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

April 22, 2025

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

1. D.04 Dietary and Ancillary Food Storage
2. D.33 Food Preparation and Service
3. D.56 Food & Nutrition Services Employee Health and Personal Hygiene

VENTURA COUNTY MEDICAL CENTER
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Ventura County Health Care System Oversight Committee
Administrative Policies - April 22, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	D.04 Dietary and Ancillary Food Storage	Triennial	Triennial review of policy. Updated policy with latest practices.
2	D.33 Food Preparation and Service	Triennial	Triennial review of policy. Updated policy with latest practices.
3	D.56 Food & Nutrition Services Employee Health and Personal Hygiene	Triennial	Triennial review of policy. Updated policy with latest practices.

Status **Active** PolicyStat ID **11353171**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	11/1/1992
Last Approved	4/2/2025
Effective	4/2/2025
Last Revised	4/2/2025
Next Review	4/1/2028

Owner	Fernando Medina: Director, Support Services
Policy Area	Dietary

D.04 Dietary and Ancillary Food Storage

POLICY:

To delineate the responsibility for supplying, storing and administering nourishments and tube feedings; maintaining kitchens including refrigerators, cupboards and ice machines in patient care units; vending machine and ice machine service.

The Food & Nutrition Services Department will supply selective food items and beverages to all patient care areas at Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and Inpatient Psychiatric Unit (IPU). Nursing is responsible for unit kitchens, monitoring and administering nourishments and tube feedings. Vending machines are contracted services.

PROCEDURE:

1. Standard nourishments are delivered daily to units that submit their orders via "Order by Demand."
2. All patient care areas will order supplies via "Order by Demand." The nourishment list of approved items is given to the department. These items will then be delivered. Additional items will be sent upon approval to the areas.
3. Nursing is responsible for placing food, beverages and some limited supplies in refrigerators and cupboards upon delivery.
4. Nursing will administer all food and drinks to patients as allowed by diet order. Any patient on a restricted calorie diet will have all extra feedings supplied only by the Food & Nutrition Services Department according to diet order.
5. All special in-between feedings requested by the Clinical Dietitian will be sent to nursing units for specific patients with name, room number, date and time labeled on the nourishment.
6. Prepared food items by the Food & Nutrition Services Department must be dated with an

expiration date before being sent to the patient care unit. Individually packaged prepared foods will have the manufacturer's expiration date.

7. Housekeeping is responsible for the cleaning of patient care refrigerators. Nursing is responsible for cleaning the cupboards and checking food and beverages to be used or discarded according to date on items, including cans and containers of tube feeding and nutritional supplements. Excess supplies should be returned to the Food & Nutrition Services Department.
8. Ice machines in any areas other than the cafeteria are the responsibility of the Facilities Department. The ice machines in the patient units will provide ice for patients.
9. The VCMC beverage vending machines are owned, serviced and maintained by Reyes Coca Cola Inc. or Vending One Inc. The beverage vending machines owned by Reyes Coca Cola is stocked by the Food & Nutrition Services Department and the Vending One Inc. vending machines are stocked and maintained through a contract between the County of Ventura and Vending One Inc. The Food & Nutrition Services Department and Vending One Inc. are responsible for stocking, cleaning and retrieval of monies from beverage vending machines that their respective department operates.
10. The snack vending machines (non-beverage) are owned, serviced and maintained by Vending One Inc. through a contract between the County of Ventura and Vending One Inc. and administered by the Auxiliary Services Department.

All Revision Dates

4/2/2025, 2/13/2019, 4/1/2010, 12/1/2007, 6/1/2006, 12/1/2001, 12/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/2/2025
Dietary Department	Fernando Medina: Director, Support Services	4/2/2025

Status **Active** PolicyStat ID **11352775**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	11/1/1992
Last Approved	4/2/2025
Effective	4/2/2025
Last Revised	4/2/2025
Next Review	4/1/2028

Owner	Fernando Medina: Director, Support Services
Policy Area	Dietary

D.33 Food Preparation and Service

Policy

The Dietary Department shall take measures to prevent the culturing of bacteria, spoilage of food or transmission of infection via prepared food.

Procedure

All food will be prepared, transported and served according to the following criteria:

FOOD PREPARATION AND SERVICE

1. Frozen food is thawed at refrigerated temperature of 41 °F or below. Frozen food that has been thawed shall be used immediately and not refrozen.
2. All ingredients for mixed salads, especially using eggs, meat, fish or potatoes, will be thoroughly chilled before preparation.
3. Stuffings are baked separately.
4. Raw eggs are not served in any form. The State of California Department of Health Services recommendations concerning preparation, holding and serving of eggs are strictly enforced. A pasteurized egg product is the primary product being used. Soft cooked or poached eggs are served only if specifically requested by the patient, their family or their physician. An internal temperature of 145° F is required while cooking an egg product that is not pasteurized.
5. Raw fruits and vegetables will be thoroughly washed under running water before use.
6. The following cooked foods must reach an internal temperature of:
    - 165° F - Poultry (Turkey/Chicken)
    - 155° F - Meats (Beef/Lamb)

- 145° F - Meats (Pork Loin/Roast/Chops)
- 155° F - Ground Meats
- 145° F - Fish

7. Polyethylene cutting boards are used which are nonabsorbent. After each separate use, the boards will be cleaned and sanitized. All boards are put through the Dishwasher daily or as needed.
8. Hot foods will be held during serving at 135° F or above (see serving temperature policy for temperature chart). Cold food will be held at 41° F or below.
9. Do not wash any produce directly in the sink. Even if the sink is sanitized, a colander shall be used to rinse produce. Rinse produce well. Cantaloupe shall be vigorously scrubbed with a brush or pad. When finishing rinsing, put colander through the dish machine in the dish room.
10. All foods shall be kept covered between time of preparation and serving.
11. Food shall be served with clean tongs, scoops, forks, spoons, spatulas, and if necessary, a gloved hand.
12. All food production equipment shall be cleaned, rinsed and sanitized, according to policy and procedure.
13. Poultry must be checked for slickness under wings and darkness on upper tail surface and where the legs join the body. Wash hands and equipment carefully before and after handling chicken.
14. Spoons used for testing are not to be put back into food.
15. China and glassware that is chipped, cracked or lost its glaze will be discarded.
16. Silverware and cups are to be handled by the handles, glasses by the bases, and dishes by edge.
17. Silverware will be put in dispensers with handles up.
18. Work units are to be kept clean at all times.
19. All patient food will be transported in closed sanitized food carts during regular service. Individual trays will have food items covered. Bulk food for special functions will be covered when transported.
20. All food not consumed on patient's trays will be discarded.
21. Food prepared and brought in from outside the hospital(s) by visitors for patients will be discarded. However, exceptions will be made when the physician gives written approval in the electronic health record (EHR).
    A. Prior to patients eating the food, nursing will determine appropriateness of foods to ensure the food is allowed on diet prescription. If nurses have any questions regarding dietary restrictions they can contact the Dietary Office at extension 6189.
    B. The food must be immediately consumed. All food shall be labeled with 2 patient identifiers, date, and contents.
    C. No unpasteurized dairy products, raw meat or fish will be allowed.

All Revision Dates

4/2/2025, 2/13/2019, 7/1/2011, 9/1/2005, 2/1/2005, 11/1/2004, 12/1/2001, 12/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/2/2025
Dietary Department	Fernando Medina: Director, Support Services	4/2/2025
Dietary Department	Alex Jose: VCMC - Dietary	6/8/2022

Status **Active** PolicyStat ID **11353116**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	11/1/1992
Last Approved	4/2/2025
Effective	4/2/2025
Last Revised	4/2/2025
Next Review	4/1/2028
Owner	Fernando Medina: Director, Support Services
Policy Area	Dietary

D.56 Food & Nutrition Services Employee Health and Personal Hygiene

POLICY:

Food & Nutrition Services staff shall adhere to strict health and personal hygiene standards. It is the policy of the Food & Nutrition Services Department that no new employee shall be permitted to begin employment without completing their pre-employment lab work and department orientation which includes rules of personnel hygiene.

PROCEDURE:

I. Employee Health

A. Food & Nutrition Services Managers are required by the Food and Drug Administration's 2017 Food Code to notify health authorities if an employee has or carries the contagious diseases Salmonella typhi, hepatitis A, Shigella, or E. coli 0157:H7. Employees may be allowed to continue working under some restrictions, such as wearing gloves or working away from food. Employees may also be excluded from work for a considerable amount of time or even permanently depending on the disease.

1. Food & Nutrition Services Management and/or the Infection Prevention Manager reserve the right to prevent exposure by not allowing an employee to remain on duty if they are demonstrating any of the above symptoms. The employee may be referred to Employee Health Services.

II. Personal Hygiene

A. Staff shall bathe daily baths and wear a clean uniform.

B. All employees shall keep their hands and fingernails clean in accordance with policy

106.055 Hand Hygiene.

1. Hand washing facilities are provided in rest rooms, the kitchen and dish room. All other kitchen sinks should **NEVER** be used for hand washing.
2. Single-use gloves shall be worn while preparing food or if an employee has cuts, sores, rashes or a burn on a hand. Gloves shall be changed as often as handwashing is required. Single-use gloves shall be discarded and not be reused.
    i. Wearing gloves is not a substitution for washing hands.

C. Clean hose or socks and comfortable, clean, low-heeled non-skid shoes with closed toes shall be worn on a daily basis.

D. Maintain clean, neat, well groomed hair that is kept off the neck in a hair net. Employees may wear a uniform skull cap, but long hair shall be completely covered by a hair net. Beards shall be covered at all times.

E. Staff shall not chew gum, eat, or drink in the kitchen area, dish room, or behind cafeteria line.

F. Staff shall refrain from touching their hair, face, nose, and mouth.

G. Staff shall remove aprons before leaving the kitchen and before using the restroom. Replace aprons as they become soiled.

H. Jewelry shall not be worn on arms and hands except for a plain ring (e.g. wedding band) while preparing food.

All Revision Dates

4/2/2025, 3/1/2014, 7/1/2011, 12/1/2007, 2/1/2005, 12/1/2001, 12/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/2/2025
Dietary Department	Fernando Medina: Director, Support Services	4/2/2025

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

April 2025

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

b. Medical Staff Forms

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2005*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/6/2024*
Next Review:	*3 years after approval*
Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.032 Ethics Committee

POLICY:

The Ethics Committee is a group of individuals from diverse backgrounds who support Ventura County Medical Center/Santa Paula Hospital with three major functions: providing ethics consultations, developing and/or revising select policies related to clinical ethics, and facilitating education about topical issues in clinical ethics.

PROCEDURE:

~~Goals of the Ethics Committee:~~**Committee Composition:**

The Ethics Committee shall be composed of at least the following voting members: five members of the Medical Staff, and five members from allied health professions. These additional members may include registered nurse (RN), medical social worker, Hospital Administration, Hospital Chaplin, community members and attorneys. Additional members may be appointed by the Chief of Staff.

Duties:

The Ethics Committee shall strive to contribute to the quality of health care provided by the Hospital by:

- Providing assistance and resources for decisions which have bioethical implications. The Ethics Committee shall not however, become a decision-maker of record.
- Educating members within the hospital community concerning bioethical issues and dilemmas.
- Facilitating communication about ethical issues and dilemmas among members of the hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.
- Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and education guidance relating to such matters.
- Provide input into review of policy and creation of policy and procedures regarding ethical issues.

Goals of the Ethics Committee:

- Promote the rights of patients
- Promote shared decision making between patients or their surrogates and their clinician(s)
- Promote fair and just policies and procedures that maximize the likelihood of achieving good, patient-centered outcomes, and;
- Enhance the ethical tenor of health care professionals and the Ventura County Medical Center/Santa

Paula Hospital.

Meetings:

The Ethics Committee functions under the aegis of the Medical Staff and is governed by the Medical Staff bylaws with regards to ~~membership, meeting frequency, etc~~meetings (Article 11 Meetings). The proceedings and records shall be confidential and protected from discovery to the extent permitted by law.

~~PURPOSE~~

~~To provide education~~
~~To provide consultation and advice on ethical questions~~
~~To consider all referrals for case review~~

~~CONSULTATIONS~~

~~Requests for consultations from the Ethics Committee may be received from any member of the professional staff, patients, their families or interested parties. All requests will be considered.~~

~~Patients and/or surrogates may participate in consultations.~~

~~Consultation requests can be made to the Medical Director, the attending physician, or the chair of the Ethics Committee.~~

- The Committee shall meet as often as necessary, at the discretion of the Committee Chair.
- Report activities and recommendations to the Medical Executive Committee at least annually.
- In the absence of a meeting, cases regarding unrepresented patients may be addressed by a subcommittee consisting of the Chair, and at minimum 2 others which may include a case manager, an RN, and/or the Hospital Chaplin.

All revision dates: 11/6/2024, 5/1/2006

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	3/17/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/15/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/15/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/27/2020*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2025*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.113 Crash Cart Checks and Restocking Process

POLICY:

Crash cart checks and the restocking process is essential to the access of supplies needed, in the event of respiratory or cardiac failure in the hospital setting. The Ambulatory Care (AC) clinics do not have crash carts. The clinics maintain Emergency Response Equipment (refer to Ambulatory Care policy AC.001 Emergency Response Equipment).

PROCEDURE:

HOSPITAL refers to Ventura County Medical Center (VCMC), including the Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU), and Santa Paula Hospital (SPH). ***See Section I below.***

CLINIC refers to Ventura County Health Care Agency Ambulatory Care (AC) clinics. ***See Section II below.***

Section I - Hospital:

CRASH CART CHECKING:

A. Crash carts shall be locked with a ~~red~~ serially numbered breakable lock at all times.
   1. Three (3) types of crash carts shall be in use:
      a. Adult- ~~Blue crash cart;~~ adult medication trays.
      b. Pediatrics- Broselow crash carts; pediatric medication trays.
      c. Neonatal- ~~Crash carts with raspberry colored draws;~~ neonatal medication trays.

B. **Departmental Personnel:** Crash carts must be easily accessible. If a patient is in the area where a crash cart is stored, department personnel must remain in the vicinity to ensure crash cart security. They are to be checked each calendar day and upon replacement (see Attachment B- Crash Cart Checklist). On days that the unit is closed, staff shall document closed on the checklist.

   Tasks associated with the crash cart check include:

   1. Complete the Crash Cart Checklist located on the the crash cart, once every calendar day (i.,e., Day 1, Day 2, Day 3, etc.) and upon replacement of the crash cart following a code event. Checking the crash cart in advance of the calendar day is not permitted. On days that the unit is closed, staff shall

document closed on the checklist.

a. Examine the external ~~red~~ numbered lock to ensure it is intact. If the ~~red~~ numbered lock is intact, the crash cart is considered complete internally. If not, the crash cart must be exchanged.

b. Record the lock number.

c. For replacement carts, document lock ~~number~~numbers and time in the "*Remarks/Corrections"* section of the Crash Cart Checklist.

d. Perform defibrillator load checks per manufacturer's recommendations.

e. Check expiration dates of supplies and medications. If an item is expired, the cart must be exchanged or the medication tray replaced.

f. Ensure the capnography machine is plugged in, if present on crash cart.

g. Ensure the oxygen tank is full.

h. Ensure only current month checklist is present. Prior month lists should be given to department manager.

i. After checking that the crash cart is complete, staff should initial the sign-in sheet.

2. ~~A Crash Cart Checklist is located on the top of the crash cart.~~

~~a. After checking that the crash cart is complete, staff should initial the sign-in sheet.~~

~~b. Replace outdated supplies or missing equipment, as needed.~~

Pharmacy:

a. A pharmacist shall inspect crash carts for expired medications, every month. During inspection, the pharmacist shall break the numbered lock to access and visually inspect the medication tray in the crash cart.

i. Any crash cart medication tray that has expired or will be expiring in the current and/or the following month, shall be replaced with a new crash cart medication tray.

b. Replace the numbered lock to secure the medication tray.

c. The pharmacist shall apply a new crash cart medication sticker to the outside of the crash cart and record:

i. new lock number

ii. name of the medication due to expire first

iii. date of expiration

iv. initials of the inspecting pharmacist

d. The pharmacist shall record the date of inspection and the new crash cart lock number, on the daily Crash Cart Checklist located on the clipboard

~~Pharmacy:~~

~~1. A pharmacist shall inspect crash carts for expired medications, every month. During inspection, the pharmacist shall break the red numbered lock to access and visually inspect the medication tray in the crash cart.~~

~~a. Any crash cart medication tray that has expired or will be expiring in the current and/or the following month, shall be replaced with a new crash cart medication tray.~~

2. ~~Replace the red numbered lock to secure the medication tray.~~
3. ~~The pharmacist shall apply a new red crash cart medication sticker to the outside of the crash cart and record:~~
    a. ~~the new lock number;~~
    b. ~~the name of the medication due to expire first;~~
    c. ~~the date of expiration; and~~
    d. ~~the initials of the inspecting pharmacist.~~
4. ~~The pharmacist shall record the date of inspection and the new crash cart lock number, on the daily Crash Cart Checklist located on the clipboard.~~

CRASH CART REPLACEMENT:

A. Crash carts shall be replaced after a code event or if a supply item or medication in the crash cart is expired.

B. **Department Personnel:**

1. Immediately after use or upon identification of an expired item, the crash cart, minus the medication tray & defibrillator, shall be taken to Central Supply for replenishment of supplies.
2. The crash cart binder shall be removed from the crash cart before the crash cart is returned to Central Supply. The crash cart clip board is to be sent with the crash cart for forms to be replaced.
3. The medication tray shall be delivered to the Pharmacy by licensed personnel.
    a. In an event of a code, the pink carbon copy of the Cardiopulmonary Resuscitation Record ~~and/or Rapid Response Form,~~ shall also be delivered to pharmacy with the medication tray.
4. The used crash cart shall be delivered to Central Supply.
5. Retrieve a replacement crash cart from Radiology ground floor (room G212) at VCMC and from Central Supply at SPH.
6. Transport the replacement crash cart to the Pharmacy for addition of the medication tray. Once the pharmacy process is complete, the replacement crash cart is ready for its final destination.
7. Once the replacement crash cart reaches its final destination, place the crash cart binder and defibrillator on the crash cart. Document the ~~red~~ lock number and time in the "Remarks/Corrections" section of the Crash Cart Checklist.

C. **Central Supply:**

1. Replacement crash carts are available in Central Supply. These are fully stocked with supplies, but do not contain a medication tray.
2. Central Supply shall restock any returned crash cart.
    a. Check for and replenish used supplies.
    b. Check for and replace any expired equipment and supplies.

    ~~Check proper function of mechanical devices.~~
3. Secure the stocked crash cart with a lock to indicate that the supplies and equipment have been checked and replenished.

a. A new ~~red~~ crash cart sticker shall be applied to the outside of the crash cart with the name of the supply due to expire first, the date of expiration and the initials of the person who restocks the Central Supply crash cart.

D. **Pharmacy:**

1. Upon delivery of the replacement cart to the Pharmacy, a pharmacist shall open the crash cart by breaking the lock and add a sealed medication tray to the replacement crash cart.
2. The pharmacist shall secure the replacement crash cart with a ~~red~~ numbered lock.
   a. Crash cart locks shall be ~~red in color and~~ serially-numbered.
   b. ~~Crash~~Medication crash cart locks shall be stocked and controlled only by the Pharmacy Department.
3. The pharmacist shall apply a new ~~red~~ crash cart medication sticker to the outside of the crash cart and record:
   a. ~~the~~ new lock number~~;~~
   b. ~~the~~ name of medication due to expire first~~;~~
   c. ~~the~~ date of expiration~~; and~~
   d. ~~the~~ initials of the pharmacist~~.~~
4. The pharmacist shall record the crash cart medication tray number and the replacement crash cart's final destination in the KitCheck program.
5. The replacement crash cart is now ready to be delivered to its final destination.
6. Pharmacy staff shall receive used or expired crash cart medication trays and restock the crash cart medication trays as follows:
   a. Medication trays shall be checked, replenished and initialed by a pharmacy technician or pharmacist.
   b. Expiration dates of items added are noted on the crash cart medication list.
   c. A pharmacist shall check the medication trays for accuracy of contents and expiration dates. Upon completion of the check, the pharmacist shall seal the medication tray.
   d. Once sealed, the crash cart medication tray is ready to be added to a crash cart.
   e. The patient shall be charged for any medications administered in a Code event.

E. **Santa Paula Process Addendum:**

1. Santa Paula Hospital shall have a sealed medication tray, of each type available, in the medication room on the Medical-Surgical Nursing Unit.
2. In the event that SPH needs to replace a crash cart when the Pharmacy is closed, the Santa Paula Nursing Supervisor shall replace the medication tray and secure the replacement crash cart with a ~~red~~ numbered lock accessed from the ~~SPMS~~Santa Paula Med-Surg Pyxis unit.
3. The used medication tray shall be stored in the medication room on the Medical-Surgical Nursing Unit.
4. The following morning, a pharmacist shall double check the crash cart and medication tray placed by the Nursing Supervisor, according to the process listed in the "CRASH CART CHECKING" section for Pharmacy.

MEDICATION/IV - CONTENTS OF CRASH CART

Attachment A - Crash Cart and Defibrillator Location List

Attachment B - Crash Cart Checklist

Attachment C - Adult Crash Cart Supply List

Attachment D - Pediatric Broselow Crash Cart Supply List

Attachment E - Neonatal Crash Cart Supply List

Attachment F - Adult Crash Cart Medication List

Attachment G - Pediatric Broselow Crash Cart Medication List

Attachment H - Neonatal Crash Cart Medication List

Section II - Clinic:

A. Ambulatory Care clinics do not have crash carts. The clinics maintain Emergency Response Equipment (refer to Ambulatory Care policy AC.001 Emergency Response Equipment).

All revision dates: 3/7/2025, 8/10/2022, 1/27/2020

Attachments

- Attachment A - Crash Cart Locations
- Attachment B- Crash Cart Checklist.pdf
- Attachment C- Adult Crash Cart Supply List.pdf
- Attachment D- Pediatric Browselow Crash Cart Supply List.pdf
- Attachment E - Neonatal Crash Cart Supply List
- Attachment F- Adult Crash Cart Medications.pdf
- Attachment G- Pediatric Crash Cart Medications.pdf
- Attachment H- Neonatal Crash Cart Medications.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/7/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/21/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/21/2025
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/21/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/1/2004*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/3/2025*
Next Review:	*3 years after approval*
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~~central nervous system 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		
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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~~A patient who 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.
4. Simpson, K.R.,&Creehan, P.A. (2014). AWHONN Perinatal Nursing 5th Edition. 2021
5. Statement on Regional Anesthesia. American Society of Anesthesiologists. October 25, 2017. Accessed 8/2022.

All revision dates: 4/3/2025, 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
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Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: OB & Surgery	Stephanie Denson: Manager, Medical Staff Office	2/24/2025
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:	*11/15/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/31/2025*
Next Review:	*3 years after approval*
Owner:	*Fernando Medina: Director, Support Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.271 Violent Disruptive Behavior

PURPOSE:

Provide Ventura County Medical ~~Center and Santa Paula Hospital~~System (VCMS) with a means of addressing workplace violence. Aims to reduce or eliminate caregiver exposure to violent conditions that lead to injury by implementing proactive security measures, work practices, systems, procedures, and training. The policy provides action guidelines in the event of a workplace violence incident, and reference to additional policies and procedures for consideration.

POLICY:

~~Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH)~~VCMS is committed to providing a safe, therapeutic environment for patients, visitors and staff members. This policy sets forth guidelines for patients, visitors, and/or caregivers who engage in disruptive behavior that may adversely impact patient, visitor and staff safety. ~~VCMC~~VCMS has zero tolerance of violent or aggressive patient and/~~SPH has zero tolerance of violent or aggressive patient and/~~or visitor behavior toward caregivers and other bystanders.

For violent disruptive behavior in the Inpatient Psychiatric Unit and Crisis Stabilization Unit, please refer to policy *Z.88 Crimes Committed in the Inpatient Psychiatric Unit/Crisis Stabilization Unit (IPU/CSU)*.

DEFINITIONS:

"Disruptive behavior" is any inappropriate behavior by a patient and/or visitor(s) that may be disruptive to the patient's own care; the care of other patients; the safety of patients, visitors or caregivers; or the general operation of the hospital. These situations can include the following:

Intentional Assault: An act with intent to cause harm by a person in control of their faculties. Includes intentional damage to property.

Non-Intentional Assault: An act without intent to cause harm or by one who does not have control of faculties (i.e., head injury/combative, medication/sedation, disease process).

Verbal Abuse: The use of language, communication, or gestures intended to demean, frighten, intimidate, humiliate, blame or threaten harm to another individual.

Non-Intentional Verbal Disruption: Causing disruption without intent to do so or by one who does not have control of faculties (dementia, developmentally delayed pts., etc.).

Threat of Harm: A statement of intent to inflict harm by one who has the ability to formulate the intent to

commit an act. Threat of harm can be received via telephone, written form, and other modalities.

PROCEDURE:

Physical Disruption

A. **Intentional Assault** – *An act with intent to cause harm by a person in control of their faculties. Includes intentional damage to property.*

1. Remove yourself and others from immediate harm.
2. Provide clear direct commands.
3. Press emergency duress button (where applicable) to alert security.
4. Call a Code Grey ~~dial~~by dialing x76666 for Ventura County Medical Center (VCMC) ~~or~~campus, x78666 for Santa Paula Hospital (SPH), or on site security if available for clinics not at VCMC campus and give the operator the location. See policy *106.059 Code Grey* for more information.
   a. For clinics not at VCMC campus, if situation intensifies or is a safety risk, call 911.

   ~~Document in patient's electronic health record, if applicable.~~
5. Security to document incident in security log.
6. Notify Director of Security if additional security rounds are needed.
7. Notify the Charge Nurse/Outpatient Clinic Administrator (OCA), Department Director and/or Nursing Supervisor.
8. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*) for VCMC or SPH patients.
9. Submit a notification form into RL Datix.
10. If caregiver injury occurred, notify the Manager/OCA/Supervisor/Nursing Supervisor/Department Director and complete a First Report of Injury (RM-75) form.
11. If behavior continues, a huddle should be called with the Primary Nurse, Charge Nurse/OCA, Department Director or Nursing Supervisor, Director of Security, and Provider (if available) to determine next steps and a safe discharge plan (see *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
    a. Safety Officer and Social Worker to attend as needed.
12. If patient requests to leave against medical advice, refer to policy *100.223 Discharge Against Medical Advice*.
13. If incident involves a visitor, notify security or police if no security on site.

B. **Non-Intentional Assault** – *An act without intent to cause harm or by one who does not have control of faculties (i.e., head injury/combative, medication/sedation, disease process).*

1. Remove yourself and others from immediate harm.
2. Provide clear direct commands.
3. Call a Code Grey ~~dial~~by dialing x76666 for ~~Ventura County Medical Center (~~VCMC~~) or~~ Campus, x78666 for ~~Santa Paula Hospital (~~SPH~~)~~, or on site security if available for clinics not at VCMC campus and give the operator the location. See policy *106.059 Code Grey* for more information.

a. For clinics not at VCMC campus, if situation intensifies or is a safety risk, call 911.

4. If any restraints are to be considered, refer to policy *100.075 Restraint and Seclusion*.
5. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
6. Document in patient's electronic health record, if applicable.
7. Submit a notification form in RL Datix.
8. If caregiver injury occurred, notify the Manager/OCA/Supervisor/Nursing Supervisor/Department Director and complete a First Report of Injury (RM-75) form.

Verbal Disruption

A. **Intentional Verbal Disruption – Threat of Harm** – *A statement of intent to inflict harm by one who has the ability to formulate the intent to commit an act. Threat of harm can be received via telephone, written form, and other modalities.*

1. Call a Code Grey ~~dial~~by dialing x76666 for ~~Ventura County Medical Center (~~VCMC~~) or~~ campus, x78666 for ~~Santa Paula Hospital (~~SPH~~)~~, or on site security if available for clinics not at VCMC campus, and give the operator the location. See policy *106.059 Code Grey* for more information.
   a. For clinics not at VCMC campus, if situation intensifies or is a safety risk, call 911.
2. Notify the Charge Nurse/OCA, Department Director and/or Nursing Supervisor.
3. Document in patient's electronic health record, if applicable.
4. Patient alert may be placed in patient's electronic health record, if applicable.
5. Submit a notification form in RL Datix.
6. If incident involves a visitor, notify security or police if no security on site.

B. **Non-Intentional Verbal Disruption** – *Causing disruption without intent to do so or by one who does not have control of faculties (dementia, developmentally delayed pts., etc.).*

1. Provide clear direct commands.
2. Document in patient's electronic health record, if applicable.
3. Continue providing care to patient while attempting to minimize auditory disruptions for other patients.
4. Consider engaging with family/visitors to assist with reorientation of patient.

C. **Verbal Interference with Health Care Operations** – *to willfully or recklessly interfere with access to or from a health care facility or willfully or recklessly disrupt the normal functioning of such facility.*

1. Call a Code Grey ~~dial~~by dialing x76666 for ~~Ventura County Medical Center (~~VCMC~~) or~~ campus, x78666 for ~~Santa Paula Hospital (~~SPH~~)~~, or on site security if available for clinics not at VCMC campus, and give the operator the location. See policy *106.059 Code Grey* for more information.
   a. For clinics not at VCMC campus, if situation intensifies or is a safety risk, call 911.
2. Notify the Charge Nurse/OCA, Department Director, and Nursing Supervisor.
3. Implement safety plan (See *Attachment A Violent/Disruptive Patient Safety Plan Checklist*).
4. Document in patient's electronic health record, if applicable.
5. Submit a notification form in RL Datix.

6. If behavior continues, a huddle should be called with Primary Nurse, Charge Nurse/OCA, Department Director or Nursing Supervisor, Director of Security, and Attending Physician (if available) to determine next steps and safe discharge plan.
    a. Safety Officer and Social Worker to attend as needed.
7. If incident involves a visitor, notify security.

Documentation

A. Patient care staff are to document the disruptive behavior (including the date and time), as well as record that the patient was informed that such behavior is inappropriate and must cease.

B. Instances of inappropriate or persistent non-compliant conduct should be documented to establish a pattern of repetitive disruptive behavior or non-compliance or otherwise inappropriate conduct.

C. Document all efforts to establish and maintain a satisfactory ~~hospital~~VCMS/patient relationship.

D. Incidents of patient disruptive behavior must be submitted in RL Datix. The incident report must include an accurate description of the situation, quotes (if possible), and actions taken.

E. If caregiver injury occurred, notify the Manager/OCA/Supervisor/Nursing Supervisor/Department Director and complete a First Report of Injury (RM-75) form.

F. For patients with repeated non-compliance to this policy, ~~Department~~department leaders will notify the Administrator on Duty (AOD) for hospitals or Regional Administrative Directors (RAD) for clinics. AOD/RAD to consider consulting additional resources, including Risk Management.

Additional Considerations for Patient and Staff Safety

A. Efforts should be made to achieve compliance from the patient and/or visitor in order to protect the safety to all patients and staff. All efforts to de-escalate and/or achieve compliance should be documented in the medical record.

1. A team huddle may be organized and conducted to develop a Patient Safety Plan for VCMC and SPH patients. The team may include, but is not limited to the Primary Nurse, Charge Nurse, Director of Security, Department Director or Nursing Supervisor, Attending Physician, Safety Officer, and Social Worker.
2. Patients will be provided with a copy of policy *100.004 Patient Rights and Responsibilities*.
3. At least two (2) members from the team should meet with the patient. The patient, his/her family or others involved in the patient's care are counseled. The counseling focus is on the patient's responsibilities, the Safety Plan for the patient if applicable, the need for compliance and the consequences of continued inappropriate behavior. If needed, provide behavioral contract (see Attachment B Behavioral Agreement) and place within the medical record.
4. If incident involves a visitor, notify security and consider disallowing visitors.
    a. For locations without security, 911 may be called.

B. Any caregiver can identify a patient and/or visitor as a possible risk to staff or other patients.

1. History of violence toward staff/patients.
2. Credible verbal threat of harm.
3. Possession of weapon or objects used as weapons.

C. Violent disruptive behavior by patients and/or visitors should be communicated in accordance with policy *100.228 Chain of Command*.

D. **Denying Patient Visitors:** A patient has a right to receive visitors or have a visitor accompany them but this right may be limited or restricted when it interferes with the patient's own care, the care of other patients, or the safety of patients, visitors or ~~Ventura County Medical Center and Santa Paula Hospital~~VCMS caregivers.

1. ~~Ventura County Medical Center and Santa Paula Hospital~~VCMS may exclude a visitor if the visitor engages in disruptive, threatening or violent behavior of any kind.
2. ~~Ventura County Medical Center and Santa Paula Hospital~~VCMS may exclude a visitor if the visitor is providing, or there is reasonable suspicion that he/she is providing, a patient with alcohol or illegal drugs.
    a. Security will ask the visitor to leave the hospital or clinic. If needed, security may contact local law enforcement at their discretion.
        i. For locations without security, 911 may be called.

All revision dates: 3/31/2025, 11/15/2023

Attachments

- Attachment A Violent Disruptive Patient Safety Plan Checklist
- Attachment B Behavioral Agreement [VCHCA-603-210]

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Safety Committee	Fernando Medina: Director, Support Services	3/31/2025
Policy Owner	Fernando Medina: Director, Support Services	3/31/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*4/19/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2025*
Next Review:	*3 years after approval*
Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.031 Confidentiality of Medical Staff/Allied Health Professional Staff Records

PURPOSE

This policy provides for the confidentiality of all records maintained by or on behalf of the Medical Staff ("Medical Staff Records") and Allied Health Professionals ("AHP"), including the records and minutes of all Medical Staff Committees, the credentials/quality and/or peer review files concerning individual practitioners (including AHPs), and the records of all Medical Staff credentialing/peer review and performance improvement activities for the Hospital.

POLICY

The Medical Staff and Hospital recognize that it is vital to maintain the confidentiality of Medical Staff Records. Medical Staff members and AHPs participate in credentialing/quality/peer review and/or performance improvement activities and rely upon the preservation of confidentiality. The members of the Medical Staff understand and agree that the confidentiality of these activities and of all Medical Staff Records is to be preserved and that these communications, reports, and records will be disclosed only in the furtherance of those credentialing/peer review and performance improvement activities, and only in accordance with this policy and the law. This requirement of confidentiality extends to: 1) the records and minutes of all Medical Staff Committees, 2) the records of all Medical Staff credentials/peer review files concerning individual practitioners, including AHPs, 3) the discussions and deliberations which take place within the confines or under the aegis of any Medical Staff Committee, and 4) the records and files of all peer review investigations.

PROCEDURE

I. Location and Security Precautions

All Medical Staff Records shall be maintained by the Medical Staff Administration. All Medical Staff Records are maintained electronically and/or locked file cabinets with the exception of some historical applications which are maintained in an offsite, secure storage facility. The electronic records are kept in a secured database. Access is granted to certain groups or individuals based on their business purpose. Medical Staff Records will only be released from that office in accordance with this policy.

II. Means of Access

1. Access by Persons Within the Hospital ~~(including any affiliates)~~ and Medical Staff

All requests for Medical Staff Records by persons within the Hospital and Medical Staff shall be presented to the Manager of Medical Staff Administration or designee. The form of access to inspect records in question will be determined by the Manager of Medical Staff Administration or designee in consultation with the Chief of Staff or Chief Medical Officer. Unless otherwise determined, a person permitted access under this policy will be given a reasonable opportunity to inspect the records in question and to make notes. ~~If necessary, copies of the record can be provided in a PDF format.~~

2. Access by Persons Performing Official Hospital or Medical Staff Functions

Medical Staff Officers, the Chief of Staff, Medical Staff Committee members, members of the Board of Directors, the Chief Medical Officer and Chief Executive Officer (CEO) or authorized representative, the Manager of Medical Staff Administration, health plan representatives, and any other persons assisting in credentialing/peer review or performance improvement activities may have access to Medical Staff Records, other than their own, but only to the extent necessary to perform their official functions as follows:

a. Department Head/ Service Chief/ Division Head

b. Medical Staff Officers

c. Medical Staff Committee Members

Medical Staff Committee members shall have access to the records of Committees on which they serve and to the credentials/quality/peer review and performance improvement files of practitioners whose qualifications or performance the Committee is reviewing as part of its official functions.

d. Board of Directors/Designated Representative

The Board of Directors, and the Chief Medical Officer and CEO of Hospital, as its designated representative, shall have access to the Medical Staff Records to the extent necessary to perform their official functions.

e. Medical Staff Administration Staff

The Medical Staff Administration staff shall have access to the Medical Staff Records to the extent necessary to perform official functions.

f. Health Plan Representatives

Health Plan representatives and payers may be permitted access to perform audits.

g. In accordance with any information sharing agreements, certain elements of the Medical Staff Records may be shared with affiliated health care entities.

3. General Access by Practitioners to Medical Staff Records

a. Credentials/Quality Files

A practitioner will have access to the credentials/quality files of other practitioners only under the circumstances outlined above. A practitioner may have copies of any documents in the credentials/quality file which he or she submitted (that is, his or her initial appointment application, application for reappointment, request for privileges, copies of licensure and certifications, or correspondence from himself or herself) or which were addressed to him or her or of which copies were earlier provided to him or her. A practitioner will be allowed access to further information in his or her credentials/quality file only if, following a written request by the practitioner, the Manager of the Medical Staff Administration or their designated representative(s) grant written permission for good cause or as permitted under the Medical Staff Bylaws. Examples of information that could be released to the practitioner are patient volume reports and/or quality performance profiles. The

patient volume/activity can also be released by medical records.

b. Medical Staff Committee Files

i. Except as provided above, a practitioner shall be allowed access to Medical Staff Committee files (including Committee minutes) only if, following a written request by the practitioner, the Chief of Staff or its designated representative, grant written permission for good cause.

ii. Minutes from Medical Staff Committees can be distributed electronically and are protected from discovery under applicable law, including but not limited to Cal. Evidence Code, section 1157. All committee minutes are maintained electronically.

4. Access By Persons Or Organizations Outside The Hospital or Medical Staff (excluding affiliates)

a. Credentialing or Peer Review at other health care facilities

i. Information contained in a credentials/quality file, or other information which is subject to this policy, may be released in response to a request from another peer review body, for credentialing or peer review purposes; for example, to verify a practitioner's medical staff membership and/or clinical privileges at the Hospital. No information shall be released until a copy of a signed authorization, and release from liability, has been received from the practitioner. Disclosure shall generally be limited to the specific information requested.

ii. All responses to inquiries regarding that practitioner shall be reviewed and approved by the Manager of the Medical Staff Administration and/or Chief of Staff or his or her designee. Legal consultation may be sought as well.

b. Request by Hospital Surveyors

Hospital surveyors (i.e., from the The Joint Commission [TJC], National Committee for Quality Assurance [NCQA], Accreditation Association for Ambulatory Health Care [AAAHC], Department of Healthcare Services [DHS], Department of Public Health [DPH], Center for Medicare & Medicaid Services [CMS] or any other Hospital Surveyors) shall be entitled to inspect Medical Staff Records on the Hospital premises in the presence of Hospital or Medical Staff personnel and/or remotely via secure access provided that the surveyor demonstrates the following:

i. Specific statutory, regulatory, or other authority to review the requested materials.

ii. That the materials sought are directly relevant to the matter being investigated.

iii. That the materials sought are the most direct and least intrusive means to carry out the survey or a pending investigation, bearing in mind that credentials/quality files regarding individual practitioners are strictly confidential.

iv. Sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff.

v. In the case of requests for documents with practitioner identifiers not eliminated, the need for such identifiers is clear.

c. Subpoenas

All subpoenas of Medical Staff Records shall be referred to the Manager of the Medical Staff Administration, who will consult with legal counsel regarding the appropriate response.

d. Other Requests

All other requests by persons or organizations outside the Hospital for information contained in the Medical Staff Records shall be forwarded to the Medical Staff Administration. In such circumstances, Medical Staff Records may only be shared as expressly required by law or by express approval of the Medical Executive Committee.

All revision dates: 3/7/2025, 4/19/2022

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/3/2025
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	3/7/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	2/24/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*4/12/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/12/2022*
Next Review:	*3 years after approval*
Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.032 Medical Staff Leave of Absence

POLICY:

In accordance with the Medical Staff Bylaws and at the discretion of the Medical Executive Committee (MEC), an existing Medical Staff member may, under certain circumstances, undergo a leave of absence when they will be away from their patient care and Medical Staff responsibilities for a period longer not to exceed a period of two (2) years, and remain a member of the Medical Staff. This Policy applies to leaves which may exceed ninety (90) days, including but not limited to, voluntary leaves for personal reasons, medical leaves of absences, and military service

PROCEDURE:

Submission of Written Leave Request to:

1. A member in good standing and whose medical records are complete may obtain consideration of approval for leave of absence by submitting a written request to the MEC, care of the Medical Staff Office, at least thirty (30) days prior to the requested leave date. Exceptions to the advance notice may be granted by the MEC for reasons including but not limited to documented health reasons, military service, or personal reasons, such as the death of an immediate family member.
2. The request must include the following information:
    a. The reason(s) for the request;
    b. The approximate period of leave desired; and
    c. Any supporting documentation as necessary.
3. In circumstances where an exception to the advance notice has been granted by the MEC, the member must provide the MEC as soon as reasonably possible, with the information listed above. The member is also responsible to complying with the remaining provisions of this Policy.

Request Review:

1. Once received, the MEC will review the member's request and may either grant or deny the leave of absence or request more information, including an interview with the member, as necessary for its determination. The member is responsible for cooperating with such requests, including providing all relevant information and granting an interview as necessary for the MEC to make its decision, in accordance with the Medical Staff Bylaws.

2. The member will be notified of the MEC's final decision.
3. If a member has been granted a leave of absence by the MEC, there shall be an automatic suspension of privileges through the duration of the leave and the member's membership rights and responsibilities shall be inactive.
4. The member shall be responsible for arranging coverage for all of his/her patients and shall meet all obligations to the hospital, including completion of all medical records, prior to the commencement of his or her leave period.

Reappointment:

1. If the member's term of appointment is scheduled to expire during the member's leave period, the member must request reappointment in a timely manner pursuant to the relevant provisions in the Medical Staff Bylaws, notwithstanding the leave.
2. If the member's appointment expired during the member's leave period, the member must submit a completed application for reappointment prior to reinstatement. Any such application shall be processed as described in the Medical Staff Bylaws for initial applications, except that any verified credentials information that exists in the Medical Staff's files may be utilized in the credentialing process, as deemed appropriate by the Credentialing Committee.

Termination of Leave:

1. At least thirty (30) days prior to the termination of the leave period, or at any earlier time, the member must request reinstatement of privileges by submitting a written notice to that effect to the MEC.
    a. As part of the request, the member shall submit a summary of relevant activities during the leave, including written verification that the member's health status and ability to assess qualifications for membership and privileges, and carry out delineated clinical privileges have been reviewed and were not adversely affected as a result of the time away from clinical practice at the hospital, if so requested.
    b. The member is responsible for cooperating and responding to requests from the MEC, including providing all relevant information as necessary for the MEC to make its decision, in accordance with the Medical Staff Bylaws.
2. The MEC will review relevant information and shall make a decision concerning the reinstatement of the member's privileges and prerogatives. Temporary resumption of clinical practice for a member who has submitted a reinstatement request may also be authorized by a joint decision of the Chief Medical Officer, Chief of Staff, and the responsible Department Chief, subject to approval by the MEC.
3. The MEC may implement requirements of the member as necessary, including but not limited to monitoring and/or proctoring, prior to the reinstatement of the member's privileges.
4. If the member's approved leave took place while an investigation or restriction on his or her clinical privileges was in place or pending, such investigation or restriction may continue prior to the member's return to practice if so determined by the MEC.
5. **Failure, without good cause, to request reinstatement in a timely manner shall result in automatic termination of the member's membership, privileges, and prerogatives at the hospital at the expiration of the term of appointment in effect at the time of leave.**
    a. A member who wishes to contest this result may seek review by the MEC, at the MEC's discretion,

by submission of a written statement and/or a meeting before the MEC.

b. Failure to request reinstatement in a timely manner shall not preclude the practitioner from submitting an initial application for membership and privileges.

All revision dates: 4/12/2022

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/3/2025
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	3/7/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	2/13/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/1983*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/12/2022*
Next Review:	*1 year after approval*
Owner:	*Fernando Medina: Director, Support Services*
Policy Area:	*Administrative - Environment of Care*
References:	

106.001 Safety Management Plan

POLICY:

The Safety Management Plan is set up to provide oversight to ensure that Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU) and the Ambulatory Care clinics are functionally safe and to maintain a secure health care environment for patients, visitors, staff, medical staff and volunteers by requiring the establishment and supporting the maintenance of the primary functions of the Environment of Care. The scope of the Safety Management Plan defines the processes which the Ventura County Medical System provides for safety in the patient care setting and ensures effective preparation of staff responsible for the safety of patients.

PROCEDURE:

AUTHORITY:

- The Joint Commission Hospital Accreditation Standards
- National Fire Protection Association Life Safety 1001
- Occupational Safety and Health Administration
- Environmental Protection Agency
- Department of Transportation
- Air Pollution Control District
- Local Fire Department

ORGANIZATION:

1. The Safety Management Plan defines the mechanisms for interaction and oversight for the primary functions involved in the Environment of Care (EOC). The program is overseen by the Safety Committee with functions and responsibilities decentralized into the following EOC subcommittees:
    1. Safety Management
    2. Hazardous Material & Waste Management
    3. Fire & Life Safety
    4. Emergency Management
    5. Security Management
    6. Medical Equipment Management

7. Utilities Management

2. The Chief Executive Officer (Hospital Administrator) and the Medical Staff Director shall appoint a Safety Officer who is qualified by experience and/or education to be responsible for the development, implementation, and monitoring of the program. The Safety Officer has the authority to intervene and take appropriate action when conditions exist that pose an immediate threat to life or health, or pose a threat of damage to equipment or buildings.
3. The Safety Committee provides oversight on the design, implementation, and monitoring of each specific management plan for the primary functions involved in the Environment of Care.
4. The Safety Committee Chair will report safety concerns to EOC Committee.
5. The Safety Committee will meet at least quarterly to review issues identified by the Safety Committee and solicit interactive review of the safety of the organization. The Safety Committee members shall include representatives from the following areas:
    1. Administration
    2. Physicians
    3. Nursing and Ancillary Services
    4. Support Services
    5. Medical Staff
    6. Infection Control
    7. Performance Improvement
    8. Ambulatory Care Clinics
6. The Chief Executive Officer will appoint the Radiation Safety Officer.
7. The Medical Staff Director may appoint Medical Staff as members of either the Safety Committee and/or the EOC Committee.
8. All policies of the Safety Management Plan are designed to apply to all departments, staff, volunteers, Medical Staff, patients, visitors, contractors and vendors.

OBJECTIVES:

1. The Safety Management Program will strive to minimize avoidable risks and injuries through sound planning, resource allocation, effective training implementation, ongoing monitoring and improvement of risk reduction activities.
2. The hospital conducts proactive risk assessments that evaluate potential adverse impact of buildings, grounds, equipment, occupants and internal systems on the safety and health of patients, staff and others.
3. These identified risks are used to implement procedures and controls to achieve the lowest potential for adverse impact on patients, staff and others.
4. The Safety Committee will meet as often as necessary, but at least quarterly, to analyze identified safety management issues, identify trends, make recommendations for actions and evaluate the effectiveness of actions taken.
5. When problems are identified, corrective action will be developed and implemented by the appropriate individuals. Such action will be documented, monitored for effectiveness and revised as necessary.

EDUCATION:

1. In-service training on the Environment of Care general safety, area specific safety and job specific hazards is provided at the initial orientation, annually thereafter, and as necessary to all staff, volunteers and Medical Staff as determined by Environmental Tours.
2. Education will be provided as necessary based on performance measures and random questions or by surveillance EOC rounds.

PERFORMANCE EVALUATION:

1. The Safety Management Program works at the sub-committee level to establish standards. The sub-committees will implement, monitor, and document evidence of EOC performance measurement.
2. The Safety Committee will submit performance improvement tasks as part of each EOC Management Plan.
3. Staff will be able to demonstrate or describe their role and expected level of performance in the Safety Management Program.
4. Staff's knowledge of policies and procedures and responsibilities under the program are periodically assessed.

PERFORMANCE IMPROVEMENT:

1. Use of Environmental Surveillance Rounds summary to identify opportunities to improve the Environment of Care.
2. Monitor and report EOC rounds routinely to department heads.
3. Re-establishing regular reporting mechanisms with Employee Health for injuries to patients or others within the hospital facilities, occupational illnesses and staff injuries. Programs will be designed to address the most common injuries.
4. Reduce the Notice of Violation by determining the root cause of violation(s).

ANNUAL EVALUATION

1. The scope, objective, performance, effectiveness and goals of the Safety Management Program will be evaluated annually to ensure it meets Safety, Risk Management, and Performance Improvement needs.
2. Safety polices and procedures are established, distributed, practiced and enforced. The policies are reviewed as frequently as necessary, but at least every year.

All revision dates: 12/12/2022, 9/17/2019, 4/1/2013, 3/1/2012, 4/1/2011, 7/1/2010, 9/1/2009, 1/1/2007, 5/1/2006, 4/1/2004, 11/1/2001, 12/1/1998, 11/1/1998, 10/1/1986

Attachments

Annual Evaluation of Safety Management Plan

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Safety Committee	Fernando Medina: Director, Support Services	3/31/2025
Policy Owner	Fernando Medina: Director, Support Services	3/31/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2010*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*8/11/2021*
Next Review:	*1 year after approval*
Owner:	*Ian McGraw: Manager Facility Operation*
Policy Area:	*Administrative - Environment of Care*
References:	

106.043 Fire Safety Management Plan

POLICY:

Ventura County Health Care Agency strives to provide that the facilities are functionally safe and maintain a secure health care environment for patients of all ages, visitors, medical staff, employees and volunteers by requiring and supporting the establishment of an effective Fire Safety Management Plan (FSMP).

Under the Fire Safety Management Plan, a mechanism exists that defines and acknowledges life safety risks that may exist for outpatients, visitors, employees, volunteers, medical staff, property and equipment and establishes procedures to manage those risks which addresses:

- Specific roles/responsibilities of personnel away from the point of origin of a fire, and
- Specific roles/responsibilities of personnel in preparing for evacuation

The goal of the FSMP is to describe the processes for protecting employees, volunteers, medical staff, patients, visitors and property from fire and the products of combustion and smoke in accordance with all applicable required structural features of fire protection addressed in Life Safety Code, National Fire Protection Association 101, 2000 Edition.

The scope of the FSMP is established to provide for the operational reliability, assess the special risks and respond to emergency situations involving systems that support the patient care environment, so as to provide a safe environment for patients, visitors, employees, volunteers and medical staff. The FSMP systems and associated personnel will be managed so that risks can be minimized and benefits maximized.

The FSMP provides oversight in the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. HCA VCMC/SPH employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by local or state agencies as part of the construction and permitting process. A vigorous construction monitoring and building commissioning program round out the design phase.

PROCEDURE:

Authority

1. The HCA Facilities Manager is responsible for the management, monitoring and reporting regarding the Fire Safety Management Plan.
2. The HCA Facilities Manager has immediate and complete access to all physical plant records and any other records that become necessary in carrying out FSMP.

ORGANIZATION

1. The HCA Facilities Manager shall keep a monthly Fire Safety Management report that is submitted quarterly to the Environment of Care Committee. This report provides information and trends concerning life safety indicators including, but not limited to:
    - Fire Suppression-testing, PM's, Repairs
    - Fire Alarm Systems-testing, PM's, Repairs
    - Fire Drills-testing, PM's, Repairs
    - Preventative Maintenance Statistics (Priority 1-3)
    - Emergency Generator Testing
2. The Environment of Care Committee shall receive, review, investigate and take action as appropriate on all FSMP reports.

RESPONSIBILITIES

1. The HCA Facilities Manager shall be responsible for the ongoing monitoring, reporting, documentation, compiling of statistics and education aspects of the FSMP.
2. The Environment of Care Committee shall review and revise all organizational Fire Safety Policies and Procedures at least every three years and as necessary, as well as provide for distribution and enforcement of these policies.
3. All Department Heads are responsible for compliance with requirements of the FSMP as far as their individual department responsibilities mandate and will provide appropriate documentation relating to the requirements of the FSMP as requested.
4. All individuals are responsible for compliance with the requirements of the FSMP as far as their individual responsibilities mandate and shall cooperate with all appropriate provisions of the Fire Safety Management Program.
5. All employees have a role in the FSMP policies specific to their department. This is reviewed at new employee orientation, an each employee has an annual safety update to complete. All employees are responsible for participating in Fire Drills and are evaluated.

ACTIVITIES

1. The FSMP monitors for trends that develop in the indicators relating to Fire Safety and Life Safety issues.
2. The FSMP gives high priority to:
    - **Managing Fire Safety Risks**
        - Protecting patients, visitors, employees, volunteers and medical staff from fire and the products of combustion;
        - Inspection, testing and maintaining fire alarms systems, including quarterly testing of all circuits and annual prevention maintenance of all components;
        - The Materials Management Department is responsible for purchasing only fire/flammability-rated replacement products meeting the standards defined. Department heads that need to purchase products coordinate product evaluations with Materials Management.

        - Building Management Plan criteria and reporting of fire and smoke barriers, fire and smoke doors, adjacent compartments and exit/emergency lighting.
    - **Statement of Conditions, maintaining existing environments of care to comply with the LSC.**
        - Reporting and investing FSMP and fire protection deficiencies, failures and user errors that may threaten the patient care environment during a fire.
        - Identifying and maintaining all applicable required structural features or fire protection to Fire Prevention Code 2000.
        - Completion of a Statement of Condition (SOC) which describes the current condition of the structural features for fire protection of each building for more consciously sedated patients. Annual review of the SOC/eSOC will be evaluated by the Facilities Manager and Architect of Record.
    - **Conducting fire drills regularly**
        - Conducting fire drills in such a manner that at least one drill per quarter is held on each shift for hospitals and one per year in clinical settings. The drills will be monitored and critiqued results will be submitted to the Environment of Care Committee.
    - **Maintaining fire safety equipment and building features**
        - Inspecting, testing and maintaining a fire alarm, and a fire detection system that minimizes smoke management and transmit s the fire alarm to local fire departments through an alarm monitoring system.
        - Inspecting, testing and monitoring the automatic fire suppression systems within the Agency/ Facility.
        - Managing portable fire extinguishers, including guidelines for identification, placement and use, a monthly inspection program and annual maintenance.
    - **Protecting the occupants of a building when the building doesn't meet the applicable LSC.**
        - Implementing, documenting and enforcing an Interim Life Safety Measures policy to compensate temporarily for the hazards posed by existing FSMP deficiencies or construction activities.
3. The FSMP provides an integrated and coordination effort toward Fire Prevention, Risk and Safety Management which complies with The Joint Commission (TJC), National Fire and Protection Association (NFPA), Fire Prevention Code (FPC), and Occupational Safety and Health Administration (OSHA) standards and assists our facility in controlling losses related to professional and general liability.
4. When a problem is identified, the system will be evaluated for cause and necessary remedial action. Action will be taken by appropriate parties including staff and or outside resources. Action taken will be documented and monitored. Monitoring will be required- unless the problem recurs.
5. A summary of Fire Prevention safety indicators will be reported to the Environment of Care Committee on a quarterly basis.

ORIENTATION AND EDUCATION PROGRAM

Training evaluations, monitoring, and observations made during fire drills, EOC surveillance rounds, monthly Facility Maintenance inspections, and annual Safety updates, are used to ensure that personnel can describe and or demonstrate the following:

1. Facility-wide fire-response needs;
2. Area-specific needs and fire evacuation routes;
3. Their specific roles and responsibilities when at a fire's point of origin;
4. Their specific roles and responsibilities when away from a fire's point of origin;
5. Use and functioning of fire alarm systems;
6. Their specific roles and responsibilities in preparing for building evacuation;
7. Location and proper use of equipment for evacuating or transporting patients to areas of refuge; and
8. Building compartmentalization procedures for containing smoke and fire.

ANNUAL EVALUATION

At least annually, there will be an evaluation and review of the Fire Safety Management Plan's scope, objectives, performance and effectiveness. The HCA Facilities Manager is responsible for performing the annual evaluation of the Fire Safety Management Plan. This will be reported to and reviewed by the Environment of Care Committee and Administration.

All revision dates: 8/11/2021, 4/1/2013, 3/1/2012, 4/1/2011, 6/1/2010

Attachments

Annual Evaluation of the Fire Safety Plan

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Safety Committee	Fernando Medina: Director, Support Services	3/31/2025
Policy Owner	Ian McGraw: Manager Facility Operation	3/31/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*3/1/2010*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*5/9/2023*
Next Review:	*1 year after approval*
Owner:	*Ian McGraw: Manager Facility Operation*
Policy Area:	*Administrative - Environment of Care*
References:	

106.044 Security Management Plan

POLICY:

The Security Management Plan describes the methods of providing security for patients, visitors, staff and equipment for Ventura County Medical System (VCMS). Security protects individuals and property against harm or loss, including workplace violence, theft, infant abduction, and unauthorized entry. All security incidents are documented, tracked and trended for analysis.

The program applies to the Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU) and Ambulatory Care Clinics.

PROCEDURE:

FUNDAMENTALS

A. A visible security presence in the hospitals helps reduce crime and increase feelings of security by patients, visitors, and staff.

B. The incident tracking and trending is essential for the reduction in crime, injury and prevention as well as theft.

C. Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.

D. Training hospital staff is critical to ensuring their performance. Staff is trained to recognize and report either potential or actual incidents to ensure a timely response.

E. Staff are trained and provided post orders to guide them with their roles and responsibilities for their designated areas.

F. Violence in the workplace is a growing problem in health care. De-escalation training is essential for addressing workplace violence.

OBJECTIVES

The Objectives for the Security Program are developed from information gathered during annual statistical data tracking and trending and risk assessment, which provide measures for improvement of the program.

The objectives for this plan are to:

- Provide the safest environment for all patients, staff, and visitors

- Provide and document adequate Security rounds on all shifts
- Respond to emergencies and requests for assistance in a timely fashion.
- Continue Security Guard training and competency evaluation
- Continue to provide a visual presence to deter crime.

ORGANIZATION & RESPONSIBILITY

A. The Safety Committee receives regular reports of the activities of the Security Program. The Safety Committee reviews reports and, as appropriate, communicates concerns about identified issues with regards to safety.

B. The Director of Security, in collaboration with the Safety Officer, is responsible for monitoring all aspects of the Security Program. The Director of Security advises and reports to the Safety Committee on security related issues which may necessitate changes to policies and procedures, orientation or education of staff.

C. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific security procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Director of Security provides department heads with assistance in developing department security programs or policies.

D. Individual staff members are responsible for learning and following job and task-specific procedures for secure operations.

SECURITY DEPARTMENT ORGANIZATION

Authority:

- The Chief Executive Officer (Hospital Administrator) has delegated Allied Universal Guard to provide contractual security services for the Ventura County Medical System.
- The Safety Officer and Director of Security have immediate and complete access to all areas of the Hospitals and to all physical facility records that become necessary in carrying out security management responsibilities.

Security Services:

- Unarmed Security Guard Services are required for Ventura County Medical System. The focus in this area is to ensure that Ventura County Medical System employees and the general public are provided a safe environment to conduct official business. Security services include patient watches, roving patrol, escort services, code response, temporary posts and many other security fire watch and other related requirements.
- Allied Universal coordinates the collection, processing, and reporting of security activity throughout the facility to support a reliable, efficient flow of information. The security staff oversees the daily operation of the VCMS security program and assists staff, patients and visitors with support and problem solving. Confidentiality will be maintained in accordance with VCMS policy.
- Respond to requests at VCMS for support and intervention. This intervention includes de-escalation of verbal irrate patients/vendors/staff, and intervention of physical altercations.

Elite Officers:

- Elite Officers must be physically capable and willing to assist VCMS staff in restraining violent persons at VCMS until authorities arrive. In the event of a physical altercation, guards may be required to physically intervene for the protection and safety of VCMS staff, clients and themselves. This response should be

considered ONLY if verbal intervention fails, but it **must** be stipulated in the post instructions for all assigned guards. Assigned guards are special guards for special areas (Emergency Department/ Inpatient Psychiatric Unit) and possess specific training.

PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Security program. Performance measures have been established to measure at least one important aspect of the Security program.

The performance measures for the Security program which are also reported to leadership include:

- 100% in performance of quarterly Code Pink Drills with appropriate written critique
- 100% in performance of quarterly Code Purple Drills with appropriate written critique
- 100% proper documentation of monthly security statistical data
- 100% camera surveillance

PROCESSES FOR MANAGING SECURITY RISKS

Management Plan

Ventura County Medical System develops, maintains and annually evaluates Security Management Plan for its effectiveness in managing the security risk of the staff, visitors, and patients at VCMS.

Security Risk Assessment

The Safety Officer and Director of Security manage the security risk assessment process for VCMS. In coordination with the Director of Security, the Safety Officer is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The Safety Officer, Director of Security and the Risk Management department ensure compliance with applicable codes and regulations.

VCMS identifies security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of annual proactive risk assessment of high-risk processes, and from daily observation and surveillance by Allied Universal, Department Managers, patients and incident reports.

The risk assessment is used to evaluate the impact of the environment of care on the ability of VCMS to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, the performance of everyday tasks, workplace violence, theft, infant abduction, and unauthorized access to the facility.

Use of Risk Assessment Results

A Risk Assessment is used to evaluate the impact of the environment of care on the ability of VCMS to perform clinical and business activities. A risk assessment will be performed by type of risk/threat to the organization. Where risks are identified, the current programs and processes to manage those risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled, action must be taken to eliminate or minimize the risk. The actions may include creating new programs, processes, procedures and training programs. Monitoring programs may be developed to assure the risks have been controlled to achieve the lowest potential for adverse impact on the security of patients, staff, and visitors.

Identification Program

All staff are required to display an identification badge on their upper body while on duty. Identification badges are to be displayed on the individual with the picture showing. Identification badges are retrieved by Department Managers upon termination of employment.

Visitors are required to wear the appropriate wristbands in order to visit a specific patient in the hospital. Wristbands are blue with the exception of Labor and Delivery, Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU), Pediatrics, Post-Partum and Obstetrics, in which case they are pink.

If a patient wristband is damaged, nursing staff shall replace it. Patient identification is not removed upon discharge. Patients are instructed to remove their identification band at home.

The Front Desk and Facilities Departments provides vendor and contractor identification. All vendors are required to have appropriate identification and a green wristband while in the hospital. See also policy *F.2 Vendor Access and Registration*.

Sensitive Areas

The Director of Security works with hospital leadership to identify security sensitive areas by utilizing risk assessments and analysis of incident reports.

The following areas are currently designated as sensitive areas:

Ventura County Medical Center

a. *Intensive Care Unit*
b. *Emergency Department*
c. *Obstetrics*
d. *Newborn Nursery*
e. *NICU*
f. *Pharmacy*
g. *Health Information Management*
h. *Pediatrics*
i. *IPU*
j. *Crisis Stabilization Unit (CSU)*
k. *Operating Room*
l. *PICU*

Santa Paula Hospital

a. *Intensive Care Unit*
b. *Emergency Department*
c. *Obstetrics*
d. *Newborn Nursery*
e. *Pharmacy*
f. *Health Information Management*

g. *Operating Room*

Security staff are reminded during their annual in-service about those areas of the facility that have been designated as sensitive. Security staff assigned to work in sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area.

Security Incident Procedures

The Director of Security, in coordination with VCMS leadership, develops post orders for area security covers. These post orders describes the written instructions for the security team. The Director of Security assists department heads in development of departmental security procedures, as requested. These policies and procedures include infant and pediatric abduction, workplace violence, and other events that are caused by individuals from either inside or outside the organization.

Individual department heads assist in the development of department-specific security policies and procedures for risks unique to their area of responsibility. The Director of Security also assists department heads in the development of new department security procedures. Organization-wide departmental security policies and procedures are distributed to all departments. Department heads are responsible for distribution of department level policies and procedures to their staff and for ensuring enforcement of security policies and procedures needed.

Security Incident Response

Upon notification of a security incident, the Director of Security or designee will assess the situation and implement the appropriate response procedures. The Director of Security will notify Administration if necessary to obtain additional support. Security incidents that occur in the Emergency Department will be managed initially by the Security Officer on Duty, or Law Enforcement officer on duty, by following the appropriate policies and procedures for that area. The Director of Security will be notified about the incident as soon as possible.

Security incidents that occur in the departments will be managed according to the departmental or facility-wide policy. The Director of Security will be notified about any incident that occurs in a department as soon as possible. Additional support will be provided from the Security Department.

In the event there is a workplace violence incident, see policy *106.075 Workplace Violence Prevention Plan*.

In the event of an infant or child reported missing, see policy *106.002 Code Pink/Code Purple-Known/ Suspected Infant Abduction*.

In the event there is an active shooter situation, see policy *106.064 Code Black - Active Shooter*.

Following any security incident, a written "Incident Report" will be filed by the Security Officer managing the incident. The Report will be reviewed by the appropriate Security Supervisor or Security Director if necessary. Any deficiencies identified in the report will be corrected. A summary of these Reports will be furnished to the Safety Committee on a regular basis.

Evaluating the Management Plan

On an annual basis, the Safety Committee and Director of Security evaluate the scope, objectives, performance, and effectiveness of the Security Plan for the safety of the staff, visitors and patients at Ventura County Medical System.

EDUCATION

Security Management in-service training is provided at the initial orientation level and subsequent annual retraining of all Security personnel. This is part of a structured staff development program that includes general security practices supplemented by sensitive areas. Sensitive areas are identified based on criteria to include the impact on the building, grounds, and organizational experience.

Security personnel receive the following training annually and/or when required by job description:

- Health Insurance Portability and Accountability Act (HIPAA)
- Emergency Medical Treatment & Labor Act (EMTALA)
- Blood Borne Pathogens (BBP)
- Crisis Prevention Intervention
- Workplace Violence
- Sexual Harassment
- Infant and Child Abduction Prevention
- First Aid/Cadiopulmonary Rescuscitation (CPR)/Automated External Defibrillator (AED)
- Fire and Safety Procedures
- FEMA 100/200
- Interactions with patients, visitors and staff
- Safe Driving Procedures
- Management of aggressive behavior
- Metal detector training

ENVIRONMENT OF CARE

SECURITY RISK ASSESSMENT INSTRUCTIONS:

Evaluate every potential event in each of the three categories of probability, risk, and preparedness. Add additional events as necessary. Events are defined as potential hazards or risk categories that may be consequential to effective operations of a facility and ability to render safe, secure, efficient and effective services to patients, staff and visitors.

Issues to consider for probability (the probability of occurrence at the facility) include, but are not limited to:

1. Known risks at VCMS facilities
2. Historical data of occurrence
3. Reported and observed recent data
4. Known sensitive areas

Issues to consider for risk level potential (in response to threat to life, health and safety, high disruption, moderate disruption, low disruption) include, but are not limited to:

1. Threat to life and/or health
2. Disruption of services
3. Damage/failure possibilities
4. Loss of community trust
5. Inability to render services in a community emergency

6. Financial impact
7. Legal issues

Issues to consider for preparedness include, but are not limited to:

1. Status of current plans, policies and procedures to identify and reduce risks
2. New employee orientation on identifying and reporting potential risks
3. Continuing education for identification and reporting of risks
4. Financial commitment of leadership to reduce risks
5. Effectiveness of hazard surveillance rounds
6. 24 hour camera surveillance.

All revision dates: 5/9/2023, 12/12/2022, 2/13/2019, 4/1/2013, 3/1/2012, 4/1/2011, 6/1/2010

Attachments

- Annual Evaluation of the Security Management Plan
- Annual Security Risk Assessment

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Safety Committee	Fernando Medina: Director, Support Services	3/31/2025
Policy Owner	Ian McGraw: Manager Facility Operation	3/31/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/14/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/17/2025*
Next Review:	*3 years after approval*
Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Nursing*
References:	

108.044 Clinical Implementation Guide for: Electrocardiogram Guided Tip Confirmation System During Peripherally Inserted Central Catheter Placement

POLICY:

To provide guidelines to facilitate standardization of practice for insertion by Registered Nurses (RN) of Peripherally Inserted Central Catheter (PICC) using Electrocardiogram (ECG) Guided catheter tip confirmation.

SCOPE:

1. This applies to RNs at Ventura County Medical Center who have successfully completed population appropriate training and demonstrated competency in Vascular Access device insertion, care and maintenance, patient/caregiver education across the care continuum.
2. RNs must also have completed the online education course on the ECG guided tip confirmation system (TCS) and yearly ECG PICC competency checkoff.

DEFINITION(S):

The ECG guided TCS is indicated for guidance and positioning of the PICC. The ECG TCS provides real-time catheter tip location information by using the patient's cardiac electrical activity. ECG TCS is indicated for use as an alternative method to chest x-ray and fluoroscopy for PICC tip placement confirmation in adult patients. Limiting but not contraindicated situations for this technique are in the patients where alterations of cardiac rhythm change the presentation of the P-wave as in atrial fibrillation, atrial flutter, severe tachycardia, and pacemaker driven rhythms. In such patients, who are easily identifiable prior to PICC insertion, the use of an additional method is required to confirm catheter tip location.

EQUIPMENT:

1. Sherlock 3CG Tip Confirmation System
2. Site Right Portable Ultrasound Machine
3. PICC Catheter with Sherlock 3CG Tip Positioning System (TPS) Stylet

PROCEDURE(S):

1. **Prepare ECG Sensor:**
    a. Enter patient identification information (name, medical record number, date of birth).
    b. Slide the fin assembly onto the sensor until fully seated and place the sensor in protective cover. Do not use excessive force when connecting or disconnecting the fin assembly to or from the sensor or equipment damage may occur.
    c. Position sensor on patient's chest with the top of sensor above the sternal notch and centered on the sternum. Place sensor as flat as possible for best result.
    d. Prepare and attach the external ECG electrodes to the lead wires. Ensure electrode locations are oil-free, completely dry, and on intact skin (e.g., not over open wounds, lesions, infected, or inflamed areas. Discontinue electrode use immediately if skin irritation occurs.
    e. Attach electrodes to all the lead wires. Remove backing and press firmly onto skin at the specified locations:
        - Place BLACK electrode lead wire on patient's lower right shoulder
        - Place RED electrode lead wire on lower left side, inferior to the umbilicus and laterally along the mid-axillary line. CAUTION: Placement of the red lead wire outside of this region may result in reduced ECG performance.
2. **Evaluate baseline ECGs:**
    a. Turn on TCS and note external waveform.
    b. Verify that P-wave is present and identifiable and consistent on the main screen.
    c. If no persistent or regular P-wave is identified, continue with procedure utilizing magnetic tracking and external measurements followed by tip confirmation via alternative method (i.e., x-ray or fluoroscopy).
    d. Adjust ECG scale as needed to endure that entire ECG waveforms are visible in the ECG window throughout the insertion procedure.
3. **Catheter Tip Guidance and Positioning**
    a. Follow Tip Locating System (TLS) "Instructions for Use" for magnetic navigation.
    b. Insert catheter until the magnetic navigation shows stylet icon (Sherlock Spyglass) moving consistently downward.
    c. Continue to slowly advance the catheter until the catheter is inserted to the external measurement determined prior to insertion and/or negative P-wave deflection is noted. Do not rely on ECG signal detection for catheter tip positioning when there are no observable changes in the intravascular P-wave. In this case, rely on magnetic tracking and external measurement for tip positioning and use chest X-ray or fluoroscopy to confirm catheter tip location as per policy and clinical judgement.
    d. ~~Press the~~Activate FREEZE ~~button~~function on TCS. This will save the current waveform on the right-side reference screen for later comparison. Repeat as needed.
    e. SLOWLY adjust catheter tip position until the maximum P-wave amplitude is reached. Compare main screen waveform to reference screen waveform while closely monitoring for negative P-wave deflection.

f. If negative deflection prior to P wave present, adjust catheter tip position to maximum P-wave amplitude with no negative deflection

g. Advance or retract catheter from maximum P-wave to place tip in desired location (the cavoatrial junction of the superior vena cava).

h. Note catheter exit site marking (centimeters from exit site to hub) and document on TCS screen.

i. To record waveforms at the final catheter tip position, ~~press~~activate FREEZE ~~button~~function on TCS. ~~Press the~~Activate "PRINT" ~~button~~function to save image

4. PICC RN/ Vascular Access Specialist inserting the catheter will notify the RN/ provider for authorization of line use. The PICC RN/ Vascular Access Specialist may order radiograph at his or her discretion when clinically indicated. PICC RN/Vascular Access Specialist will place an order to use the vascular access device.

5. TCS Documentation: Upon successful insertion and TCS confirmation, the PICC RN/ Vascular Access Specialist will follow Ventura County Medical Center process to ensure the ECG waveform determining optimal tip position will be entered into the medical record.

6. When ECG TCS is used to determine optimal PICC tip placement in the SVC, no radiographic confirmation is required. ECG technology has been proven to be a more accurate determination of tip placement than radiographs (per INS Standards). If there is a discrepancy between tip confirmation with ECG TCS and chest X-ray (CXR) read, ECG TCS is considered to be the more accurate of the two technologies. The Vascular Access Specialist inserting the catheter may approve use of the line per policy when the appropriate change in the P wave is noted. At the time of placement, the external catheter measurement will be documented.

REFERENCES:

a. Infusion Nurses Society (2016). Policies and Procedures for Infusion Nursing, (4th Ed.) Norwood, MA: Author

b. BARD Access Systems (2013). Sherlock 3CG Tip Confirmation System, www.bardaccess.com

c. Appl Health Econ Health Policy (2016). Sherlock 3CG Tip Confirmation System for Placement of Peripherally Inserted Central Catheters: A NICE Medical Technology Guidance, Megan D. www.springerlink.com

All revision dates: 1/17/2025, 3/14/2023

Attachments

Sherlock PICC Tip Confirmation Sheet.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & Medicine	Stephanie Denson: Manager, Medical Staff Office	3/19/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/21/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/21/2025
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	1/21/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*6/14/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/17/2025*
Next Review:	*3 years after approval*
Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Nursing*
References:	

108.049 Standardized Procedure for Peripherally Inserted Central Catheter (PICC) Placement

~~Purpose~~

~~To provide guidelines to standardize the practice of PICC catheter insertion, in order to minimize the risk of device related complications and optimize patient outcomes.~~

Policy

~~To provide guidelines to facilitate standardization of practice for the insertion of peripherally inserted central catheter (PICC) catheters.~~

To provide a Registered Nurse (RN) standardized procedure for Peripherally Inserted Central Catheter (PICC) insertion.

It is the policy of Ventura County Medical Center and Santa Paula Hospital that all standardized procedures are developed collaboratively and approved by the Interprofessional Practice Committee (IPC), whose membership consists of Physicians, Registered Nurses (RN), Pharmacists, Advanced Practice Nurses, and Administrators. Standardized procedures are reviewed every three years.

To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, all approved standardized procedures will be kept in Policy Stat. The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

Scope

This applies to Registered Nurses (RNs) who have successfully completed population- appropriate training and demonstrated competency in vascular access device insertion, care and maintenance, and patient/ caregiver education across the care continuum. Nurse practitioners (NPs) who have privileges for this procedure are also in scope.

Definitions

Peripherally Inserted Central Catheter (PICC): a central vascular access device (CVAD) inserted into a

peripheral vein and threaded into the central venous circulation. The tip of the PICC should reside in lower 1/3 of the superior vena cava (cavoatrial junction) for upper-body insertions.

Roles and Responsibilities

PICC placement and 3CG tip confirmation will be completed by the trained RN. RNs will review and implement these functions whenever this task is performed.

A. Scope of supervision is required
   1. The RN is responsibe and accountable to the Nurse Executives
   2. Provider consultation is to be obtained under the following circumstances
      a. Emergency conditions requiring prompt medical intervention
      b. Upon the request of the patient, RN, or physician
      c. Anytime any deviation from this protocol is necessary

B. Requirements for the RN
   1. Active California RN license
   2. BLS or ACLS, if indicated
   3. Special training: formal orientation to specific procedure referenced in this policy with demonstrated competency validation

C. A list of RNs who demonstrate competency to perform this procedure is held by the Nursing Administration Nurse Manager

Provisions

A. Selection of the appropriate vascular access device (peripheral or central) shall accommodate:
   1. Patient's vascular needs.
   2. Diagnosis.
   3. Type and length of prescribed treatment regimen.
   4. Duration of dwell.
   5. Condition of the vasculature.
   6. Patient/caregiver's preference.
   7. Ability and resources to care for the device.

B. The vascular access device shall be the smallest gauge and length with the fewest number of lumens and shall be the least invasive device needed to accommodate and manage the prescribed therapy.
   1. Select the vein or site that best accommodates the outer diameter and length of the vascular access device (VAD) required for the prescribed therapy.
   2. Catheter-to-vein ratio of <45%.
   3. VADs shall be accessed with 10ml or larger syringes.
   4. Prior to PICC insertion, review patient's history and all pertinent lab results including but not limited to platelet count, international normalized ratio (INR), glomerular filtration rate (GFR), and serum creatinine.

5. In adults, use an upper extremity site for catheter insertion.

C. Radiographic confirmation or other tip location confirmation system (TCS) will be utilized to assess location of catheter tip. Limiting but not contraindicated situations for ECG (electrocardiogram) TCS are in the patients where alterations of cardiac rhythm change the presentation of the P-wave as in atrial fibrillation, atrial flutter, severe tachycardia, and pacemaker driven rhythms. In such patients, who are easily identifiable prior to PICC insertion, the use of an additional method is required to confirm catheter tip location. See policy 108.044 ECG Guided Tip Confirmation System During PICC Placement.

   1. When ECG TCS is used to determine optimal PICC tip placement in the superior vena cava (SVC), no radiographic confirmation is required. The Vascular Access Nurse inserting the catheter may approve use of the line per policy when the appropriate change in the P wave is noted. At the time of placement, the external catheter measurement will be documented.

D. Patients admitted to the hospital with a PICC should have a chest x-ray to verify placement prior to utilization.

Considerations for Vascular Access Device Placement

1. Patient stability.
2. Areas of pain on palpation.
3. Veins previously used or compromised (e.g., bruised, infiltrated, phlebitis, scleroses, corded or with presence of venous thrombosis).
4. Areas near venous valves.
5. Areas where there are planned procedures/veins needed for other purposes
6. Neurological injury
7. Localized edema.
8. Following axillary node dissection.
9. After radiation therapy on the proposed insertion side.
10. Lymphedema at the proposed insertion site.
11. Previous history of CVAD and central occlusion such as SVC Syndrome or stenosis of major upper thoracic vessels.
12. Known or suspected allergy to materials contained in the device.
13. History of medical conditions including cerebrovascular accident (affecting extremity being considered), bleeding disorders, anticoagulation therapy, and any condition that requires crutch walking.
14. Presence of other intravascular devices within the target vessel (e.g., pacemaker, other central lines, A-V shunts for dialysis).
15. Uncontrolled bacteremia, fungemia, or other infections.
16. Thrombocytopenia or coagulopathies.
17. Fracture/orthopedic injury.
18. Decreased venous return.
19. Cardiac malformations

20. Nerve injury affecting insertion site.
21. Local infection, skin breakdown, and/or cellulitis.
22. Patient lab values.
23. Bleeding risk.
24. Areas of flexion.
25. Need for analgesia or sedation.
26. Patient with acute kidney injury and/or chronic kidney disease where upper extremity vein preservation may be indicated for future dialysis access needs such as Chronic Kidney Disease (CKD) stage 4 and above indicated by a Glomerular Filtration Rate (GFR) of 29 or lower.

A. Vascular Access Nurse should discuss case with primary physician (resident or attending) prior to insertion of PICC.

B. Primary Licensed Practitioner (LP) will then determine based on clinical judgement and review of the history if further discussion is needed with the on-call nephrologist.

C. Any discussions with physicians should be documented by the PICC nurse.

Competency

A. **Completion of an approved PICC Certification Course.**

B. **Initial competency assessment:**

1. Adult: A minimum of 5 complete PICC insertions (from assessment to tip verification) while being coached by a qualified Vascular Access Nurse, followed by a minimum of 3 successful independent ultrasound guided PICC insertions directly supervised by a qualified Vascular Access Nurse, are required for independent practice.

C. **Annual Competency:** Minimum eight hours of Continuing Education Units (CEUs) related to Vascular Access or current certification such as Certified Registered Nurse Infusion (CRNI), Vascular Access Board Certification (VA-BC), maintained.

1. Adult: A minimum of 10 successful PICC insertions per year.
2. Re-validation for those who do not meet minimum annual requirements will be 1 PICC observed by a qualified Vascular Access Nurse for a skills check-off. If this check- off is not passed, all initial competency requirements must be repeated.

Informed Consent Process

1. Informed consent must be completed by the LP. The clinician shall provide the patient/family with information on the risks, benefits and alternatives and document the informed consent in the Electronic Health Record (EHR).
2. A LP's order is required for PICC insertion.
3. A signed written consent is required prior to PICC insertion.

Device Selection

1. **PICC**: Recommended for irritants or vesicants such as chemotherapeutic agents, total parenteral nutrition (TPN) with a dextrose concentration of greater than 10%, sclerosing agents, and/or patients with poor

peripheral access.

2. **Power injectable PICC**: Required for the power injection of intravenous contrast. May also be used for hemodynamic monitoring, high flow rate Intravenous (IV) fluids, and blood administration.

PICC Insertion Barrier Precautions

1. Hair that requires removal for facilitation of catheter placement should be clipped using surgical clippers prior to catheter insertion, not shaved. Shaving may cause micro abrasions of the skin, allowing access of microorganisms into the body.
2. For PICC placement (including guidewire exchange), the person who inserts the line shall use maximal sterile barrier precautions including:
    - Sterile gloves (2 pairs).
    - Long-sleeved sterile gown.
    - Full sterile body drape with fenestration.
    - Bouffant cap.
    - Fluid shield mask or mask with protective eye wear.
3. Restrict non-essential persons from entering the patient/sterile area (within three feet) during insertion.
4. All persons entering the field and assisting with performing the procedure, shall wear sterile gown, mask, and cap.
5. Place mask on patient, as tolerated.
6. Following thorough hand hygiene, strict sterile technique shall be used throughout catheter insertion, care, maintenance, and removal.
7. The PICC must not be advanced once a post-insertion dressing has been applied.
8. Guidewire exchanges are discouraged and should not be performed unless absolutely necessary (patients having limited access sites, lack of alternative insertion sites, and/or patient is high risk such as having coagulopathy or morbid obesity). Do not use guidewire exchange if a catheter is suspected to be infected.
9. All PICCs shall have a needleless connector attached to the end of the lumen.
10. Suturing of the PICC is not recommended. Use appropriate securement device or application of sterile adhesive dressing to secure the catheter. Dressing should not wrap around the entire circumference of the patient's extremity.
11. Clinicians covered by this protocol are expected to comply with measures to mitigate central line associated bloodstream infections. See policy Central Venous Access Device policy- https://vcmc.policystat.com/policy/token_access/5ae53a8b-5087-4633-a053-a1086c21448d/

Equipment

1. Procedure kits or carts containing all necessary supplies are to be available for use at the time of PICC insertion and care/maintenance procedures (including those required for dressing change, needleless connector change, and removal).
2. Closed catheter access systems are used preferably over open systems for infusions, medication administration, and blood withdrawal. When an integral in-line administration system is unavailable,

specific add-on devices (e.g., extension sets, in-line filters, manifolds, blunt cannulas, or stopcocks) may be required to facilitate delivery of prescribed therapy. The use of these devices should be limited to reduce the risk of contamination from manipulation, misconnection, or accidental disconnection.

3. Maximum barrier kit as described above.
4. Standard PICC insertion kit that includes all necessary components.
5. Sterile probe cover.

~~Pre-~~Procedure

A. **Assessment**

1. Determine indication for PICC and obtain/verify LP order for PICC placement.
2. Verify that the informed consent has been completed, and that it is signed and dated.
3. Review patient's medical history, contraindications and indications for device placement, allergies, coagulation status, and other pertinent labs.
4. Assess patient's current vascular access.
5. Assess patient/caregiver readiness.

B. **Planning**

1. Add PICC pre-procedure order set under ordering LP's name per protocol
2. The goal is to minimize patient's discomfort during insertion and assure that the patient/caregiver will be informed of the need, purpose, and risks/benefits of PICC placement and signs/symptoms of possible complications.
3. Gather equipment/supplies.
4. Provide patient/caregiver education regarding indication for PICC, insertion procedure, and maintenance of the PICC and appropriate infection prevention measures to prevent Central Line Blood Stream Infection (CLABSI).
5. The patient's assigned nurse shall be available to assist the PICC nurse especially if the patient is unable to cooperate during procedure.
6. Close door to room/area and post sign indicating "Sterile Procedure in Progress- Do Not Enter."
7. Note: for pediatric and neonatal patients, additional nursing staff shall be available to assist during the insertion procedure to provide sedation (if indicated), to monitor for signs of patient distress and to assist the RN placing the catheter by holding the patient.

C. **Pre Procedure**

1. Perform patient identification with two appropriate identifiers (e.g., patient's full name, date of birth and/or medical identification number).
2. Explain procedure to patient/caregiver.
3. The person inserting the PICC must perform a time out with an observing Nurse before beginning the procedure and record the timeout in the EHR.
4. Perform hand hygiene and don clean gloves.
5. Conduct visual inspection of potential insertion site(s) to assess for skin integrity, erythema, edema, pain, compromised veins, etc.

6. Place ultrasound machine where ergonomically comfortable for clinician.
7. Examine the vasculature in the chosen extremity using ultrasound.
    - Ensure ultrasound probe has been disinfected with PDI® Super Sani Cloth Germicidal Disposable Wipes prior to use on patient.
    - Apply a liberal amount of sterile ultrasound gel (from single use packet) to patient's arm.
8. Apply probe to skin: visualize and note the location of veins, arteries, and nerves surrounding the proposed insertion site.
    - Assess veins for vessel size, path, round shape, and compressibility without a tourniquet.
    - Assess depth of intended vessel for venipuncture.
    - Assess for adequacy of vessel size compared to the proposed outer catheter diameter to promote hemodilution and preserve vessel health.
    - Avoid selecting smaller vessels to prevent phlebitis and thrombosis.
    - If marking the level of the proposed insertion site, utilize a single-use disposable skin marker on the outer aspect of the arm to avoid leaving ink under the dressing and to allow for appropriate skin cleansing.
    - Remove the ultrasound gel from the patient's skin.
9. To approximate the desired terminal tip location at the lower one-third of the SVC at the level of the Cavoatrial Junction (CAJ), measure from the proposed insertion site to the clavicular head on the right side and then down to the bottom of the third intercostal space on the right.
10. Remove gloves and discard.
11. Prepare for insertion, collecting necessary insertion supplies and setting up a sterile field.

D. **Procedure**

1. Perform hand hygiene.
2. Don head covering and mask.
3. Perform hand hygiene.
4. Open the insertion tray and PICC kit to create a sterile field and include items in the field using sterile technique as needed.
5. Don a pair of sterile gloves.
6. Place sterile drape under the extremity of the intended insertion site.
7. Prep the skin in the entire area where the dressing will cover. Cleanse insertion site using the preferred skin antiseptic agent of alcohol-based chlorhexidine solution according to the manufacturers' directions for use; allow to dry completely.
    - Use an iodophor (e.g., povidone-iodine) or 70% alcohol if chlorhexidine solution is contraindicated.
    - Use aqueous chlorhexidine if there is a contraindication to alcohol-based chlorhexidine.
8. Apply tourniquet proximal to the insertion site.
9. Remove sterile gloves and perform hand hygiene.
10. Don sterile gown and a new pair of sterile gloves.

11. Inside PICC kit, prime any needed extension set(s) and catheter with 0.9% sodium chloride.
12. Use stylet wires according to manufacturers' directions for use.
    - Never cut a wire of any kind.
    - If the catheter has a manufacturer-installed stylet wire, withdraw just past the desired length, bending the stylet wire over the catheter hub or locking in place before trimming the catheter to the premeasured length.
    - Stylet wire should not extend beyond the catheter tip.
13. Place large, sterile sheet drape with insertion site fenestration over the entire patient; best practice is to cover the patient's face with the large sterile drape. If the patient cannot tolerate having their face covered, the drape can be tented, and the patient can wear a mask or turn the head away from the insertion site.
14. Cover the ultrasound with the sterile probe cover and secure.
15. Apply sterile ultrasound gel to the skin over the proposed insertion site.
16. Relocate the intended vein with the ultrasound probe, verifying it is non-pulsatile and compressible.
17. Assess whether topical anesthetic agent is needed. NOTE: registered nurses who have demonstrated competency in placing PICC lines as noted above may administer lidocaine prior to the placement of a PICC line as a standardized procedure.
    - Inject local anesthetic subcutaneously at the insertion site, if needed. Before injection, aspirate for the absence of blood return.
18. Apply covered probe to skin, visualize the vessel, and insert the micro introducer needle through the skin and into the vein using a 45° angle. Place the tip of the access needle on the skin at a distance from the probe that will intersect the vein within the plane of the scan field as the catheter is advanced to the intended vein's depth. Move the ultrasound probe toward the catheter to identify the catheter tip. Move the ultrasound probe and needle in the same direction, keeping the needle tip in view on the screen as the catheter approaches and enters the lumen of the intended vessel. Make sure to keep the gel and probe away from the sterile catheter.
19. Align the path of the needle to enter the center most superficial area of the vein wall and observe the needle tip entering the lumen of the vein.
20. Confirm slow venous blood return is the color and consistency of whole blood.
    - If blood return is pulsatile, immediately abort the procedure by removing the needle and tourniquet and applying pressure to the area for 10 minutes or until hemostasis is achieved.
21. Observe for blood return in the micro introducer needle hub and visualize the needle tip in the center of the vein on ultrasound before proceeding.
22. Put the ultrasound probe down on the sterile field.
23. Reduce the angle of the micro introducer needle and stabilize.
24. Insert the floppy-tipped guidewire into the micro introducer needle, threading into the vein. The guidewire should never be inserted into a position beyond the level of the axilla without fluoroscopy guidance.
25. Carefully remove the micro introducer needle from the vein and skin by pulling it back over the guidewire.

- Do not allow the guidewire to move outward through the micro introducer needle due to risk of severing the guidewire.

26. Secure the guidewire with your nondominant hand to prevent migration in or out of the vein.
27. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
28. Make a skin nick, if needed.
    - Using a scalpel, hold the blade with the blunt side against the wire.
29. Advance the peel-away dilator/introducer over the guidewire through the skin completely into the vein using a twisting motion.
30. Remove the guidewire.
31. Release the tourniquet, using caution not to break sterile technique.
32. Slowly remove the dilator, leaving the peel-away introducer sheath in the vein.
33. Slowly advance the PICC catheter through the introducer sheath.
34. Continue to advance the catheter slowly to the predetermined measurement.
    - If using a tip-locating device, follow policy 108.044 Clinical Implementation Guide for: ECG Guided Tip Confirmation System During PICC Placement.
    - If tip-location technology is not being used, withdraw the stylet wire from the catheter lumen, using air emboli precautions.
35. Attach sterile 0.9% sodium chloride-filled syringe and aspirate for blood return (the color and consistency of whole blood) from catheter and flush to determine patency.
36. Break the wings and slowly peel away the introducer sheath as it is withdrawn, taking care to allow the catheter to remain in its terminal tip location.
37. Apply a needleless connector to each lumen.
38. Clean excess blood and ultrasound gel from the insertion site using chlorhexidine solution.
    - Ensure there is no oozing of blood from PICC entry site and hold pressure using sterile gauze to achieve hemostasis if necessary.
39. Apply sterile alcohol-free skin barrier product around the perimeter of the intended dressing site.
    - Do not apply barrier film/product directly under chlorhexidine-impregnated sponge or gel patch as the solution will block its action at the puncture site.
    - Allow product to completely dry before dressing is applied.
40. Apply chlorohexidine-impregnated sponge (e.g., Biopatch™) or gel (see **attachment A**) and securement device/product. Then apply Transparent semi-permeable membrane (TSM) dressing (e.g., Tegaderm™).
    a. If applying an antimicrobial patch, align the slit of the patch with the PICC line.
41. Flush each PICC lumen with a minimum of 10ml normal saline in a 10ml syringe.
42. Label dressing with date, time performed, and clinician's initials.
43. Place an alcohol impregnated cap on the needleless connector of each of the PICC lumens.
44. Place a sign above the patient's bed with: "NO VENIPUNCTURE OR BLOOD PRESSURE IN

UPPER EXTREMITY where PICC has been placed (e.g., Right/Left arm)."

45. Discard used supplies in appropriate receptacles.
46. Remove personal protective equipment (PPE) and perform hand hygiene.
47. Clean and disinfect ultrasound probe by removing sterile ultrasound cover, wiping away excess gel, and cleansing with PDI® Super Sani-Cloths Wipes.
48. Obtain a chest radiograph to determine tip placement if not using a tip locating confirmation system device and get verification from radiologist of PICC placement in SVC prior to use.

E. **Post Procedure:**

1. After successful PICC placement, educate patient/caregiver regarding care and maintenance of PICC, steps to avoid catheter dislodgement, and daily flushing schedule.
2. Provide education to patient/caregiver as to signs and symptoms of common complications and how and whom to report complications.
3. Measure arm circumference at the site.
4. Add PICC post-procedure order set and "okay to use" order under ordering physician's name per protocol.

Infusion Tubing Configuration

1. Any tubing and fluid/medication bags hooked up to the PICC should be new having not been hooked up to any other peripheral IV (PIV) or central lines, including secondary tubing and bags.
2. The configuration of infusion tubing is integral to the efficient and safe use of the PICC. When assembling the infusion tubing, requirements for all infusates must be considered to ensure the appropriate number of injection ports are available for set-up and to prevent unnecessarily accessing the catheter later.
3. Infusion tubing connected to the PICC shall be luer-locked.
4. To minimize entry into the PICC and decrease the risk of contamination, secondary IV tubing (used for medication administration) shall remain attached to the primary administration set and not removed after each injection.
5. If the secondary (piggyback) IV tubing is not being used or becomes disconnected it shall not be reconnected but replaced with new secondary tubing. This includes situations when a patient is receiving medications that could cause precipitate if administered through the same line. A new secondary tubing set shall be used for each infusion.
6. Eliminate open stopcocks from tubing and instead use needleless connectors, which must be vigorously cleaned with alcohol before entry.

Complications and Nursing Interventions

A. **Immediate Complications:**

1. Excessive bleeding: verify venous placement. Apply direct pressure.
2. Chest pain: Assess and rule out causes. Notify physician.
3. Numbness and tingling of arm or hand for greater than 30 minutes: Catheter must be removed.
4. Catheter Embolism: DO NOT LEAVE THE PATIENT. Immediately place finger over portion of catheter in vein to prevent migration into heart and pulmonary vasculature. For pediatric and adult

patients, place tourniquet on uppermost portion of effected extremity. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.

5. Air Embolism: DO NOT LEAVE THE PATIENT. Stop entry of air. If catheter is in place, attempt to aspirate air. Prepare for code blue. Place patient on their left side in Trendelenburg position and notify provider or call a Rapid Response.
6. Nerve irritation/damage: Stop insertion and remove all devices that have been inserted. Insert device in new location.

B. **Unsuccessful Insertion- Notify Provider:**

1. Malposition (if identified before sterile field broken): attempt to reposition catheter by partially withdrawing catheter, repositioning patient, and reinserting catheter.
2. Difficulty advancing the catheter/removing stylet: Stop procedure. If catheter and stylet can easily be removed, remove catheter and notify the provider.
3. Cardiac arrhythmias: Withdraw catheter 1 centimeter (cm) and observe for resolution: if dysrhythmias persist, continue to withdraw catheter.

Delayed Complications

1. Phlebitis: Transient phlebitis may occur in first 48 hours after insertion. Increased range of motion of extremity and applying heat may alleviate the symptoms. Consult with physician before removing catheter.
2. Infection: Swelling or tenderness on the affected side, fever. Notify LP. recommendation for neutralizing coating.
3. Malposition: Remove catheter.
4. Bleeding/hematoma: Some oozing (a few drops of blood, not a steady ooze) is expected for first 24-48 hours. Apply pressure to site for at least 5 minutes until hemostasis is achieved following insertion: a pressure dressing may be required. Place a small piece of sterile gauze under dressing to wick blood from site. If available, place topical hemostatic agent at insertion site. Investigate potential causes of persistent bleeding.
5. Occluded Catheter: Check line for kinks, constrictive dressing or precipitate from medications. If clotted catheter suspected, notify physician.

Documentation:

1. Document all insertion related elements in Cerner. Additional documentation should include:

- "Time Out" form.
- "CLIP" form.
- PICC supply charge and order for PICC supply charge.
- Post procedure note
- Reason/indication for line (line necessity).
- Hand hygiene performed.
- Maximum sterile precautions used.
- Site prep and if dry prior to access.
- Date, time, and site/vein of PICC insertion.
- Condition of site.

- Use of ultrasound/needle guidance.
- Number of placement attempts.
- Arm circumference.
- Size of PICC, length of PICC, number of lumens, manufacturer's lot number, reference number and expiration date.
- Amount of 1% lidocaine administered (if used).
- Document lidocaine administration in Medication Administration Record (MAR)
- Internal length of catheter inserted and external length from patient to hub.
- Blood return.
- Line securement (dressing).
- Patient response to the procedure.
- Complications during the procedure, and intervention.
- Verify tip location to confirm placement in the lower 1/3 of the Superior Vena Cava (i.e., Cavoatrial Junction).
- Patient education.
- PICC Tip Confirmation Sheet completed with 3CG strip, if utilized (see **attachment B**). Place in patient's paper chart for submission to Medical Records.

Continuing Care

1. Routine sterile dressing changes are every 7 days and as needed (PRN) if soiled. Antimicrobial patch, securement device (i.e. Statlock™), and transparent dressing must be changed.
    - When gauze is placed under a transparent dressing, it is considered to be a gauze dressing and is changed every two (2) days.
    - If an antimicrobial patch (such as a chlorhexidine gluconate (CHG) impregnated disk) is not applied, the first dressing change shall be performed within two (2) days (or sooner if dressing becomes compromised).
2. All patients with central access shall receive a daily full-body chlorhexidine gluconate (CHG) bath.
3. Arm circumference (at the location of the site) should be checked, documented, and trended if deep vein thrombosis (DVT) is suspected.
4. See "108.055 Central Venous Access Device (CVAD or "Central Line") Care and Maintenance for Adult Patients" policy for further PICC care and maintenance standards.

References

1. Infusion Nurses Society. *Policies and Procedures for Infusion Therapy: Acute Care*. 6th ed. Infusion Nurses Society; 2021.
2. Kaiser Permanente. (2019). Peripherally Inserted Central Catheter (PICC) and Midline Catheter Insertion. Southern California (SCAL): Regional Guideline.

All revision dates: 1/17/2025, 3/14/2024, 6/14/2023

Attachments

Attachment A- Sherlock PICC Tip Confirmation Sheet.pdf

Attachment B- Product Guide for Tegaderm™ CHG Dressing 1657.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practice Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	2/27/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/21/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/21/2025
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	1/21/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/4/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/22/2025*
Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.057 Clostridium Difficile Screening and Testing

Policy and Functions to be Performed:

To provide a guideline for the Registered Nurse (RN) to obtain Clostridioides difficile (C. Diff) specimen.

Nursing will utilize this procedure for all hospitalized patients presenting with diarrhea upon admission.

Purpose:

According to the Centers for Disease Control and Prevention (CDC), Clostridium difficile infection (CDI) now rivals methicillin-resistant Staphylococcus aureus (MRSA) as the most common organism to cause healthcare-associated infections and is one of the most problematic pathogens in healthcare institutions. There are several infection prevention strategies to combat this spore-producing organism. This nurse-driven protocol focuses on the importance of early identification and isolation of patients with suspected CDI. Important steps to take to mitigate the potential for spread include early identification of patients presenting with diarrhea that meets the criteria as stated on the algorithm, prompt initiation of contact isolation, and prompt stool collection.

Procedure

A. The RN will complete an admission intake in the electronic health record (EHR) for all admitted patients. As part of this intake, the RN will ask the patient if they have had ~~> 3~~ANY loose ~~stools~~stool in the last 24 hours. If answer to this question is yes based on patient response or RN assessment of loose ~~stools~~stool, the electronic health record (EHR) will generate an order for C diff PCR. As soon as possible, the specimen should be collected and sent to the lab for testing.

B. NOTE: Loose stool is determined by the Bristol Stool scale (score 6 or 7). See attachment.

C. If PCR is negative, RN can discontinue contact isolation. If positive, a reflex toxin test will be completed to determine colonization versus active infection.

Documentation

Document in patient chart the following:

A. Admission intake in EHR

B. Patient stool patterns and output

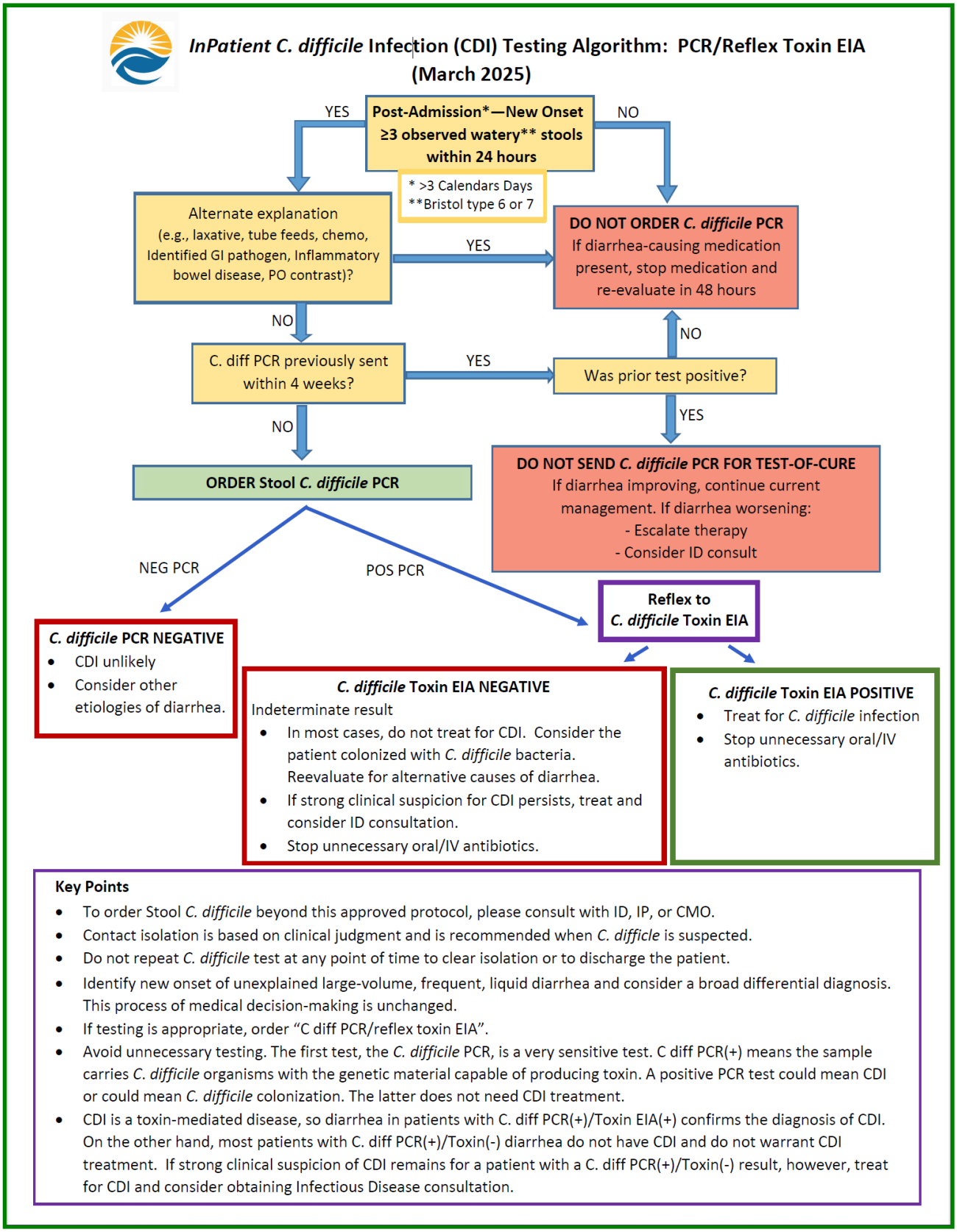
C. Complete the lab specimen task

D. Label the specimen appropriately with patient identifying information

E. Other details as appropriate.

Post-Admission Testing Algorithm

Please note that the criteria for testing after the third calendar day of admission is more stringent and as follows.



All revision dates: 3/22/2025, 3/19/2025, 1/10/2025, 1/2/2024, 11/4/2022

Attachments

Attachment C: Bristol Stool Form Scale

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/20/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/20/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/20/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*12/1/2013*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/10/2025*
Next Review:	*3 years after approval*
Owner:	*Colleen Rusin: Ambulatory Care RN II*
Policy Area:	*Ambulatory Care - Environment of Care*
References:	

AC.01 Ambulatory Care Emergency Response Equipment and Supplies

PURPOSE:

To ensure Ambulatory Care (AC) clinics have adequate equipment and supplies to provide emergency services for management of emergency medical conditions that occur on site during business hours until the emergent situation is stabilized and/or treatment is initiated by the Emergency Medical Services (EMS) system.

Clinic procedures for responding to adult and pediatric medical emergencies are outlined in 100.055 Code Blue - Adult Medical Emergency & 100.112 Code White - Pediatric Medical Emergency.

POLICY:

Ambulatory Care clinics will stock and maintain standardized emergency equipment and supplies appropriate to the patient population served, to include all items required to establish/maintain and open airway and to provide emergency medication management of anaphylactic reaction, opioid overdose, chest pain, asthma, and hypoglycemia.

Non-medical and field based practices will maintain emergency medications and supplies appropriate for their patient population and setting, and at a minimum will include items required to manage cardiopulmonary arrest and anaphylaxis.

DEFINITIONS

A. **Emergency Medical Condition**- a medical condition that is manifested by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

   1. Placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy.
   2. Serious impairment to bodily functions.
   3. Serious dysfunction of any bodily organ or part.

B. **Emergency Services**- those services required for immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

PROCEDURE

A. **Storage, Accessibility & Security**

1. Emergency equipment and supplies shall be stored together in a secure, centralized location that is readily accessible to patient care areas during regular clinic hours.
2. Emergency response carts and totes shall be locked with a red, breakable numeric tag at all times to monitor the integrity of the cart/tote contents.
    a. If the lock is intact, the emergency response cart/tote is considered complete internally.
    b. If not, a complete inventory and visual inspection of the internal contents must be performed as outlined below and any missing, opened, or expired items replaced.
3. Security devices such as padlocks which create barriers or delays to immediate access of emergency supplies shall not be used.

B. **Emergency Response Cart/Tote Contents**

1. One of two (2) types of emergency response carts/totes shall be in use as appropriate to the patient population served (See Attachment A):
    a. Adult/Pediatric/Neonatal- Child Health and Disability Prevention Program (CHDP) and family medicine practices.
    b. Adult- adult only practices.
2. Supplies and medications will be stored within locked emergency response carts/totes in an organized, standardized fashion.
    a. Only those items listed on Attachment A shall be stored in emergency carts/totes, depending on the patient population.
    b. Supplies that are frequently used together shall be stored in the same drawer/compartment.
    c. There shall be clear separation of adult and pediatric supplies.
    d. The contents of each drawer/compartment shall be clearly labeled.
3. Larger equipment including Automated External Defibrillator (AED), portable suction machine, backboard, and oxygen tank shall be stored outside but within reach of the emergency cart/tote.
4. At least one full oxygen tank designated for emergency use shall be maintained in the clinic at all times and will be stored and handled according to the procedures outlined in policy F.44 Compressed Gas Cylinders.
5. Dosage charts for emergency medications shall be kept with the emergency medications (See Attachment B).
6. Emergency phone number contacts shall be updated annually and posted in a prominent location, including:
    a. Local emergency response services (e.g., fire, police/sheriff, ambulance).
    b. Emergency contacts (e.g., responsible managers, supervisors).
    c. Appropriate State, County, City, and local agencies (e.g., local poison control number).

~~**Monthly Inspections**~~

C. **Monthly Inspections**

It shall be the responsibility of the clinic Registered Nurse (RN) or Licensed Vocational Nurse (LVN) to conduct regular inspections of emergency equipment and supplies and to ensure all items are within expiration dates and in working order.

1. The internal contents of the emergency cart/tote shall be inventoried and visually inspected monthly and following any code event.
    a. During inspection, the nurse shall break the numbered lock to access and visually inspect the contents of the emergency supply cart/tote and check for expired items.
    b. Any supplies or medications that are expired or will be expiring in the current and/or following month shall be immediately replaced.
    c. Upon completion of the inspection, a new numbered lock shall be obtained from the clinic administrator and placed on the cart/tote to alert staff that it is fully stocked.
    d. The new lock number will be recorded on the Ambulatory Care Emergency Response Cart Monthly Checklist (See Attachment C).
    e. An "Emergency Medications Contents" sticker shall be applied to the outside of the emergency cart/tote which will include:
        - The new lock number;
        - The name of medication due to expire first;
        - The date of expiration; and
        - The initials of the staff member and date completed.
    f. An "Emergency Response (Non-Medication) Supply Outdate" sticker shall be applied to the outside of the emergency cart/tote which will include:
        - The new lock number;
        - The name of the non-medication supply due to expire first;
        - The date of expiration; and
        - The initials of the staff member and date completed.
    g. An "Anaphylaxis Kit Contents" sticker shall be applied to the outside of every Anaphylaxis Kit which will include:
        - The new lock number;
        - The name of the item to expire first;
        - The date of expiration; and
        - The initials of the staff member and date completed.
2. The oxygen tank shall be checked monthly and after any code event for complete fill, and the PSI documented on the monthly checklist.
3. The suction machine shall be powered on monthly to check for proper function, and the results documented on the monthly checklist.
4. All oxygen and suction accessories will be checked monthly for correct fit with available equipment.
5. The Automated External Defibrillator (AED) shall be checked monthly or after any code event according to the manufacturer's recommendations and documented on the Ambulatory Care

Automated External Defibrillator Operator's Monthly Checklist (See Appendix D).

6. On days that the clinic is closed, staff shall document "closed" on the checklists.

D. **Restocking**

1. Emergency equipment or supplies that are in poor working condition, expired, or have been used will be replaced/restocked as soon as possible.
2. Contact the Pharmacy Department or pharmacy vendor to replace any medications that have expired or will be expiring in the current and/or following month.
3. Contact Central Supply or the medical supplies vendor to replace broken, missing, or outdated equipment or supplies.
4. Contact the Biomedical Department to replace or repair AED or suction machine when needed.
5. Contact the Facilities Maintenance Department or medical gas vendor for oxygen tank replacement when needed.

~~It shall be the responsibility of the clinic Registered Nurse (RN) or Licensed Vocational Nurse (LVN) to conduct regular inspections of emergency equipment and supplies and to ensure all items are within expiration dates and in working order.~~

1. ~~The internal contents of the emergency cart/tote shall be inventoried and visually inspected monthly and following any code event.~~
   a. ~~During inspection, the nurse shall break the numbered lock to access and visually inspect the contents of the emergency supply cart/tote and check for expired items.~~
   b. ~~Any supplies or medications that are expired or will be expiring in the current and/or following month shall be immediately replaced.~~
   c. ~~Upon completion of the inspection, a new numbered lock shall be obtained from the clinic administrator and placed on the cart/tote to alert staff that it is fully stocked.~~
   d. ~~The new lock number will be recorded on the Ambulatory Care Emergency Response Cart Monthly Checklist (See Attachment C).~~
   e. ~~An "Emergency Medications Contents" sticker shall be applied to the outside of the emergency cart/tote which will include:~~
      - ~~The new lock number;~~
      - ~~The name of medication due to expire first;~~
      - ~~The date of expiration; and~~
      - ~~The initials of the staff member and date completed.~~
   f. ~~An "Emergency Response (Non-Medication) Supply Outdates" sticker shall be applied to the outside of the emergency cart/tote which will include:~~
      - ~~The new lock number;~~
      - ~~The name of the non-medication supply due to expire first;~~
      - ~~The date of expiration; and~~
      - ~~The initials of the staff member and date completed.~~
   g. ~~An "Anaphylaxis Kit Contents" sticker shall be applied to the outside of every Anaphylaxis Kit which~~

~~will include:~~

- ~~The new lock number;~~
- ~~The name of the item to expire first;~~
- ~~The date of expiration; and~~
- ~~The initials of the staff member and date completed.~~

2. ~~The oxygen tank shall be checked monthly and after any code event for complete fill, and the PSI documented on the monthly checklist.~~
3. ~~The suction machine shall be powered on monthly to check for proper function, and the results documented on the monthly checklist.~~
4. ~~All oxygen and suction accessories will be checked monthly for correct fit with available equipment.~~
5. ~~The Automated External Defibrillator (AED) shall be checked monthly or after any code event according to the manufacturer's recommendations and documented on the Ambulatory Care Automated External Defibrillator Operator's Monthly Checklist (See Appendix D).~~
6. ~~On days that the clinic is closed, staff shall document "closed" on the checklists.~~

~~Restocking:~~

~~Emergency equipment or supplies that are in poor working condition, expired, or have been used will be replaced/restocked as soon as possible.~~

A. ~~Contact the Pharmacy Department or pharmacy vendor to replace any medications that have expired or will be expiring in the current and/or following month.~~
B. ~~Contact Central Supply or the medical supplies vendor to replace broken, missing, or outdated equipment or supplies.~~
C. ~~Contact the Biomedical Department to replace or repair AED or suction machine when needed.~~
D. ~~Contact the Facilities Maintenance Department or medical gas vendor for oxygen tank replacement when needed.~~

EDUCATION & TRAINING

Site personnel shall receive appropriate training and can describe site-specific procedures for responding to medical emergencies and demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work.

ATTACHMENTS

A. Adult/Pediatric/Neonatal Emergency Response Supply List
B. Emergency Medication Dosage Chart
C. Emergency Response Cart Monthly Checklist
D. AED Monthly Checklist

All revision dates: 2/10/2025, 5/15/2024, 6/30/2020, 6/1/2017

Attachments

- Attachment A-Emergency Response Supply List.pdf
- Attachment B-Emergency Meds Dosage Chart.pdf
- Attachment C-Emergency Response Cart Monthly Checklist.pdf
- Attachment D-AED Monthly Checklist.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Code Blue Committee	Ashley Vasquez: Senior RN	3/20/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	10/31/2024
Director of Nursing, Ambulatory Care	Cynthia Fenton: AC Director of Nursing	10/11/2024
Policy Owner	Colleen Rusin: Ambulatory Care RN II	10/9/2024

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/2/2025*
Next Review:	*3 years after approval*
Owner:	*Fernando Medina: Director, Support Services*
Policy Area:	*Dietary - Patient Care*
References:	

D.48 Dietary Department Nourishments

POLICY:

The Dietary/Food Services Department shall ensure that food is available to patients between regularly scheduled meals and provide nourishments which are part of a diet order.

PROCEDURE:

1. Food Services will provide standard nourishments in each Nursing Unit to be offered to all patients by Nursing, between meals unless counter-ordered by the physicians.
2. Nourishments, which are part of a patient's diet order, are requested by a dietitian or a patient's special request, will be prepared by Food Services and ~~sent to the units with meal cart~~delivered to each requesting unit.

Guidelines:

1. Standard stock nourishments are ordered by nursing units on the electronic nourishment form.
2. Food Services will fill nourishment orders and deliver to nursing units on a daily basis by 1:30 PM.
3. Nursing Staff will stock nourishment orders and place ~~nourishment orders~~appropriate items in refrigerators and dispense as requested.
4. Any patient who is changed to NPO will not receive a nourishment until diet is resumed on Diet List.
5. Date nourishments.
    - All items prepared by Food Services will be dated by a "pull date" which will be three (3) days after the date of preparation.
    - Milk cartons will be pulled on the date stamped on the carton and discarded.

All revision dates: 4/2/2025, 2/1/2016, 3/1/2014, 6/1/2006, 12/1/1995

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Dietary Department	Fernando Medina: Director, Support Services	4/2/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*NICU*
References:	

N.78 Cleaning and Sanitization by Microwave Steam Bag

Policy:

To provide guidelines for the sanitization of reusable breast pump parts, feeding systems, bottle brushes and pacifiers for single patient use in the Neonatal Intensive Care Unit (NICU).

Breast pump kit parts (excluding tubing and membrane cups), reusable feeding systems, non-metal bottle brushes, and pacifiers will be sanitized by microwave steam bag at least once per day.

Only the designated sanitizing microwave in the NICU will be used for steam sanitization. Do not use this designated microwave for any other purpose other than sanitizing.

Microwave steam bags are single patient use only. Bags may be reused per manufacturer's instructions.

Procedure:

I. Cleaning procedure following each use:
   a. Immediately after each use, disassemble the breast pump kit parts or reusable bottle system, thoroughly clean all parts with dish soap and water using appropriately sized bottle brush if needed, rinse well, and air dry on paper towels.
      i. Do not use wire brushes to clean the nipples, as this could damage the material and make the nipple hole larger.
      ii. If using wire cleaning brush to clean internal parts of the bottle system, replace the wire cleaning brush every 24 hours.

II. Sanitizing procedure
   a. Thoroughly clean all parts of the breast pump kit parts or reusable infant bottle system with soap and water using appropriately sized bottle brush if needed.
   b. Retrieve microwave steam bag. Ensure patient's name, MRN, and date is marked on the bag in indelible ink.
   c. Prepare workspace and sanitize items:
      i. Perform hand hygiene and don clean gloves

ii. Clean workspace, microwave exterior and microwave interior with hospital approved food safe disinfecting wipes
iii. Remove gloves, perform hand hygiene, and don clean gloves
iv. Place items to be sanitized in the microwave steam bag
v. Add tap water per microwave steam bag manufacturer's instructions
vi. Seal the bag
vii. Place the bag upright in the microwave and heat on full power per microwave steam bag manufacturer's instructions
viii. Remove the bag from the microwave using a heat protective mitt
ix. Carefully pour the hot water from the bag into a sink. Place the bag on the workspace counter after draining water
x. Remove gloves, perform hand hygiene, and don clean gloves
xi. Open the bag and allow steam to escape. Remove items and place them on clean linen or paper towels at the bedside to dry thoroughly
xii. Mark a check box on the bag after each use. Replace the bag per manufacturer's instructions. Store the steam bag at the patient's bedside when not in use.
xiii. Clean the workspace and microwave exterior hospital approved food safe disinfecting wipes

d. Sanitize the reusable infant bottle system at least every 24 hours, using a Microwave Steam Sanitizing bag.
e. Non-metal brushes used to clean the bottle system will be sanitized in the Microwave Steam Sanitizing bag every 24 hours per manufacturer's instructions.
f. Observe all safety precautions during the sanitization process to avoid injury while using
g. The microwave oven shall be cleaned after each use by staff and will be sanitized daily by EVS staff using hospital-approved food-grade sanitizing wipes. Cleaning will include the cavity and seal of the unit, as well as exterior surfaces

References:

Centers for Disease Control "How to clean, sanitize, and store infant feeding items," April 16, 2024. How to Clean, Sanitize, and Store Infant Feeding Items Frequently Asked Questions | Water, Sanitation, and Environmentally Related Hygiene (WASH) | CDC

Centers for Disease Control "About Breast Pump Hygiene," September 12, 2024. https://www.cdc.gov/hygiene/about/about-breast-pump-hygiene.html

Dr. Brown's Medical Manufacturer Suggested Cleaning Guidelines for Hospital and Clinical Environments. CHD_M4_2024.02.20. Dr.-Browns-Medical-Manufacturer-Suggested-Cleaning-Guidelines-for-Hospital-and-Clinical-Environments.pdf

Ventura County Medical System, EVS.38 Cleaning of Refrigerators, Microwaves, and Ice Machines, Jul 03, 2023. https://vcmc.policystat.com/policy/13916705/latest

Microsoft Word - Instructions for Using the Dr. Browns Microwave Steam Sanitizing Bags final 6.23.23 (1)

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/30/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/30/2025
NICU	Robert Posen: NICU Medical Director	1/30/2025
NICU	Kristina Swaim: Clinical Nurse Manager, OB	1/17/2025
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	1/17/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/10/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/1/2025*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

NPP. 07 Urinary Catheter Insertion/Maintenance/ De-escalation

~~PURPOSE:~~

Purpose

To provide a registered nurse (RN) standardized procedure to guide the insertion, maintenance, and removal of indwelling urinary catheters to prevent the incidence of catheter-associated urinary tract infections (CAUTI). This policy guides nursing staff in the management of indwelling urinary catheters. Lippincott provides an additional resource for any items not addressed in this policy.

~~POLICY:~~

It is the policy of Ventura County Medical Center and Santa Paula Hospital that all standardized procedures are developed collaboratively and approved by the Interprofessional Practice Committee (IPC), whose membership consists of Physicians, Registered Nurses (RN), Pharmacists, Advanced Practice Nurses and Administrators. Standardized procedures are reviewed every three years.

To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, all approved standardized procedures will be kept in Policy Stat. The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

Function to Be Performed

The RN under the guidance of this standardized procedure can insert, maintain and discontinue indwelling catheters, as well as perform the HOUDINI assessment and post removal algorithm (see attachments).

Applicable Departments

This standardized procedure is applicable in all areas where RNs practice in the hospital setting.

Roles and Responsibilities

A. Scope of supervision required
   1. The RN performing these functions is responsible and accountable to the nursing director in their department.
   2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the RN by phone or in person.
   3. Provider consultation is to be obtained under the following circumstances
      a. Emergency conditions requiring prompt medical intervention
      b. Upon the request of the patient, RN or physician
      c. Anytime any deviation from this protocol is necessary

B. Requirements for the RN
   1. Active California RN license
   2. BLS or ACLS if indication
   3. Orientation to this policy and the attachments

C. Evaluation of the RN competence
   1. Initial upon hire to department: the Nurse director/delegate will assess the RN's ability to perform the procedure
   2. Annually: the Nurse director/delegate will evaluate the RN's ability to perform this procedure during performance review cycle

Procedure

A. Catheter Use

1. Indwelling urinary catheters should be inserted only when necessary and left in place only for as long as necessary.
   Alternatives to indwelling urinary catheters must be considered, including external male and female catheters use and intermittent bladder catheterization.
2. Suprapubic or transurethral catheterization should be considered in patients who need prolonged bladder catheterization. If patients require prolonged catheterization, Registered Nurses (RN) should contact the Licensed Practitioner (LP) to request suprapubic catheterization.

B. Indications for Indwelling Catheter Use

1. Indwelling urinary catheters must be inserted only when there is an indication to do so. *Please see Attachment A Houdini Protocol.*
2. Indwelling urinary catheters are appropriate for measuring and collecting urine only when fluid status or urine CANNOT be assessed by other means. Location in a critical care setting alone is NOT an appropriate indication.
3. Orders for insertion and discontinuation
   1. Indwelling urinary catheters may be inserted in patients only by an order from an LP.

2. Nursing will place the standardized protocol order.
3. The RN will assess the need for indwelling urinary catheter continuation each shift. The RN will discontinue the indwelling urinary catheter utilizing the Houdini Protocol. *Please see Attachment A Houdini Protocol.*

C. Indwelling Urinary Catheters- Miscellaneous

1. If an indwelling urinary catheter is present on admission from an outside facility, the RN will: 1) document presence, 2) obtain a urine culture, 3) remove the urinary catheter, and 4) insert a new urinary catheter if warranted. The RN will consider alternatives to the indwelling urinary catheter.
2. If an indwelling urinary catheter is placed emergently, it must be removed as soon as possible ~~(within 48~~, but no later than 24 hours~~)~~, a baseline urine culture obtained, and a new indwelling urinary catheter inserted if warranted.
3. If an indwelling urinary catheter is placed in the Operating Room, the RN will remove the foley catheter ~~within 48~~as soon as possible but no later than 24 hours after surgery, unless continuation is clinically indicated.

D. Indwelling Urinary Catheter Insertion

1. Personnel who insert indwelling urinary catheters must have demonstrated competency in proper insertion technique.
2. The Lippincott procedure will guide the specific details of insertion.
3. Indwelling urinary catheters should be properly secured after insertion to prevent movement and urethral traction.

E. Documentation for Catheter Insertion

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

F. Closed Sterile Drainage

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

G. Irrigation

1. Irrigation should be avoided unless continuous bladder irrigation is ordered by a LP.
2. The RN will follow Lippincott's irrigation procedure.

H. Urinary Flow and Collection Bag

1. Unobstructed flow should be maintained
2. To achieve free flow of urine:
    a. Avoid any kinks in the catheter and collection tubing
    b. The collection bag should be emptied as needed and prior to ambulation and/or transport.

c. A separate collection container to empty the urine should be utilized. The drainage spigot should never come in contact with the urine collection container.

d. Collection bags should always be kept below the level of the bladder but should never touch the floor.

I. Perineal Care

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

Documentation

A. The RN will document the following in the electronic health record (EHR)

1. Insertion or removal of any indwelling catheter
2. Accurate output
3. Patient tolerance

REFERENCE(S):

Adams, D., Bucior, H., & Rimmer, J. (2012). HOUDINI: Make that urinary catheter disappear –nurse-led protocol. Journal of Infection Prevention, 13(2), 44-46. https://doi.org/10.1177/1757177412436818

Centers for Disease Control (CDC) (n.d.) Guideline for prevention of catheter-associated urinary infections. https://www.cdc.gov/infectioncontrol/guidelines/cauti/recommendations.html

Lippincott Procedure Manual

Dawson, C. H., Gallo, M., & Prevc, K. (2017). TWOC around the clock: a multimodal approach to improving catheter care. Journal of Infection Prevention, 18(2), 57–64. https://doi.org/10.1177/1757177416668584

Lo E., Nicolle, L., Classen D., Coffin, S., Gould, C., Maragakis, L., Meddings, J., Pegues, D., Pettis, A., Saint, S., & Yokoe, D. (2014). Strategies to prevent catheter-associated urinary tract infections in acute care hospitals: 2014 update. *Infection Control and Hospital Epidemiology, 35*(5), 464-479. https:///www.doi.org/10.1086/675718

Meddings, J., Rogers, M., Krein, S., Fakih, M., Olmstead, R., & Saint S. (2013). Reducing unnecessary urinary catheter use and other strategies to prevent catheter-associated urinary tract infections: An integrative review. *BMJ Quality and Safety 23,* 277-289. https://www.doi.org/10.1136/bmjqs-2012-001774.

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

All revision dates: 4/1/2025, 11/19/2024, 1/10/2023

Attachments

Attachment A: Houdini Protocol.pdf

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/1/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/1/2025
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/1/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/3/2025*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.02 Emergency C-Section

POLICY:

To provide a rapid and coordinated response to an emergent Cesarean Section on the Obstetrics (OB) floor.

PROCEDURE:

The OB team will activate an "Emergency C-section." The physician, registered nurse (RN), or designee will call the Paging operator and activate an "Emergency C-section."

~~**AT VCMC:**~~

AT Ventura County Medical Center (VCMC):

A. The Paging operator will call "Code Emergency C-section" overhead and will contact the following individuals:
   1. VCMC on call obstetrician
   2. VCMC on call back-up obstetrician
   3. Anesthesiologist on call
   4. Nursing Supervisor
   5. Neonatal intensive care unit (NICU) Respiratory Therapist
   6. The Charge Nurse or designee will notify NICU
   7. Unless otherwise informed, the obstetrician/physician will respond by coming directly to the OB Department. If the Obstetrician/physician on call cannot respond rapidly, the Charge Nurse or designee will begin calling obstetricians on the emergency call back list.
   8. The Nursing Supervisor will call in the ~~OR~~operating room (OR) team.
   9. Unless otherwise informed, the Anesthesiologist will respond by coming directly to the OB Department. If the Anesthesiologist on call cannot respond rapidly, the Charge Nurse or designee will begin calling Anesthesiologists on the emergency call back list.
   10. The OB operating room will be equipped and stocked for a C-Section at all times including a hysterectomy tray. The room will be checked every shift by the Charge Nurse or designee.

~~**AT SANTA PAULA HOSPITAL:**~~

A. ~~The Paging operator will call "Code Emergency C-section" overhead, and then page the Nursing Supervisor. The Paging operator will then page or call the following individuals to the Nursing Supervisor at 805-218-1712:~~

1. ~~SPH on call physician~~
2. ~~VCMC on call obstetrician~~
3. ~~Anesthesiologist on call~~
4. ~~Respiratory therapist.~~
5. ~~Unless otherwise informed, the obstetrician/physician will respond by coming directly to the OB Department. If the Obstetrician/physician on call cannot respond rapidly, the Charge Nurse or designee will begin calling obstetricians on the emergency call back list.~~
6. ~~The Nursing Supervisor will call in the OR team.~~
7. ~~Unless otherwise informed, the Anesthesiologist will respond by coming directly to the OB Department. If the Anesthesiologist on call cannot respond rapidly, the Charge Nurse or designee will begin calling Anesthesiologists on the emergency call back list.~~
8. ~~The OB operating room will be equipped and stocked for a C-Section at all times. The room will be checked every shift by the Main OR staff.~~

Prevention of Retained Surgical items during an Emergency Cesarean Section

It is the policy of **Ventura County Medical Center (VCMC)~~/Santa Paula Hospital (SPH)~~** that:

- All surgical items opened and used during a surgical procedure will be accounted for.
- A count may be initiated by any member of the perioperative team involved in the counting process
- Manual counts of radiopaque soft goods, sharps, miscellaneous items, and instruments opened onto the sterile field will be performed in all surgical invasive procedures.
- Instrument counts can be waived during the initiation of an Emergency Cesarean Section. However, subsequent counts and a final count must be done prior to the closing of the patient.
- When instrument counts are waived, unless the patient's safety is at risk, intraoperative imaging will be performed before the patient is transferred from the OR.
- Any perioperative team member (e.g., anesthesia professional, float RN) who assists the surgical team by opening sterile items onto the sterile field will:
  - count the items with the scrub person,
  - add the counted items to the count documentation (e.g., count sheet, whiteboard), and
  - promptly inform the RN circulator of what was added..
- See Policy ***S.27 Prevention of Retained Surgical Items***

All revision dates: 4/3/2025, 4/14/2021, 3/8/2018, 7/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	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:	*2/1/2012*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/3/2025*
Next Review:	*3 years after approval*
Owner:	*Jennifer Ferrick: Director, Peds/ PICU & NICU*
Policy Area:	*PEDS/PICU*
References:	

P.17 Admission, Transfer, and Discharge from the PICU

POLICY:

To define patient populations which are appropriate for admission to the Pediatric Intensive Care Unit (PICU) at Ventura County Medical Center (VCMC), and to delineate admission, transfer, and discharge criteria for the Pediatric Intensive Care Unit (PICU).

PROCEDURE:

Definitions and Abbreviations:

A. Neonate: Patients who are 28 days old or less

B. IV: Intravenous

C. Pediatric Intensivist: An individual who is board-certified or board-eligible in pediatric critical care.

Scope and Responsibility:

This policy applies to patients referred for admission to the PICU and transferred or discharged from the PICU. Compliance with this policy is the responsibility of the nursing staff, PICU Clinical Nurse Manager, pediatric intensivists, and Respiratory Care Department.

Guidelines:

Admission Criteria

1. All patients birth up to eighteen years of age, and up to 21 years of age with California Children's Services (CCS) insurance who fulfill critical care criteria may be eligible for admission to the PICU.
2. Patients in the PICU will be managed by a pediatric intensivist.
3. Per Title XXII, the pediatric intensivist shall have final decision regarding admissions to the PICU.[2]
    a. Criteria for admission to the PICU at VCMC includes, but is not limited to, the following (adapted from the American Academy of Pediatrics[1]):
        i. Pulmonary – Patients with severe or potentially-life threatening pulmonary or airway disease. Conditions may include, but are not limited to:

1. High-supplemental oxygen requirement (FiO_2 > 0.5) regardless of etiology
2. Tracheostomy
3. Continuously nebulized medications or frequently nebulized medications that cannot be administered safely on the general pediatrics ward
4. Administration of positive pressure
5. Upper airway obstruction that requires frequent racemic epinephrine
6. Persistent sustained apnea with cardiorespiratory compromise
7. Orotracheally/nasotracheally intubated patients or those who will need intubation
8. Patients with thoracostomy tubes
9. Patients with empyema and need for surgical intervention
10. Patients with status asthmaticus that require continuous infusion of nebulized bronchodilators or IV bronchodilators
11. Respiratory illness that requires the administration of heliox
12. Rapidly progressive respiratory disease
13. Children who require home ventilation
14. Need for inhaled nitric oxide
15. Patients who have undergone foreign body removal from the airway

ii. Cardiovascular – Patients with severe, life-threatening, or unstable cardiovascular disease. Conditions may include, but are not limited to:

1. Heart rate greater than 90th percentile for age or heart rate less than 10th percentile for age after appropriate therapy.
2. Mean arterial blood pressure less than 10th percentile for age
3. Shock
4. Administration of continuous vasoactive substances
5. Post-Cardiopulmonary Resuscitation
6. Life-threatening dysrhythmias
7. Hypertensive emergencies requiring continuous infusions of antihypertensive medication
8. Repaired congenital heart disease with unstable cardiopulmonary status
9. Patient that requires hemodynamic monitoring with a central venous catheter or arterial line
10. Heart failure requiring intensive cardiac monitoring and fluid monitoring

iii. Neurologic – Patients with actual or potential life-threatening or unstable neurologic disease. Conditions may include, but are not limited to:

1. Complex febrile seizures or children with simple febrile seizures and persistent alteration in mental status
2. Viral meningitis with seizures
3. Bacterial meningitis in a child <3 months of age
4. Bacterial meningitis in a child with alteration in mental status

5. Progressive neuromuscular dysfunction with or without altered sensorium requiring respiratory support
6. Status epilepticus
7. Encephalitis
8. Altered mental status with or without airway compromise

iv. Hematology – Patients with life- threatening or unstable hematologic disease. Conditions may include, but are not limited to:

1. Severe coagulopathy
2. Severe anemia
3. Thrombocytopenia with increased risk of intracranial bleeding
4. Acute chest syndrome
5. Management of tumor lysis syndrome
6. Tumors or masses that compress the vital vessels, organs, and/or airway
7. Febrile neutropenia for the first 24 hours

v. Endocrine/Metabolic – Patients with life-threatening or unstable endocrine or metabolic disease. Conditions may include, but are not limited to:

1. Severe hyponatremia (Serum Na < 125)
2. Severe metabolic acidosis (HCO3 < 12)
3. Inborn errors of metabolism that require continuous infusion therapy
4. Diabetic Ketoacidosis
5. Hyperkalemia (>6.0) or hypokalemia (<2.5)
6. Severe hypernatremia (Serum Na > 160)
7. Hypocalcemia (ionized calcium < 3.5) or hypercalcemia (ionized calcium > 5.5)
8. Hypoglycemia requiring intensive monitoring
9. Hypomagnesemia (<1.2) that requires intensive cardiac monitoring
10. Intensive fluid management in children with diabetes insipidus, syndrome inappropriate antidiuretic hormone secretion, cerebral salt wasting, or ongoing fluid/electrolyte losses.

vi. Gastrointestinal – Patients with life-threatening or unstable gastrointestinal disease. Conditions may include, but are not limited to:

1. After emergency endoscopy for removal of foreign bodies from the airway or gastrointestinal tract

vii. Surgical – Postoperative patients requiring frequent monitoring and potentially requiring intensive intervention. Conditions may include but are not limited to:

1. Major blood loss during any surgery or procedure
2. Peritonitis with risk of fluid shifts (with surgical support)

viii. Renal – Patients with life-threatening or unstable renal disease. Conditions may include, but are not limited to:

1. Acute renal injury not requiring dialysis
2. Chronic renal failure not requiring dialysis
3. Rhabdomyolysis without the need for acute dialysis

ix. Multisystem and Other – Patients with life-threatening or unstable multisystem disease. Conditions include, but are not limited to:

1. Toxic ingestions
2. Burns covering <10% of body

x. Special Intensive Technologic Needs: Patients whose condition necessitates the application of special technologic needs, monitoring, complex intervention, or treatment including medications exceeding patient care unit policy limitations

b. Transfer Criteria to the Pediatrics Floor/Discharge Home Criteria

i. A physician's order is required to be transferred to the pediatrics floor or discharged home from the PICU. Patients will be evaluated and considered for discharge based on the reversal of the disease process or resolution of the unstable physiologic condition which prompted admission to the PICU, and when complex multidisciplinary intervention and treatment exceeding patient care unit capabilities are no longer needed. Transfer criteria to the pediatrics floor/discharge home criteria are based on, but not limited to the following:

1. Stable hemodynamic parameters
2. Stable respiratory status
3. Decreasing or stable oxygen requirements
4. Administration of IV volume is no longer needed to maintain perfusion of organs
5. Neurologic stability of seizures
6. Chronic mechanically ventilated patients whose critical illness has been reversed or resolved and are otherwise stable may be discharged to designated chronic care patient care units, or when applicable to home
7. Patients with an artificial airway (tracheotomy) with routine suctioning requirements and a mature tracheostomy tract
8. The health care team in conjunction with the patient's legal guardian(s), after careful multi-disciplinary assessment and discussion, decides there would be no benefit in keeping the child in the PICU or the course of the treatment is medically futile

ii. Per Title XXII, the pediatric intensivist shall have final decision regarding transfers or discharges from the PICU.[2]

c. Transfer Criteria to a Hospital With a Higher Level of Care

i. A physician's order is required to be transferred to another hospital. Patients will be evaluated by the staff at VCMC and considered for transfer if the patient's condition cannot be safely treated or managed in the VCMC PICU. Transfer criteria to a hospital with a higher level of care are based upon, but not limited to the following:

1. Pulmonary
    - Child who may require extracorporeal membrane oxygenation (ECMO)

2. Cardiovascular
    - Unrepaired congenital heart disease
    - Child who may require ECMO
3. Neurologic
    - Suspicion of increased intracranial pressure
    - After emergent neurosurgical procedure
    - Closed head trauma with altered mental status, skull fracture, or intracranial hemorrhage without ongoing neurosurgical support.
    - Spinal cord compression or impending compression
    - Placement of external cerebrospinal fluid diversion device
    - Malfunction of ventricular decompression device
    - Brain tumor producing a mass effect
    - Spinal cord injury
4. Hematology/Oncology
    - Children in need of an exchange transfusion
    - Children in need of plasmapheresis or leukopheresis
5. Endocrine/Metabolic
    - Rhabdomyolysis with need for acute dialysis
6. Gastrointestinal System
    - Severe acute gastrointestinal bleeding leading to hemodynamic and/or respiratory instability without ongoing GI support.
    - Hepatic failure with or without coma, hemodynamic instability, respiratory instability, and/or coagulopathy requiring blood products.
    - Severe hepatitis
7. Surgery
    - Peritonitis and hemodynamic instability or peritonitis and not surgical support
    - Cardiovascular surgery
    - Thoracic surgery
    - Non-life threatening neurosurgical procedures
    - Compartment syndrome without orthopedic surgery support
8. Renal System
    - Requirement for acute or chronic peritoneal dialysis, hemodialysis, or continuous renal replacement therapy
9. Multi-System/Other
    - Corrosive ingestion (with or without immediate airway compromise)
    - Thermal injury greater than 10% of body

ii. Per Title XXII, the pediatric intensivist shall have final decision regarding transfers or discharges from the PICU.[2]

d. Comfort Care Patients

i. Comfort Care patients who fulfill criteria for admission to the PICU may remain on the pediatrics floor or may be admitted to the PICU at the discretion of the multidisciplinary team which includes the input of the legal guardian(s).

All revision dates: 4/3/2025, 4/12/2022, 2/11/2019, 3/1/2016, 10/1/2012

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/11/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/11/2025
Pediatrics	Jennifer Ferrick: Director, Peds/PICU & NICU	2/11/2025
Pediatrics	Andrei Bobrow: Medical Director, Pediatrics	1/23/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/2003*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2025*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

PH.48 Medication Error Reduction Plan (MERP)

POLICY:

~~To~~Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), and Ambulatory Care Clinics (AMB) have an established plan and multidisciplinary process for identifying, reporting and evaluating medication errors with the ultimate goal of reducing the incidence and/or the severity of medication errors.

~~**Definitions[1]:**~~

Definitions[1]:

Adverse Drug Event (ADE): An injury resulting from medical intervention related to a drug. This could include medication errors or adverse drug reactions

Adverse Drug Reaction (ADR): Any response to a drug which is noxious and unintended which occurs at doses normally used in humans for prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function. See policy PH.42 Adverse Drug Reaction Reporting System

Harm: Impairment of the physical, emotional, or psychological function or structure of the body and pain or injury resulting therefrom

Just Culture: See policy ~~107.082 Just Culture - Response to Safety Events~~107.082 Just Culture - Response to Safety Events

Medication error: "Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use."

PROCEDURE:

~~**Medication Error Reduction Plan (MERP)**~~

Medication Error Reduction Plan (MERP)

The Medication Error Reduction Plan (MERP) is a formal plan that includes the evaluation, assessment and methodology by which weaknesses and deficiencies in the medication process are identified and addressed. The medication process includes prescribing, prescription order communication, drug product labeling,

packaging and nomenclature, compounding, dispensing, distribution, administration, education, and monitoring, and use. This is a practical approach to address processes that could contribute to medication errors in the administration of medications.

The plan shall incorporate technology solutions for reducing medication errors. In addition, the MERP plan shall incorporate prospective and retrospective review of clinical care such as med pass audits and chart reviews. Effort shall be made to incorporate external medication related error alerts thus providing the initiative for modifying susceptible processes and systems.

The ~~MERP~~ plan is reviewed annually for effectiveness allowing for modifications when warranted for further reduction of medication errors (See Attachment A).

~~**Medication Error Notification System**~~

Medication Error Notification System

Medication Error Notification System is a process by which medication errors can be reported and data collected for assessment, dissemination, education, collaborative corrective measures, and medication error trends. It is a way to identify in real time, medication errors that have the potential to or have caused patient harm. If warranted, it allows the hospital to address the medication safety issues quickly and efficiently.

The effectiveness of the medication error notification system is dependent upon the amount and quality of the data collected. A robust reporting system allows the hospital to assess opportunities to improve its medication use process. A just culture supports a robust reporting system.

Medication Error Reporting:

1. Medication errors shall be reported electronically through the completion of an electronic medication notification form. Access to the notification form is available on all healthcare agency desktops.
2. All medication errors should be reported, regardless of whether the error resulted in a "near miss," caused harm, did not cause harm, or resulted in an adverse drug event.
3. Medication errors shall be ideally reported at the time of discovery.
4. The prescriber and patient shall be notified immediately of the error if indicated. If the prescriber who ordered the medication is not available, the error shall be reported to the attending prescriber or another responsible prescriber.
5. Any medication administered in error or omitted in error and the action taken shall be properly recorded in the patient's medical record. The entry in the patient's medical record ~~need~~should not indicate that an error occurred.
6. If a medication error resulted in an adverse drug reaction, both a medication error notification and an adverse drug reaction report shall be completed.
7. Records of the medication error review shall be retained by the Medication Safety Officer (MSO) for at least three (3) years from the date the record was created.
8. Important information to include in the medication error notification form
    a. Patient information
        i. Name, age, gender, weight (if pertinent to error)
        ii. Medical record number (MRN) or financial number (FIN)

b. Event ~~inform~~information
    i. Date/time of event
    ii. Date of initial report
    iii. Setting/Location
    iv. Description of event:
    v. Did the error reach the patient?
c. Relevant information
    i. Laboratory data or tests, including dates/times
    ii. Relevant history (e.g. pre-existing medical conditions, allergies)
    iii. Concomitant therapy
    iv. Dates of therapy
    v. Diagnosis/indication for use
    vi. Medical intervention(s) following the error
    vii. Actions taken and recommendation for prevention
d. Possible Cause(s) of medication error if known
    i. Identify the most common cause of the medication error
    ii. Describe known and potential contributing factors

Medication Error Analysis:

Once the medication error notification is filed, ~~the notification~~an investigation shall be initiated within two (2) business days. All medication related errors and adverse drug events should be routed to the Medication Safety Officer (MSO) ~~who shall~~or designee. The notification may also be forwarded to the appropriate department manager and/or hospital administration for notification, further review ~~and investigate~~, event analysis, root cause analysis, and/or peer review. It is important that medication error information be collected and reported as soon as ~~reasonably~~ possible. ~~The notification~~It is understood that the eventual patient outcome may ~~be forwarded to the appropriate department manager for further review and/or administration for notification, event analysis, and/or peer review. It is important that medication~~change from the time when the medication error ~~information be collected and reported as soon as possible. It is understood that the eventual patient outcome may change from the time when the medication error~~ initially occurred.

Medication Error Severity Assignment (~~attachment 1~~Attachment B): The MSO shall initially assign the severity of the medication errors with Medical Staff consultation if warranted. In addition, Patient Safety Committee, and/or MERIT (Medication Error Reduction Improvement Team) subcommittees shall review medication errors and committee members/attendees have the ability to request a reassessment and/or change in severity assignment.

All medication errors that may have contributed to or resulted in harm to the patient and required initial or prolonged hospitalization may be reported to the California Department of Public Health (CDPH) as per Policy 107.023 Adverse Events, Sentinel Events, and Unusual Occurrences.

Patient Safety Committee and MERIT Subcommittee

Patient Safety Committee is a multidisciplinary committee that meets at least quarterly to review the MERP

plan and the medication errors that were reported through the medication error notification system. Patient Safety Committee composed of various hospital department representatives, and a quorum for Patient Safety Committee shall include Administration, Medical Staff, Nursing, and Pharmacy representatives.

At minimum, Patient Safety Committee and/or MERIT subcommittee shall review and analyze those medication errors that 1) reached the patient and required monitoring to confirm no harm was done and 2) those medication errors that caused patient harm. Patient Safety Committee and/or the MERIT subcommittee shall confer on policy, procedural and system change solutions in order to reduce the incidence and severity of the medication errors discussed. If warranted, the committees may recommend further follow-up and analysis of the medication errors (e.g., change in severity coding, event analysis, peer review).

Medication Safety generated summaries, data and action plans shall be reported to the following committees

A. Performance Improvement Coordinating Council (PICC)/Patient Safety Committee
B. Pharmacy and Therapeutics Committee (P&T)
C. Medical Executive Committee (MEC)

References:

~~1. National Coordinating Council for Medication Error Reporting and Prevention. www.nccmerp.org. Accessed 10/1/2018.~~

~~2. California Health and Safety Code Section 1339.63~~

1. National Coordinating Council for Medication Error Reporting and Prevention. www.nccmerp.org. Accessed 10/1/2018.
2. California State Senate Bill (SB) 1875: Health facilities and clinics: medication-related errors, 2000.
3. California Health and Safety Code (HSC), DIV 2, CH 2.05 - Minimization of Medication-Related Errors, §1339.63
4. California Code of Regulations (CCR) Title 16, DIV 17 - California State Board of Pharmacy, Article 2, §1711 Quality Assurance Programs

All revision dates: 3/7/2025, 11/10/2021, 11/26/2018, 1/1/2014

Attachments

- NCC MERP Index for Categorizing Medication Errors.pdf
- PH.48 Medication Error Reduction Plan 2025 Summary.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/24/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/24/2025
Pharmacy Services	Sara Pendleton: Medication Safety Officer	3/7/2025

Step Description	Approver	Date

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*3/1/2006*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/7/2025*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

PH.70 High Alert Medications

POLICY:

Ventura County Medical Center (VCMC) ~~and~~, Santa Paula Hospital (SPH), Infusion Center (INF), and Ambulatory Care Clinics (AC) shall maintain a list of high alert medications in order to increase patient safety by identifying and implementing strategies to avoid preventable injuries.

While the Institute of Safe Medication Practices (ISMP) does not recommend independent double checks for all high alert medications, Pharmacy and Nursing staff shall complete independent double checks for select high risk medications, prior to medication dispensing and administration.

DEFINITIONS:

1. High Alert medications are those drugs that have been identified as potentially causing significant harm if administered incorrectly.

2. Independent double check (IDC) is a manual process requiring two licensed practitioners separately, checking each component of the work process and comparing the results. By conducting this double check independently of each other, the risk of bias is reduced, as two practitioners are less likely to make the same mistake.

3. Verification double check is the process where two licensed practitioners are simultaneously checking a portion of the work process.

4. Required witness cosign refers to the required Medication Administration Record (MAR) documentation by another licensed practitioner before the medication can be dispensed and/or administered.

5. The "seven rights" of safe medication administration includes verification of the following:

- Right patient,
- Right drug,
- Right dose,
- Right route,
- Right time,
- Right indication, and
- Right documentation.

PROCEDURE:

A. The Pharmacy and Therapeutics Committee, in conjunction with pharmacy and nursing services, shall review the list of "High Alert" medications every three (3) years or as indicated, addressing those high alert medications that have been identified from internal adverse drug events (medication errors and adverse drug reactions), Institute for Safe Medication Practices (ISMP), the U.S. Food and Drug Administration (FDA), and The Joint Commission (TJC). ~~See Attachment A.~~

1. List of High Alert Medications in the Acute Care Setting (See Attachment A)
2. List of High Alert Medications in the Ambulatory Care Setting (See Attachment B)

B. The "High Alert" medication list shall be made available in all patient care areas, for reference, and shall describe each medication or class of medication from the time of procurement, storage, ordering, preparing, administration, and monitoring.

C. Automated double check is a computerized system safeguard (e.g. bar code scanning) and should be used to compliment, not substitute, the 7 Rights of Safe Medication Administration.

~~Pharmacists shall perform independent double checks on chemotherapy/antineoplastic orders and intrathecal compounded sterile products~~

~~Pharmacists shall perform verification double checks on the following prior to dispensing:~~

1. ~~Compounded high alert medications that are normally supplied premixed.~~
2. ~~Pediatric, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) parenteral infusions~~
3. ~~Parenteral nutrition (peripheral parenteral nutrition (PPN), total parenteral nutrition (TPN))~~
4. ~~Cisatracurium infusions~~
5. ~~Amphotericin infusions.~~
6. ~~Continuous Renal Replacement Therapy (CRRT) fluids~~
7. ~~In the event there is no second pharmacist available for a verification double check, a pharmacy technician shall perform the verification double check.~~

~~Nursing shall perform IDCs with required witness cosign on the following:~~

1. ~~Anticoagulants (intravenous)~~
    a. ~~Alteplase for stroke – bolus and start of infusion~~
    b. ~~Argatroban infusion - start of infusion, rate changes, and bag changes~~
    c. ~~Heparin infusions - bolus, start of infusion, rate changes, and bag changes~~
2. ~~Chemotherapy/antineoplastics - before administration with two competent, licensed health care providers~~
3. ~~Hypertonic saline - start of infusion~~
4. ~~Insulin intravenous (IV) infusion - before administration, rate changes, and bag changes~~
5. ~~Magnesium 20 gm/500 mL - start of infusion (see policy OB.47 Magnesium Sulfate for Pre-Eclampsia and Tocolytic Therapy~~
6. ~~Oxytocin for labor induction/augmentation - start of infusion and bag changes (see policy OB.30 Oxytocin use for Labor Induction/Augmentation)~~

7. ~~Patient Controlled Analgesia (PCAs) - initial set up, reprogramming the pump, and with syringe changes (see policy 100.235 Patient-Controlled Analgesia (PCA)~~

~~Nursing should perform the following:~~

1. ~~Independent double check at pump change (e.g., between an Alaris pump and an MRI pump)~~
2. ~~Bedside review of all infusions at start of shift.~~

~~The licensed health care provider shall perform verification double checks, with required witness cosign on the following medications:~~

1. ~~Respiratory Therapist administration of inhaled epoprostenol - start of therapy (see policy R.96 Inhaled Epoprostenol (Flolan))~~

VCMC, SPH, and Infusion Center

A. Pharmacists shall perform independent double checks on chemotherapy/antineoplastic orders and intrathecal compounded sterile products.

B. Pharmacists shall perform verification double checks on the following prior to dispensing:

1. Compounded high alert medications that are normally supplied premixed.
2. Pediatric, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) parenteral infusions
3. Parenteral nutrition (peripheral parenteral nutrition (PPN), total parenteral nutrition (TPN))
4. Cisatracurium infusions
5. Amphotericin infusions.
6. Continuous Renal Replacement Therapy (CRRT) fluids
7. In the event there is no second pharmacist available for a verification double check, a pharmacy technician shall perform the verification double check.

C. Nursing shall perform IDCs with required witness cosign on the following:

1. Anticoagulants (intravenous)
   a. Alteplase for stroke - bolus and start of infusion
   b. Argatroban infusion - start of infusion, rate changes, and bag changes
   c. Heparin infusions - bolus, start of infusion, rate changes, and bag changes
2. Chemotherapy/antineoplastics - before administration with two competent, licensed health care providers
3. Hypertonic saline - start of infusion
4. Insulin intravenous (IV) infusion - before administration, rate changes, and bag changes
5. Magnesium 20 gm/500 mL - start of infusion (see policy OB.47 Magnesium Sulfate for Pre-Eclampsia and Tocolytic Therapy
6. Oxytocin for labor induction/augmentation - start of infusion and bag changes (see policy OB.30 Oxytocin use for Labor Induction/Augmentation)
7. Patient Controlled Analgesia (PCAs) - initial set up, reprogramming the pump, and with syringe changes (see policy 100.235 Patient-Controlled Analgesia (PCA)

D. Nursing should perform the following:

1. Independent double check at pump change (e.g., between an Alaris pump and an MRI pump)
2. Bedside review of all infusions at start of shift.

E. The licensed health care provider shall perform verification double checks, with required witness cosign on the following medications:

1. Respiratory Therapist administration of inhaled epoprostenol - start of therapy (see policy R.96 Inhaled Epoprostenol (Flolan))

Ambulatory Care Clinics

A. Nursing shall perform double check verification prior to admission for the following medications

1. Insulin, subcutaneous
2. Furosemide, intramuscular (IM)
3. Leuprolide Acetate Depot (IM)
4. MedroxyProgesterone Acetate Depot (IM)
5. Rho(D) Immune globulin (IM)
6. Ketorolac (IM)

Independent Double Check Procedure

Prior to medication administration, two licensed health care providers shall independently go through the steps in the double check procedure below and arrive at the same conclusion. IDC must be performed before the start of the infusion/before administration of the medication.

A. Identify the patient using two patient identifiers (name and date of birth). See policy 100.088 Patient Identification

B. Review allergies and sensitivities

C. Compare the most current prescriber order or medication administration record to the medication label to verify:

1. Right patient name
2. Right drug
    a. Right diluent if applicable
    b. Right concentration if applicable
3. Right dose
    a. Right weight based dosing if applicable
    b. Right rate of administration
4. Right frequency and time of administration
5. Right route
6. Right indication
7. Right documentation

D. Ensure the pharmacy label matches the manufacturer label (if appropriate).

E. Review expiration and/or beyond use date of the medication.

F. Perform any necessary calculations.

G. Review medication protocols when or if applicable (e.g. heparin protocol or TPN order)

H. Check the patient's relevant lab values and/or diagnostic results

I. Program the IV pump and review the settings. Confirm the rate and trace the lines.

J. If discrepancies exist, the two health care providers shall repeat the IDC process. If discrepancies remain, the health care provider shall clarify the medication order(s) with the provider.

K. If the IDC verifies the medication and process to be correct, both health care providers shall document that an IDC has been completed and the medication can be dispensed and/or administered.

L. Re-identify the patient (name and date of birth) immediately prior to administration.

All revision dates: 3/7/2025, 1/21/2025, 3/14/2023, 10/12/2021, 3/9/2021, 2/12/2020, 5/2/2019, 6/1/2008

Attachments

Attachment A - List of High Alert Medications in the Acute Care Setting

Attachment B - List of High Alert Medications in the Ambulatory Care Setting

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/24/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	3/24/2025
Pharmacy Services	Sara Pendleton: Medication Safety Officer	3/7/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*10/16/2024*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/24/2025*
Next Review:	*3 years after approval*
Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Patient Care*
References:	

PH.124 IVPB to IVP Therapeutic Interchange Protocol

POLICY:

Pharmacists ~~shall~~may convert intravenous piggyback (IVPB) medications to approved intravenous push (IVP) as authorized by Pharmacy and Therapeutics (P&T) Committee. Note: The decision to convert IVPB to IVP will be at the discretion of the pharmacy, nursing, and medical staff.

PROCEDURE:

The literature provides evidence in favor of the IVP method over the IVPB method. It has been noted that IVP offers similar pharmacokinetic exposures to IVPB, while also bringing cost savings and improving administration time of time-critical medication. Additionally, IVP reduces nursing time and minimizes equipment use.

A. Pharmacists ~~shall~~may identify patients with IVPB medication orders that are eligible for conversion to IV push equivalents (see Table 1).

B. The pharmacist shall discontinue the old IVPB order and enter the new order for the IVP equivalent into the electronic health record (EHR) utilizing the “Protocol/Standardized Procedure – co-sign” option thereby linking the order to the ordering/primary provider. Upon order entry, the pharmacist shall enter the canned text, “IVPB to IVP conversion per protocol” under order comments.

C. The pharmacist shall document conversion in a clinical intervention under the “Optimized Administration Route” category.

Table 1: Approved medications for IVPB to IVP conversion — Adults

Medication	Instructions for reconstitution	Administration time	Comments
Cefazolin	500 mg: 10 mL SWFI 1 gm: 10 mL SWFI 2 gm: 10 mL SWFI 3 gm: 15 mL	3—5 minutes	Max dose 3 gm

	SWFI		
Cefepime	1 gm: 10 mL of NS 2 gm: 10 mL of NS	2—5 minutes	Alternate diluent is SWFI or bacteriostatic water
Ceftazidime	500 mg: 5.3 mL SWFI 1 gm: 10 mL SWFI 2 gm: 10 mL SWFI	3 -- 5 minutes	
Ceftriaxone	1 gm: 10 mL SWFI 2 gm: 20 mL SWFI	2—3 minutes	Do not give while LR or calcium-containing products infusing. Stop infusion and flush line with NS Alternate diluent is NS
Daptomycin	Pharmacy will reconstitute	2 minutes	On demand, request from pharmacy
Dexamethasone	Supplied as vials as solution for injection	1—2 minutes	Max dose 10 mg Rapid administration may be associated with perineal burning or tingling
Diphenhydramine	Supplied as vials as solution for injection	2 minutes	Max dose 50 mg
Ferric Carboxymaltose	Supplied as vials as solution for injection	For doses ≤ 750 mg give IVP at 100 mg/ minute. For doses 1 gm give IVP over 15 minutes	If extravasation occurs, discontinue the administration at that site. Use syringe pump For inpatient use: • Request from pharmacy
Iron Sucrose	Supplied as vials as solution for injection	2 -- 5 minutes	Max dose 200 mg
Levetiracetam	Supplied as vials as solution for injection	2—5 minutes	Max dose 2 gm
Lacosamide	Supplied as vials as solution for injection	≤ 80 mg/minute	Max dose 400 mg
Ondansetron	Supplied as vials as solution for injection	2—5 minutes	Max dose 16 mg
Thiamine	Supplied as vials as solution for injection	1-2 minutes	Max dose 500 mg

Abbreviations: NS = Sodium chloride 0.9%; SWFI = Sterile water for injection; IVP = Intravenous push; LR = Lactated ringer

REFERENCES:

A. Lee R, Tran T, Tan S, Chun P. 602. Intravenous Push Versus Intravenous Piggyback Administration of Cephalosporin Antibiotics: Impact on Safety, Workflow, and Cost. Open Forum Infect Dis. 2021 Dec 4;8(Suppl 1):S403–4. doi: 10.1093/ofid/ofab466.800. PMCID: PMC8644673

B. Smith SE, Halbig Z, Fox NR, Bland CM, Branan TN. Outcomes of Intravenous Push versus Intermittent Infusion Administration of Cefepime in Critically Ill Patients. Antibiotics (Basel). 2023 Jun 1;12(6):996. doi: 10.3390/antibiotics12060996. PMID: 37370315; PMCID: PMC10295171.

C. Institute for Safe Medication Practices (ISMP). ISMP Safe Practice Guidelines for Adult IV Push Medications; 2015. https://www.ismp.org/guidelines/iv-push

D. Lexi-Drugs. Hudson, OH: Lexicomp. http://online.lexi.com/

E. DailyMed. Bethesda, MD: U.S. National Library of Medicine, National Institutes of Health, Health & Human Services. https://dailymed.nlm.nih.gov/dailymed/

F. Micromedex Solutions. Greenwood Village, CO: Truven Health Analytics. http://micromedex.com/.

All revision dates: 2/24/2025, 10/16/2024

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/7/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/24/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/24/2025
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	2/24/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/13/2013*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/5/2025*
Next Review:	*2 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.41 Heliox Administration

POLICY

This policy defines how Heliox (He) administration will be performed by Respiratory Therapy Staff. Heliox, a mixture of Helium and Oxygen, which has a density less than air, administered to improve oxygenation and ventilation in patients with disease processes that obstruct airflow, such as post extubation stridor, bronchiolitis, and status asthmaticus.

DEFINITIONS/CALCULATIONS

1. Heliox gas mixtures come in various premixed concentrations (80:20, 70:30, and 60:40). The mixtures must contain at least 20% oxygen to insure adequate fraction of inspired oxygen (Fi02) delivery. The use of lower concentrations of helium may be necessary to ensure adequate delivery of oxygen to the hypoxic patient.
2. Fraction of inspired helium (FiHe)
    1. FiHe is determined by the "Oxygen Monitor" or Servo-I FIO2 reading.
        a. FiHe =100% - FIO2
        b. FiHe should be 20% to 40%
        c. FiHe >40% is less effective

GENERAL INSTRUCTIONS

1. Review Electronic Health Record for verification of orders.
2. Identify the patient using 2 patient ID per National Patient Safety Goals.
3. Explain to patient and/or family/parent at bedside the therapy that is about to be performed.
4. All patients receiving He will have the following parameters monitored ~~upon~~before initiation of therapy and then every two (2) hours so response to therapy can be assessed.
    A. Vitals
        1. Heart Rate
        2. Respiratory Rate
        3. Continuous cardiac monitor and pulse oximeter (SpO2)

4. work of breathing
5. breath sounds
6. use of accessory muscles
7. appearance

5. ~~Review Electronic Health Record for orders~~2(two) Heliox tanks will be stored in PICU (Pediatric Intensive Care Unit) for immediate use
6. Call ~~facilites~~facilities and/or ~~maintanace~~maintenance to retrieve Heliox tanks from gas storage area.
    1. Inform facilities and/or ~~maintance~~maintenance when tan first tank is empty so you can have full tank on standby.
7. Basic Equipment
    A. 2 premixed cylinder of Heliox
        a. 80:20 is what is available at Ventura County Medical Center
    B. A He regulator,
        a. helium-oxygen blender with high flow and low flowmeters
    C. Flow Conversion chart when using oxygen flowmeter
    D. Oxygen devices
        a. nasal cannula
        b. non ~~rebreather~~re breather mask (NRM)
        c. ventilator (if applicable)
    E. Flowmeter and nipple adapter
    F. Oxygen Analyzer
8. Initial Set Up for all Procedures
    A. Check physician order in Electronic Medical Record (EMR)
    B. Explain procedure to patient and family
    C. Ensure helium tank regulator is attached and clear Heliox hose is connected from the regulator to the helium inlet on the HeliO2
    D. Connect oxygen hose to the wall oxygen source
    E. Crack the tank and ensure the tank reaches 500 ~~ponds~~pounds per square inch (psi)
    F. Set blender at desired concentration, Heliox concentrations must be kept 60% or greater to be clinically effective
    G. Turn on the appropriate flow meter to the desired rate. Use the "Oxygen Flowmeter Conversions" to find the rate on the flow meter that will deliver the total order gas flow
9. Precautions for use
    A. Ensure that a spare full tank is available
    B. Change tank when reading reaches 200 psi
    C. Make patient and/or parents that voice changes may occur and are temporary due to the lighter density of the He and will change back to normal with discontinuation of the therapy.

PROCEDURE:

1. **NBR Mask**
    A. Setup
        1. See initial set up procedures
    B. Initiating
        1. Apply NRB
        2. Ensure connections are tight
        3. Mask fits the patient's face with a loose seal
        4. The bag deflates by no more than 1/3 of the bags volume during inspiration
        5. The bag completely refills during exhalation
        6. Add supplemental oxygen by nasal cannula per physicians order
2. **Servo-I Ventilator**
    A. Setup
        1. See initial set up instruction with additions of the following
        2. Ventilator will be labeled "15," and the side compartment contains the Heliox Adapter
        3. connect the oxygen hose on the Servo-I inlet to the wall oxygen source
        4. Disconnect the air hose on the Servo-I inlet (on the side of the Servo-I)
        5. Disconnect the clear heliox hose to the "Heliox Adapter" that is stored in the side compartment of the Sero-I
    B. Initiating
        1. Turn the helium tank. Verify that the tank has at least 500 psi
        2. Verify the Servo-I defaults with the message "System compensated for HeO2. O2 alarm limits adjusted." And hit "OK"
        3. Connect "Oxygen Monitor" in line in the inspiratory limb prior to humidification and turn the monitor on
        4. Set the ordered Servo-I settings
            a. Observe for accuracy in the presence of He
            b. In volume modes the Vt delivered is slightly higher than what is dialed
            c. Observe patient for high PiP and excessive chest rise
        5. Allow 1-2 minutes for the system to purge before initiating patient ventilation
        6. Record the FiO2 from the "Oxygen Monitor" and Servo-I.
            a. Amount of He is determined by the oxygen analyzer
            b. FIO2 should b also verified by second source, in-line analyzer
        7. Calculate the fraction of inspired helium (FiHe)
        8. Disable the heated wire mode when on heliox. Helium conducts heat differently than nitrogen

and the delivered gas may be higher than desired.

9. If a bronchodilator is ordered deliver via MDI

Adverse Reaction

A. Hypoxemia

1. Use of Heliox gas therapy with gas mixtures that provide insufficient FiO2 to clinically hypoxemic patients who require high FiO2

B. Generally the only hazard of He in the non-intubated patient includes the change in voice (temporarily high potched voice)

Documentaion

Heli-ox therapy should be documented in patient's EMR a minimum of every two hours. This should include but not limited to

A. Tank Pressure

B. Liter flow

C. Supplemental Oxygen

D. SpO2

E. Vitals as listed above

All revision dates: 2/5/2025, 12/8/2020, 2/13/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/5/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/2007*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/5/2025*
Next Review:	*2 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.57 Respiratory Care Invasive Mechanical Ventilation

POLICY:

To establish guidelines for mechanical ventilation by Respiratory Care staff at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH). The purpose of this policy is to outline implementation, hazards, transporting, and discontinuation of mechanical ventilation.

PROCEDURE:

DEFINITIONS

Electronic Health Record-EHR
~~Electronic Self Test-EST~~
~~Liters Per Minute-LPM~~
~~Kilogram-Kg~~

~~GUIDELINES~~

Electronic Self Test-EST

Liters Per Minute-LPM

Kilogram-Kg

GUIDELINES

1. ~~Implementation~~
   - ~~A. Orders for mechanical ventilation will be obtained at the initiation of ventilation~~
   - ~~B. Orders will be made in the EHR~~
   - ~~C. Verbal orders should be entered into the EHR as soon as possible and sent for co-sign~~
   - ~~D. Orders may be written during downtime~~

   Orders
   - A. Physician is responsible for entering orders for mechanical ventilation in the EMR. Orders need to be entered as soon as clinically possible.
   - B. Verbal orders should be avoided when possible. Physician in Intensive Care Unit is available 24/7.

a. Changes in orders need to be done via "Modification" of order. Canceling an order and reentering a new one should be avoided if patient is not extubated.

C. Mechanical Ventilation orders must have

a. Mode of Ventilation

b. Respiratory Rate

c. Tidal Volume or Pressure Control

d. Oxygen Concentration

e. Positive End Expiratory Pressure

f. Pressure Support, if applicable

g. Spontanous Breathing Trial Assessment

D. Orders may be written during downtime. Staff to follow downtime ordering policy

E. The RT (Respiratory Therapist) will set the sensitivity, flow rate, inspiratory time, I:E ratio (inspiratory to expiratory ratio), flow cycle, inspiratory rise and bias flow to meet the needs of the patient, prevent air-trapping and to maximize ventilator-patient synchrony.

2. Equipment

A. ~~Mechanical Ventilator~~

~~1. Ensure EST has been completed before use~~

~~2. Home ventilators will not be used~~

~~3. Humidification~~

~~a. HME will be used for first 48 hours~~

~~b. The following patients should be placed on heaters immediately~~

~~i. ARDS~~

~~ii. Bronchiectasis~~

~~iii. Cystic Fibrosis~~

~~c. Heater will be instituted after 48 hours~~

~~i. Verify water tubing is unclamped~~

~~ii. Ensure water supply is adequate~~

~~iii. Drain condensation away from patient~~

~~iv. Use suction to empty traps~~

~~4. All ventilators will be plugged into red outlet~~

Mechanical Ventilator

a. Home ventilators will not be used

b. Check ventilator for proper operation of all systems according to manufacturer recommendations:

i. No leaks in circuit

ii. Pre use check has been preformed

iii. Alarms functional and audible

1. All ventilators will be plugged into red outlet

B. Ventilator circuit

1. Infant Circuit, 10mm
   a. Flow is less than 15 LPM
   b. Patient weight is less than 10 Kg
2. Pediatric Circuit, 15mm
   a. Flow is 15-30 LPM
   b. Patient weight is 10-20 Kg
3. Adult Ventilator Circuit, 22mm
   a. Flow is greater than 30 LPM
   b. Patient weight is greater than 20 ~~Kg~~K
4. Circuits will be changed prn (as needed)
5. When disconnecting patient from circuit red cap should be placed on circuit

~~Manual resuscitation bag and mask~~

C. Humidifier

a. Sterile water

b. Set at 37 degrees Fahrenheit

D. Manual resuscitation bag

a. Resuscitation Bag must be connected to Oxygen source

b. Proper size mask connected to resuscitation bag

c. Resuscitation bag must be present with patient on all transports within the hospital

E. Suction Equipment

1. In-line suction catheters will be used
2. In-line suction catheters will be changed prn (as needed) or per manufacturer recommendation

F. Bacterial Filter

1. Will be placed on inspiratory and expiratory limb
2. Inspiratory Filter changed once a shift and when visibly soiled

3. ~~Monitoring~~

~~A. Vital Signs~~

~~1. Pulse Oximetry~~

~~2. Heart Rate~~

~~3. Capnography should be used whenever possible~~

~~4. SpO2~~

~~5. BP~~

Monitoring

A. Physiologic Data
    1. Pulse Oximetry (Oxygenation)
    2. Ventilation (Capnography)
    3. Hemodynamics (Blood Pressure and Heart Rate)
    4. SpO2
    5. Neurologic

B. Airway
    1. Placement at teeth or gums (Oral intubation)
    2. Tracheostomy size (when applicable)
        i. Size
        ii. Drainage
        iii. Sutures
    3. Cuff pressure
    4. Security
    5. Patency
    6. Skin integrity

C. Ventilator
    1. Settings/alarms
    2. Graphics
    3. Mechanics
    4. Synchrony

D. Humidification
    1. Type
    2. Adequacy/Tempature
    3. Secretions

E. Physical Exam
    1. Inspection
    2. Auscultation

4. Documentation

A. ~~Ventilator checks should be performed Q2 hours or after ventilator changes~~Ventilator checks should be performed Q4(every 4 hours) or Q2 (every 2 hours) when indicated
    1. Complete a patient assessment within 30 minutes of initiation of mechanical ventilation
    2. Following any adjustments,
    3. Following return of the patient from transport

4. Following transfer of care from another area of the hospital

B. Ventilator checks will be documented in the EHR

1. Date and time of ventilator check
2. ~~Date and time of~~ Drop a "ventilator day" charge on the first check of the am shift
3. ETT size and placement, plus cuff pressure if applicable and skin integrity
4. ~~Ventilator settings~~Ventilator settings and dynamic patient data
    i. The RCP will assess and document current ventilator setting as indicated by ventilator mode type
5. ~~Vitals~~Vital Signs
6. ~~Water~~Heater temperature and water level on humidification

    ~~Notation that water clamp is open~~
7. Notation if tubing is drained, if tubing not drained notation should be made if condensation ~~can be~~is seen in the tubing
8. Breath sounds
9. Alarm settings
10. Patient position and if the head of bed is elevated
11. Sputum consistency and color

~~If patient workload does not permit for Q2 ventilator checks, supervisor is to be notified immediately~~

C. Alarms should be set within

1. Respiratory Rate: set 10-20 breaths per minute above set rate
2. High Minute Volume: set 10-15 above calculate minute volume
3. Low Minute Volume: set no lower than 5 per min
4. Peep: set 3 below and 3 above
5. If alarms need to be set outside these ranges documentation should be provided why

D. Discontinuation

1. An order shall be obtained for discontinuation of mechanical ventilation
2. Respiratory Therapist will verify order
3. RT's will remove ventilator from the patient room, clean, and EST before the end of their shift. If time does not permit this, the RT must notify their Lead who will assign another RT to complete this task
4. RT will document in EHR ventilator discontinuation

5. Areas of Consideration

A. ETCO2

1. Will be used when available in line
2. Should be charted in blood gases
3. Will be checked during routine ventilator checks~~,~~ and charted in the EHR

B. X-ray

1. RT will assist ~~xray~~X-ray Technicians
2. Post X-~~xray~~ray, RT will verify tube security and placement

~~Oral Care~~

~~1. Is a shared responsibility between RT and RN~~

~~2. RT and RN will coordinate the oral care of patients~~

~~3. RT's are only responsible for mechanically ventilated patients' oral care~~

C. Oral Care

1. Is a shared responsibility between RT and RN
2. Respiratory will provide oral care Q4, aligned with ventilator checks.
    i. RT will document oral care in EMR
3. Respiratory will only provide oral care to intubated patients
4. Oral Care kit to be placed at bedside immediately after intubation
5. Kits will be replaced ever 24 hours
6. Follow manufacturer recommendation

D. Weaning

1. SBT (Spontaneous Breathing Trial) will be assessed daily
    i. If patient does not meet criteria, Respiratory will document
    ii. RN and RT will coordinate daily SBT and SAT (spontaneous awaking trial) at approximately 730 am. Please refer to CPG.53

E. Notification

1. Attending physician will be notified of all sudden changes to respiratory status
2. Rounds will be completed daily in the Critical Care Unit (CCU) with an RT in attendance
3. Physicians and Residents will meet with Respiratory Therapy
4. All Hand-off Reports of ventilator patients will be performed in the unit the patient is in
5. ~~CCU will not be left without an RT~~CCU will not be left without an RT when there is an unstable ventilated patient
    i. If RT needs to leave, they will communicate with Charge RN
6. Communicate with ~~nurse~~RN when any ventilator changes are made
7. Communicate with the ~~nurse~~RN when there are any changes in patient condition

6. ~~Cleaning~~

~~A. Ventilators will be cleaned using PDI Sani Wipes AF3~~

~~1. Allow to dry before preforming EST~~

~~B. All Ventilators will complete EST before use~~

~~1. Ventilator Verification Record will be placed on top of the ventilator~~

~~2. If no Verification Record is present, complete EST before use~~

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

Cleaning

A. Ventilators will be cleaned using hospital approved wipes

1. Respiratory Therapy will follow manufacture guidelines, allow proper wet to dry time

B. All Ventilators will complete pre-op check before use

1. Any time a Servo-i vent is turned off, a pre-op check must be completed before use
2. A Hamilton T1 ventilator should be turned off after the pre-check is complete

C. Place clean equipment bag and return to clean room, keep the vent plugged in

All revision dates: 2/5/2025, 2/1/2014, 2/1/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/5/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*7/1/2007*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/7/2025*
Next Review:	*2 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.76 Respiratory Care Department Transport of Ventilator Patients

POLICY:

To establish for Respiratory Care staff a consistent method of transport for patients on mechanical ventilation. To continue the same standard of care during patient transports by simulating ventilation as closely as possible to the ventilation they are receiving.

PROCEDURE:

~~I. Equipment for transport~~

~~A. Ventilator~~

~~B. Ambu bag and mask~~

~~C. Oxygen cylinder(s) sufficient for the transport~~

~~D. Monitor capable of monitoring; heart rate, oxygen saturation, and blood pressure while on ventilator~~

~~II. Types of Transport~~

~~A. In house patient transports, patients may be transported~~

~~1. Via 100% Ambu bag~~

~~2. Or via transport ventilator~~

~~B. All patients being transported or maintained on portable transport ventilators must have a Respiratory Therapist in attendance monitoring the ventilator during the actual transport between locations.~~

~~C. Special Circumstances~~

~~1. Traumatic head injury patients requiring mechanical ventilation will be transported on a transport ventilator.~~

~~2. During MRI's the Respiratory Therapist must remain in the MRI control booth during the study.~~

~~a. MRI compatible tanks only are allowed in this area~~

~~D. During prolonged procedures, the Respiratory Therapist may return to their assigned area under the following circumstances~~

~~1. Patient is stable~~

2. ~~Patient on LTV 1200 ventilator or Servo I ventilator~~
3. ~~RN will remain at bedside during procedure for monitoring~~

The risks associated with transporting the mechanically ventilated patient needs to be minimized through careful preparation prior to the transport, good hand-off communication between all parties, continuous monitoring throughout the transport, and assurance of patient stability with final hand-off.

I. Types of Transport
   1. In house patient transports, patients may be transported
      a. Via 100% Ambu bag
      b. Transport ventilator
      c. Infant shuttle or NICU Transporter (NICU and/or PICU)
   2. Outside of Hospital Transport
      a. Transport ventilator
      b. NICU Transporter (NICU and/or PICU)

II. Transport Team
   1. Transports will be performed by a team consisting of, at a minimum, Respiratory Therapist(RT) and a Registered Nurse(RN) with critical care experience.
   2. Members of the transport team will have the appropriate advanced life support certification (NRP, PALS, and/or ACLS) to address the needs of the patient.
   3. A minimum of one member of the transport team will be competent in airway management.This team member should consist of an Anesthesiologist or A Respiratory Therapist

III. Equipment
   1. Transport Ventilator
      a. Respiratory Therapist may choose ventilator based on
         i. Destination of transport
         ii. Oxygen needs of patient
         iii. Patient Settings
   2. Manual Resuscitator (BMV)
      a. Appropriate Mask size
   3. Portable oxygen source
   4. Cardiac Monitor
   5. SpO2 monitoring capability
   6. Stethoscope
   7. Personal protective equipment and supplies

IV. Preparation
   1. Before transport, assess the patient's stability and tolerance to the ventilator.
      a. Place the patient on the transport ventilator for at least 10 minutes prior to transport to assess

patient tolerance and stability for travel.

2. Assess patient for tube security and possible need of suctioning.
3. Place settings on transport ventilator to match settings ordered
4. Transportation of mechanically ventilated patients should only be undertaken following a careful evaluation of the risk-benefit ratio.

V. Infection Control

1. All equipment should be disinfected between patients
    a. Use appropriate hospital approved wipes. Follow manufature guidelines
2. Transport curcuits are single patient use and may be stored at bedside..
    a. Store in patient belonging bag with a patient label

VI. Special Circumstances

A. Traumatic head injury patients requiring mechanical ventilation will be transported on a transport ventilator

B. During MRI's the Respiratory Therapist must remain in the MRI control booth during the study
    a. MRI-compatible ventilator and oxygen tanks only are allowed in this area

C. Communicate with Respiratory Lead to coordinate coverage of area needing to be covered while RT is on transport

D. RT may leave ICU for "STAT" transport, as long as communication to ICU Charge RN, attenting physcian has taken place, and Lead RT has occured.

E.

Documentation

I. Document a Respiratory Note

1. Documentation shall reflect parameters as well as patient's condition, vital signs and patient tolerance

II. Document Respiratory Productivity to reflect time spent during total transport

III. Complete Ventilator check to be done on return from transport.

All revision dates: 2/7/2025, 11/10/2020, 6/1/2014, 9/1/2013, 4/1/2013, 2/1/2012, 7/1/2011, 2/1/2010, 9/1/2009, 7/1/2008

Attachments

No Attachments

Approval Signatures

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

Step Description	Approver	Date
and Pediatrics		
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/7/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*1/1/2002*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/7/2025*
Next Review:	*2 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory-NICU/PICU*
References:	

R.NP.08 NICU Tackle Boxes for Respiratory Emergencies, Intubations and Resuscitations

POLICY:

To provide emergency equipment and supplies for intubation and resuscitations of a neonate during emergency situations to be used by the NRP (Neonatal Resuscitation Provider) provider.

PROCEDURE:

Respiratory therapist is responsible each shift to make sure the box is supplied with the proper equipment and supplies for intubation and resuscitations. All supplies and equipment is to be clean and unopened at all times while in the tackle boxes.

EQUIPMENT:

1. Disposable Laryngoscope Handle
2. Disposable Laryngoscope Blade
    A. Blade 00
    B. Blade 0
    C. Blade 1
3. Small scissors
4. Cloth tape
5. Endotracheal Tubes (2 of each)
    A. Size 2.5
    B. Size 3.0
    C. Size 3.5
    D. Size4.0
6. Stylets (2)
7. 5 milliliters (ML) syringe
8. Neonatal Anesthesia bag

A. Mask size 1
B. Mask size 2

9. CO_2 detector
10. Laryngeal Mask Airway (LMA)
    1. Size 0
    2. Size 0.5
    3. Size 1
11. Skin Barrier Proctectant
12. Pulse Oximetry Sensor
13. Posey Wrap
14. Suction Catheter
    A. Size 6 French
    B. Size 8 French
    C. Size 10 French
15. Lubrication
16. Feeding Tube
    A. Size 6 French
    B. Size 8 French
17. "Ram" Cannula
    1. Micropreemie
    2. Preemie
    3. Infant & Newborn

All revision dates: 2/7/2025, 10/15/2020, 11/1/2013, 1/1/2006, 1/1/2004, 1/1/2002

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/7/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1995*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*3/19/2025*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.08 Pregnancy Testing in Females of Childbearing Age

POLICY:

Female patients of childbearing age (12-55) in the Emergency Department (ED), Inpatient Psychiatric Unit (IPU) or Crisis Stabilization Unit (CSU), per physician's order, should have a pregnancy test prior to initiation of medication to guide clinical decision making and ensure that no pregnant individual is given medication which may have teratogenic effect.

PROCEDURE:

Emergency Department

1. A physician order will auto generate a point of care (POCT) pregnancy test for females of childbearing age once registered to be seen in the emergency department.

a. Urine pregnancy tests are preferred because because of the rapid result response and cost.

b. With urine pregnancy tests, the first voided AM specimen is optimal. However the test can be performed reliably on a random urine specimen.

c. A serum pregnancy may be obtained from patients who are uncooperative.

Inpatient Psychiatric Unit or Crisis Stabilization Unit

1. A physician will order a pregnancy test for females of childbearing age.

a. Urine (POCT) tests are preferred because of the rapid result response and cost.

b. With urine pregnancy tests, the first voided AM specimen is optimal. However, the test can be performed reliably on a random urine specimen.

c. A serum pregnancy may be obtained from patients who are uncooperative with providing a urine specimen.

Pregnancy Testing Exceptions

~~1. In case of emergency.~~

1. Patient history indicates tubal ligation or hysterectomy

2. Patient is having menses

All revision dates:	3/19/2025, 10/12/2021, 7/26/2017, 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2004, 2/1/2000, 2/1/1997, 2/1/1996

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Psychiatry Committee	Stephanie Denson: Manager, Medical Staff Office	2/6/2025
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

Current Status: *Pending* **PolicyStat ID:** *17635122*

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*5/1/1992*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*2/19/2025*
Next Review:	*3 years after approval*
Owner:	*Erin Olivera: Clinical Nurse Manager, IPU/CSU*
Policy Area:	*Inpatient Psychiatric Unit (IPU)*
References:	

Z.27 IPU Nursing Documentation

POLICY:

Inpatient Psychiatric Unit (IPU) patients will be assessed with a plan of care/treatment based on assessed needs.

PROCEDURE:

1. The ~~initial~~ nursing assessment will be performed by the Registered Nurse(RN) and completed ~~within 24 hours after the~~once a shift. The patient's ~~admission with this~~assessment information ~~contained in the Adult Admission Assessment~~will be entered into the Electronic Health Record (EHR).
2. Nursing Progress Notes are annotated in the "ABC" format. This format is based on clinical staffs observation, assessment, intervention and evaluation of the patient.
3. The ABC format includes:
   a. A - Appearance - discusses the patient's physiological condition and physical presentation.
   b. B - Behavior - discusses the patient's behavior (e.g., behaviors exhibited by the patient and any resultant impact of this behavior on the patient's progress).
   c. C - Content - discusses the patient's thought processes, cognition and mental functioning.
4. Progress Notes are performed as appropriate to patient condition and treatment and standards of care and consider other data available to the licensed nurse (such as patient intake and output, participation in activities and therapies, vital signs, laboratory values), however, documentation of outcomes are required once per shift. The healthcare provider may document more frequently (such as when a significant event occurs, if the patient leaves the unit, if the patient is evaluated in the Emergency Department), however a solid, clinically relevant nursing note is required once per shift.
5. Care plans will be updated daily and with a change of condition.
6. Multidisciplinary Treatment Planning: See "Multidisciplinary Treatment Plan Policy."

All revision dates: 2/19/2025, 4/12/2023, 12/12/2019, 7/1/2015, 3/1/2010, 3/1/2009, 8/1/2008, 2/1/2007, 10/1/2006, 8/1/2004, 2/1/2000, 2/1/1997, 12/1/1993, 11/1/1993, 10/1/1993

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Psychiatry Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/19/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/19/2025
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	2/19/2025

Ventura County Medical Center

Delineation Of Privileges

Family Medicine Privileges

Name:

Privilege	Requested

BASIC CRITERIA:
a. Successful completion of an ACGME or AOA-accredited residency in Family Medicine **AND;**
b. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Medicine within 1 year of completing the training **AND**;
c. *Documentation of the management of general medical problems for at least 100 inpatients and/or outpatients as the attending physician (or senior resident) during the past 2 years

~~c.~~ *Initial core privilege case volume documentation requirements waived for recent (within previous 12 mos.) Family Medicine graduates

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RENEWAL CRITERIA: A minimum of 100 inpatient and/or outpatient combined encounters during the previous 24 months

EVALUATION REQUIREMENTS: A minimum of 3 cases evaluated

If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity.

If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.

CORE PRIVILEGES: ___
Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED.

Privileges include but are not limited to the following:

Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for **ADULT** patients
Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for **PEDIATRIC** patients
Anoscopy
Arthrocentesis & therapeutic injection, large/small joint
Aspiration of subcutaneous cysts, furuncles, etc.
Assist in surgery
Breast mass aspiration, breast cyst aspiration
Cryodestruction (liquid nitrogen) of skin lesions
Diaphragm/pessary fitting/placement
Excision of nail from digit
I&D abscess, cysts, hematomas
I&D of hemorrhoid, thrombosed
IUD insertion/removal
Endometrial biopsy
Management of burns
Neonatal resuscitation standby at C-section
Reduction of displaced fractures and dislocations
Regional nerve blocks of digits
Removal of non-penetrating corneal or conjunctival foreign body
Removal of foreign body from ear, nose, skin
Skin biopsy or excision
Suture of uncomplicated lacerations
Waived testing: Rapid strep A test, amnio test, dipstick for urine, urine pregnancy test, fecal occult blood by hemoccult

CORE PRIVILEGES REQUIRING ADDITIONAL CRITERIA, DOCUMENTATION OR COMPETENCIES:

Frenulotomy - **1st case evaluated* ___

Implantable sub-dermal contraception - **Documentation of certification required* ___

Laser Tattoo Removal - **Documentation of 1-hour training with privileged physician* ___

Neonatal circumcision - **A minimum of 5 within the previous 2 years, 1st case evaluated* ___

Osteopathic Manipulative Treatment (OMT) - **Criteria: Doctor of Osteopathic Medicine (DO)*
Initial evaluation requirements: A minimum of 3 OMT case reviews ___

Provider-Performed Microscopy (PPM); wet mount for presence/absence of bacteria, fungi, parasites & human cellular elements; KOH preparations, urine sediment examination, fern testing - **Annual competency assessment required (no additional criteria or evaluation required)* ___

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Limited bedside ultrasound - **A minimum of 1 case evaluated* ___

Ventura County Medical Center

Delineation Of Privileges

Family Medicine Privileges

Name:

Privilege	Requested
Vasectomy - **A minimum of 5 within the previous 2 years, 1st case evaluated*	___

CORE OBSTETRICS **Excludes high-risk pregnancies as outlined in MS.102.023 Family Medicine Obstetrical Risk Stratification*
(Must also meet core privileging criteria)

INITIAL CRITERIA:
a. New graduates - Documentation of a minimum of 40 deliveries during residency training
b. Established physicians - Documentation of a minimum of 25 deliveries during the previous 2 years
c. Completion of BETA annual obstetrical module requirements

RENEWAL CRITERIA:
a. Documentation of a minimum of 20 deliveries in the previous 2 years
b. Completion of BETA annual obstetrical module requirements

EVALUATION REQUIREMENTS: A minimum of the first 3 deliveries evaluated

Prenatal care	___
CORE OBSTETRIC PRIVILEGES: ***Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED.***	___
Management of labor and delivery equal to or greater than 36 weeks gestation	
Limited obstetrical ultrasound, includes evaluation of presenting part, amniotic fluid index, placental position, viability	
Pudendal nerve blocks	
Paracervical nerve blocks	
Episiotomies & laceration repair of 1st, 2nd-degree lacerations	

WOMEN'S HEALTH PRIVILEGES REQUIRING ADDITIONAL CRITERIA AND/OR EVALUATION:
(Must also meet core privileging criteria)
Unless otherwise indicated, a minimum of 1 case (1st case) evaluated for each of the following privileges

Amniocentesis under ultrasound guidance to determine fetal maturity	___
Fetal biometry - **A minimum of the first 3 cases evaluated*	___
Biopsy of cervix, vagina, vulva	___
Colposcopy with biopsy and cryotherapy - **A minimum of the first 3 cases evaluated*	___
Manual vacuum aspiration (MVA)	___
Dilation and curettage:	
Diagnostic	___
Incomplete abortion	___
Suction curettage-therapeutic abortion	___
Loop electrosurgical excision procedure (LEEP) - **A minimum of 3 within the previous 2 years, first 3 cases evaluated*	___
Low forceps delivery	___
Marsupialization of glands, Bartholins, etc	___
Repair of 3rd-degree lacerations *(no additional criteria or evaluation required)*	___
Vacuum extraction delivery *(no additional criteria or evaluation required)*	___

Ventura County Medical Center

Delineation Of Privileges

Family Medicine Privileges

Name:

Privilege	Requested

ADULT PROCEDURES
(Must also meet core privileging criteria)

INITIAL/RENEWAL CRITERIA: Documentation of a minimum of 1 of each procedure requested in the previous 2 years

EVALUATION REQUIREMENTS: 1st case evaluated for each procedure requested

Arterial line placement ___

Central venous catheter placement ___

Chest tube placement ___

Endotracheal intubation ___

Lumbar puncture ___

Paracentesis ___

Peripherally Inserted Central Catheter (PICC) - require the first placement with experienced physician (i.e. interventional radiology or other physician) ___

Pleural catheter placement ___

Posterior nasal pack for epistaxis management ___

Repair of extensor tendons ___

Revision of minor amputations-digits ___

Thoracentesis ___

SPECIAL PRIVILEGES:
(Must also meet core privileging criteria)

Pediatric Moderate or Deep Sedation and Analgesia
Initial Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria: A minimum of 3 cases evaluated

Renewal Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If volume not met, the next case evaluated

Light to moderate sedation ___

Deep sedation ___

Adult Moderate or Deep Sedation and Analgesia
Initial Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria: A minimum of 3 cases evaluated

Renewal Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If volume not met, the next case evaluated

Ventura County Medical Center

Delineation Of Privileges

Family Medicine Privileges

Name:

Privilege	Requested
Light to moderate sedation	___
Deep sedation	___

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, Santa Paula Campus Hospital and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges. Applicant's electronic signature on file

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

_____
Chief, Department of Family Medicine Date

Ventura County Medical Center

Delineation Of Privileges

Pediatrics Privilege Checklist

Name:

Privilege	Requested	Granted
PEDIATRIC CATEGORIES: Please check the category which best describes your level of expertise and training		
CATEGORY C: Privileges usually granted to non-pediatrician specialty consultants who, in the opinion of the attending physician and Chief of Pediatrics, are capable of performing diagnostic consultations and/or specialty services urgently needed in the care of a critically ill patient or one with a diagnostic problem.	___	___
CATEGORY S: For those individuals who perform temporary services as contract physicians, providing care within the hospital. Current training must be commensurate with the category/class for which they would normally apply.	___	___
CATEGORY 1: Illness or problem requiring skills usually acquired after one year of pediatric training or the equivalent in experience.	___	___
CATEGORY 2: Complex or severe illness or potentially life-threatening problems usually requiring skills acquired after pediatric training sufficient for board eligibility/certification or the equivalent in experience.(Includes requirements as outlined in Category 1.)	___	___
CATEGORY 3: Intensive care of children including ventilator care and advanced life support.(Includes requirements as outlined in Category 2.)	___	___
CATEGORY 4: Illness or problem requiring expertise acquired only during subspecialty training or similar experience. (This category does not necessarily include all others. Please check other categories desired.)	___	___
NEONATAL CATEGORIES: Please check *one* class which best describes your level of expertise and training		
CLASS A: (For those requesting category 1.) Normal care of newborn infants greater than 2,000 grams.	___	___
CLASS B: (For those requesting category 2 or 3.)Care of preterm or low birth-weight infants with non-life threatening illness and not requiring special care nursery or intensive care nursery status. Board certification or board eligibility with certification achieved within four (4) years of obtaining initial privileges in neonatology or pediatrics.(Includes class A.)	___	___
CLASS C: (For those requesting category 2 or 3.) Care of all newborn infants, including those with potentially life-threatening illnesses but excluding ventilator care and advanced life support aspects. Board certification or board eligibility with certification achieved within four (4) years of obtaining initial privileges in neonatology. (Includes class A.)	___	___
CLASS D: Neonatology intensive care of all newborn infants, including ventilator advanced life support. Board certification or board eligibility with certification achieved within four (4) years of obtaining initial privileges in neonatology. (Includes class A, B, C.) Evidence of successful completion of NRP course by the AAP or AHA.	___	___
CHECK PRIVILEGES REQUESTED		
Admit and treat patients to the hospital, ER and outside clinics	___	___
Consultations	___	___
Laser Tattoo Removal (Documentation of 1 hour training with dermatologist required)	___	___
Venous Access	___	___
Arterial Access	___	___
Arterial Lines	___	___

Delineation Of Privileges

Pediatrics Privilege Checklist

Name:

Privilege	Requested	Granted
Other:	___	___
WAIVED TESTING		
Rapid STREP A Test	___	___
Amnio Test	___	___
Dipstick for urine	___	___
Urine pregnancy test	___	___
Fecal occult blood by *Hemoccult*	___	___
PROVIDER-PERFORMED MICROSCOPY (PPM) Annual competence assessment required		
Wet mount for presence/absence of bacteria, fungi, parasites and human cellular elements; KOH preparations, urine sediment examinations	___	___
Pinworm examination	___	___
SURGICAL PROCEDURES		
Chemical nasal cauterization		
Excision of nail from digit		
Venipuncture	___	___
Laceration Repair	___	___
Incision and drainage of superficial abscesses	___	___
Neonatal circumcisions Mogen Clamp- evaluate 1 Gomco – evaluate 1	___	___
Myringotomy	___	___
Simple fractures and dislocations (One procedure to be evaluated)	___	___
Exchange transfusions	___	___
Removal of foreign bodies	___	___
Umbilical vein catheterizations	___	___
Umbilical artery catheterizations	___	___
Venous cutdowns	___	___
Endotracheal intubations	___	___

Delineation Of Privileges

Pediatrics Privilege Checklist

Name:

Privilege	Requested	Granted
Pediatric Procedural Sedation Initial Criteria: a. Current PALS (NICU Providers only require NRP) b. Completion of Sedation Module (minimum score of 80%) **Evaluation Criteria:** A minimum of 3 cases evaluated Renewal Criteria: a. Current PALS (NICU Providers only require NRP) b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months - If volume not met, the next case evaluated	___	___
Thoracentesis & Chest tube placements (One procedure to be evaluated)	___	___
Subdural taps (One procedure to be evaluated)	___	___
DIAGNOSTIC PROCEDURES		
Lumbar punctures	___	___
Bladder taps (One procedure to be evaluated)	___	___
Arthrocentesis (One procedure to be evaluated)	___	___
Skin biopsies	___	___
Abdominal paracentesis (One procedure to be evaluated)	___	___
PEDIATRIC SUBSPECIALTY PROCEDURES Retrospective review of documented procedures from other institutions. Evaluation at discretion of Chief of Pediatrics		
Central venous catheter (CVC)	___	___
Percutaneous lines (PICC)	___	___
Bronchoscopies	___	___
Bone marrow aspiration	___	___
Rectal biopsy	___	___
OTHER:	___	___
OTHER:	___	___

Delineation Of Privileges

Pediatrics Privilege Checklist

Name:

Privilege	Requested	Granted
I hereby request the Pediatric Department Chief to consider my application for the procedures requested above. I am willing to provide documentation of my current clinical competence for the requested privileges. Applicant's electronic signature on file. TEMPORARY PRIVILEGE APPROVAL _____ Chief, Department of Pediatrics Date Evaluator Assignment:_____ [ ] PROVISIONAL [ ] RENEWAL APPROVAL _____ Chief, Department of Pediatrics Date Revised: 11/2011, 05.2012		

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

Ventura County Health Care System Oversight Committee

Administrative Policies

April 22, 2025

The following administrative policies were reviewed and recommended for approval by the Compliance Committee.

1. 109.001 Confidentiality of Protected Health Information
2. 109.008 Minimum Necessary Use or Disclosure of Protected Health Information
3. 109.009 Mitigation of Inappropriate Use and Disclosure of Protected Health Information
4. 109.017 Safeguarding Protected Health Information
5. 109.042 Workforce Privacy and Security Training
6. 109.045 Privacy Incident Internal Investigation Policy
7. 109.046 Notification Requirements of a Breach of Protected Health Information (PHI) to Patients, Federal and State Agencies
8. 109.047 Unauthorized Use, Access and Disclosure of Protected Health Information (PHI) Breach
9. 109.056 HCA Compliance Training

VENTURA COUNTY HEALTH CARE SYSTEM
Oversight Committee
Policies and Procedures

April 22, 2025

Policies & Procedures / Forms / Orders
The following were reviewed and recommended for approval by the Compliance Committee.

#	Title	Summary	Frequency	Page
1.	109.001 Confidentiality of Protected Health Information	Minor formatting changes and Attachment B was added to provide details of the annual acknowledgement of the PHI protection agreement.	Annual	4-9
2.	109.008 Minimum Necessary Use or Disclosure of Protected Health Information	The contents of the policy's Procedure section were re-organized for ease of flow of the information and re-labeled to clarify how the organization grants access to PHI based on either classification or categorization of a person's role.	Annual	10-13
3.	109.009 Mitigation of Inappropriate Use and Disclosure of Protected Health Information	This policy was edited to reinforce the requirement that workforce members must notify the Office of Compliance and Privacy when a suspected privacy violation has occurred. It is important to notify OCP immediately in order to comply with our reporting obligations to patient and CDPH upon detection of a suspected or confirmed privacy breach.	Annual	14-15
4.	109.017 Safeguarding Protected Health Information	Changes to Procedure 1. to align with the current practice that, upon employment, new employees sign the Confidentiality Agreement that is kept in their personnel file in Human Resources and annually thereafter employees are required to acknowledge PHI protections. Annual acknowledgement is done in the LMS or tracked in Compliance. Procedure 2 was updated to combine 2 and 3 and remove the distinction of during or after hours of operation.	Annual	16-17
5.	109.042 Workforce Privacy and Security Training	A purpose was added to the document. Under Procedure, employees will be required to complete compliance/privacy training no later than 30 days following their date of hire and annually every year thereafter.	Annual	18-19
6.	109.045 Privacy Incident Internal Investigation Policy	This policy came up for annual review. The new privacy breach reporting phone number and web portal address were added. The reference to 109.044 Definition of a Breach policy was removed since this policy will be retired.	Annual	20-23
7.	109.046 Notification Requirements of a Breach of Protected Health Information (PHI) to Patients, Federal and State Agencies	Changes included: added definitions; updated the reporting phone and web intake information; added specifics to the procedure for reporting to CDPH, to align with CDPH expectations and Compliance's reporting letter template; updated specifics regarding the information included within the report to CDPH, such as name and address of the facility involved and date and time of breach occurrence, detection, etc.	Annual	24-27

8.	109.047 Unauthorized Use, Access and Disclosure of Protected Health Information (PHI) Breach	Content updates include minor changes in tense and to be direct.	Annual	28-29
9.	109.056 HCA Compliance Training	A minor change to the Orientation Training section for clarification purpose, "Completion of Orientation Training will substitute for the Annual Compliance Training requirement for the initial training year."	Annual	30-33

Status Draft PolicyStat ID 17964681

Origination	4/1/2003	Owner	Melissa Guevarra: Acting Compliance Officer
Last Approved	N/A		
Effective	N/A	Policy Area	Administrative - Compliance
Last Revised	N/A		
Next Review	N/A		

109.001 Confidentiality of Protected Health Information

POLICY

Ventura County Health Care Agency (VCHCA) is committed to protecting the privacy and confidentiality of health information of its patients. Protected health information is strictly confidential and should never be given or confirmed to anyone who is not authorized under the VCHCA policies or applicable law, to receive this information. All information regarding care of the individual patient is maintained as confidential information. Patient health information is the property of the patient; VCHCA is the steward or caretaker of that information and the owner of the medium of storage.

PROCEDURE

1. In order to ensure confidentiality, patient information collected and/or generated within VCHCA shall be maintained in such a manner that access to it is restricted to only those with a "need to know," and the release is restricted to those with a legal right to know, as mandated by State and Federal laws.
2. It shall be the responsibility of VCHCA department heads to determine what information staff need access to in order to perform their job functions. Viewing, accessing, disclosing or obtaining information that is not needed for job completion, regardless of the medium of storage, constitutes disclosure of that information. It shall be the responsibility of VCHCA department heads to monitor and discipline staff in all matters of information security.
3. It shall be the responsibility of VCHCA department heads to inform staff of this policy and to develop and maintain, if appropriate, data confidentiality procedures which are consistent with this policy. To ensure knowledge of these policies, it shall be the responsibility of VCHCA department heads to ensure that current policies are addressed at department staff meetings on a periodic basis. In addition, these policies shall be referred to and addressed in each orientation program and shall be included in any orientation information packet provided to new employees, trainees, vendors and volunteers.

4. It shall be the responsibility of VCHCA department heads to maintain secure access to VCHCA electronic data and to provide such information in response to questions regarding potential breach of confidentiality. To the extent technologically possible, audit trails of access shall be maintained to both aggregate and patient-identifiable electronic data.
5. It shall be the responsibility of VCHCA department heads to maintain a list of all people that have been granted access to electronic databases. Access shall not be granted to staff who do not have an up-to-date, signed confidentiality agreement on file (see Exhibit "A").
6. In order to ensure that only those staff with a "need to know" are granted access to protected health information, VCHCA department heads will, on an annual basis, review the staff access to patient identifiable information.
7. Hard copy printouts of aggregate and protected health information will be stored in a secure area and maintained in a confidential manner.
8. All staff, trainees, students, vendors and volunteers at VCHCA shall be responsible for maintaining confidentiality of all information entrusted to them.
9. All staff is expected to exercise due care in any discussion or use of protected health information.
10. Confidentiality statements attesting that staff are aware of and understand the confidentiality policy, shall be signed at the beginning of employment (Attachment A) and shall be reviewed and signed and/or documented annually by all VCHCA staff who have access to patient identifiable information (Attachment B).
11. VCHCA characterizes any activity as unethical and unacceptable, through which an individual:
    a. Voluntarily allows or participates in inappropriate dissemination of protected health information;
    b. Interferes with the intended use of the protected health information resources;
    c. Without authorization, destroys, alters, dismantles, disfigures, prevents rightful access to or otherwise interferes with the integrity of protected health information and/or protected health information resources;
    d. Without authorization, invades the privacy of individuals or entities that are creators, authors, users or subjects of the protected health information resources;
    e. Shares their electronic health record password or any other password that provides access to protected health information.
    f. If a manager requests that staff share their password, they should immediately notify the Office of Compliance and Privacy. If the staff member does not report this violation to the Privacy Office, they will be held accountable for any breaches and any of the unethical behavior listed above, that was committed with the use of the password(s).
    g. Staff who have a reasonable basis to believe that a breach of confidentiality has occurred, should report the incident as soon as possible to the VCHCA Office of Compliance and Privacy, at 5851 Thille Street, Ventura, CA, 93003, (805) 677-5241.
    h. Staff who have a reasonable basis to believe that a breach of confidentiality has occurred, but **do not report it**, are subject to corrective action, including termination of employment.

i. Staff (including management) members are not permitted to investigate allegations of privacy violation prior to notifying the Office of Compliance and Privacy or absent direction from the Compliance Officer.

See Administrative Compliance Policies 109.006 Employee Sanctions for Privacy and Security Violations, and 109.044 Definition of HIPAA Breach for further information.

Applicable Laws and Regulations

45 CFR Parts 160 and 164 and California HSC §1280.15 (b) (1) (2) and § 1280.15 (c).

Attachments

109.001 A_ Employee Confidentiality Agreement.pdf

109.001 B_HCA - CONFIDENTIAL (PHI) PROTECTION AGREEMENT.pdf

Approval Signatures

Step Description	Approver	Date

EMPLOYEE CONFIDENTIALITY AGREEMENT

I understand that Ventura County Health Care Agency has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, VCMC must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems and management information (collectively Protected Health Information").

In the course of my employment/assignment at Ventura County Health Care Agency, I understand that I may access, use or disclose Protected Health Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of Ventura County Health Care Agency's Protected Health Information.

1. I will not disclose or discuss any Protected Health Information to others, including my friends or family. In addition, I understand that my personal access code, user ID, and password used to access computer systems are an integral aspect of protecting patient health information.

2. I will not access or view any Protected Health Information, or utilize equipment, other than what is required to do my job.

3. I will not discuss Protected Health Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on the shuttle bus, on public transportation, at restaurants, or at social events). It is not acceptable to discuss Protected Health Information in public areas even if a patient's name is not used. Such discussion may raise doubts among patients and visitors about our respect for their privacy.

4. I will not make inquiries about Protected Health Information for people who do not have proper authorization to access such Protected Health Information.

5. I will not willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.

6. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Protected Health Information in Ventura County Health Care Agency's computer system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Protected Health Information from Ventura County Health Care Agency's computer system to unauthorized locations (for instance, home).

7. I will log off any computer or terminal prior to leaving it unattended.

8. I will comply with any security or privacy policy promulgated by VCMC and Santa Paula Hospital to protect the security and privacy of Protected Health Information

9. I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of this Agreement or of any Ventura County Health Care Agency's information security or privacy policy.

10. Upon termination of my employment, I will immediately return any documents or other media containing Protected Health Information to VCMC or Santa Paula Hospital.

11. I agree that my obligations under this Agreement will continue after the termination of my employment.

12. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges, in accordance with Ventura County Health Care Agency's Sanction Policy, as well as legal liability.

13. I further understand that all computer access activity is subject to audit.

I have read the above agreement and agree to comply with all its terms.

Signature _____
(employee/physician/student/volunteer)

Print name _____ Date _____

TO BE FILED IN EMPLOYEE'S PERSONNEL RECORD

CONFIDENTIALITY PROTECTED HEALTH INFORMATION (PHI) PROTECTION AGREEMENT

_____ Initial

Agency & Employee Commitment to Protecting Patient Health Information. I acknowledge Ventura County Health Care Agency's (VCHCA) commitment to protecting patient privacy under HIPAA. I will comply with VCHCA's **T**reatment, **P**ayment, **O**perations **(TPO*)** guidance and the only times that I have the right to access patient information is for **T**reatment, **P**ayment, Healthcare **O**perations.

_____ Initial

Restrict Use to The Minimum Necessary Standard. The minimum necessary standard addresses whether PHI is shared and how much PHI is shared. When accessing health information, I will access only the minimal necessary to perform my job duties and limit access, use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. I understand that **"snooping"** into records of family and friends is a common HIPAA violation for which financial penalties may be imposed. Anything accessed on the computer using my network information will be traced back to me.

_____ Initial

Actions I Can Take to Protect Patient Health Information. I will not discuss patient PHI with anyone outside of the care team. Anyone outside of the care team includes the patient's family members, significant other or friends who the patient has not granted consent, my co-workers, family and friends. Additional actions I can take to protect PHI include locking my computer every time I step away; do not leave paperwork unattended, dispose of confidential papers in secure bin, never share passwords, do not take pictures in patient areas or areas where a patient or their information may be in the background, and do not post on social media regarding a patient or their data.

_____ Initial

Regulatory Agencies Applicable Penalties for Violations. Any wrongful access, inspection, use or disclosure of patient confidential information for personal gain, curiosity, or any non-business-related reason may result in disciplinary action, including termination and may be punishable as a crime. The Office of Civil Rights (OCR) may impose civil monetary penalties and criminal charges on covered entities. In California, a person can be liable for civil penalties of $2,500 per violation, a licensed health care professional who knowingly and willfully obtains, discloses, or uses medical information in violation can be fined $5,000 per violation.

_____ Initial

All Employes Are Required to Report Any Suspicious Activity. Employees are required to report any suspicious activity regardless of role or title to their supervisor and the Compliance Office. Employees may remain confidential and cannot be retaliated against for reporting. Compliance Office phone: 1-805-677-5241, email: HCA.Compliance@ventura.org Reporting website: vchca.ethicspoint.com Confidential helpline: 1-833-823-6631

_____ Initial

Attend Training & Stay Vigilant. I commit to attending all training required by VCHCA Compliance Office and my department regarding HIPAA and handling and safeguarding of Patient Health information (PHI). Employees are to review and adhere to departmental procedures for handling confidential records pertaining to their specific assignments. If employees are in doubt, discuss the matter with your supervisor before acting.

I have read and understand the forgoing statement.

_____

Employee Signature Date

_____

Employee Identification Number

Status Draft PolicyStat ID 17983554

Origination	4/1/2003
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.008 Minimum Necessary Use or Disclosure of Protected Health Information

POLICY

Under HIPAA, health care organizations are required to limit the uses and disclosures of protected health information (PHI) and Electronic PHI (ePHI) to the minimum necessary to accomplish the intended purpose. The purpose of this Policy is to ensure that the use and disclosure of protected health information is limited to the minimum necessary as required by applicable State and Federal laws and regulations.

PROCEDURE

When using or disclosing protected health information or when requesting protected health information from another entity, VCHCA will make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, unless there is an express regulatory exemption from the minimum necessary standard.

Exceptions for Minimum Necessary Standard

1. Healthcare provider for Treatment
2. To Patient
3. Required for Compliance with HIPAA Administrative Simplification provisions
4. Pursuant to Patient Authorization
5. To Health and Human Services (HHS) for HIPAA enforcement purposes
6. Required by other Law
    a. Court orders, subpoenas, authorized investigative demands

Minimum Necessary Standard & Granting Access to PHI

1. Access to PHI or ePHI will be granted based on the person or class of persons such as by role or job function. The Office of Compliance and Privacy and HCA IT will make the final determination of appropriate access by employee classification/title/job function/ organization.
2. Persons, or classes of persons will be granted access to PHI or ePHI appropriate for their role and responsibilities that is sufficient to carry out their assigned duties. Justification is required when requesting access to the entire medical record.
3. VCHCA will only use, disclose, or request an entire medical record when the entire medical record is specifically justified as being reasonably necessary to accomplish the purpose of the use, disclosure or request. The following categories of employees are permitted unrestricted access to protected healthcare information for the purpose of providing patient care:
    a. Attending physician (resident)
    b. Attending physician assistant
    c. Attending nurse practitioner
    d. Consulting physicians (medical, surgical and specialists)
    e. Nursing personnel to include registered and licensed nurses, students
    f. Respiratory therapy practitioners,
    g. Rehabilitation therapists
4. The following categories of the workforce are permitted limited access with supervision to confidential healthcare information for the purpose of providing an element of patient care:
    a. Laboratory personnel: laboratory records, order entry, pharmacy
    b. Radiology personnel: radiology records, order entry
    c. Pharmacy personnel: medication history, laboratory, nursing, order entry
    d. Social Services personnel: socioeconomic information and history, nursing
    e. Dietary personnel: socioeconomic information and history, laboratory, pharmacy, nursing
    f. Billing/Accounts Payable personnel: demographic and insurance information to include name, address, city, state, zip code, telephone number, insurance carrier, social security number, date of birth, medical record number, ancillary reports when necessary.
5. Regardless of the level of access to PHI, individuals are limited to accessing information that is required to perform their job duties for the provision of healthcare to the patient which they are responsible for. Individuals are not permitted to access PHI for those in which they are not responsible for the provision of healthcare. This means, a member of the workforce (including a physician) is not permitted to view, access or disclose any PHI of a patient in another care area; under the care of another, of a friend and relative.
6. Facilities will minimize physical access, such as isolating and locking file cabinets or records

rooms, or providing additional security.

7. Workforce members are not permitted to share passwords or to leave their workstation when access would be made available to other persons.

Minimum Necessary Uses, Disclosures, or Requests Involving Outside Party

1. Application of the minimum necessary standard applies to the use, disclosure or request for protected health information. Note: de-identified health information, as described in the Privacy Rule, is not PHI, and thus is not protected by the Privacy Rule.
2. The minimum necessary standard applies to the following situations involving use, disclosure or request of PHI.
    a. Routine and recurring disclosures of information by VCHCA (for example, claims processing) and requests for information by VCHCA. The minimum necessary amount of information required to accomplish the purpose of the disclosure.
    b. Non-routine disclosures by VCHCA of PHI are subject to review by the Office of Compliance and Privacy, Health Information Management or their designee on an individual basis, the request or disclosure to ensure that minimal necessary PHI will be disclosed.
    c. In certain circumstances, the Privacy Rule permits a covered entity to rely on the judgment of the party requesting the disclosure as to the minimum amount of information that is needed. Such reliance will be reasonable under the particular circumstances of the request. This reliance is permitted when the request is made by:
        - Other covered entities (health plans, health care providers, health care clearinghouses) for treatment;
        - A public official or agency who states that the information requested is the minimum necessary for a purpose permitted under 45 CFR 164.512 of the Rule, such as for public health purposes (45 CFR 164.512(b));
        - Research:
            - PHI may be used and disclosed for research with an individual's written permission in the form of an Authorization.
            - PHI may be used and disclosed for research without an Authorization in limited circumstances: Under a waiver of the Authorization requirement, as a limited data set with a data use agreement, preparatory to research, and for research on decedents' information.
    d. Disclosures to the individual who is the subject of the information
    e. Uses and disclosures made pursuant to an individual's authorization
3. Subpoena and/or Court orders will be handled in accordance with current state laws and requested information will be supplied appropriate to that order.

4. Business Associates are required to establish protocols that define the minimum necessary PHI for routine uses, disclosures and requests, and how to apply the minimum necessary standard with respect to non-routine uses, disclosures and requests.
5. Minimum necessary violations will be investigated and, if appropriate, reported according to regulations.

NOTE: *The rule does not require such reliance, however, and the covered entity always retains discretion to make its own minimum necessary determination for disclosures to which the standard applies.*

References

45 CFR 164.514(d)(1)

SEE ADMINISTRATIVE POLICIES: 100.019, 100.043, 109.049

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17965178**

Origination	2/1/2003	Owner	Melissa Guevarra: Acting Compliance Officer
Last Approved	N/A		
Effective	N/A	Policy Area	Administrative - Compliance
Last Revised	N/A		
Next Review	N/A		

109.009 Mitigation of Inappropriate Use and Disclosure of Protected Health Information

POLICY

Under HIPAA, health care organizations are required to take steps to mitigate any harm that occurs as a result of an inappropriate use or disclosure of protected health information (PHI). The purpose of this policy is to provide a mechanism for mitigation.

Ventura County Health Care Agency (VCHCA) shall mitigate, to the extent practicable, any harmful effect that is known to have occurred, or is likely to occur, as a result of a use or disclosure of PHI in violation of VCHCA policies and procedures regarding the improper viewing, use or disclosure of PHI by a Workforce Member, Medical Staff or Business Associate. VCHCA permits individuals to report privacy complaints and issues anonymously and imposes sanctions as applicable.

PROCEDURE

Information regarding any violation of VCHCA HIPAA privacy policies, including any unauthorized use or disclosure or violation of a patient's rights with respect to his/her PHI discovered by any Workforce Member, Medical Staff or Business Associate of VCHCA must be reported as soon as possible (within 24 hours) to the VCHCA Office of Compliance and Privacy.

A mitigation plan (MP) will be developed when inappropriate use, disclosure, access or violation of a patient's rights is substantiated. The MP shall be developed and implemented as soon as reasonably practicable to mitigate any known or reasonably anticipated harmful effects from such disclosure, but no later than 30 days. The mitigation plan shall be tailored to the circumstances of each case, but shall include as appropriate, the following elements.

- Identification of source(s) of the unauthorized use or disclosure

- Implementation of a corrective plan to deter future misuse or violation of PHI.
- With respect to unauthorized uses of PHI by a VCHCA Workforce Member following the Sanction's process outlined in Administrative policy 109.006 as applicable within 30 days of the discovery to deter further misuse or violation of PHI.
- With respect to unauthorized disclosures of PHI, contacting the recipient of the information that was the subject of the unauthorized disclosure and requesting that such recipient either destroy or return the information or take some other appropriate action to mitigate further use or disclosure.
- Monitor compliance with mitigation plan as necessary.
- VCHCA will consider terminating its Business Associate Agreement with a Business Associate who uses or disclosures protected health information in violation of VCHCA policies and procedures or HIPAA.
- VCHCA Office of Compliance and Privacy is responsible for monitoring compliance with VCHCA HIPAA privacy policies and shall develop a monitoring plan to test appropriate access use and disclosure of PHI.

See Administrative policies 109.006, 109.045, 101.018.

Applicable Laws and Regulations

45 CFR §§ 164.530(f)

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17983284**

Origination	2/1/2003
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.017 Safeguarding Protected Health Information

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), Ventura County Health Care Agency (VCHCA) is required to establish safeguards to ensure that protected health information is not used or disclosed in violation of the standards, implementation specifications, or other requirements of HIPAA. The purpose of this policy is to provide a mechanism to ensure compliance with those requirements.

POLICY

It is the policy of VCHCA to have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications, or other requirements of HIPAA, and to limit incidental uses or disclosures or protected health information made pursuant to an otherwise permitted or required use or disclosure.

PROCEDURE

1. **VCHCA** employee shall sign and comply with a Confidentiality Agreement, Attachments A of the Administrative Compliance Policy 109.001. Signed Confidentiality Agreements for new employees are kept in the employees file within Human Resources. Annually, employees are required to acknowledge PHI Protections
2. **Access to Protected Health Information.** All documents and data containing protected health information at all VCHCA facilities shall be accessible only by those employees of VCHCA who need access to those documents and data in order to perform their official duties for VCHCA.
3. **Fax Machines, Printers and Copiers**. Fax machines, printers and copiers used for printing protected health information will be located in secure, non-public locations. Printed protected

health information will not be copied indiscriminately or left unattended and open to compromise.

4. **Transfer of Protected Health Information**. When protected health information is mailed or otherwise in transit from location to location, the protected health information will be placed in envelopes, folders, sleeves or bags that make them inaccessible to those transporting the documents and receiving them for the addressee.
5. **Shredding of Documents Prior to Disposal**. Documents, including but not limited to notes, containing protected health information must be shredded prior to disposal or placed in a locked shred bin.
6. **Security Policies and Procedures**. In addition to this Policy and Procedure, all employees of VCHCA shall be subject to and comply with the following security Policies and Procedures of VCHCA.

REFERENCES

45 C.F.R. § § 160 and 164

California H.S.C. § 1280

See also Administrative policies: 100.018, 100.019, 108.012, 109.008, HCA-Id-Rm-001, HIM 100.018, HIM108.012,

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17982860**

Origination	4/1/2003
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.042 Workforce Privacy and Security Training

PURPOSE

Under HIPAA, all members of the workforce who have access to protected health information must be trained on polices and procedures regarding the proper use and disclosure of protected health information as necessary and appropriate to carry out their functions within the organization. The purpose of this policy is to ensure that the requisite workforce training takes place as required.

POLICY

VCHCA is committed to ensuring the privacy and security of protected health information. All members of the workforce will be trained on policies and procedures regarding the proper use and disclosure of protected health information as required in addition to relevant security training. Training will occur upon initial employment, and at least every year thereafter.

PROCEDURE

1. VCHCA Privacy Office shall provide privacy and security training to all members of the workforce on policies and procedures related to the proper use and disclosure of protected health information as appropriate to the employee's job function. The training will be based on the VCHCA policies and procedures and federal and state regulations regarding the proper use and disclosure of protected health information.
2. VCHCA staff are required to complete their compliance/privacy training no later than 30 days following their date of hire and annually every year thereafter.
3. Additional privacy/security training will be provided as regulations change.
4. Documentation of completion/non-completion of all training is maintained within the learning management system's online training platform. All individuals designated as supervisors within the system have access to all staff records reporting to them. Through this platform,

supervisors can access the current and historical documentation regarding all trainings assigned and completed by an employee.

5. The training content is maintained by the Office of Compliance and Privacy.

Applicable Laws and Regulations

45 CFR §164.530(b)

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17988326**

Origination	9/1/2013	Owner	Melissa Guevarra: Acting Compliance Officer
Last Approved	N/A		
Effective	N/A	Policy Area	Administrative - Compliance
Last Revised	N/A		
Next Review	N/A		

109.045 Privacy Incident Internal Investigation Policy

PURPOSE

Ventura County Health Care Agency (VCHCA) is responsible to protect and safeguard the privacy of patients' protected health information (PHI) and to report and investigate all allegations of inappropriate use or disclosure of PHI. The purpose of this policy is to provide the procedures to internally report and investigate such allegations.

POLICY

VCHCA Compliance Office is responsible for investigating privacy incidents to determine whether a privacy breach has occurred. This policy outlined what constitutes a privacy breach so that employee's and contractors who have a duty to report can confidently report potential privacy breaches using any of the available reporting methods. In addition, the Compliance Office is responsible for investigating reported privacy incidents and will follow the established investigation procedures as outlined in this policy.

DEFINITIONS

A "**privacy breach**" defined under the Health Insurance Portability and Accountability Act (HIPAA) and California law is any wrongful access, inspection, use or disclosure of patient confidential information for personal gain, curiosity, or any non-business-related reason.

A "**privacy incident**" is a claim or assertion that someone has done something illegal or wrong, as it pertains to protected health information and patient privacy.

PROCEDURE

What constitutes a privacy breach?

1. A privacy breach includes, but is not limited to: unlawful access, use or disclosure of PHI; lost or stolen unencrypted computers with PHI; lost or stolen unencrypted electronic information storage devices containing PHI; lost or stolen phones, blackberries, etc., containing PHI; all electronic systems that contain PHI; lost, stolen or miss-faxed PHI in other than electronic formats; paper or electronic copies of medical records accessed or disclosed and copies of medical records given to or sent to the wrong party or parties.
2. A privacy breach includes both intentional and unintended disclosures.

Who has a duty to report a privacy incident?

1. All VCHCA employees, physicians, contractors, have a duty to report potential privacy violations including incidental acts. As such the following measures are in place to educate employees on VCHCA's commitment to protect patient health information and agree to personally protect patient privacy.
    a. All workforce members are required to complete HIPAA Privacy, Security and HITECH training within 30 days of hire and annually thereafter.
    b. All employees and contractors are required to sign the Confidentiality Agreement.
2. Internal Notification of the breach must include the following information:
    - Date of occurrence
    - Name, address and phone number of patient whose PHI was breached
    - Facility name, address/location where breach occurred
    - Name of alleged violator(s)
    - Contact person's name and phone number where breach occurred
    - General information about the circumstances surrounding the breach
    - If Business Associate (BA) is responsible, provide name of BA, contact name and phone number.
    - Date of notification to patient
3. Employees who have a reasonable basis to believe that a breach has occurred ***but do not report it to the Office of Compliance and Privacy are subject to disciplinary action including termination.***

Where are privacy incidents reported?

1. All VCHCA employees, physicians, contractors, etc., who have a reasonable basis to believe that a privacy incident or potential breach has occurred ***must report the incident directly*** to the VCHCA Office of Compliance and Privacy at 805-677-5241, or anonymously through the Helpline at 1-833-823-6631or web portal vchca.ethicspoint.com AND to their supervisor within

24 hours of knowledge of the incident.

Investigation procedure

1. **Compliance Officer Responsibility:** It is the policy of VCHCA that the Compliance/Privacy Officer is responsible for investigating, or directing the investigation of, conduct at VCHCA which may violate applicable state and federal laws or VCHCA policies and procedures. The Compliance/Privacy Officer may conduct, direct or may designate one or more individuals to be responsible for/or assist with all or parts of the investigation.

2. **Coordination**: The Compliance/Privacy Officer may delegate investigation activity to the departmental managers or supervisors ("Internal Investigators") of the individual alleged to be responsible for the breach. The Internal Investigators shall conduct the investigation pursuant to the direction of the Compliance/Privacy Officer his or her designee and this Policy and Procedure. **Investigating an actual or suspected breach absent direction of the Compliance/Privacy Office is prohibited.**

3. **Confidential:** Investigations will be conducted to the extent possible, without compromising a thorough investigation of the facts, in a manner which (a) maintains the anonymity of the person reporting the breach; (b) protects the rights of those against whom allegations of non-compliance have been made; and (c) ensures the integrity of the investigation. All investigations will be conducted in a fair and impartial manner.

4. **Interviews**: The Compliance/Privacy Officer or designee and or Internal Investigators may interview appropriate personnel as necessary to determine the facts and circumstances of reported breach. Employees are expected to fully cooperate with any questions or requests from investigators. Failure to cooperate or provide false or misleading information in a VCHCA investigation may result in disciplinary action. VCHCA does not consent to recording any investigatory interviews.

5. **Notification:** Notification to the patient is required in the event of a privacy breach. The Compliance/Privacy Office will prepare and send such notifications.

6. **Documentation**: The Compliance/Privacy Officer or designee shall prepare, a Case File that defines the nature of the breach; summarizes the investigation process; identifies any individual(s) who the Compliance/Privacy Officer or designee believes to have either acted accidentally, deliberately or with reckless disregard or intentional indifference toward applicable laws, rules and policies, and describes the corrective action plan including any disciplinary actions.

7. **Mitigation**: Based upon the factual findings of the investigation, the Compliance/Privacy Officer or designee shall oversee and ensure that appropriate corrective action is implemented by the appropriate department within 30 days of discovery, including, without limitation, staff or business associate sanctions, staff training, development or modification of policies and procedures, follow-up monitoring and auditing to ensure the inappropriate conduct has been corrected.

8. **Closing an Investigation For Lack of Evidence**: If the allegation cannot be substantiated, or findings that the conduct is permitted, the issue will be closed.

9. **Privacy Breach Case Files:** All alleged and actual breaches will be entered into and maintained within the Office of Compliance and Privacy with all supporting documentation maintained in

the Case File. The file will contain all correspondence and notes regarding the breach.

10. **Mandated Reporting**: The Compliance/Privacy Officer shall make or direct the making of such reports of the investigation as may be required by law or under internal policies. When appropriate OCR and CDPH will be notified of results of investigation.

REFERENCES

Applicable Laws and Regulations: 45 C.F.R. § § 160, 164; California Health and Safety Code § § 1280.15 (b) (1) (2), 1280.15 (c)

See Administrative Compliance policies: 109.006, 109.009, 109.001

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17804669**

Origination	9/1/2013
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.046 Notification of a Breach of Protected Health Information to Patients, Federal and State Agencies

PURPOSE

When a breach of protected health information (PHI) VCHCA is required to notify the affected individual and federal and state authorities. The purpose of this policy is to provide the procedures to accomplish the breach notification requirements according to applicable law.

DEFINITIONS

"Privacy Breach" means each individual instance of unlawful or unauthorized access to, use, or disclosure of a specific patient's medical information.

"Access" means the ability or the means necessary to read, write, modify, or communicate data/ information or otherwise use any system resource.

"Disclosure" means the release, transfer, provision of access to, or divulging in any manner of information from the entity or individual holding the information.

"Discovered" a breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence would have been known to the covered entity. A covered entity shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the covered entity (determined in accordance with the federal common law of agency). Term used by OCR.

"Detect" means the discovery of a breach, or the reasonable belief that a breach occurred by a health care facility or business associate. A breach shall be treated as detected as of the first business day on which such breach is known to the health care facility or business associate, or by exercising reasonable

diligence would have been known to the health care facility or business associate. Term used by CDPH.

POLICY

In the event of a breach of protected health information (PHI), HIPAA and California law require a covered entity to notify affected individuals, federal and state authorities, and in some circumstances the media, of the breach. A breach is defined under HIPAA and California law to mean the acquisition, access, use, or disclosure of PHI in manner not permitted by law and/or not related to a need for medical diagnosis or treatment or other lawful purpose.

PROCEDURE

The VCHCA Compliance and Privacy Officer or designee, will provide the appropriate breach notifications in accordance with federal and state regulations. The VCHCA Compliance and Privacy Officer or designee shall initiate an investigation into the root cause of the breach, initiate actions necessary to mitigate harm, and develop a corrective action plan to prevent further occurrences.

All workforce members must report all suspected breaches to the Office of Compliance and Privacy at **805-677-5241**, the anonymous Helpline at **833-823-6631** or online through the web intake portal at **vchca.ethicspoint.com** AND their immediate supervisor within 24 hours of knowledge of the incident.

Suspected breaches include, but are not limited to: lost or stolen computers with PHI; lost or stolen electronic information storage devices containing PHI; lost or stolen phones, etc., containing PHI; all discovered attempts by unauthorized individuals to access the County's MIS and other electronic systems that contain PHI; lost, stolen, or miss-faxed PHI in other than electronic formats, use of someone else's passwords, etc.

Workforce members who have a reasonable belief that a breach has occurred ***but do not report it*** are subject to disciplinary action including termination.

Breach Notification Obligations

Notification to the Individual

The Office of Compliance and Privacy will notify the patient whose PHI was allegedly breached within fifteen business days of the discovery or detection of the breach. The notification shall be written in plain language and must include:

- A brief description of the incident including facility name and address, the date of the breach and the date of the discovery/detection of the breach if known;
- A description of the types of medical information that were involved in the breach;
- Steps the patient should take to protect themselves from harm resulting from the breach;
- A brief description of what the health care facility involved is doing to investigate the breach, mitigate harm, and protect against further breaches; and
- Contact procedures for the individual to ask questions or learn additional information.

Insufficient or out of date contact information

The notices is sent to the individual's last known address by first-class mail, or by e-mail if the individual has agreed to receive electronic notices and has not withdrawn such agreement. If insufficient or out-of-date contact information prevents individual notice, the covered entity will provide a substitute form of notice. If there are fewer than 10 affected individuals whose contact information is insufficient or out of date, substitute notice may be provided by an alternative form of written notice, or by phone or other means. If there are 10 or more affected individuals whose contact information is insufficient or out of date, VCHCA will either post a conspicuous notice on the homepage of its website for a period of 90 days, or publish a conspicuous notice in major print or broadcast media in the geographic areas where individuals affected by the breach are likely to reside. VCHCA will also include a toll-free number that remains active for at least 90 days where an individual can learn whether his or her unsecured PHI may have been included in the breach.

Notification to Government Agencies

The Office of Compliance and Privacy will notify the appropriate government agencies, including the Secretary of the United States Department of Health and Human Services (HHS), Office of Civil Rights (OCR), and the California Department of Public Health, (CDPH).

- **Notification to HHS**
    - The Office of Compliance and Privacy will report all breaches that meet the federal definition to HHS monthly or within 60 days of the end of the calendar year.
    - The information is provided according to HHS breach reporting expectations using its breach reporting form found on the website.
    -

Notification to CDPH (only applies to facilities licensed by CDPH)

- The Office of Compliance and Privacy will notify the CDPH of the breach within fifteen business days of breach detection. The following will be included in the breach report letter to CDPH.
    - Name and address of the health care facility where the breach occurred;
    - Date and time that each breach occurred;
    - Date and time that each breach was detected;
    - Name of patient(s) affected;
    - Description of the medical information breached;
    - Description of the events surrounding the breach;
    - Name(s) and contact information of the individual(s) who performed the breach;
    - Date the patient was notified;
    - contract information for the Office of Compliance and Privacy;

- Description of any corrective or mitigating action
- Any other instances of a reported event related to the particular patient; and
- A copy of the notification sent to the patient.

Breaches Affecting More than 500 individuals

- If the breach affects more than 500 individuals, the Privacy Office will notify the Secretary of the United States Department of Health and Human Services in the manner specified on the Department of Health and Human Services website.
- **Media Reporting.** In the case of a breach affecting more than 500 individuals, notification must be made to prominent media outlets and posted on VCHCA's internet site. The Privacy Officer shall determine the manner in which the public notification will occur. The Privacy Officer will designate an individual to interact with the media.

Applicable Laws and Regulations

45 CFR Parts 160 and 164.
CA HSC § 1280.15 (b) (1) (2) and § Sections 1280.15 (c)
California Civil Code §1798.29 and §1798.82

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17982940**

Origination	9/1/2013
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.047 Unauthorized Use, Access and Disclosure of Protected Health Information (PHI) Breach

POLICY

Ventura County Health Care Agency (VCHCA) has the responsibility to safeguard Protected Health Information (PHI) and to ensure that its workforce is knowledgeable in regards to unlawful access, use or disclosure of PHI. It is unlawful to view (glance), review, use, or disclose a patient's PHI without a direct need for purposes of treatment, payment, or healthcare operations or other lawful use, as required by a staff member's job, and as permitted by the California Medical Information Act, HIPAA, or other law governing such access, use or disclosure of medical information. Such improper activity is a privacy breach and VCHCA is required to notify the affected patient, State and Federal authorities. It is the responsibility of VCHCA and its workforce, business associates, contractors, etc., to protect and safeguard the confidentiality of PHI and to prevent unlawful and unauthorized access to PHI as required by State and Federal laws and regulations and VCHCA internal policies.

PROCEDURE

1. Authority for the release of PHI rests with the Health Information Management Manager who will be guided by HIPAA regulations, Medical Records Regulations, and Privacy Policy and Procedures regarding the Use and Disclosure of PHI.
2. As a workforce members you are required to follow this policy.
3. As a workforce member you are not permitted to directly access your PHI via the Electronic Health Record system or request that someone else access your PHI without following the procedures outlined in the Health Information Management Policy 109.048 Patient Rights to Access, Inspect and Copy Protected Health Information (Patient Access to Medical Records) .
4. Refer to Health Information Management Policy 109.048 for instructions for obtaining copies of PHI with the appropriate authorization.

5. Examples of unauthorized access, use, review or disclosure through any type of media (including any electronic media where PHI resides) includes, but is not limited to the following:
    - Accessing or viewing your own PHI without following the procedures outlined in Health Information Management Policy 109.048.
    - Accessing or viewing your children's, spouses', or any other family member's PHI etc. (unless you are a treating physician or it is documented in the medical record that your are involved in the treatment and care).
    - Accessing, reviewing, viewing, using, or disclosing a patient's PHI when the patient is no longer under your care.
    - Accessing, reviewing, viewing, using, or disclosing a patient's PHI without a treatment, payment or operational need or the proper consent to do so.
    - Disclosing a patient's PHI absent any legal requirement to do so.
    - Faxing the PHI to the wrong number.
    - Disclosing a patient's PHI inappropriately to receive remuneration.
6. **Federal and State Sanctions for Employees and Individuals**
   Due to the nature of PHI and the damage caused by breaches, significant sanctions can apply to employees, individuals and health care organizations for non-compliance with this policy. Federal regulations mandate sanctions, including monetary penalties or jail time, for those who violate a patient's PHI. Any workforce member found to be in violation of this policy is subject to disciplinary actions as deemed appropriate up to and including termination.
7. **Internal Notification Requirements for Unlawful Access, Use or Disclosure of PHI**
   All VCHCA workforce members are obligated to report actual or suspected unauthorized access, use, or disclosure of PHI within 24 hours to the Office of Compliance and Privacy at (805) 677-5241, to the Compliance HelpLine at 833-823--6631, AND to their manager.

See Privacy policies 109.006, 109.044.

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17983077**

Origination	9/1/2022	Owner	Melissa Guevarra: Acting Compliance Officer
Last Approved	N/A		
Effective	N/A	Policy Area	Administrative - Compliance
Last Revised	N/A		
Next Review	N/A		

109.056 HCA Compliance Training

PURPOSE

This Policy outlines the requirements for distribution and acknowledgement of the Company's Code of Conduct and other mandatory training for VCHCA and its Covered Persons.

SCOPE

This policy applies to Ventura County Health Care Agency (VCHCA), its affiliates and all satellite locations subject to VCHCA Compliance Program.

POLICY

Health care is a dynamic and constantly changing environment. Compliance training facilitates understanding of applicable laws and regulations applicable to VCHCA operations. All Covered Persons are required to complete Orientation Training and Annual Training compliance assignments and acknowledgement of VCHCA Code of Conduct. Failure to complete these requirements will result in the initiation of progressive discipline.

DEFINITIONS

A. *"**Annual Training**"* means refresher training regarding federal health care program requirements, including the requirements of the Anti-Kickback Statute, the Stark Law, VCHCA, Corporate Integrity Agreement (CIA) requirements as well as VCHCA Compliance Program's core elements. Annual Training will also include training on the key elements of patient privacy under the Health Information Portability and Accountability Act (HIPAA).

B. *"**Certifying Employee**"* means employees designated in the Corporate Integrity Agreement between The Office of Inspector General of The Department of Health and Human Services and Ventura County dated August 11, 2022 (CIA). Certifying Employees include the following:

HCA Director, VCMC Chief Executive Officer, VCMC Chief Financial Officer, and VCMC Chief Operating Officer, Compliance Officer, and Ventura County's Chief Executive Officer.

C. *"**Current Covered Person**"* means all employees, contractors, subcontractors, agents, and other persons who furnish patient care items or services on behalf of VCHCA or who perform billing or coding functions for VCHCA except those whose sole connection is selling or providing medical supplies or equipment. All physicians and non-physician members of Ventura County Medical Center's medical staff as well as employees are also Current Covered Persons. This includes personnel classified as full-time, part-time, or employed as needed (PRN) and all medical staff members including those that have courtesy privileges.

D. *"**New Covered Person**"* means newly affiliated employees, contractors, subcontractors, agents, and other persons who furnish patient care items or services on behalf of HCA or who perform billing or coding functions for HCA.

E. *"**Orientation Training**"* means initial introduction to VCHCA Code of Conduct, federal and state health care program requirements, including the requirements of the Anti-Kickback Statute, the Stark Law, VCHCA CIA requirements as well as VCHCA Compliance Program's core elements. Orientation Training will also include training on the key elements of patient privacy under the Health Information Portability and Accountability Act (HIPAA).

REQUIREMENTS BY TRAINING TYPE

Code of Conduct Distribution

Within 30 days of association with VCHCA, new Covered Persons must complete VCHCA Code of Conduct Acknowledgment. This includes agreement that VCHCA's Code of Conduct represents a mandatory policy, and that the Covered Person will abide by its requirements. For medical staff members, including new applicants as well as those being re-credentialed, VCHCA Code of Conduct will be provided, and the applicant requested, to acknowledge its provisions.

Orientation Training

Each New Covered Person must complete one hour of fraud, waste and abuse, general compliance, and privacy training within 30 calendar days of association with VCHCA. Completion of Orientation Training will substitute for the Annual Compliance Training requirement for the initial training year.

Annual Training

Each Current Covered Person must annually complete one hour of refresher training on fraud, waste and abuse, general compliance and privacy using materials designated by the Compliance Department and reviewed by VCHCA Compliance Committee. VCHCA Code of Conduct will be redistributed during Annual Training and Covered Persons will be asked to reacknowledgement its requirements.

VCHCA Oversight Committee Training

Oversight Committee members will receive training within thirty days of appointment regarding the governance responsibilities with respect to their role in review and oversight of VCHCA Compliance

Program. The training content will include risks areas and strategic approaches in its oversight of VCHCA Compliance Program. This training may be conducted by an outside compliance expert and include a discussion of the Health and Human Services Office of Inspector General's (OIG) guidance on Oversight Committee member responsibilities.

Compliance Committee Training

Compliance Committee members will be trained on their compliance program responsibilities, including the analysis of the organization's risk, assessment of policies and procedures addressing these risk areas, and recommendations for and monitoring of internal systems and controls to accomplish the organization's compliance objectives.

Certifying Persons Training

Each Certifying Person will be provided with training within thirty days of identification as a Certifying Person. The training will focus on their responsibilities to monitor and oversee activities within their areas of authority and certification of compliance with applicable Federal health care program requirements and the obligations of the CIA.

Specialized Training

Risk-based education will be provided to those Covered Persons in high-risk areas including claims coding, patient care, professional billing and quality of care. Training priorities are developed from the organization's risk assessment and may be assigned this training at the manager's discretion or as remedial action.

PROCEDURE

A. VCHCA Office of Compliance and Privacy, in coordination with Ventura County Human Resources, will ensure that a process is established to meet the requirements established by this Policy including identification and assignment of training requirements for New Covered Persons and Current Covered Persons that are employed.

B. VCHCA Office of Compliance and Privacy, in coordination with the applicable business leader, will ensure that a process is established to meet the requirements established by this Policy including identification and assignment of training requirements for New Covered Persons and Current Covered Persons not employed by VCHCA.

C. Employees on a leave of absence when Annual Compliance Training is due for completion must complete their Annual Training within thirty (30) days of their return from leave.

D. VCHCA Office of Compliance and Privacy will maintain records of the training and education requirements pursuant to this Policy in a readily available format for supervisory review.

E. VCHCA Office of Compliance and Privacy will monitor and escalate to any supervisor or applicable business leader failure to comply with compliance training and education requirements. Supervisors or business leaders who fail to take progressive discipline for New Covered Persons or Covered Persons or submit an action plan for resolution, will be reported to the VCHCA Director for further action.

F. Key modifications to VCHCA Code, Orientation Training, or Annual Training will be publicized upon issuance.

Approval Signatures

Step Description	Approver	Date