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

August 14, 2025

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

1. EVS.03 Patient Room Cleaning
2. 107.089 Responding to Law Enforcement Requests for Information

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Ventura County Health Care System Oversight Committee
Administrative Policies - August 14, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	EVS.03 Patient Room Cleaning	Trienniel	Added wall box cleaning instructions. Other minor edits.
2	107.089 Responding to Law Enforcement Requests for Information	Trienniel	-Added definition section -Addressed what to do if officer does not provide ID information

Status **Active** PolicyStat ID **18199129**

VENTURA COUNTY HEALTH CARE AGENCY

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Effective	5/20/2025
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Owner	Fernando Medina: Director, Support Services
Policy Area	Environmental Services

EVS.03 Patient Room Cleaning

POLICY:

To ensure standardize disinfecting and thorough patient room cleaning, to fight hospital acquired infections. By eliminate dust, and bioburden for the prevention of the spread of infection.

PROCEDURE:

The following steps should be taken when cleaning patient rooms:

1. Enter patient room and observe the room from ceiling to floor, including the walls. **If the room is occupied, do NOT complete high dusting.**
    A. Remove trash, clean trash receptacles when visibly soiled, and replace liners.
    B. Refill paper towel, soap, and alcohol-based hand sanitizer dispensers when they are empty or near empty.
    C. Install new batteries each time the refill is changed on the soap and alcohol-based hand sanitizer dispensers.
    D. Dust ceiling to floor with dry duster mop, including vents, walls, corners of room, and baseboards.
    E. Dust light fixtures and television.
    F. Dust window frames and sills. Clean windows as needed.
    G. First dust and then clean furniture with hospital approved cleaner-disinfectant. Allow to air dry.
    H. Ensure that furniture is in the correct layout.
    I. Spot clean walls and wash with hospital approved cleaner-disinfectant. Allow to air dry.

J. Check light switches and other high touch areas.

K. First dust and then wipe blinds with a hospital approved cleaner; leave in down position.

L. Check patient's curtains for cleanliness and make sure all hooks are attached.

M. Check and clean patient closet.

N. Clean bed, including mattress, frame, rails, remote control, head board, foot board, wheels, reusable pillows, and any attachments as per Policy EVS.01 Bed Cleaning using a hospital approved cleaner-disinfectant.

O. Dust mop the floor, then mop with hospital approved cleaner-disinfectant. Leave wet floor sign up until floor is dry.

P. Patient rooms equipped with a hemodialysis wall box shall be cleaned and disinfected with an EPA-registered, hospital approved cleaner/disinfectant.

    1. The wall box shall be cleaned daily, after each discharge, or when visibly soiled.
    2. Any wipes used to disinfect the wall box should be discarded after use and not used to disinfect other surfaces in the patient room.

- Complete daily cleaning of all high touch surfaces to include windows, window sills, counters, hand rails, sinks, shower, toilets, paper towel dispenser, phones, light switch panels, door handles, push plates and bed side tables.
- Multiple cleaning wipes or microfiber towels should be used in the cleaning of each patient room.
- Any malfunctioning equipment such as cracked, broken, split coverings of mattresses and upholstery, plumbing problems in the housekeeping closets must be immediately reported to the Housekeeping Supervisor. The Supervisor will then submit a work order to Facilities Maintenance for repairs and continue to monitor the work orders until they are repaired.
- The Housekeeping Supervisors and Leads will conduct surveillance for compliance with Housekeeping policies and procedures.
- Specific instructions/checklists (example - Bed Cleaning) can be obtained in the Department's Binder.

All Revision Dates

5/20/2025, 9/6/2024, 8/11/2021, 3/1/2013, 11/1/2012, 6/1/2012, 2/1/2009, 12/1/2008, 11/1/1992

Approval Signatures

Step Description	Approver	Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/20/2025
Infection Prevention	Magdy Asaad: Infection Prevention Manager	5/19/2025
Housekeeping Manager	Michael Lopez: Supervisor, Environmental Services	5/19/2025
Housekeeping Manager	Fernando Medina: Director, Support Services	5/19/2025

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VENTURA COUNTY HEALTH CARE AGENCY

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107.089 Responding to Law Enforcement Requests for Information

PURPOSE:

This policy provides guidance on how to process a request for information from law enforcement.

POLICY:

Ventura County Medical System has legal obligations to restrict access to non-public areas and protect confidential information while caring for its patients. Staff shall notify the house supervisor or clinic administrator of the arrival of and any request (including subpoenas, petitions, complaints, warrants, or court orders) by any Law Enforcement Officer to access a health care facility or a patient, or any request for the review of facility documents.

DEFINITIONS:

Non-public area: Areas not accessible to the general public without special permission such as patient rooms, treatment rooms, hallways, conference and meeting rooms not available for general public use, staff offices and cubicles not open to the general public, including all areas that require badge access and all areas identified as non-public or private areas with signage.

Public area: Areas accessible to the general public without special permission such as lobbies, reception areas, hallways open to the general public and not requiring badge access, public parking lots and sidewalks, and similar areas.

Subpoena: A document issued by a government agency seeking documents or evidence.

Warrant:

A. **Administrative Warrant**
A type of authorization issued by an administrative official - which may include an immigration judge or Immigration and Customs Enforcement Field Office Director - to perform a specific act, for example, to arrest an individual. This warrant may state that it was issued by an "immigration judge," and "administrative law judge," or "immigration office." This warrant does not confer authority to enter private spaces to make an arrest. This warrant does not carry the same authority as a criminal search warrant or criminal arrest warrant.

B. **Judicial Warrant:**
A type of authorization issued by a federal or state judge or other judicial official that gives authority to perform a specific act, for example, to conduct a search, to seize documents or to arrest an individual. This type of warrant is based on a showing of probable cause related to a violation of law and states that it was issued by a District Court Judge, Magistrate Judge or Superior Court Judge.

PROCEDURE:

A. Staff Responsibilities

1. Advise the Law Enforcement Officer that before proceeding with his or her request, staff must first notify and receive direction from the House Supervisor or Clinic Administrator.
2. Ask to see and note the Officer's credentials (name and badge number).
    a. If the individual refuses to provide identification, make a note and contact Security in addition the House Supervisor or Clinic Administrator.
3. Call paging to contact the House Supervisor or Clinic Administrator.
4. Ask the Officer to wait in the main lobby until the House Supervisor or Clinic Administrator arrives.
5. Decline to answer questions posed by the officer and direct him or her to speak to the House Supervisor or Clinic Administrator.
6. If the Officer orders staff to provide immediate access to the hospital or clinic, staff shall make clear their objection to the Officer's conduct but **not attempt to physically prevent entry (such as blocking the officer with your body or trying to restrain the Officer)**. If an Officer enters the premises without authority, staff shall simply document the Officer's actions while at the facility and report to the House Supervisor or Clinic Administrator.
7. Staff should complete an incident report that includes the information gathered as described above and the Officer's statements and actions.

B. House Supervisor and Clinic Administrator Responsibilities

1. Greet the Officer in the main lobby.
    a. If identification has not already been provided, ask for it again.
2. Ask the Officer to explain the purpose of the officer's visit and note the response.

3. Ask the Officer to produce any documentation that authorizes health care facility access.
4. Make copies of all documents provided by the Officer.
5. State that the facility does not consent to entry of the hospital or clinic or portions thereof and provide a copy of this policy to the Officer.
6. Without expressing consent, respond according to the requirements of the Officer's documentations. If the Officer has:
    a. An administrative warrant: Immediate compliance is not required. Inform the officer that the facility cannot respond to the warrant until after it has been reviewed by County Counsel. Provide a copy of the warrant to the Administrator on Duty (AOD) and County Counsel as soon as possible.
    b. A judicial warrant (either a search-and-seizure warrant or an arrest warrant): Prompt compliance usually is required, but, where feasible, consult with the AOD and County Counsel before responding.
    c. A subpoena for production of documents or other evidence: Immediate compliance is not required. Inform the officer that the facility cannot respond to the subpoena until after it has been reviewed by County Counsel. Give your copy of the subpoena to the AOD and County Counsel as soon as possible.
    d. A notice to appear: This document is not directed at the health care facility. Staff is under no obligation to deliver or facilitate service of this document to the person named in the document. If you get a copy of the document, give it to AOD and County Counsel as soon as possible.
7. Document the Officer's actions in as much detail as possible when he or she enters facility premises, but without interfering with the Officer's movements.
    a. If the Officer does not provide documentation of identity, authority or a legal requirement for their presence, ask them to leave the building.
8. If the Officer orders immediate access to the hospital or clinic without proper authority, the House Supervisor or Clinic Administrator shall make clear their objection to the officer's conduct but **not attempt to physically prevent entry (such as blocking the Officer with your body or trying to restrain the Officer)**. If an Officer enters the premises without authority, the House Supervisor or Clinic Administrator shall simply document the Officer's actions while at the facility and provide report to the Administrator on Duty and County Counsel.
9. If the Officer requests the location of a patient in the Inpatient Psychiatric Unit, Crisis Stabilization Unit, a patient receiving substance abuse detoxification or other "non-directory" patients, respond that no information is available about that individual. If the Officer requests the location of a patient by name who is in the hospital's patient directory, the patient's room number may be provided.
10. The House Supervisor or Clinic Administrator shall complete an incident report that includes the information gathered as described above and the officer's statements and actions.

C. Relevant Policies:

1. 100.011 Hospital Visitation
2. 100.019 Release of Patient Information
3. 109.030 Use and Disclosure of Protected Health Information Required by Law
4. 109.041 Verification of Identity and Authority of Persons or Entities Requesting Protected Health Information

All Revision Dates

7/1/2025, 2/3/2025

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Marisela Luna: Program Administrator	Pending
Ventura County Medical System Administration	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	7/11/2025
Ventura County Medical System Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	7/11/2025
Ventura County Medical System Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	7/11/2025
Ventura County Medical System Administration	Vikram Kumar: Chief Executive Officer, Ambulatory Care	7/8/2025
Policy Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	7/1/2025

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Document Approvals

July and August 2025

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b. Medical Staff Forms

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Vibha Gune: HIM Manager*
Policy Area:	*Administrative - Patient Care*
References:	

100.018 Confidentiality of Medical Records

POLICY:

It is the policy of the Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to preserve the confidentiality of medical records and to adopt guidelines for their safeguard and proper release.

PROCEDURE:

The primary health record is a patient-identifiable compilation of information created and maintained by the health care institution to document the care and services delivered to an individual patient by health care professionals. Persons receiving health care services have a right to expect that the confidentiality and privacy of individually identifiable medical information of or derived by health service providers will be reasonably preserved. The Confidentiality of Medical Information Act, 1982, governs the release of patient-identifiable information by hospitals and other health care providers. The Act establishes protection to preserve the confidentiality of medical information and specifies that a health care provider may not disclose medical information or records unless the disclosure is authorized by the Confidentiality of Medical Information Act, by other laws, or by the patient in accordance with the requirements set forth in the Act.

In accordance with the federal standards for privacy of individually identifiable health information (also known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rule), patients will be given written notification concerning the uses and disclosures of protected health information that may be made by the Hospital, as well as the individual rights, and the Hospital's legal duties with respect to protected health information. All releases of health information will be made in compliance with HIPAA regulations.

Ownership/Safeguards

The medical record is the property of the Ventura County Health Care Agency. Title 22, California Code of Regulations Section 70751(b) for general acute care hospitals and Section 71551(b) for acute psychiatric hospitals provides:

"The medical record, including x-ray film, is the property of the hospital and is maintained for the benefit of the patient, the medical staff, and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons."

Release of Medical Information

The hospital may release medical information only in accordance with the 1982 Confidentiality of Medical

Information Act, Lanterman-Petris-Short Act, HIPAA regulations on patient privacy and use of health information, and other applicable state and federal guidelines, statutes and laws (see Administrative policies 100.019 and 100.020).

Custodian of Records

It is the policy of VCMC/SPH that no original record will be removed from hospital jurisdiction (this would allow "removal" from the hospital proper to the clinics) except in compliance with a subpoena duces tecum, court order or state statute. A certified copy of the record shall be submitted whenever possible. In orders where only the original record will be accepted, only the Custodian of Records (or his/her designee) shall accompany the record to the place of hearing. In the event an original is requested by any court of law, a complete certified copy of the medical record will be offered to the court. If the court ~~insists upon retaining~~orders that they retain the original, the copy will be retained by VCMC until the original is returned.

Internal Controls

All inpatient and Ambulatory Clinic medical records shall be maintained in ~~a~~an agency approved Electronic Health Record (EHR) under the control of the Custodian of Records or designee. Only authorized personnel shall be allowed access to these records.

All authorized employees shall have on file an "Oath of Confidentiality- Workforce Confidential Agreement" as a condition of employment. (See security policy #109 for definition of authorized employees)

Records shall primarily be requested for the purpose of planning and documenting patient care, and secondarily for the purpose or use of a legal document, a research tool and a record of medical services and treatment provided as a document to transact normal hospital business for revenue, cash flow and evidence of the quality of care delivered.

Access to computerized medical information shall be limited by the Systems Manager to only those people who need access to those specific portions of the record to carry out their defined job description or patient care assignment.

All revision dates: 4/22/2025, 11/10/2021, 12/1/2013, 5/1/2006, 7/1/2004, 9/1/2001, 7/1/1990, 10/1/1989, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/30/2025

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/23/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/22/2025
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VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.035 Investigational Drugs and Devices

POLICY:

In order to meet the federal requirements for institutional review of investigational drugs and devices treatments, the Institutional Review Board (IRB) of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) is organized according to the Federal Guidelines.

PROCEDURE:

VCMC/SPH shall establish and update as necessary policies and procedures of the IRB, including the Membership Roster and Statement of Purpose. This Medical Staff Committee shall meet on call.

All investigational studies at VCMC/SPH must be reviewed by the IRB prior to initiation.

A. All patients asked to participate in an investigational research project are given a description of the expected benefits, potential discomforts, risks, alternative services and a full explanation of procedures to be followed.

B. All patients are told that they may refuse to participate and refusal will not compromise their access to service.

C. The treatment will be under supervision of the principle investigator who is a member of the VCMC/SPH Medical Staff and is responsible for ensuring informed consent is obtained from the patient.

Also see Administrative Compliance Policy 109.025 Use and Disclosure of Protected Health Information for Research Activities.

All revision dates: 8/9/2022, 5/31/2017, 7/1/2012, 5/1/2006, 7/1/2001, 10/1/1986

Attachments

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Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/25/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
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VENTURA COUNTY HEALTH CARE AGENCY

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

100.063 Registration of Patients with Unknown Identity

POLICY:

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

The same process can also be used for the following:

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

PROCEDURE:

A. Registration for trauma patients with unknown identity will be created using the quick registration function. Patients registered through this process will be assigned a pseudo date of birth (DOB) of 1-1-1900 ~~and~~for adults and 1-1-2020 for pediatrics, and use a fictitious naming convention ~~of **last name:** TRAUMA and a number ONE through NINETY-NINE (example TRAUMAONE) and **first name:** arbitrary name. When choosing a name, the registrar will ensure there are no preexisting encounters with the last name to be used.~~

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

1. For Tier 1 Traumas:
    a. **Last name:** a number ONE through NINETY-NINE and TRAUMA (example ONETRAUMA) and **first name:** arbitrary name.
2. For all other Traumas:
    a. **Last name:** TRAUMA and a number ONE through NINETY-NINE and TRAUMA (example TRAUMAONE) and **first name:** arbitrary name.

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

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

C. After the Patient Access Department has been made aware of any of the previously listed circumstances, they will immediately register the patient through the registration system. The physician's orders can then be immediately processed. Labels and a wrist band will be generated. The patient's nurse shall place the wristband and blood band identification on the patient.

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

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

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

See also policy *100.088 Patient Identification*.

All revision dates: 4/10/2025, 2/24/2025, 10/11/2022, 6/1/2016

Attachments

No Attachments

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Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/30/2025
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
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VENTURA COUNTY
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References:	

100.067 Human Immunodeficiency Virus (HIV) Testing Consent

POLICY:

California law establishes special requirements regarding consent to HIV tests and the disclosure of HIV test results in the Emergency Department (ED). An "HIV test" is defined to mean any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV (Health and Safety Code Section 120775c).

When an HIV test is ordered by a provider who is treating a patient in the Emergency Department, the law requires that: (a) the patient be informed that an HIV test is planned, (b) the patient be provided information about the HIV test, (c) the patient be informed that there are numerous treatment options available for patients who test positive and that a person who tests negative for HIV should continue to be routinely tested, (d) the patient be advised that he or she has the right to decline the HIV test, and (e) if the patient declines the HIV test, the declination should be documented in the medical record.

PROCEDURE:

1. When an adult patient presents to the ED, he or she will be offered the HIV test as a part of the initial blood work ordered by ED provider.
2. Prior to obtaining the blood specimen, the nurse shall:
   a. advise the patient that the test shall be obtained as a part of the initial blood work and that the patient has the right to decline the test.
   b. provide the patient with the HIV handout which includes information and resources about the test as well as treatment options should the test be positive.
   c. document in the patient's medical record a declination of the HIV test should the patient decline.
3. The patient should be informed that they will receive no follow-up if the HIV test is negative and that the Department of Public Health will contact him or her if a positive HIV test result is obtained.
4. The patient should be asked if they have had a test within the past 30 days. HIV testing should not be done during the current ED visit if the patient has been tested within the last 30 days.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/25/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025

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100.084 Use of Color-Coded Patient Wristbands

POLICY:

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) has a standardized process in place to identify and communicate patient-specific risk factors or special needs with the use of color-coded wristbands.

PROCEDURE:

VCMC/SPH has adopted the use of color-coded patient wristbands in order to:

- Reduce confusion regarding patient-specific care issues by adopting the use of color-coded wristbands standardized throughout California hospitals.
- Communicate patient safety risks to all health care providers throughout the facility.
- Include the patient, family members and significant others in the communication process and promote safe patient care.
- Adopt the following risk-reduction strategies:
  - A preprinted written descriptive text is used on the bands that clearly states the meaning (e.g., "Allergy," "Fall Risk" or "DNR").
  - No handwriting is used on the wristbands.
  - Color-coded wristbands may only be applied or removed by a hospital staff member as instructed by the primary Registered Nurse (RN) caring for patient.
  - When a color-coded wristband is applied, the patient/family/visitor are educated regarding the wristband message.

COLOR-CODED WRISTBAND DEFINITIONS:

- **Purple** wristbands shall be used to identify patients with a "Do Not Resuscitate" (DNR) order written in the medical record in accordance with hospital policy. The letters "DNR" shall be embossed/printed on the wristbands.
- **Red** wristbands shall be used to identify patients with allergies. The list of allergies should be written in the electronic health record (EHR) in accordance with hospital policy. Allergies should include allergies to medication(s), food, environmental allergens or other substances that may cause an allergic reaction in the patient. The letters "ALLERGY" shall be embossed/printed on the wristband.
- **Yellow** wristbands shall be used to identify patients with a risk of falling. Persons with a history of previous falls, dizziness or balance problems, fatiguability or confusion about their current surroundings should be assessed for potential fall risk. The letters "FALL RISK" shall be embossed/printed on the

wristbands. All patients should be assessed upon admission and at least every 12 hours thereafter.
~~**Orange** wristbands will be placed on all 5150 holds in the Emergency Department (ED) awaiting placement with psychiatric services.~~
~~**Green-and-white striped** wristbands will be placed on all voluntary patients awaiting placement with psychiatric services.~~

- **Pink** wristbands will be placed on those visiting patients in OB (Obstretrics), PEDS (Pediatrics) or NICU (Neonatal Intensive Care Unit) by staff at the main entrance information desk.
- **Blue** wristbands will be placed on those who are visiting patients in other areas of the hospital besides OB/PEDS/NICU by staff at the main entrance information desk.
- **Solid green** wristbands will be placed on all vendors by staff at the main entrance information desk or at Vendormate, the self-registering vendor kiosk.
- **Teal** wristband shall be used to identify patients that have been cleared by physical therapy to ambulate. The letters "Screened" will be embossed/printed on the wristbands.

Application of color-coded wristbands on patients: During the initial patient assessment, data is collected to evaluate the needs of the patient and a plan of care unique to the individual is initiated. Throughout the course of care there is ongoing reassessment, which may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors about the patient. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified. Assessment of potential risk is an interdisciplinary process. It is important to identify the staff members responsible for applying and removing color-coded wristbands, and the appropriate documentation needed and how it is communicated.

Only the RN performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands should be used for all patients with these conditions, including all inpatient and ED patients. *The RN performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment, and place the appropriate color–coded wristband on the patient.*

- The determination of a "DNR" order must be consistent with Hospital policy and must be documented in the patient's electronic health record (EHR) prior to placing the purple DNR wristband on the patient.
- Handwriting is not permitted on color-coded wristbands.
- *All color-coded wristbands shall be placed on the same wrist as the patient identification wristband.*
- If labels, stickers or other visual cues are used to document allergies, fall risk or DNR in the record, the stickers should correspond to wristband color and text.
- Upon application of the color-coded wristband, the RN shall instruct the patient and family member(s), if present, that the wristband is not to be removed.
- In the event that any color-coded wristband(s) must be removed for a treatment or procedure, *an RN will remove the wristband(s)*. Upon completion of the treatment or procedure, risks shall be reconfirmed, and new wristband(s) immediately *reapplied by the RN*.

Patient/Family Involvement and Education

- Staff should assist and encourage the patient and family member(s) to be active partners in the care provided and safety measures being used.
- The RN should teach all patients and family members to notify the RN whenever a wristband has been removed and is not reapplied, or when a new band is applied and they have not been given an explanation as to the reason.
- When applying a color-coded wristband(s) to a patient, the RN shall educate the patient and family member(s) about the meaning of the wristband(s) applied, risks associated with wearing social cause wristbands in the Hospital, and their role in the use of color-coded wristbands.

- During assessment of the patient, the RN shall educate and re-educate the patient and family members about the meanings of the color-coded wristband(s) applied, the risks associated with wearing social cause wristbands and why they are asked to remove them, and to notify the RN if color-coded wristband condition(s) have changed.

Hand–Off in Care

- The RN shall reconfirm that the color-coded wristbands are consistent with the documentation in the EHR before invasive procedures, *at transfer and during changes in level of care*.
- The RN shall also confirm this information is consistent with the knowledge of the patient, family members or other caregivers and what is in the patient's chart. Errors are corrected immediately.
- **Color-coded wristbands are not removed at discharge.** For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should follow their own policies and procedures for the banding process.

DNR (Do Not Resuscitate)

- DNR status and all other risk assessments are determined by Hospital policy and/or physician order in the EHR and acknowledged within that care setting only.
- The purple wristband serves as an alert and does not take the place of an order. DNR orders must be written and verification of advance directives must occur.

Nursing and Medical Staff Education

- Staff education regarding color-coded wristbands shall occur during the new orientation process, and reinforced as indicated during annual updates, unit in-services and staff meetings.

Patient Refusal

- If the patient is mentally competent and refuses to wear a color-coded wristband, an explanation of the benefits of wearing the color-coded wristband and the risks of not wearing the wristband will be provided to the patient. The RN will reinforce that this is an opportunity to participate in efforts to prevent errors, and it is his/her responsibility as part of the team.
- The nurse will document the patient refusal in the EHR, as well as the explanation provided by the patient.

Surrogate Decision-Maker

- If the patient is not mentally competent, an appropriate surrogate decision-maker will be selected to make decisions on the patient's behalf, pursuant to hospital policy.

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100.086 Rapid Response Team

POLICY:

The rapid assessment, treatment and stabilization of patients is essential to prevent respiratory and cardiovascular collapse and arrest. The purpose of this policy is to help staff identify pre-arrest states and activate the Rapid Response Team if needed.

PROCEDURE:

If a patient exhibits hemodynamic, respiratory or neurologic instability or deterioration (see specific criteria below) or when there is concern about a patient, health care staff shall activate the Rapid Response Team (RRT).

Calling the RRT:

When a patient is deteriorating, the primary Registered Nurse (RN) will activate the RRT by calling:

- Ventura County Medical Center (VCMC) – "7-6666"
- Santa Paula Hospital (SPH) – "7-8666"

The role of the RRT is to help with the following:

- Assess situation and condition.
- Stabilize the patient.
- Transfer the patient, if necessary.

If the primary RN (or patient/family) are concerned for the patient's condition, but signs and symptoms may not warrant immediate RRT, the primary RN may call the Rapid Response Nurse to assist with assessment. The Rapid Response RN will determine the need for the RRT activation upon assessment.

The Rapid Response RN can be reached via Tiger Text or at 805-515-8212 (##8212)

RRT Members are Advanced Cardiovascular Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certified.
RRT Team Members include:

A. VCMC (adult inpatients):
    - Rapid Response RN
    - Respiratory Therapist

- ICU attending Licensed Practitioner (LP) when in house
- Designated ICU resident
- Nursing supervisor and ICU charge nurse can attend if able but are not required.

B. VCMC (pediatric patients):
   - Rapid Response RN
   - Pediatric Intensive Care Unit (PICU) attending (when in house)
   - Pediatric/PICU Charge RN
   - Respiratory Therapist
   - Nursing supervisor can attend if able but is not required.

C. For Inpatient Psychiatric Unit (IPU) and outpatient areas, the team will include the addition of the ED RN

D. SPH: Nursing Supervisor, Respiratory Therapist and Emergency Department (ED) attending LP

Contact Nursing supervisor to designate a critical care RN to respond to the overhead page if a RRT RN is not available.

Criteria for Rapid Response Team Activation

A. Adults
   - Code Sepsis criteria
   - Heart rate <50 bpm or >130 bpm
   - Systolic blood pressure <90 mm Hg or acute changes >180 mm Hg
   - Respiratory rate <10 or >24
   - SaO2 <90%,increasing oxygen requirements or change in respiratory status
   - Acute significant bleed including postpartum hemorrhage
   - Failure to respond to therapy
   - Acute change in mental or neurologic status
   - Seizures, including eclamptic
   - Change in level of consciousness
   - New onset or increased weakness
   - Loss of pulse in extremities
   - New onset chest pain
   - Concerned staff or family member

B. Pediatrics
   - Acute change in mental or neurologic status
   - SaO2 <90%,increasing oxygen requirements or change in respiratory status
   - Seizures, unresponsive to previously ordered medications
   - Acute hemodynamic instability

- If PEWS score 3 or greater, activate RRT (see policy P.36 Pediatric Early Warning System (PEWS) Scoring):
  - For a PEWS score of 3, consult with PICU charge nurse
  - For a PEWS score of 4, notify Resident and/or Attending
  - For a PEWS score of 5 or greater, request evaluation at bedside by Resident or Attending, notify PICU attending
- Concerned staff or family member

Duty of the RRT RN:

A. The acting RRT RN will respond to the following overhead codes:
   - Rapid Response
   - Code Sepsis
   - Code Stroke
   - Code Blue
   - Code White
   - Code Telemetry
   - Trauma tier 1 and 2
   - Code Maternity

B. When the RRT is called overhead, the ICU charge nurse will respond ONLY if requested by the RRT nurse or acting in their stead.
   - The acting RRT RN may be required to document the event and outcomes on the RRT documentation record or can delegate this responsibility to another team member.
   - If the RRT RN phone is called without activating an RRT code, the acting RRT RN will assess the patient and document on the RRT documentation record

C. During and after the rapid response event, the rapid response nurse will discuss the case with the Senior resident and the medicine attending for DOU upgrades or Senior resident and ICU attending for ICU upgrades. The discussion will be documented in the rapid response nurse documentation record.

Magnetic Resonance Imaging (MRI)

Refer to policy 100.055 Code Blue - Adult Medical Emergency for process.

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/27/2025
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100.099 Safe Patient Movement and Handling

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) is committed to providing a safe and healthy work environment for all staff and patients. As part of VCMC's Injury and Illness Prevention Program (IIPP), the Safe Patient Movement and Handling policy has been implemented to improve the safety of our patients and healthcare workforce and to assure compliance with California Code of Regulations (CCR) Title 8, Section 5120, *Health Care Workers' Back and Musculoskeletal Injury Prevention* .

Safe Patient Movement and Handling provides methods or combination of methods, as required, to replace manual lifting and transferring of appropriately identified patients with powered transfer devices, lifting/ repositioning devices, or a lift team consistent with the professional judgment and clinical assessment of the Registered Nurse (RN).

Hospital staff will use appropriate handling, mobility techniques, mechanical, non-mechanical, and transfer aids or devices in accordance with education, training, and manufacturer's instructions and guidelines. Staff will refrain from manual lifting methods for safe patient handling tasks and mobility in all but exceptional or life threatening situations.

Applicable Staff /Areas

Safe Patient Movement and Handling is applicable to all VCMC/SPH employees and contract workers whose job tasks require direct, hands-on patient care. This policy is applicable at all times and for all patient care units for appropriately identified patients. It does not apply where purposeful therapeutic interventional mobility training is being performed by physical or occupational therapists or is part of the therapeutic interventions/ therapeutic carry-over of mobility techniques.

PROCEDURE:

Applicable Tasks

The tasks covered by this policy may include, but are not limited to, the identified five (5) Areas of Body Exposure per California's Safe Patient Handling and Mobility legislation [Assembly Bill (AB) 1136].

- Vertical - lifting a patient (i.e., bed to chair/wheelchair, commode, etc., return; floor to bed/stretcher/chair).
- Lateral - transferring a patient from one flat surface to another (i.e., bed to stretcher, stretcher to treatment table, return).

- Ceiling lift - same as above.
- Reposition and Boost - turning a patient every two hours, turning for care/linen changes, boosting a patient up in bed/treatment table/chair, turning for linen changes, limb holding/positioning.
- Ambulation - patient up out of bed to stand and bear weight or walk.
- Bariatric - a patient that the staff deem unsafe to move based on patient size and the patient's ability to be safely handled by staff.

Training

During new hire orientation and then on an annual basis, patient care staff will receive education on patient mobility assessment level equipment locations on unit, active participation in hands-on equipment training, safe patient handling techniques, and be required to demonstrate competencies in such. In addition, at the time of purchase of new equipment, education, training, and competencies will be completed. Refresher training will be provided to staff who have been injured during a patient lift/transfer.

Mobility Assessments

The RN will assess the patient mobility level and communicate that mobility assessment in order to plan mobility handling prior to patient handling.

Patient Handling Decisions

The RN is the coordinator of care for all patient handling and mobility tasks, but may delegate the patient handling task to appropriate staff. The decision to delegate will depend on several factors including the patient medical condition, mobility need, and acuity.

Lift Team (***The "lift team" refers to Hospital staff specifically trained to handle patient lifts, repositioning and transfers using patient transfer, repositioning or lifting devices as appropriate for the specific patient):***

When possible a Lift Team should be utilized to assist staff in mobilizing patients with the following criteria:

- Maximum Assist Patients unable to assist in own mobility
- Non-Weight Bearing per Licensed Independent Practitioner (LIP) orders
- Repositions and Boosts or Lateral Transfers
- Emergency Lift (patient fall)
- Assistance placing patient in ceiling lift

Repositioning Sheets / Slings

Repositioning sheets or slings may be assigned to a patient during the patient's length of stay. When the reposition sheet becomes soiled, dirty, or the patient is discharged, the sheet is placed in the soiled linen bags and sent to laundry to be cleaned.

Cleaning of the Lift Equipment After Use

All mechanical equipment, non-mechanical equipment and devices will be cleaned using SaniWipes between each patient use by staff using the equipment. Terminal cleaning may be performed by Environmental Services (EVS) staff. Once cleaned, the lift equipment must be placed in its designated storage area. Electrical equipment that uses a battery must be plugged into an electrical outlet while in storage.

Right to Refuse

Staff has the right to refuse to lift, reposition, or transfer a patient due to concerns about patient safety, worker safety, lack of education, training, mechanical/non-mechanical equipment or lateral transfer devices. Disciplinary action will not be taken when exercising this right. The staff member must immediately notify his/her immediate supervisor so that appropriate safe patient care and staff safety can be provided. A debrief interview with the staff member will be performed in order to identify and prevent similar circumstances in the future.

Work-Related Injury

After a work-related patient handling injury occurs, the employee must follow VCMC's IIPP: Work-related and Non-work-related Injuries and Illnesses Procedures. When released to return to work after a patient handling-related injury, staff must obtain medical clearance from their physician before starting work. Managers will evaluate any work restrictions and determine return to work status. In addition, *refresher training* will be provided to staff injured during a patient lift/transfer.

GUIDELINES

A. Assess, prior to patient handling, the patient's mobility level and plan for patient handling on admission and each shift (see "Mobility Assessment" section below).

B. Document the mobility each shift in the designated mobility assessment activity in the patient's electronic health record (EHR).

C. Document the plan for patient handling in the care plan in the EHR.

D. Indicate the last mobility assessment on the white board in the patient's room, i.e.:

- Independent to Supervised
- Minimal Assist
- Moderate Assist
- Maximum Assist

E. Communicate the mobility assessment level and need for safe patient handling equipment or device to all staff caring for the patient, in the patient's EHR, and during hand-offs including, but not limited, to:

- Nursing Assistants
- Radiology Staff
- Surgical Services
- Physical Therapy

F. Educate the patient/family regarding the patient's mobility needs, equipment, what to expect and how the patient can assist.

G. Always check equipment or device prior to use, including:

- Basic operations of device
- Adequate charge on battery
- Appropriate sling available

- Emergency features functioning

Note: If equipment or a devise appears broken or not in proper working order, remove from service and notify the Bio-Med Department.

STAFF RESPONSIBILITIES:

REGISTERED NURSE (RN) or PHYSICAL THERAPIST (PT):

a. Assesses the patient mobility level using the mobility assessment tool
b. Communicates mobility assessment and plan to patient care staff, in EHR and during hand-off's to other care givers.
c. Educates the patient and/or family on the patient mobility needs and plan.

LIFT TEAM (***The "lift team" refers to Hospital employees specifically trained to handle patient lifts, repositioning and transfers using patient transfer, repositioning or lifting devices as appropriate for the specific patient. Lift team members may perform other duties as assigned during their shifts***):

a. Performs equipment-assisted lifts, lateral transfers, turns and repositions of patients in clinical environments from admission to discharge.
b. Provides on-site instruction to both staff and caregiver to ensure safe method of transfer.

VCMC/SPH focused education consists of:

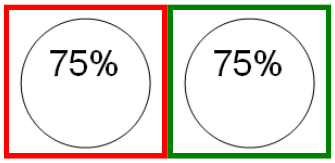
a. Policy overview
b. Skills Lab
c. Competency/Skills verification
d. Policy location
e. Employee responsibility
f. AB 1136 legislation overview and nursing responsibilities
    a. Five (5) areas of body exposure
g. Mobility Assessment
h. Equipment, device, and accessories overview
    a. Description of equipment, devices, function, safety and emergency features
i. Scenarios and Solutions
    a. Decision scenarios with description of patients with different limitations and mobility
    b. Discuss appropriate equipment selection and engaging the patient and family.
j. Equipment use and safety – *May include Vendor training*
k. Demonstration
    a. Vertical Transfer – Transfer from one surface to another (bed to chair, chair to commode, etc.)
    b. Lateral Transfer – Transfer across lateral surfaces (bed to stretcher, stretcher to OR table, etc.)
    c. Reposition/Boost- Turning, boosting up in bed (patient positioning for bathing/hygiene, etc.)

d. Ceiling lifts
e. Ambulation – Up out of bed to stand and bear weight or walk
f. Bariatric- Special equipment and accessory use

MOBILITY ASSESSMENT

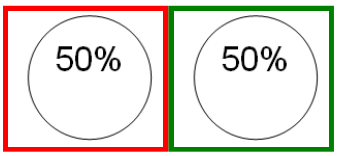
The patient mobility assessment will determine if a patient requires minimal assistance, moderate assistance, or maximal assistance. These designations are to be part of the Plan of Care.

Minimal Assistance (75%)



Patient does 75% or more of the work required to move or transfer him/herself. The patient is able to attain a standing position with no assistance or with contact guarding or standby guidance only. Very little work is required of the worker assisting. Once standing, the patient is able to balance and walk with very little risk of falling. Gait belt may be used to assist in transfer if needed or for safety during walking. Patients who require minimal assistance DO NOT generally require use of mechanical devices, but the need for a lift may be decided by the health care worker.

Moderate Assistance



Patient does 50% of the work required to move or transfer him/herself. The patient needs some support for balance. They may be able to sit up in an unsupported position. Use of a gait training belt or other assistive device is indicated. A walker is generally used for transfers or ambulation. A wheelchair may need to be readily available in case of sudden need. The use of a sit-to-stand device is recommended. There is a moderate risk of falling. Patients who require moderate or maximal assistance generally REQUIRE use of mechanical devices unless the patient care plan specifically states otherwise.

Maximal Assistance

Patient does 25% or less of the work required to move or transfer. The patient needs maximal support in transfer. They may be capable of sitting in an unsupported position and may or may not be able to use the overhead trapeze. They are unable to bend knees and lift hips off the bed. They can bear very little weight when standing and generally require a 2 person mechanically assisted transfer.

Patients who require maximal assistance REQUIRE the use of mechanical devices. ***Exception*** : purposeful therapeutic interventional mobility training performed by physical or occupational therapists or is part of the therapeutic interventions, or therapeutic carry-over of mobility techniques.

REFERENCES

CCR Title 8, Section 5120, *Health Care Workers' Back and Musculoskeletal Injury Prevention*

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100.106 Weight and Size Limits of Bariatric Equipment

POLICY:

To promote patient safety without compromising patient dignity by ensuring that appropriately sized equipment is available and used when a patient exceeds the weight or size limit of on-hand furnishings and medical equipment.

PROCEDURE:

Safety and accuracy are paramount when considering the size of medical equipment. Improperly sized equipment, at best, gives inaccurate results, and at worst can result in patient or staff injury.

Every patient at Ventura County Medical Center (VCMC) will have appropriately sized medical equipment and room furnishings.

Most of our metabolic and bariatric surgery candidates will not exceed the weight limits of existing equipment at NMC due to the BMI limits of the Metabolic and Bariatric Surgery Program.

DEFINITIONS

A. *Metabolic and Bariatric Surgery Patient* – any inpatient or outpatient who presents for a metabolic and bariatric surgery procedure (such as esophagogastroduodenoscopy) or who presents after surgery with any complications.

B. *Equipment and Furnishings* – This refers to medical equipment such as blood pressure cuffs, sequential compression devices, gowns, wheelchairs, walkers, bedside commodes, beds, bedside chairs, wall mounted toilets with supports in place, etc.

C. *Body Mass Index (BMI)* – BMI is a person's weight in kilograms (kg) divided by his or her height in meters squared. The National Institutes of Health (NIH) now defines normal weight, overweight, and obesity according to BMI rather than the traditional height/weight charts.

RESPONSIBILITIES AND PROCEDURES

A. Purchasing Department

1. Maintain information regarding maximum weight capacities of weight-bearing medical equipment.

2. When new weight-bearing equipment arrives, inspect for a manufacturer-placed weight limit label. If absent, label the equipment for staff reference.
3. Place a label with maximum weight on weight-bearing equipment already in service that has not been labeled by the manufacturer.

B. Nursing Units

1. Use appropriately sized hoists and lifting devices to move patients.
2. Avoid manual lifting whenever possible as it may result in injury to the patient and staff.
3. Ensure that an adequate number of staff members are present to complete the lift safely.

C. Diagnostic Imaging

1. Assess the weight of the patient and ensure that the radiology equipment weight and tube opening limits will not be exceeded.
2. If possible, avoid manual lifting as it may result in injury to the patient and staff. Ensure that an adequate number of staff members are present to complete the lift safely.

D. Perioperative Services

1. Assess the weight of the patient and ensure that the equipment weight limits will not be exceeded.
2. If possible, avoid manual lifting as it may result in injury to the patient and staff. Ensure that an adequate number of staff members are present to complete the lift safely.

E. Equipment

1. Furnishings such as beds, gurneys, chairs, hoist and slings have a maximum weight limit supplied by the manufacturer. The weight limit should be listed on the equipment. It is imperative that the maximum weight limit is checked and not exceeded as it will affect the stability and mechanism of the equipment. If the maximum weight limit is not listed on the equipment, the vendor of the equipment can be contacted for that information.
2. In addition to weight limits, the width of the patient needs to be considered when selecting beds, bedside chairs, wheelchairs, etc. If a patient is too wide to comfortably sit in a chair, or wheelchair, wider equipment needs to be requested to accommodate the patient.
3. Selected medical equipment such as blood pressure cuffs and sequential compression devices do not list a maximum weight, but utilize limb size guidance for selecting an appropriately sized device. Always follow the manufacturer's recommendation with regard to medical equipment sizing
4. If possible, avoid manual lifting as it may result in injury to the patient and staff. Ensure that an adequate number of staff members are present to complete the lift safely.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/2/2025
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/2/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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

100.212 Voiding and Discontinuing Electronic Orders

POLICY:

Orders entered erroneously into the Electronic Health Record will be voided or discontinued.

PROCEDURE:

Voiding Orders -

Orders should be voided under the following conditions:

- Wrong orders entered on the correct patient
- Orders entered on the wrong patient
- Orders entered on the correct patient, wrong encounter

In addition:

- Orders can be voided if entered and signed, only if they have not been acted upon.
- An order for a medication that has not been dispensed or administered can be voided.
- An order for a daily medication that has been given one time cannot be voided for subsequent days, but can be cancel/discontinued.
- Orders can be voided by any licensed clinician upon discovery of the problem before the orders are signed.
- A void reason is not required for unsigned orders.

Discontinuing Orders:

All licensed clinical providers can discontinue orders and plans within their scope of practice when all tasks associated with those orders are completed, or when the phase of care is complete (discharge from the Emergency Department or Post-Anesthesia Care Unit, or transition from labor to post-partum phase of care).

This process does not require a verbal order from the provider before the action or a cosign after the action.

A "reason for cancel/discontinue" field is available for clarifying comments. Completing the "reason for cancel/discontinue" field is NOT required.

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Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/25/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
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VENTURA COUNTY HEALTH CARE AGENCY

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100.214 Electronic Proposed Orders

POLICY:

Electronic provider orders require management within the Ventura County Health Care Agency's electronic health record (EHR) system.

PROCEDURE:

The proposed orders functionality is available to Medical Students, Physical Therapists, Occupational Therapists, Speech Language Pathologists, Respiratory Therapists, Registered Dieticians, Wound Care and Lactation Specialists and allows an order to be recommended or proposed. Proposed orders are routed to a specific provider for signature. Proposed orders are not active until signed.

Proposed Order : A suggested clinical action that is not active until it is approved. **Not for use in Urgent/ Emergent situations.** Provider actions upon receiving a proposed order are:

a. **Accept a proposal:** This is when a user that has the correct level of authority within the system clinically agrees with a suggested clinical action and turns that suggestion into something actionable.

b. **Accept with modification:** This is when a user that has the correct level of authority within the system clinically agrees with a suggested clinical action, yet still wants to make some changes and then turns that suggestion into an Order.

c. **Reject the proposal:** This is when a user that has the correct level of authority within the system clinically disagrees with a suggested clinical action and rejects the proposal. Providers can reject proposed orders. The system will not automatically notify the proposer. It is up to the provider to communicate with the proposer. It is also appropriate for the proposer to follow up on the outcome of proposed orders.

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Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
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VENTURA COUNTY
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Owner:	*Melody Donate: Stroke Coordinator*
Policy Area:	*Administrative - Patient Care*
References:	

100.226 Acute Stroke Management/Code Stroke

POLICY:

To provide a system-wide framework to deliver appropriate and consistent care for stroke patients in order to maximize stroke treatment and recovery through evidence-based medicine. These guidelines focus on emergency department and hospital management of patients with acute stroke. A neurologist is available to assess, stabilize and intervene for patients suspected of having a stroke, assist with communication, education and support as necessary.

Scope of Responsibility:

Registered Nurse (RN)
Medical Provider
Lab Personnel
Radiology Personnel
Pharmacist

Definitions:

STROKE: Stroke is a sudden reduction of blood flow to a part of the brain or hemorrhage into the brain causing inadequate oxygen supply and cell death. Depending on the extent and location of the stroke, symptoms may range from being asymptomatic to causing acute focal neurological deficits or disability. Signs and symptoms of stroke include, but are not limited to:

1. Flattened nasolabial fold/facial droop
2. Hemiparesis/hemiplegia
3. Ataxia
4. Aphasia
5. Dysphagia
6. Sensory loss
7. Apraxia
8. Persistent Vertigo
9. Atypical headache

10. Visual Field defect

Types of Stroke:

1. Ischemic stroke (embolic or microvascular) occurs when a blood vessel supplying blood to the brain is suddenly obstructed.
2. Hemorrhagic stroke (bleeds occurs when a weakened vessel ruptures followed by compression of brain structures.
3. Transient Ischemic Attack (TIA) is a transient episode of an acute/sudden onset focal neurological deficit presumed to be vascular in nature (referable to a known cerebral artery distribution) and is MRI negative.
4. Subarachnoid hemorrhage stroke occurs with a sudden rupture of an artery between the arachnoid and pia matter.

Code Stroke:

The Acute Stroke Team will be notified by calling "Code Stroke" for any patient with signs and symptoms consistent with an acute stroke onset time within 24hours.

Purpose:

1. Rapid triage and management of acute stroke patients.
2. Reduction in the incidence and complications of stroke.
3. Improve patient outcomes through rapid early treatment, best practice hospital management, education and rehabilitation efforts.

Guidelines:

1. Patients that meet criteria and demonstrate signs and symptoms of stroke are permitted to access the Stroke Program regardless of area of admission.
2. The Program, in accordance with system hospital policy, shares information with any relevant practitioner or organization to assist with the patient's continuum of care.
3. If IV thrombolytics (ie IV Tpa/alteplase) is administered at Santa Paula Hospital, the patient should be transferred during the infusion (or after completion of TnKase bolus) via paramedic ambulance with nurse presence to VCMC. Patients who receive IV thrombolytics/tPA will be transferred to the Primary Stroke Center at Ventura County Medical Center (VCMC) Emergency Department or the Intensive Care Unit for coordination and continuity of care.
4. VCMC and SPH patients requiring a higher level of care (i.e. thrombectomy or neuro-critical care) are to be transferred as indicated.
5. Teleneurology is available for acute consultation twenty four (24) hours a day, three hundred sixty five (365) days a year, barring an internal triage.
6. The Acute Stroke Team will be notified by CODE STROKE activation.
7. The Acute Stroke Team shall be notified by the hospital operator via overhead and page. The expected responders are:
    - Emergency Department (ED) physicians for ED patients
    - Attending and/or House Officer physicians for inpatients

- ED Charge Nurse for ED patients and Rapid Response RN for inpatients
- House Supervisor
- Laboratory
- Diagnostic Imaging
- Pharmacy

8. Acute stroke recommended time goals:
   - Treatment initiated for acute stroke patients based on the Code Stroke Time Goals **(see Attachment 8).**

PROCEDURE:

Patients experiencing sudden stroke-like symptoms:

- Patients in the Emergency Department **(see Attachment 1)**
- Inpatients (**see Attachment 2)**

Patients last known well less than 4.5 hours consider for:

1. Eligibility in the administration of intravenous (IV) thrombolytics, including t-PA (alteplase).
2. Endovascular interventional radiology with large vessel occlusions (LVO) on CT Angiogram (CTA) or Magnetic Resonance (MR) angiogram head/neck or positive LVO Score (**see Attachment 3).**
3. Admission to appropriate unit.
4. Stroke- Neurological checks/vital sign checks every 15 minutes for one hours, then every two hours for six hours, then per physician/hcp order **(see Attachment 4)**.
5. If IV t-PA administered follow Stroke Neurological checks/vital signs (IV t-PA flow sheet **see Attachment 5)**
6. National Institute of Health Stroke Scale (NIHSS) Score **(see Attachment 6) before** IV thrombolytic/ recanalization therapy. Patients not eligible to IV thrombolytics require an NIHSS within 12 hours of arrival.
7. Transfer to a higher level of care as indicated.

Patients last known well greater than 4.5 hours and less than 24 hours considered for:

1. Endovascular interventional radiology for (LVO) on CT Angiogram(CTA) or Magnetic Resonance (MR) angiogram head/neck or positive LVO Score (**see Attachment 3).**
2. Admission to appropriate unit.
3. Transfer to a higher level of care as indicated

Patients last known well onset 24 hours or more:

1. Admission to appropriate unit
2. Transfer to a higher level of care as indicated
3. National Institute of Health Stroke Scale (NIHSS) Score **(see Attachment 6)** is required within 12 hours of arrival. The scale is recommended to be on recognition of stroke like symptoms or arrival.

4. Admit to the appropriate unit or transfer to higher level of care (observation or inpatient) with standardized treatment for ischemic events, hemorrhagic stroke, and neurosurgical services.

Additional Considerations:

1. Imaging
    a. CT angiogram (CTA) for ischemic stroke may be ordered without current creatinine, if risk for contrast-induced nephropathy is low, based on history at the discretion of health care provider.
    b. The CT technician notifies radiologist by telephone or emergent electronic communication that a non-contrast head CT and CT angiogram is in progress, followed by a notification of head CT scan and CT angiogram completion. Notification times are documented.
2. Blood Pressure Parameters in Acute Stroke **see Attachment 7.**
3. Transient Ischemic Attack refer to CPG.24 Transient Ischemic Attack (TIA)
4. Ischemic stroke (without thrombolysis) and TIA. Allow permissive hypertension.
5. Hemorrhagic stroke (intracranial hemorrhage) refer to CPG.51 Intracerebral Hemorrhage (ICH).
6. If non-contrast head CT shows evidence of intracranial hemorrhage (intracerebral or intracerebral), request immediate neurosurgery consult.
7. Admit to the appropriate unit (observation or inpatient) or transfer to higher level of care for cases requiring interventional radiology which may include standardized treatment for acute LVO, unstable ischemic stroke, or unstable aneurysmal hemorrhage/spontaneous subarachnoid hemorrhage.

Stroke performance standards and quality measures:

Instituted for all stroke patients during their length of stay according to their diagnosis. A process improvement plan is implemented to maintain quality of care.

A. Stroke time targets (**see Attachment 8**)
B. Nursing swallow screen prior to any oral intake, including oral medications.
C. Discharge planning for recovery and community resources.
D. DVT prophylaxis (mechanical and/or pharmacological) by day two (2) of hospital stay.
E. Anticoagulate and/or antiplatelet medication is given within 48 hours of admission as treatment or prophylaxis.
F. NIH Stroke Scale Score completed prior to the administration of IV Thrombotics (i.e. t-PA/alteplase) or within 12 hours of arrival.
G. IV Thrombolytics (ie t-PA/alteplase) is considered and administered for qualified patients presenting up to 4.5 hours of symptom onset. Contraindications are documented by HCP.
H. IV Thrombolytics (t-PA/alteplase) is administered according to VCMC/SPH Clinical Practice Guideline for Stroke: Acute Ischemic Intravenous t-PA (Refer to CPG.28 Stroke: Acute Ischemic IV t-PA (Alteplase)
I. LDL is measured and treated to goal less than 70 mg/dL if deemed appropriate by HCP for patients 75 years of age and younger
J. Stroke education initiated upon admission and reinforcement during hospital stay and completed prior to discharge. Patient/caregiver education addresses the following:

- Access 911 for sudden onset of stroke-symptoms
- Recognition of the signs and symptoms of stroke
- Identified risk factors for stroke and lifestyle modifications
- Instructions in follow-up with health providers
- Community resources and the medications used for stroke prevention

K. Smoking cessation education/referral if indicated.

L. Ischemic stroke patients with atrial fibrillation/flutter - discharge on anticoagulant(s) should be considered, with risk stratification, and if there are no contraindications.

M. Rehabilitation assessment as deemed appropriate for patient, physical therapy (PT), speech therapy, occupational therapy (OT).

N. PT/OT will be completed per AHA guidelines (4.12), after 24 hours of symptom onset and must be completed before discharge/dispostion, preferably 24-48 hours. PT/OT staff may document when therapies cannot be completed due to documented medical, safety reasons or when refusal by patient.

REFERENCES:

A. 2021 Guideline for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack: A Guideline From the **American Heart Association/American Stroke Association**. Dawn O. Kleindorfer, MD, FAHA, Chair, Amytis Towfighi, MD, FAHA, Vice Chair, Seemant Chaturvedi, MD, FAHA, MD, Walter N. Kernan, MD*, Enrique C. Leira, MD, MS, FAHA, Stroke. Volume 52, Issue 7, July 2021; Pages e364-e467. https://doi.org/10.1161/STR.0000000000000375

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C. Steven M. Greenberg, Wendy C. Ziai, Charlotte Cordonnier, and on behalf of the American Heart Association/American Stroke Association(2022). 2022 Guideline for the management of patients with spontaneous intracerebral hemorrhage: a guideline from the American Heart Association/American Stroke Association. American Heart Association Journal (53)7. https://doi.org/10.1161/STROKEAHA.122.040082

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E. Hemphill, J. C., Greenberg, S. M., Anderson, C. S., Becker, K., Bendok, B. R., Cushman, M., ... & Woo, D. (2015). Guidelines for the management of spontaneous intracerebral hemorrhage a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*

F. W. J., Rabinstein, A. A., Ackerson, T., Adeoye, O. M., Bambakidis, N. C., Becker, K., ... & Jauch, E. C. (2018). Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke, 49(3), e46-e110.

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Attachments

- Attachment 1 - Emergency Department Stroke Clock Management
- Attachment 2 - Inpatient Stroke Clock Management
- Attachment 3 -Emergent Large Vessel Occlusion Algorithm-VAN Screen
- Attachment 4 - Stroke/Neuro Vital Signs
- Attachment 5 - Stroke/Neuro Checks Vitals Flow Sheet
- Attachment 6 - NIH Stroke Scale
- Attachment 7 - Blood Pressure Management Reference
- Attachment 8 - Stroke Time Targets

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	6/3/2025
Medical Staff Committees: ED & Medicine	Stephanie Denson: Manager, Medical Staff Office	6/3/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/1/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/24/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/24/2025
Policy Owner	Melody Donate: Stroke Coordinator	4/24/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
Policy Area:	*Administrative - Patient Care*
References:	

100.251 Administration and Extravasation of Antineoplastic Agents

POLICY:

Ventura County Medical System shall outline procedures for the safe and appropriate administration of medications used to treat malignancies, and to eliminate or reduce damage to soft tissues related to the extravasation of vesicant agents.

PROCEDURE:

1. Patients who are receiving treatment for malignancy should be attended by a chemotherapy-certified Registered Nurse.
    a. Medications used to treat malignancy include antineoplastic drugs and monoclonal antibodies.
2. All patients are to be assessed for appropriate room/chair assignment and nursing-to-patient ratio.

DEFINITIONS

1. Chemotherapy is the use of antineoplastic drugs in the treatment of cancer. They may be categorized as vesicants, irritants, or non-vesicants. Monoclonal antibodies are non-antineoplastic drugs used in the treatment of cancer and are considered non-vesicants.
    a. **Vesicant**: An antineoplastic drug with potential for producing severe irritation and necrosis to local tissue. (See table 1.a.)
        i. Vesicants may only be administered by:
            1. Intravenous push (IVP): Via peripheral or central line
            2. Continuous IV infusion (CIVI): **CENTRAL LINE ONLY**
            3. Intravenous piggyback (IVPB): **CENTRAL LINE ONLY**
            4. **Intravenous short infusion via minibag: Via peripheral or central line, FOR VINCA ALKALOIDS ONLY**
    b. **Irritant:** An antineoplastic drug capable of producing pain at the venous site and along the vein, with or without an inflammatory reaction. (See table 1.B.)
        i. Symptoms are usually short-lived, subsequent tissue damage is uncommon and skin necrosis is rare.

ii. Irritants may be administered by:

1. Intravenous push (IVP): Peripheral or central line
2. Continuous IV infusion (CIVI): Peripheral or central line
3. Intravenous piggyback (IVPB): Peripheral or central line

c. **Non-vesicant/non-irritant**: Antineoplastic drugs not known to cause irritation or necrosis to local tissue. This includes monoclonal antibodies. *(See table 1.C.)*

i. Non-vesicants/non-irritants may be administered by:

1. Subcutaneous (SQ)*
2. Intradermal (ID)*
3. Intramuscular (IM)*
4. Intravenous push (IVP): Peripheral or central line
5. Continuous IV infusion (CIVI): Peripheral or central line
6. IVPB: Peripheral or central line
7. Intra-arterial*: By PHYSICIAN only
8. Intraperitoneal*
9. Intravesicle*
10. Topical*
11. Oral*
12. Intrapleural*: By PHYSICIAN only
13. Intrathecal*: By PHYSICIAN only
**Only select drugs*

2. **Extravasation** is the leakage of intravenous drugs from vein into surrounding tissue.

a. Extravasation of a vesicant can cause tissue damage requiring emergency treatment.

PROCEDURE - INTRAVENOUS ADMINISTRATION:

1. Equipment:

a. 24 - 20 G IV angiocath/instyle, 21 g - 25 g butterfly may be used, if indicated
b. Normal saline or solution as prescribed by physician
c. Primary IV tubing with ports
d. Secondary IV tubing
e. Peripheral IV start or central line access supplies
f. Alcohol wipes
g. 2 x 2 gauze pads
h. Transparent dressing
i. Tape

j. Disposable absorbent pad
k. Chemotherapy agent (pre-mixed, appropriately labeled and pre-drawn into syringe, bag or bottle, tubing primed with diluent by pharmacy)
l. Chemotherapy gloves and gown
m. Chemotherapy hard plastic waste container
n. Appropriate flush for central line or peripheral line
o. Infusion device (for IVPB or IV drips)
p. Extravasation kit readily available (for vesicant administration)

2. Documentation:
   a. In Electronic Health Record (EHR):
      i. Labs checked prior to administration of chemotherapy
      ii. Signature of persons who performed verification of drug name, dose, route of administration and patient identification
      iii. Presence of existing IV or initiation of IV/central line and its patency prior to administration.
      iv. Drug(s) and dose(s) of chemotherapy and monoclonal antibodies administered including premedication.
      v. Method of administration
      vi. Sequencing of drugs administered
      vii. Date and time of administration
      viii. Amount and type of flush solution used
      ix. Patency of IV line throughout administration
      x. Vesicant precaution observed during administration of vesicant (if applicable)
      xi. Patient response to administration
      xii. Vital signs pre, post, or during administration of chemotherapy as indicated and to include pain
      xiii. Patient education
      xiv. Pre- and post-infusion assessments
3. Administration of **vesicants, irritants, and non-vesicants** by **IV Push via peripheral line or central line**:
   a. Pre-infusion assessment:
      i. Vital signs-reassess as needed
      ii. Current height and weight
      iii. Allergy history
      iv. Current infusion order
      v. Current clinical status including review of recent lab work
      vi. VAD assessment
      vii. Psychosocial assessment including ability to cope with current therapy

viii. Patient education needs

ix. All patients should be screened for presence of pain as part of each assessment using a 0-10 scale. For moderate to severe pain, further assessment should be obtained and a physician notified for intervention.

x. Medication list

b. Upon ordering (outpatient), or receiving (inpatient) chemotherapy from the Pharmacy:

i. A chemotherapy certified Registered Nurse and a pharmacist or physician will confirm patient name and 2nd identifier, drug name, dose, route of administration, BSA and dose calculation, treatment cycle and current labs with written physician order.

c. At chair/bedside identify patient with two (2) patient identifiers.

d. Confirm with patient his/her planned treatment.

e. Educate patient regarding the administration and side effects of the drugs they are receiving as well as the actions taken to minimize the side effects of the drugs. Instruct the patient to report pain, burning, or discomfort at the intravenous site or any other unusual sensations during the administration of chemotherapy.

f. Wash hands for at least 15 seconds prior to administration.

g. Prepare a peripheral route by performing venipuncture using normal saline or prepare a silastic catheter, implantable vascular access device, or other central line. Start infusion of normal saline or prescribed solution.

h. Don chemotherapy gown, and double chemotherapy gloves. Don mask and eye protection if splash or inhalation (N-95 mask) risk is present (see policy *100.205 Safe Handling of Hazardous Medications*).

i. Prior to chemotherapy administration, two chemotherapy certified RN's in the presence of the patient will verify patient identification using two identifiers, drug name, drug dose, rate, route, expiration dates/times, (if applicable), appearance, and physical integrity of drugs and rate set on infusion pump (if applicable). Document co-sign on Electronic Health Record (EHR).

j. Place drugs and supplies on a surface protected with disposable absorbent pad.

k. Place absorbent pad under site of projected administration.

l. Flush IV line with 10 - 20 mL of normal saline or compatible solution.

m. Remove syringe containing chemotherapy from re-sealable plastic bag.

n. Cleanse the primary intravenous side port, which is **most proximal** to the patient, with an alcohol wipe for at least 10 seconds. Allow to air dry.

o. Check for blood return prior to initiating chemotherapy. Aspirate with a syringe by the lowest port and clamp off fluid from the bag or use gravity to check by lowering the IV bag below the patient's IV site.

p. Remove plastic cap from luer lock syringe containing chemotherapy and attach to lowest side port of primary IV.

q. Administer chemotherapy through a free flowing intravenous solution, normal saline, or as ordered by PHYSICIAN. Infuse chemotherapy agent slowly and steadily.

r. Observe IV site throughout the administration of chemotherapy for signs of infiltration, swelling or

color change.

s. **Vesicants** are recommended to be administered prior to non-vesicants and irritants. Vesicant precautions must be observed during administration of all vesicants to include:

   i. Check and observe blood return every 2 - 5 mL.

   ii. Careful assessment of IV site for signs of infiltration, i.e. edema, erythema or patients complaint of pain or burning.

   iii. Stop administration if any signs present and follow the extravasation procedure.

t. Place 2 x 2 gauze pad or alcohol wipe around luer lock and side port. Carefully remove syringe from side port. Place equipment into the chemotherapy waste container.

u. After administration of chemotherapy agent, flush IV line with 10-20 mL of normal saline or compatible solution.

v. If more than one chemotherapy drug is to be administered, repeat steps "h" through "u."

w. If IV line is to be discontinued, clamp tubing.

x. Remove butterfly or angiocath and apply pressure to site and apply band-aid or gauze dressing.

y. Discard equipment, gloves and gowns into chemotherapy waste container.

z. Wash hands for at least 15 seconds after administration of chemotherapy.

4. Administration of **non-vesicants** and **irritants** by IVPB or continuous IV infusion via a **peripheral line** and administration of **vesicants**, **non-vesicants** and **irritants** by IVPB or continuous IV infusion via a **central line.**

   a. Follow steps "3a" through "j" at beginning of policy.

   b. Flush IV line with 10 - 20 mL of normal saline or compatible solution.

   c. Cleanse primary IV tubing sideport with alcohol wipe for 10 seconds. Allow to air dry.

   d. Remove chemotherapy bag of intravenous solution and tubing which is to be primed with NS or D5W by Pharmacy.

   e. Check for blood return prior to initiating chemotherapy. Aspirate with a syringe at the lowest port and clamp off fluid from the bag or use gravity to check by lowering the IV bag below the patient's IV site.

   f. Attach the luer lock into sideport of primary tubing.

   g. Position chemotherapy bag higher than primary IV bag. Open roller clamp on chemotherapy bag tubing. Program infusion rate via guardrails on pump to deliver drug over desired period of time and begin infusion. Observe drip chamber to assure that chemotherapy is dripping.

   h. Monitor IV site for signs of infiltration.

   i. Discard equipment, gloves and gowns into chemotherapy waste container. Wash hands for at least 15 seconds.

   j. When chemotherapy is completed, turn off infusion device and clamp tubing. Leave chemo tubing connected to mainline tubing, unless additional IVPB chemotherapy to be administered. Flush IV line with 25 - 50 mL normal saline or prescribed solution.

   k. If additional IVPB chemotherapy to be administered, repeat steps "h" through "r."

   l. Intravenous peripheral sites that are to be discontinued.

m. Flush intravenous central lines with appropriate solution.

n. Intravenous lines that are to be mainlined: re-initiate prescribed IV solution after discontinuing chemotherapy.

o. Discard equipment, gloves and gowns into chemotherapy waste container. Wash hands for at least 15 seconds at completion of chemotherapy infusion.

p. Post-infusion assessment:

i. Vital signs for chemotherapy infusion (for at least 30 minutes) and as appropriate based on patient tolerance of therapy.

ii. Patient tolerance of procedure/therapy.

iii. Current clinical status.

5. Administration of VINCA ALKALOIDS (VESICANTS) by short term infusion via mini-bag via peripheral line or central line

a. Follow steps 3a.-l. at beginning of policy

b. Flush IV line with 10 - 20 mL of normal saline or compatible solution.

c. Cleanse primary IV tubing sideport with alcohol wipe for 10 seconds. Allow to air dry.

d. Remove chemotherapy bag of intravenous solution and tubing which is to be primed with NS or D5W by Pharmacy.

e. Check for blood return prior to initiating chemotherapy. Aspirate with a syringe at the lowest port and clamp off fluid from the bag or use gravity to check by lowering the IV bag below the patient's IV site.

f. Attach the secondary tubing of Vinca Alkaloid mini-bag to the injection port closest to your patient using a needless luer lock connector.

g. Hold mini-bag at level of primary bag. Open mini-bag roller clamp and initiate infusion over 5 - 10 minutes via gravity. Primary bag may need to be lowered to empty contents completely from Vinca Alkaloid bag. DO NOT USE INFUSION PUMP.

h. Remain with patient during entire infusion. Verify blood return every 5-10 minutes during short infusion by lowering vinca alkaloid bag and IV solution below level of IV site.

i. Observe for signs and symptoms of extravasation, i.e. swelling, erythema, loss of blood return, or patient's report of pain or burning sensation. Any sign of extravasation, stop infusion and follow the extravasation procedure.

j. Once short term infusion of vesicant complete, check vein patency, clamp vinca alkaloid tubing, and flush line with 25 - 50 mL of normal saline or compatible solution.

k. Place 2 x 2 gauze pad around the luer lock and sideport and carefully remove secondary tubing from sideport. Discard equipment, gloves, and gown into chemotherapy waste container.

l. Wash hands for at least 15 seconds.

m. Remove any intravenous peripheral sites that are to be discontinued.

n. Intravenous lines that are to be mainlined: re-initiate prescribed IV solution after discontinuing chemotherapy.

6. Patient education shall include:

a. Discharge information on chemotherapy precautions.

b. Possible side effects and management.

c. Symptoms that should trigger a call to Oncology Clinic or Emergency Department visit.

PROCEDURE - EXTRAVASATION:

1. Key points:
   a. Only staff specifically trained in chemotherapy administration should manage these patients.
   b. Practitioner should have an underlying knowledge of the signs and symptoms of extravasation.
   c. Signs and symptoms of extravasation:
      i. Patient may experience swelling, erythema, stinging, burning, or pain at IV site. Loss of blood return from IV device, IV flow rate that slows or stops, or leaking around IV catheter or port needle may be noted.
      ii. Most extravasations are evident immediately during administration of the drug. However, the tissue damage and destruction may not be evident at first and may develop later. Extravasation can range from erythema, induration, and irritation to vesicle formation.
      iii. Vein irritation or a flare reaction may mimic some signs of extravasation. Red streaks or blotches along the vein are usually seen. Pain and edema usually do not occur, and blood return is still present. Symptoms subside with vigorous normal saline flush.
   d. A new peripheral intravenous site must be placed prior to vesicant administration. The digits, hands and wrists should be avoided.
   e. For implanted port administration, ensure non-coring needle is of adequate length and securely inserted.
   f. A vesicant should be administered through the injection port, closest to the patient, of a free-flowing intravenous line. Blood return should be evaluated a minimum of every 2 – 5 mL of chemotherapy solution.
   g. The peripheral IV site or central line insertion site must be visible during administration of chemotherapy (a transparent dressing should be placed over the site).
   h. Signs of infiltration or patient complaint of pain or burning during administration of a vesicant agent should be treated immediately as an extravasation.
   i. Chemotherapy and monoclonal antibodies for treatment of malignancies will only be administered by a chemotherapy certified RN. Staff who administer chemotherapy will be trained and competency assessed on a regular basis.
2. Method:
   a. Immediately STOP administering the vesicant and IV fluids.
   b. Disconnect the IV tubing from the IV device. (Do not remove the IV device or non-coring needle.)
   c. Attempt to aspirate residual vesicant from the IV device or port needle using a small syringe. DO NOT flush the IV line.
   d. Assess the site of the suspected extravasation.
   e. Assess symptoms experienced by the patient.
   f. Notify the physician.

g. Remove the peripheral IV device or port needle per physician order.
h. Initiate extravasation protocol and procedure for the specific drug (see table 1.a. and 1.b. and 2)
i. Apply a heat or cold pack as prescribed (see table 2). Do NOT apply pressure to the site.
j. Elevate the extremity.
k. Apply the appropriate topical preparation (see table 2) as prescribed. Do NOT apply DMSO if the patient will receive dexrazoxane for anthracycline extravasation.
l. Mark the infiltrated area on the patient's skin with a felt-tip marker.
m. Cover the area lightly with a sterile transparent dressing.
n. Complete a notification form.

3. Patient education:
   a. Instruct the patient and/or caregiver to recognize and report signs or symptoms of extravasation.
   b. If an extravasation has occurred, teach the patient or caregiver continued local management of the extravasation site, including application of topical medication and heat or cold application.
   c. Extravasation site will be closely monitored by physician.
4. Pain assessment:
   a. Teach the patient to use pain scale (0 - 10) upon admission. Screen all patients for the presence of pain as part of each assessment using the 0 - 10 scale, for moderate to severe pain, obtain further assessment and notify the physician for intervention.
   b. Document pre- and post-pain scales in the EHR.
5. Documentation:
   a. Record the date, time, extravasation site, venous access device type and size.
   b. Record the drug, amount, and concentration.
   c. Record patient complaints and observed signs of extravasation.
   d. Measure and record the dimensions of the tissue affected.
   e. Record the time, location, and amount of antidote and other measures applied.
   f. Record the names of clinicians notified, and to whom referrals were made (i.e., plastic surgeon, dermatologist, or rehabilitation).
   g. Document instruction given to the patient and/or the caregiver

ESSENTIAL COMPONENTS:

1. The patient must give informed consent for treatment before receiving antineoplastic medications. The general hospital "consent for treatment" document serves as the signed permission to provide antineoplastic medications.
2. Prior to administration of antineoplastic medications (IV, IM, SQ, or oral), the chemotherapy certified RN must review the active order written by a medical oncologist or a physician experienced in prescribing antineoplastic medications.
3. Cumulative doses of chemotherapy agents given at VCMS will be tracked in the electronic health record. Risk of cumulative toxicity will be reviewed by oncology pharmacists and physicians.

4. When administering SubQ or IM antineoplastic medications, follow the same safe handling precautions as intravenous administration. Refer to policy *100.205 Safe Handling of Hazardous Medications*.
5. When administering oral antineoplastic medications refer to policy *100.205 Safe Handling of Hazardous Medications*.

REFERENCES:

Drug Facts and Comparisons. Facts & Comparisons [database online]. St. Louis, MO: Wolters Kluwer Health Inc; September 2014

Chemotherapy and Biotherapy Guidelines and Recommendations for Practice. Fourth Edition. Oncology Nursing Society. Pittsburg, Pennsylvania. Copyright 2014

VCMC and SPH Ambulatory Care Nursing policy AHO 4.3. 2013. *Antineoplastics Management of Extravasation.*

VCMC and SPH Ambulatory Care Nursing policy AHO 4.2. 2014. *Antioneoplastic Administration Intravenous.*

Table 1.a. Vesicant antineoplastic drugs

Drug	Routes	Nursing considerations	Extravasation
Mechlorethamine (Mustargen®)	• Slow IV Push over 3 mins into free flowing IV	• Flush with 125-150 mL of normal saline post infusion.	• Isotonic sodium thiosulfate [5]
Dactinomycin (Cosmegen®)	• Slow IV Push	• Dose limiting toxicity: Myelosuppression	• Cold compress for 15-20 minutes at least four times daily
Mitomycin (Mutamycin®)	• Slow IV Push into free flowing IV • Intravesicular	• Dose limiting toxicity: Myelosuppression, CHF	• Cold compress [1] immediately for one hour then QID • Dexrazoxane [2] • DMSO [3] if NOT using dexrazoxane. • Elevate extremity
Daunorubicin (Cerubidine®)	• Slow IV Push over 1 – 5 minutes into free flowing IV • IV infusion over 15-30 minutes (**central line only**)	• Dose limiting toxicity: Myelosuppression, cardiotoxicity	• Cold compress [1] immediately for one hour then QID • Dexrazoxane [2] • DMSO [3] if NOT using dexrazoxane. • Elevate

Table 1.a. Vesicant antineoplastic drugs			
			extremity
Doxorubicin (Adriamycin®)	• Slow IV Push over 10 minutes into free flowing IV • Continuous IV infusion (**central line only**)	• Dose limiting toxicity: Myelosuppression, cardiotoxicity, hepatotoxicity	• Cold compress [1] immediately for one hour then QID • Dexrazoxane [2] • DMSO [3] if NOT using dexrazoxane. • Elevate extremity
Epirubicin (Ellence®)	• IV infusion over 15-20 minutes (**central line only**) • Slow IV Push into free flowing IV over 10 minutes	• Dose limiting toxicity: Myelosuppression, cardiotoxicity	• Cold compress [1] immediately for one hour then QID • Dexrazoxane [2] • DMSO [3] if NOT using dexrazoxane. • Elevate extremity
Idarubicin (Idamycin®)	• Slow IV Push over 3-5 minutes into free flowing IV	• Dose limiting toxicity: Myelosuppression, cardiotoxicity	• Cold compress [1] immediately for one hour then QID • Dexrazoxane [2] • DMSO [3] if NOT using dexrazoxane. • Elevate extremity
Vinblastine (Velban®)	• IV short term infusion via mini-bag over 5-15 minutes	• **Fatal if given intrathecally** • Dose-limiting toxicity: Myelosuppression, neurotoxicity	• **Warm compress [6]** • Hyaluronidase [4] • Apply heat after hyaluronidase to promote drug absorption
Vincristine (Oncovin®)	• IV short term infusion via mini-bag over 5-10 minutes • Continuous IV infusion	• **Fatal if given intrathecally** • Dose-limiting toxicity:	• **Warm compress [6]** • Hyaluronidase [4] • Apply heat after

Table 1.a. Vesicant antineoplastic drugs			
	(with doxorubicin - **central line only**)	Neurotoxicity	hyaluronidase to promote drug absorption
Vinorelbine (Navelbine®)	• IV short term infusion via mini-bag over 6-10 minutes. Follow with 75-125 mL of diluent	• **Fatal if given intrathecally** • Dose limiting toxicity: Myelosuppression	• **Warm compress** [6] • Hyaluronidase [4] • Apply heat after hyaluronidase to promote drug absorption

Table 1.b.: Irritant antineoplastic drugs			
Drug	Routes	Nursing considerations	Extravasation
Arsenic trioxide (Trisenox®)	• IV infusion over 1 hour	• Monitor renal function and electrolytes	• Cold compress [1] for 15-20 minutes at least four times daily
Carboplatin (Paraplatin®)	• IV infusion over 30-60 minutes • May infuse up to 24 hours continuous IV infusion	• Dose limiting toxicity: Thrombocytopenia	• Cold compress [1] for 15-20 minutes at least four times daily • Slower infusion rate, or increased diluent, or concurrent hydration may decrease pain
Cisplatin (Platinol®)	• Infuse over 30 minutes to 3 hours • May infuse as continuous IV infusion	• Dose limiting toxicity: Severe nephrotoxicity, myelosuppression	• Sodium thiosulfate [5] • Cold compress [1] for 15-20 minutes at least four times daily • May have vesicant potential if concentration > 0.5 mg/mL
Dacarbazine (DTIC®)	• IV infusion over 30-60 minutes	• Dose limiting toxicity: Severe neutropenia and thrombocytopenia	• Cold compress [1] for 15-20 minutes at least four times daily • Slower infusion rate, or increased diluent, or concurrent hydration may decrease pain
Docetaxel (Taxotere®)	• IV infusion over 1 hour	• Premedicate with oral dexamethasone as instructed by orders	• Cold compress [1] for 15-20 minutes at least four times daily • Hyaluronidase [4]

Table 1.b.: Irritant antineoplastic drugs			
Etoposide (VP-16®)	• IVPB • Infusion time varies by protocol • Over at least 30-60 minutes	• Dose limiting toxicity: Myelosuppresion	• **Warm compress** [6] • Hyaluronidase [4]
Fluorouracil (5-FU®)	• Slow IV Push • Continuous IV infusion • 46 hour infusor	• Dose limiting toxicity: Mucositis, myelosuppression	• None
Gemcitabine (Gemzar®)	• IV infusion over 30 minutes	• Dose limiting toxicity: Myelosuppression	• Cold compress [1] for 15-20 minutes at least four times daily
Ifosfamide (Ifex®)	• IV infusion over at least 30 minutes • Varies by protocol	• Dose limiting toxicity: Hemorrhagic cystitis, myelosuppression	• Hyaluronidase [4] • Cold compress [1] for 15-20 minutes at least four times daily • DMSO [3] • Phlebitis potential
Liposomal doxorubicin (Doxil®)	• IV infusion over 1 hour (First dose follow titrationorder)	• Dose limiting toxicity: Myelosuppression, cardiotoxicity	• Cold compress [1] for 15-20 minutes at least four times daily
Mitoxantrone (Novantrone®)	• IV PB over 30 minutes • Infuse through free flowing IV	• **Fatal if given intrathecally** • Dose limiting toxicity: Myelosuppression, cardiotoxicity	• Cold compress [1] for 15-20 minutes at least four times daily • DMSO [3] every 8 hours without pressure
Oxaliplatin (Eloxatin®)	• IV infusion over 2 hours	• Dose limiting toxicity: Peripheral neuropathy, myelosuppression	• None-Avoid cold
Paclitaxel (Taxol®)	• IVPB • Infusion rate varies by protocol	• Dose limiting toxicity: Peripheral neuropathy, hypersensitivity reaction	• Cold compress [1] for 15-20 minutes at least four times daily • Hyaluronidase [4]
Ado-Trastuzumab emtansine	• First infusion over 90 minutes	• Caution not to confuse with trastuzumab	• Cold compress [1] for 15-20 minutes at least four times

Table 1.b.: Irritant antineoplastic drugs			
(Kadcyla®)	• Subsequent infusions over 30 minutes (if tolerated)	(Herceptin)	daily

Therapy	Comments
1 Cold pack	• Cold pack produces vasoconstriction, reducing the transport of the drug from the affected area. • Apply a cold pack to the affected area for 15 minutes beginning within 30 minutes of the extravasation. Repeat every 6 hours for one day total. • Cold pack to Vinca alkaloids may make extravasation WORSE.
2 Dexrazoxane	• Apply cold pack (but remove at least 15 minutes prior to dexrazoxane treatment). • Dexrazoxane treatment of anthracycline extravasation: 1,000 mg/m2 on days 1 and 2 (maximum dose: 2,000 mg), followed by 500 mg/m2 on day 3 (maximum dose 1,000 mg); begin treatment as soon as possible, within 6 hours of extravasation. • Dexrazoxane should be infused over 1 – 2 hours in a large vein in an area other than the extravasation area (e.g., opposite arm). The same arm should be used only when the patient's clinical status (e.g., lymphedema, loss of limb) precludes use of the unaffected arm. And a large vein distal to the extravasation area (with dexrazoxane).
3 DMSO	• DMSO (dimethyl sulfoxide) 50% topical solution produces vasodilation and fast penetration of tissue and high solubility for drugs. DMSO increases permeability of skin which accelerates the systemic distribution of the extravasated drug. • Apply DMSO TOPICALLY (e.g., 4 drops per 10cm2) to large area surrounding the extravasation site for 45 minutes every 6 hours for 12 days. In order to prevent blisters, allow DMSO to air-dry. Do NOT cover. • Do NOT use DMSO with dexrazoxane. • Alternate DMSO with cooling
4 Hyaluronidase	• Hyaluronidase 150 units/mL. Administer 1 mL of the hyaluronidase solution as five separate injections, each containing 0.2 mL of hyaluronidase, subcutaneously into the extravasation site at the leading edge using a 25-gauge or smaller needle (change the needle with each injection).
5 Sodium thiosulfate	• Sodium thiosulfate 25%. Mix 1.6 mL in 8.4 mL sterile water for injection. Inject 1 to 4 mL through existing IV line or subcutaneously clockwise at the extravasation site within 10 minutes of the extravasation. Use clinical judgment and size of extravasation site to determine volume. • Time is essential • NOTE: Use only for large (>20mL) CISplatin infiltrates and concentration (>0.5 mg/mL)-otherwise CISplatin acts as an irritant.
6 Warm pack	• Warm pack produces vasodilation and increased blood flow which improves

Therapy	Comments
	distribution and absorption from the affected tissue and simultaneously lowers the concentration of the cytotoxic drug. • NOTE: Moisture combined with heat can lead to macerations and favor development of necrosis. • Apply a warm compress to the extravasation area for 15 – 20 minutes, four times daily for 24 - 48 hours.

All revision dates: 5/11/2021, 1/1/2017, 10/1/2004, 8/1/2003, 12/1/2001, 9/1/1998

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/22/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/8/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/8/2025
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	4/8/2025

VENTURA COUNTY HEALTH CARE AGENCY

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102.020 Provider Preventable Conditions/Patient Safety Indicators Review

POLICY:

Provider Preventable Conditions (PPCs) consist of healthcare-acquired conditions (HCACs) when they occur in an acute inpatient hospital setting and other provider-preventable conditions (OPPCs) when they occur in any healthcare setting.

Patient Safety Indicators (PSIs) are a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care. PSIs focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. Approximately 25-30 PSIs are specified each year by AHRQ and include, but are not limited to, complications such as iatrogenic pneumothorax, accidental puncture or laceration during procedure, postoperative wound dehiscence, postoperative sepsis, postoperative DVT/PE, hospital acquired pressure ulcer, central line associated blood stream infection and postoperative hip fracture.

Each PCC and PSI identified at Ventura County Medical Center and Santa Paula Hospital will be reviewed by the surgical and hospital quality teams and analysis will be used to reduce future occurrences of these events.

PROCEDURE:

GOALS:

1. To ensure that PPCs and PSIs are documented and reported accurately.
2. To identify potential adverse events that might need further study.
3. To evaluate and provide feedback on individual provider performance for PPC and PSI.

DEFINITIONS:

Provider Preventable Conditions (PCCs) are defined by the Centers for Medicare/Medicaid Services (CMS) as **health care acquired conditions (HCACs) or Other Provider Preventable Conditions (OPPCs)** which include, but may not be limited to:

HCACs

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection

- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
- Falls/trauma that result in the following:
    - Fracture
    - Dislocation
    - Intracranial injury
    - Crushing injury
    - Burn
    - Electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Stage III or IV pressure ulcers
- Surgical site infection
    - Mediastinitis following coronary artery bypass graft (CABG)
    - Surgical site infections following:
        - Bariatric surgery
            - Laparoscopic gastric bypass
            - Gastroenterostomy
            - Laparoscopic gastric restrict surgery
        - Orthopedic procedures for spine, neck, shoulder, and elbow
- Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

OPPCs - also known as *"never events"* and Serious Reportable Events under Medicare. Providers must report these three OPPCs when these occur in any health setting. "Invasive procedure" refers to a surgical procedure. For Medi-Cal, OPPCs are defined as follows:

- Wrong surgery/invasive procedure
- Surgery/invasive procedure performed on the wrong patient
- Surgery/invasive procedure performed on the wrong body part

Level 1 Review

- All patients with PPC or PSI diagnoses identified through safety notifications, EHR reports or by coders will be reported, as they are identified, to the QAPI Department and to the appropriate departments for their review.
- The following information will be included in the report:
  Medical Record Number
  Date of Procedure (if applicable)
  Diagnosis Code for PSI or PPC
- Report will be emailed to:
  Quality and Performance Improvement (QAPI) Director

Inpatient Quality Medical Director

Level 2 Review

- Cases will be reviewed by the QAPI Director, Inpatient Quality Medical Director and the appropriate department staff.
- QAPI and/or the appropriate assigned/designated staff will prepare documents to support assignment of diagnosis.

Level 3 Review

- QAPI and appropriate departmental staff will discuss cases with the Inpatient Quality Medical Director and when applicable, with the appropriate medical director thus creating a Peer Review process. The physicians will approve assignment of diagnosis and will determine action plan.
- Updated PSI list will be forwarded to Medical Records (coders) for revision as necessary.
- The Inpatient Quality Medical Director will use established peer review processes (refer to MS.102.018 Peer Review) to give provider feedback and address safety concerns.
- The Inpatient Quality Medical Director will analyze PPC and PSI diagnoses to determine trends and need for further study and/or improvement efforts. If there is a question regarding further follow-up, the case will be referred to the Chief Medical Officer (CMO).
- Serious safety concerns will be addressed through a root cause analysis (refer to 107.024 Root Cause Analysis).

Monitoring Practitioner Adverse Events

Practitioner related events will be presented monthly to the Medical Executive Committee and reviewed in closed session.

References

https://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx

AHRQ QI: Patient Safety Indicators Overview

National Committee for Quality Assurance (NCQA) Standard - CR 5: Ongoing Monitoring

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Attachments

No Attachments

Approval Signatures

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References:	

102.022 Return to Practice Plan

POLICY:

To provide a formal process for practitioners to return to clinical practice after an extended absence. Ventura County Medical Center, Santa Paula Hospital and Ambulatory Care Clinics offer a Return to Practice Plan (RPP) to support a safe return to clinical practice by those practitioners who meet the qualifications for membership and have been clinically inactive for a period of one (1) year or more. Clinically inactive is defined as not actively involved in direct patient care in the area of requested privileges. Reasons for extended leave from may include the following:

- To start a family
- Personal or family illness
- Retirement and wishing to return to clinical practice
- Participation in medical research or other non-clinical pursuits

PROCEDURE:

A. Ventura County Medical Center, Santa Paula Hospital and Ambulatory Care Clinics recognizes the importance of retaining highly qualified practitioners and supports the design and implementation of a practitioner Return to Practice Plan (RPP)to verify current clinical competency and promote a successful return to clinical practice.

B. Appointments are conditional upon timely completion and satisfactory performance of the privileges granted pursuant to the RPP.

C. Practitioners participating in a RPP are not eligible for Temporary Privileges.

D. The RPP is a component of the Medical Staff peer review and quality improvement process. The proctor (and his/her covering designee) is entitled to all of the immunities and protections from liability afforded to individuals who participate in the RPP.

E. The design and duration of the RPP, and number of cases to be reviewed and/or proctored, will be recommended by the Credentials Committee, Department Chief and subject to the approval of the Medical Executive Committee (MEC).

   1. The RPP process is to be completed within twelve (12) months of the date on which privileges are granted, unless extended by the MEC for good cause. Reason for the extension will be documented in the MEC minutes and in the practitioner's credentials file.

F. Successful completion of the RPP requires the returning practitioner to have satisfactorily completed the

required number of proctored cases with documentation indicating that, in all instances, the quality of medical care provided was appropriate. Reference Medical Staff Bylaws 7.4-4 [d. Completion of Proctoring].

G. Failure of the Practitioner returning to practice to comply with the terms or the RPP:

1. A failure to timely complete the required number of cases to be reviewed and/or proctored within the 12- month time frame will be deemed a voluntary withdrawal of Medical Staff membership and privileges, unless the MEC, for good cause, grants a time limited extension, not to exceed an additional 3-to-6-months. The inability to obtain such an extension does not give rise to procedural rights as described in Article 14 of the Medical Staff Bylaws.
2. A failure of the returning practitioner to satisfactorily perform the requirements of the RPP (including required proctoring) will result in a denial of the relevant clinical privileges. If the basis for the denial is deemed a "medical disciplinary cause or reason", the returning practitioner will be afforded hearing rights under Article 14 of the Medical Staff Bylaws.

H. **Eligibility for participation in the Return to Practice Plan (RPP):**

In order to participate in the RPP, a practitioner wishing to return to practice must:

1. Be an existing member of the Medical Staff in good standing OR, if a new applicant, satisfy all credentialing requirements for appointment to the Provisional staff category;
2. Agree to abide by, and sign-off on, the *Practitioner Acknowledgement of Responsibilities* form (Attachment A); and
3. Obtain a proctor/mentor who is currently, and will remain, a member in good standing of the Active Medical Staff during the term of the RPP and who meets the following criteria:
    a. Have demonstrated clinical competence in his/her own filed of practice and be approved by the MEC as a proctor/mentor;
    b. Cover all privileges to be exercised by the returning practitioner whenever possible;
    c. Have had no disciplinary action imposed by the MEC according to the Medical Staff Bylaws during the twelve (12) months preceding the initiation of the RPP term;
    d. Be willing to participate in the RPP and sign-off on all duties prescribed under the *Proctor Acknowledgement of Responsibilities* form (Attachment B).

I. **Existing members of the Medical Staff on Leave of Absence – Twelve (12) months or more:**

1. All existing members of the Medical Staff returning from leave of absence must follow the Medical Staff Bylaws Section 3.6 pertaining to Leave of Absence.
2. The RPP will include a period of Focused Professional Practice Evaluation (FPPE), as determined by the applicable clinical Department Chief (and, as appropriate the Division Medical Director) to evaluate medical knowledge, decisions-making, and clinical skills of the returning practitioner. Proctoring will be required and the proctor/mentor will be assigned by the Department Chief (and, as appropriate the Division Medical Director) subject to approval of the MEC.
3. An existing member of the Medical Staff returning to practice following a leave of absence due to medical illness or injury must provide documentation to the MEC that a thorough fitness to work assessment (tailored to the nature of illness or injury which addresses current cognitive capabilities, physical factors such as endurance and fatigue, emotional status and capacity to practice with or without accommodations) has been performed by a qualified physician and provide a signed

documentation of medical clearance to return to practice.

4. At the discretion of the MEC, a practitioner returning to practice may be referred to the Well-Being Committee for evaluation and/or monitoring.

J. **New applicants to the Medical Staff with no clinic practice activity between one (1) year to three (3) years:**

1. All applicants to the Medical Staff must meet the basic qualification for membership.
2. Documented evidence of fifty (50) hours of Category I Continuing Medical Education within the last twenty- four (24) months, with at least twenty five (25) of those hours within the last twelve (12) months, must be submitted with the application.
3. At the discretion of the applicable clinical Department Chief (and, as appropriate the Division Medical Director), subject to approval by the MEC, the RPP may require the returning practitioner to complete a formal outside training program in order to adequately demonstrate his/her current skill set. Tuition and/or other fees associated with any outside training requirements are the responsibility of the practitioner returning to practice. In addition, or in lieu thereof, the Department Chief may require the returning practitioner to participate in a period of Focused Professional Practice Evaluation (FPPE) to evaluate his/her medical knowledge, decision-making, and clinical skills, with proctoring to be imposed. Proctor/mentor will be assigned by the Department Chief (and, as appropriate, the Division Medical Director) subject to approval of the MEC.
4. At the discretion of the MEC, a returning practitioner may be referred to the Well-Being Committee for evaluation and/or monitoring.

K. **New applicants to the Medical Staff with no clinical practice for three (3) years or more:**

1. In addition to meeting the basic qualifications for Medical Staff membership; and
2. Documented evidence of fifty (50) hours of Category I Continuing Medical Education within the last twenty- four (24) months, with at least twenty five (25) of those hours within the last twelve (12) months, must be submitted with the application.
3. A practitioner who has been clinically inactive for three (3) years or more must include with his/her application for appointment, documentation of completion of a formal return to practice program from an accredited institution. The documentation must address the practitioner's current medical knowledge, clinical reasoning, conceptualization, communication skills and ability to work with others. Tuition and/or other fees associated with any outside training requirements are the responsibility of the practitioner returning to practice. A list of programs can be found on the Federation of State Medical Boards link: http://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf
4. Completion of the Return to Practice Plan (RPP), which will include a period of Focused Professional Practice Evaluation (FPPE), as determined by the applicable clinical Department Chief (and, as appropriate the Division Medical Director) subject to approval by the MEC and proctoring will be required.

Attachment A: Practitioner Acknowledgement of Responsibilities
Attachment B: Proctor Acknowledgement of Responsibilities

All revision dates: 6/21/2022, 6/13/2019, 9/1/2016

Attachments

- 102.022 Attachment A - Practitioner Return to Practice Acknowledgement.docx
- 102.022 Attachment B - Proctor Acknowledgement of Responsibilities

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	5/7/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	4/17/2025

VENTURA COUNTY
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102.038 Reporting Actions to the National Practitioner Data Bank (NPDB) and Licensing Boards

Policy:

This policy summarizes some of the mandatory reporting requirements applicable to the Hospital and Medical Staff in connection with reporting specific actions and events involving licensed healthcare practitioners to the National Practitioner Data Bank (NPDB) and the California licensing boards in compliance with California Business and Professions Code Sections 805, 805.01, and 805.8, and the NPDB.

This policy is intended only for guidance and not as an interpretation of the legal requirements. Legal should be contacted to assess the circumstances at issue for specific matters. The information contained in this Policy is premised on regulatory requirements at the time of drafting. It is recognized that applicable statutes may be amended. Efforts are to be made to ensure current requirements at the time of any reporting.

Purpose:

The purpose of this policy is to help to ensure that actions taken by the Medical Staff, as outlined under California Business and Professions Code Sections 805, 805.01, and 805.8, are reported accurately and promptly to the NPDB and the appropriate licensing board.

Definitions:

- **805 Report:** A report required by the California Business and Professions Code, section 805, which mandates the reporting of certain disciplinary actions, including those taken by the medical staff or hospital against a physician or healthcare practitioner.
- **805.01 Report:** A report as mandated by California Business and Professions Code, section 805.01 that requires the reporting of certain actions that may affect the practitioner's clinical privileges, including any action that limits, suspends, or revokes such privileges for medical disciplinary cause or reason.
- **805.8 Report:** A report required under California Business and Professions Code, section 805.8, which mandates the reporting of any **final administrative decision** made against a healthcare practitioner that affects the practitioner's ability to practice medicine, including any **suspension, revocation, or limitation** of privileges for reasons of **unprofessional conduct** or **substance abuse**.
- **National Practitioner Data Bank (NPDB):** A national database of information about healthcare practitioners, including actions such as malpractice payments, adverse clinical privilege actions, and other significant events.
- **Medical Board of California:** The state regulatory agency responsible for overseeing the practice of

medicine in California.

- **Osteopathic Medical Board of California:** The state regulatory agency responsible for overseeing the practice of osteopathic medicine in California.
- **Medical disciplinary cause or reason:** Term as defined in California Business and Professions Code, section 805(a)(6), which means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Policy:

1. **Reporting Requirements Under Sections 805, 805.01, and 805.8:**
    a. **Mandatory Reports to the Medical Board of California (805 Report):**
    The hospital is required to report any of the following actions taken against a healthcare practitioner to the Medical Board of California under Section 805 within **15 calendar days** of the action:
        - Denial of initial medical staff membership or privileges for a medical disciplinary cause or reason.
        - A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason.
        - Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for **a total of 30 days** or more within any 12 month period for medical disciplinary reasons.
        - Restrictions or conditions placed on medical staff privileges that materially affect the practitioner's ability to provide patient care **for more than 14 days**.
        - Any resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason.
        - A summary suspension of staff privileges, membership, or employment is imposed for a period for **more than 14 days.**

    b. **Mandatory Reports to the Medical Board of California (805.01 Report):**
    The hospital is required to report any of the following actions taken against a healthcare practitioner to the Medical Board of California under Section 805.01 within **15 calendar days** of the **final decision**:
        - Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public.
        - The use of, or prescribing for or administering to himself or herself, any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the licentiate’s ability to practice safely.
        - Repeated acts of excessively prescribing, furnishing, or administering of controlled substances or repeated acts to a patient with or without an appropriate prior examination of the patient and medical reason (this is not applicable to prescribing, furnishing, or administering controlled substances for intractable pain, as consistent with lawful prescribing).
        - Sexual misconduct with one or more patients during a course of treatment or an examination.

    c. **Mandatory Reports to the Medical Board of California (805.8 Report):**

The hospital is required to report any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the patient's representative makes the allegation, in writing, to the agency **within 15 days of receiving the written allegation** of sexual abuse or sexual misconduct.

d. **Mandatory Reports to the NPDB:**
The hospital is required to report certain actions to the NPDB within **30 calendar days** of the action:

- Any action that negatively impacts a practitioner's clinical privileges **for more than 30 days.**
- Suspension, reduction, or revocation of privileges.
- Restriction of privileges due to medical disciplinary cause or reason.
- Voluntary surrender or restriction of clinical privileges while under, or to avoid, an investigation.
  - Note that the NPDB does not require notice to the practitioner of an investigation.

2. **Notification to Practitioners:**
   a. Practitioners will be notified in writing of the decision to submit a report to the NPDB or Medical Board within **10 business days** of the action being taken, unless prohibited by law or other regulations.
   b. A copy of 805 Reports are to be provided to the practitioner, along with a statement informing the practitioner of their right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800. The notice shall also advise the practitioner that information submitted electronically will be publicly disclosed to those who request the information.
3. **Confidentiality and Compliance:**
   a. All reports will be handled in accordance with applicable confidentiality requirements and state and federal laws.
   b. The hospital and medical staff will ensure compliance with requirements for reporting actions.
4. **Failure to Report:**
   a. Failure to report actions to the Medical Board may result in a $50,000 fine per violation. Intentional or willful failure to report may result in a $100,000 fine per violation.
   b. If Health and Human Services determines that a health care entity has substantially failed to report information in accordance with NPDB requirements, the name of the entity will be published in the Federal Register, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years, commencing 30 days from the date of publication in the Federal Register.

Responsibilities:

- **Medical Executive Committee:** The Medical Executive Committee is responsible for overseeing the implementation of this policy and ensuring that reports are made when appropriate.
- **Medical Staff Administration:** The Medical Staff Administration is responsible for maintaining records of reported actions and ensuring timely submission of reports.
- **Hospital Administration:** Hospital administration is responsible for ensuring that the hospital complies with all applicable reporting requirements and for supporting the medical staff in meeting the reporting obligations.

References:

- California Business and Professions Code Section 805
- California Business and Professions Code Section 805.01
- California Business and Professions Code Section 805.8
- National Practitioner Data Bank (NPDB) Guidebook
- National Committee for Quality Assurance (NCQA) Standards
- The Joint Commission (TJC) Standards

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	7/1/2025
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	6/26/2025

Current Status: *Pending* **PolicyStat ID:** *18184297*

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Fernando Medina: Director, Support Services*
Policy Area:	*Administrative - Environment of Care*
References:	

106.003 Hospital & Clinic Emergency Call Codes

POLICY:

The call codes below are used to alert Ventura County Medical Center, Santa Paula Hospital staff and Ambulatory Care clinic staff to emergencies. Codes located at VCMC are to dial 7-6666 for paging. Codes located at SPH are to dial 7-8666 for paging. Codes located at the Ambulatory Care ~~clinic~~campus clinics are to dial 8-911, then dial 7-6666 for paging (for non-medical emergencies only). Codes located at non-campus clinics are to dial 911.

PROCEDURE:

CODE RED: Experiencing a fire, smoke or smell of something burning

- VCMC/SPH Response: Call paging with building, location floor & room # of “Code Red”. Use an extinguisher to put out fire (If safe).
  - ~~RACE: Rescue anyone in danger, Activate alarm, Close doors and windows and Extinguish fire (if safe)~~
  - ~~PASS : Pull the pin, Aim hose at base of fire, Squeeze the handle and Sweep side to side~~
- Clinic Response**:** Campus clinics call paging with building, location floor & room # of “Code Red”. Non-Campus Clinics call 911 and provide clinic location. Use an extinguisher to put out fire (If safe).
  - RACE: Rescue anyone in danger, Activate alarm, Close doors and windows and Extinguish fire (if safe)
  - PASS : Pull the pin, Aim hose at base of fire, Squeeze the handle and Sweep side to side

CODE STROKE: Person with sudden stroke symptoms onset. (Face drooping, arm weakness, difficulty speaking)

- VCMC/SPH Response~~:~~**:** Assess need, call for help. Call paging with location of “Code Stroke”.
- Clinic Response: Assess need, call for help. Call 911 and provide clinic location. Designate staff to meet ambulance/fire department and stay with the patient until help arrives.
- Refer to 100.226 Acute Stroke Management/Code Stroke.

CODE BLUE: Person 18 & older cardiopulmonary arrest.

- VCMC/SPH Response: Assess need, call for help & initiate CPR, bring crash cart. Call paging with location of “Code Blue”.
- Clinic Response: Assess need, call for help & initiate CPR, bring emergency response equipment. Call 911 and provide clinic location and if "child" or adult". Designate staff to meet ambulance/fire department

& stay with patient until help arrives.
- Refer to 100.055 Code Blue - Adult Medical Emergency.

CODE WHITE: Person under 18 cardiopulmonary arrest.

- VCMC/SPH Response: Assess need, call for help & initiate CPR, bring crash cart. Call paging with location of “Code White”.
- Clinic Response: Assess need, call for help & initiate CPR, bring emergency response equipment. Call 911 and provide clinic location and if "child" or adult". Designate staff to meet ambulance/fire departmentt & stay with patient until help arrives.
- Refer to 100.112 Code White - Pediatric Medical Emergency.

RAPID RESPONSE: Deteriorating patient status or failure to respond to treatment.

- VCMC/SPH Response: Asses & treat life threats - ABC’s. Call paging with location of “Rapid Response” and if "child" or "adult". Maintain ABC’s, assure IV access & bring crash cart.
- Clinic Response: Asses & treat life threats - ABC’s. Call 911 and provide clinic location and if "child" or "adult". Maintain ABC’s and bring emergency response equipment. Designate staff to meet ambulance/fire department & stay with patient until help arrives.
- Refer to 100.086 Rapid Response Team.

CODE SEPSIS: Patients with a positive sepsis screen and initial hypotension criteria and/or lactate ≥ 4.0 mmol/L.

- VCMC/SPH Response: Call paging with location of “Code Sepsis”.
- Clinic Response: Not applicable.
- Refer to 100.201 Sepsis Management Policy.

CODE YELLOW: Trauma victim(s) MCI multi-casualty incident (3-8 patients), Tier 1 (highest acuity), Tier 2 (moderate acuity) and Tier 3 (low acuity)

- VCMC/SPH Response: ER & Staff prepare for patient arrival. Respond per VCMC Trauma Response Plan.
- Clinic Response: Not applicable.
- Refer to T.01 VCMC Trauma Response Plan and ER.13 Helicopter Safety.

CODE MATERNITY: OB hemorrhage

- VCMC/SPH Response: Call paging with location of “Code Maternity”. Nursing Supervisor to call OR team.
- Clinic Response: Not applicable.
- Refer to OB.09 Code Maternity.

CODE PINK: Infant abduction under age one missing or reported kidnapped.

- VCMC/SPH Response: Call paging with location of “Code Pink”. Go to the closest exit and watch for a person with a large package or an infant escorted by a person without a VCMC/SPH badge. Verify infant identity (wristband) or see contents of package.
- Clinic Response: Campus clinics call 911 to report the incident then call paging with location of "Code Pink". Non-Campus Clinics call 911 and provide clinic location. Go to the closest exit and watch for a person with a large package or an infant escorted by a person without a clinic badge. Verify infant identity or see contents of package.
- Follow up: Immediately report suspect description and direction of travel to security & nursing supervisor.
- Refer to 106.002 Code Pink/Code Purple - Known/Suspected Infant/Child Abduction.

CODE PURPLE*:* Child Abduction age 1-12, missing or reported kidnapped.

- VCMC/SPH Response: Call paging with location of “Code Purple”. Go to closest exit, watch for anyone exhibiting unusual behavior. Verify child's identity (wristband).
- Clinic Response: Campus clinics call 911 then call paging with location of "Code Purple". Non-Campus Clinics call 911 to report the incident. Go to the closest exit and watch for a person with a large package or an infant escorted by a person without a clinic badge. Verify infant identity or see contents of package.
- Follow up: Immediately report suspect description and direction of travel to security & nursing supervisor.
- Refer to 106.002 Code Pink/Code Purple - Known/Suspected Infant/Child Abduction.

CODE GREY: Security situation of an escalating/ potentially violent behavior.

- VCMC/SPH Response: Clear the area to avoid others becoming involved. Call paging with location of “Code Gray”.
- Clinic Response: Clear the area to avoid others becoming involved. Immediately report incident to security and supervisor.
  Call 911 if situation intensifies or presents a safety risk.
- Refer to 106.059 Code Grey.

CODE GREEN: At risk patient elopement

- VCMC/SPH Response: All employees are to cover all exits & ask question of any patient in hospital attire. Call paging with location of “Code Green”.
- Clinic Response: Not applicable.
- Refer to 100.237 Code Green - Patient Elopement.

CODE VIOLET: Irate visitor in behavioral health (IPU) lobby only.

- IPU operator to announce internal code. All available staff to report to location.

CODE ORANGE:

Hazardous Material Spill or Release-Incidental Spill: a small spill presenting NO hazard to trained staff or environment

~~Hazardous Material Spill or Release-Incidental Spill: a small spill presenting NO hazard to trained staff or environment~~

- ~~Call~~VCMC/SPH call paging with location of “Code Orange”.
- Trainer/User clean up spill.
- Use appropriate protective equipment/decontamination materials.
- Appropriately dispose of materials.
  ~~Radioactive/Major Incident Emergency/Major Spill: a spill that presents hazard to people &/or an environment or effects are unknown.~~
  - ~~Isolate the spill area (evacuate). Deny entry to others. Notify your supervisor. Seek/coordinate medical treatment of decontaminated victim.~~

  ~~Refer to ER.50 Hazmat Shower and Tent Use or 106.066 Hospital Evacuation Plan.~~

Radioactive/Major Incident Emergency/Major Spill: a spill that presents hazard to people &/or an environment or effects are unknown.

- VCMC/SPH call paging with location of "Code Orange".
- Campus clinics call 911 then call paging with location of “Code Orange”. Non-campus clinics call 911 to report the incident.

- Isolate the spill area (evacuate). Deny entry to others. Notify your supervisor. Seek/coordinate medical treatment of decontaminated victim.
- Refer to ER.50 Hazmat Shower and Tent Use or 106.066 Hospital Evacuation Plan.

CODE TRIAGE DISASTER: Emergency Situation presenting hazard to employee or environment & interrupts normal service.

- Report to department to receive specific duty. If required, initiate your departments Callback list. Appropriately carry out your assignment. Seek/ coordinate medical treatment of victims.
  - Level 1 (9-20 Pts)
  - Level 2 (21+ Pts)
- Refer to 106.034 Emergency Management Plan or 106.066 Hospital Evacuation Plan.

CODE ZERO: Evacuation of areas that may be hazardous to life, health, or safety.

- Administrator will notify all in area of need to evacuate.
- Evacuate ambulatory, wheelchair, & then bed ridden patients.
- Report to designated assembly area.
- Refer to 106.066 Hospital Evacuation Plan.

CODE SILVER: A person is brandishing a weapon and/or has taken a hostage(s) within the hospital or its property.

- ~~Immediately~~VCMC/SPH & Campus clinics immediately call 911 & then call paging with # of suspects, physical descriptions, and type of weapon & location of “Code Silver”. ~~Close the immediate area & initiate hospital lockdown~~Non-campus clinics call 911 to report the incident. ~~Seek cover/protection & warn others.~~
- Close the immediate area & initiate hospital/clinic lockdown. Seek cover/protection & warn others.
- Refer to 106.026 Code Silver – Weapon or Hostage Situation or 106.066 Hospital Evacuation Plan.

CODE BLACK, ACTIVE SHOOTER: Person actively shooting a weapon.

- Escape the area if safe to do so, call 911.
- ~~Escape the area if safe to do so,~~VCMC/SPH & Campus clinics then call ~~911, & then call~~ paging stating there is an active shooter with their last known location, and location of “Code Black”.
- If unable to escape, find shelter, barricade doors, silence cell phones, & turn off lights.
- Refer to 106.064 Code Black - Active Shooter or 106.066 Hospital Evacuation Plan

LOCK DOWN: **Civil disturbance; weapon or chemical spill on campus**

- Monitor all entry and exits; ensure no one enters or exits the building.

All revision dates:	5/16/2025, 12/14/2022, 6/1/2016, 2/1/2013, 1/1/2012, 4/1/2011, 5/1/2006, 9/1/2004, 10/1/2001, 12/1/1986, 5/1/1983

Attachments

Attachment A: Emergency Hospital Call Codes

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	5/19/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/16/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/16/2025
Emergency Management Committee	Fernando Medina: Director, Support Services	5/16/2025
Policy Owner	Fernando Medina: Director, Support Services	5/16/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Administrative - Nursing*
References:	

108.003 Nursing Communication

POLICY:

To outline the responsibilities of nursing staff when communicating with Medical Staff, patients, Administration and other hospital departments.

PROCEDURE:

MEDICAL STAFF

The nursing staff is responsible for communicating with the medical staff in order to provide quality patient care. They are responsible for informing the medical staff of the patient's needs and condition based on frequent nursing assessment.

This is accomplished in the following ways:

1. Appropriate charting in the Electronic Health Record.
2. Participation in patient care conferences.
3. Consultation with individual physicians.
4. Providing an atmosphere that is conducive to open communication.
5. Implementing physician's orders appropriately.
6. Following the appropriate lines of communication for each patient when necessary, i.e., (1) Resident (Ventura County Medical Center (VCMC)), (2) Chief of Service (VCMC), (3) attending physician and/or Nursing Supervisor/Clinical Nurse Manager, (4) Hospital Nurse Manager, (5) Medical Director and/or Chief Nursing Officer.
7. Participation in medical staff meetings and joint practice meetings.

ADMINISTRATION

Communication is the responsibility of nursing staff and Administration. Nursing informs Administration of patient, hospital, physical plant and safety problems, and suggests possible solutions when appropriate. Further, Administration informs nursing staff of upcoming changes and solutions.
Communication occurs in the following manner:

1. Active participation in administrative meetings.

2. Participation in department staff meetings.
3. Individual consultations.
4. Written memos.
5. Use of Suggestion Box.
6. Notification forms
7. Meetings with Clinical Nurse Managers/Supervisors
8. Ad Hoc discussions

Patients

The nursing staff maintains open communication with the patient and/or family. This shall be done to provide patients the information necessary to maintain a safe, minimally stressful atmosphere conducive to the healing process, and to assist the patient in returning to his/her normal activities of daily living. Sharing of information increases the patient's knowledge of their disease process and its possible impact. This shall be accomplished in the following manner by participation in:

A. Patient care conferences with the patient and/or family.
B. Patient education.
C. Answering patient's questions as openly as appropriate.
D. Responding to the patient's expressed or observed needs.
E. Involving the patient and/or family in care planning and discharge planning when possible.

Interdepartmental/Contracted Services

The nursing staff shall maintain good communication with other departments/contracted services at all times in order to provide patients with quality care from all services and to ensure good interdepartmental relations.

This shall be accomplished through:

A. Communicating the patient care plan (warm hand-offs/situation, background, assessment and recommendation (SBAR)/communication tools).
B. Multidisciplinary patient care conferences.
C. Departmental staff meetings.
D. Individual meetings with other departments.
E. Written memos.
F. Policies and protocols.

Staff Meetings

The administrative team maintains open communication with staff to provide current information and education regarding new policies/procedures, performance improvement or problem resolution. Meetings shall be held at least once a quarter and attendance shall be documented. Minutes shall be available to those unable to attend.

All revision dates: 8/10/2022, 7/23/2018, 11/1/2013, 6/1/2006, 6/1/

	2003, 11/1/1988, 11/1/1987, 11/1/1985, 11/1/1981, 11/1/1979, 11/1/1977

Attachments

No Attachments

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/20/2025
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References:	

108.007 Patient Classification System and Assignment of Nursing Care of Patients

POLICY:

To provide a consistent method of classifying every patient on every shift to ensure optimal quality nursing care, appropriate nursing assignment and priority care, that each patient's needs are assessed every shift by a Registered Nurse (RN), that staffing assignments are made according to changing patient care needs as reflected by acuity, to establish a method for monitoring the appropriate utilization of resources, and that assignments are commensurate with qualifications and competency of the nursing staff and the identified needs of the patients.

It is the philosophy of the Nursing Department of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) that the acuity of the patient is best determined by an experienced Registered Nurse. In recognizing the difficulty in quantifying such an assessment, documentation will also allow for comments by the Resource/Charge Nurse or Clinical Nurse Manager.

PROCEDURE:

The 24-hour care of patients is planned, directed and evaluated by Registered Nurses. Staffing, both in numbers and competency, will be sufficient to ensure that:

1. An RN defines, directs, supervises and evaluates care of all patients.
2. Assessment and identification of patient care needs occurs on admission, during the patient's stay, on transfer and at discharge.
3. A staff RN retains responsibility for all patients co-assigned to students and agency staff.
4. Infection control measures are strictly adhered to.
5. Staff competency is matched to patient needs.
6. Patient emergency and safety requirements are met with appropriate equipment and staff
7. Only direct patient care providers are included in the Patient Classification System.

The RN Resource/Charge Nurse, Clinical Nurse Manager or designee in each nursing area is responsible for assigning staff for daily patient care. The following information is taken into consideration when these assignments are made:

1. The diagnosis and acuity of illness of each patient (category of nursing care required).

2. If a patient is in isolation, the type of isolation and acuity of illness is considered when assigning the number of patients to a nurse.
3. The job classification, experience and level of competence of each employee is considered, so that those patients requiring more acute assessment and deliberative nursing intervention are assigned to the more competent, experienced employee.
4. Unit geography, the availability of support services, and the method of patient care delivery, i.e., team or primary care is taken into consideration when staffing the nursing floor.
5. The hospital nursing department/service shall retain responsibility and global oversight for the nursing care and related duties when nursing students provide care within the patient care unit.
6. Supervision and evaluation of nursing care being given will be the responsibility of the Charge Nurse during hours on duty. The Clinical Nurse Manager shares this responsibility for 24-hour patient care.
7. The patient classification system will be annually reviewed and updated as necessary.

Patient Classification System

This plan includes, but is not limited to, a method of determining staffing requirements based on the assessment of patient needs, including:

1. Acuity
2. The ability of the patient to care for himself/herself
3. Degree of illness
4. Requirements for special nursing activities
5. Skill level of personnel required in his case
6. Placement of the patient in the nursing unit

A method for the formulation of staffing determinations, including:

1. State mandated staffing requirements
2. The number of staff required
3. The categories of staff available for patient care

A method for scheduling staff on a daily basis to ensure the availability of appropriate skill levels, and a method to facilitate the organization of a nursing care delivery system which will optimize the utilization of all resources and provide the best possible patient care.

The Resource/Charge Nurse, in conjunction with the Clinical Nurse Manager and the RN caring for the patient, will assess each patient, every shift, using the VCMC/SPH Patient Classification System (see attached).

The individual patient acuity will be documented on the acuity tool or in the Electronic Health Record.

The Acuity numbers will be obtained by the Nursing Office three (3) times a day to facilitate staffing for the upcoming shift.

The Nursing Supervisor/Clinical Nurse Manager will take into consideration the reported acuity values of each unit when making staffing decisions for the next shift.

A. Assignment of Patient Care

Each shift's acuity values will be used by the Clinical Nurse Manager or Resource Nurse to make appropriate patient care assignments, using policy guidelines.

B. Staffing Plan

As part of this obligation, the Nursing Department has developed a master staffing plan to meet the needs of each unit in the most efficient manner. Census staffing plans, maintained in the Nursing Office, are based on average acuity assessments and state staffing requirements.

Increases in overall acuity of a particular unit may indicate the need for additional resources. The Nursing Supervisor is to be notified of such need. Every effort will be made to meet staffing needs.

For specifics see the attached Unit Specific Plans. Nurse staffing plans for each unit define specific unit needs.

Validation:

A. On a periodic basis, the Patient Classification System will be reviewed by nursing leadership and by the Registered Nurses who provide direct patient care, to establish unit-specific quality indices. Results will be discussed and alterations made as requested.

B. Staffing Plan

The staffing plan and individual staffing patterns will be evaluated at least annually by Nursing Leadership in order to determine their effective and efficient delivery of patient care.

ATTACHMENTS:

A. VCMC Nursing Patient Classification System: Adult (18 Years and Over)

B. VCMC Nursing Patient Classification System: NICU

C. Procedure Units for NICU Infants

D. VCMC Nursing Patient Classification System & Procedure Units: PEDS & PICU

E. Emergency Department Acuity Tool

All revision dates: 8/10/2022, 11/1/2013, 8/1/2009, 6/1/2006, 5/1/2005, 1/1/2004, 10/1/2000, 6/1/1999, 1/1/1999, 9/1/1993, 11/1/1992, 5/1/1988, 5/1/1987, 5/1/1985, 5/1/1981, 5/1/1979, 5/1/1977

Attachments

- Attachment A - Patient Classification System - 18 Years and Over.docx
- Attachment B - VCMC Nursing Patient Classification System--NICU (2018)
- Attachment C - Procedure Units for NICU Infants.pdf
- Attachment D - VCMC Nursing Patient Classification System & Procedure Units - PEDS & PICU.docx
- Attachment E - Emergency Department Acuity Tool

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/20/2025
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108.013 Patient Right to Refuse Medication or Treatment

POLICY:

A patient has the right to refuse medication or treatment.

PROCEDURE:

A. When a patient verbally or non-verbally refuses medication or treatment, the nurse shall notify the patient's attending physician or his alternate. A full account of the refusal ***must*** be documented in the Electronic Health Record. Document the date, time and location of incident, medication or treatment involved and the time physician was notified.

B. On patient's Medication Record, document the appropriate date and time of refusal.

C. For patients or parents of patients with religious objections to the administration of blood or blood derivative, a form must be signed and remain a permanent part of the patient record.

D. It must be documented that the patient or surrogate has the mental capacity to refuse medication or treatment. If condition is urgent or emergent, two physicians can document necessity to provide care for life saving measures if the patient or surrogate lacks mental capacity and is refusing medication or treatment.

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Committee		
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.035 Patient Throughput (Intrafacility Admissions and Transfers)

POLICY:

To transition the patient through the care continuum within Ventura County Medical Center~~,~~ (VCMC), Santa Paula Hospital~~,~~ (SPH) with the goal of ensuring the patient is placed in the appropriate care area within one hour of bed availability.

PROCEDURE:

Prior to the start of each shift the Unit Charge Registered Nurse (RN) shall predetermine the admission flow and assign order of admission with nursing staff. Bed availability is defined as an unoccupied room with a clean bed and an RN to staff.

VCMC and SPH units (non-IPU)

1. When an inpatient bed need is identified, the unit Charge RN communicates with the House Supervisor to convey the need for admission or change in level of care.
2. The House Supervisor communicates with the receiving unit's Charge RN to determine bed availability and status of the room.
3. The House Supervisor assigns only clean and ready bed assignments, noting assigned RN's name.
    - If no clean bed is ready and available, the House Supervisor will notify the ~~Environmental Services (~~designated area EVS~~) Supervisor~~ contact.
    - The EVS contact will notify the House Supervisor ~~will notify the House Supervisor~~ when a room has been cleaned and is ready to receive a patient.
4. The House Supervisor notifies the receiving unit of the clean and ready bed.
5. The primary RN of the sending unit is responsible for calling report to the receiving unit within 15 minutes of notification of ready, clean bed. ~~A paper situation, background, assessment, recommendation (SBAR) will be filled out and sent within 15 minutes of bed assignment for the Inpatient Psychiatric Unit (IPU).~~
    - Patient transfer is expected to occur within 30 minutes of notification of a clean and ready bed.
    - Expectation from nursing is a telephonic handoff to notify the receiving unit that the patient is coming followed by a bedside handoff between sending and receiving RN. Both the sending RN and

receiving RN are responsible for this communication.

- Items to include in bedside handoff are: review of any incomplete orders, four eyes skin assessment, abnormal assessment findings
- Some exceptions may apply, for example primary RN is unable to leave unit due to staffing ratio, at which time a phone report will be acceptable.

6. If limited/unusual circumstances occur which may cause a delay, immediate communication shall occur between the House Supervisor and the receiving unit's Charge RN. Delay of transfer should not exceed a maximum of 30 minutes.

IPU

1. For patients from the Emergency department (ED), the Crisis Stabilization Unit (CSU) physician communicates with the ED physician and notifies when patient is being accepted to CSU or IPU.
2. CSU physician will notify the IPU intake coordinator about the admission and ask that they contact the ED charge nurse regarding timing.
3. IPU intake will call the ED charge nurse with transfer time.
4. For inpatient transfers to IPU, IPU intake will call the unit charge nurse.
5. The primary RN of the sending unit is responsible for calling report to the receiving unit to meet the 30 minute transfer time expectation. A paper situation, background, assessment, recommendation (SBAR) will be filled out.
    - Expectation from nursing is a telephonic handoff to notify the receiving unit that the patient is coming followed by a bedside handoff between sending and receiving RN. Transports to IPU are to occur via gurney only.
6. If limited/unusual circumstances occur which may cause a delay, immediate communication shall occur between the IPU Charge RN and the other unit charge RN, with escalation to nursing supervisor if needed. Patients in outlying hospitals also be factored into bed capacity in the IPU.

ATTACHMENTS:

- Attachment A - Patient Throughput Algorithm

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Attachments

108.035 Attachment A - Transfer Flowchart.pdf

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	6/11/2025

Step Description	Approver	Date
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VENTURA COUNTY HEALTH CARE AGENCY

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108.059 Patient Lifting, Transfer and Weighing

POLICY:

The physical demands of nursing work generally include lifting, awkward positions (such as bending, reaching, and twisting), and repetition of these body movements. These movements can increase the likelihood of back injury. The following guidelines help prevent injury on the job. These guidelines are based on information gathered during investigation of Med/Surg/Tele injury exposures and are based on the Med/Surg/Tele nursing tasks identified as the most likely to lead to back injury.

PROCEDURE:

A. **Patient movement:**

1. Patient assessment: Ask physical therapists and nurses to evaluate if patients (especially heavy ones) can assist with lifting. Many aspects of the patient's condition can affect how they are lifted or moved. In addition to their weight, consider the following:
    a. **Medical condition:** What could make the patient vulnerable to further injury (dizziness, confusion, medication, muscle spasms, etc.)?
    b. **Physical ability:** Can the patient sit up, stand up, and walk? Are they ambulatory, weight-bearing, stroke weak on one side, or have decreased upper body strength?
    c. **Acuity:** How well does the patient follow instructions? Is there general understanding or language problems?
    d. **Behavior:** What might the patient do? Are they combative, cooperative or unpredictable?
2. General guidelines for moving patients: Always make sure there are enough employees available for moving patients.
    a. Assess the patient before moving.
    b. Eliminate or reduce manual lifting and moving of patients whenever possible. Use assistive devices as appropriate.
    c. Get patient to help as much as possible by giving clear instructions with adequate time for response.
    d. Do not exceed one's own physical limits and capabilities.
    e. Get help whenever possible from both inside and outside your department. Use teamwork.

f. Plan ahead: consider the route being taken and ensure a clear path of travel.

g. Use upright, neutral postures and proper body mechanics (see section 4).

3. Guidelines for moving patients in beds, gurneys, and wheelchairs:

a. Decrease the weight or load whenever possible.

b. Store equipment between waist and shoulder height.

c. Using sliding motions instead of lifting when possible.

d. Push, don't pull. Keep loads close to the body and push with the whole body, not just the arms.

e. Move down the center of the corridor to avoid collisions.

f. Look for door handles and high thresholds which can cause abrupt stops.

B. **Equipment:**

1. Assistive equipment: There are many types of equipment and devices designed to make lifting or moving patients easier. It is important to use proper work practices and body mechanics in combination with these devices (see section 4). There are several different types of lifts to help with moving patients. See the next section for a description of the lifts available, and when they are appropriate to use.

2. Guidelines for Lateral transfers: Always make sure you have enough employees available for moving patients.

a. Position surfaces as close as possible to each other. Surfaces should be approximately waist high, with the receiving surface slightly lower to take advantage of gravity.

b. Lower the side rails on both surfaces.

c. Use draws sheets in combination with friction-reducing devices like slide boards and plastic bags.

d. Get a good handhold by rolling up draw sheets.

e. Kneel on bed or gurney to avoid extended reaches and back bending.

3. Guidelines for using gait belts:

a. Keep patient as close to the body as possible.

b. Avoid bending, reaching or twisting one's back when attaching or removing belt, lowering the patient or assisting with ambulation.

c. Pivot with one's feet to turn.

d. Use a gentle rocking motion to take advantage of momentum.

4. **Mechanical lifts:** Theses devices help reduce injury by avoiding unnecessary manual transfers, awkward postures, forceful exertions, and repetitive motions. Lifts should be used for potentially dangerous lifting or moving tasks. The following lifts are available:

a. **Maximove** (*See Nursing Procedure A.14.1*):

i. Capabilities

a. Used for moving dependents up to 500 pounds.

b. Used for moving patients from bed to wheelchair; bedside chair to bed.

c. It can fully support the patient with no assistance from patient.

d. Patient can be unconscious.
e. Only lift can raise patient from the floor.
f. One person needed to operate lift unless a very large person is being moved.
g. Located at Ventura County Medical Center only

ii. Limitations
a. Difficult to put patient in a sitting position to lever them back. A lot of force is required to attach sling lever if the patient is unable to help.

b. **Total lift / Ceiling Lift** (*See Nursing Procedure A.14.2*):
i. Capabilities
a. Maximum weight is 770 pounds.
b. Initiates sitting activities.
c. Initiates sitting to standing.
d. Located at Ventura County Medical Center and Santa Paula Hospital.

ii. Limitations
a. At least two (2) people are needed to get the patient onto the lift from the bed. Patient must first be rolled onto his/her side. Large patients may be difficult.

c. **Sara 2000** (*See Nursing Procedure A.14.3*):
i. Capabilities
a. Maximum weight is 400 pounds.
b. Moves a patient from a chair to bed.
c. Patient stands on the machine and can be wheeled to bathroom, bedside commode, etc.
d. Located at Ventura County Medical Center only.

ii. Limitations
a. Patient must be able to sit up and carry some of own weight.
b. Must be able to hold onto lift with at least one arm.
c. Patient must be cooperative and conscious.
d. Patient cannot have impacted fractures or osteoporosis.

d. **Invacare Reliant** (*See Nursing Procedure A.14.d*):
i. Capabilities
a. Maximum weight is 400 pounds.
b. Moves a patient from the floor to a chair or bed.
c. Located at Santa Paula Hospital.

e. **Hoyer Surgilift** (*See Nursing Procedure A.14.e*):
i. Capabilities
a. Maximum weight is 400 pounds.

b. Moves a patient from a gurney to a table/bed.
c. Located at Santa Paula Hospital.

ii. Limitations
a. At least two (2) people are needed to operate the lift.
b. Do not use the lift on uneven surfaces or on deep pile carpeting.
c. Do not move the lift at speeds over 2.5 feet per second.

f. **HoverMatt** (*See Nursing Procedure A.14.f*):
i. Capabilities
a. Transfers dependent patients.
b. Located at Santa Paula Hospital.

ii. Limitations
a. Do not leave patient unattended on inflated mattress.

5. **Proper Lifting Techniques** - Follow these guidelines at all times when lifting patients, equipment or supplies:
a. Bend your legs, not your back. Use your legs to do the work.
b. When lifting people, always face them.
c. Do not twist when turning. Pick up your feet and pivot your whole body in the direction you are lifting.
d. Use a wide, balanced stance with one foot slightly ahead of the other.
e. Lower objects slowly by bending your legs, not your back. Return to an erect position as soon as possible.
f. Use smooth movements and do not jerk. When lifting with the help of other people, coordinate lifts by counting together (example: "Move on the count of three")
g. For additional support, keep the patient close to the body and keep handholds between waist and shoulders.
h. Move objects towards you, not away from you, when possible.

REMEMBER!

Safety is a priority. Staff should not compromise their safety when feeling rushed. Work as quickly as possible while *safely* performing tasks.

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Attachments

No Attachments

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/11/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/11/2025

VENTURA COUNTY
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References:	

109.055 HCA Non-Monetary Compensation and Medical Staff Incidental Benefits

PURPOSE

The Physician Self-referral Law commonly known as "Stark" prohibits a physician from making referrals for designated health services (DHS) payable by Medicare or Medicaid to an entity with which he or she (or an Immediate Family Member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The purpose of this Policy is to establish guidelines to comply with the exceptions promulgated under Stark Law and Regulations when providing Non-Monetary Compensation or Incidental Benefits to Physicians or their Immediate Family Members.

SCOPE

This policy applies to Ventura County Health Care Agency (HCA), its affiliates and all satellite locations.

DEFINITIONS

A. ***"Immediate Family Member"*** means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

B. ***"Incidental Benefits"*** means compensation in the form of items or services (excluding cash or cash equivalents) from HCA to a Physician when the item or service is used on HCA campuses or sites, provided that:

   a. The Incidental Benefit is **offered** to all members of the medical staff practicing in the same specialty without regard to the volume or value of referrals or business generated between the parties.

   b. Except for the identification of medical staff members on HCA website or in advertising, the compensation is provided only during periods when the medical staff members are making rounds or engaged in other on-campus activities that benefit HCA or its patients.

   c. Examples include lab coats, Internet access to facilitates patient care, pagers,free parking and cafeteria meals on HCA campus during times when the Physician is in the hospital.

   d. Incidental Benefits are not counted against the annual Non-Monetary Compensation limits unless they exceed the threshold established for each occurrence of a benefit. As of 2025, the limit is less than $45 per occurrence.

C. ***"Non-monetary Compensation"*** is items and benefits provided without charge or for less than fair market value to a physician outside of a specific contractual relationship and unsolicited by the Physician or persons under his or her control (i.e., office staff). Non-monetary Compensation may include items such as non-working hour meals, gift baskets, event giveaways, flowers, appreciation events, parties, golf outings, concerts, or sporting events (excluding cash and cash equivalents). Non-monetary Compensation is limited to an aggregate annual amount $519 per Physician as of 2025.

D. ***"Physician"*** means a Doctor of Medicine or Osteopathy, a Doctor of Dental Surgery or Dental Medicine, a Doctor of Podiatric Medicine, a Doctor of Optometry, or a Chiropractor.

E. ***"Responsible Person"*** means any individual or department of HCA that provides or directs the provision of items or services that qualify as Non-Monetary Compensation or Incidental Benefits.

POLICY

HCA monitors non-cash items and services provided to referring Physicians to ensure compliance with Stark Law and Regulations. Non-monetary Compensation and Incidental Benefits shall not, in any manner, be related to the volume or value of referrals or business generated between the parties and cannot be solicited by the referring Physician. This Policy and related procedures provide guidelines for documenting, tracking, and recording Non-Monetary Compensation and Incidental Benefits.

Physicians employed by HCA are exempt from this Policy and may receive items or services under the terms and conditions of their employment.

PROCEDURE

The Non-monetary Compensation and Incidental Benefit limits may be adjusted annually for inflation effective January 1st of each calendar year. Annually, HCA Compliance Officer will consult the Centers for Medicare and Medicaid (CMS) website for the current annual limitations and communicate them to Responsible Persons.

NON-MONETARY COMPENSATION

A. All Responsible Persons providing Non-Monetary Compensation to Physicians must provide detailed information to the Compliance Officer prior to the provision of such items or services to ensure the applicable annual limits are not exceeded.

B. If the applicable limit will be exceeded by the anticipated cost of an item or service, HCA Compliance Officer shall notify the Responsible Person immediately to prevent the provision of such items or services to the Physician.

C. HCA may host one local, annual event for the entire medical staff without the cost subject to the Non-Monetary Compensation annual limit for those in attendance. Giveaways or gifts at such an event will count toward the annual Non-monetary Compensation limit.

D. Continuing Medical Education (CME) provided on-campus which otherwise meets the conditions set forth above in the definition of Incidental Benefits may be offered to Physicians and recorded as an Incidental Benefits unless its value exceeds the annual limits. All other CME or discount related to CME must be counted as Non-Monetary Compensation and toward the annual limit unless provided under a written agreement that satisfies another exception under the Stark Law and Regulations.

E. A single item that exceeds the Non-Monetary Compensation annual limit may not be allocated to several Physicians to fall below the threshold. For example, a gift valued at $750 may not be given to a three-

person group practice and allocated to the Physicians at $250 each. The total value of the gift must be allocated to each Physician.

F. The fair market value of items or services provided to Physicians pursuant to this Policy is the full fair market value of the item or service, not HCA cost of providing such item or service.

G. The fair market value of all items or services shall be reported to HCA Office of Compliance and Privacy along with copies of all receipts or other documentation of expenses using the Non-Monetary Compensation and Incidental Benefit Form attached hereto as Appendix A. Compliance shall maintain a complete calendar year log of all reports received by Physician.

H. Within sixty (60) days of the end of the calendar year, HCA Compliance Officer will review all Non-Monetary Compensation and Incidental Benefits provided to Physicians in the preceding calendar year and report on such to HCA Compliance and Oversight Committees.

Excessive Amounts

A. Non-monetary Compensation may be provided from multiple sources, therefore Responsible Persons should contact HCA Office of Compliance and Privacy to determine the availability of additional Non-monetary Compensation to avoid exceeding the annual limits. In the event an exact amount is unavailable, an estimate may be provided until the amount is determined.

B. In the event HCA has inadvertently provided Non-Monetary Compensation to a Physician in excess of the annual limit, such compensation may be deemed to be within the limit if:

   a. the value of the Non-Monetary Compensation is no more than (50%) greater than the annual limit; and,

   b. the Physician returns the excess Non-Monetary Compensation (or an amount equal to its value) by the earlier of the end of the calendar year in which the excess Non-Monetary Compensation was received; or, within 180 consecutive calendar days following the date that the excess Non-Monetary Compensation was received.

REFERENCES

Stark Law, § 42 U.S.C 1395nn
Non-Monetary Compensation Exception, 42 C.F.R. § 411.357(k)
Medical Staff Incidental Benefits Exception, 42 C.F.R § 411.357(m)

APPENDIX A

HCA Reporting Form for Non-Monetary Compensation For the year

Physician	Item/Service	Cost/Fair Market	Responsible Person
Total		**$**	

This form must be completed and sent to the Compliance Office within 5 business days of providing Non-monetary Compensation to a Physician.

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Attachments

No Attachments

Approval Signatures

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Oversight Committee	Melissa Guevarra: Acting Compliance Officer	7/1/2025
Compliance & Privacy Office	Melissa Guevarra: Acting Compliance Officer	6/2/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Ambulatory Care - Adult Hematology/Oncology*
References:	

AC.19 Treatment of Occluded Central Venous Catheters Using Alteplase

POLICY:

To aid Ambulatory Care health care workers in restoring patency to occluded central venous catheters. In many cases, patency in the following catheters can be restored with the prompt use of alteplase: subclavian catheters, tunneled venous catheters (Groshong, Hickman and Broviac), peripherally inserted central catheters (PICC) and implantable ports (Hickman, Groshong, and Port-a-Cath).

PROCEDURE:

Definitions:

- Catheter obstruction or dysfunction is defined as the inability to infuse fluid, sluggish flow, and/or the inability to withdraw blood.

NOTE: Central venous catheters (CVCs) may have one or more lumens. The patency of each lumen must be considered when attempting to restore patency.

Key Points:

1. Alteplase (tPA) should be used only with physician order and after all other appropriate methods of ruling out catheter obstruction have been tried.
    a. To rule out any external mechanical obstruction, ensure that:
        i. The IV tubing is not clamped or kinked
        ii. All connections are tight and there are no air leaks
        iii. The sutures are not too tight at the catheter site
        iv. The catheter is not kinked, twisted or moved out of place
    b. Request the patient to change position. Instruct the patient to lift ~~arms overhead or forward to "lift" clavicle off the subclavian vein~~arm on Central Venous Access Device side and roll shoulder back. If blood return occurs with change in position, flush catheter with 10ml normal saline. Discuss with the physician the advisability of chest x-ray to assess for internal catheter pinch-off or kink.
    c. Ask the patient to take a deep breath and cough forcefully while attempting to irrigate and withdraw blood.

d. If the catheter device is an implanted port, remove the needle and re-access with new Huber needle to ensure correct needle placement. Reassess catheter patency after accessing.

2. Never use less than 10ml syringe, as the smaller syringe has greater PSI.
3. Alteplase has a low side effect profile.
4. Consider requesting a Physician order for a contrast study for persistent or recurring unresolved Central Venous Access Device occlusion.

Equipment:

1. Alteplase 2mg/vial(s)
2. Sterile H_2O (do not use bacteriostatic) for diluents (needed if not prepared by the Pharmacy)
3. Four (4) -- 10ml syringes with normal saline
4. Two (2) – 10ml luer lock syringes with 20-22g needles for drawing up alteplase
5. Alcohol wipes
6. Gloves
7. Sterile injection caps

Method of Administration:

1. Pre-infusion assessment:
   a. Identify patient with two (2) patient identifiers and place identification armband
   b. Explain procedure and confirm with patient his/her planned treatment
   c. Vital signs
   d. Allergy history
   e. Current infusion therapy orders including therapy tolerance/side effects
   f. Current clinical status including review of recent lab work
   g. VAD assessment
   h. Psychosocial assessment including ability to cope with current therapy
   i. Patient education needs
2. Wash hands and don gloves
3. Cleanse the distal end of the catheter where it joins an injection cap or infusion tubing with three alcohol wipes. Place on a sterile 4X4 and let dry 1-2 minutes, then remove cap. Always clamp the catheter prior to cap removal for non-valved catheters.
4. Attach an empty 10ml syringe and attempt to aspirate. Unclamp catheter prior to aspiration if non-valved catheter. If aspiration is successful, withdraw clots along with 5 ml of blood and discard. Then flush catheter with 20-30 ml of normal saline.
5. If catheter remains occluded, obtain a physician’s order for the use of alteplase 2 mg/2 ml. Order shall indicate that the procedure can be repeated x1, if necessary.
6. Reconstitute alteplase according to manufacturer’s guidelines using 2.2 ml of sterile water to a final concentration of 1mg/ml. Draw up 2 ml of alteplase into a 10 ml luer lock syringe (Pharmacy may assist with preparation of alteplase)

7. The preferred method for declotting a central catheter is the Negative Pressure with One Syringe Technique:
    a. Remove injection cap. Attach syringe with alteplase to the catheter hub.
    b. Slowly pull back on syringe to the 8-9ml mark. Holding on to the plunger, slowly allow it to move back to neutral position. Do not allow plunger to snap back as the pressure could cause catheter breakage.
    c. Repeat several times using this gentle pull technique as described above.
8. Leave the alteplase instilled for 30 minutes with the catheter clamped and the syringe attached. Catheter clamping is not necessary for valved catheters, i.e. Groshong catheters.
9. After 30 minutes, unclamp, and attempt to aspirate alteplase and blood. If unsuccessful, reclamp the catheter (if non-valved catheter) for a total dwell time of 120 minutes and then again attempt to aspirate. If unsuccessful after 120 minute dwell time, a second dose may be instilled using the above procedure. If unsuccessful after two (2) attempts, notify physician as additional possible causes of catheter obstruction should be ruled out.
10. If successful, aspirate 5 ml of blood and clamp tubing (if non-valved catheter).
11. Attach a 10ml syringe filled with normal saline, unclamp catheter and flush. Repeat this step for a total of 20 ml. Use push-stop-push technique when flushing as it causes turbulence in the catheter and flushes out blood and drug more effectively.
12. Attach injection cap or resume infusion.
13. Post-infusion assessment:
    a. Vital signs
    b. Patient tolerance of procedure/therapy
    c. Current clinical status
    d. VAD assessment including patency status
14. All patients should be screened for presence of pain as part of each assessment using a 0-10 scale. For moderate to severe pain, further assessment should be obtained and physician notified for intervention.
15. Patient education-written/verbal information

Documentation:

Document the following in the Electronic Health Record (EHR):

- Procedure and outcome
- Patient education

Infection Control:

All health care workers shall routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves shall be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves shall be changed after contact with each patient. Masks and protective eyewear or face shields shall be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of mouth, nose and eyes.

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Attachments

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Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
P&T Committee	Sul Jung: Associate Director of Pharmacy Services	6/11/2025
Associate Chief Medical Officer, AC	Amelia Breckenridge: Associate Chief Medical Officer, Ambulatory Care	5/27/2025
Adult Oncology, Medical Director	Isabella Chen: Medical Director, Adult Oncology	5/20/2025
	Cathy Deen: Adult Hem-Onc Charge Nurse	5/2/2025

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CA.03 Cancer Registry Casefinding

POLICY:

Casefinding is a systematic method used to identify all eligible cancer cases seen at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

PROCEDURE:

The sources used at VCMC/SPH to identify these cases include:

A. Pathology reports

B. Cytology reports

C. Medical Record Disease Index (lists all patients including in-house, outpatient and clinic patients).

The following procedure is followed to ensure that all eligible cases are identified and included in the Cancer Registry:

Pathology/Cytology Reports : Pathology Department reports are received from the Pathology Department on a monthly basis. The histology, cytology, bone marrow, and autopsy reports are source documents for identifying eligible cases.

- *Medical Record Diagnostic Listing:* The listing is generated monthly and is used to identify all reportable cases without a pathological diagnosis at VCMC/SPH. It includes patient name, medical record number, admission and discharge dates. There is a two to three month lag between the month of the report and the request date. This ensures case coding for the month requested is complete and the listing is accurate.
- *Mortality Index Listing:* The listing is generated monthly and is used to identify all reportable cases of patients that expired at VCMC/SPH with active malignant disease, but were not diagnosed or treated for the malignancy at the facility.

Reference:

Registry Operations and Data Standards

All revision dates: 4/28/2016

Attachments

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Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

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CA.04 Cancer Registry Suspense File

POLICY:

The suspense file is a temporary file identifying eligible cases yet to be abstracted.

PROCEDURE:

A. The suspense file includes the following:
   1. All pathology/cytology reports for:
      a. Specimens positive for malignant cells or tumors.
      b. Surgical resections for cancer treatment including resections without residual tumor when preceded by excisional biopsy of the tumor, or for hormone ablation therapy such as orchiectomy for prostate cancer.
   2. A monthly Medical Record Diagnostic listing for inpatient and outpatient visits for cancer or related procedures.

B. Pathology/cytology reports are filed by month. Multiple reports for the same patient are stapled together in chronological order starting with the earliest report.

Reference:

Registry Operations and Data Standards

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Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Cancer Program*
References:	

CA.05 Cancer Registry Accession Register

POLICY:

The Accession Register is an annual sequential listing of all cases in the Cancer Registry database. It includes an accession/sequence number, the patient's name, primary site and date of diagnosis.

PROCEDURE:

The Accession Register is used to audit other registry files, monitor casefinding, access the workload, and verify patient identification. The Accession Register is computerized on CNET system and can be accessed on screen by command. A hard copy is printed as needed.

Definition:

A. A case is entered into the accession register by the year the patient was diagnosed or first seen for cancer at Ventura County Medical Center/Santa Paula Hospital. The year is identified by the first two digits of the accession number. The last four digits of the accession number indicate the numeric order in which the case is entered into the database. Example: 960150 indicates that the patient was first seen in 1996 and was the 150th case entered in 1996.

B. Each patient receives only one unique accession number, regardless of the number of primaries he or she may have.

C. The sequence number represents the order of all independent primary malignancies diagnosed in the same patient throughout their life, whether the tumors exist at the same or at different times. It is a two digit number recorded at the end of the accession number, after the back-slash. A sequence number of /01 indicates this is the first of two or more primaries. A sequence number of /02 indicates this is the second of two or more primaries, etc.

D. The accession number is assigned at the time the case is first abstracted. If the patient develops additional primaries at a later date, the sequence number is changed on the first abstract to /01. The sequence number for the subsequent primaries becomes /02, /03 etc. The accession number, however, remains the same for all subsequent primaries.

E. If malignancies occur simultaneously, assign the first sequence number to the primary with the worse prognosis. If severity of prognosis cannot be determined, sequence number assignment is arbitrary.

Reference:

Registry Operations and Data Standards

All revision dates: 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

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Policy Area:	*Cancer Program*
References:	

CA.07 Cancer Registry Follow-Up

POLICY:

Annual follow-up is performed on each eligible analytic and living Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) patient accessioned into the Cancer Registry. Cases are followed based on the last date of follow-up and are considered delinquent if the last date of contact exceeds fifteen months. An 80% successful follow-up rate is maintained on all analytic cases. A 90% follow-up rate is maintained on all analytic patients diagnosed within the last five (5) years or from the Cancer Registry reference date, whichever is shorter.

PROCEDURE:

Required follow-up rates and information to be collected:

A. Creating and Generating Follow-Up lists:

1. CNExT generates a monthly follow-up control list which identifies all patients eligible for follow-up that month, including delinquent cases. The list includes patient name, social security number, and date of birth, primary site, medical record number, accession year, accession number, and last date of follow-up.
2. The control list is created the first week of each month and lists patients eligible for follow-up for the previous month. To create the current control list, use the "select monthly follow-up patients" option in the CNExT follow-up section, and choose the current month to be followed. After CNExT has created the file of eligible patients, use the "Control List Printing" option to print the list of follow-up patients for that month.
3. The delinquent list selects all patients with a last date of follow-up greater than fifteen months. It should be generated every three months and used to identify which cases require follow-up efforts on a case by case basis.
4. The follow-up worksheet summarizing the current follow-up rates is generated each month on the last working day. The most current follow-up rates are annually to Cancer Committee meeting.

B. Follow-up Letter Approval and Use:

1. There is a different follow-up letter for each kind of follow-up source, including physician, patient and patient identified contacts. All follow-up letters must be reviewed and approved by Cancer Committee before they are used.

C. The following sequence of steps comprise the monthly follow-up procedures:

1. After generating the current control list, it should be reviewed against the hospital system to determine if any patients have been re-admitted. The charts should be reviewed and the required data recorded in CNExT. Information regarding change of address, new physicians and/or contacts should also be noted in CNExT.
2. Medical Oncology patient records should be reviewed for those patients followed by the outpatient Medical Oncology physicians. All required data should be recorded in CNExT. Information regarding change of address, new physicians and/or contact information should be noted in CNExT
3. Other hospital cancer registries that follow the same patients should be contacted by letter or phone for current information.
4. The patient's primary care physician should be contacted for all remaining patients. If that physician does not have current follow-up information, other physicians following the patient should be sequentially contacted until current follow-up is obtained or all physician resources have been exhausted. Physicians are initially contacted by letter. A "second request" letter is sent if there is no response to the first letter within two weeks. If there is still no response within the next two weeks, the physician'a office is telephoned to determine if the patient has been seen and current information is available.
5. Once all physician contacts have been exhausted, patients and other contacts listed by the patients should be contacted directly for current follow-up. Initial contact is by letter, followed by telephone calls if there is no response. Refer to patient contact policy in the next section before initiating any patient/contact communication.
6. Any shared follow-up received from the State should be reviewed and our follow-up updated if the information received from the State is more current.
7. In addition to the monthly control list, a patient delinquent list should be generated every three months.
8. Patients on the delinquent list should be re-reviewed against the hospital system to determine if they have been readmitted. Charts should be reviewed on all readmissions and the required information recorded in CNExT, including any change of address and/or new physician information.
9. Next the delinquent list should be checked against the outpatient Medical Oncology patient records.

D. Patient/Family Contact Policy:
There are situations in which it is not appropriate to directly contact patients or individuals named by patients. As a result, the following policy must be followed before contacting any patient/patient identified source by letter or phone:

1. Physician permission to contact patients and/or individuals named by patients is required. Each follow-up letter includes a "Do not contact patient/family" statement and check box. If the box is marked by the physician, the patient and all patient identified contacts should be flagged "Do Not Follow" (Code 9) on the CNExT follow-up screen with the statement "Per MD instruction."
2. Before patients/patient contacts letters are generated, a control list of these patients is printed. This list is checked against the hospital system a second time the day of or before any of these letters is mailed. This helps ensure that patient family members and friends do not receive follow-up letters if the patient has expired at VCMC/SPH after the control list was first checked for readmissions.

Definition:

A. The following cases will be followed on an annual basis:

1. All analytic cases including:
    a. Cases that were diagnosed at VCMC/SPH, but received first course of treatment at another facility.
    b. Cases that were diagnosed and treated at VCMC/SPH.
    c. Cases that were diagnosed at another facility or in a staff physician office, but received first course of treatment at VCMC/SPH.

B. The following cases are not required to be followed:
    1. All non-analytic cases including:
        a. Cases that were diagnosed and treated at another facility.
        b. Cases that were diagnosed and treated at VCMC/SPH before January 1, 2014.
    2. Patients whose primary residence is not in the United States.
    3. Carcinoma In-situ of the Cervix cases.
    4. Cervical Intraepithelial Neoplasia (CIN) cases
    5. Vaginal Intraepithelial Neoplasia (VIN) cases.

Reference:

Registry Operations and Data Standards

All revision dates: 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Cancer Program*
References:	

CA.09 Cancer Program Quality Management Plan

POLICY:

The purpose of the Ventura County Medical Center/Santa Paula Hospital Cancer Program Quality Management Plan (CPQMP) is to measure, evaluate and improve the quality of care provided to cancer patients. A monthly transmittal schedule of completed abstracts via secure website has been established with the California Cancer Registry.

PROCEDURE:

A. The purpose of the Ventura County Medical Center/Santa Paula Hospital Cancer Program Quality Management Plan (CPQMP) is to measure, evaluate and improve the quality of care provided to cancer patients, especially in, but not limited to, the following areas:

1. Appropriate diagnostic or therapeutic procedures are prescribed including absence of unnecessary as well as the inclusion and timely use of essential procedures.
2. Appropriate health care services and support mechanisms are available, accessible and identified to the patient.
3. Clinical care that is provided is appropriate, accurate and fully documented.
4. Patient consultations are appropriate and timely.
5. Diagnosis is timely and accurate.
6. The results of diagnostic tests and findings are available in a timely and appropriate manner, and follow-up of the findings is also appropriate and timely.
7. Referrals are made in an appropriate and timely manner.
8. Patients receive proper continuity of care. Patients receive diagnostic procedures and treatment modalities that are consistent with their clinical needs and current professional knowledge.
9. Programs and processes that promote an increased likelihood of desirable outcomes.
10. Programs and processes that encourage patient cooperation.
11. Programs and processes that increase patient satisfaction.

B. Components:

1. The CPQMP components include quality planning, measurement evaluation, and improvement.

C. Participants:

1. Cancer Committee members, including the Cancer Committee Chairman, Cancer Registrar, and physician liaison, must be actively involved.
2. Other members of the multidisciplinary cancer Program team also actively participate in the process as appropriate per study.
3. Clinicians or staff whose work is being evaluated by a quality measure. This can be limited to participating in the analysis and interpretation of the findings.

Cancer Committee Responsibilities:

The Cancer Committee will identify at least two important evaluation interests related to cancer patient care, and consider these improvement priorities when selecting quality measures and improvement projects. At least annually the Cancer Committee will assess the effectiveness of the quality management activities in achieving its priorities for improvement.

A. The CPQMP responsibilities include:
    1. Identify at least two cancer patient care evaluation priorities each year. The priorities must include, but are not limited to:
        a. Comparative data using NCDB data and other relevant published literature.
        b. Issues of institutional, regional, or national importance.
        c. Patient and/or family satisfaction surveys.
        d. Further analysis of unacceptable or unexpected results found during quality measurement activities.
        e. Further analysis of unexplained variations from established treatment guidelines.
    2. Use improvement priorities to:
        a. Define quality measures to evaluate one or more of the following areas:
            1. Accessibility
            2. Appropriateness of services
            3. Continuity of Care
            4. Cost of Services
            5. Patient Compliance
            6. Patient Risk minimization
            7. Patient Satisfaction
            8. Practitioner performance
            9. Record documentation
            10. Support Staff performance
        b. Identify improvement projects.
    3. At least annually, participate in two formal evaluations of quality measures relevant to its improvement priorities, using one or more of the techniques defined in "Standards of the Commission on Cancer, 2016 Edition, Ensuring Patient Centered Care." The Committee should use these results to:
        a. Determine current performance levels related to patient care activities and compliance with

current treatment guidelines.

b. Identify improvement opportunities and assess the need for intervention.

c. Approve and/or recommend actions designed to improve performances or outcomes in these areas, and achieve or refine selected improvement priorities.

d. Evaluate the effectiveness of the actions to determine whether changes in the processes resulted in the desired improvement.

e. Identify future improvement priorities.

4. Disseminate the Committee's summary reports of measurement and evaluation of findings, and improvement activities to the appropriate medical staff and administrative leadership.

5. Complete an annual evaluation of the effectiveness of the CPQMP including documentation of the previous year's quality management activities and resulting improvements, and the Cancer Program's improvement priorities for the next 12 months.

B. Cancer Committee Chairman Responsibilities:
The Cancer Committee Chairman's responsibilities include ensuring that the Cancer Program documentation confirms the Cancer Committee's involvement in the following:

1. Establishing priorities for improvement.

2. Defining quality measures.

3. Evaluating the results of quality measurement.

4. Designing and initiating actions(s) aimed at achieving desirable results.

5. Monitoring the effectiveness of action plans and all quality management activities.

C. Cancer Registrar Responsibilities:

1. Assist the Cancer Committee to identify pertinent quality measures for the improvement priorities it has identified through active participation and by providing appropriate Cancer Registry data.

2. Provide the appropriate statistical data from the Cancer Registry database for Committee use in evaluating the quality measures relevant to its improvement priorities, and assist with the analysis.

3. Participate as a member of the Cancer Committee quality improvement team to explore relevant processes of patient care, design and implementation improvements.

D. Cancer Physician Liaison Responsibilities:
The Cancer Physician Liaison responsibilities include:

1. Provide support and direction, as needed, to ensure the Cancer Program and Cancer Committee meet the quality management and improvement standards as defined by the Commission on Cancer.

2. As a Committee member, actively assist the Cancer Committee in identifying pertinent improvement priorities and defining appropriate quality measures.

3. Review the Cancer Registry data used in CPQMP processes for completeness, consistency and accuracy.

4. Assist in analyzing Cancer Program data and evaluating results.

5. Assist in presenting summary reports to appropriate committee and medical department meetings.

6. Monitor, interpret, and report the Program's performance using NCDB data and use the information to evaluate and improve the quality of care.

7. Report on CoC activities, initiatives, and priorities to the Cancer Committee.
8. Serve as liaison for the program with the American Cancer Society.

Reference:

Registry Operations and Data Standards

All revision dates: 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.15 Cancer Registry - American Joint Committee on Cancer TNM Staging

POLICY:

The American Joint Committee on Cancer (AJCC) has established a staging system entitled TNM (**T**umor Size, Lymph **N**odes affected, **Me**tastases) which is based on the clinical, operative and pathological assessment of the anatomic extent of disease. The TNM staging system is used to make appropriate treatment decisions, determine prognoses and measure end results.

PROCEDURE:

The American College of Surgeons Commission on Cancer requires that Clinical and Pathological T, N, and M components must be recorded by the managing physician(s) for all analytic cases that have an AJCC coding scheme. AJCC (T, N, M, elements and Stage Group) staging is assigned by the managing physician and recorded in the History and Physical summary of the medical record.

Clinical classification is based on evidence acquired before primary treatment. Clinical assessment uses information available prior to the first definitive treatment, including but not limited to physical examination, imaging, endoscopy, biopsy, and surgical exploration. Clinical stage is assigned prior to any cancer directed treatment and is not changed on the basis of subsequent information.

Pathological classification uses the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathological examination. The pathological assessment of the primary tumor entails resection of the primary tumor sufficient to evaluate the highest pT category and with several partial removals, may necessitate an effort at reasonable reconstruction to approximate the native size prior to manipulation. The complete pathological assessment of the regional lymph nodes (pN) ideally entails removal of a sufficient number of lymph nodes to evaluate the highest pN category.

The TNM system is an expression of the anatomic extent of disease and is based on the assessments of three components:

T - The extent of the primary tumor.
N - The absence or presence and extent of regional lymph node metastasis.
M - The absence or presence of distant metastasis.

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Attachments

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Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.18 Cancer Registry Physician Credentials

POLICY:

In order to provide the highest quality of care to cancer patients, Ventura County Medical Center (VCMC) and Santa Paula Hospital's (SPH) physicians are required to be Board Certified or in the process of becoming Board Certified in their specialty.

PROCEDURE:

- The Cancer Registry will maintain a roster of physicians referred to for diagnosis and/or treatment of VCMC/SPH cancer patients.
- The Cancer Registrar will verify with the Medical Staff office that referred physicians meet the Medical Staff bylaw requirements addressing board certification.
- The Cancer Registrar will contact the Medical Staff Office to verify the Board Certification status of each physician listed on the Medical Staff roster on an annual basis.
- The revised Medical Staff roster will be presented to Cancer Committee on an annual basis with changes noted.

Reference:

American College of Surgeons, Commission on Cancer Standards: Optimal Resources for Cancer Care 2020 Edition

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Attachments

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Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025

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Cancer Program Manager	Judy Borenstein: VCMC - Nursing	6/18/2025

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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.24 Cancer Program Genetics Counseling and Risk Assessment

POLICY:

Ventura County Medical Center/Santa Paula Hospital Hematology Oncology physicians are dedicated to helping patients and their families understand and evaluate their cancer risk. Hematology-Oncology physicians provide genetic counseling and risk assessment in order to help patients receive the best options for treating and managing their cancer diagnosis.

Every person is at a risk for cancer, but each person's risk is individual. There are many factors that affect a person's risk including genetics, family history, gender, age and lifestyle. Cancer risk assessment experts use tools to define a person's risk to develop certain types of cancer. One important component of risk assessment is estimating the chance that genetic mutation is responsible for causing the cancers in a family.

PROCEDURE:

During the initial consultation, the patient will meet with the Medical Oncologist for a review of the patient's personal and family history. The Oncologist will determine if genetic testing is indicated, and education will be provided regarding the recommendation for or against genetic testing.

Patients that meet the National Comprehensive Cancer Network guideline criteria for genetic counseling and risk assessment will be referred to the Hematology-Oncology Outpatient Clinic and provided with pretest counseling which includes:

- Reviewing the patient and family medical history by developing a 3 to 4 generation pedigree with detailed information about the patient's first, second, and third degree relatives.
- Evaluating the absolute risk the patient will develop a specific type of cancer or cancers based on their family history.
- Assessing and explaining risk for hereditary cancers and the chance of finding a mutation through genetic testing.
- Educating the patient about the suspected hereditary cancer syndrome, if appropriate, through discussion of cancer risks associated with gene mutations.
- Performing a psychosocial assessment.
- Discussion the benefits and limitations of genetic testing.
- Outlining available medical management options.
- Determining which family members would benefit from genetic counseling.

- Obtain informed consent if genetic testing is recommended.

After testing is completed, the Medical Oncologist will provide post-test counseling to include:

- Interpreting genetic test results and explaining what they mean for the patient and family members.
- Explaining medical management options.
- Recommending the patient inform other relatives.
- Recommending the patient and their physician discuss the implication of the results.
- Giving the patient referral resources.
- Scheduling follow-up visits.

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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Owner:	*Judy Borenstein: VCMC - Nursing*
Policy Area:	*Cancer Program*
References:	

CA.27 Cancer Program Navigation Process

POLICY:

Ventura County Medical Center (VCMC)/Santa Paula Hospital has a process in place to help patients navigate through the Cancer Program. All VCMC and outpatient clinic cancer care staff assist patients as they move through the continuum of care, from initial cancer diagnosis and admission to completion of treatment. These staff include receptionists, department clerical staff, laboratory staff, radiology diagnostic staff, medical assistants, physicians, RN Infusion Center staff, social workers and psychosocial support staff who all work to help patients and families throughout the care continuum.

PROCEDURE:

A Nurse Navigator with special expertise in cancer care assists patients in a focused manner on an individual basis. Nurse Navigation visits will occur as follows:

1. Initial Oncology Nurse Navigation visit is done after the 2 nd Medical Oncologist visit. If no treatment is planned, then this will be the only Nurse Navigator visit. If treatment is planned, the navigation visits will occur as listed in numbers 2 to 8 below.
2. Phone call or in person visit one to three (1 to 3) days after the first chemotherapy treatment.
3. Regular phone call or in person follow-up visits while undergoing treatment.
4. In person follow-up visit after pivotal medical visits.
5. In person follow-up visit at completion of treatment.
6. Survivorship Care Plan visit done by physician and Nurse Navigator.

Patients are assessed for barriers to their care during the navigation process. Common barriers to care and referral resources are listed in the table below.

Barrier	Internal/ External Resources
PSYCHOSOCIAL DISTRESS	Refer to on-site Social Workers
TRANSPORTATION	Provide Taxi Vouchers
LANGUAGE	Interpreters Offered On-site
HEALTH INSURANCE	Assist with sign-up to Breast and Cervical Cancer Screening Program and Medi-Cal

Barrier	Internal/ External Resources
HOUSING	Area Housing Authority of the County of Ventura
FINANCIAL ASSISTANCE	Andrea Grace Foundation
SUPPORT GROUPS	Community Memorial Hospital and St. John's Hospital Cancer Centers
NUTRITIONAL COUNSELING	St. John's Cancer Center
FOOD	Cal Fresh of Ventura County

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Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Judy Borenstein: VCMC - Nursing	6/18/2025
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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Emergency Services*
References:	

ER.05 Babies Not Born in Labor and Delivery

POLICY:

To facilitate treatment of babies born out of asepsis.

PROCEDURE:

A. Infants born outside of the Obstetrical Department are wrapped in clean, warm blankets, an initial assessment completed, and treatment given as required. ~~The~~At Ventura County Medical Center, the Obstetrics Department will be notified to a stable newborn. If pre-term or unstable, admission to the Neonatal Intensive Care Unit ~~(NICU) is notified immediately to receive~~maybe more appropriate. If born in the emergency department at Santa Paula Hospital, the infant ~~at~~will be stabilized and transported to Ventura County Medical Center. ~~At Santa Paula Hospital, the Labor and Delivery charge nurse will be notified immediately to receive the infant.~~

B. Before separating infant and mother, one (1) identification band must be placed on the baby's arm, one (1) band placed on the baby's leg and one (1) band on the mother's wrist. Refer to policy *MCH.07 Infant Identification Band and Security Tag Procedure*.

C. Infants born outside the Obstetrics Department in another hospital, home, birth center or under circumstances where asepsis can not be ascertained, may be admitted directly to the appropriate nursery in isolette or open crib. Hospitalization of the newborn is not always required, or deemed necessary in these circumstances.

D. Mothers who have delivered outside the hospital will be admitted to the Post-Partum floor. If mother presents to SPH emergency department, they will be stabilized and transferred to Ventura County Medical Center.

E. When newborn is admitted to Post Partum unit, a Infant security tag will then be placed. Refer to policy *MCH.07 Infant Identification Band and Security Tag Procedure*.

All revision dates: 4/18/2025, 3/8/2022, 1/8/2020, 3/1/2011, 7/1/2006, 10/1/1998, 1/1/1995, 10/1/1992

Attachments

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Approval Signatures

Step Description	Approver	Date
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/19/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/18/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	4/18/2025

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Owner:	*Vibha Gune: HIM Manager*
Policy Area:	*Health Information Management*
References:	

HIM.09 Correction of Duplicate Medical Record Numbers

POLICY:

To allow accurate registration information for all departments who utilize/depend upon patient identifiable information to complete their work. To ensure that each patient has only one medical record number (MRN) and to establish a process to correct single patients assigned more than one MRN.

PROCEDURE:

1. The Master Patient (Person) Index is an index of all hospital patients (persons) or guarantors. An accurate Master Patient (Person) Index (MPI) is the link tracking patients (persons) within all departments ~~and~~, Ambulatory Care clinics ~~of~~, Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). The MPI is needed to:
    a. Accurately match persons being registered for care with their records
    b. Minimize duplicate records
    c. Facilitate access to all records for a patient
2. Each patient will be assigned one medical record number on the first visit/admission. This medical record number will be used for all subsequent admissions/clinic visits. The medical record number assigned to a patient at Ambulatory Care Clinics, VCMC and SPH will be used for the same ~~medical~~patient at all facilities. This is accomplished through the interface between all integrated electronic health record ~~number assigned to a patient at Ventura County Medical Center (VCMC) and/or Santa Paula Hospital (SPH) is used for the same patient in all other clinics and departments. This is accomplished through the electronic interface between all hospital computer~~ systems.
3. When a patient is being registered, the registration personnel must verify that a patient does not have a previous medical record number by checking for similar patient names or variants of the same name (i.e., Bill/William or Jane Marie Smith/Jane Smith, Jane Smith Jones). If a patient was born at VCMC, check for the birth admission under a previous name (Patricia Gonzalez was born to Maria Gonzalez alias Maria Carillo at VCMC as ~~Baby Girl~~ Gonzalez ~~or Baby Girl~~, BabyGirlMaria or Carrillo, BabyGirlMaria). Registration staff will check the following:
    a. Patient entire name, including first, middle and last name.
    b. Prior admissions, Emergency Department (ED) visits, and/or any outpatient visits, looking for any

previously assigned number.

c. Verify using any other patient identifiable information such as social security number (SSN), date of birth (DOB), maiden name, nicknames and titles.

d. Secure patient identification (ID), if possible, to verify admission data.

4. In some cases, a new (duplicate) medical record number may have been assigned accidentally. If a duplicate number is discovered or suspected, the registration clerk must notify the Health Information Management (HIM) Department immediately for correction of the duplicate.

Essential Steps:

If the medical record number and the related medical records need to be merged because a patient incorrectly has more than one medical record number, the process must be coordinated by the VCMC HIM Department.

1. The VCMC HIM Department shall work with the department/clinic to determine if a single patient has been assigned multiple medical record numbers.
2. For potential errors that cannot be resolved by viewing the electronic health record, the ~~Chart Room~~HIM Supervisor may call clinics/departments for additional patient information. If needed, records may need to be reviewed at several clinics/departments to compare records.
3. When the actual medical record number for the patient is established, the MPI must be updated in the electronic health record based on results of the investigation. If patient is currently “in-house,” the merging of the charts will take place upon discharge.
4. ~~Merge the~~Merging the duplicate electronic health records, ~~changing~~will update all records to the accurate surviving medical record number.
5. Notify the clinics and/or departments involved regarding the merging of medical record numbers.

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Attachments

How to Prevent Duplicate MRN's.

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Health Information Management Committee	Vibha Gune: HIM Manager	6/10/2025
Health Information Management	Vibha Gune: HIM Manager	6/9/2025

VENTURA COUNTY HEALTH CARE AGENCY

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

ICU.31 Continuous EEG Monitoring (cEEG) in Burst Supression: Pentobarbital Induced Coma

Purpose:

- To assess and monitor electrical activity (burst activity in patients with medically induced coma)
- To provide a guideline to ensure accuracy of therapy for burst activity as recorded and measured by continuous electroencephalogram (cEEG)

Definitions:

A. **Burst suppression: I**n severe traumatic brain injury (TBI), considered 2-3 bursts/minute

B. **Refractory intracranial hypertension:** Sustained (> 15 min); intracranial hypertension (≥ 22 mm Hg) despite maximal medical therapy Tier 1, 2, and 3 treatment exhaustion (e.g., serum Sodium > 160, pCO2 optimized, Head of Bed (HOB) elevation, maximum sedation)

Policy:

Patients who are receiving pentobarbital for refractory increased intracranial pressure (ICP) require cEEG monitoring.

A. **Indications**

1. Persistently elevated ICP with marginal cerebral perfusion pressure (CPP) after exhausting first line measures to control ICP and maintain adequate CPP.
2. Repeat computed tomography (CT) head (if feasible) demonstrates no surgically treatable lesion
3. Neurosurgical intervention has been performed or ruled out
4. All treating providers agree to proceed
5. Goals of care conversation has been held with family and Palliative Care Consult ordered if appropriate

B. **Exclusion**

1. If deemed non-survivable head injury

C. **Requirements**

1. Attending must provide complete order through electronic health record (EHR).

2. Provider documentation/rationale for using pentobarbital on EHR.
3. RN staff trained to recognize EEG burst suppression
4. Patients:
    a. Must be mechanically ventilated with RASS of -4 to -5
    b. Be on cEEG monitoring (waiting for cEEG monitoring set-up should **NOT** preclude administration of medication to control ICP elevations)
    c. Central line is preferred for pentobarbital infusion; do not use midline

Procedures:

A. **Prepare patient**

1. EEG electrode application by EEG technologist. **Note:** Do not delay initiating therapy waiting for cEEG electrode application
    a. EEG should be read every 24 hours
2. Insertion of peripheral, central intravenous, and arterial line insertion per provider order. **Note:** Do not delay initiating therapy waiting for a central line catheter
3. ICP monitoring via intracranial catheter
4. Mechanical ventilation via endotracheal tube or tracheostomy
5. Provider order for anesthetic regimen with a goal for burst suppression that should be communicated to the bedside RN
6. Obtain order for placement of post pyloric feeding tube. After tube placement is confirmed, obtain provider order for continuous tube feeding
7. Ensure orders for deep vein thrombosis (DVT) and stress ulcer prophylaxis

B. **Monitoring:**

1. Carefully monitor for signs of hypotension or cardiac depression and provide support with vasopressors and/or inotropic medications as ordered by the provider

C. ~~**Medication Management**~~

~~1. Pentobarbital therapy - use approved EHR orderset~~

~~2. Monitored for extravasation~~

~~3. See CPG.113 Intensive Care Unit Management of Patients with Severe Traumatic Brain Injury for details.~~

Medication Management

1. Pentobarbital therapy - use approved EHR orderset
2. Monitored for extravasation
3. Pentobarbital Therapy

Initial Dose	Continuous Infusion	Serious Adverse Effects	Considerations
10 mg/kg (max 1	1 mg/kg/hr then	Hypotension;	Requires mechanical

Initial Dose	Continuous Infusion	Serious Adverse Effects	Considerations
gram) over 30-120 minutes (or rate of ≤ 25 mg/min); then 5 mg/kg/hr x 3 hours (initial dose and bolus should be adjusted depending on patient status per provider order)	attending physician to titrate 1 - 10 mg/kg/hr to achieve burst suppression on cEEG. If burst suppression on cEEG is not achieved with loading dose and/or ICP remains high, attending physician may consider giving a repeat dose (up to maximum of 800 mg) if the patient remains hemodynamically stable	respiratory and cardiac depression; paralytic ileus; complete loss of neurological function at high doses	ventilation; may require vasoactive agents for BP support; impaired liver function may lead to more pronounced effects/ side effects Drug-drug interactions: Pentobarbital may decrease the levels/ effects of CYP3A4 substrates, such as anti-epileptic medications (phenytoin, lamotrigine, topiratmate), steroids, digoxin, benzodiazepines, diltiazem, verapamil, cyclosporin, warfarin

4. See CPG.113 Intensive Care Unit Management of Patients with Severe Traumatic Brain Injury for details.

D. **Pentobarbital Therapeutic Goals:**

1. *Primary goal* is to achieve ICP control
2. Infusion rate is titrated by the provider to the lowest effective dose
3. Burst suppression should only be pursued if ICP control is not achieved at lower doses
4. If burst suppression is achieved and ICP remains refractory, further increases in pentobarbital should be avoided

E. **Patients who do not Respond to Treatment**

1. Definition: burst suppression reached without ICP control
   a. ICP = 25 – 35 for 4 hours
   b. ICP = 36 – 40 for 1 hour
   c. ICP > 40 for 15 minutes
2. If patients do not respond to treatment, consider discontinuing pentobarbital

F. **Discontinue Pentobarbital if:**

1. Burst suppression has occurred for 72 hours **AND**

2. ICP controlled < 22 mmHg for 48 hours; THEN
3. Wean pentobarbital per provider order
4. If ICP becomes uncontrolled within 12 hours of infusion discontinuation, resume at prior goal infusion rate and continue for at least 48 hours prior to attempting to wean again

G. **Intrahospital transportation to MRI or CT**

1. Consider if patient is safe for intrahospital transport
2. CT: surface EEG electrodes may remain in place
3. MRI: remove surface electrodes prior to head MRI
4. Notify EEG technologist upon returning from imaging

H. **Pentobarbital drug level**

1. Monitor level only if clinically indicated. i.e. Pentobarbital discontinued with persistent depressed neurologic status, need to rule out other causes, or in the setting of brain death declaration. (Note: This is a send out lab)

References:

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Marshall, GT, James, RF, Landman, MP, et. al. (2010). Pentobarbital coma for refractory intra-cranial hypertension after severe traumatic brain injury: Mortality predictions and one-year outcomes in 55 patients. *Journal of Trauma, 69*(2), 275-283.

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UAMS Medical Center (2024). Pentobarbital treatment guideline.

Authors: T. Slazinski, DNP-APRN, CNS

Date: 2/2025

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Intensive Care Unit 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	5/6/2025
Intensive Care Unit	Tara Paterson: Medical Director, Critical Care Services	5/6/2025
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	4/8/2025
Intensive Care Unit	Sul Jung: Associate Director of Pharmacy Services	4/1/2025

VENTURA COUNTY HEALTH CARE AGENCY

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

IS.33 Timeliness of Diagnostic Imaging Tests and Reports Interpretation

POLICY:

The Ventura County Medical Center/Santa Paula Hospital Imaging Services Department offers emergency and inpatient services 24 hours per day, 7 days per week. Imaging Services Department staff members shall perform diagnostic testing and procedures as ordered. Interpreting radiologists shall provide the timely delivery of diagnostic testing interpretation.

PROCEDURE:

1. Diagnostic tests are to be performed as requested by the medical staff member, house staff member or other authorized practitioner. Requests should include at least a provisional diagnosis, indication for exam(s), and any other relevant or pertinent clinical information to facilitate diagnostic interpretation, including the name of the physician ordering the study, and an additional contact name of an associate health care provider.
2. Diagnostic studies ordered by personnel who are only working part-time at the hospital or clinic shall have their staff enter the name of an alternative health care provider who is knowledgeable of the patient along with contact phone numbers for regular business hours and after-hours so that critical or urgent findings can be forwarded in a timely fashion by the radiologist interpreting the imaging study.
3. **INPATIENT** request for diagnostic exams are entered in the electronic health record (EHR) and are categorized by importance as follows:

STAT(S)	The imaging technologist responds immediately upon receipt of order, page or phone call. The use of "STAT" shall be limited to imaging studies which need to be interpreted as soon as possible because delay may result in permanent damage to a patient's organs or anatomy. Interpreting radiologist shall have a final diagnostic report dictated within 30 minutes of completion of all STAT exam orders.
URGENT (U)	The imaging technologist responds as soon as staffing allows. This is usually within a four (4) hour time frame from the time the order is entered into the EHR. The use of "urgent" shall be used when imaging results need to be completed as soon as possible, but permanent irreversible injury to an organ system is not likely to occur. The interpreting radiologist shall provide a final diagnostic report within 60 minutes of

	the completion of the ordered exam. The technologist shall contact the interpreting radiologist via telephone when a urgent exam is completed.
ROUTINE (R)	The imaging technologist performs exams by coordinating patient availability and needs with staffing availability. The interpreting radiologist shall provide a final diagnostic report within 48 hours on all exams ordered as a routine.

4. **OUTPATIENT** requests for diagnostic exams are entered into the EHR and are categorized as follows:

ROUTINE (R)	Routine tests are performed on a first come, first served basis, as staff and equipment become available and submitted upon completion for diagnostic interpretation. The interpreting radiologist shall provide a final diagnostic report within 48 hours for all routine outpatient exams.
CALL REPORT	Upon completion of the ordered exam, the patient either waits for the results of diagnostic interpretation or returns to their physician's office or home as instructed by the ordering physician. The completed exam, along with any previous exams, are provided to the interpreting radiologist for interpretation. The interpreting radiologist is responsible for calling the diagnostic interpretation to the ordering physician. All call report exam orders require the name and location of the person to whom the result is to be reported, along with a regular and after hours contact number. If the physician/person ordering a call report leaves prior to completion of the report, another contact person shall be listed as an alternate.

All revision dates: 3/21/2019, 5/7/2010, 2/1/2006

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Imaging Services	Matt McGill: Director, Imaging Services	6/2/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/24/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Administrative - Operating Policies*
References:	

PH.52 Medication Handling

Policy:

The following procedure shall be followed to ensure regulatory compliance with the appropriate handling such as storage, security, transport, and disposition of medications when dispensed from medication storage devices, Pharmacy Department deliveries to secured areas, and/or other means of appropriate transport.

Procedure:

1. Any medication received from the Pharmacy Department shall be placed in approved storage areas (i.e. patient cassettes, medication storage devices, unit medication refrigerators) as soon as possible.
2. All medications are obtained from an approved medication storage area, and shall be removed just prior to the designated administration time. Medications may only be removed for one patient at a time.
3. Once medications are removed from the approved storage area, they will remain with a licensed individual such as the nurse (RN), Respiratory Therapist (RT), Registered Pharmacist (RPh), Medical Doctor (MD) at all times, and will not be left unattended (unless appropriately labeled and secured).
4. Medications will not be left on or in any area exceeding 26°Celsius (C). Medications requiring refrigeration will be maintained accordingly, and removed just prior to administration or returned to Pharmacy if no longer needed. Medications not adhering to storage conditions shall be returned back to the pharmacy for disposal.
5. If a medication is not administered to a patient within 1 hour of removal from a storage area or receipt from Pharmacy, then it will be returned to the approved storage area, medication return bin, directly to the Pharmacy, and/or appropriately disposed of.
6. Medications will not be transported in clothing pockets, or in otherwise inappropriate/unsecured means unless emergent patient care needs necessitate temporary alternatives in order to sustain or resuscitate life.
    A. Saline flushes are devices and not drugs. They have the requirement for room temperature storage, but excursions up to 30°C are allowed. Due to the fact that saline flushes are routinely needed at the bedside and to avoid storage in patient rooms, it is acceptable for nurses and physicians to carry saline flushes in pants or shirt pockets throughout the day in order to have them readily available to provide necessary care.
7. Medications not stocked in unit areas or medication storage devices shall be returned to the Pharmacy Department within 24 hours if no longer required.

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Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	6/11/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	6/11/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Sul Jung: Associate Director of Pharmacy Services*
Policy Area:	*Pharmacy Services*
References:	

PH.62 Use of Pharmacy Floor Stock

POLICY:

Pharmacy floor stock may be available in approved locations but shall be approved by the Pharmacy and Therapeutics Committee.

PROCEDURE:

I. Pharmacy floor stock shall be defined as any medication or supply provided by the Pharmacy Department and stored outside of an automated dispensing cabinet in a patient care area. Medications stored in medications boxes, medication kits or crash carts are not included in this policy.

II. Only one strength or concentration of a non-controlled drug should be stocked, if possible. If it is necessary to provide more than one strength or concentration, the products shall be located in different drawers.

The following items shall **NOT** be common floor stock items:

- Concentrated vials of potassium salts
- Greater than 0.9% sodium chloride vials/ intravenous (IV) bags
- Concentrated calcium vials (available in specific units only)
- Concentrated magnesium vials (available in specific units only)

The inpatient nursing units' floor stock shall be stored, controlled, processed, and charged through the floor stock system.

III. Floor stock may be changed upon written request of the department Clinical Nurse Manager/Chief Nurse Executive and approval by the Pharmacy & Therapeutics Committee. The request for additions to floor stock shall be submitted to the Pharmacy. The request shall be forwarded to Pharmacy & Therapeutics Committee and Medical Executive Committee for review and approval.

IV. The Pharmacy & Therapeutics Committee shall review and approve the floor stock inventory on an annual basis.

V. Floor stock may be replenished daily by Pharmacy staff or upon request by the patient care unit staff.

All revision dates: 6/21/2022, 5/2/2019, 10/1/2015, 6/1/2006, 2/1/2004, 6/1/2000, 11/1/1998, 6/1/1995, 10/1/1992

Attachments

Attachment A - Pharmacy Floor Stock

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	6/11/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	6/11/2025

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

PH.83 Intravenous Potassium Administration for Adults

POLICY:

This policy defines safe methods for ordering and administering potassium infusions for adults.

PROCEDURE:

A. Do **NOT** administer intravenous (IV) potassium as a **Bolus, Intramuscular (IM), Subcutaneous (SQ) or undiluted**.

B. Potassium parenteral solutions are considered high risk medications; concentrated potassium solutions shall only be stored in the Pharmacy.

C. All potassium infusions shall be dispensed from the Pharmacy at standard concentrations.

D. Potassium infusions shall be administered at standardized rates using programmable pumps with Dose Error Reduction Software (DERs such as Alaris guardrails).

E. This policy applies to potassium chloride, potassium acetate, and potassium phosphate infusions.

F. Patient shall be placed on a cardiac monitor if potassium infusion is administered faster than 10 milli-equivalents per hour (mEq/hr) for potassium chloride and potassium acetate or 7.5 milli-moles per hour (mmol/hr) for potassium phosphate.

G. For patients on a cardiac monitor, potassium chloride infusions may be administered at a maximum rate of 20 mEq/hr. For Intensive Care Unit (ICU) and Emergency Department (ED) patients on a cardiac monitor, potassium infusions may be administered at a maximum rate of 40 mEq/hr.

I. Contraindications to potassium infusions:

   A. Severe renal impairment

   B. Severe hemolytic disease

   C. Addison's Disease (untreated)

   D. Hyperkalemia

   E. Acute dehydration

   F. Extensive tissue breakdown

   G. Heart block

II. Nursing Considerations

A. Decreased urine output: notify physician immediately.

B. Monitored patients: document heart rate and rhythm with administration.

C. Excess potassium may cause bradycardia, cardiac depression, peaking T waves, lowered R waves, depressed P wave, prolonged P-R interval, widening of QRS complex, and cardiac arrest: stop potassium infusion and notify physician immediately.

D. If patient complains of burning at IV site, assess the infusion site for signs of infiltration or extravasation.

E. Refer to Lippincott Procedure "Potassium Infusion Administration" for other considerations, equipment and documentation.

F. The Pharmacy Department shall provide potassium infusions in the standard concentrations as follows. Concentrations and delivery rates (milliliter = mL):

	Peripheral Line (Maximum concentration: 0.09 mEq/mL)		
Medication	**Standardized Concentration** IV Piggyback	**Monitored Beds** Maximum Delivery Rate	**Non-Monitored Beds** Maximum Delivery Rate
Potassium Acetate Potassium Chloride	20 mEq/250 mL 40 mEq/500 mL	20 mEq/hr **ICU & ED Attending emergent use only for K<2 and ECG changes or muscle paralysis: 40 mEq/hr**	10 mEq/hr
Potassium Phosphate	15 mmol/250 mL 30 mmol/500 mL	7.5 mmol/hr	7.5 mmol/hr
	Central Line (Maximum concentration: 0.4 mEq/mL)		
Medication	**Standardized Concentration** IV Piggyback	**Monitored Beds** Maximum Delivery Rate	**Non-Monitored Beds** Maximum Delivery Rate
Potassium Acetate Potassium Chloride	20 mEq/50 mL 40 mEq/100 mL	20 mEq/hr **ICU & ED Attending emergent use only for K<2 and ECG changes or muscle paralysis: 40 mEq/hr**	10 mEq/hr
Potassium	15 mmol/100 mL	7.5 mmol/hr	7.5 mmol/

	Central Line (Maximum concentration: 0.4 mEq/mL)		
Phosphate (KPhos)	30 mmol/250 mL	**ICU & ED Attending emergent use only for severe hypo-phosphatemia: 15 mmol/ hr (~23 meq K+/hr)**	hr

A. Concentrated potassium salts shall not be added to an already infusing IV bag.

B. Maximum dose of potassium infusion shall not exceed 40 mEq or 30 mmol per dose. If a patient requires more potassium than the maximum allowable dose, consecutive doses may be infused.

C. Potassium levels should be checked after each administration of potassium infusion.

D. Maximum potassium concentration for maintenance fluids is 40 mEq per liter. Parenteral nutrition is an exception to this requirement.

E. If potassium is less than (<) 2.5 mEq/mL and/or patient is symptomatic, potassium infusion should be delivered in a monitored bed.

~~The Pharmacy Department shall provide potassium infusions in the standard concentrations as follows. Concentrations and delivery rates (milliliter = mL):~~

	~~**Peripheral Line (Maximum concentration: 0.09 mEq/mL)**~~		
~~**Medication**~~	~~**Standardized Concentration**~~ ~~IV Piggyback~~	~~**Monitored Beds**~~ ~~Maximum Delivery Rate~~	~~**Non-Monitored Beds**~~ ~~Maximum Delivery Rate~~
~~Potassium Acetate~~ ~~Potassium Chloride~~	~~20 mEq/250 mL~~ ~~40 mEq/500 mL~~	~~20 mEq/hr~~ ~~**ICU & ED emergent use only:**~~ ~~40 mEq/hr~~	~~10 mEq/hr~~
~~Potassium Phosphate~~	~~15 mmol/250 mL~~ ~~30 mmol/500 mL~~	~~7.5 mmol/hr~~	~~7.5 mmol/hr~~

	~~**Central Line (Maximum concentration: 0.4 mEq/mL)**~~		
~~**Medication**~~	~~**Standardized Concentration**~~ ~~IV Piggyback~~	~~**Monitored Beds**~~ ~~Maximum Delivery Rate~~	~~**Non-Monitored Beds**~~ ~~Maximum Delivery Rate~~
~~Potassium Acetate~~ ~~Potassium Chloride~~	~~20 mEq/50 mL~~ ~~40 mEq/100 mL~~	~~20 mEq/hr~~ ~~**ICU & ED emergent use only:**~~ ~~40 mEq/hr~~	~~10 mEq/hr~~
~~Potassium Phosphate~~	~~15 mmol/100 mL~~ ~~30 mmol/250 mL~~	~~7.5 mmol/hr~~	~~7.5 mmol/hr~~

~~A. Concentrated potassium salts shall not be added to an already infusing IV bag.~~

B. ~~Maximum dose of potassium infusion shall not exceed 40 mEq or 30 mmol per dose. If a patient requires more potassium than the maximum allowable dose, consecutive doses may be infused.~~

C. ~~Potassium levels should be checked after each administration of potassium infusion.~~

D. ~~Maximum potassium concentration for maintenance fluids is 40 mEq per liter. Parenteral nutrition is an exception to this requirement.~~

E. ~~If potassium is less than (<) 2.5 mEq/mL and/or patient is symptomatic, potassium infusion should be delivered in a monitored bed.~~

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Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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VENTURA COUNTY HEALTH CARE AGENCY

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

R.92 Sputum Inductions

POLICY:

When a sputum sample cannot be obtained by nursing staff by means of a patient's own cough effort, Respiratory Care staff shall, with a provider's order, perform a sputum induction to obtain that sample. Sputum inductions are intended to obtain samples for microbiology or pneumocystis (PJP) samples only. There are two basic types of inductions performed by Respiratory Care. Sputum inductions are not done for cytology (see sputum induction operational protocol).

PROCEDURE:

Orders:

There must be a written provider order to induce sputum which must include the intended laboratory microbiology tests to be performed on any obtained sputum and the number of samples to be obtained.

1. Sputum inductions orders are for the number of sputum samples the provider requests. Sputum induction orders shall stay active until all requested samples are obtained or four (4) days, whichever comes first. Except as noted otherwise, sputum may be brought to the Laboratory Department at any time of the day and any day of the week.
    a. All inductions shall be preceded by the administration of 2.5 mg(miligrams) of nebulized albuterol, unless the ordering provider requests otherwise.
    b. AFB (Acid-Fast Bacilli) inductions are ordered x3 and shall be done eight (8) hours apart. The first one shall be performed once the patient is placed in appropriate isolation. It is preferred one sample be the first sputum of the day. Samples are of a series, and it should be noted to be as “1 of 3”, “2 of 3,” etc.
2. Inductions for pneumocystis jirovecii (PJP) shall also include either confirmation of a diagnosis of HIV(*human immunodeficiency virus*)/AIDS(Acquired immunodeficiency syndrome) or pre-disposing risk factors for HIV.
    a. PJP inductions are generally x3 and may be as little as four (4) hours apart. There are no restrictions on when.
    b. If multiple PJP inductions are to be done, they should be labeled as “1 of 3,” etc. as with the AFB inductions noted above.

Standard Sputum Induction:

The type of induction for most microbiology analysis including for tuberculosis.

Equipment:

- ~~EZPAP~~Positive Pressure hand-held nebulizer~~.~~
- Sterile sputum cup and biohazard bag~~.~~
- Patient label with notation of time and date added~~.~~

Medication:

A bronchodilator shall precede the solution used to induce sputum.

1. **Bronchodilator**: 2.5 mg albuterol in a 3 mL (milliliters) unit dose. Given prior to induction solutions.
2. **Induction Solution**: 4 mL of 10% hypertonic saline. Always preceded by the bronchodilator. If 15 mL vials are used, the excess solution shall be discarded with each induction.

Patient Preparation:

Sit patient upright if possible. The ideal positioning is sitting upright in bed with feet over the side. The Respiratory Therapist shall spend up to 30 minutes in the room with the patient, promoting cough.

Samples Obtained:

1. Any sputum obtained shall be collected in a sterile cup which can be securely sealed.
2. A minimum of 3 mL of sputum shall be collected in order to process.
3. The RT must activate appropriate order and print out Lab slip.
4. The cup shall have a patient sticker attached with time, date, and therapist initials written on it. If this sample is one of a series, it should be noted to be as “1 of 3,” “2 of 3,” etc.
5. The cup shall be placed in a biohazard zip lock bag. The Lab slip shall be placed in a biohazard bag.
6. Samples must be taken to Laboratory Department and properly checked in and refrigerated.
7. The provider and Respiratory Manager shall be notified if the patient is unable to produce sample.

Pneumocystis Jirovecii (PJP) Inductions:

These are inductions intended to collect samples to diagnose PJP, primarily in immunocompromised patients.

Equipment:

1. ~~EZPAP nebulizer.~~Positive Pressure hand-held nebulizer
2. Sterile sputum cup with label and biohazard bag.

Medication:

1. Bronchodilator: 2.5 mg albuterol in a 3 mL unit dose. Given prior to induction solutions.
2. Induction Solution: Using the ~~EZPAP~~ nebulizer, administer 4 mL of 10% hypertonic saline. If 15 mL vials are used,the excess solution should be discarded with each induction. Always preceded by the bronchodilator.

Patient Preparation:

Prior to induction, nursing staff shall perform thorough oral care, including having the patient brush their teeth.

Set Up:

The ~~EZPAP~~Positive Pressure hand-held nebulizer should be used for all medications.

Samples Obtained:

PJP samples may be obtained at any time. The Clinical Lab will conduct analysis only Monday through Friday during regular working hours, but they have arranged for a special handling process that allows for collection at any time including weekends and nights. Lab staff need to be notified that this is a “PJP” specimen so that they can properly preserve the sample.

1. Any sputum obtained should be collected in a sterile cup that can be securely sealed.
2. Once Sputum sample has been obtained, Respiratory Therapist shall print laboratory label and keep it with sample.
3. The cup should have a patient sticker attached with time, date, and therapist initials written on it. If the sample is one of a series, it shall be noted to be as “1 of 3,” “2 of 3," etc.
4. The cup shall be placed in a biohazard zip lock bag.
5. The Respiratory Therapist shall personally bring the sample to the Clinical Laboratory and hand it to a Laboratory technician or desk staff and inform them the sample is for a "PJP." This is to ensure that the sample is properly preserved for analysis per Laboratory procedures.

Nasotracheal Suction:

If there is a need to use nasotracheal “deep” suction to obtain a sample, that action shall be proceeded by a specific provider order allowing the procedure. It is not to be done routinely.

- **Patients with Artificial Airways:** Patients that are intubated or who have tracheostomy tubes do not require specific orders to perform suctioning.

DOCUMENTATION:

All inductions shall be documented whether the induction successfully produces sputum or not. Documentation is done with regular therapy with the addition that if multiple inductions are requested notation of sample sequence (1 of 3, etc) should be noted.

- Billing: Each induction is billed as a nebulized therapy and as a sputum induction, successful or not.
- Unsuccessful Induction: The physician and Respiratory Manager must be notified of unsuccessful induction. The Respiratory Therapist shall document in the electronic health record (EHR) a note of the unsuccessful attempt.

Bronchoscopy:

Once the medical team determines the patient shall be unable to successfully produce an adequate sputum sample, they may consult with the pulmonologist to arrange for a bronchoscopy. Bronchoscopy for rule out ~~TB~~Tuberculosis shall be performed in an preapproved airborne room with proper patient monitoring equipment. The Nursing Supervisor shall be notified to ensure there is a room available and appropriate nursing staff to support the procedure. Sputum collected via bronchoscopy will count as one collected sputum

for the series of three (3) needed.

All revision dates: 12/16/2022, 5/15/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	5/20/2025

VENTURA COUNTY HEALTH CARE AGENCY

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

T.14 Trauma Department Performance Improvement and Patient Safety Plan (PIPS)

POLICY

The Trauma Department Performance Improvement and Patient Safety Plan (PIPS) is a description of the efforts that are directed towards ensuring the consistent delivery of safe, quality, service-focused, effective health care for the trauma patients we serve at Ventura County Medical Center (VCMC).

We look to achieve this through data assessment, outcomes review, process examination, evidenced based practice research, as well as the identification of opportunities for change and improvement. This is accomplished by systematically assessing patient outcomes and support processes to identify improvement opportunities, and to act on them in a timely manner.

PHILOSOPHY OF THE TRAUMA PROGRAM

Ventura County Medical Center and the Trauma Service are dedicated to providing specialized, effective care to all injured patients brought to this facility.

This requires the ability to critique ourselves and identify issues, develop plans, and correct problems all geared to improve trauma patient care. Our mission is to provide high quality, safe patient care, through physician driven performance evaluation and patient care improvements for the community.

AUTHORITY/SCOPE

Trauma performance improvement is under the direction of the Trauma Medical Director (TMD) as delegated by the Medical Staff and hospital bylaws. The trauma service has the authority to monitor all events that occur during a trauma-related episode of care when admitted to this institution.

CREDENTIALING

All surgeons providing trauma care will be credentialed according to the VCMC Medical Staff bylaws, and the Department of Surgery Policy and Procedures before being scheduled for trauma call.

- Physicians taking trauma call will be credentialed and proctored per Medical Staff bylaws.
- Surgeons and surgical specialists taking trauma call will meet additional credentialing criteria as specified by the Division of Trauma and the Trauma Medical Director.
- Surgeons and Emergency Department (ED) boarded physicians should have taken Advanced Trauma Life Support (ATLS) at least once.

The Trauma Medical Director will do initial and annual review of credentials for the trauma call panel.

Neurosurgery, Orthopedic Surgery, and Emergency Medicine will also undergo annual review of privileges for participation on the trauma Call panel. The Trauma Medical Director in cooperation with the trauma liaisons and department chairs will complete this process.

The Trauma Program Manager in collaboration with the Nurse Managers is responsible for overseeing the continuing education of nurses working with trauma patients.

TRAUMA PATIENT POPULATION CRITERIA

A trauma patient is defined by the state trauma plan as a victim of an external cause of injury that results in major or minor tissue damage or destruction. The trauma patient is defined as any patient under National Trauma Data Standard (NTDS) patient inclusion criteria.

- All trauma activated patients
- All trauma related hospital admissions
- All injury-related deaths in the ED or after admissions

DATA COLLECTION AND ANALYSIS

All patients that meet criteria for entry into the trauma registry are monitored for compliance with or adherence of standards of care as established by the Trauma Service and Performance Improvement (PI) Committee.

Process of Care will be reviewed by utilizing audit filter and identifying those cases screened by the filters.

Cases identified through the peer review process will be reviewed through the Trauma PIPS program; information includes:

- occurrence or audit filter based issues
- provider specific issues
- trended data
- system or resource failure problems

Audit results will be shared during the Trauma Operations Performance and Patient Safety (TOPPS) meeting, at the Performance Improvement Council Committee (PICC) meeting and at least quarterly during the Medical Executive Committee (MEC) meeting. The PICC meeting allows the opportunity for Trauma PI results to be shared in a standardized format with other hospital PI initiatives and aligns the trauma PI program with hospital PI.

PROCESS FOR MONITORING COMPLIANCE

Standards of Quality Care

All trauma patients that meet criteria for entry into the trauma registry are monitored for compliance with or adhere to the standards of quality patient care as established by the Trauma Service and local, regional and national standards.

Death Reviews

Trauma patient deaths are reviewed as they relate to trauma care and trauma system issues.

Audit Filters /Indicators

Audit Filters/ Indicators as defined by the American College of Surgeons and/or the trauma program and/or the trauma system are monitored.

- Complications that occur in the trauma patient are recorded in the Trauma Registry.
- The Trauma Quality Improvement (QI) Committee will review complications from injury or treatment that significantly affect patient outcome.
- The Trauma QI Committee makes appropriate referrals and recommendations
- All complications will be reported on a monthly basis and monitored for trend analysis.

Additional audit filters, event review and report review includes the following filters:

- Surgeon arrival time for the highest level of activation
- Delay in response for urgent assessment by the neurosurgery and orthopaedic specialists
- Delayed recognition of or missed injuries
- Compliance with prehospital triage criteria, as dictated by regional protocols
- Delays or adverse events associated with prehospital trauma care
- Compliance of trauma team activation, as dictated by program protocols
- Accuracy of trauma team activation protocols
- Delays in care due to the unavailability of emergency department physician (Level III)
- Unanticipated return to the OR
- Unanticipated transfer to the ICU or intermediate care
- Transfers out of the facility for appropriateness and safety
- All nonsurgical admissions (refer to Standard 7.8)
- Radiology interpretation errors or discrepancies between the preliminary and final reports
- Delays in access to time-sensitive diagnostic or therapeutic interventions
- Compliance with policies related to timely access to the OR for urgent surgical intervention
- Delays in response to the ICU for patients with critical needs
- Lack of availability of essential equipment for resuscitation or monitoring
- MTP activations
- Significant complications and adverse events
- Transfers to hospice
- All deaths: inpatient, died in emergency department (DIED), DOA
- Inadequate or delayed blood product availability
- Patient referral and organ procurement rates

- Screening of patients for psychological sequelae (LI/LII/PTCI/PTCII))
- Delays in providing rehab services
- Screening and intervention for alcohol misuse
- Pediatric admissions to nonpediatric trauma centers
- Neurotrauma care at Level III trauma centers
- Trauma and neurotrauma diversion
- Benchmarking reports

System Issues

All identified issues that are not provider related are reviewed in the Trauma performance Improvement Committee.

REVIEW PROCESS/LEVELS OF REVIEW

First Level of Review:

The Trauma Program Manager (TPM) or designee will do the initial case review, which is done for all trauma cases. If the first level of review is completed, affirming that clinical care is appropriate and no provider or systems issues are identified, the case does not require second level or formal committee review. Or, after review of all the pertinent information, the TPM may determine that the issue should be addressed by the TMD and/or the Trauma PI Committee.

Second Level Review:

The second level of review/intake rounds can be done by the TPM and the Trauma Performance Improvement nurse. A case in which a second level review is required is when issues in clinical care, provider or systems issues are evident that require the TMD's expertise and judgment. They may begin further investigation, implement action without formal referral to a peer review or system committee, or decide to send it to the appropriate PI committee or to a hospital department for further investigation/peer review and ask for help. Cases may also be closed at this level.

Third Level Review:

The Trauma Program Manager and the Trauma Medical Director will perform an initial case review in preparation for the committee meeting identifying all background information, pertinent protocols (or lack) and specifying all individual issues to be discussed. Cases are appropriate for third level review when unresolved at second level review. The issue is then formally reviewed by the Trauma PI Committee(s)/the Multidisciplinary Peer Review Committee. The Committee may communicate with the individual physicians, other clinical sections or departments to request additional data or give input. Determination of judgments will be made by the committee using the following criteria.

DETERMINATION OF JUDGMENTS

The committee will render a judgment regarding the appropriateness of the issue and all mortalities will be reviewed. Each issue will be placed into one of the following categories:

1. Mortality and Morbidity with opportunity for improvement: An event or complication that is sequelae of a procedure, disease, illness, or injury that has the potential to be prevented or substantially be ameliorated.

2. Mortality and morbidity without opportunity for improvement (Non-preventable): An event or complication that is a sequelae of a procedure, disease, illness or injury for which reasonable and appropriate preventable steps had been taken.

3. No opportunities for improvement: can be closed at this level.

DOCUMENTATION OF ANALYSIS AND EVALUATION

The Trauma QI issues will be documented on the Trauma Quality Improvement Occurrence Tracking Form. This form tracks all aspects of the case review including the summary of the clinical care, identified issues, reference to discussion/minutes from the Trauma PI Committee(s), judgment, recommendations, actions, and loop closure.

- Identified opportunities for improvement to include interventions that address the opportunity.
- The intervention should include dates, accountability, responsibility and any auditing that may be required.
- The effectiveness of these interventions should be continuously reevaluated to determine if these revisions improved the process or outcomes in care.
- This will assist with tracking and documentation of loop closure.

The Occurrence Tracking Form will be placed into the minutes of the monthly Trauma QI Committee meetings as evidence of case review and discussion and recommendations for corrective action.

Patterns and trends identified will be shared during Trauma Operation Performance and Patient Safety (TOPPS) meeting.

REFERRAL PROCESS FOR INVESTIGATION OR REVIEW

The cases determined to require further investigation by the first and second level review or a judgment/ rating determination by the Trauma PI Committee may be referred to the appropriate hospital department via appointed liaisons, committee or department chairman for review. Events may also be brought forward for review by several sources, including individual reporting, case abstraction and risk management reporting. The scope for event review will extend from prehospital care to hospital discharge.

The Trauma PI Committee and/or the Trauma Medical Director will then review the response of the referral for follow up.

TRAUMA PI COMMITTEE STRUCTURE AND RESPONSIBILITIES

The Trauma Performance Improvement Committee is a multidisciplinary peer review committee functioning under the auspices of the Department of Surgery PI Committee that in turn reports to the Medical Executive Committee.

Recommendations and action plans with associated re-evaluation will be made when areas needing improvement are determined. Membership includes all trauma surgeons, the TPM and representatives from Orthopedic Surgery and Anesthesia, Emergency and Neurosurgery Departments. Additional attendees are invited ad hoc. The Trauma PI Committee meets monthly and provides a monthly summary report to the Department of Surgery PI Committee. Committee meets monthly with 50% attendance requirement of peer review representatives.

The charge of the committee is to evaluate the care of a trauma patient from a clinical and systems perspective and to perform interdisciplinary implementation of improvement strategies. It is responsible for establishing objective criteria for identifying issues for review and determining compliance with standard of care. The committee will systematically monitor/analyze data, and improve patient outcomes through improvement opportunities.

OPERATIONAL STAFF RESPONSIBILITY FOR THE TRAUMA PI PROGRAM

The staff responsible for the operational support of the trauma performance:

1. The trauma Medical Director and the Trauma Program Manager maintain the Trauma PI and QI process with data support from the trauma registrar and TPI committee. The Trauma Medical Director monitors this process. Representatives from the other clinical and hospital departments as well as the hospital Performance Improvement Department participate when appropriate. This ensures multidisciplinary collaboration and compliance with the hospital Performance Improvement Plan.

2. The TMD is responsible for chairing the Trauma PI Committee and for initial review of all physician related issues including all deaths and screened complications. The TMD is also responsible for coordination of all performance improvement activity relative to clinical departments/physicians as well as associated remedial action. The TMD may delegate related PI studies.

3. The TPM is responsible for identification of issues and their initial validation, the maintenance of the trauma PI database/ files and protection of their confidentiality, facilitating data trends and analysis, and coordinating surveillance of protocols/ guidelines/clinical paths. The Trauma Register and Trauma PI Nurse (s) will assist the TPM in these activities. The registrar will interface with the TPM and TMD to assist with identification of issues using registry filters, and compilation of reports to support the PI process.

4. The TPM and TMD perform continuous review of priority areas for continued PI based on review of audit filters, benchmarking and event review.

CORRECTIVE ACTION PLANNING

The Trauma Medical Director oversees all corrective action planning and their institution. Structured plans may be created by any Trauma PI team members or committees in an effort to improve sub-optimal performance identified (root cause analysis) through the PI process.

Our goal is to create forward momentum to effect demonstrable outcome change leading to subsequent loop closure.

An evaluation and re-evaluation process will be part of the plan according to instructions action plan methodology of: plan, do, check, act (PDCA). Examples of potential corrective action categories are:

- Organization of Improvement PI Teams
- Education
- Referral to peer group
- Trending
- Focus Audit
- Protocols
- Counseling
- Proctoring/change in privileges or credentials
- External Review
- Enhanced resources or methods of communication

CONFIDENTIALITY PROTECTION

- All performance improvement activities and related documents will be considered confidential and protected as specified in Ventura County Medical Center policies and HIPAA.
- All PI Information will be clearly labeled "Confidential for Peer Review Only. This report is a review function and as such is confidential and shall be used only for the purpose provided by law and shall not be public record and shall not be available for court subpoena".
- Whenever feasible, generic identifiers for patient care providers will be utilized. No PI information will be part of the patient medical record. All PI paper documents and electronic information will be kept in a secure location with limited, controlled access. Any copies distributed at meetings will be counted and collected at the close of the meeting.
- All physicians appointed to Trauma PI activities will have a signed "Physician Peer Review Confidentiality Agreement" on file.

LOOP CLOSURE AND RE-EVALUATION

Any identified issues will be subject to Level 1, 2, or 3 reviews which may result in the formation of an action plan. In order to "close the PI loop", the outcome of the corrective action plan will be monitored for the expected change and re-evaluated. A PI issue will not be considered to be closed until the re-evaluation process demonstrates a measure of performance or change at an acceptable level. "Acceptable level" may be determined by frequency tracking, benchmarking, and variance analysis as decided by the Trauma Medical Director and/or PI committee. Loop closure will be reported to the Trauma PI committee and a determination made regarding periodic or continuous monitoring. TPM, TMD or designee is accountable for

ensuring loop closure on any outstanding issues.

INTEGRATION INTO HOSPITAL PERFORMANCE IMPROVEMENT PROCESS

1. The Trauma PI program practices a multi-disciplinary and multi- departmental approach to reviewing the quality of patient care across all departments and divisions. The Trauma Performance Improvement Committee is integrated with and collaborates with the appropriate performance improvement committees as needed.

2. The Trauma PI program will report all activity through the Department of Surgery and to the Risk Management and Patient Safety hospital committee as specified in the hospital QI plan.

All revision dates: 3/14/2024, 9/29/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Trauma Operations, Performance & Patient Safety (TOPPS) Committee	Gina Ferrer: Manager, Trauma Services	6/26/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/26/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/26/2025
Trauma Services	Thomas Duncan: Trauma Medical Director	6/26/2025
Trauma Services	Gina Ferrer: Manager, Trauma Services	3/12/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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

100.012 Patient Inability or Refusal to Provide Informed Consent for Medical Care

POLICY:

It is the policy of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to protect patients' rights and to comply with all relevant State and Federal Regulations when patients are unable (e.g. unconscious, acutely psychotic) to give or refuses to give informed consent for medical care. A patient who has a mental and/or physical disorder may still have the capacity to make medical decisions and to be responsible for those decisions. A patient who has the capacity to give informed consent to a proposed medical treatment also has the capacity to refuse that treatment. The prospect of obtaining informed consent from the patient or other person(s) legally authorized to give consent should be weighed against the possibility that a delay for obtaining such consent would result in a deterioration or aggravation of the patient's medical condition. A judicial determination that a patient lacks capacity to make a medical decision is based on specific deficit(s) in mental functioning and the correlation with the specific medical decision in question.

Please see Attachment A, "*Emergency Consent Form for the Authorization from the Superior Court for Surgery or Special Diagnostic or Therapeutic Procedures,"* and instructions.

PROCEDURE:

A. In the case of a medical emergency and if there is no reason to believe that the patient (or legal guardian) would refuse treatment (e.g., based on a particular religious belief), the treatment may proceed without obtaining consent. Relevant law implies that in these circumstances that consent would be obtained on the theory that if the patient was capable of giving it, or if a legal guardian was present, the consent will be given.

B. California law defines a medical emergency as: (a) immediate services required for the alleviation of severe pain; or (b) immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed or treated. It is important to note that only the medical condition may be treated. Treatment that exceeds that needed for the emergency condition may not be rendered without the patient's consent.

C. If a delay in treatment for the purposes of obtaining consent would not reasonably cause a deterioration or aggravation of the patient's condition then proceed with the usual process of obtaining informed consent before beginning treatment or any procedures (see policy *100.008 Consent for Medical Care*).

D. If there is a suspicion of lack of capacity to consent to treatment secondary to mental deficits the

attending physician may order a psychiatric consultation with the referral question of determining capacity to consent to recommended treatment.

PROBATE CODE 3200 PETITION

A. A petition may be filed in the Superior Court on behalf of VCMC/SPH to determine if a patient lacks the capacity to make a health care decision concerning recommended treatment, and to obtain a court order authorizing recommended treatment or authorizing a designated person to make health care decisions on behalf of the patient. The petition may only be filed during normal business hours (Monday through Friday, 8:00 am to 5:00 pm, excluding judicial holidays).

1. In the event of a need for such a petition for medically necessary, but non-emergent conditions, contact the Clinical Nurse Manager, Department Manager, or House Supervisor, or Administrator on Duty (AOD) and Medical Director.
2. During business hours, the Clinical Nurse Manager or designee will contact the VCMC Compliance Officer who will coordinate the preparation and filing of a petition with County Counsel.
3. Once the facility has received the court order for consent to treatment the recommended procedures may commence.

All revision dates: 8/9/2022, 9/1/2016, 5/1/2016, 1/1/2013, 5/1/2006, 3/1/2003

Attachments

- Attachment A: Emergency Consent Form Authorization from the Ventura Superior Court for Surgery, Special Diagnostic or Therapeutic Procedures
- Attachment B: Authorization from Ventura Superior Court

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	7/21/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025

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100.030 Critical Tests and Critical Results

POLICY:

Some test results, due to their critical nature, require special notification so that treatment can be immediately initiated or altered or so that, in the case of communicable diseases, steps can be taken to prevent the spread of disease. In addition, there are critical tests whose results have been deemed necessary to communicate to the licensed responsible caregiver, regardless of the results. These are defined below as critical tests and critical results.

DEFINITIONS:

A. **Critical Tests**: tests ordered for a patient with potentially life threatening symptoms that require rapid communication of results even if the results are normal.

B. **Critical Results**: test results even from routine tests that represent a life threatening state that require rapid communication to the physician or responsible licensed caregiver.

C. **Licensed Responsible Caregiver**: personnel within the scope of their practice and in accordance with organizational policy that may receive and act on a critical result, such as Physicians, Nurse Practitioners, Physician's Assistants, Registered Nurses, Licensed Vocational Nurses, or Respiratory Therapists.

PROCEDURE:

A. This document shall be reviewed by the Medical Staff at least every two (2) years.

B. For critical lab tests & result, the results (normal or abnormal) shall be communicated by lab personnel immediately to the responsible licensed registered nurse (inpatients and Emergency Department) or ordering licensed practitioner (outpatients) but no more than thirty (30) minutes from the time the test is resulted.

C. For critical non-lab tests & results, the results (normal or abnormal) shall be communicated by the interpreting licensed practitioner immediately to the ordering licensed practitioner but no more than sixty (60) minutes from the time the result is made available.

D. Nursing is responsible for documenting critical results in Cerner and ensuring that the licensed practitioner is notified of any critical lab results within thirty (30) minutes of receipt from lab.

E. Staff is responsible for contacting the licensed practitioner even if the results are trending in the expected direction.

F. Ventura County Medical Center and Santa Paula Hospital collects and analyzes the compliance of call documentation for critical test results and reports the data to Performance Improvement Coordinating Council (PICC) quarterly and Medical Staff annually. This data will reflect monthly totals of the percentage of time critical test results are communicated. The following shall be tracked for call documentation:

1. Name of the licensed caregiver who received the communication.
2. Time and date of the call.
3. Verification that the results are recited back to the caller.

GUIDELINES:

A. The ordering licensed practitioner's name shall be included on every order.

B. Two patient identifiers (name and date of birth (DOB) or medical record number (MRN), if DOB is not available at the time) shall be used to confirm the correct patient.

C. The testing personnel shall document notification including date, time, verification of "read back" and the name of the bedside nurse who received the critical test/result. This notification shall occur immediately but must occur within thirty (30) minutes of the testing personnel becoming aware of the critical test/result.

1. For Inpatients and Emergency Department (ED) Hold Patients
    a. Testing personnel shall contact bedside nurse. The bedside nurse shall communicate the critical test/result to the licensed practitioner.
2. For Patients in the ED or Discharged from the ED
    a. Testing personnel shall contact the patient's nurse in the ED. ED nurse shall communicate the critical test/result to the ED licensed practitioner.
3. For Patients Discharged from the Hospital
    a. Testing personnel to call the ordering licensed practitioner.
    b. If there is no response, retry a second time within two hours of the result.
    c. If there is still no response, TigerText the Chief Medical Officer.
4. For Patients Seen in Ambulatory Care Clinic
    a. During clinic hours: Testing personnel shall contact a licensed responsible caregiver or the ordering licensed practitioner. See *Attachment A Ambulatory Care Critical Values Phone Lines*.
        i. In the event a licensed responsible caregiver other than the ordering licensed practitioner receives the critical test result, the ordering or covering licensed practitioner shall be contacted by the licensed responsible caregiver to report results.
    b. After hours and weekends: A critical result may NOT be left with an answering service. Critical values shall be reported to the on-call licensed practitioner by calling the clinic and following the phone tree.

D. Chain of Command for Communication

1. Hospital chain of command for communication to nursing
    a. If bedside or ED nurse is not immediately available, communication will be made via phone to the unit charge nurse. If no charge nurse is available, communication will be made via phone to the nursing supervisor.

2. Hospital chain of command for communication to licensed practitioners
    a. If the licensed practitioner is not available within ten (10) minutes, a second attempt will be made via phone to the licensed practitioner. If there is no response within 15 minutes of the initial attempt, the supervising attending physician shall be contacted. If there is no response from the supervising attending physician after 15 minutes, then the on-duty Emergency Department Attending Physician shall be contacted. If the on-duty Emergency Department Attending Physician does not respond within 15 minutes, the Chief Medical Officer (CMO) shall be contacted.
    b. The licensed responsible registered nurse shall document notification including time, date, verification of "read back" and the name and title of the provider who received the critical test/ result.
    c. Final notification to a provider must occur within thirty (30) minutes from the time the critical test result became available.
3. Ambulatory Care chain of command to licensed practitioners
    a. If the ordering or covering licensed practitioner does not respond within ten (10) minutes, a second attempt to contact the licensed practitioner shall be made. If there is no response within 15 minutes of the initial attempt, the Clinic Medical Director shall be contacted.
    b. If there is no response from the Clinic Medical Director after 15 minutes, then the Ambulatory Care Chief Medical Officer (CMO) shall be contacted.
    c. After office hours and on weekends, if the on-call licensed practitioner fails to respond to their page within 15 minutes, the on-call satellite licensed practitioner shall be contacted.

E. NOTE: In highly emergent cases where "read-back" would be impractical or impede patient care, a "repeat back" is permissible. Often, the physician receiving the information is the licensed responsible caregiver who will be immediately using the information for intervention.

F. Critical results are defined by service and listed below:
1. **Radiology/Nuclear Medicine New or Unsuspected Critical Results**
    a. Carotid or vertebral artery dissection
    b. Ectopic pregnancy
    c. Hemoperitoneum
    d. Intracranial tumor, mass effect, midline shift
    e. Ischemic stroke, acute
    f. Testicular or ovarian torsion
    g. Upper or lower extremity deep venous thrombosis (DVT)
    h. Acute aortic dissection, rupture or leak
    i. Intracranial hemorrhage (traumatic, non-traumatic)
    j. Pneumothorax
    k. Pneumoperitoneum
    l. Acute pulmonary embolism
    m. Acute spinal cord compression

n. Placental Abruption

2. **Adult Echocardiogram Critical Results**
    a. Pericardial effusion, moderate to large with echocardiographic signs of tamponade
    b. Acute aortic dissection
    c. Myocardial rupture
    d. Ruptured chordae tendinae
    e. Valvular vegetation
    f. Visible abnormalities with prosthetic valves
    g. Large Ventricular septal defect (VSD) or Atrial septal defect (ASD)
    h. Myxomas or other cardiac tumors
    i. Atrial or ventricular thrombus
    j. Decrease in ejection fraction (EF) ≤ to 40% if new finding
    k. New wall motion abnormalities
    l. History of acute trauma associated with myocardial contusion
3. **Pediatric Echocardiogram Critical Results**
    a. Pericardial effusion, moderate to large with echocardiographic signs of tamponade
    b. Transposition of the great vessels
    c. Severe obstruction of the right/left ventricular inflow or outflow
    d. Hypoplastic left or right heart
    e. Severe coarctation of aorta
    f. Tetralogy of Fallot
    g. Severe right or left ventricular hypokinesis
4. **Electrocardiogram/Holter/Event monitor Critical Results (For patients not on a cardiac monitor)**
    a. Sustained ventricular tachycardia
    b. Sinus pause > 3 seconds
    c. New second or third degree atrioventricular (AV) block
    d. Acute localized ST segment elevation suggesting myocardial infarction (MI)

G. **Blood Bank Critical Results**

1. A positive antibody screen, a positive direct antiglobulin test, or a positive crossmatch on a patient receiving blood that was emergency-released.
2. A positive antibody screen or a positive direct antiglobulin test on a pre-surgery patient. The physician will be told that the antibody could cause a delay in the availability of compatible blood.
3. Verify that a physician is aware of any suspected transfusion reaction.
4. Coombs positive infants on screening for hemolytic disease of the newborn.

H. **Microbiology Critical Results**

1. Positive blood cultures: each different accession number
    a. The first positive result (whether stain or culture)
    b. The organism identification for all pathogens
2. Salmonella/Shigella/Campylobacter/Yersinia/Shiga Toxin 1 or 2, Vibrio and other stool pathogens
3. Positive cerebrospinal fluid (CSF) Gram stain, cultures, or India Ink
4. Positive acid fast bacilli (AFB) smear
5. Clinically relevant growth in any tissue specimen, biopsies, or sterile body fluids; except urines
6. Presence of organisms with unusual resistance patterns; e.g., Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-intermediate Staphylococcus aureus (VISA), Vancomycin-resistant enterococcus (VRE), Penicillin-resistant Streptococcus pneumoniae, organisms producing extended spectrum beta-lactamases (ESBLs), carbapenem-resistant Enterobacteriaceae (CRE), etc.
7. Cultures positive for Neisseria gonorrhoeae
8. Positive blood parasite results; e.g., malaria
9. Positive human immunodeficiency virus (HIV) test
10. Positive venereal disease research laboratory test (VDRL) or fluorescent treponemal antibody absorption (FTA-ABS)
11. Positive stool Clostridium difficile (C. diff) polymerase chain reaction (PCR)

I. **Pathology Results**

1. New pathologic diagnosis of cancer, excluding non-invasive skin cancer (basal cell and squamous cell).

Laboratory Critical Results

Test	Low Critical Result	High Critical Result
Hemoglobin	≤ 6.9 g/dL	≥ 23.0 g/dL
Hemoglobin if > 65 years old	< 6.9	
Hematocrit	≤ 18%	≥ 70%
Platelets	20 x 10^3/mcL	
White Blood Cell (WBCs)	≤1.0 x 10^3/mcL	≥50K
Neutrophil # (ANC or absolute neutrophil count)	< 0.5 x 10^3/mcL	
International normalization ratio (INR)		≥ 4.0
Partial Thromboplastin Time (PTT)		> 118 sec.
Anti-Xa, unfractionated	All results to be communicated to the responsible licensed caregiver.	
Anti-Xa, low molecular weight	All results to be communicated to the responsible licensed caregiver.	
Bilirubin - Newborn		> 18 mg/dL
Calcium	< 6.0 mg/dL	> 13.0 mg/dL

Test	Low Critical Result	High Critical Result
Fibrinogen	< 100	
Glucose	< 60 mg/dL	> 500 mg/dL
Glucose – Newborn	< 40 mg/dL	> 300 mg/dL
Lactic Acid		≥ 4
Phosphorus	< 1.0 mg/dL	
Potassium	< 2.9 mEq/L	> 5.7 mEq/L
Sodium	< 128 mEq/L	> 155 mEq/L
Magnesium	< 1 mEq/L	> 8 mEq/L
Troponin I, high-sensitivity		Females: ≥120 ng/L Males: ≥120 ng/L
Ethanol		≥ 400 mg/dL
Iron (less than 12 years)		> ~~280~~350 mcg/dL
Thyroid stimulating hormone (TSH)		> 50 milli-International units/L
Cerebrospinal fluid (CSF) White Blood Cell count		≥ 10
Vancomycin trough, if > 1 month age		≥ 20 mcg/mL
Vancomycin trough, 0-1 month age		≥ 15 mcg/mL
Lead		≥ 3.5 mcg/mL

Respiratory Critical Values

Critical Value	Arterial Blood Gas (ABG)		Capillary Blood Gas (CBG)		Neonatal Arterial Blood Gas		Neonatal Capillary Blood Gas		Venous Blood Gas (VBG)		pH Cord
	Low	High	Low	High	Low	High	Low	High	Low	High	Low
pH	7.29	7.6	7.29	7.5	7.2	7.5	7.2	7.5	7.25	7.55	7.2
pCO_2 (mmHg)	22.5	60	22.5	51	20	60	20	60	20	60	
pO_2 (mmHg)	60		34.9	85.1	50	120	25	85			
Base Excess [BE] (mmol/L)					-8	8	-8	8			<-12
Total hemoglobin [tHb] (g/dL)	7.9	23	7.9	23	7.9	23	7.9	23	7.9	23	
O_2Hb (%)	<60 88% >60 86%				88%						
COHb (%)		8%		8%		8%		8%		8%	

MetHb (%)		8%		8%		8%		8%		8%	
HHb (%)		>12%		>12%		>12%		>12%		>12%	
Sodium [Na^+] (meq/L)	120	160	125	150	125	150	125	150	120	160	
Potassium [K^+] (mEq/L)	2.5	6	3	6	3	6	3	6	2.5	6	
Calcium [Ca^{2+}] (mEq/dL)	3.3	6.2	3.3	6.2	3.3	6.2	3.3	6.2	3.3	6.2	
Glucose (mg/dL)	60	16>500 16>300	45	16>500 16>300	45	300	45	300	60	16>500 16>300	
Lactate (mmol/L)		3.99								3.99	

Table Abbreviations:
pCO_2: partial pressure of carbond dioxide
pO_2: partial pressure of oxygen
O_2Hb: oxyhemoglobin
COHb: carboxyhemoglobin
MetHb: methemoglobin
HHb: deoxyhemoglobin

All revision dates: 8/6/2025, 5/15/2024, 8/16/2022, 11/18/2020, 5/2/2019, 2/11/2019, 8/1/2017, 11/1/2016, 7/1/2016, 2/1/2016, 1/1/2016, 9/1/2015, 7/1/2012, 1/1/2011, 8/1/2008, 6/1/2008, 1/1/2008, 5/1/2006

Attachments

Attachment A Ambulatory Care Critcial Values Phone Lines

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED, Medicine & Pediatrics	Stephanie Denson: Manager, Medical Staff Office	8/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/21/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/21/2024
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	11/21/2024

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Jorge Mejia: Director of Language Access*
Policy Area:	*Administrative - Patient Care*
References:	

100.064 Interpreter Services

POLICY:

Ventura County Medical Center/Santa Paula Hospital (VCMH/SPH) and the Ambulatory Care clinics will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of VCMC/SPH/Ambulatory Care is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/ clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through the use of ~~*competent* certified~~qualified and trained interpreters, ensuring that all services are delivered by competent individuals, whether through in-house staff, contracted professionals, or remote interpretation platforms. This includes proficient bilingual staff, staff interpreters, ~~contracts or~~and formal ~~arrangements~~partnerships with local organizations ~~providing~~offering interpretation ~~or~~and translation services~~, or technology and telephonic interpretation~~. We are committed to prioritizing qualified interpreter services in all interactions with Limited English Proficient (LEP) individuals. All staff will be ~~provided notice~~informed of this policy and procedure, ~~and staff that may have~~with those in direct contact with LEP individuals ~~will be trained in~~receiving training on effective communication ~~techniques~~strategies, including the ~~effective~~proper use of ~~an interpreter~~professional interpreters.

VCMC/SPH and the Ambulatory Care clinics will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary. This review will be conducted by the Language Access Director to ensure that language access services remain aligned with the evolving needs of our diverse patient population.

PROCEDURE:

IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

VCMC/SPH and Ambulatory Care Health Care Providers will promptly identify the language and communication needs of the LEP person, and will document in Cerner the name of interpreter and/or use of Language Line when used. In addition, when records are kept of past interactions with patients or family members, the language used to communicate with the LEP person will be included as part of the record.

INTERPRETERS

Language interpretation is required ~~when~~whenever a patient or their family identifies a preferred language that the care provider is unable to effectively communicate ~~with the patient in his/her primary language~~in. ~~General guidelines are:~~

General guidelines are:

1. ~~When available, qualified employees will be used as first-line interpreters.~~When available, staff interpreters will be used as the first line of support for language interpretation. If a staff interpreter is not available, qualified employees who have been trained for interpretation can be utilized.
2. VCMC/SPH will maintain a current list of available interpreters and dialects/languages spoken.
3. Contract services are to be used if interpretation is not available by employees.
4. Certification will be provided to VCMC/SPH by contractors.
5. Employees used as interpreters will be ~~certified~~qualified by Ventura County Human Resources ~~or~~and vetted through the Language Access Department at VCMC (hospital employees only) or must be an approved contractor.
6. Patient family members ~~are to~~may be used in urgent/emergent situations only and until a ~~designated~~qualified interpreter arrives.
7. The health care provider will document the following in the EHR:
    a. Name of the interpreter or interpreter ID #
    b. Date
    c. Time

ARRANGING INTERPRETATION

A. **Accessing the Language Line system at VCMC/SPH and Ambulatory Care Clinics**
    1. Mobile video units with direct access to Language Line are available throughout designated areas of hospital and clinic system. Any phone can be used to make a call to Language Line for over the phone interpreter services by calling the below toll free numbers:
        a. VCMC and SPH: Dial 1-833-789-0397
        b. Ambulatory Care: Dial 1-833-949-2320
    2. Language Line staff will help identify the patient's language if the VCMC/SPH/Ambulatory Care staff cannot.
    3. Inform the interpreter that confidential health information will be discussed.

B. **Accessing American Sign Language (ASL) at VCMC/SPH and Ambulatory Care Clinic**
    1. Interpretation services, including American Sign Language (ASL), can ~~also~~ be ~~performed~~provided via video conferencing through ~~video conferencing interpreting~~Language Line at **VCMC/SPH** ~~via~~. To request ASL interpretation, simply select 'American Sign Language ~~Line. Select American Sign Language~~,' and you will ~~then~~ be immediately ~~directed to~~connected with a sign language interpreter. ~~In~~ For in-person ASL interpretation, ~~ASL interpreting may be ordered from Interpreting~~please contact Jorge Mejia, Director of Language Access and Interpreter Services, ~~and~~at 805-652-6290. Please note that in-person ASL interpretation may require ~~a~~ 24-72 ~~hour~~hours' notice ~~of arrangement~~for

arrangements.

C. **Gold Coast Cultural and Linguistic Services** (Ambulatory Care or Out-patient Services **ONLY**)

1. Dial 1-866-421-3463 if you are a provider and enter your access code.

D. A list of VCMC/SPH bilingual Spanish-speaking staff is updated monthly from Human Resources and can be obtained from:

1. The Nursing Office (652-6001) or the Nursing Supervisor (page at 652-6075)

Some LEP ~~persons~~individuals may prefer or request to use a family member or friend as an interpreter. However, family members or friends ~~of~~will not be used as interpreters unless specifically requested by the LEP ~~person will~~individual and after being informed that interpreter services are available at no charge. This offer and the response will be documented in the individual's file. If the LEP individual chooses to use a family member or friend as an interpreter, the facility will consider the competency of the interpreter, as well as issues of confidentiality, privacy, and conflict of interest. If the family member or friend is deemed not competent or appropriate for any of these reasons, professional interpreter services will be used ~~as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.~~instead.

Children and other clients/patients/residents will ~~**not**~~not be used to interpret in accordance with federal and state regulations, ~~in order~~ to ensure the confidentiality of information ~~and~~, and to maintain accurate communication.

PROVIDING WRITTEN TRANSLATIONS

VCMC/SPH will provide translation of ~~other~~ written materials, if needed, as well as written notice of the availability of translation services, free of charge, for LEP individuals. Requests for translation should be sent to the Director of Language Access, Jorge Mejia, at Jorge.Mejia@ventura.org or by phone at 805-652-6290. Additionally, any translation created or printed must be vetted by the Language Access Department before being distributed or utilized to ensure accuracy and compliance.

PROVIDING NOTICE TO LEP PERSONS

All patients are informed of the availability of Interpreter Services by signs posted in the Emergency Department, Admitting area ~~and waiting~~, Waiting areas and any other pertinent locations.

Patients are not required or expected to use family members or friends ~~or family members~~ as interpreters, ~~but~~although they may choose to do so. In accordance with federal and state regulations, VCMC/SPH ~~must offer to arrange~~is committed to offering professional interpreter services as a ~~matter of~~ routine ~~course if~~practice whenever direct care providers are not fluent in the patient~~'~~'s preferred language. ~~Reliance~~Relying on family or friends as interpreters can lead to potential breaches of confidentiality, cause patient embarrassment or shame, create reluctance to share critical information, result in ~~confidentiality breaches, shame and embarrassment on the part of the patient, reluctance to share crucial information, incorrect information translated~~inaccurate translations due to the lack of medical terminology understanding ~~of medical terminology~~, ~~or interpreter~~and proper traioning. It can also introduce personal bias into the interpretation. The Language Access Department along with VCMC/SPH and Ambulatory Care, is dedicated to ensuring

accurate, confidential, and unbiased communication for all patients.

MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, ~~VCMH~~VCMC/SPH will assess changes in demographics, types of services ~~or~~, and other ~~needs~~factors that may require a reevaluation of this policy and its procedures. This review will occur annually and will be overseen by the Director of the Language Access Department. ~~In addition~~Additionally, ~~VCMH/SPH~~the Director will regularly assess the ~~efficacy~~effectiveness of these procedures, including but not limited to the mechanisms for securing interpreter services, the equipment used for ~~the~~delivering language assistance, complaints filed by LEP individuals, and feedback gathered from patients and community organizations. Any necessary updates to the policy and procedures will be made to ensure continued compliance and effective service delivery ~~of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc~~.

CONCERNS OR COMPLAINTS

Patients with concerns regarding interpreters may call the Patient Advocate or Nursing Supervisor. Patients with complaints may also contact the following:

Ventura County ADA Coordinator

County of Ventura

800 S. Victoria Avenue

Ventura, CA 93009

Phone: (805) 654-2864

Email: CountyExecutiveOffice@ventura.org

REFERENCES:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

Section 1557 of the Affordable Care Act (ACA)

California Health and Safety Code 1259

CMS Condition of Participation 482.13(a)(1)

All revision dates:	5/20/2025, 11/15/2023, 3/9/2021, 7/10/2019, 7/26/2017, 4/1/2016, 1/1/2014, 4/1/2012, 6/1/2006, 10/1/2004, 10/1/1986

Attachments

No Attachments

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	7/11/2025
Ambulatory Care Administration	Amelia Breckenridge: Associate Chief Medical Officer, Ambulatory Care	6/23/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	5/20/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/20/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/20/2025
Policy Owner	Jorge Mejia: Director of Language Access	5/20/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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

100.070 Moderate and Deep Sedation

POLICY:

To outline the patient care and management of inpatients or outpatients who receive medication with the intent to produce moderate or deep sedation for diagnostic or therapeutic procedures. To ensure the safe and effective administration of moderate and deep sedation.

PROCEDURE:

DEFINITIONS

There are varying levels of sedation. Increased depth of sedation increases the likelihood that the patients airway, ventilation, and cardiovascular function will be affected. In addition, medications administered with the intent to induce one level of sedation may result in a lighter or deeper level of sedation, depending upon the agent(s) used and the physical status and drug sensitivities of the individual patient.

A. **Minimal Sedation** (Anxiolysis): A drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

B. **Moderate Sedation** (previously known as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

C. **Deep Sedation**: A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilations may be inadequate. Cardiovascular function is usually maintained.

D. **General Anesthesia**: A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

COROLLARIES

A. This policy only applies to the administration of medication(s) with the intent to produce moderate or deep sedation to permit performance of a procedure. This policy does not include patients who receive calming agents for the sole purpose of managing anxiety and behavioral emergencies, patients who receive analgesia with the goal of pain control without moderate sedation or patients who are intubated.

B. Individuals administering moderate or deep sedation must be qualified and have credentials to manage and rescue patients at whatever level of sedation is achieved, either intentionally or unintentionally.

C. If the intent is to induce a state of depressed consciousness beyond deep sedation then the physician must have the expertise and advanced airway management as ordinarily provided to patients undergoing general anesthesia.

QUALIFIED STAFF AND PHYSICIANS

A. For moderate sedation, care and medication administration shall be provided by either a licensed Registered Nurse (RN) or a physician. For deep sedation, care shall be provided by a licensed RN, however deep sedation medications MUST be administered by the physician. The RN will satisfy the following conditions:

   1. For pediatric moderate or deep sedation, a current Pediatric Advanced Life Support (PALS) or Emergency Nurses Pediatric Course (ENPC) card and completion of the *Pediatric Procedural Sedation Module*.
   2. For adult moderate or deep sedation, an RN requires a current Advanced Cardiovascular Life Support (ACLS) card and completion of the *Adult Procedural Sedation Module*.
   3. Upon hire, RNs are required to complete a one-time competency. Annual renewal is required.
   4. If assistance is needed with procedure, additional personnel is required while the primary RN focuses only on monitoring/caring for the patient.

B. A. Physicians who seek privileges in moderate and deep sedation must be granted sedation privileges through the Medical Staff credentialing process, complete the sedation modules and post-test, and maintain a current ACLS (adult privileges) and/or PALS (pediatric privileges) certificate. ACLS/PALS requirements may be waived for physicians board certified in Anesthesia, Emergency Medicine, and Critical Care specialties unless otherwise specified in the department/specialty privileging requirements. Physicians must undergo initial proctoring in accordance with established privileging criteria.

C. In addition to the individual performing the procedure, a sufficient number of qualified staff must be present to evaluate the patient, to provide the sedation, to help with the procedure, and to monitor and recover the patient.

PRE-SEDATION ACTIVITIES

A. ASSESSMENT

   1. Within 48 hours prior to the procedure, the physician will complete a pre-sedation assessment in the electronic health record (EHR). Components of the pre-sedation assessment will include:
      a. Patient's diagnosis, planned procedure and location of sedation
      b. Last solid and liquid intake

c. Presence of food, drug, latex, or contrast allergies
d. Current medications have been reviewed and documented
e. Patient's pertinent review of systems (presence of any acute illness or chronic condition that may place the patient at higher risk to experience complications during sedation)
f. Presence of previous complications from sedation or anesthesia
g. Patient's weight in kilograms
h. Patient's temperature, blood pressure, heart rate, respiratory rate, pulse oximetry
i. Mallampati Classification (Attachment A)

2. The physician will assign an American Society of Anesthesiologists (ASA) status and document the ASA status in the procedural sedation note. If the patient is ASA class 3 or higher then the physician will consider consultation with anesthesiology (See Attachment B).
3. The physician will document the sedation plan.
4. The physician will perform an informed consent that includes a discussion of all reasonable risks and benefits of sedation, alternatives of sedation, risks and benefits of alternatives, and the monitoring plan.
5. Just prior to the administration of moderate or deep sedation, a Pre-Induction Assessment will be ~~performed and documented~~completed, which should include the following:
   a. Vital signs

B. VERIFICATION

1. The RN will verify that an informed consent form is completed.
2. The RN will verify that current medications have been reviewed and documented.
3. The RN will verify that the physician orders for medication are completed.
4. The RN and physician will verify the allergy status of the patient.
5. A time out will occur according to policy 100.062 Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.
6. The physician and RN will assess the patient's NPO status. The physician will consider the ASA guidelines in proceeding with sedation.

Clears	Breast Milk	Formula/Milk	Light Meal
2 hours	4 hours	6 hours	6 hours

Although recent food intake is not an absolute contraindication for administering sedation, the physician must weigh the risk of pulmonary aspiration and the benefits of providing sedation in accordance with the needs of each individual patient. In accordance with the American Society of Anesthesiologists, do not delay moderate procedural sedation based on fasting times alone in urgent or emergent situations where complete gastric emptying is not possible.

7. The RN and physician shall verify the following emergency support is available:
   a. Intact crash cart and defibrillator is secured and immediately available. The crash cart will contain emergency medications for resuscitation and reversal agents according to policy 100.113 Crash Cart Checks and Restocking Process.

b. Appropriate resuscitation equipment is available in the sedation area.

c. The pediatric airway bag is present for pediatric patients.

d. An oxygen tank is available if the patient is to be transported.

e. Medications needed for emergent intubation are available.

f. An intra-procedure monitor that is capable of performing capnography.

g. The presence of a portable monitor if the patient is to be transported while sedated.

INTRA-PROCEDURE ACTIVITIES

A. MODERATE SEDATION: ADMINISTRATION, MONITORING AND DOCUMENTATION

1. Connect automated blood pressure cuff, pulse oximetry, electrocardiogram (EKG) leads, and respiratory leads and place patient on continuous monitor. During moderate sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and continual monitoring with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment.
2. Place patient on supplemental oxygen as ordered by the physician.
3. Record the blood pressure and heart rate every five (5) minutes. Record the EKG rhythm, respiratory rate, pulse oximetry, and Richmond Agitation Sedation Scale (RASS) Score (Attachment C) every 15 minutes.
4. The physician or RN may administer the ordered medication(s) intended to produce moderate sedation. If the RN administers the medication(s), the physician must be present when the dose is administered.
5. Vital sign documentation may be performed by the physician or RN.

B. DEEP SEDATION: ADMINISTRATION, MONITORING AND DOCUMENTATION

1. Connect automated blood pressure cuff, pulse oximetry, EKG leads, and respiratory leads and place patient on continuous monitor. During deep sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and continual monitoring with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment.
2. Place patient on supplemental oxygen as ordered by the physician.
3. Record the blood pressure and heart rate every five (5) minutes. Record the EKG rhythm, respiratory rate, oximetry, and RASS score every 15 minutes.
4. Only the physician shall administer the medication(s).
5. Except in case of emergency, two physicians shall be present: one physician responsible for managing the sedated patient and another physician responsible for the procedure being performed.
6. Vital sign documentation may be performed by the physician or RN.

EMERGENCY MANAGEMENT

A. In the event of respiratory depression/compromise, perform the following immediately:

1. Stop the medication infusions.
2. Suspend the procedure

3. Support the airway as needed e.g. suction, position and oral airway.
4. Administer increased FIO_2 as needed to maintain oxygen saturations at pre-procedure levels.
5. Elevate head of bed (HOB) as permitted and reposition patient's chin, neck, and shoulders.
6. Monitor vital signs as frequently as needed.
7. Observe for changes in tissue perfusion.

B. In the event of hypotension, perform the following immediately:
1. Stop or decrease the medication infusion per the physician orders.
2. Administer IV fluids per the physician's orders.
3. Await further orders from the physician.
4. Monitor vital signs closely.
5. Observe for changes in tissue perfusion.

C. In the event of cardiac arrest, perform the following immediately:
1. Stop the medication infusions.
2. Call for "Code Blue" for adult patients or "Code White" for pediatric patients.
3. Initiate cardiopulmonary resuscitation (CPR).

POST-PROCEDURE ACTIVITIES

A. Post-Procedure expectations of physician
1. For all patients who are deeply sedated, the physician will continue to remain at the bedside until the patient meets criteria for moderate sedation.
2. If a patient meets criteria for moderate sedation, the physician may leave the bedside but must remain in the immediate area until the patient meets criteria for minimal sedation.
3. If a patient meets criteria for minimal sedation, the physician or designee must remain available in the hospital until the patient meets discharge criteria or is no longer minimally sedated.

B. Post-Procedure expectations of RN
1. For deeply sedated patients, the RN will remain at the bedside and ensure that vital signs continue to be documented every five (5) minutes.
2. Once the patient meets criteria for moderate sedation, the RN will chart vital signs at least every 15 minutes. The RN will remain at the bedside until the patient meets criteria for minimal sedation.
3. Once the patient meets criteria for minimal sedation, the RN may leave the bedside. Vital signs will be documented at least every 15 minutes until the patient meets criteria for discharge or is no longer minimally sedated.

C. In addition to the above monitoring parameters, the RN will also monitor the following:
1. Pain level
2. Procedure site and dressing as applicable
3. Ability to follow instructions as appropriate
4. Patency of peripheral IV site

D. Prolonged or overnight monitoring should be considered for the following:
    1. Full term infant who is less than 46 weeks post-gestation
    2. Pre-term infant who is less than 52 weeks post-gestation
    3. Infants with a history of apnea of prematurity
E. Any patient who has received a reversal agent must be observed for at least two (2) hours from the time of administration of the agent.
F. If procedural sedation was used to facilitate a medical procedure, a procedural sedation note should be documented in the EHR by the physician upon completion of the operation or procedure and before that patient is transferred to the next level of care.

DISCHARGE/TRANSFER ACTIVITIES

A. The physician is responsible for discharging the patient from the recovery area or from the hospital.
B. For adult patients who will be discharged, the patient and adult responsible for the patient will be given Cerner *Procedural Sedation Discharge Instructions - Adult* (Attachment D).
C. For pediatric patients who will be discharged, the adult responsible for the patient will be given Cerner *"Recovery After Procedural Sedation (Child)"* discharge instructions (Attachment E) in either English or Spanish. The RN will review instructions verbally with the parent(s) or legal guardian(s) prior to discharge.
D. The patient may be discharged when the following criteria are met:
    1. The patient has returned to baseline function.
        a. The patient's mental status has returned to baseline
        b. Cardiovascular and respiratory status has returned to baseline
        c. Patient is able to move and coordinate all muscle groups according to baseline
        d. Skin color has returned to baseline
    2. If appropriate, patient can verbalize post-sedation/discharge instructions.
    3. Pain management is effective (if appropriate).
    4. Procedure site and dressing are acceptable (if appropriate).
    5. IV has been discontinued.
    6. A responsible adult is present to accompany the patient from the hospital and assume responsibility for the patient upon discharge.

REFERENCES:

American Society of Anesthesiologists: Practice Guidelines for Moderate Sedation and Analgesia. *Anesthesiology* 2018; 128: 437-79. American Society of Anesthesiologists: Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology* 2002; 96: 1004-1017.
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The Joint Commission. Standard PC.03.01.05
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Goodwin et al: Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department. *Annals of Emergency Medicine* 2005; 45: 177-196
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Attachments

- Attachment A - Mallampati Classification
- Attachment B - ASA Status
- Attachment C - Richmond Agitation Sedation Scale (RASS).pdf
- Attachment D - Procedural Sedation (Adult) Discharge Instructions.pdf
- Attachment E - Recovery After Procedural Sedation (Child).pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine & Surgery	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	6/12/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	6/6/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.097 Malignant Hyperthermia

POLICY:

Patients undergoing procedures requiring general anesthetics will be assessed pre-operatively for risk of malignant hyperthermia by Anesthesiology Staff. Patients known or suspected to be at risk for malignant hyperthermia will receive anesthesia via a thoroughly cleaned anesthesia machine with a fresh soda lime filter. All triggering anesthetic agents will be avoided. The patient will receive appropriately prescribed medications, administered safely and as needed in the preoperative area.

DEFINITIONS:

Malignant Hyperthermia (MH) is a potentially lethal syndrome caused by a hypermetabolic response of skeletal muscle that can be triggered in susceptible individuals by volatile inhalation agents and succinylcholine.

A. **Symptoms** including but not limited to:
   1. Muscle rigidity (trunk or total body)
   2. Masseter spasm or trismus
   3. Tachycardia / tachypnea
   4. Elevated end-tidal CO2 ($ETCO_2$) / hypercarbia
   5. Myoglobinuria
   6. Increased temperatures (1° to 2° ~~C~~Celsius rise every 5 minutes; may be a late manifestation)
   7. Cyanosis, mottling
   8. Cardiac Dysrhythmia
   9. Acidotic State (respiratory and metabolic)

B. Risk Factors include:
   1. Known family history of MH
   2. Inhalation anesthetic medications such as halothane and desflurane
   3. Muscle relaxants such as succinylcholine

EQUIPMENT:

A. Malignant Hyperthermia Cart

B. Cooling equipment (hypothermia blanket, ice packs)

C. **MH / Emergency crisis ~~hotline~~hot line: 1-800-644-9737**.

PROCEDURE:

A. If crisis occurs outside of the operating room (~~PACU/ED/ICU/PICU~~OR)~~,~~ notify the anesthesiologist immediately. If crisis occurs in surgery, anesthesia to discontinue volatile inhaled agents and Succinylcholine.

B. Hyperventilate with 100% oxygen at least 10 liters/minute. Monitor ETCO2 with continuous capnography.

C. DO NOT leave the patient, call for additional help.

~~Immediately obtain MH cart AND crash cart.~~

~~1. Malignant Hyperthermia cart locations:~~

~~a. VCMC: OR suite and OB C-Section suite~~

~~b. SPH: OR suite~~

~~2. If MH crisis occurs outside of the OR suite or OB C-Section suite at VCMC, call the OB unit immediately to bring the MH cart to the location of the MH crisis.~~

~~3. If MH crisis occurs outside of the OR suite at SPH, obtain MH crash cart from OR suite.~~

D. CODE Malignant Hyperthermia Response Team

1. Anesthesiologist
2. Hospitalist or Emergency Department (ED) Attending
3. Nurse 1: Nurse assigned to care for the patient
4. Nurse 2: Rapid Response Nurse (RN). If not available, use the designated critical care RN
5. Nurse 3: House Supervisor
6. Respiratory Therapist
7. Laboratory
8. Radiology

E. Rapid Response Nurse or designated critical care RN to immediately obtain MH cart AND refrigerated 3 liters of fluid and regular insulin

1. Malignant Hyperthermia cart locations (see policy 100.257 Malignant Hyperthermia Cart Restocking Process):
    a. Ventura County Medical Center (VCMC):
        i. Ground floor: Operating Room (OR) Core (near Interventional Radiology) and OR Core Refrigerator
        ii. Second floor
            a. Cart: Obstetrics (OB) C-Section suite

b. Refrigerated fluid/insulin: Labor and Delivery Room Pyxis refrigerator

b. Santa Paula Hospital (SPH): OR Core and OR Core Pyxis Refrigerator

2. If MH crisis occurs outside of the OR suite or OB Cesarean-Section suite at VCMC, RN to access the closest available cart and fridge containing 3 liters of fluid and regular insulin.

3. If MH crisis occurs outside of the OR suite at SPH, RN to obtain MH crash cart from OR suite and fridge containing 3 liters of fluid and regular insulin.

F. Department Personnel (e.g., personnel from the department calling the code): Immediately obtain crash cart

G. Simultaneous measures need to be started immediately:

1. **Nurse 1** -- Start Cooling Measures

a. Surface cooling with ice packs and hypothermia blanket.

b. Infuse cold saline intravenously (IV).

c. Irrigate with cold saline as ordered by physician (i.e., stomach lavage).

d. Stop cooling measures if temperature < 38° Celsius (C).

2. **Nurse 2 & 3** -- Obtain Dantrolene from MH Cart

a. **Nurse 2 -- Preparer**

i. Mix each 20 milligram (mg) vial of dantrolene with 60 ~~ml~~milliliter (mL) sterile preservative-free water for injection.

b. **Nurse 3 -- Administrator**

i. Administer dantrolene 2.5 mg/kg (milligram/kilogram) IV bolus rapidly, through large-bore IV.

ii. Repeat dosages as necessary until symptoms reversed.

H. Correct metabolic acidosis. Administer sodium bicarbonate 1-2 mEq/kg (milliequivalent/kilogram) as guided by arterial blood gas and physician order.

I. Correct and treat hyperkalemia state with sodium bicarbonate, dextrose and insulin, and calcium chloride (as directed by physician).

J. Continuous cardiac monitor: Dysrhythmias usually respond to treatment of acidosis and hyperkalemia. If they persist or are life threatening, standard Advanced Cardiac Life Support (ACLS) anti-arrhythmic agents may be used. DO NOT administer calcium channel blocker.

K. Draw Labs: Arterial Blood Gas (ABG~~'s~~), Comprehensive Metabolic Panel (CMP), Creatinine Kinase (CK), Prothrombin Time/Partial Thromboplastin Time (PT/PTT), calcium, glucose, serum and urine myoglobin, lactic acid level, Fibrin/Fibrinogen split products (FSP), D-Dimer, fibrinogen and Complete Blood Count (CBC) for baseline values or as directed by physician.

L. Ensure urine output greater than 2 mL/kg/hour. Utilize fluid challenges and/or furosemide (as directed by physician).

M. Consider central venous monitoring and arterial line.

N. The Surgical Technologists are qualified to perform the following under the direct supervision of surgeon(s).

1. Apply and/or assist in patient cooling mechanisms (cooling blankets, ice packs to groin, axilla and

head).

2. Assist with cooling irrigation to body cavities as directed by surgeon.
3. Secure incision site (apply dressing and/or cover wound to protect from disruption).
4. Retrieve MH equipment and supplies:
    a. MH emergency cart
    b. Ice and iced fluids
    c. Patient cooling equipment
5. Assist the anesthesia care provider and other members of the perioperative team as needed.

O. Post Acute Phase:

1. Transfer patient to intensive care unit (ICU), place patient on continuous cardiac monitoring and temperature monitoring.
2. Observe for minimum of 24 hours.
3. Continue administration of dantrolene 1 mg/kg or more every 4-6 hours for 24-48 hours post acute episode (as directed by physician).
4. Track: arterial blood gases, creatinine kinase, potassium, urine and serum myoglobin and clotting studies every 6 hours or as directed, until they return to normal.
5. Follow urine myoglobin and treat as indicated.
6. Counsel and educate patient and family about MH. Refer to Malignant Hyperthermia Association.

P. Malignant Hyperthermia Cart Maintenance -- See policy *100.257 Malignant Hyperthermia Cart Restocking Policy*.

PATIENT / FAMILY EDUCATION

A. Provide extensive emotional support and education related to MH to patient and family.

B. Relate risks factors to patient and family regarding future anesthesia or periods of strong emotional stress once patient is stabilized.

C. Refer patient and family to Malignant Hyperthermia Association of the United States (MHAUS) www.mhaus.org.

D. MHAUS phone numbers: Non-emergency or Referral 1-800-986-4287.

DOCUMENTATION

A. Complete Notification form to track crisis

B. Nurses Notes to include:

1. Time of MH code
2. Names of personnel in room
3. Drugs and fluids administered and times of each
4. Nursing procedures completed
5. IV lines / catheters inserted.

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Attachments

Attachment A - Acute Treatment Guidelines for Malignant Hyperthermia

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Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	6/11/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/24/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/24/2025
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100.107 On-Call Physician Coverage

POLICY:

To establish guidelines for Ventura County Medical Center/Santa Paula Hospital to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions in order to meet the healthcare needs of the community as required of any hospital with an emergency department by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C., Section 1395 and all Federal and State regulations and interpretive guidelines promulgated thereunder.

PROCEDURE:

DEFINITIONS

A. **Dedicated Emergency Department (DED):**
Any department or facility of the hospital that either -

1. is licensed by the state as an Emergency Department;
2. held out to the public as providing treatment for emergency medical conditions; or
3. on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis.

B. **Emergency Medical Condition (EMC):** a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.

GUIDELINES:

The hospital will maintain a list of physicians on its Medical Staff who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual receiving treatment for an emergency medical condition (EMC). The cooperation of the hospital's medical staff members with this policy is vital to the hospital's success in complying with the on-call provisions of EMTALA. The hospital will make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff bylaws and will take all necessary steps to ensure that physicians perform their obligations as set forth herein in each document.

No physician may refuse to respond to a call based upon arbitrary, capricious or unreasonable discrimination

involving an individual's race, religion, national origin, age, gender, physical condition, economic status, ethnicity, citizenship, disability, pre-existing medical condition, marital status, sexual orientation, insurance status, ability to pay, or other categories protected by law, or perception that the individual has any of these characteristics or is associated with anyone who has or is perceived to have these characteristics.

Maintain a List

The hospital will maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The hospital provides adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

Develop an On-Call Schedule that Covers 24 Hours Each Day

The facility's governing board requires that the medical staff be responsible for developing an on-call rotation schedule that includes the name and contact information of each physician who is required to fulfill on-call duties. Physician group names are not acceptable for identifying the on-call physician. Individual physician names with accurate contact information, including a telephone number where the physician can be reached, will be put on the on-call list. The hospital MUST be able to contact the on-call physician with the number provided on the list. Each physician is responsible for updating his or her contact information as necessary. Copies of the On-Call Schedule shall be provided to the operator and Emergency Departments.

Back-up Plans and Transfers

The Medical Staff shall determine which specialties are required to have a formal back-up plan in place with a second specialist who is available to the emergency department should the first specialist be unavailable or unable to address the need. These specialties include anesthesia, neurosurgery, trauma surgery, obstetrics and critical care. In the event that the on-call physician is unable to respond and there is no pre-defined back-up physician on call, the need will be escalated to the Administrator on Duty and/or the Medical Director of the hospital to assist in identifying another staff physician within the specialty who could provide back-up coverage. This may include reaching out to the chief of the service line or others with the specialty with comparable privileges on the medical staff. At all times the physician of record shall weigh the risks and benefits of transferring the patient to another facility or keeping the patient for ongoing care. Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available and managed by the pre-admitting department in conjunction with the nursing supervisor after hours.

Simultaneous Call

When the hospital permits the on-call physician to have simultaneous call at more than one hospital in the geographic area, the hospital must be aware of the on-call schedule and must have a plan in place to meet its EMTALA obligation to the community. This plan could include back-up call by an additional physician or the implementation of an appropriate transfer.

Physician Responsibility

The on-call physician is responsible to ensure the following:

A. Immediate availability, at least by telephone, to the emergency physician for his or her scheduled "on-call" period, or to secure a qualified alternate if appropriate.

B. The emergency physician, in consultation with the on-call physician, shall determine whether the

individual's condition requires the on-call physician to see the individual immediately. Arrival to the emergency department within a reasonable timeframe (generally, response by the physician is expected within no more than 30 minutes). The determination of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual shall be controlling in this regard.

C. The on-call physician has a responsibility to provide specialty care services as needed to any individual who comes to the Emergency Department either as an initial presentation or upon transfer from another facility.

Transfer to Physician's Office

The hospital may NOT refer individuals receiving treatment for an EMC to an on-call physician's office for stabilization of an EMC. The physician must come to the hospital to examine and treat the individual if requested by the treating physician. If, however, the EMC has been stabilized, the treating physician in the emergency department may discharge the patient and arrange follow up with the on-call physician in the outpatient setting.

Financial Inquiries

Medical Staff Members who are on call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the emergency department and no facility employee may provide such information to a physician on the phone.

Physician Appearance Requirements

If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a defined period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a defined amount of time (generally, response by the physician is expected within no more than 30 minutes). For those physicians who fail to respond, the Chief of Staff and/or Medical Director of the hospital shall be informed and the matter to be addressed in Medical Staff peer review.

Records

The hospital must keep a record of all physicians on-call and on-call schedules for at least five (5) years.

All revision dates: 9/1/2015

Attachments

No Attachments

Approval Signatures

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

Step Description	Approver	Date
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	7/21/2025
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/6/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/6/2025
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100.277 Comfort Care Medication Management

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) appropriately prescribes and administers medications for symptom management at the end-of-life.

BACKGROUND & RATIONALE

Standard practice guidelines for end-of-life serve as a foundation for patient and family-centered care for the seriously ill and dying. Development of a uniform practice aims to reduce unnecessary variations in care, improve family satisfaction with care, provide best care possible, and educate providers. The MED Adult Comfort Measures order set is intended to explain practice and set standards for end-of-life care using evidenced based rationale.

PURPOSE:

- To establish a comprehensive, evidence-based, patient centered approach to symptom assessment and medication management of the patient at the end of life.
- To reduce variability in the provision of end-of-life medication management.
- To provide timely and effective symptom-based care.
- To eliminate errors and adverse effects in dosing, ordering, and administration of medications, including opioid infusions.
- To define monitoring parameters and documentation standards for medications.

DEFINITION(S):

Palliative Care: Specialized medical care for patients living with a serious illness. Palliative care is focused on providing relief from the symptoms and stress of illness. It is appropriate at any stage in a serious illness and can be provided along with curative treatments. It includes physical, emotional, social, and spiritual support for patients and their families.

End of Life: Care given to people who are near the end of life and have stopped treatment to cure or control their disease. End-of-life care includes physical, emotional, social, and spiritual support for patients and their families. The goal of end-of-life care is to control pain and other symptoms so the patient can be as comfortable as possible. Also called comfort care.

Comfort Care: End-of life care that is initiated in the hospital setting (see above).

Hospice: A service that takes place outside the hospital setting. It is for individuals who are facing life-limiting illness and have a life expectancy of six months or less. Hospice provides symptom control and compassionate care for individuals and their families.

PROCEDURES:

A. **Symptom Assessment and Management**

1. Assessment
    a. Universal Pain Assessment Tool (Numeric Pain scale with intensity)
    b. Non-verbal signs of pain (e.g., grimacing, furrowed brow, guarding, nasal flaring, and use of accessory muscles)
2. Treating pain
    a. Route of administration
        i. Consider oral/sublingual (PO/SL) as first choice as these routes enable transition out of the hospital setting.
        ii. Enteral tube access: consider liquid formulations per feeding tube
        iii. Difficulty swallowing: consider SL or intravenous (IV) administration
        iv. No IV access: consider SL or subcutaneous (SUBCUT) administration
    b. Medications
        i. Non-opioids
            a. Acetaminophen PO or rectal (PR)
            b. Lidocaine 5% patch transdermal (TD)
        ii. Opioids
            a. Morphine
                i. 20 mg/mL oral liquid
                ii. 10 mg/5 mL oral solution
                iii. IV
            b. Oxycodone
                i. 20 mg/mL oral liquid
                ii. 5 mg/5 mL oral solution
            c. Hydromorphone
                i. oral tablet
                ii. IV
        iii. Patient's previous opioid requirements should be considered.
        iv. Avoid morphine in patients with kidney injury or end-stage-kidney disease.
3. Dyspnea
    a. Assessment:

i. Patient/clinician reported anxiety
ii. Use of accessory muscles
iii. Respiratory rate (RR) > 20 breaths/min

b. Treating dyspnea
i. Opioids can be used to relieve dyspnea.
ii. Lorazepam (liquid SL or IV) can be used as a second line agent as anxiety often accompanies respiratory issues.

4. Anxiety
a. Assessment: Patient/clinician reported anxiety
b. Treating anxiety
i. Order only one medication for anxiety.
ii. Medications
a. Lorazepam (oral, SL, IV)
b. Olanzapine oral (max 10 mg/day)
c. Haloperidol (SL, SUBCUT, IV)

5. Delirium/Agitation/Restlessness
a. Medications
i. Olanzapine oral (maximum 10 mg/day)
ii. Haloperidol (SL, SUBCUT, IV)

6. Nausea/Vomiting
a. Choose medication based on cause of nausea/vomiting
b.

Cause	Medication Option
Medications, uremia, toxins, or other factors	▪ Ondansetron (SL, IV) ▪ Metoclopramide (PO, IV)
Bowel obstruction, increased intracranial pressure (ICP), medications, uremia, or toxins	▪ Dexamethasone (PO, IV)
Anticipatory nausea, medications, uremia, or toxins	▪ Lorazepam (SL, IV)
Gastroparesis, medications, uremia, or toxins	▪ Metoclopramide (PO, IV)

7. Secretions
a. Discontinue IV fluids.
b. Treating secretions
i. Glycopyrolate (SL, PO, IV, SUBCUT)

ii. Hyoscyamine (SL)

iii. Scopolamine transdermal patch

8. Fever
    a. Treatment
        i. Cooling measures if desired by patient/family
        ii. Medications
            a. Acetaminophen (PO, PR)
            b. Ketorolac (IV, IM)
9. Anti-diarrheal and Bowel Regimen
    a. Medication: Loperamide (PO)
    b. NOTE: A common side effect of opioids is constipation due to delayed gastric motility.
10. Bowel Regimen Protocol
11. Dry eyes: Ocular lubricant
12. Insomnia
    a. Melatonin (scheduled)
    b. As needed (PRN)
        i. Lorazepam (first line)
        ii. Zolpidem (first line)
        iii. Trazodone (2nd line)
13. Anergia/terminal fatigue: methylphenidate
14. Antiepileptic: lorazepam

B. **Opioid IV Infusions**

1. Indication
    a. Opioid Infusions are only necessary for uncontrolled symptoms where intermittent as-needed administration is insufficient.
    b. Patients who are already comfortable or requiring minimal breakthrough doses of opioids may not need opioid IV infusions.
    c. Some patients who are intubated with planned compassionate extubation may not need opioid infusions if they do not have respiratory failure from primary cardio-pulmonary processes or severe neurologic injury.
2. Equipment
    a. Dedicated BD Alaris infusion pump
    b. Tubing
    c. Opioid infusion in standardized concentrations
        i. Hydromorphone 1 mg/mL in NS 50 mL OR
        ii. Morphine (Premix) 1 mg/mL 100 mL

3. Roles and Responsibilities for opioid infusions are noted below.

ROLES AND RESPONSIBILITIES

Licensed Practitioner (LP)

A. All comfort care orders must be initiated and entered by a licensed practitioner into the electronic health record.
   1. Verbal or Telephone orders are unacceptable for initiating comfort care orders.
   2. The comfort care order set is called MED Adult Comfort Measures Admit
   3. The LP must only order or discontinue what is appropriate for patients' comfort.

B. The LP is responsible for completing a transfer reconciliation addressing previous medications, labs, imaging, monitoring, artificial nutrition, and nursing orders.
   1. It is recommended that the transfer reconciliation be completed prior to placing the comfort care orders.

C. Patient's nurse should be notified of comfort care initiation, request for changes, or therapy cessation.

D. Opioid Infusion
   1. The decision to start an opioid infusion for comfort care should be discussed with covering attending and/or palliative care physician.
   2. The LP is responsible for determining the initial basal rate.
   3. For opioid naive patients, the initial basal rate should be discussed with the covering attending and/or palliative care physician.
   4. How to calculate initial basal rate:
      a. Determine total opioid usage in MME (morphine mg equivalent) in 24 hours.
      b. Get hourly total by ÷ 24 hours.
      c. Dose the continuous infusion at 50%of the calculated hourly dose
   5. Allow 10-20% of the 24 hour dose to be used for breakthrough pain.

Pharmacy

Pharmacy staff shall follow related policies on pharmacy roles and responsibilities at order verification and medication dispensing.

A. PH.55 ~~Medicatioon~~Medication Order Management

B. PH.88 Controlled Substances

Nursing

A. The nurse shall call the charge nurse or manager to inform them before starting comfort care.

B. The nurse shall review the orders prior to initiation as per policy 100.025 Medications: Ordering, Administration, and Documentation)

C. Comfort Care Opioid Intravenous Infusion Protocol (Nursing driven)
   1. Set up

a. The registered nurse (RN) will call the charge nurse/nursing supervisor to inform them before starting a comfort care opioid infusion.

b. The RN will obtain the necessary equipment.

c. The RN will retrieve the opioid infusion from the automated dispensing cabinet (ADC).

2. Administration and Monitoring (See Attachment A)

a. The RN shall initiate the comfort care opioid intravenous infusion at the ordered basal rate.

b. The RN ~~shall~~should re-assess every 15 minutes until signs of discomfort are relieved.

c. The RN shall administer ordered as needed (PRN) breakthrough IV pain medications if indicated.

d. If discomfort (e.g., pain or dyspnea) is not relieved after 3 dose of PRN breakthrough IV pain medications in a 2 hour period, Nursing may increase the basal rate by 50% (multiple by 1.5).

~~i. Independent double check required.~~

e. Continue to monitor for signs and symptoms of discomfort.

f. Nursing to contact provider for unrelieved pain at maximum rate.

All revision dates: 6/5/2025, 10/9/2024

Attachments

Attachment A - Comfort Care NURSING DRIVEN Opioid Infusion 2025.pdf

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	7/10/2025
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100.282 Multidisciplinary Care Plans

POLICY:

Planning for medical, nursing, and other clinical discipline(s) care, treatment, and service(s) is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment, and services that is appropriate to the patient's specific assessed needs. To continue to meet the patient's unique needs, the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, and services; or the patient's achievement of goals. The modification of the plan for care, treatment, and services may result in planning for the patient's transfer to another setting or discharge.

The multidisciplinary care plan is an integral part of the plan of care. An individualized care plan will be developed for each patient based on assessment findings. The care plan will be initialized as soon upon admission as possible but no more than 12 hours after admission. The individualized patient care plan will be based upon nursing ~~care plan is an integral part of the plan of care. An individualized care plan will be developed~~diagnosis standards and tailored by the members of the multidisciplinary team for each individual patient ~~based on assessment findings~~as necessary. ~~The~~Disciplines who are expected to document in the care plan ~~will be initialized as soon upon admission as possible but no more than 12 hours after admission. The individualized patient care plan will be based upon~~include nursing ~~diagnosis standards and tailored by the Registered Nurse for each individual patient as necessary~~, therapy services and respiratory therapy. The ~~nursing~~ care plan will address the patient's problems both actual and potential with appropriate goals/ expected outcomes and ~~nursing~~ interventions to reach the stated goals. The care plan will be updated as often as necessary, but at least every 12 hours, and updated as appropriate to the individual patient's changing condition and/or needs.

PROCEDURE:

A. Patient care is planned to meet the individual needs of the patient and the severity of the patient's disease process, health status, impairment, or disability. The ~~nursing~~ plan of care is documented in the electronic health record (EHR). It may vary based on the patient's goals and the time frames, settings, and services required to meet those goals. For example, a documented ~~nursing~~ plan of care is not required for outpatients or < 24 hour-short stay observation patients.

B. The patient/family will be provided an opportunity to participate in the development and implementation of the care plan, if possible.

C. The plan may include, but is not limited to, identified physiological and psychosocial problems/issues,

active co-morbidities requiring management during the hospitalization, expected health care outcomes or goals, implementable interventions to reach those outcomes/goals, and time frames governing when interventions occur or to assist in evaluating progress toward those outcomes/goals.

D. The plan of care is not limited to a single tab, screen or document within the patient's medical record, but rather, all components of the patient's medical record combine to form the full plan of care, including but not limited to: medications ordered and administered; physician orders for assessment, care, and treatment; the plan for medical care; progress notes and consults; and assessments and reassessments from all disciplines including rehabilitation~~, dietary~~ and discharge planning~~; (if applicable) restraint flow sheets and documentation; intake and output flow sheets; and vital sign flow sheets~~.

E. ~~Nursing plans~~Plans of care are most often associated with a patient's active problems that are the reason for or focus of the admission. A patient's chronic problems or comorbidities are often planned for and addressed through physician orders.

F. A collaborative, interdisciplinary approach is used by the patient's care team to:

1. Identify problems.
2. Establish goals and when applicable time frames to meet goals.
3. The time frames associated with the timing of interventions and goal achievement will be defined within the order for care, treatment or service, or goals are assumed to be achieved by the time of the patient's discharge or carried forward as part of the patient's post-discharge plan.
4. Coordinate care with an approach that involves the necessary mix of clinical disciplines
5. Evaluate the effectiveness of the interventions and goals achieved. Ongoing reevaluations measure the patient's progress toward those goals and the care plan is adjusted accordingly.

G. The care plan and education plan is established in concert with and in support of the medical plan of care.

H. Information obtained from the Admission Assessment, the History and Physical, and ~~the~~ nursing ~~assessment is~~/ancillary intake assessments are used to initiate the inpatient care plan and implement interventions.

I. Review care plan, document interventions and goals once per shift.

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No Attachments

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

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/15/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/15/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/15/2025

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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.025 Robotic Assisted Surgery Credentialing and Privileging Requirements

POLICY:

This document is intended to identify and stipulate the training and credentialing requirements for performing robotic surgery for all surgeons operating at Ventura County Medical Center. These criteria will be monitored and enforced by the Robotic Steering Committee~~, which reports to~~ Chair and the Department of Surgery Committee.

PROCEDURE:

A. General Requirements

1. The surgeon must be board certified or board eligible in his or her specialty as outlined in the Medical Staff Bylaws and Department Rules and Regulations.

2. The surgeon must be a member in good standing and hold current unrestricted privileges to perform the basic surgical procedures without robotic assistance.

B. Credentialing Requirements for New Robotic Surgeons

1. The surgeon must meet the following requirements to be awarded a certificate of training by Intuitive Surgical. Training will be completed at a designated Intuitive Surgical lab site. Hands on training dates must be coordinated in collaboration with the Medical Staff Office prior to being scheduled.

- Completion of computer-based online training modules to familiarize the surgeon with the technical aspects of the robot being utilized.
- Privileges must be requested prior to scheduling hands on training in order to coordinate first case within the vendor required 7 day time-frame. Privileges will not be effective until documentation of completed hands on training is received.
- Bedside training by an Intuitive Surgical representative or other approved qualified trainer for docking, bedside assisting and resolving bedside robotic system issues.
- Completion of designated basic simulator exercises with a minimum passing score of 90%.

2. The surgeon will be required to complete a minimum of three (3) proctored robotic procedures, assisted by a qualified proctor ~~that has been approved by the Robotic Steering Committee~~ (refer to definitions).

3. After completing the proctored cases, the surgeon's next five (5) non-proctored robotic cases will undergo

focused review by the Robotic Steering Committee Chair or designee. A recommendation will be made to the Department of Surgery Committee to release the surgeon from focused review or to continue the focused review for a specified number of cases.

4. If the surgeon has requested advanced robotic assisted surgery privileges, the surgeon must complete and be released from the initial proctoring and focused review requirements for basic robotic assisted surgery privileges prior to scheduling an advanced case. Advanced cases are subject to review by the Robotic Steering Committee Chair or designee and may require additional proctoring and/or focused review.

~~5. Approvals may be sought via email ballot in the absence of a regularly scheduled Robotic Steering Committee meeting when proctoring reports and focused case review recommendations are favorable. A summary will be provided by the reviewer for Committee consideration. Results of the email ballot will be reported at the next meeting.~~

C. Maintaining Privileges

1. To maintain full independent robotic privileges, the surgeon must perform a minimum of eight (8) robotic surgeries per calendar year.

2. If the minimum annual volume requirement has not been met, the surgeon must repeat the above-referenced simulator modules with a minimum passing score of 90%. The Robotic Steering Committee Chair and the Department of Surgery Committee will determine if additional proctoring or focused review is required.

D. Surgeons with Prior Robotic Training and Experience

If a surgeon has documented equivalent prior training and current experience from another institution, verification may satisfy a portion of the requirements outlined in section B. The first 2 robotic assisted surgeries will be proctored (basic or advanced).

E. Definitions

Proctor:

- A proctor is a current member of the medical staff with current unrestricted robotic privileges.
- A board certified surgeon who is privileged to perform robotic surgery in his/her respective institution; who has been designated by Intuitive Surgical as an experienced proctor and approved ~~by the Robotic Steering Committee~~ to provide proctoring services at Ventura County Medical Center.
- An outside proctor may not function as an assistant surgeon unless temporary privileges have been requested and granted. Temporary privileges for the purpose of proctoring will be limited to scheduled cases in which the surgeon will serve as the proctor.

Robotic Steering Committee:

- Committee Composition: The Robotic Steering Committee shall be composed of a Director of the Robotics Program who serves as the Robotic Steering Committee Chair, a physician representative from each surgical specialty performing robotic-assisted surgery, the OR Director, Nurse Coordinator, and Administrative representation.

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Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	7/17/2025
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Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.028 Isolation Precautions

POLICY:

Isolation precautions are used to care for the patient with a transmissible infectious agent. The purpose of isolation precautions is to interrupt the transmission of disease and prevent transmission of infection to staff and other patients.

The use of isolation precautions is a two-tiered process. Standard precautions are used for all patients and the category of isolation precautions is added according to the mode of transmission of the disease.

The following policy applies unless advised/directed otherwise by Infection Prevention and/or Infectious Diseases. All Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and hospital-based Ambulatory Care clinic staff shall follow the guidelines below which are designed to prevent transmission of organisms to patients, care providers and multi-use equipment. Multiple drug-resistant organisms (MDRO), defined by the Centers for Disease Control and Prevention (CDC) as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents, are a threat to patient and staff health and safety. It is essential to keep these organisms contained. Compliance with the following transmission-based precaution guidelines is required to prevent transmission of organisms and enhance patient and staff safety.

See References for an alphabetical list of infectious diseases and the correct category of isolation to be used.

PROCEDURE:

Initiation of Isolation Precautions:

1. The nurse may initiate isolation precautions based on information obtained in the nursing assessment. The nurse then informs the physician of the need for an Isolation Precautions order.
2. Physician orders the appropriate isolation/precautions.
3. Infection Prevention department representative, Infectious Diseases physician or Infection Control Committee (ICC) Chairman may initiate isolation precautions.
4. Post the appropriate Isolation/Precautions sign outside the patient room.

Discontinue Isolation Precautions:

A physician's order is required.

Patient Transport

1. Notify receiving department of isolation status by entering the information in the electronic health record (EHR). Verbal communication must also occur with the receiving department prior to the patient's arrival.
2. Limit movement of the patient throughout the hospital or clinic.
3. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Airborne and droplet isolation precautions require a surgical mask be placed on the patient.
4. Remove and dispose of contaminated Personal Protective Equipment (PPE) and perform hand hygiene prior to transporting patients on Contact Precautions.
5. Don clean PPE to handle the patient at the transport location.
6. Family members and visitors are required to conform to this policy and wear appropriate PPE as directed.

Airborne Precautions

Diseases requiring airborne precautions are transmitted via airborne droplet nuclei or small particles in the respirable size range carrying infectious agents.

Patient Placement

1. Place the patient in a designated negative air pressure room.

   Santa Paula Hospital:
   Call the Maintenance Department at 652-3219 between 0800 and 1700h. After hours, page the Maintenance Department through Paging at 652-6075.
2. The doors of these rooms must remain closed at all times when the rooms are being used for airborne isolation.
3. In the event that additional negative air pressure rooms are required, contact the nursing supervisor or the Maintenance Department.

All staff entering airborne isolation rooms shall follow the proper procedure: enter the anteroom and allow the anteroom doors to completely close. Once the green light is illuminated, staff may enter the patient room. Once in the patient room, the green light will signal that the patient room doors have completely closed.

1. Place the patient in a private room, until airborne isolation room is available.
2. Patients in airborne isolation rooms must have doors closed.
3. RNs should respond to pressure alarms in a timely manner. If staff is unable to deactivate the alarm, call Facilities Maintenance at ext. 6683 for assistance.

Surgery Patients: Any patient who has been placed on Airborne Isolation for suspected or diagnosed illness and has surgery will be recovered in the OR suite and then be transported to the negative pressure room with the appropriate staff.

Ambulatory Care Clinics: Each clinic has a designated room for isolation precautions.

Behavioral Health Clinics: Clinic Administrator or designee will be made aware and client or participant will be instructed to wait outside until consultation is made with trained medical personnel, the Ventura County Behavioral Health Safety Officer or Infection Control. Client or participant may be referred for medical clearance.

Respiratory Protection

1. Healthcare workers shall wear a N95 mask or Portable Air-Powered Personal Respiratory (PAPR) when in patient room.
2. Susceptible persons should not enter the room of patients known or suspected to have rubeola (measles) or varicella (chickenpox) if other immune caregivers are available.
3. Visitors may be offered respiratory protection (i.e., N95) and should be instructed on the use of the respirator before entering an Airborne Illness Isolation (AII) room.

Droplet Precautions

Diseases requiring droplet precautions are transmitted a short distance, approximately three (3) feet, from the respiratory tract of infectious individuals to susceptible mucosal surfaces of the recipient.

Patient Placement

- Patients on droplet precautions should be placed in a private room.
- Cohorting only after discussion with Infection Prevention.

Respiratory Protection

- Wear a surgical mask.

Contact Precautions

Diseases requiring contact precautions are transmitted by infectious agents via direct and indirect contact with the patient or their environment.

Isolation supplies (PPE's, masks, etc.) are now kept in hallways closets adjacent to patient rooms.

Gloves and gown

1. Gloves and gown must be worn upon entering the room.
2. Gloves and gown must be removed immediately upon exiting the room.
3. Perform hand hygiene after removal of gloves and gown.

Hand Hygiene and the Patient with Clostridium Difficile Infection:

1. Wash hands with soap and water.
2. Do not use alcohol gel for hand hygiene.
3. Use the Contact Precautions sign with the brown color for patients with Clostridium difficile infection.

Patient Care Equipment

1. Do not share patient care equipment.
2. Return to the designated department for cleaning and disinfection.

Room Cleaning After Discharge

Proper cleaning and disinfection of the patient's room after discharge is important to prevent the spread of infection from a contaminated environment. Inspection of the mattress for intactness between patients is also recommended.

1. Isolation sign remains outside of the room after discharge.
2. The room is thoroughly cleaned, and then disinfected using the hospital-approved disinfectant (e.g. bleach-based disinfectant for Clostridium difficile).
3. The housekeeper reverses the isolation sign in its holder so that nursing staff know the room has been cleaned and disinfected and is ready for the next patient.

Multi-Drug Resistant Organism (MDRO) Isolation Quick Sheet

	Current Infection WITH Active Drainage/ Excretions	Current Infection WITHOUT Active Drainage/ Excretions	Current Colonization	History of
Methicillin-Resistant Staphylococcus Aureus (MRSA)	✓			
Candida Auris (CAURIS)	✓	✓	✓	✓ up to ~~4~~3 years
Carbapenem-Resistant Enterobacteriaceae (CRE), **Carbapenem-Resistant Pseudomonas aeruginosa (CRPA)**	✓	✓	✓	~~✓ up to 1 year~~ ✓ up to 6 months
Vancomycin-Resistant Enterococcus (VRE)	✓			
Resistant pseudomonas, ~~Carbapenem-Resistant Pseudomonas aeruginosa (CRPA),~~ resistant acinetobacter spp, or resistant stenotrophomonas spp	✓			
Extended-Spectrum Beta-Lactamase (ESBL)				

Candida Auris Screening and Isolation

Screen patients coming from high acuity post-acute care facilities including long-term acute care hospitals [LTACHs] and ventilator-capable skilled nursing facilities [vSNFs]) if they are admitted to ICU unit.

Empiric contact isolation should be applied on admission of those patients pending screening results.

Consider screening such patients if they have high risk and admitted to other location.

Patients with risk factors for acquiring C. auris, including:

- mechanical ventilation

- indwelling medical devices, including central lines, feeding tubes, urinary catheters, etc.
- receipt of complex or high acuity medical care
- frequent or long healthcare stays, especially at high-risk facilities
- colonization or infection with other multidrug-resistant organisms

For Santa Paula Hospital, screen patients coming from high acuity post-acute care facilities including long-term acute care hospitals [LTACHs] and ventilator-capable skilled nursing facilities [vSNFs]) if they have one of the above risk factors for acquiring C. auris.

Extended-Spectrum Beta-Lactamase (ESBL): No Isolation needed

Clostridioides difficile: Contact precautions are required until 48 hours after resolution of all symptoms (fever, abdominal pain, and diarrhea, formed stool)

Diarrhea for *Clostridioides difficile* testing is defined as 3 or more watery stools in a 24 hour period). Only stool corresponding to 6 or 7 on the Bristol Stool Chart will be accepted by the laboratory for C. difficile testing.

Other MDRO's: As identified by Infection Control Committee.

Personal protective Equipment (PPE) utilization for care of all patients under Standard Precautions:

- Wear gloves when anticipating contact with blood or other potentially infectious materials, mucous membranes, or nonintact skin, or potentially contaminated intact skin.
- Change gloves and sanitize hands during patient care if the hands will move from a contaminated body-site (e.g., perineal area, wound) to a clean body-site (e.g., face).
- Wear a gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated
- Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. If a patient is coughing, use a mask.
- During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract [if not using in-line suction catheters], endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., M. tuberculosis, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown)

Contact Precautions

MRSA – methicillin resistant staph aureus

VRE – Vancomycin Resistant Enterococcus faecium, Enterococcus faecalis

CRE – Carbapenamen Resistant Escherichia coli and/or Klebsiella pneumoniae

Acinetobacter baumanii - multidrug resistant

Stenotrophomonas maltophilia – multidrug resistant

Clostridium difficile – **Enteric Contact Precautions**

If there is any evidence of multidrug resistance with any other organisms, please contact the Infectious

Disease physician for guidance. In addition, continue isolation practices for other communicable diseases according to policy.

References:

- Centers for Disease Control and Prevention - CDC Isolation Transmission-Based Precautions Guidelines
- *Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.*
- *Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, Healthcare Infection Control Practices Advisory Committee (HICPAC) Management of Multidrug-Resistant Organisms in Healthcare Settings 2006;* https://www.cdc.gov/infectioncontrol/guidelines/mdro/Last update: February 15, 2017.

All revision dates:	7/10/2025, 3/19/2025, 6/11/2024, 7/31/2020, 9/17/2019, 6/13/2019, 5/1/2016, 11/1/2013, 2/1/2012, 7/1/2011, 9/1/2008, 5/1/2006, 12/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	7/10/2025
Policy Owner	Magdy Asaad: Infection Prevention Manager	7/10/2025

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

IS.35 Radiograph Labeling

POLICY:

To reduce the misinterpretation of radiographs resulting from the miscommunication of critical information. In both the inpatient and outpatient settings, the potential exists for radiographs to be mislabeled, or not completely labeled, and consequently misinterpreted.

PROCEDURE:

To prevent the mislabeling of radiographs, the Imaging Services Department requires that:

1. All images shall be marked with the correct patient information, including:
    a. Name
    b. Date of birth
    c. Medical record number
    d. Name of facility
    e. Date of exam
    f. Time of exam
    g. "RIGHT" or "LEFT" lead markers on each digital or CR image to properly identify the anatomy imaged
    h. "UPRIGHT" or "SUPINE" on each film to identify anatomical orientation
    i. Technologist's initials
2. Staff shall verify patient information on all images and match the patient information on the requisition/ order at completion of exam. The Radiology Technologist shall verify all patient information before the final quality control (QC) of the digital images in the picture archiving and communication system (PACS) before sending images for interpretation by radiologists.
3. Radiology Technologists shall re-verify patient information on all digital images and match the patient information on the requisition/order prior to interpretation by radiologists.

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	8/6/2025
Imaging Services	Matt McGill: Director, Imaging Services	6/2/2025
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	3/24/2025

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Owner:	*Kristina Swaim: Nurse Director, Maternal Child Health*
Policy Area:	*Maternal Child Health*
References:	

MCH.24 Management of Early Onset Sepsis (EOS) in the Newborn

POLICY

Ventura County Medical Center (VCMC) and Santa Paul Hospital (SPH) established evaluation and treatment guidelines for newborns **35 weeks gestational age** and older at risk for neonatal Early Onset Sepsis (EOS).

DEFINITIONS

A. Early Onset Sepsis (EOS) — invasive bacterial infection of the blood or cerebrospinal fluid (CSF) of the newborn, that occurs in the first week after birth. Neonatal Early Onset Sepsis occurs in approximately 0.3 to 0.5 cases per 1000 live births in the United States. Neonatal bacterial sepsis is the 6th leading cause of infant mortality in the United States.

B. Group B Streptococcus (GBS) — a gram positive organism known to colonize the lower gastrointestinal tract of a mother which has the potential to spread and transmit to the fetus.

C. Intra-amniotic Infection — also known as chorioamnionitis, an infection with resultant inflammation of any combination of the amniotic fluid, placenta, fetus, fetal membranes, or decidua. Symptoms of maternal fever and one or more of the following: maternal leukocytosis, purulent cervical drainage, fetal tachycardia.

D. Neonatal Sepsis Risk Calculator — a tool that calculates an individual neonate's risk of developing EOS. It is based on a multivariate analysis of five risk factors for EOS from data on over 600,000 live births with a gestational age greater than (>) 34 weeks, at 14 hospitals in the USA, between 1993- 2007. This model has an advantage over standard algorithms as it takes away the possible subjectivity of the physician in diagnosing intraamniotic infection and instead uses objective measurements including highest maternal temperature as a continuous variable, duration of rupture of membranes (ROM), gestational age, GBS status and intrapartum antibiotics to identify those infants who are at risk. This predictive model has been shown to reduce the number of newborn invasive procedures and the unnecessary exposure to antibiotics without missing those who are infected.

PROCEDURE

A. **Screening For EOS**

1. Licensed Clinical Practitioner (LCP) and registered nurse (RN) will review maternal history/ intrapartum course to determine maternal and perinatal risk factors predisposing newborns to EOS.

2. **Criteria for Screening**

· Gestational age > or = to ~~36~~35 weeks

· Maternal intra-partum temperature ≥100.4 or chorioamnionitis

· Maternal GBS+ status

Prolonged rupture of membranes (ROM) ≥ 18

· Consider screening newborns with vital sign or clinical abnormalities in the first 12 hours after birth.

B. **Management of EOS for the Newborn-Process**

1. Licensed Clinical Practitioner or RN will Calculate the EOS risk within the first 1 hour of life for all newborns ≥ or = to ~~36~~35 weeks gestational age and older with any of the following risk factors listed above in section A2 Criteria for Screening, or if there are any concern for illness including but not limited to;

- Temperature instability (Temperature ≥ 99.4 axillary, ≥ 100.4 Rectal or ≤ 97.5 axillary) ·
- Respiratory, gastrointestinal, and neurological abnormalities
- ***NOTE****:* At risk infants should have clinical reassessment performed and documented frequently in the first 4-6 hours of life because classification of clinical status and management recommendations may change.

2. Perform assessment after completion of skin to skin contact with mother and newborn, first feeding and examination of newborn.

3. The Neonatal Sepsis Risk Calculator may be used within the first 12 hours of life if the newborn is exhibiting vital sign or clinical abnormalities. Clinical judgment by the provider will be used to guide management of care.

4. Enter data into the Neonatal Sepsis Risk Calculator

a. Incidence of EOS: 0.5/1000 (this number is subject to change)

b. Gestational Age

c. Maternal Fever Intrapartum or Intra-amniotic Infection (Chorioamnonitis)

d. Rupture of membranes

e. Maternal Group B Streptococcus positive (GBS+) status.

f. Type and duration of intrapartum antibiotics given before birth.

g. Signs of clinical illness at birth.

5. Place infant in one (1) of three (3) categories in the Neonatal Sepsis Risk Calculator based on clinical assessment for completion. ***See Attachment A for Reference***

a. Clinical Illness

b. Equivocal

c. Well Appearing

6. Vital Signs & Observation Period:

Follow Sepsis Calculator "clinical recommendation" based on risk stratification:

- If recommendation is "no additional care" for infant with any risk factors:
  - Routine well newborn vital signs per institution protocol
  - Observation period 24-48 hours depending on clinical scenario
- If recommendation is for increased level of monitoring/observation:
  - Vital signs Q4 hoursX24 (following immediate post-partum period)
  - Vital signs per NICU protocol if infant admitted to NICU
  - Observation period of 24-48 hours depending on clinical scenario

6. Ensure the Neonatal Sepsis Risk Calculator information is included in shift report. If unable to complete all fields within the flow sheet, notify Primary Care Provider.

7. Notify provider if:

a. The clinical recommendation suggested by the Neonatal Sepsis Risk Calculator is to obtain labs and/or initiate antibiotics

i. Obtain vital signs every **4** hours for 24 hours.

ii. If needing to obtain a blood culture, a minimum of 1ml is needed

iii. One blood culture not two will be taken.

iv. If antibiotics are to be started, transfer to NICU

b. The infant has an equivocal exam at greater than or equal to (>) 2 hours of life.

c. The infant has clinical signs or symptoms of illness

d. The RN provider has any concerns or questions any time after birth

NICU neonatologist will be called to evaluate newborn if admission to NICU should be considered. Otherwise Primary care provider should be notified.

C. **Management of EOS for the Newborn-Patient Education**

1. Provide consistent education with families throughout the hospital stay, regarding probable length of stay

An observation period of **24-48**-hours is recommended for the following newborns with EOS risk factors listed in section A, Management of EOS for the newborn.

2. Educate parents about the implication of EOS.

Including:

- Plan of care
- Treatments, interventions
- GBS status and perinatal risks to newborn

References:

- ACOG Committee Opinion (2017). Intrapartum Management of Intramniotic Infection. American College of Obstetricians and Gynecolgists. August 2017, Number 712.
- Escobar, G.J., Puopolo KM, Wi S, et al. (2014). Stratification of risk of early-onset sepsis in newborns ≥ 34 weeks' gestation. Pediatrics, 133:30-6.
- Kersete.M et al. (2016). Application of Sepsis Calculator in Newborns with Suspected Infection. J Matern Fetal Neonatal Med 29(23), 3860-3865.

- Kuzniewicz et al. (2017). Quantitative, Risk-based Approach to the Management of Neonatal Early- Onset Sepsis. JAMA, April. · Puopolo KM, Benitz WE, Zaoutis TE, AAP COMMITTEE ON FETUS AND NEWBORN, AAP COMMITTEE ON INFECTIOUS DISEASES. (2018). Management of Neonates Born at ≥35 0/7 Weeks' Gestation With Suspected or Proven Early-Onset Bacterial Sepsis. Pediatrics, 142(6):e20182894.
- AWHONN Perinatal Nursing (2021) Fith Edition. Wolters Kluwer

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Attachments

Appendix B-Antibiotics.docx
Attachment A - Early Onset Sepsis Newborn Clinical Classification

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	7/15/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/4/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/4/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	6/4/2025

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References:	

MCH.31 Eat, Sleep, Console, Neonatal Opioid Withdrawal Syndrome and Neonatal Abstinence Syndrome Management

Purpose:

A. To standardize clinical practice in the care of the infant at risk for Neonatal Opioid Withdrawal Syndrome (NOWS)/Neonatal Abstinence Withdrawal Syndrome (NAS) through collaboration with the interdisciplinary team to optimize non-pharmacologic and pharmacologic interventions during hospitalization and facilitation of the infant/caregiver transition into the community.

B. To emphasize evidenced based treatment of NOWS/NAS to:

1. Decrease irritability and neurologic manifestations of opiate withdrawal.

2. Provide adequate nutrition and optimize weight gain.

3. Reduce the length of stay in neonates exposed to opiates.

4. Minimize separation of the mother and baby.

5. Allow appropriate sleep without excessive sedation.

6. Set families up for success when they leave in building trust in their abilities while at the hospital.

Policy:

A. Infants demonstrating signs of substance withdrawal or toxicity and infants born to mothers with one or more high-risk factors will be screened for perinatal substance exposure (OB.48).

1.

Risk factors to prompt substance exposure screening	Table #
History of maternal admission of substance use, or hospitalization for substance use	
History of prolonged narcotic prescription use	
History of no prenatal or insufficient prenatal care (< 3 visits), hypertensive episodes, severe mood swings, cerebral vascular incidents (without history of thrombophilia) ~~abruption~~abruptio placenta (without evidence of previous), unexplained late fetal demise, or repeated spontaneous abortions	
Presence of precipitous labor without discernible cause or unexplained fetal intrauterine growth restriction (IUGR) especially asymmetric IUGR	

Presence of unexplained neonatal symptomatology that can be consistent with neonatal opioid withdrawal syndrome including fetal distress or placental ~~abruption~~abruptio or hemorrhage
Positive maternal urine drug screen for opioids / opiates during pregnancy

2. Urine, meconium, and/or umbilical cord toxicology screening per physician order.

B. Consider discussion with Obstetrician or perinatologist prior to delivery to clarify maternal history and assessments for NOWS/NAS risk.

1. A Neonatology consultation is advised for a Mother who is known to use Illicit, or prescription medications by around 32-34 weeks gestation.

C. The family will be provided education on risk identified and the assessment process starting in the prenatal and intrapartum period and continuing after the newborn is delivered.

D. All infants at risk shall be referred to Clinical Social Worker who will collaborate with physicians, nursing and any appropriate community or public agencies.

E. Screening will consist of the following:

1. Assessment of medical and psychosocial history including data gathered from local agencies, where relevant, social workers, health care provider and the parents themselves.

2. Initial infant physical and gestational age assessment with physical assessments thereafter.

F. Onset of withdrawal depends on the half-life of the drug, duration of the ~~addition~~addiction and time of last maternal dose prior to delivery. Symptoms can appear during the first 24 hours of life but may not appear until day 5-10 day of life.

1. A ~~5~~ 5-7 day hospitalization is recommended for neonates whose Mothers were taking long-acting opioids such as methadone and buprenorphine or with confirmed or suspected polypharmacy exposure but may consider less than 5 day hospitalization, if infant is asymptomatic for withdrawal clinically with low ESC scoring; i.e. 0-1; baby has a negative urine drug screen and feeding well.

G. Utilize birth weight or initial dosing weight specified for ALL medication doses and weans.

H. Clinical signs of withdrawal include:

1. Neurological

a. Irritability, increased wakefulness, high pitched cry, tremor, increased muscle tone, hyperactive deep tendon reflexes, frequent yawning, sneezing, and seizures.

2. Gastrointestinal

a. Vomiting, diarrhea, dehydration, poor weight gain, poor feeding, uncoordinated and constant sucking.

3. Autonomic

a. Diaphoresis, nasal stuffiness, fever, mottling, temperature instability, piloerection, mild elevations in respiratory rate and blood pressure.

I. The ESC scoring tool and the overall clinical picture are used to determine initiation of non-pharmacologic and pharmacologic therapy.

a. ESC- Eat Sleep Console scoring tool:

I. Each of the three criteria is scored 0 or 1 (yes or no) and the ESC score (see below) is the sum of the three scores.

II. Can the neonate tolerate feeds? (~~EAT~~Eat)

III. Can the neonate sleep for >1 hour after feed? (Sleep)

IV. Is the neonate able to be consoled within 10 minutes? (Console)

b. Regardless of ESC score, Physicians may opt to initiate treatment if infant is demonstrating emesis, diarrhea, dehydration, poor feeding with insufficient weight gain, fever, inability to sleep, apnea or seizures.

CSH Eat, Sleep, Console Assessment Tool

- Assess neonate after feedings, preferably while skin-to-skin or held swaddled by mother/caregiver.
- Review neonate's ESC behaviors with mother/caregivers since last assessment 3-4 hour ago.
- If neonate assessed as "No" for one or more ESC item, perform team huddle.
- See back of sheet for definition of terms.

DATE/ TIME:	Example						
EAT							
Neonate tolerating feeds?	Yes/No						
SLEEP							
Did the neonate sleep for > 1 hour after being fed?	Yes/No						
CONSOLE							
Neonate consolable within 10 minutes?	Yes/No						
Parental/Caregiver Presence							
Parental/caregiver presence since last assessment? Specify reasons for Other	Yes/No/ Other						
Treatment Management							
Recommend a team huddle?	Yes/No						
Team huddle decision? • Optimize non-pharmacological interventions • Initiate medication treatment • Other	Yes/No						
Non-pharmacological interventions							
Skin to skin holding with parents/caregivers?	Yes/No						
Holding/rocking for comfort?	Yes/No						
Clustered care to avoid frequent disruption?	Yes/No						
Dim lights?	Yes/No						
Quiet voices?	Yes/No						
Pacifiers?	Yes/No						
Swaddling?	Yes/No						
White noise machine?	Yes/No						
Feeding when hungry?	Yes/No						
Swaddle bath?	Yes/No						
Mamaroo swing?	Yes/No						
Other interventions? Specify reasons for Other	Yes/No						

CommonSpirit

Adapted from CHI Franciscan, 12/17/2020

Procedure:

A. Labor and Delivery nurse and Obstetrician will inform the Pediatric floor, Neonatal Intensive Care Unit (NICU) and Post partum unit charge nurses when a Mother ~~Baby charge nurses when a Mother~~ whose infant

is at risk for NAS/NOWS is admitted and ~~provided~~provide assessment details that may assist in planning appropriate unit placement after delivery.

B. ESC scoring tool will be used to quantify the severity of neonatal abstinence. ESC scoring should begin:

~~1. The well appearing newborn may be initially cared for in the Mother's room in the Mother Baby Unit if the ESC score assessment can be administered per policy consistently and the infant remains asymptomatic.~~

1. Newborns may be cared for in the Mother's room on the Post partum Unit.

a. For known opiate exposed infants: ESC scoring will begin within 6 hours after birth or sooner if symptoms appear then every 3-4 hours with routine ~~care~~cares.

b. For unknown exposure: ESC scoring will begin when there is evidence supporting maternal narcotic use during pregnancy and/or the neonate is experiencing symptoms consistent with withdrawal or per physician order.

2. NICU and/or Pediatric admission ~~is~~may be required for symptomatic infants with elevated ESC scores not responding to nonpharmacological interventions, infant requires pharmacologic intervention, at the Pediatrician request, or the inability ~~to safely monitor~~of Mother/support caregivers to provide safe care for the infant ~~at risk, inability of Mother to provide safe care for the infant or a infant requiring rescue or scheduled morphine doses~~.

3. Parents and/or caregivers will be given an ESC brochure and counseled on the signs, symptoms, and management of NAS. (See attachment)

C. ESC-Eat Sleep Console scoring tool:

1. Each of the three criteria are scored 0 or 1 (yes or no) and the ESC score (see below) is the ~~sume~~sum of the three scores.

a. Can the neonate tolerate feeds? (Eat)

b. Can the neonate sleep for >1 hour after feed? (Sleep)

c. Is the neonate able to be consoled within 10 minutes? (Console)

2. Assessment includes: (See Eat Sleep Console Bedside Assessment)

3. If your total score is 0, the neonate is tolerating withdrawal symptoms.

ESC Score	Recommendation	Table #
0	No intervention needed	
1	Consider Team Huddle	
2	Consider Team Huddle	
3	Request Team Huddle and consider pharmacological therapy	

D. Team Huddle: to be initiated for discussions involving the caregiver and interdisciplinary team (Physician, RN, Social worker, etc) to include, but not limited to:

1. Ways to further optimize non-pharmacological care.

a. Keep infant swaddled during feeding with flexed positioning

b. Non nutritive sucking with pacifier

c. Clustering of Care and providing uninterrupted periods of sleep

d. Encouraging Skin to skin contact

~~e. Parental presence~~

e. Rooming - in with parent throughout the hospital stay and ensuring parental presence at the bedside as often as possible during the hospital stay

f. Encourage Holding ~~by~~/gentle rocking/swaying by a caregiver or cuddler and present one stimuli at a time.

~~g. Limiting visitors~~

g. Limit visitors to support caregivers to one at a time and to those that will be quiet and supportive

h. Assessment of the neonates environment; will need to decrease environmental stimuli and ensuring a quiet environment with low light stimulation in the room

i. Encourage breastfeeding for Mothers without concerns for continued concerning substance use or other medical contraindication.

J. Maintaining temperature stability (appropriately dressed/wrapped in blankets, avoid over warming as well)

K. May use white noise machine, infant carrier and motorized swing with safety straps.

2. Efforts to improve feeding (when applicable). The goal is for the neonate to feed when showing feeding cues (infant driven feeding) without constraints placed on length or volume of feed. ~~If optimal feeding is hindered~~Offer frequent, ~~(~~smaller feeds and consider alternating bottle and pacifier during feeds to compensate for excessive sucking.~~e~~ This may prevent emesis. ~~uncoordinated suck, emesis, lack of weight gain, inadequate volume intake, etc.) efforts to improve feeding should be instituted per physician order and may include more frequent and smaller volume feed, fortification of EBM (expressed breast milk) or formula, nasogastric enteral feedings etc.~~

3. Assessment of the neonate's environment to include excessive stimuli (light, noise, handling). Keep lights low and voices low volume.

4. If ESC scores are 1 or 2 for two consecutive scoring periods or if there is a single score of 3, despite optimal non-pharmacological care, the medical provider should be notified that a team huddle can take place to determine if the neonate is a candidate for ~~a~~ rescue (trial) dose of ~~morphine~~pharmacologic treatment.

~~a. If a rescue (trial) dose is indicated the infant will be cared for by the NICU and screened for NAS. If infants with known exposure to prescription methadone or non-prescribed substances will remain in the NICU. If the neonate continues to score 2 or greater, notify the medical provider and they can determine where another rescue (trial) dose should be administered.~~

~~b. Strongly consider every 3 hour scheduled morphine once the neonate has received 3 rescue (trial) doses in a 24 hour period.~~

~~E. Pharmacologic treatment regimens:~~

~~1. Oral morphine is preferred as a first -line pharmacological agent to treat NOWS.~~

E. If ESC scores are 2 for two consecutive scoring periods or if there is a single score of 3, despite optimal non-pharmacological care, the medical provider should be notified that a team huddle can take place to determine if the neonate is a candidate for another rescue (trial) dose of pharmacologic treatment.

~~2~~1. All neonates will remain on continuous cardiopulmonary and pulse oximetry monitoring while in the NICU and/or Pediatric floor.

~~3~~2. Preferred initial dosage of ~~oral morphine~~pharmacologic treatment should be based on birth weight (unless otherwise specified by the physician).

~~4~~a. A "stable ESC score" is defined as an average ESC score of 1 or less in the preceding 24 hours.

~~5. During daily rounds the interdisciplinary team and the physician should assess the neonate at least every 24 hours for the ability to wean.~~

b. During daily rounds the infant will be assessed for the ability to wean the Pharmacologic treatment.

~~6~~c. After discontinuing ~~morphine~~pharmacologic treatment, continue to perform ESC scoring every 3-4 hours with routine care. If ESC score is greater than 1; team huddle and consult the physician.

~~a. If ESC score is 1 or greater, recheck in 2 hours.~~

~~b. If ESC score is still 1 or greater, notify the physician to consider a rescue (trial) dose of morphine.~~

~~F. Over-sedation: Notify the attending physician of this/clinical status promptly:~~

~~1. If the neonate has a score of 0 with evidence of respiratory depression and/or does not wake for 2 consecutive feeds.~~

~~G~~F. When all medication is discontinued, continue to perform ESC scoring for ~~24-48~~48 hours before discharging the ~~neonate~~infant.

~~H~~G. Discharge

1. Infants may be discharged home directly from the ~~Mother Baby Unit if infant remains asymptomatic,~~Postpartum unit; if sufficient hospitalization time has lapsed, ESC scores ~~are 0 and~~remain 1 or less and the social worker evaluation with follow up ~~is~~has been arranged.

2. A public health nurse referral will be made in addition to the primary care physician~~; Neurodevelopmental clinic~~, ~~First 5, California Head Start, Early Start program, WIC,~~ social worker and home health nurse.

3. Collaboration with Child Family Services will facilitate other discharge activities.

~~a~~4. If the infant goes to foster care, it is preferred that the foster family be identified early and encouraged to participate in the infant's care.

~~4~~5. Provide supportive care and education to the families. Discharge teaching should include the following information but not limited to:

a. Back to sleep

b. No bed-sharing

c. Shaken Baby Syndrome

I. Documentation of ESC scoring within the electronic medical record may be entered using the abbreviation "ESC" followed by each scoring category.

a. Example "ESC 0,1,0. If the total infant score is 0, the total score may be documented as a single score "ESC =0".

Definitions:

A. Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid ~~withdrawal~~Withdrawal Syndrome (NOWS), often used interchangeably, are a generalized disorder presenting a clinical picture of central nervous system abnormalities, gastrointestinal dysfunction, respiratory distress and vague autonomic symptoms. Neonatal withdrawal occurs after delivery and the resulting sudden discontinuation of substances (illicit or prescription) that were used by the Mother during pregnancy.

B. NAS/NOWS is most seen with opioid exposure, but may also be seen after exposure to sedatives, polysubstance abuse and occasionally barbiturates and alcohol. Clinical presentation onset of symptoms varies with the drug being used by the Mother, the quantity, frequency and duration of intra-uterine exposure and the timing of withdrawal (last dose prior to delivery).

C. Eat Sleep console (ESC) is an assessment tool that relies less on subjective assessments and provides a simplified approach to assessing and caring for infants and families coping with NAS/NOWS.

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All revision dates:

Attachments

- Care pathway for Eat, Sleep, Console
- Eat, Sleep and Console Program Parent Handout
- Navigating NAS; Safe Discharge Checklist

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/21/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/21/2025
NICU	Robert Posen: NICU Medical Director	3/21/2025
NICU	Pearl Dahm: Clinical Nurse Specialist	3/4/2025
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	3/3/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Sarah Roberts: NICU Senior RN*
Policy Area:	*NICU*
References:	

N.80 Standardized Procedure for Arterial Puncture for Blood Sampling

Policy:

To provide a registered nurse (RN) standardized procedure for arterial puncture blood sampling in the Neonatal Intensive Care Unit (NICU).

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

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

Function to Be Performed:

A physician order is required for the RN to perform an arterial puncture for blood sampling.

Attempts to obtain an arterial puncture should be limited to no more than two attempts by the RN.

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

Experience/Training/Education:

A. A qualified Registered Nurse with a minimum five years of NICU experience level ~~II~~III or level ~~III~~IV; charge nurse in the NICU and will have completed initial orientation (education/training/demonstration of competency) to the NICU.

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

1. Initial Evaluation
    a. Initial competencies with return demonstration will be done with the Neonatologist and/or Clinical Nurse Specialist and the nurse will be proctored with the Neonatologist and/or Clinical Nurse Specialist for a minimum three arterial punctures. The competency and proctoring will be documented on the Neonatal Intensive Care Unit Registered Nurse competency sheet and kept in the employee file.
2. Continuing Evaluation of Competence
    a. Yearly competency evaluation is required.
    b. Continuing competency and education of the Registered Nurse will be documented on an annual basis with return demonstration to the satisfaction of the Neonatologist and/or Clinical Nurse Specialist.
    c. The Annual Competency Summary Sheet is kept in the employee file.

Roles and Responsibilities:

To ensure that proper technique is used during insertion and blood sampling

A. Scope of supervision required
    1. The RN is responsible and accountable to the neonatologist and nurse manager.
    2. Overlapping functions are to be performed in areas which allow for a consulting medical 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 legal guardian, RN or physician
        c. Any deviation from this protocol is necessary
B. Requirements for the RN
    1. Active California RN license
    2. Basic Life support and Neonatal Resuscitation Program certification
    3. Five years current NICU level III or level IV experience
    4. Special training: formal orientation to specific procedure referenced in this policy with demonstrated competency validation
C. Evaluation of the RN competence
    1. Initial upon hire to department: NICU manager will assess the RN's ability to perform the procedure
    2. Annually: the NICU manager will evaluate the RN's ability to perform this procedure during performance review cycle
D. A list of RN's who demonstrate competency to perform this procedure is held by the medical provider and/or NICU nurse manager.

Procedure:

A. **Equipment needed:**

1. Appropriate specimen containers and labels
2. 23 gauge(preferred for term infants) or 25 gauge (preferred for premature infants) butterfly needle, with "safe" needle sheathing
3. Heparinized blood gas syringe with cap
4. Sterile 2x2 gauze or 4 x4 gauze pad
5. Alcohol wipe and povidone-iodine swabs
6. 1 - or 3- ml syringe
7. Sucrose for pain management
8. Transport Biohazard lab bag
9. Gloves
10. High-intensity fiberoptic light for transillumination
11. Cardiorespiratory monitoring
12. Blanket to wrap or swaddle infant (ie. swaddling and pacifier) as condition of infant warrants

B. Explain the procedure to the parents or guardians(if present) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation.

C. Screen for and assess the neonate's pain that is consistent with the neonate's age and condition.

D. Treat the neonate's pain, as needed and ordered, using nonpharmacologic, pharmacologic, or a combination of approaches. Provide prophylactic pain management, which may include administering prescribed oral sucrose solution or human milk, swaddling (leaving the extremity for arterial puncture exposed), having an assistant perform facilitated tucking (positioning the neonate with arms and legs flexed in a midline position while the neonate is side-lying or prone), and providing a pacifier for non-nutritive sucking with or without sucrose.

E. Contraindications to arterial puncture include coagulation defects, thrombocytopenia, a circulatory-compromised extremity, and inflammation or infection at the puncture site. In addition, if a neonate has congenital heart disease that requires a shunt via the subclavian artery, the peripheral arteries on the shunt site of the body should not be used.

F. **SITE SELECTION AND PREPARATION:** Follow standardizd precautions while perfoming all steps of the puncture. Verify patient identification before performing procedure.

1. Select the site where arterial puncture is to be performed.
    a. It is preferred that a radial artery be the site of an arterial puncture. If a radial artery is the sampling site, an Allen's Test for collateral circulation should be performed prior to cleansing
    b. **Posterior Tibial:** Is the secondary choice site if the radial is not available.
    c. **ALLEN'S TEST:** Elevate the infant's hand or foot. Occlude both radial and ulnar arteries at the wrist. Occlude the dorsalis pedis and posterior tibial arteries at the ankle. Occlude arteries until the hand or foot is blanched. Release occlusion of the ulnar artery or dorsalis pedis only. Observe for return of color in less than 10 seconds, indicating adequate collateral supply. Do not puncture the radial or tibial artery if color return takes more than 15 seconds.
2. Don gloves and cleanse the site with the alcohol wipe over the area of the intended puncture site with a vigorous scrubbing motion and allow the skin surface to dry. If the betadine is to be used, use it first, then wipe clean with the alcohol pad.

G. **SAMPLING:**

1. Hold the infant's wrist in extension, neither flexed nor hyperextended.
2. Use the index finger and palpate the infant's wrist for the radial pulse at the distal crease of the wrist or transilluminate to locate the artery.
3. If accessing the tibial artery, hold the foot in a flexed position to palpate the artery or transilluminate to locate the vessel.
4. Perform arterial puncture
    a. Insert at a 30 degree angle with the tip of the needle bevel up and entering the skin at the first wrist crease is recommended. For a premature infant or extremely low birth weight infant, puncture the skin at approximately 15 degrees. (A smaller neonate requires a shallower angle of approach).
    b. Grasp both wings of the butterfly needle, penetrate the skin, and then advance the needle slowly to puncture the artery to minimize trauma to the vessel.
        i. If no blood is obtained before encountering resistance, withdraw the needle cautiously until blood returns and adjust the angle of insertion.
        ii. If complete withdrawal from skin is necessary, the site should be cleansed and a new needle should be used for the puncture.
    c. When blood return is obtained, collect the blood for specimen. Place the sample in a laboratory biohazard transport bag and send it immediately to the laboratory with the appropriate laboratory request form (if necessary).
    d. Quickly withdraw the needle and firmly apply a sterile 2x2 gauze pad against the infant's wrist, but not occlusive, pressure to the site for a minimum 3 minutes (> or equal to 5 minutes in very sick infants or those with a prolonged clotting time) to ensure adequate hemostasis. Check fingers and or toes for adequate circulation.
    e. Verify satisfactory peripheral blood flow, checking arterial pulse, capillary refill time, and temperature.
    f. Discard the needle in a puncture-resistant sharps container.
    g. Reassess and respond to the neonate's pain by evaluating the response to treatment and progress toward pain management goals.

Documentation:

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

1. Patient tolerance; results of Allen's test and infant's pain assessment with anticipatory pain management measures taken.
2. Sample collection site; time and types of labs submitted for evaluation.
3. Document any bruising of the extremity at or distal to the selected puncture site
4. Document teaching provided to the parents or guardians with understanding and follow-up teaching needed.

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All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/30/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/30/2025
NICU	Kristina Swaim: Clinical Nurse Manager, OB	6/30/2025
NICU	Robert Posen: NICU Medical Director	6/26/2025
NICU	Sarah Roberts: NICU Senior RN	6/25/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Administrative - Nursing*
References:	

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

Purpose

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

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

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

Function to Be Performed

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

Applicable Departments

This standardized procedure is applicable in all areas where RNs practice and patients are aged 14 and over in the hospital setting.

Roles and Responsibilities

A. Scope of supervision required

1. The RN performing these functions is responsible and accountable to the nursing director in their department.

2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the RN by phone or in person.
3. Provider consultation is to be obtained under the following circumstances
    a. Emergency conditions requiring prompt medical intervention
    b. Upon the request of the patient, RN or physician
    c. Anytime any deviation from this protocol is necessary

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

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

Procedure

A. Catheter Use

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

B. Indications for Indwelling Catheter Use

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

4. Once removed, the RN will use the Post-Urinary Catheter Management Algorithm as a standardized procedure. *Please see Attachment B: Post-Urinary Catheter Management Algorithm.*

C. Indwelling Urinary Catheters- Miscellaneous

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

D. Indwelling Urinary Catheter Insertion

1. Personnel who insert indwelling urinary catheters must have demonstrated competency in proper insertion technique.
2. The Lippincott procedure will guide the specific details of insertion.
3. Indwelling urinary catheters should be properly secured after insertion to prevent movement and urethral traction.
4. If a Coude catheter is required, nursing is to contact the critical care clinical nurse specialist~~,~~ or superuser ~~from ICU or DOU~~.

E. Documentation for Catheter Insertion

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

F. Closed Sterile Drainage

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

G. Irrigation

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

H. Urinary Flow and Collection Bag

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

never come in contact with the urine collection container.

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

I. Perineal Care

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

Documentation

A. The RN will document the following in the electronic health record (EHR)
   1. Insertion or removal of any indwelling catheter
   2. Accurate output
   3. Patient tolerance

REFERENCE(S):

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

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

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

All revision dates: 7/9/2025, 4/16/2025, 11/19/2024, 1/10/2023

Attachments

Attachment A: Houdini Protocol.pdf

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	7/15/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/13/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/13/2025
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	6/13/2025
Protocol Author	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/19/2025

VENTURA COUNTY HEALTH CARE AGENCY

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

R.74 Respiratory Care Chest Physiotherapy in the NICU

POLICY:

To aid Respiratory Care staff in providing adequate oxygenation and ventilation to Neonatal Intensive Care Unit (NICU) patients with lung disease or anticipated lung problems. To aid in the mobilization and removal of secretions. To attempt to make use of the neonate's own normal mechanisms in preventing and clearing excess secretions from his or her lungs, thereby improving gas exchange.

PROCEDURE:

1. Verify Order in Electronic Health Record (EHR)
2. Verify correct patient using two patient identifier
3. Gather any necessary equipment and suctioning equipment.
4. Don appropriate PPE.
5. Explain procedure to parents if applicable.
6. Asses patient’s vital signs: HR, RR, breath sounds, work of breathing, and SpO2 pre and post therapy. Document findings in EHR
7. Positioning
    i. Position infant at such an angle that gravitational draining of smaller bronchi moves secretions to larger bronchi
8. Percussion
    i. Use the first two fingers or a small cup shaped tool such as cushioned face mask of appropriate size. May also used approved mechanical vibrating percussion device.
    ii. Percuss over area to be drained for 2-5 minutes
9. Vibration
    i. Use a vibrating/shaking action with the first two fingers
    ii. Move from outer periphery inward
    iii. Perform vibration on expiration only
10. Ideally, one person should put the patient in all positions (or in the one position needing the most

drainage) and perform percussion and vibration

11. Suction Per Protocol

DOCUMENTATION:

Document pre-therapy assessment, post-therapy assessment, response to therapy, and any adverse events as appropriate in the Electronic Health Record.

Contraindications

A. Not to be done immediately after feedings. The Respiratory therapist should coordinate with the patient's nurse to find the ideal time for CPT. The Respiratory therapist should wait at least 1 hour after feeding before starting CPT.

B. Unstable head or neck injury

C. Hemodynamic instability

D. Rib fractures

All revision dates: 10/12/2021, 11/1/2013, 3/1/2010, 4/1/2008, 2/1/2004, 6/1/2001, 1/1/1999

Attachments

No Attachments

Approval Signatures

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

R.91 Care of Tracheostomy Tubes

POLICY:

~~It~~Tracheostomy care is ~~the role of the~~performed by Respiratory Therapy and Nursing jointly. Respiratory Care ~~Department to maintain/monitor the patency of artificial airways of patients with tracheostomy tubes. Respiratory Care~~ staff shall follow standardized, general guidelines and procedures for tracheostomy tube care in order to maintain patency of tracheostomy tubes, decrease potential trauma to the trachea and prevent aspiration of secretions.

PROCEDURE:

Respiratory Care Staff Responsibilities:

- New ~~tracheostomies~~tracheotomies:
  1. Assist in the placement of ~~tracheostomies~~tracheotomies during the percutaneous bedside procedure.
  2. Monitor and protect the tracheostomy tube during patient turning, movement, and physical therapy for the first seven (7) days after initial placement.
  3. Respiratory Therapist (RT) should assist the Registered Nurse (RN) at the bedside when replacing the trach ties for the first seven (7) days after initial placement.
  4. Place the appropriately sized inline suction device.
  5. ~~Place a spare tracheostomy tube of the same current size at the patient's bedside.~~Place appropriate sign (Green, Yellow, or Red) in front of patient's room, at head of bed (HOB), and with emergency trach kit.
  6. Place the obturator in a plastic bag with a patient label, then tape it above the head of the patient's bed.
  7. Complete the Artificial Airway Assessment once per shift (shift ~~equal~~equals 12 hours) in the Electronic Health Record (EHR).
- Patient admitted with an existing tracheostomy tube:
  1. Place the patient on bland or cool aerosol to meet the patient's oxygen requirements and saturation goal. May be placed on Medical Air for patient's not requiring oxygen.
  2. Assess the patient to determine the need for closed inline suction vs. open sterile suction catheters.
  3. ~~Place a spare tracheostomy tube of the same current size at the patient's bedside.~~Place emergency

trach kit in patient's room with appropriate size trach.

4. ~~If available, place~~Place the obturator in a plastic bag with a patient label, then tape it above the head of the patient's bed.
5. Complete the Artificial Airway Assessment once per shift ~~in the~~ (shift equals 12 hours) in the Electronic Health Record (EHR).

- In-house tracheostomy tube maintenance:
  1. Trach care to be done at beginning of shift. Q4 assessment. Q12 inner cannula change to be done at the beginning of every shift.
  2. Maintain bland aerosol. Check Q4.
  3. Change inline suction ~~q~~ Q72 hours or as needed, per manufacturer instructions.
  4. Complete the Artificial Airway Assessment once per shift ~~in the~~ (shift equals 12 hours) in the Electronic Health Record (EHR).

General Guidelines:

1. The tracheostomy tube will be secured with trach ties or cloth ties at either side of the neck. ~~When changing the~~Trach ties~~, the tracheostomy tube must~~ to be ~~held in place to prevent decannulation~~changed every 12 hours or when wet or soiled. Allow one finger space between neck and tie.
2. ~~Except in emergencies, generally the physician is the only one who changes the tracheostomy tube until patient family teaching begins. At that time, a RT may instruct in changing the tube.~~An obturator will be placed above the head of bed, bagged and labeled, for all trached patients.
3. A ventilator, T-piece, or trach collar will provide constant humidification for all patients with tracheostomy status. ~~Corrugated tubing should be collected in an aerosol drain bag or emptied by disconnecting the tubing and draining into an appropriate receptacle.~~
4. Water for corrugated tubing will be collected in an aerosol drain bag and will be emptied by disconnecting the tubing and drained into an appropriate receptacle.
5. T-piece or ventilator tubing will be supported to prevent trauma to the trachea.

   ~~An extra tracheostomy tube of the same size is to be kept at the bedside at all times. In pediatric areas, a tube of the same size and one size down is required to be at the bedside at all times.~~

   ~~The obturator (enclosed in a plastic bag with a patient label) must be taped to the head of the bed at all times.~~

   ~~Breath sounds will be auscultated before and after a treatment and the patient will be assessed for any adverse signs and symptoms.~~

   ~~Always use sterile technique when working with a tracheotomy.~~
6. Corrugated tubing will be changed between patients and as needed when visibly soiled or dirty. Ventilator circuits will be changed every 30 days. Aerosol tubings will be changed every 7 days.
7. Sterile disposable gloves and catheters are to be used when suctioning ~~if an inline suction device is not present~~a pt without an in-line suctioning catheter.
8. ~~All patients requiring an artificial airway will have a manual resuscitator and mask attached to an O_2 flowmeter at the bedside at all times, as well as suction set up and ready for use.~~**All patients requiring an artificial airway will have a manual resuscitator and mask attached to an O2 flowmeter at the bedside at all times, as well as suction set up and ready for use.**

9. Patients requiring continuous ventilator support will have the tracheostomy cuff inflated unless specifically ordered on a pediatric uncuffed trach.
    - ~~In the event that a patient has a Bivona style foam cuffed tracheostomy tube, the pilot balloon is to be left open to ambient pressure unless specifically ordered by the physician. If ordered, full documentation shall be made in the EHR and the Supervisor notified. Close monitoring of the patient shall be maintained. RTs shall be responsible for monitoring cuff pressures.~~ ~~**Care of a tracheotomy is primarily a nursing responsibility.**~~ ~~Trach suctioning is a shared responsibility. The RT shall be responsible for monitoring airway cuff pressures and patency of the airway. RTs shall perform minimal occluding volume technique per departmental policy and procedure.~~
    1. The RT shall be responsible for monitoring airway cuff pressures and patency of the airway. RTs shall perform minimal occluding volume.

~~Adverse Reactions:~~

~~Cuff leaks:~~

Nursing Role

1. Stoma care will be performed by nurses.
2. Oral care will be performed by RN on trach patients off ventilators in the ICU and ALL trach patients (chronic trach vent pts included) outside of the ICU.
3. Trach ties to be changed by RN once a shift and PRN (as needed)

Respiratory Role

1. Inner cannula to be changed by RT at the beginning of every shift, AM and PM.
2. Maintain proper emergency kit at bedside.
3. Oral care to be done by RT on orally intubated patients and ventilated trach patients in the ICU.
4. Trach ties to be changed by RT when visibly soiled as PRN

Shared Role

1. Dressing change is a shared responsibility.
    1. Dressing should be changed around the stoma to prevent infection and skin irritation.
2. Suctioning is a shared responsibility.
    1. Suction trach tube to remove secretions as needed.

Passy-Muir Valve

1. Before being placed on a Passy Muir Valve (PMV), speech therapy consult should be ordered and completed
2. Before being placed, patient must be cleared of secretions and cuff must be down. (Deflatted)
3. If patient is short of breath (SOB), unable to protect airway, obstructing, altered mental status, aspiration risk, excess secretions, PMV should be removed.
4. Document a Respiratory Note regarding PMV placement and removal.

Adverse Events and Special Considerations

Cuff leaks:

1. Ventilation and oxygenation must be maintained while preparation is being made for replacement of a tube with a faulty cuff.
2. It may be necessary to support ventilation by bag and mask from above.

~~Inadvertent Decannulation:~~

Inadvertent Decannulation:

1. Replacement of the tracheostomy tube should be immediately attempted, but if it cannot be accomplished immediately, ~~the tube should be completely removed~~please refer to the colored airway sign in the room and on the emergency trach kit.
2. Ventilation and oxygenation must be established by any means available, i.e. simple bag mask ventilation with occlusion of the tracheostomy stoma.
3. If unable to reinsert the trach, use a bag mouth mask resuscitation device to ventilate the patient by mouth, while covering the tracheostomy stoma with a gloved finger. However, if the patient has a complete upper airway obstruction, a gaping stoma, a laryngectomy, mask to stoma ventilation must be performed, per difficult airway instructions.

~~Obstruction: There are four (4) common causes:~~

Obstruction: There are four (4) common causes:

1. The tube may kink – slight manipulation of the head, neck, and tube will often correct the circumstances.
2. The cuff can slip or herniate over the end of the tube, causing complete occlusion. This can be immediately relieved by deflating the cuff.
3. Plugs can be within the lumen of the artificial airway causing partial or complete occlusion. Saline lavage and suction will often correct this problem.
4. The bevel of the tube may impinge upon the carina or the wall of the trachea. Simple repositioning or manipulation of the tube often relieves this.

Teamwork

Collaboration between respiratory, nursing, and other hospital professionals are crucial for tracheostomy patients.

Documentation

1. Assess patient at the beginning of the shift, every shift.
    1. Remove all excess supplies and equipment.
2. Check and verify correct orders are placed for every pt.
3. Humidification/O2 checks Q4.
4. Trach care/suctioning as needed.

All revision dates: 6/10/2025, 11/10/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	6/10/2025

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

R.NP.05 Monitoring in NICU – Transcutaneous Monitors

POLICY:

To state the procedure for Respiratory Care staff for transcutaneous monitoring(TCM) in the Neonatal Intensive Care Unit (NICU).

Indications

For continuous monitoring of transcutaneous carbon dioxide (CO2) in the neonate or for reasons otherwise specified by the ordering physician.

Equipment

A. Trancscutaneous Monitor
B. Electrode
C. Calibration Gas
D. Multi Site Attachment rings
E. Contact Gel
F. Membrane and Membrane Changer

PROCEDURE:

A. Ensure that orders for TCM, as well as low and high parameters, have been written in the Electronic Health Record.
B. Clean the area of skin with an alcohol wipe where the TCM is going to be applied, i.e. right upper chest for preductal reading, side of abdominal area, or thigh of the leg.
    1. Change probe sites when site time limit has been reached or sooner to minimize burning of skin
    2. Alternate probe sites to decrease the chances of burning.
C. Assure unit is calibrated per manufacture guidelines.
    1. Do not use units which do not pass calibration.
    2. Re-membrane the probe of units which do not pass calibration.

3. Replace calibration canisters when needed and place expended gas canisters in appropriate area when discontinued.

D. Apply multi site attachment rings to approriate site.

E. Apply one to two drops of contact solution into disc area.

F. Set temperature of the probe to 41 degrees Celsius.

G. Calibrate TCM, turn calibrating gas knob one quarter turn clockwise then enter calibration on monitor.

H. When calibration complete, attach the electrode probe to the patient fixation ring.

1. Change probe sites when site time limit has been reached or sooner to minimize burning of skin

I. Set high and low alarm limits per physician's order.

J. Allow values to stabilize for 3-10 minutes before recording values on flow sheet.

K. Check measurment site every 4 hours to ensure correct positioning of sensor and skin integrity

Documentation

A. TCM reading

B. Patient position

C. Vitals Signs (Respiratory Rate, Heart Rate, and Blood pressure)

D. Supplemental Oxygen

E. Oxygen Delivery Device

F. Ventilator Settings (if applicable)

G. Electrode placement

H. Electrode temperature

I. Skin assessment

1. Inspect probe site for burns every 2-4 hours. Document in EHR and inform nurse if a burn is found.

J. Document measurements when TCM is in use every two hours and after any parameters have been changed on the mechanical ventilator or ocsillator.

K. Inspect probe site for burns on a frequent basis. Document in EHR and inform nurse if a burn is found.Discontinuation

L. Validate order in EHR for discontinuation

M. Turn off TCM monitor

N. Remove Mutli site rings from neonate

O. Clean with appropriate disinfectant assure to adhere to appropriate wet time.

Contraindications

There are no documented absolute contraindications for use of TCM. In patients with poor skin integrity and/or adhesive allergy, alternative monitoring devices to TCM should be considered

All revision dates: 10/12/2021, 11/1/2013, 2/1/2004, 5/1/2001, 1/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	7/8/2025

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

R.NP.07 NICU Suctioning – Tracheal Aspirate for Culture

POLICY:

To obtain a tracheal aspirate specimen for culture and gram stain when respiratory infection is suspected.

PROCEDURE:

EQUIPMENT:

1. Suction tubing and appropriate size inline, closed-system suction ballard
2. Wall suction with gauge
3. Gloves and proper personal protective equipment (PPE)
4. Specimen container (mucous trap)
5. Suction canister
6. Sterile water
7. Patient label and plastic biohazard bag
8. Oxygen source
9. Resuscitation bag and appropriate size mask

PROCEDURE:

1. Obtain a physician's order from the electronic health record (EHR).
2. Obtain patient labels for specimen.
3. Verify patient identity prior to procedure by assessing two patient identifiers.
4. Gather equipment then don gloves and proper PPE
5. Attach new suction tubing to wall canister and set suction to 80 – 100 millimeters of mercury (mmHg).
6. Attach suction tubing to removable plastic connector on specimen container. Connect distal end of suction catheter to latex tubing using the appropriate size closed-system ballard for ET tube size.
7. Advance catheter to appropriate depth and suction.

8. Suction for no more than 10 seconds total.
9. Collect specimen and then remove tubing along with connector, exposing the chimney.
10. To seal specimen container, remove the catheter from the latex tubing along with the connector and connect the latex tubing to the chimney, forming an inverted "U".
11. Label the specimen with the patient name, medical record number, date and time, type of specimen and Respiratory Therapist's initials or employee idenification.
12. Place specimen container in plastic biohazard bag and walk to the Laboratory.
13. Check in specimen into the laboratory log.

DOCUMENTATION:

1. Log in specimen in EHR
2. Document amount, color, and consistency of sputum

KEY POINTS:

1. Always verify the identity of the patient prior to procedure by comparing the name and medical record number on the patient label and identification band.
2. It may be necessary to flush tubing with sterile water to clear specimen from catheter.
3. Specimen is to go to the Lab STAT or Urgent which is no later than one hour from the time obtained.

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Attachments

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

RS.08 Pediatric Intensive Care Unit (PICU) Oral Motor and Bedside Swallow Evaluations

POLICY:

a. To provide a framework of evaluation for oral motor skills and bedside swallow evaluations in the Pediatric Intensive Care Unit (PICU).

PROCEDURE:

a. Oral motor and/or bedside swallow evaluations will be ordered
   i. At physician discretion
   ii. For any patient with a change in neuromotor status which is likely to affect eating and swallowing.
   iii. For any patient showing signs of difficulty eating and swallowing (arching, spillage, coughing, choking, failure to thrive, lack of age level textures, etc).

b. Evaluation shall be addressed upon receipt by therapist. A California Children's Services (CCS) paneled Occupational Therapist (OT) or OT under the supervision of a CCS-paneled OT, or Speech Language Pathologist (SLP) will respond to the order:
   ~~i. Monday-Friday, within 24 hours.~~
   ~~ii. Weekends and holidays within 48 hours.~~
   i. Within 24 -72 hours.

c. The initial order will be entered in the electronic medical record (EMR) for OT and Speech Therapy. If the Ventura County Medical Center (VCMC) occupational therapy staff is unable to address the order:
   i. The ~~occupational~~ therapy staff will notify the attending physician and patient's nurse.
   ii. The patient's nurse will notify the appropriate service that an order has been received.

The feeding evaluation will vary depending on the child's need, medical status, functional abilities, age, and developmental status. The areas assessed may include, but are not limited to:

a. Parent/caregiver/child interview

b. Review of medical records

c. Clinical Observations

d. State modulation
e. General physical status
f. Cardiorespiratory status
g. Peripheral oral exam
h. Non-nutritive and nutritive oral motor skills (suck swallow breath rhythm, jaw, lip, cheek, tongue)
i. Bottle feeding
j. Spoon feeding
k. Cup feeding
l. Liquids
m. Purees
n. Solids

Follow Up:

a. The evaluation will be completed and filed in the EMR and/or appropriate location within 24 hours of completion.
b. Physician will be contacted in writing, electronically, or verbally and notified of diet recommendations by Speech Therapist or position and feeding strategies by Occupational Therapist.

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Attachments

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Owner:	*Gwendolyn Vontoure: Director Perioperative Services*
Policy Area:	*Surgical Services*
References:	

S.50 Surgical Staff Attire

PURPOSE:

To provide guidance to **those working within the Surgical and Procedural areas** for attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in semi-restricted and restricted areas. Guidance is also provided for personal items and electronic devices brought into semi-restricted and restricted areas. This policy covers staff working in the Operating Room (OR), Interventional Radiology, Obstetrics (OB), Preoperative Care, Post-anesthetic Care Unit (PACU) and the Sterile Processing Department. The expected outcome is that surgical and procedural area patients will be free from signs and symptoms of infection.

POLICY:

~~To provide guidance to **those working within the Surgical and Procedural areas** for attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in semi-restricted and restricted areas. Guidance is also provided for personal items and electronic devices brought into semi-restricted and restricted areas. This policy covers staff working in the Operating Room (OR), Interventional Radiology, Obstetrics (OB), Preoperative Care, Post-anesthetic Care Unit (PACU) and the Sterile Processing Department. The expected outcome is that surgical and procedural area patients will be free from the signs and symptoms of infection.~~

~~PROCEDURE:~~

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

- Clean, low linting, facility-approved surgical attire will be worn in semi-restricted and restricted areas.
- Individuals who enter semi-restricted and restricted areas ~~will~~must wear scrub attire that has been provided by the Hospital or wear single-use scrub attire provided by the Hospital intended for use within perioperative areas, with the exception of home laundered surgical caps.
  - ~~Scrub attire will be laundered after each daily use and when contaminated.~~
  - ~~Reusable cover apparel will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.~~

  Individuals who choose home laundered surgical caps must attest to the laundering of the caps before each use.

  ~~Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible and replaced with clean attire.~~
  - ~~When extensive contamination of the body occurs, a shower or bath will be taken before the clean attire is donned.~~

- ~~Scrub attire contaminated with visible blood or body fluids must be laundered at the health care-accredited laundry facility.~~
- ~~Wet or contaminated scrub attire must not be rinsed or sorted in the location of use.~~

- Laundered surgical attire will be protected from contamination during transport to the health care facility and during storage.
- Reusable cover apparel will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
- The healthcare workers must change into a fresh laundered pair of scrubs before entering semi-restricted and restricted spaces upon returning from an outside perimeter.
- The healthcare workers must change into street clothing upon leaving the facility.
- Surgical attire must be left at the health care facility for laundering.
- Perioperative personnel will change into street clothes whenever they ~~go outside or~~ leave the hospital perimeter.
- Cover apparel will be worn over scrub attire will be clean (~~e.g., lab coats~~if laundered by hospital) ~~worn over scrub attire will be clean~~ or single-use, disposable.
  ~~Identification badges will be worn above the waist by all authorized staff entering perioperative areas.~~
  ~~Dosimetry badges will be worn by staff exposed to radiation or fluoroscopy during the exposure period.~~
- Staff may wear long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when performing preoperative patient skin antisepsis.
- ~~Jewelry that cannot~~The health care worker's scalp and hair will be ~~contained or confined within the scrub attire will not be worn~~covered in the semi-restricted ~~or~~and restricted areas.
- ~~Earrings must be covered by a bouffant hat at all times.~~The health care worker's facial hair will be covered in the restricted areas and during preparation and packaging items in the clean assembly section of the sterile processing department.
- Shoes worn within the perioperative environment ~~must:~~will be clean and meet the organization's safety requirements.
  - meet Occupational Safety and Health Administration (OSHA) standards for protective footwear;
  - be constructed to prevent exposures to blood, body fluids, and other potentially infectious materials;
  - have closed toes and backs, low heels, and non-skid soles.

  ~~Surgical masks, in combination with eye protection devices (e.g., goggles, glasses with solid side shields, chin-length face shields) must be worn whenever splashes, spray, spatter, droplets of blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.~~
  ~~Staff entering the semi-restricted and restricted areas will cover their head, hair, and facial hair.~~
- Stethoscopes will be cleaned before and after each use.
- Personal items brought into the semi-restricted and restricted area will be cleaned or contained.
- It is expected that personal electronic devices will be cleaned before they are brought into the OR.
- Visitors entering the semi-restricted or restricted areas of the surgical suite will don either clean surgical attire or a single use jumpsuit that completely covers personal attire, and shoe covers.

~~*Scrub Attire*~~

- ~~Don clean scrub attire daily in the designated dressing areas before entering the semi-restricted and restricted areas.~~
- ~~Prevent clean scrub attire from contacting the floor or other contaminated surfaces while donning.~~
- ~~Ensure all personal clothing is covered by the scrub attire.~~

- ~~Wear close-fitting long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when~~
  - ~~performing preoperative patient skin antisepsis~~
- ~~Discard single-use scrub attire in a trash container or place reusable items in a designated laundry container.~~
- ~~Leave reusable hospital issued scrub attire at the health care facility for laundering.~~
- ~~Do not store reusable scrub attire that has been worn in a locker for future use.~~
- ~~Persons entering the semi-restricted or restricted areas for a brief time (e.g. law enforcement officers, parents, biomedical engineers, ancillary staff, vendors) will don clean scrub attire, single-use scrub attire, or a single-use jumpsuit (e.g. coveralls, bunny suit) designed to completely cover personal apparel.~~

PROCEDURE INTERVENTIONS:

Laundering

- Wear clean surgical attire when entering the semi-restricted and restricted areas.
- If surgical attire is worn outside of the hospital premises, they should be changed prior to reentering the operating room.
- Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible and replaced with clean attire.
- Do not wear contaminated surgical attire outside the health care facility; bag or containerize the attire and leave it at the location where it was used. Do not rinse or sort attire.
- After each daily use, leave scrub attire at the health care facility to be laundered per hospital policy, with the exception of home laundered surgical caps as described above.
- Personal clothing under scrub attire should not extend above the neckline, nor below the sleeve of the scrub shirt.
- Leave personal clothing that becomes contaminated with blood, body fluids, or other potentially infectious material at the health care facility for laundering.
- Transport laundered surgical attire in enclosed carts or containers.

Long Sleeves

- Staff may cover arms with long sleeves during performance of preoperative patient skin antisepsis.

Shoes

- ~~Wear shoes that are clean and dedicated for use within the perioperative area.~~
- ~~Wear shoe covers when gross contamination can reasonably be anticipated.~~
- ~~Remove single-use shoe covers worn as personal protective equipment immediately after use, discard, and perform hand hygiene.~~

- Footwear worn in the workplace must be closed toe, sturdy, provide a firm base and good support as well as have slip-resistant soles.

Head Coverings

- Cover your scalp and hair when entering the semi-restricted and restricted areas.
- Head covering should be worn when close to the totality of hair is covered by it and only a limited amount of hair on the nape of the neck is showing. Paper skull caps should be disposed of daily.
- Cloth caps may be used under the following conditions:
  - It is the responsibility of the wearer to validate that the cap is freshly laundered prior to donning each time.
    - As agreed upon in the signed attestation.

    - Transport of home laundered caps must ensure they are fully enclosed in a sealed container or bag until donned inside the facility.
    - When leaving the facility, the wearer is again responsible for transport of the used cap home to be laundered.
- Remove head coverings at the end of the shift or when contaminated.
- Religious head coverings (eg. head scarves [hijabs], veils, turbans, bonnets) that are clean, constructed of tightly woven and low-linting material, are without adornments, and fit securely with loose ends tucked in the scrub top may be worn to cover the hair and scalp.
- Religious head coverings that cover only portion of the hair and scalp (eg. kippah, yarmules) may be worn under another head covering.
- Beards must be covered when entering restricted areas of the surgical and sterile processing departments.

Surgical Masks

- ~~Wear a mask when~~Mask must be worn in the presence of open sterile supplies and equipment ~~are present~~.
  ~~Don a fresh, clean surgical mask before performing or assisting with each new procedure.~~
- Cover the mouth and nose with the mask and tie it securely.
  ~~Do not wear the mask hanging down from the neck.~~
  ~~Replace and discard the mask whenever it becomes wet or soiled, or has been taken down.~~
  ~~Remove the mask by handling only the mask ties and perform hand hygiene after removing the mask.~~
- Clean reusable protection devices worn with surgical masks, such as goggles, or personal glasses supplemented with solid side shields, according to the manufacturer's instructions for use before and after performing or assisting with each new procedure.

Identification Badges

- Secure identification badges must be above the waist on the scrub attire top or long-sleeved jacket.
  ~~Do not wear lanyards around the neck.~~
- Clean identification badges with a low-level disinfectant ~~regularly and~~ when ~~the badge becomes~~they become soiled with blood, body fluids, or other potentially infectious materials.

Stethoscopes

~~Do not wear stethoscopes around the neck.~~
~~Do not use fabric covers for stethoscopes.~~

- Clean stethoscopes before and after each use with a low-level disinfectant.

Personal Items

- Clean briefcases, backpacks, and other non porous personal items taken into the semi-restricted or restricted areas with a low-level disinfectant ~~and do not~~or place them ~~on the floor or leave it with the charge nurse~~in a clear bag which is stored at the front desk. Do not place them on the floor.
  ~~Clean cell phones, tablets, and other personal communication or hand-held electronic equipment according to the manufacturer's instructions for use with a low-level disinfectant before and after being taken into the semi-restricted or restricted areas.~~

~~*Head Coverings*~~

- ~~The skullcap can be worn when close to the totality of hair is covered by it and only a limited amount of hair on the nape of the neck is. Paper skull caps should be disposed of daily and following every dirty or~~

~~contaminated case.~~

- ~~Cloth caps should be covered with disposable bouffant cap. Change disposable bouffant cap when visibly soiled. All cloth caps will be home laundered.~~

~~PATIENT ATTIRE~~

1. ~~Patients scheduled to undergo surgery or an invasive procedure shall remove all necessary clothing and undergarments and put on a clean patient gown.~~
2. ~~Hair will be covered with a disposable hat.~~
3. ~~Patients will not be allowed to wear jewelry, hair pins, glasses, dentures, contact lenses or other valuables in the operating room.~~
4. ~~Hearing aids may be worn with prior approval of surgeon and/or anesthesiologist.~~

~~LEAVING THE DEPARTMENT~~

1. ~~Shoe covers are to be discarded when leaving the OR area.~~
2. ~~Masks are to be changed when leaving the OR Suite. They are not to be left hanging around the neck.~~
3. ~~Staff leaving the hospital and going outside are to remove all surgical attire and change into their street clothes.~~

Jewelry

- Jewelry that cannot be contained or confined within the scrub attire will not be worn in the semi-restricted or restricted areas.
- Earrings must be covered by a bouffant hat at all times. Earrings that cannot be covered when in a procedure, must be removed.

Finger Nails

- All staff who scrub, fingernails should be maintained as short, natural fingernails to prevent the removal of microorganisms from the nails during hand hygiene.
- Fingernails should be no longer than 2mm/0.08 inches
- Do not wear artificial fingernails or extenders in the perioperative setting
- Do not wear nail lacquer or enhanced nail lacquer while performing the scrub role

Visitor Attire

- Ensure visitors entering the semi-restricted or restricted areas of the surgical suite (eg. law enforcement officers, parents, biomedical engineers) wear clean surgical attire or a single use jumpsuit (eg. coveralls, bunny suit) designed to completely cover personal apparel.
- Ensure vendors who are required in the OR follow the health care organization surgical attire policy and procedures.

Competency

Perioperative personnel working in semi-restricted and restricted areas of the facility will receive education and complete competency verification on:

- Surgical Attire and head coverings
- The importance of effective hand hygiene in reducing the risk for health care-associated infections;

- fingernail and hand conditions
- Jewelry worn in the perioperative setting
- Performance of Hand Antisepsis

Quality

Perioperative staff working in semi-restricted and restricted areas of the facility will participate in quality assurance and performance improvement activities related to surgical attire worn in the perioperative areas.

Glossary

~~*Scrub attire:* Non-sterile apparel designed for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, long-sleeved cover jackets, and head coverings.~~

- *Surgical Attire: Scrub apparel and head coverings worn in the semi-restricted and restricted areas of the perioperative and procedural practice settings*
- Scrub apparel: Nonsterile garments that can include a disposable jumpsuit and cover jacket

Surgical attire: Non-sterile apparel designated for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, cover jackets, head coverings, shoes, masks, and protective eye wear.

Surgical mask: A device worn over the mouth and nose by perioperative team members during surgical procedures to protect both the patient and perioperative team member from transfer of blood, body fluids, and other potentially infectious materials. Surgical masks prevent the transmission of large droplets (i.e., greater than 5 microns). Surgical masks are evaluated for fluid resistance, bacterial filtration efficiency, differential pressure, and flammability.

Restricted area: A designated space contained within the semi-restricted area and accessible only through a semi-restricted area.

Semi-restricted area: The peripheral support areas of the surgical suite.

Unrestricted area: The area designated for personnel, patients and materials to pass into the semi-restricted areas. Street clothes are permitted in this area.

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All revision dates:	8/5/2025, 8/10/2022, 2/18/2020, 3/29/2018, 3/1/2016, 7/1/2011, 5/1/2010, 4/1/2005, 12/1/2004, 11/1/1998, 2/1/1996, 11/1/1992, 11/1/1991

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Step Description	Approver	Date
Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/28/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/28/2025
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VENTURA COUNTY
HEALTH CARE AGENCY

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S.59 Processing and Handling of Sterile and Clean Items

POLICY:

Clean and/or sterile supplies are separated from unprocessed supplies by maintaining the work flow pattern and physical plan area designation of the Decontamination, Assembly and Processing, and Distribution areas. Cross-contamination of supplies will be avoided by following the procedure described below.

PROCEDURE:

A. Processing of items is from dirty to clean. Designated traffic and pathway patterns in the Surgery Department and Sterile Processing Department will be followed to ensure dirty and clean supplies do not cross paths.

B. Traffic in the area of the autoclave should be minimized as much as possible.

C. Items will be moved into and out of the steam sterilizer chamber with extreme care to minimize risk of burns.

D. Items will be touched or handled only after they have completed the cooling process and the biological indicator (BI) results are read, which may vary from load to load but is generally at least 60 minutes.

E. Sterile items should be protected from excessive handling during movement and transport to minimize potential for sterile package contamination or compromise.

F. Items should be transported to the storage location as soon as possible after cooling or on a regular schedule.

G. Sterile Processing staff will inspect the integrity of each item before it is placed into storage or released for use; the person responsible for opening each package at the point of use assumes final responsibility for inspecting the integrity of the item.

H. Wrapped trays should be lifted when being moved on shelving, and should not be dragged across the shelving.

I. Sterile items transported outside the immediate perioperative areas must be in a closed cart or containment bin.

J. All storage shelving must be kept free of dust and other contaminants, and will be cleaned on an established schedule.

K. Sterility is event-related ~~and department~~unless the package denotes a specific sterilization expiration date load sticker/label. The package would then be considered sterile prior and up to that specific expiration date to include manufacturer's instructions for use (MIFUs) that require an expiration date. Department packaged items are considered sterile until the package has been opened or has been compromised, including but not limited to a breach (tear or hole), package material degradation, or contact with liquid~~, unless manufacturer's instructions for use (MIFUs) require an expiration date~~.

L. Sterile items reprocessed in either Ventura County Medical Center (VCMC) or Santa Paula Hospital (SPH) Sterile Processing areas may be used at the alternate site's operating rooms (ORs) without being reprocessed unless the sterility of the item has been compromised. If the integrity of a package is compromised, i.e., torn, punctured or wet, the item will not be used for patient care and will be returned to the Sterile Processing Department (SPD) for reprocessing.

M. All opened or used items brought to the SPD will be considered contaminated and must be sent to the decontamination area to begin processing.

N. All opened or used items will be thoroughly cleaned in accordance with manufacturer instructions for use (IFU) as the first step in the cleaning process.

O. All soiled or "non-clean, non-sterile" items will be separated from clean or sterile items upon arrival to the decontamination area.

P. All items that fall onto the floor will be reprocessed.

Q. All shelves for storage of sterile and clean items will be cleaned frequently and remain dust/lint free.

R. Evidence of moisture on any package requires the package to be reprocessed.

S. All worktables and assembly spaces are cleaned and disinfected daily.

T. All sterile items will be checked for package integrity before distribution to the required destination

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Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	7/23/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/23/2025
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	7/23/2025
Sterile Processing Department	Jeff Warren: Manager, Sterile Processing	7/23/2025

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S.60 Reducing Radiation Exposure

POLICY:

To provide guidance to perioperative staff for reducing radiological exposure to patients and staff during therapeutic, diagnostic or interventional procedures performed in the perioperative environment. The expected outcome is that the personnel and patient are free from signs and symptoms of radiation injury.

PROCEDURE:

It is the policy of Ventura County Medical Center/Santa Paula Hospital that:

- The patient's exposure to radiation will be minimized.
- The patient will be protected from unnecessary radiation exposure.
- Measures taken to protect patients during the procedure from the risks of direct and indirect radiation exposure will be documented in the health care record.
- Occupational exposure to radiation will be minimized.
- Shielding devices will be handled carefully, visually examined before use, and ~~x-rayed~~will undergo integrity checks at least annually to detect and prevent damage that could diminish their effectiveness.
- Radiation monitors or dosimeters will be worn by perioperative staff who are in frequent proximity to radiation, and monitoring must be performed in compliance with state regulation.
- Only perioperative staff who have received state-approved radiological training will be permitted to operate radiographic equipment.

Minimizing the Patient's Exposure to Radiation

- The patient's exposure to radiation will be limited to situations in which it is medically indicated and to the anatomical structures being treated.
- The perioperative registered nurse (RN) will review the patient's health care record for relevant history involving radiation exposure.
- The perioperative RN will assess the patient for any previous procedure involving radioactive material (i.e., nuclear medicine, radiation oncology).
- The perioperative RN will consult with the physician responsible for the patient's radiation treatment or diagnostic procedure to determine if planned radiation exposure levels are safe and appropriate for the patient.
- The perioperative RN will record study parameters (e.g., fluoroscopy time and the area being irradiated).
- All reasonable means of reconciling an incorrect sponge, needle, or instrument count will be attempted

before using a radiological examination to locate the lost item.

Protecting the Patient from Unnecessary Exposure

- Care will be taken to keep extraneous patient body parts out of the radiation beam to prevent injury.
- Before any radiological exposure, female patients of childbearing age will be questioned about the possibility of pregnancy by the perioperative or imaging staff.
  - If the possibility of pregnancy exists, the surgeon will be notified to determine the advisability of continuing or postponing the procedure.
  - Lead shielding will be used to protect the fetus when other areas of a pregnant patient's body are x-rayed.
- Lead shielding will be placed between the patient and the source of radiation whenever possible to reduce unintended radiologic exposure.
- Lead shielding will not be in the beam during procedures using fluoroscopy (e.g., hand surgery).
- Lead shielding will be used, when possible, to protect the patient's ovaries or testes during x-ray studies, including those performed on the hips and upper legs.
- Lead shielding will be used, when possible, to protect the patient's thyroid during x-ray studies of the upper extremities, trunk, and head.

Minimizing Occupational Exposure

- Warning signs must be posted to alert health care staff to potential radiation hazards at entrances to operating rooms (OR's) and other procedure rooms where radiological equipment is in use, in accordance with state-specific regulations .
- Perioperative staff will limit the amount of time spent in close proximity to the radiation source when exposure to radiation is possible.
- The radiation equipment operator must notify staff present in the treatment room before activating the equipment.
- During fluoroscopic procedures, perioperative staff will keep the patient as close as possible to the image intensifier side of the fluoroscopic unit and away from the tube side of the unit.
- Perioperative staff involved in fluoroscopic procedures will stand on the image intensifier side of the fluoroscopic unit, whenever possible, to reduce exposure (ie, standing on the same side as the image intensifier decreases radiation intensity experienced).
- Perioperative staff assisting with radiological procedures will not hold the patient manually for a radiographic study because of the risk of direct beam exposure.
- Whenever possible, shielding will be used to provide attenuation of the radiation being delivered to the perioperative staff who are potentially exposed. Types of shielding available may include, but are not limited to:
  - walls, windows, control booths, and doors;
  - mobile rigid shields on wheels for transport to various areas;
  - ceiling-suspended transparent barriers;
  - flexible aprons, vests, skirts, thyroid shields, and gloves; and
  - leaded safety eyeglasses with side shields.
- Perioperative staff who may have to stand with their backs to the radiation beam will wear wrap-around aprons to decrease the risk of exposure.
- Perioperative staff near the radiation beam (e.g., oblique imaging with the x-ray tube in close proximity to the lower body of the operator) will wear aprons of sufficient length to shield the upper legs and protect the long bones and bone marrow from increased doses of radiation.

- Thyroid shields will be worn by perioperative staff to protect the thyroid whenever the likelihood of the procedure places them at higher risk because of increased exposure.
- Female perioperative staff will protect their breasts from radiation exposure by using aprons that cover the area completely.
- Perioperative staff will shield the lens of the eye by using leaded face shields or leaded eyeglasses with wrap-around side shields to reduce scatter radiation when it is anticipated that increased fluoroscopic time may be necessary.
- Perioperative staff will keep all body parts out of the direct x-ray beam.
- Occupational exposure will be minimized during sentinel node biopsy.

Shielding Devices

- Before use, newly purchased leaded devices will be tested for attenuation and for shielding properties to ensure no damage (e.g., cracks or holes) occurred during transit.
- Leaded aprons with different levels of protection will be easily identifiable as to the level of safety afforded to the staff who are wearing them.
- Leaded aprons and thyroid shields will be stored flat or hung vertically and will not be folded.
- Aprons will be labeled or numbered so that each apron can be tracked, if necessary.
- Protective devices will be cleaned with an Environmental Protection Agency (EPA) registered hospital disinfectant after every use.

Radiation Monitors

- Perioperative staff who are involved routinely in fluoroscopic procedures will wear at least one radiation monitor approved by the National Voluntary Laboratory Accreditation Program.
- When using single monitoring devices, perioperative staff will wear them at the same body area (e.g., neckline outside the leaded apron)
- When using two monitoring devices, perioperative staff will wear one at the neckline outside the leaded apron and the other inside the leaded apron.
- Perioperative staff who are pregnant will wear radiation monitors or radiation dosimeters at the waist and readings will be performed monthly.
- Radiation monitoring devices or dosimeters will be removed and stored at the end of every work shift.

Pregnant Staff

- Staff will not be required to disclose pregnancy, even if their condition is obvious; however, staff are strongly encouraged to declare this condition to the Surgery Clinical Nurse Manager, in accordance with state regulations regarding pregnant staff and radiation safety.
- Occupational dose to the embryo or fetus of an occupationally exposed worker who has declared her pregnancy must not exceed 0.5 rem during the entire gestational period.
    - Occupational dose will be uniform over time and not all at once (i.e., at one point in the gestational period).
    - Deep-dose equivalent of the declared pregnant worker must be used as the dose to the embryo or fetus, in compliance with state regulations regarding the monitoring of radiation in pregnant health care staff.
- Maternity aprons must be easily identifiable and available to pregnant staff.
- Pregnant staff must wear maternity aprons to decrease the amount of radiation to the embryo or fetus.

Documentation

- Measures taken to protect patients during the procedure from the risks of direct and indirect radiation exposure will be documented in the health care record. Perioperative nursing documentation will include:
  - the type of patient protection and the areas protected and
  - the perioperative RN's post-procedure skin assessment, including signs and symptoms of injury to the skin and tissue as evidenced by:
    - redness,
    - abrasions,
    - bruising,
    - blistering, or
    - edema.
- A variance report will be completed for any procedure in which radiological exposure has occurred and wherein the procedures and interventions in this policy were not followed.
- Documentation of the readings of the dosimeters will be provided on a quarterly basis and maintained by the Radiology Department.
  - Dosimeters worn by pregnant staff will be read and documented monthly.
- Documentation of leaded protective devices testing will be maintained in accordance with the Radiology Department.
- Documentation of perioperative staff education on radiation safety will be maintained with the Surgery Manager.

~~Quality~~

~~Perioperative staff participating in operative or other invasive procedures with the potential for radiological exposure will participate in quality assurance and performance improvement activities related to radiation safety.~~

Glossary

Attenuation: The process by which a beam of radiation is reduced in intensity when passing through some material.

Beam: A unidirectional flow of particle or electromagnetic radiation.

Distance: The physical space between a source of radiation and its target (or the distance away from a source of radiation). The greater the distance an individual or target is from the source of radiation, the lower the amount of radiation exposure. The inverse-square law applies: at a 4 foot distance from the source, the exposure received is approximately one-quarter of that received at a 2 foot distance; likewise, at a 6 foot distance, the radiation is one-ninth of that received at a 2 foot distance.

Dosimeter: A device for determining the external radiation dose that a person has received.

Equipment operator: A person with demonstrated qualifications and competency to operate a fluoroscopic system while exposing a patient to radiation. According to the American College of Radiology technical standard, only a physician is qualified to hold this title. Registered and/or licensed radiologic technologists or radiation therapists may perform fluoroscopic procedures if they are monitored by a supervising physician who is readily available.

Exposure: A measure of the total quantity of radiation reaching a specific point measured in the air. The unit

of measure is based on the amount of ionization produced in air by a specified amount of x-ray energy. Radiation exposure is controlled in three ways: time, distance, and shielding.

Fluoroscopy: Observation of the internal features of an object by means of the fluorescence produced on a screen by x-rays transmitted through the object.

Leaded apron: A leaded-rubber material worn to protect staff from scatter radiation.

Occupational dose: Annual exposure limits that took effect in 1994.

- Total effective dose equivalent (TEDE) to radiation staff: 5 rem.
- Dose equivalent to the eye: 15 rem.
- Shallow dose equivalent to the skin, extremities: 50 rem.
- TEDE to any other individual organ: 50 rem.
- TEDE to an embryo or fetus of declared pregnant woman: 0.5 rem.
- Minors: 10% of worker limit.
- Members of the public: 0.1 rem.

Rem: A special unit of dose equivalent. The dose equivalent in rems is numerically equal to the absorbed dose in rads multiplied by the quality factor, which for most medical radiation is one.

Scatter radiation: Radiation is scattered when an x-ray beam strikes a patient's body, as it passes through the patient's body, and as it strikes surrounding structures (e.g., walls, OR furniture)

Shielding: Radiation interacts with any type of material, and the amount of radiation is reduced during passage through materials. A thin layer of lead can absorb most scattered diagnostic x-rays. Gamma radiation from medically useful radionuclides is substantially attenuated by 1 to 2 inches of lead.

Time factor: The less time a person is exposed to radiation, the less radiation one absorbs. Remaining close to a source of radiation for 15 minutes, an individual receives one-half the radiation dose received if the exposure time was 30 minutes.

X-ray tube: The radiation sources for x-ray and fluoroscopic machines.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	7/24/2025
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S.62 Selection and Use of Packaging Materials for Sterilization

POLICY:

To provide guidance to perioperative personnel for in the use of packaging systems for sterilization. The expected outcome is that the patient is free from signs and symptoms of infection.

PROCEDURE:

It is the policy of Ventura County Medical Center/Santa Paula Hospital that:

- Packaging systems and packaging materials will be evaluated before purchase and use.
- Packaging systems will be compatible with the specific sterilization method for which they will be used.
- Packaging materials will be processed and stored in a way that maintains the qualities for sterilization.
- Packaging materials will be used according to the packaging manufacturer and the sterilizer manufacturer's written instructions for use (IFU).
- ~~The shelf life of a packaged sterile item will be considered event-related.~~The shelf life of a packaged sterile item will be considered event-related unless the package denotes a specific sterilization expiration date load sticker/label. The package would then be considered sterile prior and up to that specific expiration date to include manufacturer's instructions for use (MIFUs) that require an expiration date.
- The total weight of an instrument containment device, including the contents, will not exceed 25 lbs.
- Count sheets will not be placed in instrument trays.

Storage and Processing

- Launder reusable textiles after every use.
- Store packaging materials at room temperature and at a relative humidity that is in accordance with the packaging manufacturer's IFU.
- Discard wrapping materials labeled for single-use after one sterilization cycle.
  - Recycle single-use packaging materials suitable for recycling if desired.

Packaging

- Package items to be sterilized in a manner that facilitates sterilization, maintains sterility, and provides for an aseptic presentation of the package contents.
- Inspect packaging materials, including filters for rigid sterilization containers, for defects and extraneous

material before using.
    - Do not use packaging materials with defects or extraneous materials that cannot be removed.
- Select the size of wrapping material required to achieve adequate coverage of the item(s) to be packaged.
- Wrap the item(s) securely in a manner that prevents gapping, billowing, or formation of air pockets.
- Position the item(s) to be sterilized within the package to allow sterilant contact with all surfaces.
- Disassemble instruments composed of more than one part unless the manufacturer's written IFU specifies that disassembly is not required.
- Position items to be sterilized that have concave or convex surfaces within packages in a manner that prevents those surfaces from retaining water.
- Place towels within instrument sets only if they are lint-free and laundered in a health care-accredited laundry facility.
- Place items to be sterilized in the package or tray in an open or unlocked position.
    - Use racks or stringers designed and intended for sterilization to maintain instruments in their open position as needed.

Chemical Indicators

- Place a chemical indicator on the outside and inside of every package to be sterilized unless the internal indicator is readable through the package material.
    - Place a class I chemical indicator (i.e., process indicator) externally.
    - Place a class III chemical indicator (i.e., single-parameter indicator), class IV chemical indicator (i.e., multi-parameter indicator), class V chemical indicator (i.e., integrating indicator), or class VI chemical indicator (i.e., emulating indicator) internally.
    - Place more than one chemical indicator for multilevel trays according to the tray manufacturer's IFU.
- Place chemical indicators in an area within the package that presents a challenge for air removal and sterilant contact.
- Follow the chemical indicator manufacturer's written instructions for storage, use, and expiration date.

Reusable, Woven Packaging Materials

- Inspect textiles on a light table for defects (e.g., holes, tears, worn spots).
    - Repair small defects using a vulcanized patch.
    - Keep the number of repairs to a minimum.
    - Discard reusable, woven packaging materials if there is a question about its suitability.
- De-lint reusable, woven packaging materials after laundering and before using.
- Mark the printed area each time the item is used if a printed area (e.g., grid system) for marking the number of reprocessings is available on the woven textile.
- Follow the manufacturer's IFU for the recommended number of reprocessings.

Peel Pouches

- Use peel pouches for small, lightweight, low-profile items (e.g., one or two clamps, scissors).
    - Do not package heavy devices, such as weighted vaginal speculums in peel pouches.
- Do not use peel pouches within wrapped sets or containment devices unless the pouch manufacturer can supply documented validation for this process.
- Do not perform double pouching (i.e., placing the item within one pouch and then placing this pouch inside another) without written instructions from the pouch manufacturer indicating that this practice has been validated and the pouch in question has been cleared by the FDA for this purpose.

- When double pouching is indicated, verify that the inner pouch
  - fits within the outer pouch without folding, and
  - faces in the same direction as the outer pouch (i.e., plastic or Mylar faces plastic or Mylar, and the paper or Tyvek faces paper or Tyvek).
- Place peel pouches on edge and spaced to permit sterilant contact and drying when loading the sterilizer.
  - Use racks designed and intended for sterilization to separate and hold pouches in a vertical position as needed.
- Label peel pouches according to the pouch manufacturer's IFU.
  - Place labels on the plastic side of the pouch.
  - Use a marker with nontoxic ink for writing on the plastic side of the pouch.

Rigid Sterilization Containers

- Follow the manufacturer's recommended sterilization method and cycle exposure times for each rigid sterilization container system.
  - Evaluate sterilization efficacy and drying effectiveness of rigid sterilization containers before initial use and periodically according to the manufacturer's written IFU.
- Refer to the containment device or organizing tray manufacturer's IFU to determine whether placing cassettes or organizing trays within rigid sterilization containers is acceptable.
- Inspect the integrity of the rigid container after each use and verify that the
  - mating surfaces and edges of the container and lid are free of dents and chips;
  - lid and container fit together correctly and securely;
  - filter retention mechanisms and fasteners are secure and not distorted or burred;
  - latching mechanisms are functioning correctly;
  - handles are working correctly;
  - integrity of the filter media is not compromised;
  - gaskets are pliable, securely fastened, and without breaks or cuts; and
  - valves are working correctly.
- Examine filter plates before and after the sterilization process.
  - Verify that single-use or reusable filters and valve systems are secured and working correctly before sterilization.
  - Use only intact filters.
  - Consider the contents unsterile if the filter is damp or dislodged or has holes, tears, or punctures.
- Remove damaged items from service and repair or replace.
- Clean rigid sterilization containers after each use.
  - Disassemble and clean all components (e.g., filter retention plates) unless otherwise specified in the manufacturer's IFU.
- Do not place additional materials (e.g., silicone mats, towels) within rigid sterilization containers unless the container manufacturer has provided directions for their use.
- Review the manufacturer's IFU to determine limitations related to density of materials, weight, and distribution of contents before placing devices within rigid sterilization containers.

Labeling

- Label packages to be sterilized before sterilization with the
  - sterilizer number or unique identifier if more than one sterilizer is in use;
  - cycle or load number;
  - date of sterilization;

    - description of the package contents (e.g., Kerrison rongeur, major abdominal set, Kleppinger bipolar forceps); and
    - identification of the assembler.
- Verify that package labels are visible and securely fixed to the package.
- Use a marker that is nontoxic, nonbleeding, and indelible to enter label information.
    - Write on the indicator tape or affixed label of wrapped packages or on the plastic side of peel pouches, and not on the packaging material.

Quality

Perioperative staff using packaging systems for sterilization will participate in quality assurance and performance improvement activities related to packaging systems for sterilization.

Glossary

Chemical indicators: Devices used to monitor exposure to one or more sterilization parameters.

- *Class I:* Process indicator that demonstrates that the package has been exposed to the sterilization process to distinguish between processed and unprocessed packages.
- *Class II:* Process indicator that is used for a specific purpose such as the dynamic air removal test (Bowie-Dick test).
- *Class III:* A single-parameter indicator that reacts to one of the critical parameters of sterilization.
- *Class IV:* A multi-parameter indicator that reacts to one, two, or more of the critical parameters of sterilization.
- *Class V* (integrating indicator): An indicator that reacts to all critical parameters of sterilization.
- *Class VI* (emulating indicator): An indicator that reacts to all critical parameters of a specified sterilization cycle.

Containment device: Reusable rigid sterilization container, instrument case, cassette, or organizing tray intended for the purpose of containing reusable devices for sterilization.

Instrument case/cassette: A container with a lid and a base to sterilize devices that permits air removal and sterilant penetration/removal. The devices require wrapping in packaging material if sterility of the container is to be maintained.

Organizing tray: A reusable metal or plastic tray that permits organization and protection of the contents. Some organizing trays have diagrams for the representative instrument etched onto the surface of the tray to facilitate their identification and location within the tray.

Paper-plastic pouch (peel pouch): A type of packaging made of Mylar® (a polyester film manufactured by Dupont) and paper that is suitable for packaging items to be sterilized in steam or a type of packaging made of Mylar® and Tyvek® (a polyethylene material manufactured by Dupont) that is suitable for packaging items to be sterilized in ethylene oxide, low-temperature hydrogen gas plasma, or hydrogen peroxide vapor.

Rigid sterilization container system: Specifically designed heat-resistant, metal, plastic, or anodized aluminum receptacles used to package items, usually surgical instruments for sterilization. The lids and/or bottom surfaces contain steam- or gas-permeable, high-efficiency microbial filters.

Woven textile: A reusable fabric constructed from yarns made of natural and/or synthetic fibers or filaments that are woven or knitted together to form a web in a repeated interlocking pattern.

References

Petersen C, ed. Infection. In: *Perioperative Nursing Data Set* . 3rd ed. Denver, CO: AORN, Inc.; 2011:254-276.

Guideline for selection and use of packaging systems for sterilization. In: *Guidelines for Perioperative Practice.* Denver, CO: AORN, Inc.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	7/31/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/23/2025
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	7/23/2025
Sterile Processing Department	Jeff Warren: Manager, Sterile Processing	7/23/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Sterile Processing Department*
References:	

S.67 Perioperative Sterilization

POLICY:

To provide guidance to Perioperative Services staff for sterilizing items to be used in the perioperative setting. The expected outcome is that the patient is free from signs and symptoms of infection.

It is the policy of Ventura County Medical Center/Santa Paula Hospital that:

- Items that enter sterile tissue or the vascular system will be sterile when used.
- Devices labeled as single-use will not be reprocessed and discarded after use.
- Items to be sterilized will be cleaned, decontaminated, inspected, packaged, sterilized, and stored in a controlled environment and in accordance with the device manufacturer's written instructions for use.
- Sterilized materials will be labeled and stored in a manner to ensure sterility, and each item will be marked with the sterilization date.

PROCEDURE:

The following steps shall be followed when sterilizing items for use in the perioperative setting:

- ANSI/AAMI ST79 is the go-to reference for steam sterilization in all healthcare facilities, regardless of sterilizer or facility size. Developed by sterilization and manufacturing professionals, ST79:2017 helps you to:

Providing a Controlled Environment

Control and monitor room temperature, humidity, and ventilation in accordance with local, state, and federal regulations and American Society of Heating Refrigerating and Air-Conditioning Engineers guidelines.

- Control room temperature, humidity, and ventilation in the decontamination areas to ensure that
  - temperature does not exceed 60° F to 65° F
  - humidity 20-60%
  - total air changes are at least fifteen per hour, and
  - airflow is negative pressure.
- Control room temperature, humidity, and ventilation in preparation and packaging areas to ensure that
  - temperature does not exceed 68° F to 75° F
  - humidity 20-60%
  - total air changes are at least fifteen per hour
  - airflow is positive pressure, and

    - relative humidity does not exceed 60%
- Control room temperature, humidity, and ventilation in sterile storage areas to ensure that
    - temperature does not exceed 60° F to 75° F
    - total air changes are at least four per hour
    - airflow is positive pressure, and
    - relative humidity does not exceed 20-60%

Workflow Patterns

Implement and maintain workflow patterns from high contamination areas to clean areas:

1. Decontamination.
2. Preparation and packaging.
3. Sterilization processing.
4. Sterile storage.
5. Clean distribution.

Cleaning and Decontaminating

Use standard precautions and wear personal protective equipment during decontamination activities.

Inspecting Items for Cleanliness and Function

- Use magnification to assist in determining cleanliness.
- Consult the manufacturer for methods to test function.

Packaging

- Follow the manufacturer's written instructions for package preparation, configuration, and sterilization.
- Monitor that the weight of each instrument set does not to exceed 25 lbs.
- Do not place combination paper-plastic peel pouches in a container or wrapped set unless the manufacturer has validated this process.

Sterilization

~~Short-cycle steam sterilization is a form of terminal sterilization that is performed on eye instruments and other surgical instruments accidentally dropped during a surgical case without having a replacement to complete the surgical case. Cleaning, decontamination, and rinsing of instruments is a crucial step in the process. Staff shall adhere to the processing steps required per the instructions for use (IFU).~~

~~The cycle is as follows: PreVac 270 4S/5D (4 min. sterilization and 5 min. dry time). This cycle will take approximately 30 min. to complete. Sterile processing staff will verify that the cycle passed and inspect wrapped or peel packed item to ensure no moisture is present prior to handing off instrument to surgery.~~

~~Tracking of short-cycle items: Separate binder will be designated when items are short-cycled with the criteria stated above.~~

~~Belimed's current parameters for sterilizers are as follows:~~

All sterilization will commence in the Sterile Processing Department.

Immediate Use Steam Sterilization (IUSS) follows the same process for saturated steam under pressure without the dry cycle. IUSS should not be used frequently because of its increased risk of infection secondary

to inconsistent cleaning practices in the operating room (OR) and the transfer of the item from the sterilizer to the point of use. IUSS should only be used in specific situations when there is not enough time for a full cycle and should include the following:

- Item sterilized
- Sterilizer number
- Cycle parameters (temperature, duration of cycle)
- Monitoring results (biologicals)
- Date and time the cycle was run
- Name of the sterilizer operator

Low inventory is not an acceptable reason for routine use of IUSS.

Implants should not be sterilized by means of IUSS except in the case of a defined emergency in which no other option is available. If and implant is processed bia IUSS, a biological indicator and type V integrating chemical indicator should be run with the load.

Emergent Processing (IUSS) Parameters follows: Short-cycle Steam Sterilization

- Short-cycle steam sterilization is a form of terminal sterilization that is performed on eye instruments and other surgical instruments accidentally dropped during a surgical case without having a replacement to complete the surgical case. Cleaning, decontamination, and rinsing of instruments is a crucial step in the process. Staff shall adhere to the processing steps required per the instructions for use (IFU).
- The cycle is as follows: PreVac 270°F 4S/5D (4 min. sterilization and 5 min. dry time).
- This cycle will take approximately 30 min. to complete.
- Sterile Processing staff will verify that the cycle passed and inspect wrapped or peel packed item to ensure no moisture is present prior to handing off instrument to surgery.
- Tracking of short-cycle items: Separate binder will be designated when items are short-cycled with the criteria stated above.

Belimed's current parameters for sterilizers are as follows:

Cycle: PreVac 270 4S/30D	Pre-treatment: 3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	Sterilizing temp./pressure: 270^0 F 2880 mbar	Sterilizing time: 4 min.	Drying time: 30 min.	Recommended load: Double-wrapped instrument trays, max. weight of 25lbs per tray Textile packages
PreVac 270 4S/5D	3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	270^0 F 2880 mbar	4 min.	5 min.	Textile packages

PreVac Bio 270 4S/1D	3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	270^0 F 2880 mbar	3 min.	1 min.	Non-wrapped porous or non-porous single instrument or non-wrapped mixed porous and non-porous instrument trays, max. weight 25lbs per tray
PreVac 460 4S/ 60D	3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	270^0 F 2880 mbar	4 min.	60 min.	Double-wrapped instrument trays, max. weight of 25lbs per tray
PreVac 270 10S/ 20D	3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	270^0 F 2880 mbar	10 min.	20 min.	Textile packages
Gravity 270 20S/ 45D	Purge time 4 min.	270^0 F 2880 mbar	15 min.	30 min.	Wrapped instrument trays, max. weight of 25lbs per tray
Bowie Dick Test	3 vacuum pulses: 80/ 100/100 mbar 2 steam pulses: 1500/1500 mbar	273^0 F 3030 mbar	3.5 min.	1 min.	One DART or Bowie Dick test pack
Leak Test	Vacuum: 65 mbar Test time: 15 min.	-	-	-	Empty chamber
Warm up & Leak Test	Vacuum: 65 mbar Test time: 15 min.	270^0 F 2880 mbar	3 min.	3 min.	Empty chamber

Storing Sterile Items

- Consider the shelf life of a packaged item as event-related unless the package denotes a specific sterilization expiration date load sticker/label. The package would then be considered sterile prior and up to that specific expiration date to include manufacturer's instructions for use (MIFUs) that require an expiration date.
  - Monitor that sterilized materials are packaged, labeled, and stored in a manner that promotes sterility;
  - Identify events that can adversely affect sterility (eg, multiple handling, seal breakage, loss of integrity, moisture penetration);
  - Label each sterilized item with the sterilization date for event related or a specific expiration date as selected or if required before storage; and
  - Rotate sterile items according to the first in, first out principle.
- Remove supplies and equipment from external shipping containers and web-edged cardboard boxes before transfer into the sterile storage area.
- Store sterile packages under environmentally controlled conditions.
- Limit access to sterile supply areas to personnel who are educated in handling sterile supplies.
- Keep sterile storage areas, including racks, shelves, bins, and containers, clean and dry.
- Store supplies in a manner that allows adequate air circulation and ease of cleaning in compliance with local fire codes and reduces the risk of contamination.
- Do not store sterile items under sinks or in other locations where they can become wet.
- Store sterile items in closed cabinets or covered carts, and use open shelving only if it is located in a secure, environmentally controlled, clean area.

Transporting Sterile Items

- Transport sterile items in covered or enclosed carts with solid bottom shelves.
- Clean carts and reusable covers after each use.

Documentation

Perioperative Services staff shall complete documentation to reflect activities related to all methods of sterilization.

- Sterilization records will be maintained according in the Sterile Processing Department and in compliance with local, state, and federal regulations.
- Every sterilization cycle and modality will be documented and will include:
  - contents of each load;
  - load identification;
  - exposure parameters;
  - the operator's name or initials; and
  - results of physical, chemical, and biological monitors.

Competency

Perioperative staff sterilizing items for use in the perioperative setting will receive education and complete competency verification activities on the principles and processes pertinent to all methods of sterilization.

Quality

Perioperative staff sterilizing items for use in the perioperative setting shall participate in quality assurance and performance improvement activities related to sterilization upon hire.

References

- American Society of Heating Refrigerating and Air-Conditioning Engineers. Room design. In: *HVAC Design Manual for Hospitals and Clinics* . 2nd ed. Atlanta, GA: ASHRAE; 2013: 151-202.
- Petersen C, ed. Infection. In: *Perioperative Nursing Data Set* . 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.
- Guideline for sterilization. In: *Guidelines for Perioperative Practice* . Denver, CO: AORN, Inc.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	7/31/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	7/23/2025
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	7/23/2025
Sterile Processing Department	Jeff Warren: Manager, Sterile Processing	7/23/2025

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

Z.28 IPU Nursing Admission Assessment Documentation

POLICY:

An Inpatient Psychiatric Unit (IPU) Registered Nurse (RN) is to complete a Nursing Admission Assessment (within ~~24~~12 hours of admission) and a Nursing Assessment every shift. The purpose of the policy is to ensure safety, to establish the baseline level of the patient's need for physical and psychiatric care, and to comply with the California Nurse Practice Act, Title 22 Regulations, and The Joint Commission Standards.

PROCEDURE:

SHIFT SUPERVISOR:

1. Assign responsibility for completion of the nursing assessment to RN at the time of admission of the patient on the Ventura County Medical Center (VCMC) Inpatient Psychiatric Unit (IPU). Use the approved Nursing Assessment Form. The admission assessment is to be completed within 12 hours of admission.

RN:

1. Collect the data or supervise and countersign the collection of data by an LPT/LVN. An RN must establish the nursing diagnosis and institute the initial plan of care.
2. Obtain information from medical records, family, case manager, and any other available source when possible. Document the source whenever it is not directly from the patient.
3. If the patient is unable to cooperate with the assessment process, document in the Progress Notes what is preventing completion of the assessment.
4. Regardless of the condition of the patient, the RN must assess the patient for safety risks and recommend precautions if appropriate. Complete the assessment ~~as able within 24 hours~~every shift, even if the information from patient and all other sources is sparse. Pass on in report that assessment is incomplete for next shift until complete.
5. Following the data collection, establish the nursing diagnosis. Focus on 1-3 significant problem areas, which can realistically be addressed in the acute care setting. Also see Precaution Policy.
6. Institute an initial plan of care based upon the nursing diagnosis. Needs which can be addressed at other levels of care may be part of the discharge plan. This may be done In the Electronic Health Record (EHR).

7. Assesses patient response to treatment plan and reports directly to the Team RN.
8. Assessment is completed by RN.
9. Admitting RN assigns patient acuity.

LPT/LVN

1. Provides direct care, maintaining therapeutic milieu.
2. Implements the treatment plan and accomplishes treatment.
3. Transcribes and audits orders, including medication.
4. Administers scheduled and PRN medication.
5. Documents on MAR and Progress Notes as appropriate administration of medication and patient response.
6. May perform medical treatments if within scope of practice and qualifications/competence.
7. Documents daily Progress Notes as assigned by the Team RN. Assists with admissions and discharges.

Health Technician:

1. Provides nursing support services.
2. Maintains accurate documentation on vital signs, locations for precautions, rounds, and percentage of meals eaten as assigned by the Team RN.
3. Provides ancillary services such as patient or legal document transport, court bailiff, Laboratory or Pharmacy errands, etc.
4. Provides rudimentary clerical support services for nursing unit such as phones, filing, forms, photocopying, list pats., etc.

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Approval Signatures

Step Description	Approver	Date
Psychiatry Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/9/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/9/2025
Inpatient Psychatric Unit & Crisis Stabilization Unit	Erin Olivera: Clinical Nurse Manager, IPU/CSU	6/9/2025

Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Basic Criteria: a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology* b. Current board certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology **OR**: c. Active participation in the examination process leading to certification within 5 years of completion of training d. Completion of BETA annual obstetrical module requirements (for obstetric privileges only) e. Documentation of case volumes as outlined in each requested privilege section **Evaluation Criteria:** A minimum of 5 cases representative of requested privileges, specific requirements outlined in each privilege section **Renewal Criteria:** a. Documentation of case volumes as outlined in each requested privilege section for renewal of privileges b. Compliance with BETA annual obstetrical module requirements ** Advanced obstetrics may be requested by family medicine physicians with the appropriate obstetrics fellowship training* *If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity. The Return to Practice Plan policy may be used to guide monitoring and/or training requirements.* *If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.*		
OBSTETRICS		
Low-Risk Obstetrics Core Privileges **Initial Criteria**: a. Documentation of a minimum of 40 deliveries in the previous 24 months **OR;** b. Documentation of a minimum of 20 deliveries in the previous 24 months **AND** a minimum of 40 during residency training E**valuation Criteria:** A minimum of 1 vaginal delivery **Renewal Criteria:** Documentation of a minimum of 20 deliveries in the previous 24 months		
Low-Risk Obstetrics Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any low risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Prenatal care Perform history and physical examination Vaginal delivery Fetal monitoring Vacuum extraction Episiotomy and/or other vaginal laceration repairs (up to 3rd-degree laceration repair) Limited obstetric ultrasound Resuscitation of infant	___	___

Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Advanced Obstetrics Core Privileges **Initial Criteria:** a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology **OR**; b. Completion of an ACGME or AOA approved family medicine residency program and an obstetrics fellowship c. Documentation of a minimum of 100 cesarean sections during fellowship **AND** 20 within the previous 24 months **Evaluation Criteria:** a. A minimum of 2 cesarean sections (1 primary and 1 repeat) b. Management of 1 complicated prenatal patient (desired but not required) **Renewal Criteria:** A minimum of 20 patients in the previous 24 months, including a minimum of 20 cesarean sections if requesting c-section privileges		
Advanced Obstetrics Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any high-risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Perform history and physical examination ~~Breech delivery~~ ~~Forceps delivery~~ ~~Cerclage placement~~ Amniocentesis and other procedures related to normal and complicated deliveries Multiple pregnancies Postpartum tubal ligation Obstetric ultrasound 4th-degree laceration repair Dilation and curettage (for pregnancy	___	___
Cesarean section (including tubal ligation done at c-section)	___	___
Breech delivery		
Forceps delivery		
Cerclage placement		
Special Privileges **Initial Criteria:** a. Completion of an Obstetrics and Gynecology residency program b. A minimum of 2 cases in the previous 24 months **Evaluation Criteria:** A minimum of 1 case evaluated **Renewal Criteria:** A minimum of 1 case in the previous 24 months		
2nd Trimester dilation and evacuation	___	___
Use of Laser - *CO2 Laser Surgery course certification required*	___	___
GYNECOLOGY **Initial Criteria:** a. Completion of an Obstetrics and Gynecology residency program b. Documentation of a minimum of 100 patients within the previous 24 months, including 20 surgical cases, unless only requesting outpatient privileges **Evaluation Criteria:** a. A minimum of 1 major gynecology procedure b. A minimum of 1 minor gynecology procedure (may be fulfilled by satisfactory completion of a major procedure) **Renewal Criteria:** A minimum of 20 patients, including 10 surgical cases, unless only requesting outpatient privileges		

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Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Gynecology Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, pre, intra-, and post-operative care and treatment of female patients of all ages presenting with illnesses, injuries, and disorders of the gynecological system and nonsurgical treatment of illnesses, and injuries of the mammary glands and urinary tract, and include: Perform history and physical examination Outpatient management Diagnostic and operative hysteroscopy Operative laparoscopy Cautery of endometriosis Hysterectomy, including cesarean hysterectomy Repair of bladder injury Repairs for pelvic relaxation and evaluation and treatment of stress urinary incontinence (suspension techniques) Endometrial ablation Reconstruction of vagina/vulva Myomectomy Bartholin cystectomy and catheter placement Biopsy (cervix, vulva, vagina, endometrium) Cervical conization Dilation and curettage Hymenotomy, Hysteroscopy I&D of abscess Oophorectomy Ovarian cystectomy Perineorrhaphy Removal of cervical polyps Repair of recto-vaginal fistula Pelvic ultrasound Presacral neurectomy Salpingectomy Suction curettage Trachelectomy Incidental cystoscopy IUD placement/removal and other contraceptive procedures Tubal ligation Uterine suspension Vaginal exam under anesthesia Simple vulvectomy	___	___
GYNECOLOGIC ONCOLOGY **Initial Criteria:** a. Completion of a gynecologic oncology fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months **Evaluation Criteria:** a. A minimum of 1 major procedure b. A minimum of 1 laparoscopy procedure **Renewal Criteria:** A minimum of 20 patients within the previous 24 months		

Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Gynecologic Oncology Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, work-up, diagnosis, and provision of surgical and therapeutic treatment to patients of all ages with malignant diseases, including carcinomas of the cervix, fallopian tubes, ovaries, uterus, vulva, and vagina, and include: Perform history and physical examination Outpatient management Radical hysterectomy with or without lymph node dissection Sentinel node biopsy Operative laparoscopy Retroperitoneal surgery for cancer Microsurgery Chemotherapy Pelvic exenteration Vulvectomy Procedures on the bowel, urethra, and bladder as indicated	___	___
MATERNAL AND FETAL MEDICINE **Initial Criteria:** a. Completion of a maternal and fetal medicine fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months **Evaluation Criteria:** A minimum of 1 complicated patient, procedure, or ultrasound **Renewal Criteria:** A minimum of 20 patients in the previous 24 months		
Maternal and Fetal Medicine Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admit, evaluate, diagnose, treat and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications, connective tissue disorders, and fetal malformations, conditions, or disease, and include: Perform history and physician examination Chorionic villus sampling Intrauterine transfusion Transuterine fetal procedures Ex Utero Intrapartum Treatment (EXIT) procedures Fetal umbilical cord blood sampling Level II ultrasound	___	___
ADDITIONAL PRIVILEGES		
Provider Performed Microscopy (PPM) - ***Annual competency modules required for each exam*** ***Indicate in the comment section below, any portion of PPM privileges NOT being requested*** Fecal WBC Fern Test Pinworm Preparations Qualitative Semen Skin KOH Urine Sediment Vaginal KOH Prep Vaginal Wet Prep	___	___

Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

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 volume not met, the next case evaluated*		
Light to moderate sedation	___	___
Deep sedation	___	___
ACKNOWLEDGEMENT OF PRACTITIONER: *I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital, and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.* Applicant's electronic signature on file **TEMPORARY PRIVILEGE APPROVAL** Department Chief's Signature: _____ Date: _____ Evaluator Assignment: _____ **[ ] PROVISIONAL [ ] RENEWAL APPROVAL** _____ Chief, Department of Obstetrics & Gynecology Date		

Ventura County Medical Center

Delineation Of Privileges

Psychiatry Privileges

Name:

Privilege	Requested	Granted
Initial Criteria: - MD or DO with successful completion of an ACGME or AOA accredited 4 year residency/fellowship in Psychiatry. - Current certification or active participation in the examination process leading to certification within 4 years of initial privileges by the American Board of Psychiatry & Neurology or the American Osteopathic Board of - Psychiatry & Neurology. - Documentation of the provision of psychiatric services for at least 30 inpatients or outpatients at an accredited facility during the past 2 years. **Evaluation Requirements:** 2 evaluators assigned 3 cases per evaluator per privilege **Renewal Criteria:** Documentation of the provision of care to a minimum of 15 patient encounters within the previous 2 years.		
Core Privileges: Privileges to admit, evaluate, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis, and adjustment disorders. If appropriate and clinically indicated, a history and physical examination, and provide basic medical management within the scope of practice Consultation with physicians in other fields regarding mental, behavioral, emotional, and geriatric psychiatric disorders Psychopharmacology Psychotherapy Consultations in the courts Emergency Department and Crisis Team Consultations Chemical dependency intervention and therapy Emergency Psychiatry	___	___
Inpatient Privileges: Privileges to admit and treat patients hospitalized in the inpatient psychiatric units, diagnose and provide treatment to patients presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis and adjustment disorders.	___	___
Special Privileges *(Must also meet the criteria above)*		
Child Psychiatry *(less than 13 years of age)* **Additional Criteria:** Successful completion of a 2-year fellowship in Child and Adolescent Psychiatry or equivalent training or experience as determined by the Department of Psychiatry.	___	___
Adolescent Psychiatry *(13 years of age and above)* **Additional Criteria:** A minimum of 1 year verified work experience specifically related to the psychiatric treatment of adolescents (13 years of age and above) or equivalent training or experience as determined by the Department of Psychiatry.	___	___
Transcranial Magnetic Stimulation (TMS) **Additional Criteria:** - Completion of an on site device-specific orientation - Demonstrated current competence and evidence of the provision of at least ten (10) TMS treatments to at least (2) patients during the past twelve (12) months, or completion of a certification course in the past thirty-six (36) months. Experience must have included the evaluation of the patient for treatment need and suitablity and immediate post treatement follow-up and evaluation at the completion of the treatment course. It must have also included device operation, cortical mapping, motor threshold determination and coil placement, and safety monitoring. Renewal Criteria: Demonstrated current competence and evidence of the provision of TMS treatments to an acceptable number of different patients during the past twenty-four (24) months based on results of ongoing professional practice evaluation and outcomes.		

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Ventura County Medical Center

Delineation Of Privileges

Psychiatry Privileges

Name:

Privilege	Requested	Granted
ACKNOWLEDGEMENT OF PRACTITIONER: *I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Health Care Agency facilities. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.* Applicant's Electronic Signature on File **TEMPORARY PRIVILEGE APPROVAL** Department Chief's Signature: _____ Date: _____ Evaluator Assignment: _____ **[ ] PROVISIONAL [ ] RENEWAL APPROVAL** Department Chief's Signature: _____ Date: _____		

Application Instructions: Review Application / Supplemental Application Verbiage

Current:

Thank you for completing your application for Medical Staff membership and/or clinical privileges at Ventura County Medical Center. Please review the information you are about to submit to ensure its accuracy and check to ensure that you have uploaded all of the required documentation.

Once your application is submitted you will no longer be able to edit the data. You can return to this site to re-print the application and application documents.

If any discrepancies are found during the credentials process, applicants will be informed in writing of the specific discrepancy and will have 14 days from the date of request to provide a written response. Applicants have the right to request a status report, please contact the Medical Staff Office. The Medical Staff office will respond to requests received from the applicant in writing within 7 business days to address the request for application status. The response will include a list of outstanding credentialing queries or missing information necessary to complete the credentialing process.

Applicants will be notified of the appointment decisions within 30 days of the approval by the Governing Board.

If you have any questions or concerns, please contact the Medical Staff Office at (805) 652-6062.

Proposed to include revised supplemental attestation statement (below):

Thank you for completing your application for Medical Staff membership and/or clinical privileges at Ventura County Health Care Agency. Please review the information you are about to submit to ensure its accuracy and check to ensure that you have uploaded all the required documentation.

Once your application is submitted you will no longer be able to edit the data. You can return to this site to re-print the application and application documents.

If any discrepancies are found during the credentials process, applicants will be informed in writing of the specific discrepancy and will have 14 days from the date of request to provide a written response. Applicants have the right to request a status report, please contact the Medical Staff Office. The Medical Staff office will respond to requests received from the applicant in writing within 7 business days to address the request for application status. The response will include a list of outstanding credentialing queries or missing information necessary to complete the credentialing process.

Applicants will be notified of the appointment decisions within 30 days of approval by the Governing Board.

If you have any questions or concerns, please contact the Medical Staff Office at (805) 652-6062.

APPLICATION ATTESTATION:

BY SUBMITTING THIS APPLICATION I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED IN THIS APPLICATION, INCLUDING ANY ACCOMPANYING DOCUMENTATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSIONS FROM THIS APPOINTMENT APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR APPOINTMENT, AND TERMINIATION OF MEMBERSHIP, PRIVILEGES, EMPLOYMENT OR PARTICIPATION.

VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Oversight Committee

Compliance Policies and Procedures

August 14, 2025

Policies & Procedures

The following revised policies are recommended by Compliance Committee for approval.

1. 109.006 Sanctions for Privacy and Security Violations
2. 109.007 Facsimile Transmission of Protected Health Information
3. 109.036 Uses Within a Covered Entity with Multiple Functions

VENTURA COUNTY
HEALTH CARE AGENCY
Setting the Standard in Health Care Excellence

Oversight Committee
Policies and Procedures

August 14, 2025

Policies & Procedures

The following Policies are recommended for approval by the Compliance Committee.

#	Title	Summary	Frequency	Page
1.	109.006 Sanctions for Privacy and Security Violations	Moderate reformatting (moving text to appropriate sections,) addition of appendices, significant rewrite of Procedure section, supported by appendices providing guidance for evaluating violations and applying corrective actions.	Annual	3
2.	109.007 Facsimile Transmission of Protected Health Information	Minor revisions consisting of moving Procedure section before Applicable Laws and Regs; other minor edits	Annual	9
3.	109.036 Uses Within a Covered Entity with Multiple Functions	Minor revisions consisting of moving Procedure section before Applicable Laws and Regs; other minor text edits	Annual	15

Status **Pending** PolicyStat ID **18692714**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	2/1/2003
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Last Revised	8/7/2025
Next Review	1 year after approval
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.006 Sanctions for Privacy and Security Violations

PURPOSE

The Ventura County Health Care Agency (HCA) is committed to complying with all applicable federal, state, and local laws, statutes, regulatory mandates, and internal policies governing its many services and activities. This policy establishes guidelines for the application of sanctions upon workforce members and business associates for committing privacy and security violations.

POLICY

It is the policy of HCA to monitor compliance with privacy and security policies and to mitigate, to the extent practicable, any harm resulting from inappropriate access, use or disclosure of protected health information, and also permit individuals to report privacy complaints and issues and to impose sanctions on Agency Workforce, as applicable and pursuant to HCA policies, for violations of HCA's privacy and security policies. The appropriateness of sanctions will at a minimum be fairly and consistently applied and be determined depending on the severity of the violation, whether the violation was intentional or unintentional, whether the violation indicates a pattern or practice of improper access.

DEFINITIONS

Agency Workforce: Includes employees, volunteers, trainees, and other persons whose conduct in the performance of work for HCA is under its direct control, regardless of whether they are paid directly by the County of Ventura.

Business Associate: Refers to individuals, subcontractors, or entities performing functions or activities

involving the use or disclosure of protected health information on behalf of HCA. Business associate functions and activities include; provide data transmission services, require access on a routine basis, offer a personal health record, or creates, receives, maintains, or transmits protected health information. See Appendix A below for examples.

PROCEDURE

Pre Sanction Procedure

1. **Compliance Helpline Reporting:** HCA Agency Workforce must promptly report potential privacy incidents to the Office of Compliance and Privacy using the Compliance Helpline Reporting feature. This includes unauthorized access, use, or disclosure of protected health information.
2. **Privacy Incident Internal Investigation -** Reported incidents undergo investigated by the Office of Compliance and Privacy (OCP), per internal policies. Upon confirmation of a breach, Human Resources is notified to initiate the sanction procedure outlined below.

Employee Sanction Procedure

1. **Fair and Consistent Application:** Human Resources will apply sanctions for privacy and security violations uniformly across HCA following applicable Employee Disciplinary Guidelines and Memoranda of Understanding with the County of Ventura. Details can be found here: http://www.ventura.org/human- resources/memorandums-of-agreement
2. **Repeat Offense Review:** Human Resources will review the employee's personnel file to assess any past privacy or security violations for the purpose determining sanctions.
3. **Sanction Determination:** The Office of Compliance and Privacy, Human Resources and the employee's manager will collaborate to decide appropriate sanctions based on violation type, severity, frequency and personnel history. See Appendix B for types of violations and Appendix C for examples of Corrective Actions.
4. **Documentation.** All sanctions will be documented in the employee's personnel file maintained by Human Resources and the Privacy Log maintained by the Office of Compliance and Privacy.
5. **Exceptions.** Sanctions will not be imposed if the employee discloses protected health information in accordance with HCA policies on whistleblower disclosures, crime victim reports, complaints to the U.S. Department of Health and Human Services, participation in investigations, or opposition to unlawful practices under HIPAA regulations.

Non-Employee Sanction Procedure

1. Non-emloyees of HCA are also bound by its polices, Code of Conduct and applicable regulations. Specific sanctions for non-employees will be determined as per the discretion of Human Resources, the relevant manager, or the Office of Compliance and Privacy, which may differ from employee sanctions.

APPENDIX A

Due to the nature of the relationship with business associates, volunteers, and other non-employee staff, sanctions for violations will be determined on a case-by-case basis by Human Resources, the Applicable Manager (or the responsible person for a Business Associate), or the Office of Compliance and Privacy.

EXAMPLES OF BUSINESS ASSOCIATE (BA) FUNCTIONS OR ACTIVITIES REGULATED BY HIPAA:

a. Patient Safety Organization
b. Health Information Organizations
c. E-prescribing Gateways
d. Vendors of Covered Entity's (CE's) Personal Health Records
e. Others that facilitate data transmission (not merely a conduit) which requires access to PHI on a routine basis.
f. Subcontractor of a BA if it creates, receives, maintains or transmits PHI on behalf of the CE even if there is no written contract between BA and subcontractor.

APPENDIX B

Violations of Privacy and Security regulations and internal policies vary from inadvertent to malicious as well as amount of occurrences therefore a list of the types and examples are provided below.

TYPES OF PRIVACY AND SECURITY VIOLATIONS AND EXAMPLES:

a. ***Accidental or Unintentional***: The violation was inadvertent and is due to human error, carelessness, or lack of knowledge or understanding.
    - Examples may include: misdirected faxes, sending a confidential email to the wrong recipient, or failing to log off or lock one's computer.

b. ***Deliberate Violation of Policies without Harmful Intent or Repeat Violations:*** The violation was due to a deliberate act despite being aware of organization policies and procedures or repeat violations.
    - Examples may include: accessing your own medical records; failure to safeguard passwords or login information; using another individuals' computer access information sending unsecured outbound confidential emails that include PHI.

c. ***Willful and/or Malicious Violation or Repeat Category I or II Violations:*** The violation was intentional and deliberate and could cause harm to the patient or to HCA or repeat violations.
    - Examples may include: snooping into unauthorized records, posting PHI to social networking sites, using or disclosing patient information for personal or financial gain.

APPENDIX C

Examples of Corrective Actions. A list of potential Corrective Actions which may apply depending on the severity of the violation is provided as a reference and is not an exhaustive list.

EXAMPLES OF CORRECTIVE ACTIONS FOR PRIVACY AND SECURITY VIOLATIONS:

a. verbal warning
b. counseling
c. education
d. training
e. memo of expectation
f. written reprimand
g. suspension
h. wage reduction
i. termination
j. reporting to licensing board
k. reporting to the Office for Civil Rights
l. reporting to other governmental oversight entities

REFERENCES

45 CFR Part 164.530 (e) (1)
45 CFR Part 164.308 (a) (1) (ii)

All Revision Dates

8/7/2025, 6/1/2013, 6/1/2006, 12/1/2004

Approval Signatures

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.007 Facsimile Transmission of Protected Health Information

PURPOSE

To establish the policy for transmission of protected health information (PHI) via facsimile (fax) or other means of electronic transfer, to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and to protect the confidentiality and integrity of PHI as required by State and Federal law, professional ethics and accreditation agencies.

POLICY

It is the policy of the Ventura County Health Care Agency (HCA) to protect the facsimile "fax" transmittal of protected health information and hold individuals responsible for following the proper procedure when protected health information is sent via fax. This policy defines the guidelines and procedures that must be followed when transmitting protected health information via fax.

PROCEDURE

All HCA staff are expected to strictly observe the following policies relating to fax transmission involving PHI:

1. **Who May Release Information**. Unless otherwise arranged through HCA Office of Compliance and Privacy 5851 Thille Street, Suite 102, Ventura, CA 93003, (805) 677-5241 or County Counsel, release of PHI in any media, including fax, may be performed only as allowed in this policy by Health Information Management (HIM) staff who are trained to perform release of information. Or qualified staff performing activities under the treatment, payment, and

healthcare operations exception.

2. **When Information May be Released Without Authorization**. Qualified staff may send PHI by fax when: (a) the original record or mail-delivered copies will not meet the immediate needs of patient care; or (b) when PHI is urgently required by a third-party payer or and failure to fax the records could result in loss of reimbursement. Faxed records may not be sent to parents or legally authorized representatives of patients.
3. **Authorization**. Except as authorized by law or in the event of a medical emergency, or as otherwise permitted by law, a properly completed and signed (by the patient or the patient's legally authorized representative) authorization must be obtained before releasing PHI. If the fax is being sent for purposes of treatment, payment (including third-party reimbursement), or healthcare operations, the patient's signed consent provided at registration serves as authorization. If the fax is being sent for any other purposes, a separate authorization for the release of the information must be signed prior to the fax being sent.
4. **Limit Release**. Staff will limit information transmitted to the minimum necessary amount reasonably necessary to meet the requesters needs or to accomplish the purpose for which the request is made.
5. **Sensitive Information**. Staff **MAY NOT** send by fax especially sensitive medical information, including, but not limited to, AIDS/HIV information, mental health and developmental disability information, alcohol and drug abuse information, Care Team or other abuse information, and other sexually transmissible disease information without separate specific written authorization by the patient or legally authorized representative and/or permission from the Directors of the HIM Department, Patient Accounting, Central Billing Office, Finance, Clinical Operations and Compliance, as appropriate.
6. **Documentation of Release**. All releases of PHI are to be documented in the medical and/or financial record. Documentation shall include the date of the release, what information was released (i.e., progress notes 6/6/01, discharge summary 3/5/99, etc.), to whom the information was released, the purpose for the release, and how the release was carried out (fax, photocopies mailed or hand delivered, verbal, etc.).
7. **Cover Page**. The cover page accompanying the fax transmission must include the Confidentiality notice listed below. Transmission of PHI via fax or other computer transmission to parties inside or outside any entity or department of will conform to all release of information policies and procedures.
    - All records containing patient information that are faxed are required to have a fully completed standard cover sheet (found in Word templates) containing the following disclosure statement (the cover sheet should not contain any PHI):
    - For those who use the Unified Fax System, the following must be inserted in the email of the Unified Fax: #secure#

Privacy Notice: *This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable federal or state law. No confidentiality or privilege is waived or lost by any misdirected transmission. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, please immediately delete it together with any attachments and all copies of it from your system,*

destroy any hard copies and notify [Enter name] at telephone number {Enter number}. You must not, directly or indirectly, use, disclose, distribute, print, or copy any part of this message if you are not the intended recipient.

- Prior to transmittal, the sender must notify the receiving party by telephone of the approximate time of fax transmittal by the entity and receive verification that the receiving fax machine is in a secured and attended area.
- Following the transmission of PHI, the individual who sent the information will verify with the intended receiver that the information was indeed received. The individual who sent the information will also print an individual transmission journal on the fax machine and attach it to the authorization, which will be subsequently filed in the patient's medical or financial record.
- Any inappropriate release of PHI may subject the releasing individual to sanctions and/or liability under state and/or federal laws.(breach). Immediate notification to the Privacy Office of any misdirected fax that contains PHI.

8. **Verification of Destination**. Staff will make reasonable efforts to send the fax to the correct destination. Staff will pre-program frequently used numbers into the fax machine to prevent dialing errors. Pre-programmed numbers should be tested prior to being used to transmit PHI. When the pre-programming of fax numbers cannot be performed, strict number verification procedures prior to transmission of information will be used to route information to the correct location. For a new recipient, the sender will verify the fax number before sending the fax and verify the recipient's authority to receive confidential information.
9. **Location of Fax Machines.** Fax machines must be in secure areas, and each department director or manager is responsible for limiting access to the machines.
10. **Handling of Received Faxes**. Each department is responsible for the proper handling of incoming faxes, and faxes are not left sitting on or near the machine, but rather shall be distributed to the proper recipient expeditiously while protecting confidentiality during distribution. Destroy or follow sender's instructions for patient information faxed in error and immediately inform the sender.
11. **Misdirected Faxes**. Misdirected (outside of HCA) faxed documents must be reported immediately to the HCA Office of Compliance and Privacy Office and noted in the affected patient's record.
12. **Audit of Speed-Dial Numbers**. Each department will periodically and/or randomly check all speed- dial numbers and computer database fax numbers to verify that the numbers are current, valid, and accurate and that the recipient is still authorized to receive PHI. This audit shall be documented showing the date performed and the individual performing the audit.

Applicable Laws and Regulations:

- 45 CFR § 164.514(d)
- 45 CFR § 164.530(c)
- California's Confidentiality of Medical Information Act (CMIA)

REFER TO ADMINISTRATIVE POLICIES 100.020 and 100.019.

All Revision Dates

8/7/2025, 11/1/2013, 6/1/2006, 12/1/2004

Approval Signatures

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.036 Uses Within a Covered Entity with Multiple Functions

POLICY

Under HIPAA, a health care organization with multiple functions must understand and comply with the privacy requirements specific to each function. The purpose of this Policy and Procedure is to provide a mechanism for separating and complying with the respective privacy requirements and standards that are applicable to this organization's health plan, health care provider, and/or health care clearinghouse functions.

It is the policy of Ventura County, Health Care Agency (HCA) to separate and comply with the respective privacy requirements and standards as applicable to our health plan, health care provider, and/or health care clearinghouse functions.

PROCEDURE

1. HCA is a hybrid entity under HIPAA and retains written documentation of covered and non-covered functions. Specific functions include; health plan, health care provider, and health care clearinghouse and the staff who assist in the performance thereof.
2. HCA complies with the privacy standards, requirements, and implementation specifications applicable to a health plan, health care provider, or health care clearinghouse when HCA is performing such health plan, health care provider, or health care clearinghouse functions. For example, when HCA is operating as a health care provider, it must comply with the privacy standards, requirements, and implementation specifications applicable to a health care provider.
3. HCA may use or disclose the protected health information of individuals who receive HCA's

health plan or health care provider services, but not both, only for purposes related to the appropriate function being performed.

4. HCA has a mechanism to ensure that all health care functions of HCA are included in policy updates, training programs, and compliance audits.
    a. HCA has an appropriate mechanism to control the flow of data from one function of HCA to another function of HCA, and such information must be segregated from any joint information systems. In particular, HCA:
        i. Has a role-based access controls between each of its functions to prevent the transmission of protected health information from crossing from one of its functions to another of its functions;
        ii. Has an electronic password or pass coding process to restrict staff from one function from accessing protected health information of another; and
    b. HCA trains staff on the correct role-based access tied to each function.
5. HCA accounts for adequate separation when staff is shared between the health plan, health care provider, and/or health care clearinghouse functions of HCA. In particular, HCA shall:
    a. Instruct such staff that the protected health information received in the separate functions cannot be used for the purpose of conducting work in the other functions;
    b. Issue such staff a separate password or pass code to be used while working in each of the functions; and
    c. Train such staff on the correct use of the password or pass code.
6. This policy, and all related documentation, must be retained by HCA for six (6) years from the date of its creation or the date when it was last in effect, whichever is later.

Applicable Laws and Regulations

45 CFR §§164.501, 164.504(g)

All Revision Dates

8/7/2025, 6/1/2013, 6/1/2006

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