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

Ventura County Health Care System Oversight Committee
Administrative Policies

May 23, 2024

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

1. 106.034 Emergency Management Plan
2. 107.023 Adverse Events, Sentinel Events, Unusual Occurrences
3. 107.024 Root Cause/Event Analysis
4. D.26 Dietary Purchasing and Receiving
5. EVS.31 Wet Floor Signs
6. PFS.01 Credits and Adjustments (Current State vs Future State)
7. R.70 Respiratory Care Scope of Operations and Availability of Services
8. RS.06 Rehab Services Missed Appointments

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Administrative Policies - May 23, 2024
Summary of Changes

#	Title	Review Period	Summary of Changes
1	106.034 Emergency Management Plan	Annual	Annual review. Added pediatric mass casualty drill requirement.
2	107.023 Adverse Events, Sentinel Events, Unusual Occurrences	Triennial	Revised policy layout. Revised language on waiving costs associated with never events (paragraph G under Procedure section).
3	107.024 Root Cause/Event Analysis	Triennial	Revised policy statement. No other changes.
4	D.26 Dietary Purchasing and Receiving	Triennial	Minor update reflecting current practices
5	EVS.31 Wet Floor Signs	Triennial	Added wet floor sign language (paragraph A under Procedure section)
6	PFS.01 Credits and Adjustments (Current State vs Future State)	Triennial	Policy was updated to reflect current practices and language.
7	R.70 Respiratory Care Scope of Operations and Availability of Services	Biennial	Reviewed. Minor typo.
8	RS.06 Rehab Services Missed Appointments	Triennial	Removed wording for "Welcome letter" as it does not exist.

Status **Active** PolicyStat ID **14597039**

Origination	2/1/2000	Owner	Fernando Medina: Director, Support Services
Last Approved	4/17/2024	Policy Area	Administrative - Environment of Care
Effective	4/17/2024		
Last Revised	4/17/2024		
Next Review	4/17/2025		

106.034 Emergency Management Plan

POLICY:

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It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and Licensed Hospital clinics to develop, maintain and continually update an Emergency Management Plan. The purpose of the Emergency Management Plan is as follows:

A. Designed to support the Hospital Incident Command System (HICS), which is a modification of the Incident Command System (ICS). ICS is the standardized and official emergency response organization adopted by city, county, and state organizations, to permit improved understanding and communications between various government agencies. VCMC/SPH joins an expanding number of health care organizations, by adopting HICS, which will permit improved coordination between other health care facilities and local government agencies.

B. To provide for effective actions which will minimize injuries and loss of life among patients, employees, volunteers, vendors, visitors and contractors during a state of disaster or extreme emergency.

C. To provide procedures for optimal use of our resources during a state of disaster or extreme emergency.

D. To provide a plan, through EMS, of mutual assistance with other hospitals, organizations and agencies for the prompt transfer of victims that we are unable to manage.

The VCMC/SPH Emergency Operations Plan (see attachment) is modeled after the HICS format. The goal is to provide a simplified disaster plan for common response by all departments and units. The specific duty for implementations of these plans is the responsibility of each department manager or supervisor. Plans are tailored to the specific needs and resources of each department.

PROCEDURE:

The Emergency Operations Plan is designed to work in conjunction with the Ventura County Sheriff

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Office of Emergency Services (OES), Ventura County Emergency Medical Services (VCEMS) Agency and Public Health. In the event of a large-scale disaster, VCMC/SPH will participate in the coordination between other healthcare facilities, as directed by the Ventura County Sheriff's OES Multi-Hazard Functional Plan and the EMS Agency. The Ventura County Medical Network (REDDINET) system will be used to assist in coordinating emergency response and hospital availability. The HICS plan will also support the medical needs of the surrounding communities.

The Emergency Operations Plan is also designed to activate the resources of Ventura County Ambulatory Care (AC) as needed. If an emergency situation occurs that necessitates assistance by AC, the Incident Commander will contact the AC Administrator-on-Call to initiate the AC Emergency Operations Plan. According to the plan, the Administrator-on-Call will determine whether to assign an AC Liaison to the VCMC ICC who will coordinate the limited mobilization of AC resources or to initiate the Ambulatory Care Incident Command Center to mobilize and coordinate massive resources, in which case an Ambulatory Care liaison would be assigned to the VCMC ICC to facilitate collaboration and coordination.

To permit optimum response and minimize the impact of the emergency on normal operations, the response effort must grow with the threat and then needs to be reduced as soon as emergency conditions permit. This requires rapid assessment of the problem, and the resources available to contain and resolve the emergency. Quickly obtaining current and accurate information enables the incident management team to estimate the potential impact on the facility and initiate plans to meet both facility and community needs.

This Emergency Operations Plan shall be prepared in compliance with the California Administrative Code, Title 17, Title 9 and The Joint Commission, which requires that all hospitals have a written Emergency Operations Plan.

Any fire service, law enforcement agency, public health agency or hospital may notify the Ventura County Sheriff's Office of Emergency Services and/or Ventura County Emergency Medical Services (EMS) Agency of any disaster that is known to have produced, or is likely to produce, multiple causalities.

AUTHORITY

A. The Environment of Care Executive Committee appoints a chairperson to be responsible for the management, monitoring and reporting regarding the Emergency Operations Plan (EOP).

B. The Chairperson of the Emergency Management Committee has immediate and complete access to all records that become necessary in carrying out the EOP.

HAZARD VULNERABILITY ANALYSIS

Hazard Vulnerability Analysis is conducted every two years, or sooner as needed.

Results of the Hazard Vulnerability Analysis are obtained through the collaborative efforts of the Emergency Management Committee.

Both natural and man-made disasters could affect this hospital at any time. It is an inherent obligation of those charged with the responsibility for the care of the sick and injured to provide an effective

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Emergency Operations Plan. This program should ensure the maximum safety and well being of all patients and staff.

DEFINITIONS

Disasters may be "Internal" or "External" to the hospital. Disasters shall be paged over the hospital intercom system and phone page system as "CODE TRIAGE" (15 or more patients/victims, regardless of mechanism or acuity i.e. trauma, chemical exposure, radiation exposure etc., are expected or received for emergency care in the Emergency Department), followed by "External or Internal," (location), (ETA if known) "All visiting hours are now ended, visitors please exit the hospital."

Disasters are defined as follows:

A. **External**
An External disaster occurs outside the hospital complex which affects the local community and which would result in a sudden influx of acutely sick and/or injured patients needing emergency care. Disasters of this type could result from fire, major accident, earthquake, flood, explosion, electrical failure, gas leakage, etc.

B. **Internal**
A disaster occurring within the bounds of the hospital complex with acute injuries, facility damage or significant disruption of service or the threat of potential injuries, due to a major calamity. Disasters of this type could result from fire, explosion, electrical failure, flood, gas leakage, earthquake, threat of an employee walkout, etc.

C. **Bioterrorism/Hazardous Substance**
Bioterrorism is the deliberate release of pathogenic microorganisms (bacteria, viruses, fungi or toxins) into a community. Most likely diseases include smallpox, anthrax, botulism, plague and tularemia, but viral hemorrhagic fever viruses such as Lassa, Marburg and Ebola may also be deliberately introduced. With the exception of smallpox, VHR and the encephalitis viruses, all bioterrorism agents can be treated with antibiotics or toxin antagonists if promptly diagnosed.

The key to rapid intervention and prevention is to maintain a high level of vigilance. Early identification of an outbreak from an unnatural source is essential. Suspicious indicators include increasing numbers of otherwise healthy persons with similar symptoms seeking treatment over a period of several hours, days or weeks, a cluster of previously healthy persons with similar symptoms who live, work or recreate in a common geographical area; an unusual clinical presentation; an increase in reports of dead animals; lower incident rates in those persons protected; an increase number of patients who expire within 72 hours after admission; any person with a history of recent travel to a foreign country presenting with S&S of high fever, rigors, delirium, rash, extreme myalgias, prostration, shock diffuse hemorrhagic lesions or petechiae; and/or extreme dehydration due to vomiting or diarrhea with or without blood loss.

Decontamination of suspected exposure to a bioterrorism agent or to reduce the extent of external contamination will be coordinated with the Hazardous Materials Team of the Fire Department. The Decon tent will be set-up by our Facilities Dept. as needed.

D. **Emergency Operations Plan**
The Emergency Operations Plan (EOP) is an "all hazards" plan to guide preparations, response,

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and recovery to emergencies and disaster for Ventura County Medical Center and Santa Paula Hospital. The EOP is a dynamic document that is modified as deficiencies and opportunities for improvement are identified in the evaluation of all emergency response exercises and all responses to actual emergencies.

INITIATION OF CODE TRIAGE

A. Authority to Initiate -- The Hospital Administrator or the Administrator on Duty in conjunction with the Nursing Supervisor and the Emergency Department Charge Nurse have the authority to initiate a Code Triage and activate the Emergency Operations Plan, or other portions of the Plan as deemed appropriate. The person activating the plan serves as Incident Commander until relieved by a Senior Administrator or relinquishes responsibility to another individual.

B. Conditions Necessary to Initiate the Emergency Operations Plan:

    1. Notification of a disaster received from the Ventura County EMS Agency or Office of Emergency Services Emergency Operations Center (EOC).
    2. Any condition that brings a significant number of patients to the Emergency Department or seriously disrupts the quality of services that the facility provides to its patients, staff and communities.
    3. A significant internal disaster.

C. The Initiation Process:

    1. In the event of a disaster, the initial notification will usually be to the Emergency Department. The Emergency Department will immediately notify the Administrator-On-Duty (Administration during the weekdays, Nursing Supervisor all other times).
    2. The Administrator, Nursing Supervisor, or Administrator on Duty reviews the need to establish the Command Center to manage the situation and, where appropriate, activates the disaster plan.
    3. The Administrator, Nursing Supervisor, Administrator on Duty or the Emergency Department Charge Nurse notifies Communications to overhead announce the disaster code: CODE TRIAGE, ER, EXTERNAL OR INTERNAL, or other code as appropriate; activates the Administrative Disaster Call-back as appropriate; notifies those needing to be informed not accessed by the paging system.
    4. Paging, after confirming a complete understanding of the notification requirements, overhead announces:

       "Code Triage, (Internal or ***External), (location) (ETA if known),*** **all visiting hours are now ended, visitors please exit the hospital."**
    5. At that time, paging will notify the appropriate personnel via pagers and cell Phones. Paging may also be instructed by Administration to notify those needing to be informed of disaster that is not accessed by the paging system. After 15 minutes, "**Code Triage in process until further notice**" should be announced by Paging.

D. Upon establishment of the Incident Command Center, located in the Large Auditorium or Academic Family Medicine Residency and Specialty Care Center in the Computer Training Center (Alternate Location) at VCMC and the Library or Nursing Office (Alternate Location) at

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SPH, an Incident Briefing Form will be developed:

1. The Incident Commander (IC) will be responsible for preparing the Incident Briefing Form (HICS 201), a brief written statement about the nature of the problem, anticipated impact on the staff, and general directions for managers to take in response to the situation.
2. Command Staff and Section Chiefs, or Branch/Unit/Team Leaders and Medical/ Technical Specialists will report to the Incident Command Center to review the Incident Briefing Form and accept assignment by the IC.
3. The IC will provide updated Incident Briefing Forms for departments as often as appropriate and as the situation permits.

STAFF ROLES AND RESPONSIBILITIES (General)

A. **General Guidance to All Staff and Physicians**: In most cases, clinical and support staff will continue their normal duties when a disaster code is called, depending on the level called, unless otherwise directed, such as being identified as a member of the command center staff. When the code is first called, staff should check their fellow staff, patients, families, and visitors; installed utilities and equipment, and if there are no injuries or damage, continue the provision of patient care or report to IC if you are a member of the command center staff. Any injuries or damage must be reported to the command center immediately. All staff and physicians should be prepared for reassignment as directed by their immediate supervisor, depending on the nature of the crisis.

B. **Communications**: The Paging Department staff is responsible for alerting key staff per the procedure and call tree when a Code is called, then providing updates via overhead announcement to all people in the hospital. All staff is responsible to check any communications equipment in their area and report system failures to the command center.

C. **Resources and Assets**: During a crisis, all staff is expected to conserve medical and non-medical supplies to the extent that it can reasonably be done without compromise to patient care. When a disaster code is called, Central Supply is responsible to verify current supply inventories, coordinate with vendors to fill any shortfalls, and be prepared to reallocate supplies as directed by the command center. Disaster Carts will be distributed to the designated areas.

D. **Safety and Security**: All staff and physicians are responsible to communicate any safety or security concerns immediately to the command center, attention the Safety Officer for resolution. All staff and physicians are also responsible in the course of their duties to report to Security anyone claiming to be on staff but without an ID badge and any personnel in, or attempting to enter, areas they are not authorized to enter.

E. **Utilities Management**: All staff and physicians are expected to reasonably conserve the demand on utilities in a crisis, without undue effect on patient care. All staff and physicians are responsible to immediately report any utility failures to the command center. Facilities department is responsible to manage primary and alternate utilities in an emergency, including the inventory of utility support requirements such as fuel, water, oil, etc.

F. **Patient Clinical and Support Activities**: All staff and physicians are responsible to communicate honestly with patients, visitors, and families, with respect to what they know, but

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should not speculate on events, situations, or plans unknown to them, but direct the question back to the command center.

STAFF ROLES AND RESPONSIBILITIES (Specific)

A. Initiate Department Call-Back Lists as necessary, based upon such information as:
    1. Nature and severity of the disaster
    2. Number of victims
    3. Type of injuries
    4. Time of day
    5. Current staffing
    6. Condition and availability of the facility, its equipment and materials
    7. Need for evaluation (consider number of patients, status, etc)

B. Medical Staff will remain in location and wait for further instruction. Medical Staff Office will initiate the call back roster as directed by the Medical Director.

C. Personnel/Volunteers will check in at the Labor pool (Located in the Cafeteria Conference Room) at VCMC and Dining Room at SPH as directed.

D. Physicians/Residents will continue their duties until otherwise assigned by Chiefs of Staff or the Medical Director.

E. The ED Physician and/or Nursing Supervisor will keep the Incident Command Center informed of the need for additional personnel to handle incoming victims and initiate the callback list for physicians and staff. Each department will initiate call back as needed or directed and send available personnel to the Labor Pool (Cafeteria Conference Room) at VCMC and (Dining Room) at SPH.

F. Employee Sign-In Section Personnel Time Sheet (HICS 252) to be used for all employees to sign in and out of each Department or Treatment Area.

G. Employee Relief: Schedule employees and assign meal breaks.

H. Resource Use: Document equipment/supplies procured from department and agencies.

I. IC to provide general guidance, resourced in the Incident Response Guide manual (IRG), for the immediate situation.

J. Report Forms: Departments will notify the Command Center within 30 minutes of initial notification, as to their ability to respond, when significant information changes, when fully staffed, and whenever requested by Incident Command.

K. Use of telephones will be limited to immediate needs of the disaster response.

L. Communications to be addressed by IC and the distribution of radios as needed.

M. In a County-Wise Disaster Event or during Off Business Hours, all personnel shall be ready to report when notified by Administration of immediate supervisor.

N. In the event that all telephone contact is out of service, all personnel shall report to the labor pool (located in the Cafeteria Conference Room) at VCMC and (Dining Room) at SPH for

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assignment and further instruction.

O. Should evacuation be required, location for all personnel is the Public Health parking lot on Hillmont Rd. to the west of the main hospital at VCMC and Parking Lot E at SPH.

P. All facility employees must wear their authorized employee identification badges at all times while in the facility or on its grounds. Personnel assigned to selected special duties may be required to wear position identification vests, ID tags and/or armbands identifying their disaster job titles.

Q. In the event of a lock-down to the facility or during a disaster, employees will use only the Lab entrance (VCMC) and the front entrance to the Emergency Department (SPH).

R. The Emergency Department Staff will use the Ambulance Bay Entrance (VCMC/SPH).

COMMUNICATION PROCESS AND TRAFFIC FLOW

Refer to Attachment A: Emergency Operations Plan.

EMERGENCY TREATMENT AREA LOCATIONS

Refer to Attachment A: Emergency Operations Plan.

DISASTER CONCLUSION

At the conclusion of the disaster, the Incident Commander will notify paging to overhead announce: CODE TRIAGE ER HAS BEEN CLEARED (**to be repeated twice**).

All HICS disaster supplies will be returned to the section chiefs. The section chiefs will ensure the supplies have been restocked and returned to storage.

EMERGENCY MANAGEMENT COMMITTEE

The Emergency Management Committee includes representatives from various key departments. The Chairman of the Committee will report activities to the Executive Environment of Care Committee and the general Environment of Care Committee. The Emergency Management Committee will meet at least quarterly. Written Drill critique will be filed with Environment of Care Executive Committee. Responsibilities of the Emergency Management Committee are as follows:

A. To coordinate and critique disaster events and drills.

B. To review and update the Emergency Operations Plan.

There will be a minimum of two emergency drills per year, at least 4 months apart, to include one that will have victim scenarios going through the system.

PERFORMANCE IMPROVEMENT

A. Immediately, or as soon as possible, following an actual disaster or drill, an informal critique of the incident will be held with major players to identify problems and successes. Location and time of the critique will be announced near the end of the incident.

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B. Each department manager will review response to the disaster (drill) with his or her staff. Items to be included in the critique are as follows:
    1. Evaluation of facilities and department disaster plans and responses.
    2. Identification of any problems encountered.
    3. Recommendation of changes to the disaster plan, procedures, supplies and materials.
    4. Communication/coordination problems.
    5. Patient and staff movement problems.
    6. Other issues as appropriate.

C. The Emergency Management Committee will meet to:
    1. Review the critiques.
    2. Recommend updates to the disaster plans, as appropriate.
    3. Make recommendations on further testing on the disaster plan.

EMERGENCY RESPONSE EXERCISES

A. The hospital activates its Emergency Operations Plan at least twice a year at each site included in the EOP.

B. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an influx of simulated patients.
    1. A pediatric mass casualty incident drill will occur at least every two years.

C. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercise include an escalating event in which the local community is unable to support the hospital.

D. For each site of the hospital with a defined role in its community's response plan, at least one of the two emergency response exercises includes participation in a community-wide exercise.

E. Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities and patients.

F. The hospital designates an individual(s) whose sole responsibility during emergency response exercise is to monitor performance and document opportunities for improvement.

G. During emergency response exercise, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire public health officials, and other health care organizations.

H. During emergency response exercise, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment, and transportation.

I. During emergency response exercise, the hospital monitors:
    1. Safety and Security;

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2. Staff roles and responsibilities;
3. Utility systems, and;
4. Patient clinical and support care activities.

J. Based on all monitoring activities and observations, the hospital evaluates all emergency response exercise and all responses to actual emergencies using a multidisciplinary process including license independent practitioners.

K. The evaluation of all emergency response exercises and all responses to actual emergencies includes written documentation to identify deficiencies and opportunities for improvement.

L. Deficiencies and opportunities for improvement are communicated to the multidisciplinary Emergency Management Committee.

M. The hospital modifies its Emergency Operations Plan based on its evaluation of emergency response exercise and responses to actual emergencies.

N. Subsequent emergency response exercise will reflect modifications and interim measures as described in the modified Emergency Operations Plan.

O. Communication and documentation of modifications of the Emergency Operations Plan will be documented in the Emergency Management Committee minutes.

EDUCATION

Staff is trained for the emergency roles in the following ways:

A. New hire staff training: During the New Employee Orientation, emergency procedure policy, codes and responsibilities are presented.

B. Annual staff training: Staff is required to complete safety training which includes emergency procedure policy, codes and responsibilities.

C. New hire physician training: During the New Physician Orientation, emergency procedure policy, codes and responsibilities are presented.

D. Incident Command System (ICS 100/200 HC) and NIMS (IS 700) training for hospital personnel who would assume a leadership role in the Hospital Command Center (NIMS Element 9 and 11).

E. National Response Plan (IS 800a) training for persons directly responsible for the Emergency Management Program (NIMS Element 10)

If Licensed Independent Practitioners volunteer or are transferred into the hospital, they will be oriented, assigned roles, and then proctored by the medical staff in accordance with the procedures established by the Emergency Management Committee according to the Emergency Operations Plan policy -- Disaster/Emergency Volunteer Health Professionals Credentialing.

EVALUATION

At least annually the Emergency Operations Plan will be reviewed and revised, if necessary, by the Emergency Management Committee chair and approved by the Emergency Management Committee. The scope, objectives, and effectiveness of the EOP, as well as the effectiveness of the emergency

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operations planning activities will be reviewed. The Environment of Care Executive Committee and Administration will approve the review.

All Revision Dates

4/17/2024, 12/13/2022, 8/2/2019, 6/1/2016, 2/1/2014, 6/1/2011, 11/1/2010, 12/1/2007, 10/1/2006, 5/1/2006

Attachments

Emergency Operations Plan

Emergency Operations Plan Appendix A 96-Hour Critical Supplies and Strategies for Extension

Emergency Operations Plan Appendix B Hazard Vulnerability Assessment

Emergency Operations Plan Appendix C Emergency Contacts Directory

Emergency Operations Plan Appendix D Emergency Supply Inventory

Emergency Operations Plan Appendix E VCMC HICS Assignments

Emergency Operations Plan Appendix F SPH HICS Assignments

Emergency Operations Plan Appendix G Evacuation Plan & Rally Points

Emergency Operations Plan Appendix H Tarp Tent Set-Up Map

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/17/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/17/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/17/2024
Emergency Management Committee	Fernando Medina: Director, Support Services	4/17/2024
Policy Owner	Fernando Medina: Director, Support Services	4/17/2024

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Owner	Alicia Casapao: Director of Quality and Performance Improvement
Policy Area	Administrative - Operating Policies

107.023 Adverse Events, Sentinel Events, Unusual Occurrences

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PURPOSE:

To establish uniform guidelines for prompt reporting of incidents that harmed or may harm patients, visitors or employees.

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) shall comply with reporting requirements of unusual occurrences, as well as adverse events which may include what may be categorized as a sentinel event.

As well, VCMC/SPH will be guided by the California Department of Public Health (CDPH), the Centers for Medicare & Medicaid (CMS), and The Joint Commission (TJC) standards related to the identification, required or voluntary reporting and management of unusual occurrences, adverse events and sentinel events. An appropriate response may include, but not limited to, conducting a timely, thorough and credible root cause or event analysis, developing an action plan designed to implement improvements to reduce risk, implementing the improvements and monitoring the effectiveness of those improvements.

DEFINITIONS

Adverse Event: A patient safety event that resulted in harm to a patient. Adverse events shall prompt notification to hospital leaders, investigation, and corrective actions, in accordance with VCMC/SPH's process for responding to patient safety events that do not meet the definition of a sentinel event. An adverse event may or may not result from an error.

Sentinel Event: Sentinel Events are a subcategory of adverse events. A patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity

of harm).

Unusual occurrence: Any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility (California Code Regs. Tit. 22, § 77036 - Unusual Occurrences)

Serious Disability: A physical or mental impairment that substantially limits one or more life activities of an individual; the loss of bodily function, if the impairment lasts more than seven days; is still present at the time of discharge from an inpatient health care facility; or the loss of a body part (Health and Safety Code Section 1279.1).

Close Call or Near Miss: An event that did not result in patient harm, but could have.

Notification/Incident Reporting: Online event/incident reporting system ***(RL Datix)*** utilized throughout VCMC & SPH.

POLICY:

All employees and providers of VCMC/SPH have a duty to participate in the identification and reporting of occurrences which have caused, or have the potential to cause, harm to a patient, employee, or visitor or which may result in a claim or lawsuit against the County or its employees. Unusual occurrences and/or adverse events that meet reporting guidelines will be reported to the California Department of Public Health Services, and when required, to the Centers for Medicare & Medicaid Services (CMS), as outlined in the Reporting Procedure section of this policy.

VCMC/SPH wants employees/providers to feel safe to speak-up and speak-out about reporting of adverse events, near misses, existence of hazardous conditions, and related opportunities for improvement as a means to identify systems changes and behavior changes which have the potential to avoid future adverse events.

VCMC/SPH endorses a Just Culture, which is considered a supportive system of shared accountability designed to balance the assessment of systems, processes, and human behavior when an error occurs, or an event is reported. Greater focus is placed on system design and management of behavioral choices enabling the organization to act where needed.

REPORTING PROCEDURE:

Any employee or provider will immediately report to their supervisors any unusual occurrence, adverse event or potential sentinel event utilizing the appropriate chain-of-command.

A. **Identification and Determination of an Unusual Occurrence, an Adverse Event, or a Sentinel Event**
    1. Reporting employee or provider will enter details of the event in RL Datix.
    2. Notification will be made to the VCMC/SPH Quality Assessment and Performance Improvement (QAPI) Department by department leadership and RL Datix alert.

3. The QAPI Department and relevant department leadership will, in concert with Hospital Administration, proceed with a review/investigation to determine next steps.

B. **California Department of Public Health (CDPH) - Reportable Unusual Occurrence or Adverse Events**

1. All reportable adverse events must be reported to the California Department of Public Health (CDPH) within five days of detection, or, if the event is an ongoing urgent or emergent threat to welfare, health, or safety of patient, personnel or visitors, no later than 24 hours after detection. (Reporting is done by VCMC QAPI Department at the direction of Hospital Administration.)
2. The event shall be disclosed to the patient or patient's significant other prior to reporting to CDPH.
3. The list of reportable adverse events is outlined in Attachment I.
4. An intensive investigation, as appropriate, by the relevant departments and QAPI Department will occur immediately and in concurrence with reporting guidelines.
5. The investigation must be completed within 45 days from the date of the facility's first notification of the event.

C. **Centers for Medicare & Medicaid Services (CMS) - Reportable Events** (See Attachment II - State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals).

1. The hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day upon knowledge of the following:
    a. Death that occurs while a patient is in restraint or seclusion, except when no seclusion has been used, and the only restraint used was a soft, cloth-like two-point wrist restraints.
    b. Death that occurs within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, two-point wrist restraint.
    c. Death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time.
        - "Reasonable to assume" applies only to those deaths that occur on days 2-7 after restraint or seclusion has been discontinued. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
        - This criterion applies regardless of the type of restraint that was used on the patient. In other words, it applies to all uses of

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restraint or seclusion where the patient has died on days 2-7 after the restraint or seclusion was discontinued, and it is reasonable to assume the use of the restraint or seclusion contributed to the patient's death. In a case where only two- point soft wrist restraints were used and there was no seclusion, it may reasonably be presumed that the patient's death was not caused by the use of restraints.

2. The staff must document in the patient's medical record the date and time the death was reported to CMS.

D. **The Joint Commission - Sentinel Events**

1. The Joint Commission (TJC) defines certain events, listed in Attachment III - The Joint Commission Sentinel Event Policy (July 2023 Update), as events requiring review. Some, but not all, of these events are also Reportable Adverse Events to the CDPH. (See Attachment III).
2. All sentinel events will undergo a timely, thorough, and credible root cause analysis, development of an action plan designed to implement improvements to reduce risk, implementation of the improvements, and monitoring of the effectiveness of those improvements.

E. **The National Quality Forum (NQF) - Serious Reportable Events or "Never Events"**

1. The NQF has developed and endorsed a set of Serious Reportable Events (SREs) or otherwise known as "Never Events". This set is a compilation of serious, largely preventable, and harmful clinical events, designed to help the healthcare field assess, measure, and report performance in providing safe care. The list can be accessed via the NQF Serious Reportable Events webpage.

F. **Reporting**

1. The Chief Executive Officer (CEO) or assigned designee has the authority to report the adverse event to CDPH. Any adverse event that meets reporting criteria as outlined by CDPH will be reported to CDPH within five (5) days after the adverse event was identified or within 24 hours after detection, if the event is ongoing, urgent or emergent or a threat to the welfare, health, safety of a patient, visitor, or staff. Any reportable adverse event will be reported via the CDPH Secure Electronic Web-Based Portal. The CDPH provides alternative means, by email or telephone, for submission when the web-based portal is unavailable. This requirement preserves patient confidentiality and standardizes reporting requirements. Reports are limited to factual information and statements or speculation in causation are to be avoided.
    a. Secure Electronic Web-Based Portal: https://healthcareportal.cdph.ca.gov/.
    b. California Department of Health Services,
       Ventura District Office,
       1889 North Rice Road, Suite #200
       Oxnard, CA 93030
       Toll Free Phone: 800.547.8267
       Phone No. 805.604.2926

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Fax: 805.604.2997
Email: CDPH-LNC-VENTURA@cdph.ca.gov

c. CDPH will investigate all reports. If there is ongoing threat of imminent danger of death or serious bodily injury, CDPH must perform an on-site investigation within 48 hours/2 business days. CDPH has 45 days to complete its investigation.

d. The Chief Executive Officer or assigned designee has the authority to voluntarily make a Sentinel Event Report to The Joint Commission (TJC).

e. VCMC/SPH will inform the patient or responsible party of the Adverse Event at the time the report is made.

G. Waiving of Costs

1. Costs directly related to never events are waived. Neither the patient nor third-party payor will receive a bill for costs associated with the identified never event.

All Revision Dates

4/16/2024, 3/16/2023, 12/22/2022, 4/17/2020, 9/1/2016, 12/1/2009, 6/1/2007

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Attachments

Attachment I Adverse Events VC 8.2023.pdf

Attachment II - State Operations Manual Appendix A - hospitals.pdf

Attachment III - TJC CAMH Sentinel Event Policy Updated July 2023.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	4/16/2024
Finances	Jill Ward: Chief Financial Officer, VCMC & SPH	3/18/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/18/2024
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/18/2024

Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/2/2024
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	3/1/2024

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Status Active PolicyStat ID 13529153

Origination	12/1/1986
Last Approved	4/16/2024
Effective	4/16/2024
Last Revised	4/16/2024
Next Review	4/16/2027

Owner	Alicia Casapao: Director of Quality and Performance Improvement
Policy Area	Administrative - Operating Policies

107.024 Root Cause/Event Analysis

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POLICY:

A root cause analysis (RCA) or Event Analysis (EA) is a retrospective approach to identify causative issues, systems, or processes that represent core reasons for occurrence of the event, to develop an action plan that will prevent recurrence of similar or related events, and to implement the action plan, evaluating the plan's effectiveness periodically. An RCA/EA is conducted on all sentinel events, an any event as determined by the Quality and Performance Improvement (QAPI) Department in collaboration with the Chief Medical Officer, and is performed in accordance with the principles of Just Culture. Findings are reported to the Medical Executive Committee and are protected under Civil Code Section 1157. The RCA/EA will be completed within 45 days of the occurrence or the discovery of the event.

PROCEDURE:

A. A root cause / event analysis contains the following characteristics:
    1. Primarily focuses on systems and processes – not individual performance.
    2. Progresses from special cause process focus to common cause system and/or organizational focus.
    3. Consistently focuses on basic, core rationale for causative factor(s).
    4. Identifies necessary redesign efforts and/or revisions in systems and processes, intended to improve performance levels and reduce the risk of event recurrence.

B. The Analysis Team will formulate a "work plan" with established objectives and target dates. Whenever possible, front line staff involved in the care of the patient shall be included.

C. Analysis Team meeting will contain the following elements:

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1. A clear definition of the issue(s) pertaining to the sentinel event;
2. Brainstorming all real or potential contributing causes;
3. Organizational and analysis of causative factors, listing these factors in identified cause/effect priority;
4. Identify those systems or processes related to the causative factors, determining the relationship of each cause to the system or process as special or common.
    a. Common causes within a system(s) will receive emphasis as identified from special causes within a process(es) i.e., special cause variation in a larger the process has a relationship.
5. Identify actions that will have immediate benefit on the organization relationship to prevention of further event recurrence. Implement the identified actions as soon as possible, regardless of the progress point of the analysis.
6. Establish a time line to assess team progress.
7. Emphasize improvement actions on identified larger systems. The most concrete and permanent benefit will result by redesigning the larger system to eliminate common causes of variation.
8. Focus improvement plans on redesigning processes and systems to eliminate identified root causes of the sentinel event.
9. Implement and monitor the action plan.
10. Function as resource personnel during action implementation.
11. Establish time frames and methodology to assess and evaluate effectiveness of the action plan.
12. Follow the evaluation time line through data collection and aggregation. Measure, assess and evaluate effectiveness of the action plan.
13. Report effectiveness of the action plan to the Administrative Team, Medical Staff Executive Committee, Performance Improvement Coordinating Council and Oversight Committee.

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All Revision Dates

4/16/2024, 6/30/2020, 9/1/2016, 5/1/2006, 2/1/2006, 6/8/2000

Approval Signatures

Step Description	Approver	Date
Hospital Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	4/16/2024

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Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/18/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	3/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/11/2024
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	3/11/2024

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Status Active PolicyStat ID 11353068

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Effective	4/17/2024
Last Revised	4/17/2024
Next Review	4/17/2027

Owner	Fernando Medina: Director, Support Services
Policy Area	Dietary

D.26 Dietary Purchasing and Receiving

POLICY:

The Dietary Services Department shall provide the highest quality food and supplies at the most competitive price from vendors who are approved by Ventura County Medical Center and Santa Paula Hospital, as well as Federal, State and local regulatory agencies. Food and supplies are to be ordered on a regular basis by the Assistant Food Services Supervisor from approved vendors in accordance with established quality standards set forth by Federal, State and local regulatory agencies.

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PROCEDURE:

I. Purchasing

A. Quality Specifications

1. Government-inspected meat, meat products, poultry, poultry products, and fish.
2. Shellfish from a reputable dealer who complies with the regulations of the State Shellfish Authority.
3. Pasteurized milk and milk products which meet the standards established by the California Food and Agriculture Code.
4. Bakery products from a food processing establishment approved by the health authority.
5. Fresh and frozen produce from reputable vendors.
6. Canned and staple food items from reputable vendors.

B. Quantity Specifications

1. Patient Food Services

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A planned one-week cycle menu serve as the basis for determining specific food items ordered.

2. Cafeteria Food Services
   A planned menu serves as the basis for ordering specific food items.
3. Quantity of items to be ordered is based upon total number of portions required. Portion yields and overall quality characteristics are considered before price.
4. Dietary/Food Services orders all supplies. Purchasing places orders for special requisition items and equipment in accordance with quality specifications established by Director of Food Services.
5. Ordering Schedule:
   a. All staples are ordered weekly by the Assistant Food Services Supervisor and stored in the Food Services Storeroom.
   b. All fresh meats, poultry and fish are ordered on a weekly basis one week ahead of time and placed for bid by the Ventura County purchasing agent.
   c. Frozen vegetables, frozen entrees, and other frozen items are ordered directly by Food Services on a weekly basis as needed.
   d. Fresh produce is ordered twice weekly.
   e. Milk is delivered twice weekly.
   f. Ice cream is delivered weekly.
   g. Eggs are delivered weekly.
   h. Bakery goods are ordered 3 times per week.
   i. Coffee and products are delivered weekly.
   j. All perishable foods are delivered directly to Dietary Services Department and checked for quality and quantity by the Assistant Food Services Supervisor or Shift Supervisor. They are dated and stored in refrigerator or freezer as indicated.
   k. The Food Services Director, Staffing Services Specialist, Assistant Food Services Supervisor and Supervisors have the key and access to the storeroom, freezers and refrigerators. All foods and supplies are requisitioned by the Food Services personnel and issued by the Assistant Food Services Supervisor or Supervisors.

II. Receiving

A. Food and supplies are received by Dietary Services personnel. This will be the responsibility of the Assistant Food Services Supervisor and/or the Food Service Assistant.

B. All received commodities are checked against the accompanying invoice for accuracy. All meats are checked for appropriate quality and grading.

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C. Providing that all goods are delivered and quality is satisfactory, the delivery invoice from the vendor is signed by the receiver. If any food products are unacceptable, they are immediately returned for credit.

D. All invoices from vendors are sent to Accounts Payable.

E. All received goods are stocked by assigned personnel in accordance with the procedure "Storage of Food".

F. Storage Locations

1. Groceries are put in the Dry Goods Storeroom, utilizing the FIFO System. (First in First Out).
2. Produce is placed in the walk-in refrigerator. (FIFO)
3. Bakery items are put in walk-in refrigerator. (FIFO)
4. Bread is stored in racks in Dry Goods Storeroom.
5. Milk and milk products are stored in the walk-in refrigerator. Milk delivery man is responsible for rotation. Eggs and pasteurized egg products are stored in the walk-in refrigerator.
6. Fresh meats are frozen in walk-in freezer if not to be used within 48-72 hours. Other meat items are put in the walk-in refrigerator.
7. Paper goods are stored in the Dry Goods Storeroom.
8. Cleaning supplies are stored in Janitor's storeroom. No toxic substances are stored in the kitchen or cafeteria area, food storeroom, or any area where food preparation occurs.

III. Approved Vendors (See Approved Vendors)

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All Revision Dates

4/17/2024, 3/1/2014, 12/1/2007

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	4/17/2024
Dietary Department	Fernando Medina: Director, Support Services	4/17/2024

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Status Active PolicyStat ID 15603547

Origination	6/1/1989
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Effective	4/22/2024
Last Revised	4/22/2024
Next Review	4/22/2027

Owner	Fernando Medina: Director, Support Services
Policy Area	Environmental Services

EVS.31 Wet Floor Signs

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POLICY:

To ensure the safety of patients, visitors and staff, all Housekeeping staff will employ the proper use of "wet floor" signs.

PROCEDURE:

A. Housekeeping staff will employ the following safety precautions with all floor care procedures which result in the wetting of a floor surface.
    1. Wet floor signs will be placed **prior** to the procedure of floor care.
    2. They will be placed a maximum of 8 feet apart.
    3. Wet floor signs will be placed as to indicate and isolate the area of floor which is wet.
    4. Wet floor signs will remain until floor is **thoroughly dry**.
    5. Wet floor signs must be cleaned with hospital approved cleaner disinfectant when visibly soiled.
    6. Damaged wet floor signs must be removed from use and replaced.

B. Liquid Spills.
    1. Whenever there is a liquid spill, a wet floor sign(s) will be placed to indicate a slipping hazard.
    2. The spill will be wiped up immediately.
    3. Wet floor signs will remain in place until the floor surface is thoroughly dry.

C. Any slipping incident involving patients, visitors or staff that is observed by Housekeeping staff shall be immediately reported to the Housekeeping Supervisor who will then report the

incident in writing to the Department Manager.

Failure to comply with these rules will result in disciplinary action.

All Revision Dates

4/22/2024, 3/1/2013, 4/1/2010, 12/1/1992

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	4/22/2024
Infection Prevention	Magdy Asaad: Infection Prevention Manager	4/18/2024
Housekeeping Manager	Michael Lopez: Supervisor, Environmental Services	4/17/2024
Housekeeping Manager	Fernando Medina: Director, Support Services	4/17/2024

Status **Active** PolicyStat ID **15500168**

Origination	2/5/2024	Owner	Molly Teron: Director, Patient Financial Services
Last Approved	4/9/2024	Policy Area	Patient Financial Services
Effective	4/9/2024		
Last Revised	4/9/2024		
Next Review	4/9/2027		

PFS.01 Credits and Adjustments (Current State vs Future State)

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POLICY:

Credits and adjustments shall be processed using the procedure listed below.

PROCEDURE:

Current State Plan

The credit report is sent out weekly to the Chief Financial Officer (CFO) team as well as the Patient Financial Services (PFS) management team, so everyone is aware of the current credit balance. Any major issues that may cause potential credits are also escalated to the CFO (e.g., payer issues with processing adjusted claims and/or copays).

A. Staff are required to do the following when a credit is identified:
    1. Identify and initiate a refund request within 60 days.
    2. Enter a detailed note on the encounter that explains the reason for the refund.
    3. If sending a Provider Dispute Resolution (PDR), to have an overpayment recouped, a detailed note will be added to the encounter, explaining why the payment will be recouped. Backup documentation will be scanned and added to the encounter as to support the recoup.
    4. If the payer is unable to recoup, then a refund by check will be processed through the Auditor-Controller's Office. Staff shall ensure all appropriate backup documentation has been scanned to the encounter along with the refund form (e.g., Explanation of Benefits).
    5. Review the encounter balance and if appropriate, adjust to reflect the credit amount

owing (unless there are still other charges being collected on). Sometimes the payer will leave the contractual on the encounter and this amount is not part of the refund.

6. Forward refund form to supervisor for review before forwarding to Cash Control, who will then process payment through the Auditor-Controller's Office.
7. If no credit is due and it is identified the credit is not a true credit but instead an over-adjusted claim, the biller may reverse the credit amount to resolve the encounter.

B. Until future state reports and processes are in place, staff are required to do the following when posting an adjustment and/or reversing an adjustment:

1. Staff shall send an email to their supervisor for any adjustment over $5000.00 for review. Staff shall follow the same dollar thresholds as listed below in the future state plan. The supervisor, manager and director are required to review the adjustment based on dollar threshold and provide a detailed note on the encounter, documenting it was approved or denied.

   **This will not include any system or payer-related adjustments. This is specifically for user adjustments by PFS billing and collections staff. Credits/adjustments posted/made by Ambulatory Care staff or Hospital staff must be reviewed by the respective Ambulatory Care or Hospital management to ensure compliance and accuracy.

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Future State Plan for Adjustments

Informatics will create an adjustment report within Cerner for PFS management to audit any adjustments with a dollar threshold of greater than $5000.00. The current report does not provide the necessary information needed and will require enhancements.

A. This new report will show:

1. The encounter number
2. The user making the adjustment.
3. The adjustment amounts.
4. The adjustment reasons.

Informatics is also working with Cerner to have adjustments and adjustment reversals over a specific dollar threshold, pend for supervisor/manager review before being released. These will route to specific worklists in Cerner for review. Management will also be required to add an encounter note for each review performed.

A. Any adjustment between the range of $5000.00 to $25,000.00 will pend for supervisor review, before releasing the adjustment to post.
B. Anything with a dollar threshold from $25,000.01 to $100,000.00 will require Manager review before being released.
C. Anything over $100,000.00 will require the Director to sign off, before being released by the Manager.

By automating the process, this will allow the management team to audit regularly and ensure the credits and adjustments are being processed correctly. Staff will be notified if any discrepancies are identified and will correct the encounter.

All Revision Dates

4/9/2024, 2/5/2024

Approval Signatures

Step Description	Approver	Date
HCA Chief Financial Officer	Michael Taylor: Chief Financial Officer, Health Care Agency	4/9/2024
Revenue Cycle Director	Molly Teron: Director, Patient Financial Services	3/26/2024
Patient Financial Services	Molly Teron: Director, Patient Financial Services	3/26/2024

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Status Active PolicyStat ID 12478211

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Last Revised	4/3/2024
Next Review	4/3/2026

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

R.70 Respiratory Care Scope of Operations and Availability of Services

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POLICY:

To outline the services offered by the Respiratory Care Department of Ventura County Medical Center/ Santa Paula Hospital and the availability of such services as directed by a licensed practitioner (LP) and California Respiratory Care Board. The practice typically focuses on:

PROCEDURE:

1. Medical consultations
    - A. Medical consultations by the Medical Director including in-patient care, bronchoscopy, and interpretation of Pulmonary Function Tests.
    - B. Medical consultation by LP directly caring for patient
2. The Respiratory Care Department will provide therapeutic services appropriate to the care of patients in need as ordered by a licensed practitioner (LP). These services include,but are not limited to, the following:
    - A. Patient assessment
        - a. physical examination
        - b. diagnostic data interpretation
    - B. Education and instruction to patients
    - C. Application of therapeutics to respiratory care
        - a. Medical gas therapy
        - b. Humidity therapy

c. Hyperinflation therapy
d. Aerosol therapy
e. Artificial airway insertion, management and care
f. Airway clearance
g. Invasive and non-invasive mechanical ventilation

D. Implementation of ventilator support
    a. Invasive
    b. Non-invasive

E. Assist and/or perform endotracheal intubation

F. Administration of aerosol medication
    a. Metered dose inhalers
    b. Large and small volume nebulizers

G. Assistance with bronchoscopies

H. Collection of Sputum Samples for processing by the Laboratory

I. Pulmonary function testing
    a. Peak Flows
    b. Pulmonary Function Test
    c. Bedside Spirometry

J. Documentation of oxygen saturation by non-invasive pulse oximetry

K. Assistance during placement, replacement, downsizing or removal of tracheostomy tubes

L. Administration of surfactant

M. Assessment of therapies

N. Provision of emergency, acute, critical, and post-acute care, including
    a. Patient and environmental assessment
    b. Therapeutic interventions
    c. Patient transports

O. Disease management of acute and chronic diseases

P. The following services are available (management should be notified to ensure services):
    1. Operation of nitric oxide
    2. Operation of Flolan
    3. Operation of Heliox
    4. Assistance with ventilator in surgical suite

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5. Out-of-facility ventilator transports

Q. The Respiratory Care Department will provide laboratory diagnostic services as noted below:

1. Analysis of whole blood for both arterial and venous samples. Testing will include:

a. Arterial Blood Gases

1. Power of hydrogen (pH), partial pressure of carbon dioxide (PCO2), partial pressure of oxygen (PO2), Bicarbonate (HCO3), Base excess (BE)
2. Lactates
3. Electrolytes
4. Glucose
5. Hemoglobin (Hgb)

b. Venous Blood Gases

1. pH, PCO2, PO2, HCO3, BE
2. Lactate
3. Electrolytes
4. Glucose
5. Hgb

c. Mixed Venous Blood

1. PO2
2. Hgb
3. Oxygen Hemoglobin

R. Patients across the age spectrum- neonatal through geriatric

S. The Respiratory Care Department will participate in Performance Improvement and Emergency Preparedness activities as deemed appropriate.

3. Availability of Services:

A. All critical Respiratory Care services are available 24/7

B. Non-critical Respiratory Care services are available during day shift hours

1. Complete Pulmonary Function Test

a. Available by appointment only

b. Contact scheduling desk to arrange an appointment

2. Chronic Obstructive Pulmonary Disease (COPD) assessments and consultation

3. Smoking cessation consultations

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All Revision Dates

4/3/2024, 11/10/2020, 7/1/2015, 1/1/2014, 2/1/2012, 2/1/2010

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices [ML]	4/3/2024
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	4/3/2024

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Last Approved	4/15/2024
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Last Revised	4/15/2024
Next Review	4/15/2027

Owner	Marcos Rodriguez: Manager, Rehabilitation Services
Policy Area	Rehab Services

RS.06 Rehab Services Missed Appointments

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POLICY:

To ensure availability of appointment times, especially during times of high volume, and to encourage effective use of staff time, patients scheduled to receive outpatient Rehab Services therapy shall be removed from the therapy schedule and referred back to their physician under certain conditions.

PROCEDURE:

Patients shall be removed from the schedule and referred back to their physician under the following conditions:

- Failure to keep two (2) consecutive appointments without calling Rehab Services to cancel (a minimum of four hours' notice is needed for a cancellation)
- Three (3) cancellations during a series of scheduled treatments
- If their prescription is over three (3) months old

Guidelines for Staff:

- Post the scheduling policy in the reception area.
- When staffing permits, call the patient to remind them of their appointment time.
    - Review the patient's attendance record prior to placing the call.
- The therapist and/or clerical staff shall remind the patient and/or their caregiver of the missed appointment policy if the patient has a history of no-shows or multiple consecutive cancellations.
- Document the notification to the patient and/or caregiver of the missed appointment policy in the EHR.

- Notify the patient's physician if a patient fails to keep their appointment and document via phone, email and/or message center in the patient's EHR.

All Revision Dates

4/15/2024, 12/1/2020, 2/25/2019

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator-AncillaryServices	4/15/2024
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	4/3/2024

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Medical Executive Committee Document Approvals

May 2024

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Medical Executive Committee Document Approvals

May 2024

a. Policies & Procedures / Forms / Orders

□he follo□ing □ere revie□ed and recommended for approval by the appropriate □epartments□Committees□and the Medical □□ecutive Committee

#	Title	Summary	Frequency	Page
1.	100.015 Patient Assessment and Reassessment	□pdated definition of physical system evaluation. □pdated □ho □ould perform shift assessment.	□riennial	2□5
2.	100.025 Medications: Ordering□Administration and □ocumentation	Removed reference to ambulatory care clinics and added infusion center. □pdated and e□panded process for medication scanning.	□riennial	6□12
□	100.0□0 Critical □ests and Critical Results	□pdated process regarding communication to the licensed practitioner and documentation in Cerner. □pdated responsibilities of testing personnel and chain of command for communication. □pdated definitions of several critical results.	□iennial	1□□21
4.	100.0□1 Processing a □eath □ Post□Mortem □□am	Clarified responsibilities of nurse/unit charge nurse/nursing supervisor□security□physician□□□M□and social services. □pdated process outlining □hen a family cannot provide for the disposition of remains. □pdated criteria for identifying deaths appropriate for hospital autopsy.	□riennial	22□□0
5.	100.0□6 Pain Assessment□Management and □ocumentation	Added process for patient re□uesting pain medication for a lesser pain indication.	□riennial	□1□□8
6.	100.24□Mechanical Chest Compression System □□□CAS □evice□□sage and Safety	□o changes	□riennial	□9□40
□	100.2□2 □uideline for □ransfers for Patients Re□uiring a □igher □evel of Care	□o changes	□riennial	41□42
8.	101.010 Cardiopulmonary Resuscitation □CPR□□raining Re□uirements	□pdated patient care areas □here AC□S/A□S is re□uired and recommended for R□s and □V□s.	□riennial	4□45
9.	102.028 Physician in □raining Moonlighting Privileges	□efined physicians eligible to be granted moonlighting privileges and outlined locations of practice.	□riennial	46□4□
10.	102.029 Ongoing Monitoring and □nterventions	□pdated to include monthly monitoring of □SA/SAMS and the SS□M□and referenced reporting ineligible practitioners to the Compliance Office.	□riennial	48□50
11.	102.0□0 Medical Staff Professional □iability □nsurance Re□uirements	□o changes	□riennial	51□52
12.	102.0□□Allied □ealth Professionals	□e□ policy□re□uired language previously included in the byla□s/rule moved to a policy for additional fle□ibility □ith licensing board changes.	□riennial	5□68
1□	102.0□4 □on□□iscriminatory Credentialing □ Recredentialing Process □□ith attachment□	Re□uired policy for payor delegated credentialing agreements	□riennial	69□□1
14.	106.028 □solation Precautions	□pdated C□C lin□to isolation precautions list.	□riennial	□2□□□
15.	106.0□9 □isaster/□mergency Volunteer □ealth Professionals	Removed responsibility of Chief □urse □□ecutive overseeing the performance of the volunteer practitioner.	Annual	□8□80

16.	AC.01 Ambulatory Care □mergency Response □□uipment	□efined the purpose of the policy and added definitions for □mergency Medical Condition and □mergency Services. Revised to reflect updated C□P□ □ □old Coast □acility Site Revie□ Standards for □mergency Procedures.	□riennial	81□86
1□	AC.□5 Ambulatory Care Medication Management	□ull policy revision to reflect the most current □PS□□standards and professional publications. Revisions include detailed definitions of medication order fre□uencies and medication management□clarified appropriate orders for AC clinics□updated ha□ardous medications to align □ith referenced policies□updated loo□a□li□e medications□and updated the MA responsibilities.	□riennial	8□96
18.	Care of the Patient Aged 14 □ears and Over Outside of Pediatrics and P□C□	□o changes	□riennial	9□98
19.	□R.29 □egal □□amination of □lood in the □mergency □epartment	□o changes	□riennial	99□100
20.	□R.□8 Patient □riage	□o changes	□riennial	101□104
21.	□C□.08 □ntensive Care □nit Alternative Patient Placement	□o changes	□riennial	105□106
22.	□C□.22 Admission Criteria to the □elemetry □nits	□pdated criteria and e□clusions for admissions. Added re□uirement of reassessment of need for continued telemetry every 24 hours and updated telemetry technician and registered nurse responsibilities. □pdated documentation timeframe re□uirements.	□riennial	10□□111
2□	□C□.24 Adult □ntensive Care □nit Admission and Scope of Service	Added re□uirement of admission or evaluation by surgical services □ithin 24 hours for □rauma patients.	□riennial	112□11□
24.	□C□.28 □argeted □emperature Management □□□M□and Shivering protocol	□pdated echocardiogram to electrocardiogram.	□riennial	114□120
25.	□S.11 Controlled □rug Access in □maging Services	Corrected minor typographical errors.	□riennial	121□122
26.	□S.□□□□am Order Verification	□o changes	□riennial	12□□124
2□	O□.4□□epatitis □ Prevention in □e□borns	□pdated purpose of policy. Clarified administration of medication and documentation re□uirements. Added ne□ policy references	□riennial	125□12□
28.	P□.115 Medication □o□es and □its □□ith attachments□	□pdated name of medication bo□and included □ntensivists to □or□flo□	□riennial	128□1□2
29.	RS.11 Rehab Services □ight □herapy	Added precautions section and moved 2 contraindications to this ne□ section.	□riennial	1□□1□4

VENTURA COUNTY
HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
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Policy Area:	*Administrative - Patient Care*
References:	

100.015 Patient Assessment and Reassessment

POLICY:

To ensure that patients admitted to Ventura County Medical Center and Santa Paula □ospital receive regular, timely, and appropriate nursing assessments and/or reassessments in order to enable sound clinical decision-making. Patients at Ventura County Medical Center (VCMC) and Santa Paula □ospital (SP□) receive nursing care based on a documented assessment and reassessment of their needs.

Each patient□s need for nursing care related to his/her admission is assessed by a Registered Nurse (RN). The initial assessment is conducted by the RN within a specified time frame. Assessment consists of two parts: (1) data collection (e.g., observation, interview, palpation, auscultation, information obtained from any medical □ewelry, clinical laboratory and diagnostic tests, and (2) data analysis, synthesis, and evaluation. Certain aspects of data collection may be delegated by the RN to a Licensed Vocational Nurse (LVN) or Licensed Psychiatric Technician (LPT). Data may be collected by physicians, Allied □ealth Professionals, laboratorians, dietitians, physical therapists, occupational therapists, social workers, and by other providers of nursing care such as LVNs, PTs, and Nursing Assistants. *Only the RN may evaluate nursing care and make changes to the patient's plan of care. The RN must assess, analyze, synthesize and evaluate nursing care on all in-patients at least once every 24 hours.*

Patient needs and nursing care are assessed and reassessed on an ongoing basis throughout the patient□s hospital stay as warranted by the patient□s condition.

Definitions:

Definition of Types of Nursing Assessments/Reassessments:

A. **Admission (Initial) Assessment**:

   1. The admission (initial) admission patient assessment is considered a comprehensive assessment and includes a head to toe physical assessment completed by the RN. Data collection is sub□ective and ob□ective and includes the following:

a. ~~A physical systems evaluation that includes: Central Nervous System, Cardiovascular, Musculoskeletal, Pulmonary, Skin, Gastrointestinal, Genitourinary, Metabolic, Reproductive, and Pain.~~A physical systems evaluation that includes full body systems assessment.

b. Assessment of psychosocial, environmental, functional (level of self-care), educational and discharge planning areas are documented. □ henever possible, data from the patient□s significant other(s) is included.

c. A nutritional risk screening assessment is completed upon admission. Nutritional Services is notified of the nutrition risk score and provide further evaluation to patients who have a nutrition risk score greater than or e□ual to six (6).

d. A functional risk assessment is completed upon admission to identify any limitations that may re□uire referral for rehabilitation services. A patient□s functional status, i.e., ability to perform activities of daily living, provides cues or indicators for potential risks for fall, development of deep vein thrombosis, and aspiration. Risk for falls is assessed using the Morse □all Scale.

e. ~~e.~~ A skin assessment is a visual assessment done for the purpose of identification of impaired skin integrity. A □raden Risk assessment is done for identification of risk for impaired skin integrity utilizing the □raden □ndex. Patients admitted with existing skin impairment or breakdown will have this noted both in the physical assessment and as a □raden Score.

f. An individualized plan of care is developed by the RN based on this comprehensive assessment and identified patient care needs and care standards. The plan is consistent with the therapies of other disciplines. Nursing staff collaborate with physicians and other clinical disciplines through an interdisciplinary team approach in making decisions regarding patient□s need for nursing care. □t is a Patient Right to participate in decisions related to the formulation of the plan of care, and is discussed with and developed as a result of coordination with the patient□s family or other representative when appropriate (Title 22, CMS).

g. Throughout the patient□s stay, the patient and, as appropriate, his/her support person(s) receive education specific to the patient□s health care needs. An assessment of the patient□s learning needs, as well as their ability to learn, is started at admission and completed within 12 hours of admission. Reassessment and evaluation of learning needs is based on identified needs. The following factors are considered when addressing the patient□s specific learning needs including:

   1. Patient□s/support person□s ability to comprehend and implement the provided education
   2. Nature and complexity of the patient/family learning needs
   3. Readiness to learn
   4. Language/Communication barriers
   5. □n preparation for discharge, continuing care needs are assessed and referrals for such care are documented in the patient□s medical record.

   ~~Patient□s/support person□s ability to comprehend and implement the provided education~~

   ~~Nature and complexity of the patient/family learning needs~~

   ~~Readiness to learn~~

   ~~Language/Communication barriers~~

   ~~□n preparation for discharge, continuing care needs are assessed and referrals for such care are documented in the patient□s medical record.~~

B. Head to Toe Assessment involves the detailed examination of the body from head to toe using the techni□ues of observation/inspection, palpation, percussion, and auscultation. The □ead to Toe assessment includes the following components/systems:

~~a. General Status~~

~~b. Vital signs~~

~~c. Head, Ears, Eyes, Nose, Throat~~

~~d. Neck~~

~~e. Respiratory~~

~~f. Cardiac~~

~~g. Abdomen~~

~~h. Pulses~~

~~i. Extremities~~

~~j. Skin~~

~~k. Neurological~~

1. General Status
2. Vital signs
3. Head, Ears, Eyes, Nose, Throat
4. Neck
5. Respiratory
6. Cardiac
7. Abdomen
8. Pulses
9. Extremities
10. Skin
11. Neurological

C. Shift Assessment is a comprehensive Head to Toe assessment that must be completed at least once a shift~~. This may be performed by a LVN or a RN, but at least once every 24 hours it must be completed by a~~ by an RN.

D. **Reassessment** is done at designated intervals and/or when there is a change in the patient's level of care (unit transfer) or status/condition (e.g. after a medical procedure). A reassessment may be as simple as an assessment of a body system or may be a thorough as a shift (head to toe) assessment and indicates the response to and effectiveness of the care and interventions.

~~**E. Reassessment** is done at designated intervals and/or when there is a change in the patient's level of care (unit transfer) or status/condition (e.g. after a medical procedure). A reassessment may be as simple as an assessment of a body system or may be a thorough as a shift (head to toe) assessment and indicates the response to and effectiveness of the care and interventions.~~

PROCEDURE:

All patients will be assessed or reassessed according to the following grids (See Attachment).

All revision dates: 4/10/2024, 7/11/2023, 8/10/2021, 5/1/2006

Attachments

Assessment-reassessment Parameters 4.10.24.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
□ospital Administration	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	4/19/2024
□ospital Administration	Diana □enner: Chief Operating Officer, VCMC □ SP□	4/11/2024
Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	4/10/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	4/10/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	4/10/2024

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VENTURA COUNTY HEALTH CARE AGENCY

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100.025 Medications: Ordering, Administration and Documentation

Policy:

Ventura County Medical Center (VCMC), Santa Paula □ospital (SP□), □npatient Psychiatric □nit (□P□), Crisis Stabilization □nit (CS□) and ambulatory care ~~clinics~~□nfusion Center (□N□) maintain processes for the safe and timely prescribing, administration, and documentation of medications to patients.

Definitions:

Licensed Practitioner (LP): physicians or mid-level practitioners contracted with the □ealth Care Agency to provide patient care.

□ealth Care Professional (□CP): licensed individuals such as registered nurses and respiratory therapists who are authorized to administer medications.

Procedure:

□. Medication Order Prescribing

A. All medications administered at VCMC, SP□, □P□, CS□, and ~~ambulatory care clinics~~□N□ shall be ordered by a licensed practitioner (LP) and noted by a health care professional (□CP) as approved in the Medical Staff bylaws.

□. A current Medical Staff Roster shall be maintained by the Medical Staff Office. A listing of all Medical Staff members recognized as having the privilege to prescribe medications within the facility shall be available to the Department of Pharmacy Services.

C. The Medical Staff Office shall maintain a log documenting Medical Staff and their Drug Enforcement Administration (DEA) numbers.

D. Medication orders to non-providers can be found on policy 100.220 Electronic Order Management.

E. Pharmacy approved prescriptive authority can be found on policy 100.216 Electronic Pharmacy Prescriptive Order Entry Authority.

□. Abbreviations used in medication orders can be found policy 107.005 Medical Abbreviations.

□□. Medication Order

A. Medication orders shall be entered into the electronic health record (E□R) and shall include the

following:

1. Medication name
2. Dosage
   i. Dosage should be expressed in the metric system except in instances where dosage must be expressed otherwise (e.g. units).
   ii. □or pediatric patients, dosage should be based on weight or body surface area (e.g. milligrams/kilogram □mg/kg□or milligram/meter s□uared □mg/m^2□).
   iii. Dose ranges are not acceptable (e.g. hydrocodone/acetaminophen 1-2 tablets every □□□4 hours As Needed for □PRN□pain).
3. □re□uency of administration
   i. □nterval ranges are not acceptable (e.g. hydrocodone/acetaminophen 1 tablet □4-6 hours PRN pain)
4. Route of administration
5. □ndication for use for the following:
   i. All PRN medications
      a. □ndication ranges are acceptable if the order does not create therapeutic duplication(e.g. hydrocodone/acetaminophen 1 tablet every 6 hours PRN mild-moderate pain).
      b. Topical medication orders shall describe the specific location of application.
      c. Acetaminophen and ibuprofen orders must be clarified to describe the specific indication for use (e.g. fever versus □vs□headache or pain). □f fever is selected, the actual temperature must also be included.
   ii. Antimicrobial orders
   iii. Anticoagulant orders
6. The date and time of the order
7. The identity of the ordering LP

□. Titratable □ntravenous (□V) medication orders shall also include the following

1. Concentration in units/milliliter (mL) such as mg/mL
2. □nitial rate of infusion
3. Loading and/or bolus doses, if applicable
4. Titration parameters
   i. □ncremental dose
   ii. Titration rate with increase and/or decrease instructions for nurse administration.
   iii. Maximum dose or specified time
   iv. Titration goal, end point, or desired patient response
5. Notify provider parameters

C. All medications orders shall follow Automatic Stop-Orders (see P□.61 Automatic Stop Orders).

□□□ Medication Order Review and Verification

A. All medication orders are routed to Pharmacy and reviewed by a licensed Pharmacist.

1. See policy P□.55 Medication Order Management
2. See policy P□.19 After □ours Pharmacy Services at Santa Paula □ospital

□. Appropriate □CPs shall review medication orders prior to administration.

□V. 0.0.0.1. Medication Distribution

A. Medications shall be available in the automatic dispensing cabinet (ADC)□however, in the event the medication is not supplied in the ADC, Pharmacy shall send the medication to the nursing unit

1. Medications not readily available in the ADC should be placed in the patient□s cassette.
2. Any discrepancies noted in the medications or labels should be brought to the attention of a Pharmacist.
3. At no time shall a medication be □borrowed□from one patient for the use of another.

□. □ hen a patient is transferred from unit to unit, the patient□s □V solutions, □V antibiotics and medications not stocked in the ADC such as insulin are to be delivered to the new unit by the nurse responsible for the patient.

C. Missing medications shall be re□uested through the E□R by the appropriate □CP.

a. □ntravenous continuous infusions for □ntensive Care □nit (□C□), Definitive Observation □nit (DO□) and Pediatric □ntensive Care □nit (P□C□) patients shall be electronically re□uested by through the electronic health record (E□R) by the appropriate □CP no later than three hours prior to the time the medication is expected to run out or time of drip change.

D. Medications for Emergency Department (ED) □old patients

1. □CPs caring for ED □old patients may re□uest scheduled medications to be dispensed from the pharmacy by submitting a re□uest through the E□R. Any scheduled medication that is not administered immediately shall be stored in a secure location.
2. Controlled substances, immediate (STAT), NO□ , and PRN medication should be obtained from the ADCs in the ED.

E. □ hen a patient is discharged, expires, or leaves the hospital Against Medical Advice (AMA), the medications remaining in the cassette are returned to Pharmacy. The label on the outside of the patient cassette is removed and placed with the medications. The medications should be returned to Pharmacy immediately or placed in the Pharmacy □out□box.

□. Pharmacy policies related to medication distribution

1. See policy P□.46 Medication Storage and Security
2. See policy P□.52 Medication □andling
3. See policy P□.55 Medication Order Management
4. See policy P□.88 Controlled Substances
5. See policy P□.92 Automated Dispensing Cabinet □sage and Documentation
6. See policy P□.96 Medication Override from Automated Dispensing Cabinets

V. Medication Administration and Documentation

A. Medication Administration Privileges

1. See policy P□.72 Staff Authorized to Administer Medications
2. Medications are administered only on the order of a member of the Medical Staff, a practitioner who has been granted temporary privileges by the Chief Executive Officer or designee, a pharmacist or nurse who is practicing under the auspices of an approved protocol, or a physician□s assistant who is practicing within the context of his/her Medical Staff-supervising physician.

□. Standard Administration Times

1. Scheduled medications shall be given up to one (1) hour before or one (1) hour after the scheduled time.
   i. □nitial emergency department (ED) orders placed prior to nursing assignment are to be given within one hour of a nurse being assigned to the patient. Antibiotics, anticoagulants, and insulin are considered time critical and need to be administered within 30 minutes after nurse is assigned to patient.
2. Time critical medications are identified as medications that re□uire administration within 30 minutes before or after the scheduled dosing time. These medications include:
   i. Antibiotics
   ii. Anticoagulants
   iii. □nsulin
3. Medications should be given during standard administration times (see Attachment A).
4. Pharmacists may ad□ust the fre□uency to comply with standard administration times taking care to ensure the first dose is initiated as originally ordered (see Attachment □ - Standard Administration Dosing Matrix).
5. Around the clock (ATC) medications should be limited to intravenous antibiotics □ intravenous diuretics and will automatically default to every □ hours from the time of the order with initiation or first dose priority per the L□P□s order.
6. □CPs can ad□ust the first administration time. □CPs shall notify pharmacy via electronic change re□uest, if subse□uent doses re□uires ad□usting.
7. Administration times may change based on patient care needs.

C. Non-standard Administration Times

1. □or medications available from the ADC, all STAT orders shall be given within 15 minutes of order, NO□ or ASAP orders shall be given within 20 minutes of order, and PRN shall be given within 30 minutes of order or patient re□uest.
2. □or medications NOT available from the ADC, the order shall be verified by pharmacy and processed as follows:
   i. STAT order shall be processed and delivered to nursing units within 30 minutes.
   ii. NO□ and ASAP orders within 60 minutes
   iii. Regularly scheduled medications and PRNs within two (2) hours.

D. Seven Rights of Safe Medication Administration

1. The Seven Rights shall be followed: right DR□G, right Patient, right DOSE, right T□ME, right RO□TE, right □ND□CAT□ON, and with the right DOC□MENTAT□ON.
2. Medications are prepared one patient at a time.
3. The □CP shall verify that the medication dispensed is what was ordered by checking the medication label with the provider□s order on the medication administration record (MAR). All aspects of the order (patient, medication, name, route, dose, fre□uency) must be correct.
4. □ hen administering an unfamiliar medication, a known resource shall be used as a reference to determine the correct dose, correct administration techni□ue, indications, contraindications, compatibility, signs/symptoms to monitor, and necessary post administration monitoring re□uirements
5. The patient□s identity shall be verified verbally by the □CP asking the patient to state their name and date of birth and then comparing and scanning that with their identification (□D) band and the MAR each time a medication is administered or blood is taken or given.
6. Non-verbal patient and neonatal and pediatric patient identities shall be verified by the □CP checking the □D band or medication record for name, date of birth, □D band number and/or medical record number. Such identifying information shall also be checked with the MAR.
7. The □CP administering medications takes the medication to the patient□s bedside or □ust outside the room, prepares and verifies the medications to be administered.
8. The □CP shall verify the MAR summary including allergies, scan the patient□s □D band, and the medication ~~barcode~~bar code before immediately administering the medication.
   i. □pon confirmation that the dose was administered, the □CP shall complete the MAR documentation.
   ii. Record patient response to medications in the medical record including PRNs and all new medications.
   iii. □f a pain medication is administered, the patient□s response must be assessed and documented as per policy 100.076 Pain Assessment, Management and Documentation.
   iv. The □CP shall immediately contact pharmacy if a medication is found to be incorrect, beyond its expiration or beyond use date. □f a medication will not scan, the □CP is responsible for completing a Medication Not Scanned Envelope to communicate with the pharmacy team to check the bar coding.
   v. □nless emergent, a □CP should not administer a medication that will not scan until the medication has been verified by a Pharmacist.
   vi. □ar Code Medication Administration (□CMA) is an evidence-based mechanism to maximize medication safety. Though logistical challenges may exist, the □CP administering the medication is responsible for attempting to scan with ALL medications.
   vii. □CMA compliance will be reported periodically by department leadership. □CP staff with scan rates below the departmental goal will be re-mediated.
9. The □CP should ade□uately assess a patient for adverse reactions following medication administration.

~~Due to logistical issues at the present time, Ambulatory Care clinics and the Emergency~~

~~Departments at VCMC and at SP□ are exempt from barcode scanning.~~

10. Crushed and/or partial dose medications
    i. Medications re□uiring crushing or splitting are scanned prior to opening at the bedside and then manipulated using a patient specific pill crusher/splitter for immediate administration.

E. □V Medication Administration and Documentation
    1. See Attachment C - Adult □V Administration Guidelines
    2. See Attachment D - Pediatric/P□C□ □V Push Drug References
    3. □ntravenous infusions shall be administered using an infusion pump with the medication guardrail parameters in place.
    4. The basic infusion setting may only be used in the event the medication to be administered is not contained in the infusion pump library.
    5. □ hen an infusion is held or stopped, the nurse must document a zero (0) rate in the □V drip section of the MAR.
    6. Documentation at shift change between the hours of 0600-0659 and 1800-1859 is the responsibility of both the ongoing nurse and incoming nurse.
        i. □ncoming nurse shall verify rates and document volumes of infusions from 0600-0659 and 1800-1859 at 0705 and 1905, respectively.
        ii. Outgoing nurse shall document infusion rate changes and any titrations.

□. □V Medication Titration (see policy CC.23 □V Medication Titration in Critical Care Areas)

G. Standardized Drug Concentrations for □V □nfusions
    i. The Pharmacy Department shall maintain guidelines for the administration and compounding of □V infusions.

□. Neonatal □ntensive Care □nit (N□C□) oral medications shall be administered by syringe through a nipple, gavage tube or buccal cavity as tolerated
    i. □ollow bitter tasting medication with 5 mL of breast milk or formula.
    ii. □lush gavage tube with 2-3 mL of sterile water post medication.

□. Medications ordered to be given on a sliding scale such as insulin, are documented in the same manner as other medications, except that the dose given (e.g. units, mg) shall also be documented.

□. □ aste documentation is not re□uired for non-controlled substances. See policy 106.35 for more information on how to properly dispose of pharmaceutical waste.

V□ Holding Medications

a. □f a medication is temporarily held because the patient is to have nothing by mouth (NPO) for a test or was unavailable at the scheduled administration time, the dose may be given later. □CPs can reschedule one (1) dose but then must consult pharmacy if further ad□ustments are needed.

b. □f a medication cannot be given, the □CP shall notify the LP. The □CP shall document on the MAR that the dose was held, the reason the dose was not given and that the LP was notified. □f the L□P decides to discontinue the medication, then an order to discontinue the medication shall be entered into the E□R.

c. □f a medication has a hold parameter and is held twice, the □CP shall notify the LP.

d. See Attachment E - Automatic □old Parameters

e. See Attachment □ - □eld medication workflow

V□□. Documentation of medication errors

a. □f a medication is given in error, the medication, name, dose, route, and time must be documented.

b. To this the following steps are followed

   i. □f the error involved a medication listed on the MAR, document the time that the dose was given. Notify the patient□s L□P to determine if the next scheduled dose should be held.

   ii. □or errors involving medications, routes or dosages not listed on the MAR, do not write □Medication error□or □error.□□ollow VCMC/SP□ procedure for notification of L□P and completion of notification and medication error forms.

V□□□. Keep vein open (KVO) Nursing Protocol

i. Nurses may order 0.9□ sodium chloride □VO orders or flushes per protocol in order to document volumes used during intermittent infusions or flushes

   1. Nurse to enter order into E□R using □□VO adult□or □□VO pediatrics.□

   2. Nurse to sign order using □Protocol/Standardize Procedure □co-sign□as the communication type.

ii. Approved □VO rates or flushes

   1. Adults: 0.9□ sodium chloride □V at 10 mL/hour (hr)

   2. Pediatrics: 0.9□ sodium chloride □V at 3 mL/hr

   3. Neonates: re□uires an order from the provider

□□. High risk medications

a. Special consideration will be taken for high risk medications and certain high risk medications re□uire an independent double check by two □CPs. See policy P□.70 □igh Alert Medications for complete list and considerations.

b. All weight-based neonatal and pediatric drug dosages and drug calculations should be double checked by another □CP prior to administration.

c. Radiopa□ue □V push medications for neonatal or pediatric patients shall be given by a LP.

d. Patient controlled analgesia (PCA) settings and amount administered are to be checked every 4 hours by the nurse and documented in the patient□s E□R in the □nteractive View (See policy 100.235 Patient-Controlled Analgesia).

All revision dates: 3/26/2024, 3/14/2023, 1/12/2022, 8/10/2021, 10/14/2020, 3/4/2020, 5/15/2019, 3/21/2019, 11/26/2018, 10/3/2017, 10/1/2016, 11/1/2015, 2/1/2015, 8/1/2013, 8/1/2012, 2/1/2012, 7/1/2011, 5/1/2006, 5/1/2005, 12/1/2004, 7/1/2004

Attachments

- Attachment A - Standard Administration Times
- Attachment □ - Standard Administration Times Dosing Matrix
- Attachment C - □ntravenous Administration Guidelines for Adults
- Attachment D - Pediatric/P□C□ □V Push Drug Reference
- Attachment E - Automatic □old Parameters
- Attachment □ - □eld Medication □ orkflow

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy □ Therapeutics Committee	Sul □ung: Associate Director of Pharmacy Services	4/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	3/26/2024
Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	3/26/2024
Policy Owner	Sara Pendleton: Medication Safety Officer	3/26/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.030 Critical Tests and Critical Results

POLICY:

Some test results, due to their critical nature, require special notification so that treatment can be immediately initiated or altered or so that, in the case of communicable diseases, steps can be taken to prevent the spread of disease. In addition, there are critical tests whose results have been deemed necessary to communicate to the licensed responsible caregiver, regardless of the results. These are defined below as critical tests and critical results.

DEFINITIONS:

A. **Critical Tests**: tests ordered for a patient with potentially life threatening symptoms that require rapid communication of results even if the results are normal.

B. **Critical Results** ~~(aka "panic values" or "redline values")~~: test results even from routine tests that represent a life threatening state that require rapid communication to the physician or responsible licensed caregiver.

C. **Licensed Responsible Caregiver**: personnel within the scope of their practice and in accordance with organizational policy that may receive and act on a critical result, such as Physicians, Nurse Practitioners, Physician's Assistants, Registered Nurses, Licensed Vocational Nurses, or Respiratory Therapists.

PROCEDURE:

A. This document shall be reviewed by the Medical Staff at least every two (2) years.

~~It is always preferable that critical tests/results are reported directly to the ordering physician. If the ordering physician is not available, the results may be reported to another licensed responsible caregiver.~~

B. For critical lab tests & result, the results (normal or abnormal) shall be communicated by lab personnel immediately to the responsible licensed registered nurse (inpatients and Emergency Department) or ordering ~~physician or responsible~~ licensed ~~caregiver~~practitioner (outpatients) but no more than ~~sixty~~thirty (~~60~~30) minutes from the time the test is ~~completed~~resulted.

C. For critical non-lab tests & results, the results (normal or abnormal) shall be communicated by the interpreting licensed practitioner immediately to the ordering ~~physician or~~ licensed ~~responsible caregiver~~practitioner but no more than sixty (60) minutes from the ~~availability of critical results to the receipt of such results~~time the result is made available.

D. Nursing is responsible for documenting critical results in Cerner and ensuring that the licensed

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practitioner is notified of any critical lab results within thirty (30) minutes of receipt from lab.

E. Staff is responsible for contacting the licensed practitioner even if the results are trending in the expected direction.

F. Ventura County Medical Center and Santa Paula Hospital collects and analyzes the compliance of call documentation for critical test results and reports the data to Performance Improvement Coordinating Council (PICC) quarterly and Medical Staff annually. This data will reflect monthly totals of the percentage of time critical test results are communicated. The following shall be tracked for call documentation:

1. Name of the licensed caregiver who received the communication.
2. Time and date of the call.
3. Verification that the results are recited back to the caller.

GUIDELINES:

A. The ordering ~~physician~~licensed practitioner's name shall be included on every order.

~~Follow department's procedure to expedite performance of a test.~~

B. Two patient identifiers (name and date of birth (DOB) or medical record number (MRN), if DOB is not available at the time) shall be used to confirm the correct patient.

C. ~~The testing personnel shall document notification including date, time, verification of "read back" and the name of the caregiver who received the critical test/result. This notification shall occur immediately but must occur within thirty (30) minutes of the testing personnel becoming aware of the critical test/result.~~

~~1. If communication is made via TigerConnect, read confirmation is acceptable.~~

The testing personnel shall document notification including date, time, verification of "read back" and the name of the bedside nurse who received the critical test/result. This notification shall occur immediately but must occur within thirty (30) minutes of the testing personnel becoming aware of the critical test/result.

1. For Inpatients and Emergency Department (ED) Hold Patients
   a. Testing personnel shall contact bedside nurse. The bedside nurse shall communicate the critical test/result to the licensed practitioner.
2. For Patients in the ED or Discharged from the ED
   a. Testing personnel shall contact the patient's nurse in the ED. ED nurse shall communicate the critical test/result to the ED licensed practitioner.
3. For Patients Discharged from the Hospital
   a. Testing personnel to call the ordering licensed practitioner.
   b. If there is no response, retry a second time within two hours of the result.
   c. If there is still no response, TigerText the Chief Medical Officer.
4. For Patients Seen in Ambulatory Care Clinic
   a. During clinic hours: Testing personnel shall contact a licensed responsible caregiver or the ordering licensed practitioner.
      i. In the event a licensed responsible caregiver other than the ordering licensed practitioner receives the critical test result, the ordering or covering licensed practitioner shall be contacted by the licensed responsible caregiver to report results.

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b. After hours and weekends: A critical result may NOT be left with an answering service. Critical values shall be reported to the on-call licensed practitioner by calling the clinic and following the phone tree.

D. Chain of ~~command~~Command for Communication

1. Hospital chain of command for communication to nursing

   a. If bedside or ED nurse is not immediately available, communication will be made via phone to the unit charge nurse. If no charge nurse is available, communication will be made via phone to the nursing supervisor.

2. ~~In the event that a~~Hospital chain of command for communication to licensed ~~responsible caregiver other than the ordering provider receives the critical test result, the ordering or covering provider shall be contacted by the licensed responsible caregiver to report results. If the ordering or covering provider does not respond within 10 minutes, a second attempt to contact the provider shall be made. If there is no response within 15 minutes of the initial attempt, the supervising attending physician shall be contacted. If there is no response from the supervising attending physician after 15 minutes, then the on-duty Emergency Department Attending Physician shall be contacted. If the on-duty Emergency Department Attending Physician does not respond within 15 minutes, the Chief Medical Officer (CMO) shall be contacted.~~practitioners

   a. If the licensed practitioner is not available within ten (10) minutes, a second attempt will be made via phone to the licensed practitioner. If there is no response within 15 minutes of the initial attempt, the supervising attending physician shall be contacted. If there is no response from the supervising attending physician after 15 minutes, then the on-duty Emergency Department Attending Physician shall be contacted. If the on-duty Emergency Department Attending Physician does not respond within 15 minutes, the Chief Medical Officer (CMO) shall be contacted.

   b. The licensed responsible registered nurse shall document notification including time, date, verification of "read back" and the name and title of the provider who received the critical test/ result.

   c. Final notification to a provider must occur within thirty (30) minutes from the time the critical test result became available.

   ~~The licensed responsible caregiver shall document notification including time, date, verification of "read back" and the name and title of the provider who received the critical test/result.~~

   ~~Final notification of a provider must occur within sixty (60) minutes.~~

3. Ambulatory Care chain of command to licensed practitioners

   a. If the ordering or covering licensed practitioner does not respond within ten (10) minutes, a second attempt to contact the licensed practitioner shall be made. If there is no response within 15 minutes of the initial attempt, the Clinic Medical Director shall be contacted.

   b. If there is no response from the Clinic Medical Director after 15 minutes, then the Ambulatory Care Chief Medical Officer (CMO) shall be contacted.

   c. After office hours and on weekends, if the on-call licensed practitioner fails to respond to their page within 15 minutes, the on-call satellite licensed practitioner shall be contacted.

E. NOTE: In highly emergent cases where "read-back" would be impractical or impede patient care, a "repeat back" is permissible. Often, the physician receiving the information is the licensed responsible

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caregiver who will be immediately using the information for intervention.

F. Critical results are defined by service and listed below:

1. **Radiology/Nuclear Medicine New or Unsuspected Critical Results**
   a. Carotid or vertebral artery dissection
   b. Ectopic pregnancy
   c. Hemoperitoneum
   d. Intracranial tumor, mass effect, midline shift
   e. Ischemic stroke, acute
   f. Testicular or ovarian torsion
   g. Upper or lower extremity deep venous thrombosis (DVT)
   h. Acute aortic dissection, rupture or leak
   i. Intracranial hemorrhage (traumatic, non-traumatic)
   j. Pneumothorax
   k. Pneumoperitoneum
   l. Acute pulmonary embolism
   m. Acute spinal cord compression
2. **Adult Echocardiogram Critical Results**
   a. Pericardial effusion, moderate to ~~severe~~large with echocardiographic signs of tamponade
   b. Acute aortic dissection
   c. Myocardial rupture
   d. Ruptured chordae tendinae
   e. Valvular vegetation
   f. Visible abnormalities with prosthetic valves
   g. Ventricular septal defect (VSD) or Atrial septal defect (ASD)
   h. Myxomas or other cardiac tumors
   i. Atrial or ventricular thrombus
   j. Decrease in ejection fraction (EF) ~~>20~~< to 40% ~~from last recent echocardiogram~~if new finding
   k. New wall motion abnormalities
   l. History of acute trauma associated with myocardial contusion
3. **Pediatric Echocardiogram Critical Results**
   a. ~~Pericardial tamponade, moderate to severe~~Pericardial effusion, moderate to large with echocardiographic signs of tamponade
   b. Transposition of the great vessels
   c. Severe obstruction of the right/left ventricular inflow or outflow
   d. Hypoplastic left or right heart

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e. Severe coarctation of aorta

f. Tetralogy of Fallot

g. Severe right or left ventricular hypokinesis

4. **Electrocardiogram/Holter/Event monitor Critical Results (For patients not on a cardiac monitor)**

   ~~Premature ventricular contractions (PVC) ≥5 in a row~~

   a. Sustained ventricular tachycardia

   b. Sinus pause > 3 seconds

   c. New second or third degree atrioventricular (AV) block

   d. Acute localized ST segment elevation suggesting myocardial infarction (MI)

G. **Blood Bank Critical Results**

1. A positive antibody screen, a positive direct antiglobulin test, or a positive crossmatch on a patient receiving blood that was emergency-released.
2. A positive antibody screen or a positive direct antiglobulin test on a pre-surgery patient. The physician will be told that the antibody could cause a delay in the availability of compatible blood.
3. Verify that a physician is aware of any suspected transfusion reaction.
4. Coombs positive infants on screening for hemolytic disease of the newborn.

H. **Microbiology Critical Results**

1. Positive blood cultures: each different accession number

   a. The first positive result (whether stain or culture)

   b. The organism identification for all pathogens

2. Salmonella/Shigella/Campylobacter/Yersinia/Shiga Toxin 1 or 2, Vibrio and other stool pathogens
3. Positive cerebrospinal fluid (CSF) Gram stain, cultures, or India Ink
4. Positive acid fast bacilli (AFB) smear
5. Clinically relevant growth in any tissue specimen, biopsies, or sterile body fluids; except urines
6. Presence of organisms with unusual resistance patterns; e.g., Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-intermediate Staphylococcus aureus (VISA), Vancomycin-resistant enterococcus (VRE), Penicillin-resistant Streptococcus pneumoniae, organisms producing extended spectrum beta-lactamases (ESBLs), carbapenem-resistant Enterobacteriaceae (CRE), etc.
7. Cultures positive for Neisseria gonorrhoeae
8. Positive blood parasite results; e.g., malaria
9. Positive human immunodeficiency virus (HIV) test
10. Positive venereal disease research laboratory test (VDRL) or fluorescent treponemal antibody absorption (FTA-ABS)
11. Positive stool Clostridium difficile (C. diff) polymerase chain reaction (PCR)

    ~~Positive respiratory syncytial virus (RSV)~~

    ~~Positive severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)~~

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I. **Pathology Results**

1. New pathologic diagnosis of cancer, excluding non-invasive skin cancer (basal cell and squamous cell).

Laboratory Critical Results

Test	Low Critical Result	High Critical Result
Hemoglobin	≤ 6.~~5~~9 g/dL	≥ 23.0 g/dL
Hemoglobin if > 65 years old	< 6.~~8~~9	
Hematocrit	≤ 18%	≥ 70%
Platelets	20 x 10^3/mcL	
White Blood Cell (WBCs)	≤1.0 x 10^3/mcL	≥50K
Neutrophil # (ANC or absolute neutrophil count)	< 0.5 x 10^3/mcL	
International normalization ratio (INR)		≥ 4.0
Partial Thromboplastin Time (PTT)		> 118 sec.
Anti-Xa, unfractionated	All results to be communicated to the responsible licensed caregiver.	
Anti-Xa, low molecular weight	All results to be communicated to the responsible licensed caregiver.	
Bilirubin - Newborn		> 18 mg/dL
Calcium	< 6.0 mg/dL	> 13.0 mg/dL
Fibrinogen	< 100	
Glucose	< 60 mg/dL	> 500 mg/dL
Glucose – Newborn	< 40 mg/dL	> 300 mg/dL
Lactic Acid		≥ 4
Phosphorus	< 1.0 mg/dL	
Potassium	< 2.9 mEq/L	> 5.7 mEq/L
Sodium	< ~~125~~128 mEq/L	> ~~160~~155 mEq/L
Magnesium	< 1 mEq/L	> 8 mEq/L
Troponin I, high-sensitivity		Females: ≥120 ng/L Males: ≥120 ng/L
Ethanol		≥ 400 mg/dL
Iron (less than 12 years)		> 280 mcg/dL
Thyroid stimulating hormone (TSH)		> 50 milli-International units/L
Cerebrospinal fluid (CSF) White Blood Cell count		≥ 10
Vancomycin trough, if > 1 month age		≥ 20 mcg/mL

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Test	Low Critical Result	High Critical Result
Vancomycin trough, 0-1 month age		≥ 15 mcg/mL
Lead		≥ 3.5 mcg/mL

Respiratory Critical Values

Critical Value	Arterial Blood Gas (ABG)		Capillary Blood Gas (CBG)		Neonatal Arterial Blood Gas		Neonatal Capillary Blood Gas		Venous Blood Gas (VBG)		pH Cord
	Low	High	Low	High	Low	High	Low	High	Low	High	Low
pH	7.29	7.6	7.29	7.5	7.2	7.5	7.2	7.5	7.25	7.55	7.2
pCO_2 (mmHg)	22.5	60	22.5	51	20	60	20	60	20	60	
pO_2 (mmHg)	60		34.9	85.1	50	120	25	85			
Base Excess [BE] (mmol/L)					-8	8	-8	8			<-12
Total hemoglobin [tHb] (g/dL)	7.9	23	7.9	23	7.9	23	7.9	23	7.9	23	
O_2Hb (%)	<60 88% >60 86%				88%						
COHb (%)		8%		8%		8%		8%		8%	
MetHb (%)		8%		8%		8%		8%		8%	
HHb (%)		>12%		>12%		>12%		>12%		>12%	
Sodium [Na^+] (meq/L)	120	160	125	150	125	150	125	150	120	160	
Potassium [K^+] (mEq/L)	2.5	6	3	6	3	6	3	6	2.5	6	
Calcium [Ca^{2+}] (mEq/dL)	3.3	6.2	3.3	6.2	3.3	6.2	3.3	6.2	3.3	6.2	
Glucose (mg/dL)	60	16>500 16>300	45	16>500 16>300	45	300	45	300	60	16>500 16>300	
Lactate (mmol/L)		3.99								3.99	

Table Abbreviations:
pCO_2: partial pressure of carbond dioxide
pO_2: partial pressure of oxygen
O_2Hb: oxyhemoglobin
COHb: carboxyhemoglobin
MetHb: methemoglobin

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HHb: deoxyhemoglobin

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED, Medicine & Pediatrics	Tracy Chapman: VCMC - Med Staff	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/18/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/18/2024
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	3/18/2024

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VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*3/1/1983*
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Owner:	*Jason Arimura: Associate Hospital Administrator-AncillaryServices*
Policy Area:	*Administrative - Patient Care*
References:	

100.031 Processing a Death & Post-Mortem Exam

POLICY:

To outline the procedure for processing a patient death at Ventura County Medical Center (VCMC) and Santa Paula □ospital (SP□).

PROCEDURE:

DEPARTMENTAL RESPONSIBILITIES

A. ~~□pon death, the nurse:~~

1. ~~Notifies the physician (unless they are otherwise in attendance).~~
2. ~~Notifies the Nursing Supervisor.~~
3. ~~Prepares the body, per nursing protocol.~~
4. ~~Obtains the signature of the next of kin on the □Release of □ody to the □uneral Director□form [DocuShare VCMC-546-042□~~
5. ~~Notifies the OneLegacy organ procurement organization at 1-800-338-6112 and calls the Nursing office with the donor number (see policy *100.048 Referral of Potential Organ and Tissue Donors*). Complete the Donor □nformation Record.~~

□pon death, the nurse or unit charge nurse:

1. Notifies the physician (unless they are otherwise in attendance).
2. Notifies the family.
3. Notifies the Nursing Supervisor at (805) 218-3443.
4. Notifies the Admitting Department at (805) 652-6071.
5. Notifies the One Legacy organ procurement organization at 1-800-338-6112 and calls the Nursing office with the donor number (see policy *100.048 Referral of Potential Organ and Tissue Donors*).
   a. Complete *Attachment A: One Legacy Contact Form [VCHCA-505-027].*
6. Reviews criteria for reporting to the Medical Examiner□s office (MEO) with the licensed practitioner (LP). Ensures that the MEO is called if criteria are met. See *Attachment B: Hospital and Nursing Care Facility Reporting Form.*
7. Completes *Attachment C: Notification of Death [VCHCA-546-021].*

8. Completes *Attachment D: Release of Body [VCHCA-546-042].*
9. Prepares the body, per nursing protocol, if death is not reportable to the MEO.
10. If mortuary arrangements are made, the family or the nursing staff calls the mortuary, except for deaths requiring MEO engagement.

B. Nursing Supervisor

~~Completes the Organ Procurement Form.~~

~~If the mortuary is designated, calls to arrange pick up.~~

1. Meets Security at room with ~~Log Book and Morgue~~log book and morgue key and escorts body to the ~~Morgue~~morgue.
2. ~~Picks up Release of Remains form, and enters~~Enters information into log book.
3. In the event there is no family, notifies Social Services and enters in log.
4. If body has not been picked up by the fifth day, contacts Health Information Management (HIM) and follows up with Social Services.
5. On day seven post-mortem, will follow up with HIM to ensure paperwork is in process.

C. Security

1. Will be notified by the Nursing Supervisor.
2. Security will meet the Nursing Supervisor at patient room for removal of body.
3. Security and Nursing Supervisor will verify the body against ~~the the Release of Body form~~*Attachment D: Release of Body [VCHCA-546-042]*.
4. Toe tag is double checked by Nursing Supervisor and Security.

D. Responsibility of the Physician:

1. Notify the family.
2. Notify the Medical Examiner's Office (MEO), if appropriate, or delegate to nursing staff who have knowledge of the case.
   a. See "Special Circumstances" below for general list of deaths that should be reported to the MEO.
   b. If MEO takes jurisdiction, MEO completes the death certificate.
      i. There may be cases where the MEO issues the death certificate and the body is released to the funeral home.
3. If MEO declines to take jurisdiction
   a. If family, after discussion with the physician, would like to obtain an autopsy, obtain signatures on ~~the **Consent for Autopsy**~~*Attachment E: Authority for Autopsy [VCHCA-546-009]* (see Special Circumstances - Autopsy).
   b. In conjunction with HIM, completes death certificate worksheet, provides the final diagnosis, and signs finalized death certificate.
4. Completes death note in Medical Record

E. Responsibility of HIM and Birth Certificates upon receipt of the ~~**Notification of Death**~~Notification of Death:

1. Obtains medical record.
2. □or deaths where the Medical Examiner□s Office declines □urisdiction, □□M facilitates (with funeral home and physician) completion of the ~~**Death Certificate.**~~Death Certificate**.**
3. ~~□or stillbirths and Public Guardian cases, □□M completes the **Application and Permit for Disposition of Human Remains** and files it with the Public □ealth Department~~
   a. ~~□or fetal deaths, □irth Certificates completes the **Application and Permit for Disposition of Human Remains**~~

   □or fetal deaths, □irth Certificates completes the Certificate of □etal Death and files it with the California Department of Public □ealth.

Fetal and Infant (Live birth) Deaths:

1. **Fetal Deaths (Abortus vs. Stillbirth)**
   a. A □etal Death is indicated by the fact that after separation from the mother, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles.
      a. Notify Social Services of any fetal or infant death to better provide emotional support to the family and discuss options of disposition of remains.
   b. Abortus vs Stillbirth
      1. □f the gestational age is considered to be less than 20 weeks, the conceptus is referred to as an abortus.
      2. □f length of gestation is undetermined and fetus is over 500 grams or over 25 cm crown-rump length, it is considered a stillborn.
   c. Management of Abortus □etal Death:
      a. The abortus will be sent to Pathology as a surgical specimen.
         i. The specimen is to be placed in formalin and properly labeled.
      b. □amily may choose to make arrangements with a funeral home for disposition of the abortus.
         i. A physician note documenting that abortus was □ 20 weeks estimated gestational age, □ 500 grams in weight, and □ 25 cm crown-rump length will be re□uired by the funeral home.
      c. □f the parents re□uest VCMC/SP□ to handle disposition of the stillborn, they will sign ~~the authorization to □Retain and Dispose of □ody.~~*Attachment F: Release of Stillborn/Abortus [VCHCA-546-022]* form. Consent of either parent is sufficient, although both parents should sign if they are available.
   d. Management of Stillborn □etal Death:
      a. All stillborn deliveries must be registered with Public □ealth Vital Records and recorded in appropriate Ventura County Medical Center/Santa Paula □ospital records. The procedure is as follows:
         1. Nursing staff will notify □irth Certificates of the following: Date and time of expulsion, sex of the fetus, mother□s name/chart number and physician.
            a. □f a member from □irth Certificates is not available, a message may be left on department phone

b. □irth Certificates will process messages on next business day

2. Nursing staff will record the weight and length and gestational age in Mother□s chart.

3. Nursing staff will record delivery information on the delivery log as follows: mother□s name, date/time of delivery, chart number, gestation, sex, and weight.

b. Nursing staff or designee will place the infant in the morgue.

i. □f an autopsy is to be performed, routine autopsy procedures will be followed.

c. **Social Services** will consult with the parents of the stillborn to determine if they wish to make arrangements with a funeral home for burial or cremation. □f the parents re□uest VCMC/SP□ to handle disposition of the stillborn, they will sign ~~the authorization to □Retain and Dispose of □ody□~~*Attachment F: Release of Stillborn/Abortus [VCHCA-546-022]* form. Consent of either parent is sufficient, although both parents should sign if they are available.

d. □irth Certificates will prepare the Certificate of □etal Death, which, whenever possible, should be signed by the attending physician~~ within 15 hours of pronouncement of legal death~~.

2. **Infant Death (Live Birth)**

a. Live births are distinguished from fetal deaths by regulation as follows: the complete expulsion or extraction from its mother the products of conception which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. □f a fetus shows any post-delivery life signs, no matter how transient, it is a live birth, regardless of the length of gestation. Routine procedures for live births will be followed (e.g., birth certificates, chart, census, etc.).

b. □f the infant expires, □ealth □nformation Management (□□M) will prepare a Death Certificate as with any other death.~~ □f the infant has lived less than 72 hours and the parents wish to donate the remains of the infant to the hospital, they may sign the □Contribution of Remains□consent and related procedures described in the preceding section should be followed.~~

SPECIAL CIRCUMSTANCES

A. MED□CAL E□AM□NER CASES

1. All deaths in the following categories must be immediately reported to the Medical Examiner□s Office (MEO) by the physician in attendance or the ~~Emergency Department (ED)~~nursing staff. (California Government Code 27491 and □ealth and Safety Code 10250.)

a. □nown or suspected homicides, suicides and accidents.

b. Deaths involving criminal action or suspicion of a criminal act.

c. Poisonings and deaths related to substance abuse.

d. All deaths in □ail or in police custody.

e. All deaths at state mental hospitals.

f. All deaths related to occupational diseases or hazards.

g. All deaths occurring outside health care facilities.

h. All deaths wherein the deceased has not been attended by physician within 20 days preceding death.

i. Deaths in which a physician is unable to reasonably state a cause of death (unwillingness does

not apply).

- Deaths involving suspected contagious diseases constituting a new public hazard.

k. Deaths of unidentified persons.

l. Deaths occurring within 24 hours of admission.

1. Medical Examiner policy that minimally attended deaths are reviewed.

m. Deaths suspected to be from Sudden Infant Death Syndrome/Sudden Unexpected Infant Death.

2. Upon notification by the physician or ED staff, the Medical Examiner's Office determines if they will take jurisdiction of the body. If the Medical Examiner decides not to take jurisdiction, normal circumstances apply.

3. The Medical Examiner (ME) has the authority to determine the extent of inquiry into reportable deaths. ME investigations do not necessarily entail an autopsy. The ME may authorize attending physicians to certify reportable deaths that are clearly from natural causes.

4. It is the duty of the Medical Examiner's Office to notify the next of kin in all deaths coming under their jurisdiction.

5. Reports shall not be made to the Medical Examiner's Office (MEO) that are not appropriate simply because autopsy permission has been refused, nor shall authentic Medical Examiner's cases be withheld from the Medical Examiner's jurisdiction and autopsied by the Hospital Pathologist because permission for autopsy has been obtained. To do either of the above willfully is a punishable offense (California Penal Code, Sec. 148).

6. Bodies under the MEO jurisdiction are not to be released to funeral homes unless the release is approved by the Medical Examiner's Office. Refer all requests to release the body to the Medical Examiner's Office.

7. The family of the decedent should not be approached for permission for an academic autopsy prior to the clearance from the Medical Examiner's Office.

8. Removal of organs or tissue for donations should not be performed without prior clearance from the Medical Examiner (see policy *100.048 Referral of Potential Organ and Tissue Donors*).

9. Dressings, intravenous (IV) catheters, airways, tracheotomies or other diagnostic or therapeutic apparatus that are in the body at the time of death should not be disturbed or removed from the body prior to the arrival of the, or without the permission of, personnel from the Medical Examiner's Office.

   a. Traumatic wounds and injuries shall not be tended to after death.

B. HOSPITAL AUTOPSIES: For deaths that do meet criteria for reporting to MEO, or, if reported, the MEO has declined to take jurisdiction

1. All autopsies must be ordered by a physician.

   a. ~~The "Authority for Autopsy" form "DocuShare VCMC-546-009"~~ *Attachment E: Authority for Autopsy [VCHCA-546-009]* must be filled out and witnessed (form available at all nursing stations and from Nursing Supervisor). The physician makes the request to the next of kin. This form is then brought directly to the pathologist or the pathology secretary.

   b. The legal order of relative priority when obtaining autopsy consent is as follows:

      1. Spouse

      2. Adult son or daughter

3. Either parent
4. Adult brother or sister
5. A guardian or conservator of the person of the deceased at the time of death.

c. An example of the legal order is if a person is married to the deceased, then he/she is the one who should decide if there should be an autopsy. If the spouse does not want an autopsy, but an adult son or daughter requests one, the spouse's request is honored. The same is true as one goes down the priority list.

d. The physician will, between the hours of 0800 and 2200, page the pathologist on-call to discuss the case, and determine if a directed autopsy vs. a full autopsy is needed. If after 2200, page the on-call pathologist at 0800 the next morning and order the body not to be released to the mortuary until after the autopsy. The pathology call schedule is available through the paging operator or in the pathology office.

e. It is imperative that the pathologist receives the above two forms before the autopsy can proceed. The forms need to be delivered to Pathology directly. Do not place the forms in the chart.

f. Autopsy Phone Consent

1. When a hospital patient dies and the next of kin resides outside the area, it is often necessary to obtain consent for autopsy over the telephone.
2. It shall be VCMC/SP policy to obtain such consents through Nursing Administration. The physician will contact the Nursing Supervisor for assistance.

g. If it is requested of the MEO to perform the medical autopsy, provide the Authority for Autopsy form to MEO.

C. IN THE EVENT THERE IS NO FAMILY

1. If there is no family, Social Services is notified by the House Supervisor or Nursing.
   a. Social Services will complete a search to locate next of kin
   b. Upon determination of no family by Social Services will:
      1. Notify HIM of Public Guardian case
      2. Complete deceased patient log in the Nursing Office
      3. Complete Public Guardian Form
      4. Send referral to Public Guardian
2. HIM upon notification by Social Services will:
   a. Complete death certificate
   b. Obtain physician signature on death certificate
   c. Complete permit for disposition of human remains
   d. ~~Electronically file Death Certificate and Permit of Disposition of Remains~~Electronically file death certificate.
3. Public Guardian
   a. Signs release of remains and cremation orders

b. Contacts mortuary

c. Mortuary will contact □□M regarding removal of remains

D. □N T□E EVENT T□AT T□E □AM□L□ CANNOT PROV□DE □OR T□E D□SPOS□T□ON O□ REMA□NS

1. ~~□or a neonatal death, stillbirth (20 weeks or greater estimated gestational age), or abortus (□20 weeks estimated gestational age)~~

   ~~a. Nursing notifies Admitting in the event of a neonatal death and Social Services in the event of a fetal death.~~

   ~~b. Nursing or Social Services speaks to the family and obtains the **Authorization to Retain and Dispose of Body and Contract for Cremation** and sends it to □□M.~~

   ~~c. □□M obtains the physician signature on the Death Certificate or the Certificate of □etal Death. An Application and Permit for Disposition of □uman Remains is also completed by □□M and filed with Public □ealth.~~

   □or a stillbirth (20 weeks or greater estimated gestational age), or abortus (□20 weeks estimated gestational age), the same procedure is followed as outlined under □□etal and □nfant (Live □irth) Deaths: □etal Deaths (Abortus vs Stillbirth).□

2. □f the patient is not a ~~neonate or~~ fetus, the same procedure is followed as outlined under □Special Circumstances: □n the Event there is No family.□

3. The □ospital Social Services Department is responsible for delivery of all personal effects to the Public Administrator that have been entrusted to the □ospital for safekeeping, including money in the patient□s trust fund, and personal articles, other than clothing, received from nursing units.

4. Nursing is responsible for delivering personal effects to the next of kin or Social Services, when indicated.

5. □n all other cases, the disposition of the body and personal effects will be at the discretion of the next of kin.

CRITERIA FOR IDENTIFYING DEATHS APPROPRIATE FOR HOSPITAL AUTOPSY

A. Deaths which come under the □urisdiction of the Medical Examiner (ME) must be reported ~~per policy *100.030 Critical Tests/Critical Results (Reported Verbally)*~~(see *Attachment B: Hospital and Nursing Care Facility Reporting Form*). Only after a potential Medical Examiner□s case has been reported to the ME and □urisdiction declined by the Medical Examiner, can the case be considered for a hospital autopsy. □n discussion with the Chief Medical Officer, the physician may re□uest a hospital autopsy.

□. ~~An~~A hospital autopsy may be indicated in the following circumstances:

1. Any death in a person with no known underlying disease or condition which would readily explain the death and where an autopsy has a reasonable likelihood of identifying the cause of death.

2. Any death in cases of unusual educational interest where the autopsy is not more appropriately performed in a university or research setting.

3. Examples of cases where an autopsy may be indicated include the following:

   a. □dentification (not □ust corroboration) of a hereditary or genetic condition where this information would be useful to the family of the deceased

b. Cases where an autopsy is likely to make a significant contribution to □uality assessment.

C. The physician who re□uests an autopsy is responsible for communicating to the pathologist a relevant clinical history and should discuss the indications for the autopsy with the pathologist. The re□uesting physician should state what □uestions he/she expects the autopsy to resolve.

D. An autopsy represents a pathology consultation. After discussion with the referring physician, the pathologist will make the final determination of the extent of the autopsy. □t is the practice of the Pathology Department to perform directed (or limited) autopsies.

E. □ecause of the known risks of transmission of infectious diseases, the presence of certain medical conditions in the deceased represents an absolute or relative contraindication for an autopsy at Ventura County Medical Center/Santa Paula □ospital. □f a relative contraindication is present, the pathologist, after discussion with the re□uesting physician, will decide whether the information which might be gained from the autopsy □ustifies the risk of disease transmission. □f the pathologist chooses to do the autopsy, the pathologist will take precautions to decrease the risk of disease transmission. These extra precautions may include having the body embalmed before the autopsy and performing a limited autopsy. □ecause of the increased risk of disease transmission, the autopsy will generally exclude opening of the cranium or examination of the spinal cord.

1. Medical conditions which represent an absolute contraindication for an autopsy at VCMC/SP□ include, but are not limited to:

   a. □acob-Creutzfeld disease.

   b. Any unexplained encephalomyopathy that might be secondary to a slow virus infection.

   c. Anthrax.

2. Medical conditions which represent a relative contraindication for an autopsy at VCMC/SP□ include, but are not limited to:

   a. □uman immunodeficiency virus (□□V) or human T-lymphotropic virus (□TLV) infection.

   b. □epatitis □.

   c. □epatitis C.

   d. □epatitis non-A, non-□.

   e. □nown or suspected disseminated Coccidioidomycosis.

   f. □nown or suspected disseminated (miliary) tuberculosis.

3. □ecause of the intended educational value of an autopsy, the physician who re□uests an autopsy should attend the autopsy whenever scheduling allows.

4. After completion of the autopsy, the pathologist will promptly communicate relevant findings to the physicians involved in the care of the deceased and will complete the provisional anatomic diagnosis and the final autopsy report in accordance with Medical Staff Rules and Regulations and in compliance with licensing and accrediting agencies.

All revision dates: 4/30/2024, 8/16/2022, 3/27/2020, 10/1/2016, 5/1/2010, 3/1/2007, 5/1/2006, 2/1/2005, 10/1/2001, 8/1/2001, 1/1/2000, 11/1/1998, 3/1/1995, 11/1/1989, 10/1/1986

Attachments

- Attachment A: One Legacy Contract □orm □VC□CA-505-027□
- Attachment □: □ospital and Nursing Care □acility Reporting □orm
- Attachment C: Notification of Death □VC□CA-546-021□
- Attachment D: Release of □ody □VC□CA-546-042□
- Attachment E: Authority for Autopsy □VC□CA-546-009□
- Attachment □: Release of Stillborn/Abortus □VC□CA-546-022□

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	pending
Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	pending
Policy Owner	□ason Arimura: Associate □ospital Administrator-AncillaryServices	4/30/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*5/1/2001*
Effective:	*Upon Approval*
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.076 Pain Assessment, Management and Documentation

POLICY:

To ensure that patients have their pain assessed and managed, and that they are involved in decisions regarding treatment of their pain consistent with the scope of care, treatment, and services provided by Ventura County Medical Center, Santa Paula □ospital and Ambulatory Care clinics in various care settings. The goal of pain management is to incorporate non-pharmacological and pharmacological interventions to ease or lighten pain which may not include the elimination of pain. Pain assessment and pain management is an organizational priority.

PROCEDURE:

Patients have the right to pain management which is determined through discussion with their providers and care team members. Management of pain is focused on easing the patient's pain using non-pharmacological and pharmacological interventions. The health care workers of the Ventura County □ealth Care Agency (□CA) shall do the following in accordance with staff scope of practice:

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and services provided in the specific care setting in accordance with staff scope of practice. All assessments and reassessments for prn and scheduled pain medication shall be documented on the Medication Administration Record (MAR).
2. Re□uire that methods used to assess a patient's pain are consistent with the patient's age, condition, and comprehension. (Refer to attachments for pain scales used throughout the Ventura County □ealth Care Agency.)
3. Assess the patient's response to care, treatment, and service implemented to address pain.
4. □f the patient does not achieve their pain goal or if the pain is not reduced to a tolerable state, the care team member should notify the physician and follow the chain of command to advocate on behalf of the patient:
    1. Ambulatory Care: Medical Assistant or Clinical Assistant shall report to nurse (registered nurse (RN) or licensed vocational nurse (LVN)), then to Nursing Supervisor, then to Clinic Medical Director and Chief Nursing Officer. Clinic Medical Director may report to Chief Medical Officer.
    2. □ospitals: Nursing Supervisor and/or Clinical Nurse Manager, then Associate Chief Nursing Officer, then Chief Nursing Officer and/or resident, then attending physician, then Chief Medical Officer.

5. Consider non-pharmacological measures as well as medication therapy, taking into account the patient's stated preferences for pain management.
6. Treat the patient's pain or refer the patient for treatment.
7. Ensure the patient's comprehensive care plan reflects the patient's pain management preferences and responses to interventions. □pdate the care plan as needed to reflect changes in the patient's pain management.
8. Assess and manage the patient's pain and minimize the risks associated with treatment.
9. □dentify physical, social and psychological conse□uences of unrelieved pain.
10. □pon clinical assessment by the registered nurse, a patient may re□uest a pain medication ordered for a lesser pain indication. The registered nurse may administer that medication and shall document the rationale in the electronic health record. □f indicated the Licensed Practitioner (LP) shall be contacted if the ordered pain medication is inappropriate.

PAIN SCALES

To ensure an age-appropriate, clinical condition assessment of pain occurs, multiple pain scales are approved for use within the organization. These scales are:

- □niversal Pain Assessment Tool (Numeric Pain scale with □ntensity)-Eight (8) years of age and older and who are able to self report)
- Critical Care Pain Observation Tool (CPOT) - paralyzed and sedated
- □LACC- Children two (2) months through three (3) years of age
- The revised (r) □LACC Scale (face, legs, activity, crying and consolability) - Developmental Delay/ Cognitive □mpairment
- N-PASS scale - Preterm and infant two (2) months of age (48 weeks gestation)
- □aces Pain Scale - Children four (4) years through seven (7) years of age

See Attachments A through □.

INPATIENT CARE SETTINGS

Upon Admission and with Change in Pain Characteristic

Patients admitted to an inpatient care setting shall receive an initial screen at the time of admission to identify the presence and severity of pain. □nitial assessment of the patient should include, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools
- The character of pain, □uality, onset, location, radiation, duration and fre□uency
- The patient's tolerance to pain and acceptable intensity of pain (pain goal)
- The patient's history of analgesic use or abuse
- The patient's respiratory risk factors
- □nterventions, therapies and medications used by the patient to alleviate or mitigate pain

Communication about Pain

Communication with the patient should include, but is not limited to, assisting them in understanding that some pain is to be expected and it may be unrealistic to expect to be completely pain-free following their procedure. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan□involve family as appropriate when discussing

the plan of care and anticipate pain goals.

Treatment of Pain

In general, inpatients shall receive treatment for any active acute or chronic pain when intensity or severity exceeds an acceptable level. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, and potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process. The same pain scale shall be consistently used as the patient's clinical condition permits.

Paralysis Considerations

Paralysis prevents the assessment of behavioral cues for pain. Increases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

1. Analgesics should be administered continuously by drip or around-the-clock dosing.
2. Opioid doses should be evaluated as tolerance can occur without symptoms of inadequate pain relief.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications. For other routes of pain medications, standards of practice shall be implemented. In addition, the patient's pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

Emergency Department

Treatment of Pain

In general, ED patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in the ED to treat chronic pain conditions. Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If no pain issues were identified during the initial assessment, then no routine reassessment is required. If at any time during the patient's stay in the ED pain issues are identified, the process of assessment/reassment should be initiated. If acute pain issues were identified, then the patient should be reassessed at least at time

of discharge or transfer. At a minimum, this reassessment shall consist of noting the intensity and severity of the patient's pain.

OPERATIVE AND INVASIVE PROCEDURE SETTINGS

Pre-Procedure Assessment

Patients seen in operative and invasive procedural settings shall be assessed prior to surgery or procedure to identify the presence and severity of pain. If this is an initial assessment of the patient (i.e., the patient is being seen as an outpatient or will be admitted following the procedure) the assessment should include, but is not limited to:

- Understanding the patient's perception of the procedure and their expectations about the extent of pain and its management.
- The intensity of pain using age or condition and ability to understand appropriate assessment tools.
- The character of pain, quality, onset, location, radiation, duration and frequency.
- The patient's history of analgesic use or abuse.
- The patient's respiratory risk factors.
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain.

It is recommended that the patient's tolerance to pain and acceptable intensity of pain (pain goal) be ascertained so that this information can be used to address the post-procedure care needs of the patient.

Post-Procedure Assessment

Patients shall receive an assessment following the operative or invasive procedure to determine the presence of pain that may have resulted from the procedure. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition appropriate assessment tools
- The location and nature of pain

Treatment of Pain

In general, these patients shall receive treatment for acute pain related for their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic condition.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

PEDIATRIC INPATIENT SETTING

Definitions

- Pain is defined as an unpleasant sensory and emotional experience associated with actual or resembling that associated with, actual or potential tissues damage (IASP 2020). Pain is an inherently subjective

multi factorial experience and should be addressed and treated as such.

Principles

- Pediatric patients will be assessed for pain using a validated developmentally appropriate pain assessment tool.
- The pediatric pain experience involves the interaction of physiologic, psychologic, behavioral, developmental, and situational factors.
- Every child and family is informed that the child has the right to the best pain relief possible and is entitled to optimal pain management.
- □ealthcare team members have a responsibility to advocate for effective pain management on the patients behalf, to promote the child's and family's learning about pain and its management and to actively involve the child and family in the decision making process related to pain assessment, management and evaluation.
- □ealthcare team members are responsible for ongoing communication with other members of the healthcare team regarding pain management outcomes.

Treatment of Pain

□ealthcare team members have a responsibility to recognize and accept that the child□s reports of pain reflect their real experiences of pain. Treatment shall be consistent with the patient's clinical presentation and ob□ective findings. The treatment modality selected shall be appropriate for the patient's needs and may include non-pharmacologic and pharmacologic approaches. Pain relief interventions will be tailored to the individual patient. Shared decision making between nursing/medical staff and parents should be employed to optimize the care of pain in children.

Paralysis Considerations(PICU)

Paralysis prevents the assessment of behavioral cues for pain. □ncreases in heart rate and/or blood pressure may be the only indication for increased need of analgesia. During the use of medically-induced paralysis, the following shall be considered:

- Analgesics should be administered continuously by drip or around-the-clock dosing.
- Opioid doses should be evaluated as tolerance can occur without symptoms of inade□uate pain relief.

Reassessment Following Treatment for Pain

□f a treatment intervention for pain is provided, the response to that intervention should be assessed to include progress toward pain goal and side effects. Reassessment shall occur within 60 minutes for oral pain medications□for other routes of pain medications, standards of practice shall be implemented. □n addition, the patient□s pain shall be reassessed at minimum once every shift.

Reassessment may include an assessment that the patient is sleeping. Documentation should reflect that the patient was sleeping at the time of reassessment.

NEONATAL INPATIENT SETTING

Initial Assessment

Patients seen in the Neonatal period (0-28d or 0-28d Corrected Gestational Age) shall be screened using the Neonatal Pain Agitation and Sedation Scale (N-PASS) to identify the presence of pain. The Neonatologist/ Pediatrician will be notified of any N-PASS score □4/10 or any time current nursing interventions and/or pain medications are not effective in lowering the patient's N-PASS score.

AMBULATORY CARE CLINICS

Initial Assessment

Patients seen in outpatient care settings shall receive a pain assessment on establishment of care to identify the presence of pain. If the patient is in pain or reports a history of persistent pain, a more in-depth assessment shall be conducted. The information that may be obtained during this assessment includes, but is not limited to:

- The intensity of pain using age or condition and ability to understand appropriate assessment tools (refer to attachment A)
- The character of pain, quality, onset, location, radiation, duration and frequency
- The patient's goal for pain management
- Interventions, therapies and medications used by the patient to alleviate or mitigate pain
- The patient's history of analgesic use or abuse
- The patient's risk level for adverse outcomes related to opioid treatment (e.g., acute psychiatric instability or high suicide risk, cognitive impairment, sleep apnea, advanced age, COPD, etc.)

Communication about Pain

Communication with the patient should include but is not limited to assisting them to understand that some pain is to be expected and it may be unrealistic to expect to be completely pain free following procedures. The provider should share with the patient a realistic understanding of anticipated duration of post-procedure pain. Engage the patient in the pain treatment plan. Involve family as appropriate when discussing the plan of care and anticipate pain goals.

Treatment of Pain

In general, Ambulatory Care patients shall receive treatment for acute pain related to their chief compliant or presenting condition when intensity exceeds their acceptable level. It is not within the scope of service in these settings to treat chronic pain conditions (unless specifically noted in the settings defined scope of service, e.g., pain clinic, designated primary care and specialty care clinics). Patients may be treated for acute exacerbation of chronic pain, but otherwise should be encouraged to seek long term treatment for their chronic pain.

When provided, treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner. The pain management treatment plan, which involves the patient, should consider the risks and benefits, potential risk of dependency, addiction and abuse (if applicable), and realistic expectations with measurable goals and the evaluation process.

Reassessment Following Treatment for Pain

If a treatment intervention for pain is provided during the care visit, then the response to that intervention must be assessed to include progress toward pain goal and side effects. Reassessment is recommended to occur within 60 minutes following treatment (depending on the type of intervention). However, by policy, this reassessment must occur at least at the conclusion of the care visit. If treatment consists of prescribing medications (or other modalities) that will be taken after the care visit, then no reassessment is required.

PATIENT/FAMILY EDUCATION

1. All education should be documented in the patient's electronic health record (E□R).
2. Patients will be taught that effective pain management will be part of their treatment.
3. Patients will be instructed to keep the nurse informed about their pain so that pain interventions may be provided as ordered. Medication may not rid the patient of all of their pain. Pain medication can reduce pain so that the patient can participate in activities to improve their health.
4. The patient and the family/significant other(s) should receive information regarding:
   a. The use of pain scales.
   b. Pain control options.
   c. Appropriate expectations for pain control.
   d. Potential limitations of pain management.
   e. □ow and when to communicate the effectiveness/ineffectiveness of pain interventions.
   f. Potential/actual side effects of pain medications/treatments.
   g. The risks of addiction and overdose, especially with prolonged use.
   h. Safe storage of medications.
5. A patient/family pain education brochure is available to support patient teaching on pain management.

During Treatment

□ hen pain medications are prescribed, patients □N ALL SETT□NGS shall receive education on pain management, the risks and benefits of medication treatment, and safe use of opioid and non-opioid medications. This information will be documented in the patient's E□R.

At Discharge

The patient/family shall receive education at discharge on the following:

- Pain management plan of care
- Side effects of the pain management treatment
- Activities that may exacerbate or reduce the effectiveness of the pain management care plan
- The risks of addiction and overdose
- Safe use, storage and disposal of opioids
- The use of controlled substances may cause the patient to be less alert resulting in increased risks when driving a car or operating machinery

PATIENT REFUSAL OF PAIN MANAGEMENT

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient's E□R.

DECISION NOT TO TREAT PAIN

□f a decision is made to not treat a patient's pain and/or refer the patient for treatment, then the clinical □ustification for that decision should be documented in the patient's E□R.

REFERENCES:

Department of □ealth and □uman Services, Centers for Medicare □ Medicaid Services, Publication 100-07 State Operations Provider Certification, Transmittal 37, October 17, 2018, Section 482.23 Nursing Care.

Center for □mprovement in □ealthcare □uality - Standard □S.2, E-mail in□uiry and reply to Traci Curtis, RCP, □ACP, Executive Director Survey Operations, Center for □mprovement in □ealthcare □uality, March 28, 1980.

The □oint Commission Standards: LD.0403.13, MS.05.01.01, PC.01.02.07, P□01.01.01, P□02.01.01.

R3 Report, Re□uirement, Rationale, Reference, A publication of The □oint Commission, □ssue 11, August 29, 2017.

VCMC Performance □mprovement Pro□ect - Addiction Medicine

C□RES (2018) - Controlled Substance □tilization Review and Evaluation System

All revision dates:	3/14/2024, 3/14/2024, 3/14/2023, 11/10/2021, 12/8/2020, 11/26/2018, 7/26/2017, 10/1/2011, 3/1/2011, 4/1/2008, 5/1/2006, 3/1/2004, 2/1/2002

Attachments

- Attachment A - □niversal Pain Assessment Tool.pdf
- Attachment E - □LACC.pdf
- Attachment □ - NPASS.pdf
- Attachment G - □LACC□R.pdf

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy □ Therapeutics Committee	Sul □ung: Associate Director of Pharmacy Services	3/21/2024
Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	3/14/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	3/14/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	3/14/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*8/11/2020*
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Last Revised:	*11/18/2020*
Next Review:	*3 years after approval*
Owner:	*Kelly Johnson: Director, ICU/ DOU/Telemetry*
Policy Area:	*Administrative - Nursing*
References:	

100.243 Mechanical Chest Compression System (LUCAS Device) Usage and Safety

Policy:

A. The LUCAS™ chest compression system may be utilized for performing external cardiac compressions by personnel trained in the use of such device. **DO NOT** delay manual cardiopulmonary resuscitation (CPR) for mechanical CPR. If the mechanical LUCAS™ device were to malfunction, rescuers must immediately return to manual compressions.

1. Indications:
   a. Atraumatic, acute circulatory arrest
   b. Adult patient ≥ 18 years of age
2. Contraindications:
   a. If it is not possible to position the LUCAS™ device safely or correctly on the patient's chest
   b. Patient is too small: LUCAS™ device alerts with three fast signals when lowering the suction cup and user cannot enter the PAUSE or ACTIVE mode
   c. Patient is too large: If user cannot lock the upper section of the LUCAS™ device to the back plate with patient in appropriate position
   d. Pregnancy
   e. Traumatic arrest
   f. In a patient who has had a sternotomy within the previous 8 weeks

Procedure:

A. Begin manual CPR as team member unpacks LUCAS™ device from the carrying bag.

B. Push ON/OFF on the User Control Panel for 1 second to power on LUCAS™ device. Device will begin self-test and green LED illuminates when the device is ready.

C. Remove the LUCAS™ Back Plate from the carrying bag.

D. Verbalize "**Stop CPR**".

E. Place the LUCAS™ Back Plate under the patient with the superior edge immediately below the armpits by rolling patient on his/her side or lifting torso of patient with support of patient's head.

1. Do not pause CPR longer that 10 seconds.

F. Verbalize "**Resume manual CPR**".

G. Hold the handles on the support legs to remove the upper part of the LUCAS™ device from the carrying bag.

H. Pull the release rings once to ensure the claw locks are open. Let go of the release rings and do not hold rings in engaged position.

I. Attach the closest support leg to the back plate.

J. Verbalize "**Stop manual CPR**".

K. Attach the distal support leg to the back plate so that both support legs are locked against the back plate. This will be indicted with a "clicking" noise.

L. Use your finger to ensure the lower edge of the Suction Cup is immediately above the end of the sternum. If necessary, move the device by the support legs to adjust to appropriate position.

M. Ensure LUCAS™ device is in ADJUST mode (Mode 1).

N. Push the suction cup down with two fingers until the pressure pad touches the patient's chest without compressing the chest.

O. Push PAUSE (Mode 2) to lock the suction cup to lock the start position.

P. Use a marker on patient's skin along the lower edge of the suction cup to identify appropriate starting position. This will help identify any migration of the device during compressions that could result in further patient injury.

Q. Push ACTIVE Continuous or ACTIVE 30:2 (Mode 3) to start compressions.

Note: If a patient suffers a Code Blue outside of a patient care room, the patient should be transferred to a resuscitation room prior to placement of the LUCAS device. However, this should not delay initiation of high performance CPR and manual compressions during transport.

All revision dates: 11/18/2020, 8/11/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED & Medicine	Tracy Chapman: VCMC - Med Staff	pending
Code Blue Committee	Ashley Vasquez: Senior RN	2/27/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	9/22/2023
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/22/2023
Policy Owner	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	9/22/2023

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Minako Watabe: Chief Medical Officer, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.272 Guideline for Transfers for Patients Requiring a Higher Level of Care

PURPOSE:

□ orkflow for difficult transfers for patients re□uiring a higher level of care (□LOC) excluding trauma, acute stroke and cardiac.

PROCEDURE(S):

1. **TRANSFER DECISION:** Emergency Department (ED) identifies patient that may need transfer to higher level of care.
   a. □f unclear that patient will benefit from □LOC, ED provider consults appropriate inpatient attending to discuss disposition.
   b. □f clear that patient re□uires □LOC, ED contacts potential receiving hospital(s).
      i. ED provider presents case to transfer center Registered Nurse (RN) and on call receiving physician.
      ii. ED Medical Office Assistance faxes face sheet and provider note to receiving facility.
      iii. ED Charge Nurse initiates and receives follow-up communications as needed.
      iv. □f initial attempts at transfer not immediately successful, proceed to □2□
2. **INITIAL TRANSFER NOT SUCCESSFUL:** ED Charge Nurse starts tiger text with nursing supervisor, case management, appropriate Ventura County Medical Center (VCMC) inpatient attending (determined by ED provider), medical director on call and Administrator On Duty (AOD) using AM□ON to contact appropriate person
   a. ED Provider discusses case with VCMC inpatient attending and discusses co-management vs admission.□□
   b. □tilization Management (□M) physician advisor continues search for receiving facility and addresses any payment barriers with receiving facility.
3. **SUBSEQUENT TRANSFER EFFORTS NOT SUCCESSFUL:**
   a. □M or CMO on call will initiate Teams Meeting with: ED physician, □ospitalists/□ntensive Care □nit (□C□) physician, appropriate specialist, □M physician advisor on call (see Amion), medical director on call (see Amion), AOD (see Amion), nursing supervisor, and case management 7am-5pm daily

(weekdays include Laura □arate) to discuss the following:

i. Ongoing ED vs □npatient management□□

ii. ED-ED EMTALA transfer (last resort and can't be performed when receiving hospital at capacity)

□Potential Scenarios
-No accepting facility yet identified
-Accepting facility identified, but transfer pending bed availability
-Accepting facility identified, but transfer pending payment issues
□□□actors to guide medical management of the patient awaiting transfer
-□s transfer predicted to occur in near future (continue ED management or comanagement)
-□s patient unstable or in need of active management of medical condition (consider admit)
-□as patient been accepted pending bed availability (consider admit (EMTALA won't apply)

Please provide MRN and brief summary to minako.watabe□ ventura.org and danielle.gabele□ ventura.org □secure□ in sub□ect line so we can keep track of these challenging transfers. □ e will continue to meet monthly to refine this process.

All revision dates:

Attachments

No Attachments

Approval Signatures

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Medical Staff Committees: ED □ Medicine	Tracy Chapman: VCMC - Med Staff	pending
□ospital Administration	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	3/18/2024
□ospital Administration	Diana □enner: Chief Operating Officer, VCMC □ SP□	3/3/2024
ED Service	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	3/1/2024
ED Service	□ulia □eig: Clinical Nurse Manager, Emergency Services	3/1/2024
Policy Owner	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	3/1/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Sharon Waechter: Clinical Nurse Manager, Nursing Education*
Policy Area:	*Administrative - Employee*
References:	

101.010 Cardiopulmonary Resuscitation (CPR) Training Requirements

POLICY:

In order to promote optimal patient safety, effective resuscitation services will be available throughout Ventura County Medical Center, Santa Paula Hospital, Inpatient Psychiatric Unit and licensed clinics. In order to meet this requirement, employees and medical staff shall maintain the following current certifications:

PROCEDURE:

A. **Basic Life Support (BLS) Provider -** Every two (2) year recertification required. Must be an approved/ accrediated American Heart Association course (called BLS) or American Red Cross course (called Health Care Provider BLS) with a "hands on" skills component.
   - Nursing (Registered Nurse (RN), Licensed Vocational Nurse (LVN), LIcensed Psychiatric Technician (LPT), Operating Room Technician (ORT), Medical Office Assistant (MOA), Nursing Assistant (NA), Medical Assistant (MA), Clinical Assistant (CA))
   - Imaging Services (Radiologic Technologist, Radiologic Specialist, Radiologic Supervisor)
   - Physical Therapist/Occupational Therapist/Speech Pathologist
   - Respiratory Therapist
   - Resident Physicians
   - Telemetry technicians

B. **Advanced Cardiac Life Support/Advanced Life Support (ACLS/ALS) –** every two (2) year recertification required. Must be an approved/accredited American Heart Association or American Red Cross course with a "hands on" skill component.
   - Resident physicians
   - Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
     - Post-Anesthesia Care Unit (PACU)
     - Preoperative Care Unit
     - Perioperative Setting
     - Interventional Radiology

        - Emergency Department (ED)
        - Definitive Observation Unit (DOU)
        - Telemetry (TELE)
        - Intensive Care Unit (ICU)
        - RNs and LVNs assigned monitoring for moderate sedation
    - Respiratory Therapist
    - ACLS/ALS is strongly recommended for RNs and LVNs who work in the ~~perioperative and~~ medical-surgical (Med-Surg) setting.

C. **Neonatal Resuscitation (NRP):** every two (2) year recertification required. Must be an approved/ accredited American Academy of Pediatrics course with a "hands on" skill component.
    - Resident physicians
    - Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
        - Neonatal Intensive Care Unit (NICU)
        - Obstetrics (OB)
        - OR/PACU RNs participating in c-sections
    - Respiratory Therapists working in the NICU and Santa Paula Hospital

D. **Pediatric Advanced Life Support (PALS)** every two (2) year recertification required. Must be an approved/accredited American Heart Association course or American Red Cross with a "hands on" skill component.
    - Resident physicians
    - Registered Nurses and Licensed Vocational Nurses working in the following patient care areas:
        - Pediatrics
        - Pediatric Intensive Care Unit (PICU)
        - Intensive Care Unit (ICU) ONLY if function as Rapid Response Nurse
        - Emergency Department (ED)/(unless they have completed Emergency Nursing Pediatric Course (ENPC))
    - Respiratory Therapists
    - PALS is strongly recommended for RNs and LVNs who work in the perioperative setting.

E. Medical staff members shall comply with the requirements specified in the Medical Staff bylaws, rules and regulations, or department privileging requirements regarding BLS, ACLS/ALS, PALS and NRP certification/recertification.

Course Offerings:

- All courses shall be taught according to the standards of, and approved/accredited by, the American Heart Association (AHA) or the American Red Cross (ARC) or the American Academy of Pediatrics (AAP).
- Cardiopulmonary Resuscitation (CPR) recertification courses (BLS Provider) shall be offered at least monthly.

- ACLS/ALS, NRP and PALS certification/recertification courses shall be offered at least biannually.
- Scheduling of AHA courses is the responsibility of the VCMC Nursing Education Department's AHA Training Center Coordinator.
- Maintaining required certification and scheduling of employees for courses is ultimately the responsibility of the individual employee (in conjunction with each department manager).

All revision dates: 4/12/2024, 11/15/2023, 5/12/2023, 3/16/2023, 12/5/2022, 7/18/2022, 2/12/2019, 5/1/2006, 12/1/2004, 9/1/2001, 11/1/1998, 3/1/1995, 8/1/1992, 11/1/1989, 10/1/1986

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/19/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/16/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/12/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/12/2024
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	4/12/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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References:	

102.028 Physician in Training Moonlighting Privileges

A family medicine physician in training holding a current unrestricted medical license issued by the State of California may be granted privileges to moonlight within the Emergency Department, Ambulatory Care Clinics or □rgent Care Clinic of the Ventura County □ealth System.

A psychiatry physician in training PG□3 and above holding a current ~~postgraduate training~~unrestricted medical license issued by the State of California may be granted privileges to moonlight within the Crisis Stabilization □nit (~~PTL~~CS□) ~~for training at Ventura County Medical Center~~and the □npatient Psychiatric □nit (~~VCMC□P□) issued by the State of California may be granted privileges to moonlight within the Emergency Department or □rgent Care Clinics of the VCMC health system~~.

- □n order to be eligible for family medicine moonlighting privileges, physicians in training must have completed at least 12 months of training and prior written approval from the Residency Program Director. A copy will be maintained by Medical Staff Administration and Medical Education.
- □n order to be eligible for psychiatry moonlighting privileges, physicians in training must have completed at least 24 months of training and prior written approval from the Residency Program Director. A copy will be maintained by Medical Staff Administration and Medical Education.
- Complete the credentialing application and physician in training delineation of privileges.
- Continuously meet privileging re□uirements.
- Complete the focused professional practice evaluation (□PPE) re□uirements.
- Comply with Medical Staff □ylaws, Rules □ Regulations, Department Rules □ Regulations, and □ospital policies.
- □ hile moonlighting, billing for patient care must follow the Centers for Medicare and Medicaid Services (CMS) regulations.

II. Work Hours

- Physicians in training are responsible for ensuring that the addition of moonlighting activities does not result in a ~~workweek~~work week that exceeds the 80-hour maximum or result in fatigue which might affect patient care or learning.
- Any adverse effects may lead to the withdrawal of permission to moonlight.

III. Membership

- Physicians in training who have been granted privileges to moonlight do not hold Medical Staff membership.

IV. Privileges

- The physician in training/moonlighting privileges automatically expire upon completion of training ~~and expiration of the PTL,~~ at which time the physician may apply for full membership and privileges.
- The physician in training/moonlighting privileges automatically expire if the physician in training is no longer affiliated with their current training program.

References:

Medical Staff □ylaws Article 5 Privileges

California □usiness and Professions Code 2064.5 (subsection b and c)

All revision dates: 4/29/2024, 9/15/2020

Attachments

No Attachments

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Medical Staff Office	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	pending
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	pending
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VENTURA COUNTY
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References:	

102.029 Ongoing Monitoring and Interventions

POL□C□

The purpose of this policy is to establish a mechanism to monitor practitioners on an ongoing basis in between the two (2) year re-credentialing cycle for licensure actions and sanctions. Sanctions and limitations will be conducted and reviewed within 30 days of the release of the report. □f reporting entities do not publish sanction information on a set schedule, sanction information must be □ueried at least every six (6) months. □f the reporting entity does not release sanction information reports, individual □ueries must be conducted for any affected practitioner 12-18 months after the last credentialing cycle.

PROCED□RE

1. The most current Medicare Opt-Out reports will be □ueried and reviewed on a monthly basis from the following websites.
    1. Direct link to Opt-Out Reports: https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
2. The most current Provider Sanctions reports will be obtained on a monthly basis from the Department of □ealth □ □uman Services, Office of □nspector General□s website and the □.S. General Services Administration□s website.
    1. Direct link to Department of □ealth □ □uman Services, Office of □nspector General□s website: https://exclusions.oig.hhs.gov/
    2. Direct link to □.S. General Services Administration□s website: https://sam.gov/exclusions-new
3. The most current Medi-Cal Provider Suspended and □neligible list will be □ueried and reviewed on a monthly basis from the State Medi-Cal Program□s website.
    1. https://www.medi-cal.ca.gov/
    2. Link to Suspended and □neligible list: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi
4. The Social Security Administration□s Death Master □ile website will be □ueried on a monthly basis.
    1. https://ladmf.ntis.gov/
5. All practitioners are enrolled in the National Practitioners Data □ank (NPD□) Continuous □uery and automatically re-enrolled annually. The Medical Staff Office receives automatic alerts from the NPD□ upon receipt of any report to the NPD□, including licensing board actions (in addition to items ~~5-12~~6-13 listed below). Reports are reviewed upon receipt of any notification.

1. Direct link to the NPD□ website: https://www.npdb.hrsa.gov/
2. Direct link to the NPD□ Organization Login: https://i□rs.npdb.hrsa.gov

6. Disciplinary actions will be obtained as decisions become final from the Medical □oard of California through the Medical □oard website by subscription and through the Enforcement Public Document website https://www.mbc.ca.gov/.
7. Disciplinary actions will be obtained as decisions become final from the California □oard of Psychology through the Psychology □oard website by subscription at https://www.dca.ca.gov/webapps/psychboard/subscribe.php.
8. Disciplinary actions will be obtained as decisions become final from the Dental □oard of California through the Dental □oard website at https://www.dbc.ca.gov/consumers/hotsheets.shtml.
9. Disciplinary actions will be obtained as decisions become final from the California □oard of Optometry through the Optometry □oard website at https://www.optometry.ca.gov/consumers/disciplinary.shtml.
10. Disciplinary actions will be obtained as decisions become final from the Osteopathic Medical □oard of California through the Osteopathic Medical □oard website at https://www.ombc.ca.gov/consumers/enforce□action.shtml.
11. Disciplinary actions will be obtained as decisions become final from the Physician Assistant Committee through the Physician Assistant Committee website at https://www.pab.ca.gov/forms□pubs/disciplinaryactions.shtml.
12. Disciplinary actions will be obtained as decision become final from the Medical □oard of California □oard of Podiatric Medicine through the Podiatric □oard website at https://www.pmbc.ca.gov/consumers/dispsumm.shtml.
13. Disciplinary actions will be obtained as decisions become final from the California □oard of Registered Nursing through the National Council of State □oard of Nursing website by subscription at https://www.nursys.com/EN/ENDefault.aspx.
14. Results will be reviewed at the appropriate Department Committee meeting at the Medical Executive Committee (via the Department□s membership and privileges recommendation form).
15. Practitioner names identified on reports will be sub□ect to review as outlined in the Medical Staff □ylaws in closed session.
16. The Medical Staff Office will notify the Compliance Office of any practitioner who is excluded, suspended, debarred, or otherwise ineligible to participate in □ederally funded health care programs or in federal procurement or non-procurement programs according to policy 109.052 Screening of □neligible Persons.

All revision dates: 4/5/2024, 8/10/2021, 1/13/2021

Attachments

□ealth Plan Audit Ongoing Monitoring □ ebsites

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Medical Staff Office	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	4/19/2024
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	4/15/2024
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VENTURA COUNTY
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References:	

102.030 Medical Staff Professional Liability Insurance Requirements

POLICY:

It is the responsibility of the Ventura County Medical Center Medical Staff to ensure all practitioners granted privileges to provide patient care, including consultations and telemedicine services, maintain professional liability insurance which covers all care provided by the practitioner in the amounts of at least 1 million/ occurrence and 3 million/aggregate. Copies of certificates of insurance (COI) coverage will be maintained in the practitioner's confidential credentialing file.

PROCEDURE:

Employees

Practitioners that are direct employees of the Ventura County Health Care Agency will be provided coverage under the County's liability carrier once privileges have been granted and for the duration of employment, which satisfies the requirements outlined in the Medical Staff Bylaws Article 2 regarding Basic Requirements.

Contractors

Practitioners that are contracted with the Ventura County Health Care Agency who are not direct employees of the County may be provided coverage through the County's liability carrier as outlined in the contract for services.

Failure to Maintain Coverage

As outlined in the Medical Staff Bylaws, failure to maintain professional liability insurance as required shall be grounds for automatic suspension of privileges until such time coverage has been reinstated. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures until such time coverage has been reinstated.

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Attachments

No Attachments

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References:	

102.033 Allied Health Professionals

INTRODUCTION

The definition of □Allied □ealth Practitioner□or □A□P□as used in this policy is as follows:
Allied □ealth Practitioner or A□P means an individual, other than a licensed physician, dentist, clinical psychologist or podiatrist, who exercises independent □udgment within the areas of their professional competence and the limits established by the Governing □oard, the Medical Staff, and the applicable State Practice Act, who is □ualified to render direct or indirect medical, dental, psychological or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the □ospital[1], and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Governing □oard, the Medical Staff □ylaws and the Rules.

This policy applies to the following categories of A□Ps, regardless of employment status:

A. Physician Assistant

□. Certified Nurse Midwife

C. Nurse Practitioner

D. Optometrist

□ualifications, scope of practice, and supervision re□uirements relevant to each of the above categories of Allied □ealth Practitioners are set forth in the Appendices to this Policy.

□. **ALLIED HEALTH PRACTITIONERS UNDER JURISDICTION OF THE MEDICAL STAFF**

A. Application of Standards

i. These standards apply to practitioners who are accorded Allied □ealth Practitioner status at the □ospital and who are under the □urisdiction of the Medical Staff. These standards are separate and distinct from any employment-related □ospital standards and policies that apply to practitioners who are employees of the □ospital.

ii. An individual is deemed included in this category if the individual holds the license of one of the aforementioned categories AND is working in a position that re□uires the license. An individual licensed as a nurse practitioner whose □ob description is of an RN, without the re□uirement for a nurse practitioner license, would not be considered a nurse practitioner for the purposes of this policy.

iii. The administrative functions necessary to the Medical Staff□s oversight shall be performed by the Medical Staff Office.

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□. Standards

□n order to □ualify for initial and ongoing Allied □ealth Practitioner status at □ospital, an Allied □ealth Practitioner shall:

i. □elong to an Allied □ealth Practitioner category that has been admitted to practice at the □ospital by the Governing □oard. The categories, which have been so admitted, are listed in the □ntroduction□

ii. Meet one of the following re□uirements:

1. □elong to an Allied □ealth Practitioner category that is not sub□ect to any exclusive contract or panel arrangement with the □ospital□or

2. □e accepted by the □ospital as part of any exclusive contract or panel arrangement that applies to the Allied □ealth Practitioner□s category□

iii. Possess any license or certificate re□uired under the laws of the State of California for the Practitioner□s category□

iv. Possess and document the background, training, experience, □udgment, ability, and physical and mental health necessary to demonstrate with sufficient ade□uacy that they are able to provide professional services as re□uested and authorized in accordance with generally recognized professional standards of □uality and efficiency□

v. Adhere strictly to generally recognized standards of professional ethics□

vi. □e able to work cooperatively with others in the □ospital so as not to adversely affect patient care or □ospital operations□

vii. Possess any other □ualifications listed in the □Re□uired □ualifications□section of the practice privileges description for the specific category of Allied □ealth Practitioner including any re□uired life support certification (e.g., □LS, ACLS, PALS)□

viii. Perform services for patients at the □ospital in con□unction with the Medical Staff member responsible for the patient□s care□

ix. Comply with all □ospital, Medical Staff and Department bylaws, rules, policies and procedures in addition to the laws and regulations of the California □oard of Registered Nursing (for advanced practice nurses) or the California Physician Assistant □oard (for physician assistants) as well as other state and federal regulations, to the extent applicable to the Allied □ealth Practitioner□

x. □e willing to participate in the discharge of administrative responsibilities as reasonably determined by the Medical Staff and the Allied □ealth Practitioner□s department□

xi. Maintain in continuous force professional liability insurance covering the exercise of all re□uested privileges, in an amount e□ual to that re□uired of members of the Medical Staff, or such other sum as may from time to time be established by the Governing □oard upon recommendation of the Medical Executive Committee. Professional liability insurance must be held with an insurance carrier approved by the State □nsurance Commissioner to conduct business in the State of California, or the Practitioner may demonstrate membership in a Physician□s cooperative acceptable to the Governing □oard, as defined in Section 1280.7 of the California □nsurance Code, with the same minimum amounts of coverage (Allied □ealth Practitioners who are employed will have the functions performed as part of their employment covered by the □ospital.)□

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xii. Pay a non-refundable application fee, the amount of which is determined by the Medical Staff (unless exempted from this re□uirement)□

xiii. Meet the conditions of any applicable contract with the □ospital□

xiv. Not be excluded from participation in any federally funded health care program, including Medicare or Medi-Cal□

xv. Provide the contact information of a minimum of three professional references (at least one of whom is a physician and at least one of whom has the same license as the A□P) who are knowledgeable of the applicant□s demonstrated current professional competence□

xvi. □ here physician supervision re□uired by law, provide evidence from the employer/supervising physician that they accept full legal and ethical responsibility for the performance of the applicant, and agreement by the employer/supervising physician to immediately notify the □ospital in the event that there is a change in the employer-employee status or termination of the agreement to provide supervision of the A□P. □ hen an applicant is supervised by more than one physician, each physician must submit an agreement to the above□

xvii. Agree to identify self to patients and public by wearing an approved name tag, to not represent themselves as employees of the □ospital unless they are employees of the □ospital, and to sign records accordingly□

xviii. Agree to complete orientation and, if appropriate, any annual compliance training and health status testing□

xix. Agree to participate in annual safety in-services□and

xx. Meet any other specific re□uirements established by the applicable department, the Medical Executive Committee, or the Governing □oard for the Practitioner□s category of Allied □ealth Practitioner.

C. □ aiver

i. □nsofar as is consistent with applicable laws, the Medical Executive Committee has the discretion to deem a practitioner to have satisfied a standard if it determines that the practitioner has demonstrated they have substantially comparable □ualifications and that this waiver is necessary to serve the best interests of the patients and of the □ospital. The Medical Executive Committee may choose to consult with the practitioner□s respective Department or Clinical Section. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted.

□□ CORRECTIVE ACTION AND APPEAL RIGHTS OF ALLIED HEALTH PRACTITIONERS UNDER JURISDICTION OF THE MEDICAL STAFF

A. Corrective Action

i. A department chairperson, the Credentials Committee, the Chief of Staff, the Chief Medical Officer, or the Governing □oard may make a re□uest to the Medical Executive Committee for an investigation or corrective action whenever an Allied □ealth Practitioner engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of □uality patient care, in violation of applicable rules or policies, or disruptive of □ospital operations. The re□uest shall be in writing and shall be supported by reference to specific conduct or activities.

ii. The Medical Executive Committee may appoint an ad hoc committee or delegate to the □nterdisciplinary Practice Committee (□PC) to carry out an investigation. Any such ad hoc or □PC

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committee shall proceed in a prompt manner with the investigation, which may include an informal meeting with the Allied □ealth Practitioner. At the conclusion of its investigation, the ad hoc or □PC committee shall forward a report, together with any recommendation for corrective action, to the Medical Executive Committee.

iii. The Medical Executive Committee shall consider the report and recommendation and shall make its own recommendation concerning any corrective action.

iv. □n the event that the Medical Executive Committee recommends suspension or termination of Allied □ealth Practitioner status or reduction in practice privilege(s), the Allied □ealth Practitioner shall be entitled to a review under Section □. □f the Allied □ealth Practitioner is the sub□ect of an adverse action or recommendation that, if adopted, would be for medical disciplinary cause and reportable to the relevant licensing agency under Section 805 of the □usiness and Professions Code, the Practitioner shall be afforded such additional procedural rights as are mandated by Section 809 of the □usiness and Professions Code and described in the Medical Staff □ylaws. □f the Allied □ealth Practitioner waives the right to a review, the matter shall be forwarded, together with the supporting materials, to the Governing □oard for a final decision.

v. □n the event that immediate action is deemed necessary in the interests of patient care or □ospital operations, any person or body entitled to re□uest an investigation or corrective action under Section A.i above may restrict or suspend an Allied □ealth Practitioner□s status or practice privilege(s) immediately. The Allied □ealth Practitioner then shall have the right to meet informally as soon as practicable with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction or suspension. □n the event that the restriction or suspension is not lifted the Allied □ealth Practitioner shall have the right to obtain review under Section □ below. The restriction or suspension shall remain in effect pending any such review.

vi. The Allied □ealth Practitioner□s status and practice privileges shall be sub□ect to automatic suspension, restriction, revocation, or other action as follows:

1. □f the Allied □ealth Practitioner□s license or other legal certification or credential authorizing practice in this state, mid-level certificate from the □.S. Drug Enforcement Agency (□DEA□) or provider status in a government-funded program is suspended, restricted, placed on probation, terminated or revoked, or if they elect to opt-out of a government-funded program, their status and practice privileges shall automatically be affected in the same manner.

2. Allied □ealth Practitioners are sub□ect to the Medical Staff□s policy pertaining to completion of records. □f an Allied □ealth Practitioner fails to comply with that policy□s re□uirements for timely and ade□uate completion of medical records, the A□P may be sub□ect to fine or suspension in accordance with that policy.

3. □f there is a lapse in the Allied □ealth Practitioner□s maintenance of professional liability insurance as re□uired by the □ospital, the Practitioner shall be automatically suspended until the re□uisite coverage is reinstated.

4. □or Allied □ealth Practitioners acting under the supervision of another practitioner, any lapse in the other practitioner□s willingness or ability to provide such supervision shall result automatically in the suspension of the Allied □ealth Practitioner□s privileges until approved supervision is reinstated.

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□. Review

i. An Allied □ealth Practitioner shall be given the opportunity to have any of the following actions or recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction which shall be effective immediately):

1. Denial of an application for initial granting of practice privileges or granting of Allied □ealth Practitioner status□
2. Denial of a re□uest for initial or additional practice privileges (except temporary practice privileges)□
3. Reduction or suspension for more than 30 days or termination of existing practice privileges (except temporary practice privilege(s)□or
4. Suspension for more than 30 days or termination of Allied □ealth Practitioner status.

ii. Notwithstanding Section □.i above, an Allied □ealth Practitioner shall have no right to obtain review in any of the following instances:

1. □ hen an application is denied because it is incomplete□
2. □ hen an application is denied because the Allied □ealth Practitioner is not from a category that the □ospital has accepted for practice on its premises□
3. □ hen an application is denied or Allied □ealth Practitioner status or practice privilege(s) is revoked because of the existence of an employment, contractual, panel, or other relationship between the □ospital and one or more other Allied □ealth Practitioners in the affected category which provides for exclusivity or limits the number of Allied □ealth Practitioners in that category who may practice at the □ospital□
4. □ hen an application is denied or Allied □ealth Practitioner status or practice privilege(s) is revoked because the physician who has agreed or is re□uired by law or Medical Staff policy to act as the Allied □ealth Practitioner□s supervising physician has given up or been deprived of that status or no longer holds the re□uisite Medical Staff membership or practice privileges□and
5. □ hen practice privileges are suspended, restricted, or revoked because of a lapse in licensure, a lapse in insurance, a lapse in DEA registration, a lapse of provider status in a government-funded health program, a lapse of supervision, medical record delin□uencies, or other administrative reasons such as the failure to pay dues and assessments, if present.

iii. The Allied □ealth Practitioner shall be notified of their right to obtain review as soon as practicable after the Medical Executive Committee has decided to make or recommend an adverse recommendation as described above. Notice means a written communication delivered personally to the addressee (including via electronic mail) or sent by □nited States mail, first-class postage prepaid, addressed to the last address on record in the Medical Staff/□ospital□s official records.

iv. To obtain review, the Allied □ealth Practitioner shall submit a written re□uest to the Chief Medical Officer, care of the Medical Staff Office. Such re□uest must be received within fourteen (14) days of the notice to the Allied □ealth Practitioner. □n the event that the Allied □ealth Practitioner does not re□uest review in this manner, the Practitioner shall be deemed to have waived any review rights. The matter then shall be forwarded to the Governing □oard for a final

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decision.

v. Review shall be in the form of a meeting with a panel. □ ithin a reasonable time in advance of the meeting, the Chief Medical Officer shall give the Allied □ealth Practitioner written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. □f appropriate, this summary shall include references to representative patient care situations or to relevant events.

vi. The meeting shall be with an ad hoc panel consisting of at least three (3) persons appointed by the Medical Executive Committee. The Medical Executive Committee shall ensure that panel members have not participated earlier in the formal consideration of the case. The Medical Executive Committee shall designate one (1) member of the panel as its chairperson and may include an Allied □ealth Practitioner from the appropriate category as a panel member. At the discretion of the panel, the meeting may be conducted virtually.

vii. The panel shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied □ealth Practitioner has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. A record of the meeting may be maintained by the panel in the form of minutes or a tape recording, or through use of a Certified Shorthand Reporter. □f a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party re□uesting a transcript or copy thereof will bear the cost of its preparation.

viii. The panel shall affirm the recommendation or action of the Medical Executive Committee, unless the Allied □ealth Practitioner demonstrates that it is arbitrary or unreasonable in light of the evidence presented at the meeting.

ix. □ollowing the meeting, the panel shall deliberate and shall issue a written decision and report. A copy of the decision and report shall be provided to the Allied □ealth Practitioner, the Chief of Staff, and the Governing □oard.

x. The Governing □oard shall consider the decision and report of the panel. □n its discretion, the Governing □oard may allow the Allied □ealth Practitioner to submit an appeal, i.e., a written statement to it commenting on the decision and report. The Governing □oard then shall make the final decision on the appeal, in accordance with its own procedures.

□□□. FOCUSED PROFESSIONAL EVALUATION OF ALLIED HEALTH PRACTITIONERS UNDER JURISDICTION OF THE MEDICAL STAFF

□ocused Professional Performance Evaluations (□PPE) is the time-limited evaluation of the A□P□s competence in performing specific privileges. This process is implemented for all newly re□uested privileges and whenever a □uestion arises regarding an A□P□s ability to provide safe, high □uality patient care. □elow follows a description of this process:

A. An Allied □ealth Practitioner who is initially granted practice privilege(s) shall automatically be sub□ect to a period of observation, to extend for a minimum of six (6) months or six (6) cases, whichever is longer. The observation period may be extended by the Department Chairperson for six (6) months every six (6) months, not to exceed twenty-four (24) months. The Allied □ealth Practitioner shall not be entitled to a review under Section □□based on a decision to continue or extend observation. □n the event that the department chairperson has not approved the full exercise of a particular practice privilege within the established observation period, that practice privilege shall cease, and the Allied □ealth Practitioner shall be entitled to a review upon re□uest. □owever, if the department chairperson has not given their approval due to the failure of the Allied □ealth Practitioner to perform a sufficient volume of work at the □ospital to facilitate an ade□uate evaluation

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within the time allotted, the Allied □ealth Practitioner will be deemed to have resigned the practice privilege in □uestion, and shall have no right to a review.

□. The Medical Executive Committee, □PC, Credentials Committee, appropriate department chairperson, Chief of Staff, or Governing □oard shall have authority at any time to re□uire that an Allied □ealth Practitioner be sub□ect to a period of observation to last as long as deemed appropriate, and shall have the authority to adopt any rules or procedures considered necessary to implement this re□uirement.

C. Observation may consist of the methods customarily used at hospitals, including concurrent or retrospective chart review, proctoring, or the re□uirement of consultation.

D. The observer shall be a practitioner on the Medical Staff or an Allied □ealth Practitioner who exercises practice privileges relevant to the activity being evaluated, provided, however, that the observer should not be the Allied □ealth Practitioner□s sponsoring or regularly supervising practitioner. Alternatively, the observer may be an outside practitioner with the necessary knowledge and experience.

□V. PROTOCOL FOR CONSIDERATION OF ALLIED HEALTH PROFESSIONAL CATEGORIES

A. Policy

i. □t is the policy of the □ospital to give appropriate consideration to the □uestion of whether a given category of Allied □ealth Professionals should be permitted to practice on its premises in Allied □ealth Professional status. The □uestion will be addressed with respect to a particular category if the □ospital receives a serious expression of interest from the Chief Executive Officer, a member of the Governing □oard, or a committee or member of the Medical Staff.

ii. The decision whether to accept or re□ect an Allied □ealth Professional category will rest exclusively with the Governing □oard. To assist the Governing □oard in making its decision, the Medical Staff adopts the procedures in this Protocol. The procedures are designed to provide the Governing □oard with complete information about the relevant issues and to afford all interested persons an opportunity to make their views known. The procedures are intended to serve as guidelines, and may be varied for good cause in any particular case.

□. Procedure

i. The Governing □oard will refer the matter to the appropriate Medical Staff or Department Committee, or a standing or ad hoc □ospital Committee. The Medical Executive Committee, on its own initiative, may also consider whether a particular category should be accepted, and make a recommendation accordingly to the Governing □oard.

ii. The body chosen will investigate the matter, including soliciting the views of those most directly involved and those able to assist it with its in□uiry. This may include, for example, members of the Allied □ealth Professional category under consideration, any Medical Staff members who might provide supervision, practitioners from related areas, other □ospital or Medical Staff personnel, representatives from licensing or certification agencies, representatives from professional associations, insurers, or members of the interested public.

iii. On the basis of its review, the body will make a recommendation to the Governing □oard, as appropriate, to be accompanied by a report describing the underlying reasons for the recommendation.

iv. The Governing □oard will review the recommendation(s) and report(s) and will render a decision on behalf of the □ospital.

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V. **MISCELLANEOUS**

A. Voting Privileges and Committee Meetings
Allied □ealth Practitioners shall not be entitled to vote on Medical Staff matters and shall not attend Medical Staff meetings. □ hen authorized by the Medical Staff, they may be invited to attend and participate actively in the practice meetings of their respective departments or services.

□. □illing (This section does not apply to A□Ps who are employees of the □ospital)
Allied □ealth Practitioners shall bill independently only as permitted by any applicable California laws or regulations.

C. Confidentiality
Allied □ealth Practitioners shall, at all times, respect the confidentiality of any and all information concerning patients treated at the □ospital and the confidentiality of all Medical Staff, department, or committee minutes, files and records regarding □uality improvement, peer review and credentialing activities.

D. □nformed Consent
□n con□unction with the responsible physician, the Allied □ealth Practitioner must obtain the informed consent of the patient or the patient□s representative for any care, treatment, or procedure to be performed by the Allied □ealth Practitioner. The discussion with the patient shall include explanation of the fact that that the Allied □ealth Practitioner is not a □ospital employee, but rather practices independently under the supervision of the responsible physician. The responsible physician or Allied □ealth Practitioner shall ensure that there is written documentation that informed consent was obtained.

E. Admission and Transfer of Patients
Allied □ealth Practitioners with admitting privileges may admit patients upon order of a member of the Medical Staff who has admitting privileges and who maintains responsibility for the overall care of the patient.

□. Leave of Absence (LOA)
Allied □ealth Professionals seeking a leave of absence must abide by Medical Staff Policy 102.032 Medical Staff Leave of Absence and notify the Medical Staff Office in writing of any leave of absence greater than 90 days.

APPENDIX A

NURSE PRACTITIONERS

1. □ualifications
   a. Nurse Practitioners shall be currently licensed as a registered nurse in California and currently certified as a Nurse Practitioner by the California □oard of Registered Nursing.
2. Scope of Practice
   a. Nurse Practitioners may receive privileges to perform the following professional services at the □ospital:
      i. Perform tasks or functions which fall within the customary scope of nursing practice□

i. □urnish or order drugs or devices (other than controlled substances) to patients under the following conditions:
   1. The drug or device is furnished or ordered pursuant to a standardized procedure.

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2. The drug or device furnished or ordered is consistent with the Nurse Practitioner□s educational preparation or established (and maintained) clinical competency.
3. The drug or device is furnished or ordered under the supervision of the attending physician, who:
   a. Collaborated in the development of the standardized procedure□
   b. Approved the standardized procedure□
   c. □s available by telephone at the time of patient examination by the Nurse Practitioner□and
   d. Supervises no more than four furnishing Nurse Practitioners at one time.
4. The drug or device is furnished or ordered pursuant to certification from the □oard of Registered Nursing that the Nurse Practitioner has completed:
   a. At least six months of physician supervised experience in the furnishing of drugs or devices□and
   b. A course in pharmacology covering the drugs and devices to be furnished.
5. The drug or device is furnished or ordered under a number issued by the □oard of Registered Nursing to the Nurse Practitioner, to be included on all transmittals of orders for drugs or devices.

ii. □urnish or order Schedule □V or Schedule V controlled substances if, in addition to the conditions above at (ii) being met, the drugs or devices are further limited to those drugs agreed upon by the Nurse Practitioner and the supervising physician and specified in the standardized procedure.

iii. □urnish or order Schedule □□□controlled substances if, in addition to the conditions above at (ii) and (iii) being met, the drugs or devices are furnished in accordance with a patient-specific protocol approved by the treating or supervising physician.

iv. □urnish or order Schedule □□controlled substances if, in addition to the conditions above at (ii), (iii), and (iv) being met, the following conditions are met:
   1. The provision in the protocol for furnishing Schedule □□controlled substances addresses the diagnosis of the illness, in□ury, or condition for which the Schedule □□controlled substance is to be furnished□and
   2. The Nurse Practitioner completes, as part of their continuing education re□uirements, a course including Schedule □□controlled substances that meets the standards of the □oard of Registered Nursing.

i. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the □ospital in accordance with the Medical Staff Rules.

1. □ormat for Standardized Procedures
   a. Standardized procedures are appropriate for certain areas of registered nursing that overlap with areas traditionally reserved exclusively to physicians. □ ith the assistance of nurses and physicians, the □PC will identify particular medical functions, performed by nurse practitioners, which are suitable for standardized procedures and will oversee the creation of individual standardized procedures for them.
   b. □n order to be approved by the □PC, a standardized procedure must be in writing, dated, and signed, and must contain the elements set forth in the applicable law or regulations promulgated by the California □oard of Nursing.

APPENDIX B

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CERTIFIED NURSE MIDWIVES

1. □ualifications
   a. Certified Nurse Midwives (CNMs) shall be currently licensed as a registered nurse in California and currently certified as a Nurse-Midwife by the California □oard of Registered Nursing.
2. Scope of Practice
   a. CNMs may receive privileges to perform the following professional services at the □ospital:
      i. Perform tasks or functions which fall within the customary scope of nurse midwifery practice, including but not limited to, the following:
         1. Attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, consistent with the Core Competencies for □asic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. □or purposes of this Appendix, □low-risk pregnancy□means a pregnancy in which all of the following conditions are met:
            a. There is a single fetus.
            b. There is a cephalic presentation at onset of labor.
            c. The gestational age of the fetus is greater than or e□ual to 37 weeks and zero days and less than or e□ual to 42 weeks and zero days at the time of delivery.
            d. Labor is spontaneous or induced.
            e. The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the certified nurse-midwife is not □ualified to independently address consistent with this section.
      ii. Perform tasks or functions consistent with mutually agreed-upon policies and protocols with a physician and surgeon that delineate the parameters for consultation, collaboration, referral, and transfer of a patient□s care, signed by both the CNM and a physician and surgeon to do either of the following:
         1. Provide a patient with care that falls outside the scope of services specified in section (a)(i)(1), above.
         2. Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.
      iii. □urnish or order drugs or devices (including for controlled substances) to patients under the conditions set forth under California □usiness □ Professions Code, Section 2746.51.
      iv. Any other professional services as otherwise permitted under California □usiness □ Professions Code, Sections 2746 *et seq*.

1. □ormat for Standardized Procedures

a. Standardized procedures are appropriate for certain areas of registered nursing that overlap with areas traditionally reserved exclusively to physicians. □ ith the assistance of nurses and physicians, the □PC will identify particular medical functions, performed by CNMs, which are suitable for standardized procedures and will oversee the creation of individual standardized procedures for them.

a. □n order to be approved by the □PC, a standardized procedure must be in writing, dated, and signed, and

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must contain the elements set forth in the applicable law or regulations promulgated by the California □oard of Nursing.

APPENDIX C

PHYSICIAN ASSISTANTS

1. □ualifications
   a. Physician Assistants shall be currently licensed by the Physician Assistant Committee of the Medical □oard of California.
   b. Physician Assistants shall perform all services at the □ospital under the direction of a □ualified supervising physician.
2. Scope of Practice
   a. Physician Assistants may receive privileges to perform the following professional services at the □ospital as specified in their Practice Agreement (defined below):
      i. Performing physical examinations, ordering □-rays and laboratory tests□ordering respiratory, occupational, or physical therapy treatments□performing routine diagnostic tests□and establishing diagnoses.
      ii. A Practice Agreement may also authorize a PA to:
         1. Order durable medical e□uipment□
         2. Approve, sign, modify, or add to a plan of treatment or plan of care, after consulting with the supervising physician, for a patient receiving home services or personal care services□ or
         3. Certify a disability under Cal. □nemp. □ns. Code section 2708.
   b. A Physician Assistant may also:
      i. Administer and provide medication to a patient□
      ii. Transmit an order to a person authorized to furnish medication or medical devices.
      iii. □urnish or order Schedule □□or □□□controlled substances as specified under the practice agreement or a patient-specific order under specified conditions.
      iv. Assist the supervising physician by arranging admissions, making appropriate entries in the patient□s medical record, reviewing and revising treatment and therapy plans, ordering, transmitting orders for, performing, or assisting the performance of radiology services, therapeutic diets, physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services, and providing continuing care to patients following discharge.
      v. □acilitate the supervising physician□s referral of patients to the appropriate health facilities, agencies and resources of the community.
      vi. Perform, outside the personal presence of the supervising physician, surgical procedures which are customarily performed under local anesthesia, which the supervising physician has determined the Physician Assistant has training to perform, and for which the Physician Assistant has privileges to perform.
      vii. Act as a first or second assistant in surgery under the supervision of the supervising physician.
   c. Physician Assistants shall not:

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i. Perform any task or function that re□uires the particular skill, training, or experience of a physician, dentist or dental hygienist□

ii. Determine eye refractions or fit glasses or contact lenses□or

iii. Prescribe or use any optical device for eye exercises, visual training or orthoptics (this does not, however, preclude administering routine visual screening tests).

3. Supervision

a. A supervising physician shall oversee the activities of, and accept responsibility for, the medical services rendered by a Physician Assistant. This does not re□uire physical presence of a supervising physician, but does re□uire adherence to ade□uate supervision as agreed to in the Practice Agreement (detailed below) and availability of a supervising physician by telephone or electronic communication at the time the Physician Assistant examines a patient.

b. Physician Assistants shall perform all services at the □ospital under the direction of a supervising physician who:

i. □s currently licensed by the Medical □oard or Osteopathic Medical □oard of the State of California□

ii. □s a current member in good standing of the Medical Staff and practices actively at the □ospital□

iii. □s not sub□ect to a disciplinary condition imposed by the Medical □oard of California prohibiting supervision or employment of a Physician Assistant□and

iv. Meets the re□uirements set forth in this Appendix.

c. □efore the Physician Assistant is permitted to perform services at the □ospital:

i. The Physician Assistant shall execute a signed, written Practice Agreement. The Practice Agreement addresses the types of medical services the Physician Assistant is authorized to perform, policies and procedures to ensure ade□uate supervision of the Physician Assistant, the methods of continuing evaluation of the competency and □ualifications of the Physician Assistant, and the furnishing or ordering of drugs or devices by a Physician Assistant.

ii. □ ith the assistance of physician assistants and physicians, the □PC oversee the creation of standard Practice Agreement.

iii. □n order to be approved by the □PC, a Practice Agreement shall be signed by one or more supervising physicians who is authorized to approve the Practice Agreement on behalf of the medical staff of the □ospital.

d. A supervising physician shall oversee the activities of, and accept responsibility for, the medical services rendered by a Physician Assistant. This does not re□uire physical presence of a supervising physician, but does re□uire adherence to ade□uate supervision as agreed to in the Practice Agreement and availability of a supervising physician by telephone or electronic communication at the time the Physician Assistant examines a patient.

e. The supervising physician shall establish the following in writing, in a form acceptable to the □ospital, together with any necessary documentation:

i. That the supervising physician accepts full legal and ethical responsibility for the performance of all professional activities of the Physician Assistant□

ii. Those specific duties and acts, including histories and physical examinations, that the Physician Assistant would be permitted to perform outside of the supervising physician□s immediate

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supervision and control□

iii. That the supervising physician is covered by professional liability insurance with limits as determined by the Governing □oard, for acts or omissions arising from supervision of the Physician Assistant (the supervising physician shall verify such coverage in a form acceptable to the Medical Staff Executive Committee)□and

iv. That the supervising physician is not sub□ect to a disciplinary condition imposed by the Medical □oard of California prohibiting that supervision or the employment of a Physician Assistant.

f. The supervising physician shall agree in writing in a form acceptable to the □ospital that:

i. They shall notify the □ospital and its Medical Staff immediately in the event that they become sub□ect to any disciplinary condition, or an action to impose a disciplinary condition, by the Medical □oard of California□and

ii. They shall comply with all Medical □oard of California regulations regarding supervision of the Physician Assistant.

g. No supervising physician shall have a supervisory relationship with more than four Physician Assistants at any one time. (Notwithstanding the foregoing, an emergency physician may have a supervisory relationship with more than four emergency care Physician Assistants at any one time, provided that the emergency physician does not oversee the work of more than four such Physician Assistants while on duty at any one time.)

APPENDIX D

OPTOMETRISTS

1. □ualifications

a. Optometrists shall be currently licensed as to practice optometry in California by the California State □oard of Optometry.

2. Scope of Practice

a. Optometrists may receive privileges to perform the following professional services at the □ospital:

i. Diagnose, prevent, treat, and manage disorders and dysfunctions of the visual system□conduct examinations of the human eyes and their adnexa, including through the use of all topical and oral diagnostic pharmaceutical agents that are not controlled substances, and the analysis of the human vision system, either sub□ectively or ob□ectively□provide habilitative or rehabilitative optometric services, including prescribing, using, or directing the use of any optical device in connection with ocular exercises, visual training, vision training, or orthoptics, and the prescribing, fitting, or adaptation of contact and spectacle lenses to, the human eyes, including lenses that may be classified as drugs or devices by any law of the □nited States or of this state, and diagnostic or therapeutic contact lenses that incorporate a medication or therapy the optometrist is certified to prescribe or provide□diagnose and prevent conditions and diseases of the human eyes and their adnexa, and treat nonmalignant conditions and diseases of the anterior segment of the human eyes and their adnexa, including ametropia and presbyopia.

b. Optometrists may also:

i. □tilize the following techni□ues and instrumentation necessary for the diagnosis of conditions and diseases of the eye and adnexa:

1. Laboratory tests or examinations, □-rays, or other imaging studies ordered or administered

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to detect indicators of possible systemic disease that manifests in the eye for the purpose of facilitating appropriate referral to or consultation with a physician and surgeon.

2. Skin testing performed in an office to diagnose ocular allergies, limited to the superficial layer of the skin.

ii. Perform the following procedures:

1. Corneal scraping with cultures.
2. Debridement of corneal epithelium not associated with band keratopathy.
3. Mechanical epilation.
4. Collection of blood by skin puncture or venipuncture for laboratory testing authorized by law.
5. Suture removal subject to supervision requirements below.
6. Treatment or removal of sebaceous cysts by expression.
7. Lacrimal punctal occlusion using plugs, or placement of a stent or similar device in a lacrimal canaliculus intended to deliver a medication the optometrist is certified to prescribe or provide.
8. Foreign body and staining removal from the cornea, eyelid, and conjunctiva with any appropriate instrument. Removal of corneal foreign bodies and any related stain shall, as relevant, be limited to that which is non-perforating, no deeper than the midstroma, and not reasonably anticipated to require surgical repair.
9. Lacrimal irrigation and dilation in patients 12 years of age or over, excluding probing of the nasolacrimal tract.
10. Administration of oral fluorescein for the purpose of ocular angiography.
11. Intravenous injection for the purpose of performing ocular angiography at the direction of an ophthalmologist as part of an active treatment plan when a physician and surgeon is immediately available.
12. Use of noninvasive devices delivering intense pulsed light therapy or low-level light therapy that do not rely on laser technology, limited to treatment of conditions and diseases of the adnexa.
13. Use of an intranasal stimulator in conjunction with treatment of dry eye syndrome.

iii. Use any additional noninvasive medical devices or technology after successfully completing any required clinical training imposed by a related manufacturer prior to using any of those noninvasive medical devices or technologies.

c. Optometrists certified to use therapeutic pharmaceutical agents may also:

i. Use or prescribe, including for rational off-label purposes, topical and oral prescription and nonprescription therapeutic pharmaceutical agents that are not controlled substances and are not antiglaucoma agents or limited or excluded by the section below.

ii. Prescribe the oral analgesic controlled substance codeine with compounds, hydrocodone with compounds, and tramadol as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.), limited to three days,

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with referral to an ophthalmologist if the pain persists.

d. Optometrists certified to medically treat authorized glaucomas may also:

   i. Use or prescribe topical and oral antiglaucoma agents for the medical treatment of all primary open-angle, exfoliation, pigmentary, and steroid-induced glaucomas in persons 18 years of age or over. In the case of steroid-induced glaucoma, the prescriber of the steroid medication shall be promptly notified if the prescriber did not refer the patient to the optometrist for treatment.

e. Optometrists certified to administer authorized immunizations may also:

   i. Administer immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2 to persons 18 years of age or over.

f. An optometrist may not:

   i. Treat patients under 18 years of age for any of the following:

      1. Anterior segment inflammation, which shall not exclude treatment of: (i) The conjunctiva; (ii) Nonmalignant ocular surface disease, including dry eye syndrome; (iii) Contact lens-related inflammation of the cornea; (iv) An infection of the cornea;

      2. Conditions or diseases of the sclera.

   ii. Perform surgery, meaning any act in which human tissue is cut, altered, or otherwise infiltrated by any means, which does not include any act that solely involves the administration or prescribing of a topical or oral therapeutic pharmaceutical.

g. Any prescription or order by an optometrist comprising written specifications for ophthalmic lenses pursuant to an eye examination must contain the following minimal information: name, address, telephone number and license number of the issuing optometrist; their signature; issue date and expiration date; and patient's name.

3. Supervision requirements

   a. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider when a situation or condition occurs that is beyond the optometrist's scope of practice. Consultations, referrals, and notifications required by this section shall be documented in the patient's record.

   b. Use of any oral prescription steroid anti-inflammatory medication for a patient under 18 years of age shall be done pursuant to a documented, timely consultation with an appropriate physician and surgeon.

   c. Use of any non-antibiotic oral prescription medication for a patient under five years of age shall be done pursuant to a documented, prior consultation with an appropriate physician and surgeon.

   d. Treatment with topical and oral medications authorized by law related to an ocular surgery shall be co-managed with the ophthalmologist that performed the surgery, or another ophthalmologist designated by that surgeon, during the customary preoperative and postoperative period for the procedure. Such co-managed treatment may include addressing agreed-upon complications of the surgical procedure occurring in any ocular or adnexal structure with topical and oral medications.

A. ^ **As the term "Hospital" is defined in the Medical Staff Bylaws.**

All revision dates:

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
nterdisciplinary Practices Committee	Tracy Chapman: VCMC - Med Staff	4/25/2024
Medical Staff Office	Minako atabe: Chief Medical Officer, VCMC SP	4/19/2024
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	4/18/2024
Policy Owner	Tracy Chapman: VCMC - Med Staff	4/18/2024

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VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Tracy Chapman: VCMC - Med Staff*
Policy Area:	*Administration - Medical Staff*
References:	

102.034 Non-Discriminatory Credentialing & Recredentialing Process

POLICY:

Medical Staff membership and/or clinical privileges shall not be denied on the basis of age, sex, gender, gender identity, gender expression, race, color, religion, ancestry, national origin, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the □ylaws or Rules of the Medical Staff or the □ospital.

The Medical Staff prohibits the discrimination of a practitioner solely on the basis of civil □udgment, criminal conviction, or other professional disciplinary action in another state if the □udgment, conviction, or professional disciplinary action is solely based on the application of another state□s law that interferes with a person□s right to receive care that would be lawful if provided in California.

PROCEDURE(S):

Monitoring and preventing discriminatory credentialing decisions include, but are not limited to:

A. Maintaining a heterogeneous Credentials and □nterdisciplinary Practice Committee membership.
   1. Committee members annually sign statements affirming that they do not discriminate and the credentialing and re-credentialing process is conducted in a non-discriminatory manner.
   2. The Committees address potential discriminatory practices identified through periodic audits of credentialing and recredentialing files (in-process, approved, withdrawn, or denied) at each meeting.

□. Practitioner complaints alleging discrimination and concerns identified through audits will be investigated and findings reported to the Medical Executive Committee.

REFERENCE(S):

Medical Staff □ylaws Article 2 - 2.4 Nondiscrimination

National Committee on □uality Assurance (NC□A) CR1: Credentialing Policies

California □nsurance Code Section 10133.641(b)

California Senate □ill 487

All revision dates:

Attachments

Annual Non-Discrimination Attestation

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Medical Staff Office	Minako □ atabe: Chief Medical Officer, VCMC □ SP□	4/19/2024
Medical Staff Office	Tracy Chapman: VCMC - Med Staff	4/18/2024
Policy Owner	Tracy Chapman: VCMC - Med Staff	4/16/2024

VENTURA COUNTY
MEDICAL CENTER

A Division of the Ventura County Health Care Agency

Medical Staff Administration
(805) 652-6062 FAX (805) 652-6169

ACKNOWLEDGEMENT OF THE NON-DISCRIMINITORY CREDENTIALING/RECREDENTIALING REQUIREMENTS

I attest that the credentialing and recredentialing processes and recommendations will be done in a non-discriminatory manner. My recommendations for an applicant's Medical Staff membership and/or clinical privileges shall not be denied on the basis of age, sex, race, color, religion, ancestry, national origin, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the Hospital.

The Medical Staff prohibits the discrimination of a practitioner solely on the basis of civil judgment, criminal conviction, or other professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

_____
COMMITTEE

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*9/1/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*7/31/2020*
Next Review:	*3 years after approval*
Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.028 Isolation Precautions

POLICY:

Isolation precautions are used to care for the patient with a transmissible infectious agent. The purpose of isolation precautions is to interrupt the transmission of disease and prevent transmission of infection to staff and other patients.

The use of isolation precautions is a two-tiered process. Standard precautions are used for all patients and the category of isolation precautions is added according to the mode of transmission of the disease.

The following policy applies unless advised/directed otherwise by Infection Prevention and/or Infectious Diseases. All Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH) and hospital-based Ambulatory Care clinic staff shall follow the guidelines below which are designed to prevent transmission of organisms to patients, care providers and multi-use equipment. Multiple drug-resistant organisms (MDRO), defined by the CDC as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents, are a threat to patient and staff health and safety. It is essential to keep these organisms contained. Compliance with the following transmission-based precaution guidelines is required to prevent transmission of organisms and enhance patient and staff safety.

See References for an alphabetical list of infectious diseases and the correct category of isolation to be used.

PROCEDURE:

Initiation of Isolation Precautions:

1. The nurse may initiate isolation precautions based on information obtained in the nursing assessment. The nurse then informs the physician of the need for an Isolation Precautions order.
2. Physician orders the appropriate isolation/precautions.
3. Infection Prevention department representative, Infectious Diseases physician or Infection Control Committee (ICC) Chairman may initiate isolation precautions.
4. Post the appropriate Isolation/Precautions sign outside the patient room.

Discontinue Isolation Precautions:

A physician's order is required.

Patient Transport

1. Notify receiving department of isolation status by entering the information in the electronic health record (E□R). Verbal communication must also occur with the receiving department prior to the patient□s arrival.
2. Limit movement of the patient throughout the hospital or clinic.
3. □ hen transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Airborne and droplet isolation precautions re□uire a surgical mask be placed on the patient.
4. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions.
5. Don clean PPE to handle the patient at the transport location.
6. □amily members and visitors are re□uired to conform to this policy and wear appropriate Personal Protective E□uipment (PPE) as directed.

Airborne Precautions

Diseases re□uiring airborne precautions are transmitted via airborne droplet nuclei or small particles in the respirable size range carrying infectious agents.

Patient Placement

1. Place the patient in a designated negative air pressure room.

   Santa Paula Hospital:
   Call the Maintenance Department at 652-3219 between 0800 and 1700h. After hours, page the Maintenance Department through Paging at 652-6075.
2. The doors of these rooms must remain closed at all times when the rooms are being used for airborne isolation.
3. □n the event that additional negative air pressure rooms are re□uired, contact the nursing supervisor or the Maintenance Department.

All staff entering airborne isolation rooms shall follow the proper procedure: enter the anteroom and allow the anteroom doors to completely close. Once the green light is illuminated, staff may enter the patient room. Once in the patient room, the green light will signal that the patient room doors have completely closed.

1. Place the patient in a private room, until airborne isolation room is available.
2. Patients in airborne isolation rooms must have doors closed.
3. RNs should respond to pressure alarms in a timely manner. □f staff is unable to deactivate the alarm, call □acilities Maintenance at ext. 6683 for assistance.

Surgery Patients: Any patient who has been placed on Airborne □solation for suspected or diagnosed illness and has surgery will be recovered in the OR suite and then be transported to the negative pressure room with the appropriate staff.

Ambulatory Care Clinics: Each clinic has a designated room for isolation precautions.

Behavioral Health Clinics: Clinic Administrator or designee will be made aware and client or participant will be instructed to wait outside until consultation is made with trained medical personnel, the Ventura County Behavioral Health Safety Officer or Infection Control. Client or participant may be referred for medical clearance.

Respiratory Protection

1. □ealthcare workers shall wear a N95 mask or Portable Air-Powered Personal Respiratory (PAPR) when in patient room.
2. Susceptible persons should not enter the room of patients known or suspected to have rubeola (measles) or varicella (chickenpox) if other immune caregivers are available.
3. Visitors shall wear a surgical mask.

Droplet Precautions

Diseases re□uiring droplet precautions are transmitted a short distance, approximately three (3) feet, from the respiratory tract of infectious individuals to susceptible mucosal surfaces of the recipient.

Patient Placement

- Patients on droplet precautions should be placed in a private room.
- Cohorting only after discussion with □nfection Prevention.

Respiratory Protection

- □ ear a surgical mask.

Contact Precautions

Diseases re□uiring contact precautions are transmitted by infectious agents via direct and indirect contact with the patient or their environment.

□solation supplies (PPE□s, masks, etc.) are now kept in hallways closets ad□acent to patient rooms.

Gloves and gown

1. Gloves and gown must be worn upon entering the room.
2. Gloves and gown must be removed immediately upon exiting the room.
3. Perform hand hygiene after removal of gloves and gown.

Hand Hygiene and the Patient with Clostridium Difficile Infection:

1. □ ash hands with soap and water.
2. Do not use alcohol gel for hand hygiene.
3. □se the Contact Precautions sign with the brown color for patients with Clostridium difficile infection.

Patient Care Equipment

1. Do not share patient care e□uipment.
2. Return to the designated department for cleaning and disinfection.

Room Cleaning After Discharge

Proper cleaning and disinfection of the patient□s room after discharge is important to prevent the spread of infection from a contaminated environment. □nspection of the mattress for intactness between patients is also recommended.

1. □solation sign remains outside of the room after discharge.

2. The room is thoroughly cleaned, and then disinfected using the hospital-approved disinfectant (e.g. bleach-based disinfectant for Clostridium difficile).
3. The housekeeper reverses the isolation sign in its holder so that nursing staff know the room has been cleaned and disinfected and is ready for the next patient.

Multi-Drug Resistant Organism (MDRO) Isolation Quick Sheet

	Current Infection WITH Active Drainage/ Excretions	Current Infection WITHOUT Active Drainage/Excretions	Current Colonization	History of
Methicillin-Resistant Staphylococcus Aureus (MRSA)	✓			
Extended-Spectrum Beta-Lactamase (ESBL)				
Carbapenem-Resistant Enterobacteriaceae (CRE)	✓	✓	✓	✓ (within 1 year)
Vancomycin-Resistant Enterococcus (VRE)	✓			
Resistant pseudomonas, resistant acinetobacter spp, or resistant stenotrophomonas spp	✓			

Clostridioides difficile: Contact precautions are re□uired until 48 hours after resolution of all symptoms (fever, abdominal pain, and diarrhea)

Diarrhea for *Clostridioides difficile* testing is defined as 3 or more watery stools in a 24 hour period). Only stool corresponding to 6 or 7 on the □ristol Stool Chart will be accepted by the laboratory for C. difficile testing.

Other MDRO's: As identified by □nfection Control Committee.

Personal protective Equipment (PPE) utilization for care of all patients under Standard Precautions:

- □ ear gloves when anticipating contact with blood or other potentially infectious materials, mucous membranes, or nonintact skin, or potentially contaminated intact skin.
- Change gloves and sanitize hands during patient care if the hands will move from a contaminated body-site (e.g., perineal area, wound) to a clean body-site (e.g., face).
- □ ear a gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated
- □se PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. □ a patient is coughing, use a mask.

- During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract if not using in-line suction catheters, endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., M. tuberculosis, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown)

Contact Precautions

MRSA methicillin resistant staph aureus

VRE Vancomycin Resistant Enterococcus faecium, Enterococcus faecalis

CRE Carbapenamen Resistant Escherichia coli and/or lebsiella pneumoniae

Acinetobacter baumanii - multidrug resistant

Stenotrophomonas maltophilia multidrug resistant

Clostridium difficile **Enteric Contact Precautions**

f there is any evidence of multidrug resistance with any other organisms, please contact the nfectious Disease physician for guidance. n addition, continue isolation practices for other communicable diseases according to policy.

References:

- Centers for Disease Control and Prevention - ~~CDC solation Transmission-ased Precautions Guidelines~~CDC solation Transmission-ased Precautions Guidelines
- *Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.*
- *Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, Healthcare Infection Control Practices Advisory Committee (HICPAC) Management of Multidrug-Resistant Organisms in Healthcare Settings 2006;* https://www.cdc.gov/infectioncontrol/guidelines/mdro/Last update: ebruary 15, 2017.

All revision dates:	7/31/2020, 9/17/2019, 6/13/2019, 5/1/2016, 11/1/2013, 2/1/2012, 7/1/2011, 9/1/2008, 5/1/2006, 12/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
nfection Prevention Committee	Magdy Asaad: nfection Prevention Manager	5/1/2024

Step Description	Approver	Date
Policy Owner	Magdy Asaad: Infection Prevention Manager	5/1/2024

Current Status: *Pending* **PolicyStat ID:** *15284796*

VENTURA COUNTY
HEALTH CARE AGENCY

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

106.039 Disaster/Emergency Volunteer Health Professionals

POLICY:

During disasters, healthcare professionals who are not employed, contracted or do not possess privileges at Ventura County Medical Center (VCMC) or Santa Paula Hospital (SPH) may be accepted to work in the hospital when the Emergency Operations Plan (EOP) has been activated. A disaster (an officially declared local, state or national emergency) due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions. The organization recognizes, even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained: 1.) Verification of identification and licensure, certification, or registration required to practice a profession. 2.) Oversight of the care, treatment, and services provided.

PROCEDURE:

1. If it has been determined by the Hospital Incident Command Center (HICC) that there is a hospital need for additional healthcare professionals, the Hospital Incident Commander or his/her designee may approve a disaster status for those who wish to volunteer their services. A request for Medical Reserve Corps (MRC) volunteers is made through the Emergency Medical Service (EMS) Agency Disaster Operation Center (DOC) or Medical Health Operational Area Coordinator (MHOAC). The EMS Agency credentials the MRC through the Disaster Health Care Volunteer System (DHV).
2. During a disaster, the Medical Staff office oversees the performance of each volunteer licensed practitioner (LP), Physician Assistant (PA) and Nurse Practitioner (NP) through direct observation by being paired with an existing member of the VCMC/SPH staff in the same specialty or department for proctoring and/or supervision as appropriate. ~~The Chief Nurse Executive (CNE) will oversee the performance of the volunteer practitioner.~~
3. The individual must present a professional license or certification valid in California, a photo identification (for example, driver's license, passport), and any other information requested by the Hospital Incident Commander or his/her designees.
4. Licensed practitioners (LPs), PAs and NPs wishing to obtain ***disaster privileges*** will be directed to Medical Staff personnel at the labor pool for credentialing.
5. Volunteer practitioners who are not LPs, such as Registered Nurses (RN), Emergency Medical

Technicians (EMT), and Paramedics, who wish to be assigned ***disaster responsibilities***, will be directed to the Nursing Administration staff at the labor pool for verification of certification and licensing.

6. Any volunteers who are not licensed or certified, will not be accepted to work in the hospital.
7. Before a volunteer practitioner is considered eligible to function as a volunteer licensed practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following (If practical, the appended form should be used to collect this information):
    - A current picture identification card from a health care organization that clearly identifies professional designation.
    - A current license to practice.
    - Primary source verification of licensure.
    - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
    - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
    - Confirmation by a LP currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a LP during a disaster.
8. During a disaster, the medical staff oversees the performance of each volunteer licensed practitioner. Based on its oversight of each volunteer licensed practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue, and reevaluated every 10 days thereafter.
9. Absent the ability to immediately perform the primary source verifications indicated below, the Hospital Incident Commander or his/her designee may choose to visually inspect the items listed above and approve disaster/emergency volunteer status.
10. Information regarding individuals approved for disaster/emergency volunteer status (including each individual's name and contact information) will be maintained and provided to the Labor Pool Unit Leader.
11. As soon as the immediate situation is under control or within 72 hours from the time the volunteer LP or volunteer practitioner presents to the hospital, the Labor Pool Unit Leader or designee will initiate primary source verification of the credentials including (see Attachments A through C):
    - current licensure
    - Relevant training and experience
    - Current competence
    - Primary hospital status in good standing and current privileges.
    - National Practitioner Data Bank query
12. Disaster/emergency volunteer status will terminate immediately upon determination that any information received through the verification process indicates any adverse information or suggests the health care professional is not capable of rendering services in a disaster or emergency.
13. If primary source verification of a volunteer LP or practitioner cannot be completed within 72 hours of

volunteer arrival due to extraordinary circumstances, the hospital will document the following and will perform verification as soon as possible,

1. Reason it could not be performed
2. Evidence of the LP or practitioner demonstrated ability to continue to provide adequate care, treatment and services.
3. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

14. The duration of disaster/emergency volunteer status will be for the period of the emergency only.
15. Individuals who are granted disaster/emergency volunteer status will be issued temporary badges or another form of identification to distinguish them as disaster volunteers.
16. Individuals who are granted disaster volunteer status, along with the effective dates, will be reported to the applicable department, administration and Governance.

**Primary source verification of licensure, certification, or registration is not required if the volunteer LP or practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.*

All revision dates: 4/16/2024, 4/12/2023, 1/13/2021, 2/12/2019, 10/1/2016

Attachments

A: Disaster Volunteer Privileges/Information Release Form
B: Disaster Volunteer Log
C: Source Verification
D. Disaster-Emergency Volunteer LP Evaluation Form

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH	4/19/2024
Hospital Administration	Diana Zenner: Chief Operating Officer, VCMC & SPH	4/17/2024
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/16/2024
Emergency Management Committee	Fernando Medina: Director, Support Services	4/16/2024
Policy Owner	Fernando Medina: Director, Support Services	4/16/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Colleen Rusin: Ambulatory Care RN II*
Policy Area:	*Ambulatory Care - Environment of Care*
References:	

AC.01 Ambulatory Care Emergency Response Equipment

PURPOSE:

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

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

POLICY:

~~Emergency Response Equipment is in place in all Ambulatory Care clinics so that staff may respond to a patient/visitor/staff medical emergency and provide emergency care during business hours until treatment is initiated by the Emergency Medical Services (EMS) system. CPR-certified clinic staff shall call 911 for critical patients, initiate CPR if needed, apply automated external defibrillator (AED), maintain open airway and administer oxygen. Non-CPR-certified staff shall only call 911 and stay with the patient until help arrives.~~

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

DEFINITIONS

A. **Emergency Medical Condition**- a medical condition that is manifested by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:
   1. Placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy.
   2. Serious impairment to bodily functions.
   3. Serious dysfunction of any bodily organ or part.

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

PROCEDURE~~:~~

- ~~A clinic RN or LVN shall check all Emergency Response Equipment for outdated, missing or damaged supplies on a monthly basis. Clinic nurses are responsible for ensuring that all equipment is in good operating use, is within expiration dates, and is replaced immediately when used.~~
- ~~The Emergency Response Equipment contains minimal resuscitation equipment and medications which are appropriate to the patient population, and are stored together in an accessible location.~~
- ~~Oxygen tanks shall be stored and handled according to the procedures outlined in policy F.44 Compressed Gas Cylinders.~~
- ~~One or more full oxygen tank shall be maintained in the clinic at all times.~~
- ~~Empty cylinders must be clearly identified and stored separately from full or partially full cylinders intended for patient care use.~~
- ~~All free-standing cylinders shall be properly chained or supported in cylinder stands/carts.~~
- ~~There is a system in place for oxygen tank replacement.~~

~~Emergency Response Equipment Inspection:~~

1. ~~If emergency equipment is in poor working condition, expired or has been used, new supplies shall be immediately obtained and restocked.~~
2. ~~Complete Emergency Response Equipment Checklist on a monthly basis~~
3. ~~Complete AED Checklist monthly.~~
4. ~~Check suction machine for proper pressure by powering it on and checking for suction.~~
5. ~~Check that the oxygen tank has an intact seal, is completely filled, and is properly stored and secured.~~

~~Interdepartmental Notification:~~

1. ~~Contact Central Supply, the medical supplies vendor or the Pharmacy Department to replace broken, missing, or outdated equipment or supplies.~~
2. ~~Contact the Biomedical Department to replace or repair suction machine when needed.~~
3. ~~Contact the Facilities Maintenance Department or medical gas vendor for oxygen tank replacement when needed.~~

~~Clinic Record:~~

1. ~~Emergency Response Equipment Monthly Checklist~~
2. ~~AED Monthly Checklist~~

~~Essential Components of the Emergency Response Equipment~~

1. ~~Mask (resuscitator code pack) with one-way valve.~~
2. ~~Ambu bags – Infant, child and adult ambu bags for clinics that provide Child Health and Disability Prevention Program (CHDP) and family medicine. Adult-only practices shall provide adult ambu bags.~~
3. ~~Backboard.~~
4. ~~Full oxygen tank with intact seal and tubing.~~
5. ~~Simple and non-rebreather oxygen masks with reservoirs – Infant, child and adult ambu bags for clinics that provide CHDP and family medicine. Adult-only practices shall provide adult ambu bags.~~

6. ~~Nasal cannula – Infant, child, adult for clinics that provide CHDP and family medicine. Adult only practices will provide adult nasal cannulas.~~
7. ~~Portable suction and tubing-required for all CHDP clinic sites.~~
8. ~~Flashlight.~~
9. ~~Oropharyngeal airways (sizes 00-5) – required for all CHDP sites.~~
10. ~~Automated External Defibrillator (AED) if present at site.~~
11. ~~Nebulizer (or metered-dose inhaler with spacer/mask) – required for all CHDP clinic sites.~~
12. ~~Tonsil tips or bulb syringe – required for all CHDP clinic sites.~~
13. ~~Monthly Emergency Equipment and AED Checklists.~~
14. ~~Clinics may keep stock supplies of Benadryl and Epinephrine: Epinephrine 1:1000 (injectable) and Benadryl 25 mg (oral) or Benadryl 50 mg/ml (injectable). These medications are only given on direct order of a physician, nurse practitioner or PA-C.~~

A. **Storage, Accessibility & Security**

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

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

1. One of two (2) types of emergency response carts/totes shall be in use as appropriate to the patient population served (See Attachment A):
   a. Adult/Pediatric/Neonatal- Child Health and Disability Prevention Program (CHDP) and family medicine practices.
   b. Adult- adult only practices.
2. Supplies and medications will be stored within locked emergency response carts/totes in an organized, standardized fashion.
   a. Only those items listed on Attachment A shall be stored in emergency carts/totes, depending on the patient population.
   b. Supplies that are frequently used together shall be stored in the same drawer/compartment.
   c. There shall be clear separation of adult and pediatric supplies.
   d. The contents of each drawer/compartment shall be clearly labeled.
3. Larger equipment including Automated External Defibrillator (AED), portable suction machine, backboard, and oxygen tank shall be stored outside but within reach of the emergency cart/tote.
4. At least one full oxygen tank designated for emergency use shall be maintained in the clinic at all

times and will be stored and handled according to the procedures outlined in policy F.44 Compressed Gas Cylinders.

5. Dosage charts for emergency medications shall be kept with the emergency medications (See Attachment B).
6. Emergency phone number contacts shall be updated annually and posted in a prominent location, including:
    a. Local emergency response services (e.g., fire, police/sheriff, ambulance).
    b. Emergency contacts (e.g., responsible managers, supervisors).
    c. Appropriate State, County, City, and local agencies (e.g., local poison control number).

C. **Monthly Inspections**

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

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

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

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

Restocking:

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

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

EDUCATION & TRAINING

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

ATTACHMENTS

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

All revision dates: 2/8/2024, 6/30/2020, 6/1/2017

Attachments

Attachment A-Emergency Response Supply List.pdf

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

Approval Signatures

Step Description	Approver	Date
Code Blue Committee	Tracy Chapman: VCMC - Med Staff	pending
P&T Committee	Sul Jung: Associate Director of Pharmacy Services	2/16/2024
Director of Nursing, AC	Cynthia Fenton: AC Director of Nursing	1/18/2024
	Colleen Rusin: Ambulatory Care RN II	1/18/2024

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Last Approved:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Cynthia Fenton: AC Director of Nursing*
Policy Area:	*Ambulatory Care - Patient Care Services*
References:	

AC.35 Ambulatory Care Medication Management

PURPOSE:

The Ambulatory Care Clinics plans its medication procedures and maintains processes for the safe and timely prescribing and administration of medications and vaccines, within the healthcare ealth care Agency.

POLICY:

The Ambulatory Care Clinics shall maximize the licensed staff in order to practice reliable medication procedures with the the goal of delivering safe and effective medications and treatments to their patients.

DEFINITION(S):

~~**Types of Medication Orders**:~~
~~**Routine**, scheduled to be given routinely~~
~~**PRN**, as needed, acted on for a specific indication or symptom~~
~~**One Time**, administration of a medication or vaccine authorized once~~
~~**Standing or Protocolized** orders, an approved prewritten medication order with specific instructions from licensed independent Practitioner to an approved clinic staff member to administer a medication or vaccine to a patient under clearly defined circumstances.~~
~~**Automatic Stop** orders, orders that may automatically and electronically discontinue or stop once given or after a set and ordered time period.~~
~~**Verbal** orders, approved for use during an emergency **ONLY**. Note: Verbal and telephone orders are especially error prone due to misinterpretation.~~
~~**Sign and Hold** orders, a new prewritten medication order and specific instructions from a licensed Practitioner to administer medications to a patient under clearly defined circumstances that become active upon release of the order at a specific date and time.~~
~~**End of Life** orders, A set of orders designed to specifically transition the patient at discharge, or end of an episode of care.~~

Types of medication order frequencies

A. **Routine:** Scheduled to be given routinely.

. **As needed (PRN):** Orders acted on based on the occurrence of a specific indication or symptom[1].

C. **One Time:** Administration of a medication or vaccine once

Medication Management related definitions

A. **Automatic Stop Orders:** Medication orders shall have defined automatic stops, which may vary in duration depending on the medication. Orders that include a date or time to discontinue a medication[1].

B. **Discharge:** The point at which an individual's active involvement with an organization or program ends, and the organization or program no longer maintains active responsibility for the care of the individual. In ambulatory or office-based settings where episodes of care occur even though the organization continues to maintain active responsibility for the care of the individual, discharge is the point at which any encounter or episode of care (that is, an office or clinic visit for the purpose of diagnostic evaluation or testing, procedures, treatment, therapy, or management) ends[1].

C. **Formulary:** A list of medications and associated information related to medication use[1].

D. **Look-Alike/Sound-Alike medications:** Similar medication names, either written or spoken, which may lead to potentially harmful medication errors when confused with each other[1].

E. **Licensed Practitioner (LP):** An individual who is licensed and qualified to direct or provide care, treatment, and services in accordance with state law and regulation, applicable federal law and regulation, and organizational policy[1].

F. **Signed and Held Orders:** New pre-written (held) medication orders and specific instructions from a licensed practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) or time(s)[1].

G. **Standardized Procedures or Standing Orders**: A pre-written medication order and specific instructions from the licensed practitioner to administer a medication to a person in clearly defined circumstances[1].

H. **Telephone and verbal orders** are spoken orders given by a licensed practitioner to a person authorized to receive and record them in accordance with applicable policies, laws, and regulations[3].

   1. Per Center for Medicaid and Medicare Services (CMS) and Joint Commission (TJC), verbal and telephone orders are susceptible to error and must be used infrequently.
   2. **Read back:** A method used to ensure understanding of information being communicated, often used between members of a care, treatment, or service team. The process involves the receiver of a verbal or telephone order writing down the complete order or test result or entering it into a computer and then reading it back and receiving confirmation from the person who gave the order or test result[1].

PROCEDURE(S):

~~Medications are ordered by an approved licensed prescriber:~~

A. ~~The following~~Medications are ~~deemed to be~~ordered by approved ~~providers, thus authorized to order medications:~~licensed practitioners as determined by their respective licensing boards[4-6].

   1. Doctor of Medicine, Osteopathy, Dentistry and Podiatry
   2. Doctor of Optometry
   3. Nurse Practitioner
   4. Certified Nurse Midwife
   5. Physician Assistant

B. All medications ~~and vaccines~~ are ordered in the electronic health record (EHR) by a ~~licensed provider,~~LP

prior to administration or dispensing to the patient. The E□R will include the following information on the patient:

1. Age
2. Sex
3. Diagnosis
4. Allergies
5. Sensitivities
6. Current Medications
7. □eight and □ eight
8. Pregnancy and lactation status
9. Lab Results

C. All medication orders will be clear, accurate and complete with the following:

1. Medication name
2. Medication dose or strength
3. Route of administration
4. □re□uency of use
5. □ndication for use (if necessary)
6. Date and time of electronic order entry
7. LP ordering the medication

D. The following types of medication orders are deemed appropriate for use in the Ambulatory Care Clinics:

~~1. Routine orders~~

~~2. PRN orders~~

~~3. One time orders~~

~~4. Now orders~~

~~5. Standing or Protocolized orders~~

~~6. Automatic stop orders~~

~~7. Verbal orders - **FOR EMERGENT USE ONLY**~~

~~8. Co-sign and held orders~~

~~9. End of Life orders~~

1. Medication order fre□uencies
   a. As needed (PRN) orders
   b. One time orders
   c. Now orders
   d. Automatic stop orders or discontinue order
2. Electronic Order Communication Types (see policy 100.220 Electronic Order Management)

a. Routine written/fax/transcribe orders

b. Protocol/standardized - Cosign orders

c. Verbal with Read □ack Verification - Cosign orders - **FOR EMERGENT USE ONLY**

d. □uture orders - No cosign

E. Policy ~~P□.24 Clinic Medications~~P□.24 Clinic Medications and Samples addresses the following medication management processes:

1. ~~□ormulary medications~~Medications and vaccines available for dispensing and administering to patients are limited to an approved formulary list~~, which is updated, and has been reviewed by Pharmacy and Therapeutics Committee (P□T)~~.

   a. □or Ventura County □ealth Care Agency (VC□CA) formulary, see policy P□.35 Drug □ormulary.

   b. Non-formulary medications can be re□uested via a non-formulary re□uest form

   ~~Non-formulary medications can be re□uested via a non-formulary re□uest form~~

2. Medication Samples

3. Controlled Substances

4. Patient Assistance Program (PAP) medications

5. Patient□s own medications brought in from home

□. □igh Alert medications are defined in policy ~~P□.70 □igh Alert Medications~~P□.70 □igh Alert Medications, and may re□uire ~~an independent double check~~verification by two licensed professionals prior to administration.

G. ~~□azardous medications are defined in policies P□.27.01 - P□.27.04 □azardous Drug Overview, and specifically covers safety, training, handling, garbing, compounding, spill and waste management of hazardous medications.~~□azardous medications

1. See policy 100.205 Safe □andling of □azardous Medications for information regarding hazardous drugs, education, personal protective e□uipment (PPE), administration, and disposal.

   a. □ ithin policy 100.250, see Attachment C: Nursing Guideline for □andling □azardous Drugs as it provides specific PPE information for antineoplastic, non-antineoplastic, and reproductive risk medications.

2. See policy 100.250 Management of Extravasation/□nfiltration Due to Non-Chemotherapy Medication Administration.

3. See policy 100.251 Administration and Extravasation of Antineoplastic Agents.

□. Medications ~~and vaccines~~ are properly stored according to manufacturer□s recommendations, in accordance with laws and regulations:

1. Medications ~~and vaccines~~ are stored and prepared in a clean, organized, and secure area.

2. Medications ~~and vaccines~~ that re□uire refrigeration or freezing are stored in approved medication refrigerators or freezers.

3. Medications are stored securely in non-traffic areas ~~with~~and access ~~which~~ is limited to approved clinic staff.

4. Medication storage rooms and refrigerators and freezers are clean~~,~~ and well labeled and ~~within date for safe administration~~provide appropriate temperatures for optimal medication storage.

a. All medications and emergency kits are checked for expiration dates monthly. See policy AC.01 Ambulatory Care Emergency Response E□uipment.

b. All expired medications are removed from inventory prior to the actual expiration date. See policy P□.24 Clinic Medications.

c. All medications labels for shelves and storage areas are clear and follow □nstitute for Safe Medication Practices (□SMP) guidelines for safety to avoid mix-up errors:

i. Tall man lettering implemented (e.g., cef**TRIAX**one)

ii. Do NOT use abbreviations are observed (e.g. □u□is spelled out - units). See policy 107.005 Medical Abbreviations.

iii. ~~Look-alike sound-alike products are separated in inventory (Dtap and DTaP)~~Look-alike sound-alike products should be separated in inventory whenever possible.

a. □or example, **T**etanus/reduced diphtheria/toxoids and acellular pertussis (**T**dap) and **D**iphtheria/**T**etanus toxoids and acellular **P**ertussis (**DT**a**P**) should be segregated

b. See policy 100.081 Avoiding □Look-Alike/Sound-Alike□Medication Errors.

iv. Adult vaccines are separated from pediatric products.

v. Vaccines for Children (V□C~~ and COV□D vaccines~~) and Vaccines for Adults (V□A) are stored separately from regular or private inventory.

□ ~~Medications~~Designated clinical staff are authorized to administer ordered medications and vaccines ~~may be prepared and administered by approved personnel~~ under the supervision of ~~a licensed Provider~~the prescribing LP or Registered Nurse and in accordance with the law[4-6].

~~Providers and designated clinical staff are authorized to administer ordered medications and vaccines under the supervision of the prescribing Provider or Registered Nurse and in accordance with the law.~~

1. Registered Nurse (RN) may administer:

a. □n□ectable medications□□ntravenous (□V) Push, □V □ydration, □ntramuscular (~~Cosyntropin~~□M), ~~□V □ydration~~Subcutaneous (SubCut), ~~□M, S□,~~ and intra-dermal (□D)

b. Oral medications, per os (PO), sublingual (SL), and buccal

c. Rectal and vaginal medications

d. Medications for inhalation such as inhalers and nebulized medications

e. Topical medications including otic and ophthalmic

2. Licensed Vocational Nurse (LVN) may administer:

a. □n□ectable medications□□M, ~~S□~~SubCut and intra-dermal

b. □nitiate □V hydration only with certification

c. Oral medications, PO, SL, and buccal

d. Rectal and vaginal medications

e. Medications for inhalation such as inhalers and nebulized medications

f. Topical medications including otic and ophthalmic

3. Medical Assistant (MA), under protocol and under direct supervision of a ~~licensed provider~~LP, RN or

LVN may deliver pre-measured medications:

a. Injectable medications and Vaccines only by IM or ~~S□~~SubCut, intra-dermal (e.g., TB skin tests) ~~Oral medications, PO, SL, and buccal including oral vaccines~~

b. Oral medications, PO, SL, and buccal including oral vaccines

c. Rectal and vaginal medications

d. Topical medications (excludes anesthetics) otic and ophthalmic

~~**All medications and vaccines prepared for administration by an MA is double checked against a written order prior to administration by an RN or LVN using the seven "rights". In the event an RN of LVN is not available, the provider will provide the double check.**~~

1. ~~All MA prepared medications and vaccines are double checked with a licensed staff prior to medication or vaccine administration is defined as follows:~~

   a. ~~Medication selected matches the medication or vaccine order and the product label.~~

   b. ~~Ensures that medication or vaccine is properly diluted if needed~~

   c. ~~Visually inspects the medication or vaccine for discoloration, and integrity~~

   d. ~~Verifies medication or vaccine to be administered is within date, not expired or beyond it's use date and time.~~

   e. ~~Verifies that the correct medication or vaccine is to be given to the correct patient, at the proper time, schedule or interval, in the prescribed dose (and amount), by the correct route of administration, for the correct indication or reason.~~

   f. ~~Verifies the patient has no allergies, sensitivities or contraindications to the prescribed medication or vaccine~~

   g. ~~Patients (or family) receiving medications or vaccines are informed about clinically significant side effects prior to administration.~~

   h. ~~Concerns and questions from the patient or family are addressed by the provider prior to medication or vaccine administration.~~

2. ~~Medication and/or vaccine administration process is as follows:~~

   a. ~~RN, LVN or MA reviews the EMR for needed treatment (Vaccines due at current visit)~~

   b. ~~RN, LVN or MA reconciles CAIR state vaccine records to the patient's EMR~~

   c. ~~A list of needed vaccines is produced for Provider review~~

   d. ~~Provider reviews patient specific treatment options and discusses a plan with the patient of patient's family.~~

   e. ~~Information is given to the family, if indicated (VIS or EMA)~~

   f. ~~The provider enters a medication or vaccine order in the EMR. The RN, LVN or MA may enter a co-sign order under strict protocol or standing orders for vaccines~~

   g. ~~RN or LVN reviews the providers order in the EMR and verifies~~

   h. ~~MA is tasked within EMR to prepare the ordered vaccine or medication~~

   i. ~~MA prepares the medication or vaccine ordered in a controlled, clean medication room using aseptic technique, and labels medications or vaccines, if indicated~~

~~j. RN or LVN double checks the order and compares and verifies with the medication pulled and prepared by the MA. See double check process above.~~

~~k. RN, LVN or MA administers the medication or vaccine using proper techni□ue for the patient's age and route of medication administration.~~

~~l. Patients who receive medications are monitored to determine the effects of the medication or vaccine, as indicated.~~

~~3. Patients who receive an in□ectable medication or a vaccine is monitored~~

~~a. Patients with a history of allergies or sensitivities are monitored for 30 minutes~~

~~b. Emergency Anaphylaxis kits are stocked and within date for all such emergencies. (AC.01 Ambulatory Care Emergency Response E□uipment)~~

~~c. All Adverse Drug Events, to include medication reactions or errors are reported internally to the □ealth Care Agency using RLDatix and externally to the state mandated agencies, such as VAERS~~

~~4. All administered medications and vaccines are properly documented in the patient's E□R, and all vaccines are also documented in state mandated sites in CA□R.~~

~~5. All controlled substances administered or prescribed by providers are documented in the patient's E□R as well as state mandated sites in C□RES.~~

~~6. Medication administration performance, ADRs and Medication Error data is identified by the Ambulatory Care □uality Department and shared with Clinic Medical Directors, Managers and Clinic Staff. Strategies for process improvement is discussed with an emphasis on Patient Safety and □mproved Patient Outcomes.~~

□. All medications and vaccines prepared for administration by an MA is double checked by an RN or LVN against a written order prior to administration using the seven □rights" of safe medication administration. □n the event an RN of LVN is not available, the LP shall provide the double check.

1. Concerns and □uestions from the patient or family are addressed by the LP prior to medication administration.
2. All MA prepared medications shall complete the following procedure for the double check verification with licensed staff prior to administration as follows:
   a. Selects the medication that matches the written order and the manufacturer□s product label.
   b. Ensures that medication is properly diluted if needed.
   c. Visually inspects the medication for discoloration and integrity.
   d. Verifies medication to be administered is within date, not expired or beyond it's use date and time.
   e. Verifies the right patient, right medication, right dose/strength, right route, right time/fre□uency, and right indication.
   f. Verifies the patient has no allergies, sensitivities, or contraindications to the prescribed medication.
3. Patients (or caregiver) receiving medications are informed about clinically significant side effects prior to administration.

□. Vaccine administration process follows policy AC.36 Vaccine Administration in the Outpatient Ambulatory

Care Clinics and is as follows:

1. Prior to the patients scheduled appointment for vaccine administration, clinic staff shall print the patient□s California □mmunization Registry (CA□R) report and perform a chart check to compare vaccine status.
2. □mport into the patients E□R any documented historical vaccines administered outside of the clinic (e.g. Retail Pharmacies and/or mass vaccination sites).
3. □dentify any care gaps between vaccine administered and age-appropriate recommended schedule of vaccines for the patient. Ensure proper dosing interval between vaccine series have been observed.
4. Clinic staff shall determine if the vaccines are available in the clinics inventory and within date.
5. Supply CA□R report to the LP to identify vaccine care gaps prior to provider visit and vaccine conversation with patient.
6. Once patient is in the clinic, obtain vaccination card or vaccination records from the patient and confirm the documentation matches E□R.
7. Provider or assignee gives the patient the current Vaccine □nformation Sheet (V□S) or Emergency □se Authorization (E□A) sheet to review.
8. Clinic staff completes the screening □uestionnaire for vaccines verbally with the patient or caregiver.
9. Provider reviews the screening □uestionnaire for contraindications or severe reactions of previous vaccines prior to vaccine administration.
10. Provider to review and address concerns or answer any □uestions patient or caregiver may have.
11. Provider to place order in the E□R and verify which vaccines are to be administered.
12. Verbal consent shall be obtained from the patient, agreeing to the vaccine administration.
13. Delegated MA may administer ordered vaccine(s) once a double check has been performed with another licensed clinic personnel.
14. Vaccine administration shall be documented in the patients E□R and in CA□R.
15. □or discrepancies or documentation errors discovered in CA□R, contact your local CA□R Representative for Ventura County for corrective action.
16. All Adverse Events shall be reported to Vaccine Adverse Effects Reporting System (VAERS) and RLDatix.

L. Patients who receive an in□ectable medication or a vaccine shall be monitored as follows:

1. Patients who receive a □new□vaccine or medication for the first time shall be monitored for 15 minutes.
2. Patients with a history of allergies or sensitivities are monitored for 30 minutes.
3. Emergency Anaphylaxis kits are stocked and within date for all such emergencies. See policy AC.01 Ambulatory Care Emergency Response E□uipment.
4. All Adverse Drug Events, to include medication reactions or errors are reported internally to the □ealth Care Agency using RL Datix and externally to the state mandated agencies, such as VAERS.

M. All administered medications and vaccines are properly documented in the patient's Electronic □ealth Record (E□R), and all vaccines are also documented in state mandated sites in California □mmunization

Registry (CA□R).

1. All controlled substances administered or prescribed by providers are documented in the patient's E□R.

N. Medication administration performance, Adverse Drug Reactions (ADRs) and Medication Error data is identified by the Ambulatory Care □uality Department and shared with Clinic Medical Directors, Managers and Clinic Staff. Strategies for process improvement is discussed with an emphasis on Patient Safety and □mproved Patient Outcomes.

~~REFERENCE(S):~~

~~The □oint Commission, Standards for Ambulatory Care, 2022 Medication Management~~
~~National Patient Safety Goals, T□C Standards for Ambulatory Care, 2022~~

REFERENCES:

1. The □oint Commission, Standards for Ambulatory Care, 2022 Medication Management
2. National Patient Safety Goals, The □oint Commission Standards for Ambulatory Care, 2022
3. American Medical Association. American Medical Association (ama-assn.org). Last Accessed 3/27/2024.
4. California □usiness and Professions Code (□PC)
   a. Medical Assistants. □PC Division (D□V) 2, Chapter (C□) 5, Article 3, □2069-2071
   b. The Nursing Practice Act. □PC D□V2, C□6, Article 1, □2725.
   c. Vocational Nursing. □PC D□V2, C□6.5, Article 2, □2860
   d. Pharmacist Scope of Practice and Exemptions. □PC D□V2, C□9, Article 3, □4052.
5. California Code of Regulations (CCR) Title 16,
   a. D□V 13 Medical □oard of California, C□3 Affiliated □ealing Arts
   b. D□V 13.8 Physician Assistant □oard
   c. D□V 14 California □oard of Registered Nursing.
   d. D□V 15 State □oard of Optometry
   e. D□V 17 California State □oard of Pharmacy
6. □An Explanation of the Scope of RN Practice including Standardized Procedures.□California □oard of Registered Nursing. 11/2012. Last Accessed 3/27/2024.

All revision dates:

Attachments

Attachment A: □n□ectable Medication Guidelines in Ambulatory Care Clinics

Approval Signatures

Step Description	Approver	Date
MEC/Oversight	Tracy Chapman: VCMC - Med Staff	pending
P□T Committee	Sul □ung: Associate Director of Pharmacy Services	4/4/2024
Chief Executive Officer, AC	Theresa Cho: Chief Executive Officer, Ambulatory Care	3/29/2024
Chief Medical Officer, AC	Allison □laze: Chief Medical Officer, Ambulatory Care	3/21/2024
	Cynthia □enton: AC Director of Nursing	3/19/2024

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*3/1/1991*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*5/13/2024*
Next Review:	*3 years after approval*
Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

Care of the Patient Aged 14 Years and Over Outside of Pediatrics and PICU

POLICY:

There are times when adolescent patients aged 14 and above are cared for in areas outside of the pediatric or pediatric intensive care unit (P□C□) setting. Decisions to place patients in adult units over age 14 may be made due to capacity in the pediatric areas, as well as clinical conditions and acuity.

Patients over 50 kilograms in weight no longer re□uire weight-based medication dosing. Patients past puberty no longer re□uire Pediatric Advanced Life Support (PALS) guidelines (Advanced Cardiac Life Support (ACLS) is used instead).

PROCEDURE:

GUIDELINES:

A. Patients with a California Children□s Services (CCS) condition aged 14 to 21, who are admitted outside the pediatric service department, shall be under the direction of the CCS paneled physician appropriate for the medical condition. See references for link to list of CCS eligible conditions.

□. Adolescents aged 14 and over who have no signs of puberty will be cared for in the pediatric or P□C□ unit (PALS is re□uired).

C. □f patients without CCS conditions aged 14 to 17 are admitted outside the pediatric services department for non-traumas, the adult and pediatric attendings will determine which team will be primary. □or trauma patients, even if pediatric patient is physically in an adult unit, the trauma surgeon is primary with P□C□ or Peds attending consulted.

D. Adolescents will be placed in private rooms or shared rooms with another adolescent of the same gender.

E. Nursing processes, individual care plans with nursing diagnoses, and standards of care are specific to adolescent patients as applicable.

□. □n the case of a surge of pediatric patients, a pediatric pre-pubescent patient may be admitted to an adult unit, may be cared for by a P□C□ Registered Nurse (RN) or PALS/ Emergency Nurse Pediatric Course (ENPC) certified RN when available. □n addition, pediatric e□uipment when available will be brought to unit. Patient will be followed by pediatric or P□C□ attending.

G. □ntensive Care □nit (□C□) □ntensivists generally can care for patients over 18 years of age if age is known.

In trauma patients of unknown age, the adult ICU team can stabilize and provide care until age is known. If age is determined to be under 18, care will be transferred to the pediatric intensivist or trauma team. Patient can be transferred to PICU if stable or remain in adult ICU if unstable for transfer or PICU bed space unavailable with PICU and trauma physician management.

DOCUMENTATION

The Pediatric admission assessment will be used when the patient is cared for by a pediatric or PICU RN. Otherwise, the adult admission assessment may be used.

All care will be documented in the electronic health record.

REFERENCES

American Heart Association, Pediatric Advanced Life Support, 2020 PALS Provider Manual.

California Code of Regulations, Title 22, Section 70537. Existing Title 22 Regulations: Pediatric Service (ca.gov)

California Children's Services Manual of Procedures, Chapter 3, Provider Standards. CALIFORNIA CHILDREN'S SERVICES MANUAL OF PROCEDURES - CHAPTER 3.37 PROVIDER CORE STANDARDS - Special Care Centers

California Children's Services Medical Eligibility Requirements

All revision dates: 5/13/2024, 9/13/2022, 1/1/2017, 12/1/2013, 6/1/2013, 5/1/2011, 5/1/2008, 5/1/2006, 6/1/2004, 6/1/2001, 6/1/1998, 11/1/1995, 7/1/1992, 3/1/1991

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Hospital Administration	Minako Hatabe: Chief Medical Officer, VCMC HSP	4/19/2024
Hospital Administration	Diana Henner: Chief Operating Officer, VCMC HSP	4/9/2024
Nursing Administration	Sherri Hlock: Associate Chief Nursing Executive, VCMC HSP	4/9/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC HSP	4/9/2024
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC HSP	4/9/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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Next Review:	*3 years after approval*
Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.29 Legal Examination of Blood in the Emergency Department

POLICY:

Ventura County Medical Center (VCMC) staff will assume the responsibility for drawing legal blood specimens from patients brought to the □ospital when re□uested in writing by a law enforcement officer. Responsibility for handling and examining the specimen, transporting to the Crime Laboratory, and testifying in court will remain with law enforcement. The arresting officer assumes all responsibility for advising the patient of his/her rights. The officer will also furnish and complete the re□uest forms used for the authorization of taking the specimen.

EQUIPMENT

A sealed blood sample envelope/kit (provided by the Ventura County Sheriff□s Department Crime Laboratory)
□lood Examination Re□uest and Consent □orm
Medical Record of □lood Specimen drawn at the re□uest of law enforcement (see attached sample)
D□□D addendum
Non-alcohol skin prep
Gloves
Gauze, Tourni□uet, two (2) 10 ml syringes, needle or vacutainers and needle
□and-aid

PROCEDURE:

A. A re□uest for blood level determination of alcohol, narcotics or barbiturates, blood typing, or other drugs for legal purposes will be made by a law enforcement officer or by a representative of the Probation Department.

□. A sealed □lood Sample envelope, provided by the Ventura County Sheriff□s Department Crime Laboratory, which contains the re□uired specimen containers will be provided to the re□uesting authority.

C. The □□lood Examination Re□uest and Consent □orm□in triplicate, is completed by the police officer, signed by the patient and person drawing blood. The original is sent to Medical Records and the officer retains the other two copies.

D. □Medical Record of □lood Specimen Drawn at the Re□uest of Law Enforcement Agency□in triplicate, completed by staff member performing blood draw. The original form should be sent to □ealth □nformation

Management, one copy given to law enforcement and one copy accompanies the specimen. (Officer handles paperwork not remaining in hospital.)

E. Driving while under the influence of drugs □D□□D addendums.□The arresting officer may re□uest an additional 10 mL vacutainer of blood. This additional blood shall be obtained only upon re□uest of the arresting officer.

□. The patient□s skin is prepared with □enzalkonium chloride. No solution containing alcohol will be used in skin preparation.

G. □lood will be drawn after the consent has been signed. □lood may be drawn if the patient refuses to sign, but does not resist. □lood may be drawn if the person refuses to sign the consent and physically resists, if the circumstances re□uire prompt testing, the arresting officer has reasonable cause to believe the arrestee is under the influence, and the test is conducted in a medically-approved manner incident to a lawful arrest. The patient□s consent is not re□uired if there is a court order for the blood sample. A blood sample may be drawn at the re□uest of the attending officer without the patient□s consent if the patient is unconscious and has been involved in a motor vehicle collision. The Emergency Department (ED) physician or nurse will draw blood.

□. □lood is labeled and handed to law enforcement officer to maintain chain of custody.

□. Patient will be registered as a Laboratory Draw patient by Admitting if brought to the ED.

DOCUMENTATION:

A. Completion of above listed forms

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Attachments

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Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	3/15/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	3/15/2024
Policy Owner	□ulia □eig: Clinical Nurse Manager, Emergency Services	3/15/2024

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ER.38 Patient Triage

POLICY:

Every patient entering the Emergency Department (ED) shall be triaged and priority of care determined based on physical and psychosocial needs, as well as factors influencing patient flow through the system. The purpose of triage is to prioritize incoming patients and to identify those patients that cannot wait to be seen:

A. The specific goals of the triage system include:
   1. Early patient assessment by a physician or RN
   2. Determination of urgency of needed care
   3. Documentation of triage findings
   4. Control of patient flow through the Emergency Department
   5. Initiation of certain diagnostic measures
   6. Initiation of standardized procedures
   7. Initiation of certain comfort measures
   8. Initiation of certain therapeutic measures
   9. Initiation of certain referrals and informing patient/family of available community resources

PROCEDURE:

A. Assessment and Priority Setting*
   1. PRIORITY 1 (ESI Level 1) Includes all life or limb threatening conditions in which life-saving interventions are required. Examples of life-saving interventions include, but are not limited to:
      a. Major trauma, patient unresponsive
      b. BVM ventilation
      c. Intubation
      d. Surgical airway
      e. Emergent CPAP
      f. Emergent BiPAP
      g. Defibrillation

h. Emergent Cardioversion
i. External Pacing
j. Chest needle decompression
k. Pericardiocentesis
l. Open thoracotomy
m. Intraoseous access
n. Significant IV fluid resuscitation
o. Blood Administration
p. Control of major bleeding
q. Administration of Naloxone
r. Administration of IV Dextrose
s. Administration of Dopamine
t. Administration of Atropine
u. Administration of Adenocard

*These are only general examples, not standards for each class. Rating of the patient must be based on the clinical presentation of the patient and the triage nurse's clinical judgment while using the Emergency Severity Index (ESI) Triage Algorithm.

2. PRIORITY 2 (ESI Level 2) Includes all patients who are not ESI Level 1, but should not wait for definitive care. This decision is made by determining:
   a. Is this a high risk situation? (A high risk patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential threat to life, limb or organ.)
   b. Is the patient acutely confused, lethargic or disoriented?
   c. Is the patient in severe pain or distress?
      i. Examples of ESI Level 2 include, but are not limited to:
         - Active chest pain (non-STEMI), suspected ACS, VS stable
         - Needle stick exposure in a health care worker
         - Signs of a stroke (but does not meet ESI Level 1 criteria)
         - Rule out ectopic pregnancy, hemodynamically stable
         - Patient on chemotherapy or otherwise immunocompromised, with a fever
         - Suicidal or homicidal patient (page Security)
         - Confused: Inappropriate response to stimuli
         - Lethargic: Drowsy, sleeping more than usual
         - Disoriented: Patient is unable to correctly answer questions about time, place or person.
         - Severe pain or distress: Self reports > 7/10 pain, with physical findings consisted with

stated pain level (diaphoresis, tachycardia, nausea/vomiting, pale, hypertensive)

3. PRIORITY 3 (ESI Levels 3, 4 & 5). Once the decision is made that the patient does not meet criteria for ESI Level 1 or ESI Level 2, patients are categorized based on the predicted number of resources needed to determine patient disposition. These patients' conditions generally need evaluation and treatment, but time is not a critical factor. Since their physical condition is stable, these patients can safely wait several hours to be seen. The triage nurse should be able to accurately predict the nature and number of tests, therapeutic interventions and consultations that a patient would need during his/her ED stay, based on their chief complaint. Based on the number of different types of expected resources needed, the nurse will assign an ESI Level as follows:
   a. ESI Level 3 = 2 (two) or more expected resources needed
   b. ESI Level 4 = 1 (one) expected resources needed
   c. ESI Level 5 = 0 (none) expected resources needed.
4. The Triage Nurse will take a full set of vital signs on all ESI Level 3, 4 & 5 patients. ESI Level 3 patients with abnormal vital signs may need to be up-triaged to ESI Level 2 (High-Risk Situation). Vital signs will be done on any patient returning to the waiting room regardless of ESI Level assigned to ensure patient safety.

ESI Resources Examples

Resources	Not Resources
Labs (blood, urine, sputum)	H & P, MSE, pelvic exam
EKG, X-rays, CT, MRI, Ultrasound, Angiography	Point-of-care testing (accucheck, urine dip, urine ICON)
IV Fluids (hydration)	Saline or Heplock
IV, IM or Nebulized medications	PO meds, Tdap (immunization), Prescription refills
Speciality Consultation	Phone call to PCP
Simple procedure (lac repair, Foley) = 1 Complex procedure (conscious sedation) = 2	Simple wound care (dressings, recheck) Crutches, splints, slings

5. The Triage Nurse will notify admitting staff of ESI Level 1-5 patients taken directly to patient treatment area to expedite registration.
6. The Triage nurse will place ESI Level 1 & 2 patient charts before ESI Level 3, 4, & 5 charts for expedient registration.
7. The Triage nurse will communicate report directly to the Charge nurse, or the nurse assuming care on all patients taken directly to the patient treatment area.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/27/2024
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Policy Area:	*Intensive Care Unit*
References:	

ICU.08 Intensive Care Unit Alternative Patient Placement

POLICY:

To provide safe, competent patient care for □ntensive Care □nit (□C□) patients during periods of high census. As approved by the Medical Executive Committee, in the event of the unavailability of a □C□ bed for a critical patient meeting the criteria for admission, patients may be held in the Emergency Department (ED). All efforts will be made to provide □C□ staff to care for the patient. Staff caring for the patient will be a Registered Nurse (RN) possessing the appropriate competencies for the critical care specialty.

PROCEDURE :

A. □hen all □C□ beds are occupied:

1. The □C□ Charge nurse will:
   a. Call the on call physician for possible transfers.
   b. Notify the Critical Care Nurse Director and/or the Nursing Supervisor.
2. The Nursing Supervisor will:
   a. □nform the Chief Nurse Executive or designee (business hours) or Administrator on Duty (AOD) (non-business hours) regarding possible ambulance diversion. Note: □ospital Chief Executive Officer (CEO) or Chief Operating Officer (COO) must approve all trauma diversions in collaboration with the trauma medical director.
   b. Notify the ED to hold the patient.
   c. Attempt to find a critical care RN to care for the boarding patients from:

      Per Diem Pool
      Off duty Nurses
      Registry
      □n □ouse Registry

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Attachments

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Policy Owner	□elly □ohnson: Director, □C□/DO□/Telemetry	1/23/2024

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Policy Area:	*Intensive Care Unit*
References:	

ICU.22 Admission Criteria to the Telemetry Units

POLICY:

The Telemetry ~~Unit provides~~Units provide care for and continuous cardiac monitoring of patients in stable condition and having or suspected of having a cardiac condition or a disease requiring telemetry monitoring, recording, retrieval and display of cardiac electrical signals. ~~This~~ICU 2 is further defined as a specialty unit ~~is further defined as a specialty unit~~ in relation to the specialized chemotherapy and oncological care provided to those patients diagnosed with cancer.

PROCEDURE:

Patient transfers from the Intensive Care Unit (ICU), Definitive Observation Unit (DOU), and/or Emergency Department/clinic referrals shall meet criteria for telemetry admission as outlined below.

CRITERIA FOR ADMISSION OF PATIENTS

~~a. Hemodynamically stable~~

~~b. Neurological evaluation limited to every four (4) hours.~~

~~c. Chemotherapy infusions (only in the ICU 1 unit).~~

~~d. One or more appropriate indications for telemetry monitoring outside the ICU/DOU (refer to Attachment A).~~

~~e. Respiratory illness requiring continuous oximetry monitoring.~~

The ACC/AHA practice standards based on expert consensus (not randomized control trials) recommends cardiac monitoring for ischemia, QT interval, Class I, and some Class II patients. It is not indicated in Class III patients:

- **Class I:** at risk of an immediate, life-threatening arrhythmia—typically ICU appropriate patients (i.e. patients in the first 48 hours of ACS or with high grade lesions awaiting intervention, acute heart failure, 2nd and 3rd degree AV block, temporary pacing, long QT syndrome, WPW with rapid anterograde conduction, IABP, post cardiac arrest, post cardiac surgery, post-PCI or ablation with complication, post pacemaker placement with pacemaker dependence and conscious sedation.
- **Class II:** individuals presenting with chest pain syndromes, syncope, known arrhythmia with active arrhythmia medication titration, heart failure, post-PCI, post-ablation or post-pacemaker placement without complications.

- **Class III:** includes rate-controlled atrial fibrillation, chronic PVCs, ESRD on HD and low risk post-surgical patients.
- A patient is deemed appropriate for downgrade from telemetry when they meet the criteria for telemetry removal based on the telemetry removal protocol (Attachment A)

EXCLUSION CRITERIA FOR ADMISSION

~~A. Hemodynamic instability and/or need for invasive hemodynamic monitoring or pressor agents.~~

~~B. Respiratory failure requiring invasive or noninvasive positive pressure ventilation.~~

~~C. Patient requiring neurological evaluation more frequently than every four (4) hours.~~

~~D. Sustained ventricular tachyarrhythmia.~~

~~E. Patients with active, uncontrolled chest pain secondary to an acute coronary syndrome.~~

~~F. Type II second-degree or third-degree AV block (symptomatic or asymptomatic).~~

~~G. Patients with acute ST segment changes on EKG.~~

~~H. Patients requiring insulin drip.~~

~~I. Severe alcohol withdrawal (with or without delirium tremens) requiring high doses of benzodiazepines.~~

A. Patients who meet Class I criteria within the first 48 hours of onset of symptoms. (consider ICU or DOU)

B. Patients who meet Class III criteria. (consider Med-Surg)

C. Patients requiring insulin drip.

D. Severe alcohol withdrawal (with or without delirium tremens) requiring high doses of benzodiazepines.

Additional Criteria includes:

A. Admission by members of Medical Staff, Residents, Emergency Department physicians.

B. Initiation of telemetry monitoring requires a ~~written physician's~~patient status change order ~~according to~~indicating the need for telemetry ~~guidelines (refer to Attachment A).~~level of care

~~**General Discharge Criteria:**~~

~~APPROPRIATENESS FOR DISCHARGE — The medical necessity of continued hospitalization is primarily determined by the presence of an acute health condition of sufficient severity that ongoing diagnostic or therapeutic intervention, or careful monitoring, is required.~~

~~When it has been determined that a patient is medically ready for discharge, the health care team must determine the most appropriate setting for ongoing care. Determinants of the appropriate site of care involve medical, functional, and social aspects of the patient's illness. The patient's acute and chronic medical conditions, potential for rehabilitation, and decision-making capacity must be taken into account.~~

~~Input is needed from multiple sources to determine the most suitable discharge plan. Involved parties often will include the patient, family, case manager, nurse, physician, physical and occupational therapist, social worker, and insurer.~~

~~In order for the patient to be deemed safe and ready for discharge to home or to a non-acute environment (rehabilitative, transitional, or chronic care), a provider must take into account a number of factors beyond the medical determinants. These factors include:~~

- ~~Patient cognitive status~~

- ~~Patient activity level and functional status~~
- ~~The nature of the patient's current home and suitability for the patient's conditions (eg, presence of stairways, cleanliness)~~
- ~~Availability of family or companion support~~
- ~~Ability to obtain medications and services~~
- ~~Availability of transportation from hospital to home and for follow-up visits~~
- ~~Availability of services in the community to assist the patient with ongoing care~~

~~At the time of discharge home, patients, with help from family or other caregivers if available, should be able to:~~

- ~~Obtain and self-administer medications~~
- ~~Perform self-care activities~~
- ~~Eat an appropriate diet or otherwise manage nutritional needs~~
- ~~Follow up with designated providers~~

~~Specific insurance benefits and availability of services in the community may also influence whether or not the patient may be safely discharged home. Home services, such as visiting nurses or infusion providers to administer intravenous infusions, may allow selected patients, who would otherwise need non-acute residential care, to manage their care needs at home.~~

~~A patient is deemed appropriate for discharge when all the following are present:~~

- ~~Hemodynamic stability~~
- ~~Cardiovascular status acceptable~~
- ~~Respiratory status acceptable~~
- ~~Stable chest findings~~
- ~~Airway status acceptable~~
- ~~Neurologic status acceptable~~
- ~~Pain and nausea absent or adequately managed~~
- ~~Abdominal status acceptable~~
- ~~Hepatic and biliary abnormalities absent or acceptable~~
- ~~Renal function acceptable~~
- ~~Urinary status acceptable~~
- ~~Temperature status acceptable~~
- ~~Vascular, soft tissue, and wound status acceptable~~
- ~~No infection, or status acceptable~~
- ~~Physiologic disorders absent, or status acceptable~~
- ~~Electrolyte status acceptable~~
- ~~No blood loss, or problem resolved~~
- ~~Behavioral health status acceptable~~
- ~~No chest tube, or status acceptable~~
- ~~Activity level acceptable~~
- ~~Intake acceptable~~
- ~~No inpatient interventions needed~~

~~SAFETY PRECAUTIONS~~

SAFETY PRECAUTIONS

~~Patients meeting one or more of the exclusion criteria above will not be admitted to the Telemetry/~~

~~Oncology unit, but rather should be admitted to (or remain in) the DOU or ICU.~~

A. Each patient on the Telemetry/Oncology unit will be assessed daily by the attending physician or designee.

B. The need for continued telemetry should be reassessed by provider every 24 hours.

C. Appropriate ~~Telemetry/Oncology~~patient status orders must be completed for all admissions indicating the need for telemetry.

D. Telemetry Monitor alarms are "on," without exception.

E. ~~ICU staff will provide overview/monitoring and response.~~Patients on telemetry will be monitored by telemetry technicians who have been deemed competent in the recognition of arrhythmias.

F. IV infusions and IV push medications allowed on the Telemetry unit are listed on the Intravenous Medication Guidelines for Adults.

PATIENT CARE

~~A. Care is provided by Registered Nurses or combination skill mix of Registered Nurse and Licensed Vocational Nurse.~~

~~B. Specialty-trained Registered Nurse will function as Resource Nurse.~~

~~C. Trained staff in Telemetry Medical System utilized for cardiac monitoring.~~

~~D. Status change reported to appropriate physician.~~

~~E. Internal Medicine attending or designee to be available for triage of patients.~~

~~F. If telemetry units (Medical Surgical 1 and ICU 1) are at capacity, five (5) beds in the post-anesthesia care unit (PACU) shall be utilized. The patient population that may be permitted to utilize this space shall be:~~

- ~~Postoperative (after recovery period)~~
- ~~Adult (14 years of age or older)~~
- ~~Without need for isolation due to infectious disease~~

~~As soon as bed availability exists on the telemetry unit, patients shall be transferred.~~

A. Care is provided by Registered Nurses who have been deemed competent in the care of telemetry patients with support from ancillary staff, including nursing assistants.

EQUIPMENT

A. Medical System Telemetry with monitoring screen~~ in the Telemetry/Oncology unit nurses' stations, DOU, and ICU~~.

B. Alarm System Response: by audible indicator and viewing information center with text information.

DOCUMENTATION

A. An admission assessment documented in electronic health record within ~~six~~eight (~~6~~8) hours of admission.

B. Nursing care plan and psychosocial questionnaire within eight (8) hours of admission.

C. Patient Care Note and Interventions.

D. EKG strip upon admission, every shift and PRN status change.

E. Indication for continuing telemetry monitoring must be documented daily.

~~KEY POINTS~~

KEY POINTS

- Report status changes promptly to physician.
- Unconfirmed dysrhythmia:
  - i. Assess patient
  - ii. ~~CCU staff backup confirmation~~Call rapid response
  - iii. Physician notification/assessment
- Efforts to protect the neutropenic patient may warrant consideration to prevent infectious exposures by omitting patients requiring isolation.
- This unit does not have capability of direct observation.
- All patients admitted to the Telemetry unit should have functional intravenous access at all times. The IV access is to be placed prior to the patient's admission to the Telemetry unit.
- Discontinuation of telemetry monitoring should be considered as soon as clinically appropriate, as outlined in ~~Attachement~~Attachment A.

References:

Sandau et. al., (2017). Update to Practice Standards for Electrocardiographic Monitoring in Hospital Settings: A Scientific Statement From the American Heart Association. Circulation 136(19), 276-344. https://doi.org/10.1161/CIR.0000000000000527

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ICU.24 Adult Intensive Care Unit Admission and Scope of Service

POLICY:

The purpose of the Intensive Care Unit (ICU) is to provide the critically ill patient with a consistently high level of quality care which is aimed at the treatment of life-threatening illnesses and the maintenance of all physical and mental functions of the individual during the illness phase. It is the intent of the unit to return each patient to an optimum state of well-being where, given the limitations of his/her disease process, he/she can lead an independent, satisfying and productive life.

PROCEDURE:

Equipment:

A. All ICU patient rooms are equipped with preliminary emergency equipment (e.g., oxygen outlets, compressed air and suction, electrocardiography (ECG) monitor, and code blue alarm notification system).

B. The emergency cart within the unit is equipped with appropriate Advanced Cardiac Life Support (ACLS) drugs and equipment.

C. Each patient room is equipped with a patient call light.

ORGANIZATION:

A. The ICU is guided by the Critical Care Committee, a multidisciplinary committee including the Medical Staff and the ICU Medical Director. The ICU is directed and staffed according to the nature of the critical patient care needs anticipated and the scope of services offered.

- Trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service within 24 hours.

B. The ICU Committee is responsible for the efficient development, operation, and improvement of the unit.

C. The ICU Committee chairperson is appointed by and responsible to the Chief of Staff. The Committee chairperson has received special training, acquired experience and demonstrated competence in critical care medicine.

D. The ICU Committee Chair works collaboratively with the ICU nursing leadership (e.g., the ICU Nursing

Director and the Clinical Nurse Specialist) to assist in writing, reviewing and approving policies and procedures.

STAFFING

A. As much as possible, staffing needs for each shift are predicted and planned for by consideration of census and individual patient acuity. Age appropriate care shall be provided and documented according to age specific competency care standards.

B. As patient acuity dictates, consideration will be given for 1:1 Registered Nurse (RN) assignments.

C. Upon hire, the ICU RN must take and pass a written ECG test. (Passing score = 80%)

D. Annually, the ICU RN must attend and complete a skills competency assessment conducted by the unit CNS.

E. All ICU nurses must be certified in ACLS within 6 months of hire.

ADMISSION POLICY AND CRITERIA

A. Admission to the ICU shall be on the acceptance of the attending physician or his/her designee. It is the responsibility of the physician to advise the patient and his/her relatives of the need for critical care.

B. Critically and seriously ill patients who require specialized medical and nursing care shall be admitted. (see attached spreadsheet for admission criteria.

DISCHARGE CRITERIA

Stability for transfer out of the unit will be based on the ICU clinician's judgment, including but not limited to hemodynamic, ventilatory, and neurologic criteria.

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Attachments

Updated ICU and DOU admission criteria 10.11.23 (002).xlsx

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ICU.28 Targeted Temperature Management (TTM) and Shivering protocol

Maintaining Normothermia in Neuroscience Patients

GOAL:

To maintain normothermia from 36.5°C to 37.5 °C in acute brain injury patients with shivering controlled or inhibited. Fevers can increase secondary brain injury, worsen functional outcome and increase mortality rate in patients with central neurologic injuries.

INCLUSIONS:

A. Traumatic brain injury with Glasgow Comas Scale (GCS) < 12

B. Intracerebral and/or Intraventricular hemorrhage (ICH; IVH)

C. Ischemic stroke

D. Other conditions with potential for increased ICP

EXCLUSIONS:

Attending physician discretion

IMPLEMENTATION:

1. Perform and document baseline assessment
   a. Vital signs
   b. Neurological exam
   c. Richmond Agitation and Sedation Score (RASS) if sedated
2. Place temperature sensing foley catheter unless patient is anuric then place esophageal temperature probe if intubated or a rectal probe.
3. External cooling device surface cooling (Arctic Sun) system is used, apply Arctic Sun cooling pads to patient and attach to cooling machine.
   a. Turn device on and set to normothermia with temperature set at 36.5°C.
   b. Contraindicated in patients with skin integrity issues

c. Initiate counter warming with bair hugger blanket on patient at 42°C.
d. Cover hands and feet with blanket.

4. Determine the correct size according to manufacturer's recommendations.
   a. Pads need to cover at least 40% of body surface area, universal pad can be added to patient's abdomen
5. Perform, assess and document:
   a. Document time of initiation
      1. Vital signs and core temperature: Every 15 minutes until target temperature is reached; then every hour
      2. Core temperature refers to Foley temperature unless patient is anuric in which esophageal temperature should be used if intubated or a rectal probe
   b. Arctic Sun water temperature: Every hour
   c. Neurological checks: Every hour
   d. RASS every hour if sedated
   e. Bedside shiver assessment Scale (BSAS): Assess for shivering every hour. If persistent shivering noted, notify MD and initiate shivering protocol.
   f. Blood Glucose monitoring every 6 hours per physician order.
   g. Full skin assessment every shift: Assess skin beneath cooling pads every 4 hours. **Notify ICU team of skin breakdown, lacerations, or dermatitis as noted.
   h. Monitor labs daily as ordered including
      1. Liver function tests every 72 hours if on acetaminophen
      2. Triglycerides every 48 hours if on propofol
      3. Magnesium level per shivering protocol

Notify the Attending physician/ICU resident for the following:

A. Inability to reach target temperature within 4 hours.
B. Inability to maintain target temperature within 1°C.
C. Continued shivering despite use of shivering protocol.
D. Water temperature < 10 °C, consider obtaining cultures
E. Deterioration in neurological exam.

Targeted Temperature Management Post Cardiac Arrest

Goals:

Targeted Temperature Management (TTM) initiated after cardiac arrest with return of spontaneous circulation (ROSC) can improve neurologic outcomes and survival rates.

Inclusion Criteria:

- In or out of hospital cardiac arrest with return of spontaneous circulation (ROSC)
- Comatose with Glasgow Coma Scale (GCS) < 8 pre-sedation (i.e. does not follow commands – two thumbs up, squeeze and release)
- Initiation of hypothermia within 6 hours of collapse (relative inclusion)
- Full Code
- Absence of multi-organ dysfunction syndrome, severe sepsis, or a comorbidity associated with minimal chance of meaningful survival independent of neurological status

Exclusion Criteria:

- Uncontrolled bleeding/ hemorrhage
- Known severely impaired pre-arrest cognitive status
- Refractory life-threatening arrhythmias
- Purposeful responses to verbal commands after ROSC
- Peripheral vasospastic disorders
- Attending physician discretion

Relative Contraindications:

- Bleeding or coagulopathy: International normalized ratio (INR) > 2.2, platelets <50 (may consider reversal agents then initiate cooling to 36°C)
- Traumatic or other known non-cardiac cause of arrest
- Terminal illness
- Long QTc on initial ~~echocardiogram~~electrocardiogram (ECG) (consider target temperature of 36°C)
- Head bleed per CT scan (consider target temperature of 36°C)
- Bradycardia with hemodynamic instability (consider target temperature of 36°C)

Goal of therapy:

The goal of therapy is to reach target temperature of 33°C or 36°C as soon as possible after ROSC and to maintain goal temperature for 24 hours. The rewarming phase is initiated after the 24 hours of hypothermia is complete with a goal to raise the patient's temperature slowly by 0.25°C/hour to a target temperature of 37°C and maintaining that for at least 72 hours.

Implementation Phase:

Initiate protocol once patient has been identified and order received by attending physician

A. Patient meets criteria

B. Patients should be intubated and mechanically ventilated with ventilator humidifier turned off. Heat moisture exchanger (HME) to be placed by respiratory therapist.

C. Triple lumen central line placed for IV access, arterial line for continuous blood pressure monitoring.

D. Obtain baseline labs and imaging including; complete blood count (CBC), complete metabolic panel (CMP), troponin, prothrombin time/PT, INR, partial thrombin time (PTT), arterial blood gas (ABG) with lytes/lactate, Type and Screen. 12 lead ECG, chest x-ray and any applicable CT scans.

E. Place temperature sensing foley catheter unless patient is anuric then place esophageal temperature probe or rectal probe.

F. Initiate sedation to achieve RASS of -4 to -5.

G. Initiate cooling as soon as possible.

H. Core temperature goal of 33°C or 36°C (attending discretion) for 24 hours.

I. External cooling device ***surface cooling (Arctic Sun)*** system is used, apply Arctic Sun cooling pads to patient and attach to cooling machine

   1. Determine the correct size according to manufacturer's recommendations.
   2. Pads need to cover at least 40% of body surface area, universal pad can be added to patient's abdomen.
   3. Turn device on and set to hypothermia with temperature set at 33°C or 36°C. (determined by attending physician).
   4. Contraindicated in patients with skin integrity issues.
   5. Initiate counter warming with bair hugger blanket on patient at 42°C.
   6. Cover hands and feet with blanket.

J. Perform, assess and document:

   1. Document time of initiation
   2. Vital signs and core temperature: Every 15 minutes until target temperature is reached; then every hour
   3. Core temperature refers to Foley temperature unless patient is anuric in which esophageal temperature should be used
   4. Arctic Sun water temperature: Every hour
   5. Neurological checks: Every hour
   6. RASS every hour if sedated.
   7. Bedside shiver assessment Scale (BSAS): Assess for shivering if persistent shivering noted, notify MD and initiate shivering protocol.
   8. Blood Glucose monitoring every 1-4 hours per physician order.
   9. Full Skin assessment every shift: assess skin beneath cooling pads every 4 hours. Notify ICU team of skin breakdown, lacerations, or dermatitis is noted.
   10. Initiate trickle tube feeds at 20ml/hr per physician order
   11. GI Prophylaxis per physician order
   12. Monitor labs every 2- 6hrs as ordered including renal panel, magnesium, phosphorus, ABG with lactate, and troponin. Liver function tests every 72 hours and triglycerides every 48 hours if on propofol.
   13. 12-lead ECG: Every 12 hours
   14. Consider daily EEG monitoring

Rewarming Phase:

A. Rewarming initiated after 24 hours of hypothermia.

B. Initiate rewarming on the arctic sun, over 16 hours at 0.25°C per hour to 37°C. Not to exceed 0.5°C/hour.

C. Continue to treat shivering during the rewarming process.

D. Turn on ventilator heater/humidifier.

E. Once the patient has reached 37°C, keep the Arctic Sun in place to keep the patient at 37°C for at least 72 hours post rewarming. Notify MD for any temperatures >37° C. Note: Arctic Sun Pads must be changed every 5 days or if soiled.

F. Monitor for hypotension related to vasodilatation.

G. Monitor for hyperkalemia.

Notify the Attending physician/ICU resident for the following:

A. Inability to reach target temperature within 4 hours.

B. Inability to maintain target temperature within 1°C.

C. Continued shivering despite use of shivering protocol.

D. Change in cardiac rhythm, frequent ectopy, cardiac instability, or new ECG changes.

E. Heart rate < 40 beats per minute (bpm) or > 120 bpm

F. Escalation of vasopressors and/or inotropes.

G. Urine output < 30 mL/hour for 2 consecutive hours (consider switching to esophageal probe)

H. Serum potassium < 3 mEq/dL or > 5 mEq/dL

I. Serum magnesium < 2 mg/dL

J. Water temp < 10 °C 12 hours after initiation of cooling if using the Arctic Sun, consider obtaining cultures

K. Deterioration in neurological exam

L. Any active bleeding

M. Worsening of skin integrity beneath cooling pads

Arctic Sun 24/7 Clinical Support Line: 866-840-9776 for troubleshooting.

Shivering Protocol

Goal:

Bedside shivering assessment score of ≤ 1.

Bedside Shivering Assessment Scale (BSAS)

Score Term Description

0 - No Absence of shivering on palpation of neck or pectoral musculature

1 - Mild Shivering localized to neck or thorax or ECG artifact

2 - Moderate Shivering involves upper extremities

3 - Severe Whole-body shivering

Stepwise approach

Step 1: Non-pharmacologic measures:

A. Insulate the hands and feet

B. Apply warm packs to the palmar surface of hands and feet

C. Apply insulative wraps to hands and feet

D. Apply insulative head wrap (i.e. warm blanket)

E. Apply Bair hugger at 42°C

Step 2: For continued shivering with a BSAS > 1 and not controlled by previous non-pharmacologic measures ADD:

- Acetaminophen
- Buspirone
- Magnesium bolus and infusion with goal magnesium level 3-4 mg/dL.
  - If CrCl < 50 mL/min, goal magnesium should be less than 3 mg/dL.
  - Check magnesium level 4 hours after bolus.
  - Titrate magnesium infusion as per physician order.
  - Do not give magnesium if:
    - CrCl < 30 mL/min
    - Neuromuscular junction (NMJ) disorders
    - 2nd or 3rd degree heart block
    - Hyperkalemia (K > 6 mEq/L)
    - Hypocalcemia (Ca < 1.1 mmol/L)

Step 3: For continued shivering with a BSAS > 1 not controlled with the previous measures ADD:

- Dexmedetomidine infusion
  - See ICU.23 Intravenous medication titration in intensive care areas for detailed titration parameter.

Step 4: For continued shivering with a BSAS > 1 not controlled with the previous measures ADD:

- Propofol infusion
  - See ICU.23 Intravenous medication titration in intensive care areas for detailed titration parameter.

Step 5: For continued shivering with a BSAS > 1 not controlled with the previous measures ADD:

- Cisatracurium infusion
  - See ICU.23 Intravenous medication titration in intensive care areas for detailed titration parameter.
    - Maintain Train of Four (TOF) 2/4.
    - Note: Magnesium will prolong the action of neuromuscular blockers

Reference

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3. Bernard SA, Gray TW, Buist MD, et al. Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia. *New England Journal of Medicine.* Feb 21 2002; 346(8):557-563.

4. Hypothermia after Cardiac Arrest Study Group. "Mild therapeutic hypothermia to improve the neurologic outcome after cardiac arrest." *New England Journal of Medicine* 346.8 (2002): 549-556.

5. Nielsen N, Wetterslev J, Cronberg T et al. Targeted temperature management at 33^0C vs 36^0C after

cardiac arrest. *New England Journal of Medicine* 2013;369(23):2197-206.

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All revision dates: 4/29/2024, 12/8/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/16/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/23/2024
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	1/23/2024

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

IS.11 Controlled Drug Access in Imaging Services

POLICY:

To provide for the safe and efficient use of controlled drugs in Imaging Services, which encompasses x-ray, Mammography, Ultrasound, Computed Tomography (CT), Nuclear Medicine and Interventional Radiology.

PROCEDURE:

1. The patient's Electronic Health Record (EHR) must be open and readily accessible for any radiographic procedure that requires the use of controlled drugs.
2. The Radiologist or Registered Nurse (RN), per licensed practitioner's (LP's) order, will administer the drug and then document the administration in the patient's EHR.

TECHNOLOGISTS ARE NOT AUTHORIZED TO SIGN OUT OR INJECT CONTROLLED DRUGS.

Access to controlled drugs is restricted to ~~a~~an LP or RN. In an emergency, and upon direction by ~~a~~an LP, a technologist may access lidocaine for administration by the physician for procedures performed in CT, Radiology, Mammography, Nuclear Medicine and Ultrasound.

For disposal of controlled substances, see policy *PH.88 Controlled Substances*.

All revision dates: 1/30/2024, 7/14/2020, 7/19/2018, 1/8/2007, 5/26/2006, 3/14/2006

Attachments

No Attachments

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Medicine Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy & Therapeutics Committee	Sul Hung: Associate Director of Pharmacy Services	2/16/2024
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	1/31/2024

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Imaging Services	Matt McGill: Director, Imaging Services	1/30/2024

VENTURA COUNTY
HEALTH CARE AGENCY

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

IS.37 Exam Order Verification

POLICY:

To ensure the correct patient exam is performed and that □uestionable orders are verified with the ordering physician.

PROCEDURE:

A. All referring physician orders placed into the patient□s electronic health record (E□R) for diagnostic exams shall be reviewed by department staff performing the study.

□. Department staff shall determine that the procedure ordered is appropriate with the stated diagnosis on the order or re□uisition and/or the patient complaint.

C. The referring physician (or his/her agent) must be consulted when the procedure ordered needs to be verified. Patient comments shall not be used to verify the procedure to be performed.

D. Conditions that indicate the referring physician (or his/her agent) needs to be consulted for verification of the order may include but are not limited to the following:

   i. Stated diagnosis on order or re□uisition does not reflect the area of interest to be studied (i.e., cervical spine order with diagnosis of low back pain, or right knee order with diagnosis of left knee pain).

   ii. The patient indicates that the area of interest is different than what is ordered.

   iii. The E□R order conflicts with the patient□s diagnosis in the E□R.

E. Department staff shall contact the referring physician directly regarding verification of the procedure to be performed. Exams that cannot be verified will be delayed until the referring physician is consulted and the exam is verified.

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Attachments

No Attachments

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Imaging Services	Matt McGill: Director, Imaging Services	2/28/2024
Imaging Services	Michael Diepfer: Medical Director, Imaging Services	1/22/2024

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

OB.43 Hepatitis B Prevention in Newborns

POLICY:

To prevent chronic hepatitis □ in all infants born to mother acutely or chronically infected with hepatitis □ virus.

~~□niversal hepatitis □ vaccine and hepatitis □ immunoglobin (□□□G) vaccine will be given, per CDC protocol, to all infants whose mothers are known □□sAg positive, or when □□sAg status is unknown (physician□s office will be contacted if necessary to obtain this information) and the mother is high risk (victim of sexual assault, drug abuser, history of multiple sex partners, sex partner of an □VDA, liver disease, deferred blood donor, resident of a home for mentally handicapped persons, history of transfusions, hepatitis □ viral infections are asymptomatic. To reduce the incidence of perinatal hepatitis □ transmission further, all newborn infants with a birth weight of greater than or e□ual to 2000 grams shall receive hepatitis □ vaccine by 24 hours of age.~~

To reduce the incidence of perinatal hepatitis □ transmission, all newborn infants with a birth weight of greater than or e□ual to 2000 grams shall receive hepatitis □ vaccine by 24 hours of age. To further reduce □epatitis □ transmission, □epatitis □ vaccine and hepatitis □ □mmune Globulin (□□□G) will be given per Centers for Disease Control and Prevention (CDC) protocol to all infants whose mothers are known to be hepatitis □ surface antigen (□□sAg) positive, □□sAg status unknown, or if the mother is known to be at high risk, which may include those who are victims of sexual assault, current history of drug use, history of multiple sex partners, liver disease, deferred blood donor.

PROCEDURE:

A. □dentify maternal hepatitis □ status:

   1. Look up hepatitis □ surface antigen (□□sAg) on prenatal records or under current lab results in Electronic □ealth Record (E□R) system.
   2. Mothers identified as □□sAg positive have babies that re□uire prompt treatment.
   3. Mothers whose status is unknown should have □□sAg testing immediately on admission.
   4. Mothers with no prenatal care shall have □□sAg drawn and shall be identified as □□sAg unknown until lab results are determined.

□. Treat baby according to maternal □□sAg status and weight in grams:

   1. □or all infants born to □□sAg positive mothers:
      a. Administer hepatitis □ vaccine and □□□G within 12 hours of birth. These should be administered in opposite legs.

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b. Re□uest □□□G from pharmacy

c. Administer □□□G in the opposite leg from the hepatitis □ vaccine

2. □or all infants born to □□sAg-unknown mothers:

a. Administer hepatitis □ vaccine within 12 hours of birth and:

b. □or infants with a birth weight greater than or e□ual to 2000 grams, administer □□□G by 7 days of age or by hospital discharge (whichever occurs first) if maternal □□sAG status is confirmed positive or remains unknown.

c. □or infants with a birth weight less than 2000 grams, administer □□□G by 12 hours of birth unless maternal □□sAG status is confirmed negative by that time.

3. □or all infants with a birth weight greater than or e□ual to 2000 grams born to □□sAg-negative mothers:

a. Administer hepatitis □ vaccine as a universal routine prophylaxis within 24 hours of birth..

b. □or all infants with birth weight less than 2000 grams born to □□sAg-negative mothers, administer hepatitis □ vaccine as a universal prophylaxis at one month of age or at hospital discharge (whichever occurs first).

VACCINATION ADMINISTRATION

Standards of administration of hepatitis □ vaccine and □□□G vaccine.

A. Obtain physician□s order.

□. Obtain signed consent from mother to permit infant to be vaccinated.

C. □dentify maternal □□sAg status and infant□s weight and gestational age.

D. Determine priority of when to give vaccinations according to this policy and procedure (identified above).

1. Collect needed materials:

a. ~~□epatitis □ vaccine from O□ medical refrigerator for patients eligible for C□DP/Medi-Cal□for private insurance carriers, vaccine is obtained from the Pharmacy (store at 2□to 8□C).~~□epatitis □ vaccine

b. □□□G is obtained from the Pharmacy ~~(store at 2□to 8□C).~~

c. Syringe and needle.

d. Current vaccination sheets (V□S).

DOCUMENTATION

A. The most current Vaccine information sheet (V□S) sheets are given to the mother when consents are needed for optional vaccinations. One V□S sheet is given to the mother and a copy is ~~stamped, dated and signed as a written consent, placed on the baby□s chart and~~ scanned into the newborns E□R. **Positive maternal HBsAg mandates immediate administration of the hepatitis B vaccine and the HBIG vaccine and does not require written consent.**

□. Document in Cerner ~~under the patient□s □mmunization Schedule~~E□R

1. □ill out re□uested information completely with baby□s identification data.
Note date, manufacturer and lot □, signature of administrator, site and V□S □D. under appropriate

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headings.

2. □□□G must be documented, if given.

C. □nitiate a Public □ealth referral using the □ospital Reporting □orm for Perinatal □epatitis □ for positive or unknown □□sAg mothers, see attachment. (P□□PP). Ventura County Public □ealth □mmunization program 805-981-5211 for □uestions.

D. A copy of the lab result should be kept in both the mother□s and infant□s E□R.

REFERENCES:

□Elimination of Perinatal □epatitis □: Providing the □irst Vaccine Dose within 24 hours of □irth□Pediatrics (2017)□Volume 140, Number 3

Management of □nfants □orn to □ omen with □epatitis □ Virus □nfection for Pediatricians□Centers for Disease Control and Prevention□September 29,2021

Ventura County Public □ealth Perinatal □epatitis □ Prevention Program

All revision dates: 2/2/2024, 9/18/2020, 3/27/2018, 2/15/2018, 7/1/2016, 11/1/2013, 12/1/2010, 3/1/2009, 8/1/2004

Attachments

□ep □ Screening and Referral Algorithm.pdf
P□□PP Newborn Report.pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: □amily Medicine, O□, Pediatrics Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy □ Therapeutics Committee	Sul □ung: Associate Director of Pharmacy Services	2/5/2024
Nursing Administration	Sherri □lock: Associate Chief Nursing Executive, VCMC □ SP□	2/4/2024
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC □ SP□	2/2/2024
Policy Owner	□ristina Swaim: Clinical Nurse Manager, O□	2/2/2024

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VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

PH.115 Medication Boxes and Kits

POLICY:

Medication boxes and kits shall be available upon the approval of the Pharmacy □ Therapeutics Committee. Medication boxes and kits shall serve a specific purpose for scenarios where the regular medication distribution process is deemed to be insufficient for patient care. Medications boxes and kits shall be secured with red breakable numbered locks or ties controlled by the Pharmacy Department. Medication boxes and kits shall be stored in agreed upon secure locations as listed in Attachment A Locations of Medication □oxes □ □its.

Exception: This policy does not apply to medication trays stored in crash carts. Refer to policy 100.113 Crash Cart Checks and Restocking Process for information on crash cart medication trays.

PROCEDURE:

A. A list of contents shall be viewable on the exterior surface of each medication box or kit. The attachments to this policy specify the contents of each kit.

□. The expiration date of the earliest expiring medication shall appear on the exterior surface of each medication box or kit.

C. A billing sheet shall be supplied in each medication box or kit.

D. □pon use, the nurse shall document the patient name, medical record number or financial identification number, date of use and medication(s) used on the billing sheet.

E. After use, the nurse shall return the used medication box or kit to the Pharmacy Department. The Pharmacy Department shall provide the nurse with a replacement medication box or kit.

□. The pharmacist shall replenish the used medication box or kit, secure the medication box or kit with a red breakable numbered lock or tie and record the lock or tie number and expiration date of the earliest expiring medication on the exterior surface.

G. Pharmacists shall inspect medication boxes or kits for integrity and the expiration date when performing monthly pharmacy inspections. Any medication box or kit found in an unapproved location shall be removed and returned to pharmacy. Any medication box or kit missing from an approved location shall be replenished.

□. Any medications boxes or kits that do not have a designated location outside of the pharmacy shall be checked out of the pharmacy and returned to the pharmacy after use.

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List of Medication Boxes & Kits

Anaphylaxis Kit

Anaphylaxis □it shall be available in the event a patient has an allergic reaction.

~~Anesthesiologist~~Anesthesia and Sedation Medication Box

~~Anesthesiologist~~Anesthesia and Sedation Medication □ox shall be available to anesthesiologists for procedures performed outside of the OR setting or to intensivists for moderate to deep sedation procedures. See attachment C for the *~~Anesthesiologist~~Anesthesia and Sedation Medication Box Log Sheet* and *~~Anesthesiologist~~Anesthesia and Sedation Medication Box Medication Administration Record*

A. Only the anesthesiologist or intensivists can sign out an ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox from the pharmacy.
   1. Change of custody shall be documented on the *~~Anesthesiologist~~Anesthesia and Sedation Medication Box Log Sheet* by both the pharmacist and the anesthesiologist/intensivists. The following shall be documented:
      a. The ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox number.
      b. The date and time of sign out.
      c. The name and signature of both the anesthesiologist/intensivists and the pharmacist.
      d. The number of fentanyl 100 mcg/2 mL vials and midazolam 2 mg/2 mL vials secured in the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox.
      e. The medication box seal number.

□. Only one ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox may be checked out by one anesthesiologist/intensivists.

C. The ~~Anesthesiologist~~Anesthesia and Sedation Medication box must be with the anesthesiologist/intensivists at all times. □ may not change hands and may not be left unattended.

D. The anesthesiologist/intensivist is responsible for all of the contents contained within the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox while it is checked out of the pharmacy.
   1. □f the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox is used, medication administration shall be documented on the *Anesthesiologist Medication Box Medication Administration Record (MAR).*
   2. The anesthesiologist/intensivist shall also document their name, sign and date the *~~Anesthesiologist~~Anesthesia and Sedation Medication Box MAR*.

E. Once the anesthesiologist/intensivist no longer needs the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox, it must be returned to the pharmacy by the anesthesiologist/intensivist who signed out the box earlier that day.
   1. Change of custody shall be documented on the *~~Anesthesiologist~~Anesthesia and Sedation Medication Box Log Sheet* by both the pharmacist and the anesthesiologist/intensivist. The following shall be documented:
      a. The date and time of return.
      b. The name and signature of both the anesthesiologist/intensivist and the pharmacist.

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c. The number of fentanyl 100 mcg/2 mL vials and midazolam 2 mg/2 mL vials remaining in the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox.

2. The pharmacist and the anesthesiologist/intensivist shall review the ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR* together.
   a. The pharmacist shall also confirm that the anesthesiologist/intensivist has documented their name, signed and dated the ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR*.
3. The pharmacist and the anesthesiologist/intensivist shall reconcile the amount at check out with the amount used and/or wasted and the amount returned to the pharmacy. These amounts shall be the same.
   a. Any discrepancy shall be immediately reported to the Director of Pharmacy Services.
4. The pharmacist shall refill the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox.
   a. The □itCheck refill record and a new ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR* shall be secured in the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox once the refill process is complete.
      i. The pharmacist shall document the refill date and sign the new ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR*.
      ii. The new ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR* shall be on top of the □itCheck refill record.
      iii. The pharmacist shall ensure that the □itCheck refill record and the new ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR* do not obstruct the view of the fentanyl and midazolam vials.
   b. The pharmacist shall check the medication box expiration sticker. □f needed, the pharmacist shall apply a new medication box expiration sticker.
   c. The pharmacist shall seal the ~~Anesthesiologist~~Anesthesia and Sedation Medication □ox with a new red breakable numbered lock or tie. The new seal number shall be documented on the ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box Log Sheet*.
5. The used ~~*Anesthesiologist*~~*Anesthesia and Sedation Medication Box MAR* and the Narcotic Delivery Signature Receipt (if applicable) shall be filed with Pharmacy Administration.

Cardiac Medication Box

Cardiac Medication □ox shall be available in the Emergency Department in the event of a prolonged resuscitation effort.

Code Blue Medication Box

Code □lue Medication □ox shall be available to the □C□ nurse and Rapid Response Team responding to a medical emergency.

Code Blue Pharmacy Medication Box

Code □lue Pharmacy Medication □ox shall be available for use by a pharmacist when responding to a medical emergency.

Code White Pharmacy Medication Box

Code □ hite Pharmacy Medication □ox shall be available for use by a pharmacist when responding to a

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pediatric medical emergency.

Code Stroke Medication Box

Code Stroke Medication □ox shall be available at Ventura County Medical Center for use by a pharmacist when alteplase is needed for an ischemic stroke. See policy 100.226 Acute Stroke Management/Code Stroke.

Epidural Medication Kit

Epidural Medication □it shall be available at Santa Paula □ospital for use by an anesthesiologist during the placement of an epidural.

Extravasation Kit

Extravasation □it shall be available in the event of an extravasation or infiltration. See policies 100.250 Management of Extravasation/□nfiltration Due to Non-Chemotherapy Medication Administration and 100.251 Administration and Extravasatin of Antineoplastic Agents

GI Lab Transport Medication Box

G□Lab Transport □ox shall be available in the event a patient needs to be transferred to and from the G□Lab.

Hydrofluoric Acid Exposure Kit

□ydrofluoric Acid Exposure □it shall be available in the event there is a hydrofluoric acid exposure.

Infusion Hypersensitivity Kit

□nfusion □ypersensitivity □it shall be available for use by the □nfusion Center Nursing staff in the event there is an infusion related reaction.

Intubation Kit

□ntubation □it shall be available in the event a patient needs to be intubated.

Neonatal Resuscitation Box

Neonatal Resuscitation □ox shall be available at Santa Paula □ospital for neonatal resuscitation.

NICU Transport Medication Box

N□C□ Transport Medication □ox shall be available in the event a N□C□ patient needs to be transported to and from the N□C□.

OB Cytotec Medication Kit

O□ Cytotec Medication □it shall be available in the event of post partum hemorrhage.

PICU Transport Medication Box

P□C□ Transport Medication □ox shall be available in the event a P□C□ patient needs to be transported to and from the P□C□.

Post Partum Vaginal Bleeding Kit

Post Partum Vaginal □leeding □it shall be available in the event of post partum hemorrhage.

Preeclampsia Medication Box

Preeclampsia Medication □ox shall be available in the event a patient experiences preeclampsia.

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Pyxis Anesthesia Emergency Drug Kit

Pyxis Anesthesia Emergency Drug □it shall be available to the Anesthesiologist during OR procedures.

All revision dates: 4/29/2024, 7/13/2022, 8/10/2021, 8/11/2020, 11/26/2018

Attachments

Attachment A: Locations of Medication □oxes and □its
Attachment □: Medication □oxes and □its □illing Sheets
Attachment C: Medication □oxes and □its Content Label

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Pharmacy □ Therapeutics Committee	Sul □ung: Associate Director of Pharmacy Services	4/29/2024
Pharmacy Services	Sul □ung: Associate Director of Pharmacy Services	4/29/2024

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VENTURA COUNTY
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Owner:	*Marcos Rodriguez: Manager, Rehabilitation Services*
Policy Area:	*Rehab Services*
References:	

RS.11 Rehab Services Light Therapy

POLICY:

Light therapy is utilized in the Outpatient Rehabilitation Services setting as a modality applied to the skin and underlying soft tissues for the purposes of increased metabolic activity, tissue repair, pain control and/or reducing inflammation.

PROCEDURE:

1. Sanitize the probe by cleaning with alcohol or other sanitizing agent
2. Explain procedure to the patient
3. Clean area to be treated with alcohol to remove surface dirt, oil, creams/lotions
4. Cover probe with thin, sanitized clear plastic if treating an open wound
5. Select dosage based on depth of target tissues and size of treatment area
6. Check all electrical connections
7. Turn on machine
8. Select light therapy setting
9. Select appropriate dosage
10. Check patient's skin
11. Apply probe to skin
12. Avoid looking directly at the crystal while machine is in use
13. Push the Start" button
14. Treat area per established protocols
15. Cleanthe probe as above and replace in cradle on machine

Contraindications:

- Cancer
- Direct irradiation of the eyes
- Treatment of patients with idiopathic photophobia or abnormally high sensitivity to light
- Patients that have been pre-treated with one or more photosensitizers

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- Direct irradiation over the fetus or the uterus during pregnancy
- Direct irradiation of the thyroid gland and /or endocrine glands
  ~~Patients with pacemakers~~
  ~~Growing children (epiphyseal plates)~~

Precautions:

- Patients with pacemakers
- Growing children (epiphyseal plates)

Age-Specific Considerations:

- As with ultrasound, light therapy should not be used over growth plates in children.
- Staff shall ask patients, especially the elderly, about all pertinent medical conditions.

All revision dates: 4/16/2024, 12/8/2020, 2/26/2019

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Tracy Chapman: VCMC - Med Staff	pending
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	4/16/2024

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