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

February 27, 2025

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

1. 107.089 Responding to Law Enforcement Requests for Information
2. F.76 Isolation Rooms
3. L.60 Laboratory Chemical Hygiene Plan
4. L.BB.41 Neonatal Transfusions
5. L.BB.61 Visual Inspection of Blood Components
6. L.BB.67 Thawing Frozen Plasma
7. L.BB.77 Validation of Blood Transport Coolers
8. L.BB.107 Look Back Protocol
9. L.SER.05 Mono Test
10. L.SER.07 Serology Quality Control
11. L.SPH.57 Manually-Entered Santa Paula Hospital Laboratory Test Result Audits
12. L.SPH.61 Biosafety Levels - Santa Paula Hospital Laboratory
13. L.SPH.62 Bioterrorism Readiness Plan for the Clinical Laboratory
14. NPP.04 Small Bore Tube Feeding Tube Insertion And Management
15. PH.17 Direct Ordering Procedure

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Ventura County Health Care System Oversight Committee
Administrative Policies - February 27, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	107.089 Responding to Law Enforcement Requests for Information	1095 days	New Policy
2	F.76 Isolation Rooms	1095 days	Updated number of rooms for both VCMC and SPH (SPH lost the 2 ICU rooms, and VCMC gained 2 with the Peds project). Update room names
3	L.60 Laboratory Chemical Hygiene Plan	730 days	New Policy
4	L.BB.41 Neonatal Transfusions	730 days	Bienniel review of policy. Minor revisions.
5	L.BB.61 Visual Inspection of Blood Components	730 days	Bienniel review of policy. Revised reference.
6	L.BB.67 Thawing Frozen Plasma	730 days	Bienniel review of policy. No changes
7	L.BB.77 Validation of Blood Transport Coolers	730 days	Bienniel review of policy. Revised reference.
8	L.BB.107 Look Back Protocol	730 days	Replaced the term "UBS" with "contracted blood supplier."
9	L.SER.05 Mono Test	730 days	Added setting for BD Macro-Vue Card Test Rotator.
10	L.SER.07 Serology Quality Control	730 days	Reviewed, no substantial change made.
11	L.SPH.57 Manually-Entered Santa Paula Hospital Laboratory Test Result Audits	730 days	Added CSF count
12	L.SPH.61 Biosafety Levels - Santa Paula Hospital Laboratory	730 days	New Policy
13	L.SPH.62 Bioterrorism Readiness Plan for the Clinical Laboratory	730 days	New Policy
14	NPP.04 Small Bore Tube Feeding Tube Insertion And Management	1095 days	Edited language to be compliant with Board of Registered Nurse language on standardized nursing procedures
15	PH.17 Direct Ordering Procedure	1095 days	Updated some wording to clarify steps and updated images to reflect website changes.

Status **Active** PolicyStat ID **17498418**

Origination	2/3/2025
Last Approved	2/3/2025
Effective	2/3/2025
Last Revised	2/3/2025
Next Review	2/3/2028
Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH
Policy Area	Administrative - Operating Policies

107.089 Responding to Law Enforcement Requests for Information

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PURPOSE:

To provide guidance on how to process a request for information from law enforcement.

POLICY:

Staff shall notify the administrator on duty (AOD) of the arrival of and any request (including subpoenas, petitions, complaints, warrants, or court orders) by any law enforcement officer to access a health care facility or a patient, or any request for the review of facility documents.

PROCEDURE:

A. Staff Responsibilities

1. Advise the officer that before proceeding with his or her request, staff must first notify and receive direction from the AOD.
2. Ask to see and make a copy of or note, the officer's credentials (name and badge number). Also ask for and copy or note the telephone number of the officer's supervisor.
3. Call paging to contact the AOD.
4. Ask the law enforcement officer to wait in the main lobby until the AOD arrives.
5. Decline to answer questions posed by the officer and direct him or her to speak to the AOD.
6. If the officer orders staff to provide immediate access to the hospital or clinic, staff

should comply with the officer's order and also immediately contact the AOD. Staff should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document. If an officer enters the premises without authority, staff shall simply document the officer's actions while at the facility.

7. Staff should complete an incident report that includes the information gathered as described above and the officer's statements and actions.

B. Administrator on Duty Responsibilities

1. Greet the officer in the main lobby.
2. Ask the officer to explain the purpose of the officer's visit and note the response.
3. Ask the officer to produce any documentation that authorizes health care facility access.
4. Make copies of all documents provided by the officer.
5. State that the facility does not consent to entry of the hospital or clinic or portions thereof.
6. Without expressing consent, respond according to the requirements of the officer's documentations. If the officer has:
    a. An ICE administrative "warrant": Immediate compliance is not required. Inform the officer that the facility cannot respond to the warrant until after it has been reviewed by County Counsel. Provide a copy of the warrant to County Counsel as soon as possible.
    b. A federal judicial warrant (either a search-and-seizure warrant or an arrest warrant): Prompt compliance usually is required, but, where feasible, staff should consult with County Counsel before responding.
    c. A subpoena for production of documents or other evidence: Immediate compliance is not required. Inform the officer that the facility cannot respond to the subpoena until after it has been reviewed by a designated administrator. Give your copy of the subpoena to County Counsel as soon as possible.
    d. A notice to appear: This document is not directed at the health care facility. Staff is under no obligation to deliver or facilitate service of this document to the person named in the document. If you get a copy of the document, give it to County Counsel as soon as possible.
7. Document the officer's actions in as much detail as possible when he or she enters facility premises, but without interfering with the officer's movements.
8. If the officer orders staff to provide immediate access to the facility, staff should comply with the officer's order and also immediately

C. Relevant Policies:

1. 100.011 Hospital Visitation
2. 100.019 Release of Patient Information

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3. 109.030 Use and Disclosure of Protected Health Information Required by Law
4. 109.041 Verification of Identity and Authority of Persons or Entities Requesting Protected Health Information

All Revision Dates

2/3/2025

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/3/2025
Policy Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/30/2025

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Status **Active** PolicyStat ID **17478915**

Origination	1/7/2007	Owner	Ian McGraw: Manager Facility Operation
Last Approved	2/3/2025	Policy Area	Facilities
Effective	2/3/2025		
Last Revised	2/3/2025		
Next Review	2/3/2028		

F.76 Isolation Rooms

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POLICY:

There are several rooms/areas throughout both hospitals that require negative pressure due to the relative activities occurring within those rooms/areas. There are 19 rooms/areas at Ventura County Medical Center and 2 rooms at Santa Paula Hospital that are identified as negative pressure rooms/areas. The rooms/areas at Ventura County Medical Center are equipped with local monitors and alarms and are also monitored 24/7 via the BMS to ensure that these rooms/areas are maintaining their negative pressure aspect. The rooms at Santa Paula Hospital must be set up before placing a patient in the room. The maintenance department is responsible for setting up and tearing down the negative air machines and checking the room's relationship while being used. Logs are available at the maintenance office.

PROCEDURE:

The 19 rooms/areas that are negative pressure at Ventura County Medical Center:

Emergency Department

Exam Room 1

Exam Room 2

Exam Room 3

Exam Room 4

ICU

Room 1

ICU/ Telle

Room 16

ICU/DOU

Room 17

Room 18

PICU

Room 1

Room 2

Pediatrics (South Tower)

Room 5

Room 8

Postpardum

Room 1

Room 22

NICU

Room 11

MedSurg 1 (First Floor)

Room 1

Room 14

MedSurg 3 (Third Floor)

Room 23

Room 38

Santa Paula Hospital:

MedSurg 174

MedSurg 179

The Room Pressure Monitor shall:
Verify at the entrance to each room that the air is flowing into the room creating a negative pressure.

If it is determined that an isolation room is not negative pressure, the Nursing Staff shall immediately contact the Facility Maintenance Department

The Engineer shall also contact the House Supervisor so that arrangements can be made to move any patient in the isolation room to another available isolation room.

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Initiate immediate repairs to the HVAC system to return the isolation room to its negative pressure status.

All Revision Dates

2/3/2025, 11/22/2021, 8/30/2018, 5/1/2017, 7/1/2016, 12/9/2013, 1/7/2008

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/3/2025
Facilities Department	Ian McGraw: Manager Facility Operation	1/28/2025

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Status **Active** PolicyStat ID **15338286**

Origination	11/15/2024	Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Last Approved	11/15/2024		
Effective	11/15/2024		
Last Revised	11/15/2024	Policy Area	Laboratory Services
Next Review	11/15/2026		

L.60 Laboratory Chemical Hygiene Plan

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POLICY:

The Laboratory is committed to providing a safe working environment and believes employees have a right to know about health hazards associated with their work so that employees can make knowledgeable decisions about any personal risks of employment, The Laboratory Chemical Hygiene Plan includes policies, procedures, and provides an outline of responsibilities designed to develop an awareness of potentially hazardous chemicals in the workplace and to train employees in appropriate, safe working conditions.

It is important that employers assume responsibility for laboratory safety. All employees will have access to pertinent safety information through their supervisory staff. The people who work in any given area are best able to detect potential hazards in either the facility or in work procedures. When safety concerns arise, employees are encouraged to contact their supervisor immediately.

PROCEDURE:

A training program has been designed for the benefit and protection of all Laboratory employees. Necessary information will be available to inform the employee how best to handle hazardous chemicals and how to make use of the new law.

Copies of the Chemical Hygiene Plan are located in the following areas:

1. Blood Gas Laboratory Safety Manual hardcopy (located in the Respiratory Care Department)
2. The Clinical Laboratory Quality Assurance Supervisor's office.
3. Electronic copies are located on most all data workstations with other Healthcare Agency (HCA) and Hospital Procedures.

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4. The Chemical Hygiene Plan will be updated as new hazards are introduced, old hazards deleted or procedures/instrumentation changed.

RESPONSIBILITIES:

A. The Laboratory Medical Director provides overall direction and approves all procedures for the Chemical Hygiene Plan.

B. The Respiratory Department Manager is the designated Chemical Hygiene Officer. Other staff members will be appointed as tasks arise. The following sections identify the responsibilities Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH) Blood Gas Laboratory staff have in regard to the Chemical Hygiene Plan.

C. Chemical Hygiene Officer/ Committee

1. The Chemical Hygiene Committee (CHC) is composed of Respiratory staff who are familiar with the current procedures used and their associated hazards.
    a. Work with administrators and other employee to develop and implement appropriate chemical hygiene policies and practices.
    b. Review the Chemical Hygiene Plan and update where necessary.
    c. Seek ways to improve the Chemical Hygiene Program.
    d. Review each existing and new Laboratory procedures for safe work practice.
    e. See the appropriate audits are maintained.
    f. Ensure that facilities and training for use of any material being ordered are adequate.
    g. Ensure that chemical compatibility is maintained for the storage of chemicals.
    h. Know the current legal requirements concerning regulated substances.
    i. Determine the required levels of protective apparel and equipment.
    j. Certify the performance of protective equipment.
    k. Assure that each new employee receives appropriate training and information and that review sessions are held in accordance with the schedule listed in "Employee Information and Training".
    l. Provide regular, formal chemical hygiene and housekeeping inspections including routine inspections of emergency equipment.

D. Respiratory Care Department Manager (Chemical Hygiene Officer):

1. Ensures that workers know and follow the chemical hygiene rules, and that protective equipment is available and in working order, and that appropriate training has been provided.
2. Knows the current legal requirements concerning regulated substances.
3. Determines the required levels of protective apparel and equipment.
4. Ensures that facilities and training for use of any material being ordered are

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adequate.

5. Provides regular chemical hygiene and housekeeping inspections including routine inspections of emergency equipment.

E. Laboratory Employees

1. All Laboratory employees are responsible for compliance with the provisions of the Chemical Hygiene Plan.
    a. Plan and conduct each operation in accordance with the Laboratory's chemical hygiene procedures.
    b. Develop good personal hygiene habits.
    c. Use appropriate safeguards for using any chemicals, including personal protective equipment.
    d. Know the location and proper use of emergency equipment.
    e. Know the location of the Safety Data Sheet (SDS) and other safety information. Know that you can all for a "fax-back" using information located on every phone.
    f. Use appropriate procedures for emergencies, including evacuation routes, spill cleanup procedures and proper waste disposal.

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STANDARD OPERATING POLICIES/PROCEDURES

A. Because few laboratory chemical are without hazards, general precautions for handling all laboratory chemicals should be adopted to include minimizing exposure and assuming that any mixture of hazardous chemicals is more toxic than the most toxic component.

B. General Rules:

1. Do not smell or taste chemicals.
2. Inspect gloves before use.
3. Do not eat, drink, smoke, or apply cosmetics or lip balm in the working area of the laboratory. Wash hands before conducting these activities.
4. Food, beverages, dishes and utensils should be stored or consumed only in designated areas.
5. Wash areas of exposed skin thoroughly before leaving the laboratory.
6. Avoid practical jokes or other behavior that might confuse, startle or distract another worker.
7. Confine long hair and loose clothing.
8. Wear shoes at all times in the Laboratory, but do not wear sandals, perforated shoes, open toe, sneakers or any shoe made of canvas.
9. Ensure that appropriate eye protection, where necessary, is worn by all persons, including visitors, in areas where chemicals are stored and handled.
10. Avoid use of contact lenses in the laboratory unless necessary; if they are used, inform supervisor so special precautions can be taken.

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11. Wear appropriate gloves when the potential for contact with toxic material exists; inspect the gloves before each use and replace them periodically.
12. Remove lab coats immediately upon significant contamination.
13. Seek information and advice about hazards, plan appropriate protective procedures and plan positioning of equipment before beginning any new operation.
14. Keep work area clean and uncluttered, with chemicals and equipment properly labeled and stored; clean up the work are on completion of an operation or at the end of each day.
15. Be aware of unsafe conditions and see that they are corrected when detected.
16. **SHARP SPECIFIC RULES:**
    a. Generally the Hospital has committed to the use of needless systems where they can be used. When the use of needles (sharps) is necessary all precautions must be taken.
    b. All needles used for arterial puncture must safe sheathing devices to cover or otherwise mitigate rick of staff injury from used needles. No safety device can be modified or otherwise defeated from it's intended use per the manufacturer.
    c. Sharps must be disposed of in the nearest sharp container to the area in which blood is drawn. It is never acceptable to carry a sharp, sheathed or not, back to the Lab.
    d. Sharps, when disposed of, must be in the appropriate container and must always be deposited in such a way that it cannot "fall out" or otherwise injure staff and/or patients. Full containers should be sealed and Housekeeping services notified of the need to replace as soon as possible. Containers can never be "shaken" or otherwise manipulated to make "more room".

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CHEMICAL INVENTORY and STORAGE

A. Inventory:
    1. Chemicals listed are those classified as hazardous by the Department of Transportation (DOT), the Environmental Protection Agency (EPA), or displaying a 2 or greater number in any section of the National Fire Protection Association (NFPA) diamond.
    2. Chemicals are listed alphabetically. The average quantity in storage on a monthly basis, as well as the physical state (e.g., solid, liquid, gas) is included. The NFPA hazard classification, is listed along with the manufacturer's name and address. A comment section is provided to further identify the chemical's location.

B. Storage:
    1. Chemical storage is kept as small as practical. Storage on bench tops is not advisable. There are no flammable liquids used in the Blood Gas Laboratory. All chemical storage for the Rapid Point 500 (RP500) analyzers is contained within a

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cartridge unit and stored in the refrigerator as required by the manufacturer. These cartridges are self-contained and are closed cartridges.

2. Toxic chemicals, including carcinogens, are stored in ventilated storage areas in unbreakable chemical resistant secondary containers. These containers are labeled "CAUTION: HIGH CHRONIC TOXICTY OR CANCER-SUSPECT AGENT". A separate inventory list of carcinogens and suspected carcinogens is maintained by the Chemical Hygiene Officer according to federal and state regulations.

HAZARD IDENTIFICATION-LABELS and SIGNS

A. The 29 Code Federal Regulations (CFR) 1910.1450 contains specific labeling requirements. Labeling must be done on all hazardous chemicals that are shipped and used in the laboratory. Labels must not be removed or defaced. All labels must comply with the Occupational Safety and Health Administration (OSHA) Hazard Communication Standard.

B. Safety Data Sheets (SDS)

1. The SDS are available in the Respiratory Department in a 3-ring binder and on computer desktops in all labs. They can also be accessed by fax-back programs. The laboratory relies on the chemical manufacturer's information to ascertain whether or not the chemical is hazardous.

C. Analyzer Cartridge Labeling

1. Upon receipt, measurement and Automatic Quality Control (AQC) cartridges are refrigerated in the appropriate laboratory and labeled appropriately as required by the manufacturer. The waste/wash self-contained cartridge is stored non-refrigerated and labeled accordingly. These cartridges are self-contained and come in one unit and are disposed of in the same unit with no opening of the cartridges.

D. Location Signs

1. Prominent signs should be posted for the location of emergency safety showers, eyewash stations, safety and first aid equipment, exits and food/beverage consumption storage.

EXPOSURE PREVENTION and MONITORING

A. Personal protective Equipment

1. Personal protective equipment (PPE) is available for all laboratory personnel. They are required to use gloves, laboratory coats, and either safety glasses, chemical splash goggles or face shields whenever working with hazardous chemicals in the laboratory. The SDS and/or container label will provide the employee with the proper personal protective equipment to use for each chemical. An inspection of all protective equipment will be conducted by the user, before use. Defective equipment will be removed and replaced.

2. All personal protective equipment is removed immediately upon leaving the work area.

3. Gloves – Employees are required to wear gloves when there is the potential for direct

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skin contact with blood, hazardous chemical and infectious materials. Gloves of the appropriate size for employee are provided by VCMC and SPH. Employees should be sure gloves fit properly- not too loose are too tight. Non- latex gloves are provided for those with identified or suspected latex allergies.

4. Lab coats – are to be worn only in the laboratory work areas and are to be buttoned to protect the employee's clothing. The coats are provided and in most cases disposable coat/covers are used. Some coats may be re-usable and are laundered by VCMC laundry service.
5. Eye protection is to be worn to prevent splashes or sprays of blood, infectious materials, or hazardous chemicals if there is a potential for eye, nose, or mouth contamination. This equipment is located in all Blood Gas Laboratory locations.

B. Engineering Controls

C. Chemical storage cabinets are no longer required for analyzer containers as they are self-contained and in cartridges which require refrigeration. Storage cabinets are available for any chemicals that require storage, but some reagents may be kept in monitored refrigeration. See Manufacture or Vendor guidelines for more information as needed.

D. Emergency Eye Wash Station is available in all areas where analyzers are located. All eyewash stations are serviced/maintained by Facilities Maintenance.

1. **Intensive Care Unit (ICU):** To the left (as you exit) the Laboratory in ICU.
2. **Neonatal Intensive Care Unit (NICU):** In the adjacent entry room to the Lab area.
3. **Emergency Department (ED):** To the left of the Lab station in the location shared with the ED Microscopy.
4. **Pediatric Intensive Care Unit (PICU):** To the immediate right of the analyzer station adjacent to the splash barrier.
5. **SPH:** The main room of the Department just outside the Lab area.
6. **VCMC Laboratory:** Three locations- Pathology/Histology area, Microbiology lab near the door, and next to the chemistry refrigerators across from the time clock.

E. If someone is splashed with a chemical, they are to be taken immediately to the eye wash station. Any clothing affected will be immediately removed as indicated (chemicals used in the Arterial Blood Gas (ABG) Lab are not corrosive). Flushing with water must continue for a minimum of 15 minutes. Medical assistance will be requested immediately.

F. Emergency Equipment is located in the ICU:

1. **VCMC ICU:** Fire Alarm is in ICU, fire extinguisher is on the wall opposite bed D.
2. **VCMC NICU:** Fire Alarm outside in hall, fire extinguisher is outside hall.
3. **SPH:** Fire alarm outside in hall, fire extinguisher in outside hall.

G. Chemical Hygiene Risk Assessment

1. Assessment of significant risk of all operations is made by the Department Manager. Chemical hygiene and safety policies will be established for each task performed and engineering controls of personal protective equipment assigned. Appendix B identifies each work station/task in the laboratory and the required controls and

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equipment.

H. Chemical Spills

1. Chemical spills are contained using the "Think C.L.E.A.N." Plan**.**
    a. **C**ontain the spill with appropriate spill kit.
    b. **L**eave the area-remove patients.
    c. **E**mergency: eye wash, shower, medical care.
    d. **A**ccess SDS
    e. **N**otify a supervisor
    f. Refer to Spill Procedure (Safety Manual, 2.9)
        i. Spills causing toxic fumes or fire-at VCMC call X6666 at SPH call X8666, follow the Fire Plan.
        ii. Call: If major spill (excess of 100 ml) at VCMC X6666, at SPH call X8666.
        iii. To complete clean-up by Lab personnel (if minor spill):
            i. Put on a new pair of gloves.
            ii. Place material in double red bags. Dispose appropriately.
            iii. Thoroughly wash and dry the spill area.

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HOUSEKEEPING

A. Housekeeping personnel will be responsible for the following:

1. Trash Disposal-Removed twice per day with the maintenance of the separation of bio-hazardous and ordinary trash. Glass and needles will have been placed in the appropriate "Sharps" containers.
2. Floors-Daily swept and mopped with appropriate cleaner.

B. Laboratory personnel will be responsible for the following:

1. Prompt cleanup of small, nontoxic spills, using appropriate personal protective equipment and proper disposal. If the spilled substance is highly toxic, a hazardous materials team must be notified at once.
2. Clear access to exits, emergency equipment and utility controls.
3. Clean work surfaces. Bench tops should be clear of unnecessary items.

C. Periodic inspections are conducted by the Department Manager to assess whether:

1. Work area is free of obstruction.
2. Waste is deposited in appropriate receptacles and properly removed from the laboratory.
3. Chemical spills are cleaned according to established protocol.

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4. Proper storage is accomplished to minimize clutter.

MEDICAL PROGRAM

A. All employees needing medical attention are referred to the Emergency Room at VCMC or at SPH.
    1. All medical examinations and consultations are performed by or under the direct supervision of a licensed physician without cost to the employee, without loss of pay, and at a reasonable time and place.

B. The employee is sent for medical evaluation:
    1. Whenever signs and symptoms associated with a hazardous chemical develop.
    2. When environmental monitoring reveals an exposure level routinely above the action level, or in the absence of an action level, the Permissible Exposure Limit (PEL) for an OSHA regulated substance.
    3. Whenever an event takes place in the work area such as a spill, leak, or explosion resulting in a hazardous chemical exposure.

C. The laboratory provides the following information to the physician:
    1. Identity of the hazardous chemical(s) to which the employee may have been exposed.
    2. A description of the conditions under which the exposure occurred-including quantitative exposure data (if available).
    3. A description of the signs and symptoms of exposure.
    4. A copy of the SDS for the chemical(s) involved.

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D. The physician provides a written opinion that will not reveal specific finding of diagnosis unrelated to the exposure but will include:
    1. Any recommendation for further medical follow up.
    2. Results of the medical examination and any associated tests.
    3. Any medical conditions that may be revealed in the course of the examination that may place the employee at increased risk as a result of exposure to a hazardous chemical found in the workplace.
    4. A statement by the physician that the employee has been informed of the consultation/examination results and any medical condition that may require further examination or treatment.

E. Records are maintained on all employee examinations and consultations. Reports should be made to the Department Manager and to the Safety Officer.

RECORD KEEPING

A. The laboratory will maintain the following records in the Blood Gas Laboratory and the Clinical Laboratory:

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1. Chemical Hygiene Plan
2. Blood Borne Pathogens Document
3. Access to SDS via Fax-back

B. The Laboratory will maintain the following records in the Department Manager's Office:
    1. Training Records
    2. Environmental monitoring as may occur
    3. The Respiratory Care Department will maintain calibration and repair records

C. The Bio-Medical Department will maintain the following records:
    1. Instrument/device inspection; repair records, if performed by Biomed
    2. Environmental monitoring records

D. The Employee Health Department of Ventura County will maintain the following records:
    1. Employee medical records
    2. Accident records

CONTAMINATED WASTE REMOVAL/DISPOSAL

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A. The Laboratory, in conjunction with the VCMC and SPH facilities, are considered a small quantity generator according to the EPA.

B. Waste generated in the Laboratories will be accumulated in the appropriately labeled containers. It is removed to a central waste storage area as needed and from the central waste storage at regular intervals.

C. Laboratory chemical wastes are sent to an approved disposal site by a County-contracted hauler.

D. Certain chemicals are permissible for drain disposal. Only those chemicals reasonably soluble in water are suitable for drain disposal. A compound is considered water-soluble if it dissolves to the extent of at least 3%. These compounds are flushed with at least 100 volumes of excess water.

EMPLOYEE INFORMATION AND TRAINING

A. VCMC will provide employees with information and training to ensure that they are adequately informed regarding laboratory operations, its risk, and what to do if an accident occurs.

B. Such information will be provided to all new employee and refresher training will be conducted periodically.

C. The employee will be informed of:
    1. Contents of this standard
    2. Location and availability of the employer's Chemical Hygiene Plan
    3. Permissible exposure limits for OSHA regulated substances or recommended exposure limits for other hazardous chemicals where there is no applicable OSHA

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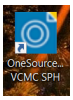
standard.

4. Signs and symptoms associated with exposures to hazardous chemicals used in the Laboratory.
5. Location and availability of known reference literature on the hazards, safe handling, storage and disposal of hazardous chemicals found in the laboratory including, but not limited to, Safety Data Sheets received from the chemical supplier.
6. Laboratory Safety Manual location.
7. Link to OneSource OneSource Docs Icon is displayed in every desktop 

D. The employee will be trained in the following:

1. Methods and observations that may be used to detect presence or release of a hazardous chemical (such as monitoring conducted by VCMC, visual appearance or odor of released hazardous chemicals, etc.).
2. Physical and health hazards of chemicals in the work area.
3. Measures employees can take to protect themselves from hazards, including specific procedures the employer has implemented.
4. Applicable details of the Chemical Hygiene Plan.

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All Revision Dates

11/15/2024

Attachments

Chemical Inventory Addendum.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	7/29/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	7/29/2024

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Status Active PolicyStat ID 15909388

Origination	11/15/2000	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	11/15/2024		
Effective	11/15/2024	Policy Area	Laboratory Services - Blood Bank
Last Revised	11/15/2024		
Next Review	11/15/2026		

L.BB.41 Neonatal Transfusions

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POLICY/PROCEDURE:

Replacement Transfusions:

A. Initial pre-transfusion workup:

1. Check Blood Bank historical records for an HDN workup on the neonate for the current admission. Testing performed should include an ABO-Rh typing and a Direct Antiglobulin Test (DAT).
    a. If testing has not been performed and the neonate was born at VCMC, check for a cord blood specimen. If a cord blood specimen is located, request an HDN order and perform testing on the retrieved cord blood.
    b. If testing has not been performed and the neonate does not have a cord blood specimen, request an HDN order and submit the Laboratory request label to a phlebotomist to collect one (1) EDTA pediatric tube and (2) yellow top pediatric tubes. Collect each tube to the maximum fill line indicated on the tubes. Label each tube with a Laboratory label or if the NICU collects the sample an addressograph label can be used.
    c. If this is a new admission, request an HDN order and submit the Laboratory request label to a phlebotomist to collect one (1) EDTA pediatric tube and two (2) yellow top pediatric tubes. Collect each tube to the maximum fill line indicated on the tubes. Label each tube with a Laboratory label or if the NICU collects the sample, an addressograph label can be used.
2. Check Blood Bank historical records for the mother's antibody screen. The mother's screen performed within 3 days of delivery, on this admission, is acceptable.
3. If an antibody screen has not been performed on the mother's specimen:

a. Check for an extra Blood Bank specimen submitted within 3 days of delivery. If a specimen is located request a type and screen order and perform testing.

b. If the mother is unavailable and there is no specimen, perform an antibody screen on the neonate's specimen and perform compatibility testing for the requested red blood cells.

B. Subsequent pre-transfusion testing (for this admission) may be omitted during the first four (4) months of age if:

1. The original antibody screen is negative.
2. All red cells transfused during this period are Group O or ABO-identical or ABO-compatible and either D negative or the same D type as the neonate. Before giving any non-group-O red cells, the neonate's serum must be checked for passively acquired maternal anti-A and/or anti-B, including the anti-globulin phase of testing.
3. Testing for Anti-A and/or Anti-B in the baby's serum/plasma:
    a. Label two 12x75 mm tubes for A1 cells and B cells.
    b. Add 2 drops of the baby's serum to each tube.
    c. Add 1 drop of A1 and B cells to the appropriately labeled tubes.
    d. Incubate the tubes at 37°C for 15 minutes.
    e. Wash the tubes 4 times with saline and then add 2 drops of anti-IgG to each tube.
    f. Spin at 3500 RPMs for 15 seconds.
    g. Read macroscopically and microscopically.
    h. Add check cells to all negative reactions.
    i. If the antibody is present ABO-compatible red cells lacking the corresponding A or B antigen must be used.

C. If the initial antibody screen (mother or neonate) demonstrates a clinically significant antibody/antibodies, transfuse units negative for the corresponding antigen(s). These units must be cross-matched with the mother's serum/plasma (or the baby's serum if the mom's serum/plasma is unavailable).

D. Record the pre-transfusion testing results. Refer to policy *L.BB.43 Blood Bank Aliquoting of Red Blood Cells for Neonatal Transfusions* for preparing small aliquots of RBCs.

E. If an infant is discharged and re-admitted, an ABO-Rh typing and antibody screen must be performed, even if the infant is less than four months of age.

F. Red Blood Cells and Plateletpheresis components for neonates must be CMV negative and Irradiated. Red Blood cells should be 10 days old or less at the time the first aliquot is made. If only older blood is available from the blood supplier contact the Pathologist.

G. Components containing unexpected or ABO-incompatible antibodies must not be transfused.

H. Normally one donor unit will be assigned to each neonate who requires transfusion for the full life span of the unit or until the unit expires earlier for some other reason. Donor units may be

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used for more than one infant when there are insufficient units to meet the need.

I. If thawed plasma is required, group AB plasma components will be used. Pediatric AB plasma units are provided by the blood supplier. These pediatric units come as 4 divided units with the same donor number. The CMV status of pediatric plasma is unknown and not required.

J. Platelets must be CMV negative and Irradiated. Try for ABO/Rh compatible Product. Refer to policy *L.BB.44 Platelet Components* for more information. (Contact a Pathologist if ABO-Rh compatible product is not available.)

1. When ordering platelet pheresis units for a baby, please order the unit sterile docked with extra bags. If the platelet pheresis is to be aliquoted refer to policy *L.BB.43 Blood Bank Aliquoting of Red Blood Cells for Neonatal Tranfusions*.
2. Reduced Volume Platelets will only be issued in cases in which the transfused product contains incompatible plasma. These platelets will be ordered and issued only with the approval of a Pathologist. If a ***reduced volume product*** (less volume) is required, the outdate of the platelet pheresis will be decreased to four hours, one hour of which is used to rest the unit and a second hour is used to rotate the unit. This leaves only 2 hours to infuse the unit. Make sure that the doctor involved in ordering this product is aware of the narrow infusion window he/she is dealing with. This procedure will be done by the blood supplier.

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Exchange Transfusion:

A. Steps A through D above apply.

B. Group O positive/negative RBCs and AB fresh frozen plasma will be used. The cells used must be less than 5 days old (if cells less than 5 days old are not available have the freshest available unit less than 10 days old washed by the blood supplier), CMV negative, Irradiated, and Hgb S negative.

C. If FFP and RBC's are used, the Blood Bank will pool the two components to arrive at the desired hematocrit (see policy *L.BB.42 Reconstitution of Blood for Exchange Transfusions*).

D. NOTE: In grave situation when the baby is subjected to bilirubin encephalopathy and kernicterus, the physician may waive the need to obtain less than 5 days old RBC unit or washed unit (which would avoid the complications of hyperkalemic cardiac arrhythmias) and accept the available product on hand (CMV neg, Irradiated, Hgb S negative O Neg RBC) for the exchange transfusion. The Blood Bank CLS will fill out a Deviation from Standard Operating Procedure form, have the pathologist approve it after he discussed with the Ordering physician and the Ordering physician acknowledges his awareness of possible complications of hyperkalemic cardiac arrhythmias from such waiver listed above.

WASHED CELLS:

A. Place a request with the blood supplier to wash a CMV negative, Leukodepleted, Irradiated red blood cell which is 10 days or less old.

B. When the washed unit arrives, transfer the contents to a 600 mL transfer pack. The expiration date is the same as that which is on the washed unit.

C. If the washed unit is to be used for aliquots proceed as you would with any pediatric unit.

If the unit is to be used for an exchange transfusion, follow the instructions in policy *L.BB.42 Reconstitution of Blood for Exchange Transfusions*.

REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, Current Edition.
2. Funk, Mark K. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.

All Revision Dates

11/15/2024, 7/25/2022, 6/5/2020, 12/1/2016, 12/1/2013, 2/1/2012, 1/1/2007

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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	10/8/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Laboratory Services - Blood Bank

L.BB.61 Visual Inspection of Blood Components

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Purpose:

This procedure provides instructions for how to perform a visual inspection of blood components.

Procedure:

	Action	Related Documents Title
1	Verify that each component to be inspected: • is in date, • is not leaking or showing other signs of damage, • is of an appropriate size or weight, and • has intact port covers or sterile cap covers.	
2	For each component that has been modified in-house: • verify the appropriateness of any modification expiration date, and • confirm that there is an original intact port on any red cell unit.	
3	Verify that the blood component is of an appropriate volume. See **Appendix A**.	Appendix A: Appropriate Volume of Blood Components
4	Use the following table to examine each component for possible abnormalities. The American Red Cross **Visual Inspection Reference Guide** can be used as an aid to help identify components that have an unusual appearance.	Appendix B: Probable Causes of Abnormalities Detected on Visual Inspection of Blood

Action	Related Documents Title
Consult **Appendix B** for probable causes, if abnormalities are found.	Components

If the component is	Then examine for
red cells or whole blood	• black or purple color of the red cell mass, • a zone of hemolysis in the supernatant above the red cell mass, • visible clots, • segments that appear much lighter in color than the bag, • murky, purple, brown or red appearance of the plasma or supernatant, • gross lipemia, and • blood or plasma in the ports or at the sealing sites.
frozen plasma or cryoprecipitate	• cracked or damaged bags, and • signs of thawing and refreezing (eg, drainage from creases, no dents where there should be, etc).
thawed plasma or cryoprecipitate	• hemolysis or red cell contamination, • grey, purple or brown color, • intense yellow color, and • gross lipemia.
platelets	• hemolysis or excessive red cell contamination, • grey, purple or brown color, • intense yellow color, and • visible aggregates.
derivatives	• damage to the sterile cap

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<table>
<tr><th></th><th colspan="2">Action</th><th>Related Documents Title</th></tr>
<tr><td></td><td colspan="2"><table><tr><th>If the component is</th><th>Then examine for</th></tr><tr><td></td><td>covers, and
• cloudiness.</td></tr></table></td><td></td></tr>
<tr><td>5</td><td colspan="2">Record the results of the visual inspection on the appropriate unit issue form.</td><td></td></tr>
<tr><td></td><td>If</td><td>Then</td><td></td></tr>
<tr><td></td><td>no abnormality is found</td><td>proceed with the Issue of Blood Products Procedure.</td><td>Issue of Blood Products</td></tr>
<tr><td></td><td>abnormality is found</td><td>proceed to Step 6.</td><td></td></tr>
<tr><td>6</td><td colspan="2">Use the following table to decide how to handle components that show any abnormalities:</td><td></td></tr>
<tr><td></td><td>If the abnormality is found when components are being</td><td>Then follow established procedures to</td><td></td></tr>
<tr><td></td><td>received from the supplier</td><td>• Quarantine the component physically and in the computer.
• Notify the supplier by telephone.
Note:Follow supplier instructions for any disposition of the component.</td><td>Criteria for the Rejection of Donor Blood</td></tr>
<tr><td></td><td>• issued,
• returned,
• used in compatibility testing</td><td>• Quarantine the product physically and in the computer.
• Notify the department supervisor who will determine the final disposition of the unit.
• Discard the unit if unit cannot be returned to supplier or returned to inventory for reissue or reallocation.</td><td>Evaluating Returned Components for Reissue or Return to Inventory</td></tr>
</table>

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Appendices:

Appendix A: Appropriate Volume of Blood Components

Appendix A: Appropriate Volume of Blood Components

Blood Component	Appropriate Volume
Red cells	240 to 340 mL
Plasma	At least 100 mL
Apheresis plasma	200 to 600 mL
Apheresis platelets	Approximately 400 mL
Cryoprecipitate, individual units each	5 to 15 mL

Appendix B: Probable Causes of Abnormalities Detected on Visual Inspection of Blood Components

If the blood component is	And the abnormality is	Then the probable cause of the abnormality is
whole blood or red cells	black or purple color of red cell mass	bacterial contamination.
	a zone of hemolysis in the supernatant above the red cell mass	• bacterial contamination, or • freezing or other mechanical damage to the red cells.
	visible clots	• bacterial contamination, or • inadequate mixing during donation.
	segments that appear much lighter in color than the bag	• bacterial contamination, or • processing error.
	murky, purple, brown, or red appearance of plasma or supernatant	bacterial contamination.
	gross lipemia	donor abnormality.
	blood or plasma in the ports or at sealing sites	damaged or inadequate seals.
plasma or cryoprecipitate	hemolysis or red cell contamination	processing error.
	grey, purple, or brown color	bacterial contamination.
	intense yellow color	donor abnormality.
platelets	hemolysis or excessive red cell contamination	processing error.
	grey, purple, or brown color	bacterial contamination.

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If the blood component is	And the abnormality is	Then the probable cause of the abnormality is
	intense yellow color	donor abnormality.
	visible aggregates	• processing error, or • bacterial contamination.
derivatives	damage to sterile cap covers	product contamination.
	cloudiness	• inadequate reconstitution, or • bacterial contamination.
	gross lipemia	donor abnormality.

References:

1. American Association of Blood Banks, Technical Manual, 21st Edition, 2023..
2. American Association of Blood Banks, Standards for Blood Banks and Transfusion Services, 33rd Edition, 2022.
3. The American National Red Cross, Visual Inspection Reference Guide, 2006.

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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	8/4/2024

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L.BB.67 Thawing Frozen Plasma

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PRINCIPLE:

Fresh Frozen Plasma (FFP) contains all the plasma clotting factors, including labile Factors V and VIII. It is indicated to control patient's bleeding caused by a deficit of plasma coagulation factors and ATP. It should not be used for volume expansion.

Several plasma alternatives can be used for coagulation factor replacement, including Fresh Frozen Plasma (FFP), Plasma Frozen Within 24 Hours After Phlebotomy (FP24), and Thawed Plasma (See SOP L.BB.69 ***Thawed Plasma – Five Day)***. Fresh Frozen Plasma (FFP) may also be obtained by using apheresis procedures. Apheresis technology allows for the collection of the equivalent of 2 units of plasma during a single donation. Plasma may be stored for as long as 1 (one) year at -18^{0}C or colder.

SPECIMEN COLLECTION:

1. EDTA K2 pink top tube (7ml).
2. All patients receiving blood or blood components must be drawn and banded with a Secure-line blood bank wristband.
3. A type and screen must be ordered by the physician.
4. Any sample, collected for transfusion of plasma, remains valid for seven (7) days with the date of draw being day 0.

REAGENTS/SPECIAL SUPPLIES AND EQUIPMENT:

1. Helmer water bath: 37^{0}C.
2. Helmer plastic overwraps.

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PROCEDURE:

1. Perform a type and screen on the patient sample.
2. Select units: ABO group specific is preferred. If ABO group specific is not available, use only the options listed below. Rh(D) type is not a consideration.
3. Retrieve the appropriate units from the freezer.
4. Place the units in the plastic overwraps and thaw at 30-37^{o}C.
5. When thawed, change the expiration date and time on the blood component label. The new expiration will be 24 hours from date and time of thaw.

PATIENT TYPE	DONOR TYPE
O	**O, A, B, AB**
A	**A, AB**
B	**B, AB**
AB	**AB**

6. Store the thawed plasma component at 2-6^{o}C before issue.

CALIBRATION: N/A

CALCULATIONS: N/A

QUALITY CONTROL:

See SOP L.BB.90 ***Quality Control***, SOP L.BB.96 ***Quality Control of Blood Bank Reagents.***

PROCEDURAL NOTES:

1. CMV status for plasma components is unknown.
2. Pediatric units are available as a single donation divided into 4 bags. Each bag holds approximately 70 mL. All pediatric units stocked are type AB.
3. Thawing will take approximately 12-14 minutes for a single donor unit.
4. Jumbo units are folded prior to freezing. Place the Jumbo plasma in the bath for approximately 5 minutes to start. Unfold the plasma after 5 minutes and extend the thaw time to approximately 14 minutes.
5. All orders for thawed plasma must be confirmed with the RN/MD prior to thawing. Usually only 1-2 units should be thawed for a patient.
6. There are diseases in which the patient may benefit from plasma exchange. In these cases larger volumes of FFP will be ordered. Jumbo apheresis FFP can be ordered and thawed for these patients.

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REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, Current Edition.
2. Cohn, et.al. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.
3. King, Karen E. Blood Transfusion Therapy, A Physician's Handbook. Bethesda, MD: American Association of Blood Banks, Current Edition.

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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	8/4/2024

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L.BB.77 Validation of Blood Transport Coolers

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PURPOSE

The purpose of this procedure is to provide instruction on how to perform the validation of blood transport coolers.

PRINCIPLE

The safe transport of blood and components requires they be packaged in such a way that the possibility of leakage from the container under normal conditions of transport does not occur. Containers should be able to safely transport the maximum anticipated volume and be easy to clean. Temperatures should be maintained within the container for the maximum anticipated time that the product remains within the container. Inspection and cleaning shall be performed as required for each container used for the transport of blood products.

SPECIMEN COLLECTION

Not applicable.

EQUIPMENT

1. Surrogate blood products (Use expired red blood cells (RBC), thawed Plasma, Platelet, and Cryoprecipitate units).
2. Blood Transport Coolers.
3. 10% bleach, a commercially prepared bleach disinfectant, or as recommended by manufacturer of coolers.
4. Calibrated Log Tag Temperature recorders with 4 ml bottle of Glycerol.

5. Appropriate Frozen and Refrigerated blocks charged, stored and packed as recommended by manufacturer of coolers.
6. Polar Pack 16 oz gel refrigerant packs stored in a 1-6°C refrigerator for at least 24 hours.
7. Safe-T-Vue ® 6 and Safe-T-Vue® 10 non-reversible blood temperature indicators.

PROCEDURE

Validation of the blood transport coolers for RBC and Plasma.

STEP	ACTION
1	Inspect all blood transport coolers for cracks on the outside and inside of the container and retire any that do not pass inspection.
2	Inspect all closures to assure that the container will remain closed during the time it is being used.
3	Remove the contents of the coolers. Use a damp cloth that contains either 10% bleach, a commercially prepared bleach disinfectant, or as recommended by cooler manufacturer. Thoroughly wipe the inside and outside of the cooler. Thoroughly wipe the inside and outside of the cooler. Use a damp cloth that contains either 10% bleach or a commercially prepared bleach disinfectant to wipe the outside of the refrigerants.
4	Place required number of expired blood product(s) with the 4 mL bottle of Glycerol in place, at the bottom of the ice chest.
5	Prepare and pack each cooler as recommended by cooler manufacturer for validation. Pack each cooler with the maximum load.
6	Monitor the cooler temperature every hour for a minimum of 4 hours. Inspect blood product safe-T-Vue indicators every 4 hours if validation to exceed 4 hours.
7	Monitor and record the color of both blood temperature indicators at 4 hours intervals. The Safe-T-Vue® non-reversible blood indicators have been placed on each blood product.
8	• If coolers meet the validation criteria, they may be placed into service. Place a validation date sticker on the cooler. • If a cooler is not acceptable, remove it from service.

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PROCEDURE

Validation of the blood transport coolers for Platelets transported to Outpatient Infusion Clinic.

STEP	ACTION
1	Inspect all blood transport coolers for cracks on the outside and inside of the container and retire any that do not pass inspection.
2	Inspect all closures to assure that the container will remain closed during the time it is being used.

STEP	ACTION
3	Remove the contents of the coolers. Use a damp cloth that contains either 10% bleach, a commercially prepared bleach disinfectant, or as recommended by cooler manufacturer. Thoroughly wipe the inside and outside of the cooler. Use a damp cloth that contains either 10% bleach or a commercially prepared bleach disinfectant to wipe the outside of the refrigerants.
4	Place a thermometer into the cooler along with one (1) unit of platelets from the platelet incubator.
5	Approximately 15-20 minutes prior to the end of the 1st hour, transport the cooler to the building where Hematology Oncology and Pediatric Oncology are located. Carry a thermometer to monitor the environmental temperature. Return to the laboratory with the cooler. After the 1st hour elapses, document the internal cooler temperature. (Note the environmental temperature change, if any, that occurs as the cooler is transported outside the building to the clinic.
6	Continue to monitor and record the cooler temperature and the environmental (outside) temperature every hour of the validation time.
7	• If coolers meet the validation criteria, they may be placed into service. Place a validation date sticker on the cooler. • If a cooler is not acceptable, remove it from service.

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CALIBRATION

Thermometers or temperature recorders (Annual)

CALCULATIONS

Not applicable

QUALITY CONTROL

1. Thermometers or temperature recorders are calibrated annually.
2. Each new lot of Safe-T-Vue® 6 and Safe-T-Vue® 10 non-reversible blood indicators must be validated prior to being put into use.
3. Blood Transport coolers - Temperature quality control - When initially put into use and periodically as needed thereafter.

RESULTS

1. Coolers will be monitored a minimum of 4 hours.
2. Temperature of cooler for RBC and thawed plasma must be ***greater than 1°C and less than 6°C*** during the 4 hour validation test.

3. Temperature of cooler for platelets must be ***greater than 20°C and less than 24°C*** during the 4 hour validation test.
4. The Safe-T-Vue® 6 non-reversible blood temperature indicator must be ***white*** at the end of 4 hours, indicating the temperature of the red blood cell/plasma units have been maintained between 1-6°C.
5. The Safe-T-Vue® 10 non-reversible blood temperature indicator must be ***white*** at the end of 4 hours, indicating the temperature of the red blood cell/plasma units have been maintained between 1-10° C.

REFERENCES

1. *Standards for Blood Banks and Transfusion Services.* Bethesda : American Association of Blood Banks, Current Edition.
2. Cohn, Claudia, et. al**.** *Technical Manual.* Bethesda : American Association of Blood Banks, Current Edition
3. Code of Federal Regulations: CFR - Code of Federal Regulations Title 21 (fda.gov)
4. *American Association of Blood Banks* Standards for Blood Banks and Transfusion Services, Reissue of Blood and Components.
5. Current manufacturer's insert for Safe-T Vue blood indicators.

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11/15/2024, 7/26/2022, 12/1/2016, 11/1/2015

Attachments

Cooler Validation

Platelet Cooler Validation

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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	8/4/2024

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L.BB.107 Look Back Protocol

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PRINCIPLE:

Look-Back is the process of identifying the disposition of components from a specific donor. The donor specific components are removed from inventory immediately. If they have been transfused the recipient will be identified so that treatment and counseling can be provided.

BACKGROUND:

The current donation from a blood donor who is found repeatedly reactive on one of the routinely performed screening assays for transfusion-transmissible diseases is withheld from distribution and destroyed. Prior donations from donors who were newly identified as infected with HIV or HCV require quarantine of un-transfused components and look-back to identify and notify the recipients of these previous potentially infectious units so they can be tested and counseled.

Look-back begins with a search by the blood collection facility for the most recent nonreactive donation from the implicated donor and all units donated during the preceding 12 months. This research assumes that any prior donations that could have been infectious but were not detected because of the window-period phenomenon would have been contained in this time frame. The information on any identified unit (or units) is forwarded to the transfusing facility, which searches its records for the recipient (or recipients). The final step is recipient notification, preferably through the recipient's physician to allow testing and counseling as appropriate. In case of HIV and HCV, notification of relative or legal representative is mandatory if the recipient is deceased or judged incompetent.

PROCEDURE:

1. **HOSPITAL NOTIFICATION:**
    a. If it is determined by the blood supplier that a blood component potentially

infectious with HIV, HCV, or HTLV I/II may have been provided to the hospital, the blood supplier will notify the Hospital (see current Hospital Services Agreement Letter).

In accordance with FDA regulations, the blood supplier shall notify Hospital:

i. Within 3 calendar days if the blood supplier provided in-date blood and blood components collected from a donor who tested reactive for evidence of HIV or HCV infection on a later donation or when the blood supplier is made aware of other reliable test results or information indicating evidence of HIV or HCV infection.

ii. Within 45 calendar days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; including notification of test results for blood and blood components previously collected from donors who later test reactive for evidence of HIV or HCV infection as required by FDA.

iii. Within 3 calendar days after the blood supplier provided blood and blood components collected from a donor infectious with HCV, whenever records are available, as set forth at 21 CFR 610.48(b)(3).

2. **QUARANTINE OF BLOOD AND BLOOD COMPONENTS:**

a. All notifications received from the blood supplier will be documented in the communication book, including the following:

i. Contracted blood supplier personnel providing notification and instructions.

ii. All instructions given by the blood supplier for the disposition of the affected products.

iii. Date and time of notification.

iv. Unit Identification Number and component type.

b. The Technologist who receives and documents the notification or the blood bank supervisor will ***immediately*** search for the unit in question and determine its status. This is best done through the blood bank computer system.

c. If the unit has not been transfused, the Technologist or blood bank supervisor will immediately remove the unit from the blood bank refrigerator. The unit will be placed in a Ziploc biohazard bag with "Do Not Use" written on the bag. The unit status will be changed in the computer to ***quarantine*** and placed on the quarantine shelf in the refrigerator if the blood supplier is to retrieve the unit. The unit status will be changed from active to ***destroyed*** in the computer and the unit placed in the appropriate biohazard waste container if the unit will not be picked up by the blood supplier.

d. If the unit has been transfused, the technologist will write down the name and hospital identification number of the patient who received the transfusion and record the date of transfusion.

3. **PATHOLOGIST NOTIFICATION**

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a. Inform the Medical Director of the name of the recipient and the physician responsible for the patient.

4. **PATIENT NOTIFICATION**
    a. Notification to the doctor of his/her obligation to notify the recipient shall come from the Medical Director.
    b. If the physician is unavailable or declines to notify the recipient, the pathologist will notify the recipient and inform the recipient of the need for follow-up testing and counseling.
    c. The follow-up shall include reasonable attempts to perform notification within 12 weeks after receiving the supplemental (additional, more specific) test results for evidence of HCV infection from the collecting establishment, or after receiving the donor's reactive screening test result for HCV if there is no available supplemental test that is approved for such use by FDA, or if under an IND or IDE, is exempted for such use by FDA.
    d. If the transfusion recipient has been adjudged incompetent by a State court, the pathologist or physician must notify a legal representative designated in accordance with State law.
    e. If the transfusion recipient is competent, but State law permits a legal representative or relative to receive the information on the recipient's behalf, the pathologist or physician must notify the recipient or his or her legal representative or relative.
    f. If the transfusion recipient is deceased, the pathologist or physician must continue the notification process and inform the deceased recipient's legal representative or relative. Reasons for notifying the recipient's relative or legal representative on his or her behalf shall be documented.

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REFERENCES:

1. Standards for Blood Banks and Transfusion Services. Bethesda, MD: American Association of Blood Banks, Current Edition.
2. Fung, Mark K MD, PhD. Technical Manual. Bethesda, MD: American Association of Blood Banks, Current Edition.
3. AABB (October 2007) *Code of Federal Regulations*.
4. U.S. Department of Health and Human Services, FDA, Center for Biologics Evaluation and Research, *Guidance for Industry, 'Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV,* August 2007.

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Attachments

Notification of Recipients and Quarantine Procdure Documentation Form

Approval Signatures

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Laboratory Services Department	Brad Adler, MD: Medical Director, Laboratory Services	11/14/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	8/4/2024

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

L.SER.05 Mono Test

COPY

PRINCIPLE

Sure-Vue® Mono reagent is a suspension of polystyrene latex particles of uniform size coated with highly purified Paul-Bunnell antigen from bovine red cell membranes. The degree of purity of the antigen is such that the Sure-Vue® Mono reagent reacts only with infectious mononucleosis heterophile antibodies. For this reason, "differential" absorptions are not necessary.

Latex particles allow visual observation of the antigen-antibody reaction. If infectious mononucleosis heterophile antibodies are present in the serum or plasma, the latex suspension changes its uniform appearance and a clear agglutination becomes evident.

SPECIMEN COLLECTION

Serum:
Use fresh serum collected by centrifuging clotted blood. If the test cannot be carried out on the same day, it may be stored between 2 and 8°C for no longer than 8 days after collection. For longer periods the samples must be frozen (-20°C).

Plasma:
Collect blood into a tube containing anticoagulant (EDTA). Other anticoagulants should be evaluated before use. Centrifuge to separate plasma from cellular elements. Test the specimen within 24 hours of blood collection.

Do not use hemolyzed or contaminated samples.

EQUIPMENT AND MATERIALS

Materials Required

- Serological or automatic pipettes.
- Disposable stirrers.
- Rotator.
- Timer.

Materials Provided

- Latex reagent – Suspension of polystyrene latex particles coated with Paul-Bunnell antigen in a buffer.
- Positive control – Rabbit IgG anti-Paul-Bummell antigen diluted in a buffer.
- Negative Control – Non-reactive diluted human serum.
- Disposable Slides.

Storage Requirements

Reagents and controls should be stored at 2-8°C. **DO NOT FREEZE**

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PROCEDURE- QUALITATIVE

1. Allow reagents and controls to reach room temperature (20-30°C).
2. Gently shake the reagent vial to disperse and suspend the latex particles. Vigorous shaking should be avoided.
3. Place 50 µL of serum or plasma in one section of the disposable slide.
4. Place one drop of reagent next to the drop of serum or plasma.
5. Mix both drops together using a stirrer covering the entire surface of the slide section.
6. Gently rotate the slide manually for 2 minutes or on a rotary shaker set at 80-100 rpm. (When using BD MACRO-VUE CARD TEST ROTATOR setting is: 98 to 102 rpm).
7. Look for the presence or absence of agglutination after the 2-minute time period.

CALIBRATION

Not applicable

CALCULATIONS

Not applicable

QUALITY CONTROL

1. Prior to each set of determinations, the latex reagents should be tested with each run using the positive and negative controls provided in the kit.
2. Both controls should be used following steps 4 through 7 of the Qualitative procedure. Do not dilute the controls prior to use.
3. The reaction between the positive control and the reagent should show a clear agglutination, different from the uniform appearance of the negative control.
4. If no agglutination takes place, the test should be repeated, and the kit discarded if there is no positive reaction.

RESULTS

The presence of agglutination indicates a clinically significant concentration of infectious mononucleosis heterophile antibody in the sample.

POSITIVE REACTIONS

- 3+ - Large clumping with clear background.
- 2+ - Moderate clumping with fluid slightly opaque in background.
- 1+ - Small clumping with opaque fluid in background.

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NEGATIVE REACTIONS

No visible clumping, uniform suspension.

REFERENCE RANGE

Although most patients will have a detectable heterophile level within three weeks of infection, occasionally a patient with strong clinical signs of infectious mononucleosis may take as long as three months to develop a detectable titer. Positive results may occur with or without any clinical symptoms or hematological evidence of infectious mononucleosis.

LIMITATIONS

1. In accord with all diagnostic methods, a final diagnosis should not be made on the results 9f a single test, but should be based on a correlation of test results with other clinical findings.
2. As with all diagnostic assays, the results of the Sure-Vue® Mono assay should be interpreted in light of the clinical symptoms shown by the patient. Occasionally, detectable levels of heterophile antibodies are late in developing in patients symptomatic for infectious mononucleosis. If symptoms persist, it is recommended to repeat the assay in several days.
3. Contaminated, lipemic, or grossly hemolyzed sera should not be used because of the possibility of nonspecific results.
4. Reaction times longer than specified might cause false positive results doe to a drying effect.

5. Due to possible prozone effects, the strength of agglui\tination in the screening test is not indicative of the IM heterophil at\ntibody
6. False negative results have been reported. Some of these may represent cases of IM which persistently remain sero-negative for the IM heterophil antibody. However, some false negative results have been shown to be due to a delayed IM heterophiil antibody response.
7. IM heterophil antibody titers have been shown to persist in some cases for months and years detected prior to the onset of clinical symptoms. Thus, caution should be exercised in the interpretation of test results.
8. Patients with exceptionally high levels of the serum sickness heterophil antibody may test falsely positive for the IM heterophil. These patients are generally found only in coutries where "horse serum is used prophylactically."
9. The IM heterophil has been associated with several diseases other than IM. These include leukemia, Burkitt's lymphoma, pancreatic carcinoma, viral hepatitis, cytomegalovirus infection, and others. In these cases, it is difficult to disprove th possibility of concurrent disease states.
10. Results should be read 2 minutes after the mixing of the reagents on the slide. A reading obtained after this period of time may be incorrect.

REFERENCES

COPY

1. Sure-Vue® Mono current manufacturer's package insert, 6004-400SV Rev. 12.2021. Fisher Healthcare.
2. SAFETY DATA SHEET (onesourcedocs.com)

All Revision Dates

11/15/2024, 12/1/2016, 1/1/2012

Attachments

SUREVUE MONO TEST PACKAGE INSERT 12.2021.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	Erlinda Roxas: Director, Laboratory Services	7/30/2024

COPY

Status **Active** PolicyStat ID **16314504**

Origination	2/27/1995
Last Approved	11/15/2024
Effective	11/15/2024
Last Revised	11/15/2024
Next Review	11/15/2026
Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Laboratory Services - Serology

L.SER.07 Serology Quality Control

COPY

PURPOSE

The purpose of the Serology Department Quality Control program is to ensure that all test results are as precise, accurate, and reliable as possible within the confines of the instrumentation and procedures utilized for obtaining these results. In all cases, manufacturer's recommendations will be followed as to the type of controls required and the frequency at which they are run. All control specimens are tested in the same manner and by the same personnel as patient samples. Quality control data is evaluated daily by the technical staff performing the testing and results of all controls must be verified for acceptability before reporting patient results.

1. Each RA and Mononucleosis test kit is provided with positive and negative controls. Control testing will be performed, and the results recorded on the testing worksheets, for each batch of tests performed.
2. External positive and negative controls are purchased separately and will be run the first time a new kit lot number &/or new shipment is opened for OraQuick *Advanced* HIV-1/2.
3. Cold Agglutinin Titers will be run in duplicate by two technologists. The results will be compared and should come within one dilution (+/-) of one another. The lower dilution will be reported. If the results are more than one dilution different then a supervisor must be notified for resolution.
4. Verify the patient information on the specimen against the information on the worksheet.
5. Record on the worksheet:
    a. Kit name, lot number, and expiration date.
    b. Positive and negative control results.
    c. Initials of the technologist performing the test.
    d. Initials of the technologist reviewing the results.

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e. Documentation of temperatures for selected procedures.

f. Documentation of rotator speed for selected procedures.

6. If controls do not perform as expected:
    a. Reread the directions thoroughly
    b. Repeat the test, using controls
    c. If the controls are still unsatisfactory, repeat testing (patient and controls) with a new test kit.
    d. If the controls are still unsatisfactory, freeze the patient's serum until the problem can be resolved.
    e. The department supervisor will review the testing problem.
7. All testing will be reviewed by the Clinical Laboratory Scientist prior to reporting results and by the Serology Supervisor at least monthly. All quality control testing will be evaluated at the time of testing and determined to be acceptable prior to reporting results.
8. All new reagent lots and/or shipments will be checked against old reagent lots before or concurrently being placed in service. For qualitative tests, minimum cross-checking includes retesting at least one know positive and one known negative patient sample from the old reagent lot against the new reagent lot, ensuring that the same results are obtained with the new lot. Use the New Reagent Parallel Testing form for documentation. CAP survey samples may be used if patient samples are not available.
9. All reagent kits and controls are stored as recommended by the manufacturer and used within their indicated expiration dates.
10. All recommendations of the manufacturer for the proper use of reagents and controls in kit procedures are followed. Components of a reagent kit are used within the kit lot unless otherwise specified by the manufacturer.
11. All reagents are properly labeled, as applicable and appropriate, with the following elements:
    a. Content and quantity, concentration or titer
    b. Storage requirements
    c. Date prepared or reconstituted by laboratory
    d. Expiration date
12. Proficiency testing is provided by the College of American Pathologists (CAP). The frequency and number of specimens is determined by CAP and will be performed by all staff on a rotating basis.

COPY

All Revision Dates

11/15/2024, 2/19/2021, 12/1/2016, 2/1/2015

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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	Erlinda Roxas: Director, Laboratory Services	7/30/2024

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Status **Active** PolicyStat ID **16069660**

Origination	12/23/2014	Owner	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services
Last Approved	11/15/2024		
Effective	11/15/2024		
Last Revised	11/15/2024	Policy Area	Laboratory Services
Next Review	11/15/2026		

L.SPH.57 Manually-Entered Santa Paula Hospital Laboratory Test Result Audits

COPY

POLICY:

To provide a process for auditing Santa Paula Hospital Laboratory test results manually-entered into the LIS, and ensuring accuracy of the data entered.

PROCEDURE:

The following test results will be audited on a monthly basis vs. the source document from the testing instrument. A minimum of two (2) results per test shall be audited each month.

- Qualitative urine HCG
- Sedimentation rate
- Serum ketones
- Infectious mononucleosis
- Gram stain
- Body fluid count
- CSF count

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, 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	10/15/2024
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	10/8/2024

Status **Active** PolicyStat ID **16404787**

Origination	11/15/2024	Owner	Erlinda Roxas: Director, Laboratory Services
Last Approved	11/15/2024		
Effective	11/15/2024	Policy Area	Laboratory Services
Last Revised	11/15/2024		
Next Review	11/15/2026		

L.SPH.61 Biosafety Levels - Santa Paula Hospital Laboratory

COPY

PRINCIPLE:

Biosafety levels are guidelines that describe appropriate containment equipment, facilities, and procedures for use by laboratory workers. The BSLs range from BSL 1 to BSL 4. Each BSL is based on increased risk associated with the pathogenicity of the microorganisms encountered. Most clinical microbiology laboratories follow BSL 2 practices. When working with highly infectious agents for which the risk of aerosol transmission is greater (eg. Brucella sp, Francisella sp, Mycobacterium tuberculosis, and systemic fungi) , clinical microbiology laboratories should follow BSL 3 practices. Because of the new threat of bioterrorism, new facility designs for public health laboratories are conforming to BSL 3 requirements. Information on BSL recommendations for specific organisms can be found on the website http://www.cdc.gov/od/ohs/biosfty/bmbl/bmbl

POLICY:

BIOSAFETY LEVEL 1: Is recommended for work with microorganisms not known to cause disease in healthy adults (e.g., Bacillus subtilis).

1. Restrict access to authorized personnel.
2. Make sinks for hand washing readily accessible.

3. Make eyewash stations readily accessible.
4. Make appropriate PPE available and ensure use.
5. Ensure that laboratory bench tops are impervious to liquids and resistant to chemicals.
6. Ensure that laboratory surfaces and equipment are easily cleaned and disinfected and that these procedures are done on a regular basis or whenever the surfaces or equipment is contaminated.
7. Decontaminate solid waste within the laboratory (e.g., by autoclaving), or package the waste to be transported off site.

BIOSAFETY LEVEL 2: Is recommended for microorganisms associated with human disease but not transmitted by aerosol (e.g., Salmonella species)

1. Follow BSL 1 practices plus the following.
2. Display universal biohazard signs outside of the laboratory
3. Perform specimen processing in a biological safety cabinet (BSC)
4. Perform centrifugation of mycobacteriologic specimens by using centrifuge safety cups.
5. Ensure that an autoclave or other decontamination equipment is available and used for treatment of infectious waste
6. Use the appropriate PPE (eg, gowns, gloves, and facial barriers)
7. Place all sharps carefully in conveniently located, puncture resistant containers.
8. Trained personnel must observe good microbiological practices and techniques.

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BIOSAFETY LEVEL 3: Is recommended for hazardous microorganisms primarily transmitted by aerosols (e.g., Mycobacterium tuberculosis)

1. Follow BSL 1 and BSL 2 practices plus the following.
2. Control access to the laboratory.
3. Perform all manipulations of cultures and clinical material in a BSC (class II)
4. Maintain a negative pressure airflow in the laboratory
5. Include double doors and an anteroom in the laboratory design

6. Discharge HEPA filtered exhaust air from BSC outside the facility
7. Use all appropriate PPE and containment devices.
8. Use HEPA filtered respirators or masks when aerosols may be generated.
9. Collect baseline serum samples from all personnel for serological determinations of immune status.

BIOSAFETY LEVEL 4: Is recommended for agents causing life-threatening or untreatable diseases by aerosols or unknown transmission by aerosols (e.g., Ebola virus)

1. Follow BSL 3 practices plus the following.
2. Change to protective clothing before entering, and shower on exit.
3. Decontaminate all waste on exit.
4. Use a BSC (class III) and full-body, air supplied, positive pressure suit for all procedures.
5. Locate facility with specialized ventilation and waste management systems separately from other laboratories.

COPY

REFERENCE(S):

1. Laboratory Accreditation Checklist for Microbiology, College of American Pathologists, August 24, 2023.
2. Denys, Gerald A. and Gray, Larry D., eds., Clinical Microbiology Handbook, 2nd ed., 2007 update, ASM Press, Washington D.C., pp. 15.3.3.1-2 and 15.3.2.2-3.
3. U. S. Department of Health and Human Services, CDC and NIH, Biosafety in Microbiological and Biomedical Laboratories—6th Edition (cdc.gov). Retrieved August 13, 2024.

All Revision Dates

11/15/2024

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	Erlinda Roxas: Director, Laboratory Services	8/13/2024

COPY

Status Active PolicyStat ID 16404876

VENTURA COUNTY HEALTH CARE AGENCY

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Effective	11/15/2024
Last Revised	11/15/2024
Next Review	11/15/2026
Owner	Erlinda Roxas: Director, Laboratory Services
Policy Area	Laboratory Services

L.SPH.62 Bioterrorism Readiness Plan for the Clinical Laboratory

COPY

PRINCIPLE:

The laboratory BT (Bioterrorism) preparedness plan should be integrated into the institutional BT preparedness plan.

NOTE: It is quite possible that the laboratory will not be contacted in advance and informed that one of the potential agents of BT is suspected. As a result, it is essential that appropriate safeguards be taken, including subculture of all blood cultures in a biosafety cabinet or behind a safety shield, and always considering the possibility of BT agents.

BIOTERRORISM PREPAREDNESS PLAN:

Purpose

1. The purpose of this protocol is to provide a formal description of the laboratory will respond to a suspected or confirmed BT event. The laboratory needs to promptly assist in the diagnosis and management of patients by providing physicians with accurate information on selection, collection and transport of specimens.
2. In a suspected or confirmed BT event, immediate and effective communication with all appropriate institutional, medical and public health officials is imperative.

Contact Protocol and Chain of Command

1. If a possible BT agent is grown in the laboratory or detected by other means, place phone calls to the responsible physician and the following individuals immediately. Contacting these individuals is not a one-person task.

2. Place phone calls to the following individuals immediately: microbiology laboratory supervisor, laboratory director, infection control officer, clinical pathologist on call.

Laboratory Response Network

1. Introduction to the LRN: The Laboratory Response Network is a partnership of laboratories that provide immediate and sustained laboratory testing and communication in support of public health emergencies, particularly in response to acts of BT. All laboratories are considered partners, and in some cases, registered members of the LRN.
2. LRN structure for BT agent testing. LRN laboratories are designated as sentinel, reference, and national laboratories.
    a. Basic sentinel laboratory is certified by the Centers for Medicare & Medicaid Services for general laboratory testing, including microbiology.
    b. The laboratory is inspected successfully in accordance with the CLIA or by an agency that has been given deemed status by the CMS. The laboratory has policies and procedures for referral of diagnostic specimens to an advanced sentinel laboratory.
    c. Advanced sentinel laboratory has been certified by the CMS as a high complexity laboratory performing the specialty of microbiology and has been inspected successfully in accordance with CLIA or by an agency that has been given deemed status by the CMS.
    d. Advanced sentinel laboratories shall meet the following:
        - Have a class II or higher certified biological safety cabinet
        - Comply with BSL-2 practices
        - Have policies and procedures for use of additional respiratory protection (e.g. N-95 fit testing

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Responsibility of the Clinical Laboratory

As members of the LRN, sentinel laboratories have access to the network and serve as “sentinels” for the early detection of and raising suspicion regarding a suspicious agent that cannot be ruled out as a possible BT associated organism.

Sentinel level clinical microbiology laboratory guidelines for BT agents.

Packing and shipping instruction

U.S., international and commercial regulations mandate the proper packing, documentation and safe shipment of dangerous goods in order to protect the public, airline workers, couriers and other persons who work for commercial shippers and who handle the dangerous goods during many segments of the shipping process.

Information Checklist

Appendix 16.12-1 shows a checklist that may help in the gathering of information in a suspected BT event. The checklist is to be filled out by shift operations manager or other designated personnel.

REFERENCE(S):

1. Garcia, Lynn S. ed., Clinical Microbiology Procedures Handbook,2nd ed, ASM Press, Washington D.C. 2007, Volume 3, pp16.12.1-16.12.27
2. www.asm.org. LRN Sentinel Level Clinical Laboratory Protocols (asm.org)

All Revision Dates

11/15/2024

Approval Signatures

COPY

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	8/13/2024

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Effective	1/14/2025
Last Revised	1/14/2025
Next Review	1/14/2028

Owner	Tess Slazinski
Policy Area	Nursing Practice Protocols

NPP.04 Small Bore Tube Feeding Tube Insertion And Management

COPY

POLICY:

To provide a guideline for the Registered Nurse (RN) superusers for placement of an IRIS post pyloric small bore feeding tube. Appropriate placements are gastric, duodenal, or jejunal. The feeding tubes are placed in the Intensive Care Unit (ICU) per a licensed practitioner (LP) order.

Indications for Use:

Patients who are unable to take nutrition by mouth and at risk for aspiration pneumonia.

Contraindications for Use:

DO NOT use this system in patients who are post transsphenoidal hypophysectomy (TPH) surgery, basilar skull fracture, suspected basilar skull fracture, and/or facial fracture(s).

Functions to be Performed and Competency:

Advanced practice nurses and registered nurse superusers who have received didactic training from the device company and performed ***three*** successful placements are permitted to place these feeding tubes. A confirmatory x-ray is obtained to ensure proper placement per a LP order.

Procedure:

A. **Pre-insertion: E**xplain the procedure to the patient and/or family.

B. **Equipment preparation (see photo A):**

   a. Position the console in direct line of sight.

   b. Plug in the power cable if necessary.

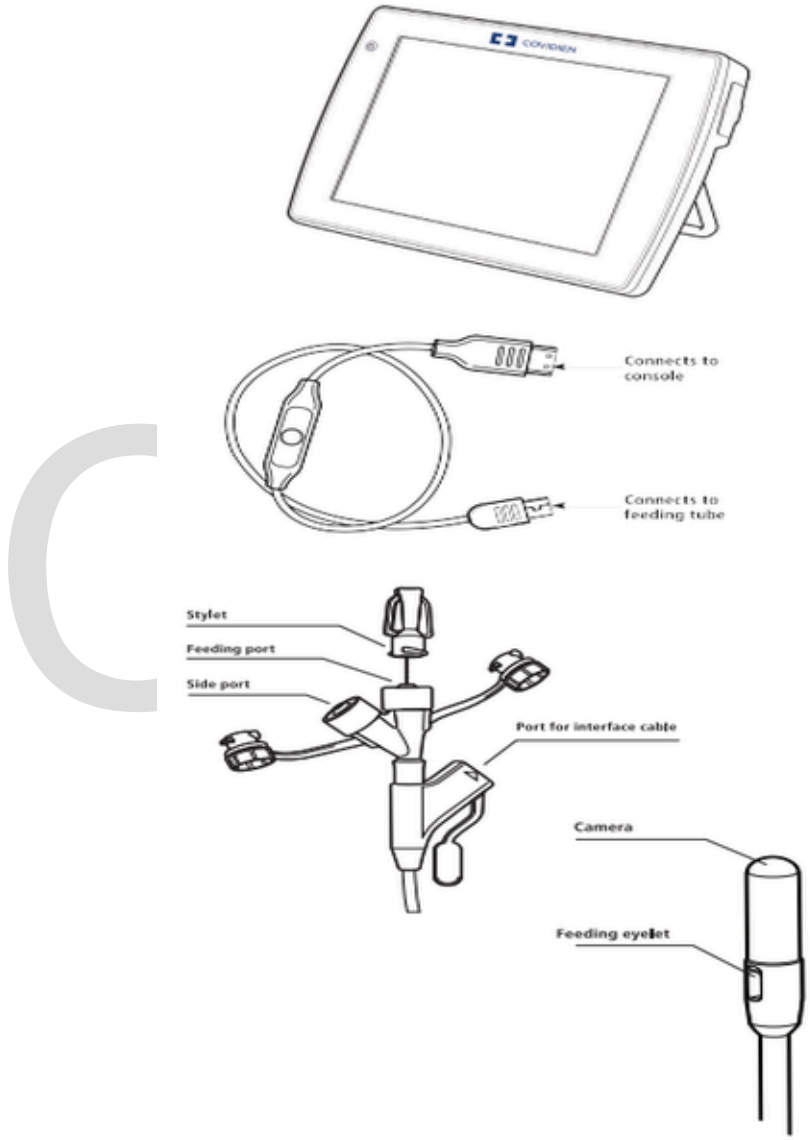
   c. Power on the console using the power button.

d. Enter login and password

e. Connect the interface cable to the console, then connect the interface cable to the feeding tube.

f. Start procedure on console and input patient information.

g. Activate the Hydromer™ coating on the tip of the tube by submerging it in water for a least 5 seconds.
Photo A:



C. **Insertion:**

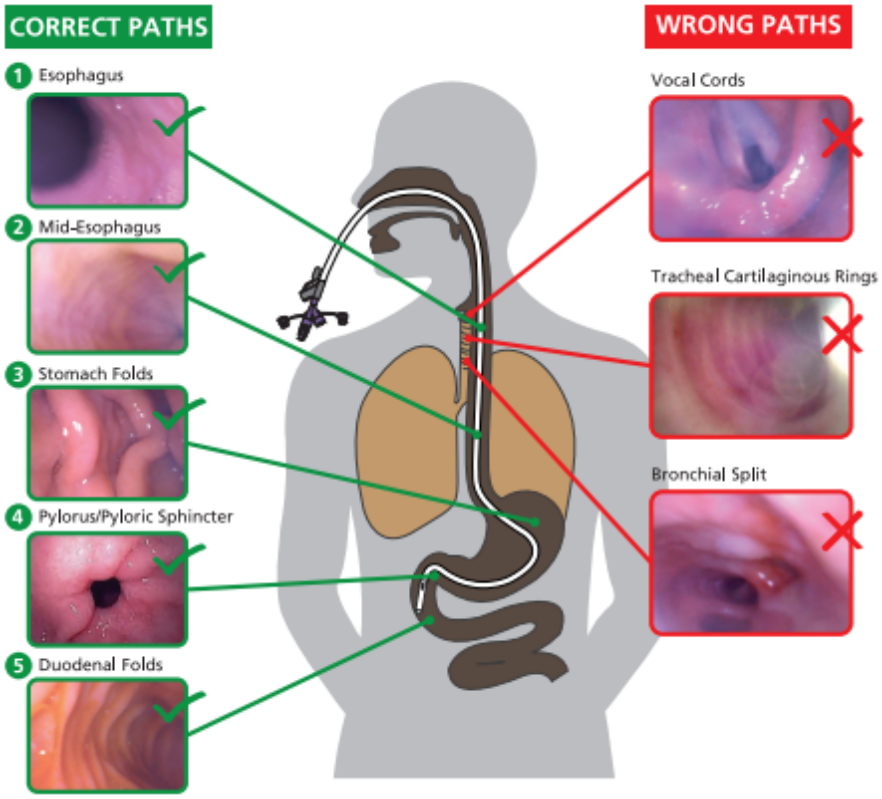
a. Position the patient for feeding tube placement and estimate feeding tube length.

b. Chose the most patent nare (oral placement is also acceptable) and insert the feeding tube with the stylet.

c. Using the console for placement

i. Utilize the console screen to correctly identify markers during placement (see

photo B)
Photo B:



D. **Capture an Image**
    a. If an image needs to be captured, it can be obtained by using the interface cable or the console.

E. **Ending the procedure**
    a. When the procedure is complete and the feeding tube has been placed properly, tap the green check mark.
        i. Tap the green check mark again to complete the procedure.
    b. Disconnect the interface cable from the feeding tube.

F. **Confirm Placement**
    a. Obtain confirmatory x-ray per LP order.
    b. Remove stylet prior to enteral nutrition delivery.
        i. The stylet is reusable (e.g., can be used to retrace the feeding tube in case it gets pulled back or out). D**o not discard.** Place in a Biohazard bag at the patient's bedside.

G. **Reconnecting**
    a. The console to place the feeding tube will retain the memory of which patient is associated to that tube.

b. Reconnecting the console to the same feeding tube will allow the console to recognize the tube and provide a patient data confirmation prompt.

DOCUMENTATION

Document in patient chart the following:

A. Tube site and assessment

B. Patient's tolerance

C. Other details as appropriate.

References

Cardona, E., et al. (2021). Bedside postpyloric enteral tube placement using Kangaroo IRIS technology: A single-center case series. *Nutrition, 86*: 111195.

Covidien User Manual (2012). Kangaroo Feeding Tube with IRIS Technology console and accessories. Covidien LLC, Maine.

Taylor, S., et al. (2021). Tube placement using "IRIS": A pilot assessment of its utility and safety. *Intensive and Critical Care Nursing, 66*.

Taylor, S., et al. (2021). Integrated real-time imaging system, "IRIS" Kangaroo feeding tube: A guide to placement and image interpretation. *BMJ Open Gastroenterology, 8*(1): e000768.

COPY

All Revision Dates

1/14/2025, 5/30/2024

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/14/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/14/2025
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	1/14/2025
Protocol Author	Tess Slazinski	12/30/2024

Status Active PolicyStat ID 16959567

VENTURA COUNTY HEALTH CARE AGENCY

Origination	6/1/1995
Last Approved	12/26/2024
Effective	12/26/2024
Last Revised	12/26/2024
Next Review	12/26/2027
Owner	Sul Jung: Associate Director of Pharmacy Services
Policy Area	Pharmacy Services

PH.17 Direct Ordering Procedure

COPY

Policy:

Direct ordering of medications from manufacturers shall be reserved for times when they are not available from the primary drug wholesaler. The following procedure ensures a uniform process and compliance with the 340B Drug Discount Program.

Procedure:

I. Confirm that a purchase order or master agreement has been created for the manufacturer.

II. If a purchase order or master agreement has not been created, the Director of Pharmacy Services or designee shall submit a purchase requisition into Ventura County Financial Management System.

III. Make a list of items needed from the manufacturer.

1. Each item on the list must have quantity needed, product description including package size, and cost.

IV. For medications that qualify for 340B Drug Pricing (see Pharmacy Policy PH.18.01 340B Drug Pricing Program), follow this procedure. For medications that do not qualify for 340B Drug Pricing, the following steps do not apply.

V. Before orders are placed with the manufacturer, determine the amount available to order on Group Purchasing Organization (GPO) and 340B accounts based on accumulations in the Verity Solutions 340B split billing software program.

1. Open the Verity Solution on-line portal https://www.i340b.com/#/login

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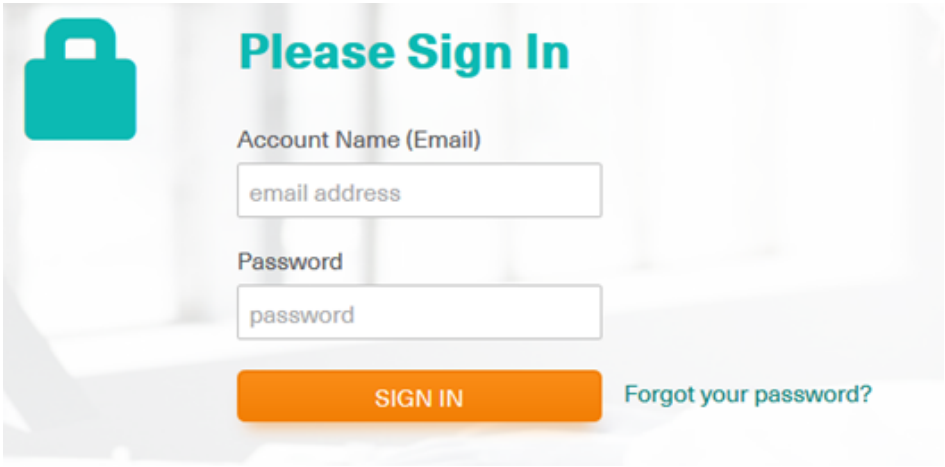
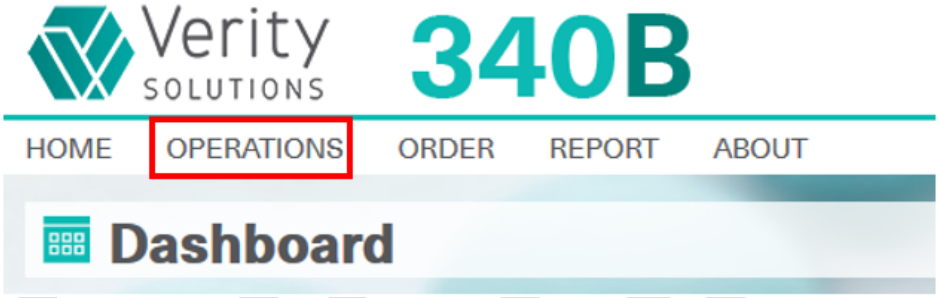
a.



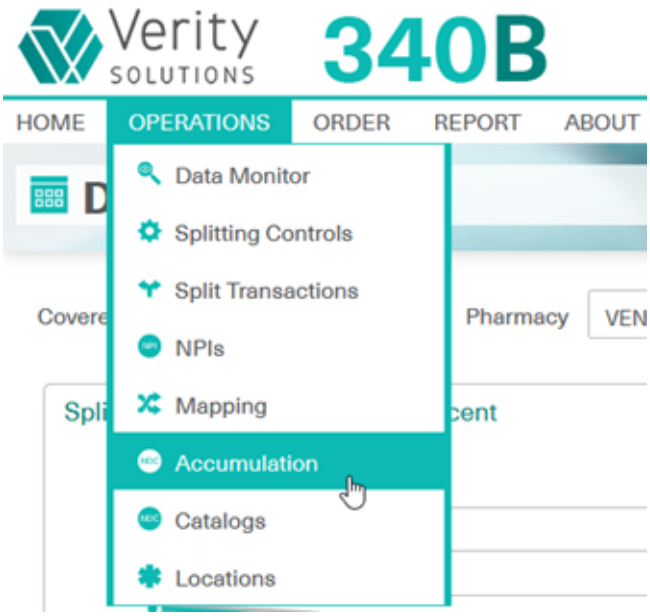
2. Click on OPERATIONS

a.



3. Click on Accumulation

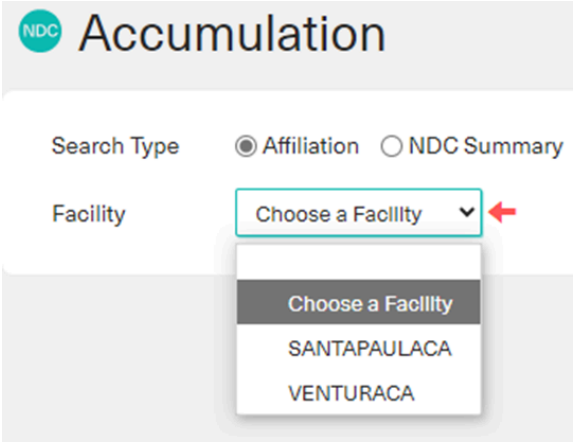
a.



4. Select the desired location from the drop down menu

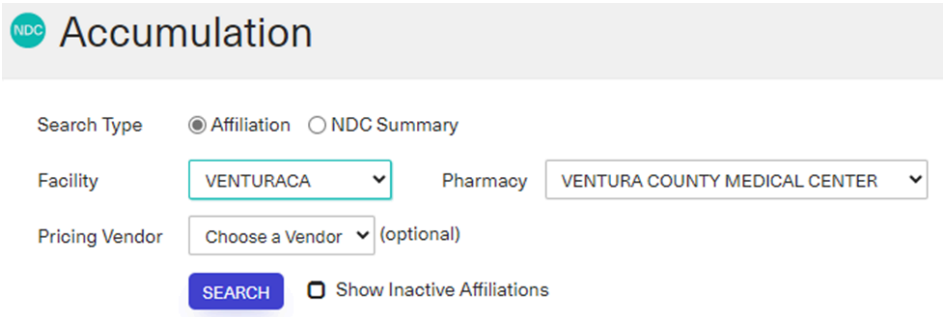
COPY

a.



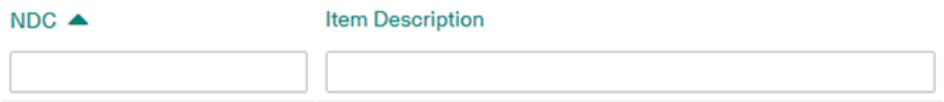
5. Click on SEARCH

a.



6. Enter NDC (National Drug Code) or Item Description

a.



7. Column Order Units under Accumulator Info will tell you what quantity can be ordered of the medication and under which account. Make sure to check the Last Used column to verify that the item is actually being accumulated. If the item is not being currently accumulated, or if there are no accumulations, order the medication WAC.

a.

Accumulator Info				Usage	
Type	Total Qty	Order Units	Avg Disp Size	First Used	Last Used
GPO	196.5	1	2.3353	4/30/2019	3/28/2024
340B	2	0	2	5/16/2024	5/16/2024

VI. When the order is received, it is checked off against the packing slip. The packing slip shall be filed in the pharmacy and a copy shall be forwarded to the Director of Pharmacy Services for reconciliation with invoices.

1. Enter the invoice into the Verity Solutions on-line portal so that the quantity is deducted from the accumulation.
2. Click on ORDER

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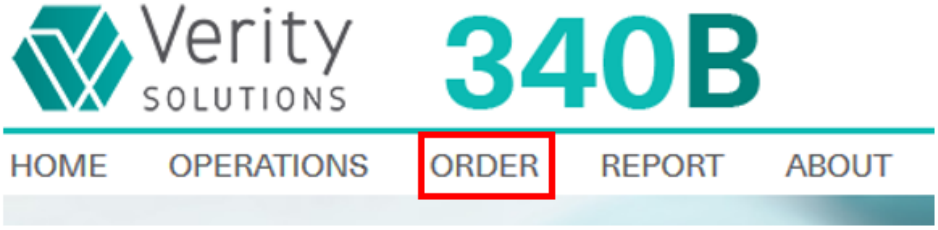
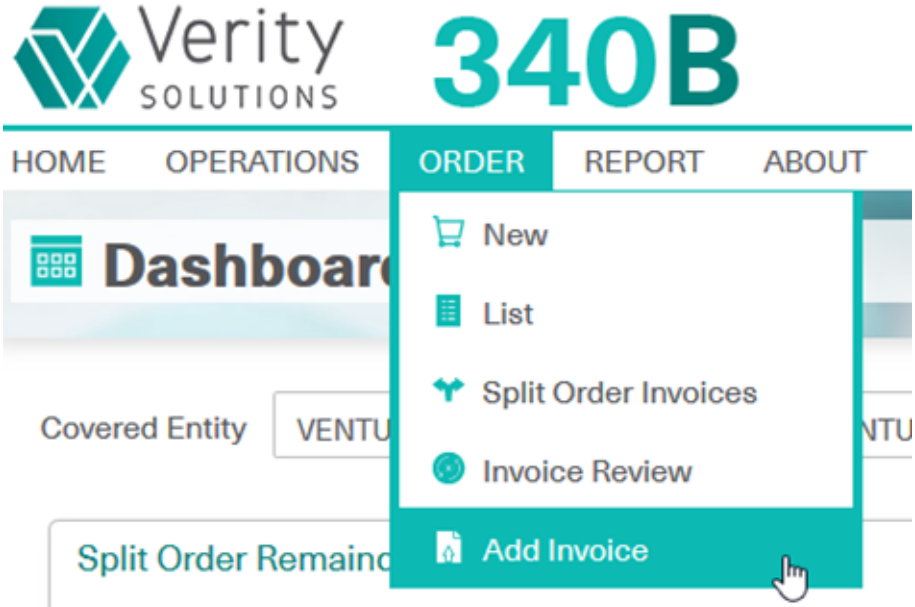
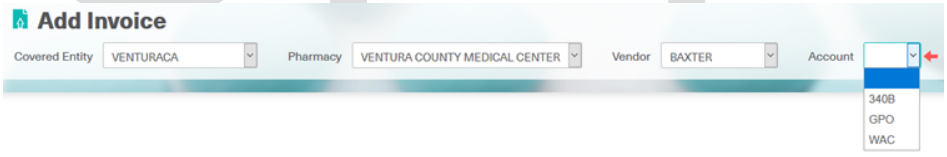
a. 

3. Click on Add Invoice

a. 

4. Select the Location, Vendor and Account from the drop down menu

a. 

5. Enter the following information:
    a. Click on Debit
    b. Enter the manufacturer Invoice Number and Date
    c. Enter the PO Number and Date
    d. Enter the NDC
    e. Enter the Vendor item, if available, if not re-enter NDC
    f. Enter Packages Shipped
    g. Enter Price Per Package
    h. Click on CREATE INVOICE

Ctrl

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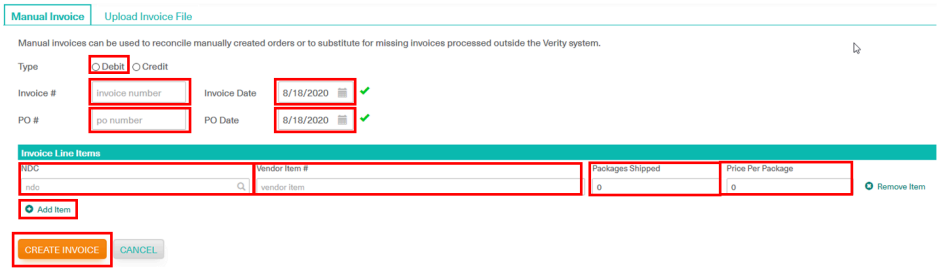
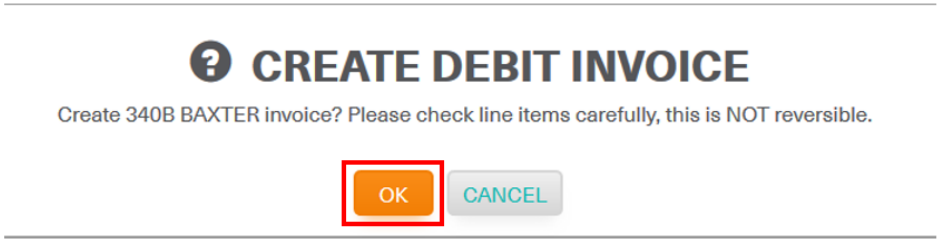
i.



6. Click on OK to complete the process

a.



All Revision Dates

12/26/2024, 11/23/2021, 6/13/2018, 4/1/2015, 11/1/1997

COPY

Approval Signatures

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Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	12/26/2024
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	11/22/2024

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VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

February 2025

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Lisa Prather: Admitting*
Policy Area:	*Administrative - Patient Care*
References:	

100.063 Registration of Patients with Unknown Identity

POLICY:

Ventura County Medical Center and Santa Paula Hospital maintains a process to immediately register patients whose identity is unknown.

The same process can also be used for the following:

- Registering victims (or perpetrators) of violent crimes
- When three (3) or more trauma patients arrive to the Emergency Department simultaneously
- At the discretion of the medical, nursing, or law enforcement staff.

PROCEDURE:

A. Registration for trauma patients with unknown identity will be created using the quick registration function. Patients registered through this process will be assigned a pseudo date of birth (DOB) of 1-1-1900 and fictitious naming convention of **last name:** TRAUMA and a number ONE through NINETY-NINE (example TRAUMAONE) and **first name:** arbitrary name. When choosing a name, the registrar will ensure there are no preexisting encounters with the last name to be used.

   Registration for non-trauma patients with unknown identity will be created using the quick registration function. Patients registered through this process will be assigned a pseudo date of birth (DOB) of 1-1-1900 and fictitious name comprised of their gender as their last name and approximate age as their first name (e.g. MALE, FORTY). When choosing a name, the registrar will ensure there are no preexisting encounters with the last name to be used. Example, if there is an existing patient Male, Forty, registrar will register patient as Male, Forty One.

B. This registration process should be initiated under the following circumstances:
   1. A patient presents whose identification is unknown;
   2. A patient is a victim (or perpetrator) of violent crime;
   3. When three (3) or more trauma patients arrive to the ED simultaneously; OR
   4. At the discretion of the medical, nursing or law enforcement staff.

C. After the Patient Access Department has been made aware of any of the previously listed circumstances, they will immediately register the patient through the registration system. The physician's orders can then

be immediately processed. Labels and a wrist band will be generated. The patient's nurse shall place the wristband on the patient.

D. The patient's family shall be made aware that the patient was given a fictitious name at the time of admission to expedite medical care, in order to avoid confusion if the patient's family calls the Hospital to inquire about the patient's condition.

E. Any patient who has been registered using this registration process will retain the fictitious name throughout the registration process. The patient's name will not be corrected until the Patient Access Department Manager or designee has checked with the Laboratory Blood Bank. This is to avoid having to re-type and cross match the patient for blood products under the patient's real name.

F. The Patient Access Department Manager or designee will perform the following:

1. Contact the Laboratory Blood Bank and verify if the patient's name and DOB can be corrected.
2. Verify with the Laboratory Blood Bank that there are no pending blood products to be infused for the patient (see policy *L.BB.17 Blood Bank Specimen Identification, Labeling and Rejection*).
3. Notify the patient's nurse and/or physician of information received from the Laboratory Blood Bank.
4. If the patient's nurse and/or physician indicate their approval, the patient's name may be changed to reflect the correct name and DOB of the patient.
    a. Notify the following of the name and DOB change:
        a. Respiratory Care
        b. Laboratory
        c. Medical Records
        d. Imaging Department
        e. Patient's nurse/physician
5. ~~Notify the following of the name and DOB change:~~
    ~~a. Respiratory Care~~
    ~~b. Laboratory~~
    ~~c. Medical Records~~
    ~~d. Imaging Department~~
    ~~e. Patient's nurse/physician~~

    Patient Access Department Manager or designee will notify the nurse or MOA on unit that patient name and date of birth has been updated and to reband patient.

See also policy *100.088 Patient Identification*.

All revision dates: 8/27/2024, 10/11/2022, 6/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	9/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/27/2024
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Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.079 Communication Amongst Providers

POLICY:

It is the policy of the Ventura County Medical System to have and implement a standard "warm hand off" approach to communication including an opportunity to ask and respond to questions. This policy defines the standards for passing responsibility of care from Heathcare Provider to Healthcare Provider in all patient care settings.

The primary objective of a "warm hand off" is to provide accurate and the most current clinical information about a patient's care, treatment and services, correct condition, and any recent or anticipated changes. The information communicated during a "warm hand off" must be accurate in order to ensuring the continuity and safety of the patient's care.

PROCEDURE:

Warm hand off shall involve the patient as appropriate and caregivers as an integral part of delivery of the patient/family centered care, and shall take place primarily at the patient bedside, unless specifically refused by the patient or caregiver. The receiver of the information should have an opportunity to review relevant patient historical data, which may include previous care, services or treatment. Interruptions during warm hand off must be minimized to reduce the likelihood that information would fail to be conveyed or forgotten. Situations involving "warm handoff" communication include, but are not limited to:

1. Warm handoff will occur at every shift change and for break relief.
2. Ancillary discipline shift changes.
3. Physicians transferring patient care to another physician, or transferring call responsibility to another physician.
4. Anesthesiologist report to post-recovery room nurse.
5. Nursing/physician handoff from emergency room to nursing/physician of inpatient unit.
6. Physician to physician communication for patient's transferred to other acute facilities.
7. Temporary responsibilities when a patient care staff leaves the unit for a short period of time.
8. Critical lab or radiology results communicated to referring physician.
9. Healthcare providers and transport teams (interfacility transfers).

GUIDELINES:

1. Shift Change
    a. Warm hand off to be completed at the change of shift between the oncoming nurse and the off-going nurse.
    b. Caregivers and patients shall be introduced to their oncoming nurse by the off-going nurse and shall be actively involved in the goal planning for the shift and the complete course of the admission, to the degree that the caregiver and patient are able to and desire to participate.
    c. Warm hand off shall take place at the patient's bedside.
        i. EXCEPTION: Information regarding the patient and/or caregivers that is not appropriate for discussion with the patient and/or caregiver.
        ii. EXAMPLE: Social/Communication issues with the staff and caregivers.
    d. Warm hand off will be completed using the SBAR (Situation, Background, Assessment, Recommendation) format and shall include:
        i. A complete overview of the patient's relevant history and current status, utilizing HEAL (High Alert Medications, Equipment, Alarms, Lines).
        ii. Pain management medications used and available.
    e. Patients IV site(s) shall be assessed and patency confirmed.
    f. IV medications and connections shall be checked and handed off by both the off-going nurse and the oncoming nurse, including independent double checks (as needed).
    g. Patient's bedside care board shall be updated with, at minimum, the oncoming nurse's name, shift goals, pain management status (last medication given, next medication due).
    h. Additional information will be given from the off-going nurse to the oncoming nurse utilizing the SBAR section of Cerner, including (as needed to supplement the information already exchanged):
        i. History
        ii. Current status
        iii. Recent changes
        iv. Upcoming needs
        v. Plan of Care
        vi. Progress towards discharge
2. Break Relief
    a. Warm hand off will be completed at break times between the nurse leaving for break and the nurse covering for break.
    b. The warm hand off shall occur at the patient's bedside using SBAR format and shall include:
        i. An overview of the patient's relevant history and current status, utilizing HEAL.
        ii. Pain medications used and available.
    c. Patient's IV site(s) shall be assessed and IV patency confirmed by both the off-going nurse and covering nurse.
    d. The off-going nurse shall note to the covering nurse any specific interventions that will be required or

that are highly likely to occur during the time of the break relief.

All revision dates: 9/14/2021, 7/19/2018, 1/1/2007

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	8/5/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/29/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/29/2024
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/29/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised:	*11/15/2024*
Next Review:	*3 years after approval*
Owner:	*Osahon Ekhaese: Chief Operating Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.088 Patient Identification

POLICY:

To ensure proper identification of patients receiving care at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and affiliated Ambulatory Care (AC) clinics, especially prior to procedures, medication administration and transport.

PROCEDURE:

A. Positive identification of hospital patients fulfills four (4) basic functions:

1. Promotes positive and accurate identification of patients from the time of presentation for treatment, through the entire continuum of care.
2. Provides a consistent and methodical process of linking patients to their existing medical records and treatment history.
3. Minimizes the possibility that identifying data can be lost or transferred from one patient to another.
4. Improves the accuracy of patient identification.

Exceptions:

A. Patients who are unable to provide identifying information or whose conditions require emergency care, therefore, are assigned an "unknown" patient name. These patients receive treatment under the "Unknown" name assignment, if such care and treatment is necessary to stabilize the patient's condition (example: unidentified patient arriving comatose to the Emergency department). See policy *100.063 Registration of Patients with Unknown Identity*.

B. Once the identity of the patient is established and verified (or the use of an "unknown" name is determined), an imprinted armband is placed on either arm of the patient, to facilitate accuracy in the continuum of care.

PATIENT IDENTIFICATION:

A. VCMC/SPH and AC clinics shall use the patient name and date of birth (DOB) as the two (2) patient identifiers when:

   1. Administering medications.
   2. Obtaining specimens in the outpatient setting.

3. Performing tests or procedures.
4. Accepting verbal or telephone orders.
5. Writing orders.
6. When the patient requires delivery of a special diet and/or meal or snack, that is part of a special diet.
7. Transport: Intra-facility and Interfacility.

B. VCMC/SPH shall use the patient name and medical record number (MRN) as the two (2) patient identifiers when:

1. Administering blood products.
2. Obtaining specimens in the inpatient setting.
3. Calling critical test results.

VALIDATION OF PATIENT IDENTIFICATION:

A. Effort shall be made to ensure accuracy in the patient identification process for each registration/ admission.

B. Acceptable forms of patient Identification (ID) includes the following:

1. California photo ID (driver's license or ID card). For identification purposes, an expired ID is acceptable.
2. Driver's license or photo ID from anywhere in the United States. For identification purposes, an expired ID is acceptable.
3. Immigration card (also known as a green card).
4. Government-issued passport from any country.
5. Government-issued form of identification from any country.
6. Student ID with photo for an "active" student.
7. Government issued Voter Registration ID with photo from another country.
8. Valid birth certificate may be used as supporting documentation to help in identifying a patient.
9. Social Security card may be used as supporting documentation to help in identifying a patient.
10. Insurance card with patient's name imprinted, may be used as supporting documentation to help identify a patient and is used to verify accurate insurance verification.

FOR ONGOING CARE:

A. Patient identity is verified through the use of the imprinted armband and no procedure is conducted when the patient's identity cannot be verified, due to an illegible or missing imprinted armband.

B. Any defective or missing ID armband is replaced immediately with a new armband.

1. For inpatients, a replacement armband is ~~made in the patient's assigned~~created by the admitting department and sent to the inpatient unit.
2. For outpatients, the registration staff for that specific area of patient care makes any replacement armband(s) needed, to ensure proper identification of patients with the same or similar names.

C. Surgical "Time Out" for patient identity: Prior to the start of any surgical and/or invasive procedure, a “Time Out” is conducted with the entire surgical team in attendance to confirm, agree upon and document the following:

   1. Correct patient;
   2. Correct procedure;
   3. Correct site for the procedure.

D. Containers used for blood and/or obtaining any specimens, are to be labeled in the presence of the patient.

INPATIENT BANDING PROCEDURES:

A. For Inpatient admissions from any point-of-entry, a tamper-proof, nontransferable ID armband is affixed to the patient. The armband contains the patient’s first name, last name, DOB, Electronic Health Record (EHR) number and a unique visit number.

B. **‘UNKNOWN’ PATIENT ADMISSIONS and TRAUMA ALIAS ADMISSIONS:** Patients admitted under an "unknown" name assignment will have an ID armband affixed, using the assigned "Unknown" name with ordinal numbers attached to the name. If the patient's identity is confirmed, the name can be updated by admitting personnel. See Policy 100.063 Registration of Patients With Unknown Identity.
NOTE: Labels on the chart remain valid as the UNKNOWN name assignment functions as a ‘valid’ AKA. Therefore, the chart does not need to be relabeled.

C. **EMERGENCY DEPARTMENT INPATIENT ADMISSIONS:** If the patient is admitted as an inpatient as a result of care and treatment in the Emergency Department/Trauma room, the already placed patient ID armband (on the patient upon presentation to the ED) is checked and verified for accuracy of name (verify spelling) and DOB. The armband contains the patient’s first name, last name, DOB, EHR number and unique visit number.

D. **SAME DAY SURGERY INPATIENT ADMISSIONS:** If the patient is admitted as an inpatient following an outpatient surgical procedure, the ID armband placed on the patient prior to the surgical procedure, serves as the inpatient ID armband. The armband contains the patient’s first name, last name, DOB, EHR number and unique visit number.

E. **SURGICAL SERVICES FOR CURRENT INPATIENTS:** Patients that are already inpatients, requiring a surgical procedure, must have an identification band placed: one on either arm, or leg.

F. **CLINIC VISIT-TO-INPATIENT ADMISSIONS:** If the patient is admitted as an inpatient as the result of an outpatient clinic visit, the ID armband containing the patient’s first name, last name, DOB, and EHR number is placed on the patient as part of the admission procedure. The Admitting Department admits the clinic patient with a new visit number as a "direct admission," and is responsible for ensuring that the identification armband is placed on the patient according to the "direct admission" procedure.

G. **DIRECT ADMISSIONS:** It is the responsibility of staff/Admitting to create an accurate identification band for any "direct" admit patient, and to ensure that the identification band is placed on the correct patient. This process is completed by staff/Admitting if the patient’s condition allows them to access the patient. If staff/Admitting cannot place the armband on the patient, the clinical staff that is caring for the patient, must be notified for assistance. Admitting clerks and/or nursing staff will check the identification armband for the correct information and compare it to the face sheet information PRIOR to placing the identification band on the patient. The patient (or family if the patient is not able) is asked to verify the patient name, the correct spelling of the name, and the DOB.

H. **PEDIATRIC PATIENTS:** As a means of identification, patients under 6 months of age will wear the soft posey ID band holder utilizing the patient information sticker with the eye. After verification of the primary caregiver(s), the primary caregivers will be issued a standard matching ID band to be worn throughout the infant's hospital stay. For those patients over 6 months of age, or who are unable to fit the the soft posey identification band, they will wear a normal identification band. After primary verification of caregiver status, the primary care giver(s) will be issued a matching ID band, to be worn throughout the pediatric patient's hospital stay.

INPATIENT IDENTIFICATION PROCESS:

During the Inpatient stay and **BEFORE** any procedure is performed on any patient or before blood is drawn, medication given or blood/blood products are given to the patient, etc., all staff will verify identity of the patient using the two (2) identifiers listed below:

For Alert Patients:

A. Patient's name is verified: Patient must accurately state their first and last name which must match exactly the first and last name on the ordering document(s), **AND**

B. Patient DOB is verified: Patient must state their DOB as an exact match to the DOB of the patient on the ordering document AND an exact match to the DOB on the patient ID armband.

NOTE: Be aware of cultural differences in stating DOB. Always repeat the DOB back to the patient if possible, using words – not numbers - to ensure accuracy in differentiating between the month and day of birth.

For Non-responsive Patients:

A. Patient name is verified: Licensed staff must compare and verify the name on the ordering document, with the name on the patient identification armband and the name on the chart, to assure that all information matches, **AND**

B. Patient DOB must be verified: Licensed staff must compare and verify the DOB on the ordering document, the DOB on the patient identification armband, and the DOB on the chart to ensure that all the information matches.

C. The patient wears the identification armband during their entire care and treatment event. The armband is NOT removed at discharge. The patient is given instruction to remove the band upon discharge.

D. In the event of a patient's death, the identification armband will remain on the patient’s body.

OUTPATIENT IDENTIFICATION PROCESS:

A. Outpatients arriving to any point of entry for care and treatment are identified through verbal communication and are verified via identification documentation that is received in compliance with this policy.

B. Outpatients scheduled to receive diagnostic testing, any kind of injectable care or treatment, or any outpatient procedure, receives an identification band that is worn during their care and treatment event. The identification armband is created and placed by the registration staff in each respective port-of-access.

C. Outpatients arriving for services in the Laboratory will be identified by registration staff in accordance with this policy. Placement of an identification armband is not required in the Laboratory for alert patients capable of verbalizing their name and date-of-birth, or for minors in the presence of their parent or

guardian.

D. For patients presenting to the Emergency Department requesting care, the registration staff makes every attempt to verify the patient's identity using established procedures, prior to completing the pre-registration process. Once the patient's identity is established, the registration staff creates an identification armband and places it on the patient's arm (if possible) and/or asks licensed staff to assist in the placement of the armband.

E. When any Emergency Department patient is admitted to inpatient status, the patient identification will be verified a second time and the results compared with the current identification armband to ensure accuracy. This process is done as part of the admission clearance procedure.

F. Before blood is drawn or any procedure is performed or medication or blood/blood products are given to any patient, etc., staff will verify identity of the patient using the criteria listed below.

1. Patient name: Patient must accurately state their first and last name (if able) which matches the first and last name on the ordering document(s), **AND**
2. Patient Date-of-Birth: Patient must state their DOB (if able) as an exact match to the DOB of the patient on the ordering document. **NOTE:** Always repeat the DOB back to the patient using words – not numbers - to identify the month to eliminate cultural barriers and improve communication of this information.
3. For outpatients wearing a patient identification armband, compare information obtained verbally against the identification armband on the patient's arm. Discrepancies are corrected prior to proceeding with any treatment or procedure.

REFERENCES:

1. The 2019 Joint Commission Hospital Accreditation Standards, National Patient Safety Goals.

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Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/3/2025
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/30/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/30/2024
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Step Description	Approver	Date

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References:	

100.089 Point of Care Testing, Waived Tests and Provider-Performed Microscopy (PPM)

POLICY:

A limited number of "bedside" laboratory tests (Point of Care Testing or POCT) have been approved by the Laboratory Director at Ventura County Medical Center/Santa Paula Hospital to be available to clinicians to provide rapid test results in the hospital and to help with treatment decisions in the clinics.

Laboratory procedures that are done at the point of care are performed under the CLIA Laboratory Certificate for Provider-Performed Microscopy Procedures issued by CMS to Ventura County Medical Center/Santa Paula Hospital. Procedures that are approved by the Laboratory Director as Waived Tests or are listed as Provider-Performed Microscopy Procedures (CDC) are the only tests that may be performed at the point of care. Point of care testing sites include bedside and nursing stations in both hospitals, Ambulatory Care clinics, and the Inpatient Psychiatric Unit and clinics.

PROCEDURE:

Overall responsibility for Point of Care Testing lies with the Laboratory Director. The Laboratory Director will designate a Point of Care Testing Coordinator. The Point of Care Testing Coordinator will:

1. Assist in the development of policy and procedures.
2. Review all procedures at least annually.
3. Oversee Quality Control/Quality Assurance.
4. Help educate staff at Point of Care testing sites.
5. Act as a liaison between the VCMC Laboratory and the staff and departments performing Point of Care testing.
6. Validate new tests, new analyzers, and, when required, new reagents.
7. Coordinate, assist, or perform initial competency assessment.
8. Participate at least monthly in departmental reviews of all glucose analyzer testing and of all Inpatient point of care patient tests, quality control and instrument maintenance logs. Ambulatory Care Administration maintains documentation of patient testing, quality control and instrument maintenance logs.
9. Act as a liaison between the POCT sites and the manufacturer should there be analyzer problems or

breakage that cannot be resolved on site by the POCT coordinator.

WAIVED TESTING:

The following waived tests that are performed at Point of Care Testing sites utilize testing instrumentation:

- Blood Glucose by Nova Statstrip method
- Hemoglobin A1c (Glycohemoglobin) by Siemens DCA Vantage
  ~~Hemocue HB201DM for hemoglobin~~
- HemoCue Hb 801 System for hemoglobin
- Cepheid Gene Xpert COVID-19 Molecular Test for SARS-CoV-2/Flu/RSV
- Cepheid Gene Xpert COVID-19 Molecular Test for SARS-CoV2
- LeadCare II System for blood lead by Magellan Diagnostics

The following waived tests that are performed at Point of Care Testing sites do not utilize any testing instrumentation:

- BinaxNOW Antigen Test Card method for SARS-CoV2
- Dipstick for urinalysis by Multistix 10SG method (10 test pads per strip)
- Dipstick for urine tests by Labstix method (5 test pads per strip)
- Fecal occult blood by Hemoccult Sensa method
- Fecal occult blood by InSureONE method
- Urine drug of abuse by Hemousure First Sign Drug of Abuse Cup Test ~~by Hemosure~~
- ~~One Step Fentanyl Drug of Abuse Dip Card Test by Hemosure~~Urine drug of abuse by Abbott iCASSETTE Fentanyl Urine Test Cassette
- Streptococcus A Screen by OSOM Ultra Strep A Test method
- Urine pregnancy test by ICON *25* hCG method
- Urine pregnancy test by Medline hCG Pregnancy Test Cassette method
- Urine pregnancy test by Medline hCG COMBO+ Pregnancy Test Cassette method

Physician privileging for non-instrumentation Waived Testing is coordinated through the Medical Staff Office and the physician credentialing process. Other waived tests may be added only after review by the Point of Care Testing Committee and approved by the Laboratory Director.

PROVIDER-PERFORMED MICROSCOPY (PPM):

A physician or mid-level practitioner may perform Provider-Performed Microscopy Procedures (PPM). Mid-level practitioners include licensed Physicians' Assistants and Nurse Practitioners. The primary instrument used is a microscope and the specimen is considered labile.

The following PPM procedures may be performed:

1. Wet mount for presence or absence of bacteria, fungi, parasites and human cellular elements
2. Potassium hydroxide (KOH) preparations
3. Pinworm examination
4. Fern test
5. Post-coital direct, qualitative examination of vaginal or cervical secretions
6. Urine sediment examinations
7. Nasal smears for granulocytes

8. Fecal leukocyte examinations
9. Qualitative semen analysis (presence or absence of sperm and detection of motility)
10. Initial and annual competency assessment for physicians performing PPM is coordinated through the Medical Staff Office and the physician credentialing process. In addition, the physician may perform Amniotest, pH of vaginal secretions.
11. "When a physician performs waived testing that does not involve an instrument, there is no Joint Commission requirement for documentation of competency assessment when the test is a logical part of his or her specialty and the organization has specifically privileged the physician for that test." Through the medical staff credentialing process, individual physician may be privileged for those specific waived tests appropriate to their scope of practice and no further assessment of skills or documentation of competence would be required. 1

COMPETENCY PROGRAM

A. The Laboratory Director, or a qualified designee, will orient, train and assess the competency of staff and independent practitioners who perform waived testing.
    i. Clinical Nurse Managers (or those requested by a Clinical Nurse Manager, the Mental Health Clinic Coordinator, or Ambulatory Care Administration) are determined to be the "qualified designee/ superuser" after initial training from the Laboratory Point-of-Care Coordinator.
    ii. "Qualified designees/superuser" are required to perform annual competencies.
    iii. Documentation of the initial training and annual competencies of the "qualified designees/ superuser" are kept by the Laboratory Point-of-Care Coordinator.
    iv. Documentation of the initial training and annual competency of staff members (Clinic Assistants, medical assistants, LVN's, RN's, or Nurse Practitioners) are kept by the Clinical Nurse Manager or qualified designee.
B. Initial orientation will include the safe use and maintenance of any instrumentation.
C. Competency is performed initially and annually and includes at least two of the following methods per person per test:
    i. Performance of a test on a blind specimen
    ii. Periodic observation of routine work by the supervisor or qualified designee
    iii. Monitoring of each user's quality control performance
    iv. Use of a written test specific to the testing
D. **Initial and Annual Competency:**

    The "qualified designee" will ensure that all new staff receives instruction of testing devices and operating policies and procedures. Initial and annual competencies will be documented utilizing two (2) methods of competency assessment (see #iii above).

    Competency Assessment and Remedial Action:

    - In the event that an employee fails to demonstrate satisfactory performance on the competency assessment, the deficiency is to be identified on the competency assessment form. Retraining and reassessment of the employee competency must occur when problems are identified with employee

performance. The deficiency will be resolved before the competency assessment is completed. Any deficiency noted for registry or temporary employees will also be reported to their employer.

- Employees who do not pass initial competency evaluation may not perform those functions including patient testing without direct supervision.
- Retraining is provided and competency reassessed and ensured by the section supervisor.
- If the employee does not pass the initial competency during the probation period, the probation period may be extended and further retraining will be provided.
- If the employee still cannot pass the competency after retraining, the Laboratory can exercise probationary termination.
- If the employee does not pass the annual competency, retraining will be provided. The competency will be repeated within 30-60 days. If the employee still cannot successfully complete the competency, disciplinary actions will be taken as recommended by the Human Resources Department.
- Completed competency assessments are to be filed in the employee's personnel file.

Quality Control:
The supervisor or manager of each Point of Care testing site will review and document each review at least monthly Quality Control and patient test results and also any required instrument maintenance. Each testing site is responsible for the performance and reporting of results for waived test Quality Control and patient tests, for instruments used in testing, and for supplies.

PATIENT RESULTS:

Test results for waived testing are documented in the patient's medical record. Quantitative test results in the patient's medical record for waived testing will include documentation of the reference ranges (normal values) for that test and age specific when appropriate.

IT maintains the network components of the NovaBiomedical "Novanet."

WAIVED TESTING OVERSIGHT:

Point of Care Testing Committee:

- Laboratory Director
- Medical Director
- Nursing Administration Representative
- Ambulatory Care Administration Representative
- Point of Care Coordinator

The Point of Care Testing Committee will meet when necessary to discuss adding any new test or new equipment, to resolve compliance problems, or to delete any test.

The Laboratory Point of Care Coordinator will periodically review and document the review of Point of Care initial and annual competency assessment.

REFERENCES:

The Joint Commission Frequently Asked Questions, "*Physician Competency For Waived and P.P.M.P*

Testing," November 24, 2008.

All revision dates: 4/16/2024, 3/14/2024, 11/26/2018, 6/1/2016, 8/1/2012

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	8/9/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	8/7/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	8/7/2024
Policy Owner	Erlinda Roxas: Director, Laboratory Services	8/7/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*4/1/2017*
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Owner:	*Alicia Casapao: Director of Quality and Performance Improvement*
Policy Area:	*Administrative - Patient Care*
References:	

100.225 Clinical Alarms

Purpose:

The purpose of this policy is to provide a systematic, coordinated approach to clinical alarm management.

Policy:

All clinical alarms utilized for patient care shall be operational and remain activated with the appropriate settings. Clinical alarms shall never be disabled.

Definitions:

Clinical patient care alarms are classified as either critical or non-critical. These are scored on a 1-3 scale with 3 (three) being of low risk to the patient and 1 (one) being of highest risk that could lead to patient harm/ death in the absence of immediate intervention.

Life Support (1)	Critical (2)	Non-Critical (3)
Any device used for the purpose of sustaining life and whose failure to perform its primary function, when used according to manufacturer's protocol, will lead to patient harm/ death in the absence of immediate intervention.	Medical equipment whose primary function and performance during its normal, intended operations by clinical personnel is essential in sustaining, stabilizing, or resuscitating life, and/or failure will most likely result in serious injury or death.	Devices that provide a low risk of patient harm and are not critical or life sustaining.

Procedure:

A. Clinical Alarm Management

1. The Patient Safety Committee shall provide oversight of all clinical alarms. New equipment with clinical alarms shall be reviewed and approved by the Patient Safety Committee.
    a. Exception: Pharmacy and Therapeutics Committee shall provide oversight of pumps used for administration of medications.
2. Alarm setting are set by the manufacturer.

a. Customizations and changes to default manufacturer alarm settings shall be reviewed and approved by the Patient Safety Committee.

3. An inventory of alarm-equipped medical devices is documented and maintained in the Biomed Department.
4. Patient Safety Committee shall review trends and patterns in alarm-related events to identify opportunities for improving alarm use.

B. Alarm Verification - Beginning of the Shift

1. The individual authorized to set alarm parameters are defined as individuals within the organization that are educated and trained on that piece of equipment/device.
2. At the beginning of each shift, the alarms shall be checked for accurate settings, proper operation and detectability. The environmental assessment shall include assurance that any visual aspects of the alarm system are working properly when activated.
3. An environmental assessment shall be done of the alarm to assure the alarm can be heard into the hallway or as designated by an individual department.
4. Trained and qualified personnel are responsible for monitoring patient care alarms.

C. Response to Patient Care Alarms

1. Nursing and/or appropriate personnel are to respond immediately to alarm activation.
   a. Any patient care concerns with alarms shall be communicated to the licensed practitioner (LP) responsible for the care of the patient.
   b. If there is no response from the LP, report the patient care concern according to policy 100.228 Chain of Command.
2. A Rapid Response may be initiated if there is not a prompt response to alarm.
3. Re-evaluate and reset alarm settings, as appropriate.
4. Alarm functions shall not be bypassed.

D. Alarm Failure and Alarm Related Incidents

1. Alarm failure is the failure to alarm in the presence of abnormal measures parameters and established set points.
2. When an alarm failure/malfunction is identified, depending on the alarm system, the Biomed Department or Facilities/Maintenance Department must be contacted and/or the device/instrument must be taken out of service to prevent inadvertent reuse.
3. All alarm failures shall be reported at each Patient Safety Committee meeting by the Biomed Department.
4. Any patient monitoring or clinical equipment alarm failure that caused or may have caused a serious injury, serious illness, a death, or a change in the plan of care shall be reported to the applicable accrediting and regulatory agencies.
5. The nurse/clinician, manager or director must immediately take affected equipment out of service and sequester the affected equipment.

E. Education

1. Education and training shall be provided to staff (including float and registry) and LPs on the purpose and proper operation of the alarm system for which they are responsible prior to initial use.
2. The patient and/or family, when appropriate, may be educated to alert the staff if an alarm is activated.

References

1. TJC Standards, NPSG.06.01.01: Improve the Safety of Clinical Alarm Systems.
2. TJC, Sentinel Event Alert Issue 50, April 8, 2013, Medical Device Alarm Safety in Hospitals.
3. Clinical Alarm Management Compendium, AAMI Foundation 2015.
4. Boston Medical Center Policy #03.81.00 Adult Cardiac Rhythm Monitoring 3/2015.
5. Psycholopedia.com, Critical Vital Signs & Symptoms, 2/6/16.
6. N-600 Factory Default Settings.
7. University of Kentucky, Policy-Alarms Managemet for Physiological Monitoring, Policy #AOS-280, 6/1/15.
8. Ventura County Medical Center/Santa Paula Hospital Policy 100.239 Physical Environment and Life Safety Alarms.

All revision dates: 5/12/2023, 5/12/2020, 4/1/2017

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	12/10/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/8/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/8/2024
Clinical Nurse Specialist	Tess Slazinski	10/8/2024
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	8/19/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Administrative - Patient Care*
References:	

100.265 Epidural Analgesia

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) provides safe and effective administration and management of epidural analgesia. The scope of this policy and procedure is to outline the patient care and management of inpatients who receive epidural analgesia for labor pain and surgical procedures.

OVERVIEW:

A. The Department of Anesthesia is the primary service responsible for assessment and management of all epidural drug administration

B. An epidural catheter may be inserted/initiated in the Operating Room (OR), Post Anesthesia Care Unit (PACU), Interventional Radiology (IR), Intensive Care Unit (ICU), and Labor and Delivery.

C. For Obstetrics (OB) patients, epidural anesthesia should not be administered until a baseline maternal-fetal assessment, physical exam, and progress of labor are evaluated by the Licensed Independent Practitioner (LIP) on duty for OB.

D. For guidance on the timing between anticoagulant and epidural insertion/removal, see CPG.46 Anticoagulation Management Surrounding Epidural-Intrathecal-Lumbar Puncture

E. Nursing shall provide nursing care consistent with the guidelines and procedures outlined in this policy. See Lippincott's for detailed process.

1. Assessment, evaluation, and documentation of the patient's baseline vital signs which include patient's level of pain, level of consciousness, motor/sensory function, effectiveness of epidural analgesia, and any untoward effects related to epidural analgesia. See policy 100.076 Pain Assessment, Management, and Documentation.
2. Maintenance of the epidural catheter and tubing used for continuous infusion.
3. Assessment of the epidural catheter site and dressing every shift.
4. Contacting Anesthesia Service for assessment and evaluation of the patient as needed

F. Controlled substance waste must be documented as per policy PH.88 Controlled Substances

PROCEDURE:

Equipment

A. Epidural Pump Set-Up
   1. ICU Medical Sapphire Patient Controlled Epidural Analgesia (PCEA) Pump
   2. Dedicated lock box with yellow label "Epidural Only"
   3. Dedicated yellow, portless epidural tubing

B. Epidural kit

C. Monitoring equipment for continuous vital signs and ~~SaO~~oxygen saturation of peripheral capillaries (SpO2) monitoring

D. Emergency supplies
   1. Crash Cart
   2. Epidural Cart (OB only)
   3. Oxygen and suction set up

E. Epidural medication bag with yellow label "Epidural Only"

Roles and Responsibilities

Licensed Independent Practitioner (LIP)

A. The LIP shall consult with the patient, explain the procedure prior to initiation, and document the patient's approval.
   1. For OB patients the LIP shall also determine the woman's knowledge, desires and concerns about methods of labor pain management. Education about analgesia and anesthesia techniques and effects, acknowledging and respecting individual and socio-cultural preferences
   2. For OB patients, the LIP shall assess patients for appropriateness in using a PCEA. The patient must be able to comprehend instructions, be willing to self-dose, and be assessed according to patient specific monitoring and assessment criteria.

B. The LIP shall make certain there are no contraindications to the procedure including platelet count, previous spinal surgery, etc.

C. The LIP shall communicate with the nurse regarding the need for the epidural.

D. The LIP shall initiate epidural orders using the appropriate, approved Epidural PowerPlan

E. The following orders may be entered by the LIP, under Anesthesia supervision:
   1. Changes to the standard starting continuous infusion rate
   2. Changes to the PCEA dosing parameters
   3. Single re-bolus injection from a vial.

F. Upon cessation of therapy, the LIP must discontinue all orders from the electronic health record (EHR).

Anesthesiologist

A. Anesthesia will monitor and maintain a sterile, patent epidural catheter in a tamper-free environment, to

administer continuous analgesia for the relief of labor or surgical pain, and to decrease the incidence of CNS depression and pulmonary complications.

B. Anesthesia will place the epidural catheter, administer the initial injection, connect the tubing to the epidural catheter connector, and initiate the continuous infusion.
    1. Additional re-boluses from the vial may be administered by the LIP.

C. Anesthesia will evaluate the catheter placement including re-evaluation of potential catheter mis-positioning with bolus test doses of local anesthetic.

D. Anesthesia will assess the duration of time the catheter will remain in place and the duration of the epidural therapy.

Nurse (RN)

A. Registered Nurses who have performed a one-time competency are able to set-up, administer medication, and monitor epidural pumps.

B. After informed consent is given by the LIP, Nursing will obtain patient signature on the consent forms, assess and reinforce patient knowledge about procedure, and answer any questions or appropriately refer them to the Anesthesiologist.

C. Set Up
    1. The RN shall ensure the patient has IV access and administer IV fluid preload as ordered.
    2. The RN shall gather the necessary equipment and supplies prior to anesthesiologist's arrival.
    3. The RN shall place patient on continuous vital sign, SpO2 and if indicated, a fetal monitor.
        a. Continuous Fetal Heart Rate (FHR) monitoring should be maintained to the best of RN's ability during catheter placement. If there is concern regarding the status of the fetus, consideration should be given to placement of fetal scalp electrode for monitoring. If the FHR has not been assessed for >15 minutes, the provider should pause to allow the RN to assess the FHR and then proceed with catheter placement.
    4. The RN shall assist the Anesthesiologist to clear visitors including support person from room.
    5. The RN shall assist the patient and Anesthesiologist with positioning patient for catheter insertion.

D. Administration
    1. The initial double check is completed with anesthesia as Anesthesiologists are initiating the initial infusion or setting as ordered. **Exception: two RN double check is permitted for certain patient areas(Labor and Delivery and adult Intensive Care Unit)**
    2. Once the epidural infusion has been established by Anesthesia, the RN has the following pump privileges:
        a. Stop and/or continue the epidural infusion
        b. Prime the pump, hang a new bag, and continue the epidural infusion at the previous ordered setting.
        c. Ordered rate change -- not to exceed 4 mL/hr per rate change.
    3. Nursing shall perform an Independent Double Check with required witness cosign in the ~~electronic health record (~~EHR~~)~~ for epidural medications following rate and bag changes. See policy PH.70 High Alert Medications.

E. PCEA Education (OB patients only)

1. The RN shall educate the patient on the proper use of the patient controlled bolus handle and the safety measures with the use of the PCEA including hourly limits and lockout time.
2. The RN shall instruct the patient and family members that "PCEA by proxy" is not allowed.
3. The RN should encourage the patient to use the bolus handle for breakthrough pain
4. The RN should inform the patient it usually takes 10-15 minutes before the full effect of the demand dose is reached.
5. The RN shall document the education to the patient and family in the EHR.
6. If the patient controlled boluses do not bring adequate pain relief, the anesthesia service should be notified for evaluation and troubleshooting.

F. Monitoring and Documentation

1. Nursing should follow the following monitoring guidelines:

Prior to Epidural Placement		
Unit	**Monitoring Parameter**	**Frequency**
OB	Vital signs, SP02	Baseline or as ordered
	Fetal monitoring	Continuous or as ordered
ICU/DOU	Vital signs, pain, respiratory rate (RR)	Baseline
	Level of sensation (Dermatome)	Baseline
	Continuous ETCO2 if ordered	As ordered

Immediately BEFORE/AFTER Epidural Placement by Anesthesia		
Unit	**Monitoring Parameter**	**Frequency**
OB	BP, HR, Sp02	Test dose (before and after) Insertion: every 15 minutes x 1 hour
ICU/DOU	BP, HR, Sp02	Test dose (before and after) Insertion: every 15 minutes x 1 hour
	Pain, sedation, RR, level of sensation (Dermatome)	Test dose (before and after) Insertion: every 15 minutes x 1 hour
	Continuous ETCO2 if ordered	As ordered

Following Initiation and after each LIP bolus		
Unit	**Monitoring Parameter**	**Frequency**
OB	BP	Every (Q) 5 minutes throughout the administration of anesthetic dose, then every 15 minutes x 2, then every 60 minutes until epidural discontinued unless otherwise indicated
	Fetal Monitoring	Continuous per policy OB.45 OB management of fetal heart rate tracing
	RR, SP02	Q1h until epidural is discontinued.
	Level of sensation (Dermatome)	Q1-2 hours, as ordered
	Pain	Q1 hour
	PCEA – total amount received	Q shift
	Line status and dressing every shift	Q shift and PRN and when assuming care
ICU/DOU	BP	Q1 hour x 4 hours, then every 2 hours while on the epidural
	RR, ETCO2, SP02	Q1 hour x 12 hours, then Q2 hours x 12 hours, then Q4h until epidural is discontinued.
	Level of sensation (Dermatome)	Q1-2 hours, as ordered
	Pain	Q1 hour
	PCEA – total amount received	Q shift
	Line status and dressing every shift	Q shift and PRN and when assuming care

After discontinuation of Epidural Catheter by Approved Clinician		
OB and ICU/DOU	Level of sensation (Dermatome)	Every 4 hrs X 24 hours
	Post-removal site	Every 4 hours x 24 hours
Abbreviation key: Obstetrics (OB), oxygen saturation (SpO2), Intensive care unit (ICU), direct observation unit (DOU), Respiratory Rate (RR), End-tidal carbon dioxide (ETCO2), Blood Pressure (BP), Heart Rate (HR), Patient Controlled Epidural Analgesia (PCEA), As needed (PRN)		

Prior to Epidural Placement		
Unit	**Monitoring Parameter**	**Frequency**
OB	Vital signs, SP02	Baseline or as ordered
	Fetal monitoring	Continuous or as ordered
ICU/DOU	Vital signs, pain, respiratory rate (RR)	Baseline
	Level of sensation (Dermatome)	Baseline
	Continuous ETCO2 if ordered	As ordered

Immediately BEFORE/AFTER Epidural Placement by Anesthesia		
Unit	**Monitoring Parameter**	**Frequency**
OB	BP, HR, Sp02	Test dose (before and after) Insertion: every 15 minutes x 1 hour
ICU/DOU	BP, HR, Sp02	Test dose (before and after) Insertion: every 15 minutes x 1 hour
	Pain, sedation, RR, level of sensation (Dermatome)	Test dose (before and after) Insertion: every 15 minutes x 1 hour
	Continuous ETCO2 if ordered	As ordered

Following Initiation and after each LIP bolus		
Unit	**Monitoring Parameter**	**Frequency**
OB	BP	Every (Q) 5 minutes throughout the administration of anesthetic dose, then every 15 minutes x 2, then every 60 minutes until epidural discontinued unless otherwise indicated
	Fetal Monitoring	Continuous per policy OB.45 OB management of fetal heart rate tracing
	RR, SP02	Q1h until epidural is discontinued.
	Level of sensation (Dermatome)	Q1-2 hours, as ordered
	Pain	Q1 hour
	PCEA – total amount received	Q shift
	Line status and dressing every shift	Q shift and PRN and when assuming care
ICU/DOU	BP	Q1 hour x 4 hours, then every 2 hours while on the epidural
	RR, ETCO2, SP02	Q1 hour x 12 hours, then Q2 hours x 12 hours, then Q4h until epidural is discontinued.
	Level of sensation (Dermatome)	Q1-2 hours, as ordered
	Pain	Q1 hour
	PCEA – total amount received	Q shift
	Line status and dressing every shift	Q shift and PRN and when assuming care

After discontinuation of Epidural Catheter by Approved Clinician		
OB and ICU/DOU	Level of sensation (Dermatome)	Every 4 hrs X 24 hours
	Post-removal site	Every 4 hours x 24 hours
Abbreviation key: Obstetrics (OB), oxygen saturation (SpO2), Intensive care unit (ICU), direct observation unit (DOU), Respiratory Rate (RR), End-tidal carbon dioxide (ETCO2), Blood Pressure (BP), Heart Rate (HR), Patient Controlled Epidural Analgesia (PCEA), As needed (PRN)		

2. Documentation in the Electronic health record
    a. Vital signs
    b. Level of sensation (every 1-2 hours as ordered)

c. Pain scale assessment (every hour and PRN)
d. Any interventions associated with assessments
e. Rate and Bag changes with independent double check
f. Total amount received from PCEA each shift
g. Condition of dressing
h. Notation of discontinuation of epidural catheter, date, time, by whom, condition of catheter
i. Wasted medication in Pyxis requires two nurse visual verification
j. Document epidural medication in EHR

3. For OB patients, see Maternal and Fetal Monitoring and Management for additional information.

G. Dressing Change

1. There is no need for regular dressing changes.
2. Secure catheter with tape or plastic dressing the entire length, to one side of the spine and secure connector to patient's gown and shoulder or neck.
3. If dressing is compromised (e.g., pad is gone or wet), call LIP.

H. Discontinuing the Catheter

1. Epidural catheter may be removed or discontinued by a LIP or OB RN who has met competency. The epidural catheter should be removed prior to transfer to another unit, unless there is a LIP's order to state otherwise.
2. If patient has been receiving anticoagulant therapy of any type while the epidural has been in place will require consultation with the anesthesiologist before removing (see CPG.46 Anticoagulation Management Surrounding Epidural-Intrathecal-Lumbar Puncture).
3. Removal of the epidural catheter will take place when the patient is stable, comfortable, and the infusion is no longer required. For OB patients, epidural catheters should be discontinued after delivery unless otherwise ordered.
4. Explain procedure to patient.
5. Position patient on their side, with their back rounded.
6. Remove tape, pulling in a downward motion.
7. If any resistance other than gentle pressure, stop and notify physician.
8. Assess skin site for redness, edema or discharge,
9. Cover site with a band-aid to the epidural site if needed.
10. Inspect catheter tip for intactness once removed, document in EHR that catheter tip is intact. If the catheter tip is not intact notify the anesthesia team ***immediately.***

Maternal and Fetal Monitoring and Management

A. **Maternal and Fetal Maintenance**

1. Responses to initial catheter dosing or during the perianesthesia period may include hypotension, alterations in fetal heart rate (FHR), signs of Intravenous (IV) injection of local anesthetic and pruritus. Nursing assessment and interventions include but are not limited to:

2. Monitoring maternal vital signs, SpO2, and FHR patterns as directed by LIP based on consideration of factors such as the type of anesthesia, route and dose of medication, the maternal-fetal response to medication, maternal-fetal condition and the stage of labor.
3. Facilitate lateral or upright maternal position with uterine displacement to minimize hypotension.
4. Patients will receive continuous fetal monitoring for at least one hour following initiation of epidural anesthesia and ongoing fetal monitoring should be performed in accordance to policy OB.45 Ob Management of Fetal Heart Rate Tracing
5. Managing hypotension or non-reassuring FHR patterns, which may include notifying the anesthesia or OB care provider or both, repositioning the patient, administering IV fluid bolus, oxygen or medications as needed and ordered.
6. Monitoring for signs of IV injection of local anesthetic, which may include FHR alterations, hypertension, dizziness, tinnitus, metallic taste in mouth, maternal dysrhythmia and loss of consciousness.
7. Notify anesthesiologist immediately if patient complains of numbness in upper extremities or shows difficulty in breathing. If this occurs, discontinue the infusion by turning off the pump.
8. Managing IV injection of local anesthetic, including initiation of emergency procedures if necessary and notifying the anesthesia or OB care provider or both.
9. Monitoring for pruritus that may occur initially or persist after medication administration; administering medication as ordered for severe or unresolved itching.

B. **Pain and Motor Blockade Assessment**

1. Evaluate maternal pain and comfort levels using pain assessment tools.
2. The dermatome level (level of sensation) should be monitored every hour by using ice or an alcohol swab to stroke the skin comparing areas of normal sensation with areas of block. Start on one thigh and work upward to determine upper boundary and repeat on the other side. (Refer to Attachment A for dermatome levels). If dermatome level is higher than T4, stop infusion and notify anesthesiologist. The goal is to maintain patients comfort with a dermatome level no more than T4.
3. NEVER administer narcotics, sedatives or anticoagulants without first discussing with and getting an order from the Anesthesiologist.
4. Urinary retention should be anticipated. Insert Foley Catheter

C. **Assessment and Management of Maternal Side Effects**

1. Monitor for nausea and vomiting; administer medication as ordered and intervene to prevent aspiration if vomiting occurs.
2. Monitor for elevations in maternal temperature and differentiate between benign fever related to anesthesia vs. infection by assessing for fetal tachycardia, uterine tenderness, foul-smelling amniotic fluid or vaginal discharge, and laboratory results.
3. Monitor of signs of postdural puncture headache; if present, avoid the upright position, provide support, administer medications as ordered and prepare for blood patch procedure if ordered.

D. **Assessment and Management of Neonatal Side Effects**

1. Communicate information about medications used for regional analgesia/anesthesia to neonatal care providers.

2. Monitor the neonate for neurobehavioral changes or decreased respiratory rate.
3. Administer narcotic antagonist as ordered if indicated.

REFERENCES:

1. Association of Women's Health, Obstetrics& Neonatal Nurse (2020) Role of Registered Nurse in the Care of Pregnant Women Receiving Analgesia and Anesthesia by Catheter Techniques:AWONN Postion Statement. Nursing for Women's Health.
2. ACOG Bulletin #36, 7/2002, Reaffirmed 2013.
3. Guidelines for Neuraxial Analgesia or Anesthesia in Obstretics. American Society of Anesthesiologists. October 13, 2021. Accessed 8/2022.
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All revision dates: 2/6/2025, 12/14/2022, 10/11/2022, 3/21/2019, 3/1/2016, 1/1/2015, 6/1/2014, 11/1/2013, 7/1/2010, 3/1/2009, 6/1/2006, 8/1/2004

Attachments

Attachment A - Dermatomes Chart
b64_b31db790-05af-4799-90cf-8a4a3817846f

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: OB & Surgery	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/3/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/3/2024
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	12/3/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*6/1/2003*
Effective:	*Upon Approval*
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Last Revised:	*5/1/2014*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.022 Infection Control Construction Policy Risk Assessment

POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital to use strategic facility design and safe construction, demolition, renovation and maintenance practices in order to promote and protect a safe patient and employee environment. Infection Prevention and Control participates in all phases of construction design, planning, monitoring and maintenance to ensure a safe patient care environment.

PROCESS:

A. Infection Prevention and Control participates in the project design and planning which allows for incorporation of infection prevention and control strategies to minimize risk for patients and employees.

B. **Design and Architectural Plans**
Designs and planned construction of patient care areas or areas surrounding patient care areas will include an Infection Prevention and Control Construction, Renovation and Design Development Considerations form (Form A) prior to the finalization of the plans and commencement of work.

C. **External Excavation and Demolition**

1. Dust containment must occur at source.
2. Frequency of wetting soil or demolished building area, truck and equipment path is adequate, but not so wet that new hazards are created.
3. Soil and dust clouds are to be managed in a proactive manner.
4. Doors, windows and other ports of entry located near the project are sealed or barred from use wherever possible.
5. Construction worker behavior such as removing heavily soiled clothing (dust, dirt) and observing good hygiene prior to entering healthcare grounds as appropriate will be observed.
6. Waste is kept to a minimum and taken off site in a timely manner.
7. Materials delivered and/or stored for later installation are properly protected, e.g. shrink wrapped.
8. Facilities Management will increase the frequency of monitoring and respond with appropriate interventions which may include, but are not limited to:
    a. Air handler efficiency and filter changes, cleaning

b. Power changes including steam supply

c. Plumbing interruptions including steam supply

D. **Internal Construction and Renovation**

1. The Infection Prevention and Control Pre-Construction Risk Assessment Form (Form B) is completed by the contractor and/or facilities management prior to commencing work. Infection Prevention and Control is responsible for reviewing and approving the infection control aspects of the plan of work.
2. A copy of the blueprint of the construction area with the construction zone outlined is attached to the form.
3. The completed, signed form is posted in a plastic sleeve on the wall in a visible location outside the construction zone.
4. Housekeeping will maintain the cleanliness of the surrounding interior corridors and increase frequency of cleaning as necessary.
5. Debris removal must be done via the shortest route, frequently and must always be covered. The work space must be kept clean without excessive buildup of trash.
6. Facilities management will ensure the HVAC, plumbing and steam systems are maintained in a safe manner.
7. The Infection Control measures listed in the ICRA will be employed as agreed upon and signed for by both Infection Prevention and Control and the requestor.
8. Once signed, any changes to the construction and/or renovation plan require renewed coordination with Infection Prevention and Control, including signoff by initialing and dating the changes/revision. If the changes are extensive, a new ICRA may be required.

E. External Construction and Renovation

1. The Infection Prevention and Control Exterior Construction Risk Assessment Form (Form C) is completed by the contractor and/or facilities management prior to commencing work. Infection Prevention and Control is responsible for reviewing and approving the infection control aspects of the plan of work.
2. A copy of the blueprint of the construction area is attached to the form with the construction zone outlined.
3. The completed, signed form is posted outside the construction zone where it is visible.
4. The contractor/subcontractor will insure:
    a. That the construction area is dust controlled at all times.
    b. That the construction area is dewatered and free of standing water near the foundation of the building.
    c. That the construction area is protected against intrusion from pests or vermin.
    d. That the garments of contractors are free of dust and gross debris upon entering the facility.
    e. Coordination and stoppage of any work that may cause dust generation during helicopter landings.
5. Debris removal must be done via the shortest route, frequently and always covered. The work space must be kept clean without excessive buildup of trash.

F. Infection control construction education:
    1. Must be documented and on file with Facilities Management.
    2. Education regarding infection prevention and control in construction and renovation projects must be completed prior to starting work.
    3. Workers must have an identifier indicating that infection control education has taken place; e.g. sticker on helmet or easily identifiable tag.
    4. Companies providing infection control education to their employees prior to starting work must provide a copy of the education to the Infection Prevention and Control department for review and approval.

G. Construction workers working within the clinical arena or support services areas must meet employee health infection control requirements as outlined in the Administrative policy 101.012, *Employee Health Services.*

H. Infection Prevention and Control participates in consultation and problem solving during all phases of construction projects.

I. In the event of infection control breaches and failure to provide a safe environment, Infection Prevention and Control will issue a "Stop Work" order until corrections are made.
    1. Remediation and a correction plan will be approved by Infection Prevention and Control prior to resuming work.
    2. Infection Prevention and Control will inform administration of the action taken and plans for correction.

REFERENCES:

1. California Code of Regulations Title 22, Division 5 Chapter 1: General Acute Care Hospitals
2. Centers for Disease Control and Prevention Guideline for Environmental Infection Control in Healthcare Facilities
3. American Institute of Architects Guideline for Design and Construction if Hospitals and Healthcare Facilities
4. Association for Professionals in Infection Control and Epidemiology (APIC): Text of Infection Control and Epidemiology
5. APIC: Construction and Renovation, A Toolkit for Professionals in Infection Prevention and Control

All revision dates: 5/1/2014, 10/1/2013, 10/1/2012, 7/1/2011, 5/1/2006

Attachments

- A: Infection Control Construction, Renovation and Design Development Considerations
- B: Pre-Construction Risk Assessment Form
- C: Infection Prevention and Control Exterior Construction Risk Assessment (ICRA) Permit

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	2/3/2025
Policy Owner	Magdy Asaad: Infection Prevention Manager	12/26/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

106.055 Hand Hygiene

POLICY:

Effective hand hygiene removes transient microorganisms, dirt and organic material from the hands, and decreases the risk of cross contamination from patients, patient care equipment, and the environment.

Hand hygiene is the single most important strategy to reduce the risks of transmitting organisms from one person to another and/or from one site to another on the same patient. By following the World Health Organization (WHO) 5 moments for Hand Hygiene (before touching a patient, before a clean/aspectic procedure, after body fluid exposure, after touching a patient, and after touching a patient surroundings and/or equipment), one increases the chance of preventing the spread of organisms. Patients and visitors should be encouraged to clean their hands as well.

HCP should perform hand hygiene by using Alcohol Based Hand Rub (ABHS) with 60-95% alcohol (70% is recommended) or washing hands with soap and water for at least 20 seconds per CDC guidelines

PROCEDURE:

A. Clean hands with either alcohol-based hand sanitizer or soap and water following the WHO's 5 Identified Moments for Hand Hygiene:
    1. Before touching a patient
    2. Before clean/aseptic procedure
    3. After body fluid exposure
    4. After touching a patient
    5. After touching patient surroundings and/or equipment
B. In addition, the employee is to wash their hands when visibly soiled, before eating, after using the bathroom, at the beginning and end of their shift, and in any other situation in which the hands may become contaminated.
C. When to use soap and water vs alcohol based hand sanitizer:
    1. Wash with soap and water:
        a. When hands are visibly soiled
        b. After exposure to a patient and/or their environment with known or suspected *Clostridium difficile* infection (CDI) or other spore forming pathogen

c. After known or suspected exposure to patients with infectious diarrhea (such as norovirus)

d. If exposure to *Bacillus anthracis* is suspected or proven

e. Before eating

f. After using a restroom

2. Use an alcohol-based hand sanitizer:

a. For everything else

D. Fingernails

1. Artificial nails or enhancements on staff who have direct patient contact is prohibited. Artificial nails are classified as any type of treatment or product applied to the natural nail, to include but not limited to: gels, shellacs, acrylics and silks.
2. Nails are to be kept short (1/4 inch of white visible above the quick).
3. Nails are to be kept clean.
4. Nail polish is permitted (if it is not chipped and can be easily removed with nail polish remover and cotton balls).

MONITORING AND COMPLIANCE

E. Compliance with hand hygiene procedure will be accomplished through random anonymous hand hygiene observations.

F. Data will be calculated quarterly and reported to all departments.

G. Data will be reported to the Infection Control Committee.

ATTACHMENTS:

A. "How to Handwash," World Health Organization

B. "How to Handrub," World Health Organization

C. "Hand Hygiene: Why, How & When?" World Health Organization

REFERENCES:

World Health Organization (WHO), *Guidelines on Hand Hygiene Care in Health Care,* 2009
The Joint Commission National Patient Safety Goals and Infection Control Standard.

CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

All revision dates: 2/3/2025, 8/10/2021, 11/26/2018, 11/1/2010

Attachments

- A: How to Handwash Poster
- B: How to Handrub Poster
- C: WHO Hand Hygiene: Why, How, and When

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	2/3/2025
Policy Owner	Magdy Asaad: Infection Prevention Manager	2/3/2025

Current Status: *Pending* **PolicyStat ID:** *16240937*

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Osahon Ekhaese: Chief Operating Officer, VCMC & SPH*
Policy Area:	*Administrative - Operating Policies*
References:	

107.056 Use of Contracted Services

POLICY:

The Joint Commission Standard LD.04.03.09 outlines the requirements for leadership oversight of care, treatment, and services provided through contractual agreement. The hospital will maintain a current list of contracted services (provider groups/service vendors) directly related to the provision of care and treatment of hospital patients. The list will include the scope and nature of the service provided and ensure that the services performed under contract are provided in a safe and effective manner by assessing and monitoring performance.

PROCEDURE:

1. The hospital will maintain a list of contracted services (provider groups/service vendors) to include:
    a. Vendor name
    b. Scope and nature of the services provided by the contractor
    c. Terms to include date of expiration
2. The Contracts Management Department shall maintain and review the list of provider groups annually and forward the list of contracted services for provider groups to the Medical Staff office for approval by the Medical Executive Committee, with final approval by the Oversight Committee.
3. The ~~Associate Hospital Administrator~~Chief Operating Officer or qualified designee will review the service vendor contract list annually with applicable department managers. The hospital will assess the services provided under contract by the following:
    a. Identify performance problems
    b. Implement appropriate corrections or improvements
    c. Monitor appropriate corrections or improvements
4. The ~~Associate Hospital Administrator (~~Chief Operating Officer or qualified designee~~)~~ will report annually to the performance improvement coordinating council (PICC). Data is trended, analyzed and reported annually and used to provide performance criteria prior to contract extension.
5. The Accounts Payable Department, Contracts Management Department or qualified designee notifies the applicable department manager prior to contract expiration to ensure continuity of service.
6. The list of contracted services (provider groups and service vendors) will be reviewed and approved by the Medical Executive Committee and the Governing Body annually.

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All revision dates:	12/23/2024, 9/27/2018, 12/1/2016, 12/1/2013, 9/1/2011

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	2/6/2025
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Policy Owner	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	12/30/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised:	*7/29/2024*
Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Operating Policies*
References:	

107.073 Bed Crisis/Census Alert

POLICY:

An overflow plan may be enacted when it is felt patient care demands cannot be met safely due to physical capacity, equipment, supplies and/or staffing limitations. The alert may be enacted specific to an individual unit, service, or the organization.

The priority will always continue to be providing safe care. This may mean that some care may be omitted or decreased in frequency to assure required care needs are met.

~~The priority will always continue to be providing safe care. This may mean that some care may be omitted or decreased in frequency to assure required care needs are met.~~

PROCEDURE:

~~A. Initiation -~~

- ~~Initiation of the alert will be at the direction of the Chief Medical Officer (CMO) or the Administrator on Duty (AOD).~~
- ~~The initiation of the alert will be based upon a variety of factors which may include but not be limited to the following:~~

~~1. More than 8 - 10 patients holding without hold nurses; or 8 - 10 patients boarding with hold nurses with high acuities (e.g. ICU, DOU).~~

~~2. More than 12 holds with hold nurses.~~

~~3. Number of PACU admits to be placed in comparison to beds available.~~

~~B. Communication -~~

~~The Hospital Operator will be directed by the CMO or AOD to send the following alert:~~

~~"Bed Crisis: __X___ patients holding in the ED. Please address discharges first thing this morning. Attending physicians please assist teams in expediting discharges."~~

~~To the following individuals:~~

- ~~Medicine Residents~~
- ~~Surgery Residents~~

- ~~Orthopedic Residents~~
- ~~The five (5) attending physicians for the Inpatient Medicine teams~~
- ~~The General Surgery attending on service~~
- ~~The Orthopedic Surgery attending on service~~
- ~~The Neurosurgery attending on service~~
- ~~The ICU Intensivists on service.~~

A. Initiation -

- Initiation of the alert will be at the direction of the Chief Medical Officer (CMO) or the Administrator on Duty (AOD).
- The initiation of the alert will be based upon a variety of factors which may include but not be limited to the following:
  1. More than 8 - 10 patients holding without hold nurses; or 8 - 10 patients boarding with hold nurses with high acuities (e.g. ICU, DOU).
  2. More than 12 holds with hold nurses.
  3. Number of PACU admits to be placed in comparison to beds available.

B. Communication -

The Hospital Operator will be directed by the CMO or AOD to send the following alert:

"Bed Crisis: __X___ patients holding in the ED. Please address discharges first thing this morning. Attending physicians please assist teams in expediting discharges."
To the following individuals:

- Medicine Residents
- Surgery Residents
- Orthopedic Residents
- The five (5) attending physicians for the Inpatient Medicine teams
- The General Surgery attending on service
- The Orthopedic Surgery attending on service
- The Neurosurgery attending on service
- The ICU Intensivists on service.
- Case Management Director and Supervisor

C. Next Steps

- Ancillary services leaders will reprioritize work to see patients who require services to be discharged.
- Medicine and surgery teams postpone teaching rounds until after discharge rounds are complete.
- Housekeeping: triage room requests in collaboration with nursing supervisor to ensure rooms are turned over in order of need.
- Unit Medical Office Assistants (MOA) work with case management to coordinate transportation for any patients with discharge orders for whom rides are not immediately available.

The Medical Staff Office at the direction of the Chief Medical Officer (CMO) or designee will notify medical staff chairs, medical staff leadership and hospitalists to assist in early disposition and discharge of patients.

All revision dates: 7/29/2024, 3/9/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	8/5/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/29/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/29/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/29/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Theresa Cho: Chief Executive Officer, Ambulatory Care*
Policy Area:	*Ambulatory Care - Patient Care Services*
References:	

AC.40 Cystic Fibrosis Foundation Care Center in Pediatrics

~~Policy:~~

POLICY:

The Cystic Fibrosis (CF) ~~Special~~Foundation Care Center (~~SCC~~FCC)~~ care~~ at the Pediatric Diagnostic Center (PDC), is an affiliated ambulatory clinic of the Ventura County Health Care Agency [HCA] and Ventura County Medical Center [VCMC], that gives multidisciplinary center care to California Children Services (CCS) patients with Cystic Fibrosis. The CF team at PDC is a multidisciplinary team that strives to give ~~multidisciplinary center~~personalized, cutting edge patient care~~ to CCS patients with Cystic Fibrosis. The CF team at PDC is a multidisciplinary team that strives to give personalized~~, ~~cutting edge patient~~while adhering to the standards of care~~, while adhering to the standards of care~~ in nationally recognized Cystic Fibrosis treatment plans to our patients. The Guidelines that are outlined here will be developed with the multidisciplinary specialties and will be reviewed, updated and maintained by the Cystic Fibrosis Team.

~~Procedure:~~

~~New Patients:~~

PROCEDURE:

NEW PATIENTS:

Children referred to the Cystic Fibrosis ~~SCC~~Foundation Care Center must have an authorization from CCS prior to rendering any service at the ~~SCC~~FCC.

Referral from Ventura County Medical Center/Ventura Health Care Agency Clinics:

1. Ambulatory referral is placed in the electronic medical record prior to discharge or from the outpatient clinic.
2. Discharge summary/clinic notes reviewed.
3. The patient's medical information will be reviewed with the medical director or designee prior to scheduling an appointment

4. Meet eligibility requirements
5. Obtain insurance authorization
6. Appointment scheduled within 2-4 weeks of discharge, or as indicated by physician

Referral from other hospitals, agencies, primary care physicians outside the Ventura County HCA and VCMC.

1. Information will be obtained from the transferring Specialty Care Center ~~(SCC)~~, hospital, and/or primary care physician office
2. Obtain discharge summary, last clinic notes, tests, and laboratory results
3. Intake conference completed with physician and nurse specialist
4. Meet eligibility requirements
5. Insurance authorization obtained
6. Appointment scheduled within 8 weeks

~~Physical Findings:~~

~~Vital Signs~~

PHYSICAL FINDINGS:

Vital Signs

Vital signs obtained on each visit: include pain assessment, temperature, heart rate, blood pressure, pulse oximetry, and respiratory rate. Height is measured in centimeters and weight in kilograms.

~~New Record and Established patients~~

New Record and Established Patients

- A complete physical exam will be performed
- Patient/parent knowledge base about the Cystic Fibrosis will be assessed to determine if initial re-education is indicated
- Patient/parent education continues at subsequent visits and the developmental stage of the patient is taken into account

~~LABORATORY AND DIAGNOSTIC/ PROCEDURES~~

~~Laboratory Testing:~~

LABORATORY AND DIAGNOSTIC PROCEDURES:

Laboratory Testing

- ~~Routine~~Cystic Fibrosis Sputum Culture

~~Other Radiological Testing:~~

- ~~CXR,~~

- ~~CT of the Lungs~~

Other Radiological Testing

- Chest x-ray (CXR).
- Computed tomography (CT) of the lungs

IN THE CLINIC SETTING:

Facilities and Equipment

- Adequate area shall be available for the provision of individual medical examinations, social work, nursing, dietary, and other appropriate professional assessment, treatment, and counseling services as required caring for the conditions appropriate to the category
- The patient will be roomed directly upon arrival at the Care Center
- There shall be an identified room to isolate patients with potentially contagious diseases
- There shall be compliance with the American with Disabilities Act (ADA)
- Accessible restrooms shall be available for patients and families that allow for needs of infants, toddlers, children and adults
- There shall be a designated area available for team conferences, teaching, and confidential patient and family conferences
  ~~There shall be a reception area with adequate seating for patients and families that contains toys appropriate for the ages of patients served and reading material for patients and for parents/caretakers~~
- All routine tests necessary, i.e Pulmonary Function Test, Sputum/CF cultures, x-ray, etc, for differential diagnosis and treatment of children with Cystic FIbrosis seen shall be available on site; Specialized tests and procedures shall be available either on site or at specific identified facilities
- Medications shall be immediately available to adequately address any medical emergencies
- The ~~SCC~~FCC shall follow the most recent American Academy of Pediatrics policy on Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers
- There shall be appropriate storage facilities for medications and vaccines including a refrigerator and separate freezer; Daily temperature logs for freezer and refrigerator shall be maintained
- Assist in housing arrangements for parents and family members of children as needed
- Clinic space sufficient to perform a 6 minute walk test.
- Standardized equipment, calibrated within the past year when appropriate, shall be available to provide anthropomorphic measurement s appropriate for the ages and physical condition of the clients served

- ~~Clinic space sufficient to perform a 6 minute walk test.~~
- ~~Standardized equipment, calibrated within the past year when appropriate, shall be available to provide anthropomorphic measurement s appropriate for the ages and physical condition of the clients served~~

~~Services~~

SERVICES:

The Cystic Fibrosis ~~SCC~~Foundation Care Center shall discuss all services and plan of care with the requesting Medical Therapy Conference (MTC) physician or designee prior to and post-intervention:

~~For authorization of ongoing neuromuscular SCC services, the CCS County MD in consultation with the MTC physician will progress towards goals and functional measures attained~~

- Services provided by health care professionals listed on the ~~SCC~~FCC directory as consultants, beyond the assessment and evaluation recommended by the team conferences, require prior authorization
  - These requests shall specify services needed, number of visits and duration, and include a medical justification
  - Extensions may be granted when indicated based on submitted medical justification

*Each sub-specialist will obtain a detailed patient history and physical examination according to their specialty. Each physician will review current imaging/laboratory studies pertaining to his/her specialty. Recommendations and a plan of treatment will be made at each visit.

~~TEAM COMPOSITION:~~

~~The Team includes: Pediatric Pulmonologist (MD), Registered Nurse (RN), Social Worker (MSW), Physical Therapy (PT), and Respiratory Therapist (RT)~~

~~CRITERIA:~~

CRITERIA:

Any patient with any of the following criteria:

1. Patients with sweat chloride level ≥ of 60 mmol/L
2. ~~infants~~Infants with presumptive CF identified through Newborn Screening Program
3. Individuals presenting with a positive newborn screen, symptoms of CF, or a positive family history, and sweat chloride values in the intermediate range (30-59 mmol/L) on two separate occasions, may have CF. They should be considered for extended cystic fibrosis transmembrane conductance regulator (CFTR) gene analysis and/or CFTR functional analysis.
4. Patients with genetic criteria consistent with Cystic Fibrosis, that includes but not limited to the following
   a. CF-causing mutation: Individuals with two copies on separate alleles will likely have CF (clinical sweat confirmation needed)
   b. Mutation of varying clinical consequence (MVCC): A mutation that, in combination with a CF-causing mutation or another MVCC mutation, may result in CF
   c. Uncharacterized mutation/mutation of unknown clinical consequence (UNK): Mutations that have not been evaluated by CFTR2 and may be disease-causing or of variable clinical consequences or benign
   d. Non-CF causing mutation: Individuals with one or more are unlikely to have CF (as a result of that allele)

~~IN THE CLINIC SETTING~~

~~Facilities and Equipment~~

- ~~Adequate area shall be available for the provision of individual medical examinations, social work, nursing, dietary, and other appropriate professional assessment, treatment, and counseling services as required caring for the conditions appropriate to the category~~
- ~~There shall be an identified room to isolate patients with potentially contagious diseases~~
- ~~There shall be compliance with the American with Disabilities Act (ADA)~~
- ~~Accessible restrooms shall be available for patients and families that allow for needs of infants, toddlers,~~

~~children and adults~~

- ~~There shall be a designated area available for team conferences, teaching, and confidential patient and family conferences~~
- ~~There shall be a reception area with adequate seating for patients and families that contains toys appropriate for the ages of patients served and reading material for patients and for parents/caretakers~~
- ~~All routine tests necessary, i.e Pulmonary Function Test, Sputum/CF cultures, x-ray, etc, for differential diagnosis and treatment of children with Cystic FIbrosis seen shall be available on site; Specialized tests and procedures shall be available either on site or at specific identified facilities~~
- ~~Medications shall be immediately available to adequately address any medical emergencies~~
- ~~The SCC shall follow the most recent American Academy of Pediatrics policy on Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers~~
- ~~There shall be appropriate storage facilities for medications and vaccines including a refrigerator and separate freezer; Daily temperature logs for freezer and refrigerator shall be maintained~~
- ~~Assist in housing arrangements for parents and family members of children as needed~~
- ~~Clinic space sufficient to perform a 6 minute walk test.~~
- ~~Standardized equipment, calibrated within the past year when appropriate, shall be available to provide anthropomorphic measurement s appropriate for the ages and physical condition of the clients served~~

~~Services~~

~~*Each sub-specialist will obtain a detailed patient history and physical examination according to their specialty. Each physician will review current imaging/laboratory studies pertaining to his/her specialty. Recommendations and a plan of treatment will be made at each visit.~~

~~MULTIDISCIPLINARY TEAM~~

MULTIDISCIPLINARY TEAM:

Team Composition

The Team includes: Pediatric Pulmonologist (MD/DO), FCC Coordinator, Registered Nurse (RN), Registered Dietitian (RD), Respiratory Therapy (RT), Physical Therapy (PT), and Social Worker (LCSW/MSW).

Medical Director/Pediatric Pulmonologist

- American Board Certification in pediatric pulmonology
- Participate in the evaluation and management of clients referred for the management of CF disorders
  - Perform a history and physical
  - Screen and approve participation of clients with Cystic Fibrosis
  - Oversight of the evaluation and management of clients referred to the ~~SCC~~FCC
- Assurance that the team conference reports and other periodic evaluation and treatment are submitted to the CCS program as well as to: members of the client's care team including the client and/or family and the client's primary care provider
- Assurance that multidisciplinary evaluations are comprehensive and include:
  - Evaluations and recommendations from all core team members and subspecialty consultants
- Collaborates with specialists and subspecialty consultants when clinical appropriate that includes but no limited to:
  - Gastroenterology
  - Cardiology

    - Psychiatry
    - Endocrinology
    - Palliative care
- Participation in development, review, and implementation of ~~SCC~~FCC policies and procedures; staff education
- Assuring the maintenance of ~~SCC~~FCC database, vital statistics, and/or the Cystic Fibrosis Registry
- Overall responsibility for quality of medical care and supervision of quality control and quality assessment activities
- Assure that the ~~SCC~~FCC adheres to consensus based standards of care for CF.
- Maintain communication with national Cystic Fibrosis Foundation.

~~SCC~~FCC Coordinator ~~Management~~

- The Coordinator has the key role in follow-up and coordination of services for eligible infants and children and their families
- The specific responsibilities of the ~~SCC~~FCC Coordinator are:
    - Serve as the primary person coordinating services among the local county CCS programs, other ~~SCC~~Care Center Programs located in CCS Program-approved facilities, local health agencies, clients/families, and others in matters related to the client's ~~SCC~~FCC services
    - Gather medical reports and assessments for review by team members, and prepare a summary report
    - When requested, ensure that a copy of the summary report is sent to the local county CCS program or State SCD Office
    - Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child
    - Assist families in establishing a medical home for the child, adolescent, or young adult
    - Assist clients/families in making linkages to necessary medical and social services
    - Ensure there is a system in place to follow up with families including those who have missed appointments. Collect documentation of the reason for missed appointments and develop a plan of action for improving SCC adherence for evaluations and assessments
    - Coordinate ~~SCC~~FCC services with the local county CCS program and State Integration Systems of Care Division (ISCD) Offices and other local programs
    - Provide referral and resource information for other social and developmental programs within the community, as needed
    - Education Services
        - Provide education and outreach about the ~~SCC~~FCC services, clinical care, required documentation on transfer, and referral options
        - Develop and provide education to parents and family members about the high-risk infant's medical condition, care and treatment, special needs and expected outcome of care
        - Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the patient
- Ensuring communication with the school and primary care provider, post-intervention

Registered Nurse

- Development, implementation, and evaluation of a patient plan of care, which includes a description of the nursing process of assessment, nursing diagnosis, education, patient advocacy
- Provision of case management, including but not limited to:
    - Assessment and monitoring of health and psychosocial needs of the patient and family

- Coordination of services and follow up
- Monitoring of all services received and evaluation of the outcome
- Provision of patient and family/caregivers teaching and education
- Family advocacy
- Coordination of home visits by other health care professional staff as appropriate
- Participation in team conferences
- Participation in quality assurance and quality improvement activities as they relate to nursing services and other services provided to the patient and family by the ~~SCC~~FCC
- Contribution to or responsibility for, the development of written policies, procedures, and guidelines provided by the ~~SCC~~FCC
- Coordination of services between outpatient and inpatient departments

- A nursing assessment is obtained with each visit and includes a cultural, financial, and educational needs assessment as well as collaboration with any community services/agencies
  - Nurse coordinator will coordinate multidisciplinary services based upon team findings. Case conference reports and clinic visits are accessible through the Electronic Health Record (EHR) for CCS and the annual case conference will be faxed to the local CCS office
  - Nurse coordinator will follow up on referrals to ensure care continuity and discuss findings or referrals subsequent visits with MD and core team members
  - The nurse specialist will document in the patient chart when these reports are faxed

- Phone triage will be done between clinic visits
- Serving as resource to school systems regarding health issues of children with CF and their medical and equipment needs
- The nurse will evaluate the patient and parents understanding of the nutritional and respiratory disorder, and discuss the educational and/or treatment concerns with the CF team for clarification with the patient and his/her family
- Medication reconciliation
- RN will provide assistance with scheduling follow-up appointments
- Initial and periodic evaluation and/or comprehensive chart review will be performed at least annually
- Physician clinic note is routed to the patient's primary care physician after each visit
- Routing CCS team conference reports and chart reviews
- Coordinating the communication with CCS to extend authorization

Registered Dietitian (RD)

- Weight (kg) and Height (cm) measured on all patients plotted on an age-appropriate growth grid for all patients < 18 years of age
- Protocols for referral to the nutritionist and treatment protocols for nutritional services for patients with CF, for which the ~~SCC~~FCC is established and standards for anthropometric measurement equipment and calibrations
- Patient's BMI will be calculated
- *Mid-arm circumference and triceps skinfold thickness measurements*
- Nutritional assessment
- Development of a plan for nutrition services which includes the SCC process for initial and ongoing nutritional assessment and identification of nutritional risks of patients
- Provide medical nutrition therapy and educate patient/family regarding nutritional needs
  Getting the right amount/review of:
  - Pancreatic enzymes

    - Formula or breastfeeding (for infants)
    - Necessary calories
    - Vitamins, minerals, fatty acids
    - Salt
- Clinical evaluation of bone health.
    - Evaluation of bone health by history, physical examination, and by radiologic and laboratory assessment which can be done but not limited to.
        - Plain radiography films (chest, long bones)
        - DEXA scan
        - Children at risk will have annual serum calcium, phosphorous, intact parathyroid hormone measured in addition to routine annual 25-hydroxyvitamin D level.
- Collaborate with other team members to establish nutrition program to compliment patient's treatment plan
- Completion of requests for nutritional products when indicated
- Pubertal status, at diagnosis and annually (MD)
    - Female: starting at age 9, annual pubertal self-assessment form (patient, or parent and patient) or physician examination for breast and pubic hair Tanner stage determination; annual question as to menarchal status.
    - Male: starting at age 10 years, annual pubertal self-assessment form (patient, or parent and patient) or physician examination for genital development and pubic hair Tanner stage determination

Respiratory ~~Status~~Therapy (RT)

- Chest examination to include anterior-posterior diameter, retractions, use of accessory respiratory muscles and auscultation findings (MD or RT)
- Assessment of cough effectiveness
- Upper respiratory tract examinations to include: presence of nasal polyps, rhinitis, sinusitis, etc. (MD)
- Extremities examination to include: clubbing, and joints (MD)
- Pulmonary function testing (at the discretion of MD/RT)
- Pulse oximetry; Pulmonary Function Testing
- Determines care and type of respiratory equipment the patient will require
- Instruction to families on strategies to improve airway clearance
- Provides education to the patient/caregivers regarding care and the use of home equipment
- Monitors patient's adjustments to the home program/equipment
- Assists in documentation required to provide funding for home care
- Coordinates orders required for respiratory home care/equipment
- Trouble shoots respiratory needs at home

Physical Therapy (PT)

- Assess and work with client and family to increase overall mobility in the areas:
    - Muscle strength
    - Range of Motion
- Monitoring the development of scoliosis and kyphosis
- Perform a 6 minute walk test.
- May recommend exercises or assistive devices to maintain optimal posture

Social Worker

- Conduct a psychosocial assessment of the CCS Program client and caregivers on initial visit and at least

annually and when there are major changes in psychosocial factors affecting a client and/or the family, and refer as necessary
- Develop, with the family/caregivers and client, a social work plan
- Ensure that the assessment and plan of care is documented in the chart and is accessible to other team members
- Begin planning for the transition of youth to adult services by the age of 14 including sources of medical, vocational, financial, and support services and safety planning for youth with disabilities
- Participate in quality assurance and community improvement as they relate to social work services or needs of clients and families served by the ~~SCC~~FCC
- Contribute to developing written policies, procedures or guidelines related to social work services in the ~~SCC~~FCC

Social Worker Psychosocial Assessment

At the initial evaluation the psychosocial history will be tailored to the needs of the family and child. During follow-up visits specific issues will be addressed depending on the situation of the family. Those issues may include:

1. Insurance coverage
2. Financial concerns
    a. Referral for CCS eligibility
    b. Transportation: ~~SCC~~FCC shall work with CCS to arrange medical transport of child when necessary, particularly children who are tracheostomy or ventilator dependent, who must be accompanied by trained personnel such as a registered nurse
3. Developmental and emotional issues
    a. Counseling referral and Parenting class referrals
4. Changes in family structure and coping (support systems, stressors, risk factors, divorce, deaths)
    a. Beacon counseling referral
    b. Department of Behavioral Health
    c. Support groups organized by CF
5. School performance:
    a. Individualized education plan (IEP); 504 Plan
    ~~c. Letters/Accommodations~~
    b. Letters/Accommodations
6. Participation in age-appropriate activities
    a. Make-A-Wish Foundation
    b. Painted Turtle Camp
7. Compliance with treatment regimens
    a. CFS referrals
    ~~9. Transitional Plan~~
    b. Transitional Plan

c. Primary care physician for adult care
d. Preparing for the end of CCS

8. Community agency referrals
    a. Tricounties Regional Center
    b. In-Home Supportive Services (IHSS)
    c. Women, Infants, and Children (WIC)
9. Transportation support through CCS, Gold Coast Health Care Plan
10. Mental Health referrals
11. Disability Rights of California
12. Environmental risk factors (patient safety concerns)
    a. CPS referrals
13. Letters of support: referrals, financial support, diagnosis, immigration
14. Interpretation services available upon request

~~10. Community agency referrals~~

~~a. Tricounties Regional Center~~

~~b. In-Home Supportive Services (IHSS)~~

~~c. Women, Infants, and Children (WIC)~~

~~e. Transportation support through CCS, Gold Coast Health Care Plan~~

~~f. Mental Health referrals~~

~~h. Disability Rights of California~~

~~11. Environmental risk factors (patient safety concerns)~~

~~a. CPS referrals~~

~~12. Letters of support: referrals, financial support, diagnosis, immigration~~

~~13. Interpretation services available upon request~~

PATIENT EDUCATION:

Ongoing (MD/DO, RN, RD, RT, ~~RD~~PT, SW)

- Each discipline is responsible for assessing educational needs regarding disease process and management
- Each discipline will provide comprehensive and on-going education to the patient and family about their condition, nutritional status, and collaborative resources and document what was taught and the family/ caretaker response in the chart
- Referral to appropriate organizations, support groups, local/national disease specific organizations will be documented in the patient chart. Families will be provided documentation of any appointments of referral sources
- The nurse specialist will be responsible for coordinating these educational efforts and discussing at the

team meeting
- All of the above will be documented in the patient chart by the discipline providing the intervention
- Copy of After Visit Summary (AVS) will be provided to the family after each visit with contact phone numbers for all referrals as well as CF Team Center contact numbers for appointments, changes or questions
- Education on diagnosis, medications, laboratory testing, genetic testing and radiologic testing

CASE MANAGEMENT:

Annual Evaluation

- For children whose care will be ongoing, the ~~SCC~~FCC shall provide, at a comprehensive assessment/ recommendation of the core team at yearly intervals, and more often (quarterly or biannual) when indicated by the child's condition
- Team conference that includes child and family (or caregivers) as participants

Comprehensive Evaluation (MD/DO, RN, ~~SW,~~ RD, RT, PT, ~~OT~~SW)

A yearly case conference will be held to review the clinical status of patients at least one time/year. Listed below should be reviewed on every patient and will vary depending upon age and clinical status of the patient

1. Growth and/or nutritional status
2. Psychosocial/ financial status
3. Complications and/or new diagnosis
4. Surgical procedures/significant changes in medical regimen
5. Follow-up imaging studies
6. Educational needs of patient and family
7. Discussion of parental concerns
8. New issues for the coming year

TEAM CONFERENCE REPORT:

- Providing initial and periodic reassessments, at least annually, including chart review by each discipline; represented on the core team and the required specific SCC standard specialists and/or ~~subspecialists~~sub-specialists; or more frequently as required by the child's medical condition
- Scheduling of return visit as needed and annually, at a minimum
- Team conferences, including patient and parents, or other caregivers, as appropriate, to coordinate decision making and delivery of health care services identified by team members, allied health professionals and parent/caregiver as needed by each child
    - Planning should focus on developing a treatment plan that includes meeting patient/family needs and consider the adequacy and utilization of community resources for on-going care, and should lead to the delivery of comprehensive services for the affected child including active collaboration with the patient's local medical doctor and dentist
    - Where appropriate, the treatment plan should address identifying any transition related resources for clients
- Each team conference generating a core team conference report
    - This report shall include the assessments and recommendations of all core team members, and shall

include the anticipated treatment plan for the next six to twelve months, including anticipated surgical procedures and hospitalizations

- Developing, with patient and parental, legal guardian, or caregiver input, a written treatment plan
  - The plan shall provide for continuity of care and services between individual team members, the ~~SCC~~FCC team and community health care providers, and with other community agencies such as local county and state CCS Program, schools and Regional Centers
  - A copy of the plan shall be provided to the patient/parents or caregivers as appropriate
  - Consultants and allied health personnel shall be responsible for providing individual written reports when providing services beyond the initial and periodic team evaluations

~~Consultants and allied health personnel, who shall be responsible for providing individual written reports when providing services beyond the initial and periodic team evaluations~~

~~Patient Follow-Up~~

- Patient Follow-Up
  - Both in-patient and out-patient follow-up including a written plan for outreach, coordination of care and services, referral for counseling, when needed, training and/or communication with and coordination of care with the patient's local pediatrician or primary care physician, dentist, local agencies such as schools, and regional centers as appropriate
- Patient and Family Teaching
  - The CCS Program team should actively solicit family participation and collaboration in the plan of care. When the child is mature enough to do so, he/she should participate in treatment decisions. Ensure that appropriate interpreters are available to assist in both verbal and written communications
- Multidisciplinary Comprehensive Team Assessments Shall Include:
  - Documentation of initial assessment and reassessments, including but not limited to the relevant diagnoses, psychosocial assessment, including cognitive assessment, and identification of any developmental disabilities
  - Provision of a written emergency care plan to be given to families/caregivers and a procedure for ensuring it is updated periodically. This shall include management of medical emergencies in the FCC
- Family-centered, culturally and linguistically competent care.
  - CCS Program services shall be provided without regard to race, color, religion, sex, national origin, disability, age, sexual orientation, or status as parent/caregiver. Teams must comply with all applicable federal, state, and local laws prohibiting discrimination
  - The FCC team will treat patients and families/caregivers in a non-discriminatory manner. Services are provided without regard to race
- Referrals to the CCS Program

- ~~Both in-patient and out-patient follow-up including a written plan for outreach, coordination of care and services, referral for counseling, when needed, training and/or communication with and coordination of care with the patient's local pediatrician or primary care physician, dentist, local agencies such as schools, and regional centers as appropriate~~
- ~~Patient And Family Teaching~~
- ~~The CCS Program team should actively solicit family participation and collaboration in the plan of care. When the child is mature enough to do so, he/she should participate in treatment decisions. Ensure that appropriate interpreters are available to assist in both verbal and written communications~~
- ~~Multidisciplinary Comprehensive Team Assessments Shall Include:~~
- ~~Documentation of initial assessment and reassessments, including but not limited to the relevant~~

~~diagnoses, psychosocial assessment, including cognitive assessment, and identification of any developmental disabilities~~

- ~~Provision of a written emergency care plan to be given to families/caregivers and a procedure for ensuring it is updated periodically. This shall include management of medical emergencies in the SCC~~
- ~~Family-centered, culturally and linguistically competent care. CCS Program services shall be provided without regard to race, color, religion, sex, national origin, disability, age, sexual orientation, or status as parent/caregiver. Teams must comply with all applicable federal, state, and local laws prohibiting discrimination~~
- ~~The SCC team will treat patients and families/caregivers in a non-discriminatory manner. Services are provided without regard to race~~
- ~~Referrals to the CCS Program~~

~~**TEAM CONFERENCE REPORT GENERATED SHALL INCLUDE:**~~

Team Conference Report Generated Shall Include:

- Physical findings and functional skills of the child related to mobility and activities of daily living
- Interventions attempted in the recent past and related outcomes
- Discussion of all relevant intervention(s) considered and the rationale for the choice of recommended treatment and anticipated goals
- Documentation of family or caregiver understanding and support for the recommended treatment
- List of concomitant medical conditions that could impact the provision of care to the child
- Summary medical evaluation by the Medical Director or physician designee
- Individual assessments and recommendations
- Care plan that has been approved by the Medical Director, to include:
  - Anticipated treatment for the next 6-12 months including:
    - Recommendations and prescriptions as appropriate for adjunctive and follow-up needs including:
      - ~~PT and/or OT services~~PT
      - Positioning
      - ~~Bracing, orthotics, adaptive equipment~~Adaptive equipment
      - Durable medical equipment
      - Surgery
  - Care plan may require separate SAR including, but not limited to:
    - OT and PT services
    - Durable medical equipment needs
    - Orthotics
    - Specialty consultations
    - Local provider services
    - Hospitalizations
    - Outpatient procedures/surgeries
    - MRI scans
  - Documentation of the child's/family's involvement in the care plan
- Individual and composite reports shall be submitted following each comprehensive evaluation to CCS
- Provide copies of the team reports to the family

COMMUNICATION WITH REFERRING DOCTORS:

Each visit (RN, Patient Navigator)

Copies of clinic visit will be sent to referring physician/primary care physician after each clinic visit

INFECTION CONTROL:

- CF ~~SCC~~FCC team will work with VCMC infection Prevention and Control to update the polices to decrease infection and high pathogenic bacteria.
- Partner with IP&C teams to implement the recommendations in this guideline, especially those that are likely to be followed in areas of the facility that are not dedicated only to people with CF.
- Implement Contact Precautions (ie, wear a gown and gloves) when caring for all people with CF, regardless of respiratory tract culture results
- Separate all people with CF from others with CF, regardless of their respiratory tract culture results, at least 6 feet (2 meters) in all settings, to reduce the risk of droplet trans- mission of CF pathogens.
- All people with CF and their family members and friends should perform appropriate hand hygiene (with either alcohol-based hand rub or antimicrobial soap and water) when there is the potential for contamination of hands with pathogens. Contamination of hands may occur when entering and exiting a CF clinic, clinic exam room, or hospital room or from respiratory secretions after coughing, performing pulmonary function tests, or performing chest physiotherapy.
- All people with CF, regardless of respiratory tract culture results, should wear a surgical (also called procedure or isolation) mask when in a ~~healthcare~~health care setting to reduce the risk of transmission or acquisition of CF pathogens.
- Perform pulmonary function tests(PFTs) to reduce transmission from one person with CF to another person with CF by performing the test in one of the following ways:
  - In the exam room at the beginning of the clinic visit, allowing 30~~minutestoelapse~~ minutes to elapse between CF patients;
  - In a negative pressure room (airborne infection isolation room)
  - In a PFT laboratory with high efficiency particulate (HEPA)filters
  - In a PFT laboratory without HEPA filters, allowing 30 minutes to elapse between individuals with CF
  - Updated recommendations for care of nebulizers in the hospital.
- Encourage and offer yearly influenza vaccines for patient and family members/caretakers.

COMMUNICATION WITH CCS COUNTIES:

Each visit (RN, Patient Navigator)

~~Copies of clinic visit will be sent to local CCS office after each clinic visit~~

~~Team collaboration with local CCS Medical Directors: via phone, email, or face to face to discuss potential medications, surgical interventions, and/or adaptive equipment~~

- Copies of clinic visit will be sent to local CCS office after each clinic visit
- Team collaboration with local CCS Medical Directors: via phone, email, or face to face to discuss potential medications, surgical interventions, and/or adaptive equipment

GOALS OF CF ~~SCC~~FCC SERVICES:

- Provide holistic care that maximizes the health, independence, and psychological development of children struggling with these disorders
- Supporting the wellbeing of these children and their families
- Family center care
  - Patient/family education
  - Identifying and discussing patient needs and concerns during team conferencing
  - Spiritual needs of the family:
    - How are the parents coping with a child with medical needs
    - How are the parents caring for themselves
    - How are the siblings coping and concerns regarding behavior
  - Family, church, and school support
- Creating a medical home and providing access to ~~subspecialists~~sub-specialists and a multidisciplinary team approach
- Care coordination
- Clinical trials

TRANSITION OF CARE:

All team members have a role in transition planning:

- Transition education for the patient and family begins around age 16
- Assessment must be documented that includes:
  - Patient and family readiness
  - Provision of referral
  - Resource information
- Patients are transitioned at age 21 years of age to adult specialists, but may continue to follow with the Pediatric Pulmonologist as needed. Patients who are > 21 and no longer qualify for CCS should be transitioned to an Adult team ~~as~~.
- May transition sooner if attending college and is deemed necessary.
- Promoting self-care management/self-advocacy by providing education and resources to enable patient to function independently within the adult ~~healthcare~~health care setting
- Troubleshooting machinery, medication, nutrition, adaptive equipment, and resources
- Written educational resources
- Final medical summary
- ~~List of adult subspecialists~~List of adult sub-specialists
- Discharge instructions are given to the patient at the final team clinic visit

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Ambulatory Care Administration	Martin Hahn: Regional Administrative Director, Ambulatory Care	12/10/2024
Ambulatory Care Administration	Theresa Cho: Chief Executive Officer, Ambulatory Care	4/2/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2012*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/29/2024*
Next Review:	*1 year after approval*
Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

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:

~~**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~~

A. **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

~~**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~~

B. **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

       ~~Chest x-ray 2 views (Ambulatory or monitor not required)~~

       ~~Chest x-ray 1 view (nonambulatory or monitored required)~~
    10. Consult LP for imaging orders
    11. Discuss presence of existing urinary catheter with provider for further instructions.

C. **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

D. ~~**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

E. **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)~~

    ~~Chest x ray 2 views (Ambulatory or monitor not required)~~

~~**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.~~

F. **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

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

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

H. **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

I. **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

J. **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

K. **Dysuria**

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

   ~~Urine point of care~~

L. **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

M. **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

N. **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~~.~~

   ~~Isolation if contagious pathogen suspected, place mask on patient~~
3. EKG if history or suspect cardiac disease
4. Oxygen at two (2) liters via nasal cannula if less than 92% 02 sat
5. Oxygen saturation monitoring

6. NPO

   ~~Chest x ray 1 view (Non-ambulatory or monitor required)~~

   ~~Chest x ray 2 view (Ambulatory or monitor not required)~~

7. Consult LP for imaging orders
8. Saline Lock
9. Lab ER panel
10. Venous Blood Gas plus electrolytes plus lactate
11. Blood culture x 2 (NOTE: If ~~pneumonia suspected~~febrile)

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

   a. Contact respiratory therapy
   b. Initiate pediatric asthma score (PAS).
   c. Consult LP

P. **Syncope**

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

Q. **Diabetic Wound**

   ~~Point of care blood glucose~~

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

R. **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

S. **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

T. **GI Bleed**

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

~~**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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Emergency Department & IPC	Stephanie Denson: Manager, Medical Staff Office	1/21/2025
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

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/17/2024
Emergency Services	Julia Feig: Clinical Nurse Manager, Emergency Services	10/17/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*Maternal Child Health*
References:	

MCH.06 Cleft Lip and Palate Repair and Oral Feedings

POLICY:

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

PROCEDURE:

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

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

C. Oral medications are given using these same methods.

EQUIPMENT

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

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

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

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

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

B. Soft rubber spoon.

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

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

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

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

PROCEDURE:

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

B. Prepare feeding materials.

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

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

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

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

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

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

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

J. Burp patient frequently.

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

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

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

N. Spoon feed pureed foods.

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

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

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

DOCUMENTATION

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

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

C. MAR in the EMR: Oral medication.

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/9/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/9/2024
Policy Owner	Jennifer Ferrick: Director, Peds/PICU & NICU	12/9/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

N.77 Standardized Procedure for Neonatal Ocular Screening Utilizing the ICON Ophthalmic Imaging System

PURPOSE:

The procedure provides standardized and safe guidelines for the Neonatal Intensive Care Unit (NICU) Registered Nurse (RN) to perform an eye examination utilizing the ICON Ophthalmic Imaging System with verification of competency and in conjunction with Neonatologist consultation.

POLICY:

The ICON Imaging system is equipped with optics designed to capture images and videos of the retinal, corneal, and external structure of the eye through both contact and non-contact methods. Dilation of the pupils for retinal imaging is required. The essential performance of the ICON is to capture, store, review and export images and video.

The ICON consists of a camera within a handpiece that uses a low power light emitting diode (LED) light source to illuminate the retina.

Experience/Training/Education:

1. A qualified Registered Nurse with a minimum five years of experience level II or level III; in the Neonatal Intensive Care and (valid State of California Registered Nurse License) will have completed initial orientation (education/training/demonstration of competency) to the Neonatal Intensive Care Unit.

Education/Training/Education Requirements of the Neonatal Intensive Care Nurse

1. Completion of Neonatal Intensive Care Unit Registered Nurse orientation and documentation of completion for the ICON Ophthalmic Imaging System class.
2. Initial Evaluation
    a. Initial competencies with return demonstration will be done with the neonatologist and the nurse will be proctored with the Neonatologist with a minimum three of the procedures with the nurse. The competency and proctoring will be documented on the Neonatal Intensive Care Unit Registered

Nurse orientation competency sheet and kept in the employee file.

3. Continuing Evaluation of Competence
    a. Yearly competency evaluation is required.
    b. Continuing competency and education of the Registered Nurse will be documented on an annual basis with return demonstration to the satisfaction of the Neonatologist with the nurse completing and documenting a minimum of three eye examinations per year.
    c. The Annual Competency Summary Sheet is kept in the employee file.

Settings in which to perform this Standardized Procedure: Neonatal Intensive Care Unit (NICU)

Scope of Supervision required: Every two years the Interdisciplinary Practice Committee will review and approve the Standardized Procedure.

Development and Approval of the Standardized Procedure:

Method of Development:

a. **Standardized Procedure developed by the Department of Nursing**
b. **Standardized Procedure approved by the Interdisciplinary Practice Committee**
c. **Standardized Procedure approved by the appropriate Medical Staff Department Committee and Medical Executive Committee.**

PROCEDURE:

Equipment:

1. ICON Ophthalmic Imaging System
2. Topical anesthetic and dilating drops
3. Clear base ophthalmic coupling gel (Gen-Teal ointment)- assist with fluid movement of the lens, and helps to refract light so that the best possible image can be taken)
4. ~~Gauze~~Sterile 2x2 gauze or Lint-Free Cloth
5. Gloves
6. Prepared wipes, detergent solution or disinfectant to clean lens
7. ~~Purified water~~Sterile normal saline to rinse lens tip
8. Blanket to wrap or bundle infant
9. Comfort measures for infant
10. Neonatal eye exam tray
11. Radiant warmer, Cardiac monitor and bag/mask

Procedure:

1. RN will verify medical order
2. RN will provide and document parent/guardian with education on ROP and ROP exam(s)
3. On the day of the scheduled exam, the nurse will verify that topical anesthetic and dilating drops are readily available and initiate administration 60 minutes prior to the start time of the exam.

a. Cyclomydril ophthalmic drops (Phenylephrine 1% and Cyclopentolate 0.2%); instill 1 drop in each eye every 5 to 20 minutes x 3 doses starting 60 minutes prior to examination
b. Tetracaine 0.5% ophthalmic drop 1 drop applied to each eye 5 minutes prior to exam.
c. Gen-Teal ointment as needed for the exam

4. Time out will be performed prior to procedure by checking the bands by 2 Registered Nurses to properly identify the last and first name of infant; medical record number with date of birth.
5. Standard universal precautions will be followed throughout the procedure.
6. RN will administer comfort measures prior to the start of the procedure and PRN as needed throughout the procedure.
7. Assisting nurses will support positioning the infant using developmental supportive principles (ie. swaddling and pacifier) to provide containment throughout the procedure.
8. Document heart rate, respiratory rate, and oxygen saturation. Document pain score prior to, during, and after the procedure per unit policy. Provide a rest period as needed during the exam based on infant's tolerance during the procedure.

Preparation of infant prior to eye examination:

1. Explain procedure to parent in a manner appropriate to his/her level of understanding
2. Administer sucrose with a pacifier at least 2 minutes before starting the bedside eye exam
3. Nurse Assist will provide non pharmacologic comfort measures during the ophthalmic exam such as; blanket for swaddling; facilitate tuck with nesting and a sucrose pacifier.
4. Assess infant for pain before, during, and after exam
5. Reduced lighting and quiet environment.

Required Device Preparation:

1. Check the ICON system for any damage, especially for damage to the infant contacting surface of the camera hand piece tip.
2. Clean and disinfect the hand piece tip and lens with alcohol wipes, sterile normal saline, and sterile 2x2 gauze.
3. Turn on the ICON system, login as a user; create new infant or choose existing infant with last and first name, medical record number (MRN), date of birth, and birth weight and Save. ~~Username: ADMIN Password: 5678~~
4. Highlight infant's name,
5. Position the handset cables so they are away from the infant and do not interfere when acquiring images.
6. Enter the Acquire Screen at bottom of screen and test the light module on/off, focus, intensity, gain and capture mechanisms to ensure the ICON system is functioning as expected prior to beginning an imaging session.

Perform White Balance- to ensure the camera colors are set prior to exams

1. The system is powered on and the user logged in, navigate to the acquire screen.
2. Remove the camera from the holster and ensure it is pointed at an open, non-reflective surface.
3. Adjust the light Intensity setting to 50 using the camera controls screen function, cart top functions, or foot

pedal functions.

4. Adjust the Gain setting to 10 using the camera controls screen function. (Gain will brighten an image without having to increase light intensity).
5. Select the light bulb picture on right side of the screen.
6. Select auto white balance from preset drop down menu under Camera Controls.
7. Point camera at gray circle in ICON book until notification disappears.

Recommended Procedure Setup-Fundus Imaging

1. Ensure that the white LED light module is inserted in the ICON camera hand piece**.**
2. Position the ICON system and foot pedal close to the examination table at a comfortable viewing distance for the examiner while standing at the head of the bed of the supine infant's feet directed away from the operator.
3. Position the monitor at eye level. Deploy the foot pedal on the floor close to the examiner's foot.
4. Reduce the ambient light of the room; minimize glare and reflections on the monitor.
5. Before retinal imaging, pre-focus the camera at infinity by pointing the tip of the camera hand piece at an object across the room, or by turning the hand piece sideways and focusing on the ICON monitor. Sharpen the image by the adjusting the focus using the foot pedal. This will set the focusing plane near the correct range for retinal imaging.
6. Either select a preset from drop down for the type of imaging session or adjust the illumination to low by adjusting the intensity with the foot pedal.
7. Select the R/L eye designation using the touch screen. Change the R/L eye designation when moving to the contralateral eye during the image series.
8. Tetracaine 0.5% ophthalmic drop 1 drop applied to each eye 5 minutes prior to exam.
9. Select appropriately sized lid speculum for age and size of infant. Insert the lid speculum into the eye being imaged.
10. Apply Gen-teal ointment as needed throughout the procedure.
11. Hold the camera hand piece close to the tip of the lens with the light module positioned over the hand between the index finger and thumb.
12. Before bringing the camera hand piece into contact with the infant's eye, the operator should deploy the foot pedal on the floor and have their foot positioned to operate the focus/capture controls.
13. Gently place the tip of the camera in the Gen-teal ointment on the eye while supporting the camera.
14. The hand piece cable should be placed at the infant's 12:00 o'clock position of the forehead to maintain the correct image orientation.
15. Adjust the intensity and focus as necessary with the foot pedal or have an assistant use the software controls. Pivot the camera to visualize the peripheral areas of the retina.

Capture Images

1. Select study with current date/time or use drop down menu at top of screen and select Create New Study.
2. Ensure the monitor is at eye level and directly in view while looking straight at zero degrees to the center.
3. Capture the 5 fields of the retina by placing the landmark of the optic nerve at the center, left, right, top

and bottom of each frame. This will result in images of the posterior pole, temporal, nasal, superior, and inferior retinal fields.

4. Capture the anterior segment image by holding the camera away from the eye so the nasal and temporal canthi (corners of the eye) are in view and the iris is in focus.
5. Select R for right eye. (OD)
6. From Preset menu, select Light Fundus or Dark Fundus.
7. Adjust focus, intensity, and gain accordingly are located in the Camera controls section. Optimize the image using these tools prior to capture. The foot pedal can also change focus and intensity. Use the left rocker for focus and right rocker for light intensity.
8. To capture an image or video, use the buttons on the touch screen or press the green button on the foot pedal.
9. Clean lens between eyes with alcohol wipes, Normal saline, and sterile 2x2 gauze.
10. For left eye, (OS) select L at top of screen and repeat steps to capture images.

Review images

1. To review images, select review on bottom of screen.
2. To delete images:
    a. Select delete media

    ~~Enter password: 5678~~

    b. Scroll through thumbnails on the touchscreen, with the computer mouse or keyboard up/down arrow keys.
    c. Click the Save Frame button.
    d. Select images to be deleted and click ok.

After procedure: Export

1. Insert USB to front of machine.
2. Select export at bottom of screen.
3. Select images
4. Export file type: JPEG with infant's data.
5. Export to: select USB and click Export
6. Click New Folder or select existing Infant's Name.
    a. a. Name folder after infant (Last name, MRN) for new infants.
    b. b. Click OK
    c. c. Open Infant's folder
    d. d. Select OK
    e. e. Export: YES
    f. f. Notification says "Export Successful"
    g. 7. Use button at top right of screen to safely eject USB

Power Off

1. Press logout tab on button of screen(task bar)
2. Press power button on screen
3. Shut down computer
4. When the computer has turned off, hold down the cart power button to turn off the cart battery.

Cleaning

1. Clean entire cart and cables with Sani Wipes
2. Clean lens with alcohol wipes, sterile normal saline, and sterile 2x2 gauze.
3. Properly store equipment.

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Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/20/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/19/2024
NICU	Robert Posen: NICU Medical Director	12/19/2024
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	12/19/2024
NICU	Pearl Dahm: Clinical Nurse Specialist	12/19/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
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References:	

P.35 Warm Handoff

POLICY:

To define the standards for passing responsibility for care from Registered Nurse (RN) to RN at breaks and shift change.

PROCEDURE:

1. Warm handoff will occur at every shift change and for break relief.
2. Warm hand off shall involve the patient as appropriate and caregivers as an integral part of delivery of the family centered care, and shall take place primarily at the patient bedside, unless specifically refused by the patient or caregiver.

GUIDELINES:

1. Shift Change
    a. Warm handoff to be completed at the change of shift between the oncoming RN and the off-going RN.
    b. Caregivers and patients shall be introduced to their oncoming RN by the off-going RN and shall be actively involved in the goal planning for the shift and the complete course of the admission, to the degree that the caregiver and patient are able to and desire to participate.
    c. Warm handoff shall take place at the patient's bedside.
        i. EXCEPTION: Information regarding the patient and/or caregivers that is not appropriate for discussion with the patient and/or caregiver.
        ii. EXAMPLE: Social/communication issues with the staff and caregivers.
    d. Warm handoff will be completed using the SBAR (Situation, Background, Assessment, Recommendation) format and shall include:
        i. A complete overview of the patients relevant history and current status, utilizing HEAL (High Alert Medications, equipment, Alarms, Lines).
        ii. Pain management medications used and available.
    e. Patients IV site(s) shall be assessed and patency confirmed.
    f. IV medications and connections shall be checked and handed off by both the off-going and the

oncoming RNs, including independent double checks (as needed).

g. Patient's bedside care board shall be updated with, at minimum, the oncoming RN's name, shift goals, pain management status (last medication given, next medication due).

h. Additional information will be given from the off-going RN to the oncoming RN utilizing the SBAR section of Cerner, including (as needed to supplement the information already exchanged):

   i. History

   ii. Current Status

   iii. Recent Changes

   iv. Upcoming needs

   v. Plan of Care

   vi. Progress towards discharge

2. Break Relief

   a. Warm handoff will be completed at break times between the RN leaving for break and the RN covering for break.

   b. The warm handoff shall occur at the patient's bedside using SBAR format and shall include:

      i. An overview of the patient's relevant history and current status, utilizing HEAL.

      ii. Pain medications used and available.

   c. Patient's IV site(s) shall be assessed and IV patency confirmed by both the off-going and covering RNs.

   d. The off-going RN shall note to the covering RN any specific interventions that will be required or that are highly likely to occur during the time of the break relief.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/19/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/19/2024
Pediatrics	Jennifer Ferrick: Director, Peds/PICU & NICU	12/19/2024
Pediatrics	Andrei Bobrow: Medical Director, Pediatrics	12/3/2024

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

P.37 Admission to the Pediatrics Department

POLICY:

To be eligible for admission to the Pediatrics (PEDS) Unit at Ventura County Medical Center, patients shall meet established standards.

PROCEDURE:

Children from birth to 13 years of age shall be admitted to the PEDS Unit using the criteria set within this policy. Children beyond the age of 13 shall not be admitted to or cared for in spaces approved for PEDS beds unless approved by the pediatrician and with the reason documented in the patient's medical record.

All CCS-eligible children under the age of 14 shall be admitted to the PEDS Unit, regardless of the reason for hospitalization. CCS-eligible children between the ages of 14 to 21 who are admitted outside the pediatric service, shall be under the direction of a CCS-paneled physician appropriate for the medical condition. CCS-eligible children over the age of 13 may be admitted to the PEDS Unit based on the criteria set within this policy.

Rooms for infants under the age of three years shall be separate from older children.

Criteria for Admission:

1. Patients acutely requiring supplemental oxygen, regardless of cause.
2. Stable tracheotomy patients, being admitted for reasons unrelated to cardio-respiratory status.
3. Patients requiring intermittent nebulized medications.
4. Patients requiring apnea work-up and cardiorespiratory monitoring.
5. Patients with non–life-threatening dysrhythmias without the need for cardioversion.
6. Patients with seizures who are responsive to therapy but require monitoring and who do not have hemodynamic compromise but have the potential for respiratory compromise.
7. Patients with altered sensorium in whom neurologic deterioration or depression is unlikely and neurologic assessment is required.
8. Patients with acute inflammation or infections of the central nervous system without neurologic deficiency or other complications.
9. Patients with head trauma without progressive neurologic signs or symptoms.

10. Patients with progressive neuromuscular dysfunction without altered sensorium requiring cardiorespiratory monitoring.
11. Patients with severe anemia without hemodynamic or respiratory compromise.
12. Patients with moderate complications of sickle cell crisis, pain, anemia, fever.
13. Patients with other moderate electrolyte and/or metabolic abnormalities (requiring therapeutic intervention), such as: hypokalemia (blood potassium concentration <2.0 mEq) and hyperkalemia (blood potassium concentration >6.0 mEq), hyponatremia and hypernatremia with alterations in clinical status (i.e., seizures or altered mental status), hypocalcemia or hypercalcemia.
14. Patients with inborn errors of metabolism.
15. Patients with a gastrointestinal foreign body or other gastrointestinal problem requiring surgery but who do not have cardiorespiratory compromise.
16. Patients who have chronic gastrointestinal disease but do not have coma, hemodynamic or respiratory instability.
17. Patients who have undergone upper or lower airway surgery.
18. Patients who have had thoracic or abdominal trauma.
19. Patients being treated for multiple traumatic injuries.
20. Patients with hypertension without seizures, encephalopathy, or other symptoms, but who require frequent intermittent therapeutic intravenous or orally administered medication.
21. Patients with uncomplicated nephrotic syndrome (regardless of cause) with chronic hypertension requiring frequent blood pressure monitoring.
22. Patients requiring the application of special technologic needs, including:
    a. Use of bilevel positive airway pressure, all chronic and/or newly initiated therapy to those patients able to remove mask in case of emergency.
    b. Tracheostomy care requiring patients standard pulmonary hygiene and suctioning, with diagnosis unrelated to cardio-pulmonary status.
    c. Pleural drains after initial stabilization (for patients who do not have respiratory or hemodynamic compromise).
23. Patients who are direct admissions from another health care facility outside the hospital (may be directly admitted for intermediate care).
24. Patients with uncomplicated toxic ingestion who do not have cardiovascular or respiratory compromise and who require cardiorespiratory monitoring.
25. Failure to thrive.
26. Hyperbilirubinemia.
27. Other conditions as discussed with pediatric hospitalist or physician with pediatric admitting privileges.

Exclusion for Admission:

1. Be at risk for hemodynamic instability-dependent on vasoactive drug therapy, shock.
2. Be at significant risk for acute hematologic dysfunction, i.e., disseminated intravascular coagulation and/or active uncontrolled bleeding.

3. Require intensive respiratory monitoring and/or acute airway management/dependent on mechanical ventilation, new trach <1 week.
4. Require intensive or invasive neurological monitoring-GCS <10 acutely, status epilepticus.
5. Have life threatening infections, septic shock.
6. DKA requiring insulin drip.
7. Have renal impairment, acute anuria, HUS, dialysis.
8. Initiation of chemotherapy with anticipated tumor lysis syndrome.
9. Exchange transfusion/plasmapheresis.
10. Surgical: cardiovascular, neurosurgical, multiple trauma, major blood loss requiring ICU care.
11. Burns, i.e, third degree.
12. Multiple organ dysfunction.
13. Toxic ingestion and drug overdose with acute potential decompensation of major organ systems.
14. Home ventilators.
15. Patient with febrile neutropenia for the first 24 hours of admission. Fever is defined as temperature 100.4F or greater and neutropenia is defined as an ANC less than 500.

Patient Flow:

1. Direct admissions are patients admitted from the Emergency Department, Surgery Department, outpatient clinics or another facility.
2. Admissions will be on the basis of bed availability and admission criteria.
3. All patients will have an acuity assigned to them.
4. Admission assessment to be completed within two (2) hours of arrival and admission health history to be completed within 12 hours of admission.

All revision dates: 10/12/2021, 6/13/2018

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/19/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/19/2024
Pediatrics	Jennifer Ferrick: Director, Peds/PICU & NICU	12/19/2024
Pediatrics	Andrei Bobrow: Medical Director, Pediatrics	8/26/2024

VENTURA COUNTY HEALTH CARE AGENCY

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

P.44 Standards for PACU Transfer to Pediatric Intensive Care (PICU) and Pediatrics (PEDS)

POLICY:

To establish criteria for the transfer of recovered post-operative pediatric patients to the Pediatrics (PEDS) or Pediatric Intensive Care Unit (PICU) following surgery.

PROCEDURE:

1. PICU patients who are not expected to be extubated following surgery, or has a planned admission to the PICU, will be transferred to the PICU immediately following surgery and recovered in the PICU.
2. PEDS and PICU patients who are expected to be extubated following surgery will be recovered in the post-anesthesia care unit (PACU) and transferred to PEDS or the PICU after the transfer criteria have been met (see below).
3. If the patient does not meet the criteria below, discuss with the pediatric intensivist or pediatric hospitalist.

Patient Transfer Criteria to PEDS or the PICU Following PACU Recovery:

1. Respiration:
    a. Patient can breathe deeply and cough spontaneously.
    b. Respiratory rate appropriate for age-based guidelines.
2. Consciousness
    a. Awake.
    b. Responds appropriately to verbal commands if over two (2) years old.
    c. Responds appropriately to verbal stimuli if younger than two (2) years old.
        - Appropriate response dependent on patient's baseline and developmental level.
3. Activity
    a. Able to move all extremities.
    b. Able to sustain head raised from pillow for ten seconds.
        - Appropriate activity dependent on patient's baseline and developmental level.
4. Circulation

a. Systemic blood pressure shall be within 20% difference of pre-anesthesia level (above or below).

5. Color
    a. Color of mucous membranes has returned to within normal limits or is at patient baseline.
6. Temperature
    a. Patient temperature shall be greater than 36.5° Celsius.
7. Aldrete Score (see Attachment A)
    1. Aldrete score will be 9 or 10.

All revision dates: 12/14/2021, 12/17/2018

Attachments

Attachment A - Aldrete Score

Approval Signatures

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Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/19/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/19/2024
Pediatric Intensive Care Unit	Jennifer Ferrick: Director, Peds/PICU & NICU	12/19/2024
Pediatric Intensive Care Unit	Jesse Wyatt: MD	12/5/2024

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Owner:	*Laura Zarate: Clinical Nurse Manager, Case Management*
Policy Area:	*Utilization Review*
References:	

UR.03 Patient Notification of the Provision, Discontinuation, Reclassification, or Non-Coverage of Care

POLICY

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) inform patients, or when appropriate the patient's representative, of the patient's status, 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), and the Medicare Change of Status Notice (MCSN) 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:

Important Message from Medicare (IM) is a statutorily required notice that explains a Medicare beneficiary's rights as an inpatient including discharge appeal rights.

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) can be issued 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 beneficiaries at an Inpatient level of care only.

Advance Beneficiary Notices of Non-coverage (ABN) ~~are~~ 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 considered to be non- covered items and/or services. For Original Medicare beneficiaries, the ABN is to inform them that items and/or services paid under Part B are not likely to be covered by Medicare in a specific case.

Medicare Change of Status Notice (MCSN) is a statutorily required notice that describes expedited appeal

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rights for eligible Original Medicare patients whose level of care is reclassified from an inpatient to an outpatient receiving OBS services.

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)

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 NON-COVERAGE (HINN)

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.

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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)

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~~
    - Not indicated by the diagnosis, treatment or illness, injury, or to improve the functioning of a malformed body member
    - Is experimental and investigational or considered research only
    - 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.

Medicare Change of Status Notice (MCSN)

1. Medicare beneficiaries with Original Medicare who have been reclassified by a hospital from an inpatient to an outpatient receiving OBS services have the right to appeal their status change to a BFCC-QIO if they meet specific additional criteria. To be eligible for the expedited determination process, the reclassification must happen while the beneficiary is still in the hospital and one of the following applies:
    - The patient has Medicare Part B, and their hospital stay was at least three days.
    - The patient does not have Medicare Part B
2. The MCSN must be delivered as soon as possible after a beneficiary is eligible for this process but no later than four hours prior to discharge.
    - Eligible patients with Medicare Part B must reach their third day before receiving the MSCN.
    - Eligible patients without Medicare Part B should receive the MSCN as soon as possible after the change in status from Inpatient to Outpatient receiving OBS services because a three-day stay is not required.
3. In instances in which the notice is delivered to a representative who has not been named in a legally binding document, the hospital must annotate the MSCN with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person, telephone, etc) of the contact.

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4. In instances in which delivery is to an offsite representative, the hospital must complete all of the following:
    - Verbally convey all contents of the MSCN and annotate the “Additional Information” section that the MSCN was communicated verbally.
    - Annotate the "Additional Information” section with the name of the staff person initiating contact, the name and phone number of the representative contacted, and the date and time of the contact.
    - Mail a copy of the annotated MCSN on the date telephone contact was made.

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 unable to comprehend the notice, it must be delivered to the beneficiary's representative.
2. **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 decisions on behalf of the beneficiary.
    - 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.

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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. 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. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections (rev 10-31-24) Section 450 - Medicare Change of Status Notice
8. 42 C.F.R. § 482.13(a)(1) (2024)
9. CMS Manual System. Pub. 100-07 State Operations Provider Certification. Transmittal 37. (October 17, 2008). Revise Appendix A, “Interpretive Guidelines for Hospitals”
10. General acute care hospitals: observation services, Cal. SB 1076 (2015-2016)

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Attachments

No Attachments

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Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Utilization Management Committee	Cheryl Lambing: Medical Director, Utilization Management	1/24/2025
Utilization Management Committee	Laura Zarate: Clinical Nurse Manager, Case Management	1/24/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/24/2025
Case Management	Laura Zarate: Clinical Nurse Manager, Case Management	1/24/2025

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Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.81 Psychiatric Assessment in the Crisis Stabilization Unit (CSU)

POLICY:

All patients presenting to the Ventura County Medical Center Crisis Stabilization Unit (CSU) shall be assessed by a licensed mental health professional.

PROCEDURE:

- The CSU psychiatrist shall provide psychiatric assessments and is available Monday through Sunday, 07:00 am to 7:00 pm. An after hours on-call psychiatrist is available from 7:00 pm to 7:00 am.
- After it is determined a patient meets the criteria for physician-level CSU services, the information shall be presented to the on duty psychiatrist.
- The psychiatrist shall complete orders in the electronic health record (EHR) when indicated. This may include orders for medications for medical conditions and psychiatric medications.
- All patients shall be seen and assessed within 24 hours of arrival and daily while in the CSU. Physician assessments shall be documented in the EHR on a daily basis.
- After hours, the on-call psychiatrist shall be responsible for completing patient orders. The on-call psychiatrist may use a three-way call with the patient and the nurse to obtain medication consent for psychiatric medications. Orders for medications for patient medical problems may also be ordered at this time.
- The CSU psychiatrist may elect to evaluate psychiatric patients in the VCMC Emergency Department (ED) under certain circumstances, such as when the CSU is at capacity or on diversion.
- Generally, patients requiring seclusion or restraints are directly admitted into the Inpatient Psychiatric Unit (IPU) under a psychiatrist's orders.
- Patients requiring immediate medical attention shall be seen by a physician in the ED.

All revision dates: 10/12/2021

Attachments

No Attachments

Approval Signatures

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Psychiatry Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/30/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/30/2024
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/30/2024

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Policy Area:	*Crisis Stabilization Unit (CSU)*
References:	

Z.90 Reporting 5150 Firearms Prohibition for CSU and IPU Patients

POLICY:

In accordance with Welfare & Institutions Code (WIC) 8103(f)(1), a Mental Health Firearms Prohibition shall be reported to the Department of Justice for any patient admitted to the CSU or IPU on an involuntary hold (5150) for danger to self or others.

PROCEDURE:

A. Whenever a patient is brought to the VCMC CSU and/or IPU on a 5150 application for Danger to Self or Others, a completed Mental Health Facilities Report of Firearms Prohibition shall be completed.

B. The Mental Health Facilities Report of Firearms Prohibition document will be included in each CSU and IPU admission packet.

C. The completed document shall be given to the IPU clerk or a designated person responsible as determined by the Charge Nurse on the day of CSU and or IPU admission.

- Incomplete documents shall be completed in it's entirety and submitted within 24 hours upon a patient's admission to the CSU and/or IPU.

D. The clerk shall report to Department of Justice on-line within 24 hours upon the patient's CSU and/or IPU admission.

- After reporting is complete, the clerk or the designated person will sign a verification reporting sheet indicating a report to the DOJ has been completed appropriately.

E. A psychiatrist may determine, after a face-to-face assessment and evaluation, to decertify the involuntary hold (5150). In this instance, at the psychiatrist's discretion, no report to the Department of Justice will be made.

F. Should a patient be placed on a 5250 (an additional 14 day hold) an additional report shall be made to The Department of Justice for a lifetime firearms ban (Part III -WIC Section 8103).

- ~~Incomplete documents shall be completed in it's entirerty and submitted within 24 hours upon a patient's admission to the CSU and/or IPU.~~

~~A. The clerk shall report to Department of Justice on-line within 24 hours upon the patient's CSU and/or IPU admission.~~

- ~~After reporting is complete, the clerk or the designated person will sign a verification reporting sheet indicating a report to the DOJ has been completed appropriately.~~

A. ~~A psychiatrist may determine, after a face-to-face assessment and evaluation, to decertify the involuntary hold (5150). In this instance, at the psychiatrist's discretion, no report to the Department of Justice will be made.~~

B. ~~Should a patient be placed on a 5250 (an additional 14 day hold) an additional report shall be made to The Department of Justice for a lifetime firearms band (Part III -WIC Section 8103).~~

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/30/2024
Inpatient Psychiatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/30/2024

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Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.93 Patient Safety Observation

PURPOSE:

The Ventura County Medical Center Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) identifies patients at risk for elopement, assault, self-harm, suicidal behaviors, damage to property, or infringement on the rights of others. While protecting patients' rights staff provide levels of observation and interventions to maximize the safety of patients, visitors, and staff.

POLICY:

All patients will be routinely observed in compliance with physician orders and prescribed protocols. The level of observation may be increased by the Physician or Registered Nurse (RN) after evaluation and assessment.

DEFINITION(S):

- **Standard / Routine Observation** – Performed at all times providing scheduled checks of the patients whereabouts, status, and environmental safety.
- **One to Two Observation** – Two patients assigned to one staff to be observed concurrently.
- **One to One Observation** – Patient has one assigned staff to maintain constant visual observation.

PROCEDURE(S)

A. Initiation / Admission

1. Patients admitted to the IPU/CSU will have a skin assessment and contraband check. The patient must remove all clothing, including undergarments and socks. Two same-gender staff (when available), one of whom must be an RN, will assist the patient. Staff will check the back of the patient's body with a hospital gown covering the front, and then, check the front of the patient's body without the gown to ensure that no contraband is present on the person and that the patient's skin is intact. The patient's belongings will also be separated and searched for contraband. Once the skin assessment and belongings check has been completed, the patient may have their searched belongings, without contraband items returned. Pajamas will be offered.
2. Should a patient decline to turn over their belongings or don the gown for the skin assessment/ contraband check, they will be immediately placed on one-to-one observation in the admission hallway. One to One observation will continue until the patient cooperates with the skin assessment and/or contraband check.

3. Physicians will assess each patient and identify those at risk during the initial Psychiatric Evaluation, utilizing a physician progress note. Based on the physician's assessment, the appropriate observation level will be ordered.
4. All observation needs for patients admitted without a face-to-face evaluation by a psychiatrist will be collaborated with the on call resident and or attending until seen by a psychiatrist. If a Registered Nurse's screening results in the need for an increased observation level, the RN will notify the Attending Physician or on call Physician of findings using SBAR and obtain a physician's order. The physician's order shall include the Observation Level and the reason for the monitoring. All communication and collaboration regarding observation levels will be reported to the Physician and noted in the Electronic Health Record under provider Notification and or the Progress Note.
5. Each patient will be assessed by an RN upon admission. Patients may require constant observation based on:
    - A history of high-risk behaviors, current symptoms, is highly volatile, impulsive, and/or suicidal, requires frequent redirection, prompting, and encouragement to maintain control, requires maximum staff structure for protection of self or others due to frequent or continuous loss of behavior control.
    - Moderate to severe risk for falls, extreme or unusual nursing care needs require the equivalent of one staff's total time during shift.
    - Patient who requires more than fifty percent assistance with ADLs or constant supervision to complete ADLs. Extreme or unusual nursing care needs require at least 2/3 of one nursing staff's time during one shift.
    - Symptoms of disorientation, confusion, agitation, delusions, or hallucinations that require interventions of longer duration or higher frequency of observation.
    - Clinical symptoms that indicate a moderate self-harm or harm to others with significant support needs.Elopement risk.
6. The patient may have his/her room searched and the charge nurse will determine which objects may stay in the room. Any object removed from the room that belongs to the patient must be labeled and told which belongings are being removed from the room and where they are stored. Documentation of the search is to occur and a doctor's order must be obtained.
7. Care provided by assigned staff will be delegated and overseen by the assigned bedside nurse. The nurse will retain the responsibility of the nursing process and administration of medications. Assigned Staff will provide physical care, within their scope of practice and training, for the patient for whom they are assigned. This may include the documentation of vital signs, meals and intake and output.
8. Assigned Staff, as directed by the nurse, will complete all aspects of Activities of Daily Living (ADL's) for the patient provided they have demonstrated competency. This includes, but is not limited to, the following: bathing, feeding, toileting, and range of motion (ROM). Exception: Security Personnel may provide observation only. They are not to assist with ADLs or physical care. Assigned Staff, other than a Registered Nurse, may not perform assessments.
9. Assigned Staff will not leave the patient without the assigned nurses' approval and/or relief. If a break is needed, a handoff to the temporary staff member will occur prior to leaving the patient. Personal cell phones are not permitted while caring for the patient. You are expected to communicate directly with the RN caring for the patient. Any information that may be useful should be provided during patient handoffs.
10. Reassessments are performed by an RN every four (4) hours or as needed according to the patient's condition. Documentation of the outcome of the assessment in the Nursing Progress Notes is required at

least once per shift (concurrent documentation of reassessments is not required). The Progress note includes a summary of the patient's behavioral health condition and is annotated in the "ABC" format. This format is based on clinical staff's observation, intervention, and evaluation of the patient.

11. All Assigned Staff must have Crisis Prevention Institute (CPI) training. In certain circumstances, you may be required to take action to prevent a patient from harming themselves. Attempt to stop these actions by giving brief, clear instructions. Repeat this up to 3 times (over one minute) in a firm yet quiet manner. Be sure that you have the patient's attention. Make eye contact when possible. If the patient persists in this harmful behavior, contact the nurse right away. Convey attitudes of compassion, empathy and understanding. Do not offer to counsel the patient spiritually or emotionally. Allow the patient to talk, but do not offer your judgments or opinions. Do not promise the patient that you will not tell the staff what you have been told.
12. In certain circumstances if the patient becomes agitated or uncontrollable, do not attempt to restrain them. Keep yourself safe: push your duress alarm or call 7-6666 for a "Code Grey". Stay calm and speak clearly so the information can be forwarded quickly and clearly.

B. CRITERIA:

A. **Standard/Routine Observation:**

1. All patients will be placed on standard/routine observations while they are admitted in the IPU. The patient will be advised of the observation level and the process involved.
2. The staff members will observe and check in with the patients at least every fifteen minutes, documenting the patient's location and status at each interval.
3. It is expected that staff will enter the room, approach the patient, and check their identity using the wristband if needed.
4. A separate hallway variable round observation of the patient will also be conducted in between the fifteen minutes and documented per policy.
5. Assigned staff will make direct visual contact with patients and confirm they are in no danger or distress.
6. Observations may not be completed standing in the nurse's station, a doorway or at a distance, particularly for patients who are sleeping. It is expected that staff will enter the room, approach the patient, and check their identity using a wristband if needed.
7. Flashlights may be used during the night rounds respectfully ensuring the flashlight is not directed at their face. Staff must verify, the patient is in his/her bed, breathing with an adequate respiratory rate visualizing the rise and fall of the chest.
8. Staff will provide interventions as appropriate and notify the Charge Nurse of any change in patients' condition or location.
9. Documentation of fifteen-minute rounds is to occur at the time of assigned patient rounds and not in advance.
10. While making patient rounds, the staff member observes the environment for unsafe conditions and reports them immediately. Staff members will monitor bed linens to avoid patients having access to multiple sheets at one time.
11. The Charge RN should review and sign the observation board at multiple intervals to ensure completion as assigned.

12. If unable to locate a patient anytime during rounds, notify the Charge Nurse and begin Elopement procedure.

B. **One to Two Observation and One to One Observation**

1. One to two staff to patient ratio. The observer is in the hallway where they can observe both patients concurrently.
2. One-to-One staff-to-patient ratio. The level of observation in the patient remains in staff view always. The physician may specify the maximum distance between the patient and the One-to-One staff (i.e., arm's length).
3. Advise the patient of observation level and process involved.
4. Search the environment for safety.
5. Initiate Patient Observation Record
6. The patient is observed continuously and has additional every fifteen-minute observation documentation.
7. The observer will notify RN of any changes in behavior.
8. The RN will document any signs of injury on the Patient Observation Record at a minimum of every 2 hours.
9. Accompany patient to bathroom/shower. The door shall be kept slightly open with all high risk patients to monitor and ensure safety. An attempt will be made to provide same gender staff.
10. A physician order will remain in place until the behavior or circumstance no longer requires the use of One to Two or One to One observation. Order must be renewed each calendar day.

All revision dates: 6/11/2024

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/30/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/30/2024
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	9/30/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*2/11/2025*
Effective:	*2/11/2025*
Last Approved:	*2/11/2025*
Last Revised:	*2/11/2025*
Next Review:	*2/11/2028*
Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.036 Medical Staff Conflict of Interest

PURPOSE:

The intent of this policy is to safeguard the integrity and reputation of the Ventura County Health Care Agency (HCA) and it's Medical Staff by fostering the proper and unbiased conduct of all Medical Staff activities.

POLICY:

A conflict of interest arises when there is a divergence between and individual's private interests and his/her professional obligations to the HCA, Medical Staff, patients, and employees, such that an independent observer might reasonably question whether the actions or decisions are determined by consideration of personal gain, financial or otherwise. Conflicts of interest are common and dependent on the situation, not on the individuals involved.

Members of the Medical Staff should conduct their affairs in a manner to avoid or minimize conflicts of interest when possible and respond appropriately when they arise. A conflict of interest, in and of itself is not grounds for adverse actions to an individual's membership and/or privileges. In any instance where a member has or reasonably could be perceived to have a conflict of interest, as defined below, such individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the Committee Chair, or, if it cannot be resolved at that level, by the Chief of Staff.

Examples of potential conflicts of interest include but are not limited to the following situations:

- Financial relationships (consulting fees, lecture fees, etc.) with companies or their agents that may provide medical equipment, services or pharmaceuticals to the HCA.
- Ownership, stock, or other securities, membership on board of directors or any other activity with an organization that provides products and services to the HCA, including organizations that are engaged in existing or potential business relationships.
- A leadership position with an organization providing products or services to the HCA.
- Influence on purchases of equipment, instruments, materials or services for the HCA from firms in which the member of the Medical Staff, or immediate family member, has financial interest.
- Unauthorized disclosure of patient or HCA information for personal gain.
- Giving, offering, or promising anything of value, as a representative of the HCA to enhance relations.
- Transmission or use of HCA or Medical Staff supported work, products, results, materials, record or information that would not otherwise made generally available, for personal gain.

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- Influence on contract negotiations between the HCA and private organizations in which the Medical Staff member, or an immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
- Improper use of institutional resources for personal financial gain.
- Acceptance of compensation or services from a vendor, service provider, or contractor of the HCA, when the Medical Staff member is in a position to determine/influence the HCA's purchases from those entities.

PROCEDURE(S):

A. The Medical Staff Conflict of Interest Declaration must be completed and on file in the Medical Staff Office by members appointed to committees as a condition of service as outlined in Article 9 (9.1.10) of the Medical Staff Bylaws. Candidates for elected office must also submit a declaration as outlined in Article 8 (8.1.3) of the Medical Staff Bylaws. It is the responsibility of each member to update their declarations when conflicts develop, and should unforeseen conflicts arise during discussion of an issue, it is the responsibility of the conflicted member to immediately disclose the conflict of interest.

B. When an officer or committee member is confronted with a situation in which a conflict or potential conflict of interest exists or the appearance of such, the individual will notify the Medical Staff Office. The Medical Staff Office will consult with the appropriate Medical Staff Leader and/or the Medical Executive Committee (MEC) to determine the appropriate response.

C. Violations and Enforcement:

1. Individuals required to complete a Medical Staff Conflict of Interest Declaration according to these guidelines, who fail to submit a declaration will be relieved of their relevant duties until they comply.
2. Any other suspected policy violations should be reported to the Medical Staff Office, Chief of Staff or Chief Medical Officer (CMO). Reports may be submitted confidentially, and even anonymously. Reports should include as much information as possible to facilitate an investigation. Raising concerns will not jeopardize anyone's employment or Medical Staff membership.
3. Violations may result in the removal of an individual from a committee and/or referral to the Medical Executive Committee for follow up and potential disciplinary action.

REFERENCE(S):

Medical Staff Bylaws: Articles 8 and 9

All revision dates: 2/11/2025

Attachments

- Conflict of Interest Guideline Chart
- Medical Staff Conflict of Interest Declaration

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	2/11/2025

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Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/11/2025
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	2/5/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	1/31/2025

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VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/14/2020*
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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.027 Medical Staff Credentialing Information Integrity (CII) and Database User Access

This policy applies to the Medical Staff credentialing files and credentialing database, including system ~~and system~~ modules used to perform credentialing, privileging and ongoing monitoring for practitioners with membership and/or clinical privileges throughout the Health Care Agency (HCA) including Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU), Ambulatory Clinics and Ventura County Behavioral Health Clinics. The credentialing process will be performed in accordance with the Medical Staff Bylaws, Rules & Regulations and Department Rules & Regulations.

Medical Staff Administration is responsible for protecting the integrity of the credentialing information, including but not limited to the credentialing application, practitioner attestation, primary source verifications, verification dates, report dates, credentialing decisions, credentialing decision dates, signatures/initials of the verifier or reviewer, committee minutes, and credentialing checklists.

I. Electronic and Paper Data Storage

A. The content of the electronic application and confidential credentialing file, including primary source verifications are stored in a secure password protected cloud based system. ~~The vendor's database security policies, security audits and contract are reviewed and on file in the Medical Staff Administration Office.~~

B. The content of the paper credentialing file is secured in locked file cabinets in the Medical Staff file room with physical access limited to the Medical Staff Administration staff (Chief Medical Officer, Department Director, Manager, Credentialing Coordinators, Peer Review Coordinator, and ~~Administrative Assistant working in~~administrative staff supporting Medical Staff Administration or projects).

~~**II. Primary Source Verifications (PSV)**~~

~~Primary source verifications are defined as verifications obtained directly from the source or an approved entity and may be obtained through an electronic query subscription, web query, direct electronic, faxed or mailed query response. In some circumstances telephone verification may be obtained from a primary source.~~

~~A. Verifications may be performed by Medical Staff Administration staff: the Department Manager, Credentialing Coordinators, Peer Review Coordinator, and Administrative Assistant working in Medical Staff Administration.~~

~~B. Verifications will be documented and tracked in each practitioner's electronic verification log. Verifications received outside of the database are scanned and attached to the appropriate verification record. A hard copy may also be placed in the confidential credentials file folder.~~

~~C. Each database verification entry indicates the type of verification, the method of verification, the date the verification was requested and received, and the identity of the database user obtaining and reviewing the verification.~~

~~D. Printed verifications will be initialed and dated by the staff member obtaining and reviewing the verification.~~

~~E. File progress is tracked via internal checklists and the database.~~

II. ~~III.~~ Database Access

Access to the database is granted and monitored by the Department Director and/or Manager and limited to the user's individual roles and responsibilities:

A. Prior to accessing the database all users must review and agree to comply with this policy and policy 102.031 Confidentiality of Medical Staff/Allied Health Professional Staff Records (Attachment A). Policy review will be required annually as part of annual database training for all active users.

1. Users with read/write access must complete the annual information integrity training module and review policies.

B. Medical Staff Administration staff: Director, Manager, Credentialing Coordinators, and Peer Review Coordinator, will have read and write access to fulfill their roles and responsibilities within the Department and maintain files.

C. Medical Staff Committee members will be granted read only access for the purposes of fulfilling their responsibility of reviewing and recommending approval of a practitioner's membership and/or clinical privileges as outlined in the Medical Staff Bylaws. Read access is limited to files subject to review and added to the secure database Virtual Committee module. If paper files are to be reviewed, the review will be conducted in the Medical Staff Administration Office or within the appropriate Medical Staff Committee meeting.

~~Ventura County Health Care Plan and Contracts Management may be granted limited read access to fulfill their specific roles related plan audits and contracts management.~~

D. The Enrollment team may be granted limited read/write access to fulfill their roles and responsibilities related to health plan enrollment, health plan rosters and managing the County's malpractice insurance.

~~The County's contracted enrollment vendor may be granted limited read access to the practitioner application information required to complete health plan enrollment applications. View access is limited to practitioners in which the County is responsible for billing/collecting for services.~~

E. Employee Health Services (EHS) may be granted limited read access to practitioner demographic information and limited write access to the practitioner medical history section of the electronic file to document annual required health ~~screenings~~screening requirements.

F. The following teams may be granted limited read only access to fulfill their specific roles and responsibilities. Access excludes primary source verifications and peer review protected documentation portions of the database.

1. Ventura County Health Care Plan
2. Enrollment Vendor
3. Contracts Management
4. Practitioner Invoicing & Payments

G. Database vendor support access is granted and tracked through the "Grant Support Access" database feature and is limited to the specific technical support case in which access has been granted. Access terminates upon completion of the support ticket and may be revoked if the activity is deemed inappropriate.

~~IV~~III. Privileging Portal Access

A. Nursing and other ~~hospital~~Health Care Agency staff may be granted read only access to the database privileging portal for the purpose of verifying privileges.

B. Hospital Pharmacy staff may be granted read access through the database privileging portal and limited to the necessary information ~~when needed~~ to verify practitioner DEA information, medication orders and as required for compliance with the Hospital 340B Drug Pricing Program.

IV. Staff Responsible for Performing Credentialing Activities & Primary Source Verifications (PSV)

Primary source verifications are defined as verifications obtained directly from the source or an approved entity and may be obtained through an electronic query subscription, web query, direct electronic, faxed or mailed query response. In some circumstances telephone verification may be obtained from a primary source.

A. Credentialing verifications are performed and documented by Medical Staff Administration staff: the Department Director, Manager, and Credentialing Coordinators.

B. Verifications are documented and tracked in each practitioner's electronic verification log. Verifications received outside of the database are scanned and attached to the appropriate verification record. A hard copy may also be placed in the confidential credentials file folder.

C. Each database verification entry indicates the type of verification, the method of verification, the date the verification was requested and received, and the identity of the database user obtaining and reviewing the verification. During the initial and reappointment cycle verifications are logged on the appropriate credentialing checklists.

D. Verifications performed by phone will include the staff member's identity, date performed, who provided the verification including their title/role and phone number.

V. Process for Documenting Updates to Credentialing Information

Staff with the appropriate level of access may add new or updated information, correct verified inaccurate information or incorrect data entries in the practitioner record, document notes, update required expiring items including but not limited to licensure, certifications, insurance, life support certifications, annual health screenings, and contact or practice information.

A. Access to modify/correct entries to the primary source verification section of the database (verification log) is limited to the Medical Staff Administration staff: the Department Director, Manager, and Credentialing Coordinators.

B. Modifications/corrections to the practitioner provided data (example: work history, addresses, affiliations etc...), and uploading file documents may be completed by the Medical Staff Administration: Department Director, Manager, Credentialing Coordinators, Peer Review Coordinator, and the Practitioner Enrollment staff.

C. Deleting practitioner file information is limited to Medical Staff Administration staff: the Department Director, Manager, Peer Review Coordinator and Credentialing Coordinators, and is limited to removing an error or inaccurate entries to the record, including confirmed duplicate entries in the credentialing application and/or database fields.

D. Deleting information in the verification section of the database (verification log) or any primary source verified credentialing data is limited to Medical Staff Administration staff: the Department Director, Manager, and Credentialing Coordinators. Deletions are limited to removing files attached in error, deleting a timed out or failed electronic verification attempts, and verification errors (for example: license verification was run for the wrong state or license type) or duplicate verifications.

E. Modifications are documented in the file by the database and include the username and the date of the modification. Staff must include relevant notes in the comment section related to the modification. Documentation will include:

1. Date/time of the modification.
2. What information was modified.
3. Reason for the modification (excludes updating expiring licensure or other mandatory expirables).
4. Who performed the modification.

IV. Inappropriate Documentation and Updates

Staff may not alter credentialing approval dates or dates of verifications unless there is a verified manual entry error. Staff may not modify or white out any portion of a hard copy verification.

A. The following modification are considered inappropriate and will result corrective action:

1. Falsifying credentialing dates (credentialing decisions, licensure, verifications, ongoing monitoring).
2. Creating documents/records without completing the required verification/activity, including photocopying and altering a prior verification.
3. Fraudulently altering existing documents, minutes, ongoing monitoring reports.
4. Attributing verifications or file review to an individual who did not perform the activity.
5. File updates by unauthorized individuals.

V. Tracking and Monitoring User Activity

A. The Department Director and/or Manager will annually review all ~~users~~user accounts to ensure their access is necessary and at the appropriate level for their roles and responsibilities. Account access will be modified when roles change.

B. The Department Director and/or Manager ~~monitors~~are responsible monitoring user activity ~~through the database security and user activity reports, and through regular~~and will conduct annual credentialing file audits.~~The Manager will audit a minimum of 5% or 50 files (whichever is less) at least annually and as often as necessary or when concerns arise regarding user activity or file integrity. The audits will include a minimum of 10 initial appointment files and 10 reappointment files.~~

1. The Department Director and/or Manager will audit a minimum of 5% or 50 files (whichever is less) annually and as often as necessary or when concerns arise regarding user activity or file integrity. The annual audits will include a minimum of 10 initial appointment files and 10 reappointment files from the previous 12 month period using the Health Industry Collaboration Effort (HICE) Credentialing Information Integrity Audit Analysis Tool (Attachment B).
2. The Director and/or Manager will conduct a re-audit within 3 to 6 months of the annual audit if inappropriate documentation is identified. The audit will be limited to those specific element found to have an inappropriate update or documentation.

C. The database security alerts are automatically generated and sent to the Department ~~Manager~~Director for

inactive user account login attempts and valid user logins from unknown IP addresses.

D. User accounts are suspended automatically if inactive for 30 days and must be reactivated by the Department Director or Manager.

E. ~~Staff~~All staff is required to report any suspected inappropriate database activity to the Department Director and/or Manager.

F. When inappropriate activity is identified, an investigation will be initiated by the Department Director and/or Manager and the user will be notified ~~and counseled~~. ~~The~~Corrective action will include counseling related to the inappropriate activity, reeducation/training and ongoing monitoring of user~~'s~~ activity. Continued violations will be ~~monitored at least quarterly for a minimum of 3 quarters by the Department Manager and~~ reported ~~on the credentialing systems control oversight report. Continued violations will be reported~~ to the Chief Medical Officer, and Human Resources for formal disciplinary action.

1. User access may be restricted, suspended, or permanently revoked.

~~User access may be adjusted, suspended, or permanently revoked if inappropriate activity is identified.~~

G. Fraud and misconduct will be reported to the Chief Medical Officer, Compliance Officer, and as required by the delegated credentialing agreements, the National Committee for Quality Assurance.

~~**VI. Modifying or Deleting Database Information**~~

~~A. Database modifications and deletions are documented in the record by the database and on the user activity reports.~~

~~B. Staff with the appropriate level of access may add new or updated information, correct verified inaccurate information or incorrect data entry in the practitioner record, document notes, update required expiring items including but not limited to licensure, certifications, insurance, life support certifications, annual health screenings and contact or practice information.~~

~~C. Access to delete database information is limited to Medical Staff Administration staff and is limited to removing an error or inaccurate entries to the record.~~

~~D. Access to delete information in the verification section of the database (verification log) or any primary source verified credentialing data is limited to Medical Staff Administration staff. Deletions are limited to removing files attached in error, deleting a timed out or failed electronic verification attempts, and verification errors (example: license verification was ran for the wrong state or license type) or a duplicate verifications.~~

~~E. Access to modify/correct entries to the primary source verification section of the database (verification log) is limited to Medical Staff Administration staff and must be documented in the notes section of the record and include the date, user name, the type of modification/correction, and reason for the modification/correction.~~

~~F. Modifications/corrections made to the practitioner provided data (example: work history, addresses, affiliations etc...) must be documented in the notes section of the record and include the date, user name, type of modification/correction and when appropriate, who authorized the change and reason for the change. These modifications may be completed by Medical Staff Administration staff and the Enrollment team.~~

~~G. Medical Staff Administration staff may remove confirmed duplicate entries in the credentialing application and/or database fields.~~

~~H. Staff may not alter credentialing approval dates or dates of verifications, unless there was a verified manual entry error. Staff may not modify or white out any portion of a hard copy verification.~~

~~I. The following modification are considered inappropriate and will result corrective action:~~

~~1. Falsifying dates (credentialing decisions, licensure, verifications, ongoing monitoring)~~

~~2. Creating documents/records without completing the required verification/activity~~

~~3. Fraudulently altering existing documents, minutes, ongoing monitoring reports~~

~~4. Attributing verifications or file review to an individual who did not perform the activity~~

~~5. File updates by unauthorized individuals~~

~~VII~~VI. Database User Accounts and Passwords

A. Account and password activations and terminations are managed by the Department Manager.

B. Each user will have a unique login and required to create a strong password, unique to the database. Passwords must be at least ~~8~~12 characters and contain alphanumerical characters or symbols, should not be written down and should be changed frequently.

C. Passwords must be changed if requested by staff or if compromised.

D. Sharing account information or allowing non-authorized user's access is strictly prohibited, including inappropriate screen sharing. User's must exit the database or lock their computer screens when stepping away from their workstations and secure physical credentials files when not in use to protect files from unauthorized access.

E. User accounts will be locked after 5 failed login attempts and access will automatically expire after 30 days of inactivity.

F. The Department Director and/or Manager will promptly remove all user access to the database upon termination or when access is no longer required to perform the user's specific job requirements.

VII. Annual Credentialing Information Integrity Training

Staff involved in credentialing or with access to the credentialing file will complete training annually. Training informs staff of the following mandatory elements.

A. The audits of staff documentation and updates to credentialing files.

B. The process for documenting and reporting inappropriate documentation and updates to the designated individuals(s) or National Committee for Quality Assurance (NCQA).

C. Consequences for inappropriate documentation and updates.

Reference:

National Committee for Quality Assurance (NCQA) Standards CR.~~1, Factors C.1 through C.5~~ 8: Credentialing Information Integrity

Health Industry Collaboration Effort, Inc. (HICE) - Delegated Credentialing Compliance

All revision dates: 1/31/2025, 3/14/2024, 5/11/2022, 7/16/2020, 7/14/2020

Attachments

Attachment A Confidentiality of Medical Staff and Allied Health Professional Staff Records

Attachment B Health Industry Collaboration Effort (HICE) Credentialing Information Integrity Audit Analysis

Tool

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	2/5/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	1/31/2025

Delineation Of Privileges

Robotic Assisted Surgery

Name:

Privilege	Requested

BASIC ROBOTIC ASSISTED SURGERY

Initial Criteria:
a. MD or DO with current privileges to perform the basic surgical procedures requested without robotic assistance
b. Certificate of Training from Intuitive Surgical*
- computer-based online training modules
- bedside training
- simulator modules with a minimum passing score of 90%

Evaluation Criteria:
a. A minimum of the first 3 basic cases proctored by an approved proctor*
b. A minimum of the first 5 non-proctored cases retrospectively reviewed
(If fellowship-trained, b is not required)
c. For surgeons with prior robotic-assisted surgery experience from another hospital, the first 2 surgeries (basic or advanced) will be proctored if the criteria in policy MS.102.025 have been met/verified*

Renewal Criteria:
a. A minimum of 8 robotic-assisted surgeries per calendar year (may be a combination of basic and advanced cases)
b. Failure to meet the minimum annual volume: repeat simulator modules with a minimum passing score of 90% and/or additional proctoring or case review deemed appropriate by the Robotic Steering Committee ~~Failure to meet the minimum annual volume; repeat simulator modules with a minimum passing score of 90%~~
~~- additional proctoring or case review deemed appropriate by the Robotic Steering Committee~~

* Refer to Robotic Assisted Surgery Credentialing & Privileging Policy
* Physicians with current unrestricted robotic-assisted surgery privileges will automatically receive bedside assistant privileges

General Surgery ___
Basic general surgery cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:
1. Cholecystectomy
2. Hernias (inguinal, umbilical)
3. Ventral hernias with fascial defect < 2 cm
4. Appendectomy
5. Right colectomy
6. Hybrid procedures approved by the Robotics Steering Committee (RSC) for sub-specialty surgeons

Gynecology ___
Basic gynecology cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:
1. Hysterectomy (total or supracervical with or without bilateral salpingo-opherectomy, uterine size < 250 grams by ultrasound)
2. Adnexal procedures (ovarian cystectomies, oophorectomies, adnexal adhesiolysis, salpingectomy)

Thoracic ___
Basic thoracic cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:
1. Wedge resection
2. Pleural biopsy
3. Lung biopsy
4. Cyst resection
5. Thoracic sympathectomy
6. Thoracic and mediastinal lymph node dissection
7. Pericardial window
8. Pericardial biopsy

Delineation Of Privileges

Robotic Assisted Surgery

Name:

Privilege	Requested

Urology ___

Basic urology cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:

1. Prostatectomy (with or without obturator lymph node dissection)
2. Subtotal Prostatectomy
3. Obturator lymph node dissection (separate procedure)
4. Nephrectomy (radical or simple)
5. Pyeloplasty
6. Pyelotomy
7. Ureteral re-implant (with or without tailoring, intra or extra vesical approach)
8. Bladder repair or fistula excision
9. Ureterolysis
10. Pelvic lymph node dissection (iliac and obturator)

ADVANCED ROBOTIC ASSISTED SURGERY

(must also meet the above criteria)

Initial Criteria:

a. Completion of all proctoring and case reviews for basic robotic-assisted surgery privileges
b. Approval from the Robotic Steering Committee
   - additional proctoring or case reviews deemed appropriate by the Robotic Steering Committee

Bariatric ___

Advanced bariatric cases* are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:

1. Sleeve gastrectomy
2. Gastric bypass

*Bariatric procedures are considered advanced; there are no basic bariatric privileges

General Surgery ___

Advanced general surgery cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:

1. Adrenalectomy (total or partial)
2. Nissen fundoplication
3. Para esophageal hernia repair
4. Hill procedure
5. Ventral hernia repair with fascial defect > 2 cm or need for component separation
6. Gastrectomy for neoplasm
7. Pyloroplasty
8. Foregut bariatric procedures
9. Transverse and descending and sigmoid colectomy
10. Colon cancer with pelvic lymphadenectomy
11. Pancreatic surgery
12. Biliary reconstructive surgery
13. Hepatectomy
14. Splenectomy (partial or total)
15. Any new, not previously described complex procedures approved by the Robotic Steering Committee (RSC)

Gynecology ___

Advanced gynecology cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:

1. Pelvic lymphadenectomy including para-aortic lymphadenectomy (requires gyn oncology privileges)
2. Retroperitoneal procedures including presacral neurectomy, ureter dissection and biopsy of masses
3. Sacrocolpopexy, Burch procedures and other pelvic reconstruction surgery
4. Stage 3 or 4 endometriosis surgery (ASRM stage 3 or 4: moderate or severe) including deep infiltrating endometriosis
5. Myomectomies (4 or less fibroids, no fibroid > 6 cm in size, uterine size < 250 grams by ultrasound)
6. Bowel surgery including appendectomy
7. Hysterectomy (total or supracervical with or without bilateral salpingo-opherectomy, uterine size > 250 grams by ultrasound)
8. Any new, not previously described complex procedures approved by the Robotic Steering Committee (RSC)

Delineation Of Privileges

Robotic Assisted Surgery

Name:

Privilege	Requested

Thoracic ___
Advanced thoracic cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:
1. Lung segmentectomy
2. Lobectomy (upper and lower)
3. Sleeve resection
4. Thymectomy
5. Esophageal resection

Urology ___
Advanced urology cases are defined as follows and are limited to procedures granted to the physician to perform without robotic assistance:
1. Adrenalectomy (total or partial)
2. Partial nephrectomy
3. Cystectomy (radical or simple, total or partial)
4. Sacrocolpopexy, Burch procedures or other pelvic reconstruction procedures
5. Bowel surgery including appendectomy
6. Any radical pelvic exenteration procedure
7. Any new, not previously described complex procedure approved by the Robotic Steering Committee (RSC)

Single Site Procedures ___
Requires basic robotic-assisted surgery privileges in the applicable specialty and completion of specialty appropriate Intuitive Single Site Course*

* It is recommended that the surgeon's first single-site procedure be performed within 2 weeks of training.

Firefly Fluorescence Imaging ___
Procedures using da Vinci Firefly Fluorescence Imaging require onsite in-service training by an Intuitive representative. Use of Firefly Technology is limited to applicable basic and/or advance robotic-assisted privileges granted.

Surgical Bedside Assistant ___
MD/DO* or PA** with current privileges to assist in open or laparoscopic surgery

Initial Criteria:
a. Certificate of Training from Intuitive Surgical (Xi module)
b. Vendor bedside training to include at minimum; set up, patient positioning and equipment orientation

Evaluation Criteria:
A minimum of the first 2 cases proctored
(proctoring waived for surgeons with robotic-assisted surgery privileges)

Renewal Criteria:
a. A minimum of 8 robotic-assisted surgeries per calendar year
b. Failure to meet the minimum annual volume; repeat training and or proctoring may be required at the discretion of the Robotic Steering Committee

* Physicians with current unrestricted robotic-assisted surgery privileges will automatically receive bedside assistant privileges
** PA assistants must have a delegation of services agreement with the surgeon on file in the Medical Staff Office

Delineation Of Privileges

Robotic Assisted Surgery

Name:

Privilege	Requested

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 Medical Center. 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

ROBOTICS STEERING COMMITTEE

Chairman's Signature: _____ Date: _____

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

_____
Chief, Department of Surgery Date