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

January 23, 2025

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

1. 101.016 Hospital Employee Annual Training
2. 107.030 Helicopter Arrivals, Departures and Safety
3. 108.006 Nurse Staffing and Scheduling
4. F.48 Helipad Operation and Support
5. IS.17 Title 17 California Code of Regulations
6. IS.36 CT Equipment Service and Daily Quality Assurance Testing
7. IS.53 MRI Preventive Maintenance and Repairs
8. IS.54 New Employee Dept Orientation/Checklist
9. L.10 Laboratory Personnel Records Requirements
10. L.13 Issuance of and Responsibility for Laboratory Keys
11. L.24 Laboratory Specimen Rejection Criteria
12. L.32 Laboratory Result Reporting
13. L.36 Patient Access to Laboratory Tests
14. L.48 Manually-Entered VCMC Laboratory Test Result Audits
15. L.50 Specimen Handling with Delay in Turnaround Time
16. L.53 Correction and Management of Laboratory Records
17. L.58 Delegation of Responsibilities

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Ventura County Health Care System Oversight Committee
Administrative Policies - January 23, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	101.016 Hospital Employee Annual Training	Triennial	Biennial review of policy. Updated policy language to reflect current process.
2	107.030 Helicopter Arrivals, Departures and Safety	Triennial	Incorporated language from ER.13 Helicopter Safety Policy (ER.13 retired).
3	108.006 Nurse Staffing and Scheduling	Triennial	Added consecutive shift language under Procedure section.
4	F.48 Helipad Operation and Support	Triennial	Remove the deactivation of the air handlers, (no longer needed). Updated policy language to reflect current process.
5	IS.17 Title 17 California Code of Regulations	Triennial	Added language from CDPH Radiologic Health Branch site and an additional link
6	IS.36 CT Equipment Service and Daily Quality Assurance Testing	Triennial	Triennial review of policy. Minor edits for clarity of coverage and revised end time from 5pm to 9pm for CTs 1&2
7	IS.53 MRI Preventive Maintenance and Repairs	Triennial	Triennial review of Policy. Language removed referencing SPH
8	IS.54 New Employee Dept Orientation/Checklist	Triennial	Triennial review of Policy. Fixed typos.
9	L.10 Laboratory Personnel Records Requirements	Biennial	Biennial review of Policy. Updated policy language to reflect current practices.
10	L.13 Issuance of and Responsibility for Laboratory Keys	Biennial	Biennial review of Policy. Reviewed and changed "transcriptionist" to "histologist."
11	L.24 Laboratory Specimen Rejection Criteria	Biennial	Biennial review of Policy. Modified policy layout. No other substantial changes made.
12	L.32 Laboratory Result Reporting	Biennial	Biennial review of Policy. Modified policy layout.
13	L.36 Patient Access to Laboratory Tests	Biennial	Biennial review of Policy. Updated policy titles and added hyperlinks to referenced policies.
14	L.48 Manually-Entered VCMC Laboratory Test Result Audits	Biennial	Removed the following tests from the list of manually entered results: 1. Platelet Function Test: test no longer performed 2. Erythrocyte Sedimentation Rate (ESR), Procalcitonin and Osmolality: instruments directly interfaced to LIS
15	L.50 Specimen Handling with Delay in Turnaround Time	Biennial	Modified policy layout. Added Medical Laboratory Technicians as testing personnel.
16	L.53 Correction and Management of Laboratory Records	Biennial	Biennial review of policy. Modified policy layout. Added reference.
17	L.58 Delegation of Responsibilities	Biennial	New Policy

Status **Active** PolicyStat ID **7441613**

Origination	5/1/1983	Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH
Last Approved	12/30/2024		
Effective	12/30/2024		
Last Revised	12/30/2024	Policy Area	Administrative - Employee
Next Review	12/30/2027		

101.016 Hospital Employee Annual Training

POLICY:

Ventura County Medical Center & Santa Paula Hospital employees shall complete a training program once each calendar year which includes a review of Mission, Vision & Values, Compliance Program, Customer Service, Teamwork & Communication, Health & Wellness, Patients' Rights & Services, Performance Improvement, Patient Safety, Environment of Care, and Infection Prevention & Control. Clinical staff shall also review topics on Patient Care Practices, Medication Safety, Patient Safety, and Safe Patient Handling & Movement.

PROCEDURE:

A. The annual training program shall consist of review of the hospital's Annual Training Handbook (see Attachment A: Annual Training Handbook).
    1. The Annual Training Handbook shall be distributed to all employees via a Cornerstone Learning Module.
    2. Employees shall review the contents of the Annual Training Handbook.
    3. Employees shall attest in Cornerstone that Annual Training Handbook review has been completed.

B. Managers may be provided a report on completion status of their respective employees.

All Revision Dates

12/30/2024, 9/1/2010, 5/1/2006, 11/1/2004, 7/1/2001, 10/1/1995, 2/1/1995, 8/1/1992, 11/1/1989

Attachments

Annual Training Handbook

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	12/30/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/27/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/27/2024
Policy Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	12/27/2024

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Origination	1/1/1985	Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH
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Effective	11/22/2024	Policy Area	Administrative - Operating Policies
Last Revised	11/22/2024		
Next Review	11/22/2027		

107.030 Helicopter Arrivals, Departures and Safety

POLICY:

It is the policy of Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH) to provide for optimal patient safety and transport through the use of FAA-approved and state-licensed heliport. The following policy has been established to standardize procedures in order to maximize safety and efficiency and to coordinate the efforts of all VCMC/SPH departments and staff involved in helicopter arrivals and departures. This policy also ensures facilitation of the safe departure and landing of helicopters on the VCMC helipad in the emergent transport of patients and equipment when conventional ambulance service would create a time delay critical to patient survival.

PROCEDURE:

A. **Initial Notification**

1. Immediately upon notification to the Emergency Department (ED) that a helicopter will be landing, the Nursing Supervisor and the Maintenance Department will be notified.
2. Maintenance staff will turn on the helipad lights. See policy F.48 Helipad Operation and Support for further information.

B. **Arriving Flights With Patients**

1. Only staff who have been oriented to the helipad and its safety regulations, may approach a helicopter. All approach directions will be initiated by the pilot.
2. The Charge Nurse in the ED will coordinate and assign landing personnel.
3. At Santa Paula Hospital, the fire department will be notified to be on hand for landing.
4. The items necessary for receiving a patient are:

a. Elevator key (VCMC only) - kept on keyring in the ED.
b. Gurney (no mattress and no sheets);
c. Portable oxygen supply
d. Other equipment requested by in-flight medical staff

5. The receiving unit will designate who will accompany the patient and assist transport from the roof.
6. Staff are to assemble outside elevators and approach the helicopter when a visual "OK" is given by the pilot.
7. Staff shall ensure that any loose clothing or medical equipment is secured, prior to landing.
8. Notify the Paging by calling 7-6666 (VCMC) or 7-8666 (SPH) if patient is a Code Yellow. When calling, specify "Code Yellow, Tier I or II, helicopter, estimated time of arrival (ETA) ____." If patient is not a trauma, specif "Helicopter, ETA ____."
9. Appropriate licensed ED staff (if possible, transport staff), Maintenance and Security staff, as assigned, will assist. Staff should remove any loose clothing, eyeglasses, name badges, etc.
10. Be aware of rotating rotors and blades.
11. Be prepared to encounter forceful air movements.

C. **Arriving Flights With Medical Personnel Only**

1. The receiving unit will designate who is to accompany incoming personnel to the designated unit.
2. The incoming flight personnel will be escorted from the elevator, into the patient unit, following the designated path of travel.
3. Maintenance or Security staff will escort flight team to landing area.

D. **Departing Flights With Personnel and/or Patients**

1. Staff will gather on the roof, outside the elevator, and away from the approaching helicopter. Staff will only approach the aircraft when the visual "OK" is received from the pilot.
2. The helicopter Medical Staff will accompany the patient to the helipad. Additional staff will be provided by the transferring unit, if necessary.
3. Notify Paging of helicopter departure.
4. Patient will be loaded onto helicopter transport gurney.
5. The Nursing Supervisor should be contacted if there are any problems.
6. The Pediatrics unit and Pediatric Intensive Care Unit (PICU) will be notified of **ALL** helicopter arrivals and departures. Patients and visitors will be removed from the playground before helicopter arrivals and departures. The Maintenance Department will be responsible for clearing the playground.

E. Safety Considerations

1. Access to the helipad is limited to patient arrivals and departures for staff only (and for Maintenance Department staff per protocol). Nursing staff are not to be on the helipad for any other reason.
2. Unless cleared to approach the helicopter, VCMC staff should wait near the elevator off the landing pad. SPH staff should wait in an area where they will not be affected by wind generated from helicopter landing to ensure safety until given the ok to approach.

F. Documentation

1. The patient's electronic health record will be adjusted to reflect means of arrival.

All Revision Dates

11/22/2024, 2/23/2021, 7/1/2016, 6/1/2006, 11/1/1998, 3/1/1995, 7/1/1989

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	11/22/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/22/2024

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Effective	12/27/2024	Policy Area	Administrative - Nursing
Last Revised	12/27/2024		
Next Review	12/27/2027		

108.006 Nurse Staffing and Scheduling

POLICY:

To recognize the rights and responsibilities of the Department of Nursing Services and Nursing staff in meeting mutual obligations for the care of the patients of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). To ensure adequate staffing is available to meet patient care requirements while utilizing staff in an optimal manner. To provide a clearly outlined sequential process for providing necessary nursing staff on all nursing units and allowing requested employee time off, while meeting projected patient care needs. To provide written records of staffing assignments on all units which allow retrospective analysis as necessary and meet external regulatory requirements.

GUIDELINES:

The Department of Nursing Services recognizes its obligation to provide an adequate number of skilled and qualified staff to meet the needs of the patients and scope of services required. It is the policy of the Nursing Department that a variety of nursing staff is used to provide necessary staffing. We believe that Registered Nurses (RN), Licensed Vocational Nurses (LVN), Nursing Assistants and Medical Office Assistants all contribute to safe efficient care when properly trained, supervised and assigned. The hospital is flexible in its staffing in order to respond to day-to-day shifts in census and workload. On low census days, or other periods of low workload, (and the hospital is adequately staffed throughout with qualified staff), employees may voluntarily take off hours of leave without pay in order to appropriately reduce the level of staff. The employee may choose to use accrued paid vacation instead.

If an excess of staff can be anticipated before the beginning of the shift, the Clinical Nurse Manager/ Supervisor may initiate phone calls to employees and offer them the opportunity to take the day off. When necessary, in times of low census, the guidelines described in the California Nurse Association Memorandums of Agreement (CNA MOA) that cover all CNA represented employees will be followed. The employee may also initiate a call to the supervisor prior to the beginning of the shift to see if he/she

is needed for duty. Leaves given in this way will also follow the plan developed by the Manager. Leave will be granted only after the needs of the hospital have been covered. The Supervisor will note on the schedule the number of hours and type of leave used by any employees. Leave With Out Pay (LWOP) may not be used or granted in advance and/or pre-planned. LWOP may be granted, at employee's request, after the Supervisor has reviewed the staffing needs for the shift. VCMC/SPH utilizes an automated scheduling system to create, project, and print long-range schedules. This system automates daily staffing allocation of available staff based on census, patient acuity and budgetary provisions.

Staffing for the nursing units will be reviewed for a 24-hour time frame on a daily basis and adjustments are made prior to the start of each shift as indicated. The Nursing Supervisor/Clinical Nurse Manager assumes this responsibility. Nursing staff may be temporarily reassigned on a shift-by-shift basis when changes occur in either the workload, the staffing requirements and/or availability of assigned staff. In these cases, Nursing Administration has the responsibility and right to assign staff to best meet the determined needs of the patient with the licensure, skill and qualification levels available. Reassignment of nursing staff on a pre-scheduled basis is made through careful consideration of all facts, which include but are not limited to the following:

A. Patient census and acuity
B. Number and classification of staff available, with consideration of floating clusters as outlined in the CNA MOA, affecting all CNA represented employees.
C. Qualifications, experience and competence of staff required and available.
D. Unfilled positions.
E. Daily shift assignments to the unit are finalized and are posted in the Nursing Administration Office at the beginning of the shift.
F. Any changes posted in staff assignments must be verified by the Nursing Supervisor/Clinical Nurse Manager.
G. Nursing staff, i.e. all CNA represented employees are assigned routinely to areas within their clusters as outlined in the CNA MOA, in which they are qualified and have received training and proper orientation. It is the intent of the nursing department that when a temporary and/or immediate assignment must be made, the needs of the patient and the needs of the employee will be considered. If immediate assignment is necessary, a "helping hands" orientation to the unit will be given and a resource person will be available. Employees are encouraged to discuss their assignments with their coordinator or supervisor in the event of concerns or problems.

Holidays: Refer to the appropriate union contract.

Vacation:

A. All employees, full-time, part-time and per diem, will submit vacation requests in writing to the Clinical Nurse Manager for approval (at the latest) prior to finalization of each six-week schedule
B. During the months of June through September, no more than 2 weeks will be granted per employee, without special approval of the Clinical Nurse Manager.
C. During the period between December 1st and January 1st, requests for vacation hours in

excess of 24 hours will require special approval by the Clinical Nurse Manager.

D. Vacation 'wrap arounds' will not be approved. The days the employees are requesting off/days needed off due to travel plans, will need to be requested and approved as the schedule allows and vacation hours utilized to cover such.

E. Vacation hours must be banked prior to vacation request being considered for approval.

F. 'X's' on request scheduled are not guaranteed.

Acuity Determination: Staffing considerations include acuity assessments. Acuity is determined using department based tools. See attachments.

PROCEDURE

Schedules are created on 6-week cycles: Schedules will be posted 3 weeks (21 days) prior to the start of the new schedule and contain the following 6 weeks of scheduled work time.

Changes in Schedule/Special Requests: For changes to the final posted schedule or special requests, the employee fills out the "Schedule Change Request" form and obtains signature of approval from the Clinical Nurse Manager before submitting request form to the staffing office.

Schedules:

Prepared on a 6 week basis to provide a method of planning the basic staffing of all nursing units within the Department of Nursing.

Updated every shift to reflect cancellations, illness, special requests and additional alterations or additions to the general staffing.

This record will be maintained for a period of 3 years.

The Clinical Nurse Manager or their designee assists in this responsibility by reviewing the staffing levels and patient care requirements and communicating special needs/problems to the nursing office. The Clinical Nurse Manager assists in this responsibility by monitoring sick calls and unexpected absences and communicating this activity to the nursing office.

Approvals for exchange of days worked are made on the basis that the exchange is made with someone of the same job class and skill level, the exchange is made within the same pay period, and minimum employment agreements are met. Approval for changes is made on the basis that no overtime is incurred and that appropriate staffing and skill mix is accomplished. Any emergency situation which is unexpected in nature will be handled on an individual basis by the Nursing Supervisor if it occurs on weekends, holidays, or after hours.

Daily Staffing:

Clinical Nurse Manager/House Supervisor reviews and makes necessary adjustments to daily staffing.

A. Census activities and acuity determinations will be reported at 4:00 AM, noon, and 8:00 PM. Additional census confirmation may also be done at 4:00 pm. The Inpatient Psychiatric Unit collects census information at 05:00 and 17:00, which is used to make daily staffing plans.

B. Staffing is reviewed and adjustments are made based on staffing guidelines and census/acuity requirements.

C. The Clinical Nurse Manager will be responsible for covering staffing needs. The Clinical Nurse Manager may request assistance to place phone calls from the Staffing Office, Nursing Supervisor and charge nurse (if time permits).

Weekend Commitment:

A. Each full-time or part-time staff member may be scheduled to work a minimum six (6) weekend shifts per 6-week schedule. For the purpose of this policy, a weekend shift is one that is scheduled to begin on or after 6:45pm Friday and scheduled to end on or prior to 7:15am Monday.

B. All Staff: Weekend absences:

1. One weekend absence allowed every calendar year. For the purpose of this policy, a weekend absence is defined as one (1) weekend shift.
2. All others subject to make up, i.e. automatically scheduled by the Clinical Nurse Manager for an extra weekend as needed by unit. This requirement is waived for employees normally scheduled to work a minimum of eight (8) weekend shifts per month.
3. Any make up weekend shift shall not be scheduled, unless by mutual agreement, prior to 21 days from the date of the missed shift. The clinical nurse manager will propose a makeup shift based on operational need. The nursing staff will make a reasonable effort to comply with the makeup shift; if there is a major conflict with identified shift, nursing staff will propose alternative shift.
4. The Clinical Nurse Manager may, by mutual agreement, cancel a make up weekend shift if the employee is not needed.
5. An employee scheduled to make up a weekend shift may request to drop a weekday shift, if operationally feasible, within that same pay period. Such a request shall not be unreasonably denied.

It is the daily responsibility of the Staffing Office, Clinical Nurse Manager and Nursing Supervisor to assign the available staff so that it matches the pattern required by the acuity and census. Skill Mix Substitutions – If insufficient numbers of staff are available in a particular skill level, then substitutions may be made within certain guidelines:

A. A higher skill level may always be substituted for a lower level, e.g., RN for LVN.

B. A lower level may be substituted for a higher level only where there is adequate RN coverage on the unit to assess patients and meet the State Staffing Ratios, to make appropriate assignments, and to carry out complex care.

Clinical Nurse Manager/Nursing Supervisor reviews the census and staffing for all units within the first 2 hours of each shift. Staffing Shortage – When there are insufficient numbers of staff in a given skill level, the Clinical Nurse Manager, Staffing Coordinator, and/or Nursing Supervisor will be responsible for finding adequate coverage by doing one of the following:

A. Assign Alternate assignment for extra personnel on duty.

B. Request regular part-time person to come in.
C. Request per diem person to come in.
D. Request on-duty staff to work overtime.
E. Request off-duty staff to work overtime.
F. Request Registry personnel.
G. Reassign on-duty staff for optimum coverage.
H. Mandate Overtime (Requires Nurse Executive or designee approval).

Supervisor moves staff from low-census to high census areas where possible. Moves are made based upon levels of licensure, training and competency of staff available.

All staff are expected to comply with appropriate requests to change their areas of work on short notice in order to provide for safe patient care throughout the hospital.

Unscheduled Leave: It is the expectation that unscheduled leave will be minimal for a 12-hour shift program. The accepted hospital standard is an average of 2.2 hours of unscheduled leave per pay period for full-time employees. Part-Time employees are assessed on a prorated basis. Consistently exceeding accepted standards may be cause for termination of the employee's 12-hour schedule, and/or disciplinary action. When it is necessary to use unscheduled leave, the 0645 to 1915 shift employee will notify the night shift supervisor by 0500; the 1900 to 0700 shift by 1700.

Scheduled Leave: All requests for scheduled leave (annual leave, educational leave, etc) will be planned in advance and must be submitted in writing at least 14 days prior to the posting of the current six-week master schedule. No more than one employee may be scheduled off, at any one time, unless coverage is available. All requests submitted AFTER the posting of the six-week master schedule may require the employee to arrange his/her own coverage. All scheduled leave requests are subject to the approval of the Clinical Nurse Manager

Overtime:

A. It is the policy of the hospital to avoid the necessity for overtime whenever possible.
B. Overtime work may sometimes be necessary to meet emergency situations, seasonal peak workload requirements or other defined times of need as determined by Nursing Administration.
C. No employee shall work overtime unless authorized to do so by his/her supervisor.
D. With consideration to staff and patient safety, no employee shall work more than five consecutive 12-hour shifts, six consecutive 10-hr shifts or seven consecutive 8-hr shifts without approval of the Chief Nurse Executive or Associate Chief Nursing Officer. Approval will be given only in emergency conditions (i.e. unable to meet state mandated nursing ratios or the like).

Guidelines:

A. Employee anticipated need
    1. Anticipated need for overtime must be communicated to the Clinical Nurse

Manager/Nursing Supervisor

2. If possible with 2 hours notice
3. If <2 hours before end of shift, ASAP
    a. Clinical Nurse Manager or Nursing Supervisor will decide course of action
    b. Authorize overtime
    c. Provide assistance to eliminate need for overtime
    d. Other action as appropriate

B. Failure to notify in advance may be grounds for disciplinary action

C. Clinical Nurse Manager or Nursing Supervisor will make telephone calls to off-duty staff, Registry, offer overtime, etc to meet patient care needs.

Mandatory Overtime:

In the event that the procedures above fail to provide safe, adequate staffing levels, it may be necessary to institute mandatory overtime. Any need to mandate overtime must be authorized by the Nurse Executive or her immediate designee. All mechanisms to provide safe patient care without mandatory overtime will have been exhausted. At the decision to mandate overtime, employees on duty will be polled to determine ability to stay. Otherwise the Nurse Executive, working with Clinical Nurse Manager or Nursing Supervisor, will make the final staffing decisions.

Mandatory overtime will continue for as short a time as possible, while continuing efforts are made to provide alternate staffing.

Failure to abide by these decisions may result in disciplinary action.

REFERENCES

1. Title 22 Department of Health Services, State of California.
2. United States Department of Health & Human Services.
3. California Department of Public Health.

All Revision Dates

12/27/2024, 11/22/2024, 4/9/2024, 3/22/2024, 3/24/2023, 1/30/2023, 1/10/2023, 11/14/2022, 11/14/2022, 8/27/2021, 5/1/2016, 11/1/2013, 12/1/2010, 12/1/2001, 3/1/2000, 1/1/2000, 1/1/1999, 12/1/1992, 9/1/1988, 9/1/1987, 9/1/1986

Attachments

Nurse Acuity MedSurgTele.xlsx

- Nurse Acuity NICU
- NurseAcuity ICU.docx
- NurseAcuity L&D.docx
- NurseAcuity Peds.docx
- NurseAcuity PICU.docx
- NurseAcuity PP.docx
- VCMC IPU Patient Acuity.docx

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/27/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/27/2024

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Last Revised	11/22/2024
Next Review	11/22/2027
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.48 Helipad Operation and Support

POLICY:

Before the arrival of a helicopter, Facilities Maintenance staff will ensure all helipad lights and walkway ramp lights are on

PROCEDURE:

1. Upon receiving the page, the Hospital Maintenance Engineer is expected to respond immediately and report to the helipad to provide assistance.
2. If the Hospital Maintenance Engineer is detained, they should contact Security at 1-805-652-6283 and request assistance. Security will then promptly turn on the light switches located on the roof level near the ramp to the helipad and secure an elevator.

All Revision Dates

11/22/2024, 7/1/2016, 10/28/2014

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	11/22/2024

Facilities Department	Ian McGraw: Manager Facility Operation	11/22/2024

Status **Active** PolicyStat ID **17104178**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	11/1/2022
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Owner	Matt McGill: Director, Imaging Services
Policy Area	Imaging Services
References	Title 17, California Code of Regulations (17 CCR)

IS.17 Title 17 California Code of Regulations

PURPOSE:

To provide an up to date reference for Imaging Services staff to the regulations established by the California Department of Public Health Radiologic Health Branch.

POLICY:

It is the policy of the Imaging Services department to provide accessibility to Title 17 for all staff.

PROCEDURE(S):

In accordance with the Laws and Regulation of the Radiologic Health Branch (RHB) "all users of radiation are required to conspicuously post a current copy of Subchapter 4, including the Jan. 1, 2021 Edition of 10 CFR 20 (PDF). (17CCR sec. 30255(b)(1).)" The electronic versions linked below meet the requirements of the RHB as they provide "internet access to both the online 17 CCR and 10CFR 20 (2021 ed.)"

Online 17 CCR

10 CFR 20 (2021 ed.)

Imaging Services staff may also utilize the web links below to access Title 17.

Title 17: Public Health Main Page

Title 17: Public Health

Title 17. Chapter 5, Sub-chapter 4: Radiation

SC4: Radiation

Title 17. Chapter 5, Sub-chapter 4.5: Radiologic Technology

SC4.5: Radiologic Technology

Title 17. Chapter 5, Sub-chapter 4.7: Nuclear Medicine Technology

SC4.7: Nuclear Medicine Technology

REFERENCE(S):

Title 17, California Code of Regulations (17 CCR)

All Revision Dates

11/21/2024, 11/3/2022

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/21/2024
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/21/2024
Imaging Services	Matt McGill: Director, Imaging Services	11/21/2024

Status **Active** PolicyStat ID **16959621**

Origination	12/1/2013	Owner	Matt McGill: Director, Imaging Services
Last Approved	1/14/2025	Policy Area	Imaging Services
Effective	1/14/2025		
Last Revised	1/14/2025		
Next Review	1/14/2028		

IS.36 CT Equipment Service and Daily Quality Assurance Testing

POLICY:

All CT scanner service shall be performed by Philips Healthcare service engineers. All Ventura County Medical Center CT scanners shall have daily quality assurance testing performed.

PROCEDURE:

- VCMC CT scanners and the SPH CT scanner shall be repaired, serviced and maintained by Philips Healthcare service engineers only.
- VCMC and SPH CT equipment shall be covered for repairs, preventive maintenance and needed parts replacement by a service contract provided by Philips Healthcare.
- The service contract coverage for the CT scanner located in the VCMC Emergency Department shall be 24/7 coverage (hard-down).
- The service contract coverage for the VCMC CT scanners located in CT room 1 and CT Room 2 shall be from 8:00 am - 9:00 pm, Monday through Friday.
- The service contract coverage for the SPH CT scanner shall be 24/7 coverage (hard-down).
- CT technologists shall perform daily quality assurance checks utilizing the water phantom following the ACR guidelines for quality control.
- The CT department shall perform these quality assurance checks in compliance with The Joint Commission's regulations and standard EC 02.04.01.
- The record of the daily quality assurance checks shall be entered into the logbook for each CT scanner.

All Revision Dates

1/14/2025, 1/4/2022, 2/13/2019, 1/1/2016, 10/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/14/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	1/9/2025
Imaging Services	Matt McGill: Director, Imaging Services	1/8/2025

Status **Active** PolicyStat ID **16959625**

Origination	12/1/2015	Owner	Matt McGill: Director, Imaging Services
Last Approved	11/22/2024	Policy Area	Imaging Services
Effective	11/22/2024		
Last Revised	11/22/2024		
Next Review	11/22/2027		

IS.53 MRI Preventive Maintenance and Repairs

POLICY:

The 3.0T MRI magnet located in the VCMC Imaging department will be covered for repairs and regular scheduled maintenance by a service contract provided by Philips Healthcare.

PROCEDURE:

A. The 3.0T MRI magnet purchased from Philips Healthcare will be maintained by Philips Healthcare Service Engineers.
    1. Philips service personnel will be responsible for performing all scheduled preventive maintenance on the magnet.
    2. Philips service personnel will be responsible for all repairs needed on the magnet.
    3. Philips will coordinate with the MRI staff at VCMC when scheduling a preventive maintenance service of the magnet. This is so patients will not be delayed or exams cancelled.

B. DMS, the vendor that VCMC leases the mobile trailer from, is responsible for all repairs and service on the MRI trailer.

All Revision Dates

11/22/2024, 2/13/2019, 1/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/22/2024
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/21/2024
Imaging Services	Matt McGill: Director, Imaging Services	11/21/2024

Status **Active** PolicyStat ID **16959629**

Origination	5/22/1980	Owner	Matt McGill: Director, Imaging Services
Last Approved	1/14/2025	Policy Area	Imaging Services
Effective	1/14/2025		
Last Revised	1/14/2025		
Next Review	1/14/2028		

IS.54 New Employee Dept Orientation/Checklist

POLICY:

It is the policy of the Imaging Services department that as part of all employee orientation, all new employees will be given direction on how to access Policy Stat in order to review all Hospital Policies, Infection Control and Safety policies. Additionally, all employees will be notified of any changes or additions to departmental or hospital policies.

PROCEDURE:

1. All new employees, upon completion of standard county and departmental orientation classes, will be shown by their immediate supervisor how to access Policy Stat in order to review the imaging departments policies, hospital policies, infection control policies and hospital safety policies.
2. As policies are amended or added, they will be updated in Policy Stat for all employees to review.
3. All employees will perform annual in-service education on CORNERSTONE TRAINING SITE. The CORNERSTONE WEBSITE compliance training will include HIPPA, infection control, radiation safety, fire safety, disaster protocols, and any additional training modules added to the employee's annual training.
4. New employee Department orientation will be documented using a criteria checklist and maintained on file in the department.

All Revision Dates

1/14/2025, 12/22/2021, 2/13/2019, 12/1/2015, 10/29/2007, 5/26/2006, 3/14/2006

Attachments

New Department Employee/Student/Registry Orientation

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/14/2025
Imaging Services	Matt McGill: Director, Imaging Services	1/9/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	11/4/2024

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Last Revised	11/15/2024	Policy Area	Laboratory Services
Next Review	11/15/2026		

L.10 Laboratory Personnel Records Requirements

POLICY:

Personnel records must be kept and maintained on all current Laboratory technical staff. Training and competency assessment records are readily available for all testing personnel, supervisory personnel, and other laboratory personnel and are retained (in paper or electronic format) for two (2) years.

PROCEDURE:

Laboratory personnel records must include the following documentation:

1. California Department of Public Health State license for technical staff (Clinical Laboratory Scientist, Medical Laboratory Technician, Certified Phlebotomy Technician)
2. Primary source verification report confirming credentials
3. Employee job description including a description of current duties and responsibilities
    a. Procedures authorized to perform
    b. Supervision required for specimen processing, test performance or result reporting
    c. Supervisory or section director review required to report patient test results
4. Dates of employment
5. Documentation of departmental training
    a. Documentation of initial, 6-month and annual competencies
6. Continuing education records
    a. Continuing laboratory education programs are available through the College of American Pathologists (CAP), American Society of Clinical Pathology (ASCP),

MedTraining Solutions (MTS), and other vendor-sponsored educational programs.

7. Other certifications, as required for employment
8. Work-related incident and/or accident records

REFERENCE:

GEN.54400 GEN.54200	Personnel Records. Laboratory General Accreditation Checklist, College of American Pathologists, August, 2023. Continuing Education. Laboratory General Accreditation Checklist, College of American Pathologists, August, 2023.

All Revision Dates

11/15/2024, 11/1/2016

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	8/19/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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L.13 Issuance of and Responsibility for Laboratory Keys

POLICY:

To describe the handling of keys in the Laboratory Department

PROCEDURE:

Laboratory Keys

1. Pathologist's Office keys are issued by the Laboratory Director. The only individuals with keys are the Pathologists, Laboratory Director, and a designated Histologist.
2. Laboratory Director's Office keys are issued by the Laboratory Director and the only individuals with keys are the Laboratory Director, Laboratory Medical Director, and two designated supervisors.
3. The storeroom key is maintained by the Chemistry Supervisor.
4. The Morgue keys are maintained by the Histology and the Admitting departments.

Inpatient Electronic Keys

1. Inpatient Psychiatric Unit (IPU) keys are issued to the phlebotomists by the IPU. Any loss must be reported immediately to the supervisor on duty.
2. OB, ER, and Nursery keys are issued by the Maintenance Department to the Phlebotomy Supervisor. Any request for additional keys must come from the Laboratory Director. Any loss of keys must be reported immediately to the supervisor on duty.

All Revision Dates

11/15/2024, 11/1/2016, 3/1/2007

Approval Signatures

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Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/8/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Policy Area	Laboratory Services

L.24 Laboratory Specimen Rejection Criteria

POLICY:

Laboratory test results are only as accurate as the condition of the specimen. Laboratory staff must reject specimens that do not meet minimum Laboratory standards and that may potentially yield substandard results. In cases where a new specimen is unobtainable and the physician insists that tests be performed on a specimen regardless of its unacceptability by Laboratory criteria, the tests ordered should be performed on the original specimen (see #2 – Handling of unacceptable specimens). Along with the test results, however, a comment will be made on the Laboratory computer report that the results were obtained from an unacceptable specimen. The substandard criteria and reason why the tests were performed will be documented.

RELATED POLICY:

A. L.27 Laboratory Test Cancellation

PROCEDURE:

A. The following factors should be considered when determining acceptability of a specimen:
    1. Discrepancies between requisition forms and labeled tubes (names, dates and times).
    2. Any sample collected with an improper tube, anticoagulant or additive.
    3. Anticoagulated specimens that contain blood clots.
    4. Markedly hemolyzed specimens, except for tests in which hemolysis does not interfere.
    5. Contaminated specimens, i.e., samples drawn above an IV or from the same vein in

which an IV is being infused.

6. Insufficient quantity of specimen to perform the tests ordered.
7. Specimens that are improperly transported and/or not delivered promptly to the Laboratory (maximum time may vary according to the tests ordered).
8. Unlabeled/mislabeled specimens. This includes specimens where the labels are in the transport bag rather than affixed to the specimen.
9. Gross lipemia or icterus that would invalidate results.
10. Specimens received broken or leaking.
11. Special procedures not followed, such as "protect from light" or "transport on ice."
12. Urines contaminated with fecal material.
13. Specimens that yield questionable or inconsistent results.

Handling of unacceptable specimens

There are two (2) possible courses of action:

A. The Laboratory must inform the patient care area that results from a mislabeled/ unlabeled specimen **WILL NOT BE REPORTED** by the Lab. If the results have already been entered into the computer system, they must be replaced with **"CANCEL" and** a reason indicated. A Corrected Report will be generated (see Corrected Reports policy).

   1. Recollect specimen by the Laboratory – See policy Test Cancellation – Specimen Acceptability.
   2. If recollection is not immediately an option (i.e., outpatient specimens), then the Laboratory will attempt to recall the patient for specimen collection and will notify the clinic and/or physician's office to let them know of the delay in testing. The Laboratory will ensure that no results are available in the Laboratory Information System computer system and note the reason for sample rejection.

B. Irreplaceable Specimens ONLY

   Certain patient specimens are considered irreplaceable and include the following:

   1. Surgical Pathology
   2. CSF
   3. Sterile fluids
   4. A toxic drug ingestion
   5. NICU specimens
   6. Cord blood
   7. Specimen drawn before treatment is administered

   The following option can only be utilized for an irreplaceable specimen. Any blood, urine,

sputum, stool or conventional specimens that can be recollected are not eligible for the option.

1. Determine if any part of the requested testing can be performed on this specimen.
2. Contact the patient's physician to discuss the situation regarding the specimen not being acceptable.
3. When there is a question concerning the integrity of irreplaceable specimens and potential testing, the pathologist MUST be consulted for approval before accepting the specimens.
4. Any testing performed requires the appropriate disclaimers and documentation of communication to the physician to be entered into the Laboratory Information System (LIS) system.
5. If the irreplaceable specimen rejection is due to mislabeling or not labeling the specimen, contact the person who mislabeled or did not correctly label the specimen to inform them of the issue. Investigate and consider the possibility of correctly labeling the specimen. Notify your immediate CLS supervisor or the pathologist on call regarding this situation. In the event that the decision is made to re-label the specimen, the individual responsible for initially labeling the sample must come to the Laboratory to correct the labeling error and sign a statement of responsibility on a **"Mislabeled Specimen Form"** (see Attachment A. Forward the completed form to the Laboratory Director.
6. All attempts must be made to obtain a properly labeled specimen for cross-matches in the Blood Bank before using a specimen with any labeling issues and only after discussion with a pathologist.

REFERENCES:

1. Laboratory General Accreditation Checklist. College of American Pathologists, August, 2023.
2. NCCLS Approved Standard, ASH-3, "Standard Procedures for the Collection of Specimens by Venipuncture."
3. McCall, RE, Tankersley, CM: *Phlebotomy Essentials*. Philadelphia; JB Lippincott Company, 1993.
4. MLO; September 2004; Liability and the lab; Barbara Harty-Golder, M.D.

All Revision Dates

11/15/2024, 11/1/2016, 7/1/2015

Attachments

A: Mislabeled Specimen Form

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/22/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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Last Revised	11/15/2024	Policy Area	Laboratory Services
Next Review	11/15/2026		

L.32 Laboratory Result Reporting

POLICY:

A. Laboratory results are reported to persons authorized by law to receive and use medical information.

B. Every two years, the laboratory medical director reviews and approves the content and format of laboratory patient reports (paper, computer screen images, and downtime reports) to ensure contents effectively communicate patient test results, and meets the needs of medical staff.

1. Report Elements:
    a. Name and address of testing laboratory (paper and electronic, Ventura County Medical Center/Santa Paula Hospital Laboratory, Reference Laboratory)
    b. Name of Laboratory Medical Director
    c. Patient Name and identification number, or unique patient identifier and identification number
    d. Name of physician or record, or legally authorized person ordering tests, as appropriate
    e. Name of test(s) performed
    f. Date and time of specimen collection
    g. Time of release of report
    h. Specimen source
    i. Test result(s) and units of measurement
    j. Reference intervals

k. Conditions of specimen that may limit adequacy of testing

PROCEDURE:

Printed Reports

A. Laboratory reports are generated from the Laboratory Information System (LIS) and are printed only when requested by a provider.

B. Referral Laboratory reports include the above information. An original or exact copy of the report is sent to medical record after documenting the Financial Identification Number (FIN) for scanning the document in patients Electronic Health Record (EHR).

C. Chart Reports are documented electronically in patient's EHR.

Result Notification

A. STAT priority results are notified electronically to the provider. Many locations have printers and the reports will automatically print upon result verification. Such locations do not require a notification.

B. Abnormal test results that fall into the defined critical range require notification of a physician or nurse. Each department manual specifies result ranges and actions required. Ml calls are entered into the computer. The computer documentation includes date, time and person notified.

Test Methodology

A. Information concerning test methodology and performance specifications is available upon request.

B. Any change in analytic methodology that results in a significant change in test results is noted on the report as a comment.

Test Reference Ranges

A. Reference ranges are established for each test. These include the appropriate age and sex related ranges. The department supervisor periodically evaluates the appropriateness of each test's reference ranges and takes corrective action if necessary.

LABORATORY REPORTS

ACTIVITY REPORTS

Purpose: To provide current test results for each patient with Laboratory activity since the last printing. These reports are documented in the EHR.

Content: All new test results for that day will be included, with the Specimens arranged in order of Collection Time. New results are preceded by an arrow.

DISCHARGE REPORT

Purpose: Final Summary of results for inpatients who have been discharged, and whose results are complete. The Discharge Report replaces the last Activity Reports. Final official copy of patient data is documented in the EHR.

Content: Results arranged by test in chronological order.

REFERENCE

A. GEN.41607 Content Format Report Review. Laboratory General Accreditation Checklist. College of American Pathologists, August, 2023.

All Revision Dates

11/15/2024, 11/1/2016, 3/1/2007

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/22/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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Last Approved	11/15/2024		
Effective	11/15/2024		
Last Revised	11/15/2024	Policy Area	Laboratory Services
Next Review	11/15/2026		

L.36 Patient Access to Laboratory Tests

POLICY:

To ensure that patients have appropriate access to their laboratory test reports.

Patient data are only accessible in a timely manner only to those health care providers who are authorized to review test results.

PROCEDURE:

The Laboratory will follow the following Ventura County Medical Center/Santa Paula Hospital Administrative policies:

A. *100.018 Confidentiality of Medical Records*
B. *100.019 Release of Patient Information*
C. *HIM.10 Patient Right to Access, Inspect and Copy Protected Health Information (Patient Access to Medical Records)*

A patient may request a copy of his or her Laboratory test report. The patient will be directed to Health Information Management (HIM). The patient cannot obtain a copy directly from the Laboratory.

All Revision Dates

11/15/2024, 11/1/2016

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/8/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	10/8/2024

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Last Approved	11/15/2024		
Effective	11/15/2024	Policy Area	Laboratory Services
Last Revised	11/15/2024		
Next Review	11/15/2026		

L.48 Manually-Entered VCMC Laboratory Test Result Audits

PURPOSE:

To provide a process for auditing manual test result entry into the laboratory information system (LIS) at the Ventura County Medical Center (VCMC) Laboratory and ensuring accuracy of the data entered.

PROCEDURE:

Manually entered test results will be audited on a monthly basis by comparing the Cerner report result to the source document from the testing instrument and/or manual worksheet. A minimum of two (2) results per test shall be audited each month. The tests include, but are not limited to:

- Qualitative Urine HCG
- Fetal Fibronectin
- Sweat Chloride
- Body Fluid pH
- Ketones
- Serology tests: Infectious Mononucleosis, HIV, Rheumatoid Factor, Cold Agglutinins, Kleihauer-Betke
- Manually entered Blood Bank results
- All Microbiology test results except susceptibilities and negative blood cultures.

1. Obtain the source document for the test to be audited.
2. Access and print the LIS test result. This may be done via Manual Expedite or a screen print.
3. Verify the LIS result matches the source document result.

RESULTS:

Source document results should match the LIS test results. Take corrective action regarding errors discovered in the audit process.

Archive audit documents for at least one (1) year.

All Revision Dates

11/15/2024, 7/26/2022, 12/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/22/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/4/2024

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Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Policy Area	Laboratory Services

L.50 Specimen Handling with Delay in Turnaround Time

POLICY:

To state the process turnaround times for Laboratory staff when handling specimens.

PROCEDURE:

Specimen Handling

If a test cannot be completed within the accepted turnaround time due to a problem with an instrument, insufficient reagents, outdated reagents, or some other system issue, the Clinical Laboratory Scientist/ Medical Laboratory Technician performing the test will ascertain when the system is expected to be operational and the test(s) can be performed. The Clinical Laboratory Scientist/Medical Laboratory Technician will notify the Laboratory Manager, Supervisor and Medical Director of the Laboratory (or the Pathologist on Call if the Medical director is not available). Specimen handling will depend on how much time will elapse before the test can be completed in house, the stability and nature of the analyte, other technical and logistical considerations, and the decision of the Medical Director.

Other Standard Operating Procedure also apply, including Administrative Laboratory policies L.22, *Laboratory Specimen Priority*, and L.33, *Laboratory Instrument Utilization*.

STAT and Urgent Requests

The Medical Director or on-call Pathologist will contact the ordering physician and will determine what time frame is acceptable for completion of the test. If the test cannot be completed in house within this time frame, the specimen will be sent to Community Memorial Hospital as a STAT test and the procedure for sending specimens to Community Memorial Hospital will be followed. If the test can be

held and done in house, the specimen will be stored as required for that particular analyte and test methodology (for example, the serum and/or plasma will be stored at room temperature, or refrigerated, or frozen).

Routine Requests

The Medical Director or on-call pathologist, based on his/her medical judgment, will determine whether the expected delay will still allow the testing to be done in house or whether the specimen will be sent to the reference lab for testing. This will depend on the analyte. If the specimen is stored in house, proper storage conditions (refrigerator, freezer, room temperature, etc.) must be followed.

When routine testing exceeds expected TAT, the "House Supervisor" will be notified as indicated above (i.e., CBC's or Basic Metabolic Panels, instrument down, expected time for repairs, backup available for testing, etc.). The "House Supervisor" will in turn notify the nursing units of the situation. In extended downtime or special circumstances, specimens may be sent to other laboratories for testing.

Notification of Testing Delays

When delays in STAT test(s) Turn Around Time (TAT) is expected to be significant for individual patients, it is the responsibility of the Clinical Laboratory Scientist/Medical Laboratory Technician performing the test to use their judgment and inform the patient's nurse of the delay and to give them an accurate expectation for completion of the testing. This information should be documented on the specimen result form or on the specimen worksheet.

This information should be documented in laboratory information system, the specimen result form or on the specimen worksheet.
When STAT test(s) TAT is expected to be significant because of instrument (system) issues, it is the responsibility of the supervisor (or senior CLS) to notify the Emergency Department (ED) and the Nursing Supervisor. The calls to ED and the Nursing Supervisor will be documented on a Notification Form originating in the Laboratory section where the responsibility for that particular instrument/testing resides. Return the form to the Laboratory Manager when the event has been completed and documented.

When test results require repeat testing (re-run or re-draw), immediately notify ordering healthcare provider responsible for the patient by phone and/or TigerText messaging.

All Revision Dates

11/15/2024, 11/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/8/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised	11/15/2024
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Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Laboratory Services

L.53 Correction and Management of Laboratory Records

Policies

A. Laboratory prohibits the use of pencil or erasable ink in recording data in laboratory records such as quality control logs, preventive maintenance logs, manual test worksheets, etc.

B. Corrections made to both paper and electronic laboratory records must be legible and indelible.

C. Original (erroneous) entries must be visible or accessible (audit trail for electronic records),

1. Correction of laboratory records such as temperature logs, preventive maintenance logs, test results worksheets, etc. are handled by drawing one ink line through the incorrect documentation and writing the correct documentation next to it. The incorrect documentation should be legible through the strike-out line.
2. Erasures and liquid “white-out” corrections are unacceptable.

D. The person performing the correction will initial and date next to the corrected documentation.

Reference

GEN.20450	Correction of Laboratory Records. Laboratory General Accreditation Checklist, College of American Pathologists, August 2023.

All Revision Dates

11/15/2024, 9/26/2022

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024

Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/17/2024

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Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Policy Area	Laboratory Services

L.58 Delegation of Responsibilities

BACKGROUND

The Laboratory Medical Director is responsible and is authorized to implement and maintain the standards of local, state, federal licensing and regulatory agencies.

Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines:

The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations.

The laboratory director, if qualified, may perform the duties of the technical supervisor, clinical consultant, general supervisor, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications under §§493.1447, 493.1453, 493.1459, and 493.1487*, respectively.

If the laboratory director reapportions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed.

The laboratory director must be accessible to the laboratory to provide onsite, telephone or electronic consultation as needed.

Each individual may direct no more than five laboratories.

The laboratory director must—

(1) Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the pre-analytic,

analytic, and post-analytic phases of testing,
(2) Ensure that the physical plant and environmental conditions of the laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical, and biological hazards
(3) Ensure that—

i. The test methodologies selected have the capability of providing the quality of results required for patient care,
ii. Verification procedures used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method; and
iii. Laboratory personnel are performing the test methods as required for accurate and reliable results;

(4) Ensure that the laboratory is enrolled in an HHS-approved proficiency testing program for the testing performed and that—

(i) The proficiency testing samples are tested as required under subpart H of this part;
(ii) The results are returned within the timeframes established by the proficiency testing program;
(iii) All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratory's performance and to identify any problems that require corrective action; and
(iv) An approved corrective action plan is followed when any proficiency testing result is found to be unacceptable or unsatisfactory;

(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur;

(6) Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system;

(7) Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratory's established performance characteristics are identified, and that patient test results are reported only when the system is functioning properly;

(8) Ensure that reports of test results include pertinent information required for interpretation;

(9) Ensure that consultation is available to the laboratory's clients on matters relating to the quality of the test results reported and their interpretation concerning specific patient conditions;

(10) Ensure that a general supervisor provides on-site supervision of high complexity test performance by testing personnel qualified under §493.1489(b)(4);

(11) Employ enough laboratory personnel with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests and report test results in accordance with the personnel responsibilities described in this subpart;

(12) Ensure that prior to testing patients' specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results;

(13) Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills;

(14) Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process; and

(15) Specify, in writing, the responsibilities and duties of each consultant and each supervisor, as well as each person engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or result reporting and whether supervisory or director review is required prior to reporting patient test results.

While the Laboratory Medical Director of the clinical laboratories at Ventura County Medical Center and Santa Paula Hospital is responsible for the overall technical and clinical operation and the administration of the laboratory, some of these responsibilities have been delegated to other qualified individuals. Delegation of these responsibilities does not negate the need for the Laboratory Medical Director involvement in the laboratory.

Any reports, problems or medical decisions are given to the Medical Director for assistance or approval.

There are programs throughout the hospital which require the Laboratory Medical Director's oversight and involvement :

A. The transfusion service medical director should be involved in, be aware of, and participate in the development and establishing the policies and procedures for blood recovery and to ensure the safety and efficacy of the recovered blood components as part of the transfusion medicine service. The Laboratory Medical Director will interact with the surgeons, physicians, and licensed healthcare providers responsible for ordering the use of the cell saving devices and oversee the use at surgery.

Clinical Consultant - Pathologist

1. Clinical Consultant provides consultation regarding the appropriateness of the testing ordered and interpreation of test results.
2. The clinical consultant must—
   (a) Be available to provide consultation to the laboratory's clients;
   (b) Be available to assist the laboratory's clients in ensuring that appropriate tests are ordered to meet the clinical expectations;
   (c) Ensure that reports of test results include pertinent information required for specific patient interpretation; and
   (d) Ensure that consultation is available and communicated to the laboratory's clients on matters related to the quality of the test results reported and their interpretation concerning specific patient conditions.

3. All responsibilities of the Laboratory Medical Director when the Laboratory Medical Director is off duty.
4. All responsibilities in Anatomic and Clinical Pathology as needed or assigned per CLIA guidelines.

General Supervisor (Laboratory Director/Laboratory Manager):

1. The general supervisor is responsible for day-to-day supervision or oversight of the laboratory operation and personnel performing testing and reporting test results.
    a. Must be accessible to testing personnel at all times when testing is performed to provide on-site, telephone or electronic consultation to resolve technical problems in accordance with policies and procedures established either by the laboratory director or technical supervisor;
    b. Is responsible for providing day-to-day supervision of high complexity test performance by a testing personnel qualified under §493.1489;
    c. Except as specified in paragraph (c) of this section, must be onsite to provide direct supervision when high complexity testing is performed by any individuals qualified under §493.1489(b)(5); and
    d. Is responsible for monitoring test analyses and specimen examinations to ensure that acceptable levels of analytic performance are maintained.
2. Laboratory Operations include scheduling staff and hiring new employees, budget, contracts, overall quality assurance and oversee all technical supervisors and other testing personnel.
3. Share responsibilities designated to technical supervisors and testing personnel as needed
4. Review compliance related documents and oversee all regulatory requirements.
5. Maintain Policy manuals. Write new and revised policies for Laboratory Medical Director to review and sign. Review and sign policy manuals every other year.
6. As the Laboratory Safety Coordinator facilitates the implementation of the various safety requirements and assists in establishing a safe work environment by collaborating with EH&S, laboratory medical director, administration, and lab personnel. The Lab Safety Coordinator is familiar with department operations, has management support, and understands laboratory safety requirements.
    a. Coordinate laboratory safety and environmental compliance efforts based on EH&S programs.
    b. Serve as liaison between the laboratory and EH&S in helping maintain safety and regulatory information, including Safety Data Sheets
    c. Attend training sessions provided by EH&S, sharing information with department personnel. Distribute and communicate safety, hazardous material, precaution information to all lab personnel.
    d. Assist EH&S in evaluating program effectiveness.
    e. Conduct or coordinates periodic laboratory self-inspections

f. Ensure that all safety and injury incidents are documented and reported to the relevant department. Keep all records as required.

g. Provide guidance on laboratory safety compliance to other laboratory members.

h. Seek information and clarification on regulatory requirements from Environment, Health, and Safety (EH&S) is essential. Compliance with EH&S regulations involves adhering to laws, policies, and workplace procedures that protect the well-being of workers and the public.

i. Assist in responding to any regulatory actions or investigations.

j. Participate in the development of the Laboratory Emergency Plans and assists with emergency management planning and response as needed.

k. Ensure that lab personnel receive all required EH&S training and lab specific information. Maintain all training documents as required by College of American pathologist.

l. Oversight that safety conditions in the laboratories are met.

m. Maintain laboratory safety postings.

n. Assist in developing, implementing, and communicating departmental safety policies and programs.

o. Coordinate laboratory submissions of hazardous materials inventories to EH&S for annual updates and storage relocations.

p. Communicate with the institute safety officer on facility issues related to safety.

q. Maintain Policy manuals. Write new and revised policies for Laboratory Medical Director to review and sign. Review and sign policy manuals every other year.

7. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Technical Supervisors

Clinical Laboratory Scientist III - Blood Bank

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing personnel) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical

Director to review and sign. Review and sign procedure manuals every other year.

6. Personnel: Staffing, training, competency assessments, evaluations, and discipline of testing personnel.
7. Quality improvement and safety specific to assigned area.
8. Computer software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing personnel (CLS II) as needed.
10. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Clinical Laboratory Scientist III - Chemistry

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing personnel) of proficiency testing, exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Personnel: Staffing, training, competency assessments, evaluations and discipline of testing personnel.
7. Quality improvement and safety specific to assigned area.
8. Computer software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing personnel (CLS II) as needed.
10. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Clinical Laboratory Scientist III - Hematology/Coagulation/ Urinalysis

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing

personnel) of proficiency testing exception investigation report.

4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Personnel: Staffing, training, competency assessments, evaluations and discipline of testing personnel.
7. Perform annual assessment and evaluation of consistency of morphological observation among personnel performing both urine sediment microscopy and blood cell microscopy.
8. Quality improvement and safety specific to assigned area.
9. Computer software and hardware issues specific to assigned area.
10. Responsibilities assigned to testing personnel (CLS II) as needed.
11. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Clinical Laboratory Scientist III - Laboratory Information System

1. Monitors and oversees the performance of the laboratory information system to ensure that it is functioning correctly and meeting the needs of the department.
2. Implements all aspects of system requirements, including system analysis, policy and procedure documentation, test plans, system performance, and user training.
3. Monitors the development and installation of software upgrades, which includes testing, quality control, and acceptance.
4. Oversees the computer operations to ensure data is processed according to the program and to ensure timely communication of results.
5. Monitor interfaces, both instrument and hospital related computer system to ensure optimum accuracy, appropriate flow of data and timely turnaround of results.
6. Ensure that the LIS complies with regulatory requirements.
7. Acts as liaison with vendors and attends vendor training.

Clinical Laboratory Scientist III - Microbiology

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing personnel) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.

5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Personnel: Staffing, training, competency assessments, evaluations, and discipline of testing personnel.
7. Quality improvement and safety specific to assigned area.
8. Computer software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing personnel (CLS II) as needed.
10. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Clinical Laboratory Scientist III - Performance Improvement/ Quality Assurance Coordinator

1. Monitors and oversees the performance of the laboratory proficiency specimen. Monitor the data from receive to submission. Review the proficiency evaluation received from Collage of American Pathology. Tabulate and compile the data from the monthly workload.
2. Verify the documentation of completed preventive maintenance of all equipment.
3. Monthly audition of the blood culture log sheet, time draw study, turnaround time study draw, critical value reporting, and responses to the regulatory agencies.
4. Monitors, evaluates, and maintains quality indicators.
5. Ensures that the laboratory and staff are survey ready at all times for regulatory agencies such as California department of Public Health and the College of American Pathologists.

Clinical Laboratory Scientist III - Santa Paula Hospital Laboratory

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing personnel) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Personnel: Staffing, training, competency assessments, evaluations, and discipline of testing personnel.
7. Quality improvement and safety specific to assigned area.
8. Computer software and hardware issues specific to assigned area.

9. Responsibilities assigned to testing personnel (CLS II) as needed.
10. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.
11. Perform annual assessment and evaluation of consistency of morphological observation among personnel performing both urine sediment microscopy and blood cell microscopy.

Testing Personnel (Clinical Laboratory Scientist I/II, Medical Laboratory Technician)

1. Analyze and report patient samples and proficiency testing materials.
2. Equipment, operations, maintenance, and function checks.
3. Perform and evaluate quality control for all testing platforms,
4. Perform annual assessment and evaluation of consistency of morphological observation among personnel performing both urine sediment microscopy and blood cell microscopy.
5. Perform annual competency assessment of testing personnel.

Non-Testing Personnel

Phlebotomy Supervisor (CPT III):

1. Personnel scheduling, staffing, education, training of phlebotomist and office standards.
2. Quality assurance including timeliness of draws.
3. Environmental digital thermometer temperature monitoring.
4. Maintain adequate phlebotomy supplies.
5. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

1. 1.

The director or technical supervisor may delegate to the general supervisor the responsibility for—

1. Assuring that all remedial actions are taken whenever test systems deviate from the laboratory's established performance specifications;
2. Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is properly functioning;
3. Providing orientation to all testing personnel; and
4. Annually evaluating and documenting the performance of all testing personnel.

Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (a)(3) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general

supervisor qualified under §493.1461.

Technical Supervisors (CLS III, Chemistry, Hematology, Microbiology, and Blood Bank Supervisors, Acting Supervisors, and Interim Supervisors):
The technical supervisor is responsible for the technical and scientific oversight of the laboratory. The technical supervisor is not required to be on site at all times testing is performed; however, he or she must be available to the laboratory on an as needed basis to provide supervision as specified in (a) of this section.

a. The technical supervisor must be accessible to the laboratory to provide on-site, telephone, or electronic consultation; and
b. The technical supervisor is responsible for
    1. Selection of the test methodology that is appropriate for the clinical use of the test results;
    2. Verification of the test procedures performed and establishment of the laboratory's test performance characteristics, including the precision and accuracy of each test and test system;
    3. Enrollment and participation in an HHS approved proficiency testing program commensurate with the services offered;
    4. Establishing a quality control program appropriate for the testing performed and establishing the parameters for acceptable levels of analytic performance and ensuring that these levels are maintained throughout the entire testing process from the initial receipt of the specimen, through sample analysis and reporting of test results;
    5. Resolving technical problems and ensuring that remedial actions are taken whenever test systems deviate from the laboratory's established performance specifications;
    6. Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is functioning properly;
    7. Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed;
    8. Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to—
        i. Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing, and testing;
        ii. Monitoring the recording and reporting of test results;
        iii. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records;
        iv. Direct observation of performance of instrument maintenance and

function checks;

v. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and

vi. Assessment of problem-solving skills.

9. Evaluating and documenting the performance of individuals responsible for high complexity testing at least semiannually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be reevaluated to include the use of the new test methodology or instrumentation.

Testing Personnel (CLS I/II):

The testing personnel are responsible for specimen processing, test performance and for reporting test results.

A. Each individual performs only those high complexity tests that are authorized by the laboratory director and require a degree of skill commensurate with the individual's education, training or experience, and technical abilities.

B. Each individual performing high complexity testing must—

1 Follow the laboratory's procedures for specimen handling and processing, test analyses, reporting and maintaining records of patient test results;
2 Maintain records that demonstrate that proficiency testing samples are tested in the same manner as patient specimens;
3 Adhere to the laboratory's quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed;
4 Follow the laboratory's established policies and procedures whenever test systems are not within the laboratory's established acceptable levels of performance;
5 Be capable of identifying problems that may adversely affect test performance or reporting of test results and either must correct the problems or immediately notify the general supervisor, technical supervisor, clinical consultant, or director;
6 Document all corrective actions taken when test systems deviate from the laboratory's established performance specifications; and
7 Except as specified in paragraph (c) of this section, if qualified under §493.1489(b)(5), perform high complexity testing only under the onsite, direct supervision of a general supervisor qualified under §493.1461.

Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (b)(7) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general supervisor qualified under §493.1461.
*All Alphanumeric references are to CLIA.

References:

1. brochure7.pdf (cms.gov)
2. https://www.ecfr.gov/current/title-42/section-493.1441

All Revision Dates

11/15/2024

Attachments

LABORATORY DIRECTOR RESPONSIBILITIES CLIA.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	11/15/2024
Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	10/8/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/4/2024

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

January 2025

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VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*7/1/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*9/27/2018*
Next Review:	*3 years after approval*
Owner:	*Melody Donate: Stroke Coordinator*
Policy Area:	*Administrative - Patient Care*
References:	

100.227 Telestroke Neurology Consultations

POLICY:

To establish a policy for the provision of telestroke/neurology consultations at Ventura County Medical Center/ Santa Paula Hospital. This policy will contribute to a standardized communication procedure for initiating an emergency telestroke/neurology consult for acute stroke/neurology patients.

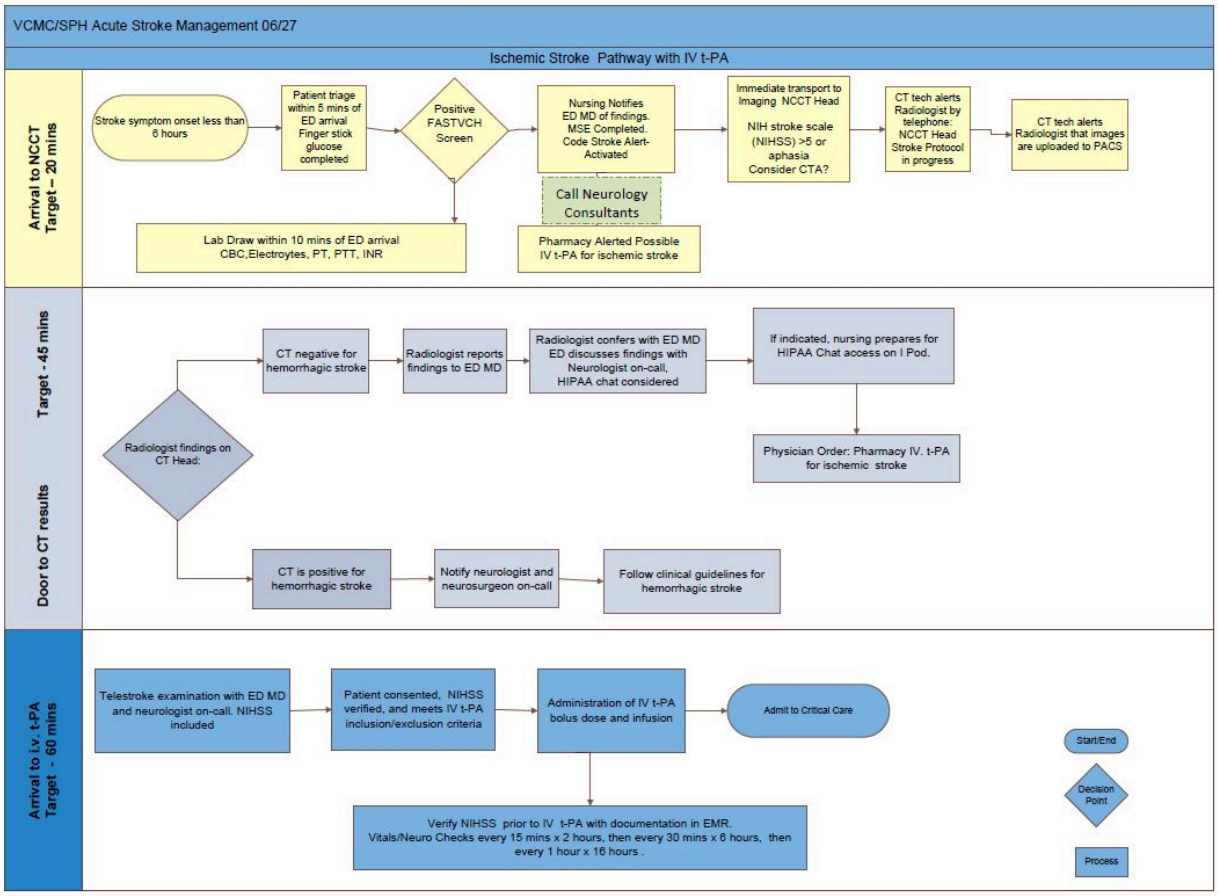
Telemedicine allows a link between a referring and consulting health care provider (i.e. neurology), thereby accommodating real-time assessment and the management of /stroke/neurology patients. With the use of a secure, HIPAA Compliant, 24/7 telemedicine portal, health providers are able to exchange patients' clinical findings and expedite interventions required in acute stroke management.

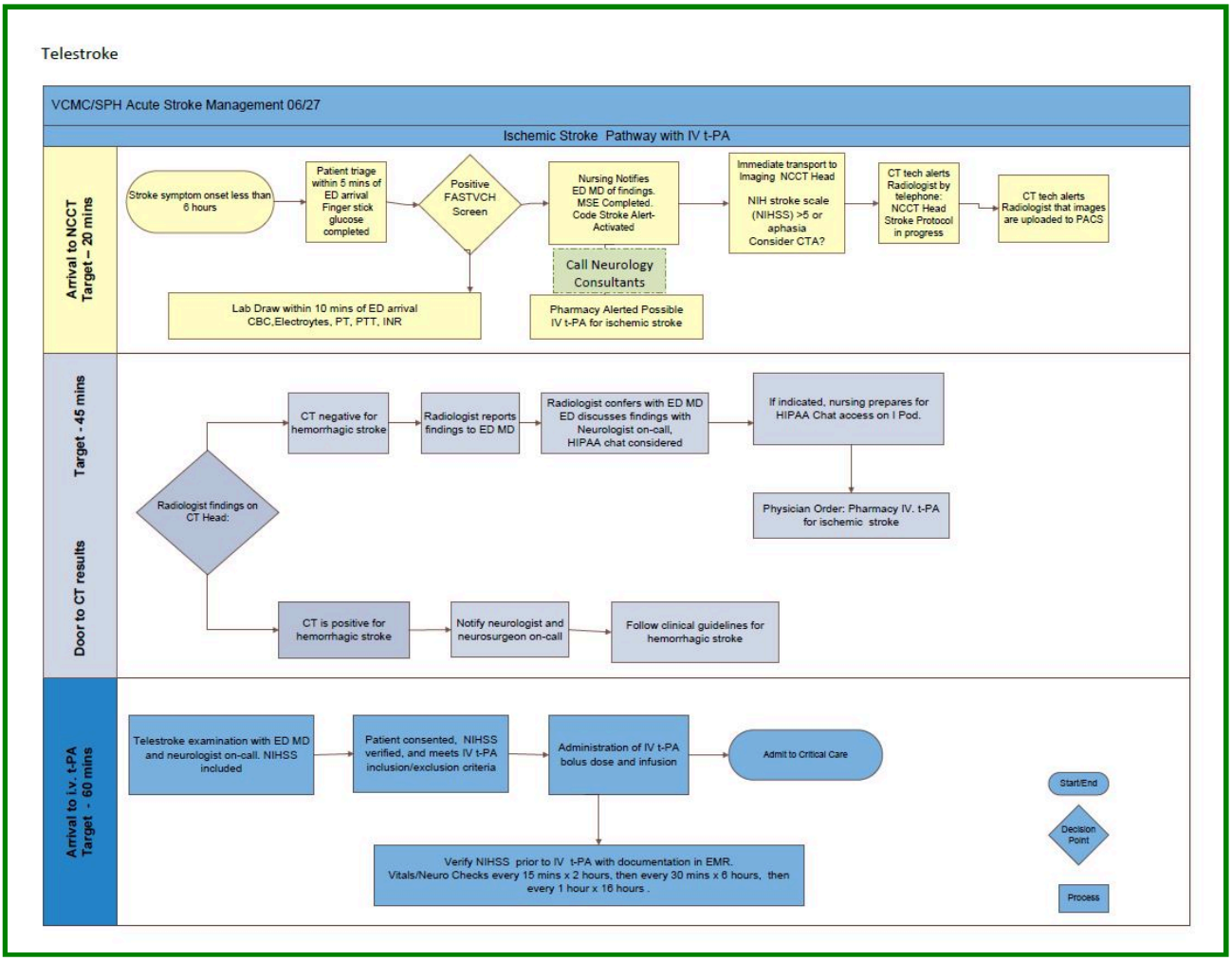
PROCEDURE:

a. Patient evaluated for symptoms consistent with acute stroke.
b. Work up and testing by Emergency Department (ED) health care provider (HCP)
c. ED HCP identifies need for telestroke/neurology consultation.
d. ED physician consults neurology through typical channels, discusses case.
e. Decision made that a telestroke/neurology consult might be valuable in specific case.
f. ED physician describes telestroke/neurology consult to patient and gets patient's verbal consent (written consent already obtained at registration includes telehealth).
g. Patient identifiers, name, medical record number, and date of birth entered into telemedicine portal by one of the following: medical office assistant, primary nurse, or health care provider.
h. Telestroke/neurology consult, audio and/or visual is initiated via telemedicine from ED physician to consulting neurologist.
i. ED nurse assists patient with the telestroke/neurology consult.
j. Telestroke/neurology consult concludes.
k. Consulting neurologist confers with ED physician on recommendations.
l. Clinical findings and decision-making from the telestroke/neurology consult documented and accessible in the electronic health record.

Appendix 1

Telestroke





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Demaerschalk, B. M., Berg, J., Chong, B. W., Gross, H., Nystrom, K., Adeoye, O., ... & Whitchurch, S. (2017). American Telemedicine association: Telestroke Guidelines. *Telemedicine and e-Health*, *23*(5), 376-389.

Schwamm, L. H., et al. 2014. American Heart Association Telemedicine Statement, Recommendations for the Implementation of Telemedicine within Stroke Systems of Care: A Policy Statement from the American Heart Association. Stroke, 40, 2635-2660.

Sikka, N., Paradise, S., & Hsu, M. 2014. Telehealth in Emergency Medicine: A Primer. American College of Emergency Physicians.

All revision dates: 9/27/2018, 7/1/2015

Attachments

Appendix 1

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED, Medicine & Pediatrics	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
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	Melody Donate: Stroke Coordinator	10/1/2024

Status **Pending** PolicyStat ID **14829408**

Origination	2/9/2021	Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH
Last Approved	N/A		
Effective	Upon Approval	Policy Area	Administrative - Patient Care
Last Revised	10/1/2024		
Next Review	3 years after approval		

100.247 Post Spinal Analgesia Patient Care

Policy:

Patients receiving spinal analgesia shall be monitored to ensure safe and effective pain management.

Procedure:

A. Patients who receive intrathecal opioids shall be monitored and documented as follows:
   1. Respiratory rate and end tidal carbon dioxide ($ETCO_2$) every hour for the first twelve hours after administration of spinal analgesia, then
   2. Respiratory rate and $ETCO_2$ every two hours for the following twelve hours.
   3. 24 hours after administration of spinal analgesia, vital signs shall be monitored as ordered by the Licensed Independent Practitioner (~~LP~~LIP).

B. If respiratory rate is <8 breaths per minute or if $ETCO_2$ is >60 mm Hg:
   1. Notify the ~~LP~~LIP or house officer.
   2. Administer naloxone as ordered.

C. Respiratory rate may be collected by a nursing assistant and interpreted by a registered nurse.

D. For anticipated post-operative admission of patients to the Medical-Surgical Unit: The Surgical Services Department shall communicate to the Medical-Surgical Unit of any patient that will be receiving spinal analgesia during the patient's surgery. The communication should occur prior to the patient's surgery to give the Medical-Surgical Unit enough time to staff appropriately. Upon transfer from the Post-Anesthesia Care Unit (PACU), a 1:4 nurse:patient ratio shall be designated if the patient is admitted to a medical-surgical unit.

All Revision Dates

10/1/2024, 2/9/2021

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	11/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/1/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/1/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/1/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*9/14/2021*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/5/2024*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.253 Naloxone for Opioid Toxicity

Purpose:

To provide guidelines for the administration of naloxone for treatment of opioid-induced respiratory depression in adults.

Procedure:

A. All prescribed opioids must have accompanying naloxone bolus orders.

B. Identify patients with signs and symptoms of opioid toxicity.

C. Administer bolus doses of naloxone as ordered.

D. Administer continuous infusion naloxone if required.

E. Monitor for continued opioid toxicity or development of opioid withdrawal.

F. Document monitoring parameters.

G. Provide patient education.

H. Restart opioid for pain management.

Opioid toxicity and naloxone use

In patients where opioid(s) are ordered, either enteral or parenteral formulation, pharmacist may enter an order for naloxone rescue dose if not already done by a license independent provider (LIP). This order will be routed back to the opioid ordering LIP as a “Protocol/Standardize Procedure – cosign”.

Classic signs of opioid toxicity:[1]

- Decreased respiratory rate (≤ 8/min)
  - Associated with low oxygen saturation, hypotension.
- Depressed mental status
  - Somnolent, difficult to arouse, or no response to physical stimulation
- Miotic (constricted, “pinpoint”) pupils
  - Note:
    - Meperidine, tramadol, co-ingestion with sympathomimetic, cocaine, or anticholinergics may present with normal or large/dilated pupils
    - Other agents that can cause constricted pupils are sedative-hypnotics, alcohol, clonidine,

nicotine, decongestants

Other signs of toxicity:[1]

- Seizures (meperidine, tramadol, propoxyphene, tapentadol)
- Hypoxia
- Decreased bowel sounds
- Chest wall rigidity
- QT interval prolongation, wide-complex tachycardia

Patient assessment:

If a patient has decreased respiratory rate and/or depressed mental status, perform the following steps.

A. Attempt to arouse the patient.
B. Count respiratory rate for 1 full minute while inspecting quality of respirations.
C. If respiratory rate is below 8 per minute and/or poor quality and/or unable to arouse, naloxone is indicated.
D. Stop all opioid/benzodiazepines if applicable.
E. Provide supplemental oxygen. Apply end-tidal CO_2 ($ETCO_2$) monitoring if not already placed.
F. Call for assistance by coworker, physicians, and/or call Rapid Response.
G. Maintain or secure IV access.
H. Administer naloxone as ordered.

Treatment:

Table 1. Naloxone dose[2]

Route	Dose and frequency
Intravenous (IV)	0.2 mg IV push every 2 minutes PRN respiratory rate ≤ 8/min. Note: LIP may consider increase dose to 2 mg if initial response is inadequate in the setting of ingestion of an unknown substance (atypical opioids).
Intramuscular (IM)	0.4 mg IM every 5 minutes PRN respiratory rate ≤ 8/min if IV route is not available Note: IM route produces a more prolonged effect and may be beneficial when used for subsequent dosing
Continuous infusion[3]	2 mg naloxone in 500 mL of D5W [Concentration of 0.004 mg/mL = 4 mcg/mL] A. Starting rate of infusion must be determined by a LIP and be part of a complete order. B. Each dose (rate) change must accompany a full order by the LIP. C. Notify LIP if patient does not meet the desired response as noted below under Monitoring.

PRN = as needed, LIP = licensed independent provider, D5W = dextrose 5% water.

Monitoring

Acute phase	Monitor and document vitals including $ETCO_2$ every 2-5 minutes while administering naloxone.

Continuous infusion of naloxone	Monitor and document vitals, $ETCO_2$, neurological assessment with start of infusion, dose change of infusion, or with extra boluses or at least every one (1) hour for the first 4 hours then every 2 hours thereafter. Desired patient response while on naloxone infusion is RASS (Richmond Agitation-Sedation Scale) -2 to 0 and respiratory rate ≥ 8. Call LIP if parameters not met.
Post naloxone administration	Monitor and document vitals including $ETCO_2$: • Every 15 minutes for 1 hour then • Every 30 minutes for 1 hour then • Every 1 hour for 2 hours. Monitor for any signs of return of opioid toxicity and/or opioid withdrawal.
Life-threatening opioid withdrawal post naloxone administration • Pulmonary edema, cardiac arrhythmias, tachycardia, profound hyper- or hypotension and cardiac arrest.[3]	

Restart of opioid for pain management

A. Pain service consult is recommended.

B. If patient has a past medical history of opioid or atypical opioid abuse, consult Addiction Medicine.

Reference

1. Kunzler NM, Devin K, Babu K, Boyer EW. Opioid Overdose, Toxicity, and Poisoning. The American Opioid Epidemic: From Patient Care to Public Health. 2018 Dec 31:79.
2. Naloxone Package Insert 2020. Access April 13, 2020.
3. Rzasa Lynn, R, Galinkin JL. Naloxone dosage for opioid reversal: current evidence and clinical implications. Therapeutic Advances in Drug Safety 2018, 9(1): 63-88.

All revision dates: 12/5/2024, 9/14/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Medicine & Surgery	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/15/2024

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/9/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/9/2024
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	9/9/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1991*
Effective:	*Upon Approval*
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Next Review:	*3 years after approval*
Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Administrative - Nursing*
References:	

108.032 Blood Glucose Testing with the Nova StatStrip® Glucose Meter

POLICY:

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

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

PROCEDURE:

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

Supportive Data:

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

Reference Ranges:

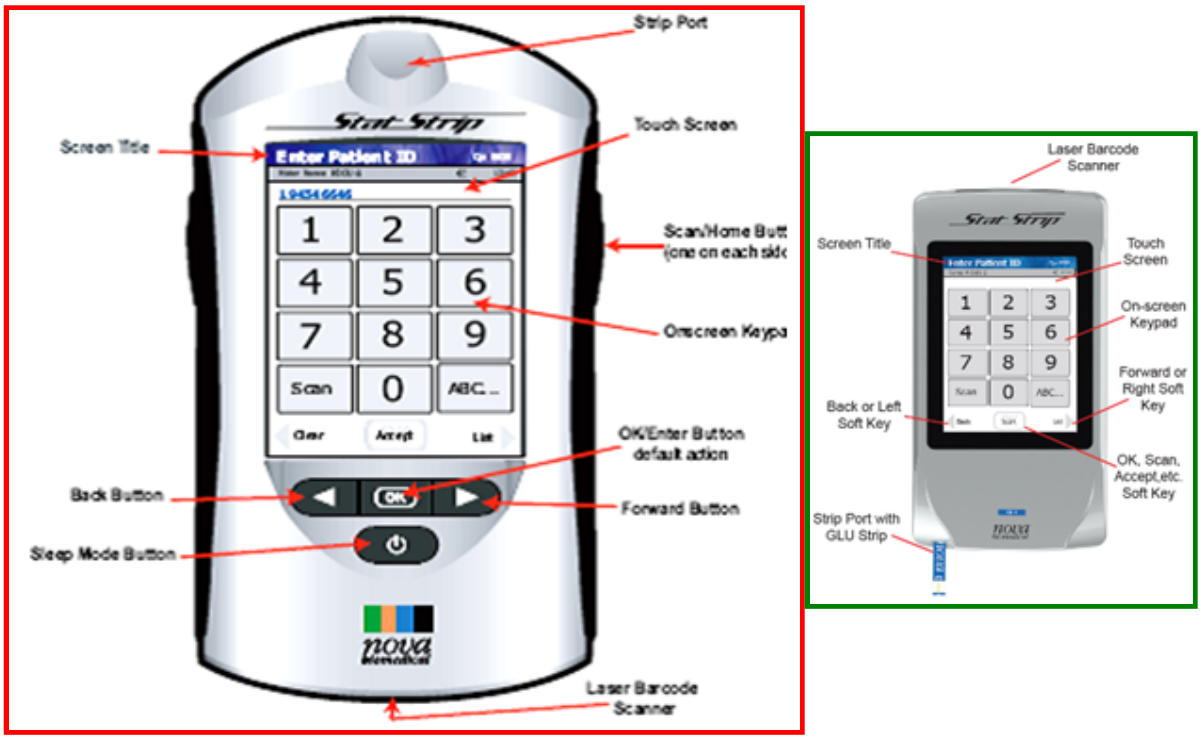
1. Non-fasting reference range: Normal: 70 – 140 mg/dL
   A single up arrow by the result indicates the result is above the normal range.
   A single down arrow by the result indicates the result is below the normal range.
2. Fasting reference ranges:
   Normal: 70 – 99 mg/dL
   Pre-diabetes: 100 – 125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

Results above this range will display as "HI."
Any HI or LO results should be retested.

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

Equipment:

NOVA StatStrip® Glucose Meter



NOVA StatStrip® Glucose Meter

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

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

Note: Clean the meter with a hospital approved disinfectant.

CAUTION:
DO NOT immerse the meter or hold the meter under running water.

DO NOT spray the meter with a disinfectant solution.

Materials

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

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

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

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

Heel warmer (for heat application as necessary)

10 % bleach wipes or 1:10 bleach solution

Reagent Handling

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

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

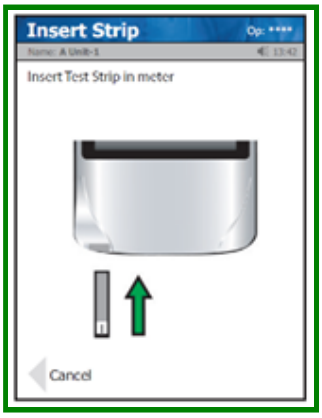
Calibration:
No calibration is necessary. Meter calibration is preset in meter using the strip lot number.

Quality Control Procedure:

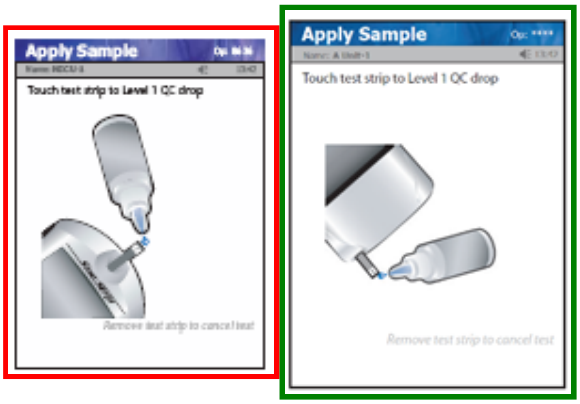
1. Quality control frequency:
   Note: *The meter will lock out testing of patients after 24 hours.*

   Level 1 and Level 3 control testing must be performed every 24 hours that patient testing is performed, or if:.
   a. A vial of strips has been left open or when the test strips have been exposed to extreme heat, humidity, or cold.
   b. The meter is dropped.
   c. When troubleshooting the meter.
   d. When patient test results contradict clinical symptoms.
2. Check the written expiration date on each level of Control solution.

3. Check the written expiration date on the *StatStrip® Glucose Test Strip vial.*
4. When removing the meter from the docking station, wait until the hour glass disappears.
5. Touch <WELCOME> on the screen, or the <OK> button.
6. Touch <LOGIN> on the screen, or the <OK> button.
7. Touch SCAN, or the <OK> button, and scan (or enter) your operator identifier (located on the front of your ID badge).
   Note: *If the meter will not allow you to login, notify the trainer on your unit.*
8. Touch <QC> block at the bottom of the screen.
9. Touch SCAN, or the <OK> button, to scan the barcode on the test strip vial.
10. Touch SCAN, or the <OK> button, to scan the barcode on the control vial being tested.
11. Gently mix control by inverting vial 5 – 10 times, or by rolling the vial between the palms for at least five seconds in two directions.
12. Wipe tip of vial and expel several drops of Control solution to removed dried concentrations of material.
13. Place the strip into the test strip port with the blue side up and the white end exposed, as shown on the screen.



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



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

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

    The screen times out in 90 seconds if there is no activity, but your identity stays in the meter for 3 minutes.
24. **Return the meter to the docking station.**
    Note: *Meter must remain in the docking station when not in use to allow patient data transmission and maintain a fully charged battery.*
25. Quality control notes:
    a. If a quality control test result displays "Fail," the problem must be corrected before the meter will allow you to proceed. Consider the following factors that may cause a failure of the quality control test:
    b. The test strip vial has been left opened for a period of time.

c. Procedural error.

d. The test strip or controls have been exposed to very high or low temperatures.

e. The test strips are expired.

f. The control solutions are expired and/or contaminated.

g. Corrective action must be documented by entering a comment in the meter.

h. Report two consecutive failures to the Laboratory Point-of-Care Coordinator.

Specimen Collection:

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

   ***Caution**: Do not touch test strip to the patient's finger or apply blood to the top of the strip.*
6. Heel puncture:
   a. Warm the collection site with heel warmer.
   b. Clean the area with alcohol and wipe dry with clean gauze or cotton ball or allow to air dry (alcohol cause erroneous blood glucose results).
   c. Puncture the heel to get free flowing blood.
   d. Consider wiping away the first drop of blood with dry gauze or cotton ball.
7. Apply sample by touching the end of the strip to a drop of the blood allowing it to migrate into the test area.

   ***Note:** Collecting the sample in a heparinized capillary tube is also acceptable.*
   a. *Tilt the tube at a downward angle and allow gravity to draw blood into tube.*

b. *Mix by gently rolling tube between two fingers.*

c. *Attach the black transfer bulb to the capillary tube.*

d. *Squeeze the bulb to transfer sample from the capillary tube to the target area of the test strip.*

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

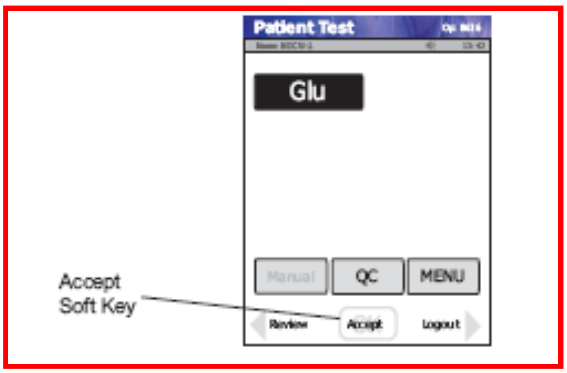
Blood Glucose Patient Testing Procedure:

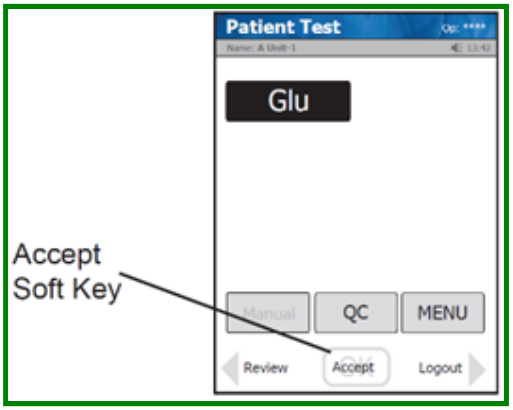
1. Standard Precautions must be followed when using the NOVA StatStrip® Glucose Meter.
    a. This procedure may expose the user to Bloodborne pathogens. To perform this procedure the user must wear gloves.
    b. Isolation: To prevent contamination to the patient and/or meter, the meter and vial of test strips may be placed into clear plastic bags prior to testing in isolation and/or high risk blood borne pathogen areas.
        - Remove two test strips for testing before entering the isolation room and place the vial in a plastic bag.
        - Once in the patient's room, scan the test strip vial through the plastic bag when prompted.

    Note: Personal protection equipment and sharps MUST be discarded according to your clinic or unit’s infection control policy.
2. Before removing meter from docking station, check to make sure it has completed the download, or you may have to redock it before testing can begin.
3. Check the expiration date on the StatStrip® Glucose Test Strip.

Note: *When opening a new vial of StatStrip® Glucose Test Strip, write the 6 month expiration date on each vial.*

4. Identify the patient using a minimum of two forms of identification prior to testing.
5. Touch <WELCOME> on the screen, or press the <OK> button, to activate the screen on the meter.
6. Touch <LOGIN> on the screen.
7. Touch <SCAN> and scan (or enter) your operator identifier (~~located on the front of your ID badge~~Employee Number).
   Note: *If the meter will not allow you to sign in, notify your Clinical Nurse Manager or Superuser on your unit.*
8. Touch the <PATIENT> box.

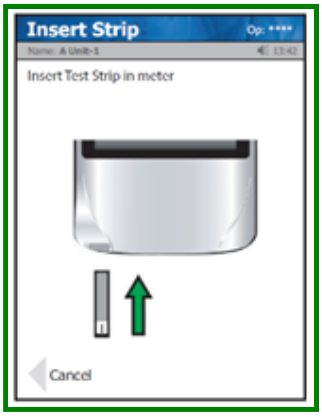




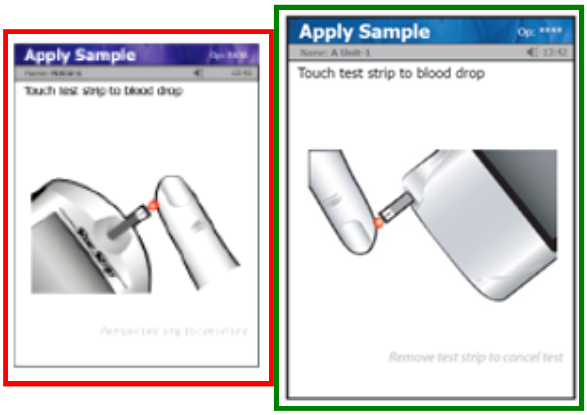
9. Touch <ACCEPT>, or the <OK> button.
10. Touch <SCAN>, or the <OK> button, to scan the barcode on the test strip vial.
11. Identify the patient: Ask patient to state name and DOB.
12. Touch <SCAN>, or the <OK> button, or manually enter ~~the~~ patient's ~~Identification~~identification number (~~6~~10 digit ~~chart~~FIN number) from the patient's armband.
    ~~***Note:***~~
    Note: *For neonate or ER patient before chart number issued: ID # = ~~use date and military time~~10 digit arbitrary number (ex: ~~born on March 5 at 1310, ID# = 051310~~1111111111)*
    ~~*For ER patient prior to chart number: ID # = 3 digit log number (ex: 003)*~~

    ~~***NEVER ENTER A FALSE ID#!!***~~

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



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



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

20. A beep will sound when enough sample has been drawn into the strip.
21. Wait for the countdown to end and the result to appear.
22. Remove strip before moving the meter.
23. Discard strip in biohazard container. Discard the lancet in the sharps container.
24. Perform hand hygiene.
25. If alert value is displayed, *actions must be documented in the meter by touching <COMMENT> and entering up to three comments by touching the appropriate comment display.* Touch <ACCEPT>, to complete the comments.
    Note: *Alert values <70 mg/dl and >300 mg/dL (neonates: <45 mg/dL and >150 mg/dL) must be repeated, using a fresh sample from a new stick, unless the patient has a documented blood glucose >300 within the past 3 hours. Report to caregiver or provider, and follow his/her recommendations. Alert values obtained by any NCA must be reported immediately to the care nurse for assessment of the patient. Results must be verified by the clinical laboratory if requested by the provider.*
26. Touch <ACCEPT>~~, or the <OK>~~ button~~, to finalized~~ to finalize result and send to ~~the~~ patient's ~~electronic~~medical record. (Touch <REJECT> button if result will be rechecked or if 10 digit arbitrary patient identifier used).

    ~~Document the blood glucose result (mg/dl), any treatment given, the time, date, and initials of operator in the patient's medical record.~~
27. Confirm blood glucose result transferred to patient's medical record. Document any physician notification or treatments given.
28. If medical record was not created at time of glucose test and 10 digit arbitrary patient identifier used, document result manually using Point of Care Results Entry.
29. To prevent others from testing under your name, logout by ~~touch~~touching the <Op: XXXX> icon at the top right corner of the screen or <LOGOUT> at the bottom of the screen.
    Note*: The screen will turn off in 90 seconds if there is no activity, but does not log you out for 3 minutes.*
30. Clean the meter between patients and/or prior to docking and PRN by following the cleaning procedure below.

31. Once meter is dry, return to the docking station.
    Note: *Meter must remain in the docking station when not in use to allow patient data transmission and maintain a fully charged battery.*

Cleaning and Disinfecting Nova StatStrip Glucose Meter:

A. The meter must be cleaned and disinfected after each patient use to minimize the risk of transmission of blood-borne pathogens between patients and healthcare professionals.

B. Cleaning the meter
    1. Clean the meter using a 10% bleach wipe after donning gloves
    2. Wipe the external surface thoroughly and discard soiled wipe into appropriate container.

C. Disinfecting the meter
    1. Using a new 10% bleach wipe, thoroughly wipe the surface of the meter (top, bottom, left, and right sides) a minimum of 3 times horizontally and 3 times vertically avoiding the bar code scanner and electrical connector.
    2. Gently wipe the surface area of the test strip port making sure that no fluid enters the port.

D. Observe manufacturer's contact time for germicidal wipe

E. Use clean gauze pad or paper towel to wipe cleaner residue from the scanner window and touch screen, as needed

F. Dispose of used wipe and gloves

G. Wash hands thoroughly with soap and water

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

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

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

Limitations and Precautions of the Procedure:

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

1. Hematocrit range is 20-65%.
2. Flow errors may occur with extreme high or low Hematocrit; repeat the test with a new strip. If the error code persists, send specimen to lab.
3. Flow errors may occur:
    a. When applying the sample the finger touched the strip, slowing the flow of the sample.
    b. The strip was not filled on the first touch of blood and was applied to the blood again.
4. The following conditions can cause erroneous results:
    a. The test strips were used after the "Use By" date on the vial.
    b. The strips were not stored in the vial with the cap tightly sealed.
    c. The strip was not filled on the first touch of blood and was applied to the blood again.

5. In situations of decreased peripheral blood flow, finger stick blood testing may not be appropriate, as it may not reflect the true physiological state. Examples include, but are not limited to, severe dehydration caused by diabetic ketoacidosis or the hyperglycemic hyperosmolar non-ketotic state, hypotension, shock or peripheral vascular disease.
6. Capillary samples must be obtained from free flowing blood. Excessive milking or squeezing of the puncture site may produce erroneous results.
7. Glucose results <10 mg/dL or >600 mg/dL are outside the linearity range and should not be considered accurate..
8. Test results are best when obtained within an operating relative humidity of 10-90% (non-condensing). Testing outside these ranges may produce inaccurate results.

Troubleshooting:

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

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

Meter Alert	Explanation	Resolution
Flow Error	May occur in patients with extremely high or low Hematocrit values. Also, when either the strip was not filled or the sample was not applied correctly.	Repeat the test with a new strip. If the error code persists, send specimen to lab. Repeat the test with a new strip.
Low Battery		Place meter in dock to recharge.
Test Strip Removed	Strip removed before test completed. Test cancelled.	Retest
Temperature	Meter will only work in temperature range of 59°-104°F (15°-40°C).	Make sure the meter is not near a heat source.
Bad Sample		Insert a new strip and retest.
Strip Rejected		Insert a new strip and retest.
Transfer Failed-Data	Meter cannot connect to the server.	Check that the computer is on. Check that all cables are connected. Call POCT.
Transfer Failed	Meter removed from dock before data transfer complete.	Re-dock the meter.

Maintenance:

Meter, base unit, and carrying case cleaning procedure:

1. Equipment must be cleaned if taken into the patient room using the "Cleaning Procedure," above. Only

the meter and the test strip to be used should go into a patient's room. The base unit, carrying case and container with strips should not go into a patient's room.

2. If cleaning solution does get on the connector, dry thoroughly with a cloth or gauze pad before returning the meter to the docking station.

Operator Competency:

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

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

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

   To activate the operator ID, the new operator's competency checklist shall be forwarded to the Laboratory Point-of-Care Coordinator. After activation, the Coordinator will return the checklist to the unit nursing manager for maintenance in the nurse's employee file.
3. **Continuing Competency:**
   Continuing operator competency shall be verified by each activated operator's completion of at least two patient tests and one QC procedure (high and low) every year. Additionally, all users shall verify competency by completion of the Nova StatStrip® Glucose Meter competency and Glucometer competency quiz.

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

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

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

All revision dates: 10/12/2024, 2/14/2024, 1/10/2023, 2/11/2019, 8/23/2018, 12/1/2013, 6/1/2010, 12/1/2004, 12/1/2001

Attachments


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Image06.PNG


s1.PNG


s2.PNG


s5.PNG

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	11/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/14/2024
Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services	Erlinda Roxas: Director, Laboratory Services	10/8/2024
Policy Owner	Hugo Ortiz: Diabetes Nurse Educator	10/4/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/1985*
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Last Approved:	*N/A*
Last Revised:	*10/9/2024*
Next Review:	*3 years after approval*
Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*NICU*
References:	

N.04 Breast Milk Storage and Collection

POLICY:

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

disposal of breastmilk.

EQUIPMENT

A. Electric Pump
B. Pump Kit
C. Sterile Bottles for Storage
D. Labels
E. Name alert stickers
F. Refrigerator or Freezer that is approved for breastmilk storage
    1. NOTE: Formula and breast milk may not be stored with food.

PROCEDURE

A. Nursing mother washes hands before handling of the breast pump parts, the breast or exposed breast milk.
B. Obtain sterile bottles.
C. Obtain electric pump and pump kit.
D. Help mother to relax by providing quiet, relaxed surroundings. Mothers may be taught to massage their breasts to facilitate emptying, if needed, and placement of warm, moist packs.
E. Plug pump into wall outlet. Set up pump kit according to enclosed manufacturer's directions*. Use sterile water bottles to collect breast milk. Double pump breasts for 10 – 15 minutes. Moisten the breast with clean warm water before placing the shield on the breast to create a "seal", center the breast shield over the nipple so the nipple can move in and out without rubbing against the sides. Turn on the pump after positioning the shield. Begin pumping with minimum suction, gradually increasing the suction to comfortable level.
F. Cap bottle of breastmilk/secure plastic bag and label with baby's name, date of brith, medical record number, date and time obtained. Use name alert stickers as appropriate.
G. Wash all pump kit parts that are exposed to mother or breastmilk in hot, soapy water. Rinse thoroughly. Place on a clean paper towel at bedside, and cover with another clean paper towel. Allow to air-dry. Breast should air-dry as well.

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

1.

Breast milk	Room Temperature (<78°F)	Refrigerator (<38°F)	Freezer (0°F)
Freshly expressed into closed container	4 hours	48 hours	3 Months in freezer compartment with separate door, 6-12 mo. in deep freezer
Previously frozen-thawed in refrigerator but not	4 hours or less	24 hours	Do not refreeze

Breast milk	Room Temperature (<78°F)	Refrigerator (<38°F)	Freezer (0°F)
warmed or used			
Thawed outside refrigerator in warm water	For completion of feeding	Do not refrigerate/ discard	Do not refreeze/discard
Infant has begun feeding	For completion of feeding; then discard	Discard	Discard

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

J. To thaw breast milk:

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

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

L. Always use oldest breast milk first.

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

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

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

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

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

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

DOCUMENTATION

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

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

REFERENCES

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

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

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

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

All revision dates: 10/9/2024, 12/1/2007, 3/1/2007, 1/1/2005

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	10/17/2024
NICU	Robert Posen: NICU Medical Director	10/9/2024

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References:	

P.45 PICU Insulin Infusion

~~POLICY:~~

Policy

Continuous intravenous (IV) insulin infusion is utilized in the Pediatric Intensive Care Unit (PICU) at Ventura County Medical Center (VCMC) to control hyperglycemia in the acutely ill pediatric patient.

~~PROCEDURE:~~

~~1. Prescribers shall order IV Insulin infusion using the PICU Diabetic Ketoacidosis (DKA) order-set in the electronic health record (EHR).~~

~~2. Only regular insulin at a standard concentration of one (1) unit insulin to one (1) mL 0.9% normal saline shall be used.~~

~~3. IV insulin infusion shall be managed by Registered Nurses (RNs) who have proven competency (Attachement A) to use the IV fluid resuscitation "two bag" system. (Attachment B)~~

~~4. The RN shall have no more than two (2) patients.~~

~~5. Glucose is monitored every hour or more frequently per prescriber's order.~~

~~6. The RN shall document blood glucose values and IV insulin titrations in the EHR.~~

~~7. Hypoglycemia is defined as glucose <70mg/dL and is treated per policy DM.003 Pediatric Hypoglycemia.~~

~~8. To transition a patient off of IV insulin infusion, the prescriber shall submit an order using the PHA Pediatric SubQ Insulin order-set in the EHR.~~

~~References:~~

- ~~Pediatric Diabetes October 2018; 19 (Suppl. 27): 155–177.~~
- ~~Ventura County Health Care Agency, CPG.12 Management of Pediatric Patients (<18 years old) in Diabetic Ketoacidosis (DKA); August, 2018.~~

Procedure

1. Prescribers shall order IV Insulin infusion using the PICU Diabetic Ketoacidosis (DKA) order-set in the electronic health record (EHR).

2. Only regular insulin at a standard concentration of one (1) unit insulin to one (1) mL 0.9% normal saline shall be used.
3. IV insulin infusion shall be managed by Registered Nurses (RNs) who have proven competency (See Attachment A-Compentency Validation Tool: DKA Tow Bag System Infusion) to use the IV fluid resuscitation “two bag” system. (See Attachment B-DKA Two Bag System Protocol)
4. The RN shall have no more than two (2) patients.
5. Glucose is monitored every hour or more frequently per prescriber's order.
6. The RN shall document blood glucose values and IV insulin titrations in the EHR.
7. Hypoglycemia is defined as glucose <70 mg/dL and is treated per policy DM.003 Pediatric Hypoglycemia.
8. To transition a patient off of IV insulin infusion, the prescriber shall submit an order using the PHA Pediatric SubQ Insulin order-set in the EHR.

References

1. Pediatric Diabetes October 2018; 19 (Suppl. 27): 155–177.
2. Ventura County Health Care Agency, CPG.12 Management of Pediatric Patients (<18 years old) in Diabetic Ketoacidosis (DKA); August, 2018.

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Attachments

Attachment A-Competency Validation Tool: DKA Two Bag System Infusion
Attachment B-DKA Two Bag System Protocol.pdf

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/23/2024
Pediatric Intensive Care Unit	Jennifer Ferrick: Director, Peds/PICU & NICU	9/23/2024
Pediatric Intensive Care Unit	Jesse Wyatt: MD	7/9/2024

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PH.27.00 Hazardous Drug Overview

Purpose:

The Department of Pharmacy Services is responsible for dispensing of hazardous drugs (HDs) for Ventura County Medical Center, Santa Paula Hospital, and Ambulatory Care Campus Clinics. This policy provides an outline of the policies and procedures that the Department of Pharmacy Services will follow in preparation and compounding of sterile drug preparations. Facilities that handle HDs must incorporate USP <800> standards into the occupational safety plan. Ventura County Medical Center Pharmacy policies must, at a minimum, include: a list of HDs, facility and engineering controls, competent staff, safe work practices, proper use of appropriate personal protective equipment (PPE), and policies for HD waste segregation and hazardous waste disposal.

Policy:

A. The Department of Pharmacy Services shall follow all policies and procedures pertaining to HDs and hazardous drug compounding to ensure patient and worker safety. The policies are as follows:
PH.27.00 Hazardous Drug Overview
PH.27.01 Hazardous Drug Training, and Safety Program
PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport
PH.27.03 Hazardous Drug Garbing, and Compounding
PH.27.04 Decontamination, Spill, and Waste Management

B. Policies, procedures, and forms will be reviewed and revised annually to reflect local, state, and federal regulatory requirements as well as professional practice standards.

C. The Department of Pharmacy Services shall not compound sterile drug preparations from non-sterile ingredients.

D. Hazardous Drug policies shall be reviewed at least annually by the Pharmacy Director and/or designee(s).

E. Any revisions or deletions to hazardous drug policies shall be communicated to all pharmacy staff involved in sterile compounding.

F. A list of HDs handled at the pharmacy will be reviewed and revised annually (Attachment A: VCMC-SPH Hazardous Drug List). This review includes an assessment of risk to determine containment strategies and work practices (Attachment B: Hazardous Drug Assessment of Risk, Attachment C: Hazardous Medication Administrate Guideline).

Reference Documents

United States Pharmacopeial Convention, Inc. <800> Hazardous Drugs-Handling in Healthcare Settings. United States Pharmacopeia National Formulary 35. Rockville, MD: US Pharmacopeial Convention, Inc., 2019.

NIOSH. Publication 2004-165. NIOSH Alert: Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings. Sept 2004. https://www.cdc.gov/niosh/docs/2004-165/pdfs/2004-165.pdf?id=10.26616/NIOSHPUB2004165 accessed on 9/30/2019.

NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016 from https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf accessed on 9/30/2019.

ASHP Guidelines on Handling Hazardous Drugs. Am J Health-Syst Pharm. 2018. from https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/handling-hazardous-drugs.ashx?la=en&hash=E0DF626948227B0F25CAED1048991E8E391F2007 accessed on 9/30/2019.

Kiffmeyer TK et al. Vapour pressures, evaporation behavior and airborne concentrations of hazardous drugs: implications for occupational safety. The Pharmaceutical Journal. Vol 268 March 2002. 331-7.

All revision dates: 12/20/2023, 1/10/2023, 11/10/2020, 11/13/2019

Attachments

Attachment A: VCMC-SPH Hazardous Drug List
Attachment B: Hazardous Drug Assessment of Risk
Attachment C: Pharmacy Guideline for Handling Hazardous Drugs

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	11/12/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	11/12/2024

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PH.27.01 Hazardous Drug Training and Safety Program

Definition and Purpose

The Hazardous Drug Training and Safety Program ensures employee safety while working with, and around, Hazardous Drugs (HDs), within the pharmacy setting. All pharmacy staff must receive training, and demonstrate competency, based on their job functions, before independently handling HDs. Employee competency will be reassessed annually. Employees must be aware of potential opportunities for exposure to HDs in their daily tasks, and demonstrate competency in the use of pharmacy equipment designated for use with HDs.

Policy

A. Hazardous drugs (HDs) are stored, prepared, labeled, packaged, transported, administered and disposed of under conditions that protect healthcare workers and patients. In addition, a HD safety program incorporates administrative, engineering, and work practice controls maintained to provide maximum protections to healthcare workers and patients.

B. Any personnel who may come in contact with HDs during the normal course of their job duties will receive training on HD handling that is specific to their job duties.

C. Compounding personnel must complete required training and competencies associated with non-HD compounding prior to completing training and competency requirements associated with HD compounding.

D. Non-compounding personnel performing environmental services in the containment secondary engineering control areas (C-SEC) must receive training in hand hygiene and garbing including competency verification.

Procedures - Administrative Controls

A. The HD Risk Acknowledgement will be read and signed by staff (see attachment).

B. Safety Data Sheets (SDS) will be immediately available for every drug on the pharmacy hazardous drug list via the SDS Online icon on each desktop.

C. All employees that handle HDs must successfully complete training and competencies annually that include the following:

1. Didactic
    a. Overview of HDs including the NIOSH List.

b. Review of the written policies that apply to the employee's job classification.
c. Review of waste disposal procedure.
d. Review of spill management procedures.

2. Observational
    a. Garbing and appropriate HD PPE
    b. HD specific compounding techniques
        i. General compounding practices that are different than or in addition to compounding of non-HDs.
        ii. Negative pressure compounding techniques to be used inside a biological safety cabinet (BSC).
        iii. Proper use of a closed system drug-transfer devices (CSTDs).
    c. Proper HD waste disposal
    d. Spill management

D. Environmental Services (EVS) personnel who enter negative pressure HD buffer rooms to perform either daily or monthly cleaning duties, must review Policy 106.013 Hazardous Substance Communication – Right to Know in addition to completing the EVS pharmacy competency for Hand Hygiene and Garbing, and Cleaning and Disinfection. Competencies to be completed initially and annually.

E. Alternate Duty - If requested, it is recommended that workers be given the option of alternate duty under the following circumstances:
    1. Staff who are pregnant,
    2. Staff who are breastfeeding,
    3. Staff actively trying to conceive a child.

Environmental Surveillance

A. Environmental surveillance of the compounding environment may be considered to evaluate and verify containment and effectiveness of controls.

B. If contamination is found, based on the level of contamination, the decision may be made to perform additional cleaning and evaluate potential change to engineering, work practice or administrative controls. This would be followed by surface re-sampling to determine effectiveness of actions.

Employees with Direct Eye or Skin Exposure to Hazardous Drugs

A. Employees will be instructed to call for help.

B. Contaminated clothing must be removed immediately.

C. Supervisor will be contacted immediately.

D. A safety data sheet for the HD will be obtained for instructions on exposure.

E. If the eye(s) are affected, they must be flushed with water or normal saline for at least 15 minutes.

F. If skin is affected, it must be washed with soap and water and rinsed thoroughly.

G. Employee will obtain medical attention.

H. The supervisor is responsible for completing the RM75 – Injury First Report (available on desktops). This

step is to be completed within 24 hours of injury.

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Attachments

Attachment A: HD Risk Acknowledgment

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport

Definition and Purpose

This policy addresses the general aspects of hazardous drug (HD) handling. HD handling includes receiving, storage, labeling, packaging and transport activities that are not directly associated with compounding activities. For the purposes of this policy, HDs are those substances which appear in the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016 as well as any subsequent updates to the NIOSH HD list as they become official. VCMC Pharmacy may choose to exempt some dosage forms if an Assessment of Risk (AOR) is performed and documented.

Policy Statements

A. HDs will be received, stored, labeled, packaged and transported using methods that protect employees, the surrounding environment, and others who may encounter them in the healthcare environment.

B. Antineoplastic HDs will be stored separately from non-hazardous drug inventory.

C. HDs not in their final dosage form will be stored in a room that is negative pressure between 0.01 and 0.03 inches of water column relative to all adjacent areas, and the room is vented to the outside with at least 12 air changes per hour (ACPH).

D. Any personnel who may be expected to handle HDs will wear appropriate personal protective equipment (PPE) as defined in policy. Activities include: receiving, distribution, stocking, inventory control, order picking, compounding, packaging for distribution or disposal, and cleaning.

Procedures

General Handling of Hazardous Drugs

A. Refer to policy PH.27.04 Hazardous Drug Garbing and Compounding for detailed instructions of the use of PPE in compounding situations and policy PH.27.05 Decontamination, Spill and Waste Management for use of PPE in HD Spill Cleanup.

B. When handling antineoplastic HDs during receiving, personnel will don a chemotherapy impervious gown and at least 1 pair of gloves that have been tested to ASTM 6978.

C. Hands must be washed before and after the use of gloves.

Receiving Hazardous Drugs

General receiving procedures:

A. Suppliers and distributors should be sending antineoplastic HDs in a container separate from other drugs and in a plastic covering that is impervious to liquids.

B. HDs will be unpacked from shipping containers in an area that is neutral/normal or negative pressure to the adjacent areas.

C. A spill kit must be accessible in the receiving area.

D. A specific area or counter is designated for antineoplastic HD receiving.

E. Those receiving deliveries with HDs in them, must first visually inspect the delivery to verify that there are no signs of damage such as visible stains from leaking containers or sounds of broken glass.

F. Upon receipt, antineoplastic HDs shall remain in the sealed transport bag for transport to the negative pressure room.

G. As these drugs are checked into inventory they will be moved directly to the HD storage area.

H. Carefully remove gloves turning them inside out and not touching the contaminated portion and discard in yellow trace waste, then remove the chemo gown by slowly turning inside out and place in the yellow trace waste.

I. Wash hands.

Summary of Requirements for Receiving and Handling Damaged Hazardous Drug Shipping Containers

A. **If the shipping container appears damaged**

1. Notify supervisor.
2. Seal container without opening and contact the supplier
3. If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous"
4. If the supplier declines return, double bag the damaged goods. Dispose of in a black RCRA U-Listed waste container.
5. Perform any required clean up per EVS.39 Management of Chemotherapy Spills.

A. **If a damaged shipping container must be opened**

1. Notify supervisor to determine if there is product in the tote that must be salvaged.
2. Seal the container in an impervious container.
3. Transport it to a C-PEC and place on a plastic-backed preparation mat.
4. Open the package and remove undamaged items.
5. Wipe the outside of the undamaged items with a disposable wipe.
6. Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous".
7. If the supplier declines return, dispose of as hazardous waste.
8. Deactivate, decontaminate, clean and disinfect the C-PEC (see Deactivating, Decontaminating, Cleaning, and Disinfecting) before returning to any sterile compounding activity.
9. Damaged packages or shipping cartons must be considered spills that must be reported by Notification Form, and managed per policy PH.27.05 Decontamination, Spill and Waste Management.

10. Segregate HDs waiting to be returned to the supplier in a designated negative pressure area.

Storage of Hazardous Drugs

A. Access to areas where HDs may be encountered will be limited to authorized staff only.

B. Specific labels have been adopted by VCMC Pharmacy and are used to designate HDs which will be affixed to shelves, drawers or bins where HD are stored.

C. Bins, drawers or containers used to routinely store HDs will be configured to reduce the risk of breakage and facilitate spill containment.

D. Antineoplastic HDs that require further manipulation (other than counting or repackaging final dosage forms are stored separately from non-HDs. These HDs will be stored in the negative pressure buffer area designated for HD compounding.

E. Non-antineoplastic, reproductive risk only and final dosage forms of antineoplastic drugs may be stored with regular inventory.

F. HDs that require refrigeration will be stored separately from non-HDs in a refrigerator in the negative pressure area dedicated for HD storage.

Packaging Hazardous Drugs

A. VCMC Pharmacy uses strategies to reduce the risk of exposure to HDs during administration which include:

1. HD labeling,
2. Appropriate use of PPE,
3. Proper disposal of waste.

B. VCMC Pharmacy selects and uses packaging containers and materials that have been shown to maintain the physical integrity, and stability.

C. Packaging materials selected also protect the HD from damage during transport.

D. HDs that do not require manipulation other than counting or repackaging final dosage forms may be prepared outside of a C-PEC and C-SEC or C-SCA unless otherwise indicated by the manufacturer or there are visible signs of exposure hazards (e.g., dust) present.

E. HDs that do not require manipulation other than counting or repackaging final dosage forms may be prepared outside of a C-PEC and C-SEC unless there are visible signs of exposure hazards (e.g., dust) present.

F. If HD dosage forms require manipulation such as crushing tablet(s) or opening capsule(s) for a single dose, personnel must don appropriate PPE and use a plastic pouch to contain any dust or particles generated.

G. Labels that have been adopted by the organization to be used to designate HDs will be affixed to the HD compounded sterile product (CSP) container itself. "Caution: Hazardous Drug".

Transport of Hazardous Drugs

A. Compounded HDs in final containers for patient administration will be placed inside a sealed transport bag that is labeled prominently "Caution Chemotherapy". Transport bags will also have labeling to indicate use of safety precautions and safe disposal.

B. HDs are transported in containers that reduce the risk of damage or breakage.

C. Pneumatic tube systems are not used to transport liquid HDs or antineoplastic HDs.

D. Personnel involved in the transport of HDs will be trained in transport and spill procedures.

E. HD spill kits will be affixed to the HD delivery tote used to transport HD CSPs.

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Attachments

No Attachments

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PH.27.03 Hazardous Drug Garbing, and Compounding

Definition and Purpose

This policy communicates and establishes work practice requirements that specifically apply to activities associated with garbing and compounding hazardous drugs (HDs). It builds upon policy already established related to USP <797>.

Policy Statements

A. Containment Primary Engineering Controls (C-PECs) and Containment Secondary Engineering Controls (C-SECs) will be used to protect and safeguard the sterility of compounded sterile products (CSPs) and the safety of workers handling HDs.

B. Specifically designed Personal Protective Equipment (PPE) must be used during the handling of HDs.

C. Specific compounding techniques are used when compounding HDs to minimize the risk of contamination of the compounding area and CSP final packaging with HDs.

D. Only trained, authorized compounding personnel may perform deactivation, decontamination, cleaning, and disinfection of the inside surfaces of C-PECs.

Procedures - Personal Protective Equipment

A. Use of PPE for preparation of HDs shall include chemo impervious gowns, gloves that shall be sterile and ASTM D6978-05 rated, and double shoe covers in addition to sterile compounding garb. PH.26.04 Sterile Compounding Attire policy must be followed along with the following prior to entering the negative pressure hazardous compounding room in the clean room suite.

1. A chemo impervious gown shall be worn on top of the regular gown. Gowns worn during compounding of HDs must be the type that close in the back, have no seams or sealed seems to prevent accidental contamination of clothes.
    a. Gowns must be changed every 3 hours during continuous compounding and immediately if they become damaged or contaminated.
2. Double shoe covers shall be donned as personnel enters the negative pressure hazardous compounding room from the ante room. Outer shoe covers should be made of water resistant materials.
3. Gloved hands shall be cleansed using waterless alcohol based cleanser.
4. A second pair of sterile, ASTM D6978-05 rated gloves shall be donned over the cuff of the chemo gown.

5. The process to exit the negative pressure hazardous compounding room in the clean room suite is as follows in order:
    a. Remove the outer pair of sterile chemo gloves and discard in the hazardous waste container.
    b. Remove the chemo impervious gown and discard in the hazardous waste container.
    c. Remove the outer shoe covers while exiting and stepping over the line of demarcation between the negative pressure hazardous compounding room and the ante room. Discard in the hazardous waste container.
    d. Hands must be washed with soap and water after removing gloves.
6. Additional PPE
    a. If there is a possibility of exposure from splashing, then goggles must be worn (eye glasses and safety glasses are not compliant with OSHA requirements)
    b. Certain drugs have been shown to volatilize (forming a vapor) in room air during normal handling: cisplatin, cyclophosphamide, etoposide and fluorouracil (Kiffmeyer, T). Other drugs may also volatilize however they have not been studied.
    c. Respiratory protection is recommended for staff who perform the following activities where there is potential to be exposed to HD vapors:
        a. Workers trained to perform spill management.
        b. Workers who are responsible for the deactivation, decontamination, cleaning and disinfection of the area under the deck (work surface) of the C-PEC since this requires opening the C-PEC.
7. Staff performing functions that require respiratory protection must be fit-tested and trained in the use of either:
    a. A NIOSH approved, full-face, dual-chamber respirator (with cartridges that filter both particles and vapors);
    b. A NIOSH approved, half-face, dual chamber respirator (with cartridges that filter both particles and vapors) AND goggles;
    c. A NIOSH approved Powered Air-Purified Respirator (PAPR)
    d. Refer to the policy on Hazardous Drug Decontamination, Spill and Waste Management (PH.27.05 Decontamination, Spill and Waste Management).
8. Material Handling Considerations in C-PECs during HD compounding
    a. Sanitize items needed with sterile 70% IPA before transferring them into the C-PEC.
    b. Place only *required* items for compounding inside the C-PEC and arrange them in such a manner as not to impede the flow of first air. Sterile plastic backed absorbent pads may be used.
    c. Small Sharps Disposal Units will be kept within the C-PEC for use in HD compounding. They will be positioned in such a way and be of a size as to minimize the disruption of first air and reduce potential turbulence.
    d. Non-sterile HDs that require manipulation will be prepared in the C-PEC. All cleanroom procedures will be followed to maintain the cleanroom environment. The C-PEC must be terminally cleaned prior to being used for compounding sterile preparations.
    e. All items used inside of the C-PEC must be considered contaminated and therefore must be

placed inside of an appropriate container or bag which is sealed and wiped down before it is removed from the C-PEC for disposal with other hazardous waste.

f. A plastic-backed preparation mat should be placed on the work surface of the C-PEC. The mat should be changed immediately if a spill occurs and regularly during use, and should be discarded at the end of the daily compounding activity.

g. Surface decontamination of the work area will be accomplished periodically throughout the day and between batches of different HDs.

h. After decontaminating the deck between batches of different HDs, once dry, the deck must be disinfected with sterile 70% IPA.

9. Use of Closed System Drug-Transfer Devices (CSTDs)

   a. Use of a CSTD in compounding is strongly encouraged by USP Chapter <800>.

   b. When CSTDs are used for compounding, they will be used within the ISO Class 5 environment.

   c. CSTDs must be placed on CSPs for HD administration to reduce risk of HD spill at point of care.

   d. IV sets will be attached inside the C-PEC in a manner that protects the tubing set from HD contamination.

   e. Prime the tubing with the solution before adding the HD to the bag.

   f. CSTDs must be placed on CSPs for HD administration to reduce risk of HD spill at point of care.

10. Quality reviews required at each step of preparation:

    a. The individual compounding the HD prepares the CSP solution and syringe for pharmacist check before injecting the drug into the solution.

    b. Pharmacist checks right solution, right drug, right dose, right tubing with CSTD attached, and confirms tubing is primed with solution.

    c. HD is injected into the IV bag. The individual checking the dose inspects final product for clarity, and particulate matter.

    d. All intrathecal chemotherapy are prepared with preservative-free drug and diluents and an independent double check is performed.

    e. It is recommended that the labeling and final packaging occur immediately outside of the C-PEC. Compounders must only be working on one patient CSP or one batch at a time so the components, labels and containers for other batches must not be present on the work surface.

    f. Pharmacist attaches medication label along with any auxiliary labels.

    g. CSP is placed in transport bag and sealed.

    h. Documentation is completed on dispensing label and compounding worksheet.

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Attachments

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PH.27.04 Decontamination, Spill, and Waste Management

Definition and Purpose

Hazardous Drugs (HDs) may pose serious health risks to employees that handle them. The purpose of this policy is to define the activities necessary to properly decontaminate areas used for hazardous drug (HD) compounding as well as provide instructions on proper spill management and disposal of HDs.

Policy Statements

HD residues are decontaminated prior to cleaning and disinfection on a regular basis as described in this document. For the purposes of this policy, decontamination means the transfer of chemically active or inactive hazardous drug residues from the target surface to a wipe which is subsequently disposed in the appropriate HD trace waste container for disposal.

To obtain an Safety Data Sheet (SDS) for HDs utilize the MSDS Management (vendor name) icon on any desktop computer and enter the name and manufacturer of the drug.

Persons who handle HDs must be knowledgeable of the spill management procedures and have access to the required supplies and equipment to carry out these actions. Spill management is part of an institution-wide safety program and is developed in conjunction with other departments and disciplines.

Procedures

A. Deactivation, Decontamination, Cleaning and Disinfection

1. Deactivation renders HD surface contamination inert or inactive. However, there is no single agent that can chemically deactivate all types of HD residue. The SDS for each HD may specify chemical agents that can be used to deactivate them, such as sodium hypochlorite solution or peracetic acid/ hydrogen peroxide solution.
2. Decontamination focuses on physically removing surface contamination/HD residue with a surfactant agent and transferring it to sterile, lint-free, absorbent, disposable materials.
3. Cleaning focuses on removing contaminants from surfaces using water, detergents, surfactants, and solvents or other chemicals.
4. Disinfection, which is intended to inhibit or destroy microorganisms, must occur in areas that are required to be sterile.
5. Decontamination, cleaning and disinfection of the Containment Primary Engineering Control (C-PEC)

must occur at least daily (when used), any time a spill occurs, after certification, anytime non-sterile HDs are prepared in the C-PEC and if operational interruption of the C-PEC occurs.

6. Deactivation, decontamination, cleaning and disinfection of the surfaces under the work tray of the C-PEC will be performed at least monthly.
7. Decontamination of the floor and high touch areas outside of the C-PEC but inside the Containment Secondary Engineering Control (C-SEC) will occur daily with a detergent cleaning agent.
    a. Decontamination will only occur when compounding is not taking place.
8. All wipes used for cleaning must be placed in a sealed bag prior to being discarded in either:
    a. Yellow trace waste container (all other wipes).
    b. Black Resource Conservation and Recovery Act (RCRA) container (wipes used for spill cleanup only)

B. HD Spill Management

1. Spill kits must be kept in areas where HD are handled such as inventory receiving area; inventory storage area; controlled compounding environment and patient care areas.
    a. After a Spill Kit is used it will be immediately restocked.
2. The management of the spill (e.g., decontamination, deactivation, and cleaning) may be dependent on the size and type of spill. Please refer to EVS.39 Management of Chemotherapy Spills.
3. All personnel who may be required to clean up a spill of HDs must receive proper training in spill management and the use of personal protective equipment PPE and NIOSH-certified respirators.
4. Spills must be contained and cleaned immediately only by qualified personnel with appropriate PPE. Qualified personnel must be available whenever HDs are being handled.
5. Personnel who are potentially exposed during the spill or spill clean-up or who have direct skin or eye contact with HDs require immediate evaluation.
6. The trained individual who cleans the spill is responsible for completing documentation and notification forms.
7. Surgical masks and N95 and N100 respirators do not provide any protection from vapors. Use of appropriate full-facepiece, chemical cartridge-type or Powered Air Purifying Respirators (PAPR) may be required if there is known or suspected airborne exposure to vapors or gases.
8. Spills occurring inside of a C-PEC.
    a. When notified of a spill, take respiratory/eye protection (PAPR or full-face respirator) as well as spill kits from their designated locations and bring to the location of the spill.
    b. If the HD is a liquid, place an absorbent towel gently on top of the liquid to prevent splashing of HD liquid.
    c. If HD is a solid or powder, cover and wipe with a low-linting wipe that has been moistened with sterile water.
    d. Place saturated/contaminated wipes into hazardous waste bag contained in spill kit.
    e. Clean up any broken glass fragments and place into the HD sharps container.
    f. Place any contaminated non-sharps supplies into the hazardous waste bag contained in the spill kit which will be deposited into a RCRA container

g. Once the visually evident spill has been contained, wipe the area thoroughly with a low-linting wipe moistened with sterile water from the areas of lesser concentration to the areas of highest concentration of HD.

h. Then follow by decontaminating the area with the designated agent.

i. Any wipes used for the spill decontamination along with the spill itself must be disposed in a black RCRA U-Listed container. All other supplies and PPE may be disposed in the trace yellow receptacles.

j. Terminally clean the C-PEC with the designated germicidal detergent/sporicidal solution. Followed by disinfection with sterile alcohol 70%.

k. Place wipes used in the cleaning process into an sealed bag, then dispose of in yellow trace waste.

C. Disposal of HD Waste

1. All items used in the preparation of HDs are considered contaminated and are discarded in the appropriate hazardous waste container.
2. Hazardous waste containers are labeled with a hazardous waste sticker. Yellow bags and yellow sharps containers are utilized for trace waste whereas black RCRA containers are utilized for HD Bulk waste and spill disposal.
3. Needles and other sharps are discarded in yellow sharps containers only.
4. Empty vials and other non-sharps items used in HD preparation are discarded in yellow sharps container.
5. All PPE used in handling of HDs will be disposed of as trace HD waste.
6. At least one hazardous waste receptacle will be located in each area where HDs.
7. When containers are full, they will be sealed and removed from pharmacy for disposal.
8. Appropriate disposal of HD waste is handled by a contracted HD waste disposal company.

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Attachments

No Attachments

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VENTURA COUNTY
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References:	

PH.109 Vancomycin Per Pharmacy

POLICY:

Pharmacists of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) may adjust the dosing, order labs and monitor vancomycin given a prescriber's order for "Vancomycin per Pharmacy Protocol". Vancomycin dosing will be individualized to each patient. An approved standardized vancomycin protocol shall be used by Pharmacists to ensure consistent monitoring and optimal use of this medication to minimize toxicity and enhance patient care under the support and surveillance of the Antimicrobial Stewardship Program. This policy promotes the safe and effective use of vancomycin.

Roles and Responsibilities:

a. Prescribers shall prescribe vancomycin using the approved electronic order set and include an initial dose or loading dose, the indication for use, goals for trough ranges and duration of therapy. The prescriber shall make themselves available for consultation and communication of dose adjustments.

b. Pharmacists shall assume subsequent dosing, lab ordering, monitoring, and adjustments to the vancomycin regimen as outlined in the policy and protocol. Pharmacists shall effectively communicate dose adjustments to the prescriber, trough level timing and co-ordination with Nursing and Lab staff. Pharmacists shall document calculations performed on an internal Pharmacy Monitoring Form and provide dose adjustment details in a PowerNote for Prescriber review. The Pharmacist shall upon request, at time prior to discharge, re-dose the vancomycin to include convenient dosing intervals such as, q12hr or Q24hr, for patient safety after discharge and release to home or skilled nursing facility.

c. Nurses shall document vancomycin administration accurately on the medication administration record (MAR) in the patient's electronic health record (EHR) and monitor the patient during vancomycin administration for infusion related reactions. The Nurse shall hold vancomycin doses for pending trough results as instructed by the Pharmacist.

PROCEDURE:

A. The Vancomycin per Pharmacy protocol shall be initiated per prescriber's order, and under the overall surveillance of the Antimicrobial Stewardship Program.

B. Clinical judgment by the prescriber must be employed to ensure judicious use of all antibiotics including the initial dose or loading dose, documentation of the indication for the use, goal troughs and duration of vancomycin therapy.

C. The institution shall dispense vancomycin products that are prepared in standardized concentrations as pre-mixed or plug-in use in order to expedite initial doses in the Operating Rooms and Emergency Departments to reduce compounding errors or contamination.

D. The Pharmacist shall follow the Vancomycin per Pharmacy protocol upon receipt of a clear and complete Prescriber's order. The Pharmacist shall then order all maintenance doses, necessary labs (including troughs) and monitor with needed adjustments based on the clinical information in the EHR.

E. Nursing shall employ the use of the Smart Pumps using guardrail technology to ensure safe rates of administration of vancomycin do not exceed 1 gm/hour.

F. Education shall be provided to prescribers, pharmacists, nursing and lab staff on the proper ordering, monitoring, documenting, dispensing and administering of vancomycin. This education shall include clearly defined roles and responsibilities for each discipline involved in the medication use process.

G. The Antimicrobial Stewardship Program shall monitor and measure the effectiveness of the protocol. Any identified opportunities for improvement or quality outcome measure shall be reported to the Pharmacy & Therapeutic Committees.

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Attachments

Vancomycin per Pharmacy Protocol

Approval Signatures

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References:	

R.49 Respiratory Care Capnography Use

POLICY:

To provide guidelines for the use and implementation of capnography by Respiratory Care staff in ventilated and non-ventilated patients.

PROCEDURE:

The use of End Tidal Carbon Dioxide monitoring provides a noninvasive means to measure the amounts of Carbon Dioxide (CO2) present at the end of exhalation. Monitors will be considered for use on all intubated patients, patients who are undergoing moderate sedation procedures, and post-procedural sedation patients.

DEFINITIONS

End Tidal Carbon Dioxide–ETCO2
Continuous Positive Airway Pressure-CPAP
Biphasic Positive Airway Pressure-BIPAP
Electronic Health Record-EHR
Trans esophageal Echocardiogram-TEE
Esophagogastroduodenoscopy-EGD
Endoscopic Retrograde Cholangiopancreatography-ERCP

GUIDELINES

1. ~~**Indications**~~
   - ~~A. Patient with artificial airway~~
     - ~~1. Orally or nasally intubated patients~~
   - ~~B. Recent Extubation~~
     - ~~1. Oral or nasal extubations~~
     - ~~2. Trach patients removed from mechanical ventilation~~
   - ~~C. Patient on CPAP, in combination with the following criteria~~
     - ~~1. Diagnosed sleep disorder~~
     - ~~2. Morbid obesity~~
     - ~~3. Receiving sedating drugs~~

D. ~~Diagnosis of Acute Respiratory Distress~~

E. ~~Patient with assisted ventilations, i.e. Bipap~~

F. ~~Previous history of respiratory failure during admission, and respiratory status has deteriorate again~~

G. ~~Morbid Obesity with diagnosis of sleep apnea~~

H. ~~Post sedation procedure~~

1. ~~Postop patient with thoracic epidural~~

I. ~~Procedural Sedation (GI Lab, Floors)~~

J. ~~Post-Code Blue~~

Indications

A. Airway & Emergency Management

1. Detects airway obstruction, ventilation problems, endotracheal tube placement & verification.
2. Provides continuous feedback on airway, breathing and ventilatory status for the non-intubated and intubated patients.

B. Critical Care Unit

1. Detects apnea immediately, regardless of supplemental oxygen administration, and provides an earlier warning than pulse oximetry.
2. Helps clinicians make decisions on weaning patients from mechanical ventilation and titrating pressure support.
3. Provides a continuum of care of ventilation monitoring from intubated patients during mechanical ventilation to monitoring the weaning of the patient from the ventilator.

C. Medical/Surgical Units

1. Monitoring patients who are receiving PCA or epidural opioid medications; detecting respiratory depression.
2. Aids in decision making for clinical staff.

D. Procedural Sedation

1. Effectively monitors the patient's airway providing the earliest indication of airway compromise

E. For the intubated patient EtCO2 can be used:

1. To verify ETT placement
2. To provide feedback regarding ventilations –too fast or too slow
3. As an indicator for ROSC (return of spontaneous circulation)
4. Rescuer fatigue during compressions
5. Prediction of survivability

F. For the non-intubated patient EtCO2 can be used:

1. Indicator of bronchospasm in patients with asthma, COPD exacerbation or anaphylaxis
2. Indicate hypoventilation caused by CHF, drug intoxication, respiratory muscle fatigue or circulatory compromise

2. ~~**Implementing**~~

A. ~~Intubated Patients~~

1. ~~Connect Filterline to monitor~~
2. ~~Attach ETCO2 sampling adaptor to ventilator circuit between ETT and patient wye~~

B. ~~Non-Intubated Patients~~

1. ~~Appropriate size sampling line~~
   a. ~~Pediatric CapnoLine~~
   b. ~~Adult CapnoLine~~
   c. ~~Choose cannula appropriate for Room Air use or Oxygen delivery~~
2. ~~Room Air Patients~~
   a. ~~Apply nasal cannula sample line to patient's face~~
   b. ~~Turn Monitor On~~
3. ~~Nasal Cannula O2 Delivery~~
   a. ~~Attached nasal cannula (with CO2 sample tube) to oxygen and ensure proper flow~~
   b. ~~Apply nasal cannula to patient's face~~
   c. ~~Connect Filterline to monitor~~
   d. ~~Connect O2 line to flowmeter~~
   e. ~~Turn monitor On~~

C. ~~Patients receiving special procedures~~

1. ~~Moderate to Deep Procedural Sedation~~
2. ~~Bite Block with CapnoLine for the following:~~
   a. ~~Bronchoscopy~~
   b. ~~TEE~~
   c. ~~EGD~~
   d. ~~ERCP~~
   e. ~~Colonoscopy~~

Procedure

1. Wash hands and observe Standard Precautions
2. Enter room, introduce self, check patient ID using two (2) identifiers and explain procedure to patient, when appropriate.
3. Gather necessary supplies
   a. Intubated Patients
      1. Connect Filterline to monitor
      2. Attach ETCO2 sampling adaptor to ventilator circuit between ETT and patient wye
   b. Non-Intubated Patients
      1. Appropriate size sampling line
         a. Pediatric CapnoLine

b. Adult CapnoLine

c. Choose cannula appropriate for Room Air use or Oxygen delivery

2. Room Air Patients

a. Apply nasal cannula sample line to patient's face

b. Turn Monitor On

3. Nasal Cannula O2 Delivery

a. Attached nasal cannula (with CO2 sample tube) to oxygen and ensure proper flow

b. Apply nasal cannula to patient's face

c. Connect Filterline to monitor

d. Connect O2 line to flowmeter

e. Turn monitor On

4. Patients receiving special procedures

1. Moderate to Deep Procedural Sedation

2. Bite Block with CapnoLine for the following:

a. Bronchoscopy

b. TEE

c. EGD

d. ERCP

e. Colonoscopy

3. **General Instructions**

A. Connect ETCO2 device to module

B. ~~ETCO2 >20 should be seen at all times~~Verify function through waveform and numerical read out

a. ETCO2 >20 should be seen at all times

C. Failure to produce ETCO2 of >20 or failure to detect, assess the following

1. Equipment Failure-disconnected or malfunction of device or ventilator

2. Loss of airway-apnea, tube migration, obstruction

3. Circulatory collapse-cardiac arrest, massive ~~PE~~Pulmonary Embolism, exsanguinations

D. Documentation

1. Procedural Sedation

a. ETCO2 will be monitored continually and recorded ~~q~~every 5 minutes;

b. or until sedation level returns to 1

2. ~~Routine ETCO2~~

~~a. Will be checked every two (2) hours and charted in the electronic health record~~

~~b. Waveform will be monitored for changes~~

Routine ETCO2

a. Capnography values will be obtained as part of the patient-ventilator system checks for patients on noninvasive or mechanical ventilation

3. Report any concerns to physician, notify the RN, and document

E. Discontinuation

1. If patient acuity decreases, discuss with physician
2. Upon extubation

F. Normal and abnormal ventilation (ETCO2) values are:

a. Normal values are 35-45 mmHg (milimeter mercury)

b. Abnormal values

i. . Less than 35 mmHg (hyperventilation/hypocapnia)

ii. Greater than 45 mmHg (hypoventilation/hypercapnia)

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Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	10/1/2024

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RS.23 Assessments – Pediatric/Adolescent

PURPOSE:

To provide a framework of evaluation on pediatric/adolescent patient for Physical and Occupational Therapy.

POLICY

Upon receipt of an order for an Occupational or Physical Therapy evaluation, the therapist will attend to the order based upon patient need as described in the Referral Response Time frames policy and according to the guidelines below.

PROVISION OF CARE

1. If a child has been referred for a diagnosis of Developmental Delay or Feeding Delay, the Developmental Occupational Therapist (OT) or Physical Therapist (PT) will evaluate the child at Ventura County Medical Center (VCMC).
2. Children/adolescents who are being referred for gait, mobility, transfer, endurance, strength training, and/or equipment analysis will be assessed by a physical therapist who is either California Children's Services (CCS) paneled or supervised by a CCS paneled physical therapist.
3. Children/adolescents who are being referred for Activities of Daily Living (ADL) needs including feeding, toileting, dressing and functional activities of living involving the upper extremities will be evaluated by an occupational therapist who is either CCS paneled or supervised by a CCS paneled occupational therapist.

PROCEDURE FOR THERAPY REQUISITION

1. In-Patients
    a. Obtain an order – in-patient services are initiated by physician order in the Electronic Medical Record (EMR).
    b. Order is verified and entered into the EMR.
2. Orders are received in the Rehab Department.
3. Out-Patient care is initiated with either a written prescription or prescription in the EMR for out-patient services.

DOCUMENTATION:

In addition to the items on the general physical/ occupational therapy evaluation, the following may be addressed as needed for age specifics:

A. Pediatric Tools used for evaluations include but are not limited to:
    1. Gesell Developmental Schedules;
    2. Beery-Buktenica Developmental Test of Visual Motor Integration.
    3. Infant/Toddler Sensory Profile.
    4. Peabody Developmental Motor Scales.
    5. HELP- Hawaii Early Learning Profile
    6. Brunicks-Oseretsky Test of Motor Proficiency.
    7. VMI- Visual Motor Inventory
    8. TVPS- Test of Visual Perceptual Skills.

B. General description of child and families participation in the assessment.

C. Living situation, including information about the house, multiple families living in the home, other disabled individuals living in the home, etc

D. Include whether child is in school/ day care or other special programs

E. Include whether child has been receiving other therapy services or whether child will be referred to other out-patient therapy services or programs.

F. If child has had multiple hospitalizations, include past level of function and whether there has been change in function.

G. List any adaptive equipment child may have and whether any changes will be recommended for equipment.

H. List any behavioral issues/problems and whether family is receiving any services in this regard, or whether child is on any behavioral medications.

I. List whether child has any sensory issues such as visual, tactile, auditory sensitivities which affect the child's ability to participate with therapy

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Attachments

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RS.24 Evaluations: Occupational Therapy (OT) in Pediatric Intensive Care Unit (PICU)

PURPOSE

a. To provide a framework of evaluation for pediatric occupational therapy in the Pediatric Intensive Care Unit (PICU).

POLICY

a. Upon receipt of an order for Occupational therapy (OT) evaluation a California Children's Services (CCS) Paneled Occupational Therapist, or Occupational Therapist under the supervision of a CCS Paneled Occupational Therapist, will respond to the order:

   i. ~~Monday-Friday, within 24 hours.~~

   ii. ~~Weekends and holidays within 48 hours.~~

   i. 24-72 hours as outlined in Policy RS. 03

Pediatric Evaluation Tools may or may not be standardized depending on the child's need, medical status, functional abilities, age, and developmental status. These tools may include, but are not limited to:

a. Parent/caregiver/child interview
b. Review of medical records
c. Clinical Observations
d. Self Care
e. Feeding
f. Oral Motor
g. Play Skills
h. Functional Mobility
i. Motor Skills and Development
j. Range of Motion (passive, active)
k. Strength

l. Tone
m. Sensation
n. Sensory Processing
o. Gesell Developmental Schedules
p. Hawaii Early Learning Profile
q. Peabody Developmental Motor Scales
r. Beery Developmental Test of Visual Motor Integration
s. Test of Visual Perceptual Skills
t. Motorfree Visual Perceptual Test
u. Developmental Eye Movement Test
v. Handwriting Without Tears Screener

Documentation

a. An evaluation will include the following and shall be documented in the Electronic Medical Record
    i. General description of the child's medical and developmental history
    ii. Reason for current admission and request for evaluation
    iii. Precautions
    iv. Social and living situation
    v. Pain Scale
    vi. Whether the child is currently receiving other services (i.e. Medical Therapy Unit OT/ Physical Therapy (PT), School Based OT/Speech Therapy, Early Intervention…).
    vii. Current adaptive equipment, orthotics, and/or splints
    viii. Age/developmental appropriate
        1. Self care skills
        2. Motor skills
        3. Play skills
        4. Sensory processing
    ix. Neuromuscular Status
        1. Strength
        2. Tone,
        3. Range of Motion
        4. Reflexes
    x. Behavior
    xi. Assessment
    xii. Child/family strengths and weaknesses
    xiii. Intervention Plan

1. Frequency of treatment
2. Modalities
3. Short and long term goals
4. Equipment, orthotic, splinting recommendations
5. Discharge recommendations (placement, services)

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Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	12/5/2024
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	10/16/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.25 Evaluations: Physical Therapy (PT) in the Pediatric Intensive Care Unit (PICU)

PURPOSE

a. To provide a framework of evaluation for pediatric physical therapy in the Pediatric Intensive Care Unit (PICU).

POLICY

a. Upon receipt of an order for physical therapy (PT) evaluation, a California Children's Services (CCS) Paneled Physical Therapist, or Physical Therapist under the supervision of a CCS Paneled Physical Therapist, will respond to the order:

   i. ~~Monday-Friday, within 24 hours.~~

   ii. ~~Weekends and holidays within 48 hours.~~

   i. 24-72 hours as outlined in policy RS. 03

Pediatric Evaluation Tools may or may not be standardized depending on the child's need, medical status, functional abilities, age, and developmental status. These tools may include, but are not limited to:

a. Parent/caregiver/child interview
b. Review of medical records
c. Clinical Observations
d. Gait
e. Balance
f. Functional Mobility
g. Motor Skills and Development
h. Range of Motion (passive, active)
i. Strength
j. Tone
k. Sensation

l. Gesell Developmental Schedules
m. Hawaii Early Learning Profile
n. Peabody Developmental Motor Scales, 2nd Edition

Documentation

a. An evaluation shall include the following and be documented in the Electronic Medical Record (EMR)
    i. General description of the child's medical and developmental history
    ii. Reason for current admission and request for evaluation
    iii. Precautions
    iv. Social and living situation
    v. Pain Scale
    vi. Whether the child is currently receiving other services (i.e. Medical Therapy Unit Physical Therapy (PT) or Occupational Therapy (OT), School Based OT/Speech Therapy, Early Intervention…).
    vii. Current adaptive equipment, orthotics, and/or splints
    viii. Age/developmental appropriate
        1. Balance
        2. Motor skills
        3. Functional Mobility skills
        4. Gait
    ix. Neuromuscular Status
        1. Strength
        2. Tone
        3. Range of Motion
        4. Reflexes
        5. Sensation/Proprioception/Coordination
    x. Behavior & Cognition
    xi. Assessment
    xii. Child/family strengths and weaknesses
    xiii. Intervention Plan
        1. Frequency of treatment
        2. Gait Training
        3. Functional Mobility
        4. Balance Training
        5. Therapeutic Exercise
        6. Home Exercise Program
        7. Patient/Family Education

8. Modalities
9. Short and long term goals
10. Equipment, orthotic, splinting recommendations
11. Discharge recommendations (placement, services)

All revision dates: 10/16/2024, 12/8/2020, 1/19/2012

Attachments

No Attachments

Approval Signatures

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Owner:	*Gina Ferrer: Manager, Trauma Services*
Policy Area:	*Trauma Services*
References:	

T.20 Guidelines for Care of the Injured Older Adult

PURPOSE:

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

POLICY:

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

PROCEDURE(S):

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

A. Prevention, Identification and Management of Dementia, Depression and Delirium- refer to CPG.53 Analgosedation in the Intensive Care Unit
    1. Assess every shift for and as needed for delirium (CAM-ICU) and depression (eg ITSS, CSSRS, etc).
    2. Customize plan of care based on score from validated assessments.
    3. Depression screen positive- consult social work and/or psychiatry.
    4. Delirium screen positive
        a. Non-pharmacologic options: early mobilization, promote healthy sleep/wake cycle. For example, keeping the room lit and blinds open during the day; decreasing interruptions at night and ensuring lights off.
        b. Pharmacological interventions as ordered: Dexmedetomidine or antipsychotic agents may be considered.
        c. Engage with patient in ways to decrease anxiety and confusion (ie speak softly, re-orient the

patient, talk about family and friends, decorate room with reminders of home, etc).

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

1. All patients admitted to the hospital will have a code status order entered- the licensed practitioner (LP) is responsible for discussions with the patient and next of kin to ensure the patient/family wishes are reflected. The patient will also be asked about preferences and goals of care by the LP.
2. The nursing staff is responsible for completing an admission intake on all patients, including older adults. This intake includes identification of a proxy decision maker, and an assessment of whether the patient has an advanced directive.
3. Palliative care consult as needed. This team is available to function as an expert resource to nursing and ancillary personnel without a physician's order for education, advanced care planning and for help in assessing the need for a referral. For older adults with life limiting injuries secondary to trauma, a consult will be ordered by the LP. The palliative care team will assist with symptom management, patient/family support, determination of code status and advanced directive assistance if needed.
4. Social work assessment and continued consults as needed to provide additional support to patient/ family and to assist with post-discharge planning.

C. Medication Reconciliation and avoidance of inappropriate medications

1. Medication reconciliation must be performed by licensed practitioner (LP) of the admitting medical team within 48 hours of admission.
2. Patients meeting the inclusion criteria should be interviewed by pharmacy technician to obtain best possible medication history list (BPMH) (hyperlink policy 100.082 Medication Reconciliation).
3. Registered nurse or LP shall assist in obtaining and documenting the medication history when pharmacy technician is unable to complete the task before 48 hours of admission
4. Obtaining and documenting the patient's home medication history or list into the EHR (Electronic Health Record) is the collaborative responsibility of providers, nurses, pharmacy staff, and licensed health care personnel involved in the patient's medication management. If a history or list cannot be obtained, the healthcare professional will document this in the EHR.
5. The specific decision of whether a patient should continue or discontinue a specific medications and treatments at various stages of their hospitalization (i.e., upon admission, upon transfer, upon discharge) shall be completed by the LP.
6. Medications that can cause fall risk will be reviewed by LP (eg diuretics, sedatives, analgesics, hypnotics and antihypertensives). Medications that can contribute to other untoward side effects in the older adult should also be reviewed and removed as appropriate.

D. Screening for mobility limitations and assurance of early, frequent, and safe mobility- promote early mobilization for all patients, including those ≥ 65 years of age (see policy 100.260 Early Mobility for more details).

1. General Guidelines for Early Mobility: 5he established early mobility protocol is representative of general guidelines for treatment by the early mobility team based on a model indicated for mechanically ventilated and critically ill patients able to tolerate a progression of mobility from edge of bed (EOB) sitting through ambulation with or without assistive equipment. Modification to the protocol may be necessary to accommodate patient populations that include, but not limited to,

patients presenting with strokes, polytrauma, varying degrees of spinal cord injury, burns, orthopedic issues and neurological impairments.

2. Forming an Interdisciplinary Culture of Early Mobility- A viable early mobility team should comprise all of the components addressed in this protocol. Interactions will occur between LPs, nurses, respiratory therapists and rehabilitation services personnel to assure appropriateness of functional mobility training and subscribe to a clinically logical and stepwise process to minimize functional decline during hospitalization.
3. Reassessment for Progression/Modification of Services- Physical Therapists/Occupational Therapists will coordinate with the LP, nurse and respiratory therapist to discuss medical status, modification or initiation of an early mobility program and discharge planning.
4. Evaluation by Physical Therapist/Occupational Therapist will Determine Appropriate Level for Initiation of Activity. Based on the clinical expertise and reasoning of the rehab therapist treating the patient ordered for evaluation, the rehab therapist will provide guidance as to what phase of the early mobility protocol to implement upon skilled intervention. Progression of functional mobility, utilization of the early mobility team staff, use of assistive equipment and treatment goals will be individualized to the patient based on level of acuity, overall medical condition, co-morbidities stability, weight bearing status, cognition and prior level of function.
5. Consider any potential contraindications for mobility and consult LP prior to mobilizing (eg increased intracranial pressure, undersedation, unstable hemodynamics, end of life, active hemorrhage, etc).
6. Mobility assessment will place patient into one of four levels: Level 1 (unconscious), Level 2 (Conscious but non-ambulatory), Level 3 (Conscious with pre-gait activities), Level 4 (Conscious and Ambulatory). The assigned level determines the interventions needed for the patient. (refer to Policy 100.260).

E. Fall Risk Assessment

1. Fall risk is assessed on all patients, including older adults, using a screening tool (i.e., modified MEDFRAT for ED, Morse for adult inpatient, Humpty Dumpty for pediatrics). Interventions to prevent falls in the hospital will be customized based on the patient's fall risk.
    a. Prevention interventions include: keeping bed in low position, call light in reach, locking wheels, providing appropriate footwear and hourly rounding to include proactive toileting.
    b. Medications and symptoms that could contribute to greater fall risk are assessed by the LP, and treatment plan may be adjusted accordingly.
2. When appropriate, the older adult will be referred to the Fall Prevention Program. Goals are to decrease the frequency and severity of fall injuries in the elderly population of Ventura County utilizing prevention strategies. This will be coordinated by the Ventura County Medical Center Department of Trauma Services Injury Prevention Program in conjunction with Ventura County Emergency Medical Services (VCEMS), Ventura County Area Agency on Aging (VCAAA), Ventura County Public Health Department, local hospitals, private physicians, skilled nursing facilities, and ancillary medical professionals in our community by utilizing a screening and intervention process.

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

1. Social work consult or consult to case management as needed for discharge planning.
2. Discharge planning evaluations are completed for all patients. Evaluation for the older adult must include the following:

a. A patient's likely need for appropriate post-hospital services including, but not limited to, care at home, care in a skilled nursing or intermediate care facility, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

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

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

d. The hospital shall provide each patient who has been admitted as an inpatient with an opportunity to identify one family caregiver/support person who may assist in post-hospital care and shall record this information in the patient's electronic health record (EHR). In the event the patient is unconscious or otherwise incapacitated upon admission, the hospital shall provide the patient or patient's legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity. Hospital staff shall promptly document the attempt in the patient's EHR. In the event the patient or legal guardian declines to designate a caregiver/support person, the declination shall be recorded in the EHR.

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

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

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

   c. Every patient anticipated to be in need of long-term care at the time of discharge shall be provided with contact information for at least one public or non-profit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living center, or other information appropriate to the needs and characteristics of the patient.

G. Medical needs of the older adult

1. The trauma team acknowledges that the care of the injured older adult ≥ 65 years old requires additional considerations. Each patient's treatment plan should be individualized to consider potential

comorbidities. This may include cardiology, syncope or neurological workup. Additional renal and infectious co-morbidities will also be considered, as well as psychosocial needs.

REFERENCE(S):

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

All revision dates: 9/4/2024, 6/17/2024

Attachments

T Med Protocol.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	11/6/2024
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
Trauma Services	Thomas Duncan: Trauma Director	10/29/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	9/5/2024

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Owner	Sul Jung: Associate Director of Pharmacy Services
Policy Area	Administrative - Patient Care

100.034 Prescribing Drugs for Non-Indicated Uses

POLICY:

Medication use at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) has been reviewed and placed on the formulary by the VCMC Pharmacy and Therapeutics Committee. In making these selections, the Committee considers all available information, including the FDA-approved therapeutic indications. It is recognized that some medications, whether on the formulary or not, may be prescribed for use or for a condition which has not been officially approved by the manufacturer and/or the FDA.

PROCEDURE:

Requests for these so-called "off-label" usages are to be the result of clinical decisions made by the licensed practitioner (LP) (in consultation with a Pharmacist or P&T Committee as appropriate) based on experience, community standards, medical literature reviews, and other sources of scientific information, including, when indicated, consultation with other colleagues.

Off-label use places specific demands on the physician. The reasons for using the drug, the therapeutic alternatives, if any, the expected benefits and the known side-effects, the scientific rationale for the use of the drug, etc., should be carefully considered and documented by the prescribing LP. When this is accomplished, the Pharmacy Department may furnish the requested drug, confident in the knowledge that a conscious and specific decision by the LP was made.

All Revision Dates

12/14/2021, 5/1/2006, 9/1/2004, 8/1/2001, 11/1/1998, 3/1/1995, 10/1/1986, 5/1/1983

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Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/6/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/22/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/22/2024
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	11/22/2024

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100.238 Monitoring Medication Effects on Patients

POLICY:

Patients are monitored to assess the effectiveness of medication therapy and to minimize the occurrence of adverse events. Each patient's response to medication administered is monitored according to their clinical needs. Ongoing patient medication monitoring shall use a collaborative approach between Licensed Practitioner (LP), Health Care Professionals (HCPs), the patient and the patient's family or caregivers.

Monitoring will address the patient's response to the prescribed medication and for potentially medication-related problems or side effects. The results of patient medication monitoring will be utilized to improve the patient's medication regimen and/or other clinical care plans and treatment processes.

PROCEDURE:

1. In the inpatient setting, all newly prescribed medications ordered by LPs shall be verified by pharmacists.
2. The assigned HCP shall monitor and assess the effect of the prescribed medication on the patient.
3. Monitoring and assessing the effect of the medication includes, but is not limited to:
    a. Direct observation of the patient during assessments, evaluations or other patient contact to determine the patient's physiological response to the medication administered and any problems or adverse effects associated with the medication.
    b. Review of the patient's clinical diagnostic studies, clinical lab values/levels, the patient's medication profile and the patient's condition and progress documented in the medical record.

c. The patient's own perceptions about medication side effects, and, when appropriate, perceived efficacy and/or sensitivities the patient may have to the medication.

All Revision Dates

12/14/2021, 3/17/2020, 1/1/2014, 4/1/2012, 10/1/2008

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Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/6/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/22/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/22/2024
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	11/22/2024

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100.248 Santa Paula Hospital After Hours Intravenous Medication Preparation

Policy:

Nursing at Santa Paula Hospital (SPH) may prepare first doses of intravenous (IV) compounded products for emergent need when the SPH Pharmacy is closed.

Definitions

1. Aseptic technique is a set of methods used to keep objects and areas free of micro-organisms and thereby minimize infection risk to patients. It is accomplished through practices that maintain the microbe count to an irreducible minimum.

2. Beyond-use-date (BUD) is the date or date and time after which administration of a compounded drug preparation shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored.

3. Compounding is the process of combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug or bulk drug substance to create a sterile medication.

4. Compounded sterile preparation (CSP) is a preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging or otherwise altering a drug product or bulk drug substance.

4. Reconstitution is the process of adding a diluent to a conventionally manufactured products to prepare a sterile solution or suspension.

Procedures

A. For after hours pharmacy services, please see policy PH.19 After Hours Pharmacy Services for Santa Paula Hospital

B. Nursing preparation of IV compounded products is restricted to the following:

1. Only the SPH Nursing Supervisor or an approved Charge Nurse may prepare first doses of IV compounded products. This restriction does not apply to reconstitution (e.g. ceftriaxone for IM administration).
2. Simple transfers of not more than 3 (three) commercially manufactured, sterile, non-hazardous medications and/or components from a manufacturer's original container.
3. No more than 2 (two) entries into one container including the IV bag or the vial.
4. Nursing shall not compound chemotherapy, hazardous medications, parental nutrition, and concentrated electrolytes such as potassium chloride repletion.

C. Preparation of the IV compounded product shall include the following process:

1. Medication orders must be reviewed for completeness (see policy 100.025 Medication Ordering, Administration, and Documentation).
2. The standard compounding recipe shall be utilized if applicable.
    a. Adult IV compounding recipes for Nursing (see Attachment A)
    b. Pediatric IV compounds recipes for Nursing (see Attachment B)
    c. Alteplase compounding instructions (see policy 100.232 Code Stroke - Intravenous for t-PA (Alteplase) Administration)
3. Preparation of the IV compounded product shall occur in a dedicated, clean, uncluttered space.
4. All medications and supplies shall be gathered before initiating the process.
5. The IV compounded product shall be prepared using aseptic technique.
6. A second nurse is required to complete a verification double check and co-signature on the medication label for all pediatric and high risk IV compounded preparations (see policy PH.70 High Alert Medications).
    ~~a. If video and audio conferencing is available, a VCMC Pharmacist may provide the verification double check in lieu of the second nurse.~~

D. The Nursing prepared IV compounded product shall be labeled with the following:

1. Patient addressograph
2. Medication name and amount added
3. Base solution and amount
4. Date and time of preparation
5. Name/initial of Nursing Supervisor or an approved Charge Nurse preparing

6. Name/initial of second nurse or VCMC Pharmacist completing the verification double check, if applicable
7. BUD of 1 hour

E. Documentation
   1. All medication administration is documented in a timely manner in the electronic health record and medication administration record.
   2. Nurse IV compounded products will not scan due to the lack of a pharmacy generated IV label with proper barcodes.

F. Nursing Supervisors or approved Charge Nurses shall be trained and demonstrate annual competency on the following:
   1. Proper hand hygiene (see policy 106.055 Hand Hygiene)
   2. Pharmaceutical calculations and terminology
   3. Aseptic technique
   4. Standard compounding recipes
   5. Quality assurance procedures
   6. Labeling

References:

United States Pharmacopeia 797 - Sterile Preparations 2008

All Revision Dates

11/22/2024, 9/10/2020

Attachments

Attachment A - Adult IV Compounding Recipes for Nursing

Attachment B - Pediatric IV Compounding Recipes for Nursing

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending

Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/6/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/22/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/22/2024
Policy Owner	Sara Pendleton: Medication Safety Officer	11/22/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area	Administrative - Patient Care

100.267 Naloxone Nasal Spray Distribution

PURPOSE

To make naloxone available to patients seen in the Emergency Department (ED) who are determined to be at risk of an opioid- related overdose.

DEFINITION

Overdose rescue kit: One bag containing naloxone nasal sprays, breathing shield, and instructional card, Fentanyl Risk education card, and "Safe Choices" resource card.

POLICY

Dispense life-saving medication, naloxone, in the form of a ~~rescue kit,~~spray to patients at risk of opioid overdose pursuant of licensed practitioner's (LP) order or otherwise ordered by a trained staff.

PROCEDURE

1. Training of staff, other than LP, will be completed by the ~~Substance Use Services~~Conejo Health, the vendor who is providing substance use navigation services in the Emergency Department (~~SUS~~ED) ~~Prevention Team~~.
    a. ~~Staff member may include substance use navigators (SUNs) and/or registered nurses or other identified members of the patient care team who have completed training.~~Staff members will be substance use navigators (SUNs).
    b. Trained staff will be required to take a refresher training every 2 years to dispense ~~overdose rescue kits~~naloxone nasal spray.

2. Issuance, delivery, distribution, maintenance of inventory in ~~ED~~the SUN office (Room A), and collection of required data will be managed by the SUNs ~~or other trained staff~~ with the use of ~~the Overdose Rescue Kit Tracking Log~~a tracking log. This maintenance shall include checking of expired medications and managing of medication recalls if applicable. Refer to the following forms.
    a. Site Inventory Tracking Log (Attachment A)
    b. ~~Overdose Rescue Kit Participant - Initial Form (Attachment B)~~
    c. ~~Overdose Rescue Kit Participant - Refill Form (Attachment C)~~
    d. Nasal Naloxone spray image (Attachment B)
    e. Nasal Naloxone standing order (Attachment C)
3. Overdose rescue kits will be stored in the locked ~~cabinet in~~SUN office adjacent to the ED ~~with the Program Inventory Binder~~.
    a. Trained staff member will document required elements on the dispensing log~~,~~ ~~remove one rescue kit from locked, secured cabinet~~.
    b. Educate the patient and/or designee regarding the use of rescue kit in the patients preferred language.
    c. Document necessary information for record keeping including progress note in electronic health record (EHR) as necessary.
4. ~~Overdose rescue kits will be dispense by SUNs or other trained staff pursuant of the attached standing order. If no SUN is available, kits can be dispensed by trained RNs or LPs (Attachment D).~~
5. ~~Substance Use Services (SUS) Prevention Team can be reached at 805-667-6333 (No Over Dose)~~
6. Overdose rescue kits will be dispense by SUNs only.
7. Conejo Health is available Monday to Friday from 0800 to 1630 in Room A adjacent to the ED. The phone number for the office is 805-652-6764. The SUNs are also available on Tiger Text.

All Revision Dates

9/23/2024, 3/14/2024, 3/14/2023

Attachments

- Attachment A: Site Inventory Tracking Log
- Attachment B: Naloxone Nasal Spray
- Naloxone Standing Order.pdf

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
ED Committee	Stephanie Denson: Manager, Medical Staff Office	1/9/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/23/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/23/2024
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Owner	Gina Ferrer: Manager, Trauma Services
Policy Area	Trauma Services

Autotransfusion Policy

Title:Autotransfusion for the Trauma Patient with Hemothorax Guideline

Purpose:

To establish a guideline for the management of a chest drainage system for autotransfusion in patients requiring thoracic drainage.

Indications for Use:

To drain, preserve and autotransfuse blood from and to the original donor as prescribed therapy for selected trauma patients, as directed by the physician trauma team leader.

Contraindications for use:

Autotransfusion is rarely contraindicated in trauma patients during the initial resuscitation phase. The following are reported ***contraindications***:

- Pericardial, mediastinal, or systemic infections
- Pulmonary and respiratory infection or infestation
- Presence of malignant neoplasm
- Enteric contaminated thoraco-abdominal cavities
- Blood that has remained in the collection chamber for six or more hours

Policy:

Patients who are receiving autotransfused blood require the following:

1. Physician trauma team leader order to utilize autotransfusion.
2. Registered nurse (RN) staff who are trained and completed a competency to perform autotransfusion.
    a. RN competency is performed ~~annually~~upon initial hire.
3. Autotransfusion performed in the appropriate patient care areas (e.g., emergency department, perioperative, and intensive care unit)

References

Catmull, S.P., & Ashurst, J. V. (2024). *Autotransfusion*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK541014/

Reichman, E. F. (2013). Autotransfusion. In E.F. Reichman (ed., chapter 191), *Emergency Medicine Procedures, 2e*. McGraw-Hill. https://accessemergencymedicine.mhmedical.com/content.aspx?bookid=683&sectionid=45343842

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	12/10/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/9/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/9/2024
Trauma Services	Thomas Duncan: Trauma Medical Director	12/9/2024
Trauma Services	Gina Ferrer: Manager, Trauma Services	12/9/2024

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

ER.38 Patient Triage

POLICY:

Every patient entering the Emergency Department (ED) shall be triaged and priority of care determined based on physical and psychosocial needs, as well as factors influencing patient flow through the system. The purpose of triage is to prioritize incoming patients and to identify those patients that cannot wait to be seen:

A. The specific goals of the triage system include:
    1. Early patient assessment by a physician or RN
    2. Determination of urgency of needed care
    3. Documentation of triage findings
    4. Control of patient flow through the Emergency Department
    5. Initiation of certain diagnostic measures
    6. Initiation of standardized procedures
    7. Initiation of certain comfort measures
    8. Initiation of certain therapeutic measures
    9. Initiation of certain referrals and informing patient/family of available community resources

PROCEDURE:

A. Assessment and Priority Setting*
    1. PRIORITY 1 (ESI Level 1) Includes all life or limb threatening conditions in which life-

saving interventions are required. Examples of life-saving interventions include, but are not limited to:

a. Major trauma, patient unresponsive
b. BVM ventilation
c. Intubation
d. Surgical airway
e. Emergent CPAP
f. Emergent BiPAP
g. Defibrillation
h. Emergent Cardioversion
i. External Pacing
j. Chest needle decompression
k. Pericardiocentesis
l. Open thoracotomy
m. Intraoseous access
n. Significant IV fluid resuscitation
o. Blood Administration
p. Control of major bleeding
q. Administration of Naloxone
r. Administration of IV Dextrose
s. Administration of Dopamine
t. Administration of Atropine
u. Administration of Adenocard

*These are only general examples, not standards for each class. Rating of the patient must be based on the clinical presentation of the patient and the triage nurse's clinical judgment while using the Emergency Severity Index (ESI) Triage Algorithm.

2. PRIORITY 2 (ESI Level 2) Includes all patients who are not ESI Level 1, but should not wait for definitive care. This decision is made by determining:
    a. Is this a high risk situation? (A high risk patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential threat to life, limb or organ.)
    b. Is the patient acutely confused, lethargic or disoriented?
    c. Is the patient in severe pain or distress?
        i. Examples of ESI Level 2 include, but are not limited to:

- Active chest pain (non-STEMI), suspected ACS, VS stable
- Needle stick exposure in a health care worker
- Signs of a stroke (but does not meet ESI Level 1 criteria)
- Rule out ectopic pregnancy, hemodynamically stable
- Patient on chemotherapy or otherwise immunocompromised, with a fever
- Suicidal or homicidal patient (page Security)
- Confused: Inappropriate response to stimuli
- Lethargic: Drowsy, sleeping more than usual
- Disoriented: Patient is unable to correctly answer questions about time, place or person.
- Severe pain or distress: Self reports > 7/10 pain, with physical findings consisted with stated pain level (diaphoresis, tachycardia, nausea/vomiting, pale, hypertensive)

3. PRIORITY 3 (ESI Levels 3, 4 & 5). Once the decision is made that the patient does not meet criteria for ESI Level 1 or ESI Level 2, patients are categorized based on the predicted number of resources needed to determine patient disposition. These patients' conditions generally need evaluation and treatment, but time is not a critical factor. Since their physical condition is stable, these patients can safely wait several hours to be seen. The triage nurse should be able to accurately predict the nature and number of tests, therapeutic interventions and consultations that a patient would need during his/her ED stay, based on their chief complaint. Based on the number of different types of expected resources needed, the nurse will assign an ESI Level as follows:
    a. ESI Level 3 = 2 (two) or more expected resources needed
    b. ESI Level 4 = 1 (one) expected resources needed
    c. ESI Level 5 = 0 (none) expected resources needed.
4. The Triage Nurse will take a full set of vital signs on all ESI Level 3, 4 & 5 patients. ESI Level 3 patients with abnormal vital signs may need to be up-triaged to ESI Level 2 (High-Risk Situation). Vital signs will be done on any patient returning to the waiting room regardless of ESI Level assigned to ensure patient safety.

ESI Resources Examples

Resources	Not Resources
Labs (blood, urine, sputum)	H & P, MSE, pelvic exam
EKG, X-rays, CT, MRI, Ultrasound, Angiography	Point-of-care testing (accucheck, urine dip, urine ICON)

IV Fluids (hydration)	Saline or Heplock
IV, IM or Nebulized medications	PO meds, Tdap (immunization), Prescription refills
Speciality Consultation	Phone call to PCP
Simple procedure (lac repair, Foley) = 1 Complex procedure (conscious sedation) = 2	Simple wound care (dressings, recheck) Crutches, splints, slings

5. The Triage Nurse will notify admitting staff of ESI Level 1-5 patients taken directly to patient treatment area to expedite registration.
6. The Triage nurse will place ESI Level 1 & 2 patient charts before ESI Level 3, 4, & 5 charts for expedient registration.
7. The Triage nurse will communicate report directly to the Charge nurse, or the nurse assuming care on all patients taken directly to the patient treatment area.

B. Children with Special Healthcare Needs
Children with special healthcare needs (CSHCN) are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. These children could be at greater risk of rapid and subtle deterioration. Consider triaging children with special needs and any physiologic abnormality to the ESI 2 category. Consider triaging all others at the ESI 3.

All Revision Dates

12/10/2024, 12/1/2013, 3/1/2011, 5/1/2006, 12/1/2004, 11/1/2001, 1/1/1995, 10/1/1992

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	1/9/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/11/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/10/2024

Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	12/10/2024

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ER.42 Standardized Nursing Procedures in the Emergency Department

POLICY:

Individuals that present to the Emergency Department (ED) at Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) will be assessed by a triage-competent Registered Nurse (RN) to determine the patient's presenting complaint and acuity. Once this assessment is complete, the triage nurse may initiate care according to the following standardized procedures or assign responsibility to the patient's primary RN.

The standardized procedures outlined in this policy are established via the established governance process to initiate and expedite care in the ED. Only ED nurses who have demonstrated competency in the role and have received specialized training for this protocol may activate these procedures. This procedure was written collaboratively with nursing and ED physician leadership and is approved via the Interprofessional Practice Committee and approved by medical staff.

The standardized procedures outlined in this policy are established to initiate and expedite care in the ED. All standardized procedures ~~and patient follow-up~~ are to be documented in the Electronic Health Record (EHR). ~~Consultation~~When additional concerns arise or conditions develop not listed in these procedures, the RN will consult with the ~~ED Licensed Practitioner~~patient's licensed practitioner (LP) ~~will occur when concern arises in assessing or implementing these standardized treatment and diagnostic procedures. Triage-competent registered nurse/ED registered nurse may choose to~~. The RN will initiate ~~none, part or~~ all ~~of the standardized procedure~~interventions in the appropriate protocol and will add orders as needed based on the ~~age and presentation of~~conditions outlined in the protocol. The LP will be notified and assume responsibility for reviewing test results and contacting the patient ~~and consultation with the ED LP. The attending ED LP will be notified and assume responsibility for reviewing~~in the event

that a patient leaves the hospital prior to completion of test results ~~and contacting the patient in the event that a patient leaves the ED prior to completion and/or review of test results.~~.

~~Standardized nursing procedures will be reviewed and revised annually. Nursing staff will complete a competency evaluation annually.~~

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

PROCEDURE:

I. **STANDARDIZED TREATMENT AND DIAGNOSTIC PROCEDURES**
The standardized procedure order sheet will include the following:

A. ~~**Blunt Trauma (Non-Tier Activation)**~~

1. ~~Ice to injury~~
2. ~~Elevate if extremity injury~~
3. ~~Immobilize injured extremity~~
4. ~~X-ray of injured body part and/or areas of palpable pain or consult LIP if fracture suspected~~
5. ~~NPO~~
6. ~~Saline Lock~~
7. ~~C-Spine Precautions if indicated~~

B. **Isolated Extremity Injury**

1. Immobilize joints above and below injury
2. Apply ice
3. Elevate injured extremity
4. Remove rings on injured extremity
5. ~~X-ray of injured body part~~Consult LP for imaging orders
6. NPO
7. Saline Lock

C. ~~**Possible Hip Fracture**~~

1. ~~Saline lock~~
2. ~~Lab ER panel~~
3. ~~Alcohol Level~~
4. ~~Extra tube for blood bank~~
5. ~~PT, PTT~~

6. ~~Urine Drug Screen~~
7. ~~Urinalysis with micro reflex to culture~~
8. ~~EKG (NOTE: perform if over 50 years old)~~
9. ~~CXR 1 view~~
10. ~~Hip x-ray 3 view and Pelvis~~

D. **2+ Systemic Inflammatory Response Syndrome (SIRS)**

- Temperature less than 96.8ºF or greater than 100.9ºF
- HR greater than 90
- RR greater than 20
- WBC less than 4,000 or greater than 12,000 or
- Bands greater than 10% with suspected or confirmed infection (Adult)

1. ~~Adults: Initiate ED Triage Sepsis Adult power plan~~Adults: Initiate EDN SIRS (2+ Systemic Inflammatory Response Syndrome) Power Plan.
2. Acetaminophen 650 mg form: Tab, oral, Once. Now.
   To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease
3. Lab ER panel
4. Venous Blood Gas with lactate
5. Venous Blood Gas plus electrolytes plus lactate (If patient is Short of breath)
6. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture
7. Blood culture x 2 (draw and hold; ~~collected~~collect from 2 different sites)
8. O2 via nasal cannula to keep O2 sat greater than 94%
9. Saline Lock
10. ~~Chest x-ray 2 views (Ambulatory or monitor not required)~~
11. ~~Chest x-ray 1 view (nonambulatory or monitored required)~~
12. Consult LP for imaging orders
13. Discuss presence of existing urinary catheter with provider for further instructions.

E. **Fever greater than 101ºF Adults**

1. Acetaminophen 650 mg form: Tab, oral, once. Now.
   To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease

F. ~~**Fever greater than 101ºF Pediatrics (patients older than 6 months)**~~

1. ~~Ibuprofen 10 mg/kg PO x 1 (Maximum dose: 400 mg) to be given if patient has a fever greater than or equal to 101ºF, and~~
    a. ~~has not received ibuprofen or other NSAIDS in the last 6 hours~~
    b. ~~not pregnant, and not on hemodialysis~~
    c. ~~not on hemodialysis or known kidney disease~~
    d. ~~does not have bleeding disorder or cancer~~
2. ~~Acetaminophen 15 mg/kg PO x 1 (Maximum dose: 650 mg) To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease.~~

Fever greater than 101ºF Pediatrics (patients older than 6 months)

1. Acetaminophen 15mg/kg PO x 1 (Maximum dose: 650 mg) To be given if patient does not have documented history of kidney or liver disease and has not received acetaminophen in the last 4 hours.
2. Ibuprofen 10mg/kg PO x 1 to be given if acetaminophen contraindicated (see above) AND patient
    i. has not received ibuprofen or other NSAIDS in the last 6 hours
    ii. is not pregnant
    iii. is not on hemodialysis or with known kidney disease
    iv. does not have bleeding disorder or cancer

G. **Fever (≥100.4) and Cancer (Adult)**:
1. Saline Lock
2. Access Central Line if present, and obtain 1st blood culture and label as central line
3. Draw second blood culture from peripheral vein and label as peripheral
4. Lab ER Panel
5. C-Reactive Protein (CRP)
6. Extra tube for blood bank
7. Notify LIP for HR greater than 140, less than 50 or O2 sat less than 90%
8. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture
9. O2 via nasal cannula to keep O2 sat greater than 94%
10. Chest x ray 1 view ~~(Non-ambulatory or monitor required)~~
11. ~~Chest x ray 2 views (Ambulatory or monitor not required)~~

H. ~~**Fever (≥100.4 using temporal artery thermometer) and Cancer (Pediatrics)**~~
1. ~~Blood Culture x 1 (from central line if patient has PICC or port labeled as central line)~~
2. ~~CBCD~~

3. ~~CRP~~
4. ~~Basic Metabolic Panel~~
5. ~~Notify LIP if O2 sat less than 94%~~
6. ~~O2 via nasal cannula to keep O2 sat greater than 94%~~
7. ~~Urinalysis with micro reflex to culture~~
8. ~~Port access or Saline Lock if no port~~
9. ~~Chest x ray 1 view (Non-ambulatory or monitor required)~~
10. ~~Chest x ray 2 views (Ambulatory or monitor not required)~~
11. ~~Nothing per rectum~~
12. ~~Apply lidocaine 4% Cream~~
13. ~~Acetaminophen 15 mg/kg PO x 1 (maximum dose: 650 mg) for temperature greater than 100.4ºF~~
    ~~To be given if patient has a fever greater than or equal to 100.4ºF, has not received acetaminophen in the last 4 hours, does not have liver disease.~~

I. **Diabetic Ketoacidosis (DKA) Suspected**

1. NPO
2. ~~Blood~~Venous blood gas ~~venous~~ plus electrolytes plus lactate
3. Glucose point of care stat
4. Lab ER panel
5. Hemoglobin A1C
6. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture
7. Saline lock

J. **Fever (≥100.4) and Cancer (Pediatric)**

a. Room patient immediately
b. Obtain IV access
c. Notify LP

K. **Eye Injury**

1. Proparacaine and Fluorescein ~~at request of ED LIP~~to provide to LP
2. Visual acuity
3. Consult ~~LIP~~LP for pain ~~medication as needed~~medications

L. **Altered Mental Status (Adult)**

1. Saline Lock
2. Cardiac monitor
3. Lab ER panel
4. Glucose point of care

5. TSH
6. Alcohol level
7. Urine drug screen
8. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture
9. EKG (NOTE: perform if HR greater than 100 or less than 60)
10. ~~Chest x-ray 1 view (Non-ambulatory or monitor required)~~Consult LP for imaging orders
11. ~~Blood~~Venous blood gas ~~venous~~ plus electrolytes plus lactate
12. ~~Lithium Level (If patient is prescribed Lithium)~~Consult LP if Lithium Level should be drawn

M. **Abdominal Pain or Flank Pain**

~~1. Urine point of care~~
~~2. Saline Lock~~
~~3. NPO~~
~~4. ER Panel~~
~~5. C Reactive Protein (CRP)~~
~~6. Ondansetron (Zofran) 4 mg IV Push/Orally Disintegrating Tablet (ODT)~~

1. Point of care UA Urinalysis with reflex micro/culture
2. Saline Lock
3. NPO
4. Lab ER Panel
5. C Reactive Protein (CRP)
6. Consult LP for antiemetic medication

N. **Dysuria**

1. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture
2. ~~Urine point of care~~

O. **Pregnancy Less Than 20 Weeks with Vaginal Bleeding and/or Abdominal Pain**

1. If greater than 20 weeks pregnant, transfer directly to Labor and Delivery Department at VCMC. At SPH, notify LP.
2. Saline lock (NOTE: insert if HR>100 or SBP<100)
3. Lab ER panel (NOTE: if HR>100 or SBP<100)
4. Type and Rh and antibody screen
5. Serum HCG
6. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture

P. **Chest Pain**

~~Appears cardiac:~~

1. EKG and give to physician within 10 minutes
2. Asprin 81 mg tablet, 4 tablets PO x 1 chewed
3. Cardiac monitoring
4. Oxygen saturation monitoring
5. Oxygen at two (2) liters via nasal cannula if less than 95% O2 sat
6. Saline Lock
7. Troponin every 2 hours x 2
8. Lab ER panel
9. PT, PTT (for patient on anticoagulant medication)
10. ~~Chest x ray 1 view (Non-ambulatory or monitor required)~~Consult LP for imaging orders
11. NPO

Q. **Shortness of Breath/Cough (Adults only)**

1. ~~Airborne and droplet isolation if contagious pathogen is suspected (NOTE: for patients with known or suspected contagious pathogen, immunosuppression or other risk factors for contagious pathogens)~~Airborne and droplet isolation until discontinued by LP
2. If wheezing or history of asthma confer with ~~LIP~~LP for nebulized treatment~~.~~
3. ~~Isolation if contagious pathogen suspected, place mask on patient~~
4. EKG if history or suspect cardiac disease
5. Oxygen at two (2) liters via nasal cannula if less than 92% 02 sat
6. Oxygen saturation monitoring
7. NPO
8. ~~Chest x ray 1 view (Non-ambulatory or monitor required)~~
9. ~~Chest x ray 2 view (Ambulatory or monitor not required)~~
10. Consult LP for imaging orders
11. Saline Lock
12. Lab ER panel
13. Venous Blood Gas plus electrolytes plus lactate
14. Blood culture x 2 (NOTE: If ~~pneumonia suspected~~febrile)

R. **Shortness of Breath/Cough (Ages 2-17)**

a. Contact respiratory therapy

b. Initiate pediatric asthma score (PAS).

c. Consult LP

S. **Syncope**

1. EKG
2. Cardiac Monitor
3. Saline Lock
4. Lab ER Panel
5. Point of care blood glucose

T. **Diabetic Wound**

1. ~~Point of care blood glucose~~
2. Lab ER Panel (includes glucose)
3. C-reactive Protein
4. Erythrocyte Sedimentation Rate (ESR)
5. Venous blood gas plus electrolytes plus lactate
6. Blood Cultures x2
7. ~~X-ray affected body part~~Consult LP for imaging orders

U. **Psychiatric Patients**

1. Point of care UA Urinalysis with reflex micro ~~reflex to~~ /culture if elderly (65 and above)
2. Mental health panel (NOTE: perform if needs clearance for mental health evaluation)
3. Drug levels if on medication (NOTE: perform for valproic acid, depakote, lithium)
4. COVID mini-respiratory panel (NOTE: perform if needs clearance for mental health evaluation/placement)
5. Aspirin and Acetaminophen levels (NOTE: perform if patient presents with suicidal ideation)
6. Nicotine patch when applicable
7. Consult physician for appropriate diet order

V. **Suspected Stimulant Intoxication**
If patients HR is >120:

1. Saline Lock
2. ~~1 liter bolus Lactated Ringers~~Consult LP regarding need for IV fluids
3. Lab ER Panel
4. Creatinine Phosphate Kinase
5. Cardiac Monitor

6. EKG

W. **GI Bleed**

1. Lab ER Panel
2. Saline Lock
3. PT, PTT
4. Extra tube for blood bank
5. Cardiac Monitoring
6. NPO

X. ~~**Epistaxis**~~
~~If HR>100 or SBP<100 or on anticoagulants~~

~~1. CBC~~
~~2. PT, PTT~~

All Revision Dates

10/29/2024, 6/14/2023, 1/13/2021, 7/23/2019, 3/21/2019, 12/1/2013

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Emergency Department & IPC	Stephanie Denson: Manager, Medical Staff Office	Pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	11/12/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2024
Emergency Services	Julia Feig: Clinical Nurse Manager, Emergency Services	10/17/2024

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Last Revised	10/22/2024
Next Review	3 years after approval
Owner	Julia Feig: Clinical Nurse Manager, Emergency Services
Policy Area	Emergency Services

ER.55 MED CODE

Policy:

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

Purpose:

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

Criteria:

1. Hemodynamic instability
    1. Adults with systolic blood pressure <80 mm Hg
    2. Children with age specific hypotension
        1. ≤ 1 year: <60mm Hg
        2. 1-10 years: <70 mmHg + 2X age in years.
2. Respiratory compromise
    1. CPAP in field
    2. Persistent 02 sat < 90% despite oxygen supplementation

3. Patient who is unresponsive to painful stimulus.
4. Judgment of ED Physician/Nursing. Examples:
    1. Concern for acute vascular dissection or rupture
    2. Concern for pericardial tamponade
    3. Concern for imminent decompensation from severe electrolyte derangement
    4. Concern for impending airway disaster

Procedure:

1. The MICN or designee will notify the Emergency Department charge nurse.
2. The MICN or designee will notify the page operator (x7-6666 at VCMC or x7-8666 at SPH) who will send an alphanumeric page stating "*Med Code ER, adult/peds/infant ETA …minutes"* to all required team members including:
    a. nursing supervisor when available
    b. certified phlebotomy technician when available
    c. x-ray technician
    d. respiratory therapist
    e. rapid response nurse
    f. VCMC only: ICU (adult patient) or PICU attending (pediatric patient)
3. A ~~med code~~Med Code is a silent page at VCMC. At VCMC, charge nurse, MOA or designee will announce Med Code overhead in department only. At Santa Paula Hospital, charge nurse, MOA or designee will call x7-8666 to ask for overhead page. ~~Charge nurse, MOA or designee will announce Med Code overhead in department only. At Santa Paula, charge nurse, MOA or designee will call x7-8666 to ask for overhead page.~~
    a. Announcement/page will state, *"Med Code ER, adult/peds/infant ETA …minutes."*
    b. If the patient self presents to the ER via triage the overhead page will state *"Med Code ER, adult/peds/infant Now."*
4. The following people are to arrive immediately to the Resuscitation Room in the ED:
    a. Physicians: Attending ED physician, ED residents
    b. Nurses: Two ED nurses (or more if requested), Nursing Supervisor, Rapid Response Nurse
    c. Ancillary Staff: certified phlebotomy technician, ~~Xray~~X-ray technician, Respiratory therapist, ER technician

All Revision Dates

10/22/2024, 9/13/2024

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	12/18/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/22/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/22/2024
Policy Owner	Julia Feig: Clinical Nurse Manager, Emergency Services	10/22/2024

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Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Ambulatory Care-Point of Care Testing

L.67 LeadCare® II Blood Lead Analyzer System

INTENDED USE:

The LeadCare II Blood Lead Analyzer and Test Kit provide a measurement of the amount of lead in a fresh capillary whole blood sample. The LeadCare II Blood Lead Analyzer is intended for in vitro (external) use only.

RATIONALE:

Lead is a common environmental contaminant present in all areas of the United States. Childhood lead poisoning is one of the most common and preventable environmental health issues in California. Exposure to deteriorated lead-based paint and lead-contaminated dust and soil are the major causes of childhood lead poisoning in California. Even low levels of lead exposure can have lasting neurodevelopmental effects. Blood lead testing at-risk children is the best way to identify children with elevated levels of lead and is mandated by California regulations.

All medical providers are required to follow the California Department of Public Health (CDPH) Standard of Care for Childhood Lead Screening:

A. **Screening**: All children participating in publicly supported programs such as Medi-Cal, Women, Infants, and Children (WIC), and Child Health and Disabilities Prevention (CHDP) should receive a blood lead test at both 12 months and 24 months of age.

B. **Assessment:** If child is NOT in a publicly funded program for low-income children, at both 12 months and 24 months of age, conduct risk assessment and perform blood lead screening if risk factors present.

C. **Catch Up:** If a blood lead test screening or assessment was not performed at 12 or 24

months, catch-up screening or assessment is required up to age 72 months.

EXPLANATION OF TEST:

The LeadCare II System uses an electrochemical technique called Anodic Stripping Voltammetry (ASV) to determine the amount of lead in a blood sample.

1. Blood is mixed with LeadCare Treatment Reagent and the red blood cells (RBC) are lysed, which releases the lead that is bound to the RBC wall.
2. A negative potential is applied to the sensor to accumulate lead atoms on the test electrode. The potential is rapidly reversed releasing the lead ions.
3. The current produced is directly proportional to the amount of lead in the sample. The area underneath the curve is used to calculate a quantitative blood lead result.

WARNINGS & PRECAUTIONS:

A. Precautions When Preparing Samples

1. Do NOT place the LeadCare II Blood Lead Analyzer in a drafty area. For example, do NOT place the analyzer near air conditioning or heating vents. If the temperature is out of operating range, or if the temperature is unstable, the following messages appear on the display.
2. Use universal precautions while collecting and handling blood samples. Blood can transmit infectious diseases.
3. Wear powder-free gloves to prevent lead contamination. Because there is lead in the environment, it is easy to contaminate blood samples, collection tubes, and test kit items. Contamination of the work environment can cause inaccurate blood lead test results.
4. Use only the heparinized capillary tubes provided with the LeadCare II Test Kit. The capillary tube must be filled to the fill line (50 µl) for accurate results. Check to make sure that the tube is free of gaps and bubbles. After collection, wipe off the sides of the capillary tube with a gauze pad (wipe downward). The accuracy of the test depends on a precisely measured sample.
5. Use only fresh, unrefrigerated, whole blood with the LeadCare Treatment Reagent. Do NOT refrigerate the blood prior to mixing with the reagent. Blood must be stored at 10o - 32oC (50o - 90oF).
6. Add blood sample to the treatment reagent within 24 hours of collection. Blood older than 24 hours may produce false negative results. Make sure the blood sample is free of blood clots, which can cause inaccurate results.
7. Any visual impairment, such as color blindness may affect the operator's ability to detect the sample color change. Operators with vision deficiencies should invert the tube 8 to 10 times to ensure that the sample is properly mixed.

B. Precautions When Testing Patient Samples

1. Wear powder-free gloves to prevent lead contamination. Because there is lead in the

environment, it is easy to contaminate blood samples, collection tubes, and test kit items. Contamination of the work environment can cause inaccurate blood lead test results.

2. Patient handwashing with soap and water is required prior to the sample collection. Alcohol swabs do not remove lead. The accuracy of the test depends on handwashing prior to sample collection. Allow to air dry.
3. Do NOT allow the inside of the treatment reagent vial or the vial cap to touch anything. This could cause inaccurate blood lead test results.
4. Mix the blood sample with the treatment reagent thoroughly, but do NOT shake the tube. Gently invert the tube ten times until the reagent turns brown. Avoid foam and air bubbles.
5. Do NOT leave the treatment reagent vial uncapped other than to add the sample or remove the sample/reagent solution. The tube and its contents could become contaminated causing inaccurate test results.
6. Before placing the sample on the sensor, make sure the display calls for sample addition.
7. Keep the sensors in their container until you need them. Do NOT touch "X" on the sensors, except when applying the sample. This could cause contamination and an inaccurate test result.

C. Precautions When Calibrating the Analyzer

1. Calibration is required for each new lot of test kits. Use only the calibration button packaged with the test kit you are using. Failure to use the correct calibration button could cause inaccurate results.
2. Do NOT use items from more than one test kit at a time.
3. Each test kit comes with a calibration button marked with the sensor lot calibration code. Always make sure that the lot numbers on the sensor container and calibration button match the SENSOR LOT number on the analyzer display.

D. Precautions When Performing Quality Control Testing

1. When testing controls, make sure that the value falls within the acceptable range for each control. Do NOT proceed to patient samples if the control results are NOT within acceptable limits.
2. Treat control material as you would patient samples; add the control to treatment reagent prior to testing.
3. Store the controls at room temperature with all other kit components. Discard unused control material when the kit is finished. Using control material with the wrong kit lot number could yield inaccurate results.

CALIBRATING THE ANALYZER:

Follow these instructions to calibrate the analyzer with each new lot of test kits:

1. Turn on the analyzer. When you first turn on the analyzer, you will hear a beep and see the

startup and self-test messages. The analyzer performs a series of self-tests to ensure the proper operation of the system's electronic components. NOTE: The first time you turn on the analyzer, you will see the “PLEASE CALIBRATE” message.

2. Locate the calibration button in the test kit. Remove the calibration button from the test kit package.
3. Match the lot number on the sensor container with the calibration code on the button.
4. Hold the calibration button to the button reader until you hear the beep. The button must touch both the center contact and metal side of the button reader. There is no need to apply pressure.
5. Calibration takes a few seconds. When calibration is complete, the screen briefly reads “CALIBRATION SUCCESSFUL”. Then the screen reads “IF NEW LOT TEST CONTROLS”, followed by the “PREPARE SAMPLE...” message.
6. Make sure the number of the button matches the display. The LeadCare II Blood Lead Analyzer is now ready for testing.

SAMPLE COLLECTION

A. Method of Collection:
    1. Use ONLY whole blood (capillary) samples collected with EDTA or Heparin. Do NOT use plasma or serum. Do NOT use venous samples.
    2. The LeadCare II test kit includes capillary tubes for the collection of a whole blood sample directly from the patient. The system is also compatible with other micro-collection devices for the collection of capillary samples.
    3. Use only heparin or EDTA as anticoagulants.

B. Sample Collection Procedure:
    1. Wash the patient’s hands thoroughly with soap and water. Allow them to air dry.
    2. Put on powder free gloves, then disinfect the puncture site with an alcohol swab.
    3. Label a treatment reagent tube with the patient ID using the label provided.
    4. Holding the heparinized capillary tube almost horizontally with the green band on top, fill to the 50 uL black line. Filling stops when sample reaches the black line.
    5. Remove excess blood from the outside of the tube with a clean gauze pad. Use a downward motion to wipe excess blood from the capillary tube. Use caution not to absorb the blood from the end of the capillary tube.
    6. Inspect the capillary tube for proper filling. Make sure there are no gaps, air bubbles, or any excess blood on the outside of the capillary tube. Any overfill or underfill could skew the test results.

C. Sample Storage:
    1. Blood Collected in Capillary Tubes- Dispense the blood from the capillary tube into a Treatment Reagent tube within 10 minutes of collection, and mix well, to prevent the blood from clotting inside the heparinized capillary tube.

2. Blood Collected in Micro-Collection Device- Use only fresh, unrefrigerated whole blood within 24 hours stored at 50°-90°F (10°-32°C). Do NOT refrigerate the blood prior to mixing with the Treatment Reagent.

BLOOD LEAD TESTING STEPS

A. Sample Preparation

1. Remove the treatment reagent cap from the tube and place it top-down on a clean surface. Do NOT allow the inside of the cap to touch anything. This could contaminate the sample.
2. Place the full capillary tube in the treatment reagent. Insert a plunger into the top of the capillary tube and push down, ensuring to dispense the entire volume into the treatment reagent.
3. Replace the tube treatment reagent cap. Invert the tube 8 to 10 times to mix the sample completely.
4. The test sample is ready when the mixture turns brown. Repeat sample collection and preparation for each sample to be tested.
5. NOTE: After mixing the blood with the Treatment Reagent, you must analyze the mixture in less than 48 hours if stored at room temperature. If stored refrigerated, analyze within 7 days and allow mixture to reach room temperature before analyzing.

B. Sample Analysis

1. Remove a sensor from the sensor container. Close the container immediately. Grasp the sensor at the end without the black bars. Keep sensors in the container until you are ready to use them. Minimize handling to prevent contamination.
2. Insert a sensor (with black bars facing up) completely into the analyzer. Make sure sensor is inserted under the sensor guides and sits flush on the analyzer deck. When inserted properly, the analyzer beeps and displays “Add Sample” message.
3. Make sure the sensor log number matches the lot number on the display. If the number does not match, recalibrate the analyzer and test controls.
4. Make sure the sample mixture is at room temperature and uniformly mixed before testing.
5. Remove the cap from the treatment reagent. Remove a transfer dropper from it’s container. Squeeze the walls of the dropper and insert tip into the sample. Release the pressure to draw the sample into the dropper.
6. Touch the dropper tip to the X on the sensor and squeeze the walls to dispense the sample. Make sure the “Add Sample to X on Sensor” message is displayed before adding the sample.
7. The analyzer will beep when it has enough sample. It will display a “Testing XXX Seconds to Go” message. After 3 minutes, the analyzer will beep again to indicated that the test is done.
8. Record the test results indicated on the display screen. You can print the results by connecting the analyzer to a compatible label printer.

9. Remove the test sensor immediately after recording the result and discard in a biohazard container. If you do not remove the sensor after recording your last result within one minute, the analyzer will sound two short warning beeps every 15 seconds until the sensor is removed. A message to “Remove Sensor Immediately” will appear on the screen.
10. The analyzer is ready for the next sample when the “Last Test Result” message appears on the screen. If you do not run another test within 60 minutes, the analyzer will automatically go into “sleep” mode and results will be lost.

INTERPRETING PATIENT TEST RESULTS

A. The analyzer’s display window shows the blood lead result. No calculation is needed. The reportable range of the LeadCare II system is 3.3 to 65 µg/dL.

B. If the analyzer displays “Low” in the results window, record result as less than (<) 3.3 µg/dL.

C. If the analyzer displays “High” in the results window, record result as greater than (>) 65 µg/dL.

D. ***A capillary blood sample that generates an elevated lead level ≥ 3.5 µg/dL must be immediately reported to the provider and confirmed with a STAT venous sample. The venous sample should be run at a reference laboratory using a high complexity testing method.***

STATE MANDATED REPORTING

Users of any blood lead testing device are considered laboratories and **must report all blood lead results** drawn in California to the CDPH Childhood Lead Poisoning Prevention Branch using the **Electronic Blood Lead Reporting (EBLR) System** at https://eblr.cdph.ca.gov/ . Reporting requirements are as follows:

A. Results greater than or equal to (≥) 3.5 µg/dL must be reported within 3 working days of analysis.

B. Results less than (≤) 3.5 µg/dL must be reported within 30 calendar days of analysis.

QUESTIONABLE RESULTS

Incorrect test results may have an adverse medical outcome. If test results are questionable or inconsistent, follow these suggestions:

A. Make sure the expiration date of the kit has not passed.

B. Check that the analyzer is properly calibrated. The lot number displayed on the screen should match the lot number printed on the Sensor container, the control vials and test kit.

C. Check the analyzer and kit contents using proper control material. The control lot number must match the Sensor lot number for a valid test result.

D. If the above steps result in unacceptable performance, see the LeadCare II User's Guide for further steps to be taken.

QUALITY CONTROL TESTING REQUIREMENTS

A minimum of two levels of controls must be run with:

A. Each new lot.

B. Each new shipment of materials, even if it's the same lot previously received.

C. Each new operator (i.e., operator who has not performed the test recently).

D. Monthly, as a check on continued storage conditions.

E. When problems (storage, operator, instrument, or other) are suspected or identified.

QUALITY CONTROL TEST STEPS

A. Prepare the Control Sample

1. Label a treatment reagent tube, "Level 1".
2. Gently swirl the control vial. Remove the cap from the Level 1 control and place it top down on a clean surface.
3. Fill one capillary tube with the control material. To accomplish this tilt the control vial, insert the capillary tube into the liquid while holding the green end of the capillary tube almost horizontally. Capillary action will fill the tube to the black line.
4. Use a clean wipe to remove excess control material from the outside of the capillary tube.

B. Mix Control Sample with Treatment Reagent

1. Remove the cap from the treatment reagent tube and place it top down on a clean surface.
2. Place the full capillary tube into the treatment reagent. Insert a plunger into the top of the capillary tube and push down, ensuring the entire volume of control is dispensed into the treatment reagent.
3. Remove the empty capillary tube and recap the treatment reagent.
4. Invert the treatment reagent tube 8 – 10 times to thoroughly mix the two. The resulting mixture will be red.

C. Analyze Control Sample

1. Insert a fresh sensor into the LeadCare II Analyzer.
2. Ensure the lot number on the display matches the sensor lot you are using. It must also match the lot number on the control vial.
3. Invert your sample to ensure the sample is well mixed, then remove the cap.
4. Using a dropper, transfer the sample to the X on the sensor.
5. When the three minute countdown is complete, record your lead result in micrograms per deciliter (µg/dL).

6. Repeat this process for the Level 2 control.

INTERPRETING QUALITY CONTROL TEST RESULTS

A. The target values are printed on the control vials.

B. The blood lead level that appears on the LeadCare II Analyzer should be within the acceptable range provided for that control.

C. If the reported value is within the acceptable limits for both the Level 1 and Level 2 controls, your LeadCare II System is operating properly and you may now test patient samples.

D. If the reported value for the Level 1 and/or Level 2 control is outside the acceptable range, refer to the troubleshooting section of the LeadCare II User's Guide. If, after following the instructions, the control value is still out of range contact LeadCare Product Support at 1-800-275-0102.

E. ***Do NOT proceed to patient samples unless both the Level 1 and Level 2 control results are within the acceptable ranges.***

LIMITATIONS OF THE TEST

A. Extremes in humidity may affect the blood lead results. Performance has been validated from 12% to 80% RH (non-condensing). Use of the LeadCare II system outside of this range is not recommended.

B. Do NOT use the LeadCare II System in drafts. This could lead to falsely low results.

C. Keep the LeadCare II System out of direct sunlight. The analyzer will only function in the temperature range of 54°- 97°F (12°-36°C). Otherwise the analyzer will display a temperature error code.

D. Clinical testing demonstrates that altitudes up to 8,000 feet (2,440 meters) above sea level do not affect results obtained with the LeadCare II System.

E. Use the Sensors, the Treatment Reagent tubes, capillary tubes and transfer droppers only once. Do NOT reuse. Reuse could lead to erroneous results.

F. Do NOT use damaged (bent, scratched, cut, etc.) Sensors.

STORAGE & STABILITY

A. Test Kit Materials

1. Test kit materials should be kept at room temperature: 60°-80°F (15°-27°C). Do NOT freeze or refrigerate.
2. Keep Sensors sealed in their container until the sample is prepared and you are ready to perform the test.
3. Use the Treatment Reagent immediately after opening the tube.
4. The test kit has an expiration date printed on the exterior of the box. Do NOT use the test kit past the expiration date. NOTE: The Treatment Reagent, Blood Lead Controls

and the Sensors have separate expiration dates. The earliest expiring component is used to set the test kits expiration date.

B. Controls

1. The control material is supplied in liquid form and ready to use. It should be stored at room temperature 60°-80°F (15°-27°C). Do NOT refrigerate.
2. Do NOT use control material beyond its expiration date. Once opened, controls are good for 90 days.
3. Controls should only be used with sensors of the same lot number. Discard remaining control solutions when the sensors are gone. Failure to do so may result in inaccurate patient results.

CLEANING & DISINFECTION

A. Remove used sensors from the analyzer as soon as a result is recorded.
B. Clean the analyzer with a damp cloth and warm, soapy water.
C. Do NOT immerse analyzer in water.
D. Disinfect with dilute (10%) bleach solution.
E. Do NOT leave any soap film on the analyzer.
F. Do NOT allow liquid of any kind into the sensor connector.
G. Do NOT get the metal pins in the sensor connector wet.
H. Do NOT wash the inside of the calibration button reader.

TECHNICAL SUPPORT

For technical support, contact Magellan Diagnostics, Inc. at (800) 275-0102 or email **LeadCareSupport@magellandx.com**

REFERENCES

1. "Standard of Care on Screening for Childhood Lead Poisoning". California Department of Public Health, 18 October 2022, https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.asp.
2. "Childhood Lead Poisoning Prevention Program". Centers for Disease Control, 20 September 2023, https://www.cdc.gov/nceh/lead/default.htm.
3. LeadCare® II Blood Lead Analyzer User's Guide, 2022.

   LeadCare® II Blood Lead Test Kit Package Insert, 4/2021.

All Revision Dates

11/15/2024, 2/7/2024

Approval Signatures

Step Description	Approver	Date
MEC/Oversight	Stephanie Denson: Manager, Medical Staff Office	Pending
Associate Hospital Administrator- Ancillary Services	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	12/27/2024
Medical Director Laboratory Services	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Director Laboratory Services	Erlinda Roxas: Director, Laboratory Services	8/8/2024
AC Chief Medical Officer	Allison Blaze: Chief Medical Officer, Ambulatory Care	6/21/2024
AC Director of Nursing	Cynthia Fenton: AC Director of Nursing	5/24/2024
Director Laboratory Services	Colleen Rusin: Ambulatory Care RN II	5/15/2024

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Owner	Kristina Swaim: Clinical Nurse Manager, OB
Policy Area	Maternal Child Health

MCH.07 Infant Identification Bands and Security Tag Procedure

POLICY:

To describe nursing responsibility regarding identification banding (ID) and security tag placement of newborns/infants and children born and/or treated at Ventura County Medical Center and Santa Paula Hospital.

DEFINITIONS:

Identification (ID) Band: A set of four bands used to identify and associate the newborn, infant or child to their birth parent and/or primary caretaker(s).

Security Tag: Using a sensor based tracking system, a security tag placed on infant to prevent abduction. For purposes of this policy, security tags will be used only at Ventura County Medical Center.

Centrak: Infant Security System

EQUIPMENT:

Four (4) infant identification bands with inserts

Centrak Security Tag and disposable band

Centrak Information Technology System

PROCEDURE:

I. Obstetrics Department-Labor and Delivery/Postpartum

A. The infant identification bands will be placed in the birth parent's chart upon admission to the hospital. The ID band inserts will be accurately filled out to include the birth parents first and last name and medical record number.

B. At the time of delivery of the newborn, the delivery or nursery nurse will write the date, time of birth, and newborn's gender on all four inserts.

C. The primary nurse will verify with a second staff member that all information was accurately written on ID band inserts. Staff members will confirm that all four (4) ID band numbers match.

D. The two verifying staff members will confirm the correct ID band numbers are recorded into the electronic medical record (EMR) and electronically sign as the witness.

E. ID band(s) must be placed on the newborn and parent(s) and or designated caretaker prior to leaving the delivery area. The delivery area may include a Labor and Delivery room, OB Operating Room, Main Operating Room or Emergency Department.

F. The receiving registered nurse (RN) who receives the infant from the delivery room will verify the ID bands and record the ID band number is documented in the EMR.

G. The receiving Postpartum nurse will place a security tag on the newborn at the time of admission to the postpartum unit. The infant will be admitted to the Centrak system. The security tag number will be documented in the EMR with a second staff member as a witness.

H. Each time the care of the infant is assumed by any staff member, the infant ID band and security tag will be verified, including the numbers.

I. At shift change or when assuming care the RN must verify ID band and security tag.

J. Each newborn must wear two ID bands and a security tag at all time

K. If ID band or Infant Security tag is found to be off baby, confirm correct information and replace securely. Document changes if necessary in EMR. Clear alarms in Centrak system as needed.

L. If ID band(s) are lost or unable to be re-secured, a complete new set of four ID bands is made following the initial banding procedure.

M. ID bands, and security tag, will remain intact when transferring to a different unit. Exception will be transferring to PICU. The security tag will be removed , and a new one placed when admitted to the PICU.

N. At the time of discharge ID bands will be verified with primary parents ID band. ID bands maybe removed at this time per parent(s) request.

O. When a newborn is discharged, the primary nurse will remove the infant security tag and discharge the patient from the Centrak system.

II. Neonatal Intensive Care Unit (NICU)

A. Upon admission to the NICU, the admitting RN will verify the ID bands and record the ID band number in the EMR

B. The admitting RN will place a security tag on the newborn at the time of admission. The infant will be admitted into the Centrak system. The security tag number will be documented in the EMR.

C. Only infants in an open crib and that weigh more than ~~2500~~2300gm will be required to wear security tag.

D. The admitting RN will place a soft band with the patient label securely attached.

E. Each time the care of the newborn is assumed by any staff member, the ID band and the security band will be verified, and the numbers documented in the EMR. The staff member will also verify the patient's name and date of birth (DOB) on the soft band. In the case of multiples, the patient MRN can also be used.

F. If ID band or security tag or soft band is found to be off the baby, confirm correct information and replace securely document changes, if necessary, in the EMR. Clear alarms in Centrak system as needed.

G. If ID bands are lost or unable to be re-secured, a complete new set of four ID bands is made and documented in the medical record.

H. At the time of discharge ID bands will be verified with primary parent's ID band. ID bands maybe removed at this time per parent(s) request.

I. At the time of discharge. The primary nurse will remove the infant security tag and discharge the patient from the Centrak system

J. When a newborn is transferred to PICU, the primary nurse will remove the infant security tag and discharge the patient from the Centrak system in the NICU. IF the patient is transferred to PEDS or Post-Partum, the infant can keep the same security tag.

III. Pediatrics/Pediatric Intensive Care Unit (PICU)

A. All patients admitted to the Pediatric Units under the age of 2 or at the discretion of the RN, will receive an ID band and a security tag upon admission. It must be worn at all times

B. The patient will be admitted to the Centrak System. The security tag number will be documented in the EMR

C. Each time the care of the patient is assumed by any staff member, the RN must verify the ID band and security tag, including the numbers, and document the ID band and security tag numbers on shift assessment

D. If ID band or Infant Security tag is found to be off the patient, confirm correct information and replace securely. Document changes if necessary in EMR. Clear alarms in Centrak system as needed

E. Only when a patient is transferred to or from the PICU will the primary nurse remove the infant security tag and discharge their patient from the Centrak system. A new security tag will be placed on the patient upon completion of transfer to the new unit. The infant security tag will remain in place upon transfer to or from any other unit (Post-Partum or NICU). All existing ID bands will remain intact upon any transfer.

F. At time of discharge, the primary nurse will remove the infant security tag and discharge the patient from the Centrak system.

KEY POINTS:

Alarm Responses

a. Refer to Policy *106.002 Code Pink/Purple-Know/suspected infant/child abduction*

b. Hospital Paging Staff will call code pink/purple overhead on unauthorized egress alarm or when notified by Maternal Child Health Staff member. Call 7666 for known or suspected abduction.

c. Security to respond to reported location to:

- Clear alarms
- Confirm patient safety
- Close doors if needed
- Enter code 3291# into keypad
- Staff member to clear alarms in Centak system.

e. Information Technology (IT) Support

- Notify IT and place work order to add users
- Centrak system to be tested every 30 days by IT support team
- For technical support or to report technical support issues please call 1-800-932-2555. AMI technical support is available 24/7

REFERENCES:

All Revision Dates

9/11/2024, 9/13/2023, 8/19/2021, 2/1/2014, 8/1/2012, 6/1/2010, 3/1/2010, 5/1/2006, 5/1/2004, 12/1/2001, 5/1/1999, 3/1/1999, 12/1/1992

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	1/3/2025

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

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Owner	Jennifer Ferrick: Director, Peds/ PICU & NICU
Policy Area	NICU

N.54 Neonatal Whole Body Cooling

POLICY:

To describe the nursing responsibilities in the care of the newborn requiring whole body cooling. Neonatal hypoxic ischemic encephalopathy (HIE) is a major cause of death and neurodevelopmental disability in term infants. The patient care guideline has been developed to define therapeutic hypothermia by whole body cooling to 33.5° - 34.5° C (92.3° F – 94.1° F) for 72 hours with the Blanketrol III for patients in the Neonatal Intensive Care Unit (NICU). Therapeutic hypothermia safely and carefully lowers the infant's body temperature by whole body cooling, the metabolic processes slow down, thereby decreasing the severity and extent of brain injury. Studies have shown that when therapeutic hypothermia is initiated within 6 hours of birth, the incidence of death or severe disability is reduced. This procedure outlines the care of infants ≥ 36 weeks who meet the criteria for therapeutic hypothermia with Moderate to Severe Hypoxic Ischemic Encephalopathy (HIE).

It is the policy of Ventura County Medical Center to ensure that all infants ≥36 weeks gestation admitted to the NICU with an admitting diagnosis of neonatal depression, acute perinatal asphyxia or encephalopathy will be evaluated for the potential treatment of total body cooling.

PROCEDURE:

Determination of eligibility for whole body cooling must be met by both physiologic and neurologic criteria:

(Clinical and Biochemical)

Eligibility criteria to be considered for cooling:

Must fulfill all three criteria

I.	Infants ≥ ~~35~~36 weeks gestational age ≤ 6 hours after birth at initiation of cooling. >1800 gms Infants must meet both physiologic and neurologic criteria. See attached Body Cooling Algorithm.
II.	Physiologic criteria (Blood gas is defined as (A) a cord gas, or (B) any blood gas within the first hour of life.) 1. Blood gas pH <7 or base deficit of >16, then proceed to neurologic criteria. 2. No blood gas **or** blood gas pH 7-7.15 or base deficit of 10-15.9 with an acute perinatal event (abruption placenta, cord prolapse, severe FHR abnormality: variable or late decels), **plus** either a or b. then proceed to neurologic criteria. a. A 10 minute apgar less than 5. b. A continued need for ventilation initiated at birth and continued for at least 10 minutes.
III.	Neurologic Criteria 1. The presence of seizures is automatic inclusion. 2. Physical exam consistent with moderate to severe encephalopathy in 3 of the 6 categories.

Neuro Exam	Moderate Encephalopathy	Severe Encephalopathy	
1. Level of Consciousness		Lethargic	Stupor or Coma
2. Spontaneous activity		Decreased activity	No Activity
3. Posture		Distal Flexion	Decerebrate
4. Tone		Hypotonic (focal, general)	Flaccid
5. Primitive reflexes • Suck • Moro		Weak Incomplete	Absent Absent
6. Autonomic System: • Pupils • Heart Rate • Respiration		Constricted Bradycardia Periodic breathing	Dilated, nonreactive Variable Apnea

A. **Procedure – Transport**

Upon the Transport team's arrival at referring facility, evaluate baby for signs of encephalopathy and the stated inclusion/exclusion criteria. The eligible infants must have at least moderate encephalopathy for cooling measures to be initiated.

Equipment

Rectal temperature probe – (9 fr)
Passive Cooling – to be started at referring hospital

1. Turn off radiant warmer or transport isolette heater or turn down to lowest setting *apply servo probe set to 34°
2. Lubricate and insert rectal temperature probe to 5 cm depth and secure with duoderm/tegaderm combo to buttocks or thigh
3. In the absence of esophageal or rectal probe during transport, rectal temp should be checked every 15 minutes.
4. Infants can cool very rapidly on transport – strict attention should be paid to monitoring core temperature (target core temperature 33.5° C/92.3° F)
   ►**Safety Point: Cooled babies have depressed metabolism, so they generate less heat. If baby has never been warmed, they are easily overcooled**
5. Once core temperature falls to 34° C (93.2° F) have external heat source available
6. If core temp falls <33° C (<91.4° F) turn on heat source to lowest settings
   a. Slowly adjust heat source as needed to achieve target temperature
   b. Continue close monitoring to prevent rapid rewarming
7. If core temp rises >34° C (>93.2° F), open isolette portholes
8. Record time of commencement of passive cooling and record temperature every 15 minutes

Vascular Access

1. Cooling causes peripheral vasoconstriction, therefore, vascular access should be established early
   a. Umbilical catheters (UAC and UVC) – preferable
   b. Peripheral access – avoid scalp IV (EEG leads will need to be placed)

Sedation

1. Maintain adequate sedation. Do NOT let patient shiver.

Monitoring

1. Obtain baseline vital signs and temperature.
2. All clinical decisions will be made using esophageal temperature. Skin temperature is used as continuous back-up monitoring in case of esophageal probe failure.
3. Document skin temp readings every 15 minutes-record the initiation time of both passive and active cooling.

If goal core temperature of 33.5° C is met during the transport phase, be sure to note the time as this marks the beginning of the 72 hour cooling period.

4. Lab
    a. ABG (Patient temperature at time of draw should be entered into analyzer)
    b. Blood cultures
    c. Lactate (if available)
    d. CBC with Differential
    e. PT/PTT/Fibrinogen/D.Dimer
    f. Blood Glucose

B. **Exclusion Criteria for Cooling:**

- <36 weeks gestation age
- BW <1800gms
- Severe Persistent Pulmonary Hypertension of the Newborn (PPHN) (at discretion of Attending Physician)
- Severe hemodynamic compromise / perfusion sensitive states (sepsis)
- Coagulopathy with active bleeding
- Need for transfer for possible Extracorporeal Membrane Oxygenation (ECMO)
- Severe congenital anomalies / syndromes / known metabolic disorders
- Confirmed Sino-venous thrombosis
- Inability to initiate cooling by 6 hours of age

C. **Identification of Infants**

Eligible infants may be identified by Labor & Delivery (Transitional Nursery, NICU or Pediatric staff/referring hospital) at the time of resuscitation or based on cord blood gases and/or initial newborn blood gases. Eligible infants should be identified and discussed with Neonatologist for possible cooling therapy as soon as possible after birth due to the narrow window of six (6) hours after birth initiate therapeutic hypothermia.

*** As soon as infant qualifies, cooling should be initiated. Studies demonstrate the sooner cooling is initiated: the amount of neuronal cell lost is decreased.**

Body Cooling Protocol Please See Attachment:

D. **Qualified/Applicable Staff**

RN must be a NICU RN who has completed training in caring for infants undergoing therapeutic hypothermia therapy and setting up the Blanketrol III System.

*** Circumstances under which RN/Qualified Individual (s) may perform the functions (s)**

1. Setting

Therapeutic hypothermia may be performed on the critical care area of the NICU.

2. Supervision
   Under the supervision of the neonatologist or neonatal nurse practitioner (physician or Nurse Practitioner will write orders).

E. **Definition of Hypothermia**

Hypothermia occurs when an infant's core (esophageal or rectal) body temperature drops below 36° C (96.8° F) or axillary temperature below 34.9° C (94.8° F).

F. **Procedure-Initiation of Cooling upon admission to the NICU**
(cooling period to last for total of 72 hours from the time target core temperature is first reached)

Labs:

1. ABG (patient temperature at time of draw should be entered into analyzer every 24 hours or more)
2. Blood Cultures (if not already obtained)
3. Lactate
4. PT/PTT/Fibrinogen/D.Dimer at 0 (zero) hours and Q24 hours x 2 and PRN.
5. CBC© Differential Q 24° & PRN
6. Blood Glucose
7. ALT, AST, total protein, ALB, Total and direct bilirubin, ALK PHOS, GGT and ABG at zero hours.

Equipment

1. CSZ Blanketrol III Unit with connecting hoses
2. CSZ Kool-Kit ® Neonate/950 which includes:
   a. Maxi-Therm lite Blanket
   b. Mittens & Booties
   c. Esophageal/Rectal Temperature Probe
3. 2 Gallons distilled water (for initial set-up)
4. Infant Warmer or Giraffe
5. Pillow Case or thin receiving blanket
6. Lubricating Jelly
7. Duoderm/Tegaderm to secure temperature probe
8. Measuring tape
9. Tape

Setting up Blanketrol III (Set up Only)*

1. Gather equipment
2. Check the water fill opening to be sure there is water at the top of the drain. If water level is not visible, gradually pour approximately enough to have water visible (maximum is 2 gallons if empty) in the reservoir. Stop pouring when the water reaches the drain visible at the bottom of the water fill opening. **Do Not** overfill. Add distilled water as needed.
3. Open the Kool Kit and remove contents.
4. Make sure unit is "Off" prior to connecting to electrical outlet.
5. Connect the blanket to the unit by attaching the quick disconnect female coupling of the connecting hose to a male outlet coupling (bottom row) of the unit. There are three outlet couplings—you may use any one of these.
6. Make sure that the connections are secure and the clamps are open. Hoses should not be twisted or kinked. The blanket should be flat.
7. Prepare bed by placing the cooling blanket on the warmer or scale if infant is currently on the warmer. Do not turn bed warmer on. The warmer will remain off until cooling phase is over.
8. Turn the power switch "On". Water will be circulated into the blanket. Check that there are no leaks in the blanket.
9. Place pillowcase or thin receiving blanket on the cooling blanket. Only one thin receiving blanket or pillowcase can be between the patient and the cooling blanket to prevent soiling.
10. Set the Celsius/Fahrenheit switch, so that "Celsius" will be displayed.
11. Pre-cool the blanket in the manual mode at 5 degrees C.
    A. Press the "Temp Set" switch
    B. Press the DOWN arrow to change the "Set Point" display to 5C
    C. Press the Manual Control switch (Allow about 15 minutes to pre-cool the blanket prior to use. Temp does not need to reach 5C before placing infant or blanket).

* Blanketrol Technical help
1-800-989-7373
1-513-772-8810

~~Brain Monitoring~~

~~Implement bedside brain monitoring via Olympic Brainz Monitor. Please follow Manufacturer's "Quick Start Guide" to initiate such (Attachment A: CFM Olympic Brainz Monitor Quick Start Guide.)~~

Amplitude-Integrated Electroencephalography Monitoring (aEEG)

A. All infants undergoing Therapeutic Hypothermia shall be monitored continuously during hypothermia and rewarming using conventional video EEG (cEEG) or amplitude-integrated EEG(aEEG).

B. aEEG(or cerebral function monitoring), a method of electrocortical monitoring in which a time-

compressed waveform representing an overall trend in brain activity is generated from raw electroencephalogram (EEG) wave forms, can be used. aEEG may be used continuously to monitor with HIE (Hypoxic Ischemic Encephalopathy) before, during, and after therapeutic hypothermia. Features that can be identified from aEEG waveforms are:

1. Background: the level of continuous electrical activity of the brain

2. Sleep-wake cycling: the presence, absence, or maturity of cyclic variations in the background that may represent periods of sleep and wakefulness.

3. Seizures: the presence and frequency of electrographic seizures.

4. Symmetry of electrical voltage between cerebral hemispheres (possible to assess when more than one channel of aEEG is recorded).

B. aEEG electrodes can be applied anywhere on the scalp, but the common locations for neonatal monitoring are parietal, central, and frontal.

C. After the electrodes have been applied to the scalp, the bedside nurse is responsible for ensuring that adequate attachment to the skin is maintained.

D. Use a head wrap to stabilize the electrodes and may need to create a safety loop with the electrode wires and secure them to the bed or head wrap to prevent accidental dislodgement or removal of the electrodes during routine care.

E. Hourly assessment of the level of impedance will ensure that problems with poor signal are resolved

F If an electrode becomes dislodged or displaced; assess the skin for any evidence of breakdown or trauma. Reapply or reinsert the electrodes or notify someone trained in the application technique.

G. Documentation -use the built-in event-marking function on the aEEG monitor whenever possible to:

1. Document times of routine care and procedures

2. Document times of medications given, especially anticonvulsants and sedatives

3. Record clinical signs of seizures

H. Medical team is responsible for interpreting the aEEG tracing and initiating any medical interventions indicated.

I. Obtain an order to discontinue use of the aEEG monitor.

J. Gently remove electrodes from the infant's head and discard them if they are not reusable.

K. Document the infant's skin condition and disposition after aEEG has been discontinued.

Placement of Esophageal Probe

1. Soften the probe prior to insertion by placing in warm water for a few minutes
2. Measure distance (with measuring tape) from nares to the ear to the xyphoid process (then minus 2 cm) and then mark the distance with a small piece of tape around tube. This should

position the temp probe in the lower third of the esophagus. Nasal placement is preferred

3. Lubricate the tube (first 5 cm) and carefully insert to desired length.
4. Secure the probe by taping to infant's cheek. Appropriate Temp probe placement may be confirmed with x-ray.
5. Insert the "s" probe into the probe jack on right side of the cooling unit.

Initiation of Hypothermia (when infant is on the blanket)

During cooling therapy, the infant should be cared for on an open warmer (heat off) as the cooling blanket should be flat and the connecting hoses should remain un-kinked. (Make sure the heater output is not inadvertently turned on during body cooling).

1. Position the pre-cooled 25" x 33" blanket fully unfolded under the infant. Lay the infant supine with occiput resting on the blanket.
2. Operate the unit in GRADIENT VARIABLE
    a. Press TEMP SET switch
    b. Press the UP arrow to SETPOINT display to 33.5° C. This will be the set point for the next 72 hours.
    c. Press the GRADIENT VARIABLE button.
    d. Set the desired gradient variable offset to 6-10° C or as ordered, and press the GRADIENT VARIABLE button again.
    e. Then press smart button.
3. The infant's esophageal temperature will begin to decrease soon after the initiation of the cooling therapy. Within the first 30-45 minutes on the blanket, it is expected for infant's esophageal temperature to drop below the eventual desired temperature of 33.5° C (target range of 33-34°). The cooling blanket system adjusts quickly and will warm the blanket water to raise the infant's temperature to 33.5° C by approximately 90-120 minutes from initiation of cooling therapy. Once stable at 33.5° C, some esophageal temperature fluctuation around the set point is to be expected, but should not be greater than ± 0.5° C.
4. Upon initiation of cooling, with the exception of the diaper worn by the infant, it is optimal not to have any material between the infant and the blanket since interposed surfaces may alter the desired cooling. Once the infant's esophageal temperature has reached the set point of 33.5° C, a single layer such as a thin receiving blanket or pillow case may be placed between the infant and the cooling blanket to prevent soiling of the cooling blanket. Rolled cloth blankets and other positioning aids maybe used but should be placed under the cooling blanket. Booties and mittens may be placed on infant for aesthetic purposes. Encourage parents to touch covered hands and feet.
5. Set Nebulizer temp to 34° (Enter patients actual temp on ABG Machine for accurate Co2 results.)

Re-warming Procedure

1. Re-warming is done gradually over minimum of 6 hours after completion of the 72-hour period

of cooling.

2. Core body temperature is slowly increased at the rate of 0.5 C per hour over a 6 hour period.
    - Each hour increase the cooling blanket SETPOINT temperature by 0.5° C (to maximum SETPOINT of 36.5° C).
3. Cooling blanket is maintained at **GRADIENT VARIABLE**
    - Press the TEMPERATURE SET switch; use the up arrow to increase the SETPOINT by 0.5° C.
    - Press the GRADIENT VARIABLE button.
    - Set the desired gradient variable offset to 6-10° C or as ordered, and press the GRADIENT VARIABLE button again.
4. At the end of the 6-hour re-warming period, the infant's thermoregulation will be returned to the overhead warmer and temperature maintenance as per NICU protocol.
5. Esophageal, cooling blanket temperature; vital signs are performed frequently, as outlined in the "Initiating hypothermia" section.
6. Monitor closely during re-warming, then at least 24 hours afterwards for:
    - Seizures
    - Rebound hyperthermia
    - Acidosis
    - Hypocalcemia
    - Hypoglycemia
    - Hyperkalemia
    - Hypermagnesemia
    - Diuresis/oliguria
    - Vasodilatation and hypotension

Conclusion of Hypothermia Therapy

1. Turn off cooling blanket. Keep the blanket and hose to connect to the unit for about 10 minutes.
2. Remove the esophageal probe from the patient and the esophageal cable from the probe jack.
3. Disconnect the power cord from the power source, loosely coil it and attach it to the back panel using nylon strap
4. Disconnect the connecting hose from the unit. Remove the blanket.
5. Needs to go to Biomed every 90 days to drain H2O.

Monitoring/Documentation

1. Esophageal, blanket/water temperatures, Heart Rate, Respiration, Blood Pressure and Oxygen Saturation are to be monitored/documented as follows:

a. Q 15 minutes for the first 2 hours (hours 0-2)
b. Q 30 minutes for the next 2 hours (hours 2-4)
c. Q 1 hour for the next 68 hours (hours 4-72)

*Frequent Vital Sign Form may need to be used during the first 6 hours

2. Labs: Frequent labs will be ordered per physician~~/NNP~~ during cooling and will be documented per policy.
3. EEG Via a cerebral function monitor/~~see~~ Olympic Brainz Monitor Quick Start Guide
4. All other documentation per VCMC NICU policy.

SPECIAL PRECAUTIONS

1. During cooling expect:
    a. Decreased Heart Rate. Lower limit of HR monitor to 80 bpm as the HR of the infant being cooled will be in the low 100's or below 100. Heart rates in the 70's may be tolerated as long as the infant has a normal sinus rhythm, stable BP and saturation.
    b. Increased blood pressure initially due to increases in peripheral vasoconstriction
    c. Increase in urine output initially due to shunting of blood to the internal organs, cold and diuresis
    d. Decrease in serum calcium, phosphorus and potassium.
    e. Labile glucose due to relative insulin resistance, decreased metabolic rate and shivering. Shivering is not unusual in these infants.
2. During re-warming expect:
    a. Increase in Heart Rate
    b. Decrease in blood pressure due to decrease in peripheral vascular resistance.
    c. Decrease in urine output due to increases in third spacing and shunting of blood to the periphery.
    d. Electrolyte shifts, as renal and liver clearance rates change.
3. Keep blanket dry and away from sharp objects.
4. Infant can be positioned and turned normally while maintaining full contact with cooling blanket. Check every two hours for skin breakdown-adjusting position to avoid pressure points.
5. Notify physician~~/NNP~~ if:
    a. Temperature falls below 31° C
    b. 02 Sats < 85%
    c. Heart Rate<80 bpm and > 180 bpm
    d. Mean arterial pressures <40 mmHg
    e. Urine output <1 ml/kg/hour
    f. Blood glucose <60 and > 180 mg/dl

g. Bleeding

h. Evidence of skin breakdown

6. If power outage, Blanketrol defaults to 37° degrees.

REFERENCES

1. Beauman S.S. and Bowles, S. (2019).Policies, Procedures, and Competencies for Neonatal Nursing Care. 6th Edition. National Association of Neonatal Nursing.
2. Blanketrol III Operation Manual; Model 233 Hyper-Hypothermia System(2020) by Gentherm Medical LLC
3. Gardner, S., Carter, B.S, Enzman-Hines, M., and Niermeyer, S. (2016) Merenstein & Gardner's Handbook of Neonatal Intensive Care. An Interprofessional Approach. 9th Edition. Elsevier. pages 956-958
4. Verklan, M.T., Walden, M. and Forest, S. (2021) Core Curriculum for Neonatal Intensive Care Nursing. 6th Edition. AWHONN; American Association of Critical-Care Nurses, National Association of Neonatal Nurses. Elsevier. pages 649-652.

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Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	1/9/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/21/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/20/2024
NICU	Robert Posen: NICU Medical Director	12/20/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	12/20/2024

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

OB.28 Elective Termination of Pregnancy

POLICY:

To provide Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) Obstetrics (OB) Departments staff with guidelines regarding their responsibilities in caring for patients for induction of fetal demise related to pregnancy termination.

PURPOSE:

To induce fetal death prior to a procedure such as dilation and evacuation (D&E) or induction of labor for termination prior to ~~22~~23+6/7 weeks gestation by LMP and/or early ultrasound dating. The purpose of this procedure is to aid in a D&E procedure or to ensure fetal demise prior to delivery for induction.

1. Induction of fetal death is indicated for patients undergoing:
    a. Induction of labor for termination of pregnancy if greater than or equal to ~~22~~23+~~0/7~~6/7 weeks gestation by best dating on the day of induction. **OR**
    b. Dilation and evacuation for termination of pregnancy if requested by surgical provider.

PROCEDURE:

A. Staff members have the responsibility to provide care to women undergoing elective termination of pregnancy. Care focuses on bio-psychosocial health promotion, maintenance, and/or restoration by attending to the woman's need for information to promote informed decision making, physiologic stability, personal hygiene, comfort, safety, and emotional support.

B. Right of staff members to participate or object to participating in an abortion:
    1. Staff members may decline to participate in an elective termination. No staff member may impose their personal beliefs onto the said patient or care provider. For the purpose of this policy staff member includes all licensed and support staff.
    2. Obligation to the patient does not stop when the patient's values conflict with those of the practitioner. While the staff member has the right to conscientiously object to participating in an abortion, the staff member is obligated to abide by the patient's values, even temporarily, until care is transferred to another staff member.
    3. A staff member shall not be penalized, harassed, embarrassed or disciplined for participating or refusing to participate in the performance of an abortion in keeping with the staff member's moral, ethical or religious beliefs.

GUIDELINES

A. Preparation of patient
    1. Reassure patient.
    2. Informed consent provided by physician team
    3. Nursing staff to obtain signed consent forms
    4. Explain the procedure to patient. Use of digoxin by physician. Insertion of lamaneria or cytotec by physician or registered nurse using sterile gloves and lubricant.
B. Digoxin 1.5-2mg/ml as ordered
C. Laminaria or Cytotec as ordered (*see Policy **OB. 24,** Use of intrauterine Cervical Ripening Agent with Fetal Demise)*
D. Preparation of equipment and supplies at bedside.
E. Assist physician as indicated.
F. Check blood pressure prior to procedure, immediately after and as ordered, more frequently if indicated. Check temperature every four (4) hours, every 2 hours if ruptured.
G. Observe carefully for excessive blood post-delivery. D&C may be required to completely empty uterus.

EQUIPMENT

A. IV Pitocin per protocol
B. BP cuff, stethoscope, thermometer
C. Amniocentesis Tray when administering Digoxin
D. Digoxin
E. Lamanaria or cytotec
F. Gloves (sterile)
G. Lubricant
H. BOA pack

I. Container or crib for fetus.

J. IV Infusion pump

DOCUMENTATION

A. Document all medication on the MAR. Document in EHR.

B. Indicate time of delivery, sex, weight, and length of fetus. Record disposition of fetus. See OB policy OB.29, *Management of Antepartum Fetal Death*.

C. In preparing fetus for Morgue, place identification bands on infant, wrap in baby blanket and chux. Place identification card with infant's name, weight, length and place on outside of chux.

D. If sent to the Laboratory, properly label container with name and hospital number of mother.

E. Place pathology order in Cerner EHR

F. Place order for Autopsy if requested by family or provider.

KEY POINTS

A. Observe Standard Precautions

B. Obtain consents; include consent for possible Dilatation and Curetage, and blood administration.

C. Psychological support of the patient is of extreme importance. Notify social worker. See OB policy OB.29, *Management of Antepartum Fetal Death*.

D. Explore patient's wishes to see or to hold fetus after birth.

E. Observe patient for pain, start Patient Controlled Analgesia as ordered and assess effectiveness.

F. Products of Conception (See OB policy OB.29, *Management of Antepartum Fetal Death*):

1. Are to be examined by the physician prior to being placed in formalin solution and sent to the Laboratory. If fetus is past 20 weeks gestation, over 500 grams in weight or over 25 cm in length, a stillborn certificate and disposition of remains are required.
2. Nursing staff will record delivery information in the delivery logbook as follows:
    a. Use green ink for **all** fetal demises. Record demises less than 20 weeks in the back of the book marked "Fetal Demise, Less Than 20 Weeks." Record demises greater than 20 weeks or greater than 500 grams if dates are unknown in regular section of delivery book.
    b. Live births over 20 weeks with heartbeat, respirations or other signs of life are recorded in regular section of book in black ink.
3. Upon request of burial by parents, arrangements with mortuary to be made by parents with social services.
4. Fetus weighed and measured in OB if indicated.
5. If patient cannot afford burial, consent form for VCMC to handle disposition of the

fetus will be signed ("Authorization to Retain and Dispose of Body Form") See OB policy OB.29, *Management of Antepartum Fetal Death*.

6. Honor patient's wishes as to hold the fetus, take 2 pictures, a lock of hair if applicable, and footprints to give to family.
7. Check OB policy OB.29, *Management of Antepartum Fetal Death,* to see that all paperwork is completed by Social Services or nursing.

REFERENCES:

www.rn.ca.gov - Board of Registered Nurses, Reproductive Privacy Act

AWHONN: Perinatal Nursing, 4th Edition, 2013

All Revision Dates

1/2/2025, 12/8/2020, 7/1/2010, 4/1/2008, 1/1/2005, 12/1/1992

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	1/9/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/15/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/30/2023
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/30/2023
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/30/2023

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VENTURA COUNTY HEALTH CARE AGENCY

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

OB.30 Induction of Labor

POLICY:

Labor induction is the initiation of labor prior to spontaneous onset by artificial means with the purpose of accomplishing delivery. All inductions will require approval from the OB/GYN attending reviewing the request.

PROCEDURE:

A. Medical indications (ACOG) for induction/delivery include:

1. ~~Chorioamnionitis~~
2. ~~Fetal demise~~
3. ~~Gestational hypertension~~
4. ~~Preeclampsia, eclampsia~~
5. ~~Premature rupture of membranes~~
6. ~~Post term pregnancy exceeding 41 0/7 weeks gestation~~
7. ~~Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)~~
8. ~~Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios)~~

i. Chorioamnionitis
ii. Fetal demise
iii. Gestational hypertension

iv. Preeclampsia or Gestational Hypertension, eclampsia

v. Premature rupture of membranes

vi. Post term pregnancy exceeding ≥ 41 0/7 weeks gestation

vii. Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome, PUPPS, thromboembolism)

viii. Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios, previous stillbirth, abnormal antenatal testing.)

B. Non-medically indicated induction/delivery does not occur prior to 39 weeks gestation.

C. For non-medically indicated inductions 39 weeks or greater, a pelvic assessment is performed to include pelvic adequacy and a Bishop Score ≥ six.

D. ~~Upon receiving physician's order, RN may administer oxytocin drugs for induction or augmentation of labor.~~

~~INDICATIONS~~

Confirmation of Gestational Age (ACOG):

To prevent iatrogenic prematurity, full term should be confirmed unless fetal maturity can be inferred from ~~any~~one of the following ~~historic~~ACOG criteria:

- Ultrasound measurement at less than 22 weeks of gestation supports gestational age of 39 weeks or greater.
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.
- Amniocentesis and documentation of fetal lung maturity.
- An ultrasound may be considered to confirm menstrual dates if there is a gestational age agreement within one (1) week by crown-rump measurements obtained in the first trimester or within 10 days by an average of multiple fetal biometric measurements (e.g., crown-rump length, biparietal diameter, head and abdominal circumference, and femur length) obtained in the second trimester (up to 22 weeks of gestation). (ACOG, 2017).

~~If any of these criteria confirms a gestational age of 39 weeks or more, it is appropriate to schedule delivery at that time. Ultrasonography may be considered to confirm menstrual dates if there is a gestational age agreement within one (1) week by crown-rump measurements obtained in the first trimester or within 10 days by an average of multiple fetal biometric measurements (e.g., crown-rump length, biparietal diameter, head and abdominal circumference, and femur length) obtained in the second trimester (up to 22 weeks of gestation). (ACOG, 2017).~~

Scheduling

If any of these criteria confirms a gestational age of 39 weeks or more, it is appropriate to schedule

Induction of labor if indicated.

1. Requesting Provider or designee will contact the labor and delivery (L&D) scheduler using the EHR Message Center Labor Induction Pool. The patients name, medical record number and date of birth will be provided. Indication for the induction of labor, gestational age at the time of induction.
2. The attending OB physician will review the request for approval. Once approved the L&D nursing team will notify the provider and patient of the proposed induction of labor date and time.
3. L&D will accommodate 3 inductions on weekdays, 0700, 1500 and 2000. And no more than two inductions on weekends, 0800 and 2000. Scheduled inductions include induction of labor by any method.
4. Patient's with medical indications will have priority over elective inductions which may delay or cancel an elective scheduled induction.
5. When resources are not available due to staffing shortage or high acuity/census, scheduled inductions will be evaluated and prioritized related to their indication and delayed as needed. L&D nursing team will notify patient and requesting provider.
6. When a request for a medically indicated induction is made and the maximum number of scheduled induction has been met, the OB attending and charge nurse may add an additional induction as resources permit, or delay a previously scheduled induction as needed.

DEFINITIONS

A. **Induction of labor**: The use of pharmacologic methods to initiate uterine contractions before spontaneous labor occurs in order to affect vaginal birth. Oxytocin is a drug used in the medical induction of labor and is also used to augment existing contraction patterns that may not be adequate for progression of labor.

B. **Augmentation of labor:** The process of increasing the strength, frequency or duration of already present uterine contractions with pharmacologic methods when spontaneous contractions have failed to result in progressive cervical dilation or descent of the fetus.

C. **Tachysystole:** Uterine Tachysystole is defined as more than five contractions in 10 minutes, averaged over a 30-minute window.

D. **Montevideo Units (MVU)**- A measurement used to calculate uterine contraction strength. Montevideo units are calculated by measuring the peak intensity, or amplitude in ~~mmHg~~mm Hg for each contraction ~~occuring~~occurring in a 10-minute period of time and adding these numbers together. Contraction amplitude is the difference between the resting tone and peak of the contraction. A contraction pattern totaling at at least 200 MVU's per 10-minute period is considered as adequate labor.

~~EQUIPMENT~~

~~A. Calibrated infusion pump/IV tubing.~~

~~B. Fetal monitor and central fetal monitoring for continuous fetal monitoring.~~

~~C. Pre-mixed bag of Pitocin in N/S.~~

~~D. O2 and suction.~~

~~E. BP cuff.~~

GUIDELINES

A. The patient will be admitted to the hospital with a physician's order indicating appropriate indication. Physician will also order type and screen. Assessment of fetal size shall be documented prior to cervical ripening or induction of labor.

B. Vertex presentation will be determined by physician with exam or ultrasound.

C. Obtain a twenty-minute recording of the baseline fetal heart rate and uterine contraction pattern with reassuring fetal strip before beginning infusion of oxytocin.

D. The patient's cervix must be examined by the RN or physician within the 2 hour period preceding the initiation of the oxytocin infusion, to assess for contraindications and establish the baseline for future examinations.

E. A controlled infusion system must be used for oxytocin administration.

1. A two-~~bottle~~ bag infusion set will be used. Oxytocin should never be used as the primary IV line.
2. Oxytocin requires a double-check when initiating an infusion or changing a bag.
3. The secondary IV shall be a pre-mixed solution of 500 ~~ml~~mL NS with 30 units of oxytocin.
   ~~2 milliunit per minute = 2 ml/hr~~
   ~~4 milliunit per minute = 4ml/hr~~
   ~~8 milliunit per minute = 8 ml/hr~~
   ~~10 milliunit per minute = 10 ml/hr~~
   ~~12 milliunit per minute= 12 ml/hr~~
4. The secondary IV shall be "piggybacked" to the primary IV infusion at the insertion port closest to the venipuncture site. Label tubing with ~~red~~ medication label near the IV pump. When starting infusions or changing bags, trace the tubing by hand from the IV bag to the pump and then to the patient for verification.
5. An IV administration pump must be used for administration of ~~Pitocin~~oxytocin.

F. A registered nurse may initiate and monitor an oxytocin infusion as follows upon a physician's order for ~~Oxytocin~~oxytocin induction/augmentation per protocol.

1. Initiation and infusing oxytocin.
   a. Unless specified otherwise by written physician's order, the initial dose of oxytocin shall be two (2) milliunits per minute, 2 ml/hr.
   b. Prior to each increase in oxytocin rate of infusion, the fetal heart rate and uterine contraction pattern should be assessed.
   c. Refer to the Induction/Augmentation Physician Orders.
2. Monitoring an oxytocin infusion.
   a. The uterine contractions and fetal heart rate shall be electronically

monitored during the administration of oxytocin. Patient may be off monitor for bathroom privileges for <10 minutes per event. Tachysystole can occur with oxytocin drugs. Contractions are monitored by quantity and strength by palpation or Intra Uterine Pressure Catheter (IUPC)~~mmHg~~ mm Hg.

b. The rate of oxytocin infusion shall be increased no sooner than every 30 minutes and no more than 2 million units/min (2 mL/hr), until labor pattern is established, meaning contractions every 2-3 minutes of moderate intensity to palpation, or 50-60 ~~mmHg~~mm Hg above baseline with IUPC use, or Montevideo units or ≥200.

    i. 2 milliunit per minute = 2 mL/hr
    4 milliunit per minute = 4 mL/hr
    8 milliunit per minute = 8 mL/hr
    10 milliunit per minute = 10 mL/hr
    12 milliunit per minute= 12 mL/hr

c. Uterine activity should not to exceed 5 contractions occurring more frequent than 5 in a 10 minutes, averaged over a 30 minute window.

d. Increase infusion rate until adequate uterine activity is achieved to a maximum dose of 20 milliunits/minute of oxytocin. ***A physician communication order is needed to increase oxytocin beyond 20 milliunits/minute.***

e. Adequate uterine activity is defined as:

    a. 3-5 contractions in a 10 minute period with a maximum, not to exceed 5 contractions in a 10 minute period.

    b. Contraction duration of 40-90 seconds.

f. Fetal heart rate and uterine activity shall be recorded in the Electronic Health Record (EHR). (Refer to Policy ~~OB .45 Management of Fetal Heart Rate Tracing~~OB.45 Management of Fetal Heart Rate Tracing) **Assessment of maternal-fetal status occurs every 15 minutes during oxytocin administration.**

g. Document in the EHR each time oxytocin in increased or decreased. If the dose remains unchanged, no further oxytocin rate documentation is required until a change in rate is made.

h. Maternal blood pressure, pulse and respiration shall be recorded in the EHR hourly, unless otherwise clinically indicated.

i. Assess maternal temperature every 4 hours, or every 2 hours if membranes ruptured or more frequent if clinically indicated.

j. Intake and output shall be monitored and recorded in the EHR as ordered.

G. During the administration of oxytocin, the attending physician must be directly available by phone. A physician capable of performing a cesarean delivery should be readily available and manage complications of induction including tachysystole.

H. The oxytocin rate of infusion shall be titrated and decreased if contractions are more frequent then every 2 minutes or when the baseline resting uterine tone increases to 30 mmHg by internal monitor.

I. **Decrease Oxytocin for:**

1. Uterine Tachysystole
2. Contractions lasting 2 minutes or more
3. Insufficient return of uterine resting tone between contractions via palpation or
4. ~~Intraamniotic~~Intra-amniotic pressure above 25 mmHg between contractions via IUPC.

Note: Decreasing the oxytocin dose by half rather than stopping it may correct the abnormal contraction pattern, and may prevent delay in delivery. Additionally changing patients position, and giving an IV fluid bolus of lactated ringers solution are interventions for internal resuscitation.

J. Observe for and discontinue oxytocin~~, for:~~ at discretion If; (***~~Notify~~ Providers must be notified when oxytocin will be stopped or discontinued).***

1. Signs and symptoms of uterine rupture-may be asymptomatic; possible signs or symptoms include vaginal bleeding, non-reassuring fetal heart rate, abdominal pain
2. ~~Non~~Category II-~~reassuring~~III fetal heart ~~pattern~~rate patterns which may include: ***See attachment Algorithm for Management of Category II Fetal Heart Rate Tracings.***
    a. Recurrent variable decelerations
    b. fetal tachycardia or bradycardia
    c. minimal to absent baseline ~~FHR~~fetal heart rate variability
    d. ~~late~~Late decelerations
    e. Tachysystole- (series of uterine contractions lasting 2 minutes or more or a contraction frequency of 5 contractions or more in 10 minutes).
    f. Hypotension
    g. Tachycardia
    h. Maternal Shock/vascular collapse
    i. Respiratory Distress. Water intoxication-combination of pitocin and large amounts of fluids.
    j. Vaginal Bleeding

Oxytocin infusion may be restarted with physician order, not more than half the dose if it had been discontinued for ~~<20 to~~less than 30 minutes. If oxytocin is discontinued for ~~>~~more than 30 to 40 minutes, it ~~may~~should be ~~resumed~~restarted at the initial dose ordered.

KEY POINTS

A. Intravenous infusion is the only accepted method of oxytocin administration before delivery. It

should be infused using a volumetric pump and never as an IV bolus.

B. Pharmacologic effects:
    1. Half-life 3 – 6 minutes (IV infusion)
    2. Contractility effect on uterus (target organ)
    3. Milk ejection
    4. Antidiuretic (vasopressin effect)
    5. Cardiovascular

C. Logistic factors to be considered:
    1. Available resources for immediate intervention
    2. Risk of rapid labor
    3. Cesarean Section capabilities

D. Relative contraindications to induction of labor include but are not limited to:
    1. Placenta or vasa previa
    2. Non-longitudinal lie
    3. Cord presentation
    4. Presenting part above the pelvic inlet
    5. Prior caesarean section
    6. Active genital herpes infection
    7. Pelvic structural deformities
    8. ~~Invasive cervical carcinoma~~
    9. Myomectomy with entry into uterine cavity
    10. Previous classical hysterotomy

REFERENCES:

AWHONN: Perinatal Nursing, ~~4~~5TH edition, ~~2013~~2021.

ACOG Practice Bulletin, Number 97, September 2008.

ACOG Practice Bulletin #106, July 2009
ACOG Bulletin #107, August 2009, Reaffirmed 2015
ACOG Practice Bulletin Number 107

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Attachments

A: Uterine Tachysystole Algorithm for Use with Oxytocin Administration

Algorithm for Management of Second Stage.pdf

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	1/3/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/6/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/5/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/5/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	11/5/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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

OB.62 Trial of Labor After Cesarean (TOLAC)

POLICY:

Trial of labor after Cesarean (TOLAC) will be allowed in ~~women~~patients who have had one or two previous Cesarean Sections and meet the other TOLAC criteria. Prostaglandins will not be administered for induction of TOLAC patients. Oxytocin use in TOLAC patients is not contraindicated.

~~Women~~Patients who have had one or two previous Cesarean Sections may have a ~~trial of labor~~Trial of Labor after Cesarean (TOLAC) if they meet the OB/GYN department's criteria and guidelines. The appropriate physician will counsel the ~~woman~~patient about the risks and benefits of a TOLAC and ~~Vaginal Birth After~~Repeat Cesarean ~~(VBAC) and Repeat Cesarean~~ Section. This must be documented and the TOLAC informed consent signed. Anesthesia and the OB surgical team will be immediately available during active labor.

PROCEDURE:

1. INFORMATION:
    A. Candidates for TOLAC:
        1. Time interval since previous Cesarean Sections will be a minimum of 18 months from last Cesarean Section to estimated delivery date (EDD).
        2. The ~~woman~~patient has had no more than two prior Cesarean Section deliveries.
        3. The ~~woman~~patient has had no other uterine scars or ruptures, whether from previous Cesarean Section or uterine surgeries.
        4. The clinical assessment suggests the ~~woman~~patient has a pelvis clinically

large enough to allow a vaginal birth.

B. Contraindications to a trial of labor:

1. A ~~woman~~patient who has had a vertical or t-shaped uterine incision scar.
2. A ~~woman~~patient with a documented small maternal pelvis or a documented macrosomic baby greater than 4500 grams. A ~~woman~~patient with any contraindication to vaginal delivery (e.g. placenta previa).

C. Staffing:

1. A physician with privileges to perform a Cesarean Section will be continuously present at VCMC when a TOLAC patient is in labor.
2. Anesthesia and surgical team are immediately available for an emergent Cesarean Section during the active phase of labor (i.e. 6 cm dilated cervix) or earlier at the discretion of the attending physician on call.

D. Induction of Labor (IOL) in TOLAC Candidates:

1. With shared decision making, induction of labor (IOL) is a reasonable option for a well counseled TOLAC candidate. Counseling should include a discussion of the possibility of a lower rate of Vaginal Birth after Cesarean (VBAC) success, and the possibility of an increased risk of uterine rupture.
2. VCHCA Induction of Labor Policy (OB.30) will be followed.
3. Cervical Ripening with a balloon catheter is acceptable. Prostaglandins, including misoprostol, are contraindicated.
4. Except as described above, the indications for, the timing of, and the counseling for IOL in TOLAC candidates is the same as for patients who have not had a prior Cesarean Delivery.

GUIDELINES:

A. **TOLAC IN HOUSE**: When a TOLAC patient is determined to be in labor, the attending physician, nurse or resident will call Operator and ask them to activate the **TOLAC In House** call list. The operator ~~and ask them to activate the **TOLAC In House** call list. The operator~~ will contact the ~~obstetrician or OB/FP~~Obstetrician or Family Medicine physician on front-up call, the Anesthesiologist and the Nursing Supervisor with a TOLAC In House page. The Nursing Supervisor will notify the scrub tech on call for TOLAC's. Time of notification will be recorded. The Obstetrician or family medicine attending with Cesarean Section privileges will assess the patient to see if she is still a TOLAC candidate. This will be documented in the electronic health record (EHR) on the "OB TOLAC Intrapartum Checklist."

B. **TOLAC ACTIVE**: When the TOLAC patient is in active labor, or earlier at the discretion of the attending physician, the attending physician will call the paging operator and ask them to activate the TOLAC Active call list. The operator will page the Obstetrician of Family Medicine physician on front-up call, the Anesthesiologist and the Nursing Supervisor with a TOLAC Active page. The Nursing Supervisor will notify the scrub tech. The Anesthesiologist and scrub tech should come immediately to labor and delivery (L&D) and sign in. Sign in time should be documented in the "TOLAC Sign In" folder in L&D using the time on a digital device (cell phone). If the obstetrician on call is not the Cesarean Section privileged physician who is

primarily responsible for the care of the TOLAC patient, the obstetrician will immediately call Labor and Delivery to acknowledge the TOLAC Active page and will prepare to come to the hospital if needed.

C. Informed consent for TOLAC will be obtained. The TOLAC consent form and Cesarean consent form will be signed.

D. Any physician with obstetrical privileges may manage a TOLAC patient, with the following expectations;

    1. The attending physician managing the patient should be present in the hospital throughout labor.
    2. A physician with Cesarean Section privileges must also be present in the hospital throughout labor.

E. Neonatal intensive care unit (NICU) will be notified of all TOLAC patients.

F. Establish intravenous accesses with # 18 gauge catheter.

G. Obtain CBC and Type and Screen.

H. Keep patient NPO, except for clear fluids.

I. Continuous fetal and uterine activity monitoring will occur in labor

J. Notify anesthesia of patient's admission.

K. Have one operating room (OR) room available as long as the patient is in labor. The scrub tech will have all packs and instruments ready for immediate opening. Availability can include Main OR when more than 1 TOLAC is on Labor and Delivery Unit.

L. The patient may receive an epidural anesthesia when desired.

M. Oxytocin may be used for patients desiring vaginal birth after cesarean, who have been evaluated by the physician and screened using criteria in the Trial of Labor After Cesarean (TOLAC) Policy and have signed the TOLAC consent form. Follow Oxytocin Administration Orders. ~~See also~~Consider use of Intra Uterine Pressure Catheter (IUPC). Follow Oxytocin Administration Guidelines Policy OB 30.

N. Rupture of membranes to induce or augment labor is acceptable.

O. Use of a ~~Foley bulb~~mechanical ripening device without Oxytocin to ripen the cervix is an acceptable practice for an unfavorable cervix. Prostaglandins including misoprostol are contraindicated.

P. ~~A~~An external cephalic version (ECV) may be attempted on patients with prior low transverse uterine incision who are at low risk for adverse maternal or neonatal outcomes from external cephalic version and TOLAC (American Collage of Obstetricians & Gynecologists (ACOG) Practice Bulletin #115) at the discretion of the physician.

NURSING CARE:

A. The nurse must provide ongoing care and assessment with particular attention to signs and symptoms of uterine rupture:

    1. Signs and Symptoms of Uterine Rupture
        a. Development of Category II (involving recurrent late or variable

decelerations) or III fetal heart rate pattern.

b. Constant discomfort, which does not subside between contractions.

c. Marked maternal restlessness and/or anxiety inconsistent with the intensity contractions or with discernible contractions.
Persistent abdominal pain over symphysis pubis, even with epidural.

d. ~~Persistent abdominal pain over symphysis pubis, even with epidural.~~

e. Difficulty obtaining technically adequate fetal heart rate and contraction pattern due to possible patient restlessness, increased uterine tonus with ongoing slow rupture or tocometer/ultrasound located over the area of rupture.

f. Ripping/tearing sensation in abdominal suprapubic area due to frank rupture

g. Perception by patient that the baby's position has changed radically (i.e. moving up near ribs ~~or palpated fetal anotomy~~).

h. Elevation in station of fetal head or presenting part cannot be palpated.

i. Abnormal pain, such as shoulder pain.

B. All Labor and Delivery RNs will complete a competency on care of the ~~woman~~patient desiring a TOLAC and recognize the signs and symptoms of uterine rupture.

DOCUMENTS:

A. TOLAC checklist

B. TOLAC consent form # 7224

C. TOLAC Candidate Physician Assessment Form

REFERENCES:

A. ACOG practice bulletin #115 Vaginal Birth After Previous Cesarean Delivery (August 2010).

B. American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. 2007. Guidelines for Perinatal Care 6th ed. P. 120-121; P 157.

C. Caughey, Aaron B. 2008. Vaginal Birth After Cesarean Delivery. Downloaded from http://emedicine,medscape.com/art 1/6/2009. p1-16.

D. Clark, Steven L., Belfoit, Michael A., Dildy, Gary A., & Meyers, Janet A. 2008. Reducing obstetric litigation through alterations in practice patterns. Obstetrics & Gynecology. 112 (6), 1279-1283.

E. Ebeell, Mark H., 2007. Point of Care Guides Predicting the Likelihood of Successful vaginal birth after cesarean delivery. American Family Physician. Downloaded from http://www.aafp.org/afp/AFP print. 1-5.

F. Landon, Mark B., 2008. Vaginal birth after Cesarean Delivery. Clinics in Perinatology. 35. 491-504.

All Revision Dates

1/6/2025, 6/11/2024, 2/1/2021, 1/12/2021, 11/17/2017, 5/1/2016

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	1/9/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/8/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/8/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	7/8/2024

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PH.69 Medications Stored at Bedside for Self-Administration

POLICY:

Limited medications may be stored at the patient's bedside for self-administration. Self-administration of medications must be specifically ordered by the provider. All self-medicated doses shall be documented in the medication administration record (MAR) in the electronic health record (EHR). Drugs listed under DEA Schedule II, III, IV, or V may not be left at bedside. Bedside medications shall not be allowed in the Inpatient Psychiatric Unit.

PROCEDURE:

I. Bedside medications shall be limited to the following medications:
   A. Metered dose inhalers.
   B. Topical Agents, skin and lip moisturizers.
   C. Exceptions to these items must be approved by the provider.
   D. For patient's own insulin pump, refer to policy DM.006, *Insulin Pumps*.

II. Patients must demonstrate to the nurse proficiency in self-administration of medication(s) before they are left at the bedside.

III. The patient's nurse shall instruct the patient as follows:
   a. The indication for the use of the medication.
   b. How to use the medication.
   c. When to use the medication.

d. How often it may be repeated.
e. How to store the medication when not in use.
f. Inform the nurse when medication is used.

IV. The patient's nurse shall verify on the first self-administration of medication that the patient properly self-administered the medication.
V. Replacement doses shall be ordered as needed from the Pharmacy Department.
VI. Self-administered doses shall be documented in the MAR.
VII. If the medication is not used, this should be noted in the nursing notes.

All Revision Dates

1/12/2022, 11/26/2018, 8/1/2015, 12/1/2004, 12/1/2001, 11/1/1998, 1/1/1993

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	12/6/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	12/6/2024

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Next Review	3 years after approval		

PH.70 High Alert Medications

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) shall maintain a list of high alert medications in order to increase patient safety by identifying and implementing strategies to avoid preventable injuries.

While the Institute of Safe Medication Practices (ISMP) does not recommend independent double checks for all high alert medications, Pharmacy and Nursing staff shall complete independent double checks for select high risk medications, prior to medication dispensing and administration.

DEFINITIONS:

1. High Alert medications are those drugs that have been identified as potentially causing significant harm if administered incorrectly.

2. Independent double check (IDC) is a manual process requiring two licensed practitioners separately, checking each component of the work process and comparing the results. By conducting this double check independently of each other, the risk of bias is reduced, as two practitioners are less likely to make the same mistake.

3. Verification double check is the process where two licensed practitioners are simultaneously checking a portion of the work process.

4. Required witness cosign refers to the required Medication Administration Record (MAR) documentation by another licensed practitioner before the medication can be dispensed and/or administered.

5. The "seven rights" of safe medication administration includes verification of the following:

- Right patient,
- Right drug,
- Right dose,
- Right route,
- Right time,
- Right indication, and
- Right documentation.

PROCEDURE:

A. The Pharmacy and Therapeutics Committee, in conjunction with pharmacy and nursing services, shall review the list of "High Alert" medications every three (3) years or as indicated, addressing those high alert medications that have been identified from internal adverse drug events (medication errors and adverse drug reactions), Institute for Safe Medication Practices (ISMP), the U.S. Food and Drug Administration (FDA), and The Joint Commission (TJC). See Attachment A.

B. The "High Alert" medication list shall be made available in all patient care areas, for reference, and shall describe each medication or class of medication from the time of procurement, storage, ordering, preparing, administration, and monitoring.

C. Automated double check is a computerized system safeguard (e.g. bar code scanning) and should be used to compliment, not substitute, the 7 Rights of Safe Medication Administration.

D. Pharmacists shall perform independent double checks on chemotherapy/antineoplastic orders and intrathecal compounded sterile products

E. Pharmacists shall perform verification double checks on the following prior to dispensing:
    1. Compounded high alert medications that are normally supplied premixed.
    2. Pediatric, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) parenteral infusions
    3. Parenteral nutrition (peripheral parenteral nutrition (PPN), total parenteral nutrition (TPN))
    4. Cisatracurium infusions
    5. Amphotericin infusions.
    6. Continuous Renal Replacement Therapy (CRRT) fluids
    7. In the event there is no second pharmacist available for a verification double check, a pharmacy technician shall perform the verification double check.

F. Nursing shall perform IDCs with required witness cosign on the following:
    1. Anticoagulants (intravenous)
        a. Alteplase for stroke - bolus and start of infusion
        b. Argatroban infusion - start of infusion, rate changes, and bag changes
        c. Heparin infusions - bolus, start of infusion, rate changes, and bag changes

2. Chemotherapy/antineoplastics - before administration with two competent, licensed health care providers
3. Hypertonic saline - start of infusion
4. Insulin intravenous (IV) infusion - before administration, rate changes, and bag changes
5. Magnesium 20 gm/500 mL - start of infusion (see policy OB.47 Magnesium Sulfate for Pre-Eclampsia and Tocolytic Therapy
6. Oxytocin for labor induction/augmentation - start of infusion and bag changes (see policy OB.30 Oxytocin use for Labor Induction/Augmentation)
7. Patient Controlled Analgesia (PCAs) - initial set up, reprogramming the pump, and with syringe changes (see policy 100.235 Patient-Controlled Analgesia (PCA)

G. Nursing should perform the following:
    1. Independent double check at pump change (e.g., between an Alaris pump and an MRI pump)
    2. Bedside review of all infusions at start of shift.

H. The licensed health care provider shall perform verification double checks, with required witness cosign on the following medications:
    1. ~~Emergency Department (ED) administration of ALL pediatric, NICU, and PICU parenteral medications - before administration.~~
    2. Respiratory Therapist administration of inhaled epoprostenol - start of therapy (see policy R.96 Inhaled Epoprostenol (Flolan))

Independent Double Check Procedure

Prior to medication administration, two licensed health care providers shall independently go through the steps in the double check procedure below and arrive at the same conclusion. IDC must be performed before the start of the infusion/before administration of the medication.

A. Identify the patient using two patient identifiers (name and date of birth). See policy 100.088 Patient Identification
B. Review allergies and sensitivities
C. Compare the most current prescriber order or medication administration record to the medication label to verify:
    1. Right patient name
    2. Right drug
        a. Right diluent if applicable
        b. Right concentration if applicable
    3. Right dose
        a. Right weight based dosing if applicable
        b. Right rate of administration

4. Right frequency and time of administration
5. Right route
6. Right indication
7. Right documentation

D. Ensure the pharmacy label matches the manufacturer label (if appropriate).
E. Review expiration and/or beyond use date of the medication.
F. Perform any necessary calculations.
G. Review medication protocols when or if applicable (e.g. heparin protocol or TPN order)
H. Check the patient's relevant lab values and/or diagnostic results
I. Program the IV pump and review the settings. Confirm the rate and trace the lines.
J. If discrepancies exist, the two health care providers shall repeat the IDC process. If discrepancies remain, the health care provider shall clarify the medication order(s) with the provider.
K. If the IDC verifies the medication and process to be correct, both health care providers shall document that an IDC has been completed and the medication can be dispensed and/or administered.
L. Re-identify the patient (name and date of birth) immediately prior to administration.

All Revision Dates

11/25/2024, 3/14/2023, 10/12/2021, 3/9/2021, 2/12/2020, 5/2/2019, 6/1/2008

Attachments

Attachment A - High Alert Medication List.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	12/6/2024
Pharmacy Services	Sara Pendleton: Medication Safety Officer	12/6/2024

Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	12/6/2024

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Owner	Sul Jung: Associate Director of Pharmacy Services
Policy Area	Pharmacy Services

PH.88 Controlled Substances

POLICY:

The Ventura County Medical Center/Santa Paula Hospital Department of Pharmacy Services is responsible for the acquisition, disposition and administration of all controlled substances used within this facility.

PROCEDURE:

The Department of Pharmacy Services is legally responsible for the procurement, disposition and administration of all controlled substances used within the Hospital. Physicians, nurses, and pharmacists shall be responsible for maintaining proper records for controlled substances.

Definition of Controlled Substances

A. Controlled substances includes all drugs listed on Schedules CII, CIII, CIV, and CV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, or the California Uniform Controlled Substances Act, as amended.

B. The disposition of these medications shall be regulated as outlined in these acts.

C. Violation of these laws can lead to dismissal, license revocation and/or criminal prosecution.

I. Procurement of Controlled Substances

   A. All orders for Schedule CII controlled substances shall be authorized by the Director of Pharmacy Services or designee (through the "Power of Attorney"). Such orders shall be completed on the Drug Enforcement Agency (DEA) form 222.

   B. All orders for Schedule CIII, CIV, and CV controlled substances may be ordered

directly from drug wholesaler or direct from the manufacturer.

II. Receiving Controlled Substances

A. All Schedule CII controlled substances received by the pharmacy shall be checked in immediately and placed in the narcotic vault.

B. All Schedule CII controlled substances shall be received and checked in by a pharmacist.

a. The pharmacist shall document the receipt of all CII medications on DEA Form 222, under the column titled "to be filled by purchaser".

b. The pharmacist shall record the number of packages received, the date of shipment and the pharmacist's initials.

C. Schedule CII, CIII, CIV, and CV medications shall be placed in the narcotic vault after receiving the medications.

D. All controlled substances in the hospital shall be stored in locked conditions at all times. The Pharmacy Department shall assume overall responsibility for the storage of all controlled substances throughout the Hospital.

III. Dispensing Controlled Substances in Automated Dispensing Cabinets (ADCs)

A. See policy *PH.92 Automated Drug Cabinet Usage and Documentation*.

IV. Dispensing Controlled Substances in Areas Without ADC's

A. The Department of Pharmacy Services shall utilize the Controlled Substance Requisition Sheet to issue specific quantities of controlled substances for nursing unit that are not automated.

a. Variety of controlled substances stocked on each unit, as well as the number of doses, shall be established by the Department of Pharmacy Services and Nursing Department and is to be updated as needed.

B. Nursing Narcotic Floor Stock Requisition

a. Narcotics may be requested by pre-printed Controlled Substance Administration Record (CSAR) and delivered by the Pharmacy to the requesting department or can be picked up at the Pharmacy.

b. The requesting nurse shall sign the request form, acknowledging the quantity to be ordered from the CSAR.

c. All requests shall be maintained on file for three (3) years.

C. Controlled Substance Administration Records

a. Under the appropriate medication column, the quantity dispensed shall be added to the existing inventory, such that the number recorded reflects the revised inventory of that medication.

b. The pharmacy technician and the licensed health care professional accepting the medication shall sign the appropriate line with the following information:

- Date
- Time
- Medications added to inventory

D. Drug Administration using the CSAR documentation:

a. When a drug is administered to a patient, the following information and record keeping will take place.

- Date
- Time dose given
- Patient's name (last name, first name)
- Patient account number
- Dose given
- Amount wasted (if applicable)
- The signature of the person administrating the medication
- A signature of a witness if wasting a controlled substance when applicable

E. Procedure kits shall be returned to the Department of Pharmacy Services at the end of procedure

V. Dispensing Controlled Substances in Adult Infusion Center

A. Dispensing of controlled substance for patients receiving treatment at the Infusion Center requires a valid prescription.

a. Controlled substance class II: Prescriber must submit a valid prescription using tamper evident security prescription pad. The prescription is valid for 30 days from the written date and for one dispense. Refills are not allowed.

b. Controlled substance class III-V: Prescriber may submit a valid prescription using tamper evident security prescription pad or called-in to the Infusion Center Pharmacy. All orally transmitted prescriptions shall be produced in hard copy form by the pharmacist receiving the order including initials of the pharmacist. This prescription is valid up to 180 days from date written or up to 6 dispenses which ever comes first.

c. Infusion Center pharmacist will transcribe the prescription order details into the electronic health record (EHR) system and label individual medication dispensed to nursing staff for patient administration during the visit. See Policy PH.55 Medication Order Management for details on labeling requirements.

d. All controlled substances (class II-V) will be kept and dispensed by the infusion center pharmacy and perpetual inventory shall be maintained.

e. All dispense must be reported to Controlled Substance Utilization Review and Evaluation System (CURES) within 24 hours of dispense.

B. No controlled substance (class II-V) shall be dispensed directly to patient for home use.

VI. Nursing Administration and Documentation

A. A current physician's order for administration of controlled drugs is required prior to administration of any controlled substance.

B. Administered doses shall also be recorded on the respective patient's Medication Administration Record (MAR).

C. Discrepancies: Any discrepancy in the controlled drugs must be reported immediately to the charge nurse on duty**.** A nurse whose shift involved discrepancy shall not leave the facility until the discrepancy is resolved or thoroughly investigated. A notification form shall be completed if the discrepancy cannot be resolved.

a. The Department of Pharmacy Services shall be notified if any discrepancy cannot be accounted by nursing staff.

D. Lockboxes and portless tubing shall be used for the following controlled substance infusions:

a. All end-of-life controlled substance infusions (e.g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL). See Attachment A - Lockbox and portless tubing workflow

b. Patient controlled analgesia (PCA) locked in the Alaris Pump PCA module

c. Epidural infusions locked into the appropriate pump

d. Other controlled substance infusions (e.g. fentanyl drip) may be placed in lockboxes with portless tubing at the discretion of the care team.

VII. Nursing: Creating a New Controlled Substance Administration Record (CSAR)

A. At any one time, there may be up to ten numbered yellow and/or blue controlled substance administration sheets distributed to each unit/department.

B. Controlled substances shall be counted and documented each shift on the CSAR and signed by two licensed healthcare professionals.

C. A new sheet shall be prepared daily. The following information shall be recorded:

a. Previous day's sheet: On the bottom line "Ending inventory/Transfer Total" the existing inventory is to be brought down to the bottom line with the signature of the individual bringing down the inventory.

b. Transfer the existing inventory from the old sheet to the top line of the new sheet with the signature of the person creating the new sheet.

VIII. Nursing: Discontinuation of Controlled Substance Infusion

A. In the event a controlled substance infusion is discontinued, stopped or titrated off, the nurse shall immediately perform one of the following:

a. Remove the controlled substance infusion bag from the patient room and waste the controlled substance, OR

b. Disconnect the tubing from the patient's intravenous line and secure the bag and tubing in the medication room if the nurse anticipates the controlled substance infusion may be restarted.

i. Controlled substances in a bag and tubing secured in the medication room under this circumstance shall be wasted if order is not restarted within 2 hours or at shift change, which ever is shorter.

IX. Disposal of Controlled Substances

A. Controlled substances shall be disposed of in a controlled substance waste container.

B. Disposal of controlled substances shall be performed by a licensed individual, with disposal activity witnessed by another licensed individual. Both individuals shall record all disposal/waste events in the automated dispensing cabinets in patient care areas.

C. Fentanyl Patches shall be disposed of in the following manner:

a. All fentanyl patches removed from patients shall be disposed of in such a manner to prevent the diversion of the fentanyl patches.

b. After being removed from the patient, the patches shall be folded in half so that the adhesive parts are attached together.

c. Steps A & B of this section shall be completed thereafter.

D. Pharmacy Only: Expired controlled substances which are intact may be removed from hospital premises by a reverse distributor. All controlled substances removed in this manner shall be itemized for proper documentation.

X. Handling of Damaged, Refused or Wasted Medications Must be Documented

A. Documenting Controlled Substance wasted from ADC's:

a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste.

b. Witness must observe the wasting and cosign in the ADC. The witness must have an existing user account.

c. Controlled Substance waste shall be rendered unusable by dumping into a locked pharmaceutical waste container and removed from the medication area in a timely manner.

B. Documenting Controlled Substance waste using CSAR:

a. All wastage shall be clearly documented on the controlled substance record.

b. Doses that are refused, contaminated, and/or a dosage other than what was ordered for administration to patients shall be considered doses not administered and shall be documented as wasted immediately.

c. The entry line on the CSAR is to include comments, indicating the following:

- Date
- Time
- Patient's name
- Chart Number
- Dose Given
- Amount Wasted
- A description of the events, (i.e., wastes, refused, damaged, contaminated, unused, etc.)
- Two health care professionals' signatures documenting waste of control has occurred

d. All items listed above shall be disposed of in the presence of a witness. The signatures of both the person administering the dose and the witness are required. The waste from controls are rendered unusable and destroyed in a locked pharmaceutical waste container.

e. For losses and thefts, see Pharmacy policy PH.23, *Reporting Controlled Substance Loss or Diversion*.

XI. Returned Controlled Substances

A. When narcotics are returned to the Pharmacy, the pharmacist shall verify the quantity received immediately.

a. Physical inspection shall be made of the items to be returned, particularly noticing whether vials or pre-filled syringes have been tampered or resealed.

b. An entry shall be recorded on the Controlled Substance Administration Record indicating the "return" of medications to the pharmacy. The signature of both the nurse and the licensed pharmacy staff member receiving the drug shall be recorded on the Controlled Substance Administration Record.

c. The returned medication shall be returned to the Pharmacy inventory.

B. If the drugs are not reusable, they shall be disposed of with a witness. The items disposed of will be itemized on the Pharmacy controlled substance disposal log.

C. The signature of a nurse and pharmacist or two pharmacists shall be required.

D. Controlled substances may also be surrendered to a pharmaceutical waste management company for proper disposal.

XII. Nursing Inventory of controlled substances

1. Two charge nurses shall complete at least weekly inventory count on ADCs of all controlled substance class II to V.
2. Two charge nurses shall complete at least weekly inventory count on CSAR for units that do not have ADCs.

3. If charge nurses are unavailable, any licensed nurse (RN) may perform this function.

XIII. Controlled Substances for Transport

1. Controlled substances (class II to V) will not be dispensed to the emergency medical transport service, i.e. ambulance, outside hospital transport team including air transport.
2. Critically ill patients who are on a continuous infusion of any controlled substances may be transported out of the facility with the oncoming transport team to be used until they reach the final destination.
    a. Additional medication infusion bags will not be made as a spare.
    b. Additional push doses of controlled substances will not be dispensed.
    c. RN sending out the patient will reconcile the medication with oncoming transport team. The amount of medication left in the bag will be documented on the electronic health record with the name of the person who is receiving the medication.

XIV. Pharmacy department will comply with Title 16 California Code of Regulation section 1715.65

A. Physical Count Inventories of controlled substances shall be performed by Pharmacist(s).
    1. C-II controlled substances shall be inventoried quarterly.
    2. C-III to C-V controlled substances shall be inventoried yearly.
    3. The inventory report shall be signed by the involved Pharmacist(s) and the Pharmacist in Charge.

B. Quarterly reconciliation report shall be prepared for the following medications and dated/signed by the Pharmacist in Charge
    1. C-II controlled substances
    2. C-IV controlled substances: alprazolam 1 mg/unit, alprazolam 2 mg/unit ,and tramadol 50 mg/unit.
    3. C-V controlled substance: promethazine with codeine 6.25 mg/10 mg per 5 mL of product

C. The inventory, quarterly reconciliation report, and records used to compile the reports shall be kept in the Pharmacy for three (3) years.

All Revision Dates

11/25/2024, 12/20/2023, 8/8/2023, 6/7/2023, 3/8/2022, 11/10/2021, 11/26/2018, 10/5/2018, 5/1/2016, 5/1/2013

Attachments

Attachment A - Lockbox and Portless Tubing Workflow

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	12/6/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	11/25/2024

Status **Pending** PolicyStat ID **16959602**

Origination	7/1/2018	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	N/A		
Effective	Upon Approval		
Last Revised	12/14/2021	Policy Area	Administrative - Patient Care
Next Review	3 years after approval		

PH.114 IV to PO Therapeutic Interchange Protocol

POLICY:

Pharmacists shall convert intravenous (IV) medications to approved enteral (PO) equivalents utilizing the IV to PO conversion protocol as authorized by Pharmacy and Therapeutics (P&T) and Antibiotic Stewardship committees.

PROCEDURE:

IV to PO conversion is the process of reviewing select IV medications and evaluating patient's eligibility for conversion to a therapeutically equivalent PO medication.[1,3] It is a cost-effective drug utilization strategy that also improves patient care and promotes patient safety. These advantages include decreased risk for infusion-related adverse effects including secondary infections, decreased hospital length of stay, decreased preparation, administration, and monitoring time, and improved patient comfort and mobility.[1-3,5,7-9]

1. Pharmacists shall identify patients with IV medication orders that are eligible for conversion to PO equivalents (see Table 1). If deemed clinically appropriate and no exclusion criteria are identified (see Table 2), the pharmacist shall notify the primary contact provider.
2. If approved by the primary contact provider, the pharmacist shall proceed with converting the IV medication to the approved bioequivalent PO dose.
3. The pharmacist shall discontinue the old IV order and enter the new order for the PO equivalent into the electronic health record (EHR) utilizing the "per protocol – cosign" option thereby linking the order to the primary contact provider. Upon order entry, the pharmacist shall enter the canned text, "IV to PO conversion per protocol" under order comments.
4. The pharmacist shall document conversion in a clinical intervention under the "IV to PO conversion" category.
5. If deemed necessary, the provider has the option to convert back to the IV route. In addition, the provider has the option of ordering, "Do not convert per IV to PO conversion protocol" in the order comments.

Table 1: Approved medications for IV to PO conversion

Drug	IV dose	PO dose	Bioavailability6	Drug specific exceptions
Antimicrobials				
Azithromycin	500mg IV daily	500mg PO daily	38%~	
Ciprofloxacin	200mg IV q12h 400mg IV q12h 400mg IV q8h	250mg PO q12h 500mg PO q12h 750mg PO q12h	60-80%	
Clindamycin	300mg IV q8h 600mg IV q8h 900mg IV q8h	150mg PO q8h 300mg PO q8h 450mg PO q8h	90%	• Necrotizing soft skin infections
Doxycycline	100mg IV q12h	100mg PO q12h	Almost 100%	
Fluconazole	1:1 IV to PO conversion		>90%	
Levofloxacin	750mg IV daily	750mg PO daily	99%	
Linezolid	600mg IV q12h	600mg PO q12h	100%	
Metronidazole	500mg IV q8h	500mg PO q8h	80%	• TX of Cdiff
Rifampin	600mg IV daily	600mg PO daily	90-95%	
Trimethoprim/ sulfamethoxazole (TMP/SMX)	1:1 IV to PO conversion 5-20 mg TMP/ kg/day in divided doses.	1 DS=160mg TMP 1 SS= 80mg TMP	90-100%	• TX of Pneumocystis pneumonia • TX of Steno-trophomonas

Non-antimicrobials				
Acetaminophen	1000 mg IV q6h PRN	975mg* PO q6h PRN	85-98%	• NPO & NPR • Postop x 24h
Esomeprazole	40mg IV daily	40mg PO daily (Lansoprazole 30mg elixir or ODT when appropriate)	90%	
Famotidine	20mg IV q12h	20mg PO q12h	20-60%^	
Folic acid	1mg IV daily	1mg PO daily	76-93%	
Levetiracetam	500mg IV q12h	500mg PO q12h	100%	• TBI prophylaxis • Status epilepticus
Levothyroxine	0.05 mg IV daily	0.1 mg PO daily	48-80%	• Myxedema coma • Endocrine consult • T4 protocol
	1:2 IV to PO conversion			
Thiamine**	100mg IV daily	100mg PO daily	5.3%	• Wernicke's encephalopathy

~Azithromycin is well distributed into tissues despite the low bioavailiabity.

*Only 325mg strength available on formulary

^ Per Micromedex: Serum levels do not consistently correspond to the famotidine dose or the degree of gastric acid inhibition.

+ Do not convert levothyroxine orders that have been adjusted per levothyroxine IV hold protocol.

**Do not convert thiamine to oral when IV is used for suspected or confirmed Wernicke's encephalopathy. Patient should receive at least 3 days of parenteral thiamine.

Table 2: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Patient is ≥ 18 years old • Patient is tolerating oral/enteral medications. • Patient is tolerating an oral or enteral diet for at least 24 hours. • ≥ 48h of IV therapy	• Patient is NPO • Patient has dysphagia and is unable to tolerate enteral medications. • Patient cannot adequately absorb oral medications ◦ Severe diarrhea (>5 loose

• **Additional antimicrobial criteria** ◦ Afebrile x 24hours (temp<100.3oF or <38oC) ◦ WBC stable or improved (WBC 4-15 K/microL) ◦ Improved s/sx and hemodynamically stable (HR≤100 beats/min, RR < 24 breaths/min, SBP≥90 mmHG ◦ Patient is not septic.	stools/day) ◦ Uncontrolled vomiting ◦ GI obstruction/motility disorder (e.g ileus or suspected ileus) ◦ Active GI bleed ◦ Malabsorption syndrome (e.g celiac disease, Crohn's disease, short bowel, etc.) ◦ Continuous gastric suctioning (>500mL/day) ◦ Receiving neuromuscular-blocking agents ◦ Septic shock requiring high dose pressors (defer to physician for norepi >5mcg/min) • **Additional antimicrobial exclusions** ◦ Indication: CNS (meningitis, epidural abscess), bacteremia, endocarditis, septic shock ◦ Osteomyelitis after consulting ID service. ◦ ID consultation that specifies IV route only

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All Revision Dates

12/14/2021, 7/1/2018

Attachments

Attachment A: IV to PO Pharmacy Workflow

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	12/6/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/29/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/29/2024
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	10/29/2024

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Owner	Laura Zarate: Clinical Nurse Manager, Case Management
Policy Area	Utilization Review

UR.03 Patient Notification of the Provision, Discontinuation, or Non-Coverage of Care

POLICY

~~The hospital must inform each patient, or when appropriate, the patient's representative as required by State and Federal law, of the patient's rights. The notifications must be provided to address the provision or discontinuation of care. All patients, inpatient or outpatient, must be informed of their rights as hospital patients.~~

~~To promote communication of patient rights regarding outpatient status designation. The policy helps to define Ventura County Medical Center and Santa Paula Hospital processes for patient notification regarding outpatient observation services, Hospital Issued Notices of Non-coverage (HINN), the Important Message from Medicare (IM) and Advance Beneficiary Notice (ABN) to Medicare beneficiaries.~~

~~PROCEDURE:~~

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) inform patients, or when appropriate the patient's representative, of the patient's rights and potential non-coverage of services in advance of furnishing or discontinuing care. This process ensures that State and Federal regulatory notifications such as the Important Message from Medicare (IM), Medicare Outpatient Observation Notice (MOON), Hospital Issued Notices of non-coverage (HINN), and Advance Beneficiary Notices (ABN), are provided to the patient and/or their representative according to regulatory time frames. In addition, both hospitals have a process to inform each patient or their representative of the patient's status as an Outpatient receiving Observation Services (OBS).

Definitions:

~~**Observation care** is a defined set of specific, clinically appropriate services, which include ongoing short-term treatments, assessments, and reassessments before a decision can be made regarding whether a patient requires further treatment as a hospital inpatient, or if a patient can be discharged from the hospital. Observation services are ordered for a patient who presents to the emergency department and who then requires a significant period of treatment or monitoring to make a decision concerning their admission or discharge.~~

Important Message from Medicare (IM) is a statutorily required notice~~, to explain the~~ that explains a Medicare beneficiary's rights ~~to a hospital patient,~~as an inpatient including discharge appeal rights. ~~The IM is given to inpatients only.~~

Medicare Outpatient Observation Notice (MOON) is a statutorily required notice that informs Medicare beneficiaries that their status is outpatient with OBS services, that outpatient days do not count toward the days needed to qualify for a skilled nursing facility (SNF), and their financial liability is under Medicare Part B.

Hospital-Issued Notices of Non-coverage (HINNs) ~~are~~can be issued ~~by the hospital~~ to Medicare beneficiaries before admission, at admission, or at any point during an inpatient stay if it is determined that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary, not delivered in the most appropriate setting, or custodial in nature. HINNs are issued to ~~inpatients~~beneficiaries at an Inpatient level of care only.

Advance Beneficiary ~~Notice~~Notices of Non-coverage (ABN) are financial liability notices issued to Medicare beneficiaries (Original Medicare only, not Medicare Advantage) as well as patients with commercial health plans in advance of providing what is ~~a financial liability notice~~considered to be ~~issued to Medicare beneficiaries in advance of providing what is considered to be~~ non- covered items and/or services. ~~ABNs~~For Original Medicare beneficiaries, the ABN is to inform them that items and/or services paid under Part B are ~~issued to outpatients only~~not likely to be covered by Medicare in a specific case.

~~**Medicare Outpatient Observation Notice (MOON)** is a standardized notice to inform original Medicare and Medicare Advantage beneficiaries who receive observation services as outpatients for more than 24 hours. The hospital must provide the MOON no later than 36 hours after observation services as an outpatient begin. The MOON informs the beneficiaries that they are an outpatient receiving observation services and are not considered an inpatient of the hospital.~~

~~Notification of Observation Status~~

1. ~~The hospital representative will provide the patient or patient representative with a Notification of Observation Status or MOON when a patient is placed on observation. The notification will include the outpatient observation status, the possibility of becoming inpatient, and the potential financial impact of outpatient observation status. When delivering the Notification of Observation Status or MOON, the hospital representative will explain the notice and its content, document that an oral explanation was provided, and answer all beneficiary questions to the~~

best of their ability. The hospital representative will then have the patient or patient's representative sign the notice to indicate that he or she has received it and understands its contents.

2. The Utilization Review registered nurse will notify the patient after Utilization Review determines that an inpatient level of care does not meet the hospital admission or inpatient criteria. In the case that there is a change of status, the Utilization Review nurse will:
    - Follow the Condition Code 44 process as required by Center for Medicare & Medicaid Services (CMS).
    - Notify Admitting of the change of status when physician order has been received.
    - Notify the patient, or patient representative if necessary, of the admit status by providing the "Notification of Observation Status" letter.
    - Document notification to the patient or patient representative in Electronic Health Record (EHR).
3. The change in status will occur prior to the patient being discharged. The patient will be notified of their observation status prior to being discharged.
4. Admitting Department will change the status in EHR prior to the patient discharge. The Financial Counselor is available to answer billing questions to the patient and/or patient representative.

California Senate Bill 1076 requires hospitals to provide written notification to any patient receiving OBS services that their care is being provided on an outpatient basis which may affect their health coverage reimbursement. VCMC and SPH use the **Non-Medicare Outpatient Observation Notice (NOON)** form to meet this requirement for patients who are not Medicare beneficiaries. .

PROCEDURE:

IMPORTANT MESSAGE FROM MEDICARE (IM)

The hospital must follow the procedures listed below in delivering the Important Message from Medicare (IM). A valid notice consists of information derived from Centers for Medicare and Medicaid Services (CMS). Notices are available on www.cms.hhs.gov/bni at the link for Hospital Discharge Appeal Notices. Hospital may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice. All Medicare beneficiaries including original or traditional Medicare and managed Medicare (primary and secondary) must receive IM.

1. The registration staff must provide the original copy of IM at or near inpatient admission, but not later than two (2) calendar days following the date of the beneficiary's admission to the hospital. Registration must ensure that the beneficiary comprehends the contents of the notice before obtaining the beneficiary's signature. If the beneficiary refuses to sign the notice, the hospital may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice. The annotation may be placed in the unused patient signature line. If for any reason Registration is unable to obtain the signature of the beneficiary or their representative within two (2) calendar days, the attempts should be documented in patient medical record and the Case Management Department will be notified immediately. The

hospital must give the original copy of the signed or annotated notice to the patient.

2. The Case Management staff or unit nursing staff must deliver the follow-up copy as far in advance of discharge as possible, but no more than two (2) calendar days before the planned date of discharge.
    - The Case Management staff or unit nursing staff will deliver the IM within one to two (1-2) calendar days when anticipating patient's discharge so that the beneficiary has a meaningful opportunity to act on it
    - The follow-up copy of IM may be delivered as late as the day of discharge when discharge cannot be predicted in advance.
    - The hospital must provide the patients at least four (4) hours to consider their right to request a QIO review if the IM is delivered on the day of discharge. Beneficiaries may choose to leave prior that time; however, hospitals must not pressure a beneficiary to leave during that time period.
    - The hospital must deliver another copy of the signed notice again within two (2) calendar days of the new planned discharge date if the beneficiary status subsequently changes after the Case Management staff or unit nursing staff delivered the follow-up copy of IM.
    - The Case Management staff or unit nursing staff will document on the IM their signature, the date, time, and the name of the representative with whom they spoke.
    - The hospital may not develop procedures for delivery of the follow-up copy of IM on the day of discharge.
3. Exception to Delivery of the Follow up Copy.
    - If the delivery of the original IM is within two (2) calendar days of the date of discharge, no follow-up notice is required. Example, if the beneficiary is admitted on Monday, no follow-up copy needs to be delivered if the beneficiary is discharged on Tuesday or Wednesday.
    - A follow-up copy is not required prior to transfer from on inpatient hospital setting to another inpatient setting. However, a follow-up copy of the signed notice is required prior to discharge to a lower level of care such as a Skilled Nursing Facility (SNF).
4. A copy of the signed notice must be retained in the medical record of the beneficiary.

Discharge Appeal Process

1. If a beneficiary disagrees with the discharge and requests an expedited appeal and contacts their Quality Improvement Organization (QIO), the nurse on the unit will contact the Case Manager.
2. QIO will contact the hospital. After QIO has contacted the hospital, the Case Manager will complete the Detailed Notice of Discharge, make a copy and provide the patient with the original copy of the Detailed Notice of Discharge. The Case Manager will provide QIO with the information they request.
3. From Friday after 4:30 PM until Monday 8:00 AM the nursing supervisor should be notified of any patients contacting QIO and will be responsible for communicating with the patient and

~~QIO as described above.~~

4. ~~Patient may not be involuntarily discharged or billed for additional days while appeal is pending.~~
5. ~~If the QIO upholds the appropriateness of the discharge, the beneficiary's liability for continued services begins at noon of the day after the QIO notifies the beneficiary and after they are given a Hospital Issued Notice of Non-coverage (HINN).~~

1. The initial IM must be provided within 2 days of Inpatient admission including when the patient's status changes from OBS to Inpatient
2. Every Medicare beneficiary entitled to benefits under Medicare part A, regardless of whether or not Medicare is the primary insurance must receive the IM. Patients with Medicare Advantage must also receive the IM.
3. Centers for Medicare and Medicaid Services (CMS) regulations require that the patient or their representative receive an oral explanation of the IM. The hospital representative will explain the IM and its content, document that an oral explanation was provided, and answer all beneficiary questions to the best of their ability
4. If the patient is incapacitated and has no representative, attempts to provide the IM should be documented in the Electronic Health Record (EHR).
5. The follow up IM, which is a copy of the original, must be delivered no more than two calendar days before the planned date of discharge. If the beneficiary's condition changes, additional follow up notices may need to be provided within two days of the new anticipated discharge date.
6. The follow-up IM can be given on the day of discharge however, if the patient is considering an appeal, the hospital must allow the patient at least four hours to consider their right to request a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) review. Beneficiaries may choose to leave prior to that time but the hospital must not pressure a beneficiary to leave during that time period.
7. If the delivery of the original IM is within two calendar days of the date of discharge, no follow-up notice is required.
8. A follow-up IM is not required prior to transfer from an inpatient hospital setting to another inpatient setting however, a follow-up copy of the signed notice is required prior to discharge to a lower level of care such as a SNF.

Medicare Outpatient Observation Notice (MOON)

1. The MOON must be provided to Medicare beneficiaries, including beneficiaries who are not enrolled in part B, who receive OBS services for more than 24 hours but no later than 36 hours after OBS began.
2. CMS regulations require that the patient or their representative receive an oral explanation of the MOON. The hospital representative will explain the MOON and its content, document that an oral explanation was provided, and answer all beneficiary questions to the best of their ability.
3. If the patient is incapacitated and has no representative, attempts to provide the MOON should

be documented in the EHR.

4. In the event the Utilization Review Registered Nurse or Physician Advisor determines the patient does not meet medical necessity for inpatient admission the Code 44 policy will be followed for provision of the MOON. (UR.02 Condition Code 44)

HOSPITAL ISSUED NOTICES OF ~~NONCOVERAGE~~NON-COVERAGE (HINN)

I. ~~**HINN 1 – Preadmission/Admission Hospital Issued Notice of Non-coverage**~~

~~***Preadmission:*** In preadmission situations, the beneficiary is liable, if admitted, for customary charges for all services furnished during the stay, except for those services for which a patient is eligible to receive payment under Part B.~~

~~***Admission:*** If the admission notice is issued ***at 3 p.m. or earlier*** on the day of admission, the beneficiary is liable for customary charges for all services furnished after receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B. If the admission notice is issued ***after 3 p. m.*** on the day of admission, the beneficiary is liable for customary charges for all services furnished on the day following the day of receipt of the notice, except Part B eligible services.~~

II. ~~**HINN 10 – Hospital Requested Expedited Review (HRR)**~~

~~This notification informs the patient that the hospital has determined that a beneficiary is no longer in need of inpatient care, but is unable to obtain the agreement of the attending physician. The hospital may request a QIO review by following the procedure outlined below.~~

- ~~The Case Manager notifies the patient of the requested review by the use of HRR letter.~~
- ~~The hospital must supply the QIO with any pertinent information by close of the business on the first full day immediately following the day the hospital submits the request for review.~~
- ~~The QIO must notify the patient, the hospital, and the physician of its decision within two (2) days of the hospital's request and receipt of any pertinent information submitted by the hospital.~~
- ~~The patient may request for reconsideration or appeal if dissatisfied with its determination.~~

III. ~~**HINN 11 – Non-covered Service(s) during Covered Stay**~~

~~The hospital will only use this letter if the item or service at issue is a diagnostic or therapeutic service excluded from coverage as medically unnecessary, and the patient requires continued hospital inpatient care.~~

- ~~Given immediately for unnecessary medical services during covered hospital stay. Effective immediately if understood and signed by the beneficiary or representative.~~
- ~~Must be issued prior to the procedure.~~

- ~~Must be reviewed and approved by Physician Advisor before issuing HINN 11-.~~

IV. ~~**HINN 12 – Non-covered Continued Stay**~~

~~This letter is to inform the patient that the hospital believes that Medicare will not cover the patient's continued hospital stay. The notification is issued to patients on the first non-covered day when there is a written physician order for discharge, and both of the following are true:~~

- ~~The care is no longer medically necessary in the acute inpatient setting.~~
- ~~The patient is not willing to leave the hospital for non-medical reason(s).~~

V. ~~**Detailed Notice of Discharge**~~

~~When a QIO notifies the hospital that a beneficiary has requested an expedited review, the hospital must deliver a Detailed Notice of Discharge (the Detailed Notice) to the beneficiary as soon as possible, but not later than noon of the day after the QIO's notification.~~

The **Preadmission/Admission HINN** notifies Medicare beneficiaries that Medicare is not likely to cover the admission because it is likely not to be considered medically necessary or can safely occur in another setting. The concurrence of the physician responsible for the care of the patient is not required. The patient has the right to an immediate appeal by the BFCC-QIO.

1. ***Preadmission:*** In preadmission situations, the beneficiary is liable, if admitted, for customary charges for all services furnished during the stay, except for those services for which a patient is eligible to receive payment under Part B.
2. ***Admission:*** If the admission notice is issued ***at 3 p.m. or earlier*** on the day of admission, the beneficiary is liable for customary charges for all services furnished after receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B. If the admission notice is issued ***after 3 p. m.*** on the day of admission, the beneficiary is liable for customary charges for all services furnished on the day following the day of receipt of the notice, except for Part B eligible services.

A **Hospital Requested Expedited Review (HINN 10)** notifies Medicare beneficiaries that the hospital has determined that they are no longer in need of inpatient care, but is unable to obtain the agreement of the physician responsible for the care of the patient. The hospital may request a BFCC-QIO review by following the procedure outlined below.

1. The Case Manager notifies the patient/representative of the requested review with the provision of the HINN 10.
2. The hospital must supply the BFCC-QIO with any pertinent information by close of the business on the first full day immediately following the day the hospital submits the request for review.
3. The BFCC-QIO must notify the Medicare beneficiary, the hospital, and the physician of its decision within two days of the hospital's request and receipt of any pertinent information submitted by the hospital.
4. If the Medicare beneficiary remains hospitalized, they may request for reconsideration or appeal if dissatisfied with the BFCC-QIO determination.

Non-covered Service(s) during Covered Stay (HINN 11) - Hospital staff will only use this letter to notify Medicare beneficiaries who are hospitalized for a medically necessary reason, that a service they are scheduled to receive is not medically necessary and they may be held financially liable. Hospital staff must follow the process below.

1. Use of the HINN 11 must be reviewed and approved by the Physician Advisor before issuing.
2. The item or service at issue must be diagnostic or therapeutic and excluded from Medicare coverage as medically unnecessary and the beneficiary must require continued hospital inpatient care.
3. The HINN 11 must be issued prior to the service being provided.
4. The HINN 11 must be given immediately for unnecessary medical services during covered hospital stay. It is effective immediately if understood and signed by the beneficiary or representative.

Non-covered Continued Stay (HINN 12) informs Medicare beneficiaries of their non-covered stay potential liability beginning on a certain date and should be used in association with hospital discharge appeal notices.

1. The notification is issued to patients on the first non-covered day when there is a written physician order for discharge, and both of the following are true:
    - The care is no longer medically necessary in the acute inpatient setting.
    - The patient is not willing to leave the hospital for non-medical reason(s).

ADVANCE BENEFICIARY NOTICE (ABN)

- ~~Issued prior to providing service or item that is usually paid for by Medicare under Part B but may not be paid for in this particular case because it is not considered medically reasonable and necessary, or is considered custodial in nature and accept potential financial liability.~~
- ~~The Case Manager or hospital representative must consult with the attending physician prior to issuing ABN.~~

1. ABNs must be issued prior to the delivery of the item or service in question.
2. Patients, or their representative, should be provided enough time to consider the options and make an informed decision on whether or not to receive the service or item in question, and accept potential financial liability.
3. For Original Medicare beneficiaries, an ABN must be issued when a Medicare item or service is not reasonable and necessary under Program standards including care that is:
    1. Not indicated by the diagnosis, treatment or illness, injury, or to improve the functioning of a malformed body member
    2. Is experimental and investigational or considered research only
    3. More than the number of services allowed in a specific period for that diagnosis
4. Patients with Original Medicare must receive the most recent version approved by the Office of Management and Budget.

Non-Medicare Outpatient Observation Notice (NOON)

1. The NOON form will be used to inform patients who do not have Original Medicare or Medicare Advantage that he or she is on observation status.
2. The NOON must be provided to patients who have unstable or uncertain conditions serious enough to warrant close observation but not so serious to warrant inpatient admission to the hospital.
3. Patients shall receive written notice, as soon as practicable, that he or she is on observation status including following a change from inpatient to observation

GENERAL NOTICE DELIVERY REQUIREMENTS (Applies to all patient notifications)

1. **In-Person Delivery**: Must be delivered to the beneficiary in person. However, if the beneficiary is ~~not able~~unable to comprehend the notice, it must be delivered to ~~and signed by~~ the beneficiary's representative.
2. ~~**Notice**~~ **Delivery to Representative**: CMS requires that notification of a beneficiary who is incompetent be made to a representative of the beneficiary. A representative is an individual who, under the State or other applicable law, may make health care ~~decision making~~decisions on behalf of the beneficiary. ~~The date the hospital conveys the information, whether in writing or telephone, is the date of receipt of the notice.~~
    - ~~Confirm the telephone contact by mailing the written notice on that same day.~~
    - ~~Place a dated copy of the notice in beneficiary's medical record, and document the telephone contact with the beneficiary's representative on the notice. The documentation should include the name of hospital staff initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact and the planned discharge date if appropriate.~~

    When direct phone contact cannot be made, send the original copy of the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. Documentation must state the attempted phone call including the date and times of the calls, the name of the staff person who attempted the calls, and the name and phone number of the patient's representative they attempted to reach. The date that someone at the representative's address signs (or refuse to sign) the receipt is the date received. Place a copy in the return receipt in the beneficiary's medical record.

    The hospital must meet the Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements if both the hospital and the patient's representative agree to send the notice by fax or email.

    - If a representative is not physically present, the hospital may telephone the representative and then mail, fax, or email the IM the same day.
    - The hospital must meet the Health Insurance Portability and Accountability Act privacy and security requirements if both the hospital and the patient's

representative agree to send the notice by fax or email

- Document the telephone contact with the beneficiary's representative on the notice and place a dated copy of the notice in beneficiary's EHR. Documentation should include the name of hospital staff initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact and the planned discharge date if appropriate.
- When direct phone contact cannot be made, send the original copy of the notice to the representative via a delivery method that requires signed verification of delivery. Document the attempted phone call including the date and times of the calls, the name of the staff person who attempted the calls, and the name and phone number of the patient's representative they attempted to reach. The date that someone at the representative's address signs, or refuses to sign, the receipt, is the date received. Place a copy of the return receipt in the beneficiary's EHR.

3. **Ensuring Beneficiary Comprehension:** Hospitals must make every effort to ensure the beneficiary comprehends the contents of the notice before obtaining the beneficiary's signature by explaining the notice, providing an opportunity for the beneficiary or representative to ask questions~~, and explaining that he or she may appeal a discharge decision without financial risk, but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal~~.
4. **Beneficiary Signature and Date:** Notices should be signed and dated by the beneficiary to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded, such as a properly annotated signature refusal (see below). The date the hospital conveys the information, whether in writing or telephone, is the date of receipt of the notice.
5. **Refusal to Sign and Annotation**: If a beneficiary or representative refuses to sign the notice, the hospitals may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt.
6. **Notice Delivery and Retention:** Hospitals must give the original copy of the signed or annotated notice to the patient or representative. Hospital must retain a copy of the signed or annotated notice except for the ABN, the original copy of ABN should be retained by the facility and a copy given to the patient or representative. All documents must be saved in the beneficiary's EHR.

REFERENCES:

1. ~~CMS Manual System Medicare Claims Processing (Pub 100-04, 06-16-06)~~
2. ~~Medicare Claims Processing Manual, (Rev. 299, 09-10-04) 50.3~~
3. ~~Medicare Claims Manual – Chapter 30 – Financial Liability Protections~~
4. ~~MNL Matters SE0622 CR 3444 Related Transmittal #R299CP~~
5. ~~Regulatory Standards CMS – CoP 482.13(a)(1)~~
6. ~~Regulations Rev. 37 Issued: 10-17-08; Effective/Implementation Date: 10-17-08) Patient's Rights~~

~~7. Medicare Outpatient Observation Notice (MOON) – Transmittal #3695, January 20, 2017~~

1. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 50 Advance Beneficiary Notice of Non-coverage (ABN)
2. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 80 Hospital ABNs (Hospital-Issued Notices of Noncoverage – HINN)
3. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 200.3 Important Message from Medicare (IM)
4. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 220 – Hospital Requested Expedited Review
5. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 240 – Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN)
6. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 08-01-24) Section 400 – Part A Medicare Outpatient Observation Notice
7. 42 C.F.R. § 482.13(a)(1) (2024)
8. CMS Manual System. Pub. 100-07 State Operations Provider Certification. Transmittal 37. (October 17, 2008). Revise Appendix A, "Interpretive Guidelines for Hospitals"
9. General acute care hospitals: observation services, Cal. SB 1076 (2015-2016)

All Revision Dates

11/29/2024, 2/2/2017

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	Pending
Utilization Management Committee	Cheryl Lambing: Medical Director, Utilization Management	12/10/2024
Utilization Management Committee	Laura Zarate: Clinical Nurse Manager, Case Management	11/29/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/29/2024
Case Management	Laura Zarate: Clinical Nurse Manager, Case Management	11/29/2024

Ventura County Medical Center

Delineation Of Privileges

Psychiatry Privileges

Name:

Privilege	Requested	Granted

Initial Criteria:
- MD or DO with successful completion of an ACGME or AOA accredited residency/fellowship in Psychiatry.
- Current certification or active participation in the examination process leading to certification within 4 years of initial privileges by the American Board of Psychiatry & Neurology or the American Osteopathic Board of - Psychiatry & Neurology.
- Documentation of the provision of psychiatric services for at least 30 inpatients or outpatients at an accredited facility during the past 2 years.

Evaluation Requirements:
2 evaluators assigned
3 cases per evaluator per privilege

Renewal Criteria:
Documentation of the provision of care to a minimum of 15 patient encounters within the previous 2 years.

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.
If appropriate and clinically indicated, a history and physical examination, and provide basic medical management within the scope of practice
Consultation with physicians in other fields regarding mental, behavioral, emotional, and geriatric psychiatric disorders
Psychopharmacology
Psychotherapy
Consultations in the courts
Emergency Department and Crisis Team Consultations
Chemical dependency intervention and therapy
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 Psychiatry ___ ___
(less than 13 years of age)
Additional Criteria:
Successful completion of a 2-year fellowship in Child and Adolescent Psychiatry or equivalent training or experience as determined by the Department of Psychiatry.

Adolescent Psychiatry ___ ___
(13 years of age and above)
Additional Criteria:
A minimum of 1 year verified work experience specifically related to the psychiatric treatment of adolescents (13 years of age and above) or equivalent training or experience as determined by the Department of Psychiatry.

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 [ ] RENEWAL APPROVAL

Department Chief's Signature: _____ Date: _____

Ventura County Medical Center

Delineation Of Privileges

Psychiatry Physician-in-Training

Name:

Privilege	Requested	Granted

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:

Initial:

- A minimum of the first 3 cases reviewed

Ongoing:

- 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.

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: _____

VENTURA COUNTY MEDICAL CENTER

DEPARTMENT OF FAMILY MEDICINE

Focused Professional Practice Evaluation/***Specific Privilege***

Formerly known as Proctoring

(Please forward to Medical Staff Administration when completed)

Practitioner under evaluation: _____ Medical Record #: _____

Name of Evaluator: _____ Admission Date: _____

Diagnosis/Procedure: _____

Complications if any: _____

Review Type: ☐ Concurrent ☐ Retrospective ☐ Inpatient ☐ Outpatient

*procedures must be proctored concurrently

AREA OF PERFORMANCE (as applicable)	YES	NO	N/A
Was there adequate evidence to support diagnosis or the need for the invasive procedure?			
Was the practitioner's documentation appropriate and informative? If NO, ☐Documentation not present ☐Documentation does not substantiate clinical course & treatment ☐Documentation not timely			
Was the practitioner's proposed use of diagnostic services (ie. Lab, x-ray, etc.) appropriate?			
Was the quality of the H&P satisfactory, complete and timely?			
Were Progress Notes and Discharge Summary complete and appropriate?			
If inpatient, was the patient seen daily?			
If inpatient, was the patient discharged to an appropriate level of care?			
Was the initial plan and level of care appropriate?			
Were the practitioner's initial orders appropriate?			
Were invasive procedures performed in a satisfactory manner?			
Was patient's length of stay appropriate?			
Did the patient suffer complications? If so, were the complications anticipated, recognized promptly, and handled appropriately?			
Was a consultation called promptly (if needed)?			
Was practitioner cooperative with colleagues and hospital staff?			
Was behavior ethical at all times?			
Did the practitioner interact and communicate appropriately with the patient and family?			
Did the physician abide by all rules and regulations of the hospital and Medical Staff in the care of this patient?			

BASIC ASSESSMENT	**Satisfactory**	**Unsatisfactory**	**N/A**	**BASIC ASSESSMENT**	**Satisfactory**	**Unsatisfactory**	**N/A**
Basic Medical Knowledge				Communication Skills			
Technical/Clinical Skills				Professionalism			
Clinical Judgement				Use of Consults			
Interpersonal Skills							

Practitioner under evaluation: _____ Medical Record #: _____

PERFORMANCE

❒ OUTSTANDING. Unusually well qualified.

❒ GOOD to AVERAGE. His/her knowledge and level of practice is quite satisfactory

❒ LESS THAN AVERAGE. The physician has displayed weakness in knowledge, conduct and/or performance.

Please provide specific information regarding any unusual strengths or weaknesses you may have observed on the back of this form. ❒ Additional comments below.

_____

Signature of Evaluating Physician Date

Recommend release from further evaluation, as noted above.

_____

CHIEF, DEPARTMENT OF FAMILY MEDICINE DATE

MEC: _____ BOARD APPROVAL: _____

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Document Approvals

anuary 2025

a. Policies & Procedures / Forms / Orders

he follo ing ere revie ed and recommended for approval by the appropriate Departments Committees and the Medical ecutive Committee

#	Title	Summary	Frequency	Page
1.	100.227 elestro e eurology Consultations	Revised path ay for patients receiving t P	riennial	2 5
2.	100.247 Post Spinal nalgesia Patient Care	pdated to define abbreviations	riennial	6 7
3.	100.253 alo one for Opioid o icity	pdated to define abbreviations	riennial	8 11
4.	108.032 lood lucose esting ith the ova StatStrip lucose Meter	pdated to include ne or flo for automatic glucose results and updated all images.	riennial	12 25
5.	.04 reast Mil Storage and Collection	References updated as ell as process for storing ep and ep C breast mil in nursery free er	riennial	26 29
6.	P.45 P C nsulin nfusion	Revised formatting	riennial	30 31
7.	Ph.27.00 a ardous Drug Overvie	o changes	nnual	32 33
8.	Ph.27.01 a ardous Drug raining and Safety Program	o changes	nnual	34 36
9.	Ph.27.02 a ardous Drug Storage andling Labeling and ransport	o changes	nnual	37 40
10.	Ph.27.03 a ardous Drug arbing and Compounding	o changes	nnual	41 44
11.	Ph.27.04 Decontamination Spill and aste Management	o changes	nnual	45 47
12.	Ph.109 Vancomycin Per Pharmacy	o changes	riennial	48 49
13.	R.49 Respiratory Care Capnography se	Complete policy re rite	iennial	50 54
14.	RS.23 ssessments – Pediatric/ dolescent	o changes	riennial	5 57
15.	RS.24 valuations: Occupational herapy O in Pediatric ntensive Care nit P C	pdated response timeframe of staff upon receipt of order for occupational therapy evaluation	riennial	58 60
16.	RS.25 valuations: Physical herapy P in the Pediatric ntensive Care nit P C	pdated response timeframe of staff upon receipt of order for physical therapy evaluation	riennial	61 63
17.	.20 uidelines for Care of the n ured Older dult	o changes	riennial	64 68
18.	100.034 Prescribing Drugs for on ndicated ses	o changes	riennial	69 70
19.	100.238 Monitoring Medication ffects on Patients	o changes	riennial	71 72
20.	100.248 Santa Paula ospital fter ours ntravenous Medication Preparation	pdated to remove video and audio conferencing to provide verification double chec in lieu of second nurse.	riennial	73 76
21.	100.267 alo one asal Spray Distribution	Revised to reflect current or flo	riennial	77 79
22.	utotransfusion Policy	e policy	riennial	80 81
23.	R.38 Patient riage	pdated to align ith pediatric readiness initiative added section to address children ith special healthcare needs.	riennial	82 86
24.	R.42 Standardi ed ursing Procedures in the mergency Department	Revised to align ith nursing scope of practice. pdated treatment and diagnosis procedure for pediatric patients ith a fever.	nnual	87 95
25.	R.55 M D COD	pdated paging instructions at VCMC and SP	riennial	96 98
26.	L.67 LeadCare lood Lead naly er System	o changes	riennial	99 108

27.	MC□.07 □nfant □dentification □ands and Security □ag Procedure	□pdated criteria of □ho receives □D band and security tag	□riennial	109□113
28.	□.54 □eonatal □ hole □ody Cooling	□pdated age eligibility for cooling. □dded process for patients under □mplitude□□ntegrated □lectroencephalography Monitoring and updated references.	□riennial	114□124
29.	O□.28 □lective □ermination of Pregnancy	□pdated gestational age eligibility	□riennial	125□128
30.	O□.30 □nduction of Labor	Policy updated to align □ith □CO□ indications. Outlined scheduling process and incorporation of induction re□uest. Defined abbreviations	□riennial	129□136
31.	O□.62 □rial of Labor □fter Cesarean □□OL□C□	□pdated to include eligibility for induction of labor. □pdated paging process and defined abbreviations	□riennial	137□141
32.	P□.69 Medications Stored at □edside for Self□□dministration	□o changes	□riennial	142□143
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34.	P□.88 Controlled Substances	□pdated to include ne□ section regarding controlled substance for transport	□riennial	149□156
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36.	□R.03 Patient □otification of the Provision□Discontinuation□or □on□Coverage of Care	Policy re□orded and reorgani□ed for clarity. □dded verbiage for Original Medicare □□□	□riennial	162□172

b. Medical Staff Forms

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2.	Psychiatry Physician in □raining Privilege Chec□list □approved by Psychiatry Committee and M□C□	Revised to include initial proctoring re□uirements	174
3.	□amily Medicine □PP□ □orm □approved by □M Committee and M□C□	Revised to be inclusive of both inpatient and outpatient practice	175□176