envelope in front of the patient and seal the envelope in front of the patient. A receipt from the envelope is given to the patient to be used as a 'claim ticket' when he/she wishes to remove the item(s). The other copy(ies) of the list of valuables placed in the safe will be placed in the patient's paper medical record. A sticker will be placed on the outer cover of the paper medical record to indicate that there is a valuables envelope in the safe as well as a notation in the medical record.

Patient Clothing:

Any patient belongings and valuables that are not sent home are noted and itemized on the Patient Belongings Inventory Form (using the electronic form), including valuables that are sent to the safe. If the paper form is used, the completed Patient Belongings Inventory Form will be kept with the patient's paper medical record. Once inventoried, place patient belongings in a clothing bag and label the bag with a patient sticker on the outside of the bag.

Patient Medication(s):

If possible, send home with family or friends. If not, the medication must be sent to the pharmacy until patient is discharged or in some cases transferred to another facility. A Patient Valuables Envelope is used to inventory and document all medications prior to being placed in the envelope with the envelope sealed in front of the patient. The patient or responsible party and a licensed nursing staff member both sign the form on the envelope. Place completed 'white' copy in patient's paper medical record and the patient/responsible party is given the 'yellow' copy. Sealed Patient Envelopes containing medications are then taken to pharmacy. At discharge, the white copy is taken to the pharmacy when retrieving the envelope.

Emergency Department (ED):

Belongings validation will be completed when a decision to admit is received, and upon completion of the safety check for all psychiatric patients. All belongings/valuables must be documented on the Patient Belongings Inventory Form and properly labeled with a patient's identification sticker when placed in bags.

A. Inpatient processing of valuables and meds are the same for all admissions in the emergency department.

B. All "CODE" patient's belongings will be placed in a patient belongings bag and labeled with a patient's identification sticker and remain with the patient until determination of destination has occurred. (i.e. transfer) Once destination is determined, continue to follow inpatient processing of belongings.

C. Psychiatric patient's belongings will be removed from patient and stored in designated safe location in emergency department until determination of destination. Refer to policy **100.023 Care of the Suicidal Patient.**

D. **All patients entering the ED at VCMC and SPH who have undergone belongings checks will have a gray armband placed. Any bags will also have a gray band attached to illustrate that a belongings check was done.**

Pre-Operative (Pre-Op)/Operating Room (OR):

A. Admission to Pre-Op (day of surgery)

1. During pre-op phone call, staff should instruct patient not to bring valuables to the hospital on the day of surgery. During pre-op assessment on day of surgery, regular belongings such as clothing and cell phone should be placed in the belongings bag labeled with patient label and should be documented on Patient Belongings Inventory Form.

2. Dentures should be placed in a labeled container and placed in belongings bag labeled with patient label.

3. Any valuables should be given to family or friend designated by patient.

4. If the patient is unaccompanied, valuables should be placed in a completed Patient's Valuables Envelope and sealed in front of the patient. The sealed envelope is then taken to the safe in Admitting. Valuables taken to the safe should be documented on Patient Belongings Inventory Form as well.

5. If patient declines to have valuables placed in safe, document the refusal in the electronic health record (EHR).

B. Patients Coming to Pre-Op from ED

1. Patients coming to Pre-Op from ED should have completed the electronic Patients Belonging Inventory Form which is reconciled upon arrival to the Pre-Op area.

Inpatients/when admitted:

A. Any patient belongings and valuables that are not sent home are noted and itemized on the Patient Belongings Inventory Form that will be kept with the patient's medical record/EHR. Patients should be encouraged to send all valuables and belongings home with loved ones beyond basic toiletries and a change of clothes.)

B. The patient is encouraged to place valuables in a' valuables envelope' for deposit into the hospital safe. A receipt from the envelope is given to the patient to be used as a 'claim ticket' when he/she wishes to remove the item(s). The other copy(ies) of the list of valuables placed in the safe will be placed in the patient's paper medical record. A sticker will be placed on the outer cover of the paper medical record to indicate that there is a valuables envelope in the safe as well as a notation in the medical record.

C. Patient clothing and other belongings not being worn or used are placed in a belongings bag(s) with a patient identification sticker and stored in the patient's room.

D. Patient belongings kept at the bedside must have a patient sticker. Hearing aids and dentures must be kept in an appropriate container/case labeled with a patient sticker (please utilize a hospital denture cup if patient does not have a container/case and label with a patient sticker).

Customer Service Deliveries:

A. Any patient belongings/gifts delivered to the Customer Service Front Desk for distribution to a patient will be received by the screener or volunteer stationed at the lobby desk.

B. The screener/volunteer will complete the Patient Delivery sticker and affix the sticker to each item. A patient belonging bag may be used if there are multiple individual items and the screener/volunteer may affix the Patient Delivery sticker to the bag. The sticker will contain the following information: Patient name, unit and room number, Date, Time, Who delivered item, Screener/volunteer name.

C. The screener/volunteer will complete the Lobby Desk Patient Delivery Log for items delivered noting the following: Patient name, Unit and room number, date, time, name/contact number of delivery person, screener/volunteer name, and delivery item category, The name and signature of staff who picks up the item from the Front Lobby desk is noted on the Delivery Log.

Patient Requesting Valuables Stored in Safe while remaining hospitalized:

A. If the patient is requesting valuables that have been placed in the safe a staff member must go to Admitting at VCMC or the Nursing Office at SPH to retrieve valuables envelope using the 'white' copy of the Patient Belongings Inventory Form found in patient's chart .

B. The sealed envelope is opened in the presence of the patient or responsible party and the contents are verified. The 'white' copy of the Patient Belongings Inventory Form is then signed by the patient/ responsible party and the witnessing staff member.

C. A new valuable(s) envelope is initiated for the remaining valuable(s) that are being returned to the safe. (Follow 'Patient Valuables' process outlined above). Place all 'white' patient valuable(s) paperwork together in the paper Medical Record.

Discharge (Belongings/Valuables/Medication(s):

A. Upon discharge, have patient or responsible party and witnessing staff member sign the 'Patient Belongings Inventory Form' upon verification of all belongings located at the bedside and in patient's room. Form is then routed to the Health Information Management (HIM) department to scan into EHR.

B. At the time of discharge, a staff member must go to Admitting at VCMC or Nursing Office at SPH to retrieve valuable's envelope using the 'white' copy of the Patient Belongings Inventory Form found in the patient's chart. Upon retrieval of the envelope, the sealed envelope is opened in front of patient or responsible party and the contents verified. The 'white' copy of the valuable's envelope is then signed by the patient or responsible party and the witnessing staff member. The document is then routed to the Health Information Management (HIM) department to scan into EHR.

C. Medication(s) stored in the pharmacy are retrieved and the sealed envelope is opened in front of patient or responsible party and the contents verified. The 'white' copy of the medication envelope is then signed by the patient or responsible party and the witnessing staff member. The document is then routed to the Health Information Management (HIM) department to scan into the EHR.

Intra-facility Transfer/Transfer to other units:

A. When a patient is transferred to another unit, belongings will need to be inventoried and reconciled with the Patient Belongings Inventory Form. The nurse transferring and the nurse assigned to receive the transferring patient will sign the Patient Belongings Inventory Form after the reconciliation has been completed. The topic of belongings should also be addressed on the SBAR Form.

B. At the time of transfer, the patient's nurse, on the transferring out unit, is responsible for checking the room any closet(s), cabinets, etc. for any patient belongings and sending them with the patient. If the patient arrives to the new unit without belongings, the receiving nurse must call the previous unit to check into the whereabouts of the patient's belongings.

C. At the time of transfer of a patient to a Critical Care Unit and/or being placed on 'Comfort Care,' the patient's nurse, on the transferring out unit should attempt to send any patient belongings and valuables home with family. Any belongings/valuables sent home will need to be inventoried and reconciled with the Patient Belongings Inventory Form and/or the Valuables envelope form. The nurse assigned to receive the transferring patient will sign the updated Patient Belongings Inventory Form after the reconciliation has been completed.

Inter-facility Transfers:

A. When a patient is transferred to another facility, belongings will need to be inventoried and reconciled with the Patient Belongings Inventory Form to ensure all belongings accompany patient. At the time of transfer, the patient's nurse, is responsible for checking the room any closet(s), cabinets, etc. for any patient belongings and sending them with the patient.

B. At the time of transfer of a patient to a Critical Care Unit at another facility, and/or being placed on ' Comfort Care,' the patient's nurse, on the transferring out unit should attempt to send any patient belongings home with family other than a change of clothes, necessary toiletries and slippers/robe, etc. Any belongings/ valuables sent home will need to be inventoried and reconciled with the Patient Belongings Inventory Form and/or the Patient Valuables Envelope form.

C. Patients should strongly be encouraged to send Valuables (both those at the bedside and those in the hospital safe) home with family/significant others. Any valuables (cell phone, jewelry, laptop, etc.) for unconscious/compromised patients found at the bedside need to be placed in the hospital safe per policy (if a patient has a valuables envelope already in the safe, all previous and new valuables must be inventoried and placed in a new envelope utilizing a new triplicate form).

D. Patients being transferred to another facility for the purposes of a procedure with a plan for the patient to return upon completion of such should not have belongings and/or valuables transported with them. If the

patient is unexpectedly kept at the facility of transfer, the nursing supervisor should collect the patient belongings and have them transported via courier to the accepting facility and hand delivered to the nursing supervisor at the accepting facility. Valuables in the safe should not be transported. The patient and /or family should be contacted to arrange pick up of valuables in the safe.

Transferring of body to Morgue/Mortuary:

A. Personal hygiene and clothing articles may be placed in belongings bag(s) with a patient identification sticker and sent to the Morgue/Mortuary with the body. {Determination still needs to be made whether the belongings bag(s) may be placed in the body bag with the deceased patient.)

B. Valuables (both those at the bedside and those in the hospital safe) should not be sent with the body to the Morgue/Mortuary. Any valuables (cell phone, jewelry, laptop, etc.) found at the bedside need to be placed in the hospital safe per policy (if a patient has a valuables envelope already in the safe, all previous and new valuables must be inventoried and placed in a new envelope utilizing a new triplicate form.)

C. If any jewelry (rings, etc.) is not easily removed, family/significant other should be contacted to inquire if the jewelry should be left in place or attempt made to remove the jewelry via 'ring-cutter,' etc.

D.The Patient Advocate is notified by Nursing Supervisor and/or Admitting of the need to contact family/ significant other(s) of need to arrange to pick up valuables.

Medical Examiner Office (MEO) Cases:

If the death is determined to be a MEO case, the MEO staff will sign for and take possession of the patient valuables/belongings/medications and return such to the family/significant other(s).

Unclaimed Patient Valuables:

The Admitting Department (VCMC)/Nursing Supervisor (SPH) will be responsible for review of the contents of the safe every 30 days to determine if patients remain hospitalized. If a patient has been discharged, the Admitting Manager (VCMC)/Nursing Supervisor (SPH) will attempt to contact the patient or family to ask them to claim the belongings. If this attempt fails, a written notice will be sent to the patient or family and a copy of such retained. If belongings remain unclaimed following this notice, the belongings will be forwarded to Administration for disposal. A copy of the letter will be placed in the patient's EHR.

Attachments:

- Attachment A: Sample of Patient Valuables Envelope
- Attachment B: VCMC-546-001 "Consent for Treatment and the Conditions of Admission" Form
- Attachment C: Patient Belongings Inventory Form (To be used ONLY during downtime).

All revision dates: 9/24/2024, 9/2/2021

Attachments

Attachment A - Sample of Patient Valuables Envelope
Attachment B - VCMC-546-001 "Consent for Treatment and the Conditions of Admission" Form
Attachment C - Patient Belongings Inventory Form (To be used ONLY during downtime).

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	9/24/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/24/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/24/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

100.277 Comfort Care Medication Management

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) appropriately prescribes and administers medications for symptom management at the end-of-life.

BACKGROUND & RATIONALE

Standard practice guidelines for end-of-life serve as a foundation for patient and family-centered care for the seriously ill and dying. Development of a uniform practice aims to reduce unnecessary variations in care, improve family satisfaction with care, provide best care possible, and educate providers. The MED Adult Comfort Measures order set is intended to explain practice and set standards for end-of-life care using evidenced based rationale.

PURPOSE:

- To establish a comprehensive, evidence-based, patient centered approach to symptom assessment and medication management of the patient at the end of life.
- To reduce variability in the provision of end-of-life medication management.
- To provide timely and effective symptom-based care.
- To eliminate errors and adverse effects in dosing, ordering, and administration of medications, including opioid infusions.
- To define monitoring parameters and documentation standards for medications.

DEFINITION(S):

Palliative Care: Specialized medical care for patients living with a serious illness. Palliative care is focused on providing relief from the symptoms and stress of illness. It is appropriate at any stage in a serious illness and can be provided along with curative treatments. It includes physical, emotional, social, and spiritual support for patients and their families.

End of Life: Care given to people who are near the end of life and have stopped treatment to cure or control their disease. End-of-life care includes physical, emotional, social, and spiritual support for patients and their families. The goal of end-of-life care is to control pain and other symptoms so the patient can be as comfortable as possible. Also called comfort care.

Comfort Care: End-of life care that is initiated in the hospital setting (see above).

Hospice: A service that takes place outside the hospital setting. It is for individuals who are facing life-limiting illness and have a life expectancy of six months or less. Hospice provides symptom control and compassionate care for individuals and their families.

PROCEDURES:

A. **Symptom Assessment and Management**

1. Assessment
    a. Universal Pain Assessment Tool (Numeric Pain scale with intensity)
    b. Non-verbal signs of pain (e.g., grimacing, furrowed brow, guarding, nasal flaring, and use of accessory muscles)
2. Treating pain
    a. Route of administration
        i. Consider oral/sublingual (PO/SL) as first choice as these routes enable transition out of the hospital setting.
        ii. Enteral tube access: consider liquid formulations per feeding tube
        iii. Difficulty swallowing: consider SL or intravenous (IV) administration
        iv. No IV access: consider SL or subcutaneous (SUBCUT) administration
    b. Medications
        i. Non-opioids
            a. Acetaminophen PO or rectal (PR)
            b. Lidocaine 5% patch transdermal (TD)
        ii. Opioids
            a. Morphine
                i. 20 mg/mL oral liquid
                ii. 10 mg/5 mL oral solution
                iii. IV
            b. Oxycodone
                i. 20 mg/mL oral liquid
                ii. 5 mg/5 mL oral solution
            c. Hydromorphone
                i. oral tablet
                ii. IV
        iii. Patient's previous opioid requirements should be considered.
        iv. Avoid morphine in patients with kidney injury or end-stage-kidney disease.
3. Dyspnea
    a. Assessment:

i. Patient/clinician reported anxiety ~~using 0-10 scale~~

ii. Use of accessory muscles

iii. Respiratory rate (RR) > 20 breaths/min

b. Treating dyspnea

i. Opioids can be used to relieve dyspnea.

ii. Lorazepam (liquid SL or IV) can be used as a second line agent as anxiety often accompanies respiratory issues.

4. Anxiety

a. Assessment: Patient/clinician reported anxiety ~~using 0-10 scale~~

b. Treating anxiety

i. Order only one medication for anxiety.

ii. Medications

a. Lorazepam (oral, SL, IV)

b. Olanzapine oral (max 10 mg/day)

c. Haloperidol (SL, SUBCUT, IV)

~~Anxiety~~

~~a. Order only one medication for anxiety~~

~~b. Lorazepam~~

~~c. Olanzapine~~

~~d. Haloperidol~~

5. Delireium/Agitation/Restlessness

a. Medications

i. Olanzapine oral (maximum 10 mg/day)

ii. Haloperidol (SL, SUBCUT, IV)

6. Nausea/Vomiting

a. Choose medication based on cause of nausea/vomiting

b.

Cause	Medication Option
Medications, uremia, toxins, or other factors	▪ Ondansetron (SL, IV) ▪ Metoclopramide (PO, IV)
Bowel obstruction, increased intracranial pressure (ICP), medications, uremia, or toxins	▪ Dexamethasone (PO, IV)
Anticipatory nausea, medications, uremia, or toxins	▪ Lorazepam (SL, IV)

Cause	Medication Option
Gastroparesis, medications, uremia, or toxins	▪ Metoclopramide (PO, IV)

7. Secretions
    a. Discontinue IV fluids.
    b. Treating secretions
        i. Glycopyrolate (SL, PO, IV, SUBCUT)
        ii. Hyoscyamine (SL)
        iii. Scopolamine transdermal patch
8. Fever
    a. Treatment
        i. Cooling measures if desired by patient/family
        ii. Medications
            a. Acetaminophen (PO, PR)
            b. Ketorolac (IV, IM)
9. Anti-diarrheal and Bowel Regimen
    a. Medication: Loperamide (PO)
    b. NOTE: A common side effect of opioids is constipation due to delayed gastric motility.
10. Bowel Regimen Protocol
11. Dry eyes: ~~Ocular~~Ocular lubricant
12. Insomnia
    a. Melatonin (scheduled)
    b. As needed (PRN)
        i. Lorazepam (first line)
        ii. Zolpidem (first line)
        iii. Trazodone (2nd line)
13. Anergia/terminal fatigue: methylphenidate
14. Antiepileptic: lorazepam

B. **Opioid IV Infusions**

1. Indication
    a. Opioid Infusions are only necessary for uncontrolled symptoms where intermittent as-needed administration is insufficient.
    b. Patients who are already comfortable or requiring minimal breakthrough doses of opioids may not need opioid IV infusions.
    c. Some patients who are intubated with planned compassionate extubation may not need opioid infusions if they do not have respiratory failure from primary cardio-pulmonary processes or

severe neurologic injury.

2. Equipment
    a. Dedicated BD Alaris infusion pump
    b. Tubing
    c. Opioid infusion in standardized concentrations
        i. Hydromorphone 1 mg/mL in NS 50 mL OR
        ii. Morphine (Premix) 1 mg/mL 100 mL
3. Roles and Responsibilities for opioid infusions are noted below.

ROLES AND RESPONSIBILITIES

Licensed Practitioner (LP)

A. All comfort care orders must be initiated and entered by a licensed practitioner into the electronic health record.
    1. Verbal or Telephone orders are unacceptable for initiating comfort care orders.
    2. The comfort care order set is called MED Adult Comfort Measures Admit
    3. The LP must only order or discontinue what is appropriate for patients' comfort.
B. The LP is responsible for completing a transfer reconciliation addressing previous medications, labs, imaging, monitoring, artificial nutrition, and nursing orders.
    1. It is recommended that the transfer reconciliation be completed prior to placing the comfort care orders.
C. Patient's nurse should be notified of comfort care initiation, request for changes, or therapy cessation.
D. Opioid Infusion
    1. The decision to start an opioid infusion for comfort care should be discussed with ~~an ICU~~covering attending and/or palliative care physician.
    2. The LP is responsible for determining the initial basal rate.
    3. For opioid naive patients, the initial basal rate should be discussed with the covering attending and/or palliative care physician.
    4. How to calculate initial basal rate:
        a. Determine total opioid usage in MME (morphine mg equivalent) in 24 hours.
        b. Get hourly total by ÷ 24 hours.
        c. Dose the continuous infusion at 50%of the calculated hourly dose
    5. Allow 10-20% of the 24 hour dose to be used for breakthrough pain.

Pharmacy

Pharmacy staff shall follow related policies on pharmacy roles and responsibilities at order verification and medication dispensing.

A. PH.55 Medicatioon Order Management

B. PH.88 Controlled Substances

Nursing

A. The nurse shall call the charge nurse or manager to inform them before starting comfort care.

B. The nurse shall review the orders prior to initiation as per policy 100.025 Medications: Ordering, Administration, and Documentation)

C. Comfort Care Opioid Intravenous Infusion Protocol (Nursing driven)

1. Set up
    a. The nurse (RN) will call the charge nurse/nursing supervisor to inform them before starting a comfort care opioid infusion.
    b. The RN will obtain the necessary equipment.
    c. The RN will retrieve the opioid infusion from the automated dispensing cabinet (ADC).
2. Administration and Monitoring (See Attachment A)
    a. The RN shall initiate the comfort care opioid intravenous infusion at the ordered basal rate.
    b. The RN shall re-assess every 15 minutes until signs of discomfort are relieved.
    c. The RN shall administer ordered as needed (PRN) breakthrough IV pain medications if indicated.
    d. If discomfort (e.g., pain or dyspnea) is not relieved after 3 dose of PRN breakthrough IV pain medications in a 2 hour period, Nursing may increase the basal rate by 50% (multiple by 1.5).
        i. Independent double check required.
    e. Continue to monitor for signs and symptoms of discomfort.
    f. Nursing to contact provider for unrelieved pain at maximum rate.

All revision dates:

Attachments

Comfort Care NURSING DRIVEN Opioid Infusion 7 26 2024.pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED, Family Medicine, Medicine & Surgery	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	8/15/2024
Policy Owner	Sara Pendleton: Medication Safety Officer	8/15/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.023 Infection Control Plan

Purpose:

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

Goals:

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

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

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

2. Establishing a reliable surveillance program by:

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

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

4. Training and educating healthcare workers through:

- General new hire orientation program

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

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

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

Objectives:

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

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

Infection Control Program (ICP)

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

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

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

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

Reporting Structure:

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

at the Medical Executive Committee and the Oversight Committee meetings.

Infection Prevention and Control ~~Practitioner~~ (~~ICP~~IPC) Responsibilities:

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

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

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

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

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

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

Infection Control Committee

Responsibility:

The Infection Control Committee (ICC) shall be responsible for:
A. Directing the hospital-wide infection control program.
B. Recommending policies and providing direction to prevent, identify, and control infections within the hospital.
C. Defining the role and scope of Employee Health Services in the Infection Control Program.

Authority

The ICC is a medical staff committee and is responsible to the Medical Executive Committee (MEC).
A. The ICC makes recommendations and reports to the MEC.
B. The ICC makes reports, recommendations, and referrals to other medical staff committees and Hospital Administration.
C. The ICC shall make policies and clinical decisions only when a quorum, one third of the physician members, is present.

Membership

The Infection Control Committee shall be a multi-disciplinary Committee.
The committee membership shall be:
A. The Committee Chairman: An active Physician with special interest in infectious diseases and infection control.
B. Hospital Epidemiologist and / or Infectious Disease
C. Medical staff representatives
D. Representative from Hospital Administration.

E. The Chief Nursing Officer or representative
F. The Infection Prevention and Control team
G. Employee Health
H. Pharmacy department representative
I. Dietary Service
J. Facilities/Engineering/Maintenance representative
K. Surgery department/Central service representative
M. Environmental Services, Central Service/Linen
The Following representation are available to the Infection Control Committee on a consultative and as needed basis:
a. Surgery Department
b. Central Service
c. Laboratory/Pathologist.
d. Human Resources.
e. Obstetric, Pediatric unit.

Meetings

The ICC shall meet monthly but not less than bimonthly. Minutes of the meeting proceedings shall be forwarded to the Medical Executive Committee for approval. Minutes shall be maintained in the Infection Control Office and shall be available to Administration and Department directors.
B. The committee shall meet more often if needed.

Functions

The functions of the infection control committee will be as follows:
A. The committee is responsible for monitoring the infection control program. The committee recommends corrective action based on records and reports of infection and infection potentials among patients and hospital personnel.
B. The infection control committee is directly responsible to the Medical Staff through its Executive Committee.
C. The committee reviews, revises and approves all infection control policies and procedures for all departments at least biannually.
D. The Committee reviews the findings of the infection control coordinator regarding Healthcare-Associated infections and other types of monitoring.
E. Policies and clinical decisions shall be made by the committee only when a physician member is present.
F. The infection control committee shall determine the type of surveillance and reporting programs to be used and approve the amount of time needed to carry out the program.
G. The committee shall approve criteria for reporting all types of infections, including respiratory, gastrointestinal, surgical wound, skin, urinary tract, septicemia and those related to the use of intravascular catheters.
H. The committee reviews infections within the hospital, particularly with regard to their proper management and epidemic potential. A determination is made as to whether an infection is Healthcare- Associated, and if so, what action the committee recommends be taken to minimize such occurrences. Review may be directed to surveillance data and when available, looking particularly for clusters of infections, infections due to unusual pathogens, or any occurrence of Healthcare-Associated infections that exceeds the usual baseline levels.
I. The committee will review results of antimicrobial susceptibility/ resistance trend studies.
J. The committee will review any pertinent findings from other hospital committees or departments.

K. The committee will review and approve all Germicidal products in use throughout the hospital and will review and approve the use of any new germicidal and other infection control related products prior to use of such products in the hospital.
L. In the event of an outbreak of infection, which is felt to be a danger to any patient or personnel, the infection control committee has the authority to institute appropriate control measures or studies.
M. The infection control committee shall report its findings and recommendations to the medical staff through the executive committee, to the chief executive officer, the chief nursing officer and any other concerned department.
N. Written minutes of the all committee meetings are maintained and are available for review by administration, medical staff and concerned department managers.
O. Pertinent findings of the infection control committee are made a part of the continuing education program and the orientation for new employees, in-service for continuing employees and continuing medical education for physicians.
P. Reviewing all dialysis related cultures and endotoxins reports that have to done on monthly basis.

Infection Control Reporting:

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

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

Weekly

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

Monthly data reporting elements may include:

- Device-Associated Reporting:
  - Central Line Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infections (CAUTI)
  - Ventilator-Associated Events (optional)
- Surgical Site Infections reporting within 30 Days of inpatient procedure:
  - Abdominal aortic aneurysm repair
  - Limb amputation
  - Appendix surgery

    - Shunt for dialysis
    - Bile duct, liver or pancreatic surgery
    - Carotid endarterectomy
    - Gallbladder surgery
    - Colon surgery
    - Cesarean section
    - Gastric surgery
    - Abdominal hysterectomy
    - Kidney transplant
    - Laminectomy
    - Neck surgery
    - Kidney surgery
    - Ovarian surgery
    - Prostate surgery
    - Rectal surgery
    - Small bowel surgery
    - Spleen surgery
    - Thoracic surgery
    - Thyroid and/or parathyroid surgery
    - Vaginal hysterectomy
    - Exploratory Laparotomy
- Surgical Site Infections reporting within 90 Days of inpatient procedure
    - Cardiac surgery
    - Coronary artery bypass graft with both chest and donor site incisions
    - Coronary artery bypass graft with chest incision only
    - Craniotomy
    - Spinal fusion
    - Open reduction of fracture
    - Herniorrhaphy
    - Hip prosthesis
    - Knee prosthesis
    - Pacemaker surgery
    - Peripheral vascular bypass surgery
    - Ventricular shunt
- Multi-Drug Resistant Organisms (LabID-based):
    - Methicillin/Oxacillin- Resistant Staphylococcus Aureus (MRSA) bloodstream infections
    - Vancomycin-Resistant Enterococcus (VRE) Bloodstream infections
    - Carbapenem-resistant Enterobacteriaceae (CRE)
    - Clostridium Difficile Infections.
- Influenza Vaccination Summary
    - Influenza Vaccination Survey
- Monthly Summary Data

Annual NHSN survey

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

COVID-19 Related reporting

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

Infection Control Surveillance:

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

A. Total House Surveillance:
All HAIs are monitored in the entire population of the facility. The main benefit of total (or whole) house surveillance is to assist in the comprehensive risk-assessment to identify real and potential infection risks that would guide the targeted surveillance.
While using total house surveillance, infection rates are calculated for specific HAIs in defined populations in the facility, such as CLABSIs per department or surgical site infections (SSIs) related to a specific operative procedure. An overall facility infection rate is not preferred and may only be calculated for self-comparison over time, it is not to be used for target performance improvement activities as crude overall rates are not sensitive enough to identify potential problems.

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

C. Surveillance Timing:

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

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

~~Patient surveys by mail or telephone.~~
~~Surgeon survey by mail.~~

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

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

Data Collection:

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

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

- Host-specific risk elements: age, diabetes, obesity, underlying disease, and other intrinsic risk factors.
- Risk related to therapy and procedures: surgical procedures, IV lines, indwelling catheters, and ventilator use. This factor might include some accounting of days of device use.
- Interventions: antibiotics, other treatment started, corrective procedures and devices removed.
- Additional data: response to treatment, length of stay, other statistical date, and costs of care.

Case Definition:

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

Benchmarking:

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

Infection Control Risk-Assessment:

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

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

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

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

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

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

- Monitoring of negative airflow in airborne infection isolation rooms
- Biological monitoring of sterilizers
- Testing of high-level disinfectants.
  3. Admission of a patient or resident known to be infected or colonized with a multidrug resistant organisms (MDRO).

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

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

Risk Mitigation:

Practices to Decrease the Risk of Transmission.

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

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

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

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

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

E. Adherence to Institute for Healthcare Improvement (IHI) device-specific bundles including:

- Prevent Central Line-Associated Bloodstream Infection Bundle
- Prevent Obstetrical Adverse Events Bundle
- Prevent Ventilator-Associated Pneumonia Bundle

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

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

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

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

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

Program Evaluation:

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

1. The organization formally evaluates and revises the Infection Control Risk-Assessment at least annually or more frequently based upon goals and program (or portions of the program) on ongoing basis and/or whenever risks significantly change.
2. The evaluation addresses emerging and re-emerging problems in the health care community that potentially affect the hospital.
3. The evaluation addresses changes in the scope and the results of the program.
4. The evaluation addresses the assessment of the success or failure of interventions for preventing and controlling infection.
5. The evaluation addresses responses to concerns raised by leadership and others within the organization.
6. The evaluation addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus
7. The Infection Control Manager facilitates the program evaluation and submits the evaluation to the Infection Control Committee for review and approval.
8. When aggregate data for any indicator is different from the expected benchmark, analysis of patterns, trends, or problems will be done to determine whether an opportunity to improve the quality of patient care or provide safer work environment for employees exists. This analysis will include, as applicable, review of the total process involving all departments and or services which has an input into the aspect of care being evaluated. Lines of communication are maintained with all services and departments involved. Information is also presented to the Infection Control Committee and the Performance Improvement Coordinating Council.
9. If an opportunity for improvement of the quality of patient care is determined, or a problem area is identified, a plan of corrective action will be initiated. This corrective action will identify the person, condition or activity that is expected to change, the person responsible for implementing action, the appropriate action in view of the effect on patient care, cause, scope, and severity and when change is expected to occur. Action is implemented through existing channels of the department, administration, or medical staff organization. Every activity will be documented, and conclusions, changes, and reevaluation will be reported.
10. Monitoring and evaluation does not end when actions are taken. Further evaluation of the important aspects of care or service should continue to evaluate the effectiveness of the actions taken, to assure that performance improvements are maintained and to further improve the quality of care and service given. If ongoing monitoring indicates that actions did not result in improving care, further evaluations and further actions should be taken. Ongoing and follow-up monitoring should ultimately show that meaningful improvement has taken place and is maintained.
11. Monitoring and evaluation data, conclusions, recommendations actions and follow-up will be communicated and disseminated through established channels to individuals and groups who are involved and affected by the information including:

    - The department(s) concerned.
    - The Infection Control Committee
    - The Performance Improvement Coordinating Council

- The Medical Executive Committee
- The Oversight Committee (Board)

List of Attached Addendum:

1. Previous year annual report

COVID-19 Surveillance and Protocol:

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

References:

Joint Commission Hospital Accreditation Standards

CMS Conditions of Participation for Acute Care Hospitals, §482.42

APIC Text, 2021

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

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

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

All revision dates: 6/26/2024, 11/17/2022, 6/9/2020, 3/21/2019, 5/1/2016, 5/1/2015, 5/1/2014, 10/1/2012, 10/1/2010, 4/1/2009, 5/1/2008, 6/1/2006, 3/1/2006, 8/1/2004, 6/1/

2004, 1/1/2003, 1/1/1999, 1/1/1995

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	9/12/2024
Policy Owner	Magdy Asaad: Infection Prevention Manager	6/5/2024

Current Status: *Pending* **PolicyStat ID:** *15037308*

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/27/2024*
Next Review:	*3 years after approval*
Owner:	*Laura Zarate: Clinical Nurse Manager, Case Management*
Policy Area:	*Administrative - Operating Policies*
References:	

107.063 Utilization Management Plan

~~POLICY:~~POLICY:

~~The Utilization Management Plan for~~ Ventura County Medical Center (VCMC)~~,~~ and Santa Paula Hospital (SPH) ~~and the affiliated Ambulatory Care~~have a Utilization Review (~~AC~~UR) ~~clinics~~plan that evaluates the appropriateness of admissions, ~~is to provide~~duration of stays and the use of services furnished by both hospitals and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs as well as other payers. The UR plan provides a uniform structure and approach~~,~~ to promote an effective and efficient use of ~~the Hospitals' resources, in striving to provide~~hospital based services in order to ensure the delivery of high quality medically necessary care to each patient ~~within~~in a timely manner.

~~PROCEDURE:~~

~~Utilization will be assessed and managed on an ongoing basis to achieve the following:~~

Utilization Review Objectives

1. ~~To ensure~~Ensure development, maintenance and execution of an effective individualized patient care and management plan.
2. ~~To promote~~Promote the efficient utilization of beds and services through ~~concurrent~~ reviews of the medical necessity for observation ~~or~~and inpatient admission, appropriate length of stay and timely and appropriate use of diagnostic and therapeutic services.
3. ~~To ensure~~Ensure cooperation and support from all external review organizations~~, in measuring~~ in evaluating the utilization and quality of services ~~established by the medical staff standards~~.
4. ~~To ensure~~Ensure that the medical record substantiates~~, through clear documentation, the quality and utilization of~~ the need for services ~~needed~~utilized for the management, progress and appropriate discharge of each patient.
5. ~~To provide~~Provide a process for responding to questions ~~or~~, appeals, denials and authorizations ~~in the~~for hospital ~~or clinics~~based services.
6. ~~To provide~~Provide education to physicians and hospital staff regarding utilization findings, performance and regulations.
7. ~~To fulfill the~~Fulfill regulatory requirements related to ~~Utilization Review (~~UR~~)~~ for Centers for Medicare & Medicaid Services (CMS), The Joint Commission ~~(TJC)~~, California Department of Health Care Services

(DHCS), and all other applicable federal and state laws and regulations.

8. ~~To analyze~~Analyze patient care data for medical necessity, quality of care~~,~~ and appropriateness of setting after the care has been delivered ~~and patterns of health care services of institutions, physicians and members~~.

~~DEFINITIONS:~~

The Utilization Review Committee (known as the Utilization Management [UM] Committee)

1. The UM Committee is a standing committee of the Medical Staff of Ventura County Health Care Agency, in accordance with the bylaws, rules and regulations of the Medical Staff and Oversight Committee, Board of Supervisors.
2. The UM Committee shall consist of at least two members of active Medical Staff, Nursing, Health Information Management and a Resident. Additional participants may include, but are not limited to representatives from executive leadership, the Chief Medical Officer, Patient Access, Finance, Compliance, Quality and Risk Management.
3. At least two of the members of the UM Committee must be physicians of medicine or osteopathy and all physician members of the Committee must be active members of the medical staff in good standing with current privileges to practice at VCMC/SPH.
4. The UM Committee is to promote cost-effective care, through proper utilization of hospital based services.
5. The UM Committee shall submit a written report to the Medical Executive Committee regarding UM Committee activities.
6. The UM Committee will meet at least four times per year. The Chairperson will call special meetings as needed. Other members of the hospital staff will attend the UM Committee meetings at the invitation of the Committee Chairperson to review findings and discuss opportunities for improvement and assist in resolving issues.
7. The UM Committee's reviews may not be conducted by anyone who has a direct financial interest in the hospital or was professionally involved in the care of the patient whose case is being reviewed.
8. The governing body delegates to the UM Committee the authority and responsibility to carry out the UR functions.
9. The UR plan is reviewed and revised based on regulatory and Medical Staff requirements and is updated as necessary after approval by the UM Committee.
10. All patient information related to UR activities is considered confidential. (refer to policy 109.011 Confidentiality of Protected Health Information)

Scope and Frequency of Utilization Review

1. Encounters for patients entitled to benefits under the Medicare and Medicaid programs will be reviewed for medical necessity of hospital admission, duration of stay, and use of professional services furnished including drugs and biologicals.
2. Review of admissions may be performed before, at, or after hospital admission.

3. Encounters reasonably assumed to be outlier cases based on extended length of stay will be reviewed.
4. Encounters for professional services reasonably assumed to be outlier cases based on extraordinarily high cost will be reviewed.

Determinations Regarding Admissions or Continued Stays

1. In the event a determination is made that an admission or continued stay is not medically necessary, the following shall occur:
    i. Before making a determination that an admission or continued stay is not medically necessary, the UR Committee must consult the practitioner(s) responsible for the care of the patient and afford them an opportunity to present their views.
    ii. The determination may be made by one member of the UR Committee if the practitioner(s) responsible for the care of the patient concur with the determination or fail to present their views when afforded an opportunity to do so.
    iii. In the event the practitioner(s) responsible for the care of the patient disagree with the determination and in all other cases, two members of the UR Committee must agree that the admission or continued stay is not medically necessary.
2. If the UR Committee decides that admission or continued stay is not medically necessary, written notification must be given no later than two days after the determination, to the hospital, the patient, and the practitioner(s) responsible for the care of the patient.

Extended Stay Reviews

1. The UR Committee will review all encounters reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis as described in 42 C.F.R. § 412.80(a)(1)(i).
2. Neither the hospital or UR Committee is required to review extended stays that do not exceed the outlier threshold for the diagnosis.

Review of Professional Services

A. The UR Committee will review professional services provided to determinine medical necessity and efficient use of available hospital based services.

DEFINITIONS:

A Physician Advisor (~~s~~PA) is a ~~physician~~ member of the Medical Staff and ~~Utilization Review~~UM Management Committee. ~~He or she~~A PA is responsible ~~for performing certain review functions under the Utilization Management Plan. A physician advisor is responsible for the following functions~~to:

1. ~~Reviews cases referred by the UR nurses, medical staff and hospital leadership.~~
2. ~~Determines the medical necessity of the admission, continued inpatient stay or level of care as needed or requested.~~
3. ~~Contacts the attending physician and discusses the admission rationale and/or treatment approach if a medical necessity is not apparent. The Physician Advisor or the second Physician Advisor may be~~

~~contacted if the attending physician does not concur with the Physician Advisor's determination.~~

4. ~~Submits information regarding physician utilization, to the Quality Assessment and Performance Improvement (QAPI) department.~~
5. ~~Follows-up with the appropriate medical staff committee, department or division, depending on the findings.~~

1. Review cases referred by the UR nurses, medical staff and hospital leadership.
2. Determine the medical necessity of admissions, continued inpatient stays or appropriate level of care as needed or requested including Medicare certifications and re-certifications.
3. Respond to payer denials by performing Peer-to-Peer discussions and preparing written appeals.
4. Contact the physician responsible for the care of the patient and discuss the admission rationale and/or treatment approach if medical necessity is not apparent.
5. Act as a liaison with physicians, Patient Financial Services to provide oversight and education to meet regulatory standards and guidelines.

The ~~Manager~~Director of Case Management oversees the implementation of the ~~hospital~~ UR program and collaborates with the UR nurses ~~or Case Managers~~, case managers and other healthcare team members to plan, organize, lead and evaluate ~~the~~ UR and ~~Utilization Management~~UM programs and services. ~~Evaluates~~The Director evaluates competency and productivity of UR staff on a regular basis.

~~**Utilization Review Nurses** or **Case Managers** are registered nurses (RN) who review the medical necessity for admission, observation and continued acute or outpatient level care, using the approved Milliman Care Guidelines (MCG) evidence-based care guidelines criteria.~~

~~They ensure the provision of clinical review information for payer approval of admission and continued care services, as well as follow-up denials of approval by outside funding sources and assist in preparation of appeals. They coordinate a team approach to UR, which includes all aspects of the utilization program, such as discharge planners, social workers and other hospital staff involved in discharge planning.~~

Utilization Review Nurses or **Case Managers** are registered nurses (RN) who are trained in the use of Milliman Care Guidelines (MCG). A UR RN or Case Manager is responsible to:

1. Review medical necessity of admissions, continued inpatient stays, appropriate level of care, and timely discharges.
2. Provide oversight for payer approval of admission and continued hospital based services, as well as follow-up on payer denials and assist in the preparation of Peer-to-Peer discussions and appeals.
3. Collaborate with the patient and family, caregiver, physician and interdisciplinary health care team to ensure that medically necessary care is provided in the appropriate setting from admission through discharge.

~~**Criteria** are reference documents~~**MCG** refers to evidence-based care guidelines used by a UR nurse ~~or a~~, Case Manager ~~to assess~~, and PA to evaluate the medical necessity of an admission and continued stay of each case. All patients, regardless of payer source or level of care, are subject to review. The UM Medical Director certifies to DHCS by May 31st annually that UM staff are using the most recent edition of MCG ~~is the criteria set chosen and implemented at VCMC/SPH to meet the CMS Conditions of Participation (CoP) requirement pertaining to the use of standard criteria. The UR Committee annually reviews and approves the criteria set chosen by the Hospital or Executive~~and reports this certification to the UM Committee.

~~**Avoidable Day** is the determination by the Physician Advisor(s) or utilization reviewer that the admission and/or days of the continued stay are not medically necessary. The payer and/or government agency with denial authority recommend contents and format of patient notifications. It is the responsibility of the UR Nurse or Case Management staff to oversee the issuance of patient notifications.~~

~~**Medical Necessity** is care required to preserve the life or health of a patient, with the expectation that the benefits of such care outweigh the risks to the patient. Medically necessary services or items are in accordance with current standards of good medical practice and are not for the convenience of the patient or provider.~~

Medical Necessity - Medically necessary services are those that are reasonable and necessary to diagnose or treat a medical condition, injury, illness, disease or its symptoms. Medical necessity requires that treatment be safe and effective and meets, but does not exceed, the patient's medical need. Medically necessary care is furnished in a setting that is appropriate to the patient's medical needs and condition. Medically necessary services or supplies are in accordance with current accepted standards of medical practice in the community and are not for the convenience of the patient or provider.

Utilization Review is the process of reviewing medical necessity based upon criteria. Medical necessity for hospitalization will be ~~addressed on a case-by-case basis,~~assessed according to evidence-based care guidelines. ~~Cases are prioritized for review as follow:~~

1. ~~Observation admissions;~~
2. ~~New admissions;~~
3. ~~Changes in level of care; and~~
4. ~~Continued stay reviews.~~

~~GUIDELINES:~~

A. ~~**Utilization Review**~~

1. ~~The UR process includes review for the medical necessity of admission, appropriate level of care, continued stay and timely discharge.~~
2. ~~The UR Nurse must determine that the services are medically required by the patient's diagnosis and condition and are of a type that can be provided safely and effectively, only in an acute inpatient hospital setting.~~
3. ~~The UR process analyzes patient care data for medical necessity, quality of care, appropriateness of setting after the care has been delivered and patterns of health care services of institutions, physicians and members.~~
4. ~~The Physician Advisor(s) provides the clinical support to the UR Department and supports the goal of promoting appropriate allocation of the hospital's resources in striving to provide high quality care to each patient in a cost-effective and timely manner. The Physician Advisor(s) acts as a liaison with staff physicians and provides oversight and education to meet regulatory standards and guidelines.~~
5. ~~The Physician Advisor(s) is a physician member of the Medical Staff and UR Committee. He or she is responsible for performing certain review functions under the Utilization Management Plan. The Physician Advisor is responsible for the following functions:~~
    a. ~~Reviews cases referred by the UR Nurses, medical staff, and hospital leadership.~~
    b. ~~Determines the medical necessity of the admission, continued inpatient stay or level of care.~~

c. Submits information regarding physician utilization to QAPI.

d. Works with denials from external payers or insurances, for appeal.

e. Acts as a physician reviewer to assist the UR Nurse. Contacts the attending physician and discusses the admission rationale and/or treatment approach if medical necessity is not apparent. S/he may contact the Physician Consultant or the second Physician Advisor if the attending physician does not concur with the physician.

B. **Utilization Review Process**

1. The UR process consists of the use of evidence based criteria for medical necessity of admission and continued stay, verification of the physician admit order, review of the physician's certification or progress notes. The UR process ensures effective and efficient utilization of facilities and services through an ongoing review or monitoring of patient care. This includes method of review, review guidelines utilized and the types of reviews performed.

2. **Admission reviews** are completed by the UR Nurse, utilizing the appropriate admission criteria in determining the appropriate status, when the patient is in observation or inpatient status. The admission review is completed upon admission or UR review within 24 hours. The UR Nurse will immediately contact the attending physician for clarification and/or additional documentation of medical necessity, if the admission does not meet criteria for an inpatient admission. The UR Nurse will contact a Physician Advisor or designee for review and action if there continues to be insufficient evidence of medical necessity for an acute level of care. The Physician Advisor or designee will review the available clinical information and discusses the case with the attending physician. If there is not sufficient evidence of medical necessity for the patient to remain at an acute level, the patient and attending physician are notified and options discussed. Medicare beneficiaries will receive appropriate notification as designated by CMS guidelines.

3. **Continued stay reviews** are done for all patients admitted to the hospital as needed, to determine from medical documentation that the continued inpatient stay meets established criteria for medical necessity. The attending physician is contacted for additional information if the continued stay does not meet criteria for appropriateness or medical necessity. If there continues to be insufficient evidence to justify continued stay, the UR Nurse presents the case to the Physician Advisor or designee. The Physician Advisor or designee and second Physician Advisor if necessary, as in the case of the attending physician not responding or if the attending physician contests the findings, then at least one additional physician member of the Utilization Review Committee must review the case and discuss it with the attending physician. If the determination was that the patient's stay is not medically necessary, the determination then becomes final. The notification of rights and appeal process is given to Medicare beneficiary per CMS-4105-F "Medicare Program; Notification of Hospital Discharge Appeal Rights" within two days of admission and within two days before discharge. Written notification of the decision, the "Hospital Issued Notice of Non-Coverage" (HINN) will be issued. Refer to Utilization Review Policy UR.03, Patient Notification of the Provision or Discontinuation of Care. The UR Nurse performs a retrospective review on a case per payer request.

4. **Retrospective reviews** analyze and evaluate an admission of patient care for medical necessity, quality of care and appropriateness of setting, after the care has been delivered or after the patient is discharged from the facility.

The UR process involves the collaboration with the patient and family, as well as caregiver, physician and interdisciplinary health care team, to maintain the continuum of care and ensure that

quality medical care is provided in the appropriate setting, upon admission through discharge.

C. **The Utilization Review Committee**

1. The Utilization Review Committee has been established as a standing committee of VCMC, in accordance with the bylaws, rules and regulations of the Medical Staff and with the approval of the Board of Supervisors. The Utilization Review Committee shall be composed of Medical Staff Physicians, two (2) Physician Advisors, the Chief Medical Officer and representatives from UR, case management, nursing, Health Information Management (HIM), Admitting/Registration, Medical Education, Finance, Compliance, Quality and Risk Management.
2. The Medical Executive Committee (or) the Chief of Staff shall appoint the Utilization Review Committee Chair for a period of two (2) years and the Chief Medical Officer, Physician Advisor or designee may chair the Committee in his/her absence.
3. At least two (2) of the members of the Committee must be physicians of medicine or osteopathy practitioners and all physician members of the Committee must be active members of the medical staff in good standing with current privileges to practice at VCMC.

D. **Duties:**

1. The Committee is to encourage cost-effective care, through proper utilization of hospital resources. The committee shall analyze and identify factors that contribute to efficient or effective hospital stays, or effective use of other services, including equipment availability and facilities, both inpatient and outpatient.
2. The Committee will pattern and trend data to identify practitioners with potential opportunities for improvement regarding either over-or-under utilization of resources.
3. The Committee shall submit a written report to the Medical Executive Committee, making appropriate recommendations designed to maximize effective utilization of the hospital and its resources and address over-and-under utilization of hospital resources.
4. The Committee will review denied days or denied costs, as appropriate.
5. The Utilization Review Committee shall maintain direct liaison with other committees of the Medical Staff, using their assistance and advice as indicated.
6. The committee will meet at least quarterly. The Chairman will call special meetings as needed. Other members of the hospital staff will attend the Utilization Review Committee meetings at the invitation of the Committee Chairman. These staff members will be invited as needed, to review findings and discuss opportunities for improvement, advise on establishing and revising screening criteria and assist in resolving issues.
7. The Committee will set annual goals based on the changes of government laws and regulations, as well as improvement of the Utilization Management process based on review findings and data analysis from the previous year(s).
8. The committee will establish policies and procedures to ensure standardized UR process and adhere to government laws, rules and regulations.

E. Authority and Responsibility

1. By approval of this policy, the Hospital appoints the governing body to authorize the establishment of a Utilization Review Committee in accordance with this policy. The governing body delegates to the Utilization Review Committee the authority and responsibility to carry out the UR functions.

F. Utilization Review Plan Evaluation

1. The UR Plan is reviewed annually and updated as deemed necessary by hospital leadership under the support of MEC, based upon the ongoing evaluation of the UR activities and their relationship to regulatory changes and the quality and efficiency of patient care delivery.

G. Confidentiality of Records

1. All patient information related to UR activities is considered confidential. The Release of Information/ Confidentiality Policies shall govern the release of the information. All Utilization Management activities are confidential and protected under peer review. Documents relating to these activities are maintained in compliance with legal requirements and accrediting standards. Qualified individuals maintain strict confidentiality through limited access to such information, as dictated by individual hospital policies.

H. Conflict of Interest

1. No physician or staff or Utilization Review Committee member may have a direct financial interest in the hospital. No person may participate in the review of any case in which he/she is professionally involved clinically.

REFERENCES:

1. Centers for Medicare & Medicaid Services; §42 CFR Part 482.30. "Conditions of Participation."
2. Centers for Medicare & Medicaid Services; §42 CFR Parts 405, 412, 422, 489 [CMS–4105–F]. "Medicare Program; Notification of Hospital Discharge Appeal Rights."

1. 42 C.F.R. § 482.30 (2024)
2. 42 C F.R. § 412.80(a)(1)(i) (2024)

All revision dates: 9/27/2024, 2/24/2021, 3/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Utilization Management Committee	Cheryl Lambing: Medical Director, Utilization Management	9/27/2024
Utilization Management Committee	Laura Zarate: Clinical Nurse Manager, Case Management	9/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/27/2024
Case Management	Laura Zarate: Clinical Nurse Manager, Case Management	9/27/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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

108.050 Patient Safety Attendant Care

PURPOSE:

To define Patient Safety Attendant Care and the guidelines for the use of Patient Safety Attendants within Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH).

POLICY:

1. An individual assigned to the role of a Patient Safety Attendant is a member of the healthcare team of Ventura County Medical Center/Santa Paula Hospital who will remain with a patient throughout a designated period of time for the purpose of maintaining patient's safety (prevention of falls, disruption of patient care, suicidal/homicidal/5150/5585, delirium, confusion, etc.).

2. A Patient Safety Attendant assures patient safety for individuals deemed to be either suicidal or on 5150 status. This requires 1:1 Observation in which an assigned staff member stays within close proximity of the patient and provides direct observation at all times.

3. A Patient Safety Attendant provides and maintains a safe environment (for pulling tubes, airway devices, etc.) for identified patients who have not been classified as either suicidal, homicidal or on 5150/5585 status. A Patient Safety Attendant can observe 1-2 patients in close proximity for these purposes.

4. Patient's families will be encouraged to partner with VCMC/SPH Hospital staff in order to provide a safe environment for the patient. As families provide a stabilizing emotional support for the patient, they will be asked to participate by staying with the patient to prevent pulling tubes, climbing out of bed, etc. Primary RN or Charge Nurse approval required to allow family or other visitor to replace Patient Safety Attendant. The patient's visitor will be instructed to notify the nurse to resume Patient Safety Attendant care when they are leaving the room. Family and visitors ~~may never Family members~~ will not be permitted to provide sitter care for suicidal/homicidal or 5150/5585 patients.

PROCEDURE(S):

A. Assessment of Safety Attendant Usage

1. The nurse will assess the patient’s physical condition, behaviors, and emotional status to determine if constant observation of the patient is required to ensure the patient’s safety.
2. The nurse assesses for the following:
    a. The patient is on suicide precautions, which requires a sitter 1:1.

b. Patient is on a legal hold.

c. The patient is confused, disoriented or cognitively impaired and at high risk to injure themselves (either by falling, wandering, etc.).

d. A confused, disoriented or cognitively impaired patient pulling at medically necessary tubes/ lines and hand mittens have been unsuccessful.

e. Patient has been placed in restraints due to patient exhibiting a danger to self or others.

3. If the patient meets the above criteria c., d., and e., the nurse will first consider the following alternate options to safety attendant usage. The use of a safety attendant for those criteria should only be considered if no other feasible alternative provides a solution, to include the following interventions with documented ineffectiveness in the medical record.

   a. Can the patient's family members provide supervision of the patient? The nurse will approach the family to determine feasibility.

   b. Can the patient be moved closer to the nursing station to provide more frequent observation by nursing staff?

   c. Have the medications, electrolytes, and blood gases been reviewed as a reversible cause of confusion/delirium?

   d. Where appropriate, can the patient be placed in a room with another patient who has a sitter?

   e. Can current shift assignment be adjusted to utilize scheduled staff to provide adequate supervision?

4. If the patient meets safety attendant criteria and all alternatives have been unsuccessful and documented, the justification for the need is documented on the 'Patient Safety Attendant Care Justification for the Non-Suicidal Patient' form (Attachment C). The patient's bedside nurse completes the form and submits to the Charge Nurse. If criterion is met, the Charge Nurse will speak to the Nursing Supervisor to arrange a Patient Safety Attendant. All completed forms are submitted to the Unit Nursing Clinical Director. Initiation of patient safety attendant will require review and approval each shift or with a change in condition.

B. General Expectations for all Safety Attendants

1. The Charge Nurse will assign a Patient Safety Attendant to provide observation of the patient. A Patient Safety Attendant may be assigned to monitor two patients in the same room or in adjoining rooms for non-suicidal and non-homicidal patients only. The Patient Safety Attendant will position him/herself to maintain an unobstructed view of both patients. If one patient requires individual attention, the Patient Safety Attendant will notify the Primary RN or Charge Nurse to provide temporary monitoring for the other patient.

2. Once Patient Safety Attendant care is initiated, patient will not be left unattended until the nurse notifies the Patient Safety Attendant that the assignment is discontinued. If a patient is in a private room, the safety attendant needs to be in the room with the patient.

3. The Patient Safety Attendant will immediately inform the nurse if there is a sudden change in the patient's condition/behavior.

4. Care provided by a Patient Safety Attendant will be delegated and overseen by the assigned bedside nurse. The nurse will retain the responsibility of the nursing process and administration of medications. A Patient Safety Attendant will provide physical care, within their scope of practice and training, for the patient for whom they are assigned including the documentation of vital signs and

intake and output. Patients who are suicidal/homicidal require every 15 minute documentation on the patient observation log (see Attachment B).

5. The Patient Safety Attendant as directed by the nurse will complete all aspects of Activities of Daily Living (ADL's) for the patient provided they have demonstrated competency. This includes, but is not limited to, the following: bathing, feeding, toileting, and range of motion (ROM). Exception: Security Personnel may provide observation only, not the ADLs/physical care. Patient Safety Attendants (unless Registered Nurses) may not perform assessments.
6. The Patient Safety Attendant will accompany the patient for any clinical tests or procedures off the unit unless patient is already accompanied by the bedside nurse. The staff member accompanying the patient will remain within line of sight of the patient unless otherwise directed by the person performing the test or procedure.
7. The Patient Safety Attendant will remain within direct sight of the patient while patient is using the bathroom or shower. The Patient Safety Attendant will attempt to maintain the patient's dignity and privacy by having same gender assistant assume temporary responsibility of the patient as needed.
8. While on duty, the Patient Safety Attendant will not leave the patient's room without the bedside nurses' approval and/or relief. If a break is needed, a hand-off to the temporary staff member will occur prior to reporting off the unit.
9. The Patient Safety Attendant will refer the patient to the nurse or physician to answer any questions regarding the plan of care.

9. **Patient Safety Attendant/Suicidal/Homicidal or Patient on a 5150/5585**

a. If a Patient Safety Attendant is required for a suicidal or patient on a 5150/5585, the Charge Nurse will assign a staff member to provide 1:1 observation of the patient.

b. If a patient is a danger to self or others, creating a safe environment is essential. The patient will not be permitted to use sharps or other items that could be used to harm self or others. For assistance in creating a safe environment see policy 100.268 Suicidal Environmental Risk Assessment.

d. Verify dietary order specifies no sharp objects and/or finger foods only. No utensils will be given to patient.

e. The Patient Safety Attendant will immediately inform the nurse:

1. If the patient expresses an intention to hurt self/others.
2. If there is a sudden change in the patient's condition/behavior.
3. The Patient Safety Attendant may not leave the patient for any reason until coverage is obtained and present.

e. The Patient Safety Attendant may not be discontinued without Licensed Practitioner order.

11. **Documentation**

a. All patient care will be documented in the Electronic Health Record.

b. Patient Safety Attendant will complete the Patient Observation Log (Attachment B).

c. Patient Safety Attendant will complete the C.A.S.E. Safety Check form (Attachment A).

12. Competency

a. All Patient Safety Attendants must complete training prior to assuming the role. Training includes a didactic course and results in a competency Assessment.

b. All Patient Safety Attendants used for violent or aggressive behavior must have Crisis Prevention Institute (CPI) training or comparable (e.g., AVADE).

c. All Patient Safety Attendants must participate in an annual refresher course to ensure maintenance of competency.

All revision dates:	9/12/2024, 12/20/2023, 7/12/2023, 4/28/2023, 4/13/2023, 4/11/2023, 4/11/2023

Attachments

C.A.S.E. Safety Checklist.pdf
Patient Observation Record.PDF
Patient Safety Attendant Care Justification for the Non-Suicidal Patient.docx

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	9/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/12/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/12/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Colleen Rusin: Ambulatory Care RN II*
Policy Area:	*Ambulatory Care - Patient Care Services*
References:	

AC.28 Standardized Nursing Procedure Anaphylaxis Emergency Care in the Ambulatory Care Setting

~~**Objectives:**~~

Purpose:

To provide guidance and clinical direction for a Registered Nurse (RN) in the Ambulatory Care Clinic setting to ~~prescribe and~~ administer intramuscular (IM) epinephrine in accordance with a standardized protocol from a 1 milligram per milliliter (mg/mL) vial/ampule to patients experiencing suspected anaphylaxis. For more information see CPG.73 Acute Management of Anaphylaxis.

Principles:

A. Anaphylaxis is a life-threatening situation that requires immediate medical intervention.

B. Anaphylaxis is characterized by sudden onset and rapid progression of symptoms.

C. Administration of IM epinephrine from a 1 mg/mL concentration vial is the first-line treatment for suspected anaphylaxis and should occur as soon as possible.

D. Failure to administer epinephrine promptly can result in death.

E. There is no absolute contraindication for the use of epinephrine when a patient is experiencing suspected, life-threatening anaphylaxis.

Applicability:

A. This procedure gives the RN the delegated authority in an emergency situation to initiate appropriate care of the patient presenting with an anaphylactic reaction while awaiting the arrival of a Licensed Independent Practitioner (LIP) or Emergency Medical Services (EMS).

B. This procedure is **not** intended to provide direction for health care professionals who administer epinephrine for suspected anaphylaxis with a patient-specific order or when an Licensed Independent Practitioner (e.g., Physician or Nurse Practitioner) is immediately available to provide an order.

C. This procedure does **not** give the RN delegated authority to prescribe epinephrine for another health care professional to administer when anaphylaxis is suspected.

Procedures:

A. **Assessment & Diagnosis**

1. The RN will rapidly assess the patient for signs and symptoms of anaphylaxis.
    a. Timing: Most occur within 15-30 minutes of vaccination or medication administration.
    b. Constitutional: Feeling of impending doom.
    c. Cutaneous: Pruritus, urticaria, flushing, angioedema.
    d. Neurologic: Confusion, disorientation, dizziness, lightheadedness, weakness, loss of consciousness.
    e. Respiratory: Shortness of breath, wheezing, bronchospasm, stridor, hypoxia.
    f. Cardiovascular: Hypotension, tachycardia.
    g. Gastrointestinal: Nausea, vomiting, abdominal cramping, diarrhea.

    ~~The RN will consider differential diagnoses, including vasovagal syncope and anxiety.~~

2. The RN recognizes that anaphylaxis is highly likely and appropriate care indicated when one of the following two criteria occurs:
    a. **Criteria 1:** Acute onset (minutes-hours) with skin and/or mucosal tissue involvement **AND** at least one of the following:
    - Airway: Respiratory compromise
    - Circulation: Reduced blood pressure **-OR-**
    - Gastrointestinal: Severe gastrointestinal symptoms

    a. **Criteria 2:** Acute onset of hypotension OR bronchospasms or laryngeal involvement after exposure to a known or high probable allergen for that patient even in the absence of skin involvement.

B. **Initial Management-** If anaphylaxis is suspected, the following interventions should be performed concurrently if another healthcare provider is available to assist the RN.

1. Remove exposure to the possible allergen/trigger (e.g., stop the IV medication).
2. Assess Airway, Breathing, & Circulation and initiate Cardiopulmonary Resuscitation (CPR) if indicated.
3. Seek immediate emergency assistance.
    a. Notify Emergency Medical Services (EMS) by dialing **911**.
    b. Alert a Licensed Independent Practitioner (LIP).
    c. Request STAT retrieval of anaphylaxis kit and emergency equipment.

C. **Pharmacological Management**

1. Administer Epinephrine (1 mg/mL concentration) INTRAMUSCULARLY to the vastus lateralis muscle (mid-outer thigh) following the dosage guidelines below.
    a. Infants under 10 kg (22lbs)-Weight-based: 0.01 mg/kg (0.01 mL/kg)
    b. Children aged 1-5 years: 0.15 mg (0.15 mL)
    c. Children aged 6-12 years: 0.3 mg (0.3 mL)
    d. Teenagers and Adults: 0.5 mg (0.5 mL)
2. DO NOT DELAY. Epinephrine is the first-line treatment for suspected anaphylaxis.

3. Use 1 mg/mL concentration only.
4. Dosage not to exceed those listed for each age group.
5. May repeat in 5 to 15 minutes as needed. Most patients respond after 1-2 doses.
6. There are NO contraindications to Epinephrine in the treatment of anaphylaxis.

D. **Non-Pharmacological Management**

1. Place patient in a supine position with lower extremities elevated (as tolerated).
2. Place in a position of comfort if there is respiratory distress or vomiting, or on left side if pregnant.
3. Infants may be held by parent.
4. When indicated, give high-flow supplemental oxygen (6-8 L/min) by facemask.
5. Monitor patient continuously if possible (e.g. blood pressure, heart rate, respirations, oxygenation) until arrival of the LIP or EMS.

E. **Transfer of Care** - Upon arrival, the LIP or EMS will assume responsibility for care of the patient and the RN will receive ongoing orders for care from that point.

Qualifications

RNs who ~~prescribe and~~ administer Epinephrine for suspected anaphylaxis will comply with the following:

~~A. **Licensure & Certifications**~~

~~1. Current California RN license.~~
~~2. Current BLS or ACLS certification.~~

~~B. **Education & Training**~~

~~1. Initial and annual completion of *Ambulatory Care Initial Office Management of Anaphylaxis* training module in Target Solutions.~~
~~2. Initial and annual review of the *Ambulatory Care Protocol for Initial Office Management of Anaphylaxis.*~~
~~3. Participation in bi-annual mock rapid response activities.~~

~~C. **Competency Validation**~~

~~1. Demonstrates ability to rapidly recognize abnormal vital signs, dyspnea, and patient distress.~~
~~2. Demonstrates knowledge of signs and symptoms of allergic reaction and anaphylaxis.~~
~~3. Demonstrates knowledge of the location, contents, and appropriate use of the Anaphylaxis Kit and other emergency response equipment.~~
~~4. Demonstrates use of critical judgment to determine if epinephrine is appropriate for the patient.~~
~~5. Demonstrates knowledge of epinephrine dosing guidelines and route of administration for initial management of anaphylaxis.~~

A. **Licensure/Certifications**

1. Maintain current California RN license.
2. Maintain current BLS or ACLS/PALS certification.

B. **Education/Training & Competency Evaluation**

1. Upon completion of education/training, initial competencies will be documented on the competency evaluation tool and kept in the RN personnel files.
2. After initial competency requirements are completed, a yearly competency evaluation will be required.

Documentation

A. ~~The RN will document all~~All activities related to the event are to be documented on the *Ambulatory Care ~~Rapid~~Medical Emergency Response Form~~.~~* and entered into the Electronic Health Record (EHR).

B. If anaphylaxis resulted from administration of a vaccine or medication, the RN will submit an *Adverse Drug Reaction Report Form [VCMC-345-008]* ~~(~~to VCMC~~-345-008) to VCMC~~ Pharmacy. For more information see PH.42 Adverse Drug Reaction Reporting System.

C. If anaphylaxis resulted from administration of a vaccine, the RN will submit a report to the Vaccine Adverse Even Reporting System (VAERS) at https://vaers.hhs.gov.

Scope of Supervision Required

A. Every three years the Standardized Procedure will be reviewed and approved by the Interdisciplinary Practice Committee.

B. Every three years the Standardized Procedure will be reviewed and approved by the appropriate Medical Staff Department.

C. Every three years the Standardized Procedure will be reviewed and approved by the Medical Executive Committee.

References

A. CDC Interim Considerations: Preparing for the Potential Management of Anaphylaxis at COVID19 Vaccination Site. 12/22/2020. Accessed 12/31/2020.

B. CPG.73 Acute Treatment of Anaphylaxis and Attachment B - Initial Office Management of Anaphylaxis (1/25/2021).

All revision dates: 9/16/2024, 8/10/2021

Attachments

Attachment A: Medical Emergency Response Form [VCHCA-603-211]

Approval Signatures

Step Description	Approver	Date
Interdisciplinary Committee	Stephanie Denson: Manager, Medical Staff Office	pending
P&T Committee	Sul Jung: Associate Director of Pharmacy Services	9/27/2024
	Colleen Rusin: Ambulatory Care RN II	9/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.102 Heated High Flow Nasal Cannula

PURPOSE:

To standardize the use of Heated High Flow within Ventura County Medical Center and Santa Paula Hospital.

POLICY:

Heated High Flow Nasal Cannula oxygen therapy is comprised of an air/oxygen blender, an active humidifier, a single heated circuit, and a nasal cannula. It delivers adequately heated and humidified medical gas at up to 60 L/min of flow and is considered to have a number of physiological effects: reduction of anatomical dead space, PEEP effect, constant fraction of inspired oxygen, and good humidification. It is to be delivered to a spontaneously breathing patient through various interfaces.

~~DEFINITION(S):~~

Abbreviations:

HHFNC - Heated High Flow Nasal Cannula

VCMC - Ventura County Medical Center

SPH - Santa Paula Hospital

NIV - Non-Invasive Ventilation

EHR - Electronic Health Record

PROCEDURE(S):

~~The purpose of respiratory support is to maintain adequate ventilation and oxygenation.~~

Indications:

1. Neonate

a. Respiratory distress from bronchiolitis, pneumonia, bronchopulmonary dysplasia

b. Respiratory support post extubation

c. Weaning therapy from NIV

d. Apnea of prematurity

e. Provider may order as needed.

2. Pediatric

a. Respiratory distress from bronchiolitis, pneumonia, asthma

b. Respiratory support post extubation

c. Weaning therapy from NIV

d. Signs of hypoxemia (SpO2<90%) and signs of moderate to severe respiratory distress

e. Provider may order as needed

3. Adults

a. Respiratory distress from ~~COPD~~Chronic Obstructive Pulmonary Disease, Pneumonia, asthma

b. Respiratory distress where patient is requiring higher minute ventilation

c. Respiratory support post extubation

d. Weaning therapy from ~~NIV~~Non Invasive Ventilation

e. Respiratory support from neuromuscular disease on spontaneously breathing patients

d. Signs of hypoxemia (SpO2 <90%) and signs of moderate to severe respiratory distress

Contraindications for all patients:

a. Blocked nasal passages, choanal atresia

b. Trauma, surgery to nasopharynx

c. Severe respiratory acidosis (ventilatory failure)

d. Patients who cannot maintain a patent airway

e. Patient who does not have a spontaneous respiratory effort

f. Active hemorrhage with hemodynamic instability

Equipment

a. Heated High Flow device

b. Sterile water

c. Patient interface: Respiratory Therapist to determine based on manufacturer's patient sizing recommendations

d. Oxygen source

e. Oxygen blender

f. Oxygen tubing

g. All patients must be on continuous vital monitoring when placed on HHFNC no matter where they are admitted to in the hospital

Procedure

a. Licensed Practitioner to enter orders into the EHR.

b. Respiratory Therapist to be notified of the order, verify order and bring appropriate equipment to the bedside.

c. Perform hand hygiene prior to setting up device.

d. Identify the patient using two patient identifiers.

e. Explain the procedure to the patient and/or family at bedside.

f. Assess appropriate indication for placement.

g. Determine the correct size of interface depending on patient's size.

h. Assemble and initiate therapy per manufacturer's guidelines.

i. Assess patient tolerance. If adjustments are made, notify provider immediately.

j. ~~Place~~Set heater to optimal humidification for comfort.

k. Assure patient is set up to ~~continuous~~cardiorespiratory monitoring

Neonatal Unit Level of Care (NICU)

a. All neonatal patients on Heated High Flow Nasal Cannula will be in NICU

b. Orders to be determined by Licensed Independent Practioner

c. Respiratory Therapist to monitor and document ~~Q~~every 2 ~~(every 2 hours)~~

Pediatric Unit Level of Care

a. Liter flow ≤ 0.5-1 L/kg/min to achieve targeted minute ventilation demand

b. Oxygen ~~demand > ~~≤ 0.5 FIO2 to maintain target saturation

c. Respiratory Therapist to monitor and document ~~Q~~every 4 ~~(every 4 hours)~~

PICU Unit Level of Care (PICU)

a.Liter flow >1 L/kg/min

b. Liter flow ~~>~~≥ 50

c. . Fio2 ~~> ~~≥ 0.5 to maintain target saturation

d. Respiratory Therapist to monitor and document ~~Q~~every 2 ~~(every 2 hours)~~

Acute Care in Adults

a. Liter flow ~~≤~~< 50

b. FiO2~~ ≤ ~~<0.~~50~~5 to maintain target saturation

c. Respiratory Therapist to monitor and document ~~Q~~every 4 ~~(every 4 hours)~~

~~Adult ICU Level of Care~~

Adult ICU Level of Care

a. Liter flow ~~>~~≥ 50

b. Fio2 ~~>~~ ≥ 0.5 to maintain target saturation

c. Respiratory Therapist to monitor and document ~~Q~~every 2 ~~(every 2~~ hours~~)~~

Documentation:

In the EHR:

a.Date and time HHFNC was initiated

b. Temperature

c. Flow rate

d. FiO2

e. Clinical findings (breath sounds, heart rate, respiratory rate, SpO2)

f. Changes in settings

g. Skin integrity

h. Interface size or type

i. Water level in the humidifier bag

Special Considerations

1. If acuity changes and the patient is in need of an increased level of care, the Respiratory Therapist and RN must stay at the bedside until the patient is transferred.

REFERENCE(S):

https://www.ncbi.nlm.nih.gov/books/NBK526071/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7027347/

All revision dates:

Attachments

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Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine	Stephanie Denson: Manager, Medical Staff Office	pending

Step Description	Approver	Date
and Pediatrics		
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/8/2024

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References:	

MCH.06 Cleft Lip and Palate Repair and Oral Feedings

POLICY:

To guide nursing staff in the oral feeding of the pediatric patient post cleft lip/palate repair.

PROCEDURE:

A. Oral feeding of post-op cleft lip/palate repair patient may be performed by RN/LVN familiar with such care, or a Nursing Assistant under the direction of such a registered nurse or licensed vocational nurse (RN/ LVN).

B. The decisions regarding what type of feeding equipment to use and method of feeding shall be interdisciplinary and individualized with regard to each patient's unique needs and situation, as ordered by physician; surgeon or medical provider.

C. Oral medications are given using these same methods.

EQUIPMENT

~~A. Pedialyte, water, juice, formula, milk, expressed breast milk, pureed food.~~

~~B. Volutrol, bottle, squeezable plastic bottle, soft rubber spoon.~~

~~C. Cross cut nipple, vertical cut nipple, lamb's nipple, flanged nipple, gravity flow nipple, special nurser (for breast feeding).~~

~~D. Syringe with feeding tube/rubber tube (Breck feeder).~~

A. Pedialyte, water, juice, formula, milk, expressed breast milk, pureed food.

B. Soft rubber spoon.

C. NUK (orthodontic) nipple; gravity flow nipple (is a general term for one-way valve systems), special Playtex nurser (for breast feeding).

D. Syringe with feeding tube/rubber tube (Breck feeder).

E. **Several types of bottles work well with infants unable to generate adequate suction which are as follows:** 1) **Special Needs Feeder** (formerly Haberman) 2) **Pigeon bottle** nipple has a y-cut hole, and is firm on one side and soft on the other. It allows the baby to use the tongue and lips to compress the nipple so milk flows easily. It may be used with other bottles. 3) **Dr. Brown's zero** resistance specialty

feeder uses a one -way valve inserted into any level of Dr. Brown's nipple to create a compression nipple. 4) If using **Medulla specialty feeder or Dr. Brown's specialty feede**r, the feeder will provide pulse compression to express small amounts of milk, following rhythm of infant's suck pattern. This is only done if infant does not have adequate suck strength to independently express milk and only provides pulses when infant is actively sucking to prevent choking on bolus or aspiration.

PROCEDURE:

A. Explain the procedure and rationale to parents/guardian. Encourage parents to participate in the infant's care and feedings.

B. Prepare feeding materials.

C. Patient should always be in upright position (30-90 degrees) during and for 5-10 minutes after feeding. The head may be supported by the caregiver's hand or cradled in the arm; this position allows gravity to assist with the flow of the liquid so that is is swallowed instead of lost through the nose.

D. Wrap infant in blanket and position such that at least one hand is free to manipulate feeding equipment. Patient may be fed in crib or in caregiver's arms or lap.

E. Older children may sit in high chair or upright in bed or crib.

F. Close attention must always be given to patient's upper extremities with regard to the patient attempting to rub or pull at surgical site. Usually soft restraining is required.

G. Position the nipple in such a way that it is compressed by the tongue and the existing palate.

H. If using a single slit nipple the slit must be vertical in the mouth so as to allow the infant to have control of milk flow.

I. Cheek support (squeezing the cheeks together to decrease the width of the cleft) may be useful in improving lip seal during the feeding.

J. Burp patient frequently.

K. When using a syringe with feeding or rubber tube, ensure that the tube is long enough to extend far enough into the oral cavity so as to prevent regurgitation through the nose, but not too far to cause gagging. With a cleft lip repair, slip the tube in from the side of the mouth to avoid operative area and to prevent the infant from sucking on the tubing.

L. Deposit a small amount (1-3 ml) of feeding in the lateral portion of oral cavity and allow patient to swallow.

M. Consult with the physician regarding thickening formula with rice cereal.

N. Spoon feed pureed foods.

O. May give small amount of water to rinse mouth after feeding. Gently clean the suture line with a saline dipped cotton swab.

P. Turn patient on his/her side to clear the oral cavity in the event of coughing, choking or vomiting.

Q. Suction the airway only if absolutely necessary and exercise caution so as not to traumatize surgical site. Gently suction the mouth and nasopharynx secretions with the Breck feeder to prevent aspiration and respiratory complications.

DOCUMENTATION

A. Nursing notes in EMR: Tolerance, type and length of feed, technique, any problems.

B. Document all intake and output on ~~flowsheet~~the EMR.

C. MAR in the EMR: Oral medication.

REFERENCES:

Hockenberry, M.; Duffy, E. A. and Gibbs, DiValerio; K. Wong's Nursing Care of Infants and Children. 12th edition, 2024. Elsevier.

The American Cleft Palate Craniofacial Association. http://www.cleftline.org

~~**Wong's Nursing Care of Infants and Children**. 9th edition, 2011.~~

~~**Ventura County Craniofacial Clinic**.~~

Ventura County Craniofacial Clinic.

All revision dates: 6/6/2024, 6/14/2021, 3/8/2018, 5/1/2011, 9/1/2004

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/16/2024
Policy Owner	Jennifer Ferrick: Director, Peds/PICU & NICU	7/16/2024

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N.04 Breast Milk Storage and Collection

POLICY:

To guide the nurse in helping a mother maintain lactation when it is not possible for the infant to breastfeed. Also, to guide the ~~Nurse~~nurse in facilitating the correct handling, collection and storage of expressed ~~breastmilk~~breast milk. The following Guidelines are also included in the event that milk is provided to an infant from a source other than the infant's own mother or human donor-banked breast milk.

PROCEDURE:

A. Mothers who choose to breastfeed are encouraged to do so. If mother and baby are separated, or mother is unable to breastfeed, the Nurse shall encourage and assist the mother to pump her breasts within six (6) hours, unless medically unstable. Electric breast pumps are to be used for mothers who cannot breastfeed for more than 24 hours, or those who anticipate long-term separation from their infants.

B. ~~VCMC~~Ventura County Medical Center will make available fully automatic breast pumps and pump kits for hospital use.

C. As pumping requires significant time and emotional investment by the mother, the Nurse will offer positive reinforcement with words and actions.

D. The Nurse will teach the mother about correct labeling and storage of ~~breastmilk~~her breast milk.

E. The Nurse will teach the mother to notify the Registered Nurse if she has a fever greater than 101° F, has lesions on her breasts, or if she is using any medications.

F. The Nurse should encourage the mother to pump every 3 hours or 8 times per day.

G. The milk from each pumping will be kept in its own container and not mixed with breastmilk from other ~~pumpings~~pumping sessions.

H. Mothers will be referred to a pump rental station for long-term use.

I. When available, a lactation consultation will be obtained to instruct the mother in use of the breast pump. If a lactation consultant is unavailable, a hospital staff person knowledgeable in the use of the breast pump will instruct the mother.

J. Expressed ~~breastmilk~~breast milk is to be labeled with the patient's name, medical record number, date and time of collection, and placed in the ~~Intensive Care Nursery breastmilk~~NICU breast milk refrigerator ~~and/~~or freezer. Name alert stickers are to be utilized if two or more infants have like surnames and/or multiples are housed in the same unit.

K. Standard Precautions for body fluids must be followed during the handling, administration clean-up and disposal of breastmilk.

~~Infants less than (<) 32 weeks of gestation will not be fed their mother's breastmilk until it has been frozen for 72 hours at -20 degrees Celsius and then thawed. This process is followed until the infant reaches 32 weeks gestational age.~~

EQUIPMENT

A. Electric Pump

B. Pump Kit

C. Sterile Bottles~~/plastic bags~~ for Storage

D. Labels

E. Name alert stickers

F. Refrigerator or Freezer that is approved for breastmilk storage

1. NOTE: Formula and ~~breastmilk~~breast milk may not be stored with food.

PROCEDURE

A. Nursing mother washes hands before handling of the breast pump parts, the breast or exposed breast milk.

B. Obtain ~~and empty~~ sterile bottles.

C. Obtain electric pump and pump kit.

D. Help mother to relax by providing quiet, relaxed surroundings. Mothers may be taught to massage their breasts to facilitate emptying, if needed, and placement of warm, moist packs.

E. Plug pump into wall outlet. Set up pump kit according to enclosed manufacturer's directions*. Use sterile water bottles to collect ~~breastmilk~~breast milk. Double pump breasts for 10 – 15 minutes. Moisten the breast with clean warm water before placing the shield on the breast to create a "seal", center the breast shield over the nipple so the nipple can move in and out without rubbing against the sides. Turn on the pump after positioning the shield. Begin pumping with minimum suction, gradually increasing the suction to comfortable level.

F. Cap bottle of breastmilk/secure plastic bag and label with ~~mother~~baby's ~~full~~ name, ~~band I.D. or~~date of brith, medical record number, date and time obtained. Use name alert stickers as appropriate.

G. Wash all pump kit parts that are exposed to mother or breastmilk in hot, soapy water. Rinse thoroughly. Place on a clean paper towel at bedside, and cover with another clean paper towel. Allow to air-dry. Breast should air-dry as well.

~~**E:** Moisten the breast with clean warm water before placing the shield on the breast to create a "seal", center the breast shield over the nipple so the nipple can move in and out without rubbing against the sides. Turn on the pump after positioning the shield. Always begin pumping with suction regulator or minimum.~~

H. ~~Breastmilk~~Breast milk storage guidelines ~~(for~~for all infants ~~> 32~~:Two weeks~~):~~ in freezer section of a refrigerator or freezer unit, where the freezer is contained within the door of the refrigerator.

1. ~~Two weeks in freezer section of a refrigerator or freezer unit, where the freezer is contained within~~

~~the door of the refrigerator.~~

~~Breastmilk~~Breast milk	Room Temperature (<78°F)	Refrigerator (<38°F)	Freezer (0°F)
Freshly expressed into closed container	4 hours	48 hours	3 Months in freezer compartment with separate door, 6-12 mo. in deep freezer
Previously frozen-thawed in refrigerator but not warmed or used	4 hours or less	24 hours	Do not refreeze
Thawed outside refrigerator in warm water	For completion of feeding	Do not refrigerate/ discard	Do not refreeze/discard
Infant has begun feeding	For completion of feeding; then discard	Discard	Discard

~~Breastmilk storage guidelines (for infants < 32 weeks):~~

~~Breastmilk~~	~~All Breastmilk to be frozen for 72 hours at -20° C prior to feedings (may be kept 6-12 months)~~		
	~~Room Temperature (<78°F)~~	~~Refrigerator (<38°F)~~	~~Freezer (-4°F/-20°C)~~
~~Previously frozen – thawed in refrigerator but not warmed or used~~	~~4 hours or less~~	~~24 hours~~	~~Do not refreeze~~
~~Thawed outside refrigerator in warm water~~	~~For completion of feeding; then discard~~	~~Do not refrigerate/ discard~~	~~Do not refreeze/ discard~~
~~Infant has begun feeding~~	~~For completion of feeding; then discard~~	~~Discard~~	~~Discard~~

I. Parents must transport ~~breastmilk~~breast milk to hospital in ice. If it has thawed, refrigerate and use within 24 hours.

J. To thaw ~~breastmilk~~breast milk:

1. Place bottle under running water (not hot), or
2. Place bottle in a bowl of warm water, or
3. Place in refrigerator to thaw overnight.
4. Do not heat in a microwave.

K. Gently shake the milk to suspend the milk fat globules.

L. Always use oldest ~~breastmilk~~breast milk first.

M. Expiration date/time should be written on label.

N. Frozen ~~breastmilk~~breast milk should be used in the order in which it was expressed (oldest milk first).

O. ~~Breastmilk~~Breast milk remaining in a bottle after feeding an infant should be discarded.

P. To prevent the wrong administration of expressed breast milk (EBM);Two licensed nursing personnel will check the breast milk label against the infants ~~ID~~identification band (date of birth, Medical Record number, and name) prior to each and every feeding. ~~Both~~Breast milk will ~~sign the flowsheet~~be co-signed in the electronic medical record. Also; the five patient rights are enforced prior to a feeding; right patient; right feeding; right volume, right route and right time as well as checking expiration date/time for breast milk.

Q. Mothers who have tested positive for HBsAg or hepatitis C should not provide stored breast milk for their infants while in the nursery because of the risk to other newborns. Although mothers who are HBsAg positive may breastfeed their infants after the infants have received hepatitis B immune globulin and vaccine, breast milk that is potentially contaminated with hepatitis B or ~~hepatitis~~Hepatitis C virus ~~will not~~may be stored in the nursery in a ziplock bag labeled with patient sticker.

R. Guidelines for in the event that milk is provided to an infant from a source other than the infant's own mother, or human donor-banked breast milk, the following actions should be taken: 1. The Physician will be notified as soon as the error is identified. 2. The incident should be documented in the infant's chart, and a report should be filed. 3. When a mistake occurs; inform both the source and biological mothers of the event and advise them on the protocol for an exposure. 4. Obtain written consent from both mothers" prenatal and obstetrical records reports for HIV; Hepatitis B(HBV) & Hepatitis C (HCV) and Cytomegalovirus (CMV). 5. Labs tests should be performed as ordered on the donor mother and infant who received another mother's milk. These may include testing for the following: a. HIV on the donor mother and infant b. Hepatitis B on the donor mother and baby c. Hepatitis C on the donor mother and d. Cytomegalovirus on the donor mother.

DOCUMENTATION

A. Follow-up by Lactation Specialist is ordered upon checkout of electric pump.

B. Pump education and usage should be recorded in patient chart.

REFERENCES

~~Lawrence, Ruth A. (1999) *Breastfeeding: A guide for the Medical Profession.* Missouri. Mosby.~~

~~The American Academy of Pediatrics (2006): *Red Book* .~~

~~Wight, Nancy E., M.D. (2005) Breastfeeding Task Force of Greater Los Angeles [Seminar].~~

~~Guidelines for Perinatal Care, 6 th Edition (2008)~~

~~CPQCC, Nutritional Support of the VBLW Infant (2007)~~

Centers for Disease Control and Prevention (January 2022). Proper Storage and Preparation of Breast Milk.https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm

Mannel, R. & Taylor, S. (2024) Best Practice for Expressing, Soring and Handling Human Milk; In Hospitals, Homes and Child Care Settings. 5th Ed. Human Milk Banking Association of North America.

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

Wight, N. Kim J., Rhine W, Mayer O., Morris M, Sey R, Nisbet C (2018) Nutritional Support of the Very Low birth Infant Toolkit by California Perinatal Quality Care Collaborative.

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Attachments

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Approval Signatures

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Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/24/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/24/2024
NICU	Melissa Krebs: Director, NICU	7/24/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	7/16/2024

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References:	

N.51 Neonatal Intensive Care Unit (NICU) Transport Team

POLICY:

To describe the Ventura County Medical Center (VCMC) NICU Transport Team composition and activities required to safely transfer a sick infant from the hospital of origin to a hospital which provides the appropriate level of medical and/or nursing care.

PROCEDURE:

A. ~~There are four different situations~~Situations requiring VCMC NICU transport:

1. A sick ~~neonate~~infant is born at a referring hospital and transported by the team to VCMC NICU.
2. A sick infant is transported to VCMC from another hospital.
3. A stable infant is returned to the hospital of origin.
4. ~~A neonate~~An infant is transported by the team for specialized testing outside VCMC.

The NICU Medical Director ~~for neonatal transport~~in conjunction with the Clinical Nurse Specialist or designee shall design the NICU transport team's training program, oversee selection and training of team members, develop and/or approve all transport policies and protocols, assist in the development and implementation of outreach and follow-up programs and review all transport cases.

The decision to transport requires the Neonatologist to designate the team members after consultation with the ~~NNP,~~NICU Charge Registered Nurse (RN) and/or referring physician. The composition of the team shall be balanced to provide all skills required during the transport. A minimum of two staff members accompany each transport and may include a ~~Registered~~ RN, Respiratory Therapist~~, Neonatal RN Practitioner~~ (RT) and/or Neonatologist.

B. RN-managed transport may include:

1. Infants greater than ~~34~~32 weeks gestation
2. Infants with mild respiratory distress stable on nasal cannula oxygen
3. Infants with hypoglycemia/hyperbilirubinemia/hyperviscosity
4. Infants with possible sepsis without evidence of shock

5. Specialized testing (e.g., CT scan or MRI) of stable ~~neonate~~infant

C. ~~RN Practitioner/~~Neonatologist-managed transports may include any of the above plus:

1. Preterm infants less than ~~34~~32 weeks
2. Birth weight less than 1250 ~~Gms~~g.
3. Respiratory Distress stable on conventional ventilation
4. Sepsis with evidence of shock
5. Surgical candidates including imperforate anus, omphalocele, gastroschisis, neural tube defect
6. Status post cardiac arrest
7. Infants on vasopressor support
8. Cyanotic cardiac lesions
9. Unstable status

The Neonatologist is informed of and decides ~~about~~upon the make up of the transport team. The Neonatologist oversees all the neonatal transports and maintains communication. The NICU Clinical ~~RN~~Nurse Manager/Nursing Supervisor may be consulted for questions on the adequacy of staffing for the transport. ~~An on-call RN may be available to assist in the NICU or on the transport.~~

EQUIPMENT

A. Transport Incubator including:

1. Ventilator
2. Cardiorespiratory/Blood Pressure/Oxygen Saturation Monitor
3. Syringe Infusion Pumps (minimum 2)
4. Oxygen Analyzer
5. Oxygen Tanks (2)
6. Air tank or Air compressor
7. Suction machine

B. Supplies:

1. Hand Antiseptic Solution
2. Stethoscope
3. Thermometer
4. Syringes – 1, 3, 5, 20, and 30 cc and needles
5. IV placement supplies
6. Infusion tubing
7. 0.2 Micron filters
8. Transducer
9. ~~Platelet~~Blood products infusion set
10. Monitoring leads/probes

11. Blood pressure cuffs
12. Lab draw supplies, including blood culture bottle
13. ABG syringe
14. Umbilical Catheter Tray, catheters (3.5 & 5 Fr), stopcocks
15. Respiratory Supplies ~~/ "Blue Box"~~

C. Medications:

A selected medication box is kept in the NICU – with the transporter

Quantity	Medication
1	Atropine 1 mg/10 ml PFS (pre-filled syringe)
2	Calcium Gluconate 10% 1gm 10 vials
2	Epinephrine 1:10000 10 ml PFS
4	Heparin 10 Units/ml ~~SDV (Single dose vial)~~flush PFS
1	Lidocaine 100 mg/5ml PFS
2	Naloxone 2 mg/2 ml PFS
3	Sodium Bicarbonate 4.2% 10 ml PFS
6	Sodium Chloride 0.9% 10ml SDV

D. IV Solutions:

1. D10W 250 ml

   ~~D5W 250 ml~~

   ~~0.45 NACL 500 ml~~

2. 0.9 NACL 250 ml

Additional supplies as indicated by patient condition.

GUIDELINES

A. The ~~resource~~Charge RN ~~assigns~~identifies a Transport RN every shift. The assigned RN checks the equipment at the beginning of the shift. If the Respiratory Therapist is unavailable, then the RN checks the oxygen tanks and ventilator also.

B. When a request for transport is received, the RN answering the phone collects data from the referring hospital as outlined, on the Infant Transport Record.

1. Reason(s) for transport
2. Gestational age, birth weight, time of birth
3. Perinatal history (maternal) including infectious disease status, complications of pregnancy, maternal medications (antenatal and intrapartum)
4. Neonate's Vital signs (temperature, respiratory rate, heart rate, blood pressure)
5. Respiratory status including: oxygen requirements and blood gas results
6. Laboratory and radiological findings
7. Therapy initiated (including medications and fluids) and neonate's response

C. The RN confers with the Neonatologist; the Neonatologist accepts or denies the request for transport. Upon acceptance of the transport, the RN then ~~confers with the NNP/physician,~~ notifies the Respiratory Therapist, calls the ambulance, and notifies the Nursing Supervisor and/or ~~Department~~Clinical Manager. The Neonatologist is responsible for approving the transport team members.

D. The Transport RN rechecks the equipment and gathers any additional supplies. The referring hospital is called back with an estimated time of arrival and any specialized supplies or equipment needed. The Transport RN gives report on assigned NICU neonates to the RNs remaining in NICU.

E. The ambulance ~~drivers~~personnel assist in moving the equipment to the ambulance. The transport battery should be preserved by using the ambulance or hospital power as much as possible. Air and Oxygen tanks must also be preserved.

F. Upon arrival to the referring hospital, the team evaluates the patient's stability for transport. The assessment includes but is not limited to the following: Temperature, Respiratory status, Cardiovascular function, and Metabolic needs. The physician will be consulted by phone if not a member of the team.

G. In consultation with the physician~~/NNP~~, the Transport RN may administer Oxygen, initiate/confirm IV access, fluids, ~~Dextrose~~D10 bolus or continuous IV fluid, medications, apply monitor leads, maintain neutral thermal environment, decompress stomach, maintain airway, check vital signs/blood glucose, and record all data. Two patient identification bands should be attached to the patient. VCMC NICU policies apply to all transport activities.

H. The RN may discuss the transport and NICU care with the parents. The parents must sign consent for transport. If a camera is available, a photograph may be taken and left with the parents along with the VCMC Parent Hand-Out containing phone numbers and visiting policies. If possible, the RN will assist the parents to view and touch the newborn prior to leaving the hospital. Infant and mother are identified by checking the birthing hospital ID Band numbers.

I. The Respiratory Therapist ~~or RN~~ will set up the ventilator or bag and Oxygen. Before and after placing the patient in the Transport Bed, the RN will check for functioning of all gases, monitors, and pumps. ~~The receiving hospital should be called with an estimated time of arrival and specialized equipment needed.~~

J. The RN assesses the patient during the transport by visual appearance and monitor readings. Problems are immediately brought to the attention of the ~~NNP/MP~~physician or RT. Vital Signs may be recorded from the monitor readouts.

K. **The ambulance radio dispatch may be used to request additional assistance**. If a physician~~/NNP~~ is not in the ambulance, a code will be conducted per Neonatal Resuscitation guidelines including use of 100% Oxygen, bag/mask ventilation, Intubation, and cardiac compressions. Emergency medication doses will be calculated prior to the transport and administered according to Neonatal Resuscitation guidelines. The Neonatologist will be immediately available by two way voice contact.

L. Upon arrival at the receiving hospital, the RN will give report to the staff, prepare the patient for removal from the Transport incubator, and ensure cleaning and restocking of the equipment and supplies.

M. Notify Admitting Department of all transported patients. A copy of the "face sheet" from referral hospital is given to the ambulance ~~driver~~personnel.

TEAM MEMBER QUALIFICATIONS

A. Requirements for RN:

1. Current CA Registered RN License.

2. Basic Life Support certification.
3. Current successful completion of the Neonatal Resuscitation Program course of the AAP and AHA.
4. Demonstrates Nursing competence in Neonatal Intensive Care. Demonstrates excellent clinical skills/knowledge necessary to provide optimal care of sick or high-risk neonate during stabilization or transport. (Annual competency required)
5. Minimum of ~~one year~~2 years NICU Level II or III experience.
6. Consistently demonstrates ability to function compatibly with transport team members, referral facilities, referral staff, and infant's parents/family.
7. Demonstrates competency in operation of transport equipment and annually thereafter.
8. Competency review in the following is required:
    a. Bag-mask ventilation
    b. Intravenous line placement
    c. Use of oxygen therapies
    d. Arterial puncture
    e. Administration of surfactant
    f. Cognitive knowledge to be able to recognize and triage the following conditions:
        1. Cardiopulmonary arrest
        2. Respiratory distress
        3. Hypoglycemia
    g. Transport Equipment/Supplies

~~ADDITIONAL REQUIREMENTS FOR NEONATAL RN PRACTITIONER~~

1. ~~All of the above requirements for Registered RN~~
2. ~~Certification as a Neonatal RN Practitioner~~
3. ~~Additional Annual competency review as directed by the Neonatologist:~~
    a. ~~Thoracostomy tube placement~~
    b. ~~Umbilical vessel line placement~~
    c. ~~Needle thoracostomy~~
    d. ~~Neonatal intubation~~
4. ~~Cognitive knowledge to be able to recognize and triage the following conditions:~~
    a. ~~Cardiopulmonary arrest~~
    b. ~~Respiratory failure~~
    c. ~~Air-leak syndromes~~
    d. ~~Congenital heart disease~~
    e. ~~Shock~~
    f. ~~Sepsis~~
    g. ~~Omphalocele and gastroschisis~~

~~h. Intestinal obstruction and perforation~~

~~i. Birth injuries~~

~~j. Hypoxic ischemic encephalopathy~~

~~k. Neonatal seizures~~

~~l. Intracranial bleeding~~

~~m. Metabolic disorders~~

~~n. Coagulopathes~~

~~o. Common malformation syndromes~~

~~p. Marginal viability~~

B. REQUIREMENTS FOR RESPIRATORY CARE THERAPIST

A. Current CA license

B. Basic Life Support certification

C. Current successful completion of the Neonatal Resuscitation Program course of the AAP and AHA

D. Demonstrated successful completion of neonatal transport training program including intubation

E. Demonstrated competency in ventilator support, oxygen therapy, neonatal respiratory assessment

F. Annual competency review showing proficiency in the following is required:

a. Bag-mask ventilation

b. Arterial puncture

c. Administration of surfactant

G. Demonstrated competency in operation of transport ventilator

H. Cognitive knowledge to be able to recognize and triage the following conditions:

1. Cardiopulmonary arrest
2. Respiratory failure
3. Air-leak syndromes

TRANSPORT CERTIFICATION FOR RN~~, NNP,~~ AND RCT

A. Ventura County Medical Center has identified the transport procedure as one that may only be performed by a certified RN~~/NNP/RCT~~ and RT.

B. Once an RN~~, NNP or RCT~~ or RT is identified as a candidate for certification (meets above requirements) the transport policy and procedure is followed, completing the tasks identified for each specific skill. At least three successful performances are required before certification is granted.

C. After an RN~~/NNP/RCT~~ RT meets the requirements for performing the Transport procedure, the completed certification form is submitted to the employee's manager/supervisor for final approval. Once approval is granted, the RN/~~NNP/RCT~~RT may perform the skill.

D. Each manager/supervisor is responsible for a current listing of all RN/~~NNP/RCTs~~RTs in their area that have obtained internal certification. This list includes the employee's name and date of certification.

E. If an RN/~~NNP/RCT~~RT has not performed the certified transport skill within 6-12 months, annual

recertification of competency may be maintained through an annual skills review (hands-on and didactic).

F. If an RN/~~NNP/RCT~~RT has demonstrated unacceptable performance, the manager/supervisor determines if the original protocol for certification should be repeated.

G. ~~Intrafacility~~Intra-facility transports may be utilized in the certification process.

DOCUMENTATION

A. ~~**Infant Transport Record.**~~RN progress note – additional observations, procedures, patient tolerance.

B. VCMC transport assessment – including vital signs, treatment, patient tolerance of transport, team members.

C. Copies of patient's hospital records and x-rays, including documentation for newborn screen and hearing screen. If patient is a newborn also include a copy of the maternal record, a vial of cord blood and maternal blood.

D. Signed consents needed include Consent for Treatment and Conditions of Admission, Transport, Surgery or Special Diagnostic or Therapeutic Procedures.

~~RN's progress note – additional observations, procedures, patient tolerance.~~

E. Code medication sheet.

F. CORE CPets Acute Inter-Facility Neonatal Transport Form

REFERENCES:

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

American Academy of Pediatrics. (2016) Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients. 4th Ed.

Beauman, S. S., & Bowles, S. (Eds.). (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th ed.). National Association of Neonatal Nurses.

Karlsen, K. (2021)The STABLE Program; Post -resuscitation/Pre-Transport Stabilization Care of Sick Infant Guidelines for Neonatal Health care Providers. 6th Ed

All revision dates: 6/17/2024, 7/1/2015, 2/1/2010, 3/1/2006, 10/1/2005, 11/1/2004, 10/1/2002, 2/1/2002, 12/1/2001

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/24/2024

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/24/2024
NICU	Melissa Krebs: Director, NICU	7/24/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	6/17/2024

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Owner:	*Pearl Dahm: Clinical Nurse Specialist*
Policy Area:	*NICU*
References:	

N.70 Very Low Birthweight Intraventricular Hemorrhage Prevention Protocol

PURPOSE

Define the care for very low birthweight (VLBW) infants less than 1500 grams and/or infants ~~31 and 6/7~~30 and 0/7 weeks and below for optimization of care and the prevention of IVH.

POLICY:

This policy will be initiated for all infants born at less than ~~31 and 6/7~~30 and 0/7 weeks or weighing less than 1500 grams. The first set of care guidelines will be followed for the first 72 hours of life followed by the second set of guidelines until the first 7 days of life. Provide parents with education about importance of specific care for the VLBW infant. Encourage parents to have active involvement in the infant's care.

DEFINITION(S)

Extremely premature infants are at high risk for neurological and developmental abnormalities in the first week of life. Intraventricular hemorrhage (IVH) is a major cause of adverse outcomes in the extremely low birth weight (VLBW) infant. The goal is to optimize development by providing an environment and experiences that support physiologic stability and allow for brain development, growth and learning of the extremely low birth weight infant.

PROCEDURE(S)

The first week of life is very important for the VLBW infant and they are at great risk for an IVH during this period. IVH best practice protocol was developed using evidence based practice to guide care of the VLBW during their first week of life to improve outcomes by decreasing the risk of IVH. The protocol should be hung at the infant's bedside on admission to ensure continuity of care.

PROCESS

1. Admission:
    A. In advance of delivery; have a pre-warmed Giraffe set up in the OR or delivery room with thermal hat over plastic covered head, warming mattress, and polyethylene occlusive wrap.
    B. Prepare the NICU admission space with items for admission and umbilical line placement prior to

delivery.

C. Pre-Warm IV fluid, boluses, medication, and blood products in isolette prior to infusion.

D. Obtain birth weight and document on admission in the EMR.

E. Hang protocol on the monitor at the bedside.

2. Thermoregulation

A. Place infant on servo-control (skin control) the first week of life at 36.6 degrees Celsius as soon as possible after delivery.

B. DO NOT dry infant but instead place directly in the Polyethylene occlusive wrap.

C. Keep infant on warming mattress throughout umbilical line placement until obtaining x-ray for confirmation of line placement.

D. Close giraffe lid and limit raising the Giraffe unless during a procedure.

E. Begin humidification set at 80% for first week of life after line placement. (Humidification aids in thermoregulation while supporting fluid balance.)

F. Keep Stethoscope bell inside of isolette to keep warm.

3. Positioning:

A. Keep head as close to midline as possible in a Snuggly and baby contained in a developmentally supported position (hand hugs/flexed) and may use rolls. (Postural changes in the premature infant can lead to changes in the cerebral circulation due to an immature systemic circulatory system).

B. Maintain HOB flat (decreases cerebral venous pressure).

C. Do not raise buttock above head for diaper changes.

4. Skin Care

A. Universal precautions (gloves) should always be used.

B. Remove betadine or any other skin preparation with saline wipe or normal saline.

C. Use of alcohol on the skin should be avoided.

D. Avoid use of adhesives

E. Handle infant gently to avoid trauma to skin

F. Tape should not be used.

G. Gently clean skin surfaces using warm water; avoid rubbing. If areas of skin breakdown are evident; use sterile water.

H. Use micro-preemie leads if available.

5. Minimal Stimulation:

A. Cluster care every 4-6 hours

B. Minimize suctioning unless infant shows signs of respiratory distress

C. Limit painful procedures

6. General Care First 72 hours:

A. Two person handling with cares

B. No prone positioning or skin to skin unless ordered by MD. Encourage parents to provide therapeutic

touch and "hand hugs"

C. No weights after birth weight obtained

D. No abdominal girths

E. No baths

F. No peripheral BP if UAC in place

G. Withdraw blood from infant over a minimum of 40 seconds, and return blood to infant over a minimum of 40 seconds. (Flushing rapidly may alter cerebral blood flow resulting in an increased incidence of IVH)

H. Encourage Moms to pump and provide colostrum for oral swabbing.

7. General Care 72 hours to 7 Days of Life:

A. May place prone or do skin to skin if physiologically stable.

B. Begin Daily weights and

C. Keep buttocks below head during diaper changes.

D. No abdominal girths

E. No baths

F. Continue two person handling with care, weights, and x-rays.

G. UAC lab draws 40 second pull and 40 second push. (Flushing rapidly may alter cerebral blood flow resulting in an increased incidence of IVH)

H. Continue to encourage Moms to pump and provide Colostrum swabbing.

REFERENCE(S)

Kochan M, Leonardi B, Firestone A, et al. Elevated midline head positioning of extremely low birth weight infants; effects on cardiopulmonary function and the incidence of periventricular-intraventricular hemorrhage. J Perinatology. 2019:39(1): 54-62.

Persad, N.; Kelly, E; Amaral, N.; Neish, A; Cheng, C; Fan,C-PS; Runeckles, K; Shah, V. Impact of a "Brain Protection Bundle" in Reducing Severe Intraventricular Hemorrhage in Preterm Infants <30 weeks GA: A Retrospective Single Center Study. Children 2021. 8, 983.

Beauman, S. S. and Bowles, S. NANN. Policies, Procedures, and Competencies for Neonatal Nursing Care. 6th edition. 2019.

All revision dates: 7/24/2024, 6/11/2024

Attachments

Please protect my brain (1).pdf

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/12/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	9/12/2024
NICU	Pearl Dahm: Clinical Nurse Specialist	8/15/2024
NICU	Melissa Krebs: Director, NICU	7/24/2024

VENTURA COUNTY HEALTH CARE AGENCY

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References:	

N.76 Breastfeeding in the NICU

GOALS:

1. To create consistency of basic breastfeeding knowledge and application among attending medical, nutrition and nursing staff.

2. To foster ideas and practices that are accurate and current relating to breastfeeding management techniques and procedures.

3. To create an environment of positive support to the breastfeeding family.

4. To provide guidelines for breastfeeding education for the infant prior to discharge.

5. To provide guidelines for optimal breastfeeding and breast milk management based on knowledge from current research.

POLICY:

1. Breastfeeding should be initiated per feeding readiness scale. Please also refer to Policy Infant-Directed Oral Feeding for the NICU (NICU Policy N.69)

2. Nurses will make an assessment of the mother's knowledge of breastfeeding and provide information and breast pumping kit as needed.

3. Most medications are not contraindicated while breastfeeding. For reference consult Drugs in Pregnancy and Lactation; A reference guide to Fetal and Neonatal Risk by Gerald G. Briggs.

4. Information about community resources and for availability of high quality pump for home use should be given to the Mother on discharge.

5. Nipple shields should be used at the discretion of the lactation consultant and should not be placed on the Mother's nipple for purposes of teaching the infant to latch-on.

6. When a Mother is unable to breast feed due to separation from infant or inability to latch instructions regarding pumping and storage should be given and pumping initiated.

7. If the Mother is unable to breastfeed every three hours, supplement breastfeeding with expressed colostrum, expressed breast milk or 20 calories/oz. infant formula per the following instructions:

1. 0-24 hours minimum 10-15 ml per feeding

2. 24-48 hours minimum 15-30 ml per feeding

3. 48 hours plus minimum 30 ml per feeding

PROCEDURE;

1. Ask Mother, when she presents to the NICU, if she intends to breastfeed her infant.

2. Instruct Mother in good handwashing technique.

Evaluate and assist the breastfeeding Mother and infant during the initial feeding and several times prior to discharge.

a. For treatment of sore, cracked nipples, instruct the Mother in expressing a small amount of colostrum/ breastmilk onto the nipple and allow to air dry.

b. For double healing, the Mother can apply a thin layer of pure lanoline cream.

3. Instruct Mother in proper positioning and latch on techniques.

4. Inform the Mothers that there is a Lactation Consultant in the hospital who can help them with breastfeeding their infants when their infants are able to breastfeed.

5. Inform the Mothers that there is a pump in the NICU that they can use when they visit their baby but that they need to remember to bring the tubing and other personal breast pump parts.

6. Assess the Mother's pumping practices (8 times/day to maintain a good milk supply).

a. Mothers should be encouraged and given ~~postive~~positive feedback for their pumping efforts.

b. Encourage parents to maintain a pumping log.

REFERENCES:

Briggs, G.G., Freeman, R. K., Yaffe, S. J. (2020) Drugs in Pregnancy and Lactation; A Reference Guide to Fetal and Neonatal Risk. 12the Ed, Lippincott Williams & Wilkins

Manuel, R, Taylor, S.(2024) Best Practice for Expressing, Storing and Handling Human Milk; In Hospital, Homes and Child Care Settings. 5th Ed. Human Milk Banking of North America.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/12/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	9/12/2024

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NICU	Pearl Dahm: Clinical Nurse Specialist	8/15/2024
NICU	Melissa Krebs: Director, NICU	7/25/2024

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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~~patient 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 JADA
        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 (operating room) 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~~blood supplier.
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~~blood supplier.
c. Move to Operating Room.

All revision dates: 9/13/2024, 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

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Policy Area:	*OB Nursing*
References:	

OB.65 Admission and Ongoing Care of a Well Newborn

POLICY:

To provide standardization of the admitting procedure for well-newborns and define the services of the perinatal registered nurse (RN). Only healthy newborns without potentially life threatening illnesses will be admitted to the Obstetric (OB) Department. A perinatal nurse will be available to provide temporary transitional care to well-newborns in a "Baby Friendly" environment that supports breastfeeding, and to care for healthy, stable newborns whose mothers are currently unable to provide care, for as brief a time as possible. Every effort will be made to reunite mother and newborn as soon as possible. Nursing interventions will be initiated based on individual patient needs. Medically stable newborns will be placed skin-to-skin with their mothers within the first hour of life. If the RN identifies a potential problem with the newborn, the RN will notify the physician or Neonatal Intensive Care Nursery (NICU) team immediately, following the chain of command. The RN will notify the physician if an attending physician has not examined the newborn within 24 hours of birth. At Ventura County Medical Center (VCMC), the Resident will do an initial newborn assessment after delivery.

PROCEDURE:

A. The perinatal nurse will provide care to healthy stable newborns in the delivery room, Operating Room, and the post-partum room for the purpose of admission. The perinatal nurse will assess newborns at birth. The admission record in the electronic health record (EHR) will be completed within two (2) hours.
    1. In the delivery room, all infants need a minimum of one (1) hour (golden hour) of skin to skin contact with the mother in a "Baby Friendly" environment.
    2. Breastfed infants need to be put to breast during this time.

B. Other babies that can be under the care of the perinatal nurse (for as brief a time as possible) include:
    1. Infants whose mother is in the main Operating Room or Recovery Room for caesarean section (C-section) or Post-Partum Tubal Ligation.
    2. Infants whose mother is unable to provide care due to her poor physical condition, including active hemorrhage, seizures, or conditions requiring the mother's transfer to cardiac care unit (CCU) or Telemetry. If it is determined that the mother will be unable to provide care for an extended period of time, the newborn will be transferred to the Pediatric or NICU departments.
    3. Infants with hypoglycemia who need monitoring and require supplemental feeding (per policy

MCH~~NOBP~~.14 Hypoglycemia in the Newborn), until determination is made to transfer baby to the NICU.

ADMISSION PROCEDURE:

The perinatal nurse will be available to assist the labor nurse with care of the newborn at time of delivery. The nursery nurse will assist with resuscitation of the newborn when needed, and will notify the NICU team if indicated:

1. The perinatal nurse will assist the labor or circulating nurse at the time of delivery when available.
2. The radiant warmer will be set up and warmed in the room prior to the delivery of the newborn.
3. When the delivery occurs in the Operating Room (OR), the NICU respiratory therapist will be notified of the cesarean section delivery and be available to assist. The perinatal nurse will maintain a sterile field and receive the newborn into the radiant warmer. ~~The NICU team will be called for any anticipated high risk delivery.~~
4. The NICU team will be present for any anticipated high risk delivery in the OR or Labor and Delivery Suite. A high risk delivery can include any of the following; urgent or emergent cesarean section, meconium stained fluid, multiple gestations, antepartum/intrapartum magnesium sulfate administration , breech delivery, instrument assisted delivery, known fetal macrosomia, shoulder dystocia, <36 week gestation, known fetal anomalies, No Prenatal Care, sustained fetal tachycardia. The NICU team can be called prior to or after delivery for consultation when needed.
5. Identify with second nurse:
    a. Name
    b. Sex
    c. ID band number
    d. Time of birth
    e. Infant's physician

    ~~Maternal Hepatitis B Surface Antigen, group B streptococcus (GBS) status, Rubella status, and blood type~~

    ~~History of pregnancy and labor~~
6. Nursing interventions will be initiated based on individual patient needs.
7. If the nurse identifies a potential problem with the newborn, the nurse will immediately notify the physician or NICU team, following the chain of command (see policy OB.22 OB Physician Consultations).
8. In a Labor ~~or perinatal~~and Delivery Room the Labor or NICU nurse if present for delivery will obtain and assign an Apgar at 1 and 5 minutes after birth. If an Apgar is less than 7, additional scores should be assigned every 5 minutes up to 20 minutes. In the operating room the Transitional Care Nurse or NICU nurse if present will obtain and assign and Apgar at 1 and 5 minutes after birth.
9. Admission/birth vital signs - Document temperature, heart rate, respiratory rate, skin color, type of respirations, tone, at least once every 30 minutes, until newborn has remained stable for at least two (2) hours. Vital signs may be taken more frequently if needed or at the discretion of the perinatal nurse. If the infant's temperature is ≤ 97.6 , further admission activities are held until infant has been warmed.
10. Perinatal nurse administers medications as ordered (see policy MCH 27~~OB.11~~ Newborn Admission

Medications, Antibacterial Eye Prophylaxis and Vitamin K).

11. Infant is weighed and measured.
12. Newborn nursing assessment is completed within two (2) hours of birth. This will be done by the ~~nursery nurse~~Transitional Care Nurse (TCN) or post-partum nurse as indicated by census and staffing availability.
13. The RN bathes the newborn when medically stable and temperature is above ~~97~~98.~~7~~0 degrees F (see policy OB.70 Newborn Bath).
14. The RN ensures that collected cord blood is sent to the laboratory (see policy N.38 Hemolytic Disease of the Newborn).
15. Footprints of infant and souvenir card are prepared, mother's fingerprint is collected prior to transfer to post-partum.
16. Photo ID is taken and printed per policy MCH 07 OB~~.44 OB~~ Infant Security - Code Pink/Code Purple .
17. Infant is warmed to 98.0 degrees, wrapped in blankets and transferred to post-partum.
18. Complete crib card with pertinent information.
19. Bulb syringe and The *Neonatal Resuscitation Program* (NRP) resuscitation equipment is placed in crib.
20. The RN will transfer the newborn with the mother to the post-partum room when both are stable, providing report to the assigned post partum RN.
21. A infant security tag will be placed on newborns ankle upon admission to post partum.
22. An adopted or surrendered newborn will be assigned and cared for in the Pediatrics unit.
23. When the nursery nurse is unavailable the admission procedure will be completed according to the nursery nurse flow sheet (see Attachment A).

NEWBORN NURSING ASSESSMENT

A. Preparation:
   1. Gather equipment needed:
      a. Stethoscope
   2. Place infant under radiant warmer with good light source.

B. Physical Assessment – Note findings of assessment and examination in newborn's EHR:
   1. Reflexes:
      a. Moro
      b. Suck
   2. Tone/Activity:
      a. Active, Quiet, Lethargic, Jittery
      b. Cry: Vigorous, Weak, High Pitched, Difficult to Elicit
      c. Moves all extremities
      d. Posture: Normal for gestational age.
   3. Head/Neck:
      a. Anterior Fontanel: Flat, Bulging, Depressed

b. Sagital Suture: Separate, Overriding
c. Facial features: Symmetrical, Asymmetrical
d. Scalp Molding, Caput Succedaneum, Cephalohematoma
e. Scalp intact: Yes, No

4. Eyes:
   a. Clear, Drainage
5. Ears, Nose, Throat (ENT):
   a. Ears: Normal, Abnormal
   b. Nares: Patent Bilaterally, Obstructed, Flaring
   c. Palate: Normal, Abnormal
6. Abdomen:
   a. Soft, Firm, Flat, Distended
   b. Bowel Sounds: Active, Diminished
7. Thorax:
   a. Symmetrical, Asymmetrical
   b. Retractions: Yes, No
   c. Clavicles: Normal, Abnormal
8. Lungs:
   a. Breath Sounds: Equal Bilaterally, Unequal
   b. Breath Sounds: Audible in all lung fields, Inaudible, Diminished
   c. Breath Sounds: Clear, Moist, Wheezing, Grunting
   d. Respiratory Rate
9. Heart:
   a. Sounds: Regular, Irregular, Murmur
   b. Rate/Beat
   c. Capillary Filling Time: Trunk, Extremities
   d. Peripheral Pulse: Normal, Weak
10. Extremities:
    a. Moves extremities, Limited range of motion (ROM), Unable to assess
    b. Number: Fingers Right, Left, Toes Right, Left
11. Umbilicus:
    a. Number of vessels
12. Anus:
    a. Patent, Imperforate
13. Spine:

a. Normal, Abnormal

14. Skin:
    a. Color: Pink, Plethoric, Pallor, Jaundice, Central Cyanosis, Nailbeds, Circumoral, Periorbital, Acrocyanosis
    b. Rash
    c. Birthmarks
15. Genitourinary (GU):
    a. Normal Male, Female
    b. Abnormal Male, Female
16. All assessment information will be documented in the electronic health record (EHR).

Ongoing Well Newborn Care

A. Staff RN Responsibilities for Couplet Care Nurse [SC1]

1. Receives report, and checks newborn identification (ID) bands with Labor and Delivery (L&D) RN or Nursery Nurse. Place infant security tag, if not in place.
2. Performs total care for assigned patients (Newborn Admission Notes).
    a. Completes physical assessment and charts as soon as possible (ASAP) (within two hours). Document ID band number in the EHR.
    b. Checks Lab results. Check the data of the Newborn Screen form with the parents (see policy MCH 02~~NOB.3~~ Newborn Screening of Infants).
    c. Educates and assists mothers with breastfeeding and/or bottle feeding. Document education provided and plan of care to continue exclusive breastfeeding if no medical indication to supplement with forumla.
    d. Assists mothers with breast pumping as indicated.
    e. Administers medications as ordered, as per unit policy.
    f. Provides parental support, information and teaching.
    g. Collaborates with ancillary personnel to coordinate patient care.
    h. Interprets data and report pertinent findings.
    i. Maintains intravenous infusion.
    j. Provides for appropriate developmental environment.
3. Completes assigned workload within shifts.
4. Demonstrates ability to handle unexpected changes in the unit or patient activity.
    a. Assesses change.
    b. Initiates appropriate actions.
    c. Notifies appropriate personnel of changes.
5. Seeks assistance when necessary.
6. Documents care using hospital and unit forms.

a. EHR charting.

b. Appropriate assignment of acuity and documentation in EHR.

c. Nursing Kardex for Couplet Care.

d. Discharge teaching sheet.

7. ~~Checks charts and reviews~~Reviews EHR for new orders throughout the shift.
8. Rounds with physician on assigned patients, when possible.
9. Keeps the ~~resource~~charge nurse informed of patient's status as needed.
10. Assists other staff members as assignment allows.
11. Delegates work appropriately to medical office assistant (MOA).
12. Delegates work appropriately to technicians.
13. Participates in quality control.
    a. Glucose meter
    b. Urine multistick
14. Locates resources in the couplet care unit.
    a. ~~Resource RN~~Charge Nurse
    b. Accesses policies in PolicyStat
15. Completes med/chart audits as per unit policy.
16. Participates in continuous improvement/peer review issues in the unit.
17. Reports to oncoming shift.

B. Physical Exam of the Neonate

1. Demonstrates head-to-toe physical assessment on a stable neonate patient every 12 hours, or as needed. Document ID bands number on Mom and Baby in EHR. Assure Infant Security Tag is in place, and check integrity of skin surrounding bands and tags.
2. Differentiates normal from abnormal findings.
3. Identifies abnormalities requiring immediate follow-up.
4. Completes assessment documentation accurately.
5. The nurse evaluates vital signs as part of the patient assessment (Continuing care: Standard of Care)
    a. Temperature, pulse and respiration will be taken every six (6) hours. Axillary temperature measurement will be performed. If axillary temperature is above 99°F, rectal temperature should be measured. The RN will notify the physician/neonatal nurse practitioner (NNP) if the vital signs are out of normal limits. Four (4) limb blood pressure may be ordered for infants suspected of a cardiac defect.
6. Feeding: as determined by Newborn Admission Orders. Breastfeeding should be supported.
7. Stools and Urine
    a. Meconium stooling is seen in 90 percent of newborns within the first 24 hours, and most of the rest do so within 36 hours.

b. Voiding, although usually occurring shortly after birth, may not occur until the second day.

c. The passage of meconium and urine in the minutes immediately after birth or during the next few hours indicates patency of the gastrointestinal and urinary tracts.

d. The physician will be notified for failure of the infant to stool or urinate after ~~these times~~24 hours.

C. Discharge from Couplet Care to Home

1. Identifies infant's and mother's progress required for discharge
2. Identifies policy and procedure for discharge
3. Identifies discharge summary and instruction required to complete discharge
4. Identifies correct lab work to be completed prior to discharge
5. Demonstrates completion of discharge teaching checklist
6. Verifies ID band matching baby and mother
7. Demonstrates proper documentation of the discharge process
8. Makes follow-up appointments as ordered by physicians
9. Ensures Newborn Screen done and completed correctly
10. Ensure Hepatitis B vaccine has been given and correctly documented in EHR
11. Ensure Hearing Screen is completed and documented and, if needed, referral made
12. Remove Infant Security Tag Prior to Discharge.

DOCUMENTATION

Normal Newborn Database – Nursing Assessment
Infant Recovery Record – Weight, Length, Vital Signs, Medications
Newborn Screen Form – Demographic data
Name Cards – Attached to Crib
Electronic Health Record – Nursing Care Plan

REFERENCE

The **Association of Women's Health, Obstetric and Neonatal Nurses** (AWHONN): Perinatal Nursing, 4TH edition, 2013

All revision dates: 9/24/2024, 12/14/2022, 2/18/2020, 3/21/2019, 6/13/2018, 2/15/2018, 4/1/2016, 11/1/2013, 12/1/2010, 3/1/2006

Attachments

No Attachments

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Step Description	Approver	Date
Medical Staff Committees: Family Medicine & Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/3/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/3/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	6/3/2024

VENTURA COUNTY
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Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*PEDS/PICU*
References:	

P.39 Pediatric Guidelines for Crib/Bed Use

POLICY:

To establish the pediatric guidelines for the use of patient cribs and beds.

PROCEDURE:

1. All children under the age of three (3) must be placed in a crib.
2. If a child is three (3) years of age or greater, the patient should be assessed for appropriate placement in a hospital bed.
3. If the parents requests that their child under the age of three (3) be placed in an adult-sized bed, a crib release form must be signed (see Attachment A).

All revision dates: 10/12/2021, 9/27/2018

Attachments

Attachment A - Consent to Placement of Child in Adult-Sized Bed.docx

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/12/2024
Pediatrics	Jennifer Ferrick: Director, Peds/PICU & NICU	9/12/2024
Pediatrics	Andrei Bobrow: Medical Director, Pediatrics	8/26/2024

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Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.51 Non-Invasive Ventilation

POLICY:

To ~~define the use of~~provide guidelines for Non-Invasive Ventilation (NIV) at Ventura County Medical Center/ Santa Paula Hospital. Patients who are physically unable to remove non-invasive ~~ventilation at Ventura County Medical Center/Santa Paula Hospital. Patients who~~ventilator mask are ~~physically unable to remove non-invasive ventilator mask are~~ not to be placed on therapy.

PROCEDURE:

To establish safe and effective guidelines for performing, documenting, and reporting issues for patients using non-invasive ventilation.

~~Definitions~~

- ~~Ventura County Medical Center - VCMC~~
- ~~Santa Paula Hospital - SPH~~
- ~~Electronic Health Record - EHR~~
- ~~Non-invasive ventilators/ventilation - NIV~~

1. **Non-Invasive Ventilator for Acute Respiratory Failure**
    1. Acute respiratory distress situations in which patients are suffering from acute hypercarbic or hypoxic respiratory failure, and where the underlying cause is generally reversible within a relatively short period of time (generally hours to days).
    2. Facilitate early extubation of spontaneously breathing patients who would normally require extended periods of invasive ventilation as a supplement therapy for respiratory support.
        a. The rescue NIV patient will remain NPO until there is an improvement in the patient's respiratory status.
        b. Avoid use of hand/wrist restraints.
        c. When used before transfer to the Intensive Care Unit (e.g. Rapid Response Team call), a Respiratory Care Practitioner should remain in the unit where the patient is located until the patient is stabilized.
2. **Skin Integrity with the Use of NIV**
    1. The Respiratory Care Practitioner, in collaboration with the Registered Nurse, is to assess the

patient risk for skin breakdown with the use of NIV. Based on the assessment, skin protective material (e.g. gel dressing) may be placed over the bridge of the nose or any other pressure points prior to placing the machine interface device mask onto the patient.

2. Skin integrity at the mask interface will be assessed and documented by the Respiratory Care Practitioner and Registered Nurse every four hours and PRN, OSA patients may be excepted.
3. If an area of skin breakdown is noted, the issue will be immediately escalated to the Registered Nurse assigned to the patient for that shift who is to consult with the wound nurse
    a. If tolerated, an order for short breaks using other oxygen delivery systems (e.g. Heated High Flow Nasal Cannula, non-rebreather) should be obtained in an effort to minimize any patient discomfort or pressure sores that may appear after extended periods of time from facial masks

3. Patient criteria for use of NiPPV
    1. Patients who choose to forego intubation
    2. Patients who are spontaneously breathing
    3. Patients who are mentally competent and cooperative and not using heavy sedation or narcotics
    4. Patients who are free of excessive pulmonary secretions
    5. Patients with bulbar muscle function adequate for swallowing without risk of aspiration
4. Contraindications for use of NiPPV may include, but are not limited to patients who:
    1. Are unable to self-manage pulmonary secretions and/or require frequent suctioning
    2. Have equipment and/or physical characteristics that will contribute to excessive air leaks with NiPPV (e.g. a nasogastric tube, facial hair)
        a. Although not a contraindication, large amounts of facial hair and gastric tubes will interfere with the mask seal and increase the leak volume.
    3. Are not cognitively aware enough to remove facemask in the event of vomiting
    4. Do not have adequate cough and gag reflex.
    5. Are hemodynamically unstable.
    6. Are not breathing spontaneously

GUIDELINES

~~**Indications**~~

~~A. Type 1 respiratory failure (hypoxic respiratory therapy)~~

~~B. Exacerbation of COPD~~

~~C. Obesity hypoventilation syndrome~~

~~D. Moderate or severe dyspnea~~

~~E. Acute hypercapnia respiratory failure~~

~~F. Hypoxemia~~

~~G. Post extubation~~

~~H. Obstructive sleep apnea~~

I. Congestive heart failure

J. Pulmonary edema

K. Neuromuscular compromise

1. Kyphoscoliosis

2. Muscular dystrophy

Contraindications

A. Recent gastric bypass

B. Facial trauma/burns

C. Basilar or skull fracture

D. Epistaxis causing pulmonary aspiration of blood

E. Active vomiting

F. Copious respiratory secretions

G. Bullous lung disease

H. Untreated pneumothorax

I. Altered mental status, not due to high $PaCO_2$

J. Presence of wrist restraints

K. Any physical restriction leaving the patient unable to remove own NIV mask

Equipment

A. NIV

1. No home NIV/CPAP units are allowed at VCMC/SPH

B. Circuit

1. Heated

i. Heater

ii. Sterile water

2. Non-Heated

C. Filter

D. Mask

1. Use sizing guide to choose appropriate size

2. Headgear to fasten the mask to the patient's face

E. 22 mm adapter

1. Only when connecting to trach patients

F. Duoderm or other protective barrier may be used to help prevent skin breakdown on bridge of nose where the mask is fitted to the patient's skin as needed.

Initiating

A. Verify order

B. ~~Perform system self-test before implementation~~

C. ~~Nasogastric feeding tubes should not be in use~~

D. ~~Review special circumstances for pediatric patients vs adults~~

1. **Indications include, but are not limited to (1)**
    1. Dyspnea
    2. Tachypnea
    3. Increased work of breathing
    4. Hpercapnic respiratory acidosis
    5. Hypoxemia
2. **Contraindications (1)**
    1. Cardiac arrest
    2. Respiratory arrest
    3. Cardiac instability
    4. Hypotension
    5. Upper GI bleeding
    6. Impaired cough or swallowing
    7. Decreased level of consciousness
    8. Status epilepticus
    9. Poor secretion clearance
    10. Extensive head or neck tumors
    11. Tumor that causes extrinsic airway compression
    12. Angioedema or anaphylaxis that causes airway compromise
    13. Vomiting
    14. High risk of aspiration
    15. Confusion
    16. Inability to cooperate
    17. Agitation
    18. Bowel obstruction
    19. Upper GI surgery
    20. Upper airway surgery
    21. Life-threatening hypoxemia
    22. Facial trauma or surgery
    23. Airway or facial burns
    24. Untreated pneumothorax
3. **Equipment**

A. Non Invasive Ventilator
   a. Rescue NIV device
   b. NIV device for consideration of Obstructed Sleep Apnea
      i. Physcians requesting NIV for suspected OSA with no sleep study for setting suggestions may order NIV with "Auto Titration" per manufacture guildelines.
   c. Home units will be used as approved by the Respiratory therapy and Biomed.(refer to policy R. 99)
      i. If a patient used a home NiPPV unit and requires rescue NiPPV ventilation, a hospital NiPPV system will be used until the home unit is approved for use in the hospital
B. Circuit
   a. Heated
      1. Heater
      2. Sterile water
      3. Place on heated circuit if on longer than 24 hours continuously.
   b. Nonheated
      i. OSA patients
C. Bacteria filter
D. Mask
   a. Use sizing guide to choose appropriate size
   b. Headgear to fasten the mask to the patient's face
   c. Gel barrier (if needed)
E. Suction Equipment as needed
F. Pule oximeter and probe
G. Vital signs monitoring equipment
H. Stethoscope
I. Gas source that can supply 50 psi (unless ventilator has internal compressor)
J. Manual resuscitation bag with reservoir
K. 22 mm adapter
   a. Only when connecting to trach patients

4. **Initiating**
   A. Verify active order in Electronic Medical Record
   B. Verify patient with 2 patient identifiers
   C. Perform proper hand hygine and adhere to contact percautions
   D. Explain the device and its purpose, how the mask is applied, the duration of use, and any restrictions or accommodations to eating/drinking during therapy.
   E. Initial set up of NIV equipment in accordance with the NIV machine manufactured guidelines.

F. Determine appropriate size and style of interface mask

a. Instruct patient how to quickly release the mask in an emergency

G. Placepatient on device with interface connected

H. Observe the patient for any leaks or discomfort and readjust as needed

I. Ensuring that all NIV machine alarms are set appropriately and audible.

J. Review special circumstances for pediatric patients vs adults

a. Age is not a limitation for NIV in hypercapnic respiratory failure

5. **Monitoring**

A. Vital Signs

1. Pulse Oximetry
2. Heart Rate
3. Monitor level of consciousness
4. Breath Sounds
5. Respiratory Rate

~~Monitor Leak~~

~~1. Leak should never be <7 cmH_20~~

~~2. <7 cmH_20 will result in a HAPU~~

B. Trach patients

1. Heated circuit will be immediately used
2. Patient will be on continuous monitoring

~~Use a 15 mm to 22 mm connector, to attach to Omni flex~~

3. Passy Muir may not be used in line with non-invasive ventilation

C. When a patient has altered mental status, due to elevated PCO2

1. Will be checked Q1H (every hour) by Nursing or ~~RT~~Respiratory

a. Changes in sensorium should be noted by ~~RN~~nursing

b. If status changes and patient is no longer altered, and able to remove mask checks should resume as Q2H ~~by RT and RN~~(every 2 hours) by Nursing and Respiratory

2. After 4 hours patient should be re-evaluated to ensure effectiveness of therapy

D. After 48 hours of continuous use patient should be reevaluated

1. Consult with the physician on plan of care
2. Notify wound care if any signs of skin breakdown is present
3. Ensure patient has been placed on heated circuit

E. Pediatric Patients

1. Pediatric patient(s) may be admitted for non-respiratory issues and will continue NIV/Cpap

i. Patients who have stable respiratory status will continue NIV/Cpap care

ii. Patients using NIV/Cpap at home will have home orders verified

iii. Home settings should be used for initial setting, unless otherwise ~~direct~~directed by the physician

iv. RT will work in conjunction with the physician to wean patient to home settings, if applicable

2. NIV may be used for patients in respiratory failure if patient is DNR/DNI status

   a. Patients with unstable respiratory status who are full code should be transferred to higher level of care and not admitted to Pediatric Floor

      a. ER will hold patient until transfer can be arranged

      b. RT will monitor in Emergency Room and provide support to ER staff

   b. NIV may be used while awaiting transfer

3. Ensure ~~a~~an appropriately sized resuscitation bag with mask is at bedside

4. Home NIV/Cpap units are ~~not~~ allowed

   i. Home nasal pillows, mask, or nasal mask may be used

~~**Documentation**~~

~~A. NIV will be checked Q2H, or after changes~~

~~B. NIV checks will be documented in the EHR~~

~~C. Alarms~~

~~1. High Pressure: set 10-15 cm H_2O above IPAP~~

~~2. Low Pressure: set 3-5 cm H_2O below IPAP~~

~~3. Low Pressure Delay: 5-60 seconds~~

~~4. Apnea: set at 20-30 seconds~~

~~i. Apnea alarm must never be turned off~~

~~ii. Apnea alarm should not exceed 30 seconds~~

~~iii. Recurrent apnea alarms should be addressed with physician~~

~~5. Low Minute Volume: set 5-10 ml below calculated average~~

~~i. Should be set < 6.0 ml~~

~~ii. High Rate: set 10-15 bpm above patient effort~~

~~6. Max rate should be 45 bpm~~

~~7. If rate is sustained over 40 bpm for 30 minutes the physician should be notified~~

~~8. Low Rate: set at 8 bpm~~

~~9. High Tidal Volume: 200-300 ml above~~

~~10. Low Tidal Volume: 200 ml below patient effort~~

~~11. Ti/Ttotal: set 0.3 to 0.4 secs~~

~~i. Greater than 0.4 secs indicates patient fatigue~~

~~ii. Longer inspiratory time may increase auto-Peep~~

6. **In-patient Level of Care**
    1. Intensive Care Unit (ICU) level of care is required for the following condition
        a. FIO2 (fraction of inspired oxygen) >60%
        b. IPAP (inspiratory positive airway pressure) > 22cmH20
        c. Patient meeting ICU criteria per LP guidelines
    2. Medical Surgical or Telemetry level of care is appropriate for the following condition
        a. Obstructive Sleep Apnea
        b. Other conditions where the patient has chosen to forego intubation yet requires rescue NiV for pallitive or comfort Care
7. **Documentation**
    A. Home NIV units will not be checked by RT (refer to policy R. 99)
    B. Chronic OSA patients using the hospital's NIV machines will be checked Q6 (every 6 hours)
    C. Acute patients in ICU, PICU, NICU and ER, will be checked *Q2 (every 2 hours)*
    D. NIV on medical floors and DOU will be checked Q4 (every 4 hours)
    E. NIV checks will be documented in the EHR with following items
        a. NIV sytem settings
            i. Settings must match LP orders
        b. Skin assessment
        c. Patient tolerance
        d. Type and size of interface
        e. Alarms
            i. Per manufacturer guidelines
            ii. To adhere to National Patient Safety Guidelines
        f. Vital Signs
        g. Date and time therapy starts, ends and/or changes
        h. Unexpected outcomes and related interventions
8. **Discontinuation**
    A. An order shall be obtained for discontinuation of non-invasive ventilation
    B. The physician should be contacted after 24 hours of non-use
        1. Re-evaluation of necessity
        2. Change in therapy is applicable
    C. Discontinued equipment will be removed before end of shift
    D. RT will document in the EHR discontinuation
9. ~~**Cleaning**~~
    ~~A. Ventilators will be cleaned using PDI Sani Wipes AF3~~

~~1. Allow to fully dry~~

~~2. Bag and return to clean room~~

Cleaning

A. Devices shall be wiped down using proper Infection Control guidelines

1. Adhere to manufacturer dwell time

2. Place equipment bag over device and store in clean room

Source: 1. Lippincott Solutions, Lippincott Procedures. "Noninvasive positive-pressure ventilation, respiratory therapy", November 28, 2002. Lippincott® Solutions (lww.com)

All revision dates:	7/24/2024, 5/3/2018, 2/1/2014, 2/1/2012, 7/1/2011, 6/1/2011, 5/1/2011, 2/1/2010, 10/1/2009, 7/1/2008, 7/1/2007

Attachments

No Attachments

Approval Signatures

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Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/24/2024

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Policy Area:	*Respiratory Care*
References:	

R.99 Patient's Own Respiratory Support Equipment

Policy:

Ventura County Medical Center & Santa Paula Hospital shall provide safe and consistent guidelines for patients to use their home respiratory support equipment.

Purpose:

To provide care for patients using personal, patient-owned respiratory support devices, such as a Non-Invasive Ventilator or Invasive Ventilator for respiratory support.

To identify responsibilities of the Registered Nurse (RN) and Respiratory Care Practitioner (RCP) caring for patients using patient-owned respiratory support equipment.

To provide a process to communicate that patient-owned equipment is in the facility, and that it is inspected for safe use.

To set forth guidelines for the patient care providers to inspect the equipment for cleanliness and basic functionality.

Procedure:

A. When using patient-owned device, the following steps must be performed to confirm appropriate and safe use of home equipment:

B. Nursing Care Management:

1. RN will confirm the physician order for the use of the patient's personal respiratory support equipment while in the hospital and RN will notify the Respiratory Care Services Department of order and that a patient has their own home equipment.

C. Respiratory Care Management:

1. RCP (Respiratory Care Practitioner) will confirm the physician order for the use of the patient's personal equipment.
2. RCP will assess the patient equipment for cleanliness.
3. RCP will notify Biomed department. See policy *F.62 Use of Personal Electrical Equipment* and *F.108 Electrical and Equipment Safety Policy*.

4. RCP will observe the patient and/or family member demonstrate proper care, application, and troubleshooting of personal equipment.
5. RCP will document in Electronic Health Record (EHR) on patient's chart under Respiratory notes that this was done.
6. RCP will provide patient and/or family member Attachment A: Patient-Owned Respiratory Device Agreement.

D. If at any time during patient stay, the RN or RCP determines the patient-owned equipment is not in the proper condition for use and/or unable to provide appropriate therapy, the patient's personal equipment will be discontinued, and therapy will be provided using hospital equipment.

E. If there is a change in orders requiring a change in ventilatory settings with the patient-owned device or the device cannot meet the physician orders, the patient's personal equipment will be discontinued, and therapy will be provided using hospital equipment.

F. Care will be taken to make sure power cords and patient tubing are placed appropriately to provide safe movement of patient and caregivers.

G. RCP will wipe the machine with hospital approved cleaning wipe and adhere to proper wet time.

H. RCP will ask patient and/or family member to turn on machine to ensure presence of adequate airflow and absence of error message on device's display read-out.

I. RCP will educate the patient and/or family member that the expectation for continued use of their personal equipment requires independent set up and appropriate use of their personal equipment throughout their hospital stay.

J. RCP will observe the patient and/or family member demonstrate that the equipment parameters and automatic safety settings are set appropriately.

1. NOTE: If there is uncertainty about the patient and/or family member's comprehensive knowledge of the equipment, the patient's therapy will be provided using hospital owned equipment.

K. If the RCP inspection determines the above criteria has been met, the patient owned-equipment may be used for therapy as ordered.

L. If at any time the home equipment does not meet criteria, it is to be tagged NOT TO BE USED and should be taken out of the facility by family member if possible. RCP will provide a detailed hand-off at shift change to the on-coming RCP including but not limited to the approval or denial of the use of the patient-owned respiratory support equipment.

DOCUMENTATION

A. RCP will perform a patient assessment on initial use and as needed to confirm proper therapy is being provided by the patient's personal equipment and that the patient and/or family member understands the expectations for continued use of their personal equipment while in the hospital.

1. If the patient-owned equipment is discontinued for failure to meet the criteria included within this policy, the RCP will notify the physician and document in the EHR what criteria was not met.

All revision dates: 6/21/2022, 3/8/2022

Attachments

Patient-Owned Respiratory Devices Agreement

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Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/26/2024

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Policy Area:	*Rehab Services*
References:	

RS.15 Assessment (Scope of Assessment)

Physical Therapy Patient Assessment:

All patients shall have an evaluation completed at the initial visit by a Physical Therapist in the Electronic Medical Record (EMR). The initial assessment is performed to determine the needs of the patient and to provide a database which is utilized in assessing the response to treatment. The initial assessment may include but is not limited to the following:

- Date of evaluation
- Diagnosis or condition necessitating referral to Physical Therapy (PT)
- Date of surgery or injury pertinent to diagnosis
- Physician's orders for service, if specific
- Precautions, limitations or contraindications for treatment, if any
- A brief history obtained from patient, EMR or medical chart, which may include a social history, occupation, developmental history, living environment, health habits, history of current conditions, medications, past interventions, past medical and surgical history, prior functional activity level.
- Test and measures are performed using standardized methods and may include one or more of the following:
    a. Muscle Function (gross/specific)
    b. Reflex testing
    c. Range of motion
    d. Sensory integrity
    e. Endurance
    f. Balance and coordination
    g. Functional assessment for age
    h. Pain
- Any limitations/needs are noted with comments:
    a. Wound – size, location, drainage, infection, odor
    b. Body condition – frail, obese, healthy, deconditioned
    c. Vision
    d. Hearing

e. Communication needs

- A body outline stamp may be utilized to define problems.
- A list of equipment needed now or in the future to achieve goals.
- Any planned surgical procedure is listed, if known.
- A comment on patient's attention, attitude, motivation.
- Social/living situation
- Referral recommendations
- Discharge planning is begun during the initial assessment with attention to functional and equipment needs for discharge.

Treatment Goals:

- Each treatment goal should be functional and measurable with an estimated time frame of achievement. The patient's goals are to be recorded. Goals are determined after completion of the evaluation and discussion with the patient/family and/or significant other.
- A prognosis is made on the potential to achieve the treatment goals (fair, good, excellent).
- Goals are revised as necessary.
- Barriers to goal achievement and factors that will facilitate goal achievements are noted.

Individualized Assessment:

The assessment process will include evaluation of those areas appropriate to the patient's needs based on age, diagnosis, and medical status. In addition to the items on the general evaluation, the following may be addressed as needed for age specifics:

~~A. Pediatric Tools used for evaluations include but are not limited to:~~

~~1. Gesell Developmental Schedules;~~

~~2. Bayley Skills of Infant Development;~~

~~3. GMFM- Gross Motor Function Measure~~

~~4. Peabody~~

~~5. HELP- Hawaii Early Learning Profile~~

~~6. Brunicks~~

~~7. VMI- Visual Motor Inventory~~

~~8. TVPS- Test of Visual Perceptual Skills.~~

~~B. General description of child and families participation in the assessment.~~

~~C. Living situation, including information about the house, multiple families living in the home, other disabled individuals living in the home, etc.~~

~~D. Include whether child is in school/ day care or other special programs.~~

~~E. Include whether child has been receiving other therapy services or whether child will be referred to other out-patient therapy services or programs.~~

~~F. If child has had multiple hospitalizations, include past level of function and whether there has been change in function.~~

~~G. List any adaptive equipment child may have and whether any changes will be recommended for~~

~~equipment.~~

~~H. List any behavioral issues/problems and whether family is receiving any services in this regard, or whether child is on any behavioral medications.~~

~~I. List whether child has any sensory issues such as visual, tactile, auditory sensitivities which affect the child's ability to participate with therapy.~~

Assessment Criteria:

Licensed therapists will perform initial assessments at the following times or under the following conditions:

- Prior to the initial treatment session when physician orders are received for therapy.
- When trigger/screening criteria developed by the services are identified and the physician agrees to an assessment.

Timely Completion of Assessment:

Inpatient assessments will be completed within the following time frames:

Physical Therapy

- Inpatient referrals will be assessed within 24-72 hours of receipt of the order for physical therapy. The following are general guidelines:
  - orthopedic and post operative within 24-48 hours
  - medical and mental health referrals within 48-72 hours

  Refer to the policy on referral response time frames for more specific guidelines.
- Out-patient referrals will be scheduled ~~within 1-3 weeks of receipt of referral and will be prioritized~~ based upon patient need (acute versus chronic). Acute diagnoses are given priority and seen within 1-2 weeks.

Documentation of the assessment findings will be done following the documentation guidelines for the department.

Inpatient assessment findings will be written in the EMR immediately following the treatment.

Out-patient assessment documentation will be completed within 72 hours of the completion of the evaluation visit.

Notification of Physician – Significant Findings:

When assessment findings warrant immediate response for inpatients or out-patients, the physician or his office will be notified and the report of the significant findings and discussion documented.

Referrals for Assessment by Other Providers:

A request for assessment/treatment by other services will be made when:

- The therapist identifies any other deficit that requires therapeutic intervention.
- The caregiver identifies a learning need that can best be addressed by another service (i.e. diabetes counseling, nutrition).

Referrals will be made in the following manner:

- For treatment requiring physician's orders, the physician will be contacted for consultation and request of

the order. This may be done, at the therapist's discretion using any of the acceptable communication procedures available (documentation of request in EMR, recommendation on physician progress statement, phone call, communication through multidisciplinary team meetings, etc.)

Priorities for Care: Inpatient

As part of the assessment process, the evaluating therapist will identify patient problems, deficits, needs and issues and will establish a priority for addressing those needs based on the following scale:

High Priority	The need, problem, deficit or issue is significant, interferes with the patient's ability to achieve desired outcomes or functional status and must be addressed within the first 3 days of service.
Medium Priority	The need, problem, deficit or issue is moderate, interferes with the patient's ability to achieve the desired discharge outcome to a lesser degree and needs to addressed during their admission.
Low Priority	The need, problem, deficit or issue is either long-standing and unlikely to respond to short-term interventions or is of a lower significance in affecting the outcome of this patient stay and will not likely be addressed during their admission.

~~Priorities will be documented in the initial evaluation.~~

Ongoing Assessment:

In addition to the formal assessment and reassessments that are performed by therapists based on the above time frames and criteria, the patient is assessed for response to treatment and change in needs at each visit. Objective measurements may include vital signs, strength, range of motion, endurance and other indicators that measure progress or lack of progress. These indicators may be recorded by a physical therapist assistant. PTA and therapy aides involved in the patient's care, and will report any noted signs, symptoms or subjective data to the therapists responsible for the patient so that this data can be included in the overall assessment and care of the patient.

Utilization of Assessment Data:

All assessment data will be documented in the medical record. This data will be utilized to establish priorities for care and develop a plan of care, educational plan and goals for patient treatment. The initial and subsequent measurements will be used to determine progress of the patient and to reevaluate needs during the care process.

Treatment Plan:

- The treatment plan is based on the patient assessment and functional goals. The treatment plan is discussed with the patient/ family and/ or caregiver and verbal consent obtained. The treatment plan is revised based on patient progress.
- Procedures utilized may include but are not limited to therapeutic exercise, functional activities, posture training, endurance training, gait training, coordination skills training and manual therapy techniques.
- Physical modalities available include but are not limited to heat, cold, water, electrical currents, sound and mobilization.
- Bronchopulmonary hygiene (postural drainage) is a function of the Respiratory Department.
- Training is provided in the proper use of equipment to maximize function (i.e., wheelchair, walker,

crutches, and cane).
- Gait training may include orthotics, donning/doffing of prosthetics, and basic ambulation to advanced functional skills.
- Various exercise equipment is used to regain strength, motion and function (free weights, balls, upper body ergometer, bicycle, platform and floor mats, etc.).
- Instruction in a home exercise program with written instructions is a part of the treatment plan where applicable. Patient/family education regarding various aspects of the treatment plan is ongoing and may include but is not limited to instruction in edema control, scar management, skin care, use of assisting devices, transfer techniques, etc.
- Treatment time is planned to optimally provide one-on-one care with preference to "hands on techniques."
- Frequency and estimated duration of treatment plan
- Electronic signature or full signature of the treating therapist or therapist of record.
- Revision of the treatment program may occur as the patient progresses or if the patient is not responding to the current approach.

Progress Record:

- Completion of the initial evaluation is documented in the patient's progress record along with the completed evaluation form.
- Each visit is recorded by date and documented by therapist.
- A List of modalities/procedures utilized is recorded by date and total time of treatment.
- Response to treatment, especially change or progress is documented.
- Home exercise or instructions in splint use, edema controls, etc., to patient/family is noted.

All revision dates:	9/23/2024, 12/8/2020, 6/1/2006, 2/1/2006, 2/1/2005, 10/1/2001, 10/1/1998, 10/1/1995, 12/1/1992, 5/1/1990

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	9/23/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.22 Assessments - Neonatal Intensive Care Unit (NICU)

PURPOSE:

To establish guidelines for referral to developmental specialist in the Neonatal Intensive Care Unit (NICU) (California Children's Services (CCS) paneled Occupational Therapist (OT) or Physical Therapist (PT) with specialized training in developmental assessments).

POLICY:

Babies will be screened for referral to developmental specialist by nursing and physicians.
Therapists attending rounds will participate in the screening process.

REFERRAL CRITERIA:

A. NICU staff will generate a referral to the developmental specialist based upon the following criteria:
   1. Infant meets standard for High Risk Clinic as defined by CCS standards and may include the following:
      a. Birth weight less than 1500g
      b. Assisted ventilation for longer than 48 hours
      c. Birth depression with a five minute Apgar of three or less
      d. History of seizure activity
      e. Documented intracranial abnormality
      f. Other potential neurologic pathologies such as central nervous system infection or intraventricular hemorrhage greater than grade one
      g. Infant was born preterm at <37 weeks gestational age
   2. Child has high risk medical condition that is not defined by CCS High Risk Infant standards but is considered by team to have concerns for developmental delay.
   3. Child appears to be functioning below developmental level.
   4. Infant is not feeding according to developmental level
   5. Staff has identified possible developmental issues such as hypo or hypertonia.

6. Staff has identified possible concerns with range of motion or positioning which may affect developmental outcome.
7. Family needs education regarding developmental facilitation.
8. Family requires referrals to community resources servicing developmental needs.
9. Child was drug-exposed anytime during the pregnancy.

B. Intervention goals are :

1. Early identification of developmental delay or neurological impairment.
2. Appropriate home programming and parent education to prevent or ameliorate problems.
3. Advance oral feeding skill development and safe consumption of nutrition.
4. Promote optimal long-term development outcomes and nurture psychosocial care of infant-parent relationship.
5. Referral to appropriate community agencies in consultation with primary physician as indicated.
6. Assist parent in transitioning from hospital to home care and out-patient services.

PROCEDURE:

A. Staff will have attending physician write order in the Electronic Medical Record (EMR) for Developmental Assessment or Feeding Assessment, or whichever assessment is appropriate.

B. In the event that the child is acutely ill or has an eminent discharge preventing an in-house developmental assessment, a referral for an out-patient developmental evaluation can be sent to the out-patient rehab department. An out-patient appointment for the assessment will be arranged for the family prior to discharge.

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Attachments

No Attachments

Approval Signatures

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Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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VENTURA COUNTY
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Owner:	*Gwendolyn Vontoure: Director Perioperative Services*
Policy Area:	*Surgical Services*
References:	

S.95 Standardized Procedure for the Certified Registered Nurse First Assistant (CRNFA)

PURPOSE

The purpose of this Certified Registered Nurse First Assist standardized procedure is to outline the standards and guidelines that must be followed to promote high-quality, safe, and effective care of the patient undergoing surgical or invasive procedures.

BACKGROUND INFORMATION

Under general direction of the Director of Perioperative Services and Surgical Leadership, the Certified Registered Nurse First Assistant (CRNFA) is responsible for the delivery of safe, effective, and quality patient-family centered care, pre-operatively, intra-operatively, and post-operatively, including tasks and procedures performed under the direction of the surgeon within scope of practice and training.

CRNFA Standardized Procedures

The CRNFA may perform the following technical functions in the following settings:

Preoperative

1. Interviews surgical patients for a comprehensive nursing documentation.
2. Performs a nursing physical assessment.

Intraoperative

1. The CRNFA may assist with the positioning, prepping, and draping of the surgical patient or perform independently if directed by the primary surgeon.
2. The CRNFA may provide retraction through:
    a. Close observation of the operative field
    b. Demonstration of stamina for sustained retraction
    c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissues.
    d. The retraction of tissues or organs by use of hand or hands
    e. Packing sponges or laparotomy pads into body cavities to hold tissues or organs out of the operative field.

f. Managing instrumentation on the surgical field to prevent obstruction of the surgeon's view.
g. Anticipated retraction needs with knowledge of the surgeons' preferences and anatomical structures.

3. Perform hemostasis by:
   a. The application of electrocautery tips or clamps to vessels in a safe and knowledgeable manner as directed by the surgeon.
   b. Sponging and utilizing pressure as necessary
   c. Utilizing suctioning techniques
   d. Placing suture ligatures in the muscle, subcutaneous, and skin layers
   e. Placing hemoclips on bleeders as directed by the surgeon.
4. Perform knot tying by:
   a. Possessing knowledge of basic knot tying techniques
   b. Firmly tying knots to avoid slipping.
   c. Avoidance of undue friction to prevent the fraying of sutures.
   d. Carrying the knot down to the tissue wit the tip of the index finger and laying the strands flat
   e. Approximating the tissue rather than pulling tightly to prevent necrosis.
5. Provide closure of layers by:
   a. Correctly approximating the layers under the direction of the surgeon.
   b. Knowledge demonstration of different types of closure.
   c. Correctly approximating skin edges when utilizing skin staples.
6. Intraoperative Tissue Manipulation; under the direction of the surgeon, the CRNFA will manipulate tissue and use surgical instruments during a surgical procedure to:
   a. Expose and retract tissue.
   b. Clamp and sever tissue.
   c. Grasp and fixate with screws, staples, and other devices.
   d. Drill, ream, and modify tissues.
   e. Cauterize and approximate tissues.
7. The CRNFA will assist the surgeon at the completion of the procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying dressings.
   c. Assisting with the application of casts, plaster splints, or other devices as determined by the surgeon.

Postoperative

1. The CRNFA may be dismissed from the procedure once an adequate replacement is present (physician)
2. The CRNFA will assist with patient recovery, transportation, and admission to the designated nursing unit.
3. The CRNFA will perform dressing changes, if necessary
4. The CRNFA can remove casts, drains, catheters, IV's ,or staples and sutures

Follow-up Treatment

1. The CRNFA will round on post-surgical patients and follow up directly with the Surgeon and Anesthesiologist to address immediate patient care needs.

Documentation

1. The CRNFA will document in the Electronic Health Record (Cerner), all abnormal findings, provider notifications, medications/treatments, and patient response.
    a. Preoperative Nursing Assessments
    b. Intraoperative Nursing Assessments
    c. Postoperative Nursing Assessments

Competency Assessment and Orientation Requirements

1. The CRNFA will demonstrate their knowledge base and technical skills set:
    a. Completion of a registered nurse first assistant training from an accredited graduate nursing program
    b. Completion of 120 hours of orientation in the Operating Room with a qualified surgeon.
    c. The CRNFA will observe the surgeon perform each procedure three times and perform the procedure three times under direct supervision.
    d. During orientation the surgeon will complete the CRNFA's competency assessment form.
    e. It is the responsibility of the CRNFA to complete the competency assessment, providing one copy to the Perioperative Educator.
    f. Medical indication and contraindication of the surgical procedure.
    g. The risks and benefits of the surgical procedure.
    h. Anatomy and physiology are associated with surgical procedures.
    i. The Hospital consent process
    j. The steps involved in the surgical procedure.
    k. Ability to accurately document the surgical procedure.
    l. Ability to interpret diagnostic results and implications.
    m. Complete annual skills/competency requirements

Clinical Privileges

In order to provide patient care services, the CRNFA and the supervising physician(s) must delineate clinical privileges commensurate with relevant training, experience, and competence on the Certified Registered Nurse First Assistant Privilege Checklist. Clinical privileges and the standardized procedure may be approved for up to 2 years and must be renewed. Privileges are subject to standard focused professional practice evaluations (FPPE).

~~1. Education Requirements:~~
    ~~a. Current license issued by the California Board of Registered Nurses (BRN)~~
    ~~b. Successful completion of a fully accredited RNFA program, using (AORN Core Curriculum for Registered Nurse First Assistant as the foundation)~~

~~c. At least 2 years of previous experience as an registered nurse first assistant~~

~~d. Certified Nurse Operating Room (CNOR)~~

1. Education Requirements:
   a. Current license as a Registered Nurse, issued by the California Board of Registered Nurses (BRN)
   b. Certified Nurse Operating Room (CNOR)
   c. Equivalent to two (2) years of recent full-time registered nurse experience in an acute surgical care nursing/intraoperative setting.
   d. Successful completion of an RNFA program that meets the Association of Operating Room Nurses (AORN) guidelines.

Renewal of Clinical Privileges

1. Continue to meet all privileging requirements
2. Complete the ongoing professional practice evaluation (OPPE) every six months.
3. The CRNFA will submit a clinical practice outcomes log with each renewal of privileges.
   a. This log will include the number of procedures performed per year, and any adverse outcomes.
      i. If an adverse outcome occurs, a copy of the procedure note will be submitted.

POLICY

1. The CRNFA will be employed by the hospital.
2. Practice under the direct supervision of the surgeon during the procedure.
   a. Exception:The CRNFA may complete the closure of subcutaneous tissue and skin with the surgeon immediately available.
3. The CRNFA will be integrated into the block schedule, based upon:
   a. Operational needs of the Department
   b. Service Line needs
4. The CRNFA will conduct services based on the daily operating room assignments and operational needs of the department.
5. Only perform as a CRNFA and not concurrently as the Scrub Technician or Scrub Nurse.
6. The CRNFA will perform duties in the hospital surgical departments.
7. If the primary surgeon is unable to complete the surgery a qualified surgeon shall be called to complete the procedure.
8. Only in extreme emergency situations will the CRNFA be expected to assist with procedures that present an unusual hazard to life.
9. The CRNFA must adhere to the policies and procedures set forth by Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).
10. The CRNFA must function within the scope of practice as stated by the Nurse Practice Act of the State of California.
11. The CRNFA will follow the Association of Operating Room Nurses (AORN), Registered Nurse First Assistant Standards of Practice.

DEFINITIONS

1. CRNFA: Certified Registered Nurse First Assistant (CRNFA)
    a. A Registered Nurse (RN) that has undergone specialized training to render direct patient care in the role of a surgical first assistant.
    b. In this expanded role utilizes a specialized knowledge base and skills set and judgment to competently assist the surgeon in performing a combination of nursing and medical functions.
    c. The role is governed by the Board of Registered Nursing (BRN), guided by the Association of Operating Room Nurses Standards and Recommended Practices.
2. AORN: Association of Operating Room Nurses

Education/Training/Licensure/Certification

1. All Certified Registered Nurse First Assistants requesting privileges must complete the hospital credentialing process and provide documentation that they meet the clinical competence requirements:
    ~~a. Current license as a Registered Nurse, issued by the California Board of Registered Nurses (BRN)~~
    ~~b. At least 2 years of previous experience as an registered nurse first assistant~~
    ~~c. Successful completion of a fully accredited RNFA program, using (AORN Core Curriculum for Registered Nurse First Assistant as the foundation)~~
    ~~d. Certified Nurse Operating Room (CNOR)~~
    a. Current license as a Registered Nurse, issued by the California Board of Registered Nurses (BRN)
    b. Certified Nurse Operating Room (CNOR)
    c. Equivalent to two (2) years of recent full-time registered nurse experience in an acute surgical care nursing/intraoperative setting.
    d. Successful completion of an RNFA program that meets the Association of Operating Room Nurses (AORN) guidelines.

Reference

Standardized procedures are not subject to prior BRN approval but must adhere to the following guidelines of the Board of Registered Nursing, title 16, the California Code of regulations (CCR), section 1474, and the Medical Board of California, Title 16 CCR Section 1379

All revision dates: 9/4/2024, 3/4/2024

Attachments

S.95 Standardized Procedures for the Certified Registered Nurse First Assistant Attachment-A Approval and Agreement_1 (4) (3).docx

Approval Signatures

Step Description	Approver	Date
Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	9/13/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/4/2024
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	9/4/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Trauma Services*
References:	

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. Medication reconciliation must be performed by licensed practitioner (LP) of the admitting medical team within 48 hours of admission.
2. 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).
3. 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
4. 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.
5. 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.
6. 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 (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:

Attachments

T Med Protocol.pdf

Delineation Of Privileges

Certified Registered Nurse First Assist (CRNFA)

Name:

Privilege	Requested	Granted

Basic Criteria:
a. Successful completion of RNFA training from an accredited graduate nursing program (using AORN Core Curriculum as a foundation)
b. Current Certification in Perioperative Nursing (CNOR)
c. Current BLS, ACLS, PALS, and NRP Certifications, with hands-on skills component
d. Equivalent to ~~A~~a minimum of 2 years of ~~clinical experience as an RNFA~~full time registered nurse expierence in an acute surgical care nursing/intraoperative setting
e. Validation of clinical experience by a qualified surgeon

Evaluation Requirements:
A minimum of the first 3 cases proctored

Renewal Criteria:
Continue to meet the basic requirements and participate in a minimum of 60 surgical cases in the previous 2 years*

** If the case volume has not been met, initial orientation requirements outlined in the standardized procedure or additional evaluation may apply*

Privileges are requested in accordance with S.95 Standardized Procedure for the Certified Registered Nurse First Assistant (CRNFA) and at the direction of the supervising surgeon.

Provide surgical exposure during procedure	___	___
Perform hemostasis	___	___
Suturing/knot tying	___	___
Interoperative tissue manipulation	___	___
Use of surgical instruments	___	___
Patient record keeping to include: preopertive nursing assessment, intraopretive nursing assessment, postoperative nursing assessment	___	___
Robotic Surgical Bedside Assistant	___	___

Initial Criteria:
a. Certificate of Training from Intuitive Surgical (Xi module)
b. Vendor bedside training to include at minimum; set up, patient positioning and equipment orientation

Evaluation Criteria:
A minimum of the first 2 cases proctored

Renewal Criteria:
a. A minimum of 8 robotic-assisted surgeries per calendar year
b. Failure to meet the minimum annual volume; repeat training and or proctoring may be required at the discretion of the Robotic Steering Committee

Delineation Of Privileges

Certified Registered Nurse First Assist (CRNFA)

Name:

Privilege	Requested	Granted

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

Applicant’s electronic signature on file

Approve requested privileges:

Supervising Physician's Signature: _____ Date: _____

TEMPORARY PRIVILEGE APPROVAL

Department Chief’s Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] INITIAL [ ] RENEWAL APPROVAL

_____
Department Chief Date