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

May 28, 2025

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

1. 100.011 Hospital Visitation
2. D.23 Purchasing and Storage of Food
3. IS.14 American College of Radiology Zone Designation in the Magnetic Resonance Imaging Department
4. IS.59 MRI Patient Comfort and Safety
5. IS.60 Exam Appropriateness and Preparation
6. PH.15 Pharmaceutical Ordering and Receiving
7. PH.45 Monthly Inspections

Ventura County Health Care System Oversight Committee
Administrative Policies - May 28, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	100.011 Hospital Visitation	Trienniel	Policy format change and update to latest practices.
2	D.23 Purchasing and Storage of Food	Trienniel	Corrected cooling temperatures and other minor edits.
3	IS.14 American College of Radiology Zone Designation in the Magnetic Resonance Imaging Department	Trienniel	Removed reference to SPH MRI Department since there currently is no MRI at Santa Paula Hospital.
4	IS.59 MRI Patient Comfort and Safety	Trienniel	New Policy
5	IS.60 Exam Appropriateness and Preparation	Trienniel	New Policy
6	PH.15 Pharmaceutical Ordering and Receiving	Trienniel	Added language for receiving pharmaceuticals content
7	PH.45 Monthly Inspections	Trienniel	Update pharmtech notification of irregularities found during inspection to be within 24 hours.

Status Active PolicyStat ID 17836651

Origination	11/22/2017	Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH
Last Approved	4/30/2025	Policy Area	Administrative - Operating Policies
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Last Revised	4/30/2025		
Next Review	4/29/2028		

100.011 Hospital Visitation

POLICY:

In order to ensure the safety and security of patients, employees and volunteers of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), to maintain an orderly environment and assist patients and visitors with finding their destination, there is controlled access to both facilities. Hospital visitation guidelines are available in English and Spanish in the Patient Information Booklet.

At designated entrances only, all guests will be required to check in as either a visitor or a vendor and will then be issued a wrist band or vendor identification (ID) badge.

Hospital visitation will not be restricted, limited or otherwise denied based on age (with the exception of children <13 year old), race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity and expression.

PROCEDURE:

There are specific designated entrances at both VCMC and SPH available for patients, visitors, vendors and employees. Any person in the hospital without a visitor or vendor wrist band, vendor ID badge or employee badge will be directed to one of the hospital entrances so that they may sign in and be issued a wrist band or vendor ID badge. All vendors shall comply with policy *106.083 Vendor Access and Registration*.

HOSPITAL VISITATION GUIDELINES

For the welfare of our patients and to contribute to each patient's recovery, we urge all visitors to observe the following visitation guidelines:

A. Regular visitation hours are from 9:00 a.m. to 9:00 p.m. daily.

B. Patient visits should not exceed two (2) visitors at any given time, unless there is a special circumstance and approved by the Department Manager or House Supervisor.

C. Visitors must be in good health. Visiting is not allowed if the visitor is ill.

D. Visitors are required to comply with all hospital infection control policies.

   1. Visitors of Neonatal Intensive Care Unit (NICU), Pediatrics Unit, Pediatric Intensive Care Unit (PICU), immunocompromised or other high-risk patients may be asked to mask based on community prevalence of respiratory illnesses or at the discretion of the provider or nurse in charge.

   2. For patients with suspected or confirmed tuberculosis, visitation is limited to household contacts only. Strict masking must be followed at all times.

E. Shoes and shirts are required for all visitors.

F. Service animals will be allowed entrance. See policy *107.076 Accessibility - Animals in Healthcare Facilities* for more information.

G. No visitors under the age of 13 are permitted in patient care areas unless they are the parents of hospitalized children, the significant other of a laboring person, a brother or sister of a child who is a patient in NICU, Pediatrics Unit, PICU, Obstetrics Unit (OB) or family members of a terminally ill patient. Visitors meeting this criteria may visit under these conditions:

   1. Siblings may visit during regular visitation hours only. They must be accompanied by a responsible adult.

   2. Siblings must be in good health, as determined (when necessary) by a nurse or physician on the unit.

H. If the patient is under guard surveillance, clearance should be made through the arresting agency before anyone can visit the patient.

I. Noise levels should be kept to a minimum in the corridors and while in patient rooms.

J. No food should be brought in from outside the hospital unless approved by physician and/or nursing staff. Visitors should only eat in patient areas after conferring with nursing staff. Visitors may go to the cafeteria to purchase food.

K. Smoking is prohibited anywhere on hospital grounds, including all parking areas. Smoking includes the use of cigarettes, cigars, water pipes, pipes, hookahs, marijuana (including medical marijuana) and electronic smoking devices, such as e-cigarettes and vaping pens. There are no designated smoking areas on Hospital property. See policy *106.004 Smoking Policy* for more information.

L. Fresh or dried flowers, or potted plants, are not allowed in patient-care areas for immunosuppressed patients.

M. Pediatrics Unit and Pediatric Intensive Care Unit (PICU)

   1. We invite parent participation in the Pediatrics and PICU Unit. One parent may stay with the patient at all times as space allows. Grandparents or other significant adult(s) may visit with a parent, unless otherwise specified. Prior to sibling visitation in the PICU, a joint discussion concerning the risks and benefits of visitation will be

had with the charge nurse, Child Life Specialist, physician and parents. See policy *P.32 PICU, NICU and PEDS Visiting Policy* for more information.

N. Neonatal Intensive Care Unit (NICU)

1. We invite parent participation in the NICU Unit. Parents will be required to wear their identification armband when visiting. One parent may stay with the patient at all time as space allows. Grandparents or other significant adult(s) may visit with a parent unless otherwise specified. See policy *P.32 PICU, NICU and PEDS Visiting Policy* for more information.

O. VCMC Emergency Department

1. No children under the age of 13 unless they are the patient, the parent of a patient, or the support person of a pregnant person.
2. Children must be accompanied by an adult, when in the ED or the waiting room.
3. In critical situations, family members can stay at bedside at the nurse's discretion.
4. To provide a safe environment, visitors are asked to refrain from multiple entries and exits from the patient care area.
5. The ED is not to be used as a thoroughfare to other areas of the hospital. Visitors should use an alternate entrance to gain entry into the hospital.
6. Visitation for ED Hold patients will follow the rules for visitation in the ED.

P. Addiction Medicine Unit (ADM)

1. There are no overnight visitors permitted in this unit. Visitation remains from the hours of 9:00 a.m. to 9:00 p.m. daily.
2. Due to potential for foodborne illness and/or contraband, family and visitors are asked not to bring food from the outside to ADM patients in the hospital. The Dietary Services department will make every effort to accommodate the dietary requests of the patients.

Q. Obstetrics Unit

1. The support person of the patient may stay in post-partum or ante-partum overnight. A sibling must be accompanied by an adult. The support person will receive an identification bands at the time of delivery.

R. Post Anesthesia Care Unit (PACU)

1. Visitors will be restricted to the parent(s) of a minor, the parents(s) or caregiver of persons with special needs and under special conditions.

S. Santa Paula Hospital

1. Visitors must enter and exit at the emergency department.
2. Wayfinding assistance is provided by signage.

T. Inpatient Psychiatric Unit (IPU)

1. Visitation hours are Monday through Friday, 5:30 p.m. through 7:20 p.m., and on weekends and holidays, 12:30 p.m. to 2:30 p.m. We do attempt to accommodate

visits during times other than those posted on an individual basis. It requires a physician's order and should be arranged in advance.

U. Exceptions to the visitation policy may be made in extenuating circumstances. This will be done with collaboration between Medical Staff, Nursing Department Director or House Supervisor, the patient and their family.

V. In the event of an infectious disease outbreak, the visitor policy may be adjusted at the recommendation of the Infection Control Committee, the Medical Director of Infection Control and Prevention, or the Hospital Chief Medical Officer. If adjusted, the policy will be reviewed on a monthly basis.

The VCMC entrance will be open daily from 5:00 am until 9:00 pm. The Customer Service desk at VCMC will be staffed by one to two Security Guards 24 hours a day, 7 days a week, as well as a Customer Service employee from 5:00 am to 9:00 pm.

Employees entering the facility must wear their employee ID badge. Employees without employee ID badge will be issued a visitor wrist band which must be worn for the duration of their time spent in the hospital.

HOSPITAL ENTRANCES

Emergency Department Entrance. The ED at VCMC and SPH will be staffed with a Security Guard 24 hours a day, 7 days a week.

VCMC Hillmont Surgery Entrance. This entrance will be designated for staff and providers only via badge access. No patients, visitors or vendors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

VCMC Loma Vista ED Parking Entrance This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

VCMC Lab Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff and providers may enter through this entrance 24 hours a day, 7 days a week.

VCMC Loma Vista Old Radiology Entrance. This entrance is closed to everyone.

VCMC Boardwalk Entrance. This entrance is closed to everyone.

SPH Staff Entrance. This entrance will be designated for staff and providers only via badge access. No patients or visitors will be permitted to enter the Hospital through this entrance. Staff may enter through this entrance 24 hours a day, 7 days a week.

REFERENCE:

Patient Information Booklet. Ventura County Medical Center and Santa Paula Hospital. [VCHCA-505-050 (01/2020)]

All Revision Dates

4/30/2025, 8/5/2024, 5/29/2024, 2/26/2024, 1/2/2024, 9/18/2023, 7/6/2023, 3/8/2023, 11/22/2017

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/30/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/15/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/15/2025
Policy Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/15/2025

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Origination	11/1/1992	Owner	Fernando Medina: Director, Support Services
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D.23 Purchasing and Storage of Food

POLICY:

All food at Ventura County Medical Center/Santa Paula Hospital shall be purchased, stored, displayed and transported according to stringent sanitation and safety standards.

PROCEDURE:

1. Food shall be purchased only from vendors who can produce proof that they are approved by the Health Department and meet State and Federal Codes.
2. All food - whether stored, displayed, or transported - shall be protected against contamination from dust, flies, rodents, and other vermin, unclean storage, unnecessary handling, flooding, drainage, overhead leakage, poisonous and toxic materials and other sources of contamination.
3. All potentially hazardous food shall be maintained at a safe temperature of 41° F or below or 135° F or above except during the necessary period of preparation and service. Potentially hazardous foods include milk, milk products, eggs, meat, poultry, fish or combinations of these foods.

GUIDELINES:

I. Purchasing
   A. Only government-inspected meat, meat products, poultry and fish shall be purchased.
   B. Only pasteurized milk and milk products are purchased which meet the standards set forth by Federal, State and Local agencies.
   C. Shellfish must come from a reputable dealer who complies with the regulations of the State Shellfish Authority.

D. Upon delivery, all products shall be checked for the following conditions, and if any are observed, the product will be returned or destroyed and credit obtained from the vendor:

1. Pest infestation
2. Bulged, leaking or dented cans
3. Mold
4. Frozen foods which show signs of having been thawed or improperly stored
5. Past the expiration date

II. Storage

REFRIGERATION AND FREEZERS

A. Temperatures

1. Temperatures of refrigerators and freezers in the main kitchen are checked and logged daily by the AM Supervisor.
2. Storage temperatures should be:

a. Fruits and vegetables (except those requiring dry storage).	36 - 41° F
b. Dairy Products, Eggs	36 - 41° F
c. Meat and Poultry	36 - 41° F
d. Fish and shellfish	36 - 41° F
e. Ice Cream	- 10 - 0° F
f. Frozen Foods	- 10 - 0° F

3. Each refrigerator and freezer shall have a thermometer accurate to plus or minus 2° F and so situated that the thermometer can easily and readily be observed for reading.
4. If any temperatures do not comply with the above, the Assistant Food Services Supervisor or Food Services Shift Supervisor, or their designee, should immediately notify the Facilities Maintenance Department.

B. General Food Storage Standards for Refrigerators and Freezers.

1. Prepared foods in refrigerators are not held longer than 72 hours (3 days) after the preparation date.
2. All foods held in refrigerators shall be covered, labeled and dated.

3. Cooked food (to be utilized later) and leftovers should be put into shallow pans and immediately refrigerated to expedite cooling. Food must reach a temperature of 70°F or below in less than two hours. If the food has not reached 70°F or below within two hours, it must be discarded or properly reheated. Reheat the food to 165° F for fifteen seconds and then cool it properly. Food must be cooled to 41°F or lower in an additional four hours, for a total cooling time of six hours. Quality Assurance monitoring will be take place when the food is placed in the refrigerator, then again at the second and sixth hour.
4. Ambient food/potentially hazardous food (time temperature control for safety food) shall be cooled within 4 hours to 41 °F or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna.
5. All fruits and vegetables, especially items for immediate consumption (without cooking), shall be thoroughly washed using the ozone sanitation equipment. Items, such as lettuce, tomatoes, cucumbers, fruits and vegetables for salad bar, fresh fruits, and vegetables for patient food production are to be washed using the ozone sanitation equipment.
6. Food items shall be stored 6" off the floor.
7. Foods are to be rotated according to first-in, first-out; i.e., rotated from back to front with new deliveries. Supervisors and staff will check for outdated product daily. The outdated product will be returned to the vendor for credit or discarded.
8. Metal, plastic, and rubber-coated shelving may be used.

C. Length of time for Food Storage - Refrigerators and Freezers.

1. Refrigeration (36 - 41° F)

a. Milk and dairy products	Manufacturer's expiration date when unopened. Once opened, use the 7 day expiration date or which ever comes first.
b. Cottage Cheese, Sour Cream, containers Frozen and Pasteurized Egg Products (Institutional Packages)	When received in large containers, do not rely on the 'Use by Date' once the product is opened. Any opened items shall be labeled and dated on the expiration day, which is 7 days once opened. If the manufacturer's expiration date is less than 7 days, the product shall be discarded on the manufacturer's expiration date. If the product has not been opened, it must be returned or discarded by the expiration date.
c. Fresh Fruits and Vegetables processed and packaged by manufacturer	Manufacturer's expiration date.

d. Eggs e. Processed hard-boiled eggs	Manufacturer's expiration date. Manufacturer's expiration date.

2. Freezer (-10-0° F) NOTE: If item has no expiration date, use one year from delivery date.

a. Meat (cooked)	Manufacturer's expiration date
b. Meat (uncooked)	Manufacturer's expiration date
c. Poultry	Manufacturer's expiration date
d. Fish and Seafood	Manufacturer's expiration date
e. Vegetables	Manufacturer's expiration date
f. Cakes and Pastries	Manufacturer's expiration date

3. Refrigerator, Leftovers (36 - 41° F)

a. Meat (cooked)	3 days
b. Meat (uncooked)	3 days
c. Salads	3 days
d. Vegetables	3 days
e. Desserts, cakes, pastries	3 days

DRY AND CANNED STORAGE

A. Temperature

1. Temperatures of the dry goods storeroom are checked by the AM Supervisor on a daily basis.
2. There will be an accurate thermometer in the storeroom.
3. Storage temperatures should be of dry goods and canned goods, i.e. between 65 -70° F.

B. General Food Storage Standards for Dry Storage

1. Storage areas shall be well lit, well ventilated and clean.
2. Temperatures shall be controlled and between 65-75° F.
3. All new stock delivered shall be placed in the back of old stock and thus continuously rotated.
4. All food items shall be clearly labeled and arranged with label toward the front of the shelf.
5. Bulging or dented cans shall be returned to the vendor for credit.
6. Flour, sugar, and dry bulk items shall be stored in metal or plastic containers with tight-fitting lids.
7. All food items shall be stored on metal shelves 6" from the floor and 18" from the

ceiling.

8. If a box is opened and not completely used, the entire box shall be put in plastic and sealed tightly or the item shall be transferred to a clean and sanitized container with a tight-fitting lid and labeled and dated.
9. Soaps, detergents, and cleaning compounds shall be clearly labeled and stored in an area separated from food storage.

FOOD STORAGE GUIDELINES

GRAINS AND GRAIN PRODUCTS Cereal, Rice, Flour, Dry Beans, Dry Legumes	Manufacturer's expiration date if present or **6 months from delivery date**
Spices and Dry Seasonings	Manufacturer's expiration date
Sugar, Syrups, Molasses	Manufacturer's expiration date
Dried Fruit, Cookies , Crackers Gelatin, Jams, Jellies, Nuts, Pickles, Relish , Pudding Mixes, Sauce and Gravy Mix	Manufacturer's expiration date
Salad Dressings and Bottled Sauces Mayonnaise	**7 Days** upon opening or manufacturer's expiration date when unopened.
CHEESE AND DAIRY PRODUCTS Cottage Cheese, Sour Cream, Grated Cheese, Sliced Cheese, Yogurt	**7 Days** upon opening or manufacturer's expiration when unopened.
Fresh Eggs and processed hard-boiled eggs	Manufacturer's expiration date
Individually-packaged, single-use portion-controlled foods regardless of classification, ie. PC or portion cup/portion control items such as gelatin, peanut butter, jellies, sugar packets, cheese sticks, juices, milk, single serve canned soup, supplements, and tube feeding formulas	Manufacturer's expiration date
Oils and Shortening	Manufacturer's expiration date
Canned Goods	Manufacturer's expiration date
All Beverages (unopened)	Manufacturer's expiration date
Opened Meats, Deli Poultry, Deli, Canned Meats	**3 days** or manufacturer' s expiration date or whichever comes first
Prepared Foods Includes Salads, Sandwiches, Hot and Cold Entrées, Starches and Vegetables	**3 days**
Opened Juices	**3 days** or manufacturer's expiration date or whichever comes first

Fresh Bread/Rolls	Manufacturer's expiration date
Frozen Ready to Bake or Heat Bread, Rolls, Pastries or Cookies	Manufacturer's expiration date
Fresh Fruit and Vegetables processed by manufacturer	Manufacturer's Expiration Date
Prepared Seafood/Fish/Shellfish	Discarded after first time use
All Soups and Stocks	Discarded after first time use

All Revision Dates

5/9/2025, 10/12/2020, 7/21/2017, 11/1/2011, 10/1/2011, 9/1/2011, 4/1/2010, 12/1/2007, 8/1/2007, 2/1/2005, 11/1/2004, 12/1/2001, 1/1/1999, 12/1/1995

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/9/2025
Dietary Department	Fernando Medina: Director, Support Services	5/9/2025

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VENTURA COUNTY HEALTH CARE AGENCY

Origination	12/1/2014	Owner	Matt McGill: Director, Imaging Services
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Effective	5/8/2025		
Last Revised	5/8/2025		
Next Review	5/7/2028		

IS.14 American College of Radiology Zone Designation in the Magnetic Resonance Imaging Department

POLICY:

To maintain a safe environment within the Magnetic Resonance Imaging (MRI) Department of Ventura County Medical Center (VCMC).

PROCEDURE:

The VCMC MRI Department shall follow the American College of Radiology (ACR) recommendations in delineating specific zones within the imaging department and the MRI exam room and control areas.

Signs shall be located in the reception/registration area, the MRI patient changing rooms, the MRI technologist computer station area and on the entry door of the MRI magnet room.

Each sign shall delineate what zone the patient and the technologist are located in.

The four zones identified in the ACR document are identified as follows:

- ZONE I: Area where the general public is located, this includes the patient registration area and waiting room.
- ZONE II: Unscreened MRI patients. The hallways located within the Imaging Services Department leading to the MRI patient changing rooms and scan room.
- ZONE III: The patient waiting rooms and changing rooms located adjacent to the MRI technologist work station as well as the MRI technologist work station area. All patients shall complete a pre-screening form before being allowed to enter this zone. Patients shall not enter this area without being escorted by an MRI Technologist.
- ZONE IV: The MRI magnet room. No one is allowed to enter this room until they have completed a screening form and have been questioned by a qualified MRI Technologist to

verify that there are no contraindications to having a MRI scan performed. Only MRI Technologists and patients are allowed into the scanner room. The entrance to the MRI magnet room is located in the technologist work station area and shall be monitored at all times.

If a patient requests that a family member accompany them into the MRI scan room (Zone IV), the family member shall complete a screening form, an MRI technologist shall review the form and question the family member to verify there are no contraindications to entering the room.

All Revision Dates

5/8/2025, 2/13/2019, 10/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/8/2025
Imaging Services	Matt McGill: Director, Imaging Services	5/8/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	1/14/2025

Status Active PolicySat ID 18175038

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Next Review	5/14/2028		

IS.59 MRI Patient Comfort and Safety

POLICY:

It is the policy of the MRI department to identify and implement patient comfort and patient safety measures related to anxiety, claustrophobia, thermal injury, and ferromagnetic objects in the MR environment.

Procedure:

Patient Comfort

The identification and screening process for anxiety and claustrophobia is managed throughout the exam process in the following ways:

- At the time an exam is ordered when the patient can have a discussion with their provider
- At the time an exam is scheduled when the patient is asked if they have had an MRI previously and/or if they have any known issues with exam related anxiety or claustrophobia
- During the patient screening process with the MRI Technologist

If exam related anxiety or claustrophobia is identified at any point during the screening process the following steps may be taken to ensure patient comfort:

- Patient may speak with their ordering provider on the use of pre medication
    - Medication cannot be administered by staff
- Time can be allocated for the patient to see the MR suite prior to their appointment
- The use of supportive instruction and communication before, during, and after the exam is employed so the patient has an in depth explanation of exam timing, sounds they may hear, and why the MRI is beneficial for what their provider is looking for. Staff will also provide

ongoing reassurance and check-ins to the extent they are effective for the patient.

- The use of positioning aids, music, and/or video

Patient Safety

Each patient will be screened prior to entry into Zone III for objects that may cause thermal injury or at risk to become a projectile. An MRI Time Out will be completed for each patient indicating; that they have been properly identified, that the screening form has been completed and reviewed, that any implanted devices they may have are classified as safe or conditional, that they have nothing on their person that may cause thermal injury, and that no ferromagnetic objects were unintentionally brought into zone IV.

An MRI Time Out Audit will be conducted each month to ensure compliance and address any issues in a proactive manner.

Staff are directed to notify their Manager and complete an RL Datix event report for all instances where thermal injury has occurred or could have occurred as well as for any ferromagnetic object that has unintentionally been brought into the scan environment.

All Revision Dates

5/15/2025

Approval Signatures

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Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/15/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	5/15/2025
Imaging Services	Matt McGill: Director, Imaging Services	5/15/2025

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Last Revised	5/14/2025		
Next Review	5/13/2028		

IS.60 Exam Appropriateness and Preparation

POLICY:

It is the policy of the CT, MRI, and Nuclear Medicine Departments as outlined in the Joint Commission Standards to verify the patient, site, position, protocol and to assess exam appropriateness prior to beginning the study.

PROCEDURE(S):

For non-scheduled patients: CT, MRI, and Nuclear Medicine staff will ensure exam appropriateness and patient preparation needs are in line with this standard by reviewing the order and associated patient history, including age and prior exams against approved protocols to ensure they are correct. Any questions will be referred to the ordering provider and/or Radiologist. Any changes or specific needs will be communicated to those performing the exam.

For scheduled patients: CT, MRI, and Nuclear Medicine staff will ensure exam appropriateness and patient preparation needs are in line with this standard by reviewing the order the day/s before the scheduled appointment. The order, along with associated patient history, including age and prior exams will be reviewed against approved protocols to ensure they are correct. Any questions will be referred to the ordering provider and/or Radiologist. Any changes or specific needs will be communicated to those performing the exam.

REFERENCE(S):

Joint Commission Standard PC.01.02.15 EP#10

Joint Commission Standard PC.01.02.15 EP #12

All Revision Dates

5/14/2025

Approval Signatures

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Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/14/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	5/14/2025
Imaging Services	Matt McGill: Director, Imaging Services	5/14/2025

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Origination	6/1/1995	Owner	Sul Jung: Associate Director of Pharmacy Services
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Next Review	5/13/2028		

PH.15 Pharmaceutical Ordering and Receiving

POLICY:

The Department of Pharmacy Services shall purchase products directly from the manufacturer or from a wholesaler who provides pedigree products directly from the manufacturer. The ordering process will be defined and established to ensure that pharmaceuticals are obtained in a cost-effective manner and that the drugs will be available to treat the patients.

PROCEDURE:

A. Each Pharmacy Department staff member is responsible for placing an order with the Pharmacy Buyer when any drug inventory is low in stock.

B. Ordering from the drug wholesaler:

1. Cardinal Health is the primary drug wholesaler for Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).
2. The drug wholesaler ordering system is password protected.
3. The Pharmacy Buyer enters the wholesaler item numbers into the wholesaler computer ordering system. The Buyer transmits the order each afternoon, Monday through Friday.
    a. Ventura County Medical Center only: Urgent orders may be transmitted before 11:00 a.m. to obtain same day delivery.
4. The Department of Pharmacy Services has established a separate account with the drug wholesaler for Group Purchasing Organization (GPO), Wholesale Acquisition Cost (WAC) and 340B drug purchases for each of its pharmacy locations. Orders are split according to historical utilization prior to submitting the order to the drug wholesaler. See policy *PH.18 340B Drug Pricing Program: Disproportionate Share Hospital* for more information.

5. Clinic medications for 340B locations shall be ordered by the VCMC Pharmacy Buyer and purchased on a 340B account.
6. Clinic medications for non-340B locations shall be ordered by the VCMC Pharmacy Buyer and purchased on a non-340B account.

C. Ordering from a manufacturer or other vendor

1. Direct orders with drug manufacturers shall follow policy *PH.17 Direct Ordering Procedure*.
2. Orders for 503A and 503B facilities shall be submitted directly to the vendor.

D. After-hours and emergency drug orders

1. Emergency orders can be placed anytime.
    a. Cardinal Health emergency phone number is 877-772-0346. An answering service will take the message and a Cardinal Health staff member will promptly return the call.
    b. Provide the following information:
        i. For Ventura County Medical Center
        Distribution Center: Valencia, CA
        Account Name: Ventura County Medical Center
        Account Number: 2057190798 (Legacy: 74108) WAC
        Your contact name and a call back phone number.
        ii. For Santa Paula Hospital
        Distribution Center: Valencia, CA
        Account Name: Santa Paula Hospital
        Account Number: 2057191412 (Legacy: 74493) WAC
        Your contact name and a call back phone number.
        iii. Pharmaceuticals may be borrowed amongst the VCMC pharmacy locations if the drug is needed before it can be acquired using regular channels. Refer to policy *PH.16 Pharmaceutical Borrowing and Loaning*.
2. Schedule II Controlled Substances may be transferred from another VCMC pharmacy location if the C-II controlled substance is required immediately. Form DEA-222 must be completed and submitted with the order.

E. Receiving pharmaceuticals

1. Delivery to the pharmacy of pharmaceuticals are only delivered to the licensed premise and signed for and received by a pharmacist.
    a. Deliveries may be made to a central receiving location within the hospital but shall be delivered to the licensed pharmacy premise within one working day following receipt and the pharmacist on duty at the time shall immediately inventory the drugs against the invoice.
2. Check products received and compare each product with the packing slip or invoice. Record the date of receipt and initials on the packing slip/invoice.

3. All drugs shall be stored according to manufacturer's recommendations. 340B purchases for the clinics will be stored separately from the hospital inventory.
4. All controlled drugs are secured in the narcotic vault or secured cabinet space. Quantity received shall be automatically logged by the narcotic vault or manually logged in each medication's perpetual inventory log. Copies of Schedule II invoices are attached to the DEA-222 order form.

F. Reconciliation of orders

1. The Pharmacy Buyer compares the signed packing slip or invoice with the order to verify that ordered pharmaceuticals have been received. The Buyer shall follow up on any discrepancies between product ordered and product received. Significant discrepancies shall be brought to the attention of the Director of Pharmacy Services or Pharmacy Supervisor within 24 hours of discovery.
2. Pricing data shall be reviewed and updated in the electronic health record as needed.
3. Invoices are signed and submitted to VCMC Accounts Payable. A copy of the invoice and packing slip shall be filed.

G. Items not Received

1. If an item is temporarily out, the Pharmacy Buyer shall get an estimated date of arrival and place the item on backorder.
2. If an item is backordered by the manufacturer, an alternative strength or size is considered. If no alternative is available, the Buyer will notify the Director of Pharmacy Services, Pharmacy Supervisor and Pharmacy staff.

All Revision Dates

5/14/2025, 6/13/2023, 9/20/2021, 5/31/2017, 2/1/2014, 11/1/1997

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/14/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	5/13/2025

Status **Active** PolicyStat ID **18161946**

Origination	10/1/1986	Owner	Sul Jung: Associate Director of Pharmacy Services
Last Approved	5/14/2025	Policy Area	Administrative - Operating Policies
Effective	5/14/2025		
Last Revised	5/14/2025		
Next Review	5/13/2028		

PH.45 Monthly Inspections

POLICY:

Pharmacists shall inspect all areas of Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and the Ambulatory Care clinics where pharmaceuticals are stored on a monthly basis. Licensed pharmacy staff shall inspect the pharmacy inventory in the pharmacy areas for expired medications on a monthly basis.

PROCEDURE:

Nursing Unit and Clinic Inspections

A. Inspections of units or clinics containing pharmaceuticals shall be conducted every month by an assigned pharmacist.
   1. Physical inspection of the drugs in the automated dispensing cabinet (ADC) shall be part of the monthly inspection performed by the pharmacist.

B. MedStorage (https://apps.pharmacyonesource.com/identifi/Auth/EmailLogin) is used to conduct and document completion of the inspections.
   1. Any medication that has expired or will be expiring in the current month or following month shall be removed from inventory. For example, in an inspection performed in February, the pharmacist shall remove any medication expiring in Feburary, the current month, or March, the following month.

C. The inspecting pharmacist shall document all findings on the MedStorage inspection form online.

D. Once the MedStorage inspection form has been completed and submitted by the pharmacist, the Unit Manager or Clinic Manager of the respective nursing unit or clinic shall be sent the results of the inspection.

E. The Unit Manager or Clinic Manager shall review and approve the MedStorage inspection online.

Pharmacy Inventory

A. Sections of pharmacy inventory shall be assigned to Pharmacy Technicians.

B. Pharmacy Technicians shall inspect their respective section of the pharmacy inventory for expiring or expired medications.

    1. Any irregularities discovered by a pharmacy technician shall be reported to the Pharmacy Supervisor within 24 hours.

C. Pharmacy Technicians shall also clean and disinfect their respective section of the pharmacy inventory.

D. Any medication, including those in medication boxes and kits, that has expired or will be expiring in the current month or following month shall be removed from pharmacy inventory and quarantined.

    1. Exceptions include products purchased from 503b facilities, high-cost medications (>$100/unit) and drugs that are in short supply nationally. These medications may be stored until its final expiration date.

E. Place a "Use Now Short Dated" sticker on any medication (except 503b compounded sterile products) that will be expiring in the next three months and place these medications at the medication's storage area.

F. MedStorage (https://apps.pharmacyonesource.com/identifi/Auth/EmailLogin) is used to document completion of the inspections. Any findings shall be documented.

G. Once the MedStorage inspection form has been completed and submitted by the Pharmacy Technician, the Pharmacy Supervisor shall review the submitted MedStorage document and approve the monthly inspection.

H. The Pharmacy Supervisor or designee shall conduct random checks of the pharmacy inventory for outdated medications and/or IV solutions.

I. The Pharmacy Supervisor or designee shall also inspect medication boxes and kits on a weekly basis to ensure there are no expired medications.

    1. Any medication that has expired or will be expiring in the current month or following month shall be removed from the medication box or kit and quarantined. Exceptions include products purchased from 503b facilities, high-cost medications (>$100/unit) and drugs that are in short supply nationally. These medications may be stored until its final expiration date.

All Revision Dates

5/14/2025, 7/11/2024, 5/15/2019, 11/26/2018, 10/1/2015, 8/1/2011, 5/1/1999, 11/1/1998

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/14/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	5/13/2025

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

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Medical Executive Committee Document Approvals

May 2025

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

1.	100.021 Correcting a Medical Record	page	2-4
2.	100.098 Pneumococcal And Influenza Vaccine Screening And Administration	page	5-6
3.	100.236 Patient Safety Plan	page	7-12
4.	100.260 Early Mobilization of Patients	page	13-17
5.	100.281 Assignment of Patient Status for Obstetrical Patients	page	18-21
6.	101.030 Work Exclusion for Healthcare Personnel with Respiratory Viral Infections	page	22-24
7.	108.000 Plan for Provision of Nursing Care	page	25-28
8.	IS.61 Voiding Cystourethrogram (VCUG)	page	29-33
9.	IS.62 Performance of the Modified Barium Swallow (MBS)	page	34-35
10.	MCH.01 NICU Admission Logbook	page	36-37
11.	MCH.30 Neonatal Bereavement Cooling System	page	38-40
12.	N.70 Extremely Low Birthweight Intraventricular Hemorrhage Prevention Protocol	page	41-44
13.	OB.16 Antepartum Testing	page	45-52
14.	OB.26 Perinatal Services Discharge Planning	page	53-54
15.	OB.74 Post-Partum Rubella Immunization	page	55-56
16.	OB.75 Admission Criteria and Standards of Care: Antepartum	page	57-59
17.	OB.79 Utilization Of Doula Care In The Obstetrics Department	page	60-62
18.	R.95 Small Volume Nebulizer Treatment	page	63-65
19.	R.NPC.01 Inhaled Nitric Oxide	page	66-69
20.	RS.01 Adult Supervision of Minor Rehab Patients	page	70-71
21.	RS.21 Assessment (Scope of Speech Language Pathology (SLP) Assessment)	page	72-78
22.	NPP.05 Standardized Nursing Procedures for the Rapid Response Nurse	page	79-83
23.	NPP.06 Diuretic Renal Scintigraphy	page	84-89
24.	Medical Staff Administration Late Fees and Fines	page	90-91

b. Medical Staff Forms

1.	Medicine Privilege Checklist (approved by Medicine Committee and MEC)	page	92-96
2.	Initial and Reappointment Application Attestation Questions (Approved by Credentials Committee and MEC)	page	97

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

May 2025

a. Policies & Procedures / Forms / Orders

The following were reviewed and recommended for approval by the appropriate Departments, Committees, and the Medical Executive Committee

#	Title	Summary	Frequency
1.	100.021 Correcting a Medical Record	No changes	Triennial
2.	100.098 Pneumococcal And Influenza Vaccine Screening And Administration	Updated CDC vaccine information statement linked in policy.	Triennial
3.	100.236 Patient Safety Plan	No changes	Annual
4.	100.260 Early Mobilization of Patients	No changes	Triennial
5.	100.281 Assignment of Patient Status for Obstetrical Patients	New policy	Triennial
6.	101.030 Work Exclusion for Healthcare Personnel with Respiratory Viral Infections	New policy	Triennial
7.	108.000 Plan for Provision of Nursing Care	No changes	Annual
8.	IS.61 Voiding Cystourethrogram (VCUG)	New policy	Triennial
9.	IS.62 Performance of the Modified Barium Swallow (MBS)	New policy	Triennial
10.	MCH.01 NICU Admission Logbook	Updated information types documented in logbook. Removed guidelines.	Triennial
11.	MCH.30 Neonatal Bereavement Cooling System	No changes	Triennial
12.	N.70 Extremely Low Birthweight Intraventricular Hemorrhage Prevention Protocol	Updated verbiage throughout to define target patients as extremely low birthweight versus very low birthweight.	Triennial
13.	OB.16 Antepartum Testing	Updated management of CSTs. Removed reference to NSTs signoff by a physician when performed by a certified nurse.	Triennial
14.	OB.26 Perinatal Services Discharge Planning	Removed reference to SPH and updated references.	Triennial
15.	OB.74 Post-Partum Rubella Immunization	No changes	Triennial
16.	OB.75 Admission Criteria and Standards of Care: Antepartum	Removed reference to SPH. Included reference to medication administration policy for pain assessment, management and documentation.	Triennial
17.	OB.79 Utilization Of Doula Care In The Obstetrics Department	New policy	Triennial
18.	R.95 Small Volume Nebulizer Treatment	Updated throughout to align with current standards.	Biennial
19.	R.NPC.01 Inhaled Nitric Oxide	No changes	Biennial
20.	RS.01 Adult Supervision of Minor Rehab Patients	No changes	Triennial
21.	RS.21 Assessment (Scope of Speech Language Pathology (SLP) Assessment)	Revised to reflect current available tests and updated procedure.	Triennial
22.	NPP.05 Standardized Nursing Procedures for the Rapid Response Nurse	New policy	Triennial
23.	NPP.06 Diuretic Renal Scintigraphy	Updated range dosing and hydration section for peds and adults. Included roles and responsibilities for imaging staff.	Triennial
24.	Medical Staff Administration Late Fees and Fines	New policy	Triennial

b. Medical Staff Forms

1.	Medicine Privilege Checklist (approved by Medicine Committee and MEC)	Revised to include practice of stabilizing critical care patients at SPH prior to transfer.
2.	Initial and Reappointment Application Attestation Question (Approved by Credentials Committee and MEC)	Revised an initial and reappointment application attestation question to align with National Association Medical Staff Services verbiage recommended by the Lorna Breen Heroes' Foundation.

Origination:	*1/1/1983*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/2/2024*
Next Review:	*3 years after approval*
Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administration - Medical Staff*
References:	

100.021 Correcting a Medical Record

POLICY:

All attempts to correctly identify patients and their medical conditions should be made prior to a provider documenting in the record, either on paper or in the electronic health record (EHR). Corrections (including Amendments, Addenda, Corrections, Retractions and Late Entries) will be allowed to ensure that documentation in the EHR is complete and accurate. Reassignment and resequencing of documents in the EHR may be necessary and will be done by the Health Information Management Department.

PROCEDURE:

DEFINITIONS

A. Amendment: An alteration of the health information by modification, correction, addition, or deletion. An amendment is made after the original documentation has been completed by the provider.

B. Addendum: Entries added to an EHR to provide *additional* information in conjunction with a previous entry.

C. Correction: A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete. Corrections may also involve removing information from one record and posting it to another within the electronic document management system.

D. Retraction: A retraction is the action of *correcting information that was incorrect, invalid, or made in error* and preventing its display or hiding the entry or documentation from further general views. However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so that the retracted document can be consulted if needed.

E. Late Entry: An addition to the health record when a pertinent entry was missed or was not written in a timely manner. Each entry should be timely and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed.

F. Re-sequencing: The process of moving a document from one location in the EHR to another within the same episode of care, such as a progress note that was dated incorrectly. No annotation of this action is necessary.

G. Reassignment: The process of moving one or more documents from one episode of care to another episode of care within the same patient record, such as the history and physical posted to the incorrect episode.

H. If the provider determines that correction is appropriate, the provider is responsible for ensuring the total content of the documentation.

I. The provider must identify the correct patient and encounter prior to documenting within the EHR, including the following information:

1. Patient name
2. Date of service
3. Account number
4. Medical record number
5. Original report that requires correction

J. The provider will ensure that the proper format is used:

1. **For handwritten documents when the paper note is still present:**
   a. Draw a single line through the inaccurate information, ensuring the original entry is still legible.
   b. Enter the correct information on the original page and sign with the current date and time.
   c. The handwritten document will be given to the Health Information Management Department for scanning into the electronic record.
2. **For electronic documentation:**
   a. Make correction in accordance with related EHR policies and procedures by one of the following:
   b. Electronically entering the entry in the applicable EHR and e-signing the document. This will automatically generate a statement on the header of the note that an addendum has been added; or
   c. By handwriting an entry on a paper copy and giving the form to the Health information Management Department for scanning into the EHR.

. If a patient or patient's representative requests an amendment of a record, follow Administration policy 109.013, *Processing Requests for An Amendment to Protected Health Information* .

All revision dates:	12/2/2024, 11/27/2024, 1/1/2014, 10/1/2011, 5/1/2006, 7/1/1995, 10/1/1986, 5/1/1983

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Health Information Management Committee	Vibha Gune: HIM Manager	4/22/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	1/15/2025

Current Status: *Pending*	PolicyStat ID: *18015596*

Origination:	*7/24/2017*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*4/21/2025*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.098 Pneumococcal And Influenza Vaccine Screening And Administration

Policy:

The licensed registered nurse shall screen patients on admission and/or discharge and administer influenza and pneumococcal vaccine for patients meeting criteria.

Procedure:

A. Upon inpatient admission, the admitting clerk enters the patient into the California Immunization Registry (CAIR) system.

B. All patients are to be screened for potential influenza and pneumococcal vaccination by the licensed nurse on admission. The screening and consent process shall be documented in the electronic health record (EHR).

   1. If the patient is unable to answer screening questions upon admission, the patient shall be re-screened and vaccinated, if indicated, prior to discharge.

C. ~~The vaccine information statement shall be provided to the patient.~~The current Vaccine Information Statement (VIS) shall be provided to the patient.

   1. CDC Vaccination Immunization Statement

D. If patient meets criteria for vaccination, the nurse shall enter an order for the appropriate vaccine(s).

   1. Refer to Attachment A for step-by-step instructions for this step.

E. Pharmacy shall verify the order and dispense the vaccine.

F. Vaccine administration shall be documented in the EHR, including manufacturer, lot number and expiration date. Any untoward events are to be documented in the narrative portions of the nursing notes and on a notification form.

G. Administering nurse shall ensure the Share document icon in the EHR is completed.

H. Prior to patient's discharge, the nurse shall ensure screening and/or administration of vaccine(s) was completed. If screening and/or administration of vaccine(s) was not completed, repeat steps B-G.

I. Notify the licensed ~~independent~~ practioner if the patient experiences severe allergic reactions (~~i.~~e.g., hives, difficulty breathing, shock).

All revision dates: 4/21/2025, 6/9/2020, 7/24/2017

Attachments

Attachment A: Immunization Screening Nursing Workflow

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/21/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/21/2025
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/21/2025

Origination:	4/14/2020
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Last Revised:	3/14/2024
Next Review:	1 year after approval
Owner:	Alicia Casapao: Director of Quality and Performance Improvement
Policy Area:	Administrative - Operating Policies
References:	

100.236 Patient Safety Plan

POLICY:

This Patient Safety Plan supports and promotes the mission, vision and values of the Ventura County Health Care Agency (HCA) through implementation of a culture that is supportive of safety and reduction of risks for all stakeholders. Recognizing that effective safety improvement and risk reduction requires an integrated and coordinated approach, the following plan relates specifically to a systematic program to minimize physical injury, accidents and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

The Patient Safety Plan is focused on an approach geared towards the avoidance of medical errors and mitigation of hazardous conditions, by utilizing a systematic, coordinated and on-going approach to reducing risk and harm while improving safety. This approach focuses on processes and a proactive approach to reduce real or potential risk, and the integration of patient safety into all aspects of patient care.

The Patient Safety Plan is implemented through the continuous integration and coordination of the patient safety activities performed by members of the medical staff, nursing, ancillary and support services with each member of the healthcare team playing a crucial role to help ensure a safe environment.

The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/healthcare errors; and integrating patient safety priorities into the design and redesign of all relevant organization processes, functions and services.

Leaders focus on establishing a culture of safety that minimizes hazards and patient harm, by focusing on process of care, modeling principles of a Just Culture and integrating patient safety into all functions and services. The framework of a Just Culture ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace.

GOALS:

The goals of the Patient Safety Program include, but are not limited to:

1. Ongoing organizational learning about errors and risk avoidance;
2. Recognition that patient safety is an integral job responsibility;

3. Development of patient safety goals into job specific competencies;
4. Encouraging the recognition and reporting of errors and risks to patient safety without judgment or placement of blame;
5. Involving patients in decisions about their health care and promoting open communication about errors;
6. Collecting and analyzing data to evaluate care processes, to identify opportunities to reduce risk and implement improvement;
7. Communication of safety findings and the actions taken to improve processes and systems, in order to reduce risk.

PROCEDURE:

The procedures for immediate response to medical/health care error are as follows:

A. Staff will obtain required orders to support the patient's clinical condition.
B. Staff will immediately report the event either to the Nursing Manager or the House Supervisor if the event occurs during off-hours.
C. If the event is at the level of a Sentinel Event or acute patient harm has occurred, the Administrator-on-call (AOC) should be notified.
D. Staff will complete the online Notification Form

Authority and Responsibility

The authority to implement this plan is granted by the Oversight Committee. The responsibility of ensuring the tasks and duties described in this document are the responsibility of the Patient Safety Officer/Team. To ensure closed loop communication regarding team activities the Patient Safety Officer or designee will report to the Medical Executive Committee (MEC) and Oversight Committee on a quarterly basis.

Patient Safety Committee

The Patient Safety Committee (PSC) is composed of an interdisciplinary group that meets to review the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The PSC meets no less than four (4) times per year to ensure the maintenance and improvement of patient safety in the establishment of plans, processes and mechanisms involved in the provision of patient care. The chairperson has the discretion to call additional team meetings and to form subgroups to address any outstanding patient safety issues.

A. The scope of the PSC includes review of medical/healthcare errors involving patients of any age, visitors, hospital/medical staff, students and volunteers. Aggregate data from internal reports and external resources will be used for review and analysis in prioritization of improvement efforts, implementation of interventions and follow-up monitoring. The severity categories of medical/health care errors include:
B. **No Harm Error:** an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
C. **Mild to Moderate Adverse Outcome:** any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome.
D. **Hazardous Conditions:** any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome.
E. **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a

significant chance of a serious adverse outcome.

F. **Sentinel Event:** an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase or risk thereof includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

G. The Patient Safety Committee (PSC) will evaluate aggregate data/processes and NOT specific clinical details related to individual occurrences. Clinical details will be reviewed/addressed through the other established processes and committees.

H. The PSC will be chaired by an appointee of the Executive Team.

   1. The responsibilities of the Chair may include but are not limited to:

      a. Compliance with patient safety standards and initiatives;

      b. Evaluation of work performance, as it relates to patient safety;

      c. Reinforcement of the expectations of the Patient Safety Plan; and

      d. Acceptance of accountability, for measurably improving safety and reducing errors.

      e. These duties may include listening to employee and/or patient concerns, and/or interviews with hospital and medical staff to determine what is being done to safeguard against occurrences, and to respond to reports concerning workplace conditions.

   2. Team members include representatives of services involved in providing patient care, i.e., Pharmacy, Laboratory, Infection Prevention, Imaging, Nursing (ED, ICU, Pediatrics, OB, Perioperative and Medical/Surgical), Performance Improvement as well as Executive Team representation. The medical staff representative(s) on the team will be the Medical Director of Inpatient uality, the Chief Medical Officer (CMO) and at least one resident/ medical student.

I. The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

   1. Reporting of potential (Good Catch) or actual occurrence through the notification system by any employee in every department;

   2. Communication amongst hospital leadership to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment;

   3. Reporting of patient safety and operational safety measurements/activity to the Patient Safety Committee (PSC), the MEC and to the Oversight Committee.

As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

A. A non-punitive approach supportive of a Just Culture;

B. Voluntary participation in the Root Cause Analysis/Event Analysis for educational purposes and prevention of further occurrences;

C. Resources such as the Employee Assistance Program (EAP) should the need exist;

D. Regular staff surveys about their willingness to report medical errors.

Methods to assure ongoing in-services, education and training programs for maintenance and improvement of staff competence and support of an interdisciplinary approach to patient care is accomplished by:

A. Providing information about reporting mechanisms to new staff in the initial orientation and during on-going training;
B. Providing ongoing education, including reporting mechanisms, through information presented during annual competency;
C. Testing staff knowledge regarding patient safety during annual competency;
D. Obtaining a confidential assessment of staff's willingness to report medical errors at least bi-annually.

Internal reporting, in order to provide a comprehensive view of both the clinical and operational safety activity of the organization:

A. These quarterly meeting reports will include ongoing activities including data collection, analysis, actions taken, and monitoring for the effectiveness of actions.
B. The minutes/reports of the Patient Safety Committee will be reported to the MEC and the Oversight Committee on a quarterly basis, or more frequently, as indicated.

External Reporting:

A. External reporting will be completed in accordance with all state, federal, and regulatory rules, regulations and requirements.

Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

A. Conversations with patients and families during manager or administrative rounds;
B. Comments from patient satisfaction surveys.
C. Procedures used in communicating with families about the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion, include:
    1. Patient's rights statements;
    2. Patient responsibilities: A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.;
D. Annual assessment for barriers to effective communication among caregivers.

A proactive component of the program includes the selection of a high-risk or error prone process for concentrated activity through a Proactive Risk Assessment (PRORA)/Failure Mode Effect Analysis (FMEA) process. The PRORA/FMEA selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement activities, infection prevention/ control, research, patient/family suggestions/expectations or other identified potential high-risk processes.

A. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes).
B. Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.
C. For each failure mode, the possible effects on patients, as well as the seriousness of the effect, will be

identified.

D. The process will be redesigned to minimize the risk of failure modes.
E. The redesigned process will be tested and implemented.
F. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

The Patient Safety Committee (PSC) chairperson will submit a Quality Assessment/Performance Improvement (QAPI) Annual Report to the MEC and to the Oversight Committee which includes review of the hospital's patient safety activities. The report may include, but not be limited to:

A. Definition of the scope of occurrences including Sentinel Events, Event Analysis or a Root Cause Analysis as well as near misses;
B. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process (PRORA/FMEA) selected for improvement efforts;
C. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis;
D. A description of how the function of process design, which incorporates patient safety, has been carried out using specific examples of process design or redesign that include patient safety principles;
E. The results of the program that assesses and improves staff willingness to report medical/health care errors;
F. A description of the examples of ongoing training and other educational programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Confidentiality

All information related to organizational patient safety performance improvement activities performed by the team members, in accordance with this plan are confidential and are protected. Confidential information may include, but is not limited to; Patient Safety Team minutes, any associated medical staff committee minutes, organizational performance improvement reports, data gathering and reporting, and untoward incident reporting.

Some information may be disseminated, as required, by federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a “need to know.”

Evaluation and Approval

The Patient Safety Plan will be evaluated annually or as changes occur, and revised as necessary at the direction of the Executive Team and/or the MEC. The evaluation of the plan’s effectiveness will be documented in a report to the MEC and Oversight Committee.

All revision dates:	3/14/2024, 9/14/2021, 4/14/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/10/2025
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/10/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/10/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/10/2025
Policy Owner	Alicia Casapao: Director of □uality and Performance Improvement	4/10/2025

Origination:	*1/28/2022*
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Last Approved:	*N/A*
Last Revised:	*3/3/2022*
Next Review:	*3 years after approval*
Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Administrative - Patient Care*
References:	

VENTURA COUNTY
HEALTH CARE AGENCY

100.260 Early Mobilization of Patients

Policy:

Ventura County Medical Center and Santa Paula Hospital shall establish and maintain an early mobility program designed to initiate functional mobility, when medically indicated, to reduce onset and risk of pressure ulcers, decrease the incidence of delirium, reduce the onset of physiologic decline, and decrease ventilator days and hospital length of stay.

Procedure:

Team Composition

A. The early mobility team may include but is not limited to:
   1. Licensed Practitioner (LP)
   2. Nurse
   3. Physical Therapist (PT)
   4. Respiratory Therapist (depending on ventilator needs)
   5. Occupational Therapist (OT)
   6. Certified Nursing Assistant
   7. Rehab Aide

Special Considerations for Early Mobility Protocol

A. General Guidelines for Early Mobility
   1. The established early mobility protocol is representative of general guidelines for treatment by the early mobility team based on a model indicated for mechanically ventilated and critically ill patients able to tolerate a progression of mobility from edge of bed (EOB) sitting through ambulation with or without assistive equipment. Modification to the protocol may be necessary to accommodate patient populations that include, but not limited to, patients presenting with strokes, polytrauma, varying degrees of spinal cord injury, burns, orthopedic issues and neurological impairments.

B. Forming an Interdisciplinary Culture of Early Mobility
   1. A viable early mobility team should comprise all of the components addressed in this protocol.

Interactions will occur between LPs, nurses, respiratory therapists and rehabilitation services personnel to assure appropriateness of functional mobility training and subscribe to a clinically logical and stepwise process to minimize functional decline during hospitalization.

C. Reassessment for Progression/Modification of Services
   1. Physical Therapists/Occupational Therapists will coordinate with the LP, nurse and respiratory therapist to discuss medical status, modification or initiation of an early mobility program and discharge planning.

D. Evaluation by Physical Therapist/Occupational Therapist will Determine Appropriate Level for Initiation of Activity
   1. Based on the clinical expertise and reasoning of the rehab therapist treating the patient ordered for evaluation, the rehab therapist will provide guidance as to what phase of the early mobility protocol to implement upon skilled intervention. Progression of functional mobility, utilization of the early mobility team staff, use of assistive equipment and treatment goals will be individualized to the patient based on level of acuity, overall medical condition, co-morbidities stability, weight bearing status, cognition and prior level of function.

Considerations & Precautions

A. Consider the following and consult the LP for potential contraindications prior to mobilizing the patient:
   1. Intracranial pressure
   2. Acute or uncontrolled intracranial event
   3. RASS score
   4. Unsecured/difficult airway
   5. Active hemorrhage
   6. Unstable blood pressure
   7. Unstable fracture
   8. Post-surgical restrictions
   9. End of life

B. For ventilated patients, see *Attachment A: Algorithm for Determination of Ventilated Patient Early Mobility Level*.

Early Mobility Protocol

A. Level 1: The Unconscious Patient
   1. Patient is unable to respond to commands or actively participate with PT/OT.
   2. Nurse shall reposition the patient every two hours as follows: left → chair mode → right → chair mode.
      a. Deflate waffle mattress prior to putting bed in chair mode.
      b. Reinflate waffle mattress when not in chair mode.
   3. Nurse shall provide pressure relieving applications.
   4. Nurse shall initiate passive range of motion (PROM) as tolerated, unless contrary to LP order.

a. 5-10 repetitions for each joint

b. Upper Extremity PROM

i. May consist of finger flexion/extension, wrist flexion/extension & ulnar/radial deviation, elbow flexion/extension and shoulder flexion/extension, internal/external rotation and abduction/adduction

c. Lower Extremity PROM

i. May consist of toe flexion/extension, ankle dorsiflexion/plantarflexion & inversion/eversion, knee flexion/extension, and hip flexion/extension, internal/external rotation and abduction/adduction.

5. Mechanical ventilation and airway clearance maintained and monitored by a Respiratory Therapist.

6. The LP and nurse shall monitor and communicate with PT/OT to determine initiation of skilled therapy via LP order.

B. Level 2: The Conscious Patient Who is Able to Participate Minimally But Not Ambulatory

1. Patient is able to respond to commands and actively participates with PT/OT.

2. Nurse shall reposition the patient every two hours as follows: left → chair position → right → chair position.

3. LP submits an order for initiation of rehabilitation services by appropriate personnel (PT/OT).

4. PT/OT shall evaluate patient and asses prior level of function, cognitive-perceptual and psychological considerations, skin integrity, use of medications, cardiac status, pulmonary status, neurological status, musculoskeletal status, functional mobility, therapy goals and execute a plan of care for treatment, discharge and education.

5. Initiate Active Range of Motion (AROM) and/or active-assistive range of motion (AAROM).

6. Practice bed mobility exercises: rolling, scooting/bridging, supine ↔ sit, sitting at edge of bed (EOB)

7. EOB Activities

a. Patient is assisted to EOB by early mobility team. RT to provide ventilator support if needed.

i. The patient will sit EOB with feet flat on floor or platform with goal of ten minutes of supported or unsupported sitting.

ii. PT/OT can initiate bedside Activities of Daily Living (ADLs) if able.

iii. All vital signs shall be monitored throughout the session.

8. Patient may be transferred to a Cardiac Chair to assess orthostatic tolerance and endurance.

9. Nurse may perform the following to increase the patient's arousal:

a. Turn the lights on during the day.

b. Open window shades during the day.

c. Reorientation as indicated

10. Criteria for Advancement to Next Level

a. Patient is able to follow commands.

b. Patient displays stable hemodynamics and adequate oxygen saturation.

c. Patient is able to sit at edge of bed with minimal support for ten minutes on two consecutive treatment sessions.

C. Level 3: The Conscious Patient Who is Able to Participate with Pre-Gait Activities
   1. The Patient is able to respond to commands and actively participate with PT/OT.
   2. Continue to perform AROM & AAROM in bed or EOB as needed.
   3. Initiate progressive resistive exercises (PRE) as tolerated.
   4. Continue with bed mobility exercises per level 2 and gradually decrease assistance as tolerated.
   5. EOB Activities
      a. Practice static/dynamic balance in sitting with reaching activities and ADLs.
      b. PT/OT to utilize rehab aide or nurse as needed.
      c. RT to offer ventilator support if needed.
   6. Transfers
      a. PT to assess ability of patient to utilize upper extremities to balance at EOB and elevate lower extremities against gravity.
         i. With use of assistive device and mobility staff as needed, PT/OT to stand patient at EOB.
         ii. Patient to practice weight shifting and/or marching in place at EOB with mobility team using assistive device.
            a. If patient is unable to stand due to weight bearing status, hemi/para/tetraplegia, or other confounding factors, the mobility team will assist with possible slide board transfers to bedside chair, commode or wheelchair.
         iii. Patient then performs pivot transfer with assistive device and mobility team into bedside chair, commode or wheelchair.
         iv. The patient is encouraged by the mobility team to remain in bedside chair up to two hours as tolerated. The mobility team is to stay with patient at bedside upon initiation of bedside transfer for at least ten minutes to assess any physiologic changes.
         v. If patient can tolerate activity, mobility team will monitor patient periodically up to two hours before returning back to bed. During that time, OT may perform ADL training.
         vi. If the patient experiences physiologic decline, the mobility team shall return and assist with back to bed transfer.
   7. Criteria for Advancement to Next Level
      a. Patient able to follow commands.
      b. Patient displays stable hemodynamics and adequate oxygen saturation.
      c. Patient is able to perform bed ↔ chair on two consecutive sessions.

D. Level 4: The Conscious Patient Who is Able to Participate in Gait Activities
   1. The Patient is able to respond to commands and actively participate with PT/OT.
   2. Continue with PRE as tolerated to all extremities in and out of bed.
   3. Bed Mobility: Continue with Level 3. In this phase, PT/OT will maximize bed mobility with goal of independence.
   4. Transfers: Continue with Level 3. Maximize transfers with assistive device as needed, working

towards goal of minimal to no assist from mobility team to complete transfer to chair.

5. OT to perform out of bed ADLs and cognitive exercises.
6. Initiate gait activities using assistive device and physical support as needed.
    a. Ambulate with mobility team as tolerated, with assistance as needed.
    b. RT may be required for respiratory support.

Documentation

A. Document the date and time of interventions in the electronic health record.

All revision dates: 3/3/2022, 1/28/2022

Attachments

Attachment A: Algorithm For Determination of Ventilated Patient Meeting Early Mobility

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/4/2025
Policy Owner	Marcos Rodriguez: Manager, Rehabilitation Services	3/4/2025

Current Status: *Pending* **PolicyStat ID:** *17671015*

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.281 Assignment of Patient Status for Obstetrical Patients

Policy:

To state the process for registering and assigning patient status for obstetrics patients at Ventura County Medical Center.

Definitions:

- **Outpatient in Bed (OPIB):** is an outpatient status in the hospital outside of the emergency room and not used for admission or observation care. Simply, the patient does not require hospital care but is not ready for discharge from the hospital due to ongoing workup or unsafe discharge plan.
- **Observation Services (OBS):** is used when a physician places a patient in observation care. The purpose of observation services is to determine the need for inpatient care (or discharge) and whose length of stay (LOS) is not expected to span more than two midnights. Observation services have a start and stop time with inclusion and exclusion criteria and determine if care should be provided in an inpatient setting or in a lower level of care. Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients or patients families, or while awaiting placement to another ~~healthcare~~health care facility.
- **Inpatient Admission:** Patient has an acute medical need that requires hospital stay. Medicare criteria includes the "two midnight rule." However, all modes of delivery, newborn admission, and neonatal deaths are considered inpatient admissions regardless of duration.

Procedures:

Step 1: Registration

A. Patient presents to Admitting and/or Emergency Department if after hours

B. Patient is registered as OB ~~Quck~~Quick Reg and placed into Outpatient in a Bed ~~STatus~~Status.

C. OB floor is called and ~~adivsed~~advised patient is awaiting transport to OB unit and picks up patient

Step 2: Initial Triage Evaluation

- Patient will always initially present as Outpatient in a bed status.
- The initial triage evaluation will be conducted by a nurse, midwife, or physician, who will assess the

patient's clinical condition, obstetric history, and presenting symptoms.

- **Key Considerations**:
  - Does the patient need further diagnostic workup (e.g., lab tests, imaging)?
  - Is the patient experiencing symptoms that warrant **observation services (Typical Time is between 6-24hrs with documentation of medical necessity)**(e.g., mild contractions, fetal movement concerns)? Consider Observation
  - Does the patient require treatment that requires acute inpatient care (Medicare also requires two midnight stay)
    Billing: The appropriate outpatient billing codes will be used.

Step 3: See below for options

Option 1: Discharge from OPIB

- **If the patient does not require further observation or inpatient care**:
  - The patient will be **discharged** home from OPIB status, with follow-up instructions.
- **Examples for Discharge**:
  - Contractions without active labor.
  - Vaginal discharge without signs of infection or labor.
  - Non-stress test (NST) showing normal fetal heart rate patterns.
  - Decreased fetal movement (FM) with normal NST and adequate amniotic fluid index (AFI).
- **If the patient is waiting for test results** (e.g., lab results, imaging, or diagnostic tests such as NST or BPP):
  - **Action**: Continue monitoring and evaluation.
  - The patient will remain in OPIB status while awaiting the test results.
  - **Outcome**: Once the test results are available, return to **Step 1** to reassess the patient based on those results and determine whether further care or discharge is warranted.

Option 2: Need for Treatment or Observation

- If the patient requires further **treatment** (e.g., for a complication like preeclampsia) or **observation** (e.g., for fetal monitoring, vital sign stability, or labor progression) a physician or licensed practitioner **must place an observation order**:
  - The patient will continue to be observed in Observation status until clinical criteria for discharge or inpatient admission are met.
  - **Observation status starts at the time of the order and requires documentation of medical necessity.**
  - **Observation Criteria** may include:
    - Vital sign monitoring (e.g., blood pressure for preeclampsia).
    - Fetal monitoring (e.g., NST for fetal well-being).
    - Symptoms requiring ongoing care (e.g., mild labor, dehydration, nausea/vomiting, or management of gestational diabetes).

Option 3: Inpatient Admission

- The physician will assess if the patient meets inpatient admission criteria based on admission criteria (see above)
  - The patient’s clinical condition requires **active management acute inpatient care or any means of delivery.**
  - **Medicare Considerations**:

- For Medicare beneficiaries, inpatient admission criteria are typically met when the patient is expected to stay for **more than 2 midnights** or needs a longer stay for clinical reasons.
- **All newborns live and neonatal demise should be assigned Inpatient status regardless of duration.**
- **If inpatient criteria are met**: The physician will **place the "PSO Admit to Hospital" order** to formally admit the patient as an inpatient.
- **Professional Fee Coding**: The appropriate inpatient admission billing codes will be used:

Examples of conditions warranting inpatient admission:

- **Labor**: When the patient is in active labor and requires ongoing monitoring and management.
- **Rupture of Membranes (ROM)**: When the patient's membranes have ruptured but there are no other contraindications to labor, requiring continued observation and care.
- **Preeclampsia with Severe Features**: When a patient with preeclampsia presents with severe features (e.g., very high blood pressure, proteinuria, or symptoms like headache and visual disturbances), necessitating inpatient care for close monitoring and possible intervention.
- **If inpatient criteria are NOT met**: The physician will **place the "PSO Assign to Observation" order** to designate the patient as under observation status.
  - **Billing**: The appropriate observation billing codes will be used:

Examples of conditions that may require observation but not full inpatient admission:

- **Rule out (R/o) preeclampsia**: The patient may need monitoring for up to 24 hours with a 24-hour urine collection and blood pressure monitoring.
- **Preterm contractions**: A patient presenting with contractions before 37 weeks gestation may need observation for up to 24 hours to assess the progress of labor and fetal well-being.

References:

CMS definition for OPIB/OB/Inpatient.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	5/6/2025

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/25/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/25/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	2/25/2025

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Owner:	*Todd Flosi, MD: Associate Chief Medical Officer, VCMC & SPH*
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References:	

101.030 Work Exclusion for Healthcare Personnel with Respiratory Viral Infections

PURPOSE:

To mitigate the risk of transmitting respiratory viral infections such as COVID-19, influenza, and other acute respiratory viruses, this policy outlines the criteria for excluding healthcare personnel (HCP) from work to ensure patient safety and limit healthcare-associated infections.

POLICY:

~~Respiratory viral infections, including COVID-19, influenza, and other acute viral infections, pose a risk of transmission to both patients and other healthcare personnel. Effective work exclusion guidelines help to balance public health safety with operational needs, ensuring that personnel who are ill do not contribute to the spread of infection within the healthcare facility.~~

~~Policy:~~

A. ~~**General Work Exclusion Criteria for Respiratory Viral Infections:**~~
   - ~~HCP with **suspected or confirmed** respiratory viral infections (COVID-19, influenza, or other acute respiratory viral infections) must not return to work until they meet the following conditions:~~
     - ~~At least **3 days** have passed since symptom onset (with **day 0** being the first day of symptoms).~~
     - ~~At least **24 hours** have passed without fever, without the use of fever-reducing medications.~~
     - ~~Symptoms must be **improving**, and the individual should feel well enough to return to work.~~

B. ~~**Work Exclusion After Positive Test in Asymptomatic HCP:**~~
   - ~~If an HCP tests **positive** for a respiratory virus (e.g., COVID-19) but remains **asymptomatic**, they may not return to work until at least **3 days** have passed since the first positive test.~~

C. ~~**Face Mask Usage:**~~
   - ~~HCP who have had a suspected or confirmed respiratory infection (whether symptomatic or asymptomatic) must **wear a facemask** in all patient care and shared areas (e.g., breakrooms) for a minimum of **10 days** after symptom onset or positive test result, whichever is applicable.~~

~~D. **Hand Hygiene:**~~

- ~~HCP must **perform frequent hand hygiene**, particularly before and after patient interactions or contact with respiratory secretions.~~

~~E. **Asymptomatic Exposure Management:**~~

- ~~For HCP who have had **high-risk exposure** to SARS-CoV-2 but are **asymptomatic**, work exclusion is typically not required. However, temporary reassignment or exclusion from patient care (especially for high-risk patients) may be considered on a case-by-case basis.~~

~~F. **Reassignment or Exclusion for Immunocompromised Patients:**~~

- ~~In certain cases, VCHCA may consider **temporary reassignment** or **exclusion** of HCP from direct patient care, especially for patients who are at **high risk** for severe disease (e.g., those who are immunocompromised).~~

~~DEFINITION(S):~~

Respiratory viral infections, including COVID-19, influenza, and other acute viral infections, pose a risk of transmission to both patients and other healthcare personnel. Effective work exclusion guidelines help to balance public health safety with operational needs, ensuring that personnel who are ill do not contribute to the spread of infection within the healthcare facility. This policy applies to all healthcare personnel (HCP) working for Ventrua County Health Care Agency, including but not limited to physicians, nurses, medical staff, administrative staff, vendors and support personnel who may have direct or indirect patient contact.

~~PROCEDURE(S):~~PROCEDURE:

A. **General Work Exclusion Criteria for Respiratory Viral Infections:**

- HCP with **suspected or confirmed** respiratory viral infections (COVID-19, influenza, or other acute respiratory viral infections) must not return to work until they meet the following conditions:
  - At least **3 days** have passed since symptom onset (with **day 0** being the first day of symptoms), making the first possible day a HCP ma return to work on day 4.
  - At least **24 hours** have passed without fever, without the use of fever-reducing medications.
  - Symptoms must be **improving**, and the individual should feel well enough to return to work.

B. **Work Exclusion After Positive Test in Asymptomatic HCP:**

- If an HCP tests **positive** for a respiratory virus (e.g., COVID-19) but remains **asymptomatic**, they may not return to work until at least **3 days** have passed since the first positive test.

C. **Face Mask Usage:**

- HCP who have had a suspected or confirmed respiratory infection (whether symptomatic or asymptomatic) must **wear a facemask** in all patient care and shared areas (e.g., breakrooms) for a minimum of **10 days** after symptom onset or positive test result, whichever is applicable.

D. **Hand Hygiene:**

- HCP must **perform frequent hand hygiene**, particularly before and after patient interactions or contact with respiratory secretions.

E. **Asymptomatic Exposure Management:**

- HCP who have had **high-risk exposure** to SARS-CoV-2 should test immediately. For HCPs who test negative and are **asymptomatic**, work exclusion is typically not required.

- Temporary HCP reassignment or exclusion from patient care (especially of high-risk patients) may be considered on a case-by-case basis.
- HCP with low low-risk exposure may return to work if asymptomatic.

F. **Reassignment or Exclusion for Immunocompromised Patients:**

- In certain cases, VCHCA may consider **temporary reassignment** or **exclusion** of HCP from direct patient care, especially for patients who are at **high risk** for severe disease (e.g., those who are immunocompromised).

REFERENCE(S):

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Respiratory-Viruses/Interim-guidance-for-healthcare-personnel-with-acute-viral-respiratory-infections.aspx

All revision dates:

Attachments

Work Exclusion Guidance for Healthcare Personnel with COVID-19, Influenza, and Other Acute Respiratory Viral Infections_AFL-25-01.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Ambulatory Care Administration	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	4/16/2025
Ambulatory Care Administration	Amelia Breckenridge: Associate Chief Medical Officer, Ambulatory Care	4/3/2025
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/3/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/16/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/16/2025
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.000 Plan for Provision of Nursing Care

POLICY:

Nursing Services are directed by a Chief Nursing Officer (CNO), who is a Registered Nurse, qualified by advanced education and management experience. The CNO and Hospital/Clinical Nurse Managers are responsible for maintaining the standards of patient care and the standards of nursing practice; for establishing and monitoring the policies/procedures of the nursing service, for performance assessment and improvement, and for ensuring the competency of nursing personnel. The Nursing Administrative team will support the hospital and nursing mission, philosophy and standards.

PROCEDURE:

The CNO has the requisite authority and responsibility to participate in the development and implementation of the Plan for Providing Nursing Care. The nursing department is responsible and accountable to the Medical Staff and Administration through its Nursing Managers and, ultimately, the CNO.

SCOPE OF NURSING SERVICE:

Nursing is an organized and systematic process provided by or under the direction of a Registered Nurse. The practice of nursing encompasses the provision of care to patients and their families. It requires specialized knowledge, judgment, and skills derived from the principles of biological, physical, behavioral, social and nursing sciences and research. The nursing process is the basic tool for identifying and assessing patient's needs and planning appropriate care. The nursing process also encompasses evaluation of the interventions and implementing revisions when necessary to provide the most effective care.

As a profession, Nursing serves as a foundation for health care, optimizing, restoring and maintaining physical and psychosocial functions of the individual. As such, Nursing includes the recognition of priority health care needs, health care teaching, managing interdisciplinary patient care and patient advocacy. Nursing services are provided in a collaborative atmosphere, working with other disciplines to provide quality, cost effective and individualized health care to all patients. The services offered are designed to meet the unique needs of Ventura County, which is composed of all ages, diverse cultures and socioeconomic backgrounds.

PROCEDURE:

The Nursing department consists of an Administrative Function, Clinical Function, Educational Function, and an Infection Control Function, which are under the jurisdiction of the CNO. The CNO is a Registered Nurse licensed in the state of California with appropriate education and experience. The CNO is employed on a full time basis and reports to the Hospital Administrator. The CNO is accountable for providing an optimal level of patient care in an environment conducive to professional practice. The CNO will oversee the provision of nursing care that is in compliance with requirements of Title 22, Joint Commission Standards and other regulatory agencies. The CNO is responsible to the Chief Executive Officer for meeting the staffing standards of the Nursing Units.

The Administrative function consists of Staffing Standards, budgetary needs, timekeeping, and payroll duties. The Nursing Supervisors and the Clinical Nurse Manager have the responsibility, each shift, for providing competent staff based on the needs of the patients. The Nursing Supervisors function as the Administrative representative in the absence of the Chief Executive Officer and CNO. An On Call Administrator (AOD) provides "back up." The Nursing Administrative team is responsible for assuring "one level" of nursing care throughout the facilities. The Administrative team is responsible to ensure all appropriate personnel possess current licensure and competency. The Hospital/Clinical Nurse Managers are responsible for establishing annual departmental goals. Each Hospital/Clinical Nurse Manager is responsible to the CNO for the planning, implementation, and evaluation of quality nursing care delivered in the respective service areas. Patient care will be delivered by competent Registered Nurses, Licensed Vocational Nurses, Nursing Assistants, and Operating Room Technicians. Job duties will be assigned based on scope of practice, regulatory requirements and competency. The Registered Nurse is responsible for overseeing the nursing process. Non-patient care duties will be performed by Health Technicians (transporters), Monitor Technicians, Medical Office Assistants, and Emergency Department supervising clerks to support and assist patient care providers.

The Education Function is directed by the Clinical Nurse Manager – Education. The Education program consists of staff development and patient/family education. The Nurse Manager is responsible for overall needs assessment, planning, implementation, and evaluation of educational programs designed for the professional and technical growth of the nursing staff and orientation of new nursing staff. The Clinical Nurse Manager is responsible for planning, implementing, and evaluating patient/family education. The Clinical Nurse Manager will network with agency and community resources to provide quality patient education.

The Infection Control Function is coordinated by a qualified Registered Nurse. The Infection Control Nurse is responsible for prevention, surveillance and control infection throughout the hospitals and affiliated clinics.

MISSION

In accordance with the mission of the Ventura County Medical Center and Santa Paula Hospital, the Nursing Department provides nursing care to the patients of Ventura County with emphasis on the indigent population and persons not having access to private health care. The Nursing Department provides quality nursing care in a professional, competent, compassionate manner regardless of age, race, creed, color, gender or economic status. As experts in providing health care, nursing will consistently meet the physical and emotional needs of our patients while respecting the cultural and spiritual needs of the patient and their families.

VISION

As nurses and patient care support staff, we all share the responsibility of creating and promoting a collaborative, supportive and safe working environment that places the patient, family and community in the center. By delivering safe, competent and compassionate services at every opportunity, and by cultivating relationships in the community that allow us to grow, our actions allow development within nursing and promote nursing as a profession that "grows their own."

PHILOSOPHY

Nursing does not occur in a vacuum. We consistently collaborate, in our practice, with residents, attending physicians, ancillary support and Administration. We believe in:

- Nursing as an art and science that delivers evidence based care across the continuum
- Patients being the center of nursing care
- Being recognized by the community for providing the highest quality nursing care for our patients and their families.
- Promoting patient and family education allowing for the optimal level of health
- Maintaining the nursing process as an integral part of our practice
- Patient focused goals allowing for collaboration from all care providers, the patient and families.
- Ethical and professional behavior allowing for a culture that supports empowerment and accountability.
- Utilizing evidence based practice through continuous quality improvement
- Nursing

STAFFING

The CNO is responsible for coordinating the overall Nursing Department Staffing Plan. The staffing will be reviewed on an ongoing basis to ensure appropriate staff mix, numbers of staff, and cost effectiveness. Daily staffing will be assessed by the Clinical Nurse Managers, Hospital Nurse Manager and Nursing Supervisors. All reasonable steps will be taken to assure that sufficient numbers of qualified staff are assigned to assess, identify problems, intervene, evaluate, delegate and coordinate safe patient care. There shall be a documented method of determining staffing requirements based on the assessment of patient acuity/needs and State staffing requirements (refer to policy *108.006 Nurse Staffing and Scheduling*).

The positions within the Department of Nursing, are outlined in a position description, this includes the scope, responsibilities, requirements, line of authority and demands of the position. In addition, each position has an evaluation, which includes specifically measurable performance criteria.

PERFORMANCE IMPROVEMENT

The Nursing department is an integral part of the performance improvement process. Nursing services actively participates in the agency wide Performance Improvement (PI) Program designed to monitor, evaluate and improve the quality and appropriateness of clinical services and patient care by:

- Following the Plan, Design, Study, Act philosophy adopted by the facility
- Identifying opportunities for improvement through a collaborative, interdisciplinary process.
- Implementing solutions and actions, which will bring about desired changes.
- Participate in the PI committees and Task teams as assigned.
- Assist with monitoring to assess for improvement and identify problem areas
- Indicators will be established to monitor in an ongoing manner, and provide linkage between risk management and performance improvement.
- Establishing indicators and thresholds to assist with performance monitoring. The pre-established levels, that when exceeded, may trigger an intensive evaluation. External and internal benchmarking (CORE) will be utilized when appropriate.
- Participate in Sentinel Event task force and root cause analysis as assigned.
- Develop Lean Healthcare management skills to allow for a more streamlined approach to change

The CNO is an active member of the Performance Improvement Coordinating Council (PICC). The Hospital/

Clinical Nurse Managers and Department Managers are active members of the Performance Improvement Teams as appropriate. Staff Members are encouraged to participate on the Performance Improvement Teams.

NURSING STANDARDS

The Nursing Department will maintain established Standards of Care and Standards of Practice to meet the needs of the patients and their families. The Nursing Departmental Standards will be based on nationally recognized standards and/or community standards when appropriate (refer to policy *108.004 Nursing Standards*).

All revision dates:	7/12/2023, 8/9/2022, 8/1/2009, 5/1/2006, 2/1/2005, 7/1/2001, 4/1/2000, 1/1/1999

Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/23/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/23/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/23/2025

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Owner:	*Matt McGill: Director, Imaging Services*
Policy Area:	*Imaging Services*
References:	

IS.61 Voiding Cystourethrogram (VCUG)

POLICY:

To outline the steps for the imaging staff and registered nurse (RN) to perform a voiding cystourethrogram (VCUG).

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. This policy was created by the Imaging and Nursing leadership teams and will be reviewed by these teams and the Radiology Medical Director.

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 3 and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

PURPOSE:

- Evaluate bladder and urethra including dynamic voiding for pathology related to
  - Urinary incontinence
  - Suspected urethral diverticulum
  - Suspected fistula from the bladder/urethra
  - Suspected vesicoureteral reflux
  - ~~UTI~~Urinary tract infection
  - Hydronephrosis
  - Postop ureteral/bladder/urethral surgery
  - Pre-renal transplant evaluation
  - Evaluate posterior urethra in male patients

SPECIAL CONSIDERATIONS/ CONTRAINDICATIONS

For bladder injury/surgery in the last 10 days, review urology clinical documentation for justification for exam. If unclear, confirm with urology/ordering provider prior to beginning the exam.

ROLES AND RESPONSIBILITIES

A. Scope of supervision required
    1. The imaging staff is accountable to the Imaging Department Director or designee.
    2. The RN performing this procedure is responsible and accountable to their nursing department director.
    3. 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.
    4. Provider consultation is to be obtained under the following circumstances
        a. Emergency conditions requiring prompt medical intervention
        b. Upon the request of the patient, staff or physician
        c. Anytime any deviation from this procedure is necessary
B. Requirements for the RN
    1. Active California RN license
    2. Life support certification: Basic
    3. Special training: formal orientation to the imaging department, Foley catheter placement and maintenance with demonstrated competency validation
    4. Evaluation of the RN competency
        a. Prior to performing this procedure, the Nurse director/delegate will assess the initial competency of the RN.
        b. Annually: the Nurse director/delegate will evaluate RN competency annually as part of the performance review process.
C. Requirements for the Imaging Tech
    1. Active California Radiology Technician (RT) and Fluoroscopy license
    2. Special training: formal orientation to the imaging equipment, inclusive of protocol selection, safety features, and dose optimization. Instruction on the location of procedure supplies and set up.
D. Evaluation of the RT competency
    1. Prior to performing this procedure, the Imaging Technologist will complete a self-assessment, and the Imaging Supervisor/delegate will assess the initial competency of the technologist.
    2. Annually: the Imaging Supervisor/delegate will evaluate the technologist competency annually as part of the performance review process.

COMMUNICATION PROCESS

A. The technologist assigned to Fluoroscopy each day will be responsible for checking the patient schedule for the following three days.

B. When an exam is scheduled requiring assistance from an RN, the technologist will send an email to

   1. Lead Technologist
   2. Technologist assigned to Fluoroscopy on the day of the exam
   3. Imaging RN
   4. Child Life Specialist
   5. Perioperative Nursing Director or designee

C. The technologist will follow up on the email until all parties are aware and appropriately assigned to the case.

D. Technologist and RN will review the patient order. Imaging staff will call the patient or guardian to provide exam specific instructions.

EQUIPMENT/SUPPLIES/CONTRAST

A. Add-A-Cath Kit

B.

Age (Years)	Recommended Catheter Size (French)
Neonatal	3.5-5
~~0 to 2~~0 to 1.99	6
~~2 to 5~~2 to 4.99	6 to 8
~~5 to 10~~5 to 9.99	8 to 10
10 to 16	10 to 12
~~16 to 18~~	~~Mary/Matt to confirm~~
>16	follow adult catheter sizing

C. Connector tubing (gravity set)

D. Adapter for connection to catheter

E. Cystografin contrast

F. Voiding receptacle

G. Chux pad placed under sheet

PRE-PROCEDURE

A. Imaging Tech Responsibilities

   1. Verify order (exam and Catheterization) and ensuring no contraindications for urinary catheter insertion such as urethral injury, urethral strictures, urinary tract surgery within last ten days, and the presence of an artificial sphincter. For these issues consult the ordering licensed practitioner (LP).
   2. Review for contrast allergy.

3. Notify RN prior to getting the patient.
4. Obtain scout KUB x-ray.

B. RN Responsibilities

1. Verify informed consent. If none present, notify LP. RN may sign as witness.
2. If the patient does not have a Foley catheter or Suprapubic tube, the nurse ~~or tech~~ will need to place a Foley.
3. When Foley catheter is needed, the RN will place under scope of standardized procedure to be co-signed by an LP. If any resistance is felt or bleeding, the nurse will not insert and will contact the radiologist for further instructions.
4. If the patient has both a Foley catheter and Suprapubic tube, consult ordering LP for further instructions.
5. Provide age appropriate comfort measures
   a. Assistance of child life specialist, if available.
   b. Consider Lidocaine gel if applicable for patient comfort.

PROCEDURE(S):

A. Imaging Tech Responsibilities

1. Utilize appropriate PPE and exam specific equipment.
2. Secure the catheter to the patients thigh.
3. Position patient upright standing.
4. Obtain scout images.
5. Begin filling bladder with contrast by gravity per Radiologist direction.
6. Fluoro intermittently during bladder filling to evaluate for reflux or other abnormality.
7. Stop filling bladder per Radiologist direction while observing patient tolerance.
8. Deflate balloon at Radiologist direction, reference the amount used by RN during insertion.
9. Obtain voiding images.
10. If patient is unable to void under fluoroscopy after multiple attempts, patient may void in bathroom. Make notation on study notes.
11. Obtain post void images (if large post void residual, have patient attempt voiding in bathroom and repeat).

B. RN Responsibilities

1. Utilize appropriate PPE and exam specific equipment.
2. While maintaining sterile technique, use breathing instructions, communication, and or distraction techniques ~~to advance~~while advancing the catheter.
3. Inflate balloon per manufacturer specifications and gently pull the catheter back until the balloon rests against the bladder neck (balloon catheters are not intended for use in neonates due to risk of urethral injury if not inflated properly).
4. Remove Foley catheter once imaging staff confirms procedure is completed.

5. Document catheter procedure with date, time, size of catheter, amount used to inflate balloon, urine amount, color, clarity, and notes on patient tolerance, complications, and teaching provided.

All revision dates:

Attachments

No Attachments

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	4/22/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/4/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/10/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/10/2025
Imaging Services	Matt McGill: Director, Imaging Services	3/10/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/7/2025

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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:	*Matt McGill: Director, Imaging Services*
Policy Area:	*Imaging Services*
References:	

IS.62 Performance of the Modified Barium Swallow (MBS)

POLICY:

The Modified Barium Swallow will be performed with a licensed Speech Language Pathologist (SLP)~~,~~ and Radiologic Technologist (RT), and may be performed under the indirect supervision of the Radiologist so long as they are present in the building and available at any time the RT or SLP requires them to be.

PROCEDURE(S):

Performing a Modified Barium Swallow (MBS) under the indirect supervision of the Radiologist may occur when the following conditions have been met:

- The Speech Language Pathologist has agreed the Radiologist can support the exam with indirect supervision based on pre-procedural patient information they have reviewed.
- The Radiologic Technologist has completed a ~~Competency~~competency specific to use of ~~Fluoroscopy~~fluoroscopy during the MBS exam where:
    - The RT has designated themselves as able to perform the MBS exam independently on the self assessment.
    - The Radiologist has directly supervised a minimum of three (3) MBS exams and has marked the RT as able to perform them independently .
- The Radiologic Technologist will notify the Radiologist whenever the fluoro-time exceeds 2.0 minutes.

~~REFERENCE(S):~~

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	5/7/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	4/4/2025
Imaging Services	Matt McGill: Director, Imaging Services	4/4/2025

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VENTURA COUNTY
HEALTH CARE AGENCY

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Last Revised:	*3/12/2025*
Next Review:	*3 years after approval*
Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Maternal Child Health*
References:	

MCH.01 NICU Admission Logbook

POLICY:

To describe the procedure for maintaining an Admission Logbook for the purpose of collecting patient data for record and statistical compilation.

PROCEDURE:

A log book is maintained for all admissions to the Neonatal Intensive Care Unit, Intermediate Care or Transitional Care Nursery. The following information will be documented:

A. Admission date/time
B. Hospital number
C. Infant's name
D. Parent's name/address/phone number
E. Delivery date/time/type
F. Weight, length, sex of infant
G. Admitting diagnosis/complications
H. Discharge date/time
I. Hearing screen: Date and pass or refer. (For NICU only)

   Other data may include:

J. Apgar scores at 1 and 5 minutes
K. Gestational age

   ~~Blood type of mother/baby~~

   ~~Coombs~~

L. Treatments/procedures
M. Follow-up care/provider
N. Discharge destination

EQUIPMENT:

A. Logbook

~~GUIDELINES:~~

~~A. Upon admission enter name, date, time of admit and available delivery information. Admitting diagnosis and complications may also be entered.~~

~~B. Other parent demographic and mother/infant information to be added, as available.~~

~~C. Discharge date, time, and other pertinent information to be entered upon discharge.~~

~~D. Medical Office Assistant and/or admitting staff are responsible for maintaining logbook.~~

DOCUMENTATION:

Neonatal Intensive Care Register

All revision dates:	3/12/2025, 10/12/2021, 3/8/2018, 1/1/2015, 1/1/2013, 1/1/2010, 3/1/2008, 7/1/2006, 5/1/2004, 3/1/2003, 1/1/2002, 8/1/2000, 1/1/1997, 1/1/1996, 1/1/1995, 1/1/1994, 1/1/1993, 1/1/1992, 3/1/1991, 11/1/1990, 11/1/1989, 11/1/1988, 3/1/1987, 12/1/1986, 1/1/1985, 12/1/1984, 3/1/1983

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/12/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/12/2025
Policy Owner	ristina Swaim: Clinical Nurse Manager, OB	3/12/2025

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Last Revised:	2/9/2022
Next Review:	3 years after approval
Owner:	Kristina Swaim: Clinical Nurse Manager, OB
Policy Area:	Maternal Child Health
References:	

MCH.30 Neonatal Bereavement Cooling System

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) offer bereaved parents the opportunity to spend as much time as possible with their deceased infants. eeping the infant cool can prolong the length of time parents keep their deceased infant in their room, giving them more uninterrupted time with their baby. If parents require respite from their infant, it should be taken to the morgue. If the parents would like more time with their infant, the Cuddle Cot may again be used.

PURPOSE:

The death of a baby is an incredible difficult event for parents. We offer bereaved parents the opportunity to spend as much time as possible with their deceased infant. The Flexmort Cuddle Cot is a mortuary quality cooling device designed to keep a deceased infant cool to delay decomposition.

CuddleCot meets hospital equipment applicable standards for use with hospital environments:

(UL 61010-1:2012)

EQUIPMENT:

- CuddleCot Cooling system
- Hose
- Drain ey (to be kept in blue box)
- Plastic cooling pads
- Bottle of Biocide
- Distilled water
- Silver insulation foil
- Crib

PROCEDURE:

Note:

1. The small cooling pad should be used for small preterm deceased infants. The larger cooling pad is for larger deceased term infants.
2. During Storage distilled or sterile water is left within the hose and the cooling pad. The use of the biocide made for the product neutralizes bacteria and algae which could accumulate without its use.

Using the CuddleCot System:

1. Explain the purpose of the CuddleCot to the patient and family. Educate the family that the baby will feel cold to touch while the CuddleCot is in use.
2. Follow manufacturer instructions for setting up and draining the CuddleCot.
3. Clean according to manufacturer's instructions.

Attachments:

Flexmort CuddleCot Instructions

References:

1 Flexmort CuddleCot Cooling System Operations Manual.

All revision dates: 2/9/2022

Attachments

Attachment A - CuddleCot Instructions

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	4/25/2025

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/10/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/10/2024
Policy Owner	□ristina Swaim: Clinical Nurse Manager, OB	12/10/2024

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Last Revised:	4/7/2025
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Owner:	Pearl Dahm: Clinical Nurse Specialist
Policy Area:	NICU
References:	

N.70 Extremely Low Birthweight Intraventricular Hemorrhage Prevention Protocol

PURPOSE

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

POLICY:

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

DEFINITION(S)

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

PROCEDURE(S)

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

PROCESS

1. Admission:
   A. In advance of delivery; have a pre-warmed Giraffe set up in the OR or delivery room with thermal hat over plastic covered head, warming mattress, and polyethylene occlusive wrap.

B. Prepare the NICU admission space with items for admission and umbilical line placement prior to delivery.

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

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

E. Hang protocol on the monitor at the bedside.

2. Thermoregulation

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

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

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

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

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

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

3. Positioning:

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

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

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

4. Skin Care

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

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

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

   D. Avoid use of adhesives

   E. Handle infant gently to avoid trauma to skin

   F. Tape should not be used.

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

   H. Use micro-preemie leads if available.

5. Minimal Stimulation:

   A. Cluster care every 4-6 hours

   B. Minimize suctioning unless infant shows signs of respiratory distress

   C. Limit painful procedures

6. General Care First 72 hours:

   A. Two person handling with cares

B. No prone positioning or skin to skin unless ordered by MD. Encourage parents to provide therapeutic touch and □hand hugs□

C. No weights after birth weight obtained

D. No abdominal girths

E. No baths

F. No peripheral BP if UAC in place

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

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

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

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

   B. Begin Daily weights and

   C. □eep buttocks below head during diaper changes.

   D. No abdominal girths

   E. No baths

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

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

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

REFERENCE(S)

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

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

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

All revision dates: 4/7/2025, 10/9/2024, 6/11/2024

Attachments

Please protect my brain (1).pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	5/7/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/10/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/10/2025
NICU	Robert Posen: NICU Medical Director	4/10/2025
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	4/7/2025
NICU	Pearl Dahm: Clinical Nurse Specialist	4/7/2025

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Owner:	Kristina Swaim: Clinical Nurse Manager, OB
Policy Area:	OB Nursing
References:	

OB.16 Antepartum Testing

POLICY:

The purpose of antepartum testing is to assess fetal well being prior to the onset of labor and delivery. Antepartum testing includes the use of electronic fetal monitoring to evaluate the fetal heart rate and/or ultrasound for such purposes as determining the amount of amniotic fluid volume, visualizing fetal movement or performing a complete biophysical profile (NST, BPP, FAST, CST). Antepartum testing is done for those patients who are at risk for uteroplacental insufficiency that may lead to fetal demise. The frequency of antepartum testing is determined by the patient's condition and reason for testing.

PROCEDURE:

A. **Non-Stress Test (NST)**

1. **Description**: A non-invasive method of assessing fetal well being by observing the response of the fetal heart rate to fetal movement. Based on the premise that the heart rate of a fetus that is not acidemic or neurologically depressed will temporarily accelerate in association with fetal movement. Reactivity is a good indicator of fetal autonomic function and a well-oxygenated fetus. There are no contraindications for the performance of this test.
2. **Relevant Data:** Most fetuses exhibit fetal heart rate (FHR) accelerations after 24 weeks of gestation. Before 32 weeks of gestation, FHR accelerations that increase in amplitude greater than or equal to 10 bpm from the baseline and are greater than or equal to 10 seconds are more commonly seen. (NICHD, 2008)
3. **Interpretation:**
   a. **Reactive:** Two (2) FHR accelerations that peak (but do not necessarily remain) at least 15 bpm above the baseline and last 15 seconds from baseline to baseline, and accompanied by a baseline rate within normal range of 110-160 bpm with moderate (6-24 bpm) variability all occurring within a 20 minute window.
   b. **Non-Reactive**: The above criteria are not met within a 40-minute time frame.
4. **Procedure**
   a. Ask patient to empty her bladder and obtain a urine specimen to assess for protein, ketones, specific gravity and any other parameters as determined by the reason for the testing.
   b. The patient should be in semi-Fowler's or left lateral recumbent position, with right or left uterine displacement.

c. Assess and record maternal vital signs.

d. External tocodynamometer and ultrasound transducer are both applied to mother's abdomen. Interpretation cannot occur without both channels of information.

e. The patient is observed until the criteria for reactive test is met or plans for additional testing are made within 24 hours.

f. If the test is initially non-reactive, the fetus may be stimulated. This may be attempted by Fetal Acoustic Stimulation Test (FAST), scalp stimulation, or ingestion of fluid or liquids.

g. If the non-stress test (NST) is non-reactive within 45 minutes, further testing such as a biophysical profile (BPP) or CST may be ordered.

h. When NST is performed in the Ambulatory Care setting as part of antepartum care, patient monitoring, fetal stimulation, and test interpretation will be the responsibility of the ordering physician or a certified nurse with advanced training. Fetal heart monitoring requires advanced assessment and clinical judgment skills and should not be delegated to unlicensed assistive personnel or others who do not possess the appropriate licensure, education, and skills validation.

i. Monitor tracings will be interpreted by a physician or certified nurse with advanced training prior to discharging the patient home from an Ambulatory Care setting. When interpretation is performed by a certified nurse, a Fetal Well Being form will be completed in the Electronic Health Record (EHR) and signed off by a physician.The patient will be notified of results and any required follow-up care before they leave the clinic.

j. Pertinent information is recorded in the EHR.

k. Monitor tracings are saved in the EHR for comparison and review.

5. **Management of NST**

   a. Reactive NST: Repeat as ordered.

   b. Non-reactive NST: Perform contraction stress test (CST) and/or biophysical profile, as ordered by physician.

   c. Unsatisfactory NST: Proceed to biophysical profile, as ordered by physician.

B. **Contraction Stress Test (CST)**

1. **<u>Description</u>**: The basis of the CST is that the well-oxygenated fetus can withstand a decreased oxygen supply during the physiologic stress of a contraction whereas a compromised fetus will demonstrate decelerations that are indicative of a decrease in uteroplacental perfusion. The uterus is stimulated until three (3) contractions with a duration of at least 40 seconds occur in a 10 minute window. This can be accomplished by spontaneous CST, nipple stimulation or Oxytocin-induced contractions.

2. **<u>Indications:</u>** Conditions warranting assessment of the uteroplacental unit. The CST is used to follow a non-reactive NST or a biophysical profile score of 6/10.

3. **<u>Contraindications to CST</u>**: Include, but are not limited to: Any condition associated with possible pre-term labor, uterine rupture, or uterine/vaginal bleeding, such as placenta previa, oligohydramnios, multiple gestation.

4. A. **Management**

   a. Positive CST: Requires intervention or further fetal assessment.

b. Suspicious, tachysystole, or unsatisfactory CST: Repeat in one day, consider biophysical profile, per physician's orders.

c. Negative CST: Repeat weekly unless fetal or maternal condition shows signs of deterioration, per physician's orders.

d. Observed severe variable decelerations (a decrease in FHR to 90 BPM or a decrease of 40 BPM below baseline lasting at least 40 seconds): Physician will evaluate for immediate delivery or perform immediate ultrasound. If amniotic fluid □5 cm is identified, physician will consider induction of labor or C-Section.

e. If CST is unsatisfactory, but criteria for reactive NST are met, manage as reactive NST.

B. **Interpretation of CST**

a. **Negative:** No late decelerations of the FHR during the entire testing time and a 10 minute period with at least three (3) contractions, each lasting at least 40 seconds. There are no late decelerations observed, there is moderate FHR variability and a baseline rate within normal range of 110-160 bmp.

b. **Positive**: Late decelerations occurring with greater or equal to 50% of the contractions, even when the FHR variability is moderate and the baseline is within normal range of 110-160 bmp. This is true even if the contraction frequency achieved is less than 10 minutes.

c. **Equivocal**: Intermittent late or variable decelerations occur.

d. **Tachysystole**: Contractions occur more often than every two (2) minutes or last longer than 90 seconds. This test is uninterpretable as well since the induced stress is considered to exceed normal uteroplacental reserve.

e. **Unsatisfactory**: Either the quality of the recording is insufficient to ensure that no late decelerations are present or the contraction frequency is less than three (3) in 10 minutes.

1. **Nipple Stimulation Test**

    a. The physician should be readily available.

    b. The patient is placed in semi-Fowler's or left lateral recumbent position with either right or left uterine displacement for baseline tracing.

    c. If not previously done, perform an NST.

    d. The blood pressure is recorded initially and as indicated.

    e. If baseline uterine activity does not meet test criteria, the patient is instructed to massage and/or roll the nipple on one breast for 2-3 minutes. Stop if contractions begin. She is then to stop for three (3) minutes. If no uterine contractions are observed, the process is repeated. If unilateral stimulation fails to induce contractions, bilateral nipple stimulation may be used brushing the palms across each nipple for 2-3 minutes. To avoid tachysystole, bilateral stimulation should not be instituted unless unilateral stimulation fails to induce contractions. Note the time of starting and stopping stimulation in the EHR. Observe the patient carefully for signs of tachysystole.

    f. Discontinue stimulation if: criteria for the test have been met or a positive test results. Discontinue if tachysystole occurs

g. If insufficient uterine activity is produced by nipple stimulation, discontinue the nipple stimulation and perform an OCT.

h. The patient is monitored for 30-60 minutes following test completion. Signs of labor are reviewed with the patient prior to her leaving the testing center.

2. **Oxytocin-Induced Contraction Stress Test (OCT)**

   a. Should be performed where cesarean delivery capabilities are readily available.

   b. The physician should be immediately available during the procedure.

   c. Place a intravenous line per protocol with a catheter and fluid ordered.

   d. The patient is placed in a semi-Fowler's or left lateral recumbent position.

   e. The baseline fetal heart rate and spontaneous uterine contractions are recorded for 10 minutes.

   f. The baseline blood pressure is recorded in the EHR. Recheck blood pressure with increase of oxytocin.

   g. An intravenous infusion is started using an infusion pump and oxytocin diluted in an IV solution. Start oxytocin infusion at 0.5 milliunits per minute (mu/min) via piggyback into the main IV.

   h. The dose of oxytocin is increased by 1-2 mu/min every 15-20 minutes until the contraction criteria are met of three (3) contractions in a ten minute window.

   i. Discontinue oxytocin when criteria for the test have been met or a positive test results. Discontinue if tachysystole occurs.

C. **Biophysical Profile**

1. Description: The presence of normal biophysical activity is indirect evidence that the portion of the CNS that controls specific activity is intact. A physical examination of the fetus utilizing real-time ultrasound equipment evaluates these parameters. The Fetal Heart Rate is monitored with an external transducer. The tracing is observed for FHR accelerations that peak (but do not necessarily remain) at least 15 beats per minuted above the baseline and last 15 seconds from baseline to baseline. Parameters measured in this evaluation include:

   a. Fetal breathing movements (FBM)

   b. Fetal movement (FM)

   c. Fetal Tone (TON)

   d. Amniotic fluid index (AFI)

   e. Non-stress test (NST)

2. **Procedure:**

   a. The BPP ultrasound parameters are performed by a physician. A score of 0 or 2 is provided for each of the parameters while observing the fetus over a maximum of a 30 minute time frame. The BPP evaluates indicators of chronic fetal hypoxia and placental function such as amniotic fluid volume in addition to more acute indicators such as fetal breathing, movement and tone.

3. **Interpretation: Table 1. Biophysical Profile Scoring:**

4.

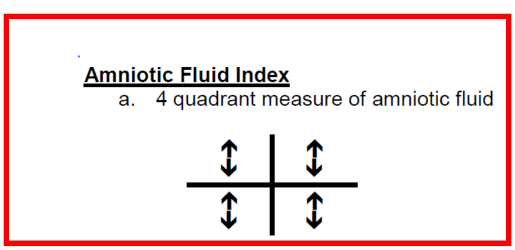
Biophysical Variable	Normal (score = 2)	Abnormal (score = 0)
Fetal breathing movements	At least one episode of FBM of at least 30 sec. duration in 30-minute observation.	Absent FBM or no episode of □30 seconds in 30 minutes.
Gross body movements	At least three discrete body/limb movements in 30 minutes (episodes of active continuous movement considered as a single movement)	Two or fewer episodes of body/limb movements in 30 minutes.
Fetal tone	At least one episode of active extension with return to flexion of fetal limb(s) or trunk. Trunk in position of flexion and head flexed onto chest. Opening and closing of hand considered normal tone.	Either slow extension with return to partial flexion or movement of limb in full extension or absence of fetal movement. Spine in position of flexion. Fetal hand open.
□Amniotic Fluid Volume	Evident through uterine cavity. Single deepest vertical pocket of amniotic fluid greater than 2 cm or an fluid index of greater than 5 cm.	Absent in most areas of uterine cavity. Single deepest vertical pocket of amniotic fluid of 2 cm or less(not containing umbilical cord or fetal extremeties) or amniotic fluid index of 5 cm or less.
Non stress test	Reactive	Non-reactive

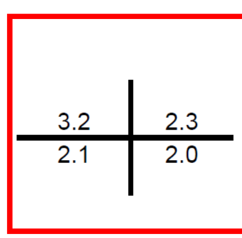
□Amniotic Fluid Index □ The summation of deepest vertical pocket of amniotic fluid in each of the four quadrants of the amniotic sac. Measurements are done in centimeters and perpendicular to the floor.

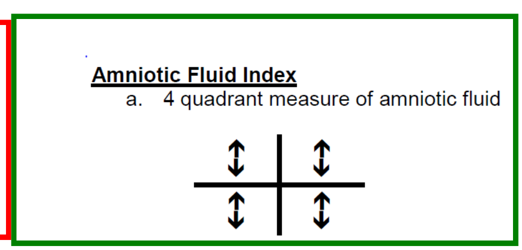
5. **Management**

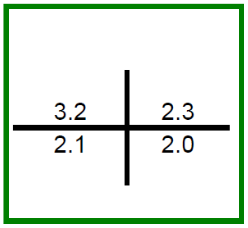
SCORE	ACTION
8-10	Equivalent to reactive NST. Manage per protocol.
4-6	If pulmonary maturity is favorable, deliver. If not, repeat test in 24 hours. If score persists, deliver if maturity is certain. Otherwise, treat with steroids and deliver in 48 hours.
0-2	Evaluate for delivery.

Assessment of Amniotic Fluid









a. Normal AFI is greater than 5 cm less than 25 cm or deepest 2x1 single vertical pocket □2 and less than 8 cm

b. Oligohydramnios less than 5 cm

c. Polyhydramnios greater than 25 cm or deepest single vertical pocket □8 cm

Fetal Acoustic Stimulation Test (FAST)

1.**Description:** The FAST is an adjunct to antepartum and intrapartum assessment. The association of a fetal heart rate acceleration of greater than or equal to 15 bmp above the baseline for a minimum of 15 seconds in response to stimuli of the vibroacoustic stimulator (an artificial larynx) is associated with fetal well-being.

2. **Procedure:**

a. a. Assess fetal monitor tracing and determine FHR baseline.
b. Place acoustic stimulator (an artificial larynx) on maternal abdomen in the area of the fetal head.
c. Activate the device for 1-2 seconds.
d. Observe the fetal heart rate pattern. If, after 5 minutes, no acceleration has occurred or if the qualifying criteria have not been met, repeat the sound/vibration stimulus. The stimulus can be repeated three (3) times at 1-5 minute intervals.
e. During the intrapartum period, the FAST may be used to improve variability and elicit accelerations in a fetus whose fetal heart rate pattern is non-reassuring.

EQUIPMENT

A. Fetal Monitor
B. BP cuff
C. Ultrasound machine for biophysical profile.

DOCUMENTATION

D. Record vital signs prior to testing and as indicated.
E. Chart appropriate exceptions of FHR tracing and interventions taken.

□E□ POINTS

F. Observe Standard Precautions.
G. Indications for antepartum testing:
Any patient at risk for developing decreased utero-placental function including but not limited to:
    1. Maternal Disease
        a. Diabetes Class A through F

b. Collagen disease
c. Pregnancy induced hypertension
d. Chronic hypertension
e. Renal disease
f. Cardiac disease
g. Thyroid disease
h. Anemia

2. History of poor obstetrical outcome
3. Post-dates pregnancy
4. Fetal indications
   a. Suspected IUGR
   b. Suspected decrease in fetal movement
   c. Irregular/abnormal FHR by auscultation
   d. RH sensitization
   e. Multiple gestation
5. See specific protocols for timing and frequency of these procedures.

REFERENCES:

ACOG Bulletin □145, July 2014, Reaffirmed 2016, Antepartum Fetal Surveillance, July 2014.

Freeman, Roger, Garite, Thomas, Nageotte, Michael, and Miller, Lisa (2012) Fetal Heart Rate Monitoring. Williams and Wilkins. Fourth Edition.

Holden, Ann et al (2006) Antepartum and Intrapartum Fetal Heart Rate Monitoring: Clinical Competencies and Education Guide. Fourth Edition. AWHONN.

Magann, EF, Chauhan, SP, Washington, W, Whitworth, NS, Martin, JN, Morrison, JC (2002) Ultrasound estimation of amniotic fluid volume using the largest vertical pocket containing umbilical cord: measure to or through the cord? Ultrasound in Obstetrics and Gynecology, 20: 464-467.

Signore, C., Freeman, Roger, and Spong, C. (2009) Antenatal Testing: A Reevaluation. Obstetrics and Gynecology. Volume 113, Number 3.

Tucker, S., Miller, L, and Miller, D. (2015) *Antepartum Fetal Assessment* in Fetal Monitoring: A Multidisciplinary Approach. Mosby, 8th Edition.

All revision dates: 2/9/2022, 12/12/2019, 6/13/2018, 5/1/2015, 5/1/2011, 7/1/2010, 1/1/2005, 12/1/1992

Attachments

Record biophysical Profile on Progress Sheet (Clinic or Hospital Chart).

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/18/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/18/2025
Policy Owner	□ristina Swaim: Clinical Nurse Manager, OB	3/18/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*11/1/2004*
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Last Revised:	*3/10/2025*
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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.26 Perinatal Services Discharge Planning

POLICY:

To ensure careful and complete discharge planning for Perinatal Services patients. Discharge planning utilizes a continuous multidisciplinary approach and systematic process which ensures patient outcome in a timely, supportive and cost effective manner.

PROCEDURE:

Discharge planning includes the following components for Perinatal Services patients:

A. Expected length of stay shall be predicted when possible and discussed with the parents.
B. A multidisciplinary team composed of the physician, staff nurse, medical social worker, dietician, lactation counselor, and other support staff, shall assess patient and parental readiness for home care.
C. All appropriate neonatal screening examinations shall be completed and their results discussed with parents. Immunizations shall be initiated when appropriate.
D. Follow-up appointments with the primary care provider or specialists and community resources shall be made when indicated.
E. A written discharge summary shall be sent to the infant's primary care provider.
F. Written home instruction shall be provided to the parents. See attached.
G. A home health agency referral shall be made when indicated, based on parent and/or infant needs. Referrals to community agencies and services shall be made when indicated. This includes:
    1. Public Health Nurse
    2. Home Health Agency
    3. Tri-Counties Regional Center
    4. Durable Medical Equipment vendor

DISCHARGE STUDIES AND CRITERIA FOR TESTING

A. Discharge Studies:

    All infants will require some or all of the following studies prior to discharge:

    1. Hearing assessment: (see policy MCH.13, *Newborn and Infant Hearing Screening*): All infants shall

have a hearing screen examination ~~just~~ prior to discharge and follow-up recommendations provided.

2. Newborn Screen: (see policy MCH .02, *Newborn Screening of Infa*nts): To outline responsibilities associated with newborn screening of infants according to California State regulation. A newborn screen specimen will be collected on each newborn prior to discharge.
3. Congenital Heart Screening: (CHD see policy Ob .68 Newborn Pulse Oximetry Screening) To detect critical congenital heart defects.
4. Immunizations: To guide nurses in ensuring infants and children at VCMC~~/SPH~~ receive appropriate immunizations per Public Health recommendations. (see policy Ob 43 Hepatitis B Prevention in the newborn).
5. Transcutaneous Bili Meter: JM-105 (TCB) To evaluate and identify those newborns/neonates at high risk for hyperbilirubinemia and acute bilirubin encephalopathy. The TCB Meter is a screening device seeking to offer measurement of TCB changes occurring to the infant as hyperbilirubinemia progresses. Documentation of these consecutive readings provides a trend of what is happening with the infant. (see policy MCH 25 Care of the infant with Hyperbilirubinemia)

REFERENCES:

AHWONN: Perinatal Nursing, ~~4th~~5th edition, ~~2013~~November 2020.

All revision dates:	3/10/2025, 10/12/2021, 7/1/2016, 9/1/2015, 11/1/2013, 7/1/2010

Attachments

No Attachments

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/10/2025
Policy Owner	ristina Swaim: Clinical Nurse Manager, OB	3/10/2025

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Owner:	Kristina Swaim: Clinical Nurse Manager, OB
Policy Area:	OB Nursing
References:	

OB.74 Post-Partum Rubella Immunization

POLICY:

Prevents congenital measles-mumps-rubella (MMR) in susceptible post-partum women (rubella titer ≤ 1:8) who are not pregnant at the time of injection. Promotes immunity to rubella by inducing production of antibodies.

EQUIPMENT

A. Physician order in electronic health record (EHR)
B. MMR consent and most current vaccine information sheet (VIS)
C. Vial of live attenuated measles-mumps-rubella virus vaccine and supplied diluents
D. Syringe and safety needle

PROCEDURE:

A. As always, refer to drug reference prior to administering unfamiliar medications.
B. Check physician order and ensure Informed Consent is documented by physician in EHR.
C. Verify rubella immunity.
D. Have patient sign bottom portion of MMR consent form.
E. Ensure post-partum patient understands the need for an effective of method of birth control and the importance of avoiding pregnancy for at least three (3) months after MMR vaccination.
F. Reconstitute vaccine using supplied diluent and shake well. Use within 8 hours of reconstitution. Dosage is 0.5 mL.
G. Inject subcutaneously in the outer aspect of upper arm. (Do **NOT** administer IV.)
H. MMR vaccination is contraindicated with a history of allergy neomycin, or if woman is pregnant, active or has untreated tuberculosis. Refer to drug reference for full list of contraindications.

DOCUMENTATION:

A. Electronic Health Record (EHR): date, time of injection, site, lot number of vaccine, expiration date.
B. Patient education: provision of information sheet and birth control/avoidance of pregnancy education

provided.

All revision dates:	2/9/2022, 10/1/2016, 12/1/2013, 11/1/2012, 11/1/2009, 2/1/2008, 8/1/2007, 12/1/2004, 10/1/2001, 12/1/1998, 10/1/1995, 4/1/1995, 4/1/1992, 4/1/1991, 4/1/1990, 4/1/1989, 4/1/1988, 4/1/1987, 4/1/1986

Attachments

No Attachments

Approval Signatures

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Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/4/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/11/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/11/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	3/11/2025

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.75 Admission Criteria and Standards of Care: Antepartum

POLICY:

Ventura County Medical Center (VCMC) ~~and Santa Paula Hospital (SPH)~~ have established criteria for the admission and care of patients admitted for inpatient antepartum care.

A. Patients will be admitted for antepartum care after obstetric (OB) triage evaluation or orders for direct admission are obtained. A provider’s order for admission is required.

B. Using the nursing process, comprehensive care will be achieved through an interdisciplinary team approach.

C. Physical examinations and procedures should be explained appropriately and only undertaken with the patient’s consent.

D. The following standards will be adhered to for all antepartum patients unless otherwise ordered by a provider. The provider will be notified of all major changes in the patient’s condition.

PROCEDURE:

I. Admission Criteria

A.
1. Acute medical obstetrical complications; not in active labor, delay of delivery desired
2. Preterm labor evaluation or stabilization
3. High-Risk pregnancy evaluation and stabilization
4. Fetal demise not in active labor; threatened or actual
5. Termination of pregnancy, prior to induction or augmentation
6. History of Substance Abuse Disorder/Medication Assisted Therapy
7. Other diagnosis as determined by the attending provider

II. Admission Assessment

A. An admission assessment of the antepartum patient will be completed upon admission to antepartum care. Assessment will include, but not limited to:

- Prenatal history, Estimated Day of Confinement (EDC) and patient’s reason for admission.

- Current height and weight
- Physical and psychosocial status
- Vital signs including, but not limited to, blood pressure, pulse, respirations, oxygen saturation, pain
- Fetal well-being and uterine activity through electronic fetal monitoring and palpation.
- Vaginal and sterile speculum examination, only when specifically ordered by provider.

III. Routine Care

A. 1. Orient patient to physical environment

2. Orient patient to plan of care, visitor policy, address any specific questions or concerns.

3. Assessment will be completed every shift. Assessment will include review of the body systems (s) as dictated by patient condition. Ongoing assessment will include, but not limited to:

~~Ongoing assessment will include, but not limited to:~~

- Fetal well-being and uterine activity through electronic fetal monitoring and palpation. Frequency based on provider's orders or change in maternal fetal status.
- Notification of the provider for any changes in patient's condition.
- Weights will be taken weekly at 2000 according to Policy 100.24 Patient Weights. Patients with preeclampsia will be weighed daily at 2000 unless otherwise indicated with provider order.
- A type and screen will be kept current on all admitted antepartum patients according to Policy L.BB.71 Blood Bank Type and Screen/Crossmatch
-

~~5. Vital Signs~~

5. Vital Signs-Routine vital signs including temperature will be performed at least every 4 hours.

~~Routine vital signs including temperature will be performed at least every 4 hours.~~

- Additional and more frequent vital signs may be performed based on changes in patient's condition or diagnosis as needed to determine the patient's response to an/or effectiveness of care given.

6. Comfort and Hygiene

- If not on bedrest, patients may shower per physician order with regular daily ambulation encouraged.
- Assistance with personal hygiene will be provided as necessary and at least every shift for patients on bedrest.
- Linens will be changed as needed to keep the bed clean and per patient's request.

7. Patients on Intravenous Therapy

- Assessment of the IV site every shift
- Change IV site according to hospital Policy 108.033 Peripheral Intravenous (IV) insertion, infusion and maintenance ~~every 96 hours or~~ as indicated.

8. Intake and output will be measured and recorded when ordered.

- Patient on modified or complete bedrest will be monitored for signs and symptoms of venous stasis.
- Dietary consultations will be obtained for patients with specific food preferences or special needs.
- Treatment and procedures will be performed based on physician orders and standards of care.

IV. Documentation in the Patient's Medical Record

A. All care activities, including assessments, physician communication, consultations, and patient education.

B. Fetal Heart tones (FHT) and uterine activity

C. Plan of Care-will be initiated and reviewed each shift and as condition changes.

D. Medication administration according to policy 100.076 Pain Assessment, management and documentation.

V. Location for Care of Antepartum Patient

A. Antepartum patients will be cared for in the Labor and Delivery (L&D) unit by nursing staff meeting competency and having completed an approved Fetal Monitoring course.

B. Unstable obstetric patients or patients in active term or preterm labor may require admission as a Labor and Delivery patient.

- Admission of the unstable patient as an active Labor and Delivery patient is at the discretion of the provider.
- Nursing may admit patient at will, who has an acute emergent condition or is in danger of imminent delivery to L&D while attending provider is notified.

C. Patients requiring admission to the Intensive Care Unit will be at the discretion of the provider. Fetal monitoring will be done by nursing staff meeting competency and having completed an approved Fetal Monitoring course.

All revision dates: 3/10/2025, 10/12/2021

Attachments

No Attachments

Approval Signatures

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Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/10/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/10/2025
Policy Owner	□ristina Swaim: Clinical Nurse Manager, OB	3/10/2025

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*OB Nursing*
References:	

OB.79 Utilization Of Doula Care In The Obstetrics Department

Policy

To improve patient assistance during labor and delivery, and postpartum by establishing a doula program at Ventura County Medical Center. The program's objectives are to raise satisfaction for patients, improve maternal and newborn outcomes, and promote the spirit of collaboration among medical and non-medical professionals.

Program Objectives

- Continuous Support: To provide continuous emotional and physical support to patients throughout the labor and delivery process
- Education: To provide education to both staff and patients about the role and benefits of doulas in the labor and delivery process
- Patient-Centered Care: Encourages a culture of patient-centered care that prioritizes autonomy and shared decision-making, as well as the recognition that doulas are present to consistently advocate for the patient.

Doula Eligibility and Certification

- Certified doulas will be recognized as part of the healthcare team.
- Orientation: Doulas are required to attend a hospital orientation session to familiarize themselves with hospital policies, procedures, and the layout of the birth center.

Implementation

- The OB department will supervise the launch of the doula program, which will involve the recruitment and credentialing of doulas.
- Staff training sessions will be organized to provide any necessary staff with information regarding the doula program, its objectives, and its implementation process.

Patient Access to Doulas

- Doulas will not be bound by standard visitor hours or limitations. They are allowed to remain with the patient throughout labor and delivery, as well as in the postpartum recovery period.

Doula Role and Responsibilities into the Healthcare Team

- Doulas will be introduced and included in the patient's plan of care to ensure that everyone in the team understands the patient's preferences
- Doulas will provide:
  - Constant emotional support, such as comfort and encouragement.
  - Physiological comfort measures, like posture, breathing exercises, and relaxation techniques.
  - Informational support, such as counseling about options available, the labor process, and advocating for the patient's birth plan.
- Doulas are prohibited from:
  - Providing medical interventions and assessments
  - Deciding on clinical decisions or managing medical treatment
- Doulas are permitted to remain with the patient during the labor process, unless hospital policy requires otherwise due to safety concerns.
- Doulas are required to adhere to all hospital protocols during emergencies and respect the decisions made by the medical team.
- Doulas will offer non-disruptive support to the patient in the event of a medical intervention, and they will be prepared to withdraw if necessary.
- Doulas are required to comply with HIPAA regulations and hospital policies regarding patient confidentiality.
- All doulas are expected to maintain a professional and respectful demeanor, and they are expected to foster a supportive environment for both patients and staff.

Evaluation and Quality Improvement

- Annual evaluations of the doula program will be conducted using the following metrics
  - Patient satisfaction scores
    - Patients will be encouraged to complete post-delivery surveys which will include questions that are tailored to their experiences with doulas.
  - Maternal and neonatal outcomes (e.g., rates of cesarean delivery, use of analgesia)
  - Feedback from healthcare providers regarding collaboration and communication
- Discuss about and learn from a normal, physiologic birth where the doula's care was or could have been very important to the patient's progress and result.
- The doula utilization will be modified in response to data collected and stakeholder feedback to guarantee ongoing improvement.

All revision dates:

Attachments

- GCHP Doula Benefit Flyer
- GCHP Doula Referral Form

Approval Signatures

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Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/16/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/16/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	4/16/2025

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

R.95 Small Volume Nebulizer Treatment

POLICY:

~~To define the indications, procedure, method and documentation of aerosolized medication~~

To standardize the delivery of inhalation aerosol drug therapy via small volume (hand-held) nebulizer. Respiratory Care Services will provide equipment and therapy for the aerosolization of pharmacological agents to maintain airway patency and provide clearance of retained secretions.

EQUIPMENT

A. Nebulizer kit
    1. Patient should use mouthpiece unless physically unable. If unable an aerosol mask may be used.
    2. Use trach mask or T-piece adapter for patients with tracheostomy
    3. Respiratory may use jet nebulaizer, BAN (breath acuated nebulizer), ultrasonic mesh nebulizer to deliver medication.

B. Pressurized gas source
    1. Flow meter for either oxygen or medical air
    2. Oxygen or medical air tank with flow regulator
    3. Nipple adapter
        ~~a. Green for oxygen~~
        ~~b. □ellow for medical air~~
    4. Prescribed unit dose medication

PROCEDURE:

A. Verify order in EMR (Electronic Medical Record)
    1. Type of solution/medication
    2. Amount/dose to be delivered
    3. Frequency/duration
    4. Mode of Administration

B. ~~Wash hands~~Perform hand hygiene and put on clean gloves following the guidelines for Standard Precautions

C. Explain purpose of therapy and procedure to the patient and/or family member at bedside

D. Prepare equipment

1. Obtain correct unit dose medication from Pyxis or pharmacy when directed
2. For initial treatment, put nebulizer kit together
    a. Store patients nebulizer in a patient bag
    b. Place patient label with date, time and Respiratory Therapist initial on nebulizer and patient bag.
3. Firmly attach end of oxygen or compressed air tubing to nebulizer, attach firmly. Attach other end of tubing to gas source.

E. Verify patient with 2 patient identifiers per National Patient Safety Goals

F. Obtain baseline vital signs ~~including heart rate, respiratory rate, and oxygen saturations. Assess breath sounds~~

1. heart rate
2. respiratory rate
3. oxygen saturations
4. breath sounds

G. Instruct patient to breathe slowly, deeply and evenly through their mouth, and hold his breath for 2-3 seconds on full inspiration.

1. Instruct proper body alignment for maximal breathing efficiency.
2. Instruct patient to breathe through the mouth or trach and to breathe slowly and deeply - a slight inspiratory pause is ideal.
3. Instruct patient to breathe diaphragmatically to assure that the maximum distribution and deposition of aerosol will occur in the basilar areas of the lung.

H. Continue with treatment until medication is exhausted.

I. Remain with patient during treatment, be sure patient keeps nebulizer upright.

J. Reassess vital signs, breath sounds at the end of treatment.

. Chronic obstructive pulmonary disease (COPD) patients, use compressed air.

L. Mechanical Ventilator

1. Place Aerogen Nebulizer on the dry side of the heater
2. Place medication/dose in the neb cup
3. Start nebulization in continuous mode for 30 mins.
4. Document in EMR

DOCUMENTATION

A. Scan patient and Medication administration directly into the EMR at bedside.

B. Document pre procedure and post procedure vital signs in Electronic Health Record (EHR).

C. Document any side effects or adverse reaction along with interventions.

Infection Control

A. Clean per manufacure guidelines

B. Change jet nebulizer every 7 days

C. Change Ultrasonic/mesh nebulizer cup every 7 days

All revision dates:	2/5/2025, 11/10/2020, 10/1/2016, 12/1/2013, 12/1/2012, 11/1/2009, 5/1/2008, 12/1/2004, 10/1/2001, 6/1/1998, 9/1/1995, 6/1/1995, 6/1/1992, 6/1/1991, 6/1/1990, 6/1/1989, 6/1/1988, 6/1/1987, 6/1/1986

Attachments

No Attachments

Approval Signatures

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/7/2025
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/5/2025

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Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory - NICU/PICU/CCU*
References:	

R.NPC.01 Inhaled Nitric Oxide

POLICY:

The primary objective of Inhaled Nitric Oxide (INO) is to provide dilatation of pulmonary vasculature, thus reducing pulmonary hypertension and improving gas exchange. The INO Vent delivery system is an integrated single unit designed to administer and monitor inhaled nitric oxide. The delivery system administers a constant concentration of nitric oxide independent of ventilator flow patterns.

PROCEDURE:

NICU Patients:

Neonatal patients inhale nitric oxide as medically necessary for term or near-term neonates (>34 weeks gestational age) when documentation confirms ALL of the following:

- Hypoxic respiratory failure with clinical or echocardiographic evidence of pulmonary hypertension; AND
- No congenital diaphragmatic hernia; AND
- Use is in conjunction with ventilator support and other appropriate agents
- As medically necessary to be determined by attending physician

PEDS Patients:

Pediatric patients requiring INO therapy is medically necessary for:

- Pulmonary hypertension with unstable hemodynamics with hypoxia despite conventional (non-INO) therapies
- Hypoxic respiratory failure associated with evidence of pulmonary hypertension
- As medically necessary to be determined by attending physician

Critical Care Unit:

- Evidence of right heart failure
- Hypoxic respiratory failure associated with evidence of pulmonary hypertension
- Primary Pulmonary Hypertension (PPHN)
- Refractory ARDS with severe hypoxemia
- As medically necessary to be determined by attending physician

General Instructions:

1. Attending physician to confirm patient meets criteria to begin INO therapy. Complete order must be entered into the Electronic Health Record (EHR) prior to placing patient on therapy.
    a. Dose of INO in PPM (parts per million; starting range to be 10PPM to 40PPM)
    b. Physician to update order in EHR before Respiratory Therapist adjusts settings
2. Respiratory Therapist to ensure all maintenance and quality checks have been performed prior to placing patient on machine.
    a. High calibration must have been completed and passed within a one (1) month time frame before placing patient on INO delivery device.
3. Respiratory Therapist will set up machine per manufacturer's guidelines.
    a. Respiratory Therapist shall follow instructions on the Pre-Use Checklist.
4. Respiratory Therapist shall document the patient's baseline vitals in the EHR.
    a. Perform pre-Arterial Blood Gas analysis per physician or NICU nurse practitioner order.
5. Respiratory Therapist to set up resuscitation bag to back-up INO system.

Maintenance and Weaning of Nitric Oxide:

1. Once INO is initiated and running, the Respiratory Therapist shall document INO settings and monitored parameters q2 in the EHR.
2. A Low-Cal procedure will be performed every day and documented in EHR.
3. Alarms will be set as follows:
    a. Low and high nitric alarm shall be set 2PPM above and below current ordered dose.
    b. High INO2 alarm shall be set at 2PPM.
    c. Low Fi02 shall be 10% below set Fi02.
    d. High Fi02 shall be set as appropriate for the patient.
4. An INO cylinder should be replaced at 400 PSI.
    a. Follow the manufacturer's instructions to replace without disruption of therapy.
5. When the physician and Respiratory Therapist determine the patient is ready to be weaned, an order must be entered into the EHR with doses and instructions to wean.
    a. Decrease dose per physician orders and allow patient to stabilize for 15-20 minutes before making any more changes. Document SATS and PAP if available.
    b. Repeat the process as long as the patient’s vitals remain stable.
        - SATs remain within 3%
        - Systolic PA pressure remains within 10mmHg
6. Once the patient is at 0PPM, leave equipment in the room until next shift to ensure the patient tolerates being weaned.

Contraindications:

Neonates/PEDS Patients:

- Cyanotic congenital heart disease
- Major congenital abnormalities
- Persistent severe hypotension
- Severe hepatic dysfunction
- Severe thrombocytopenia (platelet count <50,000)
- Neurologic compromise inconsistent with function recovery

Adults/Pediatric Patients:

- Refractory hypotension despite adequate volume and vasopressor support.
- Patients with a disease process that is refractory to any further medical support.
- At risk for serious bleeding complications such as:
  - Intraventricular hemorrhage, Grade III or higher
  - Active pulmonary or gastrointestinal hemorrhage
  - Disseminated Intravascular Coagulation (DIC)
  - Severe thrombocytopenia (platelet count <50,000)
  - Patients with a disease process that is refractory to any further medical support

Indicators of Hypoxemia:

P/F Ratio: The ratio of arterial oxygen concentration to the fraction of inspired oxygen-scales the arterial oxygen concentration for the FiO_2 required to achieve it.

- P/F Ratio = P_aO_2/F_iO_2
  For example, with normal oxygenation in air:
  - P_aO_2 =100 torr, F_iO_2 = 0.21
  - P/F Ratio = 100/0.21 = 476
- 'Normal' P/F ratio is around 500
- ARDS classification:
  - Mild ARDS – P/F ratio 201-300 on CPAP/PEEP ≥ 5
  - Moderate ARDS – P/F 101-200 on PEEP ≥ 5
  - Severe ARDS – P/F ≤ 100 on PEEP ≥ 5

Oxygen Index (OI): Similar to the P/F ratio, but also accounts for the fact that oxygenation is influenced by mean airway pressure (MAP).

- OI = F_iO_2 x MAP x 100/PaO_2 = MAP x 100/(P/F ratio)
  With normal oxygenation with natural airway:
  - P_aO_2 = 100, FiO2 = 0.21, 'natural' MAP = 3 cm H_2O
  - OI = 3 cm H_2O x 100/476 = 0.63
- The higher the OI, the more severe the lung dysfunction.

All revision dates: 5/13/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/7/2025
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/7/2025

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VENTURA COUNTY HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.01 Adult Supervision of Minor Rehab Patients

POLICY:

It is the policy of Rehabilitation Services to ensure that an appropriate parent or guardian accompanies all non-emancipated minors during outpatient treatment and that the parent or guardian is accessible for emergent needs.

PROCEDURE:

Inpatient

1. The Rehabilitation therapist is to introduce themselves to the minor patient, verify the patient's identity and approach/communicate in an age-appropriate manner.
2. Parents/guardians are encouraged to assist therapist in obtaining child's cooperation and participation in care. In absence of parental presence, the therapist may wish to enlist the help of nursing.

Outpatient

1. The parent or legal guardian must accompany the minor child on the initial therapy visit to ensure that there is parental understanding and consent to the treatment plan and goals.
2. The parent, guardian or designated adult caregiver must routinely remain on the building premises during the treatment unless prior arrangements have been made with the treating therapist.
3. When the treating therapist authorizes absence of the attending adult or caregiver, an emergency contact number must be obtained and a return time designated by the therapist. Parents should be within 5-10 minutes distance of being able to return to the Department at any time.
4. If the attending adult fails to return at the designated time, the Department will not authorize future exceptions to the supervision rule.

All revision dates:	4/12/2022, 6/13/2019, 12/1/2013, 12/1/2010

Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	4/8/2025

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VENTURA COUNTY
HEALTH CARE AGENCY

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Effective:	*Upon Approval*
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Next Review:	*3 years after approval*
Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.21 Assessment (Scope of Speech Language Pathology (SLP) Assessment)

Patient Evaluation:

All patients shall have an evaluation completed at the initial visit by a Speech Therapist. The initial assessment is performed to determine the needs of the patient and to provide a database which is utilized in assessing the response to treatment. The initial assessment may include and is not limited to the following:

- Date of evaluation
- Diagnosis or condition needing referral to Speech Therapy
- Date of surgery or injury pertinent to diagnosis
- Physician orders for service
- Precautions, limitations or contraindications for treatment, if any
- A brief medical history, obtained from patient, Electronic Medical Record (EMR) or medical chart
- Previous functional level and living environment
- All testing is done utilizing standardized procedures of one or more of the following:

    ~~a. Assessment of Cognition~~

    ~~b. Observation of Pharyngeal Muscles~~

    ~~c. Vocal Quality~~

    ~~d. Hearing~~

    ~~e. Aphasia~~

    ~~f. Delayed speech and language~~

    ~~g. Functional disorders of articulation~~

    ~~h. Stuttering and rhythm problems~~

    ~~i. Cleft palate~~

    ~~j. Cerebral Palsy~~

    ~~k. Tongue thrusting~~

    ~~l. Visual perceptual dysfunction~~

    ~~m. Dysphagia~~

    ~~n. Aphasia~~

~~o. Other speech defects or disturbances~~

a. Apraxia
b. Aphasia
c. Dysphagia
d. Dysarthria
e. Cognitive Communication
f. Voice
g. Language
h. Articulation/Phonology
i. Stuttering/Dysfluency
j. Other speech defects or disturbances

- Any planned surgical procedure is listed, if known.
- Barriers to learning such as language, hearing deficits, chronic cognitive deficits, attitude and cooperation are noted~~.~~
- Problems are identified and prioritized.
- Patient/Family Goals
- Discharge plan or needs
  ~~Feeding recommendation~~
- Diet consistency and/or swallow strategy recommendations
- Speech Therapy recommendations

Treatment Goals:

- Each treatment goal should be functional and measurable with an estimated time frame of achievement. Goals are determined after completion of the evaluation and discussion with the patient/family and/or significant other.
- Functional and/or behavioral goals **might** include:

a. Patient/family/staff educational goals
b. Improvements in ~~cognition~~cognitive communication
c. Improved speech intelligibility, word finding, language, and/or communication for participation and ADLs
d. Compensatory strategies for swallowing, cognitive and communication deficits
e. Equipment/DME Recommendations
f. Advancement of ~~feeding~~diet consistency protocols

Evaluation of Speech and Language Disorders:

A. All evaluations include a case history with emphasis on information concerning the cause and a description of the problem.

B. ~~Specialized tests are administered to evaluate areas of deficiencies and the results recorded for individual problems, e.g., Minnesota Test Differential Diagnosis of Aphasia (MTDDA) for Aphasia and Goldman Fristo Test for Articulation and Disarticulation.~~Specialized tests are administered to evaluate areas of deficiencies and the results recorded for individual problems. Example of special tests include:

1. Western Aphasia Battery
2. Cognitive-Linguistic Quick Test (CLQT)
3. Goldman-Fristoe Test
4. Expressive/Receptive one word picture vocabulary test
5. Speech and/or Language sample
6. Conversation Sample
7. Reading and/or writing sample
8. Phonation and s/x ratio sample
9. Bedside/clinical swallow evaluation
10. Modified Barium Swallow Study

C. A patient's evaluation indicates the following areas of deficiencies; speech language, voice, quality, rhythm and hearing.

- Evaluation results are interpreted and recorded
- Judgment is made on ~~the~~ potential to achieve the treatment goals ~~(fair, good, excellent).~~
- Goals are revised as necessary.
- Barriers to goal achievement and factors that will facilitate goal achievements are identified~~.~~

Individualized Assessment:

The assessment process will include evaluation of those areas appropriate to the patient's needs based on age, diagnosis, and medical status. ~~In addition to the items on the general Speech Language Pathology (SLP)~~Various standardized and non-standardized assessments may be used during the evaluation~~, the following may be addressed as needed:~~ process

~~The following tests and materials may be utilized in a Speech Therapy Assessment:~~

~~**Tests**~~
~~Sequenced Inventory of Communication Development~~
~~Illinois Test of Psycholinguistic Ability~~
~~McDonald Deep Test of Articulation~~
~~Expressive One Word Picture Vocabulary Test~~
~~Templin Darley Test of Articulation~~
~~Minnesota Test for Differential Diagnosis of Aphasia~~
~~Test of Auditory Comprehension of Language~~
~~Goldman-Fristoe Test of Articulation~~
~~Peabody Picture Vocabulary Test~~
~~Communicative Abilities in Daily Living~~
~~Carrow Elicited Language Inventory~~
~~Porch Index of Communicative Ability~~
~~Word test~~
~~Utah Test of Language Development~~
~~Minnesota Multiphasic Personality Inventory~~

~~Strong Vocational Interest Test~~
~~Wechsler Adult Intelligence Scale~~
~~Wechsler Intelligence Scale for Child~~

~~**Language Materials**~~
~~Consonant Articulation Drills~~
~~The Adult Language Activities in Spanish~~
~~The S/Z AMP Articulation Modification Program~~
~~The R Articulation Modification Program~~
~~The Workbook for Aphasia by Brubaker~~
~~Rehabilitation Materials for the Language Impaired~~
~~Speech and Language Rehabilitation by Keith~~
~~Therapy Guide for the Adult with Language and Speech Disorders, Volume I (VNA), II & III~~
~~Steps Toward Basic Concepts Development Workbook I, II~~
~~PICAC Administration and Scoring Manuals~~
~~Whatsitsname, A Guide to Speech and Hearing Development~~
~~Miscellaneous childrens books~~
~~Complete set of word making cards~~
~~Crayons~~
~~Preposition Concepts~~
~~Singulars and Plurals~~
~~Opposites~~
~~Verb Concepts~~
~~Adjective Concepts~~
~~Spacial Relation Picture Cards~~
~~Same or Different Proportion Cards~~
~~Motivational card games~~
~~S Phoneme~~
~~Miscellaneous DSM abstracts~~
~~Mirror~~
~~Various magazine pictures, objects, blocks, waiting room toys (sorting, opposites)~~
~~8 puzzles~~
~~Sequence cards~~
~~Flannel board story kit~~
~~Spanish flash cards~~
~~Hi-Ho Cherry Game~~
~~Creative Playthings, shape book~~
~~Metronome~~
~~Big Book of Sound~~
~~Monterey Language Program~~
~~Portage Project Development Program~~
~~box reinforcement toys~~
~~Playskool number match-ups~~
~~Tape Recorder~~

~~Assessment Criteria:~~

Assessment Criteria:

Licensed therapists will perform initial assessments at the following times or under the following conditions:

- ~~Prior to the initial treatment session when physician orders are received for therapy.~~
- ~~When trigger/screening criteria developed by the services are identified and the physician orders an assessment.~~

- When physician's orders are received for evaluation and treatment.
- When the SLP, or another Rehab professional identify the need for further SLP evaluation and requests a physician's order for evaluation and treatment.

Timely Completion of Assessment:

~~Inpatient assessments~~Assessments will be completed within the following time frames:
~~Speech Therapy~~

- Inpatient referrals will be assessed within 24-72 hours of receipt of the order for Speech therapy. Refer to policy on response ~~timeframes~~time frames for referrals.
- Out-patient referrals will be scheduled within 1-2 weeks of receipt of referral and will be prioritized based upon patient need (acute versus chronic).

Documentation of the assessment findings will be done following the documentation guidelines for the department.

~~**Inpatient** assessment findings will be placed in the EMR one the same day following the treatment.~~

~~**Out-patient** assessment documentation will be completed within 72 hours of the completion of the evaluation visit.~~

- **Inpatient** assessment findings will be placed in the EMR one the same day following the treatment.
- **Out-patient** assessment documentation will be completed within 72 hours of the completion of the evaluation visit.

Notification of Physician – Significant Findings:

When assessment findings warrant immediate response for inpatients or out-patients, the physician or his office will be notified, and report of the significant findings and discussion documented.

Referrals for Assessment by Other Providers:

A request for assessment/treatment by other services will be made when:

- The therapist identifies any other deficit that requires therapeutic intervention.(i.e. GI, ENT for GERD or vocal cord evaluation, schoold-based psychoeducational assessment.)
- The caregiver identifies a learning need that can best be addressed by another service (i.e. diabetes counseling, nutrition, school-based assessment for learning disability).

Referrals will be made in the following manner:

- For treatment requiring physician's orders, the physician will be contacted for consultation and request of the order. This may be done, at the therapist's discretion using any of the acceptable communication procedures available (documentation of request in the EMR, recommendation on physician progress statement, phone call, communication through multidisciplinary team meetings, etc.)
- For needs not requiring physician's orders, the caregiver may contact the involved service directly and

coordinate the referral process.

Priorities for Care:

As part of the assessment process, the evaluating therapist will identify patient problems, deficits, needs and issues and will establish a priority for addressing those needs based on the following scale:

High Priority	The need, problem, deficit or issue is significant, interferes with the patient's ability to achieve desired outcomes or functional status and must be addressed within the first 3 days of service.
Medium Priority	The need, problem, deficit or issue is moderate, interferes with the patient's ability to achieve the desired discharge outcome to a lesser degree and needs to address during this admission.
Low Priority	The need, problem, deficit or issue is either long-standing and unlikely to respond to short-term interventions or is of a lower significance in affecting the outcome of this patient stay and will not likely be addressed during this admission.

Priorities will be documented on the initial evaluation form.

Ongoing Assessment:

In addition to the formal assessment and reassessments that are performed by therapists based on the above time frames and criteria, the patient is assessed for response to treatment and change in needs at each visit. Objective measurements may include vital signs, strength, range of motion, endurance and other indicators that measure progress or lack of progress.

Utilization of Assessment Data:

All assessment data will be documented in the medical record. This data will be utilized to establish priorities for care and develop a plan of care, educational plan and goals for patient treatment. The initial and subsequent measurements will be used to determine progress of the patient and to reevaluate needs during the care process.

Treatment Plan:

- The treatment plan is based on the patient assessment and functional goals. The treatment plan is discussed with the patient, family and/ or caregiver and verbal consent is obtained.
- Procedures utilized may include cognitive and perceptual therapy, swallowing instructions, dysphagia therapy, patient/caregiver education, and vocal/communication skills as indicated.
- Instruction in a home exercise program with written instructions is a part of treatment plan where applicable. Patient/family education regarding various aspects of the treatment plan is ongoing and may include but is not limited to instruction in patient positioning, verbal exercises, food consistency, use of adaptive equipment, effective communication training etc.
- Treatment time/frequency and estimated duration of treatment is planned to optimally provide ~~one-on-one~~1:1 care.
  ~~Frequency and estimated duration of treatment plan~~
  ~~Electronic or full signature of the evaluating therapist~~
- Treatment plan signed by Therapist

Progress Record:

- Therapist records each visit by date.
- List of modalities/procedures utilized are recorded by date and total time of treatment.
- Responses to treatment, especially change or progress are documented.
- Home exercise or instructions to patient/family are noted.

Summary:

- Revision of treatment program is done if goals are not being achieved.
- A discharge summary is performed at the completion of the therapy sessions. It should include:
  a. Diagnosis
  b. Number of treatments and dates of service
  c. Summary of treatment program
  d. A review of functional goals and whether goals were met.
  e. A comments section which may address response to treatment, degree of functional improvement, etc.
  f. Recommendation for further care, discharge or referral if needed
  g. If patient fails to complete the episode of care, the reason for the discontinuation of service will be noted

All revision dates: 4/10/2025, 12/8/2020, 12/1/2010, 12/1/1995

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	4/10/2025

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Nursing Practice Protocols*
References:	

NPP.05 Standardized Nursing Procedures for the Rapid Response Nurse

~~PURPOSE:~~

POLICY:

To provide a guideline and standardized procedure for the rapid response registered nurse (RN) to provide care in urgent and emergent situations. Individuals who ~~present to the Emergency Department (ED) or who~~ decompensate in the nursing units and require a response from a rapid response (RR) nurse will be assessed by an RN competent to determine the patient's presenting complaint. Once the assessment is complete, the ~~triage-competent ED~~RR RN ~~or the RR RN~~ may initiate care according to the following standardized procedures in the adult nursing units only.

~~The standardized procedures outlined in this policy are established to initiate and expedite care in the ED or in rapid response situations. All standardized procedures are to be documented in the Electronic Health Record (EHR). When additional concerns arise or conditions develop not listed in these procedures, the RN will consult with the ED licensed practitioner (LP). The RN will initiate all interventions in the appropriate protocol. The ED LP will be notified and assume responsibility for reviewing test results and contacting the patient in the event that a patient leaves the hospital prior to completion of test results.~~

~~Competency for the procedures listed will be assessed annually. The procedures herein will be reviewed annually also.~~

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, Physician Assistants (PA) 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.

ROLES AND RESPONSIBILITIES:

The items in the below protocols will be completed by the Rapid Response RN. Only Rapid Response RNs will review and implement these functions.

A. Scope of supervision required
   1. The RN is responsible and accountable to the Nursing Administration Nurse Manager.
   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 outside of the interventions in these protocols
      b. Upon the request of the patient, RN or physician
B. Requirements for the RN
   1. Active California RN license
   2. Life support certification: basic and advanced
   3. Special training: formal orientation to the rapid response role with demonstrated competency validation
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
D. A list of RNs who demonstrate competency to perform this procedure is held by the Nursing Administration Nurse Manager.
E. All standardized procedures are to be documented in the Electronic Health Record (EHR). The RN will initiate all interventions in the appropriate protocol.

PROCEDURE(S):

A. **The following procedures may be initiated by the RR RN in response to clinical assessment.**
   1. Altered mental status
      a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
      b. Cardiac monitoring and cardiac rhythm interpretation
      c. ~~ER Laboratory Panel~~Lab ER Panel (includes electrolytes)
      d. Glucose point of care
      e. Alcohol level
      f. Urine drug screen
      g. Point of care urinalysis with reflex to micro and culture

    h. 12 lead E□G
    i. Chest x-ray 1 view
    j. Blood gas, venous
    ~~Electrolyte panel~~
    k. Lactate level
    l. Notify Licensed Practitioner (LP).
    m. Vital signs ~~every 5 minutes~~ until symptoms improve or mental status returns to baseline.

2. Respiratory symptoms- for patients exhibiting any signs of respiratory distress including but not limited to desaturation, dyspnea, tachypnea, shortness of breath, labored breathing and use of accessory muscles
    a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
    b. Cardiac monitoring and cardiac rhythm interpretation
    c. Supplemental oxygen to maintain saturations □ or = 90%
    d. Chest x-ray 1 view
    e. Venous blood gas and electrolyte panel.
    f. Notify LP.
    g. ~~Page~~Contact respiratory therapist if not already present.
    h. Vital signs ~~every 5 minutes~~ until symptoms improve.
3. Chest pain- for patients exhibiting new onset of substernal chest pain and/or pain radiating to the neck, back, jaw or arms
    a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
    b. 12 lead E□G
    c. Supplemental oxygen via nasal cannula for saturations □ or = 90%
    d. Cardiac monitoring and cardiac rhythm interpretation
    e. Lab ER ~~Laboratory~~ Panel
    f. Chest x-ray 1 view
    g. Troponin-I High Sensitivity now and in 2 hours
    h. Notify LP.
    i. Vital signs ~~every 5 minutes~~ until symptoms improve.
4. Cardiac symptoms- for patients exhibiting signs and symptoms of symptomatic hypotension, arrhythmia or new onset of chest pain
    a. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.
    b. Immediately notify LP.
    c. Cardiac monitoring and cardiac rhythm interpretation
    d. 12 lead E□G
    e. Chest x-ray, 1 view

f. ~~ER Laboratory Panel~~Lab ER Panel (includes electrolytes)

g. Troponin-I High Sensitivity now and in 2 hours

h. Blood gas, venous

~~Electrolyte panel~~

i. Lactate Level

j. Vital signs ~~every 5 minutes~~ until symptoms improve or BP returns to baseline.

5. 2 Systemic Inflammatory Response Syndrome (SIRS): Temperature less than 96.8F or greater than 100.9F; HR greater than 90; RR greater than 20; WBC less than 4,000 or greater than 12,000 or Bands greater than 10% with suspected or confirmed infection (Adult)

   a. Adults: Initiate ED Triage Sepsis Adult power plan

   b. Lab ER panel

   c. Venous Blood Gas with ~~lytes and~~ lactate

   d. Blood cultures x 2

   e. Urinalysis with micro reflex to culture

   f. O2 via nasal cannula to keep O2 sat greater than 94%

   g. Insert peripheral intravenous (PIV) catheter and/or ensure patient has functioning PIV.

   h. Chest x-ray 1 view

   i. Notify LP.

   j. Vital signs until symptoms improve or BP returns to baseline.

   k. Discuss presence of existing urinary catheter with provider for further instructions.

B. **Documentation**

1. ~~**The ED or RR RN is responsible for ensuring complete documentation on all interventions selected from these standardized procedures in the EHR.**~~ The RR RN is responsible for ensuring complete documentation on all interventions selected from these standardized procedures in the electronic health record (EHR).

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/26/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/26/2025
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	2/26/2025
Protocol Author	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/14/2025

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Nursing Practice Protocols*
References:	

NPP.06 Diuretic Renal Scintigraphy

~~Policy:~~

~~To provide a guideline for the diagnostic use of radiopharmaceuticals and diuretics in evaluating overall renal function and/or obstruction.~~

~~Background:~~

~~Diuretic renal scintigraphy using radiopharmaceuticals and diuretic agents is indicated for patients who have reduced renal function due to known or suspected urinary tract obstruction.~~

~~TTc-99m-MAG3 (mercaptoacetyltriglycine) is one of the technetium radiopharmaceuticals used in renal imaging. It is indicated to assess renal perfusion, size, position, function, and upper urinary tract obstruction. It has a high extraction ratio into the kidney (40-50%) and is predominantly cleared via active tubular secretion (97%). The rate of appearance, excretion, and concentration of MAG3 in the kidney and bladder can be monitored to assess renal function. To minimize bladder exposure to radiation, adequate hydration before and after administration and frequent voiding for 4-6 hours post administration is recommended.~~~~[1-2]~~

Policy:

To provide a guideline and standardized procedure for the RN for the diagnostic use of radiopharmaceuticals and diuretics in evaluating overall renal function and/or obstruction.

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 3 and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

Functions to Be Performed:

Diuretic renal scintigraphy using radiopharmaceuticals and diuretic agents is indicated for patients who have reduced renal function due to known or suspected urinary tract obstruction.

Tc-99m-MAG3 (mercaptoacetyltriglycine) is one of the technetium radiopharmaceuticals used in renal imaging. It is indicated to assess renal perfusion, size, position, function, and upper urinary tract obstruction. It has a high extraction ratio into the kidney (40-50%) and is predominantly cleared via active tubular secretion (97%). The rate of appearance, excretion, and concentration of MAG3 in the kidney and bladder can be monitored to assess renal function. To minimize bladder exposure to radiation, adequate hydration before and after administration and frequent voiding for 4-6 hours post administration is recommended.[1-2]

Furosemide is a loop diuretic that inhibits reabsorption of sodium and chloride in the ascending loop of Henle and proximal and distal renal tubules, interfering with the chloride binding cotransport system, thus causing its natriuretic effect. By increasing urine flow rate, loop diuretics help distinguish between an obstructed or unobstructed ureter. This is based on the concept that an unobstructed system will clear radiopharmaceutical rapidly because of high urine flow following diuretic administration. Conversely, if an obstruction is present a high flow rate will not occur and a decrease in clearance of ureteral activity will be seen.[1,5]

Contraindications for the use of pharmacologic diuretics in renal scintigraphy:

- Anaphylaxis to furosemide
- Anuria
- If a patient has either of these contraindications, RN will notify physician for further orders.

Roles and Responsibilities:

See policy IS.32 Department of Nuclear Medicine Overview for roles of the imaging staff.

~~Procedures:~~

Intravenous catheter placement, monitoring and medication administration for this procedure will be completed by the RN. RNs will review and implement these functions whenever this type of exam is performed.

A. Scope of supervision required

   1. The RN performing this procedure is responsible and accountable to their Nursing Department Director.

   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

B. Requirements for the RN

   1. Active California RN license

   2. Life support certification: Basic (BLS), Advanced (ACLS), Pediatric (PALS)

   3. Special training: formal orientation to nuclear medicine

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 competency annually as part of the performance review process.

Procedures:

A. Order Placement

B. Patient Preparation

   1. Patient should not fast before the procedure.

   2. Chronic diuretic medications shall be held the morning of the study.

   3. Explain procedure to patient, and confirm patient understands process and purpose of this exam.

   4. Intravenous (IV) access shall be established using a 22-24 gauge cannula by the RN or imaging tech.

      a. For pediatric patients, consider applying an anesthetic cream on the potential venous access site

   ~~Patients should arrive well hydrated and receive an additional 5-10 mL/kg of oral fluids 30-60 minutes before the procedure~~

      ~~a. Pediatric patients who are unable to adequately hydrate with oral fluids should receive 15-20 mL/kg of IV fluids.~~

   ~~Patients should void bladder before radiotracer administration.~~

   ~~A bladder catheter should be inserted if it is anticipated the patient will have difficulty voiding.~~

C. Hydration

1. The patient should be instructed to increase fluid intake the day before and the morning of the examination while avoiding coffee, tea and other caffeinated beverages. An additional 12 ounces of fluid with each of the 3 meals totaling 1L is a reasonable goal. Patients should receive an additional 5-10 mL/kg of oral fluids 30-60 minutes before the procedure.
    a. IV fluids will be administered 30 to 60 minutes before procedure as follows:
        i. Adults: normal saline 10 ml/kg
        ii. Pediatrics: normal saline 20 ml/kg
2. Patients should void bladder before radiotracer administration.
3. A bladder catheter should be inserted by the RN if the patient is unable to void prior to radiotracer administration.

D. Radio-tracer agent and protocols shall be determined per Society of Nuclear Medicine and Molecular Imaging (SNNMI), European Association of Nuclear Medicine (EANM), and the American Society of Nuclear Medicine (ASNM) guidelines.

E. IV administration guidelines for diuretic agents in renal scintigraphy

1. Monitor for signs and symptoms of anaphylaxis.
2. ~~Administer~~RN to administer furosemide IV bolus on frame 20 of 40 after radiotracer injection. 1 frame = 1 minute.
3. Adult furosemide dose: 0.5 mg/kg or 40 mg
    a. Higher doses to a maximum (Max) of 80 mg may be administered in those patients with impaired renal function or on chronic diuretic use at home.
    b. Administer the IV push over 1-2 minutes.
4. Pediatric furosemide dose: 1 mg/kg (Max 40 mg)
    a. Pharmacy to dispense furosemide 2 mg/mL in ~~Dextrose 5% in water~~Normal Saline (~~D5W~~NS)
    b. Administer the IV push over 5 minutes.

Medications:

All medications shall be supplied and maintained by Pharmacy and given in conjunction with provider order.

Table 1 Medications and IV fluids (IVF) available in Nuclear Medicine for Diuretic Renal Scintigraphy

Medication and IVF	Dose	Comments
~~D5W or 0.9%~~ Normal Saline (NS)	Adults: ~~5-10~~10 mL/kg Pediatrics~~ 15-20~~: 20 mL/kg	Administer 30-60 minutes before the procedure.
Furosemide	Adults: 0.5 mg/kg or 40 mg (MAX 80 mg) over 1-2 minutes Pediatric: 1 mg/kg (MAX 40 mg) over 5 minutes.	Adults: furosemide is located in Pyxis. Pediatrics: contact pharmacy for compounded sterile product. Flush immediately after with 10 mL of NS.

Equipment:

Gamma Camera

Low energy high resolution collimator

~~References:~~

Documentation:

Document in patient chart the following:

A. IV site and assessment
B. Any additional indwelling devices, including urinary catheter
C. Any medications administered on the Medication Administration Record (MAR)
D. Patient's tolerance
E. Other details as appropriate.

References:

1. Board of Registered Nursing. Article 7. https://www.rn.ca.gov/pdfs/regulations/npr-i-19.pdf
2. Taylor, AT, Brandon, DC, Palma, DD, Blaufox, MD, Durand, E., Erbas, B.,...Morsing, A. (2018). SNMMI Procedure Standard/EANM Practice Guideline for Diuretic Renal Scintagraphy in Adults with Suspected Upper Urinary Tract Obstruction 1.0 Seminars in Nuclear Medicine, 48(4), 377-390.
3. Blaufox, MD, Palma, DD, Taylor, AT, Szabo, Z, Pregient, A, Samal, M,...Tulchinsky, M. (2018). The SNMMI and EANM practice guideline for renal scintigraphy in adults. European Journal of Nuclear Medicine and Molecular Imaging; 45(12), 2218-2228.
4. Housestaff Manual (12th ed.), (2015-2017). Palo Alto, CA: Lucille Packard Children's Hospital Stanford.
5. Majd, M, Bar-Sever, Z, Santos, AI, and Palma DD. (2018). The SNMMI and EANM Procedural Guidelines for Diuresis Renography in Infants and Children. Journal of Nuclear Medicine, 59(10), 1636-1640.
6. Lasix Oral (furosemide) - Sanofi (n.d.) Retrieved December 3, 2018 from http://products.sanofi.ca/en/lasix.pdf.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	4/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/12/2025

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/12/2025
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	3/12/2025
Protocol Author	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/12/2025

Current Status: *Draft* **PolicyStat ID:** *17633798*

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

Medical Staff Administration Late Fees and Fines

POLICY:

The intent of this document is to establish the process for the assessment of fees and fines for practitioners granted membership and/or privileges within the Ventura County Health Care Agency at the discretion of the Medical Executive Committee. Fees and fines include but are not limited to:

- Reappointment application late fees
- Delinquent medical record fines

PROCEDURE:

Reappointment Applications:

Medical Staff Administration shall provide each practitioner with a reappointment application at least 180 days prior to the expiration date of their appointment term. Completed reappointment applications and required forms shall be returned to Medical Staff Administration within 30 days from the date the application was electronically delivered. Reappointment applications submitted beyond this day will be assessed a late fee as follows:

- Applications submitted between 31-45 days will be assessed a $100 late fee.
- Applications submitted between 46-60 days will be assessed a $200 late fee.
- Applications submitted between 61-90 days will be assessed a $300 late fee.
- Applications submitted beyond 90 days will be assessed a $500 late fee.

Failure to submit a reappointment application in a timely manner may result in a lapse of membership and/or privileges.

Delinquent Medical Records:

Medical records must be completed within 14 days from the date of discharge for inpatients or patient encounter for outpatients (California Code of Regulations, 22 CCR § 70751). For failure to complete medical records within fourteen (14) days, a practitioner's clinical privileges (except with respect to his or her patients already in the hospital) and his/her rights to admit patients and to provide any other professional services shall be administratively suspended. The fines below will be assessed based on the number of accumulated suspension days within the calendar year:

- 30 days - $500

- 60 days - an additional $1000
- 90 days - an additional $2000

All assessed fines and/or late fees must be paid to be eligible for reappointment.

Exceptions:

Physicians with membership and/or privileges currently enrolled in a County of Ventura run fellowship or residency program will be exempt from fees, unless the MEC identifies a significant pattern of incomplete records suspensions impacting patient care and/or hospital billing in which the Medical Executive Committee may elect to impose a reduced fine.

Failure to Pay Dues or Fines:

If the member fails to pay required dues or fines within 30 days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. If after 60 consecutive days of suspension the member remains suspended, the member will be considered to have voluntarily resigned from the Medical Staff.

REFERENCE(S)

Medical Staff Bylaws Article 13.3.4 Medical Records

Medical Staff Bylaws Article 13.3.7 Failure to Pay Dues or Fines

107.061 Legal Health Record and Designated Record Set

AC.30 Timeliness of Documentation

VCBH Clinical Documentation Operational Guideline

DEFINITION(S):

Delinquent Medical Record- A medical record that has not been completed fourteen (14) or more days after the patient encounter.

All revision dates:

Attachments

No Attachments

Ventura County Medical Center

Delineation Of Privileges

Medicine Privilege List

Name:

Privilege	Requested	Granted
CATEGORY 1: This category includes those physicians who have successfully completed not less than three (3) years of approved residency training in Internal Medicine, Family Practice or equivalent sub-specialty training appropriate to clinical practice. These physicians should be either board certified or board admissible in their specialty area. Such physicians should seek consultations when: a. diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness; b. unexpected complications arise which are outside their level of competence; c. specialized treatment or procedures are contemplated with which they are not familiar Specific area in which privileges are requested:	___	___
Dermatology	___	___
Internal Medicine	___	___
Neurology	___	___
CATEGORY 2: This category includes those physicians who have successfully completed not less than three (3) years of graduate medical education in an approved internal medicine residency, and in addition, are considered sub-specialists in that they have additional education and a high level of competence in a given field or equivalency. They are qualified to act as consultants and should, in turn, request consultation whenever needed. These physicians must be either board certified or board admissible in their sub-specialty area. Sub-specific area in which privileges are requested:	___	___
Allergy/Immunology	___	___
Cardiology	___	___
Endocrinology & Metabolic Diseases	___	___
Gastroenterology	___	___
Geriatric Medicine	___	___
Hematology	___	___
Infectious Diseases	___	___
Nephrology	___	___
Oncology	___	___
Pulmonary Diseases	___	___
Rheumatology	___	___
Other: ___________________________________	___	___
CATEGORY 1 PRIVILEGES:		
Admit patients to the hospital; includes history and physical examination	___	___
Treat patients in the hospital, Emergency Department & outside clinics	___	___
Osteopathic Manipulative Treatment (OMT)	___	___
Laser Tattoo Removal INITIAL CRITERIA: Documentation of 1 hour training with dermatologist	___	___
Consultations only	___	___

Ventura County Medical Center

Delineation Of Privileges

Medicine Privilege List

Name:

Privilege	Requested	Granted
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 the volume is not met, the next case evaluated	___	___
Adult deep sedation in the ICU/CCU/Interventional Radiology **(Request on Critical Care/Radiology Privileges)** INITIAL & RENEWAL CRITERIA:documentation of current ACLS, module completion w/minimum score of 80%	___	___
Bone marrow aspiration	___	___
Bone marrow biopsy	___	___
Abdominal paracentesis	___	___
Lumbar puncture	___	___
Arthrocentesis	___	___
Fine needle aspiration biopsy of thyroid	___	___
Insert central venous catheter	___	___
Insert arterial catheter	___	___
Insert thoracostomy tubes	___	___
Post gastric feeding tube placement	___	___
Percutaneous aspiration of organ, mass lesion, arterial venous cannulization, including PICC placement with fluoroscopy/CT or ultrasound	___	___
Suprapubic bladder taps	___	___
Thoracentesis	___	___
Venous cutdowns	___	___
I & D – abscesses, cysts and hematomas	___	___
Culdocentesis	___	___
Direct laryngoscopy	___	___
Flexible sigmoidoscopy	___	___
Rigid sigmoidoscopy	___	___
Endotracheal intubation	___	___
Monopolar hemorrhoid management	___	___
Parenteral hyperalimentation	___	___

Delineation Of Privileges

Medicine Privilege List

Name:

Privilege	Requested	Granted
Admit and treat patients in the ICU/CCU **(Request on new Critical Care Privileges)** EVALUATION CRITERIA: Refer to ICU Focused Professional Practice Evaluation criteria	___	___
Consult and treat patients in the ICU	___	___
Resuscitation and stabilization of SPH critical patients pending transfer to a higher level of care to include but not limited to ventilator management, management of vasopressors and sedative drips, management of arrhythmias, shock and other emergent case	___	___
Bedside ultrasound in urgent or emergent conditions (Refer to *Screening ultrasound by ICU Physicians*)	___	___
Management of patients in respiratory failure requiring ventilator assistance for less than 48 hours	___	___
Admit patients for observation of suspected cardiac disease	___	___
Management of uncomplicated myocardial infarctions	___	___
Management of chemotherapy	___	___
WAIVED TESTING		
Rapid STREP A Test	___	___
Amnio Test	___	___
Dipstick for Urine	___	___
Urine Pregnancy Test	___	___
Fecal Occult Blood by Hemoccult	___	___
PROVIDER-PERFORMED MICROSCOPY (PPM) CRITERIA: Annual competence assessment required		
Wet mount for presence/absence of bacteria, fungi, parasites and human cellular elements; KOH preparations, urine sediment examinations	___	___
PERFORM AND INTERPRET THE FOLLOWING CARDIAC NON-INVASIVE STUDIES:		
ECG	___	___
Treadmill Stress Test	___	___
Holter ECG	___	___
DERMATOLOGY PROCEDURES		
Cryosurgery	___	___
Skin biopsies	___	___
FLUOROSCOPY PROCEDURES FOR: CRITERIA: Fluoroscopy certificate required,		
Gastrointestinal Procedures	___	___
Cardiac Procedures	___	___
Pulmonary Procedures	___	___
CATEGORY 2 PRIVILEGES:		

Delineation Of Privileges
Medicine Privilege List

Name:

Privilege	Requested	Granted
PERFORM AND INTERPRET THE FOLLOWING CARDIAC NON-INVASIVE STUDIES:		
Echocardiogram with/without intravenous saline contrast	___	___
Perform and interpret neurologic non-invasive graphic studies CRITERIA: must be proficient in EEG, EMG and nerve conduction velocity studies	___	___
Angiography	___	___
Insert Swan-Ganz flotation catheter	___	___
Pericardiocentesis	___	___
Elective Cardioversion	___	___
Placement of transvenous temporary pacemakers	___	___
Placement of transcutaneous temporary pacemakers	___	___
Pleural biopsy	___	___
Lung biopsy	___	___
Kidney biopsy	___	___
Liver biopsy	___	___
Bronchoscopy with/without biopsy	___	___
Esophagogastroduodenoscopy with/without biopsy CRITERIA: must request Adult Procedural Sedation, complete module & submit documentation of current ACLS	___	___
Colonoscopy with/without biopsy CRITERIA: must request Adult Procedural Sedation, complete module & have current ACLS	___	___
Polypectomy	___	___
ERCP with/without biopsy CRITERIA: Current Fluoroscopy certificate required	___	___
ERCP with/without spincterotomy CRITERIA: Current Fluoroscopy certificate required	___	___
Esophageal dilation	___	___
Endoscopic Ultrasound	___	___
pH Probe placement and interpretation	___	___
Peritoneoscopy	___	___
Percutaneous endoscopic gastrostomy (PEG)	___	___
Esophageal manometry with interpretation	___	___
Management of patients in respiratory failure requiring assisted ventilation greater than 48 hours CRITERIA: must be able to perform endotracheal intubations and insert chest tubes	___	___
Management of peritoneal dialysis in patients with renal failure	___	___
Management of hemodialysis inpatients with renal failure	___	___

Delineation Of Privileges

Medicine Privilege List

Name:

Privilege	Requested	Granted
Management of plasmapheresis in patients requiring plasmapheresis	___	___
Manage complicated cardiac arrhythmias CRITERIA: Elective cardioversion & temporary pacemaker placement privileges required	___	___
Manage cardiogenic shock and/or severe heart failure	___	___
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 Medicine Date		

Current Language	Proposed Change
Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations?	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?