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

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

November 14, 2024

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

1. L.CHEM 2.16 Triiodothyronine (T3)
2. PH.20 Recalled/Discontinued Medication
3. PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays
4. RS.14 Rehab Services Documentation Requirements

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

#	Title	Review Period	Summary of Changes
1	L.CHEM 2.16 Triiodothyronine (T3)	Biennial	Migrated from paper format to PolicyStat. Biennial review with no changes.
2	PH.20 Recalled/Discontinued Medication	Triennial	Triennial review of policy with minor updates to reflect current practices.
3	PH.100 Kit Check for Pharmacy Boxes, Kits and Anesthesia Medication Trays	Triennial	Updated policy and attachment to include short dated beyond use date sticker for refrigerated item.
4	RS.14 Rehab Services Documentation Requirements	Triennial	Triennial review of policy with a minor edit.

Status **Active** PolicyStat ID **15649967**

Origination	3/30/2013	Owner	Yewubdar Argaw: Supervisor-Chemistry, Laboratory Services
Last Approved	10/15/2024		
Effective	3/30/2013		
Last Revised	10/15/2024	Policy Area	Laboratory Services - Chemistry
Next Review	10/15/2026		

L.CHEM 2.16 Triiodothyronine (T3)

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Policy

TRIIODOTHYRONINE (T3)

Principle of the Test

The ADVIA Centaur T3 assay is a competitive immunoassay using direct chemiluminescent technology. T_3 in the patient sample competes with a T_3 analog, which is covalently coupled to paramagnetic particles in the Solid Phase for a limited amount of acridinium ester-labeled monoclonal mouse anti-T_3 antibody in the Lite Reagent.
The system automatically performs the following steps:

Reagents

Storage and Stability

- Store the reagents upright at 2 – 8°C.
- Lite Reagent and Solid Phase stable until the expiration date on the pack label, or for 28 days onboard the system.
- T3/T4/VB12 Ancillary Reagent stable until the expiration date on the pack label, or for 14 consecutive days after accessing the ancillary reagent pack.
- T3 Diluent stable until the expiration date on the vial label.
  CAUTION:
- Discard the primary reagent packs at the end of the onboard stability interval.

Do not use reagents beyond the expiration date.

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Ingredients

Reagent ingredients for the ADVIA Centaur T3 assay are as follows:

Reagent	*Volume*	*Ingredients*
Lite Reagent	8.0 mL/ reagent pack	Monoclonal mouse anti-T_3 antibody (~60 ng/mL) labeled with acridinium ester in buffered saline with sodium azide (0.1%), sodium barbital, and ANS
Solid Phase	24.0 mL/ reagent pack	T_3 analog (~13.3 µg/mL) covalently coupled to paramagnetic particles in HEPES buffer with sodium azide (0.1%), sodium barbital, and ANS
T3/T4/VB12 Ancillary Reagent	25.0 mL/ reagent pack	0.4N sodium hydroxide
T3 Diluent	10 mL/vial	human plasma and sodium azide (0.1 %)

Risk and Safety

- **HARMFUL:** Harmful if swallowed. After contact with skin, wash immediately with plenty of soap and water. Contains: sodium azide; Lite Reagent, Solid Phase.
- **IRRITANT:** Irritating to eyes and skin. In case of contact with eyes, rinse immediately with plenty of water and seek medical advice. Wear suitable gloves and eye/face protection. Contains: sodium hydroxide; Ancillary Reagent.
- **CAUTION. POTENTIAL BIOHAZARD:** Contains human source material. While each human serum or plasma donor unit used in the manufacture of this product was tested by FDA-approved methods and found nonreactive for hepatitis B surface antigen (HBsAg), antibody to hepatitis C (HCV), and antibody to HIV-1/2, all products manufactured using human source material should be handled as potentially infectious. Because no test method can offer complete assurance that hepatitis B or C viruses, HIV, or other infectious agents are absent, these products should be handled according to established good laboratory practices.
- **CAUTION:** This device contains material of animal origin and should be handled as a potential carrier and transmitter of disease.
- **NOTE:** Sodium azide can react with copper and lead plumbing to form explosive metal azides. On disposal, flush reagents with a large volume of water to prevent the buildup of azides, if disposal into a drain is in compliance with federal, state, and local requirements.

Specimen Collection and Handling

Specimen Collection

	**BIOHAZARD** All products or objects that come in contact with human or animal body fluids should be handled, before and after cleaning, as if capable of transmitting infectious diseases. Wear facial protection, gloves, and protective clothing.

- Serum is the recommended sample type for this assay.

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- Allow samples to clot adequately before centrifugation.
- This assay requires 50 µL of sample for a single determination.
- Before placing samples on the system, ensure that samples are free of fibrin or other particulate matter and that samples are free of bubbles.

Specimen Storage and Stability

- Keep tubes stoppered and upright at all times.
- Do not use samples that have been stored at room temperature for longer than 8 hours.
- Tightly cap and refrigerate specimens at 2 to 8°C if the assay is not completed within 8 hours.
- Freeze samples at or below -20°C if the sample is not assayed within 48 hours.
- Freeze samples only once and mix thoroughly after thawing.

Procedure

Test Steps

- Dispenses 50 µL of sample and 50 µL of T3/T4/VB12 Ancillary Reagent into a cuvette
- Dispenses 100 µL of Lite Reagent and 300 µL of Solid Phase and incubates for 7.5 minutes at 37°C
- Separates, aspirates, and washes the cuvettes with reagent water
- Dispenses 300 µL each of Acid Reagent and Base Reagent to initiate the chemiluminescent reaction

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reports results according to the selected option, as described in the system operating instructions or in the online help system

An inverse relationship exists between the amount of T_3 present in the patient sample and the amount of relative light units (RLUs) detected by the system.

Clinical Application and Usefulness

For *in vitro* diagnostic use in the quantitative determination of triiodothyronine (T_3) in serum using the ADVIA Centaur and ADVIA Centaur XP systems.

Reagents Special Preparation

No special preparation of reagents is required.

Calibration

The ADVIA Centaur T3 assay is traceable to an internal standard manufactured using U.S.P. (United States Pharmacopeia) material. Assigned values for calibrators are traceable to this standardization.

For detailed information about scheduling a calibration, refer to *Scheduling Calibrators*.

Calibration Material	Calibrator A
Calibration Scheme	Two-point calibration

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Calibration Interval	Every 28 days of any lot
perform a two-point calibration when the following conditions occur	• When changing lot numbers of primary reagent packs • When replacing system components • When quality control results are repeatedly out of range

Defining Calibrator Values

Use the barcode reader to enter the calibrator values from the *Calibrator Assigned Value* card onto the system.

1. At the workspace, select **Calibration**.
2. Select **Calibrator Definition**.
3. Select **Scan Data**.
4. Use the handheld barcode reader to scan the barcodes (from top to bottom) on the *Calibrator Assigned Value* card.
5. Ensure that the calibrator values are correct. After you select Save, you cannot add or delete a test from a calibrator definition.
6. Select **Save**.

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Defining the Master Curve

The ADVIA Centaur T3 assay requires entry of Master Curve calibration data when using a new lot number of Lite Reagent and Solid Phase. Use the barcode reader to enter the Master Curve values from the *Master Curve* card onto the system.

Ensure that the lot number on the *Master Curve* card matches the lot number of the ReadyPack.

1. At the workspace, select **Calibration**.
2. Select **Master Curve Definition**.
3. Select **Scan Data**.
4. Use the handheld barcode reader to scan the barcodes on the *Master Curve* card. **IMPORTANT:** Ensure you are scanning the side of the *Master Curve* card labeled ADVIA Centaur.
5. Select **Save**.

Quality Control (QC)

For detailed QC procedural information, refer to the *Operator's Guide*.

Use commercially available quality control materials with at least two levels (low and high).

Analyze all levels of quality control material on each day that samples are analyzed.

Analyze all levels of quality control material each time a two-point calibration is performed.

Troubleshooting Out-of-Range QC Values

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If the quality control results do not fall within the Expected Values or within the laboratory's established values, do not report results. Take the following actions:

- Verify that the materials are not expired.
- Verify that required maintenance was performed.
- Verify that the assay was performed according to the instructions for use.
- Rerun the assay with fresh quality control samples.
- If necessary, contact your local technical support provider or distributor for assistance.

Results

Reporting Results

As with all *in vitro* diagnostic assays, each laboratory should determine its own reference range(s) for the diagnostic evaluation of patient results.

Reference Interval

- Euthyroid: 60 – 181 ng/dL (0.92 – 2.79 nmol/L)
- Hypothyroid: < 60 ng/dL (< 0.92 nmol/L)
- Hyperthyroid: > 181 ng/dL (> 2.79 nmol/L)

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Units for Reporting Results

The system reports serum T_3 results in ng/dL (mass units) or nmol/L (SI units), depending on the units defined when setting up the assay. The conversion formula is 10 ng/dL = 1.54 nmol/L. You can define the units and the number of decimal places for test results using the Worklist – Test Summary window.

Procedure Notes

Calculations

For detailed information about how the system calculates results, refer to the *Operator's Guide*.

Disposal

Dispose of hazardous or biologically contaminated materials according to the practices of your institution. Discard all materials in a safe and acceptable manner, and in compliance with all federal, state, and local requirements.

Dilutions

- Serum samples with T_3 levels greater than 528 ng/dL (8.13 nmol/L) must be diluted and retested to obtain accurate results.
- The system does not run onboard dilutions for the ADVIA Centaur T3 assay. Use T3 Diluent to dilute samples. Prepare manual dilutions.
- If dilution is required, use T3 Diluent to manually dilute patient samples, and then load the diluted sample in the sample rack, replacing the undiluted sample.
- Ensure that results are mathematically corrected for dilution. If a dilution factor is entered when scheduling the test, the system automatically calculates the result.

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Method Limitations

Reportable Range

The reportable range of the ADVIA Centaur T3 assay is 10 – 528 ng/dL (0.15 – 8.13 nmol/L).

Other Limitations

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed. Additional information may be required for diagnosis.

Specimens that are . . .	***Have an insignificant effect on the assay up to . . .***
Hemolyzed	250 mg/dL of hemoglobin
Lipemic	1000 mg/dL of triglycerides
Icteric	20 mg/dL of bilirubin

Interference testing was determined according to CLSI Document EP7-A2.
For additional information on performance characteristics including cross-reactivity and dilution recovery, see the product information in the ADVIA Centaur T3 product insert.

Equipment and Supplies

- ADVIA Centaur T3 ReadyPack
- ADVIA Centaur Calibrator A
- ADVIA Centaur T3/T4/VB12 Ancillary Reagent
- ADVIA Centaur T3 Diluent (optional)
- ADVIA Centaur Acid Reagent (0.5% H_20_2, 0.1N HNO_3)
- ADVIA Centaur Base Reagent (0.25N NaOH and surfactant)
- ADVIA Centaur Cleaning Solution Concentrate (~52.5 g/L sodium hypochlorite)
- ADVIA Centaur Sample Cups and Caps
- ADVIA Centaur Cuvettes
- ADVIA Centaur Tips
- Reagent Water

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References

1. Siemens Healthcare Diagnostics ADVIA Centaur T3 Product Insert.
2. Siemens Healthcare Diagnostics ADVIA Centaur Reference Manual.
3. Siemens Healthcare Diagnostics ADVIA Centaur XP Operator's Guide.
4. Clinical and Laboratory Standards Institute (CLSI). Clinical Laboratory Technical Procedure Manuals; Approved Guideline, GP2-A5, 2006.

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5. Clinical and Laboratory Standards Institute (CLSI). Interference Testing in Clinical Chemistry; Approved Guideline, EP7-A2, 2005.

All Revision Dates

10/15/2024

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/15/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	10/8/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	6/17/2024
Laboratory Services Department	Yewubdar Argaw: Supervisor-Chemistry, Laboratory Services	6/17/2024

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Status **Active** PolicyStat ID **16872815**

Origination	6/1/1995	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	10/11/2024		
Effective	10/11/2024	Policy Area	Pharmacy Services
Last Revised	10/11/2024		
Next Review	10/11/2027		

PH.20 Recalled/Discontinued Medication

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POLICY:

The Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) Pharmacy Department shall maintain a system whereby drugs subject to recall or discontinuation by the manufacturer or the FDA can be immediately identified, removed from active inventory and sequestered. The system shall include drugs distributed to VCMC/SPH and Ambulatory Care clinics.

PROCEDURE:

All recalled products shall be removed from the Pharmacy Department and patient care areas. The recalled products shall be quarantined until they are returned or destroyed as outlined in the manufacturer notice. It shall be the responsibility of the Director of Pharmacy Services or designee to remove recalled medications from all areas of the hospitals and/or clinics where medications are stored.

Recall Classifications:

Class I Recall
Dangerous or defective products that predictably could cause serious health problems or death.

Class II Recall
Products that might cause a temporary health problem, or pose only a slight threat of a serious nature.

Class III Recall
Products that are unlikely to cause any adverse health reaction, but that violate FDA labeling or manufacturing laws.

Procedure:

1. The Pharmacy Department will be notified of a manufacturer or FDA recall or medication

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discontinuation proceedings through direct mail, the wholesaler's notification, a written or electronic FDA Safety Alert or Recall notification. A chronological file of such notifications, alerts and recall notices shall be maintained for at least three (3) years.

2. The Pharmacy Department buyers shall remove all lots of recalled or discontinued drugs if found to be in inventory in a timely manner after receiving the recall/discontinuation notice. The recalled/discontinued drugs shall be sequestered and secure until the drug is repackaged and returned per the manufacturer's instructions. A record of actions taken shall be recorded on the recall/discontinuation notice; including none found in inventory and the date the action was taken. The notice shall be available to the Director of Pharmacy Services upon completion of the recall/discontinuation action.
3. All drug storage areas of the hospital will be inspected, including patient care areas, automated dispensing cabinets, and clinics.
4. A second person from the Pharmacy Department will conduct an independent check of all drug storage areas of the hospital, including patient care areas, automated dispensing cabinets, and shall be documented.
5. The Pharmacy Department shall send the recalled/discontinued notice to all affected Ambulatory Care clinics notifying the recall/discontinuation and to return all affected lots to the Pharmacy Department (see Recall Notification form).
6. All recalled or discontinued drugs shall be returned to the VCMC Pharmacy buyer, placed in a bag, marked as recalled or discontinued and quarantined from the Pharmacy inventory.
7. When the Pharmacy receives information about medication recall or discontinuation by the manufacturer or the FDA for safety reasons, the pharmacist or designee shall inspect the patient's own medications stored in the Pharmacy for recalled or discontinued medications. If such a medication is found, the appropriate physicians and patients will be notified for follow-up.
8. Recall and Discontinuation alerts from the FDA and manufacturers shall be presented at the Environment of Care Committee.

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All Revision Dates

10/11/2024, 11/26/2018, 8/1/2015, 8/1/2011, 6/1/2008, 12/1/2003, 6/1/1998

Attachments

Urgent Recall Notification

Approval Signatures

Step Description	Approver	Date

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Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/11/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	10/10/2024

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Status Active PolicyStat ID 16930734

Origination	9/2/2020	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	10/22/2024		
Effective	10/22/2024		
Last Revised	10/22/2024	Policy Area	Pharmacy Services
Next Review	10/22/2027		

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

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POLICY:

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

PROCEDURE:

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

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

C. Responsibility
    1. Pharmacy technician

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

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

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

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

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

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Process.

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

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

G. System Management and Maintenance

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

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All Revision Dates

10/22/2024, 2/20/2024, 3/24/2023, 9/13/2022, 9/2/2020

Attachments

Attachment A: Kit Check Procedure Manual

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	10/22/2024

Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	10/22/2024

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

Attachment A.

A. PROCEDURES

System Login

1. The user should open a oogle Chrome ro ser and navigate to https://itchec luesight.com/.

The user types in the email address and password as shown below in

2. igure 1.

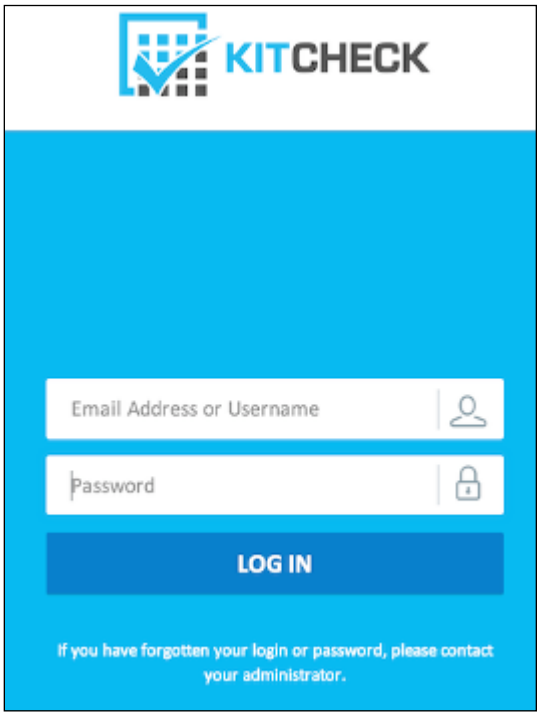


Figure 1: System Log in

Changing Password

3. f using the it Chec system for first time the user must change the pass ord. The user clic s on their account utton in the upper right hand corner of the screen, selects "User Settings," and then types in the previous and ne pass ords.

Figure 2: Changing Password

Tagging Medication – Vials and Ampules

1. The la□el is peeled off the roll.
2. The user places the la□el across the vial/ampule so that it does not □loc□the lot and expiration date and "flags" it. These steps are sho□n in □igure 15.

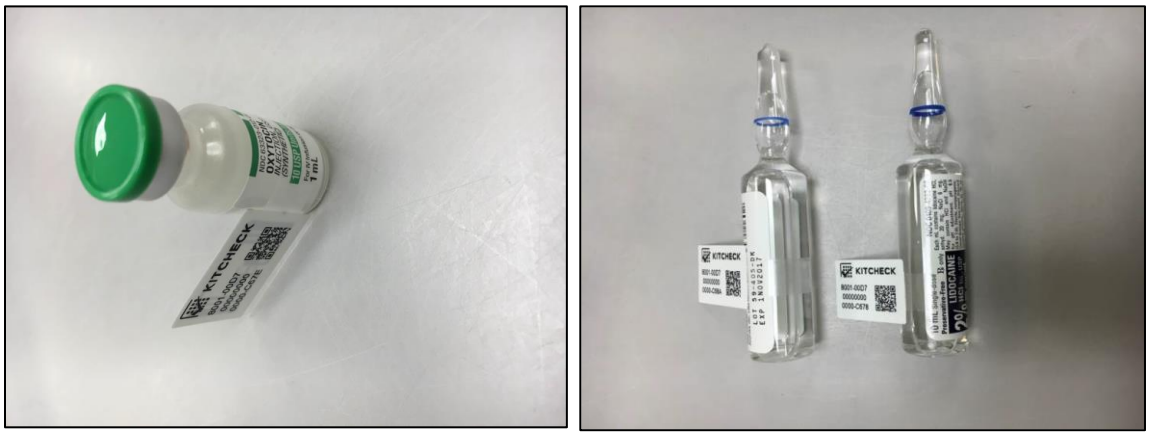


Figure 15: Tagging Medications – Vials & Ampules

Tagging Medications – Boxes

3. The la□el is placed on the □o□in a location □hich does not o□struct any e□isting la□eling. Loo□for a □lan□area or an area that does not contain any clinical dosing information. These steps are sho□ in □igure 16.

Figure 16: Tagging Medications- Boxes

Tagging Medications – Foil Bags, Packages and Ampules

1. Ta□e a normal tag and flag the R□□□ portion of it off to the side of the □ag□li□e one □ould do □ith a small vial.

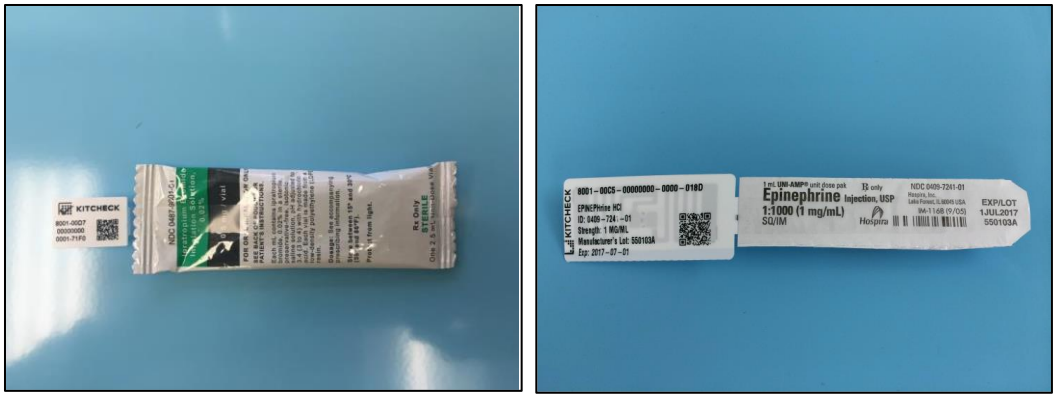


Figure 17: Tagging Medication – Foil Bags Normal Tags

The R□□□ inlay □ill not □e directly attached to the metal material of the □ag□and therefore □ill not interfere □ith scanning. □igure 17 is a picture of a normal tag flagged to the side of a foil lined □ag.

Tagging Compound Medications - Syringes

4. The user places the la□el across the lot and expiration date and "flags" it. □ tagged syringe is sho□n □elo□ in □igure 1□

Figure 18: A Tagged Syringe

Tagging Kits and Trays

1. The la□el is peeled off the roll
2. The tagged is placed on the □it or tray. The process is sho□n □elo□ in □igure 19.
3. □f there is an indentation on the side of the tray□attempt to place the tag in the indentation so the tag □ill not □e distur□ed over time.
4. Try to avoid placing the □it tag on the top of a closed tray to avoid □ear and tear to the tag over time.

Figure 19: Tagging Kits and Trays

Associating Item Tags

1. The user first applies the tags to medications□then places the tagged items for a specific □□C and Lot □atch into the scanning station and clic□s the Scan □utton.
2. □pon scanning□□it Chec□□ill as□users to verify the num□er of tags they have placed into the scanning station. Once the data is entered□they clic□*Next*.

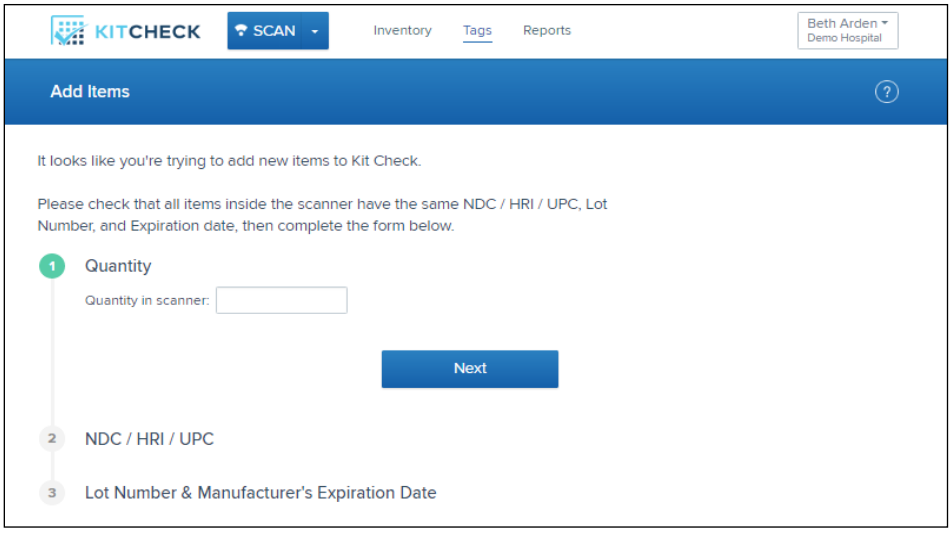


Figure 3: Add Items Step 1: Quantity in Scanner

3. □f the □uantity entered is correct□the user is then prompted to scan the item using the system □arcode scanner ne□t to the computer. □f the item e□ists in the □it Chec□data□ase□it □ill □ecome availa□le for selection under

NDC/Manufacturer's ID. If the item is already added to the hospital's electronic formulary a bookmark icon shows. This is shown in figure 4.

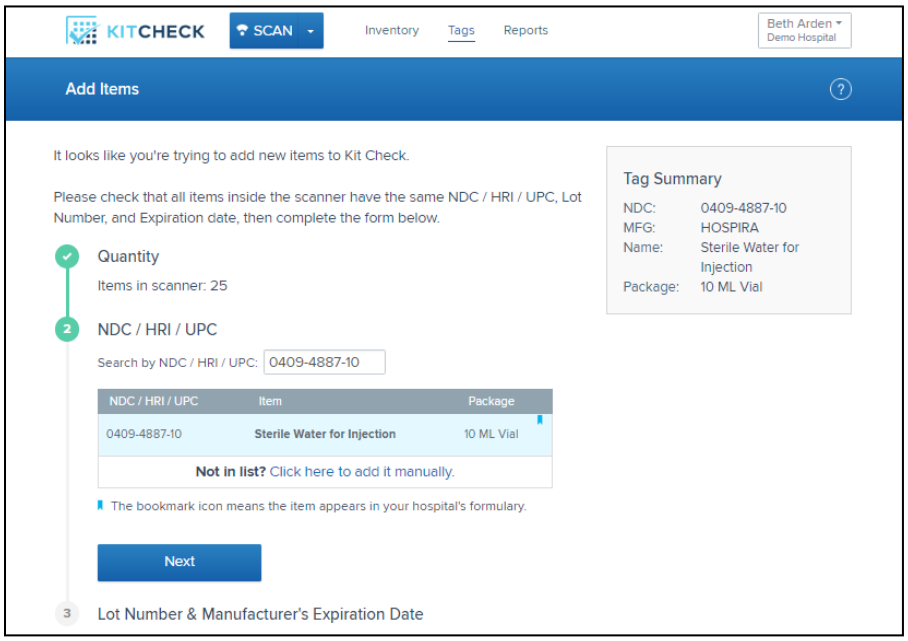


Figure 4: Add Items Step 2: Enter NDC

4. If the item is not in the database when scanned the user will be prompted for manual entry of its attributes. The user clicks the text "**Not in list? Click here to add it manually.**" To manually add an item to the formulary the user provides the following information:
5. Manufacturer's Name
6. NDC/Manufacturer's ID
7. Item Name
8. Item Strength
9. Item Strength Unit of Measure
10. Package Size
11. Package Size Unit of Measure
12. Package Quantity
13. Package Description
14. Dictionary Type
15. Tag Type (if applicable)
16. Expiring Soon (if applicable)
17. Alternate Expirations (if applicable)

This is sho□n in □igure 5.

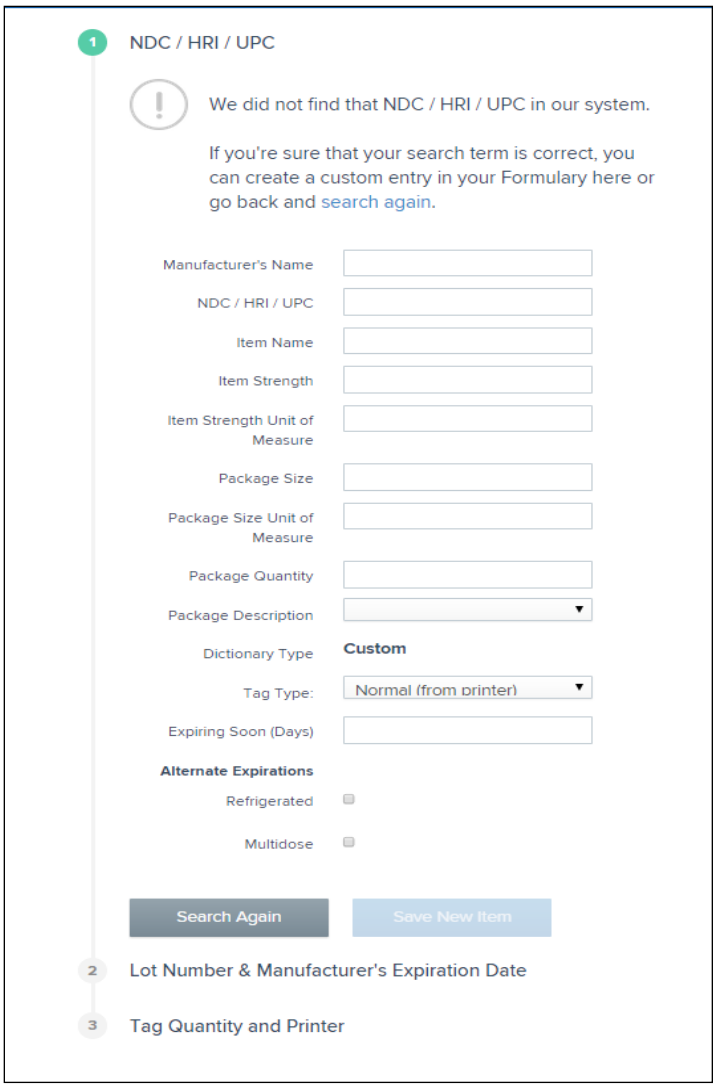


Figure 5: Item Not Found and Manual Entry of Item

1□ Tips and tric□s for manual entry of an item:

- The information must □e entered e□actly as it appears on the manufacturer la□el (this includes all hyphens□dashes□uppercase letters□ etc.).
- □tem strength should □e listed as it appears on the vial (e□amples: 5mg/10mL□20 mg/mL□2□ □or 1:200□000 (2□)□etc.).

19. □f the item □eing created re□uires refrigeration the user □ill need to assign an alternate e□piration as sho□n in □igure 6.

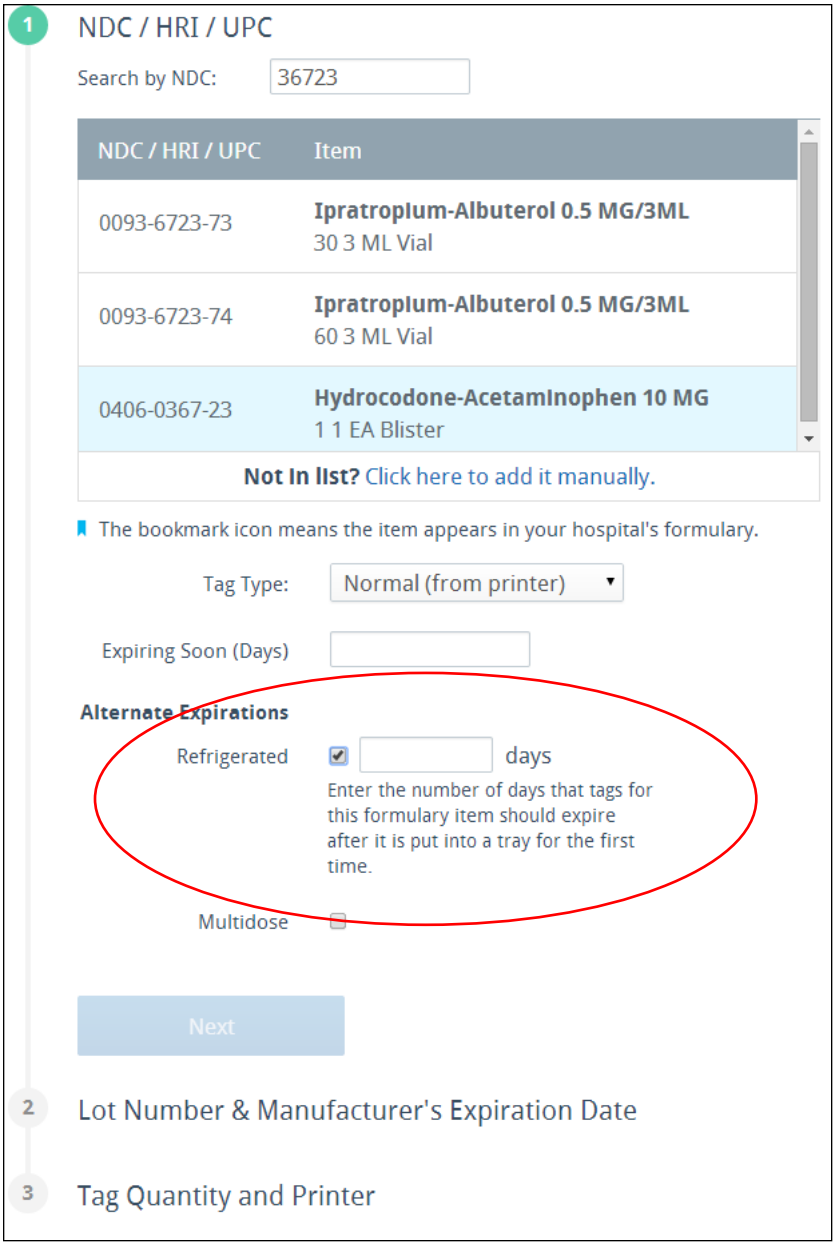


Figure 6: Refrigeration Expiration

20. The system opens the Lot Number & Expiration Date step once the first two steps are completed. The lot number and expiration date are manually typed in the appropriate fields. This are shown below in Figure 7.

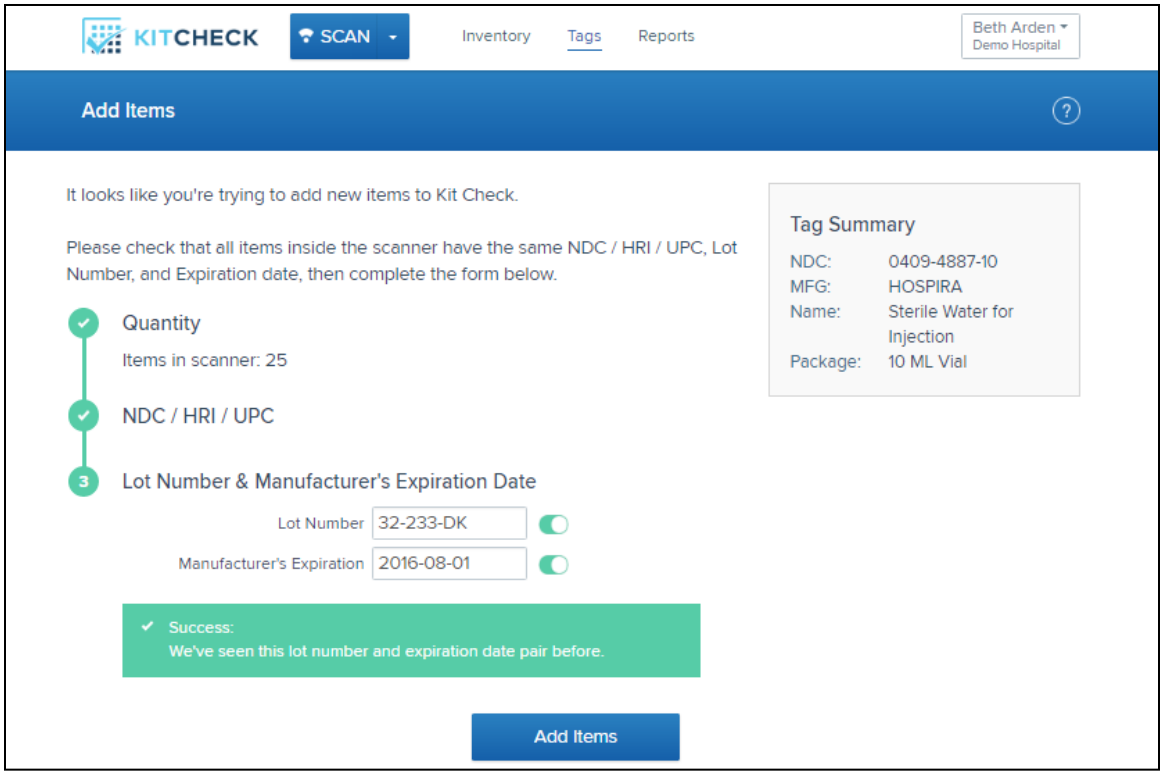


Figure 7: Add Items Step 3: Lot and Expiration Date entry

21. When tagging multiple items of the same medication it is important to ensure that the lot numbers and expiration dates all match.
22. Lot number should be entered exactly as it appears including dashes if applicable and distinguishing between the numerical digit 0 and the letter O lowercase L capital I and numerical digit 1.
23. If entering a lot number for the first time dual verification of the entry is required.
24. If the item does not have a lot number and/or expiration date click on the sliding button to the right of the lot or expiration date fields to turn this field off. These buttons are shown in Figure 8 below.

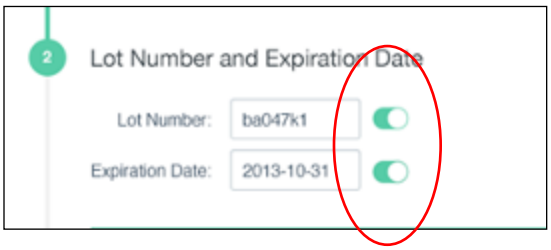


Figure 8: No Lot Number and No Expiration Date Buttons

25. If a medication lists the expiration as September 2017 this means that it expires on the 31st of the month. Therefore it should be entered as 2017-09-31.

26. If a medication lists the expiration as 1 September 2017 or September 1 2017 it should be entered as 2017-09-01.

    i. If the expiration fields do not match the user will see the message included in Figure 9. The user will set aside the medications needing to be tagged and contact a Kit Check administrator at their hospital to complete the expiration date correction.

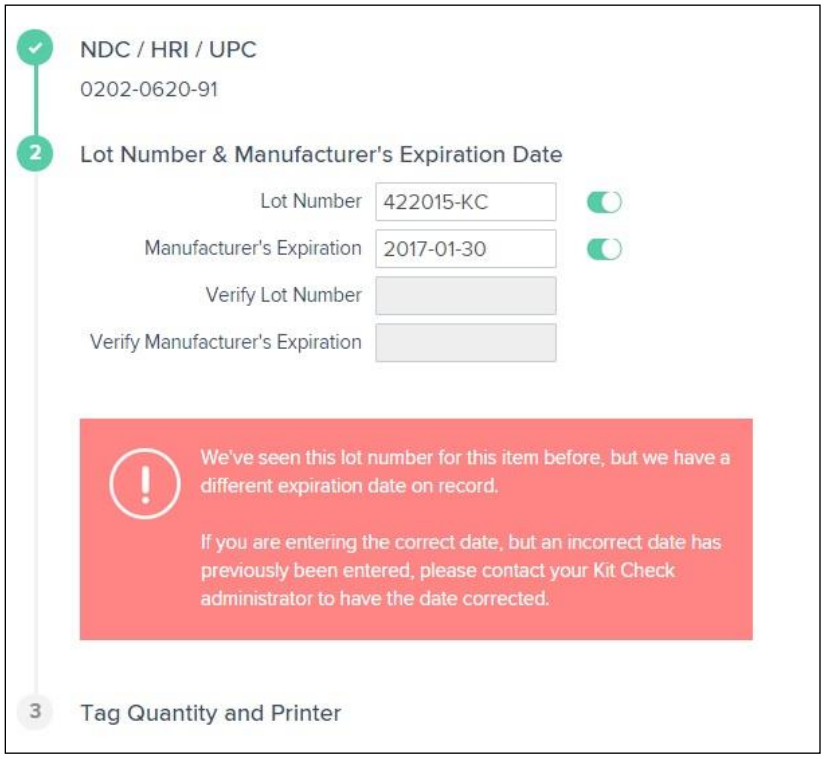


Figure 9: Expiration Date Error Message – Regular User

27. If the user is an administrator the error in Figure 10 will be displayed. The administrator will follow the "correct the expiration date" link to complete an expiration date correction for the items.

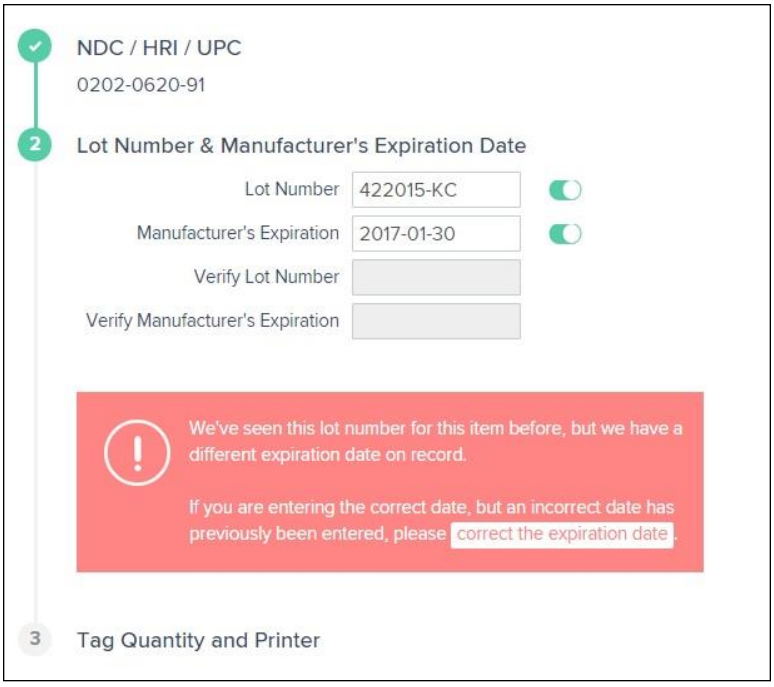


Figure 10: Expiration Date Error Message – Administrator User

Associating Kit Tags

2□ □sers first place one □asic Tag into the scanning station and select the Scan □utton. □sers □ill □e prompted to ma□e a selection from a toggle □ar. □n this case□users should select □it and then scroll through the □it types□until the desired □it is selected.

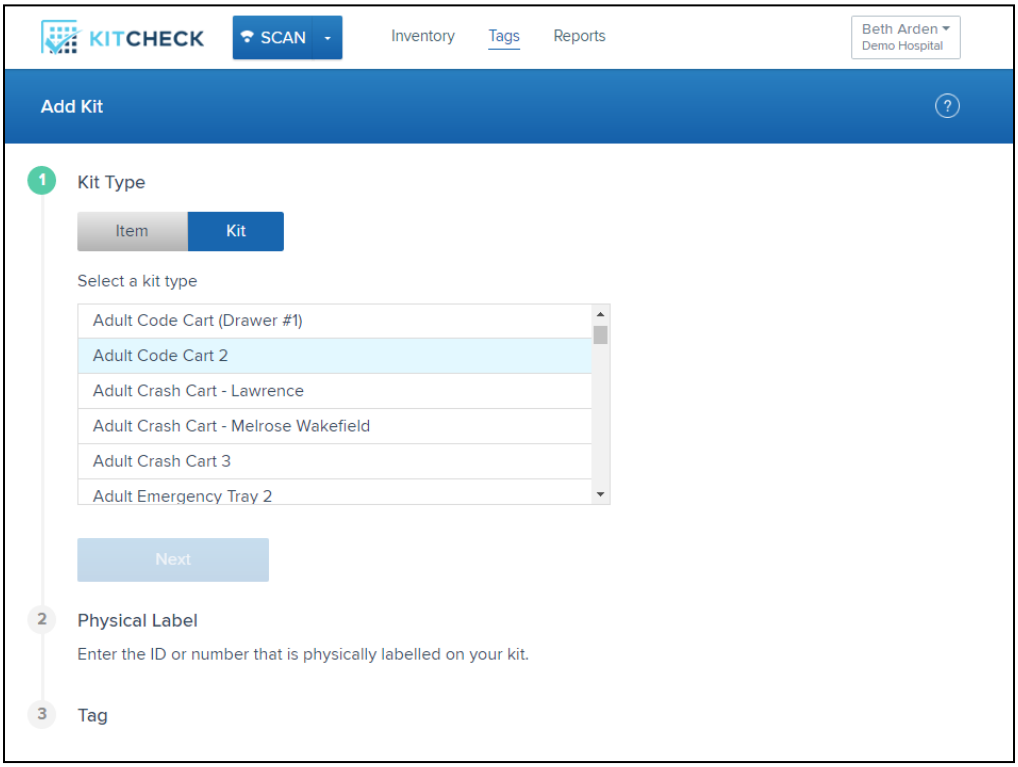


Figure 11: Add Kit Tags Step 1

29. □ physical □□ for the □it or tray is assigned □y the user. This is a visual uni□ue name or number on the kit or tray. The user then clicks on “Next.” These steps are sho□n in □igure 12.

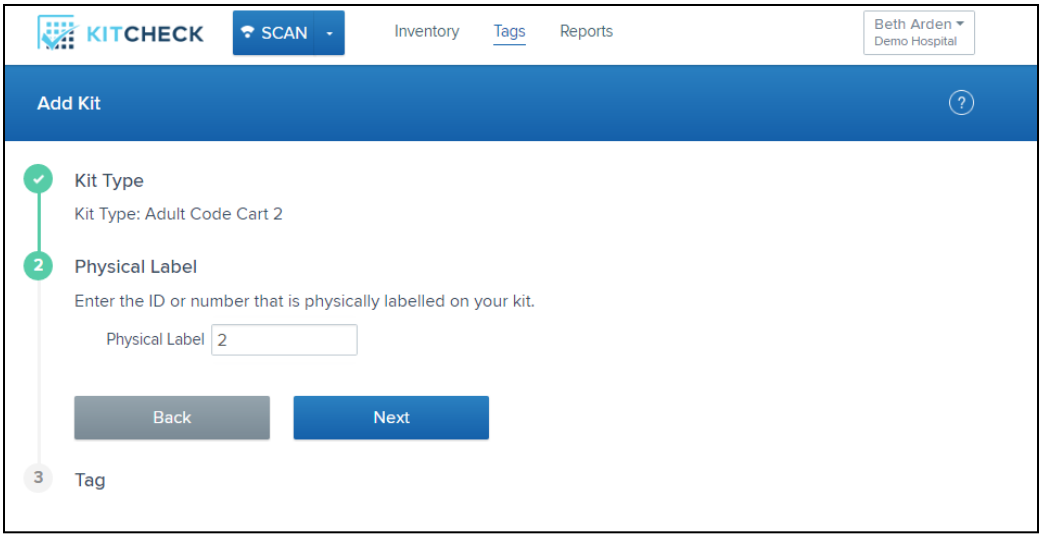


Figure 12: Selecting Kit or Tray Type and Assigning a Physical ID

30. The user adds the □it tag □y selecting the □dd □it □utton. □ user □ill see a success message upon successful association□as sho□n in □igure 13.

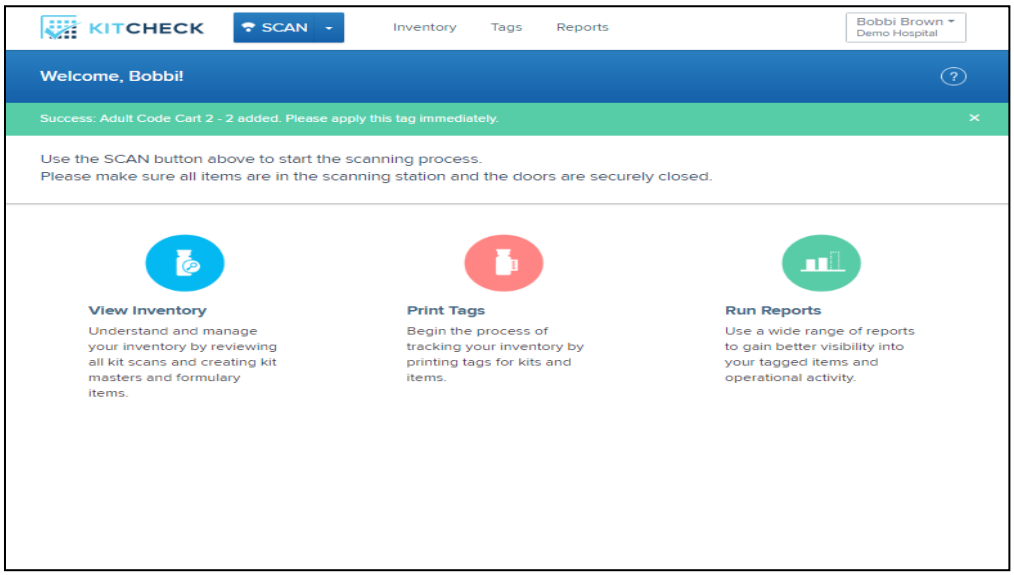


Figure 13: Kit Tag Success Message

Scanning Trays/Kits

1. The user places one tray or □it into the □it Chec□scanning station and closes the doors.
2. The user clicks on “Scan” from the tool□ar on the top of the page□as sho□n in □igure 3.

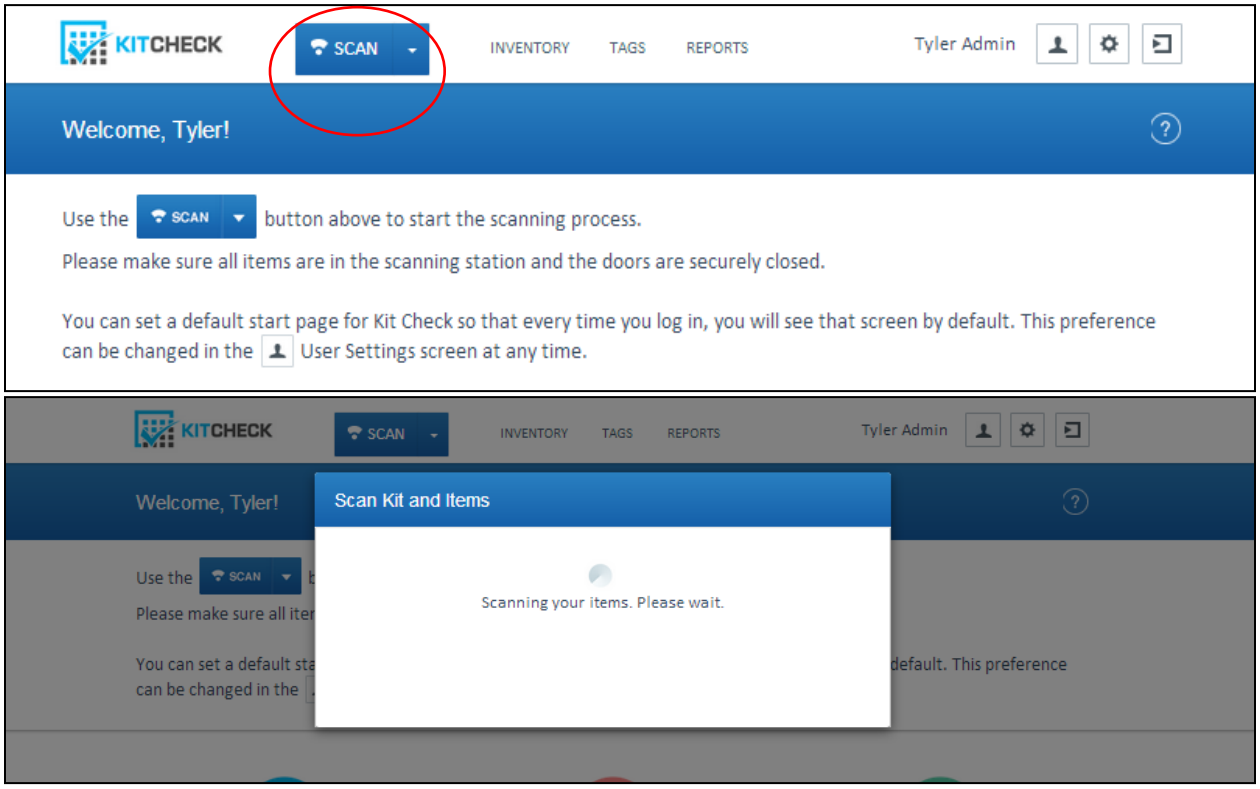


Figure 3: Scan Kit/Tray and Items

3. □fter a scan□the screen sho□s any missing□e□tra□or e□pired items. This screen is sho□n in □igure 4.

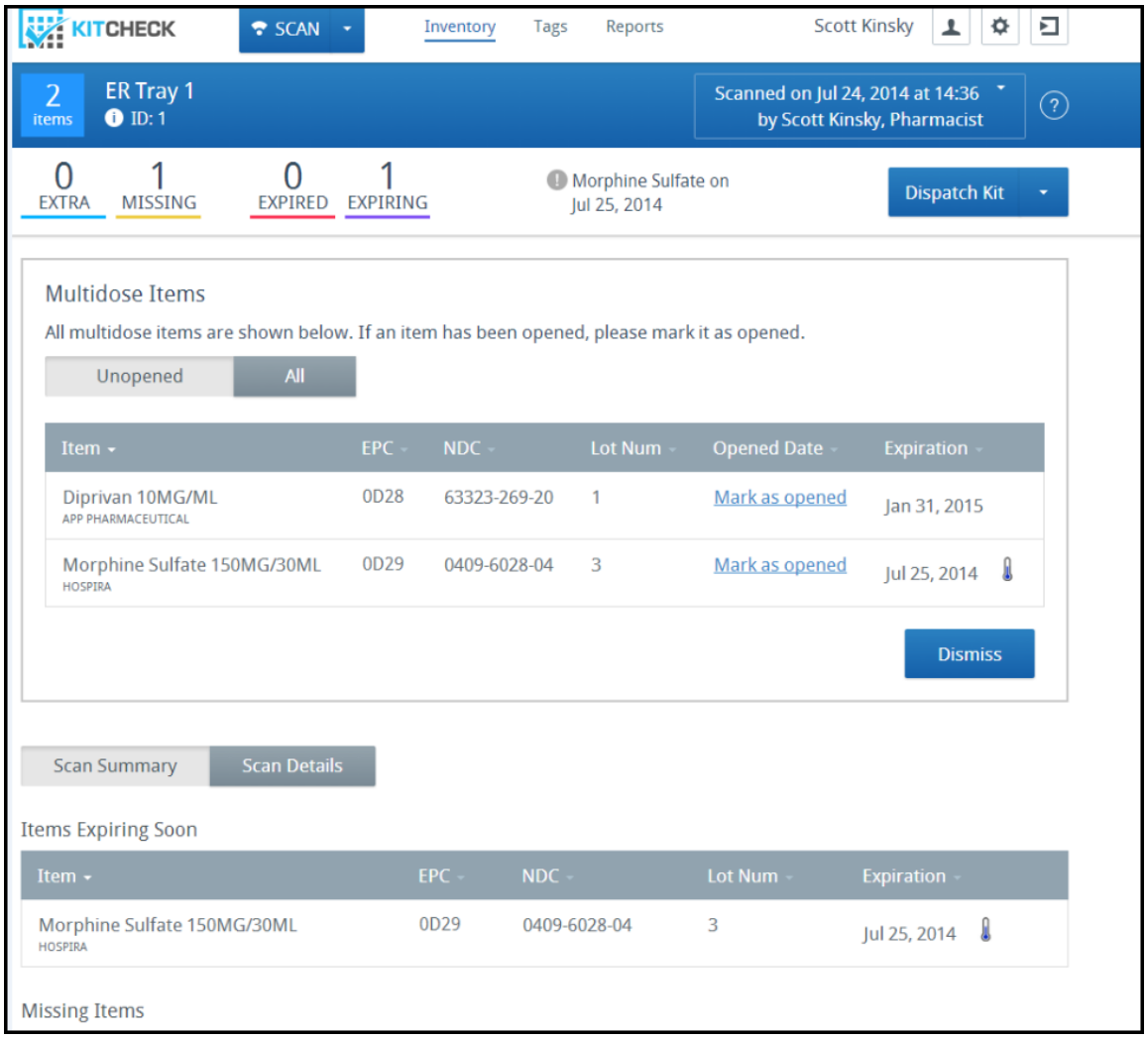


Figure 4: Scan Summary

5. The user replaces any missing items and removes any e□tra items from the tray. □ny items identified to have e□pired are replaced.
    a. □ear e□piration is defined per hospital.
    □. □or items □ith alternate e□pirations (e.g. rocuronium) □the user must also place the appropriate □eyond use date stic□er.
6. The user selects "Scan" after modifying the tray. This action is sho□n in □igure 5.

Figure 5: Scan

7. The user continues steps 5 and 6 until the "This Kit is complete" screen appears. This screen is sho□ in □igure 6.

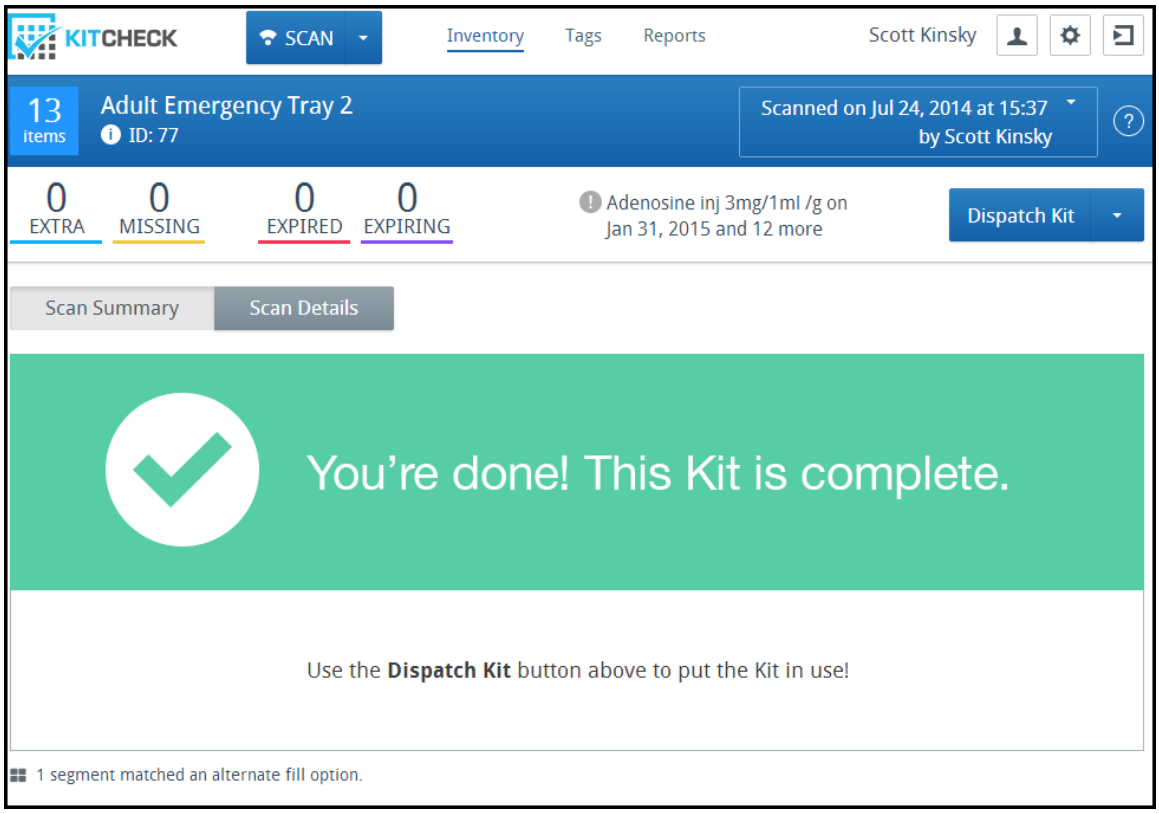


Figure 6: Kit is Complete screen

□ □ hen a tray is replenished and complete□the user selects “Dispatch Kit” as sho□n in □igure 7.

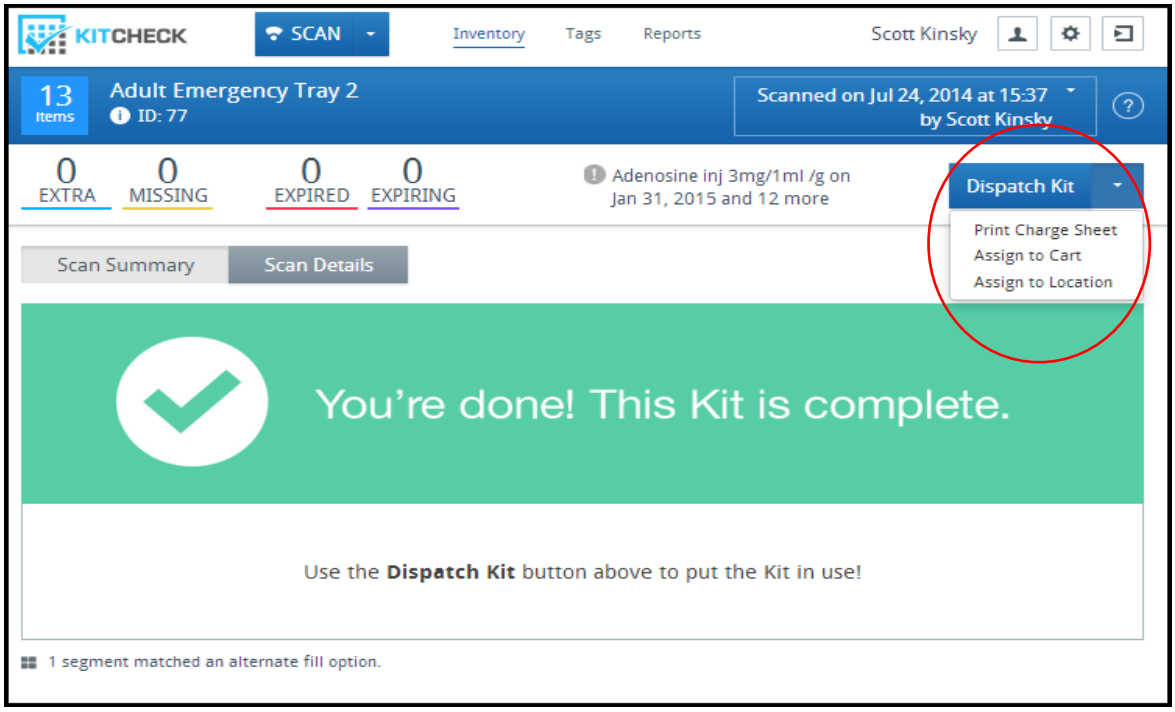


Figure 7: Dispatch Kit

9. To dispatch a □it□the user selects the appropriate information from the drop□do□n menu □ased on the desired dispatch type as sho□n in □igure □:
    1. □ssign to Cart: select cart type
    2. □ssign to Location: select location
    3. Print Charge Sheet: select the “Print Charge Sheet” box

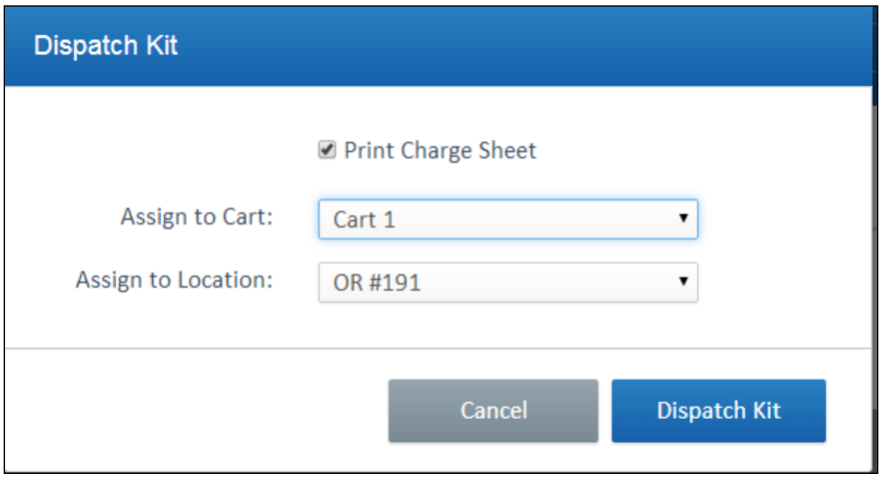


Figure 8: Dispatch Kit

Scanning with Restricted Items

1. If an item has neither tagged nor verified by a pharmacist it is considered a restricted item. When the user clicks on “Scan” and there are restricted items in the tray/kit the user receives a blocked scan message as shown in figure 9.

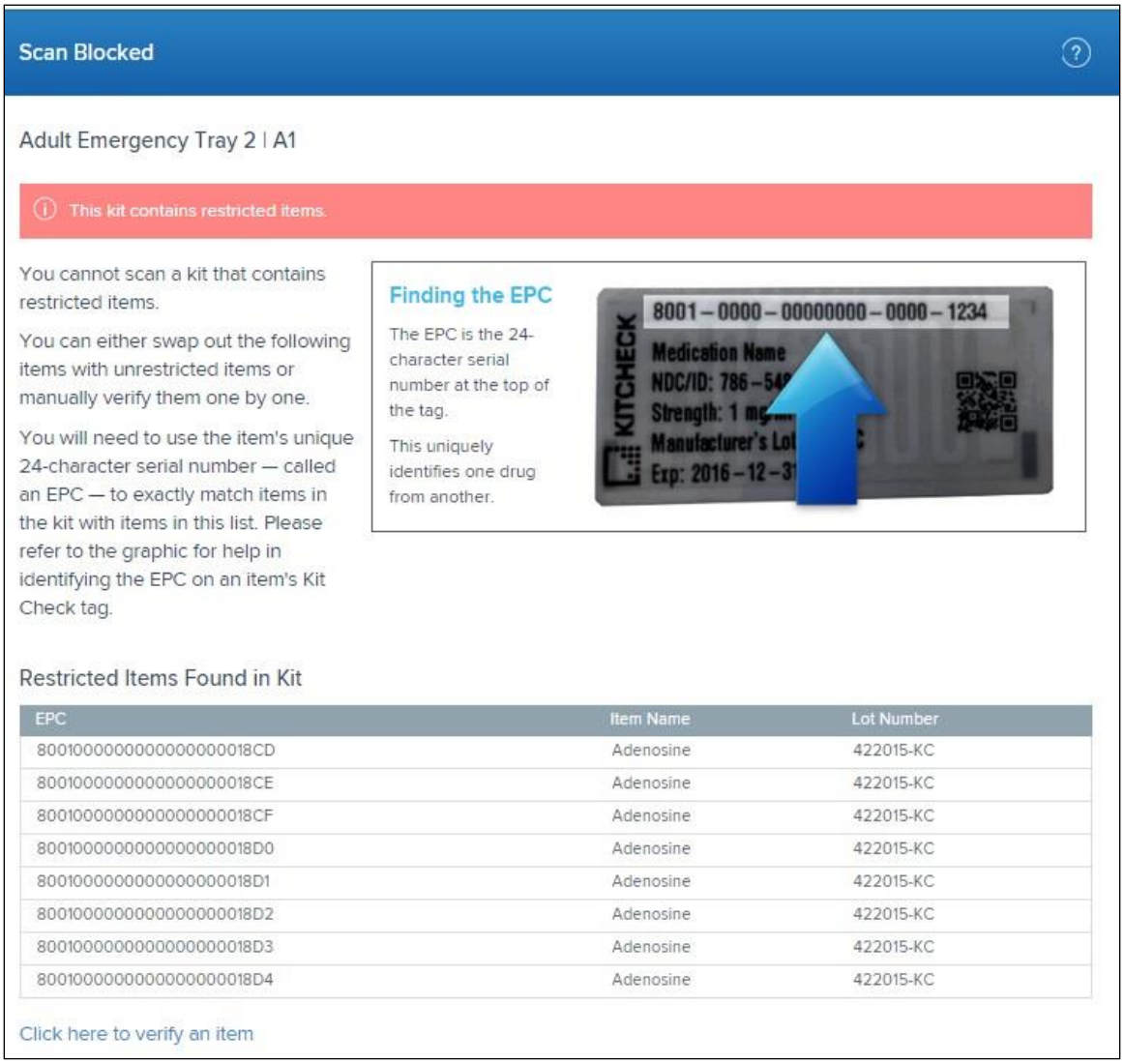


Figure 9: Restricted Medications Message

2. A pharmacist verification of the medications is needed. Only certain users can double check tags after they have been attached. The user who has encountered the error must find a qualified user to do the verification. See the Pharmacist Verification SOP for instructions on how to verify restricted items.
3. Once the verification has been performed the qualified user logs out of the system. The first user logs back into the system and the kit scanning process continues.

Scanning a Kit/Tray with No Tag

1. When the user clicks on “Scan” and there is no kit tag on the kit/tray, an error message appears that says the scan is blocked. This notification is shown in figure 10.

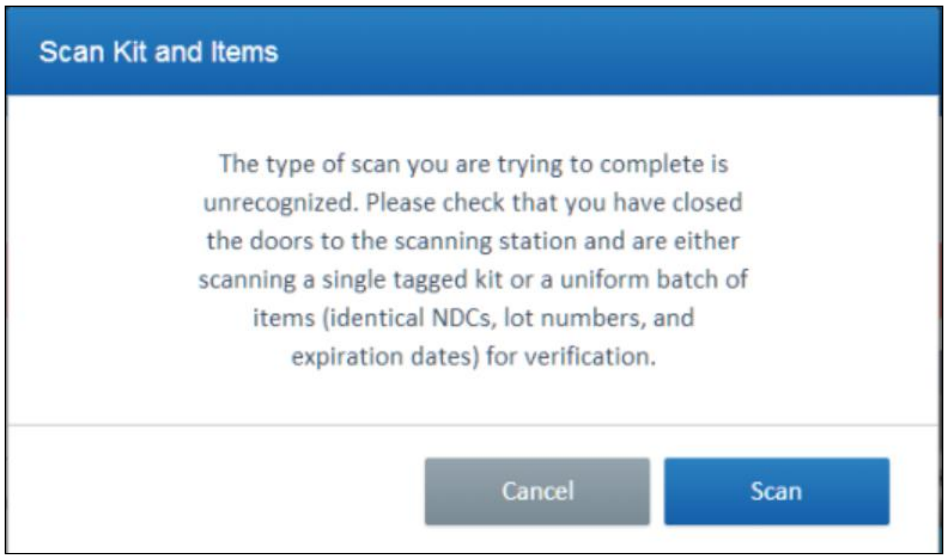
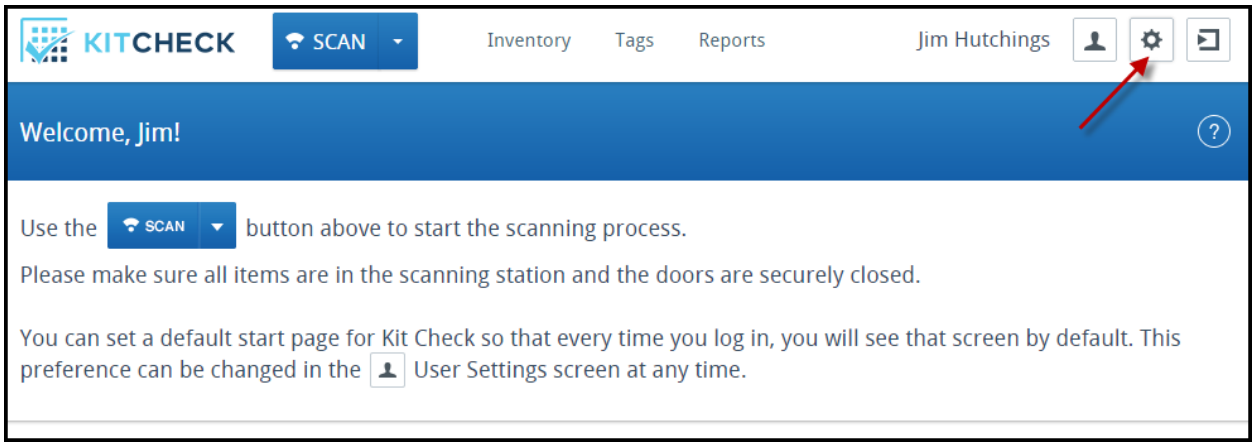


Figure 10: Scan Blocked Error Message

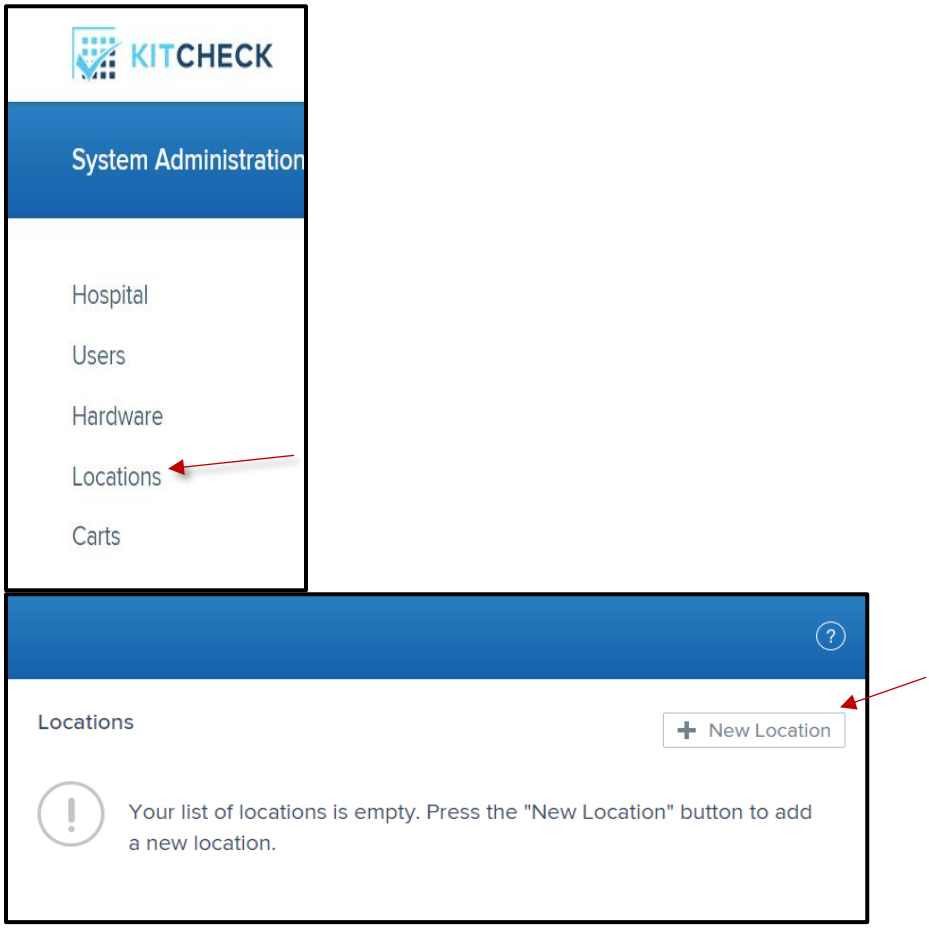
2. All trays and kits must have a kit tag to be scanned. The user prints a kit tag for the tray/kit. See the Printing Tags and Tagging Items Guide for instructions on how to print kit tags.

Cart and Location Setup

1. First hospitals must input hospital locations and carts into the Kit Check application. To do this click on the ⚙ icon.

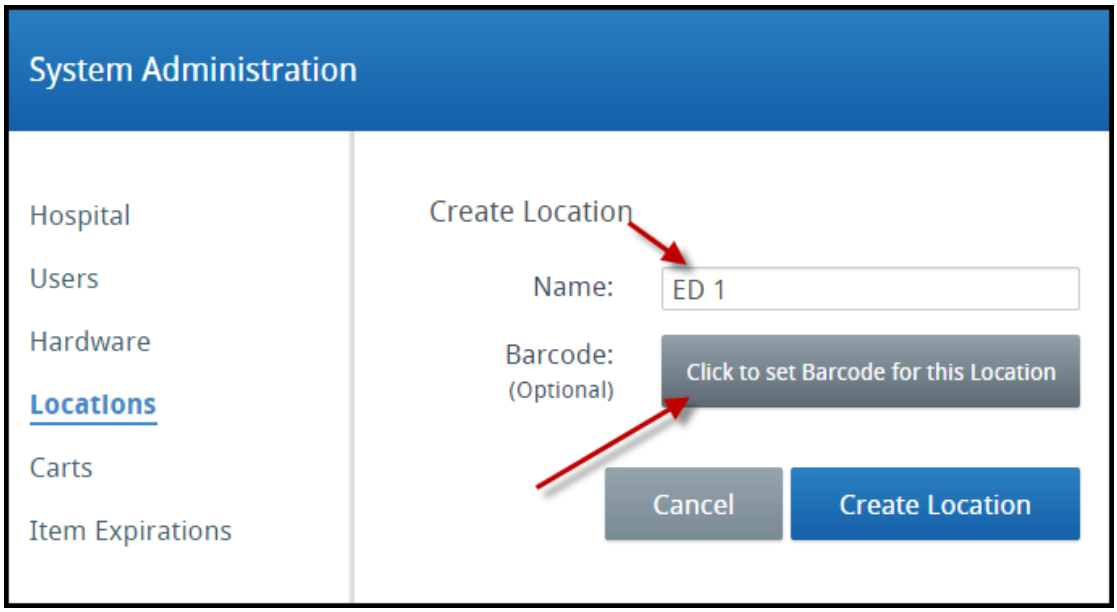


2. □e□t, click on the “Locations” link on the left hand side and click on the “New Location” button.

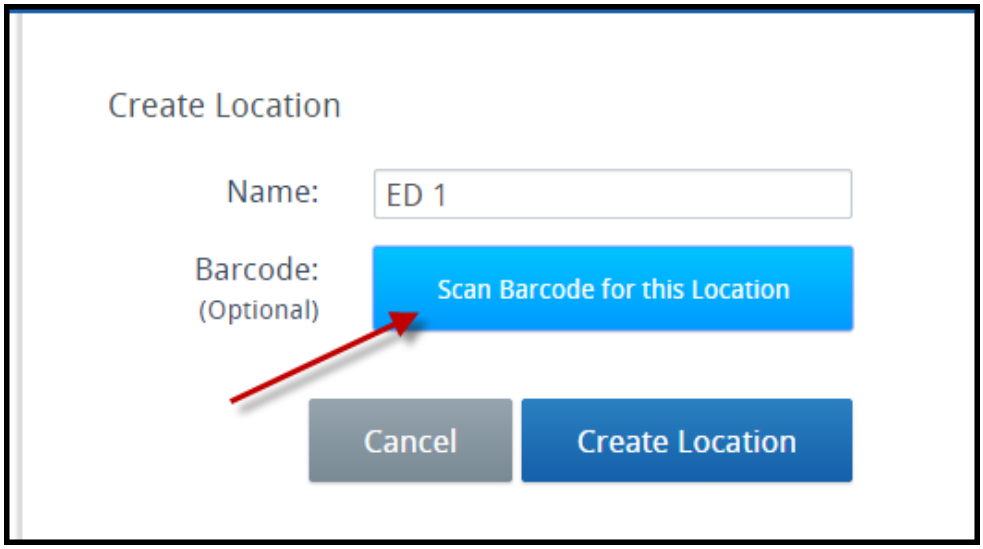


Barcode Setup

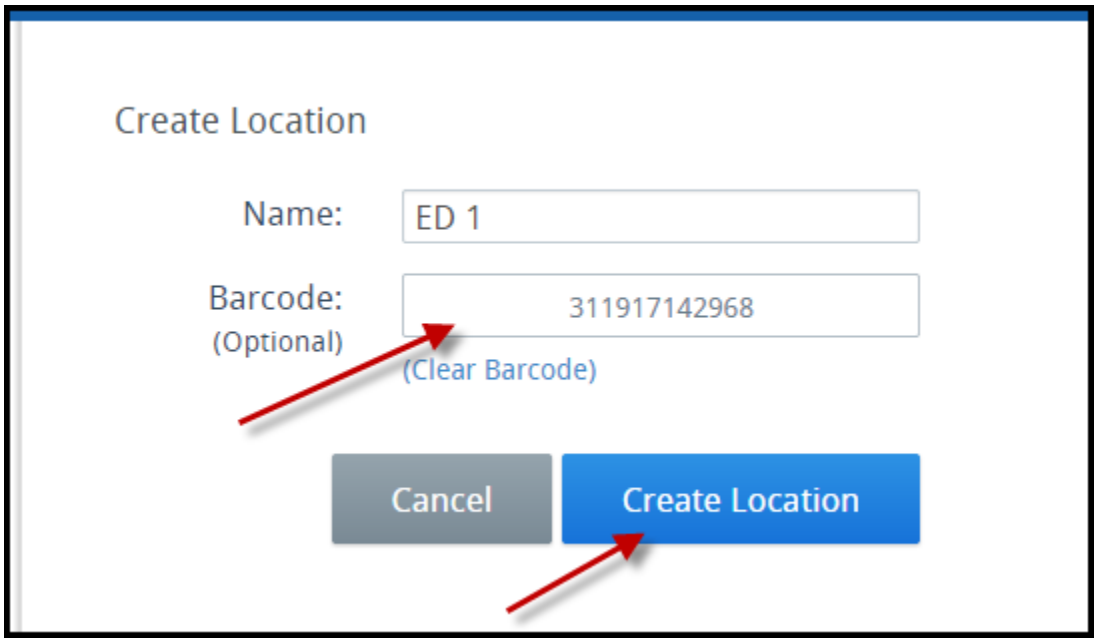
1. Once carts and locations are set□a □arcode can □e created or assigned to each cart and location to aid in the dispatch of trays. To do this□navigate to a particular cart or location, and select “Click to set Barcode” button.



2. The “Click to set Barcode” button will turn blue, and prompt a user to “Scan the barcode” to be used for this specific location.



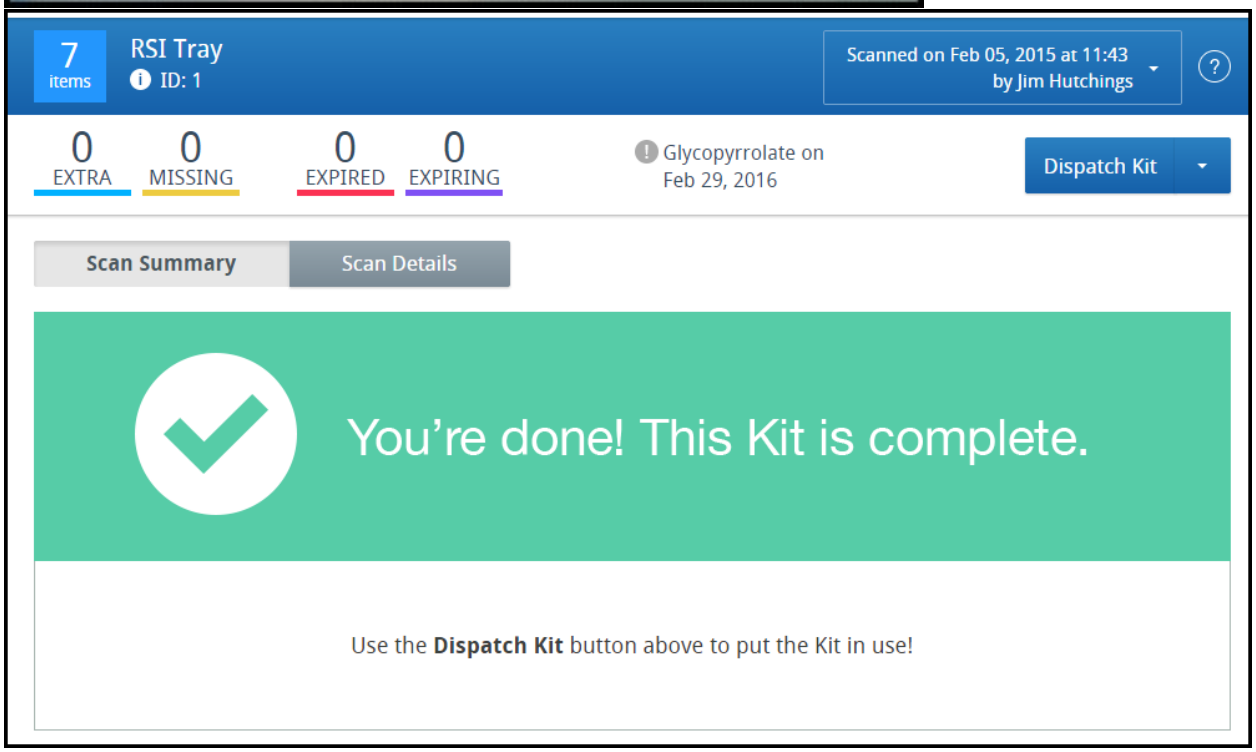
3. The □arcode must □e at least four characters in length to register □ithin the application. Scan the □arcode □ith the □it Chec□ □arcode scanner and the value will be displayed. Finally, click the “Create Location” button to save the entry.



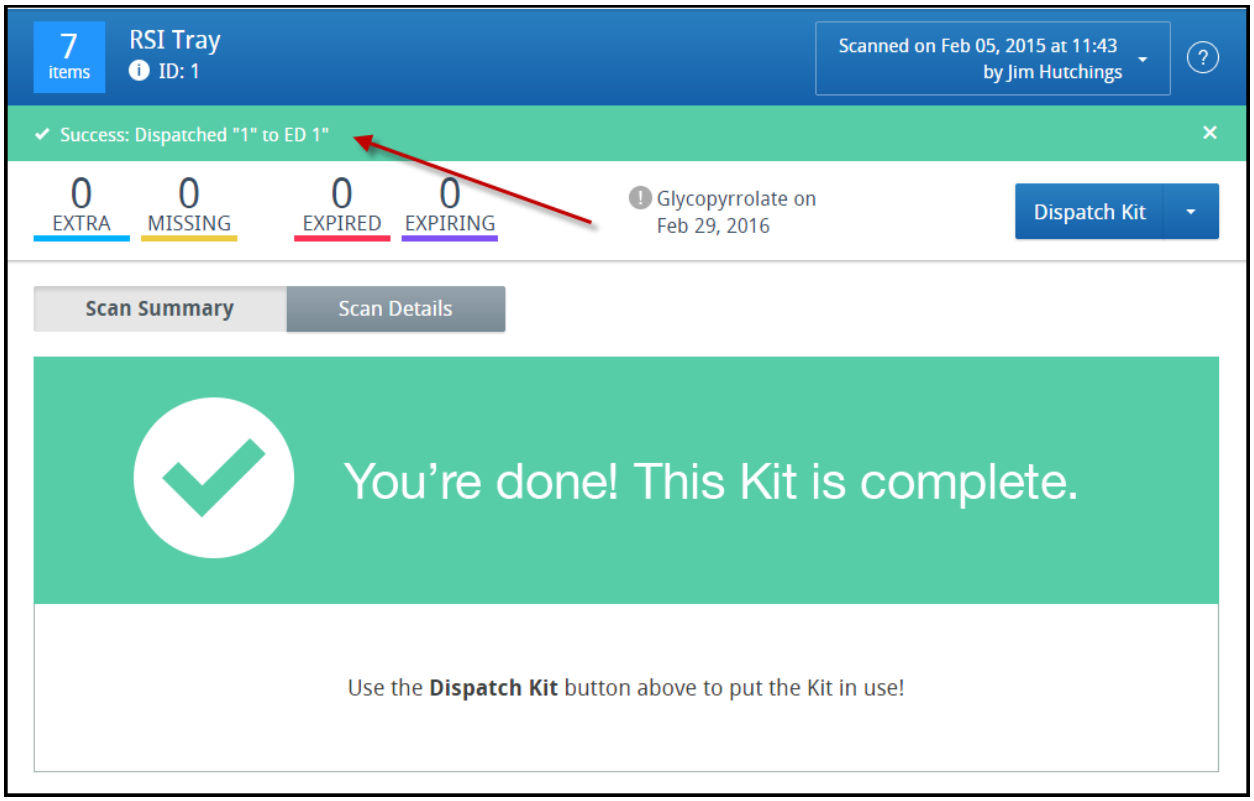
4. The ne□ hospital location □ill no□ □e displayed □ith the □arcode assigned to it. Creating □arcodes for carts is done in the same fashion.

Assigning Trays to Carts and Locations via Barcodes

1. □rom any screen in the application□□egin □y scanning the □R code on the □it tag of the tray □eing processed. This □ill □ring up the last scan for this tray.



2. Once on the last scan summary screen□scan the □arcode of the appropriate location or cart.
3. On the top of the scan summary page you □ill see the tray has □een dispatched to the ne□ location.



□gain□the same can □e done for assigning a tray to a cart.

System Logout

1. To log out of the system the user clic□s on the  icon at the top of the page. This is sho□n in □igure 11 □elo□.

Figure 11: Logging Out

Status **Active** PolicyStat ID **14596847**

Origination	2/1/2005	Owner	Marcos Rodriguez: Manager, Rehabilitation Services
Last Approved	9/24/2024		
Effective	9/24/2024	Policy Area	Rehab Services
Last Revised	9/24/2024		
Next Review	9/24/2027		

RS.14 Rehab Services Documentation Requirements

COPY

POLICY:

To describe the Rehab Services Department documentation requirements for patient assessment, treatment and discharge from services.

PROCEDURE:

All patient interventions shall be documented by Rehab Services' staff in the Electronic Medical Record (EMR) consistent with the following documentation standards:

Required Documentation:

Outpatient and Inpatient Rehab Services documentation shall be maintained in the EMR. Documents that are considered part of the medical record are:

1. Physician's order(s).
2. Initial evaluation and treatment plan.
    a. The initial evaluation and/or functional assessment of each patient shall be performed by a therapist to determine a treatment plan based on the evaluation findings and the physician's order. The patient and his/her family shall participate as appropriate in determining the treatment plan and in establishing goals for treatment.
    b. The initial evaluation will include, but is not limited to:
        i. Diagnosis.
        ii. Treatment.
        iii. Frequency and duration.
        iv. Goals:

- Goals shall be measured and described in functional or behavioral terms and should include time frames in number of visits for achievement if evident.
- Goals shall be consistent with the patient's rehabilitation potential, and the patient's needs and limitations will be indicated, as necessary.
- If goals have not been achieved in the number of visits indicated, the patient shall be discontinued from therapy OR the patient's goals shall be reevaluated.
- If goals have not been met in the time frame indicated by the physician, the plan of care shall be evaluated for changes and the physician shall be contacted to extend services if the patient exhibits potential for further progress.

v. Actual evaluation findings, i.e., subjective and objective information.

vi. Precautions,if appropriate.

vii. Treatment plan that includes method of treatment, objectives of treatment/goals, assessment of patient potential, discharge planning as appropriate.

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3. Patient care notes
    a. Patient care notes shall be written in the EMR to indicate treatment for every visit.
    b. Additional documentation shall be completed whenever there is a significant change in response to treatment.
4. Progress notes - Outpatient
    1. Progress notes are to be completed by Therapist of Record during approved series of visits
    2. The Progress note shall be sent to the referring Physician for review and approval
    3. A Progress note signed by the Physician may be sufficient to function as an order for additional treatment sessions and / or change of treatment plan and shall be kept in the EMR as part of the Patient's medical record.
    4. Items addressed on the Progress note may include, but are not limited to:
        a. Status of short term and long term goals
        b. Treatment plan and any changes
        c. Frequency and duration of Therapy sessions
        d. Recommendations for other medical services, referrals, etc.
        e. Issues affecting outcome of care
5. Home treatment programs: If a home program is given, a copy of the program OR documentation of a standard program shall be included in the EMR.
6. Other educational activities and response: A summary of what was taught, who was taught,

level of understanding or ability to return demonstrate.

7. Discharge summary
    a. The discharge note shall summarize the status of the patient at the time of dismissal and recommend further care if needed.
    b. The discharge note shall include the diagnosis being treated, the actual treatment program, a description of progress toward goals, a review of any discharge planning or home teaching done and a comparison of patient status at initiation of treatment compared to patient status at discharge.
    c. The discharge note shall include the plan for post-discharge (e.g., home program, discharge to another facility, continuation of therapy on an outpatient basis, etc.).

Reporting Time Frames:

1. The initial assessment form for inpatients shall be completed the day of the visit and documented in the EMR.
2. The Evaluation form for Outpatients shall have all other required documentation completed within 72 hours.
3. Daily record of treatment charges shall be completed each day.
4. Physical Therapist Assistant and Certified Occupational Therapist Assistant notes shall be cosigned by a Physical Therapist / Occupational Therapist within 72 hours.
5. Discharge notes on outpatients and inpatients shall be completed in accordance with Rehab Services policies and procedures.

Disposition of Records:

1. Inpatient records
   All original copies or inpatient records will be retained in the EMR.
2. Outpatient records shall be retained in the EMR. Any outside documentation, etc. shall be scanned into the EMR.

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All Revision Dates

9/24/2024, 4/27/2020, 12/1/2013, 12/1/2010, 6/1/2006

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	9/24/2024

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VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

November 2024

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

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2.	100.240 Suicide Risk Assessment	page	8-14
3.	108.030 Fall Prevention	page	15-22
4.	108.045 Urinary Catheter Insertion/Maintenance/De-escalation	page	23-27
5.	AC.37 Ambulatory Care Clinic Standing Protocol for Medication Refills	page	28-39
6.	Admission Criteria and Standards of Care of the Postpartum Patient	page	40-44
7.	ER.14 Admitted Patients/Holding Patients in the Emergency Department	page	45-46
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9.	OB.12 Labor and Delivery Admission and Assessment	page	49-55
10.	OB.31 Cervical Ripening	page	56-60
11.	PH.122 Nonsterile Pharmaceutical Compounding	page	61-67
12.	RS.26 Patient Care Plan	page	68-70

b. Medical Staff Forms

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3.	Continuing Education Attestation for Psychologists	page	73
4.	Psychiatry Physician in Training Privilege Checklist	page	74

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/18/2024*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

□□□.□□□ Antimicro□ial Stewardship Program

POLICY:

This policy outlines the scope of the Antimicrobial Stewardship Program (ASP) and duties of the ASP Medical Director and Clinical Pharmacist.

Definitions:

1. ASP Medical Director – Infectious Disease (ID) Physician responsible for overall direction of the program, education, and goal development. He/she will be available for direct or indirect discussion to assist ~~physicians~~licensed practitioners (LP) with antibiotic education, selection, or discontinuation.
2. ASP Clinical Pharmacist: Full-time Pharmacist on staff performs daily antimicrobial rounds, consults with ~~physicians~~LP, and performs duties as assigned by ASP Medical Director and/or Director of Pharmacy Services.

PROCEDURE:

~~An antimicrobial stewardship program measures and promotes the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.~~

To comply with evidence-based guidelines or best practices regarding antimicrobial prescribing and promote rational and appropriate antimicrobial therapy while improving clinical outcomes while minimizing unintentional side-effects of antimicrobial use, including toxicity and emergence of resistant organisms.

ASP Team Personnel:

The ASP shall be physician-directed or supervised with support provided by a multidisciplinary inter-professional team. The antimicrobial stewardship team should include 1 or more members who have training in antimicrobial stewardship. The ASP composition should include but are not limited to:

A. A physician trained in infectious diseases and able to provide clinical judgment in peer-to-peer consultations involving the prescription of antimicrobial treatments.

B. A pharmacist trained in infectious diseases

C. A clinical microbiologist

D. An infection prevention personnel

E. Clinical registered nurse

F. Informational technology support as needed

Duties of the ASP Clinical Pharmacist:

A. Adherence to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

B. ~~Review the Antibiotic Rounding Report each day.~~Daily review of patients on antimicrobials

~~Monday through Friday, the ASP Clinical Pharmacist will print the Antibiotic Rounding Report.~~

~~Inpatient antimicrobial use will be compared to culture results. Those cases where a narrower spectrum agent can be used will be flagged and the physician will be contacted.~~

~~In situations where the organism is resistant to the current antimicrobial therapy, the physician will be contacted.~~

1. Antimicrobial orders will be reviewed for appropriateness, dose, frequency, and safety. If another agent is more appropriate or safer to use, the physician will be contacted.

   ~~Antimicrobial doses & frequency will be adjusted by the ASP Clinical Pharmacist as needed.~~

   ~~The ASP Clinical Pharmacist will review patient charts and make recommendations in the form of clinical interventions.~~

   ~~While on the floor, the ASP Clinical Pharmacist will discuss the patient's antimicrobial therapy with the physicians managing the patient's care.~~

2. Selected orders on a case-by-case basis will be reviewed and discussion with feedback will be given to the provider.
3. Intravenous to oral conversion of antimicrobials
4. Therapeutic interchanges
5. Antibiotic streamlining
6. The ASP Clinical Pharmacist will document all clinical interventions in the electronic health record. The clinical interventions will be tallied and reported to the Antimicrobial Stewardship Committee ~~on a monthly basis.~~

C. The ASP Medical Director and Clinical Pharmacist will develop criteria for use for all restricted antimicrobial agents.

1. Criteria will be reviewed and approved by the Antimicrobial Stewardship Committee and Pharmacy & Therapeutics Committee.
2. Criteria for use will be listed in the Restricted Antimicrobials Procedure.

D. Review all requests for restricted antimicrobials.

~~During working hours Monday-Friday 0800-1600, the ASP Clinical Pharmacist will be responsible whenever there is a request for a restricted antimicrobial.~~

1. The ASP Medical Director or the ASP Clinical Pharmacist will review the patient's medical chart to determine if patient meets the criteria for use. If the ~~patients~~patient meets the criteria, the staff pharmacist will be notified to verify the order and dispense the drug.
2. If the patient fails to meet the criteria for use, the ASP Medical Director or the ASP Clinical Pharmacist will recommend an alternative antimicrobial.

E. The ASP Clinical Pharmacist will review all requests for new antimicrobials or ~~vaccine~~vaccines.

1. A drug monograph will be completed and presented to the Antimicrobial Stewardship ~~committee~~Committee and Pharmacy & Therapeutics Committee.

   ~~If a request is rejected, a letter will be sent to the physician who submitted the original request explaining why the antimicrobial or vaccine was not added to the formulary.~~

F. Perform daily monitoring of microbiological data.

G. Perform Medication Use Evaluations (MUEs).

1. MUE criteria will be developed by the ASP Medical Director and ASP Clinical Pharmacist.
2. The ASP Clinical Pharmacist will collect and tabulate the data. A summary will be presented at the Antimicrobial Stewardship Committee meeting.
3. The ASP Medical Director will recommend the steps needed to resolve the issues identified by the MUE.

H. Track Antimicrobial usage and expenditures:

1. The restricted antibiotic report will be tabulated every three (3) months and presented at the next ASP meeting.

I. Perform periodic review of antimicrobial susceptibility rates:

1. The ASP Medical Director, the ASP Clinical Pharmacist, and the microbiologists work together to create the yearly antibiogram.
2. The ASP Medical Director and ASP Clinical Pharmacist will create empiric therapy guidelines based on antimicrobial susceptibility.

J. Develop empiric treatment guidelines, protocols, and ~~Power Plans~~electronic record order sets to minimize the development of resistant organisms.

K. Develop antimicrobial dosing guidelines to improve patient outcomes.

L. Review all serious adverse events caused by an antimicrobial or vaccine.

M. Create procedures to prevent adverse events by antimicrobials from occurring.

N. Provide ~~physicians~~LP and staff education.

Duties of the ASP Medical Director:

A. With input from the ASP Clinical Pharmacist, will develop criteria for use for restricted antimicrobials.

B. Develop MUE criteria with the ASP Clinical Pharmacist.

1. After the MUE is completed, the ASP Medical Director will recommend the steps needed to resolve the issues identified by the MUE.

C. Create empiric therapy guidelines based on antimicrobial susceptibility rates that will be published in the antibiogram.

D. Develop empiric treatment guidelines and protocols to minimize the development of resistant organisms.

E. Provide ~~physicians~~LP and staff education:

1. Give presentations at department meetings and Medical Grand Rounds on ~~Antimicrobial Stewardship~~antimicrobial stewardship issues.

2. Contact ~~physicians~~LP and provide education if the practice is not in line with Antimicrobial Stewardship Program goals and recommendations.
3. Give lectures on treatment of common infections.

F. Educating patients, and their families as needed, regarding the appropriate use of antimicrobial medications, including antibiotics.

Duties of ASP Clinical Registered Nurse

A. Reporting culture results from microbiology to primary physician.

B. Reporting allergies or drug reactions from antibiotics or vaccines.

C. Report all infusion-related reactions and proper care afterward.

Duties of Micro□iology

A. Guide the proper use of tests and the flow of results.

B. Work collaboratively to ensure that lab reports present data in a way that supports optimal antibiotic use.

1. Selective reporting of sensitivity results
2. Notes interpreting lab results

C. Contribute to antibiogram development and education.

Duties of Infection Control Personnel

A. The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.

B. All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.

C. Communication and collaboration with the hospital's QAPI program on infection prevention and control issues.

D. Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies and procedures.

E. The prevention and control of hospital-acquired infections (HAIs), including auditing of adherence to infection prevention and control policies and procedures by hospital personnel.

F. Communication and collaboration with the antibiotic stewardship program.

Duties of Informational Technology Personnel

A. Assist with integrating stewardship protocols into existing workflow.

B. Implement clinical decision support for antibiotic use.

C. Create prompts for action to review antibiotics in key situations and facilitate the collection and reporting of antibiotic use data.

Restricted Antimicro□ial Approval Process

A. Restricted antimicrobials require Infectious Disease (ID) approval and/or ID consult (See Attachment A - Restricted Antimicrobials Criteria for Use).

B. Criteria for use shall be indicated on the order and shall follow the approved indication for use.

C. ID physician and pharmacist shall assume responsibility for approving the use of restricted agents.

D. Contact Procedure

1. Medications in Attachment A that require **ID Approval** (amikacin, anidulafungin, aztreonam, daptomycin, ertapenem, fosfomycin, linezolid, meropenem, maintenance voriconazole)
    a. Monday through Sunday between 0800 - 1600: Licensed provider (LP) place order through electronic health record (EHR). Pharmacy staff will review the indication to confirm criteria for use (See attachment A).
    b. Monday through Sunday between 1600 - 0800: LP place order through EHR. Pharmacy staff will review the indication to confirm criteria for use (See attachment A). If use criteria are not clearly met but LP still feels that restricted antimicrobial is needed, dispense doses due before 0800.
2. Medications in Attachment A that requires **ID Consult** (amphotericin B liposomal, ceftaroline, ceftazidime-avibactam, colistimethate IV/Inhalation, imipenem-cilastatin, isavuconazole, treatment/ new start voriconazole)
    a. Monday through Sunday all hours: Contact ID physician

E. Pharmacy staff will monitor restricted antimicrobials daily and contact the LP/attending physician for any recommendations for change in therapy.

F. Pharmacy staff will document clinical interventions related to review of and recommend to restricted antimicrobial use.

Additional Support for Optimal Antimicro□ial Use

A. A. Licensed Practitioners are required to document in the medical record or during order entry a dose, duration, and indication for all antimicrobials.

1. Policies PH.55 Inpatient Drug Distribution System and 100.025 Medication Order, Administration, and Documentation address required dose and indication for all antimicrobials.
2. Policy PH.61 Automatic Stop Orders addresses automatic soft stop durations for antibiotics, antifungals and antivirals.
3. These policies are supported at order entry with automatic durations and required fields for dose and indication.
4. Review the appropriateness of any antibiotics prescribed after 48-72 hours from the initial orders (e.g., antibiotic time out).

B. The following Clinical Practice Guidelines (CPG) and checklist are based on national guidelines and local susceptibility to assist with antimicrobial selection for common clinical conditions

1. CPG.01 Management of Hospitalized Adults with Uncomplicated Cellulitis
2. CPG.05 Management of Hospitalized Adults with Diabetic Foot Infections

3. CPG.08 HIV in Pregnancy
4. CPG.09 Pregnant Patients with HIV – Newborns of Mothers with HIV
5. CPG.11 Procalcitonin Algorithm for Guidance in Antibiotic Therapy Decisions in Respiratory Tract Infection and Sepsis
6. CPG.17 Algorithm for Management of Adults with Clostridium Difficile Infection
7. CPG.32 Fever in Pediatric Cancer Patients
8. CPG.59 Antimicrobial Prophylaxis in Elective Surgery
9. Checklist for Managing Patients Suspected of Having Measles

C. The following interventions are pharmacy-driven and support antimicrobial stewardship.
1. PH.114 IV to PO Therapeutic Interchange Protocol
2. Dose Optimization
   a. PH.109 Vancomycin per pharmacy
   b. PH.119 Piperacillin-tazobactam (Zosyn) Adult Dosing Protocol

Keywords: Restricted medication

All revision dates: 9/18/2024, 7/12/2023, 11/10/2021, 10/1/2016

Attachments

Attachment A - Restricted Antimicrobials: Criteria for Use

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/20/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/20/2024
Policy Owner	Sara Pendleton: Medication Safety Officer	9/20/2024

Current Status: *Pending* **PolicyStat ID:** *15966005*

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*4/1/2020*
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Next Review:	*2 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

□□□.2□□ Suicide Ris□ Assessment

~~Purpose:~~

PURPOSE:

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

~~Policy:~~

POLICY:

~~Patients who are being evaluated or treated for a behavioral health condition as their primary diagnosis, and those that express~~All admitted patients age 12 and up will be screened and assessed for suicidal ~~ideation during the course of their care will be screened and assessed for suicidal ideation and~~ risk using a validated tool. To ~~identify and assure~~promote safe handling of patients with ~~potential~~ risk for suicide, the assessment will include identification of specific factors that may increase or decrease the risk for suicide on admission and an ongoing basis. Once the assessment is complete, hospital staff are expected to ensure that any risks are mitigated or removed.

~~Departments:~~

DEPARTMENTS:

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

~~Definitions:~~

DEFINITIONS

1. **Suicide:** Death caused by self-inflicted injurious behavior or endangerment with an intent to die as a result of the behavior.
2. **Suicidal Ideation~~:~~**: Thinking about, considering, or planning suicide. The term suicidal behavior may also be used to describe this state.
3. **Suicide Attempt:** ~~Refers to~~ self-inflicted life-threatening attempt at suicide that did not lead to death.

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4. **Suicide Ris Factor:** ~~:~~ Factors that can increase the risk for individuals to attempt to harm themselves.
5. **Protective Factors:** Factors that can serve to decrease a patient's suicide risk especially when several are present.
6. **Emotional or ehavioral Disorder:** ~~:~~ refers to any DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis or condition, including those related to substance abuse.
7. **Chief Complaint:** ~~Refers to~~ the patient's main reason for seeking treatment that day.
8. **Involuntary legal hold**: refers to a process by which a person is held due to danger to self, others or grave disability.

PROCEDURE:

~~EMER ENCY DEPARTMENT ED :~~

EMER ENCY DEPARTMENT ED :

1. The Registered Nurse (RN) in the ED will initiate a continuous observation of ~~the patient if the patient's~~all patients with a chief complaint ~~is~~of:
   a. Suicidal ideation
   b. Homicidal ideation
   c. ~~Legal~~Involuntary Hold Status (ie 5150, 5585)
2. The RN will complete the ~~Columbia Suicide Severity Rating Scale (C-SSRS)~~validated suicide screening tool during triage on every patient ~~age~~aged 12 and up ~~when~~. If the patient~~'s chief complaint is of a behavioral health and /or psychological nature. If the patient is~~ not able to be assessed due to altered mental status, the RN will document that finding in the electronic health record (EHR).
   - ~~If the patient answers "no" on the C-SSRS screening questions 1, 2 and 6, the patient is considered not to be at risk for suicide at this time.~~
   - ~~If the patient answers "yes" to any of the questions on the C-SSRS then the screening algorithm will be followed, and the correct risk level will be placed based on the Suicide Screening answers.~~

   a. If the adult patient answers "no" on the screening questions 1, 2 and 6 (3 months), the patient is considered not to be at risk for suicide at this time. If the patient aged 12-17 answers 'no' on the questions 1 and 2, the patient is considered not to be at risk for suicide at this time.
   b. If the patient answers "yes" to any of the questions on the tool, then the screening algorithm will be followed, and the correct risk level will be placed based on the Suicide Screening answers.
3. If patient is found to be at no, low, or moderate risk of suicide:, the RN will re-screen the patient if there is a new occurrence of suicidal behavior, ideation, statement or other noteworthy clinical change.
4. If the patient is found upon assessment to be at at low risk for suicide~~:~~, the RN in the ED will Notify the Licensed Practitioner (LP) and Charge Nurse of the risk level.
   a. ~~The RN in the ED will:~~
      - ~~Notify the Licensed Practitioner (LP) and Charge Nurse of the risk level.~~
      - ~~Consider an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.~~
      - ~~Document any interventions in the EHR.~~

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Consider an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.

b. ~~The ED LP will consider addressing suicidality in the treatment and discharge (if applicable) plan. Provide counseling and follow up care upon discharge, as well as suicide prevention information.~~Document any interventions in the EHR.

5. If the patient is found to be at moderate to high suicide risk, the RN in the ED will:

a. ~~The RN in the ED will~~Initiate continuous (1:

- ~~Initiate the continuous level of observation and notify the LP and Charge Nurse of the risk level.~~
- ~~Conduct an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.~~
- ~~Document any interventions in the EHR.~~

1) observation and notify the LP and Charge Nurse of the risk level.

b. Conduct an environmental risk assessment that identifies and removes features in the physical environment that could potentially be used for harm.

c. Document any interventions in the EHR.

d. The ED LP or licensed clinical social worker (LCSW) will assess the patient and document in the EHR.

e. Complete (validated assessment tool) and/or consult psychiatry.

f. ~~The ED LP will assess the~~If assessment confirms patient ~~and document in the EHR:~~

- ~~Complete suicide assessment and/or consult psychiatry.~~
- ~~If assessment confirms patient is moderate to high risk, follow mitigation plan and continue suicide precautions if indicated.~~
- ~~If patient meets criteria for safe discharge, directly address suicidality, refer for appropriate level of follow up care and provide suicide prevention information.~~
- ~~If suicide assessment cannot be completed, the reason and safety plan will be documented in the EHR.~~

is moderate to high risk, follow mitigation plan and continue suicide precautions if indicated.

g. If patient meets criteria for safe discharge, directly address suicidality, refer for appropriate level of follow up care and provide suicide prevention information.

h. If suicide assessment cannot be completed, the reason why not and safety plan will be documented in the EHR.

i. When an ED Psychiatric consultation is initiated by the ED staff, the consulting Psychiatric liaison will:

1. Complete and document a Psychiatric evaluation and Suicide Assessment (this may take place in the Crisis Stabilization Unit (CSU) or Inpatient Psychiatric Unit (IPU) at the discretion of the covering psychiatrist).
2. If the patient remains in the ED, provide Psychiatric care recommendations including level of observation and ongoing collaboration

~~When an ED Psychiatric consultation is initiated by the ED LP, the consulting Psychiatric liaison will:~~

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- ~~Complete and document a Psychiatric evaluation, and Columbia Suicide Severity Rating Scale (C-SSRS) Suicide Assessment (this may take place in the Crisis Stabilization Unit (CSU) or Inpatient Psychiatric Unit (IPU) at the discretion of the covering psychiatrist).~~
- ~~If the patient remains in the ED, provide Psychiatric care recommendations including level of observation and ongoing collaboration.~~

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

1. The Registered Nurse (RN) will assess for the presence of Suicide Risk Factors.
   a. Identification of risk factors results in further assessment for presence of a ~~patient's~~ plan and/or intent.
2. Upon admission, the RN will complete a ~~Columbia Suicide Severity Rating Scale (C-SSRS)~~validated screening tool and full assessment on every patient admitted to the CSU or IPU.
3. After admission the patient will be assessed each shift with the ~~Columbia Suicide full~~suicide assessment ~~(recent)~~tool until discharge, transfer or no longer deemed suicidal.
4. If there is a change in the patient's medical condition, a subsequent assessment will be completed by the RN upon readmission to the ~~inpatient Psychiatric Unit~~IPU or the CSU.
5. If the patient is not able to be assessed due to altered mental status, the RN will document that finding in the EHR.
6. Based on the RN assessment findings, the RN will:
   a. Initiate the appropriate level of patient observation.
   b. Obtain LP order for continuous observation if needed and the justification. Enter in the EHR.
   c. ~~Obtain order for Suicide Precautions.~~Obtain order for additional safety precautions.
7. The Psychiatrist will assess the patient within 24 hours of admission to the CSU/IPU for suicidality, and will:
   a. Complete and document the Psychiatric Evaluation in the EHR.
   b. Document the level of observation required and the justification.
   c. Review the Plan of Care and recommend specific interventions to manage patient's risk of harm to self or others. Recommendations to manage the risk of harm will be made and modified as needed.

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

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

MEDICAL/HOSPITAL UNITS:

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

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

PATIENT EDUCATION:

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

1. "If you feel unsafe or feel that you might want to harm yourself or others, you can:"

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a. CALL 211 for Mental Health Intervention Services.

b. Call 1-800-273-8255 or 988 for the National Suicide prevention lifeline.

c. Call 911 or go to the nearest emergency room.

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

STAFF EDUCATION COMPETENCY:

1. All Registered Nursing staff will be educated and evaluated for competency on suicide risk assessment and mitigation upon hire, and when transitioning to another role where they may care for patients at risk.
2. Staff who could be assigned to the care of a patient at risk for suicide will ~~be educated and evaluated for competency in~~receive training on the validated screening tool and suicide ~~risk mitigation yearly~~prevention measures annually.

REFERENCES

The Joint Commission, (2019) https://www .jointcommission.org//media/tjc/documents/standards/national-patient-safety-goals/2020/npsg chapter_bhc_iul2020.pdf.

ENFORCEMENT

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

All revision dates:	9/28/2024, 2/14/2024, 1/10/2023, 9/14/2021, 10/19/2020

Attachments

C.A.S.E. Safety Checklist
Columbia Suicide Rating Assessment with SAFE-T
Columbia Suicide Severity Rating Scale
CSSRS form in Cerner

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	9/30/2024
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	9/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/4/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/4/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/4/2024

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Step Description	Approver	Date

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VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/26/2018*
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Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

□□□.□□□ Fall Prevention

PURPOSE

To provide guidelines for:

1. The identification of patients at risk for falls;
2. Implementation of fall reduction strategies; and
3. Post-fall evaluation and management

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) strive to identify patients at risk for falls, outline interventions for the nursing management of patients at risk for falls or who have a history of falls, and thus reduce the risk of harm resulting from patient falls. An interdisciplinary group of practitioners and administrators work toward a unified goal of reducing falls within the institution.

To reduce fall rates, VCMC/SPH has implemented a process to assess an individual's risk for falling, determine and apply interventions that will most appropriately prevent a person from falling, and review occurrences of falls with the goal of identifying and eliminating the cause of the fall.

PROCEDURE:

Definition:

A patient fall is defined as a "sudden, unintentional descent, with or without injury to the patient, which results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., trash can). When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured.

□UIDELINES:

INPATIENTS

~~The Morse Fall Scale is used to assess all inpatients for fall risk (see Attachment A).~~

The Morse Fall Scale (MFS) is used to assess all inpatients for fall risk (see Attachment A). The total MFS score provides an indication of the likelihood that a patient will fall. However, it does not identify how to protect

the patient from falling. An important goal of the MFS is to identify □ □**Y** a patient is at risk for falls. Focusing on the areas of risk identified by the MFS will help to recognize specific interventions to prevent patient falls.

A. Fall risk is based upon certain risk factors and is more than a total score.

B. **Staff shall complete a fall assessment:**
   - **On admission**
   - **Every □2 hours**
   - **At change of condition**
   - **Upon transfer to a new unit**
   - **After a fall**

C. Determine fall risk factors and target interventions to reduce risks.

IMPLEMENTATION

Standard Fall Precautions and the Morse Fall Scale should be used as the minimum standard of care with adult patients.

A. Standard fall precautions:
   1. Assess:
      a. History of falling
      b. Secondary diagnosis
      c. Ambulatory aid
      d. IV
      e. Gait
      f. Mental status
   2. Ensure patient's footwear is adequate, i.e. rubber soled shoes or slippers. If no footwear is available, provide non-skid socks.
   3. Keep bed in low position
   4. Lock wheels on all wheelchairs, beds, commodes, and gurneys
   5. Wipe up spills immediately
   6. Ensure adequate lighting
   7. Keep nurse call system, telephone, and personal items accessible to patients
   8. Maintain rooms free from excessive clutter

B. Review medications for potential fall risk
   1. Diuretics
   2. Sedatives
   3. Analgesics
   4. Hypnotics
   5. Antihypertensives

C. Review symptoms and diagnoses for potential fall risk

1. Orthostatic hypotension
2. Lower extremity fracture
3. Urinary frequency and urgency
4. Problems with vision
5. Mental confusion
6. Dehydration
7. Dizziness
8. Dementia
9. Secondary diagnoses, i.e. neuropathy
10. Advancing age
11. Poly-pharmacy
12. Pregnancy
13. Hemorrhage

D. ~~High risk fall precautions:~~**MFS MODERATE ris fall precautions:** If your patient scores ~~> 45~~**2-** on the Morse Fall Scale ~~or experiences a fall~~, implement ~~the High~~Moderate Risk Fall Precautions ~~in addition to~~**in addition to** the Standard Precautions.

1. ~~Mandatory:~~
   a. ~~Re-assess patient's condition, and re-orient to the environment, time, person, place as frequently as needed. Ensure patient is given a call light and educated about fall risk and factors to reduce falls.~~
   b. ~~Assess environment for fall hazards~~
   c. ~~If bed alarm is available, turn on and educate patient~~
   d. ~~Ensure a fall risk sign, fall risk armband (yellow) and non skid socks are provided to the patient~~
   e. ~~Notify physician in an event of a patient fall and complete Notification form.~~
   f. ~~Educate patient and family on fall risk reduction~~
   g. ~~Ensure supervision and assistance with elimination, transfer and ambulation activities. Patients in this category must be accompanied while toileting. Staff must remain within arm's length at all times when patient is performing any of these activities. Do not leave patient at high risk alone in bathroom or on bedside commode.~~
   h. ~~Document in the electronic health record (EHR) nursing assessment Morse fall risk scale and/or progress note~~
   i. ~~Initiate a plan of care which addresses medications, cognitive function, gait and balance, as well as other condition that may contribute to patient falls~~

   Mandatory:

   a. Offer toileting every 2 hours **no toileting alone**
   b. If bed alarm is available, activate and educate patient
   c. Ensure a fall risk sign, fall risk armband (yellow) and non skid socks are provided to the patient

d. Initiate a plan of care which addresses medications, cognitive function, gait and balance, as well as other condition that may contribute to patient falls

e. Educate patient and family on fall risk reduction

2. Suggested:

a. Place patient in a room close to the nurses' station

~~Implement a sitter, as ordered by physician~~

~~Consider a bed alarm located in the nurses' station~~

3. Family education:

a. Use eyeglasses, footwear, hearing aids and any personal assistive devices (e.g. braces, ambulatory aids and prosthetic items)

b. Call for assistance, if needed, to transfer, ambulate, toilet or to retrieve hard to reach items

c. Lock wheelchair before transferring

d. Inform nurse of any symptoms (e.g. dizziness, lightheadedness) with postural change (for example, lying, sitting, standing)

e. Avoid bending to pick up items

E. **MFS □I□□-RIS□ fall precautions:** If your patient scores □ □□ on the Morse Fall Scale or experiences a fall, implement the High Risk Fall Precautions in addition to the Standard Precautions.

1. Mandatory:

a. Re-assess patient's condition, and re-orient to the environment, time, person, place **as fre□uently as needed.** Ensure patient is given a call light and educated about fall risk and factors to reduce falls.

b. Assess environment for fall hazards

c. If bed alarm is available, turn on and educate patient

d. Ensure a fall risk sign, fall risk armband (yellow) and non skid socks are provided to the patient

e. Notify physician in an event of a patient fall and complete Notification form.

f. Educate patient and family on fall risk reduction

g. Ensure supervision and assistance with elimination, transfer and ambulation activities. Patients in this category must be accompanied while toileting. Staff must remain within arm's length at all times when patient is performing any of these activities. Do not leave patient at high risk alone in bathroom or on bedside commode. **No toileting alone.**

h. Document in the electronic health record (EHR) nursing assessment Morse fall risk scale and/or progress note

i. Initiate a plan of care which addresses medications, cognitive function, gait and balance, as well as other condition that may contribute to patient falls

2. Suggested:

a. Place patient in a room close to the nurses' station

b. Implement a sitter, as ordered by physician

c. Consider a bed alarm located in the nurses' station

3. Family education:
    a. Use eyeglasses, footwear, hearing aids and any personal assistive devices (e.g. braces, ambulatory aids and prosthetic items)
    b. Call for assistance, if needed, to transfer, ambulate, toilet or to retrieve hard to reach items
    c. Lock wheelchair before transferring
    d. Inform nurse of any symptoms (e.g. dizziness, lightheadedness) with postural change (for example, lying, sitting, standing)
    e. Avoid bending to pick up items

E□ALUATION

The success of the VCMC/SPH Fall Prevention program will be determined by evaluating how well fall prevention strategies are incorporated into the patient's care plan and reinforced at each change of shift report.

A. The evaluation process will include:
    1. Identifying and evaluating conditions which preceded falls
    2. Identifying and analyzing actual and/or suspected breaks in procedure
    3. Analyzing data gathered from the notification form process
    4. Identifying patterns or trends and establishing measurable plans for improvement
    5. Communicating data and plans for improvement to all stakeholders as appropriate
    6. Reporting fall prevention data to the Performance Improvement Coordinating Council (PICC)

PEDIATRIC PATIENTS

The patient, family, and caregiver shall all be involved in falls prevention through education. Pediatric falls are predominately the function of extrinsic factors, including accidental and environmental hazards. The etiology of a fall in the pediatric patient is typically different from adults and therefore requires a separate fall risk scale and set of interventions.

1. **Anticipated physiological□intrinsic**: Patient diagnosis or characteristics that may predict patient's likelihood of falling
2. **Unanticipated physiological□intrinsic**: Unpredictable if no previous history is present and no risk factors identified from assessment
3. **Extrinsic□Accidental**: An accidental fall is defined as when a patient is oriented but rolls out of bed or trips/slips due to environmental risk factors; or an infant is dropped by a parent or caregiver
4. **Developmental**: Non-injurious falls that are common to infants/toddlers as they are learning to walk, pivot and run

□eneral guidelines to prevent falls in pediatric patients:

1. Orient patient and family to environment.
2. Beds will be in low position with brakes on unless treatment needs require otherwise. After procedures, the bed will be returned to the low position.
3. High-sided or bubble tops cribs will be used when patient/parents state or the child demonstrates that s/

he might climb out.

4. Call light (assume patient can use), bedside table, telephone and other frequently used items will be kept within reach of the patient, as developmentally appropriate.
5. Sensory aids, i.e., eyeglasses, hearing aids, etc. will be accessible to patient.
6. Provide assistance, as appropriate, to child requiring assistive devices (e.g., walker, crutches, etc.)
7. Ambulating patients must wear shoes or non-slip, non-skid footwear. Patients will be accompanied when ambulating for the first time or whenever their clinical status indicates that they are at risk for falling. This would include but not limited to medication side effects, neurological impairment and/or developmental state.
8. Built-in safety straps will be used for babies placed in infant seats and children using their personal wheelchairs. Children using a wagon or infant activity center must be supervised continuously.
9. Children being transported by gurney or crib will have the side rails up at all times as a safety precaution; children transported off the unit will be continuously supervised.
10. Children and infants should not be placed or allowed to play in unsafe areas, such as on windowsills, on top of tables, etc.
11. Keep environment clear of hazards.
12. Consider use of nightlight during night shift via Biomed.
13. Assist with elimination as needed.
14. Implement evaluation of medications that predisposes patients to falls. This includes anticonvulsants, opioids, benzodiazepines, diuretics, anti-hypertensives, analgesics, and bowel preps.
15. Educate patients and family regarding fall prevention strategies.

Fall assessment in pediatric patients:

1. The Humpty Dumpty Falls Scale (HDFS) will be used for fall risk assessment on admission to PEDS and/or PICU (Pediatric Assessment/Reassessment Flowsheet. See Attachment B).
2. Patient's fall risk will be reassessed and documented by nursing per admission every shift, or more frequently if changes in condition or high-risk medication regimen (e.g., narcotics, sedatives, anti-hypertensives, etc.).
3. Patients are scored in the HDFS (range 7-23) and may be low risk (score 7-11 points) or high risk (score 12 and above). Patients scored "low risk" should continue with use if safety precautions as above.
4. The following interventions constitute high risk interventions and are appropriate for patients with a HDFS of 12 or above:
    a. Identify patient's fall risk with Humpty Dumpty sign on door frame.
    b. Include patient's high risk status in all hand off communication reports.
    c. Educate patient and family on fall prevention precautions.
    d. Consider commode at bedside.
    e. Continuous supervision while toileting. Do not leave patient at high risk alone in bathroom or on bedside commode.
    f. Accompany patient with ambulation, including in hallways and within room/bathroom.

g. Consider moving patient closer to nurses' station.
h. Provide continuity of staff.
i. Assess your patient's need for supervision. Educate family or others on fall prevention strategies.
j. Evaluate medication administration times.
k. Remove all unused equipment and furniture from the room.
l. Use protective barriers to close off any gaps in bed where patient may be able to attempt escape.
m. Keep door open at all times unless droplet or airborne precautions are in use. Closed door requires closed circuit monitoring.
n. Consider obtaining consult for physical therapy and/or occupational therapy i.e., for assistive devices.
o. Document fall prevention interventions.

5. In the event of a fall:
   a. Assess patient for signs of injury.
   b. Assess and document vital signs in EHR. Consider checking glucose level if no known cause for fall.
   c. Assess environment and consult with patient/family for potentially contributing factors.
   d. Notify physician.
   e. Complete Notification reports in EHR.
   f. Objectively describe incident and results in patient's EHR.
   g. Modify patient's plan of care based on risk factors leading to fall.
   h. Communicate in all hand off communication reports.

EMER□ENCY DEPARTMENT

Emergency Department patients will be screened for fall risk using specific assessment screening elements. Screening will take place at the time of triage using an age-appropriate fall risk screening tool ~~(See Attachment C)~~(See Attachment C). Appropriate fall prevention measures will be implemented for all patients identified as "at risk" for falls.The staff will document all fall reduction interventions and patient/family education in the medical record.

POST-FALL MANA□EMENT

After a patient fall:

- Stay with patient and request assistance
- (Non-licensed personnel) - Provide comfort measures until licensed staff member arrives and assesses patient for injury
- Inform Licensed Practitioner and obtain follow-up orders as appropriate
- If patient has struck head/face and/or is on anticoagulation therapy, immediately notify physician, and initiate neuro-checks.
- Conduct a post-fall huddle to identify factors that contributed to the fall, and to identify the actions necessary to prevent another fall for that patient. Complete the Post-Fall Huddle Form ~~(See Attachment D)~~(See Attachment D)

- Complete an event notification
- Document clinical status and description of fall in the Electronic Health Record
- Complete a fall risk reassessment and update care plan accordingly
- Implement additional intervention as needed or as ordered (e.g., increased level of supervision)

All revision dates: 10/30/2024, 7/12/2023, 11/26/2018

Attachments

Attachment A - Morse Fall Scale.pdf
Attachment B - Humpty Dumpty Falls Scale.pdf
Attachment C - ED Fall Risk Assessment Tool
Attachment D - Post-Fall Huddle Form

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	11/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/30/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/30/2024

Current Status: *Pending* **PolicyStat ID:** *16969742*

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/10/2023*
Effective:	*Upon Approval*
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Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

□□□. □□□ Urinary Catheter Insertion□Maintenance□ De-escalation

PURPOSE:

To guide the insertion, maintenance, and ~~de-escalation of~~removal of indwelling urinary catheters ~~in order~~ to prevent the incidence of catheter-associated urinary tract infections (CAUTI). This policy guides ~~the~~ nursing staff in the management of indwelling urinary catheters. Lippincott provides an additional resource for any items not addressed in this policy.

POLICY:

A. Catheter Use

1. ~~Urinary~~Indwelling urinary catheters should be inserted only when necessary and left in place only for as long as necessary. ~~They should not~~
   Alternatives to indwelling urinary catheters must be ~~used soley for the convenience of patient-care personnel or patient preference~~considered, including external male and female catheters use and intermittent bladder catheterization.
   a. ~~Alternatives to indwelling catheters must be considered first if suitable in a specific patient. These include the use of external male and female catheters, intermittent bladder catheterization and bladder massage.~~
2. ~~To avoid urethral strictures associated with prolonged transurethral catheterization, suprapubic or transurethral catheterization should be considered in patients who need prolonged bladder catheterization for more than 4 weeks (e.g. those with neurogenic bladder or ulceration in perineal area).~~Suprapubic or transurethral catheterization should be considered in patients who need prolonged bladder catheterization. If patients require prolonged catheterization, Registered Nurses (RN) should contact the Licensed Practitioner (LP) to request suprapubic catheterization.

~~□. Leadership for Appropriate Catheter Use~~

1. ~~The clinical nursing unit leadership will oversee and support the safe use of urinary catheters as outlined in this policy.~~

C. Indications for Indwelling Catheter Use

1. ~~Urinary catheters must be inserted only when there is an indication to do so. Indications include:~~
    a. ~~Hematuria, gross~~
    b. ~~Obstruction, urinary~~
    c. ~~Urologic/gynecologic surgery~~
    d. ~~Decubitus ulcer-open sacral or perineal wound in incontinent patient~~
    e. ~~Intake and output (I & O)- actively using urine output to guide therapy in critically ill patients~~
    f. ~~Neurogenic bladder dysfunction, chronic indwelling catheter or No Code/Comfort Care~~
    g. ~~Immobility due to physical constraints (e.g. unstable fractures)~~
2. ~~Orders for insertion and discontinuation~~
    a. ~~Foley catheters may be inserted in patients only by an order from a Licensed Independent Provider (LIP).~~
    b. ~~The order will include the "Discontinuing a Urinary Catheter Utilizing the Houdini Protocol" order set~~
    c. ~~The nurse will conduct an assessment of need each shift and will discontinue the catheter upon an order from a LIP and/or utilizing the Houdini Protocol. ***Please see Attachment A Houdini Protocol.***~~

~~D. Indwelling Transurethral Catheters Present on Admission or Placed Emergently~~

1. Indwelling urinary catheters must be inserted only when there is an indication to do so. *Please see Attachment A Houdini Protocol.*
2. Indwelling urinary catheters are appropriate for measuring and collecting urine only when fluid status or urine CANNOT be assessed by other means. Location in a critical care setting alone is NOT an appropriate indication.
3. Orders for insertion and discontinuation
    1. Indwelling urinary catheters may be inserted in patients only by an order from an LP.
    2. Nursing will place the standardized protocol order.
    3. The RN will assess the need for indwelling urinary catheter continuation each shift. The RN will discontinue the indwelling urinary catheter utilizing the Houdini Protocol. *Please see Attachment A Houdini Protocol.*

E. Indwelling Urinary Catheters- Miscellaneous

1. ~~If an indwelling transurethral urinary catheter is present on admission, it should be documented as having been present and removed immediately, and a new catheter inserted if still warranted. A urine culture should be sent at this time. However, considerations should be given to alternative devices including external male and female urinary catheters.~~ If an indwelling urinary catheter is present on admission from an outside facility, the RN will: 1) document presence, 2) obtain a urine culture, 3) remove the urinary catheter, and 4) insert a new urinary catheter if warranted. The RN will consider alternatives to the indwelling urinary catheter.

2. If an indwelling ~~transurethral~~ urinary catheter is placed emergently, it must be removed as soon as possible (~~**after no longer than □□ hours** □since adherence to aseptic technique cannot be ensured~~within 48 hours), a baseline urine culture obtained, and a new indwelling urinary catheter inserted if ~~still~~ warranted.
3. If an indwelling urinary catheter is placed in the Operating Room, the RN will remove the foley catheter within 48 hours after surgery, unless continuation is clinically indicated.

F. Indwelling Urinary Catheter Insertion

1. Personnel who insert indwelling urinary catheters must have demonstrated competency in proper insertion technique.

   ~~Hand hygiene must be performed with an antimicrobial soap and water or an alcohol hand sanitizer before insertion and immediately before and after any manipulation of the catheter site or drainage system.~~

2. The Lippincott ~~and American Association of Critical Care Nurses (AACN)~~ procedure ~~manual~~ will guide the specific details of insertion.

   ~~Only one attempt at insertion is allowed for each catheter.~~

3. Indwelling urinary catheters should be properly secured after insertion to prevent movement and urethral traction.

   ~~The foley catheter bag should be dated and timed as well as the securement device.~~

□. Documentation for Catheter Insertion

~~1. The following information must be documented in the patients medical record after catheter insertion:~~
   ~~a. Indication for catheter insertion~~
   ~~b. Date and time of catheter insertion~~
   ~~c. Individual who inserted the catheter~~
~~2. The date and time of removal of the catheter should also be documented in the patient's medical record~~
~~3. Documentation should be accessible in the patient's medical record and recorded in a standard format for data collection and quality improvement purposes.~~

~~□. Reminders to Nurses to Assess Indications for Catheter~~

~~1. Nurses will assess the indications for a catheter during each shift and will document in the medical record. If indications are not met for ongoing catheterization, the nurse will utilize the Houdini Protocol and remove the catheter.~~
~~2. The LIP may also indicate that the catheter be removed and intermittent catheterization performed or replaced with an external device.~~

1. Document indwelling urinary catheter insertion in the proper location in the Electronic Health Record.

I. Closed Sterile Drainage

1. A sterile, continuously closed drainage system sealed to the catheter must be maintained.
2. If ~~breaks in aseptic technique,~~ disconnection, or leakage ~~occur~~occurs, the indwelling urinary catheter and drainage collection system ~~sealed to the catheter~~ should be replaced ~~using aseptic technique~~.

□. Irrigation

1. Irrigation should be avoided unless continuous bladder irrigation is ordered by a ~~LIP~~LP.
2. ~~The catheter-tubing junction must be disinfected before disconnection.~~The RN will follow Lippincott's irrigation procedure.

□. Urinary Flow and Collection □ag

1. Unobstructed flow should be maintained
2. To achieve free flow of urine:
   a. Avoid any kinks in the catheter and collection tubing
   b. The collection bag should be emptied as needed and prior to ambulation and/or transport.
   c. ~~The~~A separate collection ~~bag~~container to empty the urine should be ~~emptied when it is 2/3 full or before any ambulation and/or transport. A separate collection container for each patient should be~~ utilized. The drainage spigot ~~and non-sterile~~should never come in contact with the urine collection container ~~should never come in contact~~.
   d. Collection bags should always be kept below the level of the bladder but should never touch the floor.

~~If the catheter becomes obstructed, it should be removed. If there is a continued need for bladder catheterization, a new catheter should be inserted using aseptic technique.~~

L. Perineal Care

1. The perineum should be cleaned ~~daily~~at least once per shift and after each incontinence episode with ~~soap and water~~hospital-approved product. Chlorhexidine (CHG) is not recommended for perineal care.

   ~~Do not clean the perimeatal area with antiseptics to prevent CAUTI while the cateter is in place. Routine hygiene is sufficient.~~

~~M. Catheter Change~~

~~1. Indwelling catheters should be changed only as clinically indicated.~~

~~N. □ladder Scanners~~

~~1. The bladder scanning protocol can be found in policy *100.244 Discontinuing a Urinary Catheter Utilizing the Houdini Protocol*.~~

REFERENCE□S□:

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Mitchell, B., Curryer, C., Holliday, E., Rickard, C., & Fasuka, O. (2021). Effectiveness of meatal cleaning in the prevention of catheter associated urinary tract infections and bacteriuria: An updated systematic review and meta-analysis. *BMJ Quality and Safety 11*(6), e046817. https://www.doi.org/10.1136/bmjopen-2020-046817

All revision dates: 10/29/2024, 1/10/2023

Attachments

Attachment A: Houdini Protocol.pdf
Attachment B: Post-Urinary Catheter Management Algorithm (1).pdf

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	10/29/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/29/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/29/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*1 year after approval*
Owner:	*Cynthia Fenton: AC Director of Nursing*
Policy Area:	*Ambulatory Care - Patient Care Services*
References:	

AC.□□ Am□ulatory Care Clinic Standing Protocol for Medication Refills

PURPOSE:

To provide a process for approved licensed staff to safely review and ~~authorize~~approve maintenance prescription refill requests, ~~saving time for the prescribing Providers,~~ and ensure timely patient access to ~~medication~~medications refills in the Ambulatory Care Clinics. ~~Approved prescribing Providers must co-sign these standing orders and include Primary Care Providers (PCPs), Specialists and Advanced Practice Providers (APPs).~~

DEFINITION□S□:

A. Licensed Practitioner (LP) is an individual who is licensed and qualified to direct or provide care, treatment, and services in accordance with state law and regulation, applicable federal law and regulation, and organizational policy[1]. In the Ambulatory Care Clinics, LPs include Specialists, Physicians, Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNMs).

B. Standing Order: A pre-written medication order and specific instructions from the licensed practitioner to administer a medication to a patient in clearly defined circumstances[1]. This policy shall refer to standing orders as a standing protocol.

POLICY:

- ~~Registered Nurses (RNs) may refill maintenance medications for providers with the use of standing orders and provider co-sign.~~
- ~~Licensed Vocational Nurses (LVNs) may also refill maintenance medications for providers with the use of the standing orders and requires provider co-sign.~~
- ~~Medical Assistants or Medical Office Assistants (MAs or MOAs) may be authorized to conduct refill requests under this protocol with approval the Provider or Specialist. Refill requests shall be supervised and cosigned by a licensed provider. MA/MOAs must receive training and education to perform this specific function and must follow California statute and regulations.~~

~~DEFINITION□S□:~~

~~**Standing Order**: A pre-written medication order and specific instructions from the licensed practitioner to administer (or refill) a medication to a patient in clearly defined circumstances.~~

A. Prescribing Licensed Practitioners (LP) must co-sign refill requests per standing protocol and include Specialists.

B. The prescribing LP may opt out of this process and authorize their own refill requests generated for their patients.

C. Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) may authorize refill maintenance medications for LP with the use of standing orders and provider co-sign[5-6].

D. Medical Assistants (MAs) may assist in the refill process only[5]. This may include calling in refills to a pharmacy, under the direct supervision of the physician or podiatrist. The medication refills must be exact and have no changes in the dosage levels. The refill must be documented in the patient's chart as a standing order, patient specific. Medical assistants may not call in new prescriptions or any prescriptions that have any changes[8].

PROCEDURES:

Ambulatory Care Clinic Medication Refill Overview

A. Ambulatory Care Clinic Staff shall respond to medication refill requests within 3 working days (72 hours) for all routine refills. In the event urgent attention is required, the refill shall be processed within 48 hours or sooner.

B. Refill requests shall be processed and communicated by calling, faxing or submitting electronically to a licensed pharmacy.

C. When the refill request comes from the retail pharmacy, obtain the following information from the requesting retail pharmacy: patient's name, date of birth, retail pharmacy, retail pharmacy phone number, medication requested (dose and route), amount requested, and the last date the medication was ordered/dispensed.

D. When the refill request comes from the patient, obtain information from either the Electronic Health Record (EHR) or from the retail pharmacy where the medication was last prescribed: patient's name, date of birth, retail pharmacy, retail pharmacy phone number, medication requested (dose and route), amount requested, and the last date the medication was ordered/dispensed.

E. All requests for written prescriptions for the patient must be signed by the LP.

F. All refill requests, communication, questions, or concerns requiring LP authorization must be routed to the prescribing LP. In the event the prescribing LP is unavailable, the request shall be routed to the covering LP or the Medical Director.

G. Refill quantities may be changed from a 30-day supply to a 90-day supply, per patient request or to meet insurance requirements for the mail order benefit. Gold Coast members may receive a 90-day supply.

H. A LP may decide to delegate authorization for refill requests for a time period shorter than outlined on this standing order, as long as this is clearly communicated to the RN and LVN assigned to that LP. All refill requests that exceed these standing protocol time ranges requires prescribing LP review and authorization.

I. Specialty LPs shall customize a refill authorization list of medications that are pre-approved for the RN or LVN to authorize under the direct supervision of the Specialist LP under the co-sign standing protocol function. Specialty LP parameters are separated on the refill authorization list of medications.

~~Respond to medication refill requests within 3 working days (72 hours) for all routine refills. In the event urgent attention is required, the refill shall be processed within 24 hours or sooner.~~

~~Refill requests shall be processed and communicated by calling, faxing or submission electronically to a licensed pharmacy.~~

~~When the refill request comes from the pharmacy, obtain the following information from the requesting pharmacy: patient's name, date of birth, pharmacy, pharmacy phone number, medication requested (dose and route), amount requested, and the last date the medication was ordered/dispensed.~~

~~When the refill request comes from the patient, obtain information from either the EHR in Cerner or from the pharmacy where the medication was last prescribed: patient's name, date of birth, pharmacy, pharmacy phone number, medication requested, amount requested, and the last date the medication was ordered/dispensed.~~

~~All requests for written prescriptions for the patient must be signed by the provider.~~

~~All refill requests, communication, questions, or concerns requiring providers authorization must be routed to the prescribing provider.~~

~~Refill quantities may be changed from 30-day supply to 90-day supply, per patient request or to meet insurance requirement for the mail order benefit. Gold Coast members receive a 30-day supply.~~

~~A provider may decide to delegate authorization for refill requests for a time period shorter than outlined on this standing order, as long as this is clearly communicated to the RN and LVN assigned to that provider. All refill requests that exceed these protocolized time ranges requires prescribing provider review and authorization.~~

A. The RN or LVN shall process the refill request by first reviewing the patient's medical record ~~and~~, identifying the class of medication being requested for refill and reviewing the prescribing ~~provider~~'LP's last clinic note, to include the following information:

1. Medication name, dosage, route and frequency~~: Ensure that the patient is requesting the correct medication, strength and at the frequency the provider prescribed. Ensure the request is not too early or that as needed medications are not being used too frequently (e.g., sublingual nitroglycerin, migraine, rescue inhaler medications). Ensure that the medication is marked as a maintenance, and not an acute one-time, prescription.~~

    a. Ensure that the patient is requesting the correct medication, strength and at the frequency the provider prescribed.

    b. Ensure the request is not too early or that as needed medications are not being used too frequently (e.g., sublingual nitroglycerin, migraine, rescue inhaler medications).

    c. Ensure that the medication is a maintenance medication, and not an acute one-time, prescription.

    d. Ensure the medication requested for refill is on the list of approved medications under the correct indication or class of medication (See Attachment A: Ambulatory Care Medication Refill Guide).

2. Clinic Visit ~~frequency~~Frequency~~: All patients requesting refills must have had a visit with their provider within the last 1 year. Patients who have not been seen in the clinic by the provider in more than one year shall be scheduled for an appointment and the refill request authorized for 30 days.~~

~~For any medication where more frequent visits are recommended as outlined in the table below, the timeline listed supersedes the 1-year interval. Any refill request for a patient who has not been seen in over 2 years should be routed to the provider. If the provider has departed our system, the request can be routed to the medical directors.~~

a. All patients requesting refills must have had an encounter within the last year. Patients who have had an encounter within or nearing one year shall be scheduled for an appointment and the refill request authorized for 30 days.

b. For any medication where more frequent visits are recommended as outlined in Attachment A: Ambulatory Care Medication Refill Guide, the timeline listed supersedes the 1-year interval.

c. Any refill request for a patient who has not had an encounter in over 1-year should be routed to the LP. If the LP has departed our system, the request can be routed to the medical directors.

3. Lab testing and monitoring: ~~Ensure that lab testing and monitoring has been performed and is within normal limits or at goal, prior to authorizing the refill. The table below titled "Monitoring Parameters and Refill Intervals for Selected Medications" outlines which labs shall be reviewed for each medication class. If the patient is due for testing or monitoring, a refill may be provided so long as the lab test is scheduled. It is within the scope of an LVN or RN to place the order for lab testing per this protocol. The RN or LVN shall message the prescribing provider which labs are being ordered and inquire if any additional labs may be required by the provider.~~

   a. Ensure that lab testing and monitoring have been performed and are within normal limits or at goal, prior to authorizing the refill.

   b. Attachment A: Ambulatory Care Medication Refill Guide outlines which labs shall be reviewed for each medication class.

   c. If the patient is due for testing or monitoring, a refill may be provided so long as the lab test is scheduled. It is within the scope of an LVN or RN to place the order for lab testing per this protocol.

   d. The RN or LVN shall message the prescribing LP which labs are being ordered and inquire if any additional labs may be required by the LP.

4. Medication alerts: ~~:~~ Verify that the patient has ~~had~~ a previous order for the medication and has tolerated the medication ~~and then proceed with the refill~~before refilling the medication.

5. Indications for ~~us~~use~~e~~: ~~Verify the medication requested for refill is indicated for use for the patient's diagnosis or problem list. Check for excessive use or therapeutic duplications. Verify with the provider for approval with any concerns identified, prior to authorizing the refill.~~

   a. Verify the medication requested for refill is indicated for use for the patient's diagnosis or problem list.

   b. Check for excessive use or duplications.

   c. Verify with the LP for approval with any concerns identified prior to approving the refill.

6. Patient allergies ~~&~~and potential sensitivity: Verify the patient does not have any allergies or sensitivities to the medication, prior to authorizing the refill.

B. ~~Authorize~~RN and LVN shall authorize the refill for the duration specified ~~on the table below, "Monitoring Parameters and~~in Attachment A: Ambulatory Care Medication Refill ~~Intervals for Selected Medications"~~Guide. ~~If no future appointment with the provider is scheduled or the last appointment was over a year ago, schedule an appointment and refill the medication for a quantity up to 30 days, enough~~

~~to last until the future appointment. Contact the patient and inform them of refill authorization, any appointments made on their behalf for lab draws ordered or required monitoring. If the patient has missed their most recent appointment, forward the refill to the provider.~~

1. If no future appointment with the LP is scheduled or the last appointment was over a year ago, schedule an appointment and refill the medication for a quantity of up to 30 days, OR enough to last until the future appointment.
2. Contact the patient and inform them of refill authorization, and any appointments made on their behalf for lab draws ordered or required monitoring.
3. If the patient has missed their most recent appointment, forward the refill to the LP.

C. Document that the medication was refilled per standing ~~orders~~protocol and include the following information in the Encounter Form or Multidisciplinary Progress Note:

1. The full name of the drug, strength/dose, route, frequency, and number dispensed, directions for use, and number of refills.
2. The time and date called or faxed in, name and phone number of the retail pharmacy, name of the person at the retail pharmacy who took the order (when applicable), and the staff member's signature including first initial, last name, and title.
3. The patient's name, date of birth, and medical record number.

D. Update the patient's medication profile in ~~Cerner~~the EHR under Medication List to include the medication refill.

Medications and indications excluded from the refill policy:

The following medications must be routed ~~the licensed Provider~~to the LP (e.g., Specialist, Physician, NP, PA, and CNM) who prescribed the medication(s):

- ~~Drug Enforcement Agency (DEA) Scheduled II-V controlled substances. Examples include, opioids, benzodiazepines, phenobarbital, zolpidem, pregabalin, cough medicines that contain codeine, pseudoephedrine, and testosterone.~~
- ~~Oral steroids such as prednisone and hydrocortisone.~~
- ~~Immunosuppressant medications, examples include, methotrexate, leflunomide, azathioprine, mycophenolate mofetil and cyclosporine.~~
- ~~Chemotherapeutic agents~~
- ~~Antiarrhythmic agents such as amiodarone and sotalol. (NOT beta blockers like metoprolol)~~
- ~~Antibiotics~~
- ~~Antipsychotics including, risperidone, quetiapine, olanzapine, paliperidone, aripiprazole and clozapine.~~
- ~~Hormone replacement therapy most commonly, estrogen and progesterone.~~
- ~~Warfarin or other anticoagulants (may be filled by an anticoagulation therapy RN)~~
- ~~Antiplatelets other than aspirin, Clopidogrel, ticagrelor and prasugrel.~~
- ~~Vitamin D doses greater than 2000 IU daily.~~

~~Route medications refill re□uest to the patient□s Provider if any of the following are true:~~

- ~~The patient's medication list in not current or reconciled.~~
- ~~The medication requested is not on the patient's active medication list.~~
- ~~The mediation was prescribed by a provider outside the clinic or from the hospital or emergency room.~~
- ~~The medication requested is for treating a condition that does not appear stable, for example the dose is~~

~~being titrated or changed.~~

- ~~The required monitoring has not occurred (see tables below).~~
- ~~There are indications of medication over use or underuse.~~
- ~~There are indications that the patient may be experiencing a side effect or drug interaction from the medication.~~
- ~~Request to change from a brand name to a generic medication when the prescribing provider specified that the brand names should be dispensed.~~
- ~~The patient is pregnant or lactating (unless the request is for prenatal vitamins or iron).~~
- ~~The RN or LVN has other questions arise regarding the appropriateness of the medication refill.~~

A. Drug Enforcement Agency (DEA) Scheduled II-V controlled substances. Examples of controlled substances include, opioids, benzodiazepines, phenobarbital, zolpidem, pregabalin, cough medicines that contain codeine, and testosterone.

B. Pseudoephedrine

C. Oral steroids (e.g., prednisone and hydrocortisone).

D. Immunosuppressant medications (e.g., methotrexate, leflunomide, azathioprine, mycophenolate mofetil, hydroxychloroquine and cyclosporine).

E. Chemotherapeutic agents

F. Antiarrhythmic agents (e.g., amiodarone and sotalol, but NOT beta blockers like metoprolol).

G. Antibiotics

H. Antipsychotics (e.g., risperidone, quetiapine, olanzapine, paliperidone, aripiprazole and clozapine).

I. Hormone replacement therapy (e.g., estrogen and progesterone, but NOT Oral Contraceptives).

J. Warfarin or other anticoagulants; however, anticoagulants may be filled by an anticoagulation therapy RN.

K. Anti-platelets other than aspirin (e.g., clopidogrel, ticagrelor and prasugrel).

L. Vitamin D doses greater than 2000 International Unit daily.

Route medication refill request to the patient's LP if any of the following are true:

A. The patient's medication list is not current or reconciled.

B. The medication requested is not on the patient's active medication list.

C. The mediation was prescribed by a LP outside the clinic or from the hospital or emergency department.

D. The medication requested is for treating a condition that does not appear stable (e.g., the dose is being titrated or changed).

E. The required monitoring has not occurred (see Attachment A: Ambulatory Care Medication Refill Guide).

F. There are indications of medication overuse or under use.

G. There are indications that the patient may be experiencing a side effect or drug interaction from the medication.

H. Request to change from a brand name to a generic medication when the prescribing LP specified that the brand names should be dispensed.

I. The patient is pregnant or lactating unless the request is for prenatal vitamins or iron.

J. The RN or LVN has other questions arise regarding the appropriateness of the medication refill.

Monitoring Parameters and Refill Intervals for Selected Medications :

~~Medications not in the table below should be forwarded to the provider for refill. When the provider does not specify different monitoring parameters, medications in the table below may be refilled for the duration specified in column D. If the patient has been seen by a provider regarding the indicated use of the requested medication within the interval specified in column C and the required monitoring in column B had been performed:~~

~~Medication Class or Name~~	~~Column B: Required Monitoring~~	~~Column C: Patient should have been seen by Provider within~~	~~Column D: Authorize Refill for~~
~~Ace Inhibitors and Angiotensin Receptor Blockers, K sparing Diuretics (spironolactone, eplerenone) and thiazides (HCTZ, chlorthalidone)~~	~~Within 2 weeks of initiation AND every 12 months OR dosage change:~~ ~~• BMP: K+ and Creatinine~~ ~~• Blood pressure~~	~~1 year if BP is well controlled~~	~~6 months~~
~~Nonsedating Antihistamines (Claritin, Zyrtec)~~		~~2 years~~	~~1 year~~
~~Allopurinol~~	~~Annually:~~ ~~• CBC~~ ~~• Creatinine~~ ~~• Uric acid~~	~~1 year~~	~~1 year~~
~~Alpha-Agonist (clonidine, methyldopa)~~	~~Annually and with dosage change:~~ ~~• Blood pressure~~	~~6 months~~	~~6 months~~
~~Alpha Blockers (tamsulosin, prazosin)~~	~~Annually and with dosage change:~~ ~~• Blood pressure~~	~~1 year~~	~~1 year~~
~~Antidepressants~~		~~New start: should be seen within 3 months Ongoing prescription at stable dose: 6 months~~	~~3 months~~
~~Antiepileptics and Anticonvulsants~~	~~Annually:~~ ~~• Drug level~~	~~Initial or dose change: send to~~	~~3 months~~

Medication Class or Name	Column □: Re□uired Monitoring	Column C: Patient should have □een seen □y Provider within	Column D: Authori□e Refill for
	(carbamazepine, phenytoin, valproic acid) • CBC (carbamazepine, valproic acid) • LFTs (carbamazepine, valproic acid) • Sodium (carbamazepine, oxcarbamazepine) • BMP (topiramate)	provider Ongoing: 6 months	
Antimuscarinics and Incontinence Medications (oxybutynin, solifenacin)		1 year	1 year
Anti-Ulcer Drugs (H2 Blockers and Proton Pump Inhibitors)		H2 blocker: 1 year PPI: 3 months after initiation, 1 year for stable dose	H2 blocker 6 months PPI 3 months
Asthma Controller Medication Inhaler		1 year	6 months
Asthma Rescue Inhaler (albuterol, ipratropium)	If asthma is not on the problem list, schedule follow up and refill until follow up date	3 months	1 month (do not refill for patient with asthma, refer to provider. OK to refill for patients with COPD)
Beta Blockers other than sotalol	Annually and with dosage change: • Blood pressure • Heart rate	1 year	6 months
Calcium Channel Blockers	Annually and with dosage change: • Blood pressure • Heart rate (diltiazem, verapamil)	1 year If BP is well controlled	6 months
Constipation Medications		1 year	1 year

Medication Class or Name	Column B: Required Monitoring	Column C: Patient should have been seen by Provider within	Column D: Authorize Refill for
Diabetic Supplies (includes alcohol swabs, syringes, pen needles, glucometer supplies, lancets)		1 year	1 year It is okay to change the brand of supplies if required by insurance but keep the testing frequency indicated for the previous supplies.
Dialysis Medications (Renagel, Nephrovite)		1 year	1 year
Loop Diuretics (bumetanide, bumex, furosemide, lasix, torsemide)	6 months and with dosage changes: • BMP • Blood pressure	3 months	3 months
Ezetimibe	Annually and with dosage change: • Lipid panel	1 year	6 months
Fibrates	Annually and with dosage change: • LFTs • Lipid panel • Creatinine if eGFR is less than 60mL/min/m2	1 year	6 months
Insulin	Always refill if diabetic but ensure monitoring scheduled: If A1c is over 8% q3 months if A1c is less than 8% q6 months	Always refill but ensure provider has seen patient within last 6 months If A1c is over 8%, ensure provider has seen patient within last 3 months	Always refill but ensure follow up scheduled within 3 months
Metformin	6 months: • Creatinine • A1c	1 year	6 months
Non-controlled Migraine		6 months	6 months

Medication Class or Name	Column □: Re□uired Monitoring	Column C: Patient should have □een seen □y Provider within	Column D: Authori□e Refill for
Medications (sumatriptan, rizatriptan)			
Non-Steroidal Anti-inflammatory drugs (NSAIDs)	Annually: • Creatinine • Hemoglobin	40 years old or less: 1 year Over 40 years: 6 months	3 months
Oral Contraceptives	If the patient has missed one dose, advise the patient to take two pills today and then resume one pill daily. If the patient has missed two or more doses, obtain a pregnancy test, and notify the primary provider who will determine whether to refill the medication.	1 year	1 year
Diabetes Medications other than metformin and insulin (includes sulfonylureas, GLP1, SGLT2)	Annually: • BMP • A1c every 3 months if over 8% • A1c every 6 months if less than 8%	6 months 3 months if A1c is over 8%	3 months
Osteoporosis Medications		1 year	1 year
Statins	Annually and with dosage change: • Lipid panel or LDL	1 year	6 months
Thyroid Agents (levothyroxine, liothyronine)	Annually and with dosage change: • TSH	1 year 3 months if changing doses	1 year
Vitamins (other than vitamin D > 2000 IU daily)		1 year	1 year

A. If a medication or class of medication is not listed in Attachment A, the refill request shall be forwarded to the LP for review, processing, and clarification.

B. When the LP does not specify different monitoring parameters, medications in Attachment A may be refilled for the duration specified in Column E.

C. If the patient has been seen by an LP regarding the indicated use of the requested medication within the

interval specified in Column D and the required monitoring has been performed in Column C, the refill shall be approved.

REFERENCES

1. The Joint Commission, Standards for Ambulatory Care, 2022 Medication Management
2. California Code of Regulations (CCR) Title 22
    a. Div 5 Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, CH3 Skilled Nursing Facilities, Article 1, §72109
3. National Patient Safety Goals, The Joint Commission Standards for Ambulatory Care, 2022
4. American Medical Association. American Medical Association (ama-assn.org). Last Accessed 3/27/2024.
5. California Business and Professions Code (BPC)
    a. Medical Assistants. BPC Division (DIV) 2, Chapter (CH) 5, Article 3, §2069-2071
    b. The Nursing Practice Act. BPC DIV2, CH6, Article 1, §2725.
    c. Vocational Nursing. BPC DIV2, CH6.5, Article 2, §2860
    d. Pharmacist Scope of Practice and Exemptions. BPC DIV2, CH9, Article 3, §4052.
6. California Code of Regulations (CCR) Title 16,
    a. DIV 13 Medical Board of California, CH3 Affiliated Healing Arts
    b. DIV 13.8 Physician Assistant Board
    c. DIV 14 California Board of Registered Nursing.
    d. DIV 15 State Board of Optometry
    e. DIV 17 California State Board of Pharmacy
7. "An Explanation of the Scope of RN Practice including Standardized Procedures." California Board of Registered Nursing. 11/2012. Last Accessed 3/27/2024.
8. “Can Medical Assistants call in refills to a Pharmacy?” Medical Board of California. FAQs | MBC (ca.gov). Last Accessed 4/25/2024.

All revision dates:

Attachments

AC.37 Attachment A - Ambulatory Care Medication Refill Guide 6.24.cleaned (1).pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/14/2024

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, Medicine & Pediatrics	Stephanie Denson: Manager, Medical Staff Office	9/27/2024
Chief Executive Officer, Ambulatory Care	Theresa Cho: Chief Executive Officer, Ambulatory Care	9/17/2024
Chief Medical Officer, Ambulatory Care	Allison Blaze: Chief Medical Officer, Ambulatory Care	6/21/2024
	Cynthia Fenton: AC Director of Nursing	6/21/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

Admission Criteria and Standards of Care of the Postpartum Patient

~~Purpose:~~

~~To establish criteria for the admission and care of patients admitted for postpartum maternal and well newborn care.~~

PURPOSE:

To establish criteria for the admission and care of patients admitted for postpartum maternal and well newborn care.

Following the immediate recovery period after delivery, the Labor and Delivery (L&D) nurse will assess the patient to ensure she is stable for transfer to Post Partum which will consist of, but is not limited to, a normal amount of vaginal bleeding, alert and oriented and stable vital signs. Report will be given by the Labor and Delivery nurse to the nurse receiving the patient in the postpartum unit.

~~Policy:~~

POLICY:

A. Patients will be admitted to the postpartum unit after delivery as a transfer or direct admission as a postpartum patient or well baby. A physician order for transfer or direct admission is required

B. Patients who may have delivered prior to admission, are in the immediate postpartum period, or infants transferred from the neonatal intensive care unit (NICU) may also be care for on the postpartum unit based on the LCP clinical judgment.

C. Patients placing their newborn for adoption or who have experienced perinatal loss can be given the option to be transferred to a different unit.

D. Using the nursing process as its framework, comprehensive care will be achieved through a collaborative interdisciplinary team approach including the medical and clinical care team, patient, family,guardian and support person(s).

E. Physical examinations should be explained appropriately and only undertaken with the patient's consent.

F. Check patient Identification (ID) band and baby ID band: two ID bands on the baby and one ID band on

the mother with all having the same number.Upon admission to postpartum, a security tag will be placed on the newborns ankle which will activate the infant security system. This process should be explained to parent(s).

G. The following standards will be adhered to for all postpartum patients and newborns unless otherwise ordered by a LCP. The LCP will be notified of all major changes in the patient's condition and documentation of each notification will be made.

~~PROCEDURE:~~

~~I. Admission Criteria~~
~~A. Delivered maternal patient after initial recovery period, stable; delivered in-hospital or prior to arrival~~
~~B. Well newborn after initial transition period; delivered in-hospital or prior to arrival~~
~~C. Well newborn transferred from NICU~~
~~D. Maternal patient in the immediate postpartum period requiring obstetrical-focused care.~~

~~II. Maternal-Admision Assessment~~
~~A. An admission assessment of the postpartum patient will be completed upon arrival to the postpartum department.~~
~~B. Upon admission to postpartum, care will be provided as ordered by LCP until discharge. Assessment will include, but not limited to:~~
~~1. Vital Signs (pulse, respiration, blood pressure, oxygen saturation)~~
~~2. Fundal tone, height~~
~~3. Lochia amount, color, consistency~~
~~4. Perineal laceration or incision, if applicable~~
~~5. Abdominal incision and dressing, if applicable~~
~~6 .IV Sites~~
~~7. Pain Level~~
~~8. Infant Bonding~~
~~9. Edinburgh Post Partum Depression Screening~~
~~C. Ongoing assessments are performed every shift and as indicated when the mother's condition changes~~
~~D. Skin to skin and breastfeeding on demand for stable mother and infant is encouraged.~~
~~E. Patients are encouraged to ambulate early in the recovery process per LCP orders with Registered Nurse (RN) assistance and then regularly and independently when gait is steady. Sequential compression devices (SCD's) if present, should remain in place as ordered.~~
~~F. For abnormal assessment findings, notify resident or attending physician and if needed, the Rapid Response Nurse.~~

~~III. Newborn Admission Assessment and Routine Care *(see OB 65 Ongoing Admission and Care of the Newborn)*~~

~~DOCUMENTATION~~

PROCEDURE:

I. Admission Criteria

A. Delivered maternal patient after initial recovery period, stable; delivered in-hospital or prior to arrival

B. Well newborn after initial transition period; delivered in-hospital or prior to arrival

C. Well newborn transferred from NICU

D. Maternal patient in the immediate postpartum period requiring obstetrical-focused care.

II. Maternal-Admision Assessment

A. An admission assessment of the postpartum patient will be completed upon arrival to the postpartum department.

B. Upon admission to postpartum, care will be provided as ordered by LCP until discharge. Assessment will include, but not limited to:

1. Vital Signs (pulse, respiration, blood pressure, oxygen saturation)
2. Fundal tone, height
3. Lochia amount, color, consistency
4. Perineal laceration or incision, if applicable
5. Abdominal incision and dressing, if applicable
6. IV Sites
7. Pain Level
8. Infant Bonding
9. Edinburgh Post Partum Depression Screening

C. C. Ongoing assessments are performed every shift and as indicated when the mother's condition changes

D. Skin to skin and breastfeeding on demand for stable mother and infant is encouraged.

E. Patients are encouraged to ambulate early in the recovery process per LCP orders with Registered Nurse (RN) assistance and then regularly and independently when gait is steady. Sequential compression devices (SCD's) if present, should remain in place as ordered.

F. For abnormal assessment findings, notify resident or attending physician and if needed, the Rapid Response Nurse.

III. Newborn-Admission Assessment and Routine Care *(see **OB.65 Ongoing Admission and Care of the Newborn**)*

IV. Discharge

A. Prior to discharge, a physician order will be placed to include, but not limited to discharge, medication, follow-up postpartum appointments, necessary medical equipment, home health services and any referrals to community resources.

B. Discharge education will be provided to include, but not limited review of warning signs that require immediate return to hospital. Importance of follow-up and newborn care.

C. Patient will be discharged in a wheelchair with infant held in arms of parent. If the patient will be discharged without an infant, the patient will be offered a wheelchair or may request to ambulate by preference.

DOCUMENTATION:

A. All assessments and patient care notes are done in patient's Electronic Health Record (~~HR~~EHR).

B. Vital signs in EHR.

C. Care plan for vaginal delivery or C-Section delivery.

D. Document medications in EHR.

E. Discharge

REFERENCES:

AWHONN: Perinatal Nursing, 5th edition, 2021
American Academy of Pediatrics and the American College of Obstetrician and Gynecologist Guidelines for Perinatal Care (8th Ed.) Elk Grove, IL: American Academy of Pediatrics; Washington, DC: The American College of Obstetrician and Gynecologists

All revision dates: 9/11/2024, 2/23/2024, 11/20/2017, 2/1/2014, 7/1/2010, 11/1/2004

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	10/25/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/11/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/11/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	9/11/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised:	*10/1/2024*
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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.□□ Admitted Patients□□olding Patients in the Emergency Department

POLICY:

To provide Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) Emergency Department (ED) staff with information on holding patients in the department when there are no available beds in the hospital.

PROCEDURE :

A. In the event of all Intensive Care Unit, Definitive Observation Unit, Telemetry, or Medical/Surgical beds being full, it may be necessary to hold patients in the ED while they are awaiting admission.

B. When admission/transfer orders are complete, the Admitting Department will admit patients into a virtual bed in Cerner to facilitate ancillary orders.

C. Physician's orders and all patient care treatments will be initiated and performed as necessary.

D. The Clinical Nurse Manager or House Supervisor will be notified of ED holds.

E. The Charge Nurse will maintain communication with the House Supervisor. The patient will be transported to an inpatient room as soon as a bed is available. The ED Charge Nurse will then notify Admitting.

F. The Charge Nurse will request extra staffing from the House Supervisor as needed for holds.

G. The actual time the patient leaves the ED shall be documented in the patient's electronic health record.

H. Patients that are being held in the ED for greater than ~~three~~four (~~3~~4) hours shall have all pending orders initiated.

All revision dates: 10/1/2024, 1/28/2020, 11/1/2016, 12/1/2013, 4/1/2011, 10/1/2010, 5/1/2006, 12/1/2004, 11/1/2004, 1/1/1995, 10/1/1992

Attachments

No Attachments

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Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	11/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/1/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/1/2024
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	10/1/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

ICU.□□ Intensive Care Unit Alternative Patient Placement

POLICY:

To provide safe, competent patient care for Intensive Care Unit (ICU) patients during periods of high census. As approved by the Medical Executive Committee, in the event of the unavailability of a ICU bed for a critical patient meeting the criteria for admission, patients may be held in the Emergency Department (ED). All efforts will be made to provide ICU staff to care for the patient. Staff caring for the patient will be a Registered Nurse (RN) possessing the appropriate competencies for the critical care specialty.

PROCEDURE :

A. When all ICU beds are occupied:

1. The ICU Charge nurse will:
   a. Call the on call physician for possible transfers.
   b. Notify the Critical Care Nurse Director and/or the Nursing Supervisor.
2. The Nursing Supervisor will:
   a. Inform the Chief Nurse Executive or designee (business hours) or Administrator on Duty (AOD) (non-business hours) regarding possible ambulance diversion. Note: Hospital Chief Executive Officer (CEO) ~~or Chief Operating Officer (COO)~~ must approve all trauma diversions in collaboration with the trauma medical director.
   b. Notify the ED to hold the patient.
   c. ~~Attempt to find~~Identify a critical care RN to care for the boarding patients from:

      Per Diem Pool
      Off duty Nurses
      Registry
      In House Registry

All revision dates: 6/25/2024, 5/15/2024, 12/14/2022, 9/27/2018, 1/1/2017, 11/1/1995, 11/1/1989

Attachments

No Attachments

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Intensive Care Unit Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/27/2024
Intensive Care Unit	Tara Paterson: Medical Director, Critical Care Services	8/27/2024
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	7/17/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

O□.□2 La□or and Delivery Admission and Assessment

POLICY:

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

To establish criteria for the admission and care provided for perinatal patients that present to Labor and Delivery for outpatient, acute, emergent, or urgent services. In addition to provide guidelines for maintaining a consistent standard of care for all patients seen as an outpatient or admitted to Labor and Delivery.

PROCEDURE:

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

B. Admission Criteria-Obstetrical patients that present to the OB triage area and require acute, emergent, or urgent evaluation will be cared for as an outpatient in a bed (OPIB), until admitted to inpatient or assigned to observation.

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

C. The registered nurse (RN) will review prenatal record for:

   1. Problem list
   2. Lab results: blood type and RH, unusual antibodies, Hepatitis B Surface AG, GBS, Rubella, VDRL and HIV status
   3. Results of tests, PPD, chest X-ray and therapeutic measures prescribed

4. Obstetric history, Estimated Date of Conception (EDC)
5. Ultrasound results
6. Risk factors, infection or other illness
7. Feeding Plan.
8. Language-Assess for the need of interpretation services
9. Age

D. General Admission Assessment: An admission assessment of the patient will be completed upon admission to the Labor and Delivery Unit. May include, but not limited to.
   1. Vital signs – temperature, pulse, respiratory rate, and blood pressure.
   2. Urinalysis-as ordered per physician.
   3. Neuro: deep tendon reflexes (DTRs) - assess clonus, headache.
   4. Skin integrity-edema, varicosities, scars, tattoos, bruises, abrasions, open sores, and rashes.
   5. Head, Eyes, Ears, Nose and Throat (HEENT) - Note any possible airway obstruction
   6. Allergies
   7. Nutrition screen.
   8. Education: assess learning needs, barriers to learning and education preferences.

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

F. Laboratory:
   1. Urine dip for protein/specific gravity/ketones/glucose.
   2. Urinealysis (UA) as ordered.
   3. Complete Blood Count (CBC) as ordered.

4. : Type and Screen
5. For patients with no prenatal care or unknown prenatal history strongly consider: Prenatal Panel (including CBC, ABO and RH, Hepatitis B Surface AG, Rubella, VDRL/RPR) and HIV.
6. Urine drug screen (UDS) as ordered with consent.

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

If it is determined that the patient is not in active labor or does not present with an emergent or urgent need, further assessments will be dependent upon the physician's orders.

H. Admission to Labor and Delivery from OB triage
1. Patients may be admitted for inpatient, or assigned to observation, per physician order.

I. Discharge from OB Triage/Labor and Delivery Unit
1. Discharge from OB Triage/L&D requires a physician order
2. Discharge criteria is dependent on the providers independent judgment and may include;
   a. False or Early Labor
   b. Primary concern was resolved
   c. Stabilized medical or obstetrical condition which can be appropriately managed as an outpatient.
3. Discharge education and Follow-Up may include, but is not limited to:
   a. Warning signs and symptoms that require immediate return to the hospital or call to primary care provider
   b. Signs and Symptoms of Labor
   c. Fetal movement assessment and techniques
   d. Referral to community support services as needed
4. Discharge from OB Triage/L&D unit may be ambulatory by patient preference or by wheelchair.

J. Ongoing assessment of Admitted Labor and Delivery:

1. Vital Signs
    a. If patient is not in active labor, routine vital signs including temperature. ~~(Cytotec, Cervadil for Induction of Labor)~~
    b. Check blood pressure, pulse and respiration hourly (more often, if indicated by any change in condition) during the first stage of labor, and every 30 minutes during the second stage of labor.
2. Check temperature every two hours if ruptured or if indicated. Otherwise, check temperature every four hours.
3. Pain should be assessed every hour, or more frequently if indicated by any change in condition.
4. Fetal Heart Tones (FHT) and Uterine Contraction (UC) activity will be assessed per policy guidelines. ***See ~~Ob.45 Management of Fetal Heart Rate Tracing~~OB.45 Management of Fetal Heart Rate Tracing***
5. Document labor activity and all cervical exams.
6. Movement throughout labor will be encouraged as appropriate
7. Continuous Fetal Heart Rate-Uterine Contraction (FHR-UC) monitoring is recommended. Candidates for intermittent FHR-UC monitoring must have a reactive NST and absence of decelerations to be allowed to ambulate. Continuous FHR-UC monitoring must be instituted whenever conditions, maternal or fetal, change to high risk. ***See ~~Ob.45 Management of Fetal Heart Rate Tracing~~OB.45 Management of Fetal Heart Rate Tracing***
8. Oxygen may be available for use with provider's order
9. Nursing management of the newborn and assignment of Apgar scoring will occur immediately post delivery per Neonatal Resuscitation (NRP) guidelines.
10. Notify physician for any unexpected change in patient condition
11. If Auscultation of Fetal Heart Rate (FHR) is used, should be assessed:
    a. At least every 30 minutes in early labor.
    b. At least every 15 minutes in active labor or 5-15 minutes in second stage of labor.
    c. Auscultation should be done following a contraction.
12. The nurse in attendance should have:
    a. Thorough knowledge of principle of FHR and UC physiology and pathophysiology.
    b. Clinical experience and validation of competency in fetal heart rate pattern assessment
13. Recovery-Maternal
    a. The nurse will perform a recovery assessment immediately following completion of delivery of placenta or vaginal repair, or upon arrival of cesarean delivered patients to the L&D PACU
    b. Assessment and monitoring will be performed on all patients who have had regional (e.g. spinal, epidural) or general anesthesia following "Recovery Room" guidelines.
    c. Continuous cardiac monitoring will be maintained for at least one hour after arrival to the L&D PACU
    d. When both the mother and baby stable, the nurse to ratio may be changed to 1:2

14. Approximately every 15 minutes for one (1) hour, and then every hour or as needed until transfer to postpartum level of care, the following will be assessed:
    a. Vital Signs (pulse, respiration, blood pressure, oxygen saturation)
    b. Fundal tone, height and location
    c. Lochia amount, color, consistency
    d. Perineal laceration or incision and dressing, if applicable
    e. Abdominal incision and dressing, if applicable
    f. Bladder and urinary elimination status
    g. IV site
    h. Pain level
    i. Mobility Status
    j. Emotional Status
    k. Infant bonding (intial contact and interaction)
    l. Temperature and Intake and Output will be recorded hourly or as needed.
    m. Continue skin to skin through the first feeding
    n. Provide the patient with adequate pain relief as ordered by provider
    o. Assist and encourage ambulation if appropriate. Assist with first void.
    p. Procedure for complications of Maternal Recovery-Notify the obstetrician, anesthesia and, if needed, the Rapid Response Team. For excessive or continued bleeding, initiate "Code Maternity' protocol. ***See Policy ~~OB09 Code Maternity.~~OB.09 Code Maternity.***
15. Recovery-Newborn
    a. To facilitate the bonding process for both mother and newborn, skin-to-skin contact is strongly encouraged immediately post delivery and during the recovery process when both mother and newborn are deemed stable. Vital signs and immediate care assessments can be performed on both the mother and newborn while the infant is in the mother's arms and during breastfeeding.
    b. A licensed RN competent in newborn assessment will evaluate the immediate condition of the neonate. Abnormal findings will be reported to resident or attending provider.
    c. Approximately every 30 minutes until transfer to postpartum level of care assessment will be done according to ***Policy ~~OB65 Admission and Ongoing Care of a Well Newborn~~OB.65 Admission and Ongoing Care of a Well Newborn.***
    d. No later than two (2) hours after birth, a comprehensive newborn assessment will be performed.

IDENTIFICATION SYSTEM

A. Patient is given an identification band with patient's name, chart number and date of birth.
B. The mother will also have an identification band when blood is drawn for blood bank.
C. Allergy to medication is noted on red wrist band.
D. Four Mother/Infant Identification bands are placed on chart upon admission. They will be placed on mother, infant, and significant other in the delivery room, ***see Policy ~~MCHO7 Infant Identification Bands~~***

~~and Security Tag Procedure~~*MCH.07 Infant Identification Bands and Security Tag Procedure*.

E. A security tag will be placed on the newborns ~~ankle~~ankle when admitted to couplet care. ***see Policy*** ~~***MCH07 Infant Identification Bands and Security Tag Procedure.***~~*MCH.07 Infant Identification Bands and Security Tag Procedure.*

EQUIPMENT

A. Fetal monitoring.

B. Blood pressure cuff, stethoscope.

C. Thermometer.

D. Oxygen (O_2)and Wall suction.

E. Percussion hammer.

DOCUMENTATION

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

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

B. Allergies

C. Patient's obstetrical history.

D. Patient's physical exam.

E. Uterine pattern and strength per policy.

F. Fetal monitoring system for fetal well- being per policy.

G. Care plan.

H. Medication Reconciliation.

I. Patient belongings.

J. Patient charges for supplies used in Labor & Delivery.

K. Initial Newborn recovery care and initial assessment

REFERENCES:

1. Pac Lac Prenatal and Intrapartum Guidelines of Care, 2009
2. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) FHR monitoring – Principles and Practice, Second edition.
3. Simpson, K.R., & Creehan, P.A. (Eds.): AWHONN Perinatal Nursing-Fifth Edition 2021. Philadelphia, PA: Lippincott

All revision dates: 10/8/2024, 2/14/2024, 8/19/2021, 10/14/2020, 12/21/2017, 11/20/2017, 2/1/2014, 7/1/2010, 1/1/2008, 11/1/2004, 12/1/2001, 12/1/1992

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/8/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/8/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	10/8/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*OB Nursing*
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O□.□□ Cervical Ripening

POLICY:

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

PROCEDURE:

Candidates for Misoprostol□Dinoprostone □aginal or Cervical Ripening □alloon include:

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

Contraindications:

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

Essential Steps:

A. Determine vertex presentation with ultrasound.

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

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

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

E. Have patient void.

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

G. Re-dosing is withheld if:

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

Misoprostol:

A. Equipment: 25 or 50 mcg misoprostol tablet, sterile gloves. Dosing can include the following.

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

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

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

D. Oxytocin may be started 2-6 hours after last dose of misoprostol

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

Dinoprostone □aginal:

A. Equipment: dinoprostone, sterile gloves.

B. Dose is 10 mg in a vaginal insert.

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

D. Inserted by LIP or registered nurse.

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

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

G. Assess for removal if tachysystole (5 or more contractions in a 10 minute period) or hypertonus (contraction lasting greater than 120 seconds).

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

Labor Induction/Augmentation.

I. Monitor for 30 minutes after removal.

Cervical Ripening □alloon In-Patient:

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

B. Pass catheter through cervix.

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

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

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

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

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

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

Cervical Ripening □alloon Out-Patient:

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

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

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

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

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

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

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

F. Notify LIP of suspected rupture of membranes, fever, abnormal bleeding, non-reassuring fetal heart tones

(FHT) or tachysystole.

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

□IS□OP□S SCALE:

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

EQUIPMENT

A. Sterile gloves.

B. Fetal heart monitor.

C. Written order

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

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

DOCUMENTATION

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

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

□EY POINTS

A. Observe standard precautions.

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

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

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

E. Patient may progress to active labor status.

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

G. Exercise caution when using in patients with:

1. Asthma or history of asthma

2. Glaucoma

H. Oxytocin may be started ~~4-6~~2-6 hours after last dose of misoprostol and 30 minutes after removal of dinoprostone vaginal insert.

REFERENCES:

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

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Attachments

Cervical Ripening Consent2020.pdf
Cervical Ripening Patient Educaiton .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	10/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/17/2024
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P□.□22 Nonsterile Pharmaceutical Compounding

Policy

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

Procedure

Nonsterile Compounding Overview

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

B. CNSPs include but are not limited to the following dosage forms:

1. Solid oral preparations
2. Liquid oral preparations
3. Rectal preparations
4. Topical preparations

C. The following practices are not considered compounding:

1. Administration: Preparation of a single dose for a single patient when administration will begin within 4 hours of beginning the preparation.
2. Reconstitution: Reconstitution of a conventionally manufactured nonsterile product in accordance with the directions contained in the manufacturer approved labeling.
3. Repackaging: Repackaging of conventionally manufactured drug products (refer to PH.31 Drug packaging).
4. Splitting tablets: Breaking or cutting a tablet into smaller portions.

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

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

Training and Evaluation of Staff in Nonsterile Compounding

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

Training and Process □alidation

A. All CNSP compounding staff shall be trained and demonstrate competence on the following:
    1. Nonsterile compounding policies, procedures, and USP Chapter 795
    2. Pharmaceutical calculations and terminology

       ~~Master formulation~~

       ~~Nonsterile compounding documentation~~

       ~~Quality assurance procedures~~
    3. Proper use and documentation of master formula
    4. Proper hand hygiene and garbing
    5. General conduct in the compounding area
    6. Cleaning, ~~sanitizing~~sanitization, and ~~maintaining~~maintenance of the equipment and the designated area
    7. Container, equipment, and closure system selection
    8. Quality assurance procedures

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

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

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

Facilities and E□uipment

This section defines the facility and equipment used in preparing CNSPs. The cleaning, sanitizing, and maintenance of the facility and equipment are described to ensure safe and accurate CNSPs.

Facility

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

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

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

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

E. Direct compounding area

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

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

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

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

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

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

E□uipment

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

B. Hazardous nonsterile drug preparations shall be prepared in a negative pressure biological safety cabinet (BSC) (refer to PH.27.03 Hazardous Drug Garbing, and Compounding). BSC must be terminally cleaned prior to preparing compounded sterile products (CSP).

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

Drug Preparation□La□eling□End-product□and Record □eeping

This section ensures final products are correctly prepared prior to dispensing. The pharmacist has the responsibility and authority to inspect and approve or reject all components, drug product containers, closures, in-process materials, and labeling used during the nonsterile compounding process. The pharmacist shall review all compounding records for quality assurance. The pharmacists are responsible for the proper maintenance and cleanliness of all equipment used in the nonsterile compounding process.

PROCEDURE:

Nonsterile Drug Preparation

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

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

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

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

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

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

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

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

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

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

J. ~~Terminally clean the BSC after hazardous CNSP is completed prior to commencing sterile compounding.~~Prepare patient specific doses in the negative pressure sterile compounding room for National Institute of Occupational Safety and Health (NIOSH) category 1 medications. For NIOSH category 2 and 3 medication in its final form, consult Assessment of Risk document (AoR) on policy PH.27.00 Hazardous Drug Overview Attachment B.

La□eling

A. All nonsterile products shall be labeled with the following information:
    1. ~~Assigned internal identification number~~Pharmacy-assigned lot number
    2. All active component(s) names, amounts, strength, and concentrations (when applicable)
    3. Dosage form
    4. Date compounded
    5. Total amount or volume in each container
    6. Instructions for storage and handling if other than controlled room temperature
    7. Beyond use date
    8. Identification of the responsible pharmacist and technician with their initial
B. CNSP labeling should display the following information:
    1. Prescribed administration regimen, when appropriate (e.g. route of administration)
    2. Appropriate auxiliary labeling (e.g. precautions)

       ~~Identification of the responsible pharmacist and technician with their initial~~
    3. Name, address, and contact information of the compounding facility
C. The label shall be affixed directly to the final product.

End-product Evaluation

A. The responsible pharmacist shall verify that the CNSP was prepared and labeled correctly. The pharmacist shall complete visual inspection for appearance and container closure integrity.
B. The pharmacist(s) shall initial the label on the final product, which confirms end-product evaluation was performed and the final product was prepared correctly and adhered to proper nonsterile compounding procedures.

Record □eeping

A. Documentation for nonsterile preparations shall include the following:
    1. Name, strength or activity, and dosage form of the CNSP
    2. The date and time of preparation
    3. Pharmacy-assigned lot number of the finished batched product
    4. Name, manufacturer, lot number, expiration date, and weight or measurement of each component
    5. The package size ~~and the number of units prepared~~
    6. The BUD of the finished product
    7. Physical description of the final CNSP
    8. Results of quality control procedures (e.g., visual inspections)
    9. Initials of the individuals involved in the compounding process and verifying of the final CSNP
    10. Master Formulation Record reference for the CNSP
B. Nonsterile compounding logs shall be maintained by the Pharmacy Department for at least three (3)

years.

□eyond Use Dates

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

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

   1. Non-preserved aqueous or water containing = 14 days refrigerated
   2. Preserved aqueous = 35 days refrigerated or controlled room temperature

Quality Assurance Program

Definitions

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

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

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

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

Policy

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

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

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

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

Procedure

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

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

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

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

1. Designated Person or ~~Director of~~ Pharmacy Supervisor shall start an investigation and review:
   a. ~~compounding logs~~Compounding logs
   b. ~~active~~Active ingredients used
   c. ~~master~~Master formula
2. The action plan shall include any procedural changes, educational needs, mitigation plan, and monitoring. See policy PH.26.06 Sterile Compounding Quality Assurance Program Attachment A.
3. For unacceptable results relating to potency of labeled strength, staff shall review of pharmaceutical calculations and nonsterile product compounding technique.

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

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

F. If advised that a patient has been harmed by using a nonsterile compounded product potentially attributable to the pharmacy shall report the event to FDA MedWatch within 72 hours of the pharmacy being advised. [CA BCP 4126.9 (c)]

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/15/2024
Infection Prevention	Magdy Asaad: Infection Prevention Manager	9/9/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	9/9/2024

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References:	

RS.26 Patient Care Plan

PURPOSE:

To provide Physical, Occupational and Speech Therapy intervention and necessary sessions to meet functional goals critical to ensure optimum discharge and long term outcomes.

POLICY

Frequency of patient treatment is to be based upon patient needs, ability to tolerate therapy intervention, ability to participate, limitations and goals.

IN-PATIENT FREQUENCY OF TREATMENT

A. Frequency of Physical Therapy (PT) Interventions (inpatient)
   1. 7-14 visits per week
      a. Patient requires physical therapy intervention to optimize functional mobility.
      b. Patient who's only criteria for discharge from hospital is achievement of physical therapy goals.
      c. Patient unable to tolerate one complete intervention, therefore, two or more brief treatment sessions are warranted.
      d. Patient presenting with primary balance disorder & making significant daily gains toward achieving maximal functional balance and independence
      e. Patient requires skilled PT intervention to retain progress between interventions
      f. Patient w/ multiple extremity involvement or complicated orthopedic needs requiring increased intensity of intervention due to extent of involvement.
      g. Patient admitted with a reversible condition, presenting with less than fair strength and an inability to carryout any aspect of strengthening program without skilled manual assistance.
   2. One to seven visits per week
      a. Patient admitted with underlying condition different from admitting diagnosis, where admitting diagnosis prevents patient from carrying out baseline mobility program and requires skilled follow-up to reassess and progress program.
      b. Patient presents with impaired arousal and medical instability and has the potential for improvement once medical status stabilizes. Patient will be monitored for change in status and

reassessed as indicated.

c. Patient with established mobility program that can be safely and effectively carried out by caregiver and requires follow-up by skilled physical therapist to reassess and progress program.

d. Patient has the potential for decline in strength and needs monitoring for change in status

3. The frequency will be established by the therapist as part of the overall treatment plan and forwarded to the ordering physician.

B. Occupational Therapy (OT) Treatment Frequency (in-patient)

1. 4-7 visits per week as tolerated by patient

a. Patient has acute needs, (neurologic, Range of Motion (ROM), etc.) that need OT intervention and who is making gains in ROM/joint mobility.

b. Patient has OT needs that are keeping the patients from being discharged from hospital.

c. Patient presents with impaired functional mobility, self care skills, and is making significant daily gains toward achieving maximal functional independence. Patient requires skilled intervention to retain progress and gains between interventions.

d. Patient with potentially reversible joint mobility/ROM restrictions such that lack of volitional movement could impact the joints. Patient requires skilled therapy to optimize ROM.

e. Patient with impaired arousal and/or mental status and has potential for progress as evidenced by alteration in responses to skilled intervention.

2. 3-5 visits per week as tolerated by the patient

a. Patient has neurologic, ROM, orthopedic or cognitive needs that need frequent skilled intervention to continue to progress toward maximal independence.

b. Patient and caregiver are independent and compliant with current ROM program and patient is making measurable gains between interventions.

c. Patient requires skilled follow-up to reassess and progress ROM program.

d. Patient with impaired level of arousal and has potential for progress. Patient requires daily repetition of current program that can be carried out by Caregiver before progression can be made by OT. Patient requires intervention by Occupational Therapist to progress and update program.

3. 1-2 visits per week

a. Patient or caregiver is proficient and compliant with ROM, strengthening, self care program and can be seen weekly to monitor for continued efficacy and to reassess as needed.

b. Patient has made maximal gains and is independent with home programs, but has the potential for a decline in function and is therefore monitored for change in status and reassessment as needed.

c. Patient presents with impaired arousal and medical instability. Patient has potential for improvement once medical status stabilizes. This patient will be monitored weekly for change in status and reassessed as indicated.

4. The frequency will be established by the therapist as part of the overall treatment plan and forwarded to the ordering physician.

OUT-PATIENT FREQUENCY OF TREATMENT

A. Frequency of Physical, Occupational & Speech Therapy for out-patients will be determined by the therapist and patient following the initial evaluation to achieve maximum functional outcome and goal achievement and meet the patient's needs (taking into consideration their transportation constraints, insurance authorizations, work schedules, etc.). The frequency will be established by the therapist as part of the treatment plan in absence of specific physician instructions.

All revision dates: 12/8/2020, 12/1/2010

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
MEDICAL CENTER

A Division of the Ventura County Health Care Agency

CONTINUING MEDICAL/PROFESSIONAL EDUCATION REQUIREMENTS

The Medical Staff Bylaws outlines requirements regarding continuing medical education in section 2.6 Basic Responsibilities of Medical Staff Membership. Each Medical Staff member and practitioner exercising temporary privileges shall continuously meet the responsibility below:

> *2.6.17 Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.*

The Medical Board of California has regulations regarding Continuing Medical Education (CME) requiring the completion of at least **50 hours** of approved CME during the renewal cycle, which is the two-year period immediately preceding the expiration date of your current appointment.

All CME courses must be Category 1-approved. Category 1 means courses that directly relate to one of the following: patient care, community or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship.

Any subspecialty privileging related CME requirements outlined on the privilege checklist will require documentation be provided in addition to the attestation below.

CONTINUING MEDICAL EDUCATION ATTESTATIONS

I, _____ (PRINT NAME) hereby certify and attest that I have completed a minimum of 50 hours Category I Continuing Medical Education (CME) credits in the last two years. I understand that the Medical Staff Office of the Ventura County Health Care Agency will conduct random audits, and therefore I may be asked to provide evidence of the completion of such CME. I understand that misrepresentations involving information submitted by me may result in denial of my application or termination of my membership/privileges, employment or physician participation agreement.

_____

Signature Date

VENTURA COUNTY
MEDICAL CENTER

A Division of the Ventura County Health Care Agency

CONTINUING EDUCATION
REQUIREMENTS FOR NURSE PRACTITIONERS

The Medical Staff Bylaws outlines requirements regarding continuing education in section 2.6 Basic Responsibilities of Medical Staff Membership. Each Medical Staff member and practitioner exercising temporary privileges shall continuously meet the responsibility below:

> *2.6.17 Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.*

In the State of California Registered Nurses are required by law (California Code of Regulations Section 1451 Article 5) to complete 30 contact hours of continuing education every two years approved CE during the renewal cycle which is the two year period immediately preceding the expiration date of the license.

All CE courses must be Category 1 approved. Category 1 means courses that directly relate to one of the following: patient care community or public health preventive medicine quality assurance or improvement risk management health facility standards the legal aspects of clinical medicine bioethics professional ethics or improvement of the practitioner patient relationship.

Any privileging related CE requirements outlined on the privilege checklist will require documentation be provided in addition to the attestation below.

CONTINUING EDUCATION ATTESTATION

_____ (PRINT Name) hereby certify and attest that I have completed a minimum of 30 hours Category 1 Continuing Education (CE) hours in the last two years. I understand that the Medical Staff Office of the Ventura County Health Care Agency will conduct random audits and therefore I may be asked to provide evidence of the completion of such CE. I understand that misrepresentations involving information submitted by me may result in denial of my application or termination of my privileges or employment.

_____ Signature

_____ Date

VENTURA COUNTY
MEDICAL CENTER

A Division of the Ventura County Health Care Agency

CONTINUING EDUCATION REQUIREMENTS FOR PSYCHOLOGISTS

The Medical Staff Bylaws outlines requirements regarding continuing medical education in section 2.6 Basic Responsibilities of Medical Staff Membership. Each Medical Staff member and practitioner exercising temporary privileges shall continuously meet the responsibility below:

> *2.6.17 Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.*

All licensed psychologists must have completed at least **36 hours** of acceptable continuing education each time they renew their license. The required number of hours of CE must be accrued within the 24 months immediately prior to the expiration date of your license.

Any privileging related CME requirements outlined on the privilege checklist will require documentation be provided in addition to the attestation below.

CONTINUING EDUCATION ATTESTATIONS

I, _____ (PRINT NAME) hereby certify and attest that I have completed a minimum of 36 hours Category I Continuing Medical Education (CME) credits in the last two years. I understand that the Medical Staff Office of the Ventura County Health Care Agency will conduct random audits, and therefore I may be asked to provide evidence of the completion of such CME. I understand that misrepresentations involving information submitted by me may result in denial of my application or termination of my membership/privileges, employment or physician participation agreement.

_____

_____

Signature Date

Ventura County Medical Center

Delineation Of Privileges

Psychiatry Physician-in-Training

Name:

Privilege	Requested

Physician-in-Training privileges will automatically expire upon completion of training program.

Initial Criteria:

- Current California State Medical License (none PTL)
- DEA registration
- Be in good standing at an accredited Psychiatry Residency program at the PGY-3 level or beyond
- Letter of support from training program director.

Evaluation Requirements:

- Outpatient - Bimonthly review of each outpatient by staff Psychiatrist
- Inpatient - Review of each inpatient within 72 hours by staff Psychiatrist

Core Privileges: ___
Privileges to admit, evaluate, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis and adjustment disorders.

Privileges Include:

- Consultation with physicians in other fields regarding mental, behavioral, emotional and geriatric psychiatric disorders
- Psychopharmacology
- Psychotherapy
- Emergency Department and Crisis Team consultations
- Chemical dependency intervention and therapy
- Consultations in the courts
- Emergency Psychiatry

Inpatient Privileges: ___
Privileges to admit and treat patients hospitalized in the inpatient psychiatric units, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis and adjustment disorders.

~~**Special Privileges**~~
~~*(Must also meet the criteria above)*~~

~~**Child & Adolescent Psychiatry Additional Criteria**~~

- ~~Successful completion of the first year of a child and adolescent psychiatry fellowship~~

~~**Child Psychiatry**~~ ___
~~*(Less than 13 years of age)*~~

~~**Adolescent Psychiatry**~~ ___
~~*(13 years of age and above)*~~

ACKNOWLEDGEMENT 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 Health Care Agency facilities. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's electronic signature on file

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

PROVISIONAL APPROVAL

Department Chief's Signature: _____ Date: _____