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

October 7, 2025

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

1. 107.037 Event Notification Form (Downtime)
2. 107.050 Recognition and Evaluation of Abuse
3. 107.071 Patient Clothing Donations
4. L.27 Laboratory Test Cancellation

Status **Active** PolicyStat ID **16122050**

| | |
|---|---|
| Origination | 1/1/1986 |
| Last Approved | 9/5/2025 |
| Effective | 9/5/2025 |
| Last Revised | 9/5/2025 |
| Next Review | 9/4/2028 |
| Owner | Alicia Casapao: Director of Quality and Performance Improvement |
| Policy Area | Administrative - Operating Policies |

# 107.037 Event Notification Form (Downtime)



## POLICY:

The ~~Notification~~organization's notification system is used to identify occurrences or events which may lead to real or potential sub-optimal patient care and to track trends relating to patient care and treatment which may result in an adverse effect. This process helps to reduce malpractice or other liability and may also help to improve the overall treatment and care of the patients at Ventura County Medical Center/Santa Paula Hospital and Ambulatory Care clinics.

## PROCEDURE:

An electronic Notification Form is to be completed by hospital or hospital-based Ambulatory Care clinic employees or physicians for incidents which are not consistent with routine care and treatment of a patient. All events that occur at the hospital or clinic involving an injury or possible effect to a patient or visitor are to be reported regardless of how minor or insignificant the incident may seem.

The Notification Form should be completed as instructed on the form. This form does not take the place of thorough charting or notification of the physician when appropriate. The form should **not** be referred to or entered into the patient's medical record.

Submission of the form should include the patient's MRN and the location *where the incident took place*. Including the identity of the reporter is helpful ~~if~~in case further information regarding the incident is needed.

The Notification Form is initiated and then routed electronically to the Quality Assessment Performance Improvement (QAPI) Department for review. The QAPI staff review notifications on a regular basis. Significant patient safety events will be shared immediately with quality and hospital/clinic leadership. All ~~Notifications~~notifications will be sent from QAPI to the appropriate department/clinic manager or

administrator. The manager/administrator will then request further information if needed, take appropriate action, document follow-up in the Notification Form and route the form back to QAPI. Once follow-up is complete and documented, the Notification Form will be closed by QAPI.

Data from Notification Forms, including type, location and severity of events will be analyzed by the QAPI department and reported regularly to the Quality Assessment and Performance Improvement ~~Coordinating Council~~and Patient Safety Committee (~~PICC~~QAPI/PS).

In case of computer downtime, staff shall use a paper notification form (see Attachment A). Staff shall complete both sides of this double-sided form and either submit the form to their department manager or gray mail it to the QAPI department.

## All Revision Dates

9/5/2025, 8/27/2021, 7/2/2018, 12/1/2015, 2/1/2011, 2/1/2008, 5/1/2006, 7/1/2001, 11/1/1998, 10/1/1986

## Attachments



Attachment A - Paper Notification Form Rev 5.2025.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Osahon Ekhaese: Chief Operating Officer, VCMC & SPH | 9/5/2025 |
| Policy Owner | Alicia Casapao: Director of Quality and Performance Improvement | 7/1/2025 |

Status **Active** PolicyStat ID **18534857**

| | |
|---|---|
| Origination | 12/1/1998 |
| Last Approved | 9/5/2025 |
| Effective | 9/5/2025 |
| Last Revised | 9/5/2025 |
| Next Review | 9/4/2028 |
| Owner | Danielle Gabele: Chief Nursing Executive, VCMC & SPH |
| Policy Area | Administrative - Operating Policies |

# 107.050 Recognition and Evaluation of Abuse



# POLICY:

To provide Ventura County Medical Center/Santa Paula Hospital staff and physicians with the most common criteria for identifying, handling, and reporting possible physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse or neglect. To outline the responsibilities of mandated reporters.

# PROCEDURE:

I. **GENERAL EXPECTATIONS:**

1. Patients are evaluated for signs of potential abuse or neglect upon entry into the hospital.
2. The hospital maintains a list of agencies to refer patients to for continuing care.
3. Hospital staff are educated about the signs and symptoms of possible abuse and neglect via this policy, as well as in department- specific trainings.
4. Suspected abuse or neglect should be reported into RL Datix, as well as to external agencies in accordance with local law.

II. **SUSPECTED CHILD ABUSE REPORT:**

Any mandated reporter who has knowledge of or observes a child, in his /her professional capacity or within the scope of his/ her employment, whom s/he knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to the designated Child Welfare Services office immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.
The contact information for the local Child Welfare Services Office is:

Director, Ventura County Child Welfare Services
4651 Telephone Rd, Suite 300
Ventura, CA 93003
(805) 654-3200
Fax (805) 654-5597

III. A "child" is a person under the age of 18 years.

IV. The term "Mandated Reporter" within the context of suspected child abuse includes but is not limited to the following: A social worker, a physician, psychiatrist, psychologist, resident, licensed nurse, marriage, family and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code **.**

The mandated reporter will make all the necessary reports (Suspected Child Abuse, Dependent Adult / Elder Abuse, Domestic Violence - only required by those who provide medical services) on behalf of all of the mandated reporters within the facility.

A mandated reporter of suspected child abuse must complete and submit the Suspected Child Abuse Report Form, SS 8572, to be completed by Mandated Child Abuse Reporters, pursuant to Penal Code Section 11166, even if some of the requested information is not known.

After completing the form, the reporting party should file one photocopy in the patient's chart with a label to be scanned into the electronic health record EHR, and send the original to the designated agency.

V. **REPORT OF SUSPECTED DEPENDENT ADULT / ELDER ABUSE** :

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, abduction, isolation, financial abuse, or neglect (including self-neglect), or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate Adult Protective Services agency.

The contact information for the local Adult Protective Services Office is:

Adult Protective Services
1001 Partridge Drive, Suite 365
Ventura, Ca 93003
Hotline: 805-654-3200

Link for online direct reporting: https://www.ventura.org/human-services-agency/adult-protective-services/

I. An "Elder" is any person residing in this state who is 60 years of age or older.

A "Dependent Adult" is any person residing in this state, between the ages of 18 and 59, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

Dependent adult includes any person between the ages of 18 and 59 who is admitted as an inpatient to a 24-hour health facility as defined in Sections 1250,1250.2, and 1250.3 of the Health and Safety Code.

A mandated reporter of suspected dependent adult/elder abuse must complete and submit the Report of Suspected Dependent Adult/Elder Abuse, SOC 341, as required under Welfare and Institutions Code (WIC) Sections 15630 and 15658. After completing the form, the reporting party should file one photocopy in the patient's chart, with a label to be scanned into the EHR and send the original to the designated agency.

A mandated reporter shall not be required to report a suspected incident of elder or dependent adult abuse where all of the following conditions exist:

A. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

B. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

C. In the exercise of clinical judgment, the mandated reporter reasonably believes that the abuse did not occur.

D. When a Report is not made based upon the above circumstances, the clinical record should include notes describing the patient's report, the patient's diagnosis and conservatorship status, if applicable, attempts made to seek evidence of the patient's report and the lack of evidence, and the clinical judgment and decision-making on the part of the mandated reporter.

E. **SUSPECTED VIOLENT INJURY / SUSPECTED DOMESTIC VIOLENCE INJURY REPORT**

Mandated reporters must report domestic violence issues if they believe a crime has been committed and no report has yet been filed. VCMC staff may assist the patient in making such reports themselves with support. Patients shall be routinely screened for signs and symptoms of domestic abuse. Any health practitioner employed in a health facility, who provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows:

1. Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm
2. Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct or if there is imminent serious risk, staff shall make a report to the local law enforcement agency in the jurisdiction where the domestic violence occurred for appropriate intervention.
3. The facility/staff will take reasonable measures to protect the victim.

4. Provide patient references including Hot lines, Women's shelters, Legal service and information about temporary restraining orders.

The reporting requirement is as follows:

1. A report by telephone shall be made immediately or as soon as practically possible to the police station in the city of origin where the domestic violence occurred
2. Law enforcement may request a face-to-face interview or assign a case number, and request the form be mailed as a matter of record for future reference.
3. Complete the Suspected Violent Injury /Suspected Domestic Violence Injury Report form.
4. Copy the completed form; send the original to the designated law enforcement agency within two working days of receiving the information regarding the person.
5. File a photocopy in the patient's chart with a label to be scanned into the EHR.
6. Copy page 2 of the form and give this to the patient.
7. Document in the patient's medical record that the patient received this information.

A mandated reporter with respect to domestic violence must complete and submit the Suspected Violent Injury/Suspected Domestic Violence Injury Report, pursuant to Penal Code Section 11160-11163.

After completing the form, the reporting party should file one photocopy in the patient's chart with a label to be scanned into the EHR, and send the original report to the designated law enforcement agency. F or assistance in obtaining appropriate forms, contact Social Services.



# PHYSICAL ABUSE

## PHYSICAL AND BEHAVIORAL OBSERVATIONS THAT MAY SUGGEST ABUSE

| PHYSICAL : | BEHAVIORAL: |
|---|---|
| Cachexia (physical wasting and malnutrition) | Depression |
| Poor Hygiene | Agitation |
| Inappropriate dress | Fearfulness |
| Mobility impairment | Cringing |
| Sensory impairment | Withdrawal |
| Absence of assistive devices(e.g., glasses, hearing aid,cane or walker) | Confusion |
| | Unresponsiveness |
| | Inappropriate behavior |
| | Aggressiveness |
| Communication impairment (e.g., language barrier, sensory | Obsession |

| PHYSICAL : | BEHAVIORAL: |
|---|---|
| impairment, cognitive impairment) | |
| | Paranoia |
| | Hallucinations |
| | Suicidal Ideation |
| Debilitation | Quality of interactions with care giver |

## INDICATORS OF PHYSICAL AND PSYCHOSOCIAL ABUSE

| PHYSICAL : | PSYCHOSOCIAL: |
|---|---|
| Bruises | Post-Traumatic Stress Disorder |
| Welts | Fear, Anxiety, Mistrust |
| Lacerations | Shame, Humiliation |
| Scratches | Strong ambivalent feelings toward abuser. |
| Abrasions | |
| Puncture Wounds | |
| Bleeding | |
| Human Bite Marks | |
| Bilateral Bruises on Forearms, suggesting shaking | |
| Imprint Injuries, (i.e. marks in the shape of fingers, thumbs, hands, belts, sticks, rulers) | |
| Burns, (e.g., inflicted by cigarettes, matches, rope, irons, immersion in hot water) | |
| Marks left by a gag | |
| Sprains, Dislocations, Fractures | |
| Alopecia (spotty balding) from pulling hair | |
| Eye Injuries (black eye, conjunctivitis [red eye], detached retina) | |
| Missing Teeth | |
| Unexplained Scars | |
| Internal Injuries | |
| Adapted from Ramsey-Klawsnik | |

# SEXUAL ABUSE

## INDICATORS OF SEXUAL ABUSE/RAPE

### PHYSICAL

- Trauma (e.g., bruising, bleeding, wound, infection, scarring, redness, irritation, pain) about the genitals, breasts, rectum, mouth
- Presence of sexually transmitted disease, particularly if patient has not engaged in consensual sexual activity
- Injury to face, neck, chest, abdomen, thighs, buttocks
- Human bite marks

### PSYCHOSOCIAL

- Post-Traumatic Stress Disorder
- Fear, anxiety, mistrust
- Shame, humiliation
- Strong ambivalent feeling toward abuser
- Extreme discomfort or upset when bathed, toileted, or undergarments changed

---

Adapted from Ramsey-Klawsnik (1993a)



## INDICATORS OF SEXUAL ABUSE/RAPE IN THE CHILD

### PHYSICAL

- Difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Pain, swelling, or itching in genital area
- Pain on urination
- Bruises, bleeding or lacerations in external genitalia, vaginal or anal areas
- Vaginal/penile drainage
- Venereal disease, especially in pre-teens
- Poor sphincter tone
- Pregnancy

### BEHAVIORAL

- Unwilling to change for gym or participate in physical education class
- Withdrawal, fantasy or infantile behavior
- Bizarre, sophisticated, or unusual sexual behavior or knowledge
- Poor peer relationships

- Delinquent or runaway
- Reports sexual assault by care taker
- Change in performance in school

# *RECOGNIZING AND RESPONDING*

# TO DOMESTIC VIOLENCE IN A HOSPITAL SETTING

# STEP BY STEP CHECKLIST

**Compiled from *The Physician's Guide to Domestic Violence* , by Patricia R. Salber, M.D. and Ellen Taliaferro, M.D.**

1. **Look for Clues from the Patient**
    - the history of the accident is not consistent with the kind of injury
    - there is a time delay between injuries and presentation
    - the patient may have an accident-prone history
    - suicide attempts or depression
    - repetitive psychosomatic complaints
    - signs and symptoms of alcoholism and drug abuse
    - injury during pregnancy
    - signs and symptoms of post-traumatic stress syndrome
    - patient is frightened, ashamed, embarrassed or evasive
2. **Patient's Companion Can Be a Clue**
    - if batterer has accompanied patient for medical visit, he asks to stay with patient for entire visit
    - s/he answers questions for the patient
    - patient may seem afraid or reluctant to disagree with her companion's explanation of what occurred.
    - patient does not attempt to speak for him/herself
    - companion may display hostility or anger directed at patient or medical staff
3. **Clues from the Physical Examination**
    - victims of domestic violence may try to hide injuries by wearing long sleeves or turtlenecks
    - they may conceal black eyes with dark glasses or heavy make-up
    - whenever possible, have patients change from their street clothes into a hospital gown.

- injuries due to domestic violence may have a central pattern - injuries to the face, neck, throat, chest, breasts,
  abdomen and genitals
- be suspicious of injuries suggestive of a defensive posture, such as bruises to the ulnar aspect of the forearm
- multiple injuries in various stages of healing suggest physical violence occurring over a period of time

4. **What to Do When Patient Says Yes to Questions About Abuse**
   - most important: assess, with the patient, her safety and that of her children
   - ask if she has protective friends or family with whom she can stay
   - ask where her children or other dependents are and if she thinks they will be safe
   - ask if she wants immediate access to a shelter; if not, provide phone numbers in case she needs to go later
   - consider whether she needs immediate physical or psychiatric intervention
   - if she wants to go home, be sure a definite follow-up appointment is scheduled
   - ask if she wants to report the incident to the police (Medical Staff should be familiar with the response of local police and attorney to battering so they can help the victim understand what to expect)
   - involve social worker if available
5. **Document Findings**
   - record a description of the abuse as the patient described it
   - record all physical findings using a body map
   - if the patient agrees, take instant photographs of injuries - documented evidence of injuries sustained by the patient can play an integral part in both prosecuting the batterer and protecting the victim
   - name, date, time, medical record number, as well as doctor's name and that of a witness should be recorded at the bottom of the photo or attached, with photo, to the chart
   - efforts should be made to have follow-up pictures taken 24-48 hours after bruises are received because heir heightened discoloration will make them more apparent
   - If actual size and location of the injuries sustained cannot be adequately determined by standard photographs, use Polaroid Spectra GridFilm, which superimposes a grid over the victim's body to provide an accurate scale - or superimposes a grid over the victim's body to provide an accurate scale - or take photos next to a ruler or a familiar household object to indicate actual size
   - photograph from different angles, full body and close-up , taking at least two pictures of every major trauma area
   - include the patient's face in at least one picture
   - preserve all physical evidence - torn or bloodstained clothing or a weapon can be

sealed in an envelope or paper bag.

- if the patient does not confirm the abuse, but you are still suspicious, be sure to record this in the record and explain why

6. **Important Messages to Give Patient**
    - her options - safety plan, referrals, counseling, social services, legal services, law enforcement
    - she is not alone and that help is available - from you and your staff as well as a host of resources in the community
    - that battering is a common problem affecting millions of women and family members
    - she does not deserve to be battered - no matter what

# CHILD ABUSE

## CHECKLIST OF PHYSICAL AND BEHAVIORAL

## INDICATORS OF CHILD ABUSE/NEGLECT



### PHYSICAL ABUSE

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| Unexplained bruises or welts<br>• on face, lips, mouth<br>• torso, back, buttocks, thighs<br>• in various stages of healing<br>• clustered, forming rectangular patterns, reflecting shape of article used to inflict (Electric cord, belt buckle)<br>• on several different surface areas<br>• regularly appear after absence, weekend or vacation | Feels deserving of punishment |
| Unexplained burns<br>• cigar, cigarette burns, especially on soles, palms, back or buttocks<br>• immersion burns (sock-like, glove-like, doughnut-shaped on buttocks or genitalia)<br>• patterns like electric burner, iron, etc.<br>• rope burns on arms, legs neck or torso<br>• infected burns, indicating delay in seeking treatment | Wary of adult contact |
| Unexplained fractures/dislocations | Apprehensive when other children cry |

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| • to skull, nose, facial structure<br>• in various stages of healing<br>• in various stages of healing | |
| Unexplained lacerations or abrasions<br>• to mouth, lips, gums, eyes<br>• to external genitalia<br>• in various stages of healing | Behavioral extremes |
| Bald patches on scalp | Aggressiveness or Withdrawal |
| | Frightened of parents |
| | Afraid to go home |
| | Reports injury by parents |
| | Vacant or frozen stare |
| | Lies very still while surveying surroundings (infant) |
| | Responds to questions in monosyllables |
| | Inappropriate or precocious maturity |
| | Manipulative behavior to get attention |
| | Capable of only superficial relationships |
| | Indiscriminately seeks affection |
| | Poor self-esteem |



**PHYSICAL NEGLECT:**

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| Underweight, poor growth pattern, e.g., small in stature failure to thrive | Begging or stealing food |
| Consistent hunger, poor hygiene, inappropriate dress | Extended stays at school (early arrival, late departure) |
| Consistent lack of supervision especially in dangerous activities or for long periods | Rare attendance at school |
| Wasting of subcutaneous tissue | Constant fatigue, listlessness or falling asleep in class |

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| Unattended physical problems or medical records | Delayed speech |
| Bald patches on the scalp | Inappropriate seeking of affection |
| Abandonment | Doesn't change expression |
| Abdominal distention | Assuming adult responsibilities and concerns |
| Delinquency (e.g., thefts) | Alcohol or drug abuse |
| | Talks in a whisper or whine |
| | States there is no caretaker |

# HUMAN TRAFFICKING

Victims of human trafficking may present with signs of physical or sexual abuse, as noted above. Care of this population should include the important components noted below.

- Assessment: If human trafficking is suspected, staff will utilize a trauma informed approach to assess patient. This will include clinical information as well as observation of the patient and interactions with any companions. Interview of the patient should be in private and all companions asked to step out. The assessment phase should utilize the PEARR tool (See Attachment). PEARR is an acronym for care of the victim of human trafficking that stands for privacy, education, ask, respect and respond.
- Reporting: Hospital staff will follow policy for reporting to law enforcement any situation of immediate danger, as well as mandatory reporting requirements.
- Resources: Suspected victims should receive resources to ensure safety: National Human Trafficking (888)-373-7888 (toll-free) or text "BeFree" (233733) or Family Violence and Human Trafficking Response Hotline (800)636-6738
- Staff training: Upon hire, all nursing staff and emergency department personnel (including admitting clerks/registrar) must complete foundational training on:
    - Recognizing trafficking indicators
    - Confidential requirements
- All licensed staff who conducts private interviews will receive advance training covering:
    - Trauma-informed communication, assessment, and documentation

# ELDER ABUSE

## PHYSICAL ABUSE POSSIBLE INDICATORS:

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury which has not been properly cared for (injuries are sometimes hidden on areas of

the body normally covered by clothing)

- Poor skin condition or poor skin hygiene
- Absence of hair and/or hemorrhaging below scalp
- Dehydration and/or malnourished without illness-related cause
- Weight loss
- Burns may be caused by: cigarettes, caustics, acids, friction from ropes or chains, or contact with other objects
- Soiled clothing or bed

## PSYCHOLOGICAL/EMOTIONAL ABUSE POSSIBLE INDICATORS:

| | |
|---|---|
| Helplessness | Fear |
| Hesitation to talk openly | Withdrawal |
| Implausible stories | Depression |
| Confusion or disorientation | Denial |
| Anger | Agitation |

## FINANCIAL ABUSE POSSIBLE INDICATORS:



- Unusual or inappropriate activity in bank accounts
- Signatures on checks, etc., that do not resemble the older person's signature, or signed when older person cannot write
- Power of Attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by care giver that an excessive amount of money is being expended on the care of the older person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate
- Lack of amenities, such as TV, personal grooming items, appropriate clothing that the estate can well afford
- Missing personal belongings such as art, silverware, or jewelry
- Deliberate isolation, by a housekeeper, of an older adult from friends and family, resulting in the care giver alone having total control

## NEGLECT BY CAREGIVER POSSIBLE INDICATORS:

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice on elder
- Elder is inadequately clothed

- Elder is malnourished or dehydrated
- Elder has an untreated medical condition

## SELF-NEGLECT POSSIBLE INDICATORS:

- Inability to manage personal finances, e.g., hoarding, squandering, giving money away or failure to pay bills
- Inability to manage activities of daily living, including personal care, shopping, meal preparation, housework, etc.
- Suicidal acts, wanderings, refusing medical attention, isolation substance abuse
- Lack of toilet facilities, utilities or animal infested living quarters (dangerous conditions)
- Rashes, sores, fecal/urine smell, inadequate clothing, malnourished, dehydration, etc.
- Changes in intellectual functioning, e.g., confusion, inappropriate or no response, disorientation to time and place, memory failure, incoherence, etc.
- Not keeping medical appointments for serious illness

## ABUSE FROM THE CAREGIVER POSSIBLE INDICATORS:



- The elder may not be given the opportunity to speak for him or herself, or see others, without the presence of the care giver (suspected abuser)
- Attitudes of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family member or care giver blames the elder (e.g. accusation that incontinence is a deliberate act)
- Aggressive behavior (threats, insults, harassment) by care giver toward the elder
- Previous history of abuse of others
- Problems with alcohol or drugs
- Inappropriate display of affection by the care giver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the care giver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the care giver to comply with service providers in planning for care and implementation
- Inappropriate or unwarranted defensiveness by care giver

## All Revision Dates

9/5/2025, 5/9/2023, 10/3/2022, 2/1/2016, 12/1/2013, 8/1/2009, 5/1/2006, 2/1/2005

## Attachments

PEARR Tool.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Osahon Ekhaese: Chief Operating Officer, VCMC & SPH | 9/5/2025 |
| Hospital Administration | Minako Watabe: Chief Medical Officer, VCMC & SPH | 7/16/2025 |
| Policy Owner | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 7/14/2025 |

Status **Active** PolicyStat ID **16122044**

| | |
|---|---|
| Origination | 8/27/2021 |
| Last Approved | 9/5/2025 |
| Effective | 9/5/2025 |
| Last Revised | 9/5/2025 |
| Next Review | 9/4/2028 |
| Owner | Laura Zarate: Clinical Nurse Manager, Case Management |
| Policy Area | Administrative - Operating Policies |

# 107.071 Patient Clothing Donations



## POLICY:

To outline the Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) guidelines for accepting donations of clothing for the patient clothes ~~closet located in the Emergency Department,~~closets and to define what constitutes appropriate clothing to be accepted and distributed to patients in need of attire upon discharge from the hospital in compliance with SB1152.

## PROCEDURE:

- VCMC/SPH ~~does~~will not ~~accept~~provide clothing for patients that contain religious statements or symbols or that could be deemed offensive to any reasonable person. Donations that are received and determined not to be appropriate will in turn be given to a local charity.
- Per the Centers for Disease Control and Prevention (CDC) guidelines on how to properly launder clothing, the following guidelines apply to all donated clothing:
    1. All donated clothing shall be washed before being distributed to patients. The CDC recommends a temperature of at least 160°F (71°C) for a minimum of 25 minutes is commonly recommended for hot-water washing. The use of chlorine bleach assures an extra margin of safety. Household bleach can be used at normal concentrations. All donated clothing shall be dried COMPLETELY in a clothes dryer.
    2. Donated shoes shall be sprayed with a disinfectant prior to distributing to patients. Although new shoes/sandals are best, gently worn flats, tennis shoes, boots and sandals are also accepted.
    3. All clothing placed in the patient clothes closet shall be clean and folded or hung on a hanger.
    4. Socks, scarves and beanies (hats) are accepted with the above-stated guidelines followed.

- Only staff are allowed access to the patient clothes closet. Under no circumstances shall patients be allowed in the patient clothes closet.
- ***Discarded patient clothing shall not be placed in the patient clothes closet. Discarded clothing shall be sent to the Security Department or disposed of with appropriate documentation noted in the electronic health record (EHR).***
- ~~Per the Centers for Disease Control and Prevention (CDC) guidelines on how to properly launder clothing, the following guidelines apply to all donated clothing:~~
    1. ~~All donated clothing shall be washed before being distributed to patients. The CDC recommends a temperature of at least 160°F (71°C) for a minimum of 25 minutes is commonly recommended for hot-water washing. The use of chlorine bleach assures an extra margin of safety. Household bleach can be used at normal concentrations. All donated clothing shall be dried COMPLETELY in a clothes dryer.~~
    2. ~~There is no need to disinfect the tubs of washers or tumblers of dryers if all cycles are run until they are completed.~~
    3. ~~Donated shoes shall be sprayed with a disinfectant prior to distributing to patients. Although new shoes/sandals are best, gently worn flats, tennis shoes, boots and sandals are also accepted.~~
    4. ~~All clothing placed in the patient clothes closet shall be clean and folded or hung on a hanger.~~
    5. ~~Socks, scarves and beanies (hats) are accepted with the above-stated guidelines followed.~~
- ~~*Only staff are allowed access to the patient clothes closet. Under no circumstances shall patients be allowed in the patient clothes closet.*~~
- ***VCMC/SPH does NOT accept bedding, sleeping bags, pillows, etc.***



**Before accepting clothes for donation, ensure that donors check clothing pockets for any valuables as VCMC/SPH are not liable for lost or stolen items.**

## DOCUMENTATION:

Staff shall document in EHR that patient was offered weather appropriate clothing from the patient clothes closet.

# REFERENCES:

1. Background G. Laundry and Bedding. Guidelines for Environmental Infection Control in Health-Care Facilities (2003)

## All Revision Dates

9/5/2025, 8/27/2021

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Osahon Ekhaese: Chief Operating Officer, VCMC & SPH | 9/5/2025 |
| Infection Prevention Committee | Magdy Asaad: Infection Prevention Manager | 7/21/2025 |
| Policy Owner | Laura Zarate: Clinical Nurse Manager, Case Management | 7/19/2025 |

Status **Active** PolicyStat ID **16426942**

| | | | |
|---|---|---|---|
| Origination | 5/26/2009 | Owner | Gayle Haider: Supervisor-Quality Assurance, Laboratory Services |
| Last Approved | 9/8/2025 | | |
| Effective | 9/8/2025 | Policy Area | Laboratory Services |
| Last Revised | 9/8/2025 | | |
| Next Review | 9/8/2027 | | |

# L.27 Laboratory Test Cancellation



## ~~POLICY:~~

~~When a Laboratory specimen is unacceptable for processing, the unique specimen number must be cancelled and the cancellation communicated to the patient's nurse or physician. Then a new request is entered into Laboratory Information System (LIS) and a new specimen drawn. The redraw must have its own unique specimen number.~~

## POLICIES:

A. As soon as laboratory personnel becomes aware of a potential error in patient identification or other information in specimen label such as date/time of specimen collection, initials of person collecting specimen, wrong container, or wrong blood in tube, improper specimen handling and transport, this must be communicated to healthcare provider or ordering physician. Specimen must be redrawn or recollected.

B. When a Laboratory specimen is unacceptable for processing, the unique specimen number must be cancelled and the cancellation communicated to the patient's nurse or physician. Then a new request is entered into Laboratory Information System (LIS) and a new specimen drawn. The redraw must have its own unique specimen number.

C. Incident is investigated, appropriate corrective action developed, and reported in incident reporting system.

## PROCEDURE:

The three major areas that can impact errors in patient results are:

1. Questionable Specimen Integrity

a. Clotted Specimen
b. Hemolyzed Specimen
c. QNS (Quantity Not Sufficient)
d. Incorrect Collection Tube
e. Improper Handling

2. Contaminated Specimen
   The most common problem that causes a specimen to be contaminated is a draw that is either above an IV or a situation where the phlebotomist draws in the arm that a patient is receiving an IV. This situation is most often identified in the testing area by the testing personnel (Clinical Laboratory Scientist ~~(CLS~~or Medical Laboratory Technician).
3. Mislabeled Specimen
   The discovery of a mislabeled specimen(s) can occur before or during testing of the specimen(s). If there is suspicion that a specimen has been mislabeled, the testing and reporting of results must be halted on everything that was potentially mislabeled.

   ~~If the integrity of a specimen is questionable or thought to be contaminated or mislabeled, all departments with orders on the same specimen(s) must be alerted and testing stopped until the specimen(s) can be checked. That way, if a redraw is necessary in more than one department, the patient is not re-drawn for each department separately.~~

If the integrity of a specimen is questionable or thought to be contaminated or mislabeled, all departments with orders on the same specimen(s) must be alerted and testing stopped until the specimen(s) can be checked. That way, if a redraw is necessary in more than one department, the patient is not re-drawn for each department separately.

**The ~~person~~testing personnel who first discovers the questionable acceptability is responsible for coordinating the following:**

1. Alert all ~~Laboratory~~laboratory sections that would be affected by the acceptability issue.
2. Stop patient testing on those specimens questionable for acceptability.
3. Collect all specimens that are questionable for acceptability.
4. Notify the patient's nurse of the issue and the need to recollect the specimen(s).
5. Cancel the questionable specimen(s) and document the reason for cancellation.
6. Mislabeled specimens are documented on the general hospital Notification Form. Forward the completed form to the Laboratory Manager.

NOTE: If the patient is an outpatient, they must be notified to return for a recollection of their specimen(s). A copy of the order must then be placed in the future order file and the registration desk notified.

# Laboratory Information System (LIS) CANCELLATION & DOCUMENTATION

A. Cancellation Process (In LIS)

a. Order entry, select cancel order in the TASK menu

b. Enter SPEC #: Enter yy-julian-day -#, (i.e. 13-330- ####), Patient Name, or MR#

c. Select Record

d. Enter the reason for Cancel

e. Add the cancellation and submit the request.

f. Cancellation Comments:

**COMBINE ORDERS. SEE: TIME: DATE: BY:**

****CANCELLED -. PATIENT REFUSED TO BE DRAWN****
**NOTIFIED: TIME: DATE: BY:**

****ORDER ENTRY REQUESTS CANCELLATION OF THESE ORDERS****

**CANCEL ORDER - RECEIVED FROM: TIME: DATE: BY:**

****CLOTTED SAMPLE RECEIVED - REJECTED****
**REQUEST REDRAW. NOTIFIED: TIME: DATE: BY:**

****HEMOLYZED SPECIMEN: REQUEST REDRAW****
**NOTIFIED: TIME: DATE: BY:**

****LAB ERROR - TEST NOT PERFORMED** REQUEST REDRAW.**

****CANCELLED — BLUE TOP TUBE NOT COMPLETELY FILLED** REQUEST REDRAW.**
**NOTIFIED: TIME: DATE: BY:**

****DUPLICATE ORDERS** SEE: NOTIFIED: TIME: DATE: BY:**

****SPECIMEN REJECTED: REQUEST REDRAW****

****CANCELLED - IMPROPERLY HANDLED SPECIMEN****
**NOTIFIED: TIME: DATE: BY:**

****CANCELLED - IMPROPERLY LABELED SPECIMEN****
**NOTIFIED: TIME: DATE: BY:**

****CANCELLED - PATIENT DISCHARGED****

****CANCELLED - PATIENT EXPIRED****

## CORRECTED RESULTS

This task is performed by the CLS following the procedure outlined in Laboratory policy L.25, *Corrected Laboratory Results*. When correcting results that have already been verified in LIS, it must be assumed that the report could have been already viewed by a physician or nurse. The corrected results must be phoned to the physician or nurse. The call must be documented on the patient's corrected result. The erroneous results will be cancelled with an explanation of the occurrence.

# REFERENCES:

GEN.40492 Specimen Label Correction. Laboratory General Accreditation Checklist. College of American Pathologists, August, 2023.

## All Revision Dates

9/8/2025, 11/1/2016, 11/1/2013

## Approval Signatures



| Step Description | Approver | Date |
|---|---|---|
| Hospital Administration | Jason Arimura: Associate Hospital Administrator, VCMC & SPH | 9/8/2025 |
| Laboratory Services Department | Erlinda Roxas: Director, Laboratory Services | 9/6/2025 |
| Laboratory Services Department | Brad Adler, MD: Medical Director, Laboratory Services | 11/14/2024 |
| Laboratory Services Department | Gayle Haider: Supervisor-Quality Assurance, Laboratory Services | 10/8/2024 |

# VENTURA COUNTY MEDICAL CENTER

*Property of the Medical Staff, Privileged and Sensitive Information*

**CONFIDENTIAL**

## Medical Executive Committee Document Approvals

September 2025

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

| | | | |
|---|---|---|---|
| 1. | 100.037 Hospital Admission Procedures | page | 2-4 |
| 2. | 100.081 Look-Alike/Sound-Alike Medications | page | 5-8 |
| 3. | 100.087 Anticoagulation Management | page | 9-10 |
| 4. | 100.113 Crash Cart Checks and Restocking Process | page | 11-15 |
| 5. | 100.205 Safe Handling of Hazardous Medications | page | 16-20 |
| 6. | 100.235 Patient-Controlled Analgesia (PCA) | page | 21-30 |
| 7. | 100.259 Vinca Alkaloid Administration By Minibag | page | 31-33 |
| 8. | 100.262 MRI Infusion Pump | page | 34-36 |
| 9. | 100.263 Intramuscular Methotrexate For Ectopic Pregnancy | page | 37-41 |
| 10. | 102.041 Bloodborne Pathogen Post-Exposure Evaluation & Management for Non-Employed Medical Staff | page | 42-48 |
| 11. | 107.005 Medical Abbreviations | page | 49-50 |
| 12. | 108.060 Cardiac Monitoring/Intrahospital Transport/Alarms Management Clinical Guidelines (Nursing) | page | 51-56 |
| 13. | AC.18 Chemotherapy Home Infusion | page | 57-60 |
| 14. | ER.33 Mobile Intensive Care Nurse (MICN) Staffing in the Emergency Department | page | 61-62 |
| 15. | IS.03 Imaging Services Medication List | page | 63-69 |
| 16. | IS.32 Nuclear Medicine Department Overview | page | 70-75 |
| 17. | IS.34 Radionuclide Accident Victims | page | 76-79 |
| 18. | PH.41 The Drug Use Evaluation Program | page | 80-81 |
| 19. | PH.88 Controlled Substances | page | 82-88 |
| 20. | PH.103 Tretinoin (ATRA) Inventory | page | 89 |
| 21. | PH.113 Intravenous Immune Globulin Dosing | page | 90-92 |
| 22. | PH.117 Rasburicase Dosing for Adults | page | 93-95 |
| 23. | PH.121 Tissue Plasminogen Activator (tPA, Alteplase) and/or Dornase Alfa for Pleural Effusion or Empyema | page | 96-98 |
| 24. | R.98 Inpatient Tracheostomy Orders | page | 99-100 |
| 25. | T.03 Pediatric Trauma Guidelines | page | 101-102 |
| 26. | T.22 Prevention of Inadvertent Retained Foreign Objects (RFO) | page | 103-105 |
| 27. | UR.06 Patient Status Orders | page | 106-113 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/1/1978* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/16/2022* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sherri Block: Associate Chief Nursing Executive, VCMC & SPH* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.037 Hospital Admission Procedures

# POLICY:

It is the policy of Ventura County Medical Center (VCMC) & Santa Paula Hospital (SPH) to establish policies for the admission of patients which allow for patient safety and prompt and efficient service. The following admission procedures have been established.

# PROCEDURE:

**Admission to the Critical Care Unit**

1. Direct admission to the Intensive Care Unit (ICU) should be initiated through a phone call from the admitting physician to the hospital Emergency Department (ED) where the admitting physician will speak to the Emergency Department attending physician.
    1. Interfacility transfers must be cleared via protocol in the pre-admitting department, or via nursing supervisor.
2. ED staff shall ascertain if a bed in ICU is immediately available. If there is none, the patient is to be directed to the ED for evaluation and treatment while a bed is being arranged.
3. If a bed is available, the house officer or resident assigned to the case is to be notified of the admission. If the house officer is not immediately available, the float resident will assume responsibility for attending the patient until the house officer arrives. An ED physician or licensed nurse will accompany the patient to the unit.
4. Resident physicians, Clinical Nurse Managers, a Utilization Review Representative, Unit Director and Medical Director will be requested to evaluate admissions for appropriate utilization of the unit.

Please refer to policy *CC.09 Critical Care Unit Admission Criteria and Scope of Care*.

**Admission and Transfer to Neonatal Intensive Care Unit**

Procedures for the admission and transfer of patients to the Neonatal Intensive Care Unit (NICU) are documented in policy *100.007 Admission Criteria to the NICU*.

Procedures for the admission and transfer of patients to the Pediatrics Unit are documented in policy *P.37 Admission to the Pediatrics Department*.

**Admission or Transfer of Patients from Other Facilities**

Procedures for the admission of patients transferred from other facilities (i.e., hospitals, skilled nursing

facilities) are documented in policy *100.014 Patient Transfer to Ventura County Medical Center and Santa Paula Hospital*.

**Elective Admissions (Morning (AM) Admit and Outpatient Surgeries)**

In order to provide prompt and efficient service to the patient and to allow for the completion of any required pre-operative orders and pre-operative anesthesia visits, the following procedures should be followed:

1. After a clinic visit when a decision for surgery is made, an independent utilization review (IUR) is initiated and sent to the Pre-Admitting office.

   After the authorization process is completed, the surgery is scheduled and the patient is given an appointment for a preop anesthesia visit on a date one to five (1 to 5) days before the scheduled surgery. The anesthesia visit will be conducted by a registered nurse (RN), with the exception of high-risk anesthesia patients that need to be seen in the high-risk anesthesia clinic.

   Admit patients who are scheduled for surgery on the day before admission should follow the same process.
2. The scheduling physician should see the patient within a week of the surgery date and before the anesthesia visit so that preop orders and a history and physical can be performed.
3. The order must specify whether the patient's admission will be "Outpatient Surgery" or "AM Admit" as well as the admission date.
4. Physician orders, including any dietary instructions, must be given to the Pre-Admitting Office in writing prior to the time of admission. If this is not done, the patient will be held at Admission pending contact with the physician.

| | |
|---|---|
| All revision dates: | 8/16/2022, 7/26/2017, 5/1/2006, 4/1/2006, 1/1/2005, 11/1/1998, 3/1/1995, 7/1/1990, 11/1/1989, 10/1/1986, 5/1/1983, 4/1/1978 |

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Hospital Administration | Osahon Ekhaese: Chief Operating Officer, VCMC & SPH | 8/11/2025 |
| Hospital Administration | Minako Watabe: Chief Medical Officer, VCMC & SPH | 6/25/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 6/20/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/20/2025 |
| Policy Owner | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/20/2025 |

| Step Description | Approver | Date |
| --- | --- | --- |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *6/1/1979* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *6/3/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sara Pendleton: Medication Safety Officer* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.081 Look-Alike/Sound-Alike Medications

## POLICY:

~~A. Provide an organization-wide drug safety policy to prevent "look-alike/sound alike" (LASA) medication errors.~~

~~B. Increase patient safety by avoiding preventable injuries associated with LASA drug labeling/packaging to the greatest extent possible.~~

~~C. Decrease unnecessary costs associated with preventable adverse drug events.~~

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), and Ambulatory Care Clinics (AMB) address the safe use of look-alike/sound-alike (LASA) medications by completing the following:

- Reviews internal and external reports of actual and potential LASA medication errors.
- Develops and annually updates a prioritized list of error prone LASA medications that VCMC, SPH, and AMB stores, dispenses, and administers.
- Optimizes safeguards to prevent errors involving the error medications on the LASA list.

## Background:

LASA medications are medications with names that look similar or sound similar. The physical appearance of the medication and/or packaging can also be similar. Because of this LASA potential, a medication can easily be mistaken for another medication.

By pro actively identifying LASA risks and implementing safeguards, preventable adverse drug events (ADE) may be avoided leading to improved patient safety.

## PROCEDURE:

~~A. Medications identified as potentially at risk for LASA confusion shall be reviewed by Patient Safety and Pharmacy & Therapeutics (P&T) committees for possible risk reduction strategies.~~

~~B. Patient Safety Committee shall review and update a list of identified LASA drugs once a year.~~

~~C. Drugs which are identified from the drug formulary list with potential for LASA errors shall be stored with color coded labels on the bins within the pharmacy.~~

~~D. Every effort shall be made to separate LASA medications from being in close proximity to each other in the automated dispensing cabinets (ADCs).~~

E. ~~The LASA list shall be circulated through out the hospital to raise awareness of the potential mix-ups associated with these medications.~~

~~There are four separate areas in the medication use process where LASA errors can be prevented. These areas include:~~

A. ~~Drug Selection~~

1. ~~Manufacturers are required to provide unique packaging and labeling to avoid the potential for LASA errors.~~
2. ~~Serious medication errors that can be attributed to LASA labeling or packaging shall be reported to the Federal Drug Administration (FDA) Medwatch program.~~

B. ~~Computerized Physician Order Entry (CPOE): Medications~~

1. ~~Tall man lettering shall be used for LASA medications in the Electronic Health Record (EHR) when ordering medications.~~

C. ~~Drug Dispensing~~

1. ~~Drugs with a known potential for LASA medication errors shall be stored separately in the pharmacy.~~
2. ~~Other recommendations to avoid LASA confusions:~~
   a. ~~Use of tall man lettering at the ADCs.~~
   b. ~~Change manufacturers of one product to reduce similarity.~~
   c. ~~Apply auxiliary labels to those drugs with high potential for error.~~
   d. ~~Use different color labels for the storage bins.~~
   e. ~~Physically separate LASA medications within the pharmacy.~~
3. ~~Pharmacy technicians shall double check all medications with LASA names when refilling the ADCs.~~

D. ~~Drug Administration~~

1. ~~Minimize drugs stored on nursing units by removing infrequently used drugs from the ADCs.~~
2. ~~Contents and location of drugs stored in ADCs shall be evaluated regularly to minimize the potential for LASA medication mix-ups.~~
3. ~~Follow the "seven rights" of drug administration and utilize bar code medication administration technology.~~

A. Procurement

1. LASA potential shall be reviewed by Pharmacy and Therapeutics committee when new medications are presented for formulary addition.
2. Pharmacy may identify unanticipated LASA potential for new products, new manufacturers, and back ordered alternatives. Pharmacy may pursue purchasing from a different manufacturer to reduce this risk.

B. Nomenclature

1. Consistent use of Tall-man lettering is recommended to draw attention to key differences in similar sounding/looking medication names (e.g., lev**ETIRA**cetam and levo**FLOX**acin).
2. To aid in correct medication recognition, the following best practice recommendations may be

utilized

a. Require pratictioners to enter at least 5 letters of the medication name during a medication search.

b. Enable/display both the generic and brand names

c. Develop order sets and order sentences that include the indication for the medication.

3. Electronic alerts may be utilized to alert practitioners of LASA medication error potential.

C. Storage

1. In Pharmacy and ambulatory care clinics, LASA medications should be stored in separate physical locations away from each other with clear labeling. Color coded labels/bins and auxillary labels may be used to differentiate error prone LASA medications.

2. In the automated dispensing cabinets, LASA medications should be stored in locked, lidded pockets instead of open matrix drawers.

3. Pyxis Anesthesia System (PAS) medication trays should be organized to allow for vials to lie label up whenever possible. In addition, LASA medications should be separated from each other in the trays.

D. Prescribing

1. Avoid use of abbreviated drug names (e.g., "TPA" versus "TXA" versus "TNK") when communicating or ordering a medication as this can lead to the wrong medication reaching the patient. See policy 107.005 Medical Abbreviations

2. VCMC, SPH, and AMB minimize the use of verbal and telephone orders.

a. See policy 100.220 Electronic Order Management

b. See policy AC.35 Ambulatory Care Medication Management

3. Utilize Computerized Physician Order Entry (CPOE) to prescribe medications. When this is not possible, aim to use preprinted order sets (e.g., adult chemotherapy preprinted orders) to help minimize handwriting and transciption errors.

E. Order verification at VCMC, SPH, and Infusion Center. See Policy PH.55 Medication Order Management

F. Administration

1. For VCMC, SPH, and infusion center, see policy 100.025 Medications: Ordering, Administration, and Documentation for med pass best practices to reduce the likelihood of LASA administration errors (e.g., use of barcode medication scanning).

2. For ambulatory care clinics, see the following policies

a. See policy AC.35 Ambulatory Care Medication Management

b. See policy AC.36 Vaccine Administration in the Outpatient Ambulatory Care Clinics

G. Reporting and Annual Review

1. Actual and potential LASA medication errors should be reported through the online event/incident reporting system (i.e., RL Datix).

2. VCMC, SPH, and AMB annually reviews internal and external reports of actual and potential LASA medication errors.

3. The LASA list(s) are updated annually with committee approval to optimize safeguards and

ultimately reduce LASA errors

4. The LASA list is readily available in order to raise awareness of the potential mix-ups associated with these medications.

# References


1. Institute for Safe Medication Practices (ISMP). Adopt strategies to manage look-alike and/or sound-alike medication name mix-ups. *ISMP Medication Safety Alert! Acute Care*. 2022;27(11):1-4
2. Institute for Safe Medication Practices (ISMP). ISMP List of Confused Drug Names. ISMP 2023: 1-4
3. Institute for Safe Medication Practices (ISMP). FDA and ISMP Lists of Look-Alike Drug Names and Recommended Tall Man letters. ISMP 2016: 1-6
4. The Joint Commission. Medication Management Elements of Performance. MM.01.02.01. Accessed 5/28/2025.


All revision dates: 6/3/2025, 6/21/2022, 8/7/2018, 8/1/2015, 4/1/2012, 4/1/2008

## Attachments

- Attachment A - Look Alike Sound Alike Drug List
- Attachment B - Look Alike Sound Alike Cephalosporins List
- Attachment C - Look Alike Sound Alike Oncology List
- Attachment D - Look Alike Sound Alike Vaccine List

## 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 | 8/8/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/3/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 6/3/2025 |
| Policy Owner | Sara Pendleton: Medication Safety Officer | 6/3/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *6/1/2008* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/8/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sara Pendleton: Medication Safety Officer* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.087 Anticoagulation Management

## POLICY:

This policy provides evidence-based recommendations that help ensure the safe and effective use of oral and parenteral anticoagulants for the prevention and treatment of various thrombotic disorders.

A. Anticoagulant therapy shall be individualized to each patient.

B. Clinical judgment shall be employed at the time of initiation, continuation and with the decision to stop anticoagulation.

C. Anticoagulants that are packaged as oral unit-dose medications, pre-filled syringes, and pre-mixed infusion bags shall be used, when available, to minimize the risk of compounding and labeling errors.

D. ~~Anticoagulation~~Quality and Performance Improvement and Patient Safety Committee, ~~Patient Safety Committee,~~ and Pharmacy & Therapeutics (P&T) Committee shall evaluate anticoagulation use, identify potential safety issues and modify any protocols and/or clinical practice guidelines addressed in this policy as needed.

## PROCEDURE:

A. Providers shall become familiar with the protocols and clinical practice guidelines addressed in this policy. Providers shall place orders for the desired anticoagulation therapy and relevant baseline labs.

B. Pharmacists shall review and verify the physician order for appropriate indication, baseline labs, dosage, and ensure appropriate monitoring takes place for the duration of anticoagulation therapy.

C. Nursing staff shall review the seven rights of medication administration prior to administering any anticoagulant therapy. Continuous infusions shall be delivered via smart infusion pump using the appropriate Dose Error Reduction Software (DERs). Independent double checks for anticoagulation are described in policy PH.70 High Alert Medications

D. Nurses, pharmacists and providers share the responsibility to assess for signs and symptoms of bleeding and potential treatment failure (e.g. recurrent thrombosis).

E. Adverse drug events, medication errors and near-misses of medication errors should be reported via the appropriate notification system.

All revision dates: 8/8/2025, 12/14/2021, 3/17/2020, 7/26/2017, 10/1/2016, 8/1/2015, 12/1/2010

## Attachments

- Attachment A - Warfarin Protocol.pdf
- Attachment B - Adult Heparin Infusion Protocol.pdf
- Attachment C - Low Molecular Weight Heparin (Enoxaparin) Protocol.pdf
- Attachment D - Adult Argatroban Drip Protocol.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/3/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 6/3/2025 |
| Policy Owner | Sara Pendleton: Medication Safety Officer | 6/3/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *1/27/2020* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *7/23/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sherri Block: Associate Chief Nursing Executive, VCMC & SPH* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.113 Crash Cart Checks and Restocking Process

# POLICY:

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

# PROCEDURE:

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

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

# Section I - Hospital:

**CRASH CART CHECKING:**

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

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

   Tasks associated with the crash cart check include:

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

document closed on the checklist.

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

b. Record the lock number.

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

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

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

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

g. Ensure the oxygen tank is full.

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

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

2. Pharmacy:

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

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

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

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

i. new lock number

ii. name of the medication due to expire first

iii. date of expiration

iv. initials of the inspecting pharmacist

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

# CRASH CART REPLACEMENT:

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

B. **Department Personnel:**

1. Immediately after use or upon identification of an expired item, the crash cart, minus the medication tray & defibrillator, shall be taken to Central Supply for replenishment of supplies.

2. The crash cart binder shall be removed from the crash cart before the crash cart is returned to Central Supply. The crash cart clip board is to be sent with the crash cart for forms to be replaced.

3. The medication tray shall be delivered to the Pharmacy by licensed personnel.
    a. In an event of a code, the pink carbon copy of the Cardiopulmonary Resuscitation Record shall also be delivered to pharmacy with the medication tray.
4. The used crash cart shall be delivered to Central Supply.
5. Retrieve a replacement crash cart from Radiology ground floor (room G212) at VCMC and from Central Supply at SPH.
6. Transport the replacement crash cart to the Pharmacy for addition of the medication tray. Once the pharmacy process is complete, the replacement crash cart is ready for its final destination.
7. Once the replacement crash cart reaches its final destination, place the crash cart binder and defibrillator on the crash cart. Document the lock number and time in the "Remarks/Corrections" section of the Crash Cart Checklist.

C. **Central Supply:**

1. Replacement crash carts are available in Central Supply. These are fully stocked with supplies, but do not contain a medication tray.
2. Central Supply shall restock any returned crash cart.
    a. Check for and replenish used supplies.
    b. Check for and replace any expired equipment and supplies.
3. Secure the stocked crash cart with a lock to indicate that the supplies and equipment have been checked and replenished.
    a. A new crash cart sticker shall be applied to the outside of the crash cart with the name of the supply due to expire first, the date of expiration and the initials of the person who restocks the Central Supply crash cart.

D. **Pharmacy:**

1. Upon delivery of the replacement cart to the Pharmacy, a pharmacist shall open the crash cart by breaking the lock and add a sealed medication tray to the replacement crash cart.
2. The pharmacist shall secure the replacement crash cart with a numbered lock.
    a. Crash cart locks shall be serially-numbered.
    b. Medication crash cart locks shall be stocked and controlled only by the Pharmacy Department.
3. The pharmacist shall apply a new crash cart medication sticker to the outside of the crash cart and record:
    a. new lock number
    b. name of medication due to expire first
    c. date of expiration
    d. initials of the pharmacist
4. The pharmacist shall record the crash cart medication tray number and the replacement crash cart's final destination in the KitCheck program.
5. The replacement crash cart is now ready to be delivered to its final destination.
6. Pharmacy staff shall receive used or expired crash cart medication trays and restock the crash cart

medication trays as follows:

a. Medication trays shall be checked, replenished and initialed by a pharmacy technician or pharmacist.

b. Expiration dates of items added are noted on the crash cart medication list.

c. A pharmacist shall check the medication trays for accuracy of contents and expiration dates. Upon completion of the check, the pharmacist shall seal the medication tray.

d. Once sealed, the crash cart medication tray is ready to be added to a crash cart.

e. The patient shall be charged for any medications administered in a Code event.

E. **Santa Paula Process Addendum:**

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

## ~~MEDICATION/IV - CONTENTS OF CRASH CART~~

~~Attachment A - Crash Cart and Defibrillator Location List~~

~~Attachment B - Crash Cart Checklist~~

~~Attachment C - Adult Crash Cart Supply List~~

~~Attachment D - Pediatric Broselow Crash Cart Supply List~~

~~Attachment E - Neonatal Crash Cart Supply List~~

~~Attachment F - Adult Crash Cart Medication List~~

~~Attachment G - Pediatric Broselow Crash Cart Medication List~~

~~Attachment H - Neonatal Crash Cart Medication List~~

# Section II - Clinic:

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

All revision dates: 7/23/2025, 4/15/2025, 8/10/2022, 1/27/2020

## Attachments

Attachment A - Crash Cart Locations

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

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/18/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 7/24/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 7/24/2025 |
| Policy Owner | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 7/24/2025 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *1/1/2017* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *1/13/2021* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Patricia Bollendorf-Perez: Pharmacy Supervisor* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.205 Safe Handling of Hazardous Medications

# POLICY:

To identify and define hazardous medications given at Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and the VCMC Outpatient Infusion Center, and to outline their safe handling, preparation and administration.

Hazardous drug spills are detailed in a separate policy (see policy *EVS.39 Management of Chemotherapy Spills*). Disposal of hazardous drug waste is not outlined in this policy.

Hazardous drugs are only compounded by pharmacists and pharmacy technicians that have been adequately trained and have successfully demonstrated competency in hazardous drug preparation and aseptic technique.

Clinical staff is to utilize engineering controls, administrative controls, and work practice controls to reduce the potential for occupational exposure to hazardous drugs.

Parenteral/subcutaneous antineoplastic drugs (Appendix A), along with an active order written by a medical oncologist or physician experienced in prescribing cancer chemotherapy, are only to be administered by registered nurses that have successfully completed a comprehensive chemotherapy administration program that includes competency assessment (e.g., ONS Chemotherapy and Biotherapy Course) or qualified licensed independent practitioners. There is a separate policy for the administration of antineoplastic drugs (see policy *CC.17 Administration and Extravasation of Antineoplastic and Non-Antineoplastic Agents*).

Oral antineoplastic medications may be administered by any registered nurse who has an active order entered or approved by medical oncologist or physician experienced in prescribing cancer chemotherapy. Other hazardous (non-antineoplastic) medications may also be administered by a registered nurse with an active order. Registered nurses administering antineoplastic and non-antineoplastic oral medications must have completed training and shown competency in the safe handling and administration of hazardous drugs. Competency must be reassessed yearly.

Monoclonal antibodies being used for oncologic indications are to be administered along with antineoplastic therapy by a chemotherapy certified nurse. Monoclonal antibodies ordered for any other indication may be given by a registered nurse (i.e. rheumatoid arthritis, ulcerative colitis).

# DEFINITIONS:

*Administrative controls:* Establish awareness of an issue and provide clear direction for reducing exposure

(e.g., policies, training)

*Antineoplastic Agent (chemotherapy):* A cytotoxic medication that kills or controls the growth of cells. It is usually used for treating cancer, but may be used for non-oncologic conditions (see Appendix A).

*Compounding Aseptic Containment Isolator (CACI):* A form of isolator that maintains an aseptic compounding environment throughout the compounding and material transfer process and protects personnel from airborne drug exposure using a pass-through system and negative pressure. The Infusion Center Pharmacy located in the 5$^{th}$ floor of the clinic building is the only location that currently compounds hazardous drugs, with the exception of intramuscular (IM) methotrexate for the use of ectopic pregnancy.

*Engineering Controls:* Protect the sterility of the drug and provide containment of drug residue generated during the compounding process (e.g., CACI's).

*Hazardous Drug (HD):* Drugs that exhibit one or more of the following six characteristics in humans or animals:

- Carcinogenicity
- Teratogenicity or other developmental toxicity
- Reproductive toxicity
- Organ toxicity at low doses
- Genotoxicity
- Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria

*Monoclonal Antibody*: Genetically engineered medication formulated to specifically target on antigens on the offending agent, whether it be an antigen on a tumor cell or an offending agent in rheumatoid arthritis.

*NIOSH:* National Institute for Occupational Safety and Health.

*Personal protective equipment (PPE):* Medications that are determined to be hazardous require pharmacists and registered nurses to utilize appropriate PPE during preparation, handling and administration to decrease the risk of exposure. This includes medications that are administered orally. PPE consists of:

- Non-powdered gloves tested against permeability to hazardous drugs with cuffs long enough to cover the gown cuff. Gloves are to be changed every 30 minutes or when torn, punctured or contaminated.
- Disposable gown made of lint-free, low permeability fabric that has a solid front and fitted cuffs. The gown should be closed in the back. Gowns should be disposed of immediately if contaminated and at the end of each handling activity.
- Plastic goggles or a face shield should be worn to protect the eyes, nose and mouth when there is risk of splash.
- In the event that there is risk of aerosolization of a hazardous drug, a fit tested N95 mask should be worn. This risk is highest among hazardous drugs given via inhalation.

*Work practice controls:* Minimize the generation of HD contamination and maximize the containment of inadvertent contamination (e.g. PPE).

# PROCEDURES:

I. Hazardous Drugs List:

   a. VCMC/SPH maintains a list of formulary drugs that are hazardous (see policy *PH.27.00 Hazardous Drug Overview*).

b. The NIOSH Hazardous Drugs list, Oncology Nursing Society (ONS) list of hazardous drugs, package insert and information on each drug is used as a reference for inclusion on the VCMC Hazardous Drugs (HD) List.

c. Newly approved oncology agents will be treated as hazardous drugs until the Pharmacy and Therapeutics ("P&T") Committee can assess the medication for inclusion into the formulary.

II. Staff Education:

a. All staff members who may be exposed to HD's will complete education and training specific to their role and job requirement prior to handling HD's and annually.

b. Education records are maintained indefinitely in the employee's personal file.

III. General guidelines for PPE and handling:

a. Staff must utilize PPE during all procedures involving preparation and administration of HD's.

b. Hands are to be washed before and after removing PPE.

c. Chemotherapy gloves are worn when handling hazardous drugs. Chemotherapy gloves should meet ASTM D6978 – 05 standard.

d. An impervious gown and double chemotherapy gloves are worn together when administering intravenous HD and whenever there is a potential for HD leaking/ splashing (not required when administering oral hazardous drugs).

e. When wearing a gown, tuck the cuff of the inner glove under the gown sleeve and the cuff of the outer glove over the gown sleeve.

f. Gowns are removed after each patient encounter, and immediately when damaged, contaminated, or administration of medication is complete.

g. Procedure for removing gown/ gloves: Outer gloves are removed and sealed in a zipper-lock bag, gown is removed and discarded then inner gloves are removed.

h. All PPE used during handling of HD's are discarded in a yellow hazardous waste container.

i. Eating, drinking, applying makeup, and the presence of foodstuff are not allowed in areas where hazardous drugs are prepared or administered.

j. Employees who experience any unusual symptoms (e.g., dizziness, cough, etc.) during the preparation, administration or handling of hazardous drugs must report these symptoms immediately to their department manager or supervisor and report to Employee Health Services.

k. Employees who are actively trying to conceive, pregnant or breast feeding may request an alternative work assignment or transfer to an area where there is no exposure to hazardous drugs. Whenever possible, administration will comply with these requests.

IV. In the event that a hazardous drug is ordered at VCMC or SPH:

a. A nursing supervisor will ensure proper placement of the patient with a nurse who is competent in administering the prescribed hazardous medication. This may involve transferring the patient or re-organizing the current nurse to patient ratio.

b. The hazardous drug(s) will be provided by the Infusion Center Pharmacy which operates Monday through Friday from 6:00 am to 4:30 pm. Weekend and holiday chemotherapy doses will be delivered to the main Pharmacy for distribution on the due date.

V. VCMC Inpatients Receiving HD from Pharmacy:

a. All hazardous drugs are prepared by the Infusion Center Pharmacy. Exception: IM methotrexate for ectopic pregnancy is prepared by the main Pharmacy when the Infusion Center Pharmacy is closed.

b. All HD doses to be administered over the next 24 hours will be delivered daily by pharmacy staff.

c. Tubing will be attached and primed with appropriate diluent within the Infusion Center Pharmacy for all intravenous doses of hazardous drugs. Drugs that are primed with the drug itself will be labeled as such.

d. Specific orders for the HD will be reviewed by two licensed personnel, being either a pharmacist, oncology pharmacist intern, or registered nurse.

VI. Labeling

a. All HD's are labeled as either (see Attachment A for specific drugs):

i. "Chemotherapy": Oral, intravenous, intrathecal, intravesicular, intraocular

ii. "Cytotoxic": Ganciclovir, Cidofovir

iii. "Biohazard": BCG Bacillus calmette-guerrin

iv. "Hazardous": Non-antineoplastic hazardous drugs

b. If tubing is primed with the drug, there will be a label attached to the specific bag.

VII. Administering HD's (refer to policy *CC.17 Administration and Extravasation of Antineoplastic and Non-Antineoplastic Agents*).

a. Hazardous drug spill kits, containment bags, and appropriate disposal containers are readily available in all areas where hazardous drugs are administered.

b. Use Luer-Lok fittings for all injectable needleless systems, syringes, needles, infusion tubing and pumps.

c. Always work below eye level.

d. Visually examine hazardous drug dose while it is still contained in the transport bag. If hazardous drug dose appears intact, it may be removed from the transport bag.

e. Intravenous administration

i. Place a plastic-backed absorbent pad under the administration area to absorb leaks and prevent drug contact with the patient's skin.

ii. Place a gauze pad under the connection at the injection ports during administration to catch leaks.

iii. Discard hazardous drug containers with the administration sets attached; do not remove the set.

f. Intramuscular or subcutaneous administration

i. Do not expel air from syringe or prime the safety needle.

ii. For doses delivered to ER, PPE will be provided along with dose delivery.

g. Oral administration

i. Solid, oral hazardous drugs are not to be crushed, split or modified on the nursing unit.

ii. All oral hazardous drug doses that require manipulation (i.e., crushing, dissolving, cutting of tablets) will be done only by pharmacy personnel in a protected CACI environment.

h. Wash surfaces that come into contact with hazardous drugs with detergent, sodium hypochlorite

solution, and neutralizer, if appropriate.

VIII. Caring for VCMC inpatients recently treated with HD's

a. A cytotoxic precaution paper is to be posted on the patient's door frame that alerts all staff members to utilize protective apparel while administering cytotoxic agents and handling any body fluids following administration. The precaution paper is to remain in place for 48 hours following chemotherapy/biotherapy administration (see Attachment A: Cytotoxic Agent Alert).

b. PPE is to be worn when handling excreta from patients who have received chemotherapy in the last 48 hours. Eye protections should be worn if splashing is possible.

c. For patients who are discharged while still receiving hazardous drugs (oral and systemic), education regarding safe handling shall be provided to patient, family and/or caregiver (see Attachment B: Chemotherapy Precautions for the Caregiver and Family).

IX. Disposal of HD Waste

a. Contaminated waste from preparation and administration of hazardous drugs includes materials and personal protective apparel used in the preparation or administration of these agents. These materials are to be disposed of in chemotherapy waste containers.

b. Linen contaminated with HD's or excreta from patients who have received HD's in the past 48 hours is a potential source of exposure to employees. Linen contaminated with HD's should be placed in specially marked laundry bags, then placed in a labeled impervious bag.

c. Bulk hazardous waste (over 100 mL) is to be returned to the Infusion Center Pharmacy for proper disposal.

X. Spill management: Refer to policy *EVS.39 Management of Chemotherapy Spills* .

All revision dates: 1/13/2021, 1/1/2017

## Attachments

- Attachment A: VCMC Cytotoxic Agent Alert
- Attachment B: Chemotherapy Precautions for Caregiver and Family
- Attachment C: Nursing Guideline for Handling Hazardous Drugs

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| 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 | Patricia Bollendorf-Perez: Pharmacy Supervisor | 6/4/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *2/1/1991* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *6/11/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.235 Patient-Controlled Analgesia (PCA)

# POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) appropriately prescribes and administers patient controlled analgesia for pain management.

# PURPOSE:

To improve patient safety and manage patients' pain by allowing patients to self-administer a predetermined amount of analgesia as needed and/or provide continuous basal IV infusion, thus decreasing patients' anxiety around pain management.

To provide guidelines for the safe use of Patient-Controlled Analgesia (PCA).

# BACKGROUND:

**Indication:**

A. Treatment for postoperative pain and acute pain (moderate and severe) from procedures, surgical conditions, trauma, and cancer

B. Patients who have an order for comfort care or end of life care and who are receiving PCA therapy are excluded from the monitoring requirements set forth by this policy. These patients shall be monitored per the Attending Physicians orders.

**Assessing Appropriateness of Therapy:** It is important to assess patients for appropriateness in using PCA therapy. The patient must be able to comprehend instructions, be willing to self-dose and be assessed according to patient specific monitoring and assessment criteria.

A. Cognitive ability: To effectively and safely use a PCA, the patient must be cognitively intact. The patient must be able to comprehend instructions for use of the pump and understand the link between experiencing pain, pushing the PCA button, and pain relief.

B. Willingness to self-dose: Patients may have difficulty with the concept of PCA use and may be uncomfortable with initiating a dose of pain medication without the nurse's intervention.

C. Physical ability to self-dose: A patient must have the manual dexterity to use the PCA button. Patients who have had bilateral surgical procedures on their hands/arms or have severe physical deformities (e.g., arthritis) may be unable to push the button.

D. Risk Factors for Respiratory Depression in PCA patients (See Table 1): Some patients may be predisposed to a more exaggerated effect from opiates. For example, a patient with sleep apnea may experience profound

respiratory depression from an opiate because the sedative effects of opiates are compounded by the pre-existing apnea. **Patients with risk factors for respiratory depression need vigilant assessment, appropriate dosing, and monitoring.**

| Table 1 Risk Factors for Respiratory Depression in PCA patients[1] |
|---|
| Use of basal infusion |
| Advanced age |
| Obesity |
| Upper abdominal surgery |
| Obstructive sleep apnea |
| Concurrent use of Central Nervous System (CNS) depressants |
| Impaired renal, pulmonary, hepatic, or cardiac function |
| Pump programming errors |
| Families pushing PCA buttons (PCA by proxy) |
| Lack of opioid tolerance |


| Table 1 Risk Factors for Respiratory Depression in PCA patients[1] |
|---|
| Use of basal infusion |
| Advanced age |
| Obesity |
| Upper abdominal surgery |
| Obstructive sleep apnea |
| Concurrent use of Central Nervous System (CNS) depressants |
| Impaired renal, pulmonary, hepatic, or cardiac function |
| Pump programming errors |
| Families pushing PCA buttons (PCA by proxy) |
| Lack of opioid tolerance |


**Contra-indication:** PCA use is contra-indicated in patients unable to understand how to activate doses or in patients who have impaired physical abilities

# PROCEDURE:

## Equipment

A. Dedicated BD Alaris PCA pump and attached BD Alaris End Tidal CO2 (ETCO2) module

B. Nasal cannula ETCO2 tubing

C. PCA Medication in standardized concentrations

1. Hydromorphone (Dilaudid) 10 mg/50mL PCA syringe
2. Morphine sulfate 50 mg/50 mL PCA syringe
3. Remifentanil 2000 mcg/40 mL PCA syringe

## Roles and Responsibilities

### Licensed ~~Independent~~ Practitioner (~~LIP~~LP)

A. ~~LIP~~LP must screen the patient for opioid tolerance and sleep apnea.

1. Opioid tolerance is defined as morphine 60 mg/day x 7 days or the morphine equivalent.
2. Screening for sleep apnea (See Table 2)

| Table 2. Screening for sleep apnea[1] |
|---|
| Is the patient's body mass index > 25? |
| Does the patient have a history of excessive daytime sedation? |
| Does the patient have a history of snoring? |
| Does the patient have a history of hypertension? |
| **If two of the factors are positive, consult respiratory therapy for a modified Berlin sleepiness screening** |


| Table 2. Screening for sleep apnea[1] |
|---|
| Is the patient's body mass index > 25? |
| Does the patient have a history of excessive daytime sedation? |
| Does the patient have a history of snoring? |
| Does the patient have a history of hypertension? |
| **If two of the factors are positive, consult respiratory therapy for a modified Berlin sleepiness screening** |


B. PCA orders must be entered by the ~~LIP~~LP through the electronic health record in ~~Cerner~~CERNER using an approved ~~PowerPlan~~order set.

1. Patients should be initiated on standardized dosing (See Table 3). Orders will reflect loading dose (if indicated), PCA dose, lock out interval, and 1 hour max limit.
2. **Continuous or basal rate is restricted to opioid tolerant patients and may only be ordered by an Attending ~~LIP~~LP.**
    a. **Continuous O2 monitoring should also be ordered for patients who are on continuous or basal rate.**
3. Upon cessation of therapy, all active orders must be discontinued from the EHR.

| Table 3. Standardized Starting PCA dosing[1] | | | |
|---|---|---|---|
| **Morphine** | **Most Patients** | **Over 64 years or sleep apnea** | **Opioid tolerant** |
| PCA dose | 1 mg | 0.7 mg | 1.2 mg |
| Lockout interval | 10 min | 10 min | 10 min |
| Continuous dose | -- | -- | 2 mg/hr (optional) |
| Maximum hourly limit | 6 mg | 4.2 mg | 8.2 mg |
| Loading dose | 3 mg | 2 mg | 4 mg |
| **HYDROmorphone** | **Most Patients** | **Over 64 years or sleep apnea** | **Opioid tolerant** |
| PCA dose | 0.2 mg | 0.15 mg | 0.3 mg |
| Lockout interval | 10 min | 10 min | 10 min |
| Continuous dose | -- | -- | 0.3 mg/hr (optional) |
| Maximum hourly limit | 1.2 mg | 0.9 mg | 2.1 mg |
| Loading dose | 0.6 mg | 0.4 mg | 1 mg |
| **Loading dose IV every 4 hours if needed for breakthrough pain** | | | |

C. Remifentanil PCA

1. Remifentanil PCA orders are restricted to OB laboring patients that are not candidates for epidural analgesia.
2. Only Anesthesiologists may order a remifentanil PCA using the approved order set.
3. Remifentanil PCAs must be administered through an independent line to ensure other concurrent medications and fluids do not cause an inadvertent bolus.
4. Remifentanil PCA must be discontinued once the OB patient is transferred to postpartum.


| Table 3. Standardized Starting PCA dosing[1] | | | |
|---|---|---|---|
| **Morphine** | **Most Patients** | **Over 64 years or sleep apnea** | **Opioid tolerant** |
| PCA dose | 1 mg | 0.7 mg | 1.2 mg |
| Lockout interval | 10 min | 10 min | 10 min |
| Continuous dose | -- | -- | 2 mg/hr (optional) |
| Maximum hourly limit | 6 mg | 4.2 mg | 8.2 mg |
| Loading dose | 3 mg | 2 mg | 4 mg |
| **HYDROmorphone** | **Most Patients** | **Over 64 years or sleep apnea** | **Opioid tolerant** |
| PCA dose | 0.2 mg | 0.15 mg | 0.3 mg |
| Lockout interval | 10 min | 10 min | 10 min |
| Continuous dose | -- | -- | 0.3 mg/hr (optional) |
| Maximum hourly limit | 1.2 mg | 0.9 mg | 2.1 mg |
| Loading dose | 0.6 mg | 0.4 mg | 1 mg |
| **Loading dose IV every 4 hours if needed for breakthrough pain** | | | |


## Pharmacy

See the following related policies on pharmacy roles and responsibilities at order verification and medication

dispensing:

A. PH.55 Medication Order Management

B. PH.88 Controlled Substances

## Nursing

A. Set up

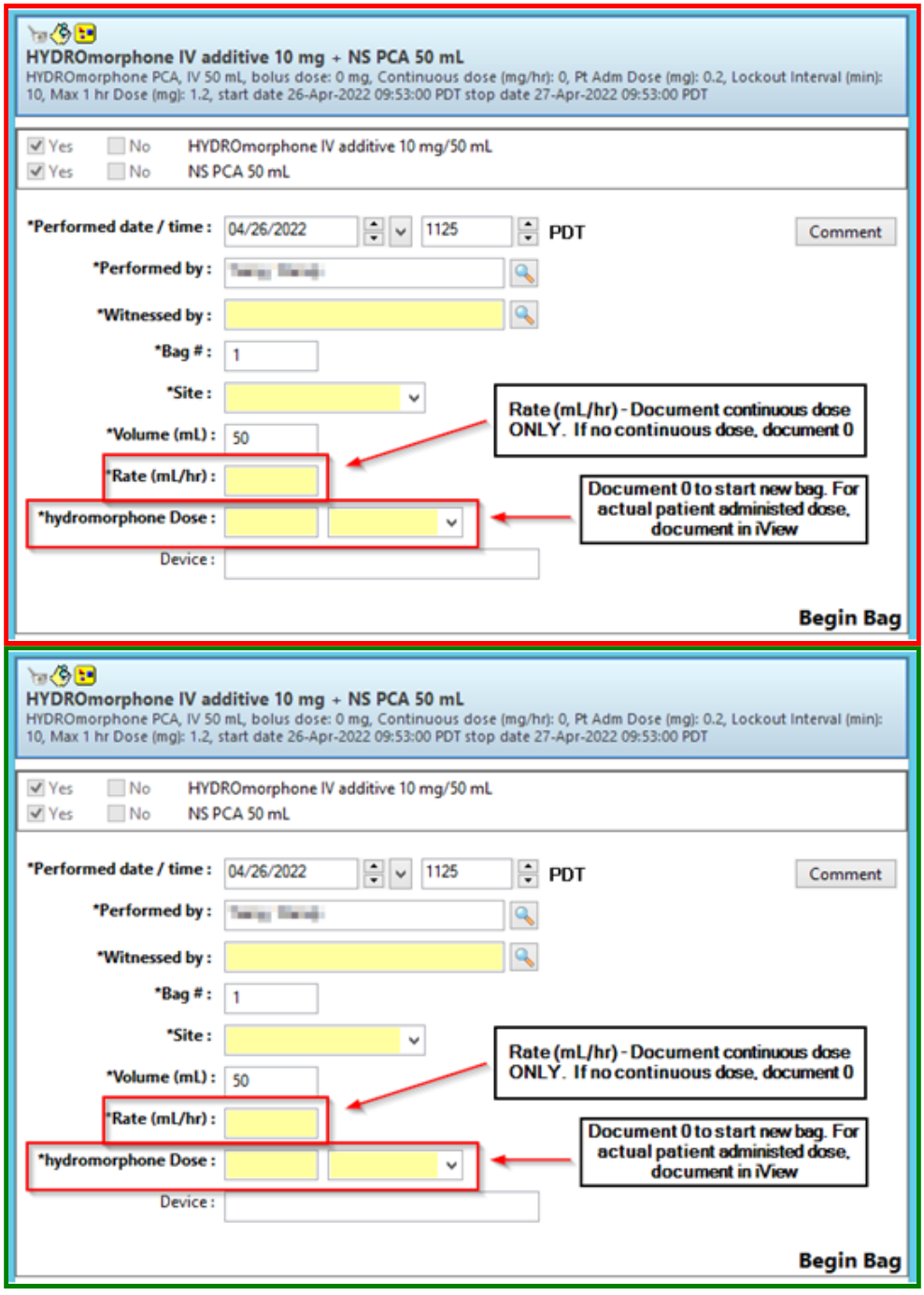
1. The nurse (RN) will call the charge nurse/nursing supervisor to inform them before starting a PCA.
2. The RN will obtain the necessary equipment.
3. The RN will assemble the PCA pump and ETCO2 module with nasal canula tubing attached.
4. The RN shall retrieve the PCA medication from the Automated Dispensing Cabinet (ADC).
    a. If the PCA medication is not available as a premix, Pharmacy shall compound and dispense the PCA medication.

B. Patient education

1. The nurse shall educate the patient on the proper use of the administration button and the safety measures with the use of the PCA including hourly limits and lockout time.
2. The nurse shall instruct the patient and family members that "PCA by proxy" is not allowed.
3. The nurse shall document the education to patient and family in the electronic health record (EHR).

C. Administration

1. Two RNs shall perform an independent double check (IDC) for 7 rights of safe medication administration during PCA initiation, any changed settings at the pump, and all syringe changes (see policy PH.70 High Alert Medications).
2. At change of shift, dosing shall be verified as accurate with an IDC by two RNs at the bedside who shall review the pump settings.
3. PCA syringes should be changed every 96 hours or as needed.
4. The RN shall document on the Medication Administration Record (MAR). See screen shot below.



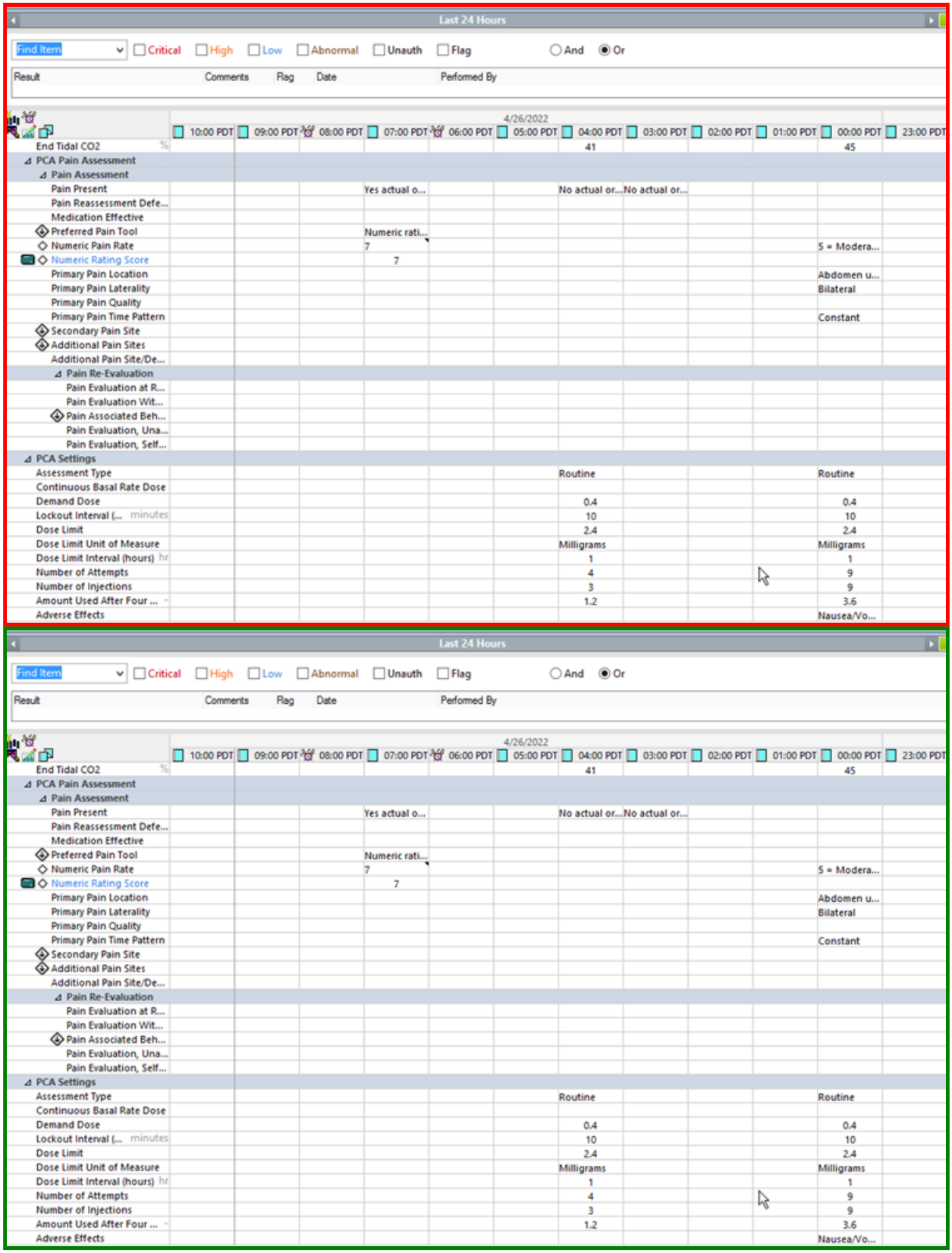

D. Monitoring and Documentation

1. The nurse shall monitor the patient's pain using a standardized pain scale the patient can understand.
2. The nurse shall monitor and document vital signs and assess pain, respiratory rate (RR), level of consciousness (LOC), ETCO2, and continuous O2 saturation as per table 4.

| Table 4 Monitoring Frequencies based on Clinical Scenarios | | | | | |
|---|---|---|---|---|---|
| **Cognitive Opioid Tolerance** | **Pain** | **LOC** | **RR** | **spO2** | **ETC02** |
| Baseline (upon initiation of PCA/arrival to unit) | X | X | X | X | X |
| Postoperative Management<br>- Upon initiation of PCA and/or Upon arrival to unit<br>- Every 30 minutes x 2<br>- Every 1 hour x 2<br>- Every 2 hours x 24 hours<br>- Then every 4 hours unless patient's condition warrants frequent monitoring | X | X | X | X | X |
| Change of medication order<br>- Every 30 minutes x 2<br>- Every 1 hour x 2<br>- Then every 4 hours | X | X | X | X | X |
| Dose Increase or bolus<br>- Every 30 minutes x 2<br>- Then every 4 hours | X | X | X | X | X |
| Event deterioration or oversedation<br>- Immediately upon discovery of oversedation or deterioration<br>- Every 5 minutes until stable | X | X | X | X | X |

| Table 4 Monitoring Frequencies based on Clinical Scenarios | | | | | |
|---|---|---|---|---|---|
| **Cognitive Opioid Tolerance** | **Pain** | **LOC** | **RR** | **spO2** | **ETC02** |
| Baseline (upon initiation of PCA/arrival to unit) | X | X | X | X | X |
| Postoperative Management<br>- Upon initiation of PCA and/or Upon arrival to unit<br>- Every 30 minutes x 2<br>- Every 1 hour x 2<br>- Every 2 hours x 24 hours<br>- Then every 4 hours unless patient's condition warrants frequent monitoring | X | X | X | X | X |
| Change of medication order<br>- Every 30 minutes x 2<br>- Every 1 hour x 2<br>- Then every 4 hours | X | X | X | X | X |
| Dose Increase or bolus<br>- Every 30 minutes x 2<br>- Then every 4 hours | X | X | X | X | X |
| Event deterioration or oversedation<br>- Immediately upon discovery of oversedation or deterioration<br>- Every 5 minutes until stable | X | X | X | X | X |

1. The nurse shall notify the ~~LIP~~LP in the event the patient is over sedated and/or their clinical condition deteriorates.
2. The nurse shall document total PCA amount infused in mg and total number of attempts at administration every 4 hours in the EHR (See screen shot below).




1. The nurse shall clear the medication history stored on the PCA every four (4) hours, at patient hand off, and at shift change.
2. Upon discontinuation of the PCA, any unused medication remaining in the syringe shall be wasted and

documented in the Automated Dispensing Cabinet with a witness (see policy PH.88 Controlled Substances).

E. Management of Change in Condition

1. The nurse shall troubleshoot and provide interventions as indicated.
2. Emergent situations (e.g., severe respiratory depression: RR <7, SpO2<85%, ETCO2 ≥ 60 mmHg, or unresponsive patient)
    a. Stop the infusion. Do NOT leave the patient unattended.
    b. Immediately check the patient's O2 saturation, ETCO2, blood pressure, and heart rate.
    c. Notify the ~~LIP~~LP.
    d. Call a Rapid Response or CODE Blue if indicated.
    e. Assemble manual resuscitation bag/mask; attach to oxygen flowmeter; and turn flowmeter to greater than 15 liters; provide manual breaths if appropriate.
    f. Re-assess every hour x 12 hours: RR, O2 saturation, pain score, and level of consciousness.
    g. Check PCA pump for drug total and programmed settings once patient is stable.
3. Urgent situations
    a. Inadequate pain control
        i. Check the tubing connection for looseness and wetness.
        ii. Check the IV catheter site for patency and signs of infiltration.
        iii. Check the PCA pump.
    b. Respiratory depression
        i. Check the nasal cannula for disconnect from the flowmeter.
        ii. Check the PCA pump.
        iii. Assess lung capacity. Have the patient use an incentive spirometer if able.
    c. Somnolence
        i. Check the PCA pump settings and total dose infused.
        ii. Review level of consciousness trend over the past 24 hours and notify the LIP of declining condition.
    d. Severe itching unrelieved by ordered as needed (PRN) medication.
    e. Excessive nausea unrelieved by ordered PRN medication.
4. The PCA pump and ETCO2 module is programmed with PCA alarms and pause functionality (See Table 5). Once paused, the PCA pump will require clinical assessment to restart. That is, the PCA pump will not automatically resume regardless of the ETCO2 module readings.

| Table 5. PCA pump and ETCO2 module settings | |
|---|---|
| **PCA Alarm setting** | **Value** |
| EtCO2 High (mmHg) | 60 mmHg |
| EtCO2 Low (mmHg) | 10 mmHg |
| RR High (bpm) | 48 |
| RR Low (bpm) | 7 |
| No breath delay (sec) | 30 seconds (sec) |
| FiCO2 High (mmHg) | 10 |
| **PCA Pause Protocol** | **Value** |
| *RR Lower Limit (bpm)* | *5* |
| Initial value (bpm) | 6 |

## References

1. Beware of Basal Opioid Infusions with PCA Therapy. ISMP. 3/12/2009. https://www.ismp.org/resources/beware-basal-opioid-infusions-pca-therapy. Accessed 11/1/2021.

All revision dates: 6/11/2025, 8/23/2022, 6/29/2018, 11/1/2017, 1/1/2017, 4/1/2016, 8/1/2015, 4/1/2014, 1/1/2014, 4/1/2012, 10/1/2011, 12/1/2004, 12/1/2001, 12/1/1998, 10/1/1995, 2/1/1995, 2/1/1992

## Attachments

Attachment A: Alaris™ System with Guardrails™ Suite MX
b64_b8cbd48d-3132-4aa5-a54d-ceb6565771ac

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 7/25/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 7/10/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 7/10/2025 |
| Policy Owner | Sul Jung: Associate Director of Pharmacy Services | 7/10/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *12/14/2021* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *12/14/2021* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Patricia Bollendorf-Perez: Pharmacy Supervisor* |
| **Policy Area:** | *Pharmacy Services* |
| **References:** | |

# 100.259 Vinca Alkaloid Administration By Minibag

## Policy:

This policy establishes the requirements for prescribing, preparation, dispensing, transport and administration of vinca alkaloids to ensure safe administration and eliminate the risk of wrong route administration. This policy will be used in conjunction with Policy 100.251 Administration and Extravasation of Antineoplastic Agents.

## Definition and Purpose:

Vinca alkaloids (vinBLAStine, vinorelbine, vinCRIStine) can cause fatal neurological effects if given by the intrathecal route. The Food and Drug Administration updated the product labeling of vinCRIStine to indicate that it should be administered ONLY in mini-bag, not in a syringe.

A prevention strategy that reduces the risk of accidentally administering vinca alkaloids via the intrathecal route is to dilute the drug in a mini-bag that contains a volume that is too large and creates a mechanical barrier for intrathecal administration. There have been no reports of accidental administration of a vinca alkaloid by the intrathecal route when dispensed in a mini-bag.

This standard is supported by The Joint Commission, the Institute for Safe Medication Practices, the American Society of Clinical Oncology, the Oncology Nursing Society, the National Comprehensive Cancer Network, and the World Health Organization.

## Procedures:

## Prescribing

Vinca alkaloids shall only be prescribed by clinicians with appropriate skills, training and qualifications in the management of cancer.

## Preparation and Dispensing

Vinca alkaloids shall only be prepared and dispensed by appropriately trained staff that have been assessed as competent to prepare and dispense chemotherapy.

Vinca alkaloids shall NOT be prepared at the same time in the same location as medications that are intended

for intrathecal administration.

Vinca alkaloids shall be prepared and supplied in a mini-bag of compatible solution, never in a syringe.

- For all adult patients, vincristine and other vinca alkaloids shall be prepared and supplied in a mini-bag containing a total volume of 50mL or more.
- For pediatric patients vincristine and other vinca alkaloids shall be prepared and supplied in a mini-bag containing a total volume of 25mL or more.

For pediatric patients where an individual risk assessment has determined that infusion with a 25mL mini-bag is problematic, the vinca alkaloid mini-bag may be attached to an infusion assist device comprised of a 3-way stopcock and a 50 mL syringe.

- This includes pediatric patients with slow flow rate, small bore venous access or difficulty getting blood return on safety measures

All vinca alkaloids shall be labeled clearly with the warning "FOR INTRAVENOUS USE ONLY – FATAL IF ADMINISTERED BY ANY OTHER ROUTE"

# Distribution and Transport

Vinca alkaloids shall be transported by pharmacy staff who are aware of the potential hazards and the procedures to follow in the event of a hazardous spill.

Chemotherapy intended for intravenous administration, including vinca alkaloids, shall never be dispensed or transported with chemotherapy intended for intrathecal administration.

Vinca alkaloids shall never be sent to procedural areas where lumbar punctures occur.

# Administration

Vinca alkaloids shall never be administered intrathecally.

Vinca alkaloids shall only be administered by appropriately trained staff who have been assessed as competent to administer chemotherapy.

Staff administering vinca alkaloids shall be aware of the risk of extravasation and ensure procedures for preventing, monitoring, and treating extravasation are followed. Please refer to policy 100.251 Administration and Extravasation of Antineoplastic Agents.

- Administration of VINCA ALKALOIDS (VESICANTS) shall be by short term mini-bag infusion via peripheral line or central line.
- 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.
- This policy does not address continuous IV infusion (CIVI): **CENTRAL LINE ONLY** of vinCRIStine and other vinca alkaloids.

# Compliance

Adherence to this policy is essential to ensure safe and appropriate use of all vinca alkaloids.

Any instances of noncompliance to this policy shall be reported through the health care agency's approved notification system.

Training records of staff should be audited for competency.

All revision dates: 12/14/2021

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Pharmacy Services | Patricia Bollendorf-Perez: Pharmacy Supervisor | 6/4/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 11/12/2024 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *4/18/2022* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *4/18/2022* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Matt McGill: Director, Imaging Services* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.262 MRI Infusion Pump

## Policy

Ventura County Medical Center (VCMC) shall safely administer prescribed Intravenous (IV) fluids and medications to patients during Magnetic Resonance Imaging (MRI) scans by use of a MRI compatible IV smart pump.

## Scope

This policies applies to patients requiring continuous medication infusions during MRI.

## Procedure

A. The MRidium MRI Infusion System shall be used to deliver prescribed IV fluids and medications to patients receiving MRI scans.
   1. Patients requiring more than six continuous medication infusions during MRI scan require a discussion about the necessity and urgency of the MRI with the Licensed Independent Provider (LIP).
   2. For a complete list of medications in the MRI drug library see Attachment A - MRI Dose Error Reduction Software (DERs).

B. The system is for use by licensed medical personnel and is not intended for long term patient care outside of a MRI environment.

C. The infusion pump and related supplies are housed in the MRI department.
   1. Department staff from the patient's nursing unit will retrieve the pump and the MRidium IV sets from the MRI department
   2. Only MRidium IV sets shall be used with the MRI pump.

D. Transition of continuous medications to the MRidium Infusion System shall occur on the Nursing Unit prior to and after their procedure.
   1. An independent double check is required (see policy PH.70 High Alert Medications).
   2. Department staff from the patient's nursing unit shall return the MRI pump to the MRI department.

E. The MRI department will inspect the MRI pumps for physical damage and will clean the MRI pumps after each use as per manufacturer's instructions for use. See policy 106.061 Cleaning and Disinfection of

Patient Care Equipment

# Reference guides

A. MRI Pump Drug Library (see Attachment A)

B. MRI Pump DERs Quick Reference Card (see Attachment B)

C. MRidium 3860+ MRI Infusion Pump Reference Guide (Attachment C)

D. MRidium 3860+ MRI Infusion Pump Quick Reference Guide (see Attachment D)

E. MRidium IV Set Flyer (see Attachment E)

# Supplies

A. MRidium 3860 Infusion Pump

B. MRidium IV Pump SideCar

C. IV tubing Set (May only need one of the sets listed below

   1. MRidium MRI Infusion Set (Ref 1056)
   2. MRidium MRI IV Extension Set (Ref 1058)
   3. MRidium Syringe Adaptor Set (Ref 1057)

D. Non-magnetic IV pole

E. Wireless remote control

F. DERs (dose error reduction software) Library Card

# References

1. Mridium 3860+ MRI Infusion/Monitor System Operation Manual. Ref 1138, Release 4D, 2017-05. IRadimend Corporation.

All revision dates: 4/18/2022

## Attachments

- Attachment A - MRI Pump drug library
- Attachment B - MRI Pump DERs Quick Reference Card
- Attachment C - MRidium 3860+ MRI Infusion Pump Reference Guide
- Attachment D - MRidium 3860+ MRI Infusion Pump Quick Reference Guide
- Attachment E - MRidium IV Set Flyer

## Approval Signatures

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

| Step Description | Approver | Date |
|---|---|---|
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/2/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 6/2/2025 |
| Policy Owner | Matt McGill: Director, Imaging Services | 6/2/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *6/6/2022* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *5/28/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sara Pendleton: Medication Safety Officer* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# 100.263 Intramuscular Methotrexate For Ectopic Pregnancy

# Policy:

- Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) appropriately treats confirmed ectopic pregnancies, ensuring optimal outcome for patients and decreasing the risk of ectopic rupture.
- The scope of this policy and procedure is to establish the safe and effective use of intramuscular (IM) methotrexate. In addition, it is an educational tool for Pharmacists in the preparation and non-chemo certified Nurses in the administration of IM methotrexate.
- Nursing staff who is pregnant or nursing will not administer the medication.
- Methotrexate is a folate antimetabolite that blocks nucleotide synthesis thus affecting DNA repair and cell replication. As a result, active proliferating tissues such as trophoblastic tissue are targeted.
- Methotrexate for ectopic pregnancy should be provided as urgent priority as appropriate.
- Pharmacy shall prepare the sterile methotrexate syringe for administration through a closed system transfer device (CSTD) thus minimizing hazardous drug exposure.

## Indications

According to the American College of Obstetricians and Gynecologists' Committee

Medical management of ectopic pregnancy can be considered for women with a confirmed or high clinical suspicion of ectopic pregnancy who are hemodynamically stable, who have an unruptured mass, and who do not have absolute contraindications to methotrexate. These patients generally also are candidates for surgical management. The decision for surgical management or medical management of ectopic pregnancy should be guided by the initial clinical, laboratory, and radiologic data as well as patient-informed choice based on a discussion of the benefits and risks of each approach. Women who choose methotrexate therapy should be counseled about the importance of follow-up surveillance.

## Contraindications

A. Allergy or sensitivity to methotrexate

B. Intrauterine pregnancy

C. Immunodeficiency

D. Hepatic, renal, or hematologic disease or disorder

E. Active pulmonary disease. *Asthma does not exclude patients from methotrexate*.

F. Active peptic ulcer disease

G. Breastfeeding

H. Ruptured ectopic pregnancy

I. Hemodynamically unstable patient

J. Inability to participate in follow-up

### Relative Contraindications

Relative contraindications indicate the potential for reduced effectiveness of methotrexate in certain settings.

A. Gestational sac >4 cm

B. Embryonic cardiac motion

C. High initial hCG concentration

D. Refusal to accept blood transfusion

### Potential Risks

A. Ectopic pregnancy rupture

B. Potential for fetal death or teratogenic effects

### Side Effects

A. Gastrointestinal issues (e.g., nausea, vomiting, stomatitis)

B. Vaginal spotting

C. Abdominal pain

D. Less common side effects include elevated liver enzymes, alopecia (rare), and pneumonitis.

# Procedure:

## Equipment

A. Methotrexate syringe with CSTD prepared by Pharmacy

B. Chemo gown

C. Chemo gloves

D. Black Resource Conservation and Recovery Act (RCRA) container

E. Chemotherapy transport bag

F. Appropriate needle for IM administration

G. Yellow chemotherapy trace waste container

H. Hazardous drug spill kit

## Responsibilities

### Licensed ~~Independent~~ Practitioner (~~LIP~~LP)

A. All orders must be entered via the electronic health record.

B. Lab orders: CBC, platelets, CMP, type and screen, and serum quantitative human chorionic gonadotropin (hCG)

C. Premedication with an anti-emetic regimen may be indicated

D. Methotrexate dosing is based on body surface areas (BSA)

1. BSA ($m^2$): √height(cm) x weight (kg)/3600
2. Single dose methotrexate regimen 50 mg/$m^2$ intramuscular (IM) x 1 (day 1)

E. Follow-up orders

1. Serum quantitative hCG on days 4 and 7
2. Outpatient OB follow-up appointment on day 7
3. Additional methotrexate doses to be determined by quantitative hCG on days 4 and7
   a. If >15% decrease then continue quantitative hCG weekly until non-pregnant level
   b. If <15% decrease between days 4-7, consider additional methotrexate 50mg/$m^2$ IM and repeat hCG level.
   c. If hCG levels plateau or increase during follow-up, consider additional methotrexate for persistent ectopic pregnancy.

## Pharmacy Dose Preparation

A. VCMC Pharmacy will prepare the methotrexate dose for IM administration

1. Confirm with nurse that the patient is ready before preparing the dose.
2. VCMC Pharmacy will prepare the methotrexate dose with the appropriate CSTD in the biological safety cabinet (BSC) and place the syringe in a chemotherapy transport bag for hand delivery to the patient's nurse.
3. Pharmacy will also dispense the following supplies with the methotrexate to the Nursing Unit
   a. Chemotherapy gown
   b. Two pairs of chemotherapy gloves
   c. Yellow chemotherapy trace waste container

B. For Santa Paula Hospital after hours need, the methotrexate dose for IM administration will be prepared by the VCMC Pharmacy as noted above and couriered to the Santa Paula Hospital Pharmacy upon opening (business hours: 0800-1630). Afterwhich, the methotrexate dose and supplies will be hand delivered to the patient's nurse.

## Nursing

A. Nursing shall confirm that patient understands post care instructions given verbally and in a handout.

B. Nursing shall confirm medication and supplies are assembled or readily available (e.g., spill kit if needed).

C. Non-chemo certified nurse may administer methotrexate IM for ectopic pregnancy.

1. Don the appropriate PPE (chemo gown and double chemo glove)
2. Perform the seven rights of safe medication administration (see policy100.025 Medications: Ordering, Administration, and Documentation)

~~**Complete an independent double check with required witness cosign on the medication**~~

~~administration record (see policy PH.70 High Alert Medications).~~

3. Attach appropriate size needle for IM administration to the CSTD Connector Luer Lock.
4. Administer IM dose. Do not expel air from the syringe or prime the safety needle.
5. Dispose of syringe and PPE in the yellow chemotherapy trace waste container.
6. Place yellow chemotherapy trace waste container in soiled utility room for Environmental Services pickup.

## Related Policies

A. PH.27.00 Hazardous Drug Overview
B. PH.27.01 Hazardous Drug Training and Safety Review
C. PH.27.02 Hazardous Drug Storage, Handling, Labeling, and Transport
D. PH.27.03 Hazardous Drug Garbing and Compounding
E. PH.27.01 Decontamination, Spill, and Waste Management
F. Policy 100.205 ~~Safet~~Safe Handling of Hazardous Medications

## References


A. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology. ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy. Obstet Gynecol. 2018 Mar;131(3):e91-e103. doi: 10.1097/AOG.0000000000002560. Erratum in: Obstet Gynecol. 2019 May;133(5):1059. PMID: 29470343.

B. NIOSH [~~2016~~2024]. NIOSH list of ~~antineoplastic and other~~ hazardous drugs in healthcare settings, ~~2016~~2024. By Ovesen JL, Sam mons D, Connor TH, MacKenzie BA, DeBord DG, Trout DB, O'Callaghan JP, Whittaker C. Cincinnati, OH: U.S. ~~Department of Health and Human Services,~~ Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication ~~Number 2016-161~~No. 2025-103 (Supersedes ~~2014-138~~2016-161), https://doi. org/10.26616/NIOSHPUB2025103

C. Product Information: methotrexate intramuscular intravenous intra-arterial injection, methotrexate intramuscular intravenous intra-arterial injection. Hospira, Inc. (per FDA), Lake Forest, IL, 2011.

D. United States Pharmacopeial Convention, Inc. <800> Hazardous Drugs-Handling in Healthcare Settings. United States Pharmacopeia National Formulary 35. Rockville, MD: US Pharmacopeial Convention, Inc., ~~2019~~2023.


All revision dates: 5/28/2025, 6/6/2022

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 5/28/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 5/28/2025 |
| Policy Owner | Sara Pendleton: Medication Safety Officer | 5/28/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

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

# 102.041 Bloodborne Pathogen Post-Exposure Evaluation & Management for Non-Employed Medical Staff

# POLICY:

This policy outlines the procedure to follow when a non-employed health care worker (HCW) at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) or an Ambulatory Care clinic is exposed to a bloodborne pathogen or other workplace exposure.

# DEFINITION(S):

**Bloodborne Pathogens (BBP)**- pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include but are not limited to Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV).

**Engineered Sharps Injury Protection (ESIP)**- Devices that include non-needle sharps or needle devices containing built-in safety features that are used for collecting fluids or administering medications or other fluids, or other procedures involving the risk of sharps injury, such as shielded or retracting needles.

**Exposure Incident**- A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

**LAB-Needle Stick Exposed Employee (NSE**)- Initial post-exposure bloodwork panel for testing exposed employee. Includes HIV 1-2 Ab/Ag EIA Reflex to Confirmatory Testing-PH Lab, Hepatitis B Surface Antibody (HBsAb), and Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C Genotype (Quest).

**LAB-Needle Stick Source Patient (NSS**)- Post-exposure bloodwork panel for testing source patient. Includes Human Immunodeficiency Virus Enzyme-STAT (HIV STAT), Hepatitis B Surface Antigen (HBsAg), and Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C Genotype (Quest).

**Occupational Exposure**- Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

**Other Potentially Infectious Materials (OPIM)**- Includes but is not limited to human body fluids (semen,

vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva during dental procedures, any other body fluid that is visibly contaminated with blood); any unfixed tissue or organ; and any cell, tissue, or organs, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV. Urine, feces, vomit, sweat, tears and saliva are not considered to be a risk for BBP transmission unless there is visible blood in them.

**Parenteral Contact**- piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

**Post-Exposure Prophylaxis (PEP)**- Medication to prevent HIV following possible exposure. Must be started within ***72 hours*** after a recent possible exposure to HIV.

# PROCEDURE(S):

## Exposed Health Care Worker Responsibilities

A. Remove all soiled clothing and perform first aid:

1. Wash the site of the needlestick or cut with soap and water.
2. Flush splashes to the nose, mouth, or skin with water.
3. Irrigate eyes with clean water, saline, or sterile irrigant.

B. Immediately notify manager/supervisor of the exposure incident. If exposure occurs after hours or on the weekend, hospital staff report to the House Supervisor.

~~Obtain printed copies of all forms and documents contained within the "Employee Form Package" tab of the *Employer's First Report of Injury Form (RM-75)* see section "C" under Manager/Supervisor/House Supervisor Responsibilities for complete list.~~

C. Non-County Employees present **within (≤) 2 HOURS** to the Santa Paula Hospital (SPH) or Ventura County Medical Center (VCMC) Emergency Department (ED) for laboratory testing & counseling on need for post-exposure prophylaxis (PEP) retroviral therapy. If source patient known, provide Medical Record Number (MRN) to ED staff.

D. Notify Medical Staff Administration of exposure incident within **3-7 days** at (805) 652-6062 **and schedule a visit with PCP for any future lab draws, establish monitoring for bloodwork results, and assess medication tolerance (if appropriate).**

~~**Provide manager/supervisor with the following forms when complete:**~~

~~1. ***Worker's Compensation Claim Form (DWC-1)*** **- Complete employee portion and return to manager/supervisor within one working day of the exposure incident.**~~

## Manager/Supervisor/House Supervisor Responsibilities:

A. Immediately meet with employee upon receiving notification of exposure incident.

B. Identify and document source individual Medical Record Number (MRN) and if available, obtain consent and arrange for source patient blood work.

1. **Ambulatory Care Clinics:** Immediately notify provider of exposure incident and provide source patient MRN. Patient provider will order **LAB- Needle Stick Source Patient (NSS**). If patient consents, labs will be drawn ***prior to source patient departure from clinic***. Transport specimen/s to VCMC Laboratory via STAT courier.

2. **VCMC/SPH:** Immediately notify ED of exposure incident at (805) 652-6168 and provide source patient MRN. ED provider will order **LAB- Needle Stick Source Patient (NSS)**. If patient consents, labs will be drawn ***prior to source patient discharge home.***

~~Provide employee with printed copies of all forms and documents contained within the "Employee Form Package" tab of the *Employer's First Report of Injury Form (RM-75)*, which can be accessed from the desktop icon link to http://myvcweb.co.ventura.ca.us/index.php/supervisor-reporting-landing-page.~~

- ~~Employee Injury Reporting Informational Handout~~
- ~~Disability & Absence Management Team Contacts Handout~~
- ~~Authorized Medical Network for Treatment of Occupational Injury or Illness Handout~~
- ~~Pharmacy First Fill Card~~
- ~~*Worker's Compensation Claim Form (DWC-1)*~~
- ~~*Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)*~~
- ~~*Application for Paid Industrial Leave (RM-67)* (if applicable)~~

C. Advise ~~employee~~medical staff to report within **(≤) 2 HOURS** to the VCMC or SPH Emergency Department for laboratory testing & counseling on need for post-exposure prophylaxis (PEP) retroviral therapy.

D. ~~Complete and submit all required notifications:~~

1. ~~Complete *Employer's First Report of Injury Form (RM-75)* and submit electronically **within 24 hours of the exposure** to alert Employee Health Services, Human Resources, and Risk Management of the incident.~~
2. ~~Instruct employee to complete "Employee Section" of the *Worker's Compensation Claim Form (DWC-1)*. **Within one working day of receipt**, complete the "Employer Section" and submit to Sedgwick Claims Administrator and Leave of Absence/Return to Work Coordinator for employee work location.~~
3. ~~Complete and electronically submit *RL Datix Report for Employee Event-Exposure to Blood/Body Fluid* **within one working day** of the exposure incident.~~

Advise medical staff to report incident to medical staff office (805)652-6062 or via email to tracy.chapman@ventura.org or CMO on call.

## ~~ED Admitting Clerk Responsibilities:~~

A. ~~Upon completion of patient registration, provide both County & Non-County employees with the *State of California Doctor's First Report of Occupational Injury or Illness (390-220)* with instructions to complete the Employee Section (#1-17). The document can be obtained on the State of California's Division of Workers' Compensation web page athttps://www.dir.ca.gov/dwc/forms/5021.pdf~~

B. ~~Ensure all County employees have also been provided a hard copy of the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* by their manager/supervisor. If employee cannot provide a copy, obtain a copy from https://vcportal.ventura.org/CEO/risk/docs/PhysiciansNoticeOfReturnToWork_ver20210309.pdf. Instruct employee to complete Employee Section (#1-17) of the form.~~

C. ~~Place the partially completed *Doctor's First Report of Occupational Injury or Illness (390-220)* and the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* on the ED chart.~~

## ED Medical Office Assistant (MOA) and/or Clerical Supervisor Responsibilities:

~~A. When ED chart is received, fax *State of California Doctor's First Report of Occupational Injury or Illness (390-220)* to Sedgwick Claims Administrator and scan a copy to Medical Records. This is required for both County & Non-County employees.~~

~~B. For County employees only, fax the *Physician's Authorization & Return to Work Report or Temporary Medical Restrictions (RM-505)* to Sedgwick Claims Administrator ***within 5 days*** of employee ED visit. Provide a hard copy to the employee and email a copy to the Leave of Absence/Return to Work Coordinator assigned to employee work location.~~

A. **Register Medical Staff to 5270 Ventura County Medical Center (Client Billing Location)**

## ED Registered Nurse (RN) Responsibilities:

~~Verify employee has completed the Employee Section (#1-17) of the *State of California Doctor's First Report of Occupational Injury or Illness (390-220)*.~~

A. Document MRN ONLY of source patient on ED chart.

B. Provide employee with educational materials from the Centers for Disease Control & Prevention (CDC).

1. *Exposure to Blood: What Health Care Personnel Need to Know*
2. *PEP 101*
3. *Occupational HIV Transmission and Prevention among Health Care Workers*

C. ED nurse or phlebotomist draws blood on exposed employee and source patient (if appropriate) in anticipation of physician order/s.

D. If Post Exposure Prophylaxis (PEP) is ordered, verify that a Comprehensive Metabolic Panel (CMP), Complete Blood Count with Differential (CBCD), & Urine Pregnancy test have also been ordered by the provider and drawn/collected on the employee.

## ED Licensed Practitioner (LP) Responsibilities:

A. Review employee medical history and medications.

B. Conduct assessment of exposed employee to determine whether post-exposure bloodwork and/or Post-Exposure Prophylaxis (PEP) is indicated.

C. Utilize the ***"EMER Post Exposure Prophylaxis (Needlestick) Powerplan"*** in Cerner to:

1. Document the source patient Medical Record Number.
2. Order **LAB-Needle Stick Exposed Employee (NSE)** on exposed employee if indicated.
3. Order Post-Exposure Prophylaxis (PEP) if indicated.

D. Order **LAB-Needle Stick Source Patient (NSS)** on source if available and not already completed by clinic provider. Source patient labs are NOT ordered through the "EMER Post Exposure Prophylaxis (Needlestick) Powerplan".

E. Contact the Infectious Disease Specialist or national resource such as the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at 1-888-448-4911 as needed for consultation.

F. Discuss treatment options with exposed employee.

G. If placing employee on Post Exposure Prophylaxis (PEP) medications:

1. Order baseline Comprehensive Metabolic Panel (CMP) and Complete Blood Count with Differential

(CBCD) through the **"EMER Post Exposure Prophylaxis (Needlestick)" Powerplan**. Urine Pregnancy test is ordered by protocol for every woman of childbearing age.

2. **Provide employee with first 7 days of treatment from VCMC/SPH Pharmacy. ~~E-prescribe~~Prescribe remaining 21-days of therapy to ~~Farmacia Estrella and instruct patient to pick up prescription. Review side effects, precautions, and drug interactions with employee.~~pharmacy of choice**

H. Refer employee to PCP for follow-up care within **3-7 working days.**

I. Provide specific discharge instructions depending on employment status and whether or not PEP was prescribed.

1. Non-County Employee, PEP not offered
2. Non-County Employee, PEP offered

## ~~Employee Health Services (EHS) Responsibilities:~~

~~A. EHS will monitor follow-up blood work in 6 weeks, 12 weeks and 6 months for employees not taking PEP. Labs will include:~~

~~1. Alanine Transaminase (ALT)~~
~~2. Hepatitis C Antibody (HCVAb) with reflex to Hep C RNA with reflex to Hep C Genotype (Quest)~~
~~3. HIV 1-2 Ab/Ag EIA with reflex to Confirmatory Testing (Public Health Lab)~~

~~B. In the event there is seroconversion, EHS will refer employee to Public Health.~~

## Safety Officer Responsibilities:

A. The Safety Officer will receive electronic notification of all exposure incidents via the *Employer's First Report of Injury Form (RM-75).*

B. Work-related bloodborne exposure incidents that meet one or more of the following requirements will be recorded on the *OSHA 300 Log* by the Safety Officer.

1. The incident requires medical treatment beyond first aid.
2. The incident results in the diagnosis of a bloodborne illness, such as HIV, Hepatitis B, or Hepatitis C.
3. The incident results in a significant injury or illness diagnosed by a physician or other licensed health care professional.
4. The incident results in loss of consciousness.
5. The incident results in death.
6. The incident results in days off work, restricted work, or transfer to another job.

C. Exposure incidents involving a needlestick or other sharps injury will also be recorded on the Sharps Injury Log, and will include the following:

1. Date and time of the sharps-related exposure incident.
2. Type and brand of the sharp involved in the incident.
3. A description of the incident including:
   - The job classification of the exposed employee
   - The department or work area where the incident occurred;

- The procedure being performed
- How the incident occurred
- The body part injured
- If the engineered sharps injury protection (ESIP) safety mechanism was or was not activated.
- If the incident occurred before action, during activation or after activation of the safety mechanism
- If the incident involved a sharp without ESIP, the employee's opinion if ESIP could have prevented the injury.

D. For any case that is later diagnosed with an infectious bloodborne disease, the Safety Officer will update the case description and classification on the *OSHA 300 Log*.
   1. The case description will identify the infectious disease.
   2. The case classification will be changed from an injury to an illness.

E. **Billing and Collections: For non-employed physicians and other licensed practitioners who are members of our medical staff, the billing department will review these charges (under 5270 Ventura County Medical Center) and waive these charges per this policy. I If professional services bills are generated, Seaside Emergency (professional fee billing) will also waive professional fees through Seaside Medical Group**

F. **For other workplace exposures involving non-employed medical staff, the medical staff office will work in collaboration with the employee health office to arrange for appropriate follow-up. When appropriate, the same billing and collections work flow noted above will be applied to additional testing and treatment upon approval from the chief medical officer of the hospitals or the chief medical officer of ambulatory care.**

# REFERENCE(S):


1. Centers for Disease Control and Prevention. (2003, July). *Exposure to Blood: What Healthcare Personnel Need to Know*. Retrieved November 29, 2022, from https://stacks.cdc.gov/view/cdc/6853.
2. Centers for Disease Control and Prevention. (2022, October*). PEP.* Retrieved November 29, 2022 from https://www.cdc.gov/hiv/pdf/library/consumer-info-sheets/cdc-hiv-consumer-info-sheet-pep-101.pdf.
3. Centers for Disease Control and Prevention. (2015, June). *Occupational HIV Transmission and Prevention among Health Care Workers*. Retrieved November 29, 2022 from https://www.cdc.gov/hiv/pdf/workplace/cdc-hiv-healthcareworkers.pdf.
4. Centers for Disease Control and Prevention. (2001, June 29). *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendation for Postexposure Prophylaxis*. Morbidity and Mortality Weekly Report (MMWR) Series, Volume 50 (No. RR-11). Retrieved November 1, 2022 from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm .
5. United States Department of Labor (n.d.). Occupational Safety & Health Administration. Standard Number 1904.7- General Recording Criteria. Retrieved December 15, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.7.
6. United States Department of Labor (n.d.). Occupational Safety & Health Administration. Standard Number 1904.8- Recording Criteria for Needlestick Sharps Injuries. Retrieved December 15, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.8.
7. United States Department of Labor (n.d.). Occupational Safety & Health Administration. *Standard Number*

*1910.030- Bloodborne Pathogens*. Retrieved November 1, 2022, from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030.

All revision dates:

## Attachments

BBP Exposure Response Poster.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Staff Office | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medical Staff Office | Minako Watabe: Chief Medical Officer, VCMC & SPH | 8/21/2025 |
| Policy Owner | Minako Watabe: Chief Medical Officer, VCMC & SPH | 8/21/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *6/1/1980* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/10/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Vibha Gune: HIM Manager* |
| **Policy Area:** | *Administrative - Operating Policies* |
| **References:** | |

# 107.005 Medical Abbreviations

# POLICY:

Ventura County Medical Center (VCMC) /Santa Paula Hospital (SPH) and Ambulatory Care (AC) clinics will use standardized abbreviations, acronyms and symbols in the medical record.

# PROCEDURE:

1. VCMC, SPH, and AC clinics will use the Medical Abbreviations electronic web version as reference for approved and unapproved abbreviations. Facility specific "Do Not Use List" (attachment A) and "Regional Organizational Abbreviations List" (attachment B) are also available on the Medical Abbreviations electronic web version.
2. If multiple definitions are possible for an abbreviation, the intended definition must be clear and unambiguous in the context of its use to any reader of the medical record.
3. Unapproved abbreviations must not be used in any form, whether upper or lower case, with or without periods in the medical record.
4. The "Do Not Use List" will be reviewed annually or as necessary by the Health Information Management (HIM) Committee.
    a. If an unapproved abbreviation is used, nursing will call the Physician or Licensed ~~Independent~~ Practitioner (~~LIP~~LP) for clarification of the order. The order will not be carried out until that clarification is made. ~~The Medical Staff office will track and report those LIPs who have written an unapproved abbreviation and will work closely with the LIPs to eliminate the recurrence of such use.~~

    ~~Concurrent and closed record audits will be ongoing and the results reported to the HIM Committee and the Chief Medical Officer.~~

All revision dates: 8/10/2025, 6/21/2022, 1/8/2020, 4/16/2019, 2/12/2019, 8/7/2018, 4/1/2008, 7/1/2006, 5/1/2006, 7/1/2004, 2/1/2004, 8/1/2001, 4/1/1995, 10/1/1992, 7/1/1986, 5/1/1985, 7/1/1984, 5/1/1983, 5/1/1982

## Attachments

Attachment A - Do Not Use List

Attachment B - Approved Regional Organizational Abbreviation List

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Health Information Management Committee | Vibha Gune: HIM Manager | 8/10/2025 |
| Health Information Management | Vibha Gune: HIM Manager | 8/10/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *8/12/2025* |
| **Effective:** | *8/12/2025* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *N/A* |
| **Next Review:** | *2 years after approval* |
| **Owner:** | *Tess Slazinski: Clinical Nurse Specialist, Critical Care* |
| **Policy Area:** | *Administrative - Nursing* |
| **References:** | |

# 108.060 Cardiac Monitoring/Intrahospital Transport/Alarms Management Clinical Guidelines (Nursing)

# Purpose:

To provide guidelines for patient cardiac monitoring/intrahospital transfer/alarm(s) management.

# Guidelines:

Cardiac Monitoring--Divided into 3 sections (VCMC Centralized Telemetry Monitoring for units supported by centralized monitoring)

1. **Section One:** Cardiac monitoring for VCMC Adult Intensive Care Unit (ICU)/Post Anesthesia Unit (PACU)/Emergency Department (ED)
2. **Section Two:** Cardiac Monitoring for Pediatrics/Pediatric Intensive Care Unit (PICU)/Neonatal Intensive Care Unit (NICU)/VCMC ED
3. **Section Three:** Cardiac Monitoring for SPH Definitive Care Unit (DOU)/Telemetry (Tele)/Post Anesthesia Care Unit (PACU)/Emergency Department (ED)

## Section One: Cardiac monitoring for VCMC Adult ICU/ PACU/ED:

1. **Qualified Personnel - Cardiac Monitoring:**
    a. Qualified personnel includes a Registered Nurse (RN) who has:
        i. Completed a basic ECG course and passed the VCMC/SPH approved ECG examination
            - ECG written test is required for all new hires
            - A score of at least 80% is required to pass
            - Missing more than one lethal ECG rhythm will result in a non-passing score
            - Clinical nursing staff have two attempts to pass the ECG written test
        ii. Completed annual competency of ECG identification (determined by each respective unit)
2. **Requirements for cardiac monitoring:**

a. Adult ICU/PACU: all patients require ECG monitoring

b. ED: any patient presenting to the ED with clinical necessity determined by the physician and/or RN

3. **Procedure:**

   a. Verify physician order

   b. Attach patient electrodes to the patient, utilizing the bedside monitor default leads placement, II and V1 (see Lippincott Procedures: Cardiac Monitoring and AACN Procedure Manual)

      i. If artifact is present from V1, then MCL may be utilized by the RN

   c. Ensure the ECG tracing from the bedside and central station does not include artifact

   d. Default heart rate alarm settings are standardized as follows:

      i. Adult: Upper range: 130 bpm; lower range: 50 bpm

   e. Heart rate alarm limits exceptions:

      i. Heart rate alarm limits may be changed by the bedside RN, without an physician order, if the clinical condition warrants

      ii. RN notifies provider

      iii. RN to change alarm parameter back to default if clinical justification(s) is resolved

   f. Frequency of ECG rhythm strip documentation: upon admission, transfer into unit, every 12 hours, and prn (acute rhythm changes)

   g. Provide and document patient education

4. **Arrhythmia Notification**

   a. RNs are required to:

      i. Notify the physician with rhythm changes

      ii. Implement and document ordered interventions

      iii. Refer to the Code Blue policy for cardiopulmonary arrest

5. **Patient refusal** (unit responsibility): if a patient/family refuses cardiac monitoring the physician will be notified, and a discussion will occur.

# Section Two: Cardiac Monitoring for Pediatrics/PICU/ NICU/VCMC ED:

1. **Qualified Personnel - Cardiac Monitoring**

   a. Qualified personnel include an RN who is: PALS/NRP certified

2. **Requirements for cardiac monitoring:**

   a. all patients in the PICU and NICU settings require ECG monitoring

3. **Procedure:**

   a. Verify physician order

   b. Attach patient electrodes to the patient, utilizing the bedside monitor default lead placement, II and V1 (see Lippincott Procedures, cardiopulmonary status monitoring, pediatrics, and cardiopulmonary status monitoring, neonatal)

i. If artifact is present in V1, then MCL may be utilized by the RN without an physician order

4. **Ensure the ECG tracing is clear and achieved at the bedside**
5. **Default heart rate alarm settings are standardized as follows:**
   a. Pediatrics/PICU: upper range: 160 bpm; lower range: 75 bpm
   b. NICU: upper range: 200 bpm; lower range: 100 bpm
   c. Heart rate alarm limits exceptions:
      i. Heart rate alarm limits may be changed by the bedside RN if condition warrants. A notification to the phsyician and order from the physician needs to be obtained.
   d. Frequency of ECG rhythm strip documentation: upon admission into unit, transfer, every 12 hours, and prn (acute rhythm change)
   e. Provide patient/family education
6. **Arrhythmia Notification**
   a. RNs are required to:
      i. Notify the physician with new rhythm changes and/or symptoms
      ii. Implement and document ordered interventions
      iii. Refer to the Code Blue policy for cardiopulmonary arrest
7. **Patient refusal** (unit responsibility)
   a. If patient/family refuse cardiac monitoring the physician will be notified, and a discussion will occur.

# Section Three: Cardiac Monitoring for SPH DOU/Tele/ PACU/ED:

1. **Qualified Personnel - Cardiac Monitoring:**
   a. Qualified personnel includes a Registered Nurse (RN) who has:
      i. Completed a basic ECG course and passed the VCMC/SPH approved ECG examination
         - ECG written test is required for all new hires
         - A score of at least 80% is required to pass
         - Missing more than one lethal rhythm will result in a non-passing score
         - Clinical nursing staff have two attempts to pass the written ECG exam
      ii. Completed annual competency of ECG identification (determined by each respective unit)
2. **Requirements for cardiac monitoring:**
   a. *DOU/Tele/PACU*: all patients require ECG monitoring
   b. ED: any patient presenting to the ED with clinical necessity determined by the physician and/or RN
3. **Procedure:**
   a. Verify physician order
   b. Attach patient electrodes to the patient, utilizing the bedside monitor default leads placement, II and V1 (see Lippincott Procedures: Cardiac Monitoring and AACN Procedure Manual)

i. If artifact in V1, then MCL may be utilized by the RN with a provider order

c. Ensure the ECG tracing does not have artifact

d. Default heart rate alarm settings are standardized as follows:

i. **Adult**: Upper limit = 130 bpm; Lower limit = 50 bpm

ii. **Pediatrics (ED)**: Upper limit = 160 bpm; Lower limit = 75 bpm;

iii. **Neonatal (ED)**: Upper limit = 200 bpm; Lower limit = 100 bpm

e. Heart rate alarm limit exceptions:

i. heart rate alarm limits may be changed by the bedside RN, with an physician order, if clinical condition warrants

ii. RN documents physician notification

iii. RN to change alarm parameter back to default if clinical justification(s) is resolved

4. **Arrhythmia Notification**

a. RNs are required to:

i. Notify the physician with rhythm changes

ii. Implement and document ordered interventions

5. **Patient/family refusal**

a. if a patient/family refuses cardiac monitoring the physician will be notified, and a discussion will occur

# Intrahospital Transport

A. See VCMC Centralized Telemetry Monitoring policy for units that are supported by centralized telemetry

B. **VCMC** Adult ICU/ED/PACU/Pediatrics/PICU/NICU and **SPH** ED/DOU/Tele/PACU:

1. RN competency:

a. All RNs require ACLS/PALS/NRP for their respective areas

i. AHA algorithms may be utilized by RN staff for the management of lethal dysrhythmias during intrahospital transport

2. RN to accompany patient during intrahospital transport

3. Patient preparation: assemble the following equipment:

a. ECG monitor

b. Oxygen tank/ambu bag/mask (if receiving supplemental oxygen or mechanical ventilation)

c. Respiratory therapist (RT) to accompany ALL mechanically ventilated patients; utilize portable ventilator

***NOTE:** if ambu bag is utilized during intrahospital transport; only RN/RT/physician to perform

4. Notifies other appropriate personnel (e.g., physician/charge nurse/RRT/APP) to provide additional assistance during transport, as necessary

5. Attach patient to monitoring equipment and ensure that all equipment is operational prior to transport (e.g., HR volume must be turned on)

a. Ensure patient's bedside telemetry monitor remains intact until portable monitor is attached and operational

b. Baseline physiological parameters such as ECG, BP, HR, EtCO2 (intubated patient), and pulse oximetry will be monitored. Additional monitoring may be required for transport (e.g., arterial line, ICP, etc.)

c. Any patient with an arterial line is also required to transport with a NIBP cuff

d. The ECG monitor needs to be visible for the RN who is transporting the patient

6. RN to perform line checks prior to, during, and upon unit return

# Alarms Management

A. Clinical alarms management committee

1. Multidisciplinary clinical alarms management committee will meet, as needed, to discuss the following:

a. Clinical alarms management priorities

b. Updates in alarm settings, operation, and signal audibility

i. Alarm maintenance and testing (Biomedical team) per manufacturer's recommendations

c. Warranted educational topics with clear advice on expected actions

d. Data collection to measure, assess, and improve organizational processes

e. Disabling medical equipment/device alarms

i. Alarm changes/updates to be approved by clinical nursing representatives

# References:


- AACN Procedure Manual for Critical Care, (2024), 8th Edition.
- Albanowski, K., et al. (2023). Ten years later, alarm fatigue is still a safety concern. *AACN Advanced Critical Care, 34*(3), 189-197. https://doi.org/10.4037/aacnacc2023662
- American College of Cardiology/American Heart Association: Update to Practice Standards for Electrocardiographic Monitoring in Hospital Setting. (2017).
- Chromik, J., et al. (2022). Computational approaches to alleviate alarm fatigue in intensive care medicine: A systematic literature review. *Frontiers in Digital Health, 4.* https://doi.org/10.3389/fdgth.2022.843747
- Lippincott Procedures: Cardiac monitoring (2024).
- Lippincott Procedures: Pediatric Critical Care: Cardiopulmonary status monitoring, pediatrics (2024).
- Lippincott Procedures: Neonatal Critical Care: Cardiopulmonary status monitoring, neonatal (2024).
- Nyarko, BA, et al. (2022). The effect of educational interventions in managing nurses' alarm fatigue: An integrative review. *Journal of Clinical Nursing, 32*. https://doi.org/10.1111/jocn.16479


All revision dates:

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 8/26/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 8/26/2025 |
| Policy Owner | Tess Slazinski: Clinical Nurse Specialist, Critical Care | 8/26/2025 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *12/1/2013* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *11/1/2016* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Cathy Deen: Adult Hem-Onc Charge Nurse* |
| **Policy Area:** | *Ambulatory Care - Adult Hematology/Oncology* |
| **References:** | |

# AC.18 Chemotherapy Home Infusion

# POLICY:

To define policies and procedures for patient chemotherapy home infusion.

# PROCEDURE:

The pharmacist shall prepare the chemotherapy dose for administration by the Oncology/Infusion Center. A chemotherapy-certified registered nurse shall carry out the oncologist order for chemotherapy home infusion. The patient shall be educated and supported for home infusion.

## Definitions:

Infusor: A portable, non-electric, disposable/single-use infusion device which has a range of twelve (12) hours to seven (7) days continuous infusion.

## Key Points:

1. Chemotherapy medications for home infusion shall only be administered through a central line.
2. Physician's order shall include:
    a. Chemotherapy dose
    b. Duration of infusion
3. Personal Protective Equipment (PPE) shall be worn during initiation and discontinuation of chemotherapy infusion.

## Equipment:

1. Normal saline 10mL syringe
2. Injection cap
3. Chemotherapy in infusion pump with attached tubing--primed with normal saline (NS)
4. Carrying case with contents to include gloves, extra plastic bag, and infusion pump information sheet
5. PPE - gown and gloves
6. Alcohol wipes

## Patient Preparation:

1. Explain procedure and confirm with patient his/her planned treatment based on their age, individual beliefs, language preference, education level, race, gender, ethnicity, religion, physical or emotional disabilities and family structure.
2. Pre-infusion assessment:
    a. Use two (2) patient identifiers and place identification armband.
    b. Vital signs should include: temperature, pulse, respirations, height and weight, and blood pressure pre and post infusion.
    c. Allergy history.
    d. Review physician order
    e. Tolerance of previous therapy.
    f. Pain assessment.
    g. Vascular Access Device (VAD) assessment.
    h. Review infusion pump information sheet. RN to sign and give one copy to patient and scan one copy into Electronic Health Record (EHR) medication list.

## Procedure Steps:

1. Perform proper hand hygiene.
2. Review chemotherapy dose, route, time interval, cycle number, BSA and dose calculation, recent labs and order with Pharmacist or prescriber.
3. Prepare central line or implantable vascular access device per policy.
4. Don chemotherapy gown and gloves.
5. Prior to administration at chair side two chemotherapy certified nurses will:
    a. Verify patient identification using two (2) patient identifiers.
    b. Verify accuracy of drug name, dose, volume, rate, route, expiration dates/time and appearance and physical integrity of the drugs.
6. Place chemotherapy and supplies on surface protected with a disposable, absorbent/fluid resistant pad (chux).
7. Place absorbent pad under site of projected administration.
8. Cleanse injection cap with alcohol wipes.
9. Check CVC for blood return and flush with 10-20mL normal saline.
10. Open the closing cone of the patient connector.
11. Connect the patient connector of the pump to the patient’s venous access device.
12. Ensure the flow restrictor is taped on the patient’s skin.
13. Make sure the filter is not covered by any dressing.
14. Open the clamp for starting the infusion.
15. Place infusor in carrying case.

16. Patient to return after completion of infusion. RN to disconnect infusor and flush VAD with10mL NS and dispose of infusor in chemotherapy waste container.

## Patient Education:

The nurse shall educate the patient on the following:

1. First aid measures if the infusor leaks or breaks -
    a. Skin exposure: Remove contaminated shoes and clothing and cleanse affected area(s) thoroughly by washing with mild soap and water. If irritation or redness develops and persists, move away from exposure and into fresh air. Flush eyes with clean water and seek medical attention.
    b. Eye exposure: If irritation or redness develops, move away from exposure and into fresh air. Flush eyes with clean water and seek medical attention.
    c. Inhalation: If respiratory symptoms develop, move away from exposure and into fresh air. If symptoms persist, seek medical attention.
    d. Ingestion: If swallowed, seek emergency medical attention.
2. Spills: A home chemotherapy spill kit is given to every patient at the time of their first treatment with the infusor. Instruct the patient and demonstrate on the proper use of the home spill kit. Teach the patient to follow the instructions inside the spill kit if needed at home.
3. Keep the injection site as still as possible. Avoid strenuous activity or anything that requires you to frequently move around.
4. Avoid direct sunlight on the infusion pump. Sunlight may cause the medicine to not work as well. Use a carrying case at all times to protect the pump and the medication.
5. Avoid temperature extremes. Exposing the mediation infusor to very hot or very cold temperatures can cause the medicine to run faster or slower, and cause the medication to deteriorate.
6. Bathing: Do not get the pump or the injection site wet. Use extreme caution when taking a shower or bath.
7. Extravasations. If there is swelling, redness or pain at the injection site, the patient should clamp the tubing to stop the infusion and contact the clinic as soon as possible.
8. Medication: Provide the patient with the “Patient Information - Infusion Pump” document/teaching tool.
9. Point of contact: Instruct the patient to call the clinic with any problems/questions during normal business hours, and the VCMC Inpatient Pharmacy after hours.
10. At the completion of infusion, instruct the patient to return to the Oncology/Infusion Center.

## Documentation:

Document in the EHR:

1. Vital signs, height and weight.
2. Medication dose, infusion time, route.
3. Two chemotherapy-certified RNs to verify dose, physician order and two (2) patient identifiers.
4. VAD assessment.
5. Patient tolerance.
6. Patient education to include patient and RN signed “infusion pump information” sheet.

## Infection Control:

1. All health care workers should observe Standard Precautions and routinely use PPE as appropriate barrier precautions.
2. Two (2) pairs of chemotherapy-tested gloves should be worn for all hazardous drug handling activities.
3. Chemotherapy gowns shall be worn during the following: compounding, administration, disconnection, disposal of hazardous drugs, spill clean-up, and handling excreta.
4. Respiratory protection is required when cleaning hazardous drug spills or when there is a risk of exposure to aerosol or vapors through inhalation.
5. Eye protection for potential splashes.
6. Face shield shall be worn for protection against splash exposure to eyes/face.

All revision dates: 11/1/2016

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| MEC/Oversight | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| P&T Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| 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 | 4/29/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *12/1/1989* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *6/17/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Julia Feig: Nurse Director, Emergency Services* |
| **Policy Area:** | *Emergency Services* |
| **References:** | |

# ER.33 Mobile Intensive Care Nurse (MICN) Staffing in the Emergency Department

## POLICY:

To state the requirements of Mobile Intensive Care Nurse (MICN) coverage in the Emergency Department (ED) at Ventura County Medical Center (VCMC).

## PROCEDURE:

As a base station hospital, VCMC will provide 24-hour MICN coverage in the ED.

~~It is the requirement for all~~ ED Registered Nurses (RNs) working ~~at least part time~~an average of 24 hours per week or more may be invited to obtain their Ventura County MICN certification per ~~pay period to obtain within two years of hiring their Ventura County MICN certification~~the ED Director's discretion (depending on class size and ER staffing needs).

Upon completion of MICN certification, the ED Registered Nurse is expected to keep current with educational requirements and to recertify at appropriate two (2) year intervals.

For further policies and procedures, refer to the Paramedic Policy and Procedure Manual located in the Pre-Hospital Care Coordinator's office, and/or refer to Ventura County Emergency Medical Service (EMS) policies located in the Paramedic Radio Room.

## Source:

Ventura County EMS Authority

All revision dates: 6/17/2025, 1/28/2020, 12/1/2013, 12/1/2004, 1/1/1995, 10/1/1992

### Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Emergency Department Committee | Stephanie Denson: Manager, Medical Staff Office | 9/3/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 6/19/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 6/17/2025 |
| Policy Owner | Julia Feig: Clinical Nurse Manager, Emergency Services | 6/17/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/1/2009* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *5/11/2022* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Matt McGill: Director, Imaging Services* |
| **Policy Area:** | *Imaging Services* |
| **References:** | |

# IS.03 Imaging Services Medication List

# POLICY:

To provide a procedural outline for acquiring information about patient medications and to provide guidance for Interventional Radiology patient care staff in the instance of certain identified medications (as related to contrast or radiopharmaceutical administration).

# PROCEDURE:

a. This policy will be required only when contrast media, radiopharmaceuticals, or some other injectable medication is to be given.

b. The patient will be asked to list his/her medications to the best of his/her ability on the patient verification form (if the patient brings a list from home it will be noted on the verification form, but the patient will not be asked to re-list his/her medications).

c. The technologist will compare the medications that the patient has listed to the list of drugs on the modality specific medication reconciliation table.

d. If the patient is taking any of the medications on the prepared list, the technologist will take action as identified in medication reconciliation table.

e. If the patient is to receive IV iodinated contrast media, the technologist will specifically ask if the patient is taking any diabetes medication that contains metformin (see reconciliation table). If the patient is taking one of the drugs listed, or any other metformin based medication, the technologist will take action as identified on the table (the physician must order that the medication be discontinued for 48 hours following the administration of IV iodinated contrast media).

**Computed Tomography (CT)/Angiography Medication Reconciliation Table:**

| Drug | Rationale |
|---|---|
| Coumadin (warfarin)<br>Xarelto (rivaroxaban)<br>Savaysa (edoxaban)<br>Eliquis (apixaban)<br>Pradaxa (dabigatran)<br>Aspirin<br>Aggrenox (aspirin-dipyridamole)<br>Plavix (clopidogrel) | The technologist should know if the patient is taking a blood thinner to alert them to the fact that the puncture site needs **close observation** following an injection (also **may need** to wrap arm with **coban).** |

| | |
|---|---|
| Effient (prasugrel)<br>Brilinta (ticagrelor) | |
| Beta Blockers:<br>Sectral (Acebutolol)<br>Tenormin (Atenolol)<br>Zebeta (Bisoprolol)<br>Lopressor (Metoprolol)<br>Toprol (Metoprolol)<br>Corgard (Nandolol)<br>Inderal (Propranolol) | Beta blockers are a class of drugs that block beta-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Alpha Blockers:<br>Cardura (Doxazosin Mesylate)<br>Uroxatral (Alfuzosin)<br>Hytrin (Terazosin)<br>Flomax (Tamsulosin)<br>Minipress (Prazosin) | Alpha blockers are a class of drugs that block alpha-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Diabetic medications containing metformin:<br>Actoplus Met<br>Avandamet (rosiglitazone and metformin)<br>Fortamet (metformin)<br>Glucophage (metformin)<br>Glucophage XR<br>Glucovance<br>Glumetza<br>Glyburide and Metformin<br>Janumet (sitagliptin and metformin)<br>Metaglip (glipizide and metformin)<br>Metformin Hydrochloride<br>Riomet (metformin)<br>Avandamet (Rosiglitazone Maleate and Metformin) | Metformin containing medication should be temporarily discontinued at the time of the procedure or prior to the procedure for eGFR < 30 mL/min/1.72 m2 and withheld for 48 hours following the procedure and reinstitution only after the renal function has been re-evaluated and found to be normal or at baseline. Metformin is contraindicated in eGFR < 30 mL/min/1.72 m2. In the event a patient on Metformin with an eGFR < 30 mL/min/1.72 m2 has been identified, the ordering physician will be notified and it will be the responsibility of the ordering physician to address. Emergent CT will not be held regardless of metformin usage. |
| Anxiolytics (sedatives):<br>Valium (diazepam)<br>Ativan (Lorazepam)<br>Xanax (Alprazolam)<br>Klonopin (Clonazepam) | If the patient is taking a sedative to relieve anxiety about having the scan, they **must have a ride home.** (Some of these medications are prescribed for other reasons, such as to mitigate seizures. If the patient is on one of these medications long term and insists that they normally drive, contact their physician for clearance to allow them to drive themselves home.) |

**MRI Medication Reconciliation Table:**

| Drug | Rationale |
|---|---|
| Coumadin (warfarin)<br>Xarelto (rivaroxaban) | The technologist should know if the patient is taking a blood thinner to alert them to the fact that the puncture site needs **close observation** following an |

| | |
|---|---|
| Savaysa (edoxaban)<br>Eliquis (apixaban)<br>Pradaxa (dabigatran)<br>Aspirin<br>Aggrenox (aspirin-dipyridamole)<br>Plavix (clopidogrel)<br>Effient (prasugrel)<br>Brilinta (ticagrelor) | injection (also **may need** to wrap the patient's arm with **coban).** |
| Beta Blockers:<br>Sectral (Acebutolol)<br>Tenormin (Atenolol)<br>Zebeta (Bisoprolol)<br>Lopressor (Metoprolol)<br>Toprol (Metoprolol)<br>Corgard (Nandolol)<br>Inderal (Propranolol) | Beta blockers are a class of drugs that block beta-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Alpha Blockers:<br>Cardura (Doxazosin Mesylate)<br>Uroxatral (Alfuzosin)<br>Hytrin (Terazosin)<br>Flomax (Tamsulosin)<br>Minipress (Prazosin) | Alpha blockers are a class of drugs that block alpha-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Anxiolytics (sedatives):<br>Valium (diazepam)<br>Ativan (Lorazepam)<br>Xanax (Alprazolam)<br>Klonopin (Clonazepam) | If the patient is taking a sedative to relieve anxiety about having the scan, they **must have a ride home.** (Some of these medications are prescribed for other reasons, such as to mitigate seizures. If the patient is on one of these medications long term and insists that they normally drive, contact their physician for clearance to allow them to drive themselves home.) |

**Nuclear Medicine Medication Reconciliation Table:**

| Drug | Rationale |
|---|---|
| Coumadin (warfarin)<br>Xarelto (rivaroxaban)<br>Savaysa (edoxaban)<br>Eliquis (apixaban)<br>Pradaxa (dabigatran)<br>Aspirin<br>Aggrenox (aspirin-dipyridamole)<br>Plavix (clopidogrel)<br>Effient (prasugrel)<br>Brilinta (ticagrelor) | The technologist should know if the patient is taking a blood thinner to alert them to the fact that the puncture site needs **close observation** following an injection (also may need to wrap the patient's arm with **coban).** |
| Beta Blockers: | Beta blockers are a class of drugs that block beta-adrenergic substances |

| | |
|---|---|
| Sectral (Acebutolol)<br>Tenormin (Atenolol)<br>Zebeta (Bisoprolol)<br>Lopressor (Metoprolol)<br>Toprol (Metoprolol)<br>Corgard (Nandolol)<br>Inderal (Propranolol) | such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.**<br><br>Beta blockers can interfere with cardiac scans. Please refer to policy NM-802. **Contact the patient's physician before discontinuing any medications.** |
| Alpha Blockers:<br>Cardura (Doxazosin Mesylate)<br>Uroxatral (Alfuzosin)<br>Hytrin (Terazosin)<br>Flomax (Tamsulosin)<br>Minipress (Prazosin) | Alpha blockers are a class of drugs that block alpha-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Anxiolytics (sedatives):<br>Valium (Diazepam)<br>Ativan (Lorazepam)<br>Xanax (Alprazolam)<br>Klonopin (Clonazepam) | If the patient is taking a sedative to relieve anxiety about having the scan, they **must have a ride home.** (Some of these medications are prescribed for other reasons, such as to mitigate seizures. If the patient is on one of these medications long term and insists that they normally drive, contact their physician for clearance to allow them to drive themselves home.) |
| Vasodilators:<br>Aggrenox (aspirin/ dipyridamole ER - oral)<br>Persantine (dipyridamole)<br>Nitroglycerin (brand names):<br>Nitro-Bid<br>Nitro-Dur<br>Nitrostat<br>Transderm-Nitro<br>Minitran<br>Deponit<br>Nitrol<br>Isorbil<br>Sorbitate (isosorbide Dinitrate)<br>Imdur<br>Ismo<br>Monoket (isosorbide mononitrate) | These medications interfere with certain cardiac imaging studies. Please refer to policy NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Bronchodilators:<br>Xanthine (some cough medications contain xanthine) | These medications interfere with various nuclear medicine studies, including certain cardiac and thyroid imaging studies. Please refer to policy nuclear medicine-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| ACE Inhibitors:<br>Altace (ramipril) | These medications interfere with various nuclear medicine studies including certain renal imaging studies. Please refer to policy |

| | |
|---|---|
| Capoten (captopril)<br>Lotensin (benazepril)<br>Vasotec (enalapril)<br>Prinivil and Zestril (lisinopril)<br>Monopril (fosinopril)<br>Aceon (perindopril)<br>Accupril (quinapril)<br>Univasc (moexipril)<br>Mavik (trandolapril) | NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Cardiotonics:<br>Lanoxin (digoxin)<br>Crystodigin (digitalis) | These medications interfere with various nuclear medicine studies including certain cardiac (cardiac) imaging studies. Please refer to policy NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Diuretics:<br>Lasix (furosemide)<br>Demedex (torsemide)<br>Bumex (butethamide)<br>Hydrodiuril (hydochlorthiazide)<br>Zaroxolyn (metolazone) | These medications interfere with various nuclear medicine studies including certain renal imaging studies. Please refer to policy NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Narcotics:<br>Demerol (meperidine)<br>Avinza (morphine)<br>Kadian (morphine)<br>Infumorph (morphine) | These medications interfere with various nuclear medicine studies including gallbladder **(HID**A) imaging studies. Please refer to policy NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Thyroid Medications:<br>Cytomel and Triostat (liothyronine)<br>Levoxyl and Synthroid (levothyroxine) | These medications interfere with various nuclear medicine studies including certain thyroid imaging studies. Please refer to policy NM-802 for guidance. **Contact the patient's physician before discontinuing any medications.** |
| Caffeine | Caffeine interferes with various nuclear medicine studies including certain cardiac imaging studies. Please refer to policy NM-802 for guidance. |
| Radiological Contrast Media | Contrast media interferes with various nuclear medicine studies including certain cardiac imaging studies. Please refer to policy NM-802 for guidance. |

| **PT and PC Medication Reconciliation Table** | |
|---|---|
| ***If IV contrast is used for CT, refer to CT table** | |
| **Drug** | **Rationale** |
| Coumadin (warfarin)<br>Xarelto (rivaroxaban)<br>Savaysa (edoxaban)<br>Eliquis (apixaban)<br>Pradaxa (dabigatran)<br>Aspirin<br>Aggrenox (aspirin-dipyridamole) | The technologist should know if the patient is taking a blood thinner to alert them to the fact that the puncture site needs **close observation** following an injection (also may need to wrap the patient's arm with **coban).** |

| | |
|---|---|
| Plavix (clopidogrel)<br>Effient (prasugrel)<br>Brilinta (ticagrelor) | |
| Beta Blockers:<br>Sectral (Acebutolol)<br>Tenormin (Atenolol)<br>Zebeta (Bisoprolol)<br>Lopressor (Metoprolol)<br>Toprol (Metoprolol)<br>Corgard (Nandolol)<br>Inderal (Propranolol) | Beta blockers are a class of drugs that block beta-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction.<br><br>This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Alpha Blockers:<br>Cardura (Doxazosin Mesylate)<br>Uroxatral (Alfuzosin)<br>Hytrin (Terazosin)<br>Flomax (Tamsulosin)<br>Minipress (Prazosin) | Alpha blockers are a class of drugs that block alpha-adrenergic substances such as epinephrine, and can interfere with treatment to a reaction. This information should be gathered so that it is **available to the emergency response team if there is a drug reaction.** |
| Diabetic medications:<br>Insulin<br>Actoplus Met Avandamet (rosiglitazone and metformin)<br>Fortamet<br>Glipizide and Metformin<br>Glucophage<br>Glucophage XR<br>Glucovance<br>Glumetza<br>Glyburide and Metformin<br>Metformin Hydrochloride<br>Metaglip<br>Riomet | The technologist should know if the patient is diabetic and on medication. No specific action needs to be taken other than to do a blood glucose test to determine if the patient's glucose levels are within the ranges acceptable for a PET scan. Refer to policy PT-805 or PC-805. |
| Anxiolytics (sedatives):<br>Valium (diazepam)<br>Ativan (Lorazepam)<br>Xanax (Alprazolam)<br>Klonopin (Clonazepam) | If the patient is taking a sedative to relieve anxiety about having the scan, they **must have a ride home.** (Some of these medications are prescribed for other reasons, such as to mitigate seizures. If the patient is on one of these medications long term and insists that they normally drive, contact their physician for clearance to allow them to drive themselves home.) |

All revision dates: 5/11/2022, 3/21/2019, 2/1/2013

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Imaging Services | Matt McGill: Director, Imaging Services | 6/2/2025 |
| Imaging Services | Michael Hepfer: Medical Director, Imaging Services | 4/28/2025 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/21/2019* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/7/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Matt McGill: Director, Imaging Services* |
| **Policy Area:** | *Imaging Services* |
| **References:** | |

# IS.32 Nuclear Medicine Department Overview

# POLICY:

The Nuclear Medicine Department provides nuclear medicine services to the Ventura County Health Care Agency patient population and provides support to Medical Staff through the use of diagnostic procedures utilizing both stable and unstable nuclides, including the use of radioactive isotopes, neutron activation analysis, nuclear magnetic resonance (stable isotope spectrometry), therapeutic use of radionuclide from unsealed sources (radioactive colloids, Iodine-131), and other related applications based on isotope analysis. All nuclear medicine procedures shall be performed in compliance with institutional and individual license requirements.

# PROCEDURE:

## Roles and Responsibilities

### Imaging Services Manager:

The Nuclear Medicine Department is overseen by the Imaging Services Manager who is responsible for the following:

- Maintaining proper Radioactive Materials Licensure (RAML) for the Nuclear Medicine Department.
- Ensuring that all nuclear medicine procedures are performed in accordance with appropriate regulations.
- Confirming that Nuclear Medicine staff are properly licensed and qualified to perform their duties safely.
- Integration of the Nuclear Medicine Department into the primary functions of the hospital.
- Coordination and integration of interdepartmental and intradepartmental services.
- Continuous assessment and improvement of quality of care and services provided.
- Validating that nuclear medicine technologists are performing all required quality control programs, including daily quality control of cameras, and are in compliance with all other regulatory requirements.
- Orientation and continuing education of all Nuclear Medicine Department staff.
- The Imaging Services Manager, in consultation with other health professionals, shall be responsible for the development, implementation and review of Nuclear Medicine policies and procedures. These policies and procedures shall be approved by the Pharmacy and Therapeutics Committee (P&T), Medical Executive Committee (MEC) and the Oversight Committee.

### Nuclear Medicine Radiologist:[i]

The Nuclear Medicine Radiologist is responsible for:

- Interpreting all nuclear medicine examinations.
- Updating all nuclear medicine exam protocols so that the exams meet current nuclear medicine standards.
- Providing consulting services to all patients receiving I-131 treatment, including explaining the risks and benefits of I-131 treatment.
- Calculating correct isotope dosage for nuclear medicine exams.
- Nuclear Medicine Technologists, Diagnostic Technicians, Registered Nurses and the Radiation Safety Officer shall report to the Nuclear Medicine Radiologist concerning all aspects of the medical use of radionuclides, including compliance with radiation safety standards, quality control procedures, indication, procedures, and performance of studies.[v]

## Nuclear Medicine Physicist:

The Nuclear Medicine Physicist is responsible for:

- Performing all quarterly, semi-annual and annual quality control testing on gamma cameras.
- Calibrating the well counter on a semi-annual basis in compliance with State of California Title 17 regulations.

Nuclear Medicine Physicist support is available to the Nuclear Medicine Department on a consultant basis. The Nuclear Medicine Physicist is:

~~Amy L. York, MS.~~
~~York Medical Physics~~
~~22805-C Savi Ranch Parkway~~
~~Yorba Linda, CA 92887~~

David Goetsch, MS.
Therapy Physics, Inc
2501 Cherry Ave., Suite 270
Signal Hill, CA 90755

## Chief Nuclear Medicine Technologist:[ii]

The Chief Nuclear Medicine Technologist is responsible for:

- Updating exam protocols in consultation with the Nuclear Medicine Radiologist and providing the updated protocols to the Nuclear Medicine Technologists by placing them in the Nuclear Medicine Department Protocol Book.
- Performing daily quality control procedures.
- Tracking isotopes delivered from Cardinal Radiopharmacy.
- Performing daily checks of syringes, needles and other waste products that have been placed into the lead-lined decay trash receptacle to validate that they are decaying properly.[iii]

## Nuclear Medicine Technologist:[ii]

The Nuclear Medicine Technologist is responsible for:

- Performing all nuclear medicine exams, including injection of isotopes, validating that the ordered exam is appropriate, contacting the Nuclear Medicine Radiologist if there are questions about a specific exam, assist with the daily Quality control duties, are also responsible with tracking and documenting the delivery of isotopes from the Cardinal Radiopharmacy. Also assist and monitor waste products located in the lead lined decay receptacle.

- Nuclear Medicine Technologists performing peripheral venipuncture for the purpose of administering radio-tracer doses of radiopharmaceuticals shall follow the guidelines in the California Code of Regulations, Title 17, Subchapter 4.7, Article 1, section 30500 and Article 3, section 30533 (a) (2).

### Diagnostic Technician:

The Diagnostic Technician's primary duties are:

- Placing 12-lead EKG wiring harness on patients prior to treadmill examinations.
- Assisting with monitoring patients' cardiac output during treadmill examinations.
- Removing lead wires upon completion of treadmill examinations.

### Radiation Safety Officer:[iv]

The Radiation Safety Officer is responsible for:

- Providing direction on radiation safety practices.
- Knowledge related to the safe handling of isotopes.
- Quality control in the Nuclear Medicine Department.
- Knowledge of correct hot lab processes.
- Assessing Imaging Services staff dosimetry badges.
- Review of all surveys performed in the Nuclear Medicine Department.
- Proper use and maintenance of sealed sources.
- Verifying all tests and procedures are performed in accordance with the radiation materials license.
- Assisting in the event of a radiation emergency.

### Registered Nurse (RN):

The Registered Nurse is responsible for:

- Monitoring the patient's vital signs before, during and after treadmill stress tests.
- Validating that there is a valid order for all exams and medication in Powerchart.
- Obtaining all required medications from the Pyxis and injecting medications for ordered exams. Charting all medications administered in the Medication Administration Record (MAR). The RN shall return any unused medications back into the Pyxis and dispose of any leftover medication following the correct Pyxis disposal process.
- Assisting the cardiologist as needed during exams.
- The RN reports to Nursing Administration and not to the Imaging Services manager. All RN assignments to assist in the Nuclear Medicine Department are given by the Chief Nursing Officer or designee.

## Appropriateness of Nuclear Medicine Exams:

1. The appropriateness of each requested procedure is ascertained by the Chief Nuclear Medicine Technologist and/or Nuclear Medicine Radiologist prior to the initiation of the procedure. This is achieved by reviewing the patient's EHR (inpatients), history taking and/or examination (outpatients), and discussion with the referring physician when indicated.
2. The Nuclear Medicine Radiologist shall contact the patient's physician and discuss the procedure if the Nuclear Medicine Radiologist judges the procedure to be:
    - Inappropriate.
    - Less likely to produce the desired information as compared to an alternate procedure.
    - Likely to be inaccurate or suboptimal because of existing clinical factors (i.e., medications).

- Technically infeasible because of the patient's clinical condition.

3. The Nuclear Medicine Radiologist shall outline to the Nuclear Medicine Technologist all modifications or special techniques to be used for a particular procedure.
4. All organ imaging studies are inspected by the Nuclear Medicine Radiologist or Chief Nuclear Medicine Technologist for quality and information yield before the patient leaves the Department. Repeat or additional images shall be obtained as necessary.
5. Each typed report is proofread and electronically signed by the dictating Nuclear Medicine Radiologist.

## Hours of Operation:

See policy IS.23 Imaging Services Hours of Operation.

## Nuclear Medicine Department Security:

1. The Nuclear Medicine Department shall be locked during non-working hours. All radioactive material shall be confined to the locked radio-pharmacy room ("hot lab"). [vi]
2. Access to the Department shall be limited to the Nuclear Medicine Radiologists, Imaging Services Manager, and Nuclear Medicine Technologists.
3. The radiopharmacy room (hot lab) shall be restricted to Nuclear Medicine Physicist and Nuclear Medicine staff. Non-Nuclear Medicine staff, such as Housekeeping and Security Services, may enter this restricted area only under the direct supervision of Nuclear Medicine staff.

## Scope of Service:

1. Stress Tests (exercise and pharmacologic): IS.26 Pharmacologic Stress Test
2. Renal/urinary tract studies: NPP.06 Diuretic Renal Scintigraphy
3. GB/HIDA scans
4. Pulmonary perfusion/ventilation studies
5. GI bleed studies
6. Bone imaging
7. Liver/spleen imaging
8. Thyroid function imaging
9. Lymphoscintigraphy
10. MUGA scans
11. Octreotide scans
12. Tumor/abcess imaging
13. See also:
    - ER.47 Treatment of Patients with Radiation Contamination
    - IS.34 Radionuclide Accident Victims
    - CC.18 Radioactive Iodine Therapy
    - CC.19 Thallium Treadmill with Dobutamine

## Medications:

1. PH.72 Staff Authorized to Administer Medications
2. IS.03 Imaging Services Medication List
3. IS.11 Controlled Drug Access in Imaging Services
4. IS.29 Imaging Services Medication Administration

## Radioactive Materials:

- Radioactive material shall be ordered by authorized Nuclear Medicine Radiologists and/or Nuclear Medicine Technologists. Ordered materials shall not exceed the possession limits as defined by the radioactive material license.
- All areas that are designated for the use and storage of radioactive materials shall be clearly marked with the appropriate signs (“Caution – Radioactive Area” or “Caution – Radioactive materials”).[vii]
- All radioactive materials shall be confined to the radiopharmacy (hot lab)[vi] for proper storage, safe preparation, and appropriate disposal thereof. Any materials leaving the radiopharmacy shall be for administration and instrument calibration purposes only.
- The areas designated as containing radioactive materials shall be cleaned by Housekeeping only during the hours of departmental operation. (IS.30 Nuclear Medicine Department Cleaning Procedures).

## Safety:

- Portable lead shielding shall be utilized as necessary to minimize radiation exposure to other patients, staff and any instrumentation in use.
- For inpatient exams, Nuclear Medicine Technologists shall place the isotope syringe inside a lead syringe cover which shall be placed inside a lead lined transport container before entering the patient's room to inject isotopes.
- The Nuclear Medicine Technologist will speak to the RN taking care of the patient about the isotope injection and how long the patient will need to stay in their bed before they are taken to the Nuclear Medicine Department to have exam performed. Once injected, the patient shall be considered radioactive. The isotope shall take approximately 30-45 minutes to be absorbed by the patient.
- If the patient needs to use the restroom before the study, the toilet shall be flushed two times after each use.
- All outpatients shall be given instructions after the completion of their specific study on how to use the restroom at home, how long the isotope will remain in their system, to avoid holding small children, and other information as necessary for the safety of the patient and their family.
- See also IS.19 Imaging Services Radiation Dosimetry Monitoring.

## Maintenance:

- 106.035 Hazardous Materials/Hazardous Waste Management Plan
- IS.04 Biomedical Equipment Inspection and Service Records
- IS.30 Nuclear Medicine Department Cleaning Procedures

## References:


- i - Title 17 Subchapter 4.7 section 30506

- ii - Title 17 Subchapter 4.7 sections 30500, 30520
- iii - Code of Federal Regulations (CFR) Title 10: 20.2001
- iv - Title 17 Subchapter 4.7 section 30333.07
- v - Title 17 Subchapter 4.7 section 30507
- vi - Code of Federal Regulations (CFR) Title 10: 20.1801
- vii - Code of Federal Regulations (CFR) Title 10: 20.1901, CFR Title 10: 20.1902 (a)

All revision dates: 8/7/2025, 5/11/2022, 3/21/2019

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Imaging Services | Michael Hepfer: Medical Director, Imaging Services | 6/24/2025 |
| Imaging Services | Matt McGill: Director, Imaging Services | 6/2/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *12/1/2013* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *6/2/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Matt McGill: Director, Imaging Services* |
| **Policy Area:** | *Imaging Services* |
| **References:** | |

# IS.34 Radionuclide Accident Victims

# POLICY:

To outline the procedure to be followed whenever persons present to the Emergency Department (ED) for care that have been accidentally exposed to excessive ionizing radiation.

# PROCEDURE:

I. **GENERAL PROCEDURES:**

A. Immediate Notification (see also Nuclear Medicine Disaster Plan).

1. The Radiation Safety Officer at 1-805-645-2010.
2. The Radiology Department at ext. 3336.
3. The Radiation Safety Physicians:
   Dr Mark Beller
   Nuclear Medicine VCMC: 1-805-652-6080

   Dr Olga Lyass
   Nuclear Medicine 1-323-578-9230
4. Notify the appropriate authorities (see Section H below).

B. If one or two patients are involved, the Observation Room in the Emergency area will be used. If more than two patients are involved, the Family Care Center will be activated. Follow the directions of the Radiation Safety Physician and the ED physicians.

C. Persons exposed to external radiation from x-ray generators, particle accelerators, radon sources, neutron sources and sealed sources of radionuclides **without** contamination with radionuclides **are not** hazardous to others. They should be observed and treated for radiation sickness.

D. Emergency Supplies

The following supplies shall be available to the ED or designated area to treat the casualty.

1. Absorbent pads, paper
2. Surgical scrub suits, caps
3. Shoe covers, disposable gloves, and masks

4. Lab coats or surgical gowns
5. Lead aprons from Radiology
6. Film badges or pocket dosimeters (as available)
7. Plastic bags, sheets
8. Containers or barrels to hold contaminated liquid
9. Radiation survey meter (to be brought to the ED by Nuclear Medicine personnel. The meter will be checked for operating condition, re-batteries). The survey meter can detect beta and gamma radiation.
10. Signs labeled "Radioactive Material" and/or "Radiation Area."

E. Handling of the Casualty

The procedures outlined apply to persons who have had surface or internal contamination with radionuclides that are deposited on the skin, inhaled, ingested or that has entered through wounds.

1. The first principle when dealing with radioactive contamination is to prevent unnecessary spread of the contamination.
    a. The survey meter will be required for the monitoring of patients and personnel and for evaluating decontamination. However, if no monitoring equipment is available, all possible exposed persons should be regarded as contaminated.
    b. The ED will be evacuated of all non-essential personnel. They should not be allowed to return until the Radiation Safety Physician has declared the area safe.
        i. Air conditioning and ventilation will be shut down to avoid the spread of contamination. Switches are located in the utility rooms.
        ii. All extra supplies and equipment will be removed.
    c. The floor should be covered with absorbent paper to avoid contamination.
    d. Personnel doing the monitoring and triage personnel should wear protective clothing with disposable gloves, shoe covers and pocket dosimeters or film badges (as available).
2. On arrival, and preferably while still in the ambulance, the patient will be checked for contamination. Do this by making a survey with the survey instrument over the entire body with the clothes on. Internal contamination must be determined by counting urine, blood, or other specimens as the physician orders. If the patient has been exposed to external radiation exposure only and is not contaminated, the patient should be treated for trauma in the normal fashion. Follow the guidelines of the Radiation Safety Physician and attending physician for the treatment procedure.
3. All persons and articles in the area shall be considered contaminated until proven otherwise. The ambulance and ambulance driver and attendant will not be dismissed until released by the Radiation Safety Physician.

F. Decontamination

1. Remove the victim's clothing. Place clothing in a double plastic bag, label the bag "radioactive," and remove the bag to another isolated area for monitoring. Re-monitor patient.
2. Thorough cleansing of the body or affected areas should be performed. Commercially available

detergents can be used. Seal open wounds with plastic and/or waterproof adhesive tape to prevent contamination from being washed into the wounds. Shower or wash with warm water and detergent or soap, taking care that contamination from high level areas are washed off rather than spread over the rest of the body. Repeated washing may be necessary. Avoid abrading the skin.

3. Irrigate contaminated wounds with copious amounts of saline.
4. The Radiation Safety Physician (or Radiation Safety Officer) will re-survey the wound and skin areas at periodic intervals with the GM survey meter.
5. If possible, cleaning should continue until the contamination is negligible or no further diminution in radioactivity readings is achieved.
6. If there is evidence of massive exposure to external radiation or radionuclides, it may be necessary to limit any extensive medical care. Dose estimates of over 2,000 roentgens for external radiation, or over 2,000 Rems for external radionuclide contamination would indicate that little could be offered to such patients. The guidance of the Radiation Safety Physician and/or the Health Physicist is essential.
7. In treating penetrating wounds such as punctures, splinters or slivers in the skin, a small block dissection is frequently indicated. If such excision is done promptly, absorption within the body can be significantly decreased. Obviously, such therapy should be more radical for alpha emitters, other bond seekers such as 90 Sr and for millicurie or curie amounts. For microcurie quantities or shorter-lived radionuclides such as I31I, 32p, or 198 Au, more conservative therapy can be employed.
8. Place all contaminated disposable supplies in plastic bags for decay-storage and monitoring and label them. Save all specimens in containers for appropriate monitoring and storage.
9. Place all gowns and other articles of clothing of attending personnel in another bag for monitoring and storage. Monitor all personnel for radioactive contamination before they leave the control area. Decontaminate as necessary.
10. For further information, refer to "Hospital Emergency Plans for Radiation Accidents" by Irv Johnson, former Ventura County Radiological Health Physicist, dated January 1975.

G. Disposition of Patient

1. Once the patient is treated for both trauma and contamination, the patient shall be sent to the appropriate area of the health complex. The Radiation Safety Physician and the attending physician will determine what protective measures are necessary (i.e., isolation).
2. If the patient has inhaled or ingested radioactive material, special procedures for collecting urine and feces may be necessary. Follow physician's order. Save all containers of specimens for appropriate monitoring and storage.
3. Observe the patient for development of radiation effects. Administer appropriate therapy as determined by the physician.

H. Notify Appropriate Authorities

1. Notify the Office of Emergency Services (OES) at (916) ~~391-7716~~845-8911.
2. If the OES cannot be reached or the potential threat is of great magnitude, contact the Energy Research & Development Administration (ERDA) at:

Daytime: (213) 341-1120, Ext. 2774
Nights and weekends: (213) 341-2285

3. Do not make any public statements relative to the situation until cleared by the Radiation Safety Officer, Hospital Administration and appropriate agencies.

I. Records

1. Prepare a record of the accident (Radiation Safety Physician, attending physician and possible Health Physicist).
2. The following factors are useful in classifying releases of radioactivity (as known):
    a. Amount released
    b. Whether release is normal or accidental
    c. Radionuclides present
    d. Amount of radioactivity at the source
    e. Physical and chemical form of material when released
    f. Area affected
    g. Potential hazards to general public and occupational worker

J. Waste Disposal

1. All contaminated articles - disposable and non-disposable - shall be monitored and stored following the guidelines for "Radioactive Waste Disposal."

All revision dates: 6/2/2025, 3/21/2019, 2/1/2016, 10/1/2015

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| Imaging Services | Michael Hepfer: Medical Director, Imaging Services | 6/24/2025 |
| Imaging Services | Matt McGill: Director, Imaging Services | 6/2/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *12/1/1986* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/1/2015* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Pharmacy Services* |
| **References:** | |

# PH.41 The Drug Use Evaluation Program

## POLICY:

The Pharmacy Department has a criteria-based, ongoing planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help ensure that they are provided appropriately, safely, and effectively.

## PROCEDURE:

I. The Drug Use Evaluation (DUE) Program includes the routine collection and assessment of information to identify opportunities to improve the use of drugs and resolve problems in their use.

II. Drugs and drug therapies for inclusion in the DUE Program are identified in the following manner:

   A. From clinical experience, it is known that the drugs or drug therapies carry significant risk of toxicity.

   B. The drugs or drug therapies are used in patients with high risk of toxicity.

   C. The drugs or drug therapies have been identified by appropriate staff committees for DUE.

   D. The drugs or drug therapies represent considerable cost to the patient and/or institution.

   E. The drugs or drug therapies have a high frequency of use.

   F. The drugs that have been identified through our program improvement that have been identified as problematic or that have some potential for improvement.

III. Each due audit is based upon objective criteria established in cooperation with appropriate medical staff members that reflect current knowledge, clinical experience and relevant literature.

IV. Screening mechanisms are employed to identify drugs for more intensive evaluation.

V. DUE evaluations results and data shall be reviewed by the appropriate committee.

All revision dates: 8/1/2015, 11/1/1998, 12/1/1989

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/23/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/1/2009* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *8/23/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Pharmacy Services* |
| **References:** | |

# PH.88 Controlled Substances

# POLICY:

The Ventura County Medical Center/Santa Paula Hospital Department of Pharmacy Services is responsible for the acquisition, disposition and administration of all controlled substances used within this facility.

# PROCEDURE:

The Department of Pharmacy Services is legally responsible for the procurement, disposition and administration of all controlled substances used within the Hospital. Physicians, nurses, and pharmacists shall be responsible for maintaining proper records for controlled substances.

Definition of Controlled Substances

A. Controlled substances includes all drugs listed on Schedules CII, CIII, CIV, and CV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, or the California Uniform Controlled Substances Act, as amended.

B. The disposition of these medications shall be regulated as outlined in these acts.

C. Violation of these laws can lead to dismissal, license revocation, and/or criminal prosecution.

I. Procurement of Controlled Substances

   A. All orders for Schedule CII controlled substances shall be authorized by the Director of Pharmacy Services or designee (through the "Power of Attorney"). Such orders shall be completed on the Drug Enforcement Agency (DEA) form 222.

   B. All orders for Schedule CIII, CIV, and CV controlled substances may be ordered directly from drug wholesaler or direct from the manufacturer.

II. Receiving Controlled Substances

   A. All Schedule CII controlled substances received by the pharmacy shall be checked in immediately and placed in the narcotic vault.

   B. All Schedule CII controlled substances shall be received and checked in by a pharmacist.

      a. The pharmacist shall document the receipt of all CII medications on DEA Form 222, under the column titled "to be filled by purchaser".

      b. The pharmacist shall record the number of packages received, the date of shipment and the pharmacist's initials.

C. Schedule CII, CIII, CIV, and CV medications shall be placed in the narcotic vault after receiving the medications.

D. All controlled substances in the hospital shall be stored in locked conditions at all times. The Pharmacy Department shall assume overall responsibility for the storage of all controlled substances throughout the Hospital.

III. Dispensing Controlled Substances in Automated Dispensing Cabinets (ADCs)

A. See policy *PH.92 Automated Drug Cabinet Usage and Documentation*.

~~Dispensing Controlled Substances in Areas Without ADC's~~

~~A. The Department of Pharmacy Services shall utilize the Controlled Substance Requisition Sheet to issue specific quantities of controlled substances for nursing unit that are not automated.~~

~~a. Variety of controlled substances stocked on each unit, as well as the number of doses, shall be established by the Department of Pharmacy Services and Nursing Department and is to be updated as needed.~~

~~B. Nursing Narcotic Floor Stock Requisition~~

~~a. Narcotics may be requested by pre-printed Controlled Substance Administration Record (CSAR) and delivered by the Pharmacy to the requesting department or can be picked up at the Pharmacy.~~

~~b. The requesting nurse shall sign the request form, acknowledging the quantity to be ordered from the CSAR.~~

~~c. All requests shall be maintained on file for three (3) years.~~

~~C. Controlled Substance Administration Records~~

~~a. Under the appropriate medication column, the quantity dispensed shall be added to the existing inventory, such that the number recorded reflects the revised inventory of that medication.~~

~~b. The pharmacy technician and the licensed health care professional accepting the medication shall sign the appropriate line with the following information:~~

- ~~Date~~
- ~~Time~~
- ~~Medications added to inventory~~

~~D. Drug Administration using the CSAR documentation:~~

~~a. When a drug is administered to a patient, the following information and record keeping will take place.~~

- ~~Date~~
- ~~Time dose given~~
- ~~Patient's name (last name, first name)~~
- ~~Patient account number~~
- ~~Dose given~~
- ~~Amount wasted (if applicable)~~
- ~~The signature of the person administrating the medication~~

- ~~A signature of a witness if wasting a controlled substance when applicable~~

~~E. Procedure kits shall be returned to the Department of Pharmacy Services at the end of procedure~~

IV. Dispensing Controlled Substances in Adult Infusion Center

A. Dispensing of controlled substance for patients receiving treatment at the Infusion Center requires a valid prescription.

a. Controlled substance class II: Prescriber must submit a valid prescription using tamper evident security prescription pad. The prescription is valid for 30 days from the written date and for one dispense. Refills are not allowed.

b. Controlled substance class III-V: Prescriber may submit a valid prescription using tamper evident security prescription pad or called-in to the Infusion Center Pharmacy. All orally transmitted prescriptions shall be produced in hard copy form by the pharmacist receiving the order including initials of the pharmacist. This prescription is valid up to 180 days from date written or up to 6 dispenses which ever comes first.

c. Infusion Center pharmacist will transcribe the prescription order details into the electronic health record (EHR) system and label individual medication dispensed to nursing staff for patient administration during the visit. See Policy PH.55 Medication Order Management for details on labeling requirements.

d. All controlled substances (class II-V) will be kept and dispensed by the infusion center pharmacy and perpetual inventory shall be maintained.

e. All dispense must be reported to Controlled Substance Utilization Review and Evaluation System (CURES) within 24 hours of dispense.

B. No controlled substance (class II-V) shall be dispensed directly to patient for home use.

V. Nursing Administration and Documentation

A. A current physician's order for administration of controlled drugs is required prior to administration of any controlled substance.

B. Administered doses shall also be recorded on the respective patient's Medication Administration Record (MAR).

C. Discrepancies: Any discrepancy in the controlled drugs must be reported immediately to the charge nurse on duty**.** A nurse whose shift involved discrepancy shall not leave the facility until the discrepancy is resolved or thoroughly investigated. A notification form shall be completed if the discrepancy cannot be resolved.

a. The Department of Pharmacy Services shall be notified if any discrepancy cannot be accounted by nursing staff.

D. Lockboxes and portless IV tubing shall be used for the following controlled substance infusions:

a. All ~~end-of-life~~ controlled substance infusions ~~(e~~in the ICU shall be placed in a lock box and portless IV tubing used.~~g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL). See Attachment A - Lockbox and portless tubing workflow~~

b. All end-of-life controlled substance infusions (e.g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL).

c. Patient controlled analgesia (PCA) locked in the Alaris Pump PCA module

d. Epidural infusions locked into the appropriate pump

e. Other controlled substance infusions (e.g. fentanyl drip) may be placed in lockboxes with portless IV tubing at the discretion of the care team.

~~Nursing: Creating a New Controlled Substance Administration Record (CSAR)~~

~~A. At any one time, there may be up to ten numbered yellow and/or blue controlled substance administration sheets distributed to each unit/department.~~

~~B. Controlled substances shall be counted and documented each shift on the CSAR and signed by two licensed healthcare professionals.~~

~~C. A new sheet shall be prepared daily. The following information shall be recorded:~~

~~a. Previous day's sheet: On the bottom line "Ending inventory/Transfer Total" the existing inventory is to be brought down to the bottom line with the signature of the individual bringing down the inventory.~~

~~b. Transfer the existing inventory from the old sheet to the top line of the new sheet with the signature of the person creating the new sheet.~~

VI. Nursing: Discontinuation of Controlled Substance Infusion

A. In the event a controlled substance infusion is discontinued, stopped or titrated off, the nurse shall immediately perform one of the following:

a. Remove the controlled substance infusion bag from the patient room and waste the controlled substance, OR

b. Disconnect the tubing from the patient's intravenous line and secure the bag and tubing in the medication room if the nurse anticipates the controlled substance infusion may be restarted.

i. Controlled substances in a bag and tubing secured in the medication room under this circumstance shall be wasted if order is not restarted within 2 hours or at shift change, which ever is shorter.

VII. Disposal of Controlled Substances

A. Controlled substances shall be disposed of in a controlled substance waste container.

B. Disposal of controlled substances shall be performed by a licensed individual, with disposal activity witnessed by another licensed individual. Both individuals shall record all disposal/waste events in the automated dispensing cabinets in patient care areas.

C. Fentanyl Patches shall be disposed of in the following manner:

a. All fentanyl patches removed from patients shall be disposed of in such a manner to prevent the diversion of the fentanyl patches.

b. After being removed from the patient, the patches shall be folded in half so that the adhesive parts are attached together.

c. Steps A & B of this section shall be completed thereafter.

D. Pharmacy Only: Expired controlled substances which are intact may be removed from hospital premises by a reverse distributor. All controlled substances removed in this manner shall be itemized for proper documentation.

VIII. Handling of Damaged, Refused or Wasted Medications Must be Documented

A. Documenting Controlled Substance wasted from ADC's:

a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste.

b. Witness must observe the wasting and cosign in the ADC. The witness must have an existing user account.

c. Controlled Substance waste shall be rendered unusable by dumping into a locked pharmaceutical waste container and removed from the medication area in a timely manner.

~~Documenting Controlled Substance waste using CSAR:~~

~~a. All wastage shall be clearly documented on the controlled substance record.~~

~~b. Doses that are refused, contaminated, and/or a dosage other than what was ordered for administration to patients shall be considered doses not administered and shall be documented as wasted immediately.~~

~~c. The entry line on the CSAR is to include comments, indicating the following:~~

- ~~Date~~
- ~~Time~~
- ~~Patient's name~~
- ~~Chart Number~~
- ~~Dose Given~~
- ~~Amount Wasted~~
- ~~A description of the events, (i.e., wastes, refused, damaged, contaminated, unused, etc.)~~
- ~~Two health care professionals' signatures documenting waste of control has occurred~~

~~d. All items listed above shall be disposed of in the presence of a witness. The signatures of both the person administering the dose and the witness are required. The waste from controls are rendered unusable and destroyed in a locked pharmaceutical waste container.~~

~~e. For losses and thefts, see Pharmacy policy PH.23, *Reporting Controlled Substance Loss or Diversion*.~~

IX. Returned Controlled Substances

A. When narcotics are returned to the Pharmacy, the pharmacist shall verify the quantity received immediately.

a. Physical inspection shall be made of the items to be returned, particularly noticing whether vials or pre-filled syringes have been tampered or resealed.

~~An entry shall be recorded on the Controlled Substance Administration Record indicating the "return" of medications to the pharmacy. The signature of both the nurse and the licensed pharmacy staff member receiving the drug shall be recorded on the Controlled Substance Administration Record.~~

b. The returned medication shall be returned to the Pharmacy inventory.

~~If the drugs are not reusable, they shall be disposed of with a witness. The items disposed of will be itemized on the Pharmacy controlled substance disposal log.~~

~~The signature of a nurse and pharmacist or two pharmacists shall be required.~~

B. Controlled substances that are not usable shall be disposed in the appropriate controlled substance waste container and documented in the ADCs with another licensed witness.

a. If the controlled substance is wasted in the Pharmacy, Pharmacy must document waste in the Controlled Substance Waste Log with licensed witness.

C. Controlled substances may also be surrendered to a pharmaceutical waste management company for proper disposal.

X. Nursing Inventory of controlled substances

1. Two charge nurses shall complete at least weekly inventory count on ADCs of all controlled substance class II to V.

~~Two charge nurses shall complete at least weekly inventory count on CSAR for units that do not have ADCs.~~

2. If charge nurses are unavailable, any licensed nurse (RN) may perform this function.

XI. Controlled Substances for Transport

1. Controlled substances (class II to V) will not be dispensed to the emergency medical transport service, i.e. ambulance, outside hospital transport team including air transport.
2. Critically ill patients who are on a continuous infusion of any controlled substances may be transported out of the facility with the oncoming transport team to be used until they reach the final destination.
   a. Additional medication infusion bags will not be made as a spare.
   b. Additional push doses of controlled substances will not be dispensed.
   c. RN sending out the patient will reconcile the medication with oncoming transport team. The amount of medication left in the bag will be documented on the electronic health record with the name of the person who is receiving the medication.

XII. Pharmacy department will comply with Title 16 California Code of Regulation section 1715.65

A. Physical Count Inventories of controlled substances shall be performed by Pharmacist(s).
   1. C-II controlled substances shall be inventoried quarterly.
   2. C-III to C-V controlled substances shall be inventoried yearly.
   3. The inventory report shall be signed by the involved Pharmacist(s) and the Pharmacist in Charge.

B. Quarterly reconciliation report shall be prepared for the following medications and dated/signed by the Pharmacist in Charge
   1. C-II controlled substances
   2. C-IV controlled substances: alprazolam 1 mg/unit, alprazolam 2 mg/unit ,and tramadol 50 mg/unit.
   3. C-V controlled substance: promethazine with codeine 6.25 mg/10 mg per 5 mL of product

C. The inventory, quarterly reconciliation report, and records used to compile the reports shall be kept in the Pharmacy for three (3) years.

All revision dates: 8/23/2025, 1/21/2025, 12/20/2023, 8/8/2023, 6/7/2023, 3/8/2022, 11/10/2021, 11/26/2018, 10/5/2018,

5/1/2016, 5/1/2013

## Attachments

Attachment A - Lockbox and Portless Tubing Workflow

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/1/2013* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *4/1/2016* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Pharmacy Services* |
| **References:** | |

# PH.103 Tretinoin (ATRA) Inventory

# POLICY:

The Ventura County Medical Center (VCMC) Inpatient Pharmacy shall always stock Tretinoin capsules for emergency induction treatment of patients with acute promyelocytic leukemia.

# PROCEDURE:

A. Tretinoin, also known as all-trans retinoic acid, or ATRA, is used to induce remission in patients with acute promyelocytic leukemia (APL), French American British (FAB) classification M3 (including the M3 variant) characterized by t(15;17) translocation and/or PML/RARα gene presence.

B. Tretinoin capsules are expensive and infrequently used. However, Tretinoin will be needed urgently for treatment of a patient in APL crisis. Tretinoin capsules can cause birth defects and thus require special handling.

C. The VCMC Inpatient Pharmacy shall stock a quantity of at least sixty tretinoin 10 mg capsules for emergency induction treatment of patients with acute promyelocytic leukemia.

D. Tretinoin capsules shall be stored in the oral chemotherapy section of the VCMC Inpatient Pharmacy.

All revision dates: 4/1/2016

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/23/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *10/4/2018* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *10/4/2018* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# PH.113 Intravenous Immune Globulin Dosing

# POLICY:

Pharmacists of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) may adjust the dosing of Intravenous Immune Globulin (IVIG) based on adjusted body weight (AdjBW) in appropriate patients. An approved standardized IVIG protocol shall be used by Pharmacists to ensure optimal use of this medication to minimize toxicity and enhance patient care. This policy promotes the safe and effective use of IVIG. This will include all orders for adult inpatient areas as well as VCMC adult outpatient areas.

## Background:

Immunoglobulin is a concentrated product derived from pooled human donor plasma. Initially developed for the treatment of immunodeficiency syndromes, IVIG clinical applications have now expanded into hematological, infectious, neuro-immunologic, and immune-modulation. IVIG distributes minimally into lipophilic material, so dosing by adjusted body weight should achieve appropriate therapeutic levels of IgG.

Pharmacokinetic and physiological factors that suggest that AdjBW may be appropriate for obese patients:

- IVIG is a relatively polar molecule with a small volume of distribution. Therefore, penetration of the active ingredient into adipose tissue/lipophilic environments has been postulated to be poor, although this will be affected by active transport and inflammation.
- Perfusion of adipose tissue relative to lean tissue is also known to be poor.
- Blood volume relative to AdjBW is reduced in obese patients compared with lean patients (50 ml/kg versus 75 ml/kg).

In addition to expense, there are patient safety and convenience considerations for using the minimum, but clinically effective dose in obese patients:

- An increase in the incidence of adverse events is associated with larger doses of IVIG.
- Obese patients are at a higher risk of suffering serious adverse drug reactions independent of dose, due to additional vascular risk factors.
- Administration of large volumes of IVIG is time-consuming, and therefore inconvenient for the patient and costly to the health system.

# PROCEDURE:

If the indication and dosing are appropriate, the pharmacist will verify the dose. The physician will be contacted to clarify any doses that are not within the range for the specified indication. Dose will be based on

the patient's Adjusted Body Weight if the patient's actual body weight is greater than 20% of Ideal Body Weight. Actual body weight will be reserved for use in patients under 5 ft. in height or those in whom actual body weight is less than ideal body weight.

## Calculations

Adjusted Body Weight is utilized in dosing if the Actual Body Weight is > 20% above IBW.

- Actual Body Weight is patient's current measured body weight in kilograms (kg)
- Adjusted Body Weight (IBW) in kg is calculated as follows:
- IBW male: 50 kg + (2.3 x inches over 5 feet)
- IBW female: 45.5 kg + (2.3 x inches over 5 feet)
- Adjusted Body Weight (kg) = IBW + 0.4 (Actual body weight – IBW)

In addition, the pharmacist will round the dose within 10% to the nearest vial size (5 gram), preferentially rounding down. For orders where dose rounding is applied, the pharmacist must document the change on the pharmacy paper chart as well as in Cerner.

## Written Order Documentation:

1. If the IVIG order is written, the pharmacist will complete a paper "IVIG Adjusted Body Weight (pharmacist) order."
2. The pharmacist will sign/date the order, place it into the patient chart attached to the original paper orders. Dose changed from __ grams to __ grams per IVIG Adjusted Body Weight policy, by _____ (name of pharmacist) on _____ (date of change).

## Cerner Order Documentation:

1. If the IVIG order requires adjustment based on adjusted body weight, the pharmacist will discontinue and reenter the electronic order within Cerner using the physician prescribing and "per P&T policy" as the order source.
2. The pharmacist should add into the comments of the order, "Dose rounded per IVIG Adjusted Body Weight Policy."

# REFERENCES:


- Hodkinson JP. Considerations for dosing immunoglobulin in obese patients. Clin Exp Immunol. 2017 Jun; 188(3):353-362. Epub 2017 Apr 17.
- Siegel J, "Immunoglobulins and Obesity," Pharmacy Practice News, 2010, 37:1.
- Ballow M. Clinical and investigational considerations for the use of IVIG therapy. Am J Health-Syst Pharm 2005; 62: S12-S18.


All revision dates: 10/4/2018

## Attachments

IVIG workflow

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/23/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *5/15/2019* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *7/25/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Pharmacy Services* |
| **References:** | |

# PH.117 Rasburicase Dosing for Adults

# POLICY:

The use of rasburicase for adults shall be limited to defined indications and doses.

# PROCEDURE:

Contraindication: Glucose-6-phosphate dehydrogenase deficiency, hypersensitivity reaction to medication.

**Criteria for use:**

- Patient must have cancer-related hyperuricemia

or

- For the use of rasburicase as prophylaxis for prevention of tumor lysis syndrome (TLS), the clinician should consider the following criteria to be designated as “high risk” of developing TLS. This shall be documented on electronic health record (EHR).[1] (For complete list and guide refer to Cairo MS, et al. TLS Expert Panel. Recommendations for the evaluation of risk and prophylaxis of tumor lysis syndrome (TLS) in adults and children with malignant diseases: an expert TLS panel consensus. British journal of haematology. 2010 May; 149(4):578-86.)
    a. High tumor burden
    b. High grade tumor with rapid cell turnover
    c. Pre-existing renal impairment or renal involvement by tumor
        i. Low risk disease with renal dysfunction or renal involvement, abnormal uric acid, potassium and/or phosphate is considered high risk
    d. Increased age
    e. Treatment with highly active, cell-cycle specific agents
    f. Concomitant use of drugs that increase uric acid levels including, alcohol, ascorbic acid, aspirin, caffeine, cisplatin, diazoxide, thiazide diuretics, adrenaline (epinephrine), ethambutol, levodopa, methyldopa, nicotinic acid, pyrazinamide, phenothiazine, theophylline

Table 1. Risk criteria for developing TLS.

| **Type of Cancer** | **Low risk** | **Intermediate risk** | **High risk** |
|---|---|---|---|
| **Solid cancer** | Solid cancer | Germ cell cancer, Small-cell lung cancer, | |

| | | | |
|---|---|---|---|
| | | neuroblastoma, high burden solid cancer | |
| **Hematologic** | • CML<br>• CLL using alkylating agents<br>• Hodgkin lymphoma<br>• Myeloma<br>• AML with WBC <25 and LDH < 2x ULN | • CLL using targeted and/or biological therapies<br>• AML with WBC <25 and LDH ≥ 2x ULN<br>• AML with WBC 25-100 | • ALL<br>• Burkitt lymphoma<br>• AML with WBC ≥ 100 |
| **PPX recommendation** | Monitoring, hydration, ± allopurinol | Monitoring, hydration, allopurinol | Monitoring, hydration, rasburicase |
| ALL: acute lymphoblastic leukemia, CLL: chronic lymphocytic leukemia, CML: chronic myeloid leukemia, AML: acute myeloid leukemia, ULN: upper limit of normal<br>Cricuolo et al. Expert review of Hematology 2016;9(2): 197, Cairo et al. Br J Haematol. 2010;149(4):578 | | | |

or

- For treatment of laboratory TLS (LTLS), documentation of two or more of the following criteria must be met.

| Table 2. Laboratory Tumor Lysis Syndrome Criteria – meet two of the following | | | |
|---|---|---|---|
| Uric acid | > 8 mg/dL | OR | Increase by > 25% from baseline |
| Potassium | > 6 mEq/L | | |
| Phosphorus | > 4.5 mg/dL | | |
| Calcium | < 7 mg/dL | | Decrease by > 25% from baseline |

or

- For the treatment of clinical TLS associated hyperuricemia, patient must meet the above LTLS criteria as well as is experiencing one of the following: renal failure, cardiac arrhythmia, or seizure.

**Dosing Guidelines**[4-6]

| Table 3. Rasburicase dosing guide per indication* | | |
|---|---|---|
| | **BMI < 30 kg/m$^2$** | **BMI ≥ 30 kg/m$^2$** |
| **Prophylaxis** | 3 mg IV once | 4.5 mg IV once |
| **Treatment of LTLS** | 3 mg IV once | 4.5 mg IV once |
| **Treatment of CTLS** | 6 mg IV once | 7.5 mg IV once |
| *Hematology/Oncology physicians may dose outside of this guideline based on patient's clinical status. | | |

## REFERENCES:

1. Jones, G. L., Will, A., Jackson, G. H., Webb, N. J., Rule, S., & British Committee for Standards in

Haematology. (2015). Guidelines for the management of tumour lysis syndrome in adults and children with haematological malignancies on behalf of the British Committee for Standards in Haematology. *British journal of haematology*, *169*(5), 661-671.

2. Criscuolo, M., Fianchi, L. U. A. N. A., Dragonetti, G., & Pagano, L. I. V. I. O. (2016). Tumor lysis syndrome: review of pathogenesis, risk factors and management of a medical emergency. Expert review of hematology, 9(2), 197-208.
3. Cairo, M. S., Coiffier, B., Reiter, A., Younes, A., & TLS Expert Panel. (2010). Recommendations for the evaluation of risk and prophylaxis of tumour lysis syndrome (TLS) in adults and children with malignant diseases: an expert TLS panel consensus. British journal of haematology, 149(4), 578-586.
4. McBride, A., Lathon, S. C., Boehmer, L., Augustin, K. M., Butler, S. K., & Westervelt, P. (2013). Comparative evaluation of single fixed dosing and weight-based dosing of rasburicase for tumor lysis syndrome. Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy, 33(3), 295-303.
5. Patel, K. S., Lau, J. E., Zembillas, A. S., & Gallagher, E. M. (2017). Single 4.5 mg fixed-dose of rasburicase for hyperuricemia associated with tumor lysis syndrome. Journal of Oncology Pharmacy Practice, 23(5), 333-337.
6. Boutin, A., Blackman, A., O'Sullivan, D. M., & Forcello, N. (2018). The value of fixed rasburicase dosing versus weight-based dosing in the treatment and prevention of tumor lysis syndrome. Journal of Oncology Pharmacy Practice, 1078155217752075.

All revision dates: 7/25/2025, 5/15/2019

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 7/25/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *9/14/2021* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *9/13/2022* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sul Jung: Associate Director of Pharmacy Services* |
| **Policy Area:** | *Administrative - Patient Care* |
| **References:** | |

# PH.120 Tissue Plasminogen Activator (tPA, Alteplase) and/or Dornase Alfa for Pleural Effusion or Empyema

## Purpose

Standardize the use of tissue plasminogen activator (tPA, Alteplase) or dornase alfa (DNase - Dornase) administered through a chest tube into the pleural cavity for instillation for the treatment of pleural effusion or empyema.

## Procedure

A. Patient should be on appropriate antibiotics (see Table 1).

B. Pleural fluid shall be collected and analyzed.

C. Chest tube MINIMUM bore size is 10 French on -20 cm $H_2O$.

D. Chest tube must be securely attached to the patient.

E. Dose

1. Alteplase
    a. Adults >18 years old: Alteplase 10 mg; twice daily for up to 3 days
    b. Pediatric patients ≤18 years old: Alteplase 2 or 4 mg; may repeat daily for up to 3 days, dosing per discretion of ordering provider
2. Dornase alfa
    a. Adult >18 years old: Dornase alfa 5 mg; twice daily for up to 3 days

F. Pharmacy Preparation

1. Adults >18 years old:
    a. Alteplase 10 mg in 50 mL of sodium chloride 0.9% (NS) in 60 mL syringe
    b. Dornase alfa 5 mg in 40 mL of sterile water in 60 mL syringe
2. Pediatric patients ≤18 years old:
    a. Alteplase 2 mg in 10 mL of sodium chloride 0.9% (NS) in 20 mL syringe
    b. Alteplase 4 mg in 20 mL of sodium chloride 0.9% (NS) in 30 mL syringe

3. Both medications will be labeled with beyond use dating of 8 hours (tPA) and 1 hour (dornase alfa) with "Intrapleural only" sticker

A. Administration

1. Intrapleural administration of either alteplase or dornase alfa will be done by a licensed independent practitioner (LIP)
2. Place three way (3-way) stopcock on chest tube.
3. Adults >18 years old: administer alteplase 10 mg in 50 mL of NS via 3-way stopcock over 30 seconds. Then, administer dornase alfa 5 mg in 40 mL of sterile water via 3-way stopcock over 30 seconds.
    a. For adults, after both medications are given, administer a 10 mL NS flush for pigtail catheters up to 16 French catheters; use a 50 mL NS flush for catheters up to or greater than 18 French.
4. Pediatric patients ≤18 years old: Administer alteplase 2 mg in 10 mL NS or 4 mg in 20 mL NS via 3-way stopcock over 30 seconds followed by a 10 mL NS flush.
5. Close stopcock for 2 hours. During the 2 hours, encourage patient to move by walking, sitting, or rotating in bed.
    a. Pediatric patients ≤18 years old: Close stopcock for 1 hour and encourage patient to move.
6. After 2 hours, remove the stopcock and place chest tube back to suction for one hour. Document chest tube output.
    a. Pediatric patients ≤18 years old: After 1 hour, remove the stopcock and place chest tube back to suction.

B. Obtain surgical consult for the following:

1. Sign and symptoms of pleural infection is still present after at least 48 hours of alteplase and/or dornase alfa therapy with
    a. Lack of resolution on chest computed tomography (CT) or
    b. Pleural thickening and abscess/necrotizing pneumonia.

Table 1. Antibiotic recommendation from American Thoracic Society 2017.

| Type of infection | Recommended antibiotics |
|---|---|
| Community-acquired empyema (Class IIa LOE C) | Parenteral 2nd or 3rd generation cephalosporin (ceftriaxone) with metronidazole<br>OR<br>Parenteral aminopenicillin with b-lactamase inhibitor (ampicillin/sulbactam) |
| Hospital-acquired or postprocedural empyema (Class IIa LOE C) | Include antibiotic active against methicillin-resistant *Staphylococcus aureus* or *Pseudomonas aeruginosa*<br>• Vancomycin and piperacillin/tazobactam |
| Other recommendations | |
| • Avoid aminoglycosides (Class I LOE B)<br>• There is no role for intrapleural administration of antibiotic (Class IIa LOE C)<br>• Choose antibiotic based on culture results if possible (Class I LOE C) | |

- Duration of antibiotics based on organism, source control, and clinical response (Class IIb LOE C)
  - Duration range of 2-6 weeks.
  - At least 2 weeks from time of drainage and defervescence.

# Reference


1. Rahman, NM, et al. Intrapleural use of tissue plasminogen activator and DNase in pleural infection. *N Engl J Med* 2011; 365:518-26.

2. Majib, A., et al. Concurrent intrapleural instillation of tissue plasminogen activator and DNase for pleural infection. A single-center experience. *Ann Am Thorac Soc* 2016; 13(9):1512-8.

3. Shen, K. Robert, et al. "The American Association for Thoracic Surgery consensus guidelines for the management of empyema." *The Journal of thoracic and cardiovascular surgery* 153.6 (2017): e129-e146.

4. Bedawi EO, Hassan M, Rahman NM. Recent developments in the management of pleural infection: a comprehensive review. The clinical respiratory journal. 2018 Aug;12(8):2309-20.

5. Khemasuwan D, Sorensen J, Griffin DC. Predictive variables for failure in administration of intrapleural tissue plasminogen activator/deoxyribonuclease in patients with complicated parapneumonic effusions/ empyema. Chest. 2018 Sep 1;154(3):550-6.

6. Majid A, Ochoa S, Chatterji S, Fernandez-Bussy S, Kheir F, Rivera E, Cheng G, Folch E. Safety and efficacy of tissue plasminogen activator and DNase for complicated pleural effusions secondary to abdominal pathology. Annals of the American Thoracic Society. 2017 Mar;14(3):342-6.

7. Livingston MH, Mahant S, Connolly B, MacLusky I, Laberge S, Giglia L, Yang C, Roberts A, Shawyer A, Brindle M, Parsons S. Effectiveness of intrapleural tissue plasminogen activator and dornase alfa vs tissue plasminogen activator alone in children with pleural empyema: a randomized clinical trial. Jama Pediatrics. 2020 Apr 1;174(4):332-40.

8. James CA, Braswell LE, Pezeshkmehr AH, Roberson PK, Parks JA, Moore MB. Stratifying fibrinolytic dosing in pediatric parapneumonic effusion based on ultrasound grade correlation. Pediatric radiology. 2017 Jan 1;47(1):89-95.


All revision dates: 9/13/2022, 9/14/2021

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Pharmacy & Therapeutics Committee | Sul Jung: Associate Director of Pharmacy Services | 8/23/2025 |
| Pharmacy Services | Sul Jung: Associate Director of Pharmacy Services | 8/8/2025 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *3/30/2022* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *3/30/2022* |
| **Next Review:** | *2 years after approval* |
| **Owner:** | *Jessica Rodriguez: Manager, Cardiopulmonary Services* |
| **Policy Area:** | *Respiratory Care* |
| **References:** | |

# R.98 Inpatient Tracheostomy Orders

# POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) will maintain an environment prepared to immediately deal with loss of airway emergencies for our patients with a Tracheostomy.

# DEFINITIONS:

Practitioner: physicians, residents or mid-level practitioners approved to provide patient care within the Hospital.

Respiratory Therapist (RT): Persons licensed by the state of California to provide Respiratory Care and employed by either the County of Ventura or an approved Contract Agency.

Health Care Professional (HCP): licensed individuals such as registered nurses and respiratory therapists who are authorized to administer medications.

# PROCEDURE:

Upon receiving an order from a practitioner, the RT will verify and document in the electronic health record (EHR) the in-room availability of specifically listed items as to avoid and/or assist with a Tracheostomy Airway Emergency on an every shift schedule.

RT will notify the practitioner if a patient with a Tracheostomy is identified and supplies/equipment are not ordered.

## ORDERS:

The practitioner or HCP designee will order the following from the EHR “Inpatient Tracheostomy” order set:

A. The appropriate “How to Ventilate” sign:
    1. Green: Patent Upper Airway
    2. Yellow: Obstructed Upper Airway
    3. Red: Total Laryngectomy
B. Oxygen Therapy via Continuous Aerosol to deliver humidity and, if required, oxygen to the tracheostomy.
C. Suction Set-up
D. Tracheostomy Suction whenever necessary (PRN) Secretions

E. Tracheostomy Room Set-up that will include:

1. Emergency/Travel Airway Kit that consists of:
    - One (1) cuffed Tracheostomy same size.
    - One (1) inner Cannula same size.
    - One (1) cuffed Tracheostomy one size down
    - One (1) Tracheostomy Tie
    - One (1) cuffed endotracheal tube (ETT) one size down
    - Two (2) lubricant, single use, packets
    - One (1) 10 mL syringe
    - Two (2) 15 mL 0.9% saline vials for lavage
    - One (1) disposable (MAC 3) laryngoscope blade with handle
    - Two (2) appropriate size catheter and glove kits
    - Appropriate size LMA
    - Two (2) sterile gauze
2. One Resuscitation Bag w/ Mask & PEEP Valve.
3. Two appropriate size Catheter and Glove Kits for suction separate from the Emergency/travel kit.
4. Appropriate size inner cannula x 2 for routine and PRN changes separate from the Emergency/travel kit.
5. Tracheostomy Obturator at head of bed.

All revision dates: 3/30/2022

## Attachments

VCMC-SPH Trach Signs.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Medicine Committee | Stephanie Denson: Manager, Medical Staff Office | 8/28/2025 |
| Respiratory Care | Jessica Rodriguez: Manager, Cardiopulmonary Services | 7/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *4/1/2009* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *6/25/2025* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Gina Ferrer: Manager, Trauma Services* |
| **Policy Area:** | *Trauma Services* |
| **References:** | |

# T.03 Pediatric Trauma Guidelines

# POLICY:

To establish a guideline for the care of the pediatric trauma patient at Ventura County Medical Center (VCMC).

# PROCEDURE:

A. Pediatric population age range is based on the American College of Surgeons definition of pediatric trauma (≤ 14 years old). Or, the age range can be based on the discretion of the trauma surgeon. A patient <18 years old will be evaluated by the pediatric medicine (P-Med) service upon admission (if patient requires a full admission > 23 hours, or has significant co-morbidities requiring evaluation by the P-Med service even if patient is an observation only status ≤ 23 hours).

B. All patients are to have a thorough Primary Survey with immediate management of any life threatening issues

C. After completion of the Primary Survey, a complete secondary survey can be performed

D. Pediatric trauma patients who are admitted to the pediatric floor will be admitted to the TRAUMA SERVICE. The Trauma Service will consult the pediatric hospitalist as needed.

E. Pediatric trauma patients who require admission to the PICU will be admitted to the Trauma Service and co-followed by the pediatric intensivist.

F. If VCMC cannot meet the medical needs of a pediatric trauma patient, then the trauma team will contact another facility for transfer.

1. The primary and secondary survey should be performed as usual, and life threatening issues should be dealt with immediately.
2. If a pediatric trauma patient requires an emergent procedure in order to be stabilized, these will be performed prior to transfer.
3. During the time awaiting transfer, the Trauma Team will contact the pediatric hospitalist or pediatric intensivist as needed.
4. The Trauma Surgeon will be expected to evaluate and document the patient's stability prior to transfer or emergent surgery by another service.
5. This may include, but are not limited to:
    i. Pediatric Traumatic Brain Injury

ii. Pediatric Spine Injury

iii. Complex pediatric orthopedic injuries

iv. Complex pediatric ophthalmologic injuries

G. Criteria for selection of appropriate transport service

1. For pediatric patients who require transfer to another facility, the trauma surgeon or the ER physician who contacts the accepting hospital will discuss with them and determine the most appropriate type of transport and availability

H. Process for initiation of transfer

1. Refer to Policy Stat/CPG 100.272- Guideline for Transfers for Patients Requiring Higher Level of Care

I. Plan for transfer of patient information

1. For pediatric trauma patients that require transfer to another facility, the trauma surgeon and/or the ER physician will coordinate with the nursing staff to send a patient packet which includes all imaging reads, documentation, and CD/disk of imaging performed

J. Integration of family-centered care

1. By following the four concepts of family/patient-centered care; dignity and respect, information sharing, participation, and collaboration, the team at VCMC will ensure all pediatric patients and families receive the most equitable and highest standard of trauma care.

All revision dates: 6/25/2025, 6/11/2024, 7/1/2013

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| MEC Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| TOPPS Committee | Gina Ferrer: Manager, Trauma Services | 8/27/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 8/27/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 8/27/2025 |
| Pediatric Services | Andrei Bobrow: Medical Director, Pediatrics | 8/27/2025 |
| Pediatric Services | Jesse Wyatt: MD | 7/17/2025 |
| Trauma Services | Thomas Duncan: Trauma Medical Director | 6/26/2025 |
| Trauma Services | Gina Ferrer: Manager, Trauma Services | 6/25/2025 |

VENTURA COUNTY
HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *N/A* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *N/A* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Gina Ferrer: Manager, Trauma Services* |
| **Policy Area:** | *Trauma Services* |
| **References:** | |

# T.22 Prevention of Inadvertent Retained Foreign Objects (RFO)

## Purpose

To establish a standardized process to prevent inadvertent Retained Foreign Objects (RFO), particularly wound packing materials placed by Emergency Medical Services (EMS) or other Pre-Hospital agencies, ensuring accurate documentation, anatomical location, communication, and imaging follow-up from Emergency Department (ED) through ongoing patient care. This policy governs retainment management of objects placed in the Pre-hospital or ED setting.

## Scope

This policy applies to all ED staff, trauma nurses, trauma surgeons, emergency physicians, radiology staff, and EMS or Pre-Hospital personnel involved in the care of trauma patients with wound packing or foreign object placement.

## Definitions

- **Retained Foreign Object (RFO):** Any foreign material intentionally left inside a patient after a medical procedure or trauma care, including dressings, sponges, packing materials, or other items.
- **Wound Packing:** Placement of gauze or other dressing material inside a wound, typically to control bleeding, sometimes applied by EMS or Pre-Hospital agencies prior to hospital arrival. Packing may be placed by family members, attendants, or other first responders/support people present at the scene.
- **SBAR:** Situation, Background, Assessment, Recommendation – a communication framework used for handoff reporting.

## Policy Statement

All foreign objects or wound packing materials introduced in the pre-hospital setting or within the ED must be accounted for, documented (including anatomical location), communicated during handoffs, and confirmed with appropriate imaging to prevent inadvertent RFOs

# Procedures

## On Arrival to Emergency Department

- **Initial Assessment:**
  - Quick Clot is considered a dressing and is not included in any surgical count. This dressing and others like it are commonly placed in the pre-hospital setting. In all cases where these hemostatic dressings or any other type of wound packing exist:
    - EMS or Pre-Hospital personnel must verbally report anatomical location of wound packing material(s) placed, including number and type of dressing(s).
    - Trauma or Scribe nurse must immediately document the presence, type, anatomical location, and quantity of all foreign objects or dressings applied in the pre-hospital setting, within the patient's medical record. If this information is only provided to other Licensed Practitioners (LPs), it is the responsibility of the LP to enter this information into the medical record.
    - Waiting for an EMS record to be scanned into the chart does NOT constitute sufficient documentation.
- **Documentation Requirements:**
  - Specific description of foreign objects or dressings (e.g., number of gauze strips, type of packing).

## Hand-off Communication

- Upon patient transfer from EMS to ED physician or nursing staff, there must be a **verbal handoff** that includes:
  - Description of foreign objects/wound packing.
  - Number and type of dressing(s) used.
  - Any concerns about retained materials.
  - Anatomical location of foreign object/wound packing.
- During subsequent handoffs (e.g., ED physician to trauma surgeon, trauma nurse to next/accepting nurse), the presence, status, and anatomical location of all foreign objects/dressings must be verbally communicated using the **SBAR framework**.

## Imaging

- **X-ray Requirement:**
  - An x-ray (or equivalent imaging) should be initiated promptly in the Emergency Department to verify the absence or presence of retained foreign objects, even after removal of said retained foreign object. Said imaging will be conducted after the stability of the patient has been acquired.
- **Exceptions:**
  - If immediate surgery or transfer to the Operating Room (OR) or Intensive Care Unit (ICU) is necessary and x-ray (or equivalent imaging) cannot be performed in the ED, this must be clearly communicated during handoff using SBAR, including the need for x-ray (or equivalent imaging) to be performed as soon as possible post-operatively or in the next care setting.

## Ongoing Care

- All subsequent caregivers (nurses, physicians, surgical teams) must verify and document the presence or removal of all foreign objects/dressings during each shift or care transition.
- Documentation must be updated to reflect any changes in foreign object status.

- Any member of the health care team involved in the management of a patient with an intentionally placed RFO is empowered to voice concern if a discrepancy arises about the process of removal and final clearance of said object.

All revision dates:

## 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 | 8/8/2025 |
| Nursing Administration | Gina Ferrer: Manager, Trauma Services | 8/8/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 8/8/2025 |
| Trauma Services | Thomas Duncan: Trauma Medical Director | 8/8/2025 |
| Trauma Services | Gina Ferrer: Manager, Trauma Services | 8/8/2025 |

VENTURA COUNTY HEALTH CARE AGENCY

| | |
|---|---|
| **Origination:** | *N/A* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *N/A* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Laura Zarate: Clinical Nurse Manager, Case Management* |
| **Policy Area:** | *Utilization Review* |
| **References:** | |

# UR.06 Patient Status Orders

## ~~Patient Status Orders~~

## SCOPE:

This policy applies to Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). (See policy *100.281 for Assignment of Patient Status for Obstetrical Patients)*

## POLICY:

VCMC and SPH have a process to ensure that Patient Status Orders (PSO) with the appropriate accommodation are entered timely for all hospitalized patients and are reviewed daily to ensure ongoing accuracy. ~~Patient Status Orders~~All PSOs must be co-signed by an attending physician. PSOs are reflected in the electronic health record (EHR) and on all claims documentation to ensure proper billing to all payers and to be in compliance with third party payer requirements, including those issued by the Centers for Medicare & Medicaid Services (CMS).

## ~~DEFINITIONS:~~

## DEFINITIONS:

A. **Patient Status** means Inpatient, Outpatient with Observation Services (OBS), or Outpatient in a Bed (OPIB).

B. **Inpatient** status means a set of clinical criteria has been met and that a patient has been admitted to VCMC or SPH for the purpose of receiving medically necessary hospital services that can only be provided in an inpatient setting. Inpatient status must be supported by appropriate documentation.

C. **Outpatient with OBS** status means a patient is receiving clinically appropriate services which include ongoing short-term treatment, assessment and reassessment to determine whether a patient will require further treatment as an Inpatient or if the patient can be discharged from the hospital. Outpatient with OBS status must be supported by appropriate documentation.

D. **OPIB** status means a patient is occupying an acute care bed to receive outpatient treatment but without meeting medical necessity for Inpatient or OBS.

E. **Admitting or Attending Physician** means, in the context of this policy, a physician ~~or any licensed independent practitioner (LP)~~ who is legally accountable for establishing the patient's diagnosis and has

been granted admitting privileges by VCMC and SPH Medical Staff.

F. **PSO** means an order signed by the physician ~~or LP~~, nurse practitioner (NP), physician assistant (PA), or resident admitting the patient or by the physician responsible for the patient's general medical management during the admission. The order may be electronic, in writing, or a telephone order as allowed by VCMC and SPH Medical Staff bylaws. If the PSO is entered by a resident physician, NP or PA, it must be authenticated and co-signed by an attending physician. Telephone orders for PSO may only be entered by Registered Nurses (RN) in Case Management or in some specialty areas (i.e. NICU)

G. **Accommodation** means the level of care a patient receives regardless of their location in the hospital. Accommodation may include but is not limited to: Observation, Med Surg, Telemetry, Intensive Care Unit (ICU), ICU Trauma, ~~DOU~~Direct Observation Unit/Stepdown, Newborn/Nursery, Pediatrics, ~~PICU~~Pediatric Intensive Care Unit, Obstetrics, ~~Psych~~Psychiatry, and NICU (I,II,III,IV).

H. **Utilization Review (UR) Registered Nurse (RN)** means, for the purpose of this policy, a case manager appropriately trained in the accurate application of MCG or other approved clinical screening criteria.

I. **MCG** refers to clinical decision support guidelines used by UR RNs and ~~PAs~~Physician Advisors to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

J. **Authorization** means a process by which the hospital contacts the payor to seek preauthorization/ precertification/authorization for patient status and accommodation as ordered by the Admitting/Attending Physician ~~or LP~~, resident physician, NP, or PA.

K. **Two Midnight Rule** provides that inpatient services are generally payable under Medicare Part A if a physician/~~LP~~resident physician, NP, or PA expects a patient to require medically necessary hospital care that spans at least two midnights and is supported by clinical documentation.

# PROCEDURE:

It is the responsibility of the Admitting/Attending Physician/~~LP~~resident physician, NP, or PA to determine the appropriate patient status and accommodation and enter the PSO on admission. Orders entered by resident physician, NP, or PAs must be authenticated and co-signed by an attending.

A. Nursing and Case Management staff are responsible for ensuring that appropriate electronic or ~~telephone or~~telephonic PSOs have been entered by the physician.

B. If a PSO has not been entered, Nursing or Case Management should contact the physician/~~LP~~resident physician, NP, or PA to obtain the order. The PSO must clearly indicate the patient's status by explicitly using the terms "Inpatient" or "Outpatient," along with the appropriate level of care or accommodation.

C. All staff are prohibited from leading the physician to a certain PSO or accommodation or from attempting to influence the physician/~~LP~~resident physician, NP, or PA's order. A UR RN or ~~PA~~Physician Advisor may educate the physician/ ~~LP~~resident physician, NP, or PA on the differences between Inpatient, OPIB, the Two Midnight Rule and Outpatient with OBS based on regulatory guidance and/or clinical screening criteria.

D. For payors with an authorization process the UR Nurse will follow the payor's authorization process and utilize MCG when there is a dispute with the payor regarding patient status, accommodation and/or length of stay as ordered by the physician/~~LP~~resident physician, NP, or PA.

## Physicians/~~LP should enter a PSO to "Admit to~~

## ~~Inpatient" if:~~resident physician, NP, or PA should enter a PSO to "Admit to Inpatient" if:

A. The patient needs a level of care based on the severity of illness and intensity of services required for an episode of illness or condition that is the result of disease, trauma, and/or recovery from major surgery. Inpatient care is often used for patients with serious medical conditions, acute illnesses, or severe trauma.

B. The physician/~~LP~~resident physician, NP, or PA expects the patient to ~~remain in the~~require Inpatient hospital care for two or more midnights from the onset of care including care received in the Emergency Department (ED), or the patient requires a procedure that is specified as inpatient-only on the CMS Inpatient Only List for the current year. The medical record documentation must support the expectation.

C. The Admitting/Attending Physician must enter a PSO for inpatient status in the EHR prior to discharge, but entering the order upon admission is the expectation.

## Physicians/resident physician, NP, or PA ~~Physicians/ LP~~ should enter a PSO for "Place in Observation" if:

A. The patient requires a period of treatment or monitoring, usually within 24 hours, before a decision is made whether to admit the patient as an Inpatient or discharge. The medical record documentation must support the expectation.

B. The physician/resident physician, NP, or PA cannot reliably predict a Medicare beneficiary to require a hospital stay of two or more midnights from the onset of care, inclusive of ED services. The medical record documentation must support the expectation.

### Requirements for OBS are as follows:

~~a. The observation period begins at the time the PSO for observation is signed.~~

~~b. OBS time ends when all medically necessary services related to observation care are completed.~~

~~c. OBS time ends with the Physician's order to change the patient status from OBS to inpatient or when the patient status changes from OBS to discharged.~~

~~d. These timestamps serve as the official start and stop times and are clearly documented and retrievable in the medical record to ensure compliance with regulatory and billing requirements.~~

~~e. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the patient would benefit from OBS care.~~

~~f. Clinical findings must justify the need for OBS care and must be documented. For patients whose payors do not have an authorization process, medical necessity for OBS must be documented in a manner consistent with federal or state requirements, the Two Midnight Rule, or MCG.~~

A. The observation period begins at the time the PSO for observation is signed.

B. OBS time ends when all medically necessary services related to observation care are completed.

C. OBS time ends with the physician/resident physician, NP, or PA's order to change the patient status from OBS to inpatient or when the patient status changes from OBS to discharged.

D. These timestamps serve as the official start and stop times and are clearly documented and retrievable in the medical record to ensure compliance with regulatory and billing requirements.

E. The medical record must include documentation that the physician assessed patient risk to determine that the patient would benefit from OBS care.

F. Clinical findings must justify the need for OBS care and must be documented. For patients whose payors do not have an authorization process, medical necessity for OBS must be documented in a manner consistent with federal or state requirements, the Two Midnight Rule, or MCG.

G. For Medicare beneficiaries in Observation, the Medicare Outpatient Observation Notice (MOON) is required in accordance with Policy UR.03 Patient Notification of the Provision, Discontinuation, Reclassification, or Non-Coverage of Care

H. Status changes between Observation and Inpatient for Medicare beneficiaries are governed by the Condition Code 44 process outlined in Policy UR.02 Condition Code 44

## Situations not appropriate for OBS are as follows:

~~a. The convenience of the patient, the patient's family, or the physician (e.g., physician is unavailable when the patient is clinically ready for discharge, or the patient is awaiting placement in a long-term care facility), lack of staff, scheduling of transportation, or coordination of post-acute care services are not appropriate for OBS unless a payer with an authorization process preauthorizes OBS for these reasons.~~

~~b. Medically appropriate inpatient admission.~~

~~c. For patients whose payers do not have an authorization process, services included in the payment for another service, such as:~~

~~i. Routine preparation services furnished prior to diagnostic testing and/or therapeutic services in a hospital outpatient department and routine recovery afterwards.~~

~~ii. Scheduled therapeutic services such as blood transfusions.~~

~~iii. Routine postoperative or post procedure monitoring during a standard recovery period.~~

~~1. A patient must not be placed in OBS status following an outpatient procedure based on a standing order, an order given prior to the procedure, or an order that does not articulate patient-specific findings justifying the need for OBS. Notwithstanding the foregoing, if a payer with an authorization process pre-authorizes OBS pursuant to a standing order, an order given prior to the procedure or without patient-specific findings, the hospital may provide OBS care to the patient as authorized. Documentation must support this level of care.~~

A. The convenience of the patient, the patient's family, or the physician (e.g., physician is unavailable when the patient is clinically ready for discharge, or the patient is awaiting placement in a long-term care facility), lack of staff, scheduling of transportation, or coordination of post-acute care services are not appropriate for OBS unless a payer with an authorization process preauthorizes OBS for these reasons.

B. Medically appropriate inpatient admission.

C. For patients whose payers do not have an authorization process, services included in the payment for another service, such as:

i. Routine preparation services furnished prior to diagnostic testing and/or therapeutic services in a hospital outpatient department and routine recovery afterwards.

ii. Scheduled therapeutic services such as blood transfusions.

iii. Routine postoperative or post procedure monitoring during a standard recovery period.

1. A patient must not be placed in OBS status following an outpatient procedure based on a

standing order, an order given prior to the procedure, or an order that does not articulate patient-specific findings justifying the need for OBS. Notwithstanding the foregoing, if a payer with an authorization process pre-authorizes OBS pursuant to a standing order, an order given prior to the procedure or without patient-specific findings, the hospital may provide OBS care to the patient as authorized. Documentation must support this level of care.

## Physicians/resident physician, NP, or PA ~~Physicians/LP~~ should enter a PSO for "Place in OPIB" in the following situations:

A. **Post-Outpatient Procedure Monitoring**
After an outpatient surgery or procedure requiring post-op monitoring or short-term treatment, without complications and not meeting observation or inpatient criteria.

B. **Outpatient Therapeutic Treatments**
For patients receiving outpatient treatments such as blood transfusions, chemotherapy, hemodialysis, or infusions—when no observation or inpatient services are required.

C. **Social or Convenience Admissions**
When a patient is placed in a bed for non-medical reasons (e.g., social, family convenience, transportation issues, overnight travel concerns) and does not require clinical observation or inpatient-level care.

D. **Short-Term Pre- or Post-Treatment Monitoring**
When a patient needs brief pre- or post-procedure recovery (e.g., pre-procedure hydration, post-sedation recovery) but does not meet criteria for observation or inpatient care.

E. **Extended Recovery After Ambulatory Surgery**
For patients who need a longer-than-usual recovery period (e.g., pain control, nausea, delayed discharge) following outpatient surgery but do not meet clinical criteria for OBS or ~~IP~~Inpatient status.

## PSO considerations specific to obstetric patients see policy *100.281 Assignment of Patient Status for Obstetrical Patients*

## PSO considerations specific to Newborns and the Neonatal Intensive Care Unit (NICU)

**Newborn Inpatient PSO:** The admitting or attending physician has primary responsibility for entering the PSO for newborns however, the PSO may be entered by nursing by protocol at the time of birth or admission. The order must be entered as "Inpatient" status with the appropriate level of care (e.g., Routine Nursery). A licensed provider is required to cosign the order per organizational policy to meet regulatory requirements.

## NICU PSOs, Accommodations, and Workflow

A. PSOs in the NICU will be placed by the physician upon admission. The order and accommodation code will be reviewed daily during rounds. If it is identified that the accommodation code or status needs to be changed, the physician will change the order during rounds.

B. If changes need to be made outside of daily rounds, the NICU RN will notify the physician and modify the order using the ~~TORB~~telephone order read back order type. Any diagnosis must be provided by the physician.

C. Accommodation codes in the NICU are defined as follows:

i. Level I: (Newborn Nursery) - Routine care of apparently normal full-term or pre-term neonates

ii. Level II: (Continuing Care) - Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates

iii. Level III: (Intermediate Care) - Sick neonates, who do not require intensive care, but require 6-12 hours of nursing each day

iv. Level IV: Intensive Newborn Care (ICU or 1:1) - Babies at this level are the sickest of all and require constant one to one nursing care.

**Physicians/resident physician, NP, or PA~~Physicians/LP~~ should enter a PSO "Change Accommodation Order" when the physician ~~or LP~~/resident physician, NP, or PA determines the need for a change in level of care.**

A. Example, a change from Telemetry to Med-Surg.

B. The order should be placed prior to the patient's location change.

## Patient Status Adjustment Orders

A. Adjustment Orders may be used to align patient status with the UR Nurse or Physician Advisor review when it is determined that the patient did not meet criteria for the PSO entered by the physician/resident physician, NP, or PA ~~review when it is determined that the patient did not meet medical necessity criteria for the PSO entered by the physician or LP~~.

B. Only UR Nurses trained in the use of Adjustment Orders and ~~PAs~~Physician Advisors shall be able to enter Adjustment Orders.

C. Adjustment orders shall not be used when it is known that the primary payer is Original Medicare unless in the instance of a documented clerical error.

a. CMS allows corrections to a PSO only if:

i. The initial order was a clear clerical mistake (e.g., "Outpatient" selected when "Inpatient" was intended).

ii. The provider documents the reason for the correction (e.g., "Clerical error: patient met inpatient criteria at the time, incorrect status selected.")

iii. The adjusted order reflects the original intent as documented in the EHR at the time of admission, not based on hindsight or how the stay progressed.

# Workflows to Ensure Accurate Accommodation

## Bed Board Monitoring for Patient Status and Accommodation Accuracy

~~Nursing is responsible for monitoring the bed board throughout their shift to ensure each patient has an active PSO and that the patient is assigned the correct accommodation (e.g., med/surg, telemetry, ICU).~~

~~Nursing is responsible for reconciliation of PSO orders and accurate accommodation on the bed board prior to midnight to support accurate patient classification, regulatory compliance, and proper billing. Any missing or incorrect status orders must be escalated promptly to the provider for correction.~~

A. Nursing is responsible for monitoring the bed board throughout their shift to ensure each patient has an active PSO and that the patient is assigned the correct accommodation (e.g., med/surg, telemetry, ICU).

B. Nursing is responsible for reconciliation of PSO orders and accurate accommodation on the bed board prior to midnight to support accurate patient classification, regulatory compliance, and proper billing. Any missing or incorrect status orders must be escalated promptly to the physician or LP for correction.

C. If an error is found after midnight, Case Management staff should be notified.

## Clinical Review of OBS Encounters

~~UR Nurses or PAs must review all OBS for medical appropriateness prior to releasing the billing hold.~~

~~UR RNs and PAs must closely monitor the entire OBS census at the beginning of, and prior to the end of each business day.~~

~~A summary report of OBS must be presented to the Utilization Management Committee at regular intervals.~~

# ~~Compliance~~

A. UR RNs and/or Physician Advisors must review all OBS for medical appropriateness prior to releasing the billing hold.

B. UR RNs and/or Physician Advisors must closely monitor the entire OBS census by the end of each business day.

C. A summary report of OBS must be presented to the Utilization Management Committee at regular intervals.

# DOCUMENTATION

A. Patients with Observation or Inpatient status orders require complete documentation to include all regulatory elements, including full admission documentation.

B. Patients under Outpatient in a Bed status do not require a full admission intake but do require a focused clinical assessment, physician orders, and discharge orders. Complete documentation is required if patient status changes to Observation or Inpatient.

# COMPLIANCE

Randomized audits will be conducted by the Case Management as well as external agencies.

# ~~References:~~

# REFERENCES:

CMS Benefit Policy Manual, Ch. 1, §10:

All revision dates:

## Attachments

- Access Manangement Office
- Admit to Inpatient
- Changing from Inpatient to Observation
- PSO Instructional Job Aid
- VCHCA Patient-Status-Outpatient-In-A-Bed

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Stephanie Denson: Manager, Medical Staff Office | pending |
| Hospital Administration | Osahon Ekhaese: Chief Operating Officer, VCMC & SPH | 8/11/2025 |
| Hospital Administration | Minako Watabe: Chief Medical Officer, VCMC & SPH | 7/21/2025 |
| Nursing Administration | Sherri Block: Associate Chief Nursing Executive, VCMC & SPH | 7/19/2025 |
| Nursing Administration | Danielle Gabele: Chief Nursing Executive, VCMC & SPH | 7/19/2025 |
| Policy Owner | Laura Zarate: Clinical Nurse Manager, Case Management | 7/19/2025 |