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Owner	Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services
Policy Area	Laboratory Services - Blood Bank

L.BB.25 Criteria for Rejection of Donor Blood

Unused donor blood may be rejected and returned to the blood supplier if:

1. The unit is mislabeled.
2. There is evidence of bacterial growth, or the cells appear discolored.
3. The plasma appears discolored.
4. The donor cells exhibit a positive direct antiglobulin test.
5. The blood supplier provides clinical evidence that the donor had an infectious disease at the time of donation.

If a suspicious donor unit is found, place the unit in the quarantine section of the blood storage refrigerator. Contact the blood supplier to notify them that there is a unit to be returned and the reason for the return.

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Paper copy reviewed on 12/12/2023 by Janette O'Neill.
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All Revision Dates

2/9/2026, 2/27/2024, 6/5/2020, 12/1/2016, 12/1/2011

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Step Description	Approver	Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	2/9/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/8/2026
Laboratory Services Department	Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services	2/5/2026
Laboratory Services Department	Linda Lee: Medical Director, VCMC Blood Bank	1/29/2026

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 1.1 Specimen Rejection, Acceptability and Stability Criteria - Hematology

PRINCIPLE:

Specimen integrity is extremely important when testing and reporting patient results by laboratory personnel. To ensure consistent reliable results all specimen requirements should be strictly followed regarding post draw stability of hematology specimens.

PROCEDURE:

Before patient testing occurs, all specimens should be evaluated and rejected if:

- Specimens are found to be unlabelled or incorrectly labeled. For proper label requirements refer to VCMC General Phlebotomy: **Procedure 5.2 - Specimen Labeling Requirements.**
- Specimens received are in the incorrect container or preservative.
- Specimens received are found to be contaminated. (i.e., drawn above intravenous (IV) line)
- Specimens are found to be insufficient or unsuitable for procedure(s): If the quantity received is not sufficient for test requirements, Tube received broken or leaking, or the incorrect specimen is received for test ordered.
- Specimens were found to be clotted specimens **for Complete Blood Count/ Differential and Sedimentation Rate** orders. *NOTE:* All specimens collected in Microtainer (MAP) tubes must be manually checked for clots using wood stick applicators. Other containers may be visually inspected for clots before testing.
- Specimens spun before being received by testing personnel.
- Specimens collected in expired tubes.
- Specimens received past testing stability limit.

- Specimens received frozen or were previously frozen.

Any re-allocation of specimens such as aliquots, transfers or dilutions from primary container **MUST** be visibly labeled with two patient identifiers (preferably patient Name and Medical Record Number.)

PROCEDURE NOTES:

ONLY the following specimen containers are accepted for the following tests:

A. **Complete Required specimen:**

1. Whole blood should be collected in EDTA-2K or EDTA-3K anticoagulant.
2. **Body Fluids**

A. Approved Body Fluid sample types are:

- Peritoneal
- Pleural
- Synovial
- CSF

B. Serous (Peritoneal and Pleural) and Synovial, fluids should be collected in EDTA-2K anticoagulant.

C. The use of anticoagulant with CSF specimens is neither required nor recommended.

- **Sedimentation Rate (ESR) Orders**
  - All K_2EDTA- Purple/Lavender top (UNSPUN),
- **Cerebral Spinal Fluid (CSF) Count and Differential Orders***
  - CSF containers (no additives/anticoagulants) (UNSPUN)
  - Clear top (no additives/anticoagulants) (UNSPUN)
- **Crystal Orders***
  - Syringe capped (No needles attached): If needle is present DO NOT remove needle. Notify collecting staff to remove needle.
  - Clear top (no additives/anticoagulants) (UNSPUN)
  - Red top (no additives/anticoagulants) (UNSPUN)

A. Acceptable Containers for Hematology Testing

Test	K_2EDTA Purple/ Lavender Unspun	K_2EDTA Pink Unspun	K_3EDTA Purple/ Lavender Unspun	No additives CSF tube Unsp	No additives Clear or Red Unspun	No additives syringe capped
CBC/CBCD/RETIC	√	√	√			

Whole Blood						
ESR Whole Blood	√	√				
Body Fluids Serous Fluids	√				√	√
Crystals Body Fluids	√				√ (Preferred)	√ (Preferred)
CSF Cerebral Spinal Fluids				√		

B. Specimen volumes required:

Analysis Method	Specimen	Sample Tube	Cap	Required Sample Volume	Aspirated Sample Volume
Sampler Analysis	**Whole Blood**	**Regular Sample Tube**	**Closed Tube**	**1mL**	**88 µL**
		RBT Micro Collection tube	**Closed Tube**	**250 µL**	
Manual Analysis	**Whole Blood**	**Regular Sample Tube**	**Closed Tube**	**1mL**	**88 µL**
			Open Tube	**300 µL**	
		RBT Micro Collection Tube	**Closed Tube**	**250 µL**	
		Micro Collection Tube	**Open Tube**	**160 µL**	
	Diluted Blood	**Regular Sample Tube**	**Open Tube**	**300 µL**	**70 µL**
		Micro Collection Tube	**Open Tube**	**140 µL**	
	Body Fluid	**Regular Sample Tube**	**Closed Tube**	**1mL**	**88 µL**
			Open Tube	**300 µL**	
		Micro Collection Tube	**Open Tube**	**160 µL**	

C. Limitation:

Stability for Hematology Testing is listed as follows:

Test	Sample	Stability
CBC/CBCD/	Whole	EDTA blood samples should be analyzed within 4 hours whenever

RETIC	Blood	possible. If samples cannot be analyzed within 4 hours, store in a refrigerator at 2-8°C. Allow refrigerated samples to come to room temperature and mix well before analysis. *Refer to XN Series IFU for stability specifications*. Do not place CBC and Diff samples on a mechanical racker. Constant rocking may alter white cell membranes, resulting in false interpretive messages.
ESR	Whole Blood	4 hours after collection at room temperature (18-30°C). 24 hours after collection when refrigerated at 2-8°C.
BF/Crystals	Serous Fluids	4 hrs after collection at room temperature (18-30°C). After stability limit, cell counts may be considerably compromised. For Crystal analysis, refrigeration is NOT recommended.
CSF	Cerebral Fluids	2 hours after collection at room temperature (18-30°C). After stability limit, cell counts may be considerably compromised.

Specimen containers received past listed stability should be cancelled and ordering physician or designated nursing personnel should be notified, and notification documented.

- NOTE: Due to the difficulty and infrequency of collecting CSF and BF's, containers collected incorrectly or specimens exceeding stability criteria, should still be tested according to corresponding procedure and the following mnemonic should be appended: **LRQ** – Results Questionable Due to Specimen Condition. If authorization is needed to proceed testing questionable samples, consult with pathologist and indicate approval on test comments. Clotted samples should be cancelled.

A. **Characteristics that may affect test result:**

- Lipemia,
- Icterus
- Hemolysis
- Cold agglutinins.

REFERENCES:

College of American Pathologists (CAP) Hematology-Coagulation Checklist.

Sysmex America Inc., Lincolnshire, IL. XN Applications Manual.

ALCOR Scientific iSED Operator's Manual.

Patient Safety Monitoring in International Laboratories – Specimen Management -Specimen Acceptability Criteria

Patient Safety Monitoring in International Laboratories – Specimen Management -Appendix A -Specimen Acceptability Criteria

CAP Checklist Requirements

HEM.22050 CBC Anticoagulant

HEM.22150 Specimen Quality Assessment – CBC

HEM.22200 Hemolyzed or Lipemic Specimens-CBC

HEM.22625 Storage and Stability – Hematology

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 1.2 Hematology Whole Blood Reference Ranges - Hematology Department

PRINCIPLE:

Reference intervals (Normal Population Reference Ranges) were developed using normal individuals. The range for each parameter is calculated for 95% confidence intervals. The table below shows the normal population Reference Ranges.

The selection criteria of a healthy population of individuals are defined by the establishing or validating institution. For details on the establishment of VCMC Hematology Reported Reference Ranges see Sysmex NX-3100 Instrument Validation Binders.

Reference Range

Parameter	Ranges for Females	Ranges for Males	Units
WBC	3.98 - 10.04	4.23 - 9.07	X10³/µL
NEUT%	34.0 - 71.1	34.0 - 67.9	%
LYMPH%	19.3 -51.7	21.8 - 53.1	%
MONO%	4.7 -12.5	5.3 -12.2	%
EO%	0.7 – 5.8	0.8 -7.0	%
BASO%	0.1 - 1.2	0.2 -1.2	%
NEUT#	1.56 – 6.13	1.78 - 5.38	X10³/µL
LYMPH#	1.18 – 3.74	1.32 – 3.57	X10³/µL
MONO#	0.24 – 0.36	0.30 – 0.82	X10³/µL

EO#	0.04 – 0.36	0.04 – 0.54	X10³/µL
BASO#	0.01 – 0.08	0.01 – 0.08	X10³/µL
NRBC%	0 – 0.2	0 – 0.2	/100WBC
NRBC#	0 – 0.012	0 – 0.012	X10³/µL
RBC	3.93 – 5.22	4.63 – 6.08	X10⁶/µL
HGB	11.2 – 15.7	13.7 – 17.5	g/dL
HCT	34.1 – 44.9	40.1 – 51.0	%
MCV	79.4 – 94.8	79.0 – 92.2	fL
MCH	25.6 – 32.2	25.7 – 32.2	pg
MCHC	32.2 – 35.5	32.3 – 36.5	g/dL
RDW-CV	11.7 – 14.4	11.6 - 14.4	%
RDW-SD	36.4 – 46.3	35.1 43.9	fL
RET%	0.5 – 1.7	0.51 – 1.81	%
RET#	0.0164 – 0.0776	0.026 – 0.095	X10⁶/µL
IRF	3.0 – 15.9	2.3 – 13.4	%
PLT	182 - 369	163 - 337	X10³/µL
MPV	9.4 – 12.3	9.4 – 12.4	fL

Reference Values for IG% IG#

	IG%	**IG #**(X10³/ µL)
Mean	**0.215**	**0.0138**
SD	**0.107**	**0.0086**

REFERENCES:

CAP Accreditation Program – Hematology and Coagulation, All Common Checklist 8.24.2023

XN SeriesXN-3000/XN-3100 Instructions for Use.

CAP Checklist Requirements

COM.29950 Reference Intervals

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Laboratory Services Department	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Effective	12/14/2023	Policy Area	Laboratory Services
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L.HEM 1.3 Critical Results - Hematology Department

PRINCIPLE:

Critical results are tests results that represent a life-threatening state to the patient and require rapid communication to the physician or responsible licensed caregiver (limited to Nurse Practitioner, Physicians Assistant, Registered Nurse, or Licensed Vocational Nurse). It is the policy of Ventura County Medical Center (VCMC) & Santa Paula Hospital (SPH) to safeguard patients by defining the process of reporting critical results. Critical results are established by the VCMC/SPH Medical staff and are reviewed every two years and reported to the Performance Improvement Coordinating Council (PICC) quarterly.

All hematology critical results should be communicated immediately to the ordering physician or licensed responsible caregiver. Report must be verbally communicated no more than one (1) hour from the availability of critical results.

This policy is derived from **Administrative Policy: 100.030 Critical Test Results** and is designed to fit the workflow of the hematology department.

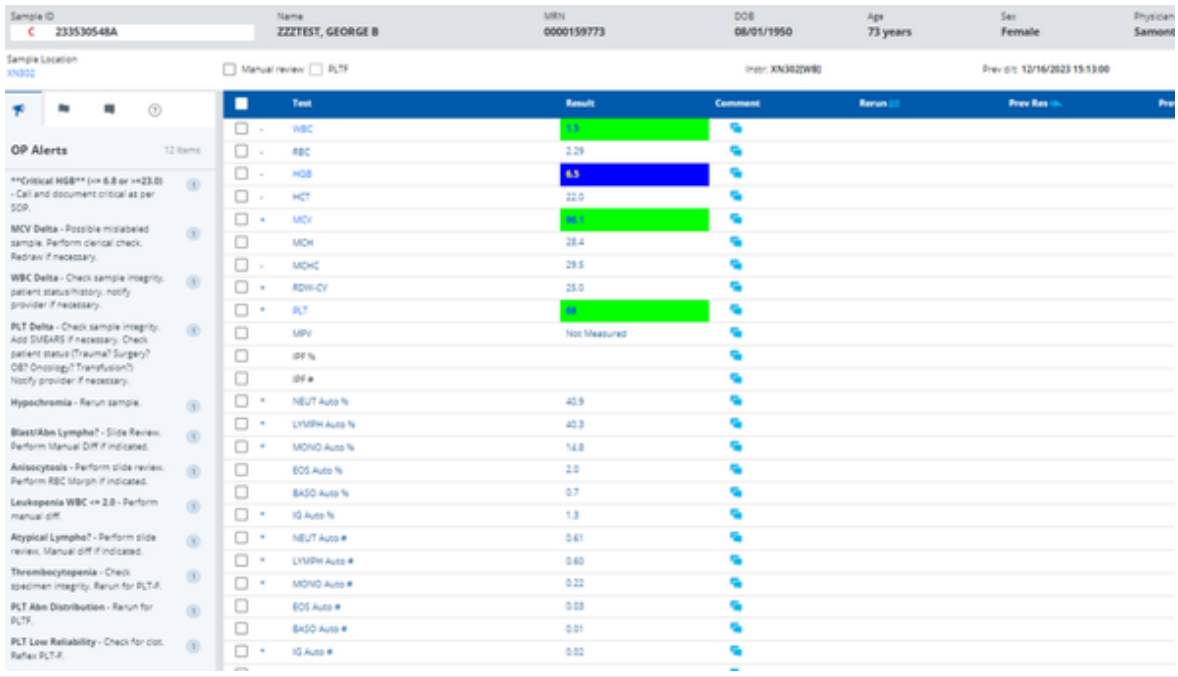
PROCEDURE:

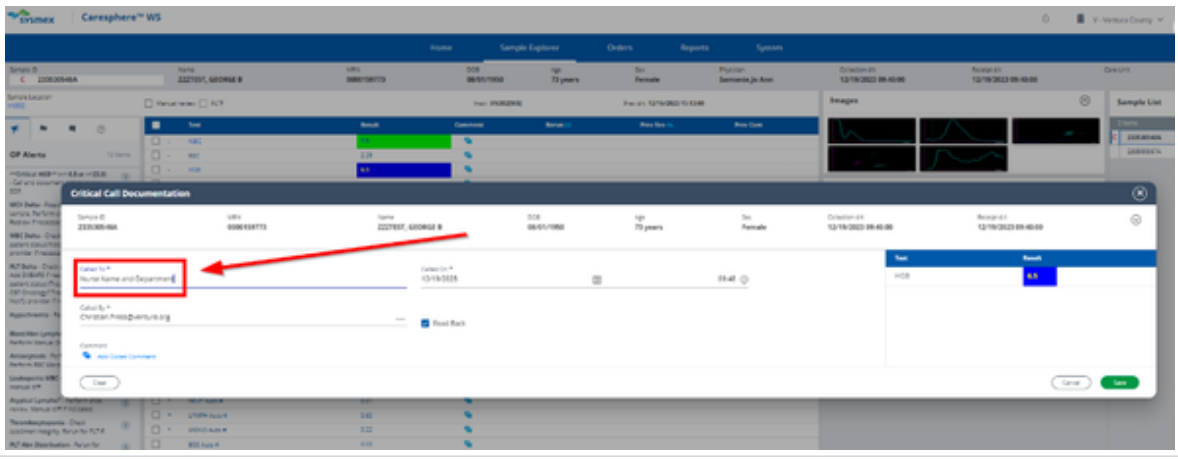
The following results have been established as critical results in the VCMC Hematology Department by the VCMC Medical Staff:

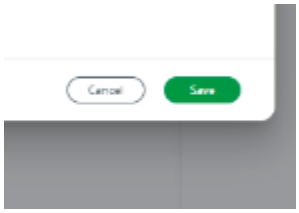
Test	Low Critical Result	High Critical Result
Hemoglobin	≤6.5 g/dL	≥23.0 g/dL
Hemoglobin patient age >65	≤6.8 g/dL	≥23.0 g/dL
Hematocrit	≤18%	≥70%

Platelets	≤20 Th/mm^3	
White Blood Cell (WBCs)	≤1.0 Th/mm^3	
Absolute Neutrophil Count (ANC/Neutrophil#)	<0.5 Th/mm^3	≥20.0
International normalization ratio (INR)		≥4.0
Partial Thromboplastin Time (PTT)		>118 sec.
Fibrinogen	<100 µg/dL	
Heparin, Anti-Xa (UF)		>0.7 IU/mL
Heparin, Anti-Xa (LMW)		>1.2 IU/mL

RESULTS:

1. The Critical/Delta Call Documentation pop-up displays a form to enter the call information when a sample ID with critical/delta results is validated.
2. 

3. 

4.	This pop-up documents the critical/delta results that have been called to the appropriate medical professional. Press save and result will be verified on Cerner. . 
	Note: Call licensed care giver or physician and fill call prompt ensure there is a "read-back" of the critical results. Record FIRST and LAST name and VOCATION of personnel receiving critical results. *For clinic's (outpatient) results analyzed during off hours (1700-0700) See corresponding Memo.

REFERENCES:

Administrative Policy: 100.030 - Critical Test Results

CAP Accreditation Program – Hematology and Coagulation Checklist 8.24.2023

CAP Checklist Requirements

COM.30000 Critical Result Notification

COM.30100 Critical Result Read-Back

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Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026

Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 1.4 Canceling and Re-ordering Laboratory Tests After Rejection

PRINCIPLE:

Specimen integrity is extremely important in accurately testing and reporting patient results by laboratory personnel. In whole blood testing platforms, unacceptable specimens may be discovered during pre-analytical, analytical & post-analytical sample analysis. For acceptability criteria on pre-analytical see hematology procedure: **Specimen Rejection, Acceptability and Stability Criteria.** For acceptability criteria on analytical and post analytical see corresponding test procedure.

Furthermore, the technological aspect of specimen analysis requires the laboratory personnel to reorder blood specimens due to the need for proper documentation for all laboratory specimens. **One accession number is permitted per specimen submission.** Upon rejection and cancellation, a new order must be placed in the information system after the patient's licensed caregiver is informed of the rejection.

PROCEDURE:

A. CBC/CBCD/H&H/RETIC Orders

1.	Cancel order in Caresphere by selecting Cancel Order from the details tab on the bottom left. Use a cancel reason or leave comment under cancel options that state why you cancelled the order.
2.	Cancel the order in Cerner and leave an LCALL that states who on the patient's care team you spoke with about the sample needing to be recollected.
3.	Reorder a new sample in Department order entry. *YOU MUST VERIFY THE FOLLOWING DETAILS MATCH THE ORIGINAL ORDER: a. **Order Priority** b. **Ordering Doctor**

c. **Order Name**

d. **FIN** number found at the top of the screen in Order Result Viewer

e. **Patient Name**

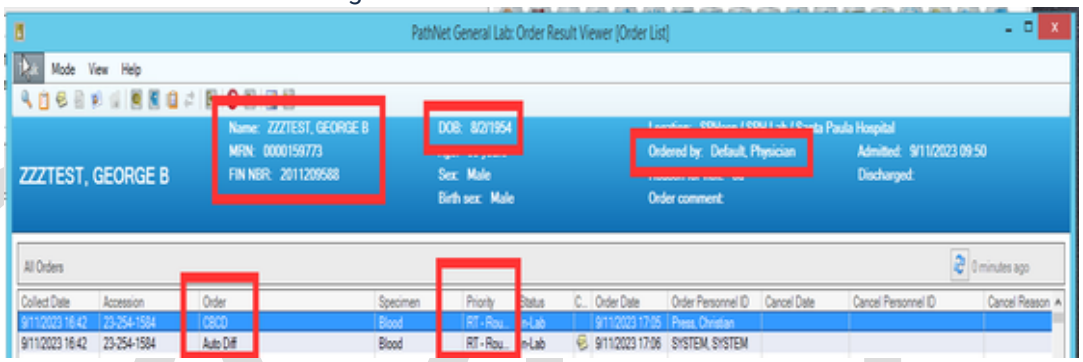
f. **Patient MRN**

g. **Patient DOB**

4. The following screen shots will aid the user in reordering a test.

A. Open Department Order Entry on the AppBar

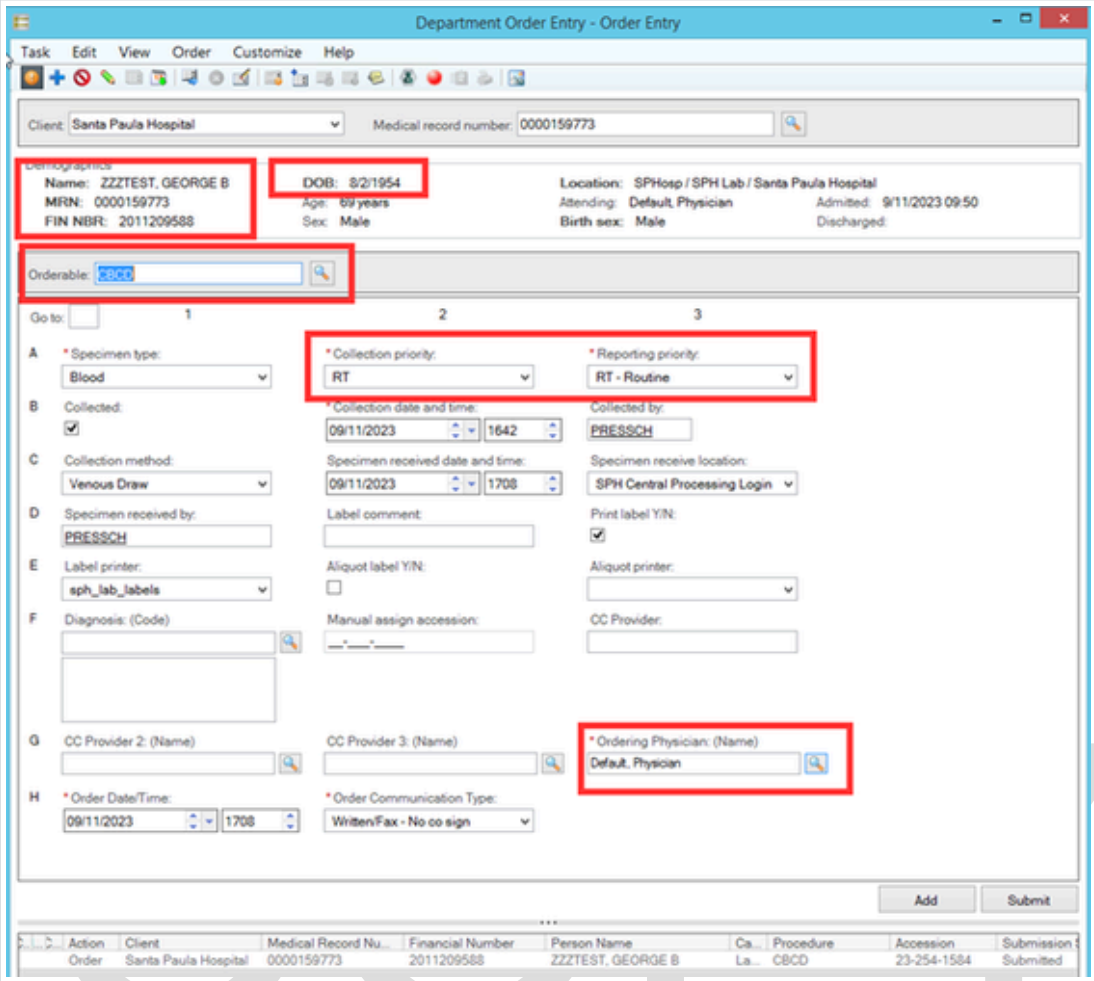
B. Observe the details of the original order



(continued)

C. Enter details from previous step into Department order entry screen in the following order.

1. **MRN**
2. **FIN –** make sure you select the proper encounter (FIN) after entering the MRN
3. **Orderable**
4. **Collection Priority**
5. **Reporting Priority**
6. **Ordering Physician**



5. Select submit to complete the reordering procedure

CAP Checklist Requirements

HEM.22100 Specimen Quality Assessment – CBC

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Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
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Policy Area	Laboratory Services

L.HEM 2.3 Running Patient Specimens in Slidemaker and Stainer SP-50

PRINCIPLE:

This procedure describes the mechanical method to make and stain hematology department peripheral smears. The blood film generated by SP-50:

- Allows for the differentiation of white blood cells.
- Facilitates the characterization of red blood cells and platelets.
- Aids in the identification of blood components and cellular abnormalities.

EQUIPMENT:

SP-50

SPECIMENS:

Whole blood collected in EDTA anticoagulated tubes

REAGENTS/MATERIALS:

Sysmex Micro Slide MS-101

Wright Wright Stain

Concentrated Phosphate Buffer – pH 6.8

Methanol, anhydrous (99.9%)

Deionized Water

CELLPACK DCL

PROCEDURE:

1.	**SP -50 Start-up:** Make sure the main power switch to the analyzer is in the ON position. Verify there are a minimum of 2 magazines in the feed out table. Verify there are enough glass slides for the daily volume. If used, verify the waste containers are at an acceptable level. empty if necessary. • Make sure that there are no racks on the measurement line of the sampler. 1. Follow instructions for XN-3100 start up procedure **HEM1.2.2** 2. SP-50 automatically powers on when XN-3100 starts up. 3. Log on and enter password, then touch [OK]. NOTE: Once the power on the instrument turns ON, a self-check automatically runs. The self-check consists of initialization of the mechanical units, rinsing the hydraulic unit, and replenishment of reagent.
2.	Samples refrigerated must be brought to room temperature before analysis. Frozen specimens are NOT acceptable. **NOTE:** Any samples not acceptable for specimen testing should be canceled and reordered. Refer to **Canceling & Reordering Tests for Unacceptable Specimens HEM1.1.4** procedure for guidelines.
3.	**SP-50 - Sample Requirements**

Slide prep	Sample tube	Cap	Position	Required volume	Aspirated volume
Sampler preparation	Regular sample tube	With cap	Sample rack	500 µL	70 µL
Manual preparation	Regular sample tube	With cap	Regular tube holder	500 µL	70 µL
	Regular sample tube	Without cap	Regular tube holder	300 µL	38 µL
	Raised Bottom tube	With cap	Regular tube holder	250 µL	70 µL
	Micro collection tube	Without cap	Micro tube holder	110 µL	38 µL

4. Slide Preparation Mode:

Slide prep mode	Description
[**Smearing and staining**] mode	Use this mode when you want to print sample information on the glass slide and perform sample smear preparation and staining.
[**Smearing**] mode	Use this mode when you want to print sample information on the glass slide and only prepare the smear, without staining.
[**Staining**] mode	Use this mode when you want to stain a smear that was prepared manually, or a sample for which only [Smearing] mode was performed.
[**Print**] mode	Use this mode when you only want to print sample information on the glass slide. No smear will be performed.

5. Smear Preparation Modes - Sampler & Manual

The prepared smears will be loaded into the magazine.

When preparation of all smears is completed, the magazine containing the smears is ejected to the storage location for the slide preparation mode used.
Retrieve the magazine that contains the smears.
• In [Smearing and Staining] mode, the magazine is fed out to the magazine storage unit.
• In [Smearing] mode, the magazine is fed out to the manual magazine holder.
NOTE:
* The magazines are ejected to the magazine storage unit after a pre-set amount of time or after the magazine is filled with stained smears. Magazines can be ejected on-demand by pressing the [Eject] button on the front of the unit.
*You must use the designated RBT rack with yellow stripes when processing RBT samples in the Sampler Mode

6.

Manual Modes:

In the following cases, prepare the smear manually.
• When you want to interrupt sampler preparation for an urgent sample.
• When you want to prepare a smear using a regular sample tube, micro collection sample tube or Raised Bottom Tube.
• When you only want to stain an already-prepared smear.
• When you only want to print sample information on the glass slide.

A. Stain Only: (Use this mode when you only want to stain an already-prepared smear)

1. If the sample tube holder has not been ejected, press the [Mode Switch] button on the front of the main unit.
2. To change the slide preparation mode, touch [Select mode].
3. Touch [Staining].
4. Touch [OK].
5. Open the manual magazine holder cover.
6. Pull out the manual magazine holder.
7. Load smeared glass slides into an empty magazine, with the frosted side facing the front.
8. Load the magazine that holds the glass slide into the manual magazine holder.
9. Push in the manual magazine holder, then close the manual magazine holder cover.
10. Ensure the status display LED of manual magazine holder is green.
11. Press the [Start] button on the front of the main unit.

12. For additional smears, follow steps 5 - 11, using the other manual magazine holder.
13. To return to sampler mode processing, press the [Mode Switch] button on the front of the main unit.
14. The prepared smears will be loaded into the magazine. When preparation of all smears is completed, the magazine containing the smears is ejected to the storage location for the slide preparation mode used. Retrieve the magazine that contains the smears.

B- Smear & Stain:

Use this mode for the following cases:
• When you want to interrupt sampler preparation for an urgent sample.
• When you want to prepare and stain a smear using a regular sample tube, micro collection sample tube or Raised Bottom Tube.
1. If the sample tube holder has not been ejected, press the [Mode Switch] button on the front of the main unit.
2. To change the slide preparation mode, touch [Select mode].
3. Touch [Smearing and staining].
4. Touch [OK].
5. Touch [Manual] and verify the smear preparation settings.
• For micro collection tubes.
• Uncheck [Read barcode] and enter the sample number.
• Select [Cap Open].
• For Raised Bottom Tubes, select [RBT].
6. Touch [OK].
7. Mix the sample according to your laboratory's protocol.
8. If [Cap Open] is selected or the smear will be prepared from a micro collection sample tube, open sample tube cap.
9. Set the sample tube in the sample tube holder.
• Regular sample tubes and RBT samples are placed in the front tube holder.
• Micro collection tubes are placed in the rear tube holder.
10. Press the [Start] button on the front of the main unit
11. Following aspiration, the sample tube holder will eject, and the sample tube can be removed.
12. To process additional manual samples, return to step 5.
• For RBT: touch [Manual], deselect [RBT], then touch [OK]
13. To return to sampler mode processing, press the [Mode Switch] button on the front of the main unit
14. The prepared smears will be loaded into the magazine. When preparation of all smears is completed, the magazine containing the smears is ejected to the storage location for the slide preparation mode used. Retrieve the magazine that contains the smears.

C- Smear Only:

Use this mode when want to prepare a smear using a regular sample tube, micro collection sample tube or Raised Bottom Tube,
1. If the sample tube holder has not been ejected, press the [Mode Switch] button on the front of the main unit.
2. To change the slide preparation mode, touch [Select mode].
3. Touch [Smearing].
4. Touch [OK].
5. Open the manual magazine holder cover.
6. Pull out the manual magazine holder and load an empty magazine.
7. Push in the manual magazine holder, then close the manual magazine holder cover 8. Ensure the status display LED of manual magazine holder is green.
9. Touch [Manual] and verify the smear preparation settings,
10. Touch [OK].
11. Press the [Start] button on the front of the main unit.
12. For additional smears, follow steps 5 - 11, using the other manual magazine holder. 13. To return to sampler mode processing, press the [Mode Switch] button on the front of the main unit.
14. The prepared smears can be removed from the manual magazine holder upon completion

PROCEDURE NOTES:

Slide stain and distribution quality should be evaluated every day by each slide review performing CLS on a slide-by-slide basis. The slide should be microscope-ready, precipitate-free, with appropriate cell color, superior cell distribution and good morphology. If any criterion in the cell distribution and stain quality is poor, notify supervisor as slide making/staining adjustments may be needed.

REFERENCES:

CAP Accreditation Program – Hematology and Coagulation Checklist 8.24.2023

Automated Hematology Analyzer XN-3100™ Quick Guide

CAP Checklist Requirements

HEM.34300 Blood Film Quality

All Revision Dates

1/26/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Origination	12/14/2023	Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
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L.HEM 2.4 Complete Blood Count and Differential Review Criteria

PRINCIPLE:

All hematology laboratories have accepted guidelines ("rules" and "checks") or applied criteria for review of Complete Blood Count (CBC) and differential results from automated hematology analyzers. Using a consensus study from (ISLH) International Society for Laboratory Hematology (which includes laboratories servicing tertiary care hospitals, oncology hospitals, community hospitals, children's hospitals, and doctor's offices) in conjunction with reviewing historical hematology results from (VCMC) Ventura County Medical Center patient population and input from hospital physicians and laboratory pathologists, these review criteria rules for VCMC were adopted.

Decision rules built into VCMC Sysmex are generated by patient values, patient history, instrument suspect flags, messages codes or specimen abnormalities. Rules which trigger a review of automated results can be caused by a variety of situations potentially leading to further testing or blood smear review in efforts to provide optimal patient care.

A delta limit is an amount by which the most recent test result may differ from a previous test result before triggering a delta check. Delta checks are a way of monitoring pre-analytical quality assurance for testing of the patient sample and validating the analyzer result. Delta limits at VCMC were set to monitor WBC, Hemoglobin, Hematocrit, MCV and Platelet parameters.

PROCEDURE:

DELTA CHECKS

The following delta limits are setup in the LIS system (Cerner) and will NOT flag on the Sysmex

instrument print out. Delta limits are often exceeded due to an intravenous line or a recent transfusion. A patient's medical condition or medication can also trigger delta checks such as dehydration, dialysis, neupogen etc.

The *corrective action* for delta checks is to evaluate specimen integrity (check for clots, lipemia, icterus, QNS or stability limit) and check patient status or history to identify the cause of the delta flag. Add comments in the LIS system such as result checked, post-partum, nurse notified, patient transfused, etc. to confirm that laboratory personnel are properly performing quality assurance on released patient results.

Hematology Delta Limits

	Delta Limit	Time Period (within)
WBC	50%	7 days
HGB	2 gm/dL	7 days
HCT	20%	7 days
MCV	3fL	45 days
PLT	50%	7 days

REVIEW HIGH/LOW AND CRITICAL RESULTS

Review action limits and critical are a guide to inform the physician that a CBC result(s) is/are abnormal. Possible causes of abnormal parameters:

- High RBC, HGB or HCT -- dehydration, polycythemia, shock, chronic hypoxia
- Low RBC, HGB or HCT -- anemia, thalassemia and other hemoglobinopathies
- Low MCV -- microcytic anemia
- High MCV -- macrocytic anemia, liver disease
- Low WBC -- sepsis, marrow hypoplasia
- High WBC -- acute stress, infection, malignancies
- Low platelets -- risk of bleeding
- High platelets -- risk of thrombosis

The *corrective action* for a review low/high majority of the time is to review the blood smear and confirm automated results. Some parameters may require a manual differential. For critical results, corrective action, see hematology **Critical Results Procedure**.

Hematology Review & Critical Values

	Critical Low	Critical High	Review Low	Review High	Review Low/High Corrective Action
WBC/ CWBC	≤1.0		≤2.0	≥30.0	Perform manual differential
RBC			≤2.00	≥8.50	Perform RBC morphology if necessary
HGB (age < 65	≤6.5	≥23.0			

yrs.)					
HGB (age ≥ 65 yrs.)	≤6.8	≥23.0			
HCT	≤18.0	≥70.0			
MCV (age > 2 mos.)			<65	>110	Perform RBC morphology if necessary
MCV (age < 2 mos.)			<65	>120	Perform RBC morphology if necessary
MCHC				≥37.8	Low MCHC and normal MCV check patient history and for possible contamination. High MCHC see Spurious Results Protocols.
PLT	≤20	≥700	<100	>700	Check platelet histogram
RDW				>22	Perform RBC morphology if RBC Morph not performed within 45 days.
Neutrophil Absolute (NE#)	<0.5			≥20.0	Perform manual differential
Lymphocyte Absolute				>7.0	Perform slide review
Automated NRBC				>3.0	Perform slide review

XN-3100 Result Interpretation

The XN-3100 Flagging Interpretation Guide is designated to serve many objectives including:

- Providing users with an explanation of criteria used for the XN-L Series Interpretive Program (IP) Messages.
- Suggesting actions to be taken when samples generate IP messages.
- Suggesting action to resolve sample related Problems.

VCMC laboratory is selecting abnormal patient results and patient samples which the automated analyzer could not verify. The rules assist in reducing the number of hematology result reviews and subsequent procedures performed, without losing any useful clinical patient data.

Corrective actions for each rule situation vary based on the full clinical picture and suggestive actions are listed in the table below.

VCMC XN-3100 Decision Rules

Flag/ Notation	Meaning / Description	Suggested Action
[----]	Indicates that analysis error or parsing error has occurred, and the value cannot	Check sample for clots, redraw, if necessary, cancel order due to specimen

	be displayed	integrity and reorder.
[++++]	Out of range indicate that the data cannot displayed because the value exceeds the linearity.	For WBC, RBC, HGB, PLT, Ret dilutes the sample and rerun results above linearity. For HCT report calculated HCT=(RBCXMCV)/10
[*]	Indicates that the reliability of the data is low.	Check sample for clots, redraw, if necessary, cancel order due to specimen integrity and reorder.
[ ]	No order / or specimen not received in Cerner	Check the order and log in the specimen
Abnormal, WBC Abn Scattergram	Clustering in WDF scattergram is abnormal dashes (-) or asterisk (*) may appear in place of data that was not calculated. This flag can appear due to increased abnormal cells, unlysed RBCs, Plt clumps, interfering substance.	1-Dashes (--): rerun the specimen, performing a MDIFF 2- Asterisk (*): Slide review for abnormal cells or PLT clumps to estimate the WBC and PLT counts, performing a MDIFF. 3- if no abnormalities are found and WBC, PLT estimate is consistent with analyzer result with (*) may be reported.
NRBC?	NRBC Present only appears when the NRBC result (NRBC/100 WBC) greater than 0.01/100 WBC.	The XN-Series analyzers identify and count NRBCs simultaneously while counting WBCs. No further correction of the WBC count is required. If NRBCs are greater than 0.01/100 WBC, the lymphocyte counts are corrected. An uncorrected WBC count can be found in the Service/WNR tab of the Browser Screen. Use the TNC-N as the uncorrected WBC count, if needed, in manual correction calculations for NRBCs or megakaryocytes.
IG Flag	The IG Present message indicate the threshold for the IG% or IG# exceed 5% or 0.5 x10^3/µL.	1. Scanning the peripheral smear for the presence of immature granulocytes, promyelocytes, myelocytes and metamyelocytes band cells. And in increased numbers toxic granulation or vacuolation of neutrophils and other abnormal cell. 2. If the IG% or IG# has an asterisk (*), verify differential results by scanning the slide for abnormal cells and performing a manual

		differential if abnormal cells are observed. 3. If no abnormalities are found when reviewing the smear and the analyzer results are consistent with smear review findings, the results with asterisks (*) may be reported.
Blasts/ Abn Lympho?	The Blasts / Abn Lympho message indicates that the analyzer has detected abnormal clustering in the region for blasts and abnormal lymphocytes in the WDF scattergram. An asterisk (*) appears next to the Neutrophil, Lymphocyte, Immature Granulocyte and Monocyte % and #. The asterisk (*) indicates these results may be unreliable and should be confirmed.	1. Scanning the peripheral smear for the presence of blasts, lymphoblasts, myeloblasts, and myelomonoblasts, immature granulocytes, promyelocytes, myelocytes, metamyelocytes, atypical or immature lymphocytes, other abnormal cells. 2. If no abnormalities are found when reviewing the smear and analyzer results are consistent with smear review findings, the results with asterisks (*) may be reported. 3. If dashes (— —) are in place of numeric data, verify differential results by repeating the sample or performing a manual differential.
Left Shift	The Left Shift message indicates that the analyzer has detected abnormal clustering in the region for left shift (bands) in the WDF scattergram. When bands are present, they are included in the neutrophil population. If the WBC is <0.50 x 103/µL in the Whole Blood (WB) mode or <0.20 x 103/µL in the Low WBC (LW) mode the Left Shift flag will not be generated. An asterisk (*) appears next to the Neutrophil and Eosinophil % and #. The IG% and IG# may also have an asterisk. The asterisk (*) indicates these results may	scanning the peripheral smear for the presence of: • band cells in increased numbers. • toxic granulation or vacuolation of neutrophils. • other abnormal cells. 2. If no abnormalities are found when reviewing the smear and analyzer results are consistent with smear review findings, the results with asterisks (*) may be reported. 3. If dashes (— —) are in place of numeric data, verify differential results by repeating the sample or performing a manual differential.

	be unreliable and should be confirmed. .	
Atypical Lympho?	Indicates that the analyzer has detected significant clustering in the region for atypical lymphocytes that is in the upper left lymphocyte region on the WDF scattergram. An asterisk (*) appears next to the Neutrophil, Lymphocyte, Monocyte, Eosinophil and Immature Granulocyte % and #. The asterisk (*) indicates these results may be unreliable and should be confirmed.	1. Scanning the peripheral smear for the presence of: • atypical or variant lymphocytes • abnormal or atypical monocytes • immature lymphocytes, such as seen in ALL or CLL • immature monocytes • smudge cells • other abnormal cells 2. If no abnormalities are found when reviewing the smear and analyzer results are consistent with smear review findings, the results with asterisks (*) may be reported. 3. If dashes (— —) are in place of numeric data, verify differential results by repeating the sample or performing a manual differential.
RBC Abnormal Distribution	The histogram pattern from RBC channel is abnormal or when RBC <0.50 x10^6/ µL. Dashes (-) appear in place of the RDW-SD, RDW-CV. This may cause the RBC, HCT, MCV, MCH, MCHC, RDW-SD, RDW-CV to be marked with (*).	1-Scan the peripheral smear for presence of abnormal RBC morphology such as: anisocytosis, fragmented RBCs, poikilocytosis, rouleaux. 2- If no abnormalities are found report the result with (*). 3- If (--) are in place of numeric data repeating the sample or reporting RBC morphology from smear review.
Abnormal, Dimorphic Population	Dashes (-) appear in place of the RDW-SD, RDW-CV. Certain RBC to be marked with an (*)	1-Scan the peripheral smear for presence of abnormal RBC morphology such as: anisocytosis, fragmented RBCs, poikilocytosis, rouleaux. Multiple RBC populations after recent blood transfusion. 2- If no abnormalities are found report the result with (*). 3- If (--) are in place of numeric data repeating the sample or reporting RBC

		morphology from smear review the results with asterisks (*) may be reported 4- If the RBC Morphology is normal
RBC Agglutination?	The RBC Agglutination is determined by calculation and size comparison of certain RBC items (MCHC, MCH, RBC An (*) appears next to the RBC, MCV, HCT, MCHC, and RET#	1-Scan the peripheral smear for presence of agglutinated RBCs. 2- If agglutinated RBC s present, warm the sample at37°C for 15-30 minutes then rerun the specimen 3- In cases with high cold agglutination titers a dilution or Plasma replacement using warm CELLPACK DCL. 4- In case warm- reacting antibody has caused agglutination use room temperature CELLPACK DCL for Plasma replacement.
Turbidity/HGB interference	Occurs when MCHC is>37.5 g/dL indicate that turbidity may be present in the diluted and lysed sample. An (*) appears next to HGB, MCH, MCHC.	*See Troubleshooting Chart (Page 8)
Fragments?	The Fragments determined from RET Scattergram and/or by calculation and size comparison of certain RBC and PLT items (MCV, RDW-SD, MCHC, RBC)	1-Scan the peripheral smear for the presence of fragmented RBCs and other poikilocytosis. 2-report significant RBC morphology.
RET Abn Scattergram	An (*) appears next to RET%, RET#, IRF, and RET-He which indicts that possible presence of NRBC, Howell-Jolly Bodies, or parasites.	1-rerun specimen with dilution order from action menu. 2- dilute sample 1:5 with CELLPACK DCL. Multiply the RET# by dilution factor and report the result. 3-if the flag not eliminated or RBC count is <.50x10^6/µL review the peripheral smear.
PLT Abnormal Distribution	The PLT Abn Distribution indicate that calculation and size comparison of certain PLT items and MPV.	1. Re-analyze the sample with CBC and PLT-F. By ordering the CBC and PLT-F the platelet measurement is done using a nucleic acid stain specific for platelet organelles and flow cytometry. The PLT-F result may be reported with no further action. 2. If on rerun an asterisk (*) is present scan the peripheral smear to estimate the platelet

		count and review for the presence of abnormal RBC or PLT morphology such as: • large or giant platelets • small platelets • platelet clumps • fragmented RBCs • microcytic RBCs • parasites 3. If no abnormalities are found when reviewing the smear and the analyzer platelet result is consistent with smear review findings, the results with asterisks (*) may be reported. 4. If platelet estimate does not confirm accuracy of analyzer count, confirm with an alternate method such as a manual platelet count. Report any clinically significant RBC and/or PLT morphology. 5. If platelet clumps have interfered, check the specimen for clot, prewarm specimen, vortex, and rerun or perform slide review from prewarmed sample for WBC and PLT estimate. NOTE: If necessary, reporting results that cannot be measured or calculated (e.g., dashes [— —] in place of results) by using a code for "do not report" or "not measured" in place of the suppressed results
PLT clump	An (*) appears next to PLT, MPV. Dashes may appear next to MPV	1. Re-analyze the sample with CBC and PLT-F. 2-Check the specimen for clot. Prewarm specimen, vortex, and rerun. 3-perform slide review from prewarmed

		sample for WBC and PLT estimate.
BF WBC abnormal Scattergram	An (*) appears next to WBC-BF. Dashes may appear in place of data.	1-Rerun the specimen. 2-Diluting the sample with CELLPACK DCL. 3-Performe manual cell count. 4- If no abnormalities are found report the result with(*).

- **Troubleshooting Chart**

Pattern of Results	**Encountered in**
Low or Normal MCV High MCHC (>37.5 g/dL)	-Hemolysis - Plasma electrolyte abnormalities (i.e., low sodium) affect hematocrit results. - Severe lipemia. - Icterus. -Severe leukocytosis affecting hemoglobin measurement. - Abnormal plasma protein precipitation affecting hemoglobin measurement.
High MCV High MCHC (>37.5 g/dL)	-RBC Agglutination -Rouleaux

Troubleshooting Chart		
low Sodium Affecting Hematocrit?	**RBC Agglutination?**	**Severe Lipemia, Icterus, Abnormal Protein or Leukocytosis Affecting Hemoglobin Measurement or Hemolysis?**
1. Perform a 1:5 dilution of sample with CELLPACK DCL 2. Allow the dilution to equilibrate for ten to fifteen minutes 3. Rerun after equilibration 4. Correct results for dilution factor prior to reporting. NOTE: MCV, MCH, MCHC, RDW-SD, RDWCV, IPF%, MPV, Ret-He, IRF and differential percent results are **unaffected by dilution and do not require correction**	1. Prewarm at 37°C for fifteen to thirty minutes then rerun 2. Severe cold agglutinins or rouleaux may require dilution or plasma replacement with CELLPACK DCL. 3. For severe cold agglutinins, additional incubation at 37°C may be necessary following dilution or plasma replacement.	1. Perform a 1:5 dilution of sample with CELLPACK DCL 2. Repeat diluted sample 3. Correct results for dilution factor prior to reporting. Lipemia or Icterus Only Perform a plasma replacement procedure. Hemolysis: Recollect a new sample.

PROCEDURE NOTES:

Misleading results can occur if:

- The specimen is not properly collected, stored, or transported.
- Specimen contains clots (which causes falsely depressed results for all parameters). Always use good laboratory practices for inspecting specimens for clots and verifying results.
- Specimen is not properly mixed. Do not bypass or circumvent the automated mixing process used on the analyzers.
- Sample exceeds the reportable/measuring range. These results may be remedied by performing sample dilution.
- Specimen contains pseudomacrocytosis (due to microclots, cold agglutinins, rouleaux, or osmotic matrix effects), pseudoleukocytosis (due to platelet agglutination, giant platelets, unlysed erythrocytes, nucleated erythrocytes, megakaryocytes, red cell inclusions, cryoproteins, circulating mucin), erroneous hemoglobin and indices (due to lipemia or leukocytosis), falsely low red cell concentration and hematocrit (due to in vitro hemolysis or extreme microcytosis), and other rare clinical conditions.

REFERENCES:

Sysmex XN Series Flagging Guide Document Number:CF-07937 Septmber 2023

Cornbleet Joanne, M. D; "Spurious Results from Automated Hematology Cell Counters." Laboratory Medicine, Vol. 14, No,8 August1983.

CAP Accreditation Program – Hematology and Coagulation Checklist 08.242023

Complete Blood Count using HMX. 2007-2008NHANES. www.cdc.gov/nchs/data/nhanes/nhanes_07_08/cbc_e_met.pdf

CAP Checklist Requirements

HEM.30150 Spurious Results

HEM.30200 Red Cell Indices

HEM.30250 Reportable Range

HEM.34200 WBC Differential Verification

HEM.35150 Spurious Results - Retics

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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L.HEM 3.1 White Blood Cell Count and Platelet Estimates

PRINCIPLE:

Unusual patient samples containing interfering substances or abnormal cells may produce erroneous results on automated hematology cell counters. When such samples are encountered, the incorrect parameters must be investigated and assayed by alternate methods or treatments.

Recognition of these erroneous CBC and differential results by the technologists not only prevents reporting of incorrect results but may also provide important patient information regarding underlying causes. The objective of this procedure is to demonstrate methods for reprocessing the problem specimens in the most appropriate way to obtain reliable results.

When reviewing a blood smear, peripheral estimation of the white blood cells (WBC) and platelets (PLT) should be done to check the accuracy of the actual count.

SPECIMEN:

A Wright-stained blood smear made from EDTA anti-coagulated blood; preferably within 1 hour from blood collection to avoid distortion of cell morphology.

REAGENTS/MATERIALS:

Cellavision DI-60

Microscope, Low power 10X objective and 50X and 100X oil immersion objectives

Cell differential counter

Immersion Oil

Calculator

QUALITY CONTROL:

The quality of every slide should be evaluated by each CLS on a slide-by-slide basis. The slide should be microscope-ready, precipitate-free, with appropriate cell color, superior cell distribution and good morphology. If any criterion in the cell distribution and stain quality is poor, notify the supervisor as slide making/staining adjustments may be needed.

PROCEDURE:

A. WHITE BLOOD CELL (WBC) ESTIMATE

1.	Place the stained slide (specimen side up) on the Cellavision DI-60 or microscope stage.
2.	See Cellavision DI-60 Section **Hem 5.1** Using The Microscope: Focus the microscope on the 10X objective (low power). Examine the feathered edge of the smear to determine blood film adequacy. If the number of white cells on the feathered edge exceeds 2-3 times the number per field of white cells in the monolayer area, another blood smear must be remade and evaluated. **NOTE:** Incorrectly prepared films may have too many large cells at the film edges, leaving relatively smaller cells, such as lymphocytes, in the center resulting in inaccurate manual differential counts.
3.	WBC estimation is performed using high power 50X oil immersion field (OIF) objective.
4.	Count the number of WBCs in ten (10) fields of the stained smear.
5.	Calculate the WBC estimate. See Calculations below for formula. This number should be within ±25% of the actual white cell count. If it is not within this range, the white blood cell count, and the estimation should be repeated.

B. PLATELET (PLT) ESTIMATE

1.	Place the stained slide (specimen side up) on the Cellavision DI-60 or microscope stage.
2.	See Cellavision DI- 60 Section Hem 5.1. Using The Microscope: Focus the microscope on the 10X objective (low power). Examine the feathered edge of the smear to determine blood film adequacy. If the number of white cells on the feathered edge exceeds 2-3 times the number per field of white cells in the monolayer area, another blood smear must be remade and evaluated. **NOTE:** Incorrectly prepared films may have too many large cells at the film edges, leaving relatively smaller cells, such as lymphocytes, in the center resulting in inaccurate manual differential counts.
3.	Check the smear for platelet clumps or platelet satellitism; if present, do not perform platelet estimate. See **HEM 3.5 – Platelet Clumping and Satellitisms**.

4.	PLT estimation is performed using high power 100X oil immersion field (OIF) objective.
5.	Count the number of PLTs in five (5) fields of the stained smear.
6.	Calculate the PLT estimate. See Calculations below for formula. This number should be within ±50% of the platelet count. If the estimate is within range, report the automated platelet count and remove any flags which may be present in Cerner. MPV should be reported as "Not reported."
7.	If PLT count is not within ±50% of the PLT estimate range, a manual platelet count should be performed.

CALCULATIONS:

White Blood Cell (WBC) & Platelet (PLT) Estimate Calculations

WBC Estimate (50x oil immersion) = (Sum of WBC's counted in 10 fields) x 300

PLT Estimate (100x oil immersion) = (Sum of PLT's counted in 5 fields) x 3,000

Examples:

WBC	**Total Cells Counted (10 fields - 50x OIF)**	**Calculations**	**WBC Estimate**	**Automated Results**	**Actions**
Example A	240	(240) x (300) = 72,000	**72,000**	43,000	Repeat all testing
Example B	26	(26) x (300) = 7,800	**7,800**	9,000	Release automated count
PLT	**Total Cells Counted (5 fields - 100x OIF)**	**Calculations**	**PLT Estimate**	**Automated Results**	**Actions**
Example C	110	(110) x (3,000) = 330,000	**330,000**	296 x 10^3/µL	Release automated count
Example D	23	(23) x (3,000) = 69,000	**69,000**	28 x 10^3/µL	Perform manual PLT count

LIMITATIONS:

Sampling errors, uncontrollable errors in cell distribution on the blood film, and human inconsistency in cell interpretation can produce inconsistent cell review results.

REFERENCES:

Leukocyte Differential Count, NCCLS Document H20-A, Vol. 12 No. 1, March 1992.

Brown, Barbara A., Hematology: Principles and Procedures, Lea and Fibiger Book Publisher, Sixth Edition,

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Hoffman, Ronald, and Hematology: Basic Principles and Practice, Second Edition, Churchill Livingston Inc., 1995.

McPherson and Pincus. Henry's Clinical diagnosis and Management by Laboratory methods. 22nd edition. 2012

SOP BHHRL/005PR01 Quality Control of May-Grunald Giemsa Stain.

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.30150 Spurious Results

HEM.30300 Platelet Abnormalities

HEM.30350 Spuriously High WBC Concentration

HEM.30400 Platelet Count Verification

HEM.33350 PLT Estimate

HEM.34300 Blood Film Quality

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Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 3.2 Platelet Count – Manual Methods

PRINCIPLE:

Unusual patient samples containing interfering substances or abnormal cells may produce erroneous results on automated hematology cell counters. When such samples are encountered, the incorrect parameters must be investigated and assayed by alternate methods or treatments.

Recognition of these erroneous CBC and differential results by the technologists not only prevents reporting of incorrect results but may also provide important patient information regarding underlying causes. The objective of this procedure is to demonstrate methods for reprocessing the problem specimens in the most appropriate way to obtain reliable results.

Microscopic counting of platelets (PLT) in a counting chamber after the lysis of red blood cells in ThromboCount solution allows for quick, easy, clean, and precise counting of platelets.

SPECIMEN:

Whole blood collected in EDTA anticoagulant (Lavender top tube)

Whole blood collected in Sodium Citrate anticoagulant (Blue top tube)

REAGENTS/MATERIALS:

Microscope

Thrombo-TIC® vial (prefilled with 990µL of ThromboCount solution)

10 µL Pipette and pipette tips

In CYTO C-Chip (Neubaeur) hemocytometer

Low power 10X objective and 40X objectives

Cell differential counter

Calculator

PROCEDURE:

1.	Using a 10µL pipette transfer 10µL of well mixed whole blood sample to a prefilled Thrombo-TIC® vial.
2.	Invert and shake the Thrombo-TIC® vial to mix the contents.
3.	Allow mixture to settle for a minimum of 5 minutes to complete red cell lysis.
4.	After 5 minutes mix the vial contents. Using a pipette, aspirate 10µL of the sample and load it into the Incyto C-chip disposable hemocytometer side A. Load another 10 µL on side B.
5.	Allow cells to settle in hemocytometer for 5-10 minutes.
6.	Place the loaded hemocytometer (specimen side up) on the microscope stage.
7.	Focus the microscope on the 40X objective. Count the number of platelets (PLT) in the recommended area of the hemocytometer in sides A and B. • Platelets in the ThromboCount solution appear nearly round, colorless with a darker rim, frequently have one or more dendritic processes, and are about 30% of a red blood cell size. • **NOTE:** For further clarifications, see **Procedure Notes** for PLT hemocytometer counting.
8.	If cells are overlapping or there are >500 platelets in the 1mm^2 area, to ensure accuracy, a dilution should be performed. Use the ThromboCount solution for performing dilutions. **FOR EXAMPLE:** A serial dilution may be performed by taking 10µL of the first diluted Thrombo-TIC® vial and injecting it into another Thrombo-TIC® vial. This would be a 1:100 dilution.
9.	If platelet estimate is significantly low (less than 20,000), a smaller dilution should be performed. Inoculate 20µL of whole blood sample into Thrombo-TIC vial. Use the Low PLT formula to calculate platelet count.
10.	Calculate the total number of PLT's. See **Calculations** for details. The manual PLT count should correlate within 25% of your platelet estimate. Order "Platelet Count Manual," and report the manual count. Result "See manual" for the automated platelet.

CALCULATIONS:

Hemocytometer Manual PLT Count Calculation

PLT count (EDTA tube) = () x 1,000 x dilution factor

PLT count (Sodium Citrate tube) = () x 1,111 x dilution factor

Low PLT (20µL sample) (EDTA tube) = () x 505

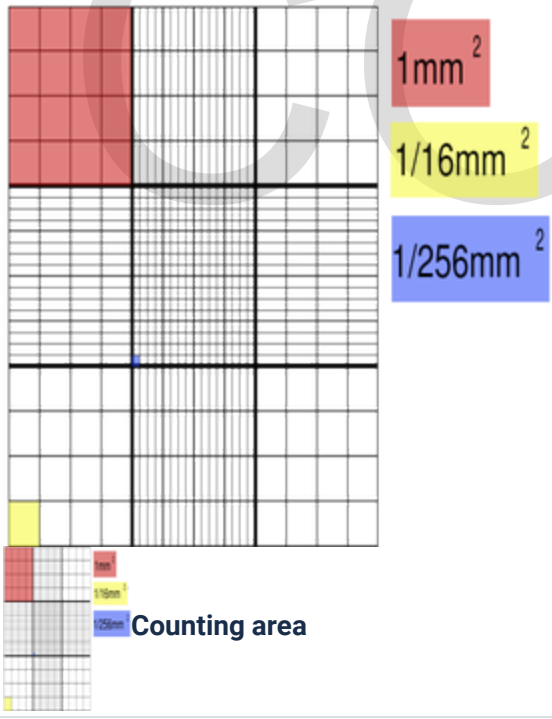
Low PLT (20µL sample) (Sodium Citrate tube) = () x 561

Examples:

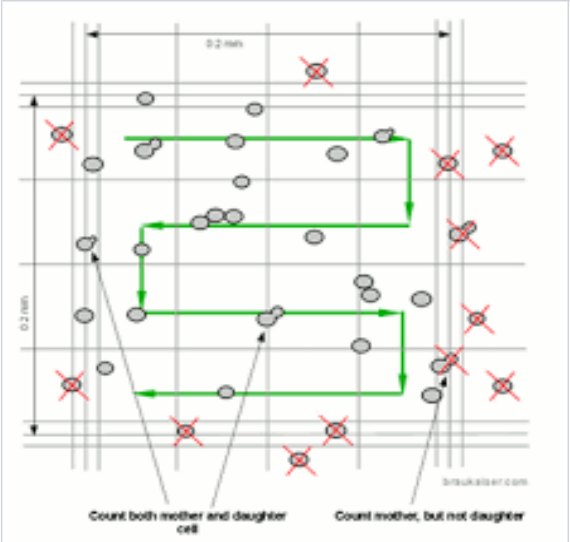
PLT	Cytometer Side A	Cytometer Side B	Calculations	Reported Results
Example A	322	294	() x (1,000) = 308,000	**308 x 10^3/µL**
Example B (20µL sample)	8	13	() x (505) = 5,303	**5 x 10^3/µL**
Example C	76	152	Platelet satellitism seen. Manual PLT count should not have be performed. Redraw w/ Sodium citrate tube.	
(recollected w/ Sodium Citrate)	86	99	() x (1,111) = 103,879	**104 x 10^3/µL**
Example D (1:100 dilution)	15	12	() x (1,000) x (100) = 1,350,000	**1,350 x 10^3/µL**

PROCEDURE NOTES:

PLT Hemocytometer Counting



PLT's should be counted in the 1/256 mm^2 squares. The entire 1 mm^2 area of the 1/256 mm^2 squares should be counted. Count both sides A and B of the hemocytometer. The difference between the two sides should be within 20%.



Cells are counted in a linear progression.
When counting ensure that the lines and chamber are bright, clean, and free of scratches. When cells are found on the border, only two adjacent corners should be counted, the other two should not.

LIMITATIONS:

Sampling errors, uncontrollable errors in cell distribution on the blood film, and human inconsistency in cell interpretation can produce inconsistent cell review results.

Strongly increased or decreased cell values can complicate correct cell counting. In these cases, a suitable dilution should be chosen and accounted for in the calculations.

Slides exhibiting platelet clumps, platelet clumping, or numerous fibrin stands should not be quantified as this can produce erroneous platelet counts.

REFERENCES:

Thrombo-TIC® - 1:100 Single Tests for Quick, Simple Clean and Precise Counting of Platelets. Bioanalytic GmbH packing insert.

iNCYTO C-Chip Disposable hemocytometer - System Neubauer Improved package insert.

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.30150 Spurious Results

HEM.30300 Platelet Abnormalities

HEM.30400 Platelet Count Verification

HEM.33250 Manual Counts – PLT/WBC

HEM.33330 Cell Count Controls

All Revision Dates

1/26/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 3.3 WBC Correction for Nucleated Red Blood Cells (NRBC's) and Megakaryocytes

PRINCIPLE:

Unusual patient samples containing interfering substances or abnormal cells may produce erroneous results on automated hematology cell counters. When such samples are encountered, the incorrect parameters must be investigated and assayed by alternate methods or treatments.

Recognition of these erroneous CBC and differential results by the technologists not only prevents reporting of incorrect results but may also provide important patient information regarding underlying causes. The objective of this procedure is to demonstrate methods for reprocessing the problem specimens in the most appropriate way to obtain reliable results.

Nucleated Red Blood Cells (NRBC's) and Megakaryocytes are counted within an automated Uncorrected White Blood Cell (UWBC) count. The obtained UWBC count must be corrected for the number of NRBC's or megakaryocytes in the circulation. This correction should be evaluated for when performing a WBC estimate and only corrected by manual calculation when required.

SPECIMEN:

A Wright-stained blood smear made from EDTA anti-coagulated blood; preferably within 1 hour from blood collection to avoid distortion of cell morphology.

REAGENTS/MATERIALS:

Microscope

Low power 10X objective and 50X and 100X oil immersion objectives

Cell differential counter

Immersion Oil

Calculator

QUALITY CONTROL:

The quality of every slide should be evaluated by each CLS on a slide-by-slide basis. The slide should be microscope-ready, precipitate-free, with appropriate cell color, superior cell distribution and good morphology. If any criterion in the cell distribution and stain quality is poor, notify the supervisor as slide making/staining adjustments may be needed.

PROCEDURE:

1.	Do not verify the automated White Blood Cell (WBC) count or differential parameters. Perform a White Blood Cell Estimate. See procedure **HEM 3.1 - White Blood Cell and Platelet Estimates.** If there is a presence of NRBC's or megakaryocytes and the estimate is not within ±25% of the automated white cell count, a manual correction will be required.
2.	Perform a *(100 cell)* Manual Differential according to procedure **HEM 2.5 - Manual Differentials and Slide Review**. Any NRBC's or Megakaryocyte should be counted using the designated NRBC key. Do **NOT** verify differential results!
3.	When the differential is completed fill out the electronic WBC Correction Worksheet.
4.	Right click WBC count in Cerner and ensure that the result is in numeric mode. Enter the corrected WBC count from the manual worksheet. Append comment **LWBCC – WBC corrected for nucleated red blood cell and/or megakaryocytes**.
5.	**Perform** results first, to ensure absolute differential counts are calculated, then **verify**.

CALCULATIONS:

WBC Correction for NRBC's and Megakaryocytes Calculations

Corrected WBC = (100 / (100 + NRBC's and/or megakaryocytes counted)) x UCWBC

LIMITATIONS:

Sampling errors, uncontrollable errors in cell distribution on the blood film, and human inconsistency in cell interpretation can produce inconsistent differential and cell review results.

REFERENCES:

Leukocyte Differential Count, NCCLS Document H20-A, Vol. 12 No. 1, March 1992.

Brown, Barbara A., Hematology: Principles and Procedures, Lea and Febiger Book Publisher, Sixth Edition, 1993.

Lee, Richard G., Windrobe's Clinical Hematology; Lea and Febiger Book Publisher, Ninth Edition, 1993.

Hoffman, Ronald, and Hematology: Basic Principles and Practice, Second Edition, Churchill Livingston Inc., 1995.

McPherson and Pincus. Henry's Clinical diagnosis and Management by Laboratory methods. 22nd edition. 2012

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.30100 Detection/Correction Procedure - WBC

HEM.30150 Spurious CBC Results

HEM.30300 Platelet Abnormalities

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
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L.HEM 3.4 Platelet Clumping & Satellitism

PRINCIPLE:

Unusual patient samples containing interfering substances or abnormal cells may produce erroneous results on automated hematology cell counters. When such samples are encountered, the incorrect parameters must be investigated and assayed by alternate methods or treatments.

Recognition of these erroneous CBC and differential results by the technologists not only prevents reporting of incorrect results but may also provide important patient information regarding underlying causes. The objective of this procedure is to demonstrate methods for reprocessing the problem specimens in the most appropriate way to obtain reliable results.

When reviewing a blood smear, peripheral evaluation of the platelets (PLT) should be done to check the accuracy of the actual count. Platelet clumps may adhere to one another for a myriad of reasons. It may be caused by poor collection technique (particularly with capillary blood samples), adequate mixing upon collection, platelet agglutinins, and occasionally, EDTA induced platelet clumping as an in vitro phenomenon.

If platelet clumps are identified on the blood smear, steps should be taken to eliminate the clumps because they can artificially decrease the platelet count (pseudo thrombocytopenia). In addition, platelet clumps may be counted as leukocytes and cause falsely increased white cell counts (pseudo leukocytosis). The measured mean platelet volume (MPV) will also be affected.

SPECIMEN:

A Wright-Giemsa-stained blood smear made from EDTA anti-coagulated blood.

Whole blood collected in EDTA anticoagulant (Lavender top tube)

Whole blood collected in Sodium (Na^+) Citrate anticoagulant (Blue top tube)

REAGENTS/MATERIALS:

CellaVision DI-60

Microscope, Low power 10X objective and 50X and 100X oil immersion objectives

Immersion Oil

Calculator

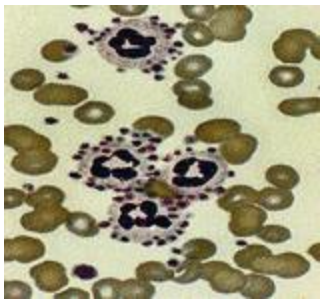
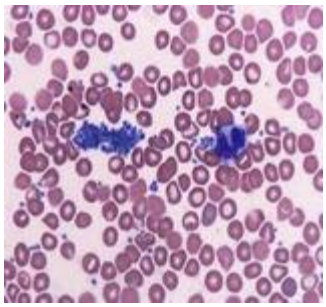
QUALITY CONTROL:

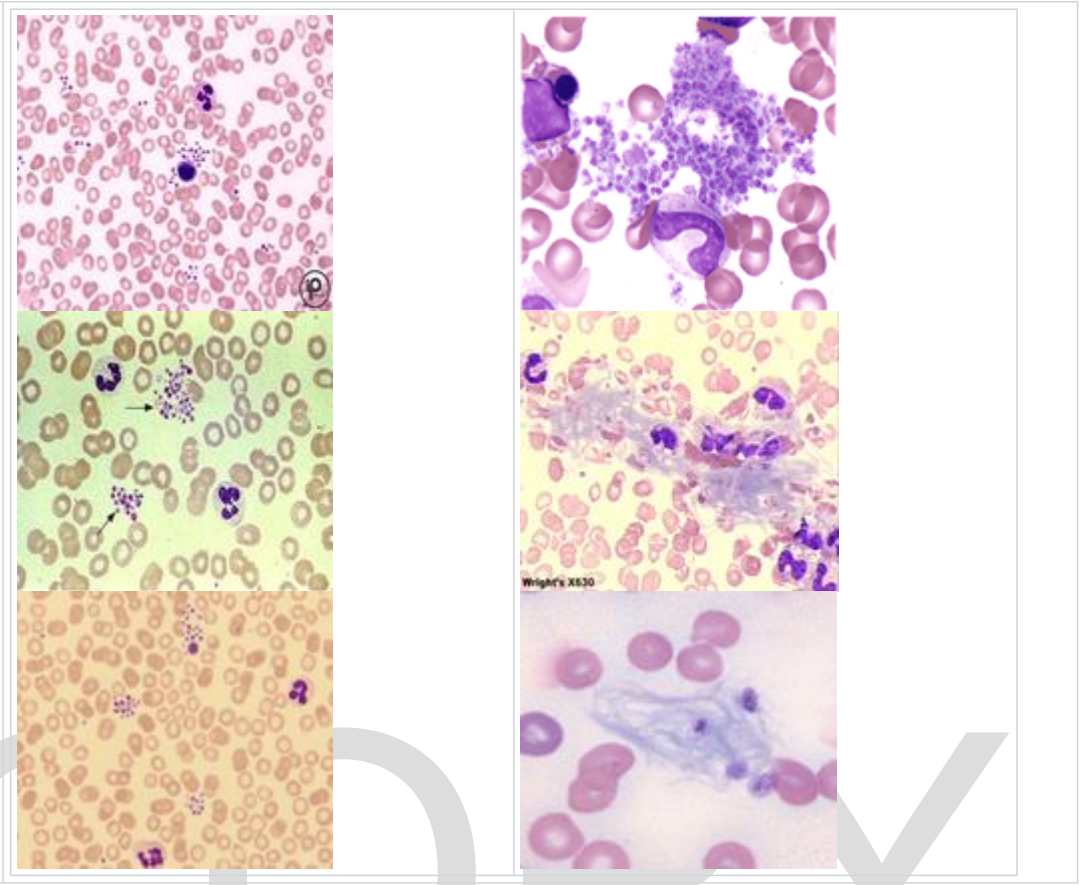
The quality of every slide should be evaluated by each CLS on a slide-by-slide basis. The slide should be microscope-ready, precipitate-free, with appropriate cell color, superior cell distribution and good morphology. If any criterion in the cell distribution and stain quality is poor, notify the supervisor as slide making/staining adjustments may be needed.

PROCEDURE:

A. EVAUATION OF PLT's ON BLOOD SMEAR

1. Refer to **Procedure 2.5 – Manual Differentials & Slide Review, (Step C.)** for guidelines on platelet evaluation.
   NOTE: Probable suggestions on corrective actions may be deduced by the platelet morphology seen of blood smear.

Typically, the appearance of platelet aggregates and platelet satellitism is attributed to EDTA induced in-vitro clumping. This is typically resolved by requesting a redraw using Sodium Citrate (Blue top tube).	The appearance of enormous clumps and fibrin strands are usually attributed to traumatic events or poor collection techniques. This may be resolved by simply requesting a redraw of the sample. In cases where a redraw may not be possible, see below for further guidelines.
	



B. CBC/CBCD with SODIUM CITRATE (blue top tube)

1.	Request a redraw of the patient specimen in blue (sodium citrate) and lavender (EDTA) top tubes.
2.	Order from **Department Order Entry** in Cerner tests **XBP (no spin)** - extra blue platelet and **CBC/CBCD**.
3.	Before running patient specimens, ensure the blue top tube meets the coagulation criteria of not being under or over-filled. Refer to **Procedure 2.1.1 – Specimen Rejection, Acceptability and Stability Criteria - Coagulation** for guidelines. Also, blue top tube MUST NOT be spun. Platelet counts cannot be verified from spun specimens.
4.	Load lavender and blue top tubes on XN3100 analyzers in accordance with **HEM-1.2.2 Running Patient Specimens**. **NOTE:** Warming specimen tubes or vortexing samples before testing may disperse platelet aggregates and generate acceptable specimen results.
5.	Based on the results from the sample run, report PLT count as follows: a. EDTA PLT (no flags), Na^+ Citrate PLT (no flags) → Report EDTA PLT result b. EDTA PLT (no flags), Na^+ Citrate PLT (flags for review) → Report EDTA PLT result c. EDTA PLT (flags for review), Na^+ Citrate PLT (no flags) → Multiply Na^+ Citrate WBC

and PLT by 1.1 and report calculated WBC and PLT. Report Na^+ Citrate MPV. Attach comments **LNACIT- Count performed on Sodium Citrate (Blue Top) Tube** to all three parameters. Report remaining CBC parameters from EDTA results.

d. EDTA PLT (flags for review), Na^+ Citrate PLT (flags for review) → Evaluate blood smear from the lavender top (EDTA) tube. Proceed as follows:

    i. If no platelet clumps are seen upon scan of blood smear. Perform a WBC and platelet estimate to verify counts, see **HEM 3.1 – White Blood Cell Count and Platelet Estimates.**

    ii. If platelet clumps are still present upon scan of blood smear, perform a WBC estimate to verify WBC count. Report PLT count as "See comment" and append comment. **LPCNP-Platelet Count not provided due to platelet clumping. Platelets appear ____**. In blank space give a general description of your platelet evaluation. For example, platelets appear (adequate, slightly decreased, slightly increased, e.t.c)

    iii. MPV should be reported as "Not reported." Report remaining CBC parameters from EDTA results.

NOTE: Evaluation of blood smears, differentials and morphologies MUST be performed from lavender top EDTA tubes.

PROCEDURE NOTES:

- In cases where redrawing the patient is not possible, ensure there is a recent (1-7 days) platelet result.
- Perform a WBC estimate to verify the WBC count. Report PLT count as "See comment" and append comment. **LPCNP-Platelet Count not provided due to platelet clumping. Platelets appear ____**. In blank space give a general description of your platelet evaluation. For example, platelets appear (adequate, slightly decreased, slightly increased, e.t.c) .
- Report on remaining CBC parameters.
- If the WBC count does not appear accurate, CBC MUST be canceled. (NO EXCEPTIONS)
- MPV should be reported as "Not reported."

CALCULATIONS:

Reported WBC count: WBC count (from Sodium Citrated tube) x 1.1

Reported PLT count: PLT count (from Sodium Citrated tube) x 1.1

LIMITATIONS:

Sampling errors, uncontrollable errors in cell distribution on the blood film, and human inconsistency in cell interpretation can produce inconsistent cell review results.

REFERENCES:

Leukocyte Differential Count, NCCLS Document H20-A, Vol. 12 No. 1, March 1992.

Brown, Barbara A., Hematology: Principles and Procedures, Lea and Febiger Book Publisher, Sixth Edition, 1993.

Lee, Richard G., Windrobe's Clinical Hematology; Lea and Febiger Book Publisher, Ninth Edition, 1993.

Hoffman, Ronald, and Hematology: Basic Principles and Practice, Second Edition, Churchill Livingston Inc., 1995.

McPherson and Pincus. Henry's Clinical diagnosis and Management by Laboratory methods. 22nd edition. 2012

SOP BHHRL/005PR01 Quality Control of May-Grunald Giemsa Stain.

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.30150 Spurious Results

HEM.30300 Platelet Abnormalities

HEM.30350 Spuriously High WBC Concentration

HEM.30400 Platelet Count Verification

HEM.33350 PLT Estimate

HEM.34300Blood Film Quality

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026

Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Effective	12/14/2023	Policy Area	Laboratory Services
Last Revised	1/26/2026		
Next Review	1/26/2028		

L.HEM 3.5 Pre-Warm Technique & Plasma Replacement

PRINCIPLE:

Unusual patient samples containing interfering substances or abnormal cells may produce erroneous results on automated hematology cell counters. When such samples are encountered, the incorrect parameters must be investigated and assayed by alternate methods or treatments.

Recognition of these erroneous CBC and differential results by the technologists not only prevents reporting of incorrect results but may also provide important patient information regarding underlying causes. The objective of this procedure is to demonstrate methods for reprocessing the problem specimens in the most appropriate way to obtain reliable results.

Lipemia, icterus, cold agglutinins and other interfering substances can interfere with the accurate determination of specific CBC parameters on most hematology analyzers. The Sysmex XN-3100 analyzer directly performs cell counts (WBC, RBC & PLT), measures Hemoglobin (HGB), Mean Cell Volume (MCV) and Mean Platelet Volume (MPV). The remaining CBC parameters are calculated from those results. To correct erroneous results seen when interference is detected, samples may be warmed using pre-warm technique or the sample plasma may be replaced with warm saline.

Typically, an MCHC greater than 36 g/dL can alert the scientist that interfering substances are detected. In the VCMC/SPH laboratory a MCHC greater than 37.8 must be corrected before any CBC parameters may be released.

SPECIMEN:

Whole blood collected in EDTA anticoagulant (Lavender top tube)

REAGENTS/MATERIALS:

Heat block (37°C)

Warm saline

Disposable pipettes

Sysmex XN-3100 approved microcentrifuge tubes (no caps)

A. 5mL graduated microcentrifuge tubes with caps.

PROCEDURE:

CBC results which indicate the presence of a cold agglutinin or interfering substances typically will flag for MCHC ≥ 37.5 g/dL. This result must be corrected before CBC results are released.

NOTE:

MCHC values greater than 36.0 g/dL may also indicate possible cold agglutinins and may need to undergo pre-warm technique. This can be determined on a case-by-case basis by a CLS experienced in hematology.
To determine whether a sample should be processed for pre-warm technique or plasma replacement:
Check if the sample in question was collected with another tube which may be spun (i.e., chemistry green top tube, yellow top tubes, etc.). **DO NOT** spin lavender top tube. The scientist should observe the supernatant of spun tube.

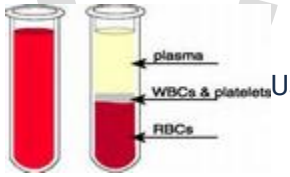
- If lipemia or icterus is seen, perform plasma replacement.
- If supernatant is clear, prewarm technique should be performed.
- If gross hemolysis is seen, request a redraw as RBC results will also be erroneous.
- If there is not a spun sample to observe, proceed with the prewarm technique, and if results do not correct, perform plasma replacement.
- In cases where the patient appears to have extremely strong interfering substances, and the initial CBC results appear to not be compatible with life, perform plasma replacement and see **STEP 8d**, before beginning plasma replacement procedure.

1. PRE-WARM TECHNIQUE

1.	Warm lavender top tube in 37°C heat block or incubator for 30 minutes.
2.	Rerun sample on XN- 3100 analyzer immediately after sample is removed from warm atmosphere.
3.	Proceed as follows:

	• If result correct (MCHC < 37.5 g/dL) proceed to step 4. • If results do not correct (MCHC > 37.5 g/dL) but appear to decrease significantly from initial MCHC results, return sample to heat block or incubator for an additional 30 minutes, and reanalyze. • If results do not correct (MCHC > 37.5 g/dL) and does not appear to be decreasing from initial MCHC result, perform plasma replacement.
4.	When results correct, verify all CBC results from warmed sample run and attach comment pneumonic **LWARM – Results corrected at 37 degrees,** to HGB, MCV and MCHC parameters.
5.	Release automated differential or perform manual differential/slide review according to standard VCMC protocol. See **HEM 1.2.2 – Running Patient Specimens – XN-3100** and **HEM 1.2.5 – Manual Differentials & Slide Review** for guidelines.

2. PLASMA REPLACEMENT

1.	Place an aliquot of CELLPACK-DCL or saline (can be found in the Blood Bank dept.) in a 37°C heat block or incubator.
2.	Aliquot a minimum of 1mL of the patient sample into a labelled 1.5 mL graduated microcentrifuge tube with caps.
3.	Place the patient sample microcentrifuge tube and a balance in the IEC Micromax microcentrifuge and spin at 3500rpm for 5 minutes.
4.	Carefully remove patient sample microcentrifuge tube from the centrifuge and mark the line to indicate the top of the plasma. Mark the bottom of the meniscus to obtain accurate results.
5.	 Using a transfer pipette, pipette patient's plasma without disturbing the buffy coat (WBC's and platelets) or red blood cells and discard plasma.
6.	Using a transfer pipette, add 37°C warm saline to microcentrifuge tube to the marked meniscus line.
7.	Thoroughly mix the saline replaced sample using a pipette. Then, transfer the sample to the Sysmex XN3100 approved microcentrifuge tubes (no caps) and run the sample in the manual mode. **NOTE:** DO NOT run plasma replacement sample under the original accession number, as this is a modified sample and should not be transmitted to Cerner.
8.	Compare cell counts WBC, RBC and PLT from plasma replacement result to the initial results. a. If cell count results increase significantly after plasma replacement, it may be that saline was not added to sample in sufficient quantities, and the procedure must be repeated. b. If cell counts results decrease significantly after plasma replacement, it may be because cells were mistakenly pipetted when discarding plasma, and procedure must be repeated.

	c. If results are comparable proceed to Step 9. d. In cases where the patient appears to have extremely strong interfering substances, and initial results were not compatible with life, comparing cell counts may not be possible. So, perform the plasma replacement procedure on a normal patient sample simultaneously and compare cell count results from the normal sample to verify your plasma replacement technique. **NOTE:** There are rare cases where a patient sample may require a subsequent (2^{nd}) plasma replacement due to an overwhelming number of interfering substances. In such instances, it is crucial to ensure that cell counts are not decreased due to poor technique.
9.	If plasma replacement technique is acceptable (cell counts are comparable), ONLY HGB, MCH and MCHC can be verified from the plasma replacement results. Append comment pneumonic **LCORIS - Results corrected for interfering substances** to the corrected parameters.
10.	The remaining CBC results should be verified from the original/initial results. If the patient's initial results were invalid, (as explained in **Step 8d**.) result remaining CBC parameters as Invalid and append comment pneumonic **LINT – Interfering substance present on all "invalid" results** to invalid results.
11.	Automated differentials, manual differentials, or slide reviews must be released or performed from the original sample and cannot be derived from plasma replacement sample.

LIMITATIONS:

- Patient whole blood samples exhibiting spherocytosis may have a MCHC>36.0 which will not correct, as this is a true value, not caused by interfering substances. This is determined by observing the peripheral smear and confirming the presence of spherocytes.
- Plasma replacement may cause erroneous results if the performing technique is not adequate. Cell count should be used to minimize and eliminate such errors.

REFERENCES:

NCCLS. H15-A3 Reference and Selected Procedures for Quantitative Determination of Hemoglobin in Blood. Approved Standard, 3^{rd} ed. Wayne, Pa; 2000

McPherson and Pincus. Henry's Clinical diagnosis and Management by Laboratory methods. 22^{nd} edition. 2012

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.30150 Spurious Results

HEM.30200 Red Cell Indices

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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VENTURA COUNTY HEALTH CARE AGENCY

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Next Review	1/26/2028
Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 4.1 Erythrocyte Sedimentation Rate Test – iSED

PRINCIPLE:

Erythrocyte Sedimentation Rate is a simple non-specific screening test that indirectly measures the presence of inflammation in the body. It reflects the tendency of red blood cells to settle more rapidly in the face of some disease states, usually because of increases in plasma fibrinogen, immunoglobulins, and other acute-phase reaction proteins. Changes in red cell shape or numbers may also affect the ESR.

When anticoagulated whole blood is allowed to stand in a narrow vertical tube for a period of time, the RBCs – under the influence of gravity - settle out from the plasma. The rate at which they settle is measured as the number of millimeters of clear plasma present at the top of the column after one hour (mm/hr). The RBCs sediment because their density is greater than that of plasma; this is particularly so, when there is an alteration in the distribution of charges on the surface of the RBC (which normally keeps them separate from each other) resulting in their coming together to form large aggregates known as rouleaux.

Rouleaux formation is determined largely by increased levels of plasma fibrinogen and globulins, and so the ESR reflects mainly changes in the plasma proteins that accompany acute and chronic infections, some tumors and degenerative diseases. In such situations, the ESR values are much greater than 20mm/hr. Note that the ESR denotes merely the presence of tissue damage or disease, but not its severity; it may be used to follow the progress of the diseased state, or monitor the effectiveness of treatment.

SPECIMEN:

Whole blood collected in EDTA anticoagulated (Purple/Lavender top tube) or BD Microtainer (false-bottom) MAP tubes.

EQUIPMENT/INSTRUMENT:

ALCOR Scientific iSED

QUALITY CONTROL:

Seditrol Control Level 1 & 2 (Stability: 31 days once opened), always stored at room temperature

PROCEDURE:

A. QUALITY CONTROL: QC must be valid for every 24 hours of patient testing.

1.	Remove Seditrol controls from iSED storage compartment.
2.	Place the two levels of controls on Hematology rocker for at least 25 minutes.
3.	Print ESR Worksheet in Cerner, by selecting **Worklist Request** icon.
4.	In Worklist Request, select **Task** in top left corner, **New Worklist**. Highlight **VCMC ESR - iSED** → **OK**. Then, select the **Print Icon** to print worklist. NOTE: It is not necessary to save the worklist upon exiting.
5.	After controls are well mixed, follow instructions **steps (4-7) of Procedure B. RUNNING PATIENT SPECIMENS.**
6.	Ensure QC is run and resulted in Cerner using the QC identifier located on the Worklist. The results of all levels of controls must be reviewed for acceptability before reporting patient results.

B. RUNNING PATIENT SPECIMENS

1.	Upon receipt of specimen, refer to procedure **Specimen Rejection, Acceptability and Stability Criteria** to verify specimen acceptability and stability.
2.	Visually inspect all specimens for clots.
3.	If specimen is acceptable mix specimen thoroughly, by allowing it to mix for a minimum of 5 minutes on Hematology rocker.
4.	Touch the **Add Sample** icon
5.	Wait until sample wheel rotates to position the next open slot in the sample entry port. **NOTE:** Load **CAPPED** tubes **ONLY**
6.	Insert barcoded tube with the barcode oriented to the right. A red light will illuminate and a distinctive beep will sound when the barcode is successfully recognized.
7.	Results will print out after analysis, record results on the VCMC Manual Heme Worksheet.
8.	Enter all patient results in Cerner applications under Accession Result Entry. **NOTE:** Sed Rate results are filed monthly and stored for a minimum of two years.

PROCEDURE NOTES:

The iSED tests are only verified within the following ranges:

iSED Sedimentation Rate Clinical Reportable Range		
Lower Range	**Upper Range**	Patient test resulted as: **less than 1 mm/hr** should be reported as: **<1** Patient test resulted as: **greater than 130 mm/hr** should be reported as: **>130**
1 mm/hr	130 mm/hr	

LIMITATIONS:

- Some interferences which increase ESR:
    - Increased level of fibrinogen, gamma globulins
    - Technical factor: mechanical vibration, high room temperature
- Some interferences which decrease ESR:
    - Abnormally shaped RBS (sickle cells, spherocytosis)
    - technical factors: low room temperature, delay in test performance, clotted blood sample, excess anticoagulant, or bubbles in tube

If a control is found to be "out of range" inspect specimen appearance, temperature (should be analyzed at room temperature) and expiration date. If all listed parameters are valid, (***attach comment: rerun same vial***) and rerun controls.

- If control continues to result as "outside of target range" (for the second time) proceed with each step as follows:

a. Open a new sample of that level of control and rerun (***attach comment: new bottle control***). If the new bottle control opened results outside of target range proceed to next step.

b. Notify staff when QC processes causes interruptions in workflow. During "off hours," call operator to notify Emergency Department and House Supervisor of possibly delay in patient results due to instrument malfunction.

NOTE: If any control is found out of range DO NOT rerun control more than 3 times without performing AND documenting corrective actions.

REFERENCES:

ALCOR Scientific, iSED Erythocyte Sedimentation Rate Analyzer, Operator's Manual. Cat 112-00101

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.19360Daily QC – Nonwaived Tests

HEM.20120QC Handling

HEM.20140QC Confirmation of Acceptability

HEM.20143QC Corrective Action

HEM.30250 Reportable Range

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
Policy Area	Laboratory Services

L.HEM 4.2 Cerebrospinal and Body Fluid Cell Counts – XN-3100

PRINCIPLE:

WBC and RBC cell counts provide extremely important information for the diagnosis and treatment of diseases involving CSF, serous, and synovial cavities. Infections, hemorrhages, and malignancies are the primary concerns.

Cell counts for cerebrospinal fluid (CSF) are obtained to assist in diagnosing central nervous system infection, tumors or vascular accidents. Body fluid (pleural, peritoneal, synovial, etc.) cell counts results are used to decipher between a transudate due to increased hydrostatic or decreased plasma oncotic pressure; and an exudate secondary to a wide variety of pleural diseases, e.g. increased capillary permeability, infection, infarction, rheumatoid disease, collagen disease; or secondary to malignancy.

Cell counts at VCMC laboratory may be performed by manual or automated methods.

The XN-3100 Body Fluid mode adds a quantitative, automated procedure for analyzing Body fluid through the fluorescent flow cytometry using side scattered light are used to determine the WBC counts. The DC detection method is used for the RBC counts.

SPECIMEN:

Acceptable specimen types for body fluid cell count and differentials are collected without anticoagulant or with EDTA:

CSF or Shunt fluid

Ascites or Peritoneal fluids

Pleural fluids

Pericardial fluids

Synovial or Joint fluids

NOTE: Other specimen types will ONLY be performed with pathologist approval. If the specimen amount received is not sufficient for all ordered testing, notify physician to specify which testing should be performed.

EQUIPMENT/INSTRUMENT:

Sysmex XN-3100 analyzer systems

PROCESSING SPECIMENS:

If the specimen received is a CSF fluid, distribute as follows:

1. For all CSF fluids, record the total volume of the specimen received.
2. Mix the sample for homogeneity.
3. Evaluate specimen color and character. For details, see **Procedure Notes**.
4. CSF is typically collected in sequential order. Tubes are labeled in the order drawn. Depending on the amount of CSF tubes received proceed with the following:

Containers	**Send outs / Serological Tests**	**Chemistries**	**Microbiology Cultures**	**Cell Counts, Differentials and Cytology**
One tube received	First, give sample to Microbiology department, then aliquot remaining specimen into the appropriate containers for the ordered testing.			
Two tubes received	**Tube 1**		**Tube 2**	
Three tubes received	**Tube 1**		**Tube 2**	**Tube 3**
Four tubes received	**Tube 1**	**Tube 2**	**Tube 3**	**Tube 4**

- Cell Counts are **ONLY** performed on the last collected tube and should not be performed on combined tubes or counted on any additional tubes.

QUALITY CONTROL:

- performed every 8 hours of patient testing. Sysmex XN-3100 Body Fluid Controls (XN CHECK™ BF)

PROCEDURE:

QUALITY CONTROL: For every **8 hours** of patient testing, 2 levels can be tested.

1.	Bring the QC material to room temperature for 15 minutes.
2.	Make sure the analyzer is in the" Ready" State. If ***new control sample is opened, place new expiration date on tube*** (see Heme Product Open Stability Table) HEM 2.1. open BF QC expired 30 days if it is stored refrigerated at 2°-8° C.
3.	Run QC XN CHEK BF See **Section HEM 2.1**
4.	Select Body Fluid, [OK], wait for the BF Background Check to complete.

RUNNING PATIENT SPECIMENS

1.	Upon receipt of specimen, refer to procedure **HEM 1.1 - Specimen Rejection, Acceptability and Stability Criteria** to verify specimen acceptability and stability. **NOTE:** Any samples not acceptable for specimen testing should be canceled and reordered. Refer to **HEM 1.4 - Canceling & Reordering Tests for Unacceptable Specimens** procedure for guidelines.
2.	Visually inspect all specimens for clots. If any clumps, debris or clots are seen, do **NOT** perform automated cell count testing. See manual cell count procedure.
3.	Press the [Mode Switch] button on the analyzer.
4.	Touch the [Change Analysis Mode] button.
5.	Select [Body Fluid].
6.	Touch [OK].
7.	Touch the [Manual Analysis] button on the control menu
8.	Confirm that 'Read ID' is checked, or uncheck 'Read ID' to enter the sample ID manually
9.	Mix the sample and place the tube in the appropriate sample tube holder.
10.	Press the start switch.

REPORTING RESULTS:

VCMC XN-3100 Linear Range

Parameter	Linear Range
RBC	**<2,000 - >5,000,000/µL**
WBC	**<3 - >10,000/µL**
TCBF	**<3 - >10,000 µL**

Body Fluids Cell Count Reference Ranges:

Reference intervals for body fluids Due to the unavailability of obtaining normal body fluid samples, it is difficult for laboratories to reference intervals. Adult reference intervals for body fluids are included from

a widely known textbook. According to C49-A "Analysis of Body Fluids in Clinical Chemistry", clinical laboratories have not established reference ranges for body fluids.

Reference ranges for body fluid types:

Fluids	RBC	TNC
CSF (Neonates)	0 – 10 cells/ µL	0 – 30 cells/ µL
CSF (Adults)	0 – 1 cells/ µL	0 – 5 cells/ µL
Serous Fluids (Pleural, Thoracic)	0 – 1000 cells/ µL	0 – 1000 cells/ µL
Serous Fluids (all others)	0 – 100 cells/ µL	0 – 150 cells/ µL
Synovial/Joint	0 – 2000 cells/ µL	13 – 180 cells/ µL

Neonate reference ranges for body fluid types:

Fluids	RBC	TNC
CSF (Neonates)	0 – 10 cells/ µL	0 – 30 cells/ µL

PROCEDURE NOTES:

VCMC Fluid Reported Color and Clarity

Color	Clarity
Colorless	Clear
Pale yellow	Slightly hazy
Yellow	Hazy
Pink	Cloudy
Red	Turbid
Other	Bloody

Xanthochromia: Xanthochromia is coloration of the cerebrospinal fluid (CSF) which distinguishes in vivo hemorrhage from a traumatic tap. Xanthochromia can only be determined from a spun specimen. Since cell counts cannot be performed from spun specimens, xanthochromia may be determined from spun chemistry aliquots.

NOTE: For CSF, append comment **L1BL4** (first collected tube is visibly bloodier than the last collected tube) if tube 1 is visible bloodier than tube 4.

LIMITATIONS:

- Cells in body fluids may undergo cell lysis if the following resting time is permitted:
  - Sitting after dilution >10 minutes
  - Sitting after plating >15 minutes
- If the specimen contains significant clots or tissue fragments, the cell count will be

compromised. Confirm with a pathologist before performing the cell count. If cell count is to be performed, it should be performed manually and append comment **LRQ** – Results Questionable Due to Specimen Condition and specify that the specimen was clotted.

- CELLPACK DCL should be used as the diluent.

Touch mode on the control menu then dispense.

Place the uncapped empty micro collection tube in the sample tube holder and press start. Analyzer dispense20µL. See Dispense function for pre dilution Mode in **HEM2.2**

REFERENCES:

XN-3100 series Quick Guide

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Cerebrospinal Fluid, analysis, routine – color and appearance, cell count and differential, College of American Pathologists. CAP.5M293

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Peritoneal Fluid Analysis, College of American Pathologists. CAP.5M293

Modified from Davidson, Israel and Henry, John B.: Todd-Sanford Clinical Diagnosis by Laboratory Methods, 15th edition, Philadelphia, 1974, W.B. Saunders Company.

Medical Laboratory Observer, Tips on Technology - "Cell Counts on Joint Fluids", August, 1983.

KJeldsberg, Carl R., Knight, Joseph A. **Body** Fluids - **Laboratory** Examination of **Amniotic**, Cerebrospinal, Seminal, Serous & Synovial Fluids, econd edition, American Society of Clinical Pathologists , Chicago, 1986

Kreig AF, Kjeldsberg CR. Cerebrospinal fluid and other body fluids. In: Henry JB, ed. Clinical Diagnosis and Management by Laboratory Methods, Philadelphia PA: W.B. Saunders Co.;1991:445-473

CAP Accreditation Program – Hematology and Coagulation Checklist 8.24.2023

CAP Checklist Requirements

HEM.35319 Diluting Equipment

HEM.35338 Background Checks- Manual Counts

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Step Description	Approver	Date

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Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Policy Area	Laboratory Services

L.HEM 4.3 Cerebrospinal and Body Fluid Cell Counts – Manual Method

PRINCIPLE:

WBC and RBC cell counts provide extremely important information for the diagnosis and treatment of diseases involving CSF, serous, and synovial cavities. Infections, hemorrhages, and malignancies are the primary concerns.

Cell counts for cerebrospinal fluid (CSF) are obtained to assist in diagnosing central nervous system infection, tumors or vascular accidents. Body fluid (pleural, peritoneal, synovial, etc.) cell counts results are used to decipher between a transudate due to increased hydrostatic or decreased plasma oncotic pressure; and an exudate secondary to a wide variety of pleural diseases, e.g. increased capillary permeability, infection, infarction, rheumatoid disease, collagen disease; or secondary to malignancy.

Cell counts at VCMC laboratory may be performed by manual or automated methods.

SPECIMEN:

Acceptable specimen types for body fluid cell count and differentials are collected without anticoagulant or with EDTA:

CSF or Shunt fluid

Ascites or Peritoneal fluids

Pleural fluids

Pericardial fluids

Synovial or Joint fluids

NOTE: Other specimen types will ONLY be performed with pathologist approval. If the specimen amount received is not sufficient for all ordered testing, notify physician to specify which testing should be performed.

REAGENTS/MATERIALS:

C-Chip (Neubaeur) Hemocytometer

10 µL Pipette and pipette tips

Microscope

40X microscope objective lens

Cell counter

VCMC Body Fluid Excel worksheet

PROCESSING SPECIMENS:

If the specimen received is a CSF fluid, distribute as follows:

1. For all CSF fluids, record the total volume of the specimen received.
2. Mix the sample for homogeneity.
3. Evaluate specimen color and character. For details, see **Procedure Notes**.
4. CSF is typically collected in sequential order. Tubes are labeled in the order drawn. Depending on the amount of CSF tubes received proceed with the following:

Containers	**Send outs / Serological Tests**	**Chemistries**	**Microbiology Cultures**	**Cell Counts, Differentials and Cytology**
One tube received	First, give sample to Microbiology department, then aliquot remaining specimen into the appropriate containers for the ordered testing.			
Two tubes received	**Tube 1**		**Tube 2**	
Three tubes received	**Tube 1**		**Tube 2**	**Tube 3**
Four tubes received	**Tube 1**	**Tube 2**	**Tube 3**	**Tube 4**

- Cell Counts are **ONLY** performed on the last collected tube and should not be performed on combined tubes or counted on any additional tubes.

QUALITY CONTROL:

- One level performed every 8 hours of patient testing, per performing CLS.
  Cell Chex Level 1-UC and Level 2 (Cerner **QC-90412** and **QC-90413** respectively)

PROCEDURE:

A. QUALITY CONTROL:

A. For every **8 hours** of patient testing, 1 level of body fluid QC should be performed **per** testing personnel.

1.	Remove one level of Chex-Cell control from fridge and warm at room temperature for 5-10 minutes. (Control levels are alternated monthly) **NOTE:** If ***new control sample is opened, place new expiration date on tube*** (see Heme Product Open Stability Table).
2.	After 5 -10 minutes, mix Chex-Cell control by inverting the tube and rolling the tube by hand a couple of times.
3.	Follow **steps 4-9** from **Section B – RUNNING PATIENT SPECIMENS.**
4.	Report calculated QC results under Accession Result Entry in Cerner. BF CELL CNT Level 1 accession: **QC-90412** BF CELL CNT Level 2 accession: **QC-90413** The results for one level of control must be reviewed for acceptability, per performing personnel before reporting patient results. **NOTE:** If any control is found out of range, see **Troubleshooting QC** below.

B. RUNNING PATIENT SPECIMENS

1.	Upon receipt of specimen, refer to procedure **HEM 1.1 - Specimen Rejection, Acceptability and Stability Criteria** to verify specimen acceptability and stability.
2.	Visually inspect all specimens for clots. If small or micro clots are seen, append comment **LRQ** to results**.** If large or significant clots are seen confirm with a pathologist before performing the cell count. If cell count is to be performed, append comment **LRQ**.
3.	If specimen is acceptable mix specimen thoroughly to evaluate fluid color and clarity. Enter the fluid type, macroscopic analysis AND methodology in Cerner to ensure that results trigger appropriately. For methodology, use: • **Manual:** manual hemocytometer testing • **Automated:** for XN-10 testing ONLY Select **PERFORM**. **NOTE:** Not performing the macroscopic evaluation in Cerner first, or selecting verify first for the

	macroscopic results, will cause the additional testing parameters to **NOT** be triggered.
4.	If the fluid type is CSF, Xanthochromia and total fluid volume should be resulted. Select **PERFORM**.
5.	Using a pipette, aspirate 10µL the patient sample and load into the Incyto C-chip disposable hemocytometer side A. Load another 10 µL on side B. **NOTE:** A separate pipette tip or tube may be coated with new methylene blue or 5% acetic acid and used to stain fluids before loading sample onto hemocytometer. This can aid in WBC and RBC cell differentiation and can improve count accuracy. Acetic acid will lyse the RBC's and new methylene blue would stain the WBC. Acetic Acid cannot be used for synovial fluids. For synovial fluids, hyaluronidase may be added to the specimen and allowed to equilibrate for 5-10 minutes before running the sample on the automated analyzer. The amount held by a wooden stick is sufficient for a 2mL sample.
6.	Allow cells to settle in hemocytometer for 3-5 minutes.
7.	Place the loaded hemocytometer (specimen side up) on the microscope stage.
8.	Focus the microscope on the 40X objective. Count the number of red cells (RBC) and white cells (WBC) in the recommended areas of the hemocytometer in sides A and B. • RBC's have a distinct outline with halos and clear centers. If created, they have many fine-pointed projections. • WBCs are granular. • Tissue cells are usually large granular cells with irregular outlines. They should not be included in either the RBC or the WBC counts. **NOTE:** For further clarifications, see **Procedure Notes** for RBC/WBC hemocytometer counting.
8.	If cells are overlapping or there are >100 cells in a $1mm^2$ area, to ensure accuracy, a dilution should be performed. Use CELLPACK DCL diluent fluid for performing dilutions. If < 1 cell is seen when counting CSF, count all nine of the $1mm^2$ square areas.
9.	Using the VCMC Body Fluid worksheet (Microsoft Excel file) enter the cell counts as performed. Reported calculated results are displayed once all required fields are completed. For cell counts above 20, the percent difference between the two sides of the hemocytometer should be within 30%.

CALCULATIONS:

Hemocytometer Manual Cell Count Calculation

WBC/RBC count = (**Total number of cell(s) counted**) x dilution factor x depth factor

(Total number of squares counted)

Examples:

		Cytometer Side A	Cytometer Side B	**Calculations**	**Reported Results**
Example A (undiluted)	RBC	44	50	() x (1)x (10) = 117.5	**118**

		(Four 1mm^2 squares counted)	(Four 1mm^2 squares counted)		
	WBC	15 (Four 1mm^2 squares counted)	18 (Four 1mm^2 squares counted)4	() x (1)x (10) = 41.25	**41**
Example B (undiluted)	RBC	4 (Four 1mm^2 squares counted)	23 (Four 1mm^2 squares counted)	Count not within 10-30% sample must be reloaded and repeated.	
	WBC	2 (Nine 1mm^2 squares counted)	1 (Nine 1mm^2 squares counted)	() x (1)x (10) = 1.67	**2**
	RBC (repeated)	22 (Four 1mm^2 squares counted)	18 (Four 1mm^2 squares counted)	() x (1)x (10) = 50	**50**
Example C (1:20 dilution)	RBC	121 (Four 1mm^2 squares counted)	113 (Four 1mm^2 squares counted)	() x (20)x (10) = 5,850	**5,850**
	WBC	85 (Four 1mm^2 squares counted)	89 (Four 1mm^2 squares counted)	() x (20)x (10) = 4,350	**4,350**

PROCEDURE NOTES:

VCMC & SPH Fluid Reported Color and Character

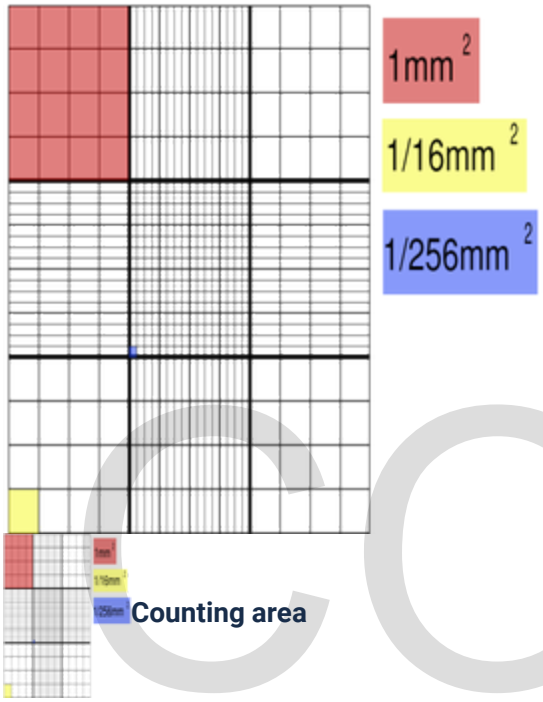
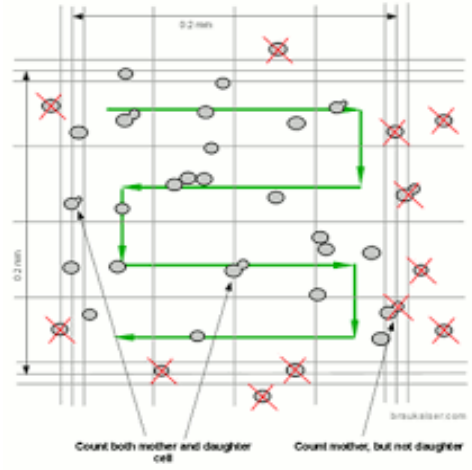
Color	Character
Colorless	Clear
Pale yellow	Slightly hazy
Yellow	Hazy
Pink	Cloudy
Red	Turbid
Xanthochromia*	Bloody
Other	

- Xanthochromia is coloration of the cerebrospinal fluid (CSF) which distinguishes in vivo

hemorrhage from a traumatic tap. Xanthochromia can only be determined from a spun specimen. Since cell counts cannot be performed from spun specimens, xanthochromia may be determined from spun chemistry aliquots.

NOTE: For CSF, append comment **L1BL4** (first collected tube is visibly bloodier than the last collected tube) if tube 1 is visible bloodier than tube 4.

RBC/WBC Hemocytometer Counting

	RBC's and WBC's should be counted in the four outmost ($1mm^2$) squares. Count both sides A and B of the hemocytometer. The difference between the two sides should be within 30%. For CSF, if WBC are not seen in the four $1mm^2$ squares, more squares should be counted.
	Cells are counted in a linear progression. When counting ensure that the lines and chamber are bright, clean and free of scratches. When cells are found on the border, only two adjacent corners should be counted, the other two should not.

REPORTING RESULTS:

Expected Cell Count in Body Fluids

Fluids	RBC	WBC

CSF (Neonates)	0 – 2 cells/mm^3	0 – 30 cells/mm^3
(Adults)		0 – 5 cells/mm^3
Ascites/Peritoneal/Pericardial	0 – 10,000 cells/mm^3	< 500 cells/mm^3
Pleural	0 – 10,000 cells/mm^3	< 1000 cells/mm^3
Synovial/Joint	0 – 2000 cells/mm^3	< 200 cells/mm^3

TROUBLESHOOTING QC:

If a control is found to be "out of range":

1. Inspect control appearance, temperature (should be analyzed at room temperature) and expiration date. If all listed parameters are valid, when resulting QC ***select/attach comment: repeat, same control vial***, and repeat control cell count. If control continues to result as "outside of target range" (for the second time) proceed to (2).
2. Open a new sample (same lot or new lot) of that level of control and rerun (***select/attach comment: new bottle control***). If the new bottle control opened results outside of target range proceed twice to (3).
3. Contact Hematology Supervisor. When resulting QC ***select/attach comment: other***. Specify actions taken to resolve QC in results section.

Notify medical staff when QC processes causes interruptions in workflow. During "off hours," call operator to notify Emergency Department and House Supervisor of possibly delay in patient results.

NOTE: If any control is found out of range DO NOT rerun control more than 3 times without performing AND documenting corrective actions.

Quality control results are reviewed monthly by CLS supervisor.

LIMITATIONS:

- Cells in body fluids may undergo cell lysis if the following resting time is permitted:
    - Sitting after dilution >10 minutes
    - Sitting after plating >15 minutes
- If the specimen contains significant clots or tissue fragments, the cell count will be compromised. Confirm with a pathologist before performing the cell count. If cell count is to be performed, append comment **LRQ** – Results Questionable Due to Specimen Condition and specify that the specimen was clotted.
- In cases where small clumps/clusters of cells are seen on the hemocytometer (but are not visible in the specimen) a comment should be attached that the cell count may be inaccurate.
- When performing a cell count on bloody fluids only intact red cells should be enumerated. If ghost red cells are present these should be addressed in an attached comment.
- Manual hemocytometer counting should not exceed 500 of a cell line on each side (or >100 per mm^3 area). When cells are numerous in hemocytometer, cell counts are liable to

inaccurate and irreproducible results. The sample should be diluted before proceeding with the cell count.

REFERENCES:

Cell-Chex Body Fluid Cell Control insert - Fluid Control package Insert 2014

iNCYTO C-Chip Disposable hemocytometer - System Neubauer Improved package insert 06/06

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Cerebrospinal Fluid, analysis, routine – color and appearance, cell count and differential, College of American Pathologists. CAP.5M293

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Peritoneal Fluid Analysis, College of American Pathologists. CAP.5M293

Modified from Davidson, Israel and Henry, John B.: Todd-Sanford Clinical Diagnosis by Laboratory Methods, 15th edition, Philadelphia, 1974, W.B. Saunders Company.

Medical Laboratory Observer, Tips on Technology - "Cell Counts on Joint Fluids", August, 1983.

KJeldsberg, Carl R., Knight, Joseph A. **Body** Fluids - **Laboratory** Examination of **Amniotic**, Cerebrospinal, Seminal, Serous & Synovial Fluids, econd edition, American Society of Clinical Pathologists , Chicago, 1986

Kreig AF, Kjeldsberg CR. Cerebrospinal fluid and other body fluids. In: Henry JB, ed. Clinical Diagnosis and Management by Laboratory Methods, Philadelphia PA: W.B. Saunders Co.;1991:445-473

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

HEM.35319 Diluting Equipment

HEM.35338 Background Checks – Manual Counts

HEM.35340 Manual Cell Count Controls

HEM.35347 Counting Chamber and Optical Grid Quality

HEM.35357 Body Fluid Analysis Procedure

HEM.35376 Cell Clumps/Debris – Manual Methods

HEM.35395 Red Cell Confirmation Techniques

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Policy Area	Laboratory Services

L.HEM 4.4 Body Fluid Differentials

PRINCIPLE:

Body Fluid cell differentials provide extremely important information for the diagnosis and treatment of diseases involving CSF, serous, and synovial cavities. Infections, hemorrhages, and malignancies are the primary concerns. In addition to basic cell identification, cells must be examined for the presence of inclusions that provide information concerning disease possibilities or state.

Body Fluids where the cell count is zero, it is still imperative to concentrate the specimen by preparing a cytocentrifuge slide, increasing the chance of identifying rare abnormal cells, especially in patients with a history of central nervous system malignancy. Using elevated cell counts to decide whether to prepare a cytocentrifuge slide is not recommended, as malignant cells can be present in fluids with low cell counts. In these cases, a slide review may be appropriate and should include statements on the general cell composition and the presence of malignant cells.

Body fluid differentials are performed on a stained smear. They are most accurate when performed on cytospin preparations. However, push smears may be useful if the fluid is grossly bloody. Body fluid differentials at VCMC laboratory are generally performed by concentration of cells on cytospin preparations.

SPECIMEN:

A Body fluid cytoprep Wright-Giemsa stained slide

(Appropriate fluid types are as follows: CSF or Shunt fluid, Ascites or Peritoneal fluids, Pleural fluids, Pericardial fluids and Synovial or Joint fluids)

NOTE: Other specimen types will ONLY be performed with pathologist approval.

REAGENTS/MATERIALS:

Microscope

Low power 10X objective and 50X and 100X oil immersion objectives

Cell differential counter

Immersion Oil

VCMC Body Fluid Excel worksheet

PROCEDURE:

Differential/Slide Review

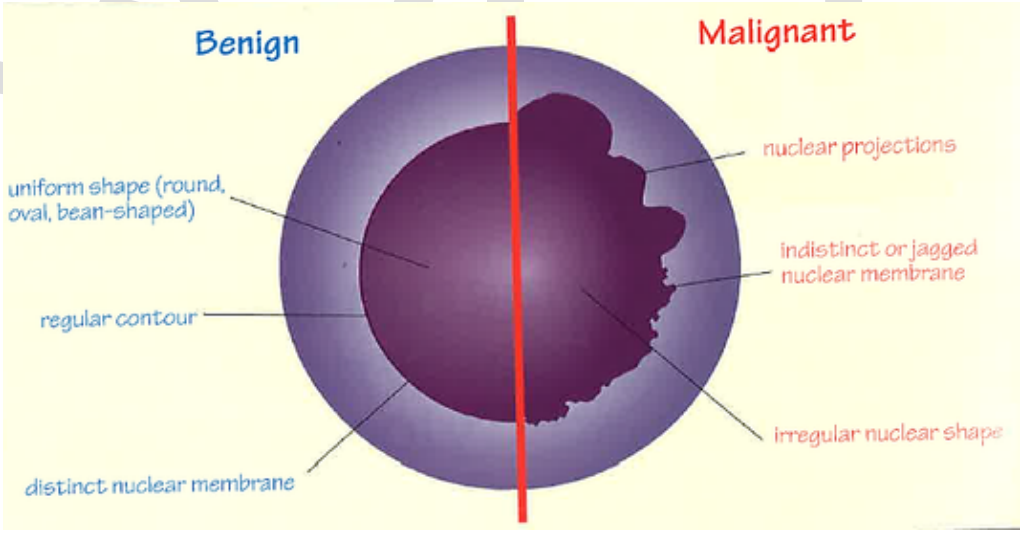
1.	The cell count must first be resulted in Cerner in **PERFORMED** status to trigger the body fluid differential, or Slide review parameters.
2.	Differentials are performed using the high power (50 or 100X) oil immersion objective. **NOTE:** If the 50X objective is used to perform the differential, the 100X must be utilized to classify any immature cells.
3.	Verify that the body fluid slide is labeled with two patient identifiers and the slide preparation date.
4.	Place the stained slide (specimen side up) on the microscope stage.
5.	Focus the microscope on the 10X objective (low power). Examine the slide for appropriate cell distribution and cell clumping. If the cells appear to be distorted or overcrowded, another slide must be remade and evaluated. **NOTE:** Incorrectly prepared slides may have too many cells. Diluting the sample to make an adequate slide is recommended. Push smears for grossly bloody specimens, may also be adequate in these situations.
6.	If body fluid TNC/WBC cell count is: • **0:** Scan cytospin slide for any abnormal cells or malignancies. • **1-4:** Differential is not required. Scan cytospin slide, comment in the results, which cell is predominating. Scan for any abnormal cells or malignancies. • **≥5:** Perform Body Fluid differential
7.	To perform the differential, find an area of the slide where the cells appear evenly distributed. Add immersion oil, and change objective to an oil objective.
8.	Count and differentiate 100 nucleated cells ensuring that there is no back tracking over a previously counted area. • Note any abnormalities, and place results in WBC Comment field. • Malignant appearing cells are to be counted as part of the Other cell category and submitted for a pathologist review as a PRF order for further interpretations. • Mesothelial cells should be counted as part of the Mononuclear cells category and semi-quantitated as 1+, 2+ or 3+, if present. Mesothelial cells do not need a pathologist consult unless they appear malignant. • **1+:** Few meso's present not up to 1 meso seen in each 50X field • **2+**: About 1 meso's present per 50x field • **3+**: ≥2 meso's present per 50X field

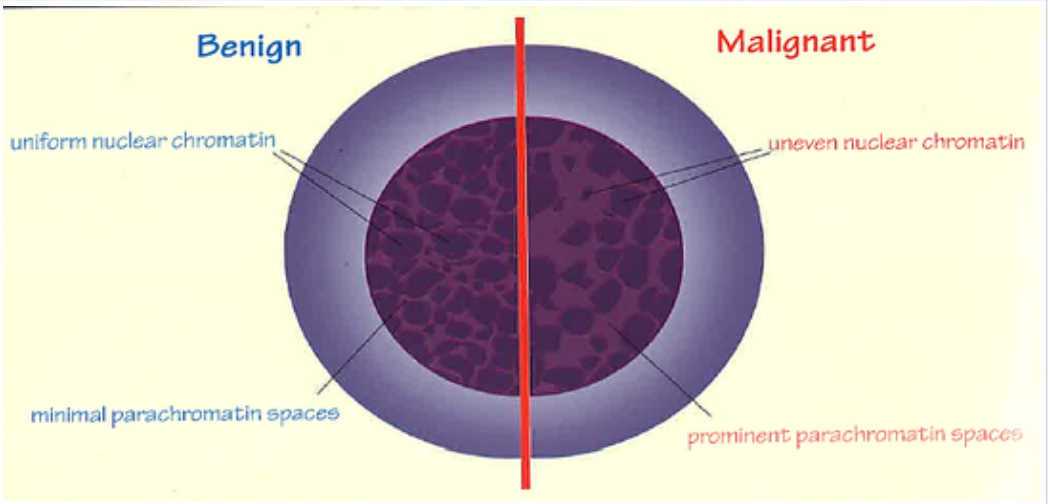
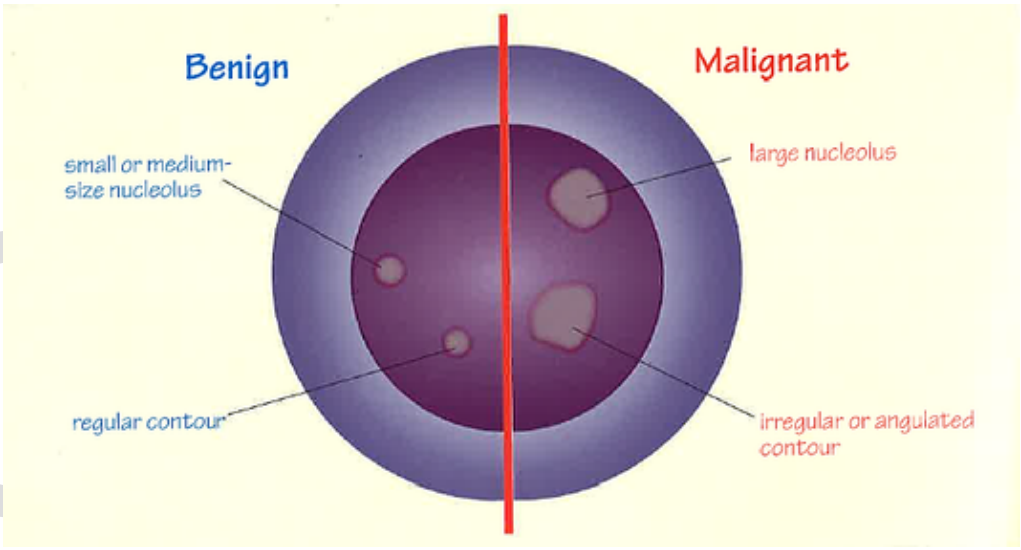
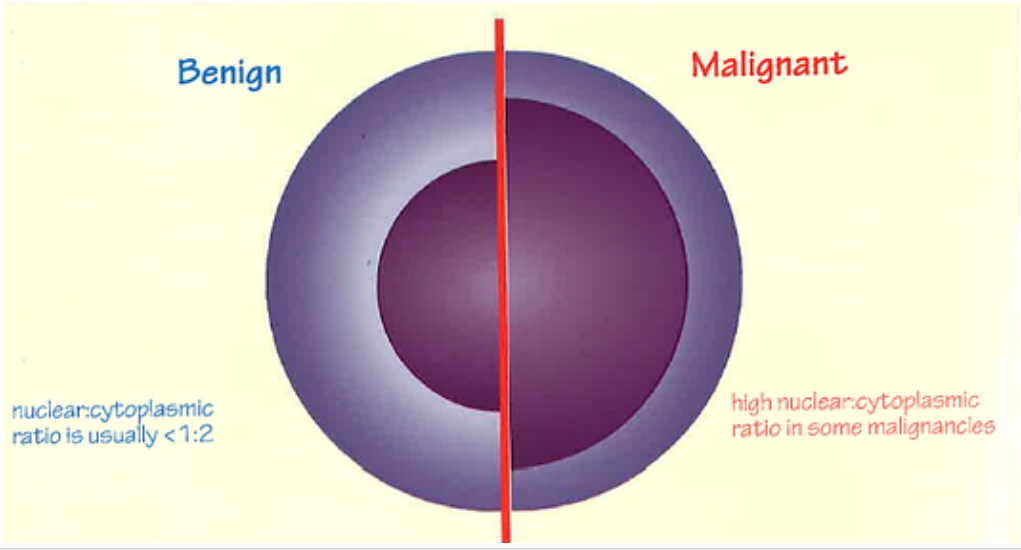
7.	Reviewed slides are stored daily in the same slide case as blood smears and kept in slide drawer for a minimum of three weeks.

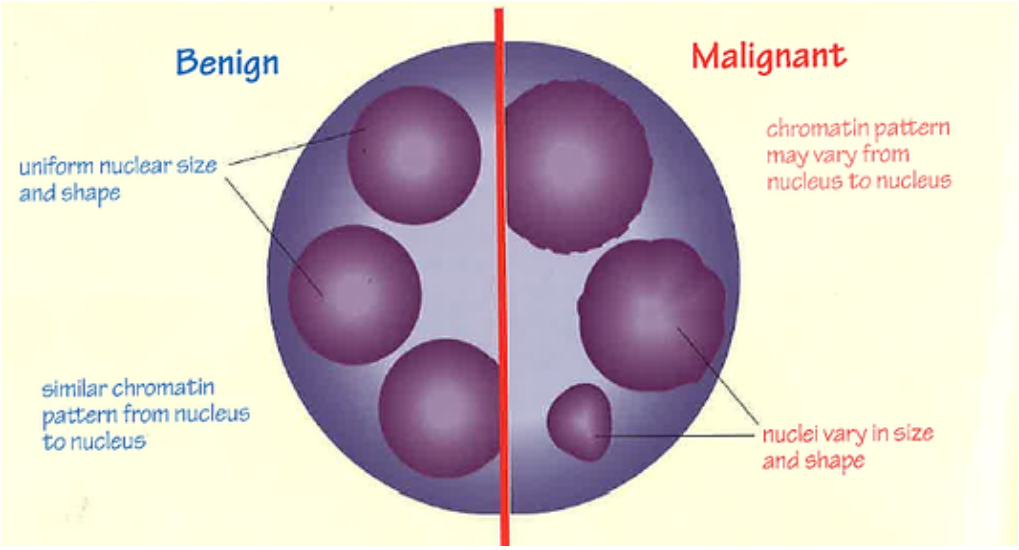
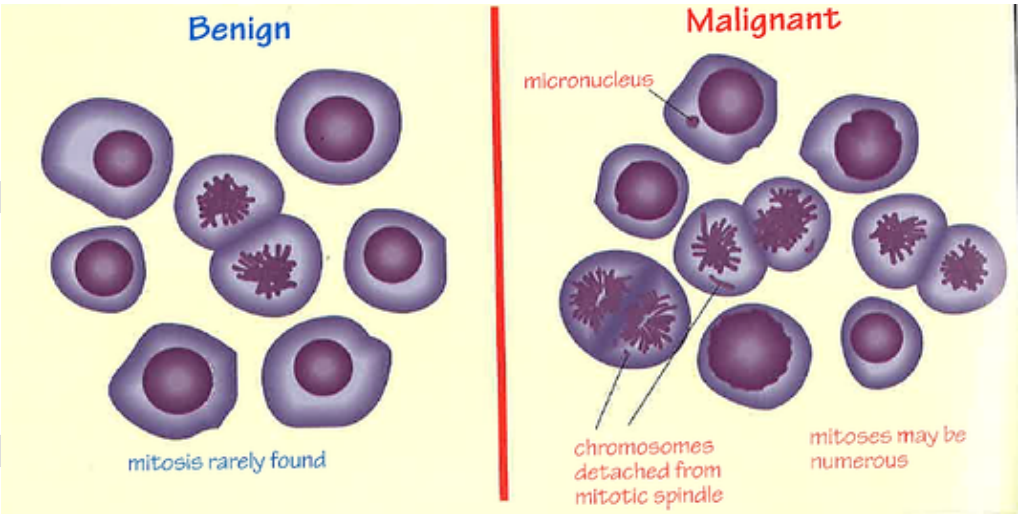
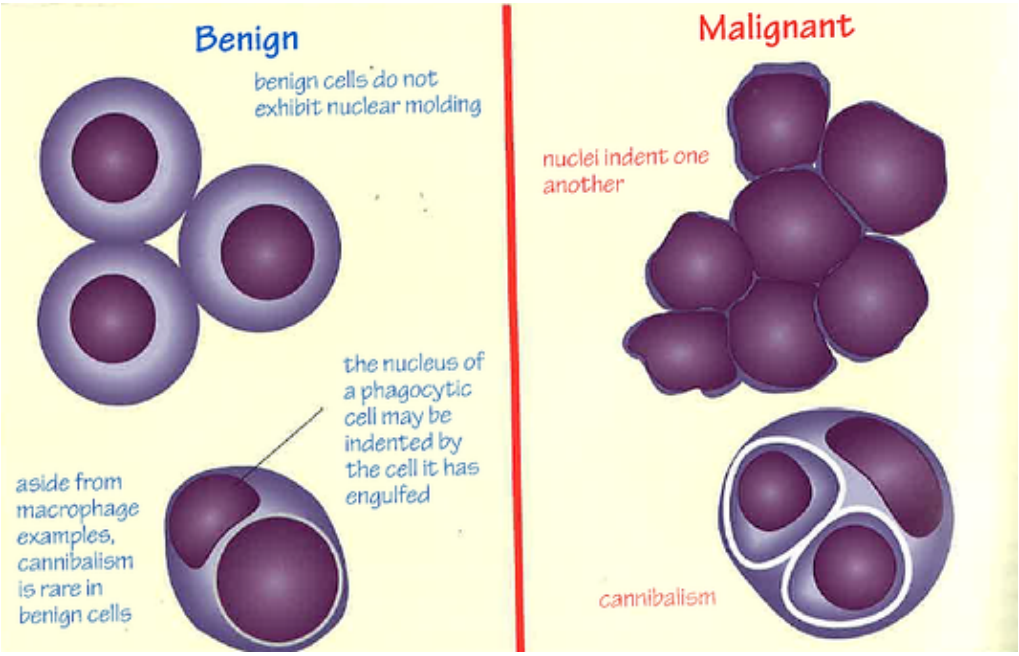
VCMC Manual Differential Cell Descriptions

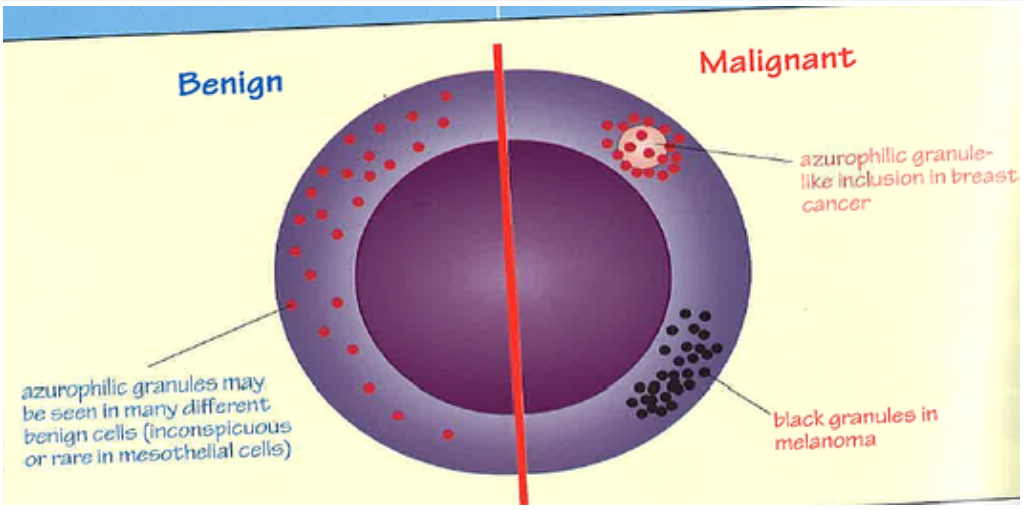
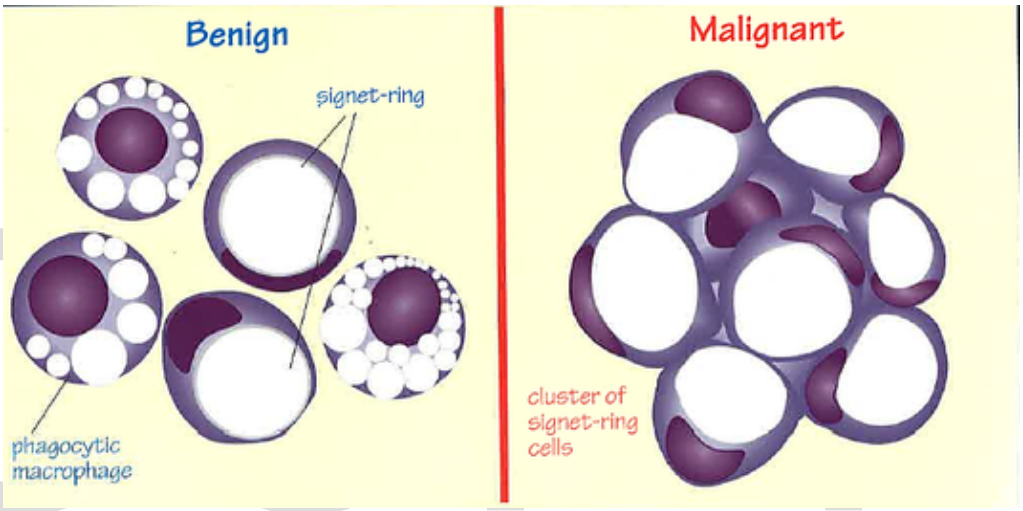
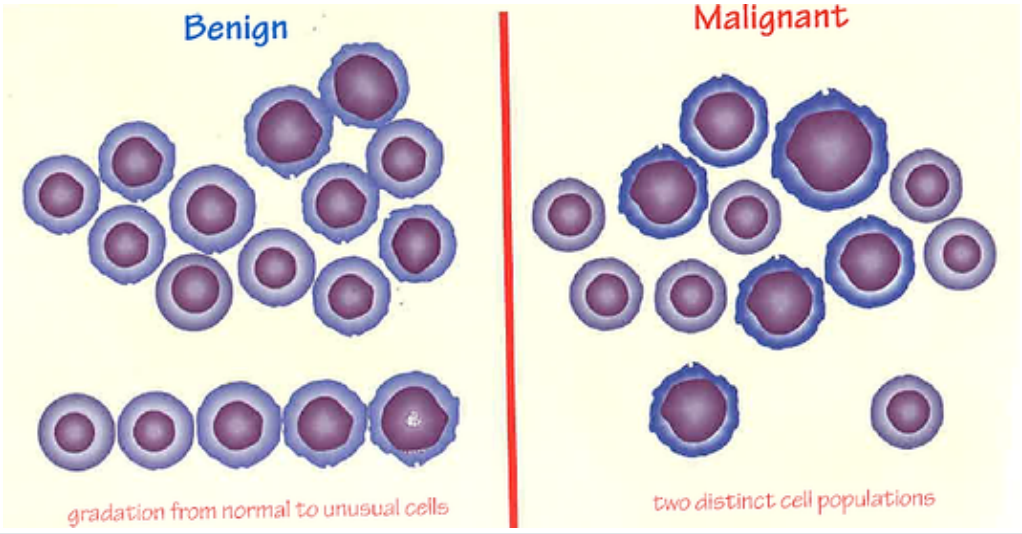
Body Fluid Categories	Cells	Descriptions
Polymorphonuclear Cells	Basophils & Mast Cells Eosinophils Neutrophils & Bands Immature Granulocytes	Classically identifiable cell categories typically containing more than one nucleus segment.
Mononuclear Cells	Lymphocytes Monocytes & Macrophages Mesothelial Cells	Classically identifiable cell categories typically containing one uniform appearing nucleus.
Other Cells	Blasts Malignant Cells Unidentified Cell	Large pleomorphic cells with prominent nucleoli or irregular nuclear shapes

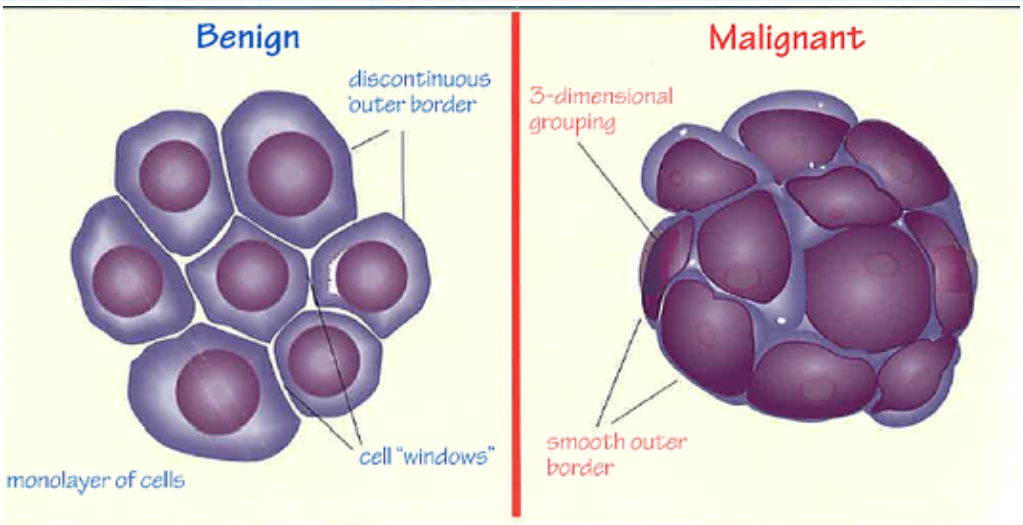
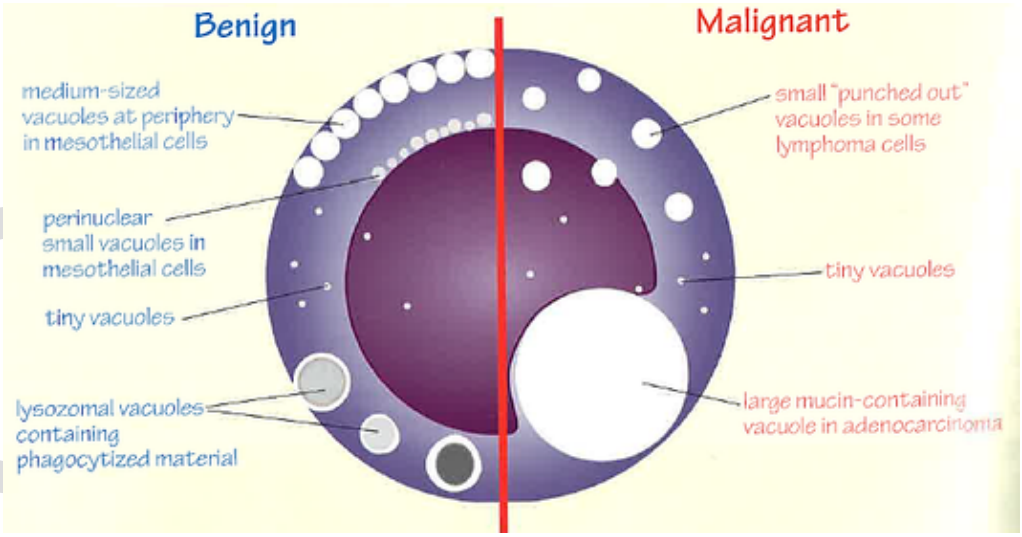
Identifying Malignant Cells

Morphological Feature	Distinguishing Characteristics
Nuclear Contour and Nuclear Membrane	

Nuclear Texture	
Nucleoli	
Nuclear: Cytoplasmic Ratio	

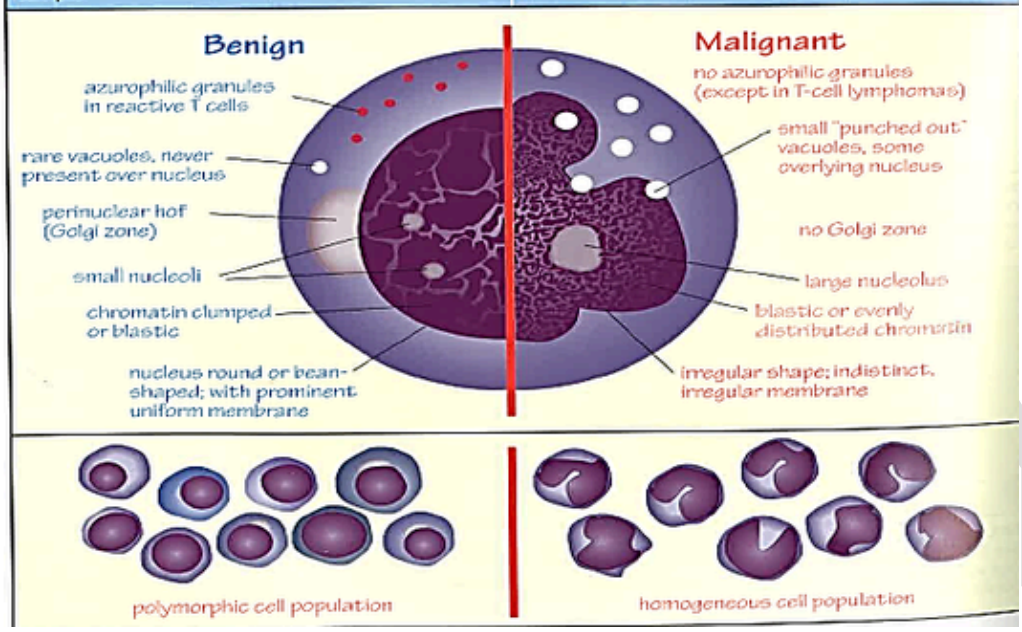
Multinuclearity	
Mitotic Cells	
Nuclear Molding and Cannabalism	

Cytoplasmic Granules	
Signet Ring Cells	
Unusual Homogenous Population	

Cell Clusters	
Cytoplasmic Vacuoles	

Lymphoid Cells

Benign	Malignant
Reactive lymphocytes may have lightly to intensely basophilic cytoplasm, but often show a clear perinuclear Golgi zone.	Lymphoma cells often have basophilic cytoplasm, but a Golgi region is absent.
Azurophilic granules are seen in reactive T-lymphocytes, or T-immunoblasts.	Azurophilic granules are not seen in B-cell lymphoma. They may be present in the uncommon T-cell lymphoma.
Vacuoles are uncommon and occur only in the cytoplasm.	Small clear vacuoles may be seen over the nucleus as well as in the cytoplasm.
The nucleus is round to bean-shaped, with a regular nuclear contour and prominent nuclear membrane.	The nucleus may have an uneven contour, with an indistinct nuclear membrane.
The nuclear chromatin varies from condensed to "ropey" to blastic (in the immunoblast).	The nuclear chromatin is blastic (or fine, uncondensed) in large cell lymphoma.
Several small nucleoli may be present.	Nucleoli may be large.
Reactive lymphocytes display heterogeneity; many different morphologic forms often are found in the sample.	A homogeneous infiltrate of lymphoid cells may be present.



For further descriptions and examples regarding cell identification, Color Atlas of Body Fluids, CAP Hematology and Clinical Microscopy Resource Committee should be used as a guide.

REPORTING NOTES:

- Differential results are reported as a percentage of the total nucleated cells counted.
- WBC Comments: (pneumonic codes for when TNC/WBC cell counts = 0-4)
  - **LBFN** - No abnormalities seen
  - **LBFPC** - ____ predominating cell seen
  - **LBFS** - ____ segmented neutrophils seen

REFERENCES:

Galagan, K.A., Blomberg, D, Cornbleet, P.J., Glassy, E.F. Color Atlas of Body Fluids: An Illustrated Field Guide Based on Proficiency Testing, College of American Pathologists. CAP.2006

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Cerebrospinal Fluid, analysis, routine – color and appearance, cell count and differential, College of American Pathologists.

CAP.5M293

Fascicle VI, Patient Preparation & Specimen Handling, Chemistry/Clinical Microscopy, Peritoneal Fluid Analysis, College of American Pathologists. CAP.5M293

Modified from Davidson, Israel and Henry, John B.: Todd-Sanford Clinical Diagnosis by Laboratory Methods, 15th edition, Philadelphia, 1974, W.B. Saunders Company.

Medical Laboratory Observer, Tips on Technology - "Cell Counts on Joint Fluids", August, 1983.

KJeldsberg, Carl R., Knight, Joseph A. Body Fluids - Laboratory Examination of Amniotic, Cerebrospinal, Seminal, Serous & Synovial Fluids, econd edition, American Society of Clinical Pathologists , Chicago, 1986

Kreig AF, Kjeldsberg CR. Cerebrospinal fluid and other body fluids. In: Henry JB, ed. Clinical Diagnosis and Management by Laboratory Methods, Philadelphia PA: W.B. Saunders Co.;1991:445-473

CAP Accreditation Program – Hematology and Coagulation Checklist 08.22.2018

CAP Checklist Requirements

HEM.35528 Quantitative Differentials

HEM.35547 Body Fluid Smear Quality

HEM.35566 Morphologic Observation Assessment – Body Fluid

HEM.35585 Slide Review

HEM.35604 Microscopic Result Comparison

HEM.35623 Cytomorphology Reference Library

HEM.35642 Slide Retention

All Revision Dates

1/26/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026

Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Origination	12/14/2023	Owner	Samah Meshreky: Supervisor-Hematology, Laboratory Services
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Next Review	1/26/2028		

L.HEM 4.5 Body Fluid Crystal Analysis

PRINCIPLE:

Body fluid crystal analysis is extremely important in the diagnosis of gout, pseudogout and septic or rheumatoid arthritis.

Gout describes a group of metabolic disorders where crystals of monosodium urate (uric acid) deposit in the tissues. Pseudogout is an acute, inflammatory form of arthritis. Like gout, pseudogout involves the deposit of crystals, in this case calcium pyrophosphate, in and around the joint tissues.

In some cases where crystals are not present there may be large numbers of inflammatory cells, in this case the diagnosis may be suspicious of septic arthritis, otherwise known as bacterial arthritis. The patient benefits from a rapid diagnosis and treatment of this condition because joints may deteriorate in a short period of time.

SPECIMEN:

Acceptable specimen types for body fluid cell count and differentials are collected without anticoagulant:

Synovial or Joint fluids

NOTE: If specimen received is in EDTA, testing may be performed, though not ideal. Other specimen types will ONLY be performed with pathologist approval.

REAGENTS/MATERIALS:

10 x 75mm reagent tubes

Microscope slide and coverslip

Microscope and polarizer

10X and 40X microscope objective lens

Centrifuge

Disposable transfer pipettes

QUALITY CONTROL:

Performed with **EVERY** patient sample: A preserved known slide of monosodium urate crystals or Cell Chex Level 1-UC.

PROCEDURE:

1.	Upon receipt of specimen, refer to procedure **HEM 1.1 - Specimen Rejection, Acceptability and Stability Criteria** to verify specimen acceptability and stability.
2.	Samples received refrigerated must be brought to room temperature before analysis (do NOT incubate cold specimens). Frozen specimens are NOT acceptable. **NOTE:** Refrigerated samples may facilitate the formation of artificial crystals, however, refrigerated samples are acceptable for analysis.
3.	Centrifuge the fluid sample for 5 minutes in the urinalysis centrifuge to concentrate the specimen.
4.	Using a transfer pipette, aspirate the sediment/pellet from the bottom of the specimen and place 1 drop of well-mixed sediment on a glass microscope slide. Cover drop with glass coverslip.
5.	Adjust the microscope to dark phase contrast and scan the entire microscope slide for crystals under (10x) low power field.
6.	If crystals are seen, identify the crystal seen using the polarizer under (40x) high power field. **NOTE:** Crystals should be found under low power 10x dark phase contrast and identified using a polarizer under 40x.
7.	Print VCMC Body Fluid worksheet and record results.
8.	Under Accession Result Entry, enter patient results and file completed worksheet in body fluid tray. **NOTE:** Worksheets printouts are filed daily and kept for a minimum of two years in storage boxes.

PROCEDURE NOTES:

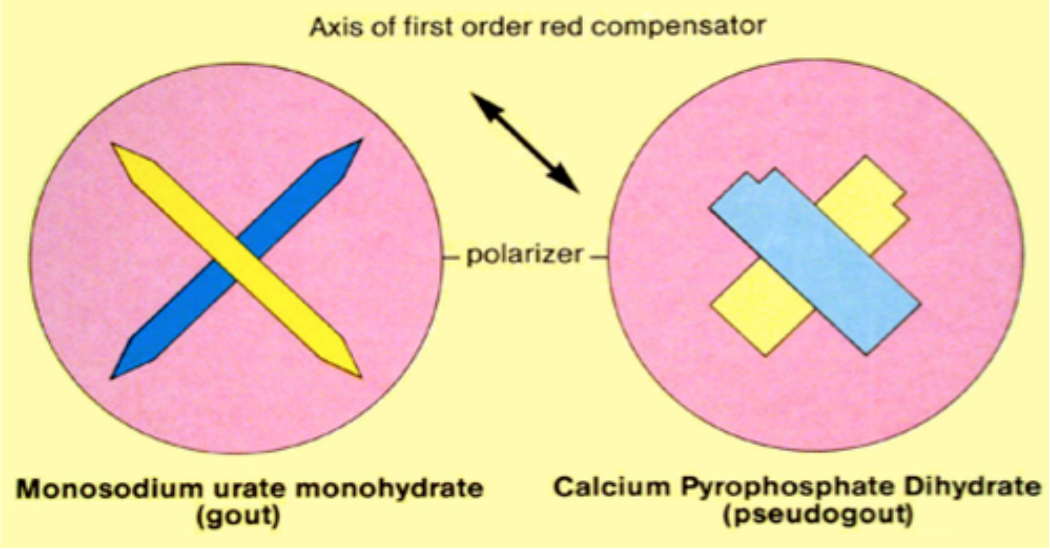
Crystals are identified based on polarization/birefringence characteristics:

Crystal Identification

Crystals	Condition	Appearance	Polarization	Birefringence*

			Appearance (using a red compensator)		
			Parallel to axis	**Perpendicular to axis**	
Monosodium Urate (MSU)	Gout	Intra/extracellular needles	Yellow	Blue	Negative birefringence
Calcium Pyrophosphate Dihydrate (CPPD)	Pseudogout	Intra/extracellular rods, needles or rhombics	Blue	Yellow	Positive birefringence
Other Crystals					
Cholesterol – notched, extracellular rhombic plates that are weakly birefringent, seen in chronically inflamed joints, such as those due to rheumatoid arthritis					
Calcium Oxalate –bipyramidal morphology, easily identified under phase contrast, mostly reported in patients undergoing chronic renal dialysis and those with rare inborn error of metabolism					
Talc – exhibit the characteristic "Maltese Cross" when polarized					
Corticosteroid – flat, variable shape, intracellular plates that are both positively and negatively birefringent					
Hydroxyapatite – small intra/extracellular needles that cannot be seen without electron microscope					

MSU and CPPD Appearance under Polarization



MSU and CPPD crystals are not normally seen in synovial or joint fluids, and the presence of even one crystal is significant.

Quality control results are reviewed monthly by CLS supervisor.

REPORTING RESULTS:

Select one the following from drop down menu:

Test	Results	Interpretations
Fluid Crystals	None Seen	No crystals seen
	MSU	Monosodium Urate crystals present
	CPPD	Calcium Pyrophoshate Dihydrate crystals present
	OTHER	Cholesterol, talc, calcium oxalate or other crystals present
QC Fluid Crystals	Performed	MSU crystals adequately identified on QC slide

REFERENCES:

Henry, J.B., Clinical diagnosis and Management by Laboratory Methods, 18th ed., W.B. Saunders Company Harcourt Brace Jovanvich, Inc Philadelphia, PA 1991, pp. 459-460

Crystal Identification in Gout Testing, package insert – Leeds Precision Instruments, Inc.

All Revision Dates

1/26/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/26/2026
Laboratory Service Dept	Samah Meshreky: Supervisor-Hematology, Laboratory Services	1/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	1/24/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	1/24/2026

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Origination	9/25/2004	Owner	Ian McGraw: Manager Facility Operation
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Effective	1/30/2026		
Last Revised	1/30/2026		
Next Review	1/29/2029		

F.001 Operation of Central Heating Plant During Emergency or Unusual Circumstances

POLICY:

To provide guidelines for operation of the central heating plant at Ventura County Medical Center by other than the assigned stationary engineers because of unusual conditions. The provisions of this procedure apply to personnel assigned to the Central Heating Plant and other Facilities Maintenance Department personnel as may be assigned to the plant by the Facilities Maintenance Supervision during unusual conditions for a temporary period.

PROCEDURE:

With the limited number of Stationary Engineers assigned to the central heating plant, it is possible that when unusual circumstances occur or during a natural disaster there would be insufficient staff to operate the plant. Were the plant to be inoperable, shutdown of the Ventura County Medical Center and other County facilities would be imminent. Therefore, it will be necessary to assign other Facilities Maintenance personnel to monitor the plant. Such assigned personnel will be assisted by one of the following skilled trades: Air Conditioning/Heating Mechanic or Senior Maintenance Electrician.

The duties of the person(s) on duty will be limited to a "watch" status. He/she will not be required to perform maintenance unless working with a Stationary Engineer nor will he/she be required to perform boiler water analysis, blow down the boilers, regenerate the water softener, switch boiler feed pumps or add chemicals to the boilers.

DUTIES:

The duties of the person performing "watch" shift are:

1. Observe water level in gauge glass.
2. Observe that steam pressure is at 125 PSI, ± 5 PSI at all times.
3. Observe that the boiler feed water pumps operate at 165 to 185 PSI and pumps emit no excessive noise.
4. In the event of "dead plant" due to an electrical power failure, watch water level in gauge glass. If water rises above ¾ glass, secure gate valve to left of Copes valve and tag valve handle as "CLOSED".
5. If water goes below glass, DO NOT FIRE BOILER; secure it.

WHEN POWER IS RESTORED:

1. Check feed water pump for proper operation.
2. Boiler controls will come on automatically. Reset gas pressure switches (Gas switches trip when power is off).
3. Switch to "manual" and "low fire".
4. Fire-eye will show on readout: "BURNER ON", "HRS", "CYCLES", "HOLD D-8" and "HI PURGE OPEN". Purge will last 60 seconds.
5. Observe start- up on flame through sight glass in front of burner. Fire-eye readout will show "FLAME SIGNAL" readout of 40 to 60 is normal.
6. After a flame is on for one minute or more, move potentiometer to ¼ fire (more if warranted) to bring steam pressure to 125 PSI. Monitor closely until stabilized.
7. When boiler sight glass reaches ½ glass, throttle water feed at Copes valve slowly, watching water level until Copes valve has settled. Then open valve to full position.
8. Switch boiler to "auto" after boiler gauge reads 125 PSI and return potentiometer to "low fire" position. Again, monitor pressure to ensure it is stabilized.

WATER SOFTENER OPERATION:

Perform softness test on water softener for water softness.

AIR COMPRESSOR OPERATION:

Monitor the operation of the air compressor(s) and check oil level periodically. Air pressure is set at 120 PSI ± 15 PSI.

REPORTS AND OPERATIONS:

1. Observe and log operation of all changes, failures, etc. (time and brief description).
2. Report any unusual conditions and/or equipment failure, no matter how small, to the Senior Stationary Engineer or available engineer, by telephone. Enter in Operator's Log.
3. The Senior Stationary Engineer is to conduct a class of a minimum of one hour of instruction and orientation for "watch" personnel. This class will show location, operation and purpose of

equipment and all accessories.

WARNING:

If the water level is not visible in the water gauge, shut the boiler down by turning off the switches on the control panel. **DO NOT PUT ANY WATER IN THE BOILER.** Damage and/or explosion could result. Call the Senior Stationary Engineer or designee.

All Revision Dates

1/30/2026, 2/7/2017, 7/1/2016, 12/9/2013, 3/31/2011, 3/13/2008, 9/25/2004

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/30/2026
Facilities Department	Ian McGraw: Manager Facility Operation	1/30/2026

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VENTURA COUNTY HEALTH CARE AGENCY

Origination	9/25/2004
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Next Review	1/29/2029
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.002 Stationary Engineers Maintenance and Inspection Requirements

POLICY:

To state the requirements for stationary engineers daily shift maintenance and inspection requirements in boiler room at Ventura County Medical Center.

PROCEDURE:

DAILY MAINTENANCE

1. Check water level. An unstable water level can indicated several problems such as excessive solids or water treatment, contamination from oil, overload or control malfunction. **Ensure water is in proper level in sight glass**.
2. Blow down boiler. Blow down the boiler in accordance with the recommendation of your water treatment consultant. A water quality and chemical treatment program will dictate frequency of boiler blow down.
3. Check combustion visually. Look at the flame to see if something has changed. Changes in color or flame pattern may be an indication that a problem is developing.
4. Treat water according to the established program. Add chemicals and take tests as outlined by your chemical water treatment consultant. This task is designated to graveyard shift Stationary Engineer for chemical adjustments.
5. Record boiler operating pressure and temperature. An excessive steam or water temperature drop will alert you to excessive loading on the boiler.
6. Record feed water pressure and temperature. A change in pressure or temperature may

indicate a problem is developing with your feed pump(s), deaerator or packaged feed system.

7. Record stack temperature. Changes in stack temperatures could indicate the boiler is sooting, scaling, or there is a problem with the baffles or refractory.
8. Record oil pressure and temperature. Change in pressure and/or temperature could have an effect on combustion in the boiler and could indicate a problem in the oil regulators or oil heater, if running on fuel oil.
9. Record oil atomizing pressure. Changes in pressure could have an effect on combustion in the boiler, if running on fuel oil.
10. Record gas pressure. Changes in pressure could have an effect on combustion in the boiler and indicate a problem in the gas delivery system.
11. Check general boiler/ burner operation. Maintaining top efficiency is the simple and basic reason for having operating personnel. Is anything different than it was the day before? If so, why?
12. Check auxiliary equipment. There is a vast difference between "is it running?" and "is it running properly?" Take nothing for granted as auxiliary equipment can shut down your operation.

WEEKLY MAINTENANCE

1. Blow down the water level controls to purge the float bowl of possible sediment accumulation.
2. Inspect burner operation. Do a visual inspection of the pilot flame, main burner flame throughout the firing range, free movement of motor, gears and general burner operation.
3. Check indicating lights and alarms. Check for burned out or loose light bulbs. Also check to ensure the alarm bell or horn sounds on the appropriate shut down condition.
4. Check for leaks, noise, vibration, unusual conditions, etc. Checking for these conditions is a cost-effective way to detect system changes. Small problems can be corrected before they become large problems.
5. Check operation of all motors. By developing a routine, any change in operation or bearing temperature will usually be caught in time to avoid a failure.
6. Check gauge glass. Ensure there are no cracks or etching in the glass or leakage around the packing

MONTHLY MAINTENANCE

1. Check operating and limit controls. Check to ensure these controls shut the burner down at their pre-determined set-point. Settings should be verified by checking actual pressures and temperatures on the boiler gauges.
2. Check safety and interlock controls. Check to ensure these controls shut the burner down at their pre-determined set-point. Settings should be verified by checking actual pressures and temperatures on the boiler gauges.
3. Check operation of water level controls. Stop the boiler feed pump and allow the control to stop the boiler under normal "low fire" conditions. See your operating manual for a more detailed procedure.

4. Check for flue gas leaks. Ensure something hasn't changed in the breaching, stack or overall system that allows flue gas to be drawn into the boiler room.
5. Check packing glands on all pumps and metering devices. Proper tension on packing glands will extend life of the equipment.
6. Inspect for hot spots using Infrared. Inspect the boiler to ensure no hot spots are developing on the outside of the boiler. Hot spots can indicate a refractory failure or baffle failure, which could cause improper gas flow through the boiler or the cooling lines could be plugged or disconnected.
7. Check all combustion air supply inlets to the boiler room and burner assembly to ensure sufficient air is being supplied.
8. Check the fuel system to make certain that strainers, vacuum gauges, pressure gauges and pumps are in good working order.
9. Check lubrication requirements of all bearing supported equipment. Do not over lubricate electric motors.
10. All terminals should be checked for proper torque, taking care NOT to over tighten.

SEMI-ANNUAL MAINTENANCE

1. Clean low-water cutoff(s). Remove the head assembly or probes, inspect and clean out any sediment or contamination in the column or piping. Determine why sediment or contamination condition exists.
2. Clean oil pump strainer and filter. Ensure they are not plugged, thus reducing the flow of the required oil to the burner.
3. Review boiler blow down to ensure treated water is not going to waste. Check water treatment and testing procedures with your feed water consultant.
4. Performed by contracted vendor – repair refractory. Immediately upon opening the fireside areas, give the refractories an inspection and start repairs as soon as possible. Read and follow refractory repair instructions.
5. Performed by contracted vendor – check pump coupling alignment. Check alignment of all couplings to ensure the tolerances are within the manufactures recommendations.

ANNUAL MAINTENANCE

Note: Annual maintenance should be coordinated with the regular pressure vessel inspection performed by insurance or government groups. Establish a firm procedure with all outside inspection groups so that your equipment will be in a proper state of readiness. As a matter of routine, establish a procedure using good safety practices whenever a boiler is taken off-line. Disconnect all power supplies and lock switches in the "OFF" position. Whenever there is more than one boiler connected to a common header establish a routine procedure of locking the header valve on any unit that is down for cleaning or inspection, close any flue gas outlet dampers, and all pieces of equipment required to isolate the boiler.

1. Performed by contracted vendor – Clean fireside surfaces by brush or use a powerful vacuum cleaner to remove soot. After the cleaning process and if boiler is to be left open, it is

advisable to spray all fireside surfaces with some type of corrosion preventative.

2. Performed by contracted vendor – Clean breaching. Inspect breaching and stack removing any soot build up.
3. Performed by contracted vendor – Clean waterside surfaces. Remove all hand hole, man-way plates and inspection plugs from water column tees and crosses. Remove float assemblies from water columns and thoroughly wash all waterside surfaces.
4. Performed by contracted vendor – Check gauge glass for damage. If internal erosion at water level is noted, replace with new glass and gaskets. On all unattended boilers, the gauge glass mounting should be of the safety style with stop-checks in case of glass breakage.
5. Performed by contracted vendor – Inspect condition of fuel oil pump and rebuild or replace as necessary.
6. Performed by contracted vendor – Chemical feed systems should be completely emptied, flushed and reconditioned. Metering valves or pumps should be reconditioned at this time.
7. Performed by contracted vendor - Remove and test pressure safety valves. Any adjustments must be made by an authorized pressure safety valve service.
8. Performed by contracted vendor – Analyze and set to combustion specifications (tune-up boilers). Take the flue gas analysis over the entire firing range, comparing the combustion analysis and stack temperature readings. The entire combustion process should be carefully checked, O_2 readings taken and necessary burner adjustments made. Make certain the readings are recorded and used as a basis of comparison for future tests. Combustion adjustments should only be made by those thoroughly familiar with all aspects of burner adjustments and combustion.

All Revision Dates

1/30/2026, 4/26/2022, 2/1/2017, 7/1/2016, 12/9/2013, 3/31/2011, 3/13/2008, 9/25/2004

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/30/2026
Facilities Department	Ian McGraw: Manager Facility Operation	1/30/2026

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Last Revised	1/30/2026		
Next Review	1/29/2029		

F.007 Facilities Maintenance Mold Remediation

POLICY:

To define the responsibilities, methods, procedures and training required to safely and effectively remove or clean mold-contaminated materials and contents of buildings owned or operated by the Ventura County Health Care Agency.

PROCEDURE:

Definitions -

A. Approved Contractor - A contractor who has been approved by the Facilities Maintenance Department and Infection Control to perform mold remediation work.

B. Flame Resistant Polyethylene Sheeting - Six millimeter flame resistant polyethylene sheeting meeting NFPA 701.

C. Level I Mold Remediation Project- Projects requiring the remediation of less than ten square feet of mold-contaminated materials. Typically completed by trained Facilities Maintenance Personnel.

D. Level II Mold Remediation Project- Projects involving remediation of greater than ten feet of mold contaminated materials. Shall be completed by an approved contractor.

E. Mold-Contaminated Materials – Materials determined to be mold-contaminated through visual and/or olfactory inspection or other sampling methods.

F. Post-Remediation Verification- A post-remediation inspection performed by industrial hygienist or by industrial hygiene consultants. The inspection may include visual, olfactory or other sampling as deemed appropriate. The purpose of the inspection is to verify that the remediation has been properly executed and that the area has been restored to what would be considered a normal indoor environmental fungal ecology.

G. Trained Individuals- An individual who has completed mold remediation training.

RESPONSIBILITIES

A. Shall evaluate suspected areas of mold contamination and assess appropriate Facilities response.

B. Shall in conjunction with Facilities Department identify the underlying causes of mold contamination and identify response to prevent recurrence.

C. Shall perform mold remediation project oversight for level II projects.

D. Shall provide appropriate training to Facilities Department staff that perform mold remediation.

E. Shall perform periodic reviews of the overall effectiveness of the Mold Remediation Procedures and update as required.

F. Shall maintain all sampling, training and post-remediation verification documentation.

Facilities Services

A. Shall notify EHRS of mold growth in excess of ten square feet and other non-routine water releases.

B. Shall perform mold remediation as outlined in this procedure.

C. Shall work in conjunction with EHRS to pre-qualify remediation contractors for level II projects.

D. Shall attend appropriate training and follow remediation work practices as outlined in the training and this procedure.

GENERAL INFORMATION

A. Only non-porous (ex: metals, glass, hard plastics, etc.) and semi-porous (ex: wood and concrete) materials that are structurally sound can be cleaned and reused. Cleaning should be completed using an appropriate cleaning agent. All materials that will be reused should be dry and visibly free from mold.

B. Porous materials such as ceiling tiles, insulation and gypsum board may not be cleaned and should be removed and discarded as described in this procedure.

C. The use of gaseous, vapor-phase or aerosolized biocides or odor suppressants for remedial purposes is not permitted without specific approval from EHRS.

PROCEDURE

Level 1: Limited Areas of Mold Contamination (10 square feet or less of mold-contaminated materials)

A. EHRS notification is optional.

B. Trained Facilities Department personnel may conduct remediation.

C. Personal protective equipment including at minimum, gloves and eye protection, shall be worn.

D. Building occupants should be temporarily relocated during the remediation project.

E. Containment of the remediation area is not required. A polyethylene drop cloth should be installed in the immediate area of the remediation activity.

F. Contaminated materials that cannot be cleaned should be removed from the building in a sealed plastic bag or wrapped and sealed in polyethylene sheeting and disposed of. There are no special requirements for the disposal of moldy materials.

G. **Hidden mold - If additional mold contamination is discovered during the remediation project, contact EHRS to have the project re-evaluated**.

H. **At the completion of the remediation project, all surfaces, including carpeting, in the vicinity of the remediation area shall be HEPA vacuumed**. Additionally, non-porous surfaces shall be damp wiped and the floors mopped with the appropriate cleaning agent.

I. All areas should be left dry and visibly free from contamination and dust/debris.

Level II: Mid to Large Areas (greater than 10 square feet of mold-contaminated materials)

A. EHRS must be notified of the intent to remediate as soon as possible.

B. Remediation shall be completed by an approved contractor with nationally accepted standards such as IICRC S500-Standard and Reference Guide for professional Water Damage Restoration and IICRC S520- Standard and Reference Guide for Professional Mold Remediation.

C. Contractor is required to submit a work plan detailing methods and procedures used to complete the remediation project to EHRS for approval at least two working days in advance of the project.

D. EHRS shall review the work plan, request changes if necessary, and give the contractor permission to proceed.

E. EHRS shall perform project oversight to include periodic inspections to ensure that the project is completed in compliance with the work plan and complete post-remediation verification.

F. EHRS shall provide a written post-remediation verification report to Facilities Department and the occupants of the remediation area.

TRAINING

All personnel involved with the mold remediation shall receive training consistent with their duties. Employees will receive training in order to acquire the understanding, knowledge and skills necessary fort the safe performance of the duties assigned under this program.

Training shall be provided to each affected employee;

A. Before an employee is first assigned duties.

B. Whenever the employer has reason to believe that there are deviation from the mold remediation procedures or that there are inadequacies in the employee's knowledge or use of these procedures.

C. The training shall establish employee proficiency in the duties required and shall introduce new or revised procedures, as necessary, for compliance.

Training content shall include:

OSHA Hazard Communication Standard (29CFR 1910.1200) and Global Harmonization System (GHS).

Methods and procedures for mold remediation to include:

A. Isolation of HVAC systems
B. Installation of isolation barriers and protection of non-contaminated materials within the remediation area
C. Remediation, cleaning and disposal of mold-contaminated materials
D. Final cleaning of remediation area

Personal protective equipment including OSHA Respiratory Protection Standard (29CFR 1910.134)

DOCUMENTATION

A. Training documentation shall be kept for all affected employees. Training rosters shall indicate the employee's name, date and the instructor who performed the training. EHRS shall maintain all training rosters and a copy of the training outline. The most current training record shall be kept for each affected employee.
B. EHRS shall maintain copies of all work plans.
C. EHRS shall maintain all post-remediation sampling reports.

REFERENCES

Institute of Inspection Cleaning and Restoration Certification- IICRC S500- Standard and Reference Guide for Professional Water Damage Restoration.

Institute of Inspection Cleaning and Restoration Certification- IICRC S520- Standard and Reference Guide for Professional Mold Remediation.

All Revision Dates

1/30/2026, 12/9/2013, 3/1/2010

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.013 Fire Alarm System

POLICY:

The Ventura County Medical Center/Santa Paula Hospital fire alarm system shall be continuously monitored by an appropriate outside monitoring system. The monitoring system shall be tested quarterly by the service to ensure alarms are being transmitted.

PROCEDURE:

The Ventura County Medical Center/Santa Paula Hospital fire alarm equipment is maintained by the Rincon Inspection Group Inc and Monitoring service is provided by S.A.S. Bay Alarm Company.

All Revision Dates

1/30/2026, 3/13/2023, 7/1/2016, 12/9/2013, 8/25/2009, 1/4/2008, 12/13/2001

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.015 Facilities Maintenance Worker Guidelines for Patient Interactions

POLICY:

To state basic recommendations for Facilities Maintenance staff when working around Ventura County Medical Center/Santa Paula Hospital patients or in patient rooms.

PROCEDURE:

1. Avoid intruding on the private relationship between physicians, nurses and patients.
2. Do not discuss the patient's illness or give advice to patients. Make no comments and avoid giving opinions. This is the responsibility of the nurse and/or the physician.
3. Never discuss a patient with visitors or friends.
4. Do not assist the patient even if they ask for assistance. Patient care is the responsibility of nursing staff. Maintenance workers are not trained in patient care and could cause harm to patients. If the occasion arises, inform the patient you will notify nursing staff of the patient request.
5. Maintain patient privacy. Before entering a patient's room, check in at the nursing station. Knock when entering a patient room, even if the door is open. After completing the task, inform nursing staff that the work is completed.
6. If a patient is a personal friend, they must be regarded as a patient first. Personal visits to the patient should be conducted during normal visiting hours.
7. Facilities Maintenance Department staff must be clean; not only their persons, but the equipment they use.

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.016 Electrical Safety

POLICY:

The following safety precautions shall be followed at all times at Ventura County Medical Center/ Santa Paula Hospital when electrical devices are utilized.

PROCEDURE:

- Electrical devices shall be protected from wet floors.
- The frame of all electrically operated machinery shall be grounded.
- Brass light sockets within reach shall be replaced with non-conducting material.
- Extension lights shall be equipped with rubber handles, sockets and lamp guards. The cords shall be of approved rubber-covered type.
- Non-conducting links shall be inserted in brass pull chains.

Prompt repairs shall be made to any electrical equipment from which a reported "shock is felt."

Care is to be maintained when connecting and disconnecting electrical equipment. Switch to "off" position before connecting or disconnecting.

Do not disconnect the plug from the wall by grasping the power cord. Grasp the plug itself and disconnect.

Report and remove from service any device that has been dropped, abused, had liquid spilled on it or has evidence of overheating.

Discontinue use of equipment that has any wire or power cord that shows fraying, extreme wear, damaged insulation or evidence of burning. Report any deficiencies to the Facilities Maintenance Department at ext. 6683.

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Next Review	1/29/2029		

F.018 Facilities Maintenance Building and Maintenance Program

POLICY:

An ongoing Building Maintenance Program at Ventura County Medical Center/Santa Paula Hospital has been developed to establish frequencies of inspection, testing and adjustment of the components of life safety.

The Building Maintenance Program shall collect historical data for tracking/trending purposes and the maintenance of equipment and systems through-out the facility.

PROCEDURE:

The Building Maintenance Program includes:

- Inspection schedules and records of inspections
- Corrective maintenance records
- Report(s) on each asset and provides the tools for management oversight

The following components of the life safety program will be included in the building maintenance program. All items will be properly functioning and properly sealed as appropriate.

- ½ hour FRRA (Fire Resistance Rated Assembly) doors, and 1 – hour FRRA doors that include occupancy separation doors, stair doors, horizontal exit doors and hazardous are room doors
- Linen/trash chute inlet and outlet doors
- Smoke barrier doors
- Corridor doors

- Smoke barrier wall penetrations
- HVAC
- Corridor wall penetrations
- Means of egress illumination devices
- Exit signs
- Means of egress maintained free of ice and snow
- Exhaust hoods, exhaust duct systems and grease removal devices cleaned and maintained

Rated assembly and barrier maintenance and penetration.

- Develop accurate drawings that clearly show the location of barriers. If necessary, talk to long-time employees about this issue because they may have knowledge that others don't about the barriers.
- Provide the drawings to contractors so they know which walls are barriers.
- Put into any construction or renovation contract that workers must repair and properly seal any penetrations they create.
- All work conducted by contractors will be inspected by the IOR of the project to ensure proper penetration sealant.
- Inspect any penetration sealing before payment is issued to the final contractor.

Emergency Power Systems

Medical Gas and Vacuum Systems

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Next Review	1/29/2029		

F.019 Extension Cords

POLICY:

To state the proper use of extension cords at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

- Use of extension cords in non-emergency situations is discouraged. Extension cords may only be utilized on temporary basis until permanent electrical fixtures are installed.
- All extension cords must be less than 25 feet in length and be constructed of hospital-grade material.
- Electrical cords must be tested for electrical safety.

Except where installed in accordance with NFPA, extension cords shall not be used:

- As a substitute for fixed wiring.
- When run through holes in walls, ceilings or floors.
- Attached to building surfaces.
- Concealed behind building walls, ceilings or floors.

Under no circumstances shall extension cords be used in areas where explosive gases are present.

- When used in the operation of electrically powered construction, maintenance or cleaning equipment, appropriate signs shall be posted to identify tripping hazards.
- All cords must have hospital-grade plugs and receptacles. They must be of a minimum of 16 gauge wire.
- This policy shall be approved by the Safety Committee.

PROCEDURES:

- The Facilities Maintenance Department will be responsible for inspection and approval of any extension cord used within the hospital.
- Any department needing the use of an extension cord must submit a written request describing why an extension cord is needed and details of use (i.e., where, when, and how).
- Department directors shall be responsible for the implementation of this policy in their departments.
- The Facilities Maintenance Manager shall be responsible for control of this policy.

All Revision Dates

1/30/2026, 12/9/2013, 3/31/2011, 10/25/2004

Approval Signatures

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Next Review	1/29/2029		

F.021 Security Access: Key Control

POLICY:

It is the policy of the Ventura County Health Care Agency (HCA) that the Facilities Maintenance Department provides a high degree of security by maintaining control over the issuance and accountability of all keys to buildings, offices and other lockable pieces of equipment.

PROCEDURE:

A. Key control is focused on building control. Desks, file cabinets and special departmental equipment keys and locks are tracked through the HCA Facilities Maintenance Department Key Request system.

B. Key Audit: When key control in an area appears weak, a list of keys that were issued to that department and its employees will be sent to the responsible area for verification and/or corrective action. It is the department's responsibility to conduct audits and report the results to the HCA Facilities Maintenance Manager.

C. To ensure keys are issued to the authorized employee, a copy of the employee badge or photo ID must be submitted with the Key Request to use as identification confirmation upon delivery of key to employee. For security purposes, requests will not be processed without a copy of the identification.

D. Key Transfer: Keys shall not be transferred to other staff within a department. Each time an employee leaves employment with the County, it is up to the responsible department to ensure that employee keys are returned to the appropriate designated area to clear that person's record. This is covered in the release packet completed by all employees upon separation from employment. However, a new request form shall be completed and signed by individuals transferred into the department (see Attachment A).

E. Lost Keys: Loss or theft of hospital keys must be reported immediately to the immediate supervisor and other appropriate designated individuals. All key records must be immediately

updated to reflect loss of keys and any corrective actions required. Administrators, Department Heads, Directors or Office Managers will ensure appropriate incident reports are completed and, where indicated, appropriate disciplinary action taken.

F. Contractors will be issued keys on a very restrictive basis and only for the specific area of need for the job. In a very limited number of cases, a Great Grand Master may be justified for use by a contractor. In all cases, the project manager is responsible for retrieval of the key when the project is completed.

G. Unauthorized duplication of hospital keys is strictly prohibited. USE BLANKS STAMPED "DO NOT DUPLICATE" FOR ALL KEYS.

POLICY STATEMENT

The HCA Facilities Manager designates and HCA Facilities Maintenance employee to be responsible for the control, distribution and installation of all locks and keys covered by this policy. No building keys or locks will be issued, changed, duplicated, deleted or replaced without written authority and direction by the HCA Facilities Manager. The issue of all locks and keys will require a written request by the Administrators, Department Heads, Directors or Office Managers. The duplication, or attempted duplication, of any lock or key used throughout the facilities is strictly prohibited except as authorized.

PROCEDURE

The designated HCA Facilities Maintenance employee has overall responsibility for control of the issuance of all HCA keys and card key access, the delegation of duties, as well as operational guidelines. Present delegation for Great Grand Master key issuance is to the HCA Facilities Manager, along with re-keying, key cuts, access to custodial closets, electrical and mechanical rooms and maintenance of the key system. The HCA Facilities Maintenance Manager, with approval of the Chief Executive Officer, is required to sign off on issuance of Great Grand Key Master Keys. Departmental key requests for building master keys and individual keys required by department employees, are the responsibility of the Administrators, Department Heads, and Directors or Office Managers.

OBTAINING KEYS: DEPARTMENTAL AND HOSPITAL GENERAL RESPONSIBILITY ACTION

Employee completes a key request form, including a copy of badge for identification and submit to supervisor (see Attachment A).

SUPERVISOR

1. Determine the keys required to gain access desired and control features needed. List those keys on key request form and verify form is completed accurately and completely.
2. Obtain appropriate Administrators, Department Heads, Directors or Office Manager's signature on key request form.
3. Submit key request form to HCA Facilities Maintenance Office. Only keys listed should be issued. The designated HCA Facilities Maintenance employee will issue keys to employee and

ensure proper signatures have been obtained.

PROJECT MANAGER

1. Determine the keys required to gain access (applicable for contractors desired and control features needed. List only those keys on the key request form.
2. Submit key request form to HCA Facilities Maintenance Manager.
3. Upon completion of project, ensure assigned keys are returned.

HCA FACILITIES MANAGER

1. Review need and validity of key assignment to contractors based on project scope. If appropriate, approve request.
2. Approve issuance of keys to contractor.

LOST, MISSING OR STOLEN KEYS

EMPLOYEE

1. Upon discovery of lost, missing or stolen keys, immediately notify supervisor. HCA Facilities Maintenance Office, Ventura Police Department (if applicable) and any other designated individuals.
2. Complete a key request form and submit to supervisor.
3. Complete a Critical Incident Report (CIR) form.

SUPERVISOR

1. Determine the keys required to gain access desired and control features needed. List only those keys on the key request form.
2. Review CIR and determine if disciplinary action is warranted.
3. Obtain appropriate Administrator, Department Head, Director or Office Manager's signature on the key request form.
4. Submit key request form to HCA Facilities Maintenance Office.
5. Forward CIR to appropriate Administrator, Department Head, Director or Office Manager with recommendations regarding disciplinary action.

TRANSFER/SEPARATION OF EMPLOYMENT/ RETIREMENT

EMPLOYEE

1. Notify supervisor of intent to transfer, resign or retire from employment.

2. Turn keys into Department Manager.

DEPARTMENT MANAGER

Return keys to HCA Facilities Maintenance Manager for deactivation.

ATTACHMENTS:

Attachment A - Key Request Form

All Revision Dates

1/30/2026, 12/29/2017, 7/1/2016, 12/9/2013, 3/31/2011, 10/25/2004

Attachments

A: Key Request

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/30/2026
Facilities Department	Ian McGraw: Manager Facility Operation	1/30/2026

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Next Review	1/29/2029		

F.026 HVAC System Failure

POLICY:

To state the process to be followed in the event of failure of any part of a HVAC system at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

1. Check the thermostat
2. Check air handlers
3. If blowers are running and unit in not cooling, verify chilled water delivery to unit.
4. If no chilled water, verify pump operation and chiller operation.
5. If pumps and chillers are running, check valves and control systems at air handler.
6. If any component of system is not running check;
    - Electrical supply
    - Mechanical components
7. If chiller is not operating verify condenser water circulating pumps, if unit is water-cooled, and operation of cooling tower.
8. If Facilities Maintenance staff are unable to identify the problem, contact an HVAC technician. If an HVAC technician is unavailable, notify the on-call Supervisor.

HEATING FAILURE:

1. Check thermostat
2. Check air handlers

3. If blowers are running, check hot water delivery to coils.
4. If no hot water, check pumps and heat exchangers.
5. If pumps and heat exchangers are running check valves, control systems and strainers at coil, (flush if necessary).
6. If any components of system are not running check;
    - Electrical supply
    - Mechanical components
7. If Facilities Maintenance staff are unable to identify the problem, contact an HVAC technician. If an HVAC technician is unavailable, notify the on-call Supervisor.

All Revision Dates

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Next Review	1/29/2029
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.039 Grounds Safety

POLICY:

The Facilities Maintenance Department is responsible for maintaining the grounds of Ventura County Medical Center/Santa Paula Hospital campus and all Health Care Agency (HCA) Ambulatory Care Clinics in a safe manner for personnel, patients and visitors.

PROCEDURE:

- Under the direction of the HCA Facilities Maintenance Manager, the Security Department will make daily inspection rounds of exterior buildings and campus grounds. Any hazardous conditions shall be noted and submitted to the Engineering Department where corrective action is taken immediately.
- The campus buildings and grounds are maintained by the HCA Facilities Maintenance Department. The facility landscaping is maintained by an outside landscape contractor whom reports to the HCA Facilities Maintenance Manager.

All Revision Dates

1/30/2026, 12/9/2013, 8/25/2009, 1/4/2008, 10/18/2004

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F.058 Domestic Hot Water Temperature

POLICY:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Academic Family Medicine Center (AFMC), Crisis Residential Treatment (CRT), Inpatient Psychiatric Unit (IPU), and Crisis Stabilization Unit (CSU) have established and estimated temperature setting to prevent accidental or inadvertent scalding of patients, visitors or staff

PROCEDURE:

Facilities Maintenance department will maintain domestic hot water temperature between 105 degrees to 120 degrees Fahrenheit.

Daily Inspections: HME (Hospital Maintenance Engineer) performing rounds is responsible to verify and document the temperature supply to the Hospital or building every shift. The North Tower domestic hot water is monitored and recorded on the BMS (Building Management System).

Monthly Inspections: The Facilities Manager or assignee is responsible to ensure that water temperature is tested in random patient care areas and documented.

Reporting: If temperature is out of range, HME (Hospital Maintenance Engineer) performing rounds is responsible for making adjustments or escalating the issue to the maintenance plumber and reporting the variance to the The Facilities Manager/Supervisor

All Revision Dates

1/30/2026, 10/22/2022, 12/9/2013, 3/31/2011, 3/13/2008, 9/25/2004

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Last Revised	1/30/2026
Next Review	1/29/2029
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.062 Use of Personal Electrical Equipment

POLICY:

To state the rules allowing usage of patient, staff or visitor electrical equipment.

PROCEDURE:

Patients:

- All use of personal electrical appliances should be absolutely discouraged. If patients insist, however, on using a personal electrical appliance, it must first be checked by the Biomedical Department to ensure that it is safe before it can be used by the patient.
- The Biomedical Department shall tag the equipment with the date so as to indicate it has been checked and passes inspection. These inspections are to be done during regular hours only. Patients cannot use their equipment until it has been checked.
- No electrical equipment except that qualified by the Facilities Maintenance Department as being in compliance with NFPA standards shall be used in any flammable anesthetizing location.

Hospital and Physicians:

- Prior to use in the hospital, any personally-owned electrical equipment must be approved by the appropriate hospital staff.
- The Facilities Maintenance Department has the responsibility of determining safety requirements.
- Safety approval must be in writing.
- The Safety/Environment of Care Committee may designate exceptions.
- When a physician wishes to use his/her personal electrical equipment, it shall first be inspected by the Biomedical Department and if judged to comply with NFPA, be so labeled.

NOTES:

- It is the recommendation of the Facilities Maintenance/Biomedical Department that no personal electrical equipment be brought into the facility.
- If the facility chooses to allow the use of personal electrical equipment, it must recognize that any equipment checked by the facility's Biomedical Department and ensured safe may invite liability.

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1/30/2026, 7/1/2016, 12/9/2013

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Next Review	1/29/2029
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.067 Failure of Oxygen Systems

POLICY:

To define the process for the Facilities Maintenance Department to follow in the event of a failure of oxygen systems.

PROCEDURE:

1. Possible reasons for an oxygen system failure:
   - Equipment malfunction
   - Depletion of gas
   - Rupture of gas line
2. Warning signs or indicators of failure:
   - Audible alarm due to pressure loss
   - Call from nursing unit or other patient care area
3. Back-up mechanisms and/or reserves:
   - Reserve bulk gas supply (controlled by Support Services Department)
   - Reserve gas cylinders available from the Respiratory Department
4. Areas which may be affected:
   - Inpatient nursing units
   - Labor and delivery
   - Operating Room/Recovery/Outpatient surgery
   - Emergency Room

- Radiology

5. Identify the cause of the failure. Use caution: the risks of combustion are much greater in an environment of pure oxygen. **NO SMOKING!** Avoid skin contact with liquid oxygen because of its extremely low temperature.
6. Check to ensure the reserve supply is on-line and system pressure is satisfactory.
7. If both "Oxygen Supply" and "Reserve" have been disabled and the problem cannot be corrected immediately, notify the Respiratory Therapy Department to deliver portable cylinders to the critical care areas STAT and connect "H" cylinders to the gas line in the unit. (Page Respiratory staff, if necessary.)
8. Notify Nursing Administration and request that they alert all affected units.
9. Call and request emergency delivery of oxygen, as needed. (Refer to Emergency Telephone List.)
10. Make minor repairs or request outside assistance, as appropriate. (Refer to Emergency Telephone List.)
11. Coordinate tests of the oxygen system with Respiratory Therapy staff, if tests are necessary.
12. Notify the on-call Supervisor and the Nursing Supervisor.

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Next Review	1/29/2029		

F.070 Loss of Electrical Power

POLICY:

To define the steps that should be taken by Facilities Maintenance staff in the event of a loss of electrical power.

PROCEDURE:

Possible reasons for loss of electrical power are:

- Distribution in all or part of internal electrical distribution system
- Distribution of external power (utility company equipment)

Warning or indicators of loss of power and failure of emergency power

- Total loss of power and light in all areas

Warning signs or indicators of loss of external power only

- Visible transfer of power (lights/equipment) in the Facility
- Alarm in electrical service building
- The generators are running. If so, Facilities Maintenance shall transfer to "Emergency Power" indicators on ATS in electrical service building.

1. Backup mechanisms and reserves for loss of external power
    a. Emergency power generators (automatic)
        - Supply power to entire campus
        - Begin operating within one (1) second of power failure and transfer all critical hospital services within 10 seconds

b. Diesel
c. Portable battery packs
d. Uninterrupted power supplies on designated equipment

Areas that may be affected by loss of electrical power and failure of emergency generators:

a. Alarm systems
b. Blood, bone and tissue storage units
c. Corridor lighting
d. Delivery rooms
e. Egress illumination
f. Elevators
g. Emergency care areas
h. Emergency communication system
    - Telephone
    - Nurse Call
    - Intercom
i. Medical air compressors
j. Medical/surgical vacuum systems
k. Newborn nurseries
l. Operating rooms
m. Postoperative recovery rooms
n. Specialty care units

The single line drawings of the electrical distribution system are located in the plan room in the Facilities Maintenance building.

GUIDELINES:

Loss of electrical power and failure of emergency generator:

1. Call for assistance and notify key personnel
    a. Notify the on-call Supervisor and designee Electrician
    b. Call the generator repair service and request dispatch of service person immediately. (Refer to emergency telephone list.)
    c. Notify the Nursing Supervisor or Administrator on Duty (AOD) that there has been a total power outage and that you will keep them updated.
2. Determine the reason for failure of the generator:
    a. Failure of generator engine

b. Transfer switch or control panel malfunction

c. Contaminated fuel

3. Attempt to manually start the generator per the manufacturer instructions
    a. If the generator does not start, check the starter system and batteries.
    b. If the starter system is functional, check to see if there is adequate fuel in the day tank. If there is not, refuel the day tank from the main supply or, if necessary, contact the fuel supplier for STAT delivery of additional fuel. (Refer to emergency telephone list).
    c. If the starter system is not functional or additional fuel must be obtained from the supplier, call the utility company to determine the estimated time of power outage and notify the Nursing Supervisor or AOD as to when external or emergency power will be restored, whichever occurs first.
4. If the generator started, check all trip relays
    a. If no relays or breakers tripped, check the control panel for fault indicators.
    b. If there are no fault indicators, follow manual transfer procedures.
    c. If the transfer switch cannot be thrown manually or a fault is indicated on the control panel, call an electrician immediately. (Refer to emergency telephone list). Do not attempt to throw transfer switch manually if there is a fault light indicator on the control panel. Call the utility company to determine the estimated time of the power outage and notify the Nursing Supervisor or AOD as to when external or emergency power will be restored, whichever occurs first.
    d. If the transfer switch can be thrown, do so, then notify the Nursing Supervisor or AOD that the hospital is now on emergency power and that power usage should be reduced accordingly.

GUIDELINES:

Loss of electrical power

1. Determine whether loss of power is due to internal or external disruption
    a. Check main electrical distribution system in the electrical service building.
    b. Call Supervisor on-call and designated electrician
    c. Call utility company
2. If power loss is due to disruption in the external power source, notify the on-call Supervisor, on-duty electrician, Nursing Supervisor and AOD.
3. **Notification following an electrical outage:**

    NOTE: Always follow the *Systems Failure and Basic Staff Response* guidelines as posted in each department:

    Facilities Notification Procedure:

Department notification of Emergency Power status will not occur until the following is determined:

a. **All emergency power and transfer switches have been verified by Facilities Maintenance.**

b. **Utility Power Company (SCE) has been contacted as to severity and longevity of the outage.**

c. **Initiation of Full Equipment Reset (hospital-wide). Critical Equipment Reset is required of all critical hospital equipment. Verify all critical equipment operation.**

NOTE: Once all systems have been verified, Facilities Maintenance will notify Hospital Administration and/or the AOD.

Facilities Maintenance (if time allows) will notify specific departments on status and estimated time to power restoration:

Paging x6075, Security x6283, NICU x6088, ICU x6195 Surgery x6237, CT Scan x6013, ER x6165, Nursing Sup. x6001, OB x6058, Lab x6037, Central S x6247, Boiler Room x6688

4. If power loss is due to disruption in the internal electrical distribution system, try to identify the problem.

RESTORATION FOLLOWING LOSS OF ELECTRICAL POWER

5. When the power has been restored, restart/reset equipment in the power plant, mechanical room, or other parts of the hospital that have been affected.

All Revision Dates

1/30/2026, 2/1/2017, 7/1/2016, 12/9/2013, 8/25/2009, 12/4/2004, 12/10/1992

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Facilities Department	Ian McGraw: Manager Facility Operation	1/30/2026

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F.081 Filter Inspection and Change Process

POLICY:

This instruction is developed for Facilities Maintenance staff to standardize the procedure for the inspection and maintenance of the Air Handlers Filters for the hospital.

PROCEDURE:

An integral part of the maintenance program is the scheduled replacement and/or cleaning of the air filters throughout the hospital. This aspect of the program is crucial for ensuring the cleanliness of the hospital environment.

- All filters will be cleaned or replaced as defined by the Preventative Maintenance schedule.
- Work orders are generated by the Computerized Maintenance Management System (CMMS) identifying the quantity, location, size, frequency and the date work is to be completed.
- The following is the procedure for Inspecting the Air Filters:
  - **PERFORM MAGNEHELIC READINGS BEFORE FILTER CHANGE**
  - SUPPLY: _____ (.5 TO 1.5)
  - RETURN: _____ (.20 TO 1.0)
  - FILTERS NEED TO BE CHANGE? YES _____ NO _____
  - FILTERS CHANGE STEPS:
  - 1) _____ WEAR PPE BEFORE PERFORMING THE TASK
  - 2) _____ REMOVE OLD FILTERS FROM UNIT
  - 3) _____ INSTALL NEW PRIMARY FILTERS TO UNIT
  - 4) _____ INITIAL AND DATE THE NEW INSTALLED FILTER(S)
  - 5) _____ CLEAN WORK AREA

- 6) _____ DISCARD ALL OLD FILTERS IN AUTHORIZED TRASH CONTAINER.
-
- **PERFORM MAGNEHELIC READINGS AFTER FILTERS CHANGE**
  SUPPLY: _____ (.5 TO 1.5)
  RETURN: _____ (.20 TO 1.0)

All Revision Dates

1/30/2026, 7/27/2022, 12/9/2013, 8/25/2009, 1/7/2008, 12/13/2001

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Facilities Department	Ian McGraw: Manager Facility Operation	1/30/2026

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

CONFIDENTIAL

Medical Executive Committee Document Approvals

February 2026

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VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.001 Hospital Mission Statement

POLICY:

As a member of the Ventura County Health Care Agency, Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) are part of a fully-integrated, comprehensive system of hospitals, clinic and specialty services. The system provides access to high quality, compassionate health care to residents throughout Ventura County.

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) provide comprehensive, cost-effective, compassionate health care for our diverse community, especially those facing barriers, through an exceptional workforce, education, and forward thinking leadership.

The vision of VCMC/SPH is to set the standard in health care excellence. Healthy people in healthy communities throughout Ventura County.

All revision dates: 8/9/2022, 11/1/2013, 6/1/2006, 12/1/2004, 11/1/2004, 9/1/2001, 8/1/1998, 9/1/1991

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Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/13/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/26/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/26/2025
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VENTURA COUNTY
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100.009 Sterilization Regulations, Required Consent and Waiting Periods

POLICY:

State and federal regulations mandate special informed consent requirements for certain reproductive sterilizations. There is no difference under the law between sterilization of male or female patients. Regulations apply to elective sterilization only. Certain additional restrictions and requirements apply when the patient's treatment costs are reimbursed by Medi-Cal or certain other federally funded programs (e.g. Family PACT). Treatment which is not for the purpose of, but results in, sterility is not subject to the special sterilization consent requirements.

STERILIZATIONS PERFORMED AS A NECESSARY INCIDENT TO TREATING AN EMERGENCY CONDITION ARE NOT COVERED BY THE REGULATIONS.

PROCEDURE:

REQUIREMENTS APPLICABLE TO ELECTIVE STERILIZATION

An elective sterilization may be performed only when the following conditions are met:

1. Informed consent for the sterilization procedure has been obtained from the patient.
2. The sterilization consent has been signed by the necessary parties.
3. The required waiting period has been satisfied.

PERSONS WHO MAY GIVE INFORMED CONSENT

To give informed consent for sterilization, the patient must be:

1. Able to understand the content and nature of the informed consent process
2. Not in a condition or mental state in which judgment is significantly altered, including conditions resulting from the influence of alcohol or other substances that affect the individual's state of awareness.
3. Not in labor, and not less then 24 hours postpartum or post-abortion.
4. Not seeking to obtain or obtaining an abortion. This sterilization and abortion procedure may be performed concurrently, but only when consent for the sterilization was not given at the time when an abortion decision or arrangement for an abortion were made or during the abortion procedure.
5. A private patient must be eighteen years of age or older, or under 18 and:

a. Has entered into a valid marriage, whether or not the marriage is terminated.
b. Is on active duty with the United States Armed Services;
c. Is over fifteen years old, lives apart from his or her parents and manages his or her own financial affairs; or
d. Has received a declaration of emancipation pursuant to Family Code

6. A Medi-Cal or federally funded patient must be 21 years of age or older.

ADDITIONAL CRITERIA FOR MEDI-CAL AND CERTAIN FEDERALLY FUNDED PATIENTS

At the time consent is obtained, or at the time the patient undergoes an elective sterilization, the patient must *not* be:

1. A "mentally incompetent individual."
2. An "institutionalized individual," that is an individual who is:
   a. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility.
   b. Confined under a voluntary commitment for the care and treatment of mental illness.

REQUIREMENTS OF INFORMED CONSENT – APPLICABLE TO *ALL* PATIENTS

A patient has given informed consent if the person who obtained consent for the sterilization procedure:

1. Offered to answer any questions that the patient to be sterilized may have concerning the procedure.
2. Provided the patient with the appropriate sterilization information/booklet and a copy of the appropriate sterilization consent form (Medi-Cal: pm 330 – Non-Federally Funded: pm 284).
3. Orally provided all of the following information to the patient to be sterilized:
   a. Advise that he/she is free to withhold or withdraw consent to the sterilization procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
   b. A full description of available alternative temporary methods of birth control.
   c. Advise that the procedure is considered to be irreversible.
   d. A full explanation of the specific procedure to be performed.
   e. A full description of the discomforts and risks that may accompany or follow the procedure, including explanation of type and possible effects of anesthetic to be used.
   f. A full description of benefits or advantages to be expected as a result of sterilization.
   g. Approximate length of hospital stay.
   h. Approximate length of time for recovery.
   i. Financial cost to patient.
   j. Information as to whether procedure is new or established.
   k. Advice that the sterilization will not be performed for at least 30 days, except under specified circumstances (see “Required Waiting Period” section of this policy).
   l. Name of physician performing procedure. If another physician is substituted, the patient must be notified, prior to administering pre-anesthesia medication, of the physician's name and the reason for

substitution.

4. The person who obtains the patient's consent must determine that the sterilization was requested without fraud, duress, or undue influence, and that the patient's consent was knowingly and voluntarily given.

PERSONS PARTICIPATING IN THE INFORMED CONSENT

The informed consent discussion and review of the consent form must be conducted by the physician who will perform the sterilization, or by the physician's designee. A designee may be a non-physician but should have special knowledge and training in sterilizations. The operating physician or designee who secures consent must sign the consent as soon as the discussion with the patient is completed. By signing the consent form, the physician or designee certifies that he or she has personally:

1. Advised the patient that no federal benefits may be withheld or withdrawn because of the decision not to be sterilized.
2. Explained orally to the patient the information required for informed consent as contained on the consent form and in the regulations.
3. Determined to the best of his or her knowledge and belief, that the patient appeared mentally competent and knowingly and voluntarily consented to be sterilized.

If person giving consent is not fluent in the languages used on the consent form, an interpreter must be provided. If one is provided, the interpreter must certify, by signing the consent form, that the interpreter:

1. Transmitted the information and advice presented orally to the patient.
2. Read the consent form and explained its contents to the patient.
3. Determined, to the best of the interpreter's knowledge and belief, that the patient understood what the interpreter told the patient.

If person giving consent is blind, deaf or otherwise handicapped, suitable arrangements must be made to ensure that the required information listed above and contained on the consent form is communicated.

In cases where the sterilization of an incompetent patient is permitted, the patient's conservator or another person authorized to consent will necessarily be involved. In addition, the conservator must apply for a court order pursuant to Probate Code.

REQUIRED WAITING PERIOD

The following waiting period requirements apply after the informed consent discussion has been completed and the consent form has been signed by the patient or conservator, the physician or designee who obtained the patient's consent, and the interpreter, if any.

1. Thirty days, but not more than180 days, must pass after the appropriate sterilization consent form was signed by the patient or conservator.
2. An elective sterilization may be performed less than 30 days after the patient signed the consent form only in the following circumstances:
    i. A non-federally funded (aka private pay) patient voluntarily requests in writing that the 30-day waiting period be waived to no less than 72 hours.
    ii. The elective sterilization is performed under one of two emergency circumstances: (1) at the time of emergency abdominal surgery or (2) at the time of premature delivery, and only if:

- The physician certifies that informed consent was given and the sterilization consent form was signed at least 30 days before the intended date of sterilization; or
- The physician certifies that at least 72 hours have passed since informed consent was given and the sterilization consent for was signed; and
- The physician describes the emergency or indicates the prior expected date of delivery on the sterilization consent form.

3. If an interpreter is used, this must be reflected on Consent Form to include name, job classification or relationship to the patient.
4. The operating physician must review the consent process with the patient within 72 hours of the time before preoperative medication is administered and must complete the Consent Form.

A. **COPIES OF THE CONSENT FORM**

1. Original retained in the patient's medical record.
2. Copy provided to the patient.
3. Attached to the bill for Medi-Cal or certain other federally funded patients.

REPORTING REQUIREMENTS

The hospital must report to the Medical Board of California any physician who performs a sterilization procedure that was not in compliance with the informed consent requirements. A quarterly report on the number and types of sterilizations done at Ventura County Medical Center/Santa Paula Hospital will be submitted by Health Information Management to the State Department of Health containing the following:

1. The total number of such sterilizations performed, including diagnosis and types of procedures employed.
2. The numbers and types of such sterilizations performed by each physician on the medical staff preserving the anonymity of the physician and patient.
3. Such demographic and medical data as required by the State.

All revision dates: 1/10/2023, 6/13/2019, 5/1/2006, 8/1/2004, 7/1/1990, 10/1/1986

Attachments

No Attachments

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Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/24/2025

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/24/2025
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Policy Area:	*Administrative - Patient Care*
References:	

100.014 Patient Transfer to Ventura County Medical Center and Santa Paula Hospital

POLICY:

Unless extenuating circumstances are documented in the patient's Electronic Health Record (EHR), no patient shall be arbitrarily transferred to another hospital if the hospital where he is initially seen has the means for providing adequate care. The patient shall not be transferred until the receiving hospital or facility has consented to accept the patient, and the patient is considered sufficiently stabilized for transport. Responsibility for the patient during transfer shall be established and all pertinent medical information shall accompany patient being transferred.

PROCEDURE:

It is the policy of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to accept an appropriate *transfer* of a patient with an unstabilized *emergency medical condition* who requires specialized capabilities or facilities when VCMC/SPH has the *capacity* to treat the individual.

A log shall be maintained which documents inquiries for transfers which shall include names, if known, and conditions of patients, the outcome of the call and the reason if VCMC/SPH refuses to accept the transfer.

All requests for medically emergent transfers shall be handled by the Nursing Supervisor to determine bed availability and capacity. The Nursing Supervisor shall then contact the service line attending to determine appropriateness of the transfer and identify the accepting physician. If the patient is to be seen in the Emergency Department by the accepting physician and not transferred to an inpatient bed, the accepting physician shall call the Emergency Department attending with details and plan. All interfacility patient transfers will be directed through the Pre-Admitting office during regular business hours (8:00 am to 5:00 pm, Monday through Friday).

Emergency Department-to-Emergency Department transfers shall receive an Emergency Department evaluation after the Emergency Department physician has accepted the transfer. Interfacility transfers shall be routed to the assigned inpatient bed.

Patients not being evaluated in the Emergency Department (inpatient-to-inpatient transfers) shall have all documentation with regards to the transfer in his/her medical record.

Acute care patients are considered appropriate for transfer to VCMC/SPH. VCMC shall accept patients for the following services: Intensive Care, Medical/Surgical, Neonatal Intensive Care, high risk OB, Pediatrics and

Santa Paula Hospital patients, based on the patient's clinical condition. Transfers between VCMC and SPH shall be based upon the patient's clinical condition, available staffing levels and resources.

It is expected that the attending physician at the referring facility will, in all instances, obtain approval of the appropriate VCMC receiving physician prior to any transfer.

Questions concerning any transfers in or out of the facility may be directed to the Chief Nursing Officer and/or the Medical Director.

QUALITY MANAGEMENT

Monitoring ***Emergency Medical Treatment and Labor Act (EMTALA)*** compliance is the responsibility of VCMC/SPH Administration, the Medical Staff, Department Heads, Quality Assessment/Performance Improvement and Risk Management. Please refer to details in policy 100.068 Medical Examination and Transfer from Ventura County Medical Center/Santa Paula Hospital .

All revision dates: 3/21/2019, 5/1/2016, 6/1/2006, 11/1/2004, 4/1/2000, 12/1/1998, 4/1/1995, 7/1/1989, 5/1/1986, 4/1/1984

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100.019 Release of Patient Information

~~POLICY:~~

POLICY:

In accordance with the State Department of Health (Title 22 Admin. Code Sec. 70707), the California Hospital Association's (Consent Manual) recommendations, the 1983 Confidentiality of Medical Information Act (Part 2.6 of Division 2 of the Civil Code, commencing with Sec. 56), the Lanterman-Petris-Short Act, and other applicable State and Federal guideline ~~statues~~statutes and laws, the following policy regarding Release of Patient Information is hereby adopted by Ventura County Medical Center (VCMC) and Santa Paula Hospital(~~S PH~~SPH).

The authority and responsibility for releasing medical information rests with the Manager of Health Information Management (HIM).

~~PROCEDURE:~~

PROCEDURE:

In general, no information of a medical nature will be released from the medical record without a proper, written authorization from one of the following:

1. Patient~~. -~ If patient is an adult with the ability to understand the significance and use of the authorization, or if the patient is a minor with the ability to understand the significance and use of the authorization, and minor patient could have lawfully consented to care.
2. Parent or legal guardian, ~~or other person in loco parents, if~~if the patient is a minor ~~(~~except in cases where minor ~~patient could~~has the legal right to consent to their own care~~)~~.
3. Guardian or agent appointed by patient under a Power of Attorney specifically for health care, if patient is mentally incompetent.
4. The Personal Representative of a decedent including the executor or administrator of the patient's estate ~~of a beneficiary~~. ~~"Beneficiary" means a person who receives money or property under the deceaseds' will.~~ If the deceased ~~did not have a will~~died intestate, a ~~beneficiary is an heir under the law usually a~~ surviving spouse, state registered domestic partner or ~~child~~the informant listed on the person's death certificate may request records. A copy of the death certificate ~~should~~must be ~~requested~~presented with the request for records. ~~A copy of the will should also be requested to determine if the~~If a person requesting records

of a deceased patient is ~~indeed a beneficiary or executor. If a person requesting records of a deceased patient is~~ an administrator of the estate, ~~he or she should be able to~~they must provide ~~a~~probate court ~~document~~order appointing them to that role as proof.

The authorization shall be in compliance with the ~~confidentiality~~Confidentiality of Medical Information Act (CMIA) and the Health Insurance Portability and Accountability Act (HIPAA) and includes the following:

1. Signature of appropriate person as listed above~~, the patient or his/her legal representative (for minors or incompetent) or spouse (if for billing purposes only), or by the beneficiary (for deceased)~~.
2. ~~States the specific uses and limitations on the types~~The type(s) of information to be disclosed.
3. ~~States the~~The name or other specific identification of the ~~health care provider~~Licensed Independent Practitioner (LIP) releasing the information.
4. ~~States the~~The name or specific identification of the persons/entities ~~receiving~~authorized to receive the information.
5. ~~States the specific~~The purpose of the use or disclosure~~, including limitations of the information being released~~.
6. ~~States a specific~~Specific expiration date, after which the authorization is no longer valid.
7. ~~Advises~~Advisement to the patient of his/her right to receive a copy of the authorization.
8. ~~States~~A statement that the recipient of the protected health information under the authorization is prohibited from disclosing the information, except with a written authorization or as specifically permitted by law.
9. ~~States~~A statement that the ~~healthcare provider will~~LIP may not condition the provision of care or the receipt of benefits on the signing of the authorization.
10. ~~States~~A statement the patient~~'s personal representative's~~ has a right to revoke the authorization in writing.

Whenever possible, the hospital ~~release~~authorization form shall be used (see Attachment A). ~~No authorization will be honored if more than six months old.~~

RELEASE WITHOUT PATIENT AUTHORIZATION

Mandatory Disclosure: The hospital will disclose medical information when the disclosure is compelled by one of the following:

~~1. by a court order,~~

~~2. by a subpoena duces tecum,~~

~~3. by a board, commission or administrative agency pursuant to its lawful authority (i.e., Medical Board of California),~~

~~4. by a Workman's Compensation appeals board,~~

~~5. by a search warrant, and~~

~~when disclosure of information by a health provider is required by law (e.g., communicable disease, suspected child abuse). In all cases, psychiatric or drug abuse records will only be released directly to the judge of the issuing "court" (or commission).~~

1. by a court order.
2. by a subpoena duces tecum, accompanied by proof of service of a "notice to consumer or employee"

form pursuant to California Code of Civil Procedure §§ 1985.3 and 1985.6.

3. by a board, commission or administrative agency pursuant to its lawful authority (e.g., Medical Board of California) in response to either a patient authorization or proper service of a subpoena.
4. by a Workman's Compensation appeals board.
5. by a search warrant and.
6. when disclosure of information by a Licensed Independent Practitioner (LIP) is specifically required by law (e.g., communicable disease, suspected child abuse). When such disclosures involve specially protected health information under 42 CFR Part 2, HIV test results (Health & Safety Code § 120980), or mental health records (W&I Code § 5328), those records shall only be disclosed as specifically authorized by law or by court order.

~~DISCRETIONARY DISCLOSURE WITHOUT AUTHORIZATION~~
DISCRETIONARY DISCLOSURE WITHOUT AUTHORIZATION

In addition, ~~the Act indicates a number of situations in which medical information may be disclosed~~California and federal law permit disclosure, without patient authorization, in certain situations subject to certain limitations. Such release is discretionary with the ~~provider~~LIP. Since there is no absolute requirement that such disclosure be made, the ~~provider~~LIP may make certain conditions for its release, ~~such as charging a fee,~~ or may decline to release the information if the request seems *unreasonable* or *questionable* in some way. Ordinarily such requests are honored ~~since~~if the information ~~may~~appears to be needed for the **continuing care** of the patient or for **obtaining payment for care** .

These include release to the following:

- A ~~licensed health care provider~~Licensed Independent Practitioner for the purpose of diagnosing or treating the patient; this includes emergency medical personnel who are at the scene of an emergency or in emergency transport and communicating by radio with medical personnel at a licensed hospital.
- A ~~licensed health~~Licensed Independent Practitioner to assist that practitioner in obtaining payment for care ~~provider to assist that provider in obtaining payment for care~~ given to the patient.
- Person or entity responsible for paying for the health care services ~~that were~~ rendered, but only to the extent necessary for the purpose of determining responsibility for payment.
- Person or entity providing billing, claims management, medical data processing, or other administrative services for ~~providers~~practitioners or insurers as mentioned above.
  ~~Organized committees and agents of professional societies or medical staffs of licensed hospitals engaged in reviewing competence or qualifications of health care professionals.~~
- Professional review organizations or other persons or organizations responsible for reviewing health care services for medical necessity, level of care, quality of care, or justification of charges.
- Persons or entities responsible for defending any claim of professional liability by the individual whose care of the patient is documented in that ~~the provider may incur~~record.
- ~~County Coroner.~~Medical Examiner or Sheriff- Coroner.
- Researchers for bona fide research purposes and as authorized by the VCMC Institutional Review Board (IRB).
- Licensing or accrediting agencies responsible for licensing or accrediting ~~providers of heath~~the practitioners of the health care documented in the record.
- Patient's employer, if the medical information was created as a result of employment-related health care services at the prior written request and expense of the employer ~~and it either is relevant to a legal action~~

~~involving the patient and the employer in which the patient has placed the medical information at issue or describes functional limitations of the patient~~.

- A sponsor, insurer, or administration of a group or individual insured or uninsured plan or policy by which the patient seeks coverage if the information was created at the request and expense of the sponsor, insurer, or administrator to evaluate an application of the patient.
- A group practice prepayment health care service plan by ~~providers~~practitioners contracting with the plan for purposes of administration.
- Probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial or continuing conservatorship or guardianship over the person whose information will be disclosed.
- Tissue bank processing the tissue of a decedent for transplantation into the body of another person.
- State or federally recognized disaster relief organization of basic information about the patient only, in response to disaster welfare inquiries.

~~**Release to News Media:** It is generally recognized that it is in the public interest to make limited amounts of basic information available to the news media upon request unless a patient has specifically requested that the hospital not release any information about his or her hospitalization or if there is a police order prohibiting release of information.~~

Sensitive Personal Information (AB 81): Medical Information related to a patient's immigration or citizenship status, national origin, or other protected personal characteristics shall not be collected, used, or disclosed unless required by federal or state law, or expressly authorized in writing by the patient. Such information shall not be disclosed to law enforcement or any third party without lawful authority or the patient's written consent.

Release to News Media: Under no circumstances shall any information that could reveal a patient's immigration or citizenship status, ethnicity, or other protected personal identifiers or details of the patient's care be disclosed to the media.

~~Any inquiries made by the news media to~~ **No information** will be released at any time by any County employee at VCMC/SPH~~, either by phone or in person, **MUST** be forwarded immediately to the Hospital Administration~~ or Health Care Agency to the news media. ~~**No information** will be released at~~Any inquiries made by the news media to any ~~time by any County~~ employee at VCMC/SPH~~ or Health Care Agency. The~~, either by phone or in person, MUST be forwarded immediately to the Hospital Administration. Outside of regular business hours the Hospital Chief Executive Officer, Administrator on Duty or designee or the Nursing Supervisor ~~will~~should be contacted for response. ~~Patient rights and confidentiality will be protected at all times. News media inquiry made about specific patient~~Per general conditions ~~must be routed to Hospital Administration. Per general conditions~~ listed below, the Nursing Supervisor can be authorized to release information after confirmation from the Administrator on Duty has been obtained.

Basic Information Which May Be Released to the News Media

1. Basic information is defined to include:
    a. General condition
2. Definition of General Condition:
    a. GOOD - Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
    b. FAIR - Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.

c. SERIOUS – Vital signs are unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.

d. CRITICAL - Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.

e. DECEASED - Announcement of death is not routinely made by the hospital. However, news of the death of a patient is public information after the family ~~as~~has been notified or after all reasonable efforts to notify the family have been made. The hospital may release information on the death certificate after it has been signed by a physician.

~~Elaboration on General Condition:~~

~~It may prove necessary in describing patient condition to provide description of the nature of the accident (e.g. automobile, plane) or injuries. Such description should be limited.~~

DISASTER

~~The~~When the hospital ~~should work with public figures to answer~~is handling large number of victims from a **disaster or a multiple casualty incident**, every attempt will be made to keep news media ~~inquiries with minimum disruption for all concerned and provide the fullest reasonable cooperation with the media~~informed through Hospital Administration and the Public Information Officer. ~~When the hospital is handling large number of victims from a **DISASTER**, every attempt should be made to keep news media informed through Hospital Administration and the Public Information Office. The nature of the medical care provided through the Emergency Department, however, requires that extra precautions be taken when releasing information.~~

MENTAL HEALTH OR DRUG AND ALCOHOL ABUSE AND DEVELOPMENTALLY DISABLED PATIENTS

Disclosure of information about these categories of patients shall comply with 42 CFR Part 2, W&I Code § 5328, and HIPAA Privacy Rule 45 CFR § 164.512. No Information may be disclosed to any third party, including law enforcement, without specific patient consent or court order.

Federal regulations and California law strictly prohibit the giving of information about developmentally disabled, psychiatric or drug and alcohol abuse patients, including information from the police concerning persons who subsequently become psychiatric or drug and alcohol abuse patients. It is recommended that all such inquiries be answered, "We cannot, under Federal regulations and/or California law, comment on this case." Refer to the California Hospital Association Consent Manual.

EMERGENCY DEPARTMENT

1. In the Emergency Department, during treatment of persons in the custody of law enforcement agencies, ~~only~~no more than a **brief** status report may be given to the officer stating **only** whether or not the patient needs further hospitalization and/or medical care.
2. Particular care must be exercised to ascertain whether law enforcement officers have a subpoena or search warrant if they desire more than a brief Emergency Department status report.
3. Cases of public record are those which by law are reportable to public authorities such as police, ~~coroner~~Medical Examiner or public health officer. ~~Requests for details must be referred to proper authority.~~

~~BIRTH INFORMATION~~

~~Notices of birth shall be released to the news media on a regular basis from HIM. This information shall include the name of the mother and father (unless requested otherwise by the mother), the place of residence, "boy" or "girl" and birth date.~~

RELEASE TO PATIENTS

Patients ~~shall~~ have a right to review and have a copy of their record. All requests for such copies shall be in writing. HIM will allow inspection within five (5) working days ~~working days~~ after receiving the written request. HIM will make photocopies available or will send copies within fifteen (15) calendar days after receiving the written request consistent with Health & Safety Code § 123110.

A fee for all copies shall be assessed.

~~The patient's primary physician may be contracted before release is made and offered the opportunity to release a "summary" of the patient's care instead of copies of the entire chart and a reasonable fee will be assessed for the preparation of this document.~~

Additional guidelines are provided in Administrative policy 109.048 - *Patient Access to Medical Records.*

RELEASE TO ATTORNEYS

1. Copies of medical records (excluding psychiatric, alcohol and drug abuse records) will be released to attorneys, other than attorneys retained by the hospital (see Discretionary Disclosure Item) only upon the receipt of a written authorization ~~of~~signed by the patient or a proper subpoena. Records shall be processed within five (5) days for all subpoenas with an additional 10 days allowed for all civil cases in which the subpoenaing party does not represent the patient. Appropriate fees shall be assessed in accordance with California law.
2. Records of psychiatric, alcohol and drug abuse treatment patients **May Not** be released in response to a subpoena **UNLESS:**
    a. the patient signs an authorization to disclose the records, or
    b. the subpoena is accompanied by a court order signed by a judge, or
    c. the judge reviews records in camera and orders release.
    (For instructions on the release of Psychiatric, Alcohol & Drug Abuse records, see Administrative policy 109.030.)

SECONDARY RELEASE OF RECORDS

Copies of records received from other health care providers will be treated as correspondence and will be placed under correspondence after patient's care. No secondary disclosure of these records shall be made except as authorized by law or patient authorization.

In all cases, the California Hospital Association Consent Manual and Health Information Portability and Accountability Act policies will be used as guidelines in regard to release of information, with special requirements for any psychiatric, alcohol or drug abuse records.

REFERENCES

- Title 22, Cal. Code Reg. § 70707
- California Civil Code § 56 et seq. (CMIA)
- 45 CFR Part 164 (HIPAA Privacy Rule)
- 42 CFR Part 2 (Substance Use Disorder Records)
- California Health & Safety Code § 123100 et seq. (Patient Access to Health Records)
- California Health & Safety Code § 120980 (HIV Test Confidentiality)
- W&I Code § 5328 (Mental Health Records)
- [Assembly Bill 81 (2024) - Protection of Sensitive Personal Information including Immigration Status]

(See also Administrative policies 100.018 and 100.020.)

All revision dates: 12/3/2025, 6/21/2022, 11/10/2021, 3/9/2021, 12/1/2013, 3/1/2010, 5/1/2006, 12/1/2004, 11/1/2001, 11/1/1998, 4/1/1995, 7/1/1992, 12/1/1989, 10/1/1986, 5/1/1983, 7/1/1976, 11/1/1974

Attachments

- Authorization For Use & Disclosure of PHI 800-10 (fillable)
- Authorization For Use & Disclosure of PHI 800-10spanish (fillable)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/12/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/3/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/3/2025
Policy Owner	Vibha Gune: HIM Manager	12/3/2025

VENTURA COUNTY HEALTH CARE AGENCY

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References:	

100.022 Withdrawal of Patient Life Support

POLICY:

The ethical implications of withdrawal of life support has been a concern nationally [1] and locally, and indeed prompted the formation of the Ventura County Medical Center and Santa Paula Hospital Ethics Committee. Among the duties of the Ethics Committee, when originally formulated, was to provide policy recommendations on such issues as non-resuscitation orders and withdrawal of life support. The former has been addressed in a policy which has been approved by the Medical Staff. Since its inception, the Ethics Committee has dealt with issues of withdrawal of life support and a number of its opinions have been placed in written form in the patients' charts.

The present policy statement is general and is intended to serve only as a broad guideline to help direct the process of problem solving. It will also reflect the ethical thinking of the diverse group of individuals, physicians, and lay people alike, who voluntarily serve the Ethics Committee.

PROCEDURE:

INTRODUCTION

Though each clinical circumstance differs, the Ethics Committee has found it helpful to classify circumstances which tend to amplify or focus specific concerns as follows:

1. Patients who are clinically brain dead.
2. Patients who are irreversibly comatose.
3. Patients who are not comatose, but may vary in their perception of their own illness and may vary in their capacity to participate in any decision making process.

PATIENTS WHO ARE CLINICALLY DEAD

The Ethics Committee has found, in prior discussions on the subject of withdrawal of life support, that a physician has no duty to provide treatment which is futile. Nowhere is it clearer than in the patient who has suffered irreversible cerebral function. The State of California has enacted statutes which reflect the generally held feeling that to prolong somatic survival when the entire brain ceases to function is an act of futility. Clearly the most important issue here is one of accurate diagnosis which can be easily accomplished simply by following standard and recognized guidelines.[2] Once clinical brain death has been determined by qualified licensed physicians, then all life support should be promptly withdrawn giving proper considerations to the

sentiments and grieving process of the patient's relatives.[3]

The Ethics Committee would, in principle, support the concept of organ donation. To this end, it would encourage the prompt diagnosis of clinical brain death when that diagnosis can be supported unequivocally. We would encourage also the ongoing cooperation with the Regional Organ Procurement Agency and, while being attentive to the needs of the family, agree with aggressive support of the donor while organ harvesting is pending.

PATIENTS WHO ARE NOT CLINICALLY BRAIN DEAD

In previous deliberations, the Ethics Committee generally has found no impediments to withdrawal of life support where the following general conditions are met:

1. That the prognosis is agreed upon by experienced clinicians and the patient may be considered to be terminal within a reasonably short period or, that intervention, though preserving life, would only serve to prolong an unwanted existence. Additionally, treatment would certainly preserve for the patient an expectation of prolonged suffering or yet more painful demise than would occur should life support be withdrawn presently.
2. That the patient primarily, and his or her family, acting in good faith, share an understanding of the prognosis and of the intended course of management with its consequences.
3. That the patient can be made comfortable, with pain relief and anxiety management and those other symptoms attendant to impending death will be attended to in a humane and caring manner.

To clarify the issues further, implied by the paragraph above, is that withdrawal of life support need not be considered only in the case of patients who are imminently terminal, terminal or irreversibly comatose. Many circumstances arise in the clinical practice of medicine where an opportunity to treat an otherwise fatal illness may only preserve a patient for a worse fate. Though court cases, such as **Quinlan** and **Eichner**, initially concerned patients who were irreversibly comatose, subsequent court cases have served to underscore the notion that patients other than those who are considered irreversibly comatose may be proper subject for concern regarding withdrawal of life support. (See **Bartling et al. vs.** Glendale Adventist Medical Center [l63 Cal. App 3d 186].)

Of immediate interest when considering withdrawal of life support is the issue of consent. Just as patients may accept advanced forms of life support, they may refuse it as well. The refusal of life support may bring into conflict the interests of the medical profession and perhaps State interests. The Committee has felt that non-institution of life support measures or withdrawal of life support are commonly synonymous and may be consistent with fundamental ethical principles of medicine, i.e., view of prevention of suffering and the absence of a duty to carry out care which is futile. With respect to State interest, one here is concerned only with the "prevention of irrational self-destruction." It is therefore the responsibility of the treating clinician to look upon issues of consent and of competency as relative matters to be weighed in the light of a specific clinical situation.

CONSENT

A competent patient's decision to forego life support systems is not significantly different from a decision to decline other types of medical care. The right of a competent adult patient to decline to have any medical treatment initiated or continued is well established. The right is founded on the constitutional right to privacy, the common law right to self-determination and the fundamental interest in patient autonomy which recognizes an individual's personal interest in directing the course of his or her own medical care.

In the specific instance of a decision to withdraw or forego life support systems, the competent patient is asserting his right to die a natural death without dependence on medical technology. As with all other medical care decisions, it is desirable that the patient be informed of relevant matters, such as the probable risks and benefits of the use or withdrawal of various life support systems, the nature of the patient's medical condition and prognosis for recovery. Once relevant medical facts are available, it is ultimately the decision of the competent patient to exercise the option. It is more frequently the case that decisions regarding the withholding or withdrawing of life support systems must be made concerning incompetent patients, i.e., patients whose mental functioning is so severely impaired that they are incapable of considering and making decisions regarding their own health care. In such cases, the most reliable reference point is evidence of what their particular patient would have done if in sufficient possession of his faculties to choose for herself/himself. In recent years, certain written vehicles have been used to memorialize, in advance, such desires. Two such forms are the "Durable Power of Attorney for Health Care"[4] and the so-called "Living Will."

The Living Will has also been used as a means to set forth in writing an individual's wishes concerning the withholding or withdrawal of life support systems[5]. Although this document does not have the legal force of a traditional will, the Living Will has been recognized as evidence of a patient's wishes. The most important aspect of both of these documents from an ethical point of view is their expression of individual choice in advance in a thoughtful and explicit way. The primary function, from an ethical point of view, is to preserve the exercise of individual self-determination for a time when physical circumstances make self-determination impossible. The directive to physicians also serves a similar function when a patient is diagnosed as having a terminal condition.[6]

Reliance on a Living Will or a Durable Power of Attorney is one type of substituted judgment. A decision maker other than the patient is, in effect, substituting his or her judgment for that of the patient. However, in the case of a Living Will or Durable Power of Attorney or some other type of written expression of the patient's wishes, the reliance on the patient's will is greatest.

"Living Will" and "Durable Power of Attorney" represent and reflect a general, though usually not specific, attitude towards life support. It remains the task of those charged with the patient's care to assess the applicability of previously expressed wishes to the present circumstances and not blindly rely upon these vehicles.

In other situations of substituted judgement, there is a greater need to gather facts indicative of the patient's wishes concerning life support systems, such as recollections of family, friends and acquaintances. In the absence of any evidence regarding the patient's wishes, family and friends, in consultation with those providing medical treatment, must attempt to reflect upon all of the circumstances to determine if the continued use of medical technology is proportionate or disproportionate in terms of the benefits to be gained for the patient verses the burdens caused.[7] Factors to be considered in this balancing test are the reasonable probability of return to cognitive and sapient life as distinguished from the continuance of mere vegetative existence. Underlying this standard, as a basis for substituted judgment, is the perception that even in the absence of an explicit expression, individuals generally recognize that the primary purpose of life support systems is not merely to suspend the act of dying, and prolong biological existence, but should be directed toward healing, enabling a return to a functioning life.

As a practical matter, any decisions to withhold life support systems should reflect, as much as possible, the patient's individual decision. The medical chart should reflect the nature of this evidence and a general description of the process leading to the ultimate decision, such as consultation with family, the treating staff, and other interested parties.

WITHHOLDING/WITHDRAWING LIFE SUPPORT

Special Issues with Regard to Infants and Children: Since an infant has never achieved competence, decision making based on autonomy or substituted judgement are clearly not applicable. However, decisions based on the principle of proportionate versus disproportionate treatment[8] in terms of benefits to be gained versus the burden caused, should also be applicable when the patient is an infant.

The presence of underlying handicaps (such as retardation) "justify a decision not to provide life-sustaining treatment only when they are so severe that continued existence would not be a net benefit to the infant."[9]

Parents are the most appropriate decision-makers, with those decisions based on information from the infant's physicians regarding diagnosis, prognosis, and available treatment options.[10] If there is conflict between the parents, or if their decision is felt by the infant's physicians or other caretakers to be against the best interests of the infant, the decision should be reviewed by the Medical Ethics Committee. In urgent cases, of course, it is the clinician's responsibility to secure court orders, if necessary, if it is in the child's best interests.

The California child abuse reporting statute (effective January l, l985) defined medical neglect as the willful or negligent failure of any person who is responsible for the child to provide adequate medical care, and further states that an informed and appropriate medical decision made by the parent or guardian after consultation with physicians who have examined the child does not constitute neglect.[11] Federal child abuse regulations define medical neglect as including withholding of medically indicated treatment (further defined as failure to respond to life threatening conditions by providing treatment which would be likely to be effective in ameliorating or correcting such conditions) except in narrowly defined circumstances which include:

1. The infant is chronically and irreversibly comatose.
2. The provision of such treatment would merely prolong dying.
3. The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.[12]

CMA GUIDELINES:

The VCMC/SPH Ethics Committee recommends that the following CMA Documents be used as supplemental information: "Do-Not-Resuscitate Decisions," "Documenting Decisions to Forgo Treatment." Due to copyright rules, the CMA document cannot be included here, but it is readily available in the California Physicians legal handbook, Volume 1, 12:19 & 12:20-21. This handbook is located in the Medical Director's Office and the contact number is 652-6062

All revision dates: 1/10/2023, 5/1/2006, 11/1/1998, 7/1/1998

Attachments

No Attachments

Approval Signatures

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

Step Description	Approver	Date
Committee		
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/12/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/24/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/24/2025
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VENTURA COUNTY HEALTH CARE AGENCY

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100.026 Declaration of Brain Death and Apnea Testing

POLICY:

Ventura County Medical Center/Santa Paula Hospital has a policy in place for determination of brain death that is consistent with regulatory mandates and medical-legal-ethical guidelines.

PROCEDURE:

A. In accordance with state law, patients who have suffered irreversible cessation of entire brain function, despite the presence of spontaneous cardiac activity, are considered dead. **Brain death** is defined as the irreversible loss of the clinical function of the whole brain, including the brainstem. Declaration of brain death then allows withdrawal of artificial means of respiratory and hemodynamic support in addition to allowing organ harvesting for transplantation. The formal process of declaring brain death is usually not necessary for withdrawal of life support from patients whom either irreversible cessation of conscious functioning (vegetative state) is present **or** continued support is considered futile or known to be against the wishes of the patient and/or family (see Administrative policy 100.022, *Withdrawal of Life Sup*port, and/or policy 100.050, *Non-Heart Beating Donor*).

B. Declaration of brain death must be verified and documented independently by two licensed physicians, neither of whom have any relationship to the transplantation centers, and who are members of the medical or resident staff of this hospital. **At** least one of the physicians must hold staff privileges and must be experienced in the process of determining brain death. The time of death should be recorded as the time the second physician documents the brain death.

Declaration of brain death at VCMC requires the following prerequisites:

C. Known Cause of Coma/Brain Injury:

1. Clinical evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death.
2. A diagnosis as to the cause of brain injury must be known. Where the cause is not apparent, diagnostic studies should be carried out to establish the nature of the injury before declaration of brain death.

D. The presence of brain death cannot be declared if one of the following conditions exists:

1. Drugs, severe hypothermia or other metabolic derangements, alone or in association with head

injury. Any or all may cause severe depression of CNS function leading to an incorrect assessment of the degree of brain injury. Hence, the following should be considered in all cases:

a. Core temperature should be at least 95 degrees Fahrenheit.

b. An intoxicated state must be excluded by a reliable history or negative toxicity students for CNS depressant drugs.

c. Hypoperfusion, hypoxemia, hypercarbia or recent use of neuromuscular blocking drugs should also be excluded (i.e., demonstrated absence of neuromuscular blockade).

d. Other complicating medical conditions that can confound clinical assessment (e.g., severe electrolyte, acid-base or endocrine disturbance).

E. In the presence of confounding variables, brain death can still be determined with the aid of ancillary tests. A period of observation of at least 24 hours without clinical neurological change is necessary if the cause of the coma is unknown.

F. Guidelines for the determination of brain death in adults shall be established by the Medicine and Surgery Committees.

G. Guidelines for the determination of brain death in infants and children shall be established by the Pediatric Committee.

H. Guidelines should be reviewed on a regular basis to be sure they comply with the most recent national standards.

I. In patients one year of age or less, **a pediatric consult must be obtained, and a pediatric neurologist should be involved if available. Detailed neurological examinations should be done at least 24 hours apart by a pediatrician experienced in the neurological examination of the child. A confirmatory test should be performed if deemed appropriate by the pediatric consultant. If an EEG is obtained, it must be coordinated and interpreted by the pediatric neurologist.**

BRAIN DEATH DETERMINATION PROTOCOL

The following protocol will assist the physician in determining brain death. It is necessary to confirm the absence of cranial nerve function, motor response and spontaneous respirations for determination of brain death.

J. Absence of cranial nerve function:

1. Absent pupillary light reflex (pupils fixed at 4-9 mm and unresponsive to light).
2. Absent corneal reflex.
3. Absent oculocephalic reflex -- doll's eyes (no ocular movement with head turning).
4. Absent gag reflex (no response to suctioning of pharynx, trachea or bronchi).
5. No swallowing, yawning or blinking.
6. No oculovestibular reflex - cold calorics (with irrigation of ears with up to 120 mL of ice water).

K. Coma with complete absence of motor response to central pain stimulation (i.e., intense pain stimuli delivered above the clavicles, excluding spinal reflexes). NOTE: It is common to witness non-purposeful movements and spinal reflexes in brain death.

L. Absence of spontaneous respirations. Apnea testing can be performed as follows (**an attending physician must be present during apnea testing**):

(The use of an arterial line is suggested to expedite the drawing of ABG's.)

1. Core temperature: 95°F or higher (if possible)
2. Systolic BP: ≥ 90mmHg
3. PaCO2: ≥40mmHg (a normal PaCO2)
4. Arterial pH: 7.35-7.45 (if possible)
5. Preoxygenate with 100% FIO2 for 20 minutes. Obtain ABG.
6. Disconnect ventilator, give O2 @ 8-10 LPM by tracheal cannula. Do NOT extubate and do not occlude the tracheal cannula. (Remove nasal prongs from cannula and pass through ETT.)
7. Observe continuously for spontaneous respirations.
8. After 10 minutes, draw ABG. (If the patient becomes unstable before 10 minutes, reconnect the ventilator and immediately draw ABG.)
9. Reconnect the ventilator.
10. Patient is apneic if PaCO2 is ≥ 60 mmHg or pH ≤ 7.30 or PaCO2 ≥ 20 mmHg over baseline, and there is no respiratory movement.
11. If hypotension and/or arrhythmia develop, immediately reconnect the ventilator and consider another confirmatory test.

CONFIRMATORY TESTS

Brain death is a clinical diagnosis. If severe facial trauma, pre-existing pupillary abnormalities, toxic levels of various drugs are present, inability to tolerate apnea test, or if the patient has a baseline severe chronic retention of CO2, other confirmatory testing may be required.

One should consider a Neurology or Neurosurgery Consult.

12. An electroencephalograph may be ordered. No electrocerebral activity present during at least thirty (30) minutes of recording adheres to the minimal technical criteria for EEG recording in suspected brain death. The core body temperature must be above 95°F.
13. A cerebral blood flow study demonstrating no cerebral blood flow.
14. A cerebral angiography demonstrating no cerebral blood flow.

DOCUMENTATION

The declaration of brain death must be documented independently in the medical record by two (2) licensed physicians (one of whom must be a staff physician) and should address the following points. Each licensed physician must sign, date and time the notation.

M. Time of declaration of brain death
N. Cause and irreversibility of the condition
O. Absence of brainstem reflexes
P. Coma including absence of motor response to pain
Q. Absence of respiration by PaCO2 or pH criteria (as per apnea test)

ORGAN PROCUREMENT

The hospital is required to call OneLegacy at (800) 338-6112 before the withdrawal of life support and in a timely manner on all individuals whose death is imminent or who have died. OneLegacy will determine if the patient may be an appropriate candidate for organ procurement. They will assist in patient management and will approach the family if donation is appropriate**.** A physician is NEVER to initiate a conversation about organ procurement with a family member.

REFERENCES

A. Hufford, William E., ed. Critical Care Handbook of the Massachusetts General Hospital. Philadelphia, Lippincott Williams and Wilkins, 2009.

B. OneLegacy Organ Donor Manual. Southern California Transplant Services, 2010. http://www.onelegacy.org/site/professionals/libary/manual.html.

C. Nakagawa TA: Guidelines for the determination of brain death in infants and children: An update of the 1987 Task Force recommendations. Crit Care Med 2011; 39: 2139-2155.

All revision dates: 1/10/2023, 6/1/2012, 10/1/2006, 5/1/2006, 2/1/2001, 11/1/1994, 1/1/1992, 3/1/1991, 11/1/1990, 11/1/1988

Attachments

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Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/13/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/10/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/10/2025
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100.033 Blood Alcohol Test Procedures

POLICY:

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) perform phlebotomy for the purpose of obtaining blood alcohol specimens for law enforcement agencies.

PROCEDURE:

The arresting officer assumes all responsibility for advising the individual of his rights to the choice of tests. He or she will also furnish and complete the request form used for the authorization for taking the specimen.

VCMC/SPH staff will assume the responsibility for drawing blood alcohol specimens from persons brought to the hospital when requested 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 the Law Enforcement Department.

The arresting officer assumes all responsibility for advising the individual of his/her rights. He or she will also furnish and complete the request forms used for the authorization for taking the specimen.

The "Implied Consent" law is applicable to any person who has a California Driver's License and/or drives a motor vehicle upon a highway. Juveniles are not exempt in those cases where the arresting officer requests a chemical test. Parents of the juvenile do not have the right to refuse the test.

The VCMC/SPH procedures for obtaining blood samples will be as follows:

1. Personnel authorized to obtain blood samples in ranking order of availability at the time of request include:
    a. Nursing staff; if not immediately available, then:
    b. Clinical Lab Scientist or Certified Phlebotomy Technician; if not immediately available, then:
    c. Physician
2. Personnel are obligated to follow the above sequence of availability and should not refuse to draw blood alcohol specimens for inappropriate reasons.
3. The Ventura County Medical Center/Santa Paula Hospital staff will obtain only blood samples for use in determination of alcohol content. Should a patient request the breath test or urine test, the officer will be responsible for making such arrangements.
4. Prior to obtaining specimens from a patient, the law enforcement officer will present the hospital with a

signed Blood Specimen Request and Consent form (Attachment A). In addition, a Medical Record of Blood Specimen Drawn at Request of Law Enforcement Agency form (Attachment B) will be initiated in triplicate by the law enforcement officer and then completed by the individual responsible for drawing the blood. According to the District Attorney's Office, the use of this form should alleviate the need to testify on the part of the individual obtaining the specimen. One copy of the completed form should be forwarded to Medical Records, one copy to the officer for Law Enforcement Agency files; and one copy should be sent with the specimen. Finally, in what is called a Driving Under the Influence of Drugs (DUID) case, the arresting officer may request an additional 10 mL vacutainer of blood. This additional blood shall be obtained only upon request of the arresting officer.

5. Blood alcohol kits, which are furnished by the Crime Laboratory and stored in the Emergency Department (ED), will be used in obtaining blood specimens. A non-alcohol based cleanser will be used to cleanse the skin.
6. Specimens will be turned over to the officer for handling and transporting to the Crime Laboratory. Hospital personnel are responsible for obtaining specimen **only**.
7. Blood will be drawn after the consent has been signed. Blood may be drawn if the person refuses to sign but does not resist. Blood may be drawn if the person refuses to sign the consent and physically resists if the circumstances require 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 lawful arrest. The patient's consent is not required if there is a court order for the blood samples. A blood sample may be drawn at the request of the attending officer without the patient's consent if the patient is unconscious and has been involved in a motor accident. The Emergency Department physician or nurse will draw blood.
8. The cooperation consists of assisting the law enforcement officer in obtaining specimens, so long as it does not offend the conscious of the court. Unconscious or deceased patients are included among these patients from whom specimens may be taken.
9. When individuals responsible for drawing blood specimens are subpoenaed to testify as a witness, the subpoena should include the statement "please be on call". The District Attorney's Office has clarified that this statement requires that individuals remain available by phone or in person during that schedule trial session.

All revision dates: 1/10/2023, 1/28/2020, 9/1/2016, 11/1/2013, 5/1/2010, 5/1/2006, 12/1/2004, 8/1/2001, 1/1/1999, 12/1/1998, 8/1/1992, 5/1/1983, 1/1/1976

Attachments

- Attachment A: Blood Specimen Request and Consent
- Attachment B: Medical Record of Blood Specimen Drawn at Request of Law Enforcement Agency

Approval Signatures

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

Step Description	Approver	Date
Committee		
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/12/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	11/25/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/25/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/25/2025
Policy Owner	Julia Feig: Nurse Director, Emergency Services	11/25/2025

VENTURA COUNTY HEALTH CARE AGENCY

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References:	

100.049 Advance Healthcare Directives

POLICY:

To provide information to Ventura County Medical Center/Santa Paula Hospital patients in accordance with "The Patient Self-Determination Act" of their rights under state law to make decisions concerning their medical care, and to communicate patients' wishes to their healthcare team in a timely manner.

DEFINITIONS:

ADVANCE HEALTHCARE DIRECTIVE

1. "A document that authorizes another person to make healthcare decisions for a patient when they are no longer able to make decisions for themselves" and/or
2. Information provided about a patient's desires concerning healthcare decisions.

HEALTHCARE DECISION is defined by the Healthcare Decision Law (Probate Code Section 4617) as a "decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's healthcare," which may include:

1. Selection and discharge of healthcare providers and institutions.
2. Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.
3. Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare, which may include cardiopulmonary resuscitation.
4. Make a disposition under the Uniform Anatomical Gift Act.
5. Authorize an autopsy.
6. Direct the disposition of remains.
7. Receive and review medical records information, and consent to the disclosure of medical records and information.
8. Consent to HIV testing.

An agent or surrogate may not consent to the following:

1. Commitment to or placement in a mental health treatment facility
2. Convulsive treatment

3. Psychosurgery
4. Elective Sterilization
5. Abortions

INDIVIDUAL HEALTHCARE INSTRUCTION is a patient's written or oral direction concerning a healthcare decision.

CAPACITY is defined as a patient's ability to understand the nature and consequences of proposed healthcare, including its significant benefits, risks, and alternatives, and to make and communicate a healthcare decision.

PROCEDURE:

Upon each admission, all adult inpatients (and emancipated minors) will receive informational material informing them of their right, under state law, to formulate advance directives concerning healthcare decisions. In special circumstances, if a patient is incapacitated at the time of admission, the information will be provided to a family member or surrogate. The patient will be provided with the information when he/she becomes able to understand and to respond to the information.

An adult patient (or an emancipated minor) may give an "individual healthcare instruction." The patient may designate another adult as a surrogate to make healthcare decisions for him or her. If it is a written document it should be placed in the patient's chart and communicated to the healthcare team. However, it is not required that the patient provide this information in writing. The patient may provide this information orally, directly to the primary physician. This information will be documented in the chart by the primary physician and discussed with the healthcare team. The oral designation of an adult surrogate is effective only during the current stay in the hospital. The patient, having capacity, may revoke his or her request of a surrogate at any time in writing or by personally informing the primary physician. The primary physician will promptly document the revocation in the chart. If the patient informs a hospital employee who is not the primary physician of their wish to revoke an advanced directive, the primary physician must be notified immediately.

Social Services will maintain competency in the discussion and completion of advance directive forms, and will assist the patient upon request. If the patient desires to execute an advance directive, Social Services is responsible for assisting the patient in the completion of the forms.

Any advance directive executed by the patient becomes a part of the patient's permanent medical record. It is the joint responsibility of Admitting, Social Services, and Nursing to acquire copies of advance directives and place in the chart, and communicate the patient's wishes to the healthcare team members. The patient will not be discriminated against based upon whether or not an advanced directive has been executed, or the content of the advance directive.

It is recognized that a patient may wish to discuss such issues prior to a hospital admission or at other times. Therefore, Advance Directive Informational brochures will be made available upon the request of the patient in the outpatient clinic areas.

In accordance with California Probate Code (section 4734), a healthcare provider may decline to comply with an individual healthcare instruction or healthcare decision for reasons of conscience. Please refer to Administrative policy 101.009, *Staff Rights*. In the event the patient's physician is uncomfortable with a patient's directive for reasons of conscience, and the directive does not require medically ineffective healthcare or healthcare contrary to generally accepted healthcare standards, he/she must:

1. Discuss with the patient/family promptly.

2. Notify the Medical Director.
3. Request the input of the Ethics Committee, if appropriate.
4. Arrange to transfer the care of the patient to another physician who is willing to comply with the instruction or decision.
5. If necessary assist with arranging for the patient to transfer to another facility.
6. Provide continuing care (including pain management and palliative treatment) to the patient until the transfer arrangements are completed.

According to California Probate Code (sections 4673-4675) there are several components of written advance directives, and limitations in regards to who may be an agent or surrogate (section 4659). If any questions arise, please refer to the CHA Consent Manual located in the Nursing Office or Hospital Administration, or refer to the Medical Director for legal counsel evaluation.

REVOCATION of an advanced directive occurs in the following ways:

1. Unless it is stated otherwise, a power of attorney for healthcare is of unlimited duration. A patient having capacity may revoke the designation of an agent by a signed writing or personally notifying the primary physician.
2. A patient may also revoke all or part of an advance healthcare directive, other than designation of an agent, at any time and in any manner that communicates the intent to revoke.
3. A healthcare provider, agent, conservator, or surrogate who is informed of a revocation of an advance healthcare directive must promptly communicate the fact of the revocation to the supervising healthcare provider (primary physician) and to any healthcare institution where the patient is receiving care.

PROCEDURE:

1. During the admission process, the Admitting staff or Registered Nurse will supply the patient with the Advance Directive Informational brochure and assess the patient's desire for more information, assistance with formulating an advance directive, or existence of an advance directive. This information will be documented during the nurse's assessment and noted in the Electronic Health Record (EHR) under the nursing module.
2. If the patient requests more information or assistance with advance directives, information will be noted in the EHR, which in turn will be sent to Social Services for follow up.
3. If the patient has an Advance Directive, it will be placed in the chart and communicated to the healthcare team as soon as possible.
4. If the patient has an Advance Directive and does not have it with them and family is unable or unaware of its existence, the Admitting Clerk or Registered Nurse will notify Social Services for assistance in locating the written advance directive. The primary physician is responsible for discussing the patient's wishes and documenting them in the medical record.
5. If the patient has an Advance directive and has previously provided it to VCMC/SPH, the Admitting Clerk or Registered Nurse will notify Medical Records for assistance with locating the Advance Directive.
6. If the assessment for Advance Directive cannot be completed due to the condition of the patient, this information will be documented on the chart. The Registered Nurse is responsible for daily assessment of patient condition. If a change in condition enables the patient to respond, the Registered Nurse is responsible for noting this information in the EHR.

REFERENCE:

California Healthcare Association Consent Manual

All revision dates: 5/2/2019, 5/1/2016, 5/1/2010, 5/1/2006, 9/1/2001, 1/1/2001, 8/1/1999, 2/1/1999, 10/1/1998

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/16/2026
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/13/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/4/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/4/2026
Policy Owner	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Erlinda Roxas: Director, Laboratory Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.085 Tissue Acquisition, Receipt, Storage and Issuance

POLICY:

Whenever a surgical procedure at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) involves the use of tissue, the following procedures must be followed for acquisition, receipt, storage and issuance of tissue. The tissue program may involve areas outside the clinical Laboratory such as the Surgery Department, outpatient areas, and tissue banks. This applies to human and non-human cellular-based transplantable products whether classified by the U.S. Food and Drug Administration (FDA) as a tissue or a medical device. Examples of tissue specimens include, but are not limited to, bone, tendons, cartilage and synthetic tissue (artificially prepared, human and non-human based) and other cellular and tissue-based transplant or implant products.

VCMC/SPH only uses tissue source facilities licensed by the State of California and/or registered as a tissue establishment with the U.S. Food and Drug Administration (FDA).

VCMC/SPH will comply with any changes to state and federal regulations regarding the acquisition, receipt, storage and issuance of tissue.

PROCEDURE:

The following procedures must be adhered to for acquiring, receiving, storing and issuing tissues:

A. ACQUISITION

1. The Surgery Department will assign a responsible person to oversee and coordinate the program regarding the acquisition, receipt, storage and issuance of tissue.
2. Frozen tissues will be ordered on an "as needed" basis prior to each surgical case by the Surgery Buyer or delegate. The Surgery Department maintains a small inventory of freeze-dried tissue.

B. TRANSPORT

1. The transport, handling, storage, and use of tissues will be done according to the written specifications of the tissue bank (issuer) or manufacturer.

C. RECEIPT

1. Frozen tissue is delivered to the Laboratory Department. Room temperature tissue is delivered to the Surgery Department.

a. Upon receipt, the department will record the tissue arrival in an Implant Tissue Tracking Log sheet that records the product, source/manufacturer, serial/lot number, expiration date, date and time received and from whom, package integrity, storage destination, temperature, person signing in and the date/time to storage.

b. Attach and secure the original copy of the Implant Tissue Tracking log sheet (Attachment A) to the implant in a clear plastic bag. A copy is kept in a Tissue log book. This copy will be retrieved when the tissue is dispensed or removed from storage/freezer and discarded when the original Implant Tissue Tracking Log is completed.

c. The receiving department will be responsible for monitoring the tracking and maintaining the integrity and temperature of the tissue until utilized by the Surgery Department.

D. STORAGE

1. All freeze-dried tissue will be stored at controlled temperatures of between 15°C and 30°C. Freeze-dried tissue may not be frozen.
2. All refrigerated tissue will be stored between 1°C and 10°C. At this temperature range, tissue can be stored until the expiration date determined by the tissue source.
3. The tissue storage refrigerator will be armed with an alarm that sounds when set temperatures are not maintained. If the temperature of the refrigerator has failed, the tissue will be immediately sent to be stored in the Laboratory refrigerator that can maintain a temperature between 1°C and 10°C.
4. All frozen tissue will be stored between -40°C and -90°C. At this temperature range, tissue can be stored until the expiration date determined by the tissue source. Tissue can be stored for up to 6 months at -20°C. **The tissue package must be clearly marked with the new expiration date.**
5. The tissue storage freezer will be armed with an alarm that sounds when set temperatures are not maintained. If the temperature of the freezer has failed, the tissue will be immediately sent to be stored in the Laboratory freezer that can maintain a temperature of at least -20°C.
6. If the tissue is stored in a freezer about -40°C range, the new expiration date must be marked on the package and noted in the tissue log. If the tissue has been thawed for more than 2 hours, it must be stored at least 4°C but cannot be refrozen and must be used within 24 hours.
7. Expired or unused tissue/implant is placed in a red bag to be disposed by the Laboratory. Complete Trace Card to send to the source of implant/tissue.
8. The receiving department will have continuous monitoring of the tissue and have functional alarms (frozen tissue only).
9. In the event the primary Laboratory tissue storage freezer malfunctions, then tissue can be stored in the Blood Bank freezer.

E. ISSUANCE

1. The Surgery Department will retrieve the needed tissue immediately before the case and will log the tissue out with the date, time and signature or initials of the person retrieving the tissue.
2. Enter patient's (recipient) name and chart number or place patient's label where indicated.
3. If the tissue is not used within 24 hours, it must be discarded. Discarded tissue will have the discard time noted on the tissue log.
4. Complete processing material preparation when freeze-dried tissues need to be rehydrated or when tissue reconstitution is needed. Document the log number, expiration date of the solution.

5. When retrieving tissue from storage, and more than one (1) of a specific tissue/implant type is present, pull the tissue/implant item with the soonest expiration date.

F. Any deviation from the policy must be immediately reported to the Clinical Nurse Manager of the Surgery Department, the Chief Nursing Officer or the Laboratory Manager.

RECORD KEEPING

1. The VCMC/SPH Surgery Department will keep records confirming that the tissue suppliers are registered with the U.S. Food and Drug Administration (FDA) and review these records annually by the Clinical Nurse Manager of the Surgery Department or designee.
2. VCMC/SPH strictly follow manufacturer's directions in preparing or processing tissue. The VCMC Surgery Department will keep records of the manufacturer's directions.
3. The VCMC/SPH Surgery Department will keep traceable records of tissue from the donor or source facility to all recipients, or final disposition, including discarding tissue.
4. A copy of the implant record is kept in the log book in the Surgery Department or Surgery storage to permit tracing of any tissue from the donor to all recipients for a minimum of ten (10) years.
5. The Laboratory (frozen tissue) and the Surgery Department (room temperature tissue) will maintain a log book with full documentation of the information in Item D.
6. All records of storage temperatures, procedures, manuals and publications will be retained for a minimum of ten (10) years.
7. All persons involved, dates and times regarding tissue preparation is documented in the OR record and is kept in the patient's chart.
8. All tissue information cards will be completed by the OR staff by the end of the case and returned to the issuing/source facility including discarded tissue.

ADVERSE EVENTS/PATIENT NOTIFICATION

A. Any contamination of the tissue or any tissue reported by the source facility as contaminated will be sequestered immediately and reported to the Clinical Nurse Manager of the Surgery Department, the Chief Nursing Officer and the Laboratory Manager.

B. The Medical Director and the Hospital Chief Executive Officer will manage the event investigation and inform recipients of the infection risk.

C. Recipients of any tissue from a donor with HIV, HTLV I/II, viral Hepatitis or other infectious agents known to be transmitted by tissue are identified and informed of infection risk.

REFERENCES:

- The Joint Commission Standards, TS.03.01.01, TS.03.02.01 and TS.03.03.01
- Food and Drug Administration (FDA)
- California DHS

Note: The Laboratory Medical Director must review and sign all policies related to Tissue Banking.

All revision dates: 7/10/2019, 7/1/2016, 10/1/2010, 6/1/2010, 7/1/2009

Attachments

Implant Tissue Tracking Log: Acquisition, Receipt, Storage, and Issuance

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/29/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/24/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/23/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/23/2026
Policy Owner	Erlinda Roxas: Director, Laboratory Services	1/23/2026

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VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Operating Policies*
References:	

100.236 Patient Safety Plan

~~POLICY:~~

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

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

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

PURPOSE

The purpose of this Patient Safety Plan (PSP) is to establish a comprehensive, organization-wide approach to promoting patient safety, reducing preventable harm, addressing disparities, and fostering a culture of transparency and continuous improvement. This plan ensures compliance with California Health & Safety Code requirements, including the provisions established under **AB 3161.**

~~The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing~~Leaders promote a culture of safety that minimizes hazards and patient ~~safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/healthcare errors; and integrating patient safety priorities into the design and redesign of all relevant organization~~harm by focusing on care processes, modeling principles of a Just Culture, addressing disparities, and integrating patient safety into all functions and services.

~~Leaders focus on establishing a culture of safety that minimizes hazards and patient harm~~ The framework of a Just Culture ensures balanced accountability for both individuals and the organization, ~~by focusing on process~~

~~of care, modeling principles of a Just Culture and integrating patient safety into all functions and services. The framework of a Just Culture ensures balanced accountability for both individuals and the organization~~which is responsible for designing and improving systems in the workplace.
See Policy 107.082 Just Culture - Response to Safety Events.

~~GOALS:~~

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

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

~~PROCEDURE:~~

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

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

~~Authority and Responsibility~~

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

NONDISCRIMINATION POLICY

It is the policy of the County of Ventura to take all necessary steps to prevent and correct discrimination and harassment based upon race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age (over 40), military/veteran status, sexual orientation, citizenship status, familial/parental status, AIDS/HIV status, political activities or affiliations, and status as a victim of domestic violence, assault, or stalking.

This policy applies to all County employees—including managers, supervisors, and co-workers—as well as

third parties such as customers, contractors, and vendors.
Within the context of this Patient Safety Plan, these protections extend to all **patients, visitors, and individuals engaging with Ventura County Health Care Agency services**. The organization is committed to preventing, identifying, and addressing discrimination or bias in any form and ensuring equitable, safe, and respectful care for all patients. See Attachment A: **Policy No. Chapter VIII (A) - 23 Harassment, Discrimination, and Retaliation Prevention Policy.**

Definitions

A. **Patient Safety Event:** Any unexpected or unintended event or circumstance that could have or did lead to patient harm.

B. **No Harm Error:** an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

C. **Near Miss:** An event that did not reach the patient but could have caused harm.

D. **Adverse Event:** An event resulting in injury to a patient.

E. **Discrimination:** Differential treatment of a patient on the basis of race, ethnicity, language, sexual orientation, gender identity, disability, socioeconomic status, or other protected characteristics.

F. **Racism:** Policies, actions, or behaviors that create inequitable outcomes for patients based on race or ethnicity.

G. **Hazardous Conditions:** any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome.

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

Governance

The Patient Safety Officer/Team is responsible for ensuring all duties described in this plan. To maintain closed-loop communication, the Patient Safety Officer reports quarterly to the:

- Patient Safety Council (PSC)
- Medical Executive Committee (MEC)
- Oversight Committee

Responsibilities:

A. Review and approve the Patient Safety Plan and any annual updates.

B. Oversee the event reporting, analysis, and corrective action processes.

C. Monitor patient safety metrics and trends, including disparities identified through stratified analyses.

D. Ensure compliance with AB 3161 requirements.

E. Report findings, recommendations, and improvement actions to hospital leadership and the MEC.

Event Identification and Reporting

All members of the medical staff, nursing, ancillary, and support services are expected to report:

- Adverse events

- Near misses
- Unsafe conditions
- Potential bias, discrimination, racism or inequitable care

Reports must be entered in the hospital's event reporting system. See Policy 107.023 Adverse Events, Sentinel Events, Unusual Occurrences.

Reporting Options for Staff, Patients, and Families (Includes Anonymous Options)

- Event reporting system (RLDatix)
- Ventura County Health Care Agency - Online
- California Department of Public Health (CDPH) - Online Reporting Portal
- CDPH Mailing Address: 1889 North Rice Avenue, Suite 200, Oxnard, CA 93030
- Joint Commission Online Reporting Portal or 1-800-994-6610
- Patient Complaints and Grievance Process. See Policy 100.005 Patient/Visitor Complaints and Grievances

Event Triage, Review, and Analysis

A. Initial Triage

1. All reports submitted through the event reporting system are reviewed by Patient Safety personnel.

B. Investigative Processes

1. Events may undergo:

   a. Root Cause Analysis^2 (RCA^2)

   b. Case Review

   c. Focused reviews relating to discrimination or inequity

   d. Stratified event analysis (race, ethnicity, gender identity, language, sexual orientation, disability status, age, and payor)

Multidisciplinary involvement is included as appropriate. See also Policy 107.024 Root Cause/Event Analysis

Stratified reviews determine whether disparities or inequitable outcomes are present. Findings are reviewed by the PSC and incorporated into improvement planning.

Proactive Risk Reduction / Failure Mode and Effects Analysis (PRORA/FMEA)

A proactive component of the program includes the selection of a high-risk or error-prone process for in-depth analysis through PRORA/FMEA. Selection may be informed by:

- Joint Commission Sentinel Event Alerts
- Risk management data
- Performance improvement trends
- Infection prevention concerns
- Patient/family suggestions
- Other identified high-risk processes

Culture of Safety and Just Culture

Consistent with Just Culture principles, staff involved in safety events are supported through:

- A non-punitive approach

- Voluntary participation in RCA2/event analysis
- Access to Employee Assistance Program (EAP) and Care for the Caregiver
- Routine Culture of Safety surveys

Training and Education

Ongoing education is provided to maintain competence and support interdisciplinary care through:

- Orientation and annual training on event reporting mechanisms
- Annual competency assessments measuring patient safety knowledge
- Training on recognizing and reporting bias, racism, and discrimination
- Reinforcement of Just Culture principles

Patient Safety ~~Committee~~Council (PSC)

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

A. ~~The scope of the PSC includes review of medical/healthcare errors involving patients of any age, visitors, hospital/medical staff, students and volunteers. Aggregate data from internal reports and external resources will be used for review and analysis in prioritization of improvement efforts, implementation of interventions and follow-up monitoring. The severity categories of medical/health care errors include:~~

B. ~~**No Harm Error:** an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.~~

C. ~~**Mild to Moderate Adverse Outcome:** any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome.~~

D. ~~**Hazardous Conditions:** any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome.~~

E. ~~**Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.~~

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

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

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

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

a. ~~Compliance with patient safety standards and initiatives;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Providing information about reporting mechanisms to new staff in the initial orientation and during on-going training;

B. Providing ongoing education, including reporting mechanisms, through information presented during annual competency;

C. Testing staff knowledge regarding patient safety during annual competency;

D. Obtaining a confidential assessment of staff's willingness to report medical errors at least bi-annually.

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

A. These quarterly meeting reports will include ongoing activities including data collection, analysis, actions taken, and monitoring for the effectiveness of actions.

B. The minutes/reports of the Patient Safety Committee will be reported to the MEC and the Oversight Committee on a quarterly basis, or more frequently, as indicated.

External Reporting:

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

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

A. Conversations with patients and families during manager or administrative rounds;

B. Comments from patient satisfaction surveys.

C. Procedures used in communicating with families about the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion, include:

1. Patient's rights statements;

2. Patient responsibilities: A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.;

D. Annual assessment for barriers to effective communication among caregivers.

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

A. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes).

B. Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.

C. For each failure mode, the possible effects on patients, as well as the seriousness of the effect, will be identified.

D. The process will be redesigned to minimize the risk of failure modes.

E. The redesigned process will be tested and implemented.

F. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

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

A. Definition of the scope of occurrences including Sentinel Events, Event Analysis or a Root Cause Analysis as well as near misses;

B. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process (PRORA/FMEA) selected for improvement efforts;

C. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis;

D. A description of how the function of process design, which incorporates patient safety, has been carried

~~out using specific examples of process design or redesign that include patient safety principles;~~

~~E. The results of the program that assesses and improves staff willingness to report medical/health care errors;~~

~~F. A description of the examples of ongoing training and other educational programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.~~

The PSC oversees the Patient Safety Program through systematic, coordinated, and continuous review of processes related to patient care.

Meeting Frequency and Reporting Structure

- Meets **at least quarterly**
- Reports quarterly to MEC and Oversight Committee
- May convene additional meetings or subgroups to address emerging issues

Integration Across the Organization

A coordinated patient safety program requires collaboration across all departments.

1. **Event Reporting**
   - All employees across all departments are responsible for reporting potential ("Good Catch") or actual safety events through the established notification system.
2. **Leadership Communication**
   - Leadership ensures a comprehensive understanding of clinical and environmental safety factors.
3. **Safety Data Reporting**
   - Regular reporting of patient safety and operational safety data to the PSC, MEC, and Oversight Committee.
4. **Equity Oversight**
   - Quarterly equity reviews to identify patterns of disproportionate harm
   - Maintenance of equity dashboards for real-time visibility of disparities
   - Sharing de-identified disparity findings with front-line teams, leadership, and relevant committees to promote transparency and guide interventions

Annual Quality Assessment and Performance Improvement (QAPI) Reporting

The PSC chairperson submits an annual QAPI report summarizing:

- Ongoing activities, data trends, corrective actions, and outcome monitoring
- Results of proactive risk assessments (PRORA/FMEA)
- Culture of Safety survey findings
- Education and training initiatives

Confidentiality

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

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

All information related to patient safety performance improvement activities, including PSC minutes, medical staff committee minutes, and data reports, is confidential and protected. Dissemination of information is restricted to individuals or agencies that demonstrate a legitimate need to know or as required by regulatory or federal review agencies.

Evaluation and Approval

The Patient Safety Plan ~~will be~~is evaluated annually ~~or as changes occur~~—or sooner, if necessary—and revised ~~as necessary at~~under the direction of the Executive Team and/or ~~the~~ MEC. ~~The evaluation~~Effectiveness of the plan~~'s effectiveness will be~~ is documented in a report submitted to the MEC and Oversight Committee.

All revision dates: 12/9/2025, 3/14/2024, 9/14/2021, 4/14/2020

Attachments

VCGOV Harassment.Discrimination&Retaliation Prevention.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/12/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/4/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/9/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/9/2025
Policy Owner	Alicia Casapao: Director of Quality and Performance Improvement	12/9/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/16/2026*
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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.284 General Inpatient Hospice Care

PURPOSE:

The purpose of this policy is to outline the process by which patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) are placed into the general inpatient hospice program.

POLICY:

Hospice General Inpatient (GIP) Care is for hospice patients who require pain control or symptom management that cannot be managed in other settings. This policy outlines the specific admission criteria for acceptance of individuals for which hospice general inpatient services are requested.

PROCEDURE(S):

A. The licensed practitioner (LP) will place a patient status order (PSO) of hospice-inpatient. The order will be sent to the case management department at VCMC.

B. Case management will contact the Hospice Company Livingstone with the referral information.

C. The hospice team will assess the patient referral for appropriateness of admission to hospice based on the following criteria:

1. The patient/family desires hospice care with an understanding that it is palliative in nature and not curative, and that the patient may be waiving other benefits related to the terminal diagnosis.
2. The referring physician must certify that the patient has a terminal illness with a life expectancy of six months or less, if the disease runs its expected course.
3. There must be a reasonable expectation that the Plan of Care can be followed in a safe environment, including the availability of a willing and able caregiver.
4. The hospice medical director, in consultation with, or input from, the patient's attending physician, recommends admission to hospice.

D. Admitting procedure

1. The Nursing unit where the patient is housed notifies the Admitting Department (Admitting) of the patient's conversion to inpatient hospice at (805) 652-6075 or (805) 652-6071.
2. Admitting discharges the existing inpatient account using disposition 'Hospice-Medical Facility'.
3. Admitting re-registers patient in new encounter using Livingston as the Guarantor.

E. If the patient is determined to be appropriate for hospice admission, the hospice licensed practitioner (LP) will assess the patient for appropriateness for admission to the General Inpatient level of care and will document such in the electronic health record.

F. Inpatient hospice orders will utilize the Hospice Admission Power Plan.

G. If the patient meets the criteria for admission to hospice at the GIP level of care, a hospice registered nurse (RN) will meet with patient/family as soon as possible to initiate services. A hospice RN will visit the patient daily and document in the electronic health record.

H. The hospice nurse will complete an assessment, initiate the Plan of Care, and obtain orders from the hospice physician.

I. General nursing care will be documented by the hospital nursing staff in line with policy: see Policy 100.015 Patient Assessment and Reassessment.

J. At time of patient expiration, nursing will contact the hospital medicine team on call overnight or on site during the day to pronounce the patient. Nursing unit staff will notify Livingston of expiration date and time. All other care will following the hospital's death processing requirements. See Policy 100.031 Processing a Death.

K. Refer to Attachment A for hospice process.

EDUCATION

A. Contracted hospice agency staff will comply with all hospital policies. They will undergo orientation to the hospital upon hire.

B. Contractor will provide education on hospice care as needed to direct care team members caring for the hospice population.

C. Nursing staff providing care of the inpatient hospice patient will receive orientation to the program during initial on-boarding to the hospital.

All revision dates: 1/16/2026

Attachments

HOSPICE final 2026.pdf

Approval Signatures

Step Description	Approver	Date
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	pending

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Magdy Asaad: Infection Prevention Manager*
Policy Area:	*Administrative - Environment of Care*
References:	

106.028 Isolation Precautions

POLICY:

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

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

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

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

PROCEDURE:

Initiation of Isolation Precautions:

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

Discontinue Isolation Precautions:

A physician's order is required.

Patient Transport

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

Airborne Precautions

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

Patient Placement

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

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

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

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

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

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

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

Respiratory Protection

1. Healthcare workers shall wear a N95 mask or Portable Air-Powered Personal Respiratory (PAPR) when in patient room.
2. Susceptible persons should not enter the room of patients known or suspected to have rubeola (measles) or varicella (chickenpox) if other immune caregivers are available.
3. Patients with respiratory symptoms (e.g., cough, fever, sore throat, congestion, or known/suspected COVID-19 or influenza) should be advised to wear a well-fitting mask (as tolerated) while in healthcare facilities.
4. Visitors may be offered respiratory protection (i.e., N95) and should be instructed on the use of the respirator before entering an Airborne Illness Isolation (AII) room.

Droplet Precautions

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

Patient Placement

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

Respiratory Protection

- Wear a surgical mask.
- Patients with respiratory symptoms (e.g., cough, fever, sore throat, congestion, or known/suspected COVID-19 or influenza) should be advised to wear a well-fitting mask (as tolerated) while in healthcare facilities.

Contact Precautions

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

Isolation supplies (PPE's, masks, etc.) are now kept in hallways closets adjacent to patient rooms.

Gloves and gown

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

Hand Hygiene and the Patient with Clostridium Difficile Infection:

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

Patient Care Equipment

1. Do not share patient care equipment.

2. Return to the designated department for cleaning and disinfection.

Room Cleaning After Discharge

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

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

Multi-Drug Resistant Organism (MDRO) Isolation Quick Sheet

	Current Infection WITH Active Drainage/ Excretions	Current Infection WITHOUT Active Drainage/ Excretions	Current Colonization	History of
Methicillin-Resistant Staphylococcus Aureus (MRSA)	✓			
Candida Auris (CAURIS)	✓	✓	✓	~~✓ up to 3 years~~ ✓ Indefinite
Carbapenem-Resistant Enterobacteriaceae (CRE), Carbapenem-Resistant Pseudomonas aeruginosa (CRPA)	✓	✓	✓	✓ up to 6 months
Vancomycin-Resistant Enterococcus (VRE)	✓			
Resistant pseudomonas, resistant acinetobacter spp, or resistant stenotrophomonas spp	✓			
Extended-Spectrum Beta-Lactamase (ESBL)				

Candida Auris Screening and Isolation

Screen patients coming from high acuity post-acute care facilities including long-term acute care hospitals [LTACHs] and ventilator-capable skilled nursing facilities [vSNFs]) ~~going to the Intensive Care Unit (ICU) or the Definitive Observation Unit (DOU)~~.

Empiric contact isolation should be applied on admission of those patients pending screening results.

The licensed practitioner (LP) should consider screening such patients with additional risk factors as noted below:

- Mechanical ventilation
- ~~Indwelling medical devices, including central lines, feeding tubes, urinary catheters~~ Indwelling medical devices, particularly those who are mechanically ventilated or trached.
- Colonized or infected with a carbapenemase-producing organism (CPO) especially those in receipt of complex or high acuity medical care
- Healthcare exposure outside of ~~California~~United States in the past 12 months
- Potential exposure to other patient with C. auris

Extended-Spectrum Beta-Lactamase (ESBL): No Isolation needed

Clostridioides difficile: Contact precautions are required until 48 hours after resolution of all symptoms (fever, abdominal pain, and diarrhea, formed stool)

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

Other MDRO's: As identified by Infection Control Committee.

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

- Wear gloves when anticipating contact with blood or other potentially infectious materials, mucous membranes, or nonintact skin, or potentially contaminated intact skin.
- Change gloves and sanitize hands during patient care if the hands will move from a contaminated body-site (e.g., perineal area, wound) to a clean body-site (e.g., face).
- Wear a gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated
- Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. If a patient is coughing, use a mask.
- During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract [if not using in-line suction catheters], endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., M. tuberculosis, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown)

Contact Precautions

MRSA – methicillin resistant staph aureus

VRE – Vancomycin Resistant Enterococcus faecium, Enterococcus faecalis

CRE – Carbapenamen Resistant Escherichia coli and/or Klebsiella pneumoniae

Acinetobacter baumanii - multidrug resistant

Stenotrophomonas maltophilia – multidrug resistant

Clostridium difficile – **Enteric Contact Precautions**

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

References:

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

All revision dates: 1/20/2026, 1/14/2026, 11/12/2025, 8/15/2025, 3/19/2025, 6/11/2024, 7/31/2020, 9/17/2019, 6/13/2019, 5/1/2016, 11/1/2013, 2/1/2012, 7/1/2011, 9/1/2008, 5/1/2006, 12/1/1999

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	1/20/2026
Policy Owner	Magdy Asaad: Infection Prevention Manager	1/20/2026

VENTURA COUNTY HEALTH CARE AGENCY

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

108.057 Clostridium Difficile Screening and Testing

Policy and Functions to be Performed:

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

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

Purpose:

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

Procedure

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

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

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

Documentation

Document in patient chart the following:

A. Admission intake in EHR

B. Patient stool patterns and output

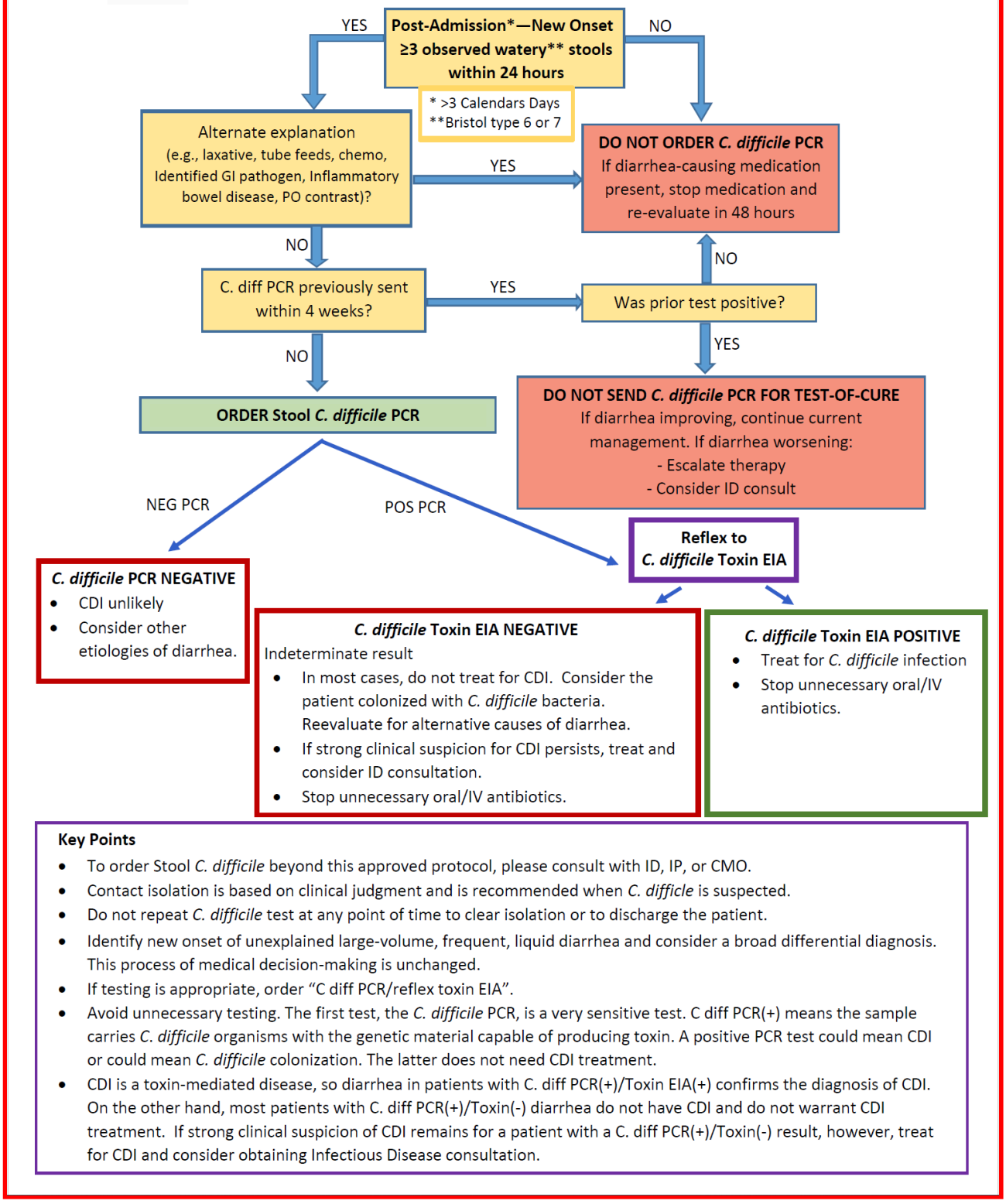
C. Complete the lab specimen task

D. Label the specimen appropriately with patient identifying information

E. Other details as appropriate.

Post-Admission Testing Algorithm

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



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

See Diagram for c._difficile_diagnostic_testing_algorithm_2025_07

All revision dates:	1/20/2026, 4/16/2025, 3/19/2025, 1/10/2025, 1/2/2024, 11/4/2022

Attachments

- Attachment C: Bristol Stool Form Scale
- Inpatient c._difficile_diagnostic_testing_algorithm.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/20/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/20/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/20/2026

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Ambulatory Care - Environment of Care*
References:	

AC.01 Ambulatory Care Emergency Response Equipment and Supplies

PURPOSE:

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

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

POLICY:

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

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

DEFINITIONS

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

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

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

PROCEDURE

A. **Storage, Accessibility & Security**

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

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

1. ~~One of two (2) types of emergency response carts/totes shall be in use as appropriate to the patient population served (See Attachment A):~~
    ~~a. Adult/Pediatric/Neonatal- Child Health and Disability Prevention Program (CHDP) and family medicine practices.~~
    ~~b. Adult- adult only practices.~~
    Emergency response carts/totes must be stocked with supplies and equipment appropriate to the patient population served (See Attachment A):
    a. Adult and Infant/Pediatric- includes all adult supplies plus additional items required for infant and pediatric emergency care.
    b. Adult Only- includes supplies and equipment necessary for managing adult medical emergencies.
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.

~~The internal contents of the emergency cart/tote shall be inventoried and visually inspected monthly and following any code event.~~

~~a. During inspection, the nurse shall break the numbered lock to access and visually inspect the contents of the emergency supply cart/tote and check for expired items.~~

~~b. Any supplies or medications that are expired or will be expiring in the current and/or following month shall be immediately replaced.~~

~~c. Upon completion of the inspection, a new numbered lock shall be obtained from the clinic administrator and placed on the cart/tote to alert staff that it is fully stocked.~~

~~d. The new lock number will be recorded on the Ambulatory Care Emergency Response Cart Monthly Checklist (See Attachment C).~~

~~e. An "Emergency Medications Contents" sticker shall be applied to the outside of the emergency cart/tote which will include:~~

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

~~f. An "Emergency Response (Non-Medication) Supply Outdate" sticker shall be applied to the outside of the emergency cart/tote which will include:~~

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

~~g. An "Anaphylaxis Kit Contents" sticker shall be applied to the outside of every Anaphylaxis Kit which will include:~~

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

~~The oxygen tank shall be checked monthly and after any code event for complete fill, and the PSI documented on the monthly checklist.~~

1. The internal contents of the emergency cart/tote shall be inventoried and visually inspected monthly and following any code event, and the results documented on the Emergency Response Cart Monthly Checklist (See Attachment C).
    a. During inspection, the nurse shall break the numbered lock to access and visually inspect the contents of the emergency cart/tote and check for expired items.
    b. Any supplies or medications that are expired or will expire in the current and/or following month shall be immediately replaced.
    c. Expiration dates for all medications and supplies shall be documented on the Emergency Response Cart Monthly Checklist and updated accordingly whenever items are replaced.
    d. 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.
    e. The new lock number will be recorded on the Ambulatory Care Emergency Response Cart Monthly Checklist .
2. The ~~suction machine~~oxygen tank shall be ~~powered~~checked monthly and after any code event for complete fill, and the PSI documented on the monthly ~~to check for proper function, and the results documented on the monthly~~ checklist.
3. All oxygen ~~and suction~~ accessories will be checked monthly for correct fit with available equipment.
4. 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~~Attachment D).
5. On days that the clinic is closed, staff shall document "closed" on the monthly checklists.

D. **Restocking**

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

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

~~Adult/Pediatric/Neonatal Emergency Response Supply List~~

~~Emergency Medication Dosage Chart~~

A. Ambulatory Care Emergency Response Equipment & Supplies

B. Ambulatory Care Emergency Medication Dosage Charts

C. Ambulatory Care Emergency Response Cart Monthly Checklist

D. ~~Emergency Response Cart~~Ambulatory Care AED Monthly Checklist

~~AED Monthly Checklist~~

All revision dates: 1/8/2026, 4/16/2025, 5/15/2024, 6/30/2020, 6/1/2017

Attachments

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Code Blue Committee	Ashley Vasquez: Senior RN	1/13/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/3/2025
Director of Nursing, Ambulatory Care	Cynthia Fenton: AC Director of Nursing	9/3/2025
Policy Owner	Colleen Rusin: Ambulatory Care RN II	9/3/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Cathy Deen: Adult Hem-Onc Charge Nurse*
Policy Area:	*Ambulatory Care - Adult Hematology/Oncology*
References:	

AC.10 Chemotherapy / Immunotherapy Nurse Certification

POLICY:

Ventura County Ambulatory Care shall provide individualized treatment and safe chemotherapy/~~biotherapy~~immunotherapy administration to all patients. Only nurses certified in chemotherapy/~~biotherapy~~immunotherapy administration may administer chemotherapy.

PROCEDURE:

To obtain certification, RNs shall have completed the following:

1. Successful completion of ONS/ONCC Chemotherapy~~/Biotherapy online~~ Immunotherapy Certificate on-line course ~~or equivalent~~ (standard ASCO/ONS #1).
2. Demonstration of proficiency with three (3) chemotherapy administrations, including one vesicant IV push and one vesicant mini-bag. Independently performed technical skills with each administration following the Chemotherapy Certification Criteria Checklist. A certified chemotherapy nurse is responsible for observing chemotherapy administration.
3. A minimum of three (3) days orientation in the Adult Hematology/Oncology Infusion Center to complete the clinical portion of the certification.

Essential Components:

1. ~~Only RNs certified in chemotherapy/biotherapy administration may administer chemotherapy.~~Only RNs who have successfully completed the online course and clinical competency may administer chemotherapy/immunotherapy.
2. The process of certification involves satisfactory completion of the didactic education criteria every two (2) years, and clinical performance criteria annually. Newly hired RNs must complete the initial certification within 6 months of hire date.
3. ~~Each RN is responsible for keeping their certification up to date.~~Each RN is responsible for keeping their certification up to date. There is a 30-day grace period after the expiration of their certification. After the 30-day grace period, the RN will no longer be considered "Chemotherapy Certified" and will no longer be able to administer chemotherapy.
4. Each RN is responsible for the successful completion of the Chemotherapy Certification Checklist annually.

5. Chemotherapy Certification Checklist to be kept in employee's personnel file as evidence of competency.
6. Use rights of medication administration with every administration of drug.
7. Observe Standard Precautions and PPE requirements during the administration of chemotherapy/~~biotherapy~~immunotherapy.

All revision dates: 1/30/2026, 9/13/2022, 11/1/2016

Attachments

AC.10_Attachment A_Chemotherapy Certificaiton Checklist.pdf

Approval Signatures

Step Description	Approver	Date
MEC/Oversight	Stephanie Denson: Manager, Medical Staff Office	pending
Associate Chief Medical Officer, AC	Amelia Breckenridge: Associate Chief Medical Officer, Ambulatory Care	1/30/2026
Adult Oncology, Medical Director	Isabella Chen: Medical Director, Adult Oncology	1/30/2026
	Cathy Deen: Adult Hem-Onc Charge Nurse	1/30/2026

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Owner:	*Amelia Breckenridge: Associate Chief Medical Officer, Ambulatory Care*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.30 Timeliness of Documentation

I. **SCOPE:**
To define the expectation for completion of ambulatory care clinic medical records and establish a procedure to support a member of the Medical Staff, including Licensed ~~Independent~~ Practitioners (~~LIP~~LP) and ~~healthcare~~health care workers who provide direct services to patients, has either incomplete medical records or is delinquent in completion of medical records.

II. **PURPOSE:**
Timely completion of visit documentation is necessary to provide safe and effective care to our patients. Incomplete or untimely documentation creates delays in care and negatively impacts patients.

III. **DEFINITIONS:**

EHR- Electronic Health Record.

~~LIP~~LP- Any Licensed ~~Independent~~ Provider (LP) who can provide a visit, including but not limited to; doctor, nurse practitioner, physician assistant, psychologist, licensed clinical social worker and registered dietician.

Healthcare Workers- Any professional who provides documentable direct service to patients including ~~LIPs~~LPs.

Medical Staff Member- Any ~~LIP~~LP who is a member of the Medical Staff.

Clinic Administration- Program or clinic managers responsible for the oversight of clinic operations.

Medical Director- Clinic Medical Director.

Day- Calendar Day

Day 0- Day of clinic encounter

Incomplete Record- A medical record that has not been completed more than three ~~(3) days (i.e.~~ 72 hours~~)~~ after the patient encounter.

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

patient encounter.

IV. POLICY:

A. The patient's clinic medical record should be completed and signed electronically in the Electronic Health Record (EHR) or signed legibly in ink during EHR down-time by those ~~providers~~LPs involved in the patient's care within ~~3 days~~72 hours after each encounter. The ~~3-day (or~~ 72 hour~~)~~ period is consecutive (inclusive of weekdays, weekends and holidays) and will commence at 11:59 PM PST on the day of the encounter. Clinic Administration will monitor progress and provide support, including but not limited to, sending email notifications of deadlines for the submission of encounter records in accordance with section V of this policy in order to reach the submission ~~timelines~~timeliness, as defined in this document, if encounters are not closed at 14 days.

B. The ambulatory clinic record should include the following elements if applicable to the license practitioner's (LP) scope of practice and the nature of the visit:

1. Updated demographic data.
2. Clinical documentation, including the dates and time of the visit, with the patient's history, physical examination, and all information necessary to support a well-informed assessment and treatment plan.
3. Treatment recommendation should include any notation of prescriptions and/or diet instructions given, if applicable and self-care instructions.
4. Updated summary list, as appropriate, including chronic medical problems, medications, and allergy documentation.
5. Consultation reports.
6. Reports of all ancillary services, including laboratory tests, medical imaging examinations and pathology reports.
7. If a procedure was performed, a well-documented note summarizing the essential details of the procedure, including the techniques used, the findings and tissue removed or altered, as appropriate, and medications given.
8. Referral information from other ~~providers~~LPs.
9. Consent forms.
10. Resident physician documentation associated with the encounter.
11. Telemedicine encounters and electronic consults.
12. Billing and charges applicable to the visit.

C. Clinic Administration will utilize report for determining incomplete medical records, and for documentation requirements.

D. A failure to complete records shall not be cause for administrative suspension if the member is unavailable due to an unexpected emergency and the member notifies Clinic Administration of the absence in advance, and completes the medical record(s) in question within fourteen (14) days of his/her return.

V. PROCEDURE:

A. Medical records are expected to be completed within ~~3 days/~~72 hours after the encounter to facilitate care coordination as defined in IV(A).

B. All healthcare workers shall be responsible for completion of the medical record documentation for the clinic visit, entering all documentation, including progress notes and ambulatory clinic procedure notes, into the EHR. During down time, handwritten notes shall be completed using an approved clinic form and scanned into the EHR. All billing and charges must be supported by the appropriate documentation of services.

C. For each patient encounter, clinic documentation is expected to be in the record, signed and submitted, within 3 days after the encounter. Clinic notes forwarded for an attending physician's co-signature are expected to also be completed, signed and submitted within 3 days after the encounter.

D. If at any time the ~~practitioner~~LP contests the incomplete or delinquent medical record, it is the responsibility of the ~~practitioner~~LP to contact Clinic Administrator promptly. Clinic Administrator, with the Medical Director's support, will investigate the practitioners claim, taking into consideration any mitigating circumstances to make a final determination. The timeline for any pending action against the ~~practitioner~~LP will be stopped immediately after written/emailed submission of his/her contestation, until such determination is made by Clinic Administrator in writing via email response, thereafter the timeline for pending disciplinary action will resume from when it was stopped.

E. When clinic documentation is not completed within ~~3 days~~72 hours after the encounter, the process will proceed as follows:

1. Time = Day 4 after patient encounter: Clinic Administrator will inform ~~provider~~LP and Medical Director of the incomplete documentation. The notification shall be via email and shall include the date of potential suspension. If the documentation is not completed, the process continues as below.
2. Time = Day 7: The Clinic Administrator will evaluate the incomplete medical record(s) to confirm responsibility and will establish formal contact with the ~~provider~~LP via email. The Clinic administrator may utilize text messaging or phone call in addition to email to contact the ~~provider~~LP, but these methods are not required and shall not replace formal contact via email. The clinic administrator shall inform the Medical Director of the incomplete medical record(s) and potential for suspension if the medical record is not completed within the next 7 days.
3. Time = Day 12: Clinic Administrator notifies Medical Director, Regional Administrative Director (RAD) and Ambulatory Care Chief Medical Officer (CMO) of provider's incomplete record(s). Medical director informs provider of potential suspension. The notification shall be in writing via email and shall include the date of potential suspension, if the record(s) become delinquent.
4. Time = Day 14: If the subject medical record(s) is/are still incomplete, they are now considered delinquent. Clinic Administrator will notify the provider, Medical Director, RAD, Ambulatory Care CMO, and/or their designee of the imminent administrative suspension. If the record is not immediately completed, the Clinic Administrator will notify the Medical Staff Office of administrative suspension of privileges.
5. Notification shall be provided to ~~providers~~LPs timely, taking into consideration weekends, holidays, and approved employee time off.

F. Once the suspension of privileges for delinquent medical records has been initiated, the Ambulatory Care CMO or designee will:

1. Contact the ~~provider~~LP via phone call.
2. Forward a suspension letter to the ~~provider~~LP via email (See Suspension Letter Template).

3. Send a certified copy of the suspension letter to the ~~provider~~LP via USPS.
4. Notify the ~~providers~~LPs Department Chair.
5. Notify the clinic Medical Director.
6. Notify the Ambulatory Care CEO

G. Patients who require care will be referred to the medical director to triage their care needs until the physician's privileges are restored. Scheduled clinic time that is disrupted due to suspension will still count towards work hours but with zero productivity for patient care encounters.

H. While under suspension of privileges for delinquent medical records, no new non emergent procedures or clinic days will be allowed.

I. The Clinic Medical Director may, on an individual basis, decide to withhold suspension for delinquent records in emergent situations as necessary. No suspension shall compromise patient safety. ~~Providers~~LPs shall have the right to request an extension for completing medical records in the event of an emergency to the Clinic Medical Director in order to withhold suspension, and shall not be unreasonably denied.

J. The ~~practitioner~~LP will remain on suspension until the ~~practitioner~~LP has completed all delinquent medical records.

K. Upon completion of all delinquent records, the Ambulatory Care CMO and/or their designee will notify the ~~provider~~LP and personnel listed in section V.F.1-6 via email, text messaging, or phone call, of immediate reinstatement. In addition, reinstatement of privileges shall be confirmed with formal contact with email to the ~~provider~~LP. The ~~provider~~LP shall also have the right to request immediate reinstatement after completion of documentation.

L. Exceptions may be made by the Ambulatory Care CMO for providers with delinquent medical records who are ill, on vacation, or out of town for an extended period of time, depending on the exigent circumstances. In the ~~provider's~~LPs absence, the delinquent medical records shall be reassigned to the Ambulatory Care CMO for administrative closure.

M. Monitoring- The Clinic Administrator shall conduct a monthly review encompassing all clinical services to determine chart completion compliance. Results shall be reported to the Medical Executive Committee for further action as appropriate.

N. Instances of incomplete documentation shall not be included in the employee's Personnel Files if all documentation is completed prior to Day 7. Employees who complete all incomplete documentation prior to Day 7 shall still be considered to be in "good standing" and "satisfactory" within County's policies and regulations.

All revision dates: 1/16/2026, 5/8/2023, 10/11/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Health Information Management Committee	Vibha Gune: HIM Manager	pending
Chief Medical Officer / Interim CEO, AC	Allison Blaze: Chief Medical Officer, Ambulatory Care	1/16/2026

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Diabetes Management*
References:	

DM.002 Pediatric Inpatient Diabetes and Hyperglycemia Management

POLICY:

To state the importance of glucose management at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). Glycemic control results in lower rates of hospital complications. Glycemic targets can be reached safely and reliably through the use of clinical practice guidelines and policies.

PROCEDURE:

I. Definitions
   A. Severe hyperglycemia is defined as blood glucose (BG) > 300 mg/dL
   B. Hyperglycemia is defined as blood glucose (BG) >180 mg/dL.
   C. Hypoglycemia is defined as blood glucose <70 mg/dL.
   D. Critical hypoglycemia is defined as blood glucose <40 mg/dL.

II. Multidisciplinary ~~Diabetes Management Team~~diabetes management team
   A. The Diabetes Management Team, led by the Director of Diabetes Management, includes ~~physicians~~Licensed Practitioners (LP), ~~nurses~~Nurses, ~~registered dietitians~~Registered Dietitians (RD), ~~certified diabetes educators~~Certified Diabetes Educators, ~~pharmacists~~Pharmacists, ~~laboratory~~Laboratory staff and ~~case managers~~Case Managers.
   B. This team shall monitor and manage patients with diabetes according to this policy when admitted to our hospitals.
   C. Audits of insulin use are conducted by the Diabetes Management Team.

III. Glycemic monitoring in the hospital
   A. Pediatric patients with known diabetes will have laboratory blood glucose testing upon admission.
   B. Pediatric patients with diabetes will have point-of-care (POC) blood glucose monitoring at least four (4) times a day with appropriate therapeutic intervention.
   C. The provider will order a HbA1c on admission, if one has not been performed in the preceding 2-3 months.

IV. Glycemic management in the non-critical care setting

A. POC BG testing will be performed by ~~nursing~~Nursing staff according to the following schedules:

1. Patients who are eating or receiving bolus enteral feeds: before meals and at bedtime or with each bolus.
2. Patients who are NPO, receiving continuous enteral feeds or TPN: every six (6) hours.

B. Coordination of insulin administration and meal delivery:

1. Nursing staff (Registered Nurses~~,~~ and Licensed Vocational Nurses~~, and Nursing Assistants~~) shall check BG prior to each meal.
2. Meal tray is delivered to the patient per the Food and Nutrition Services Department schedule.
3. Nursing staff assesses mealtime carbohydrate intake.
4. Nurse administers rapid-acting analog insulin to cover carbohydrates for meals and snacks and to correct pre-meal hyperglycemia, per ~~provider~~LP's orders.

V. Glycemic management in the critical care setting

A. Critical care patients with hyperglycemia can be managed with subcutaneous insulin if hemodynamically stable, without need for pressor agents, and if they remain well-controlled.

B. Critical care patients with diabetic ketoacidosis or persistent hyperglycemia shall be managed with continuous intravenous insulin infusion.

VI. Subcutaneous insulin use

A. ~~Providers~~LPs shall use approved subcutaneous insulin electronic order-set in the Electronic Health Record (EHR).

B. Basal-bolus insulin therapy is used for inpatient diabetes treatment, rather than exclusively using a "sliding scale" method.

C. Scheduled subcutaneous insulin therapy consists of basal insulin given once or twice a day in combination with rapid-acting insulin administered before meals and snacks.

D. Mealtime rapid-acting insulin bolus administration is based on observed or predicted carbohydrate intake.

VII. Intravenous (IV) insulin infusion to be managed by PICU ~~Attending~~LP in consultation with Pediatric Endocrinologist.

VIII. Insulin pump use in the hospital: refer to policy DM.006 Inpatient Use Of Patient's Own Insulin Pump.

IX. Prevention and management of hypoglycemia

A. ~~Provider~~LP reevaluates POC BGs daily and adjusts insulin regimen as needed to maintain BGs in the target range.

B. ~~Provider~~LP should consider modifying therapy when BG values fall below 90 mg/dL.

C. ~~Provider~~LP shall modify therapy when BG values fall below 70 mg/dL.

D. Nurses will treat hypoglycemia per VCMC administration policy DM.003 or per IV Insulin software program.

E. Blood glucose data will be routinely tracked by the Diabetes Management Team, with intervention and communication with the ~~provider~~LP if patient is hypoglycemic without a change in management.

F. Critical hypoglycemia cases (BG<40 mg/dL) are reported to the Diabetes Committee and the Medication Safety Officer for review.

X. Medical Nutrition Therapy

A. Medical ~~nutrition therapy~~Nutrition Therapy (MNT) is provided for patients with diabetes.

B. RD assesses the appropriateness of MNT per dietary protocol.

C. Provider may order a Consistent Carbohydrate diet, providing consistent-carbohydrate (45-60 grams) meals for patients with Type 2 diabetes or a Peds 2 Carb Count diet for patients with Type 1 diabetes.

XI. Perioperative hyperglycemia management

A. Blood glucose will be monitored and controlled at the time of surgery.

B. For elective surgery, preoperative HbA1c will reflect good diabetes control.

C. Nursing staff will check BG in all patients with diagnosis of diabetes and will notify anesthesiologist, attending surgeon and Diabetes Management Team if glucose is >180mg/dL.

D. Patients with diagnosis of diabetes will have BG rechecked hourly in Preoperative Unit and in the ~~OR~~Operating Room (OR) and Post-Anesthesia Care Unit (PACU).

E. Patients with hyperglycemia will receive appropriate corrective insulin therapy, typically SQ insulin for short, minor cases (< 1 hour) and IV insulin drip for longer, major cases (>1 hour).

F. Anesthesia and ~~surgery~~Surgery staff will consider canceling elective cases when the BG is excessively high. Elective surgical cases should be rescheduled or delayed until hyperglycemia responds to corrective doses of insulin. See administrative policy #100.202

G. Post-operative management of hyperglycemia for NPO patients includes IV insulin drip, basal SQ insulin, or insulin pump for basal insulin coverage.

H. Post-operative management of hyperglycemia for PO patients includes IV insulin drip with meal bolus, basal/bolus SQ insulin, or insulin pump for basal and bolus insulin coverage.

XII. Patient discharge

A. Transition from hospital to home

1. Patients previously well-controlled may resume pre-hospital diabetes medications, as long as no contraindications exist.
2. Discharge medication plan for patients with suboptimal control prior to admission will be discussed with outpatient diabetes specialist, with consideration for an intensified diabetes medication regimen, barring history of treatment non-adherence.
3. Initiation of insulin administration, when clinically appropriate, shall begin at least one day before discharge to allow assessment of efficacy and safety, and to provide patient/parent/guardian education.

B. Diabetes self-management and nutrition education shall be provided to patients with diabetes and/or parents/guardians of patients with diabetes, particularly patients who are not optimally controlled.

C. ~~Providers~~LPs, ~~nurses~~Nurses, RDs and ~~nurse educators~~Nurse Educators shall provide clear instructions regarding diabetes management, including insulin, prior to discharge.

D. Follow-up appointment is made prior to discharge. The inpatient pediatric hospitalist team will communicate the diabetes management plan with the outpatient provider at the time of discharge.

Guidelines:

A. Hyperglycemia is defined as blood glucose over 180 mg/dL.

B. Hypoglycemia is defined as blood glucose less than 70 mg/dL.

C. Critical hypoglycemia is defined as blood glucose less than 40 mg/dL.

D. Consistent Carbohydrate Diet consists of 45 – 60 grams of carbohydrates per meal.

E. Perioperative hyperglycemia management

1. For elective surgery, goal preoperative HbA1c is < 8%
2. Blood glucose goal at time of surgery is < 180 mg/dL
3. Patients with BG > 180 mg/dL will receive appropriate corrective insulin therapy

REFERENCES:

American Diabetes Association. Standards of Medical Care in Diabetes 2018. *Diabetes Care* 41: Supplement 1, S144-s151, January 2018.

Assessment and management of hypoglycemia in children and adolescents with diabetes. ISPAD Clinical Practice Consensus Guidelines 2014 Compendium. *Pediatric Diabetes* 15: 180-192, 2014.

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Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	2/2/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/12/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/13/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/13/2025
Diabetes Management	Hugo Ortiz: Diabetes Nurse Educator	10/22/2025

Step Description	Approver	Date

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References:	

DM.003 Pediatric Hypoglycemia

POLICY:

To define, identify and treat hypoglycemia in infants and children according to evidence-based standards. For management of neonatal hypoglycemia, please see separate Neonatal Hypoglycemia protocol. It is the policy of Ventura County Medical Center~~/~~, Santa Paula Hospital, and Ambulatory Care Clinics that pediatric hypoglycemia will be identified and immediately treated according to evidence-based standards.

Definitions and Classifications

Per ISPAD Clinical Practice Consensus Guideline 2018, "hypoglycemia is a fall in blood glucose level that exposes a patient to potential harm and there can be no single numerical definition of hypoglycemia for all patients and situations."

The threshold for initiating treatment is a blood glucose value less than or equal to (≤) 70 mg/dL.[1-2]

~~**Characterization of Hypoglycemia[2]**~~

Characterization of Hypoglycemia[2]

Level 1	Blood glucose value between 54 mg/dL and 70 mg/dL
Level 2	Blood glucose value less than (<) 54 mg/dL
Level 3	Severe hypoglycemia characterized by altered mental and/or physical status requiring assistance in the treatment of hypoglycemia

~~**Signs and Symptoms of Hypoglycemia[1]**~~

Signs and Symptoms of Hypoglycemia[1]

Autonomic	Shakiness, sweatiness, trembling, palpitations, pallor
Neuroglycopenic	Poor concentration, blurred or double vision, disturbed color vision, difficulty hearing, slurred speech, poor judgement and confusion, problems with short term memory, dizziness and uneasy gait, loss of consciousness, seizure
Behavioral	Irritability, erratic behavior, agitation, nightmares, inconsolable crying
Non-specific	Hunger, headache, nausea, tiredness

Per ADA 2020, "[Blood glucose] targets should be individualized, and lower targets may be reasonable based on benefit-risk assessment. Blood glucose targets should be modified in children with frequent hypoglycemia or hypoglycemia awareness."

PROCEDURE:

A. Assessment:
   1. Assess for signs and symptoms of hypoglycemia
   2. If symptoms present:
      a. Have patient stop all activity
      b. Perform a STAT bedside blood glucose
      c. Begin treatment per protocol
      d. Inform provider of hypoglycemia

B. Treatment:
   1. If patient responsive and able to take oral medications, give 15 grams of carbohydrates.[3]
      a. 120 mL (4 oz) apple, cranberry, or orange juice (do not give orange juice to patients with renal insufficiency)
      ~~OR~~OR
      b. 120 mL (4 oz) non-diet soda OR
      c. 4 glucose tablets OR
      d. 15 grams of glucose gel
   2. If patient unresponsive, NPO, and/or unable to swallow, give weight based IV push of dextrose
      i. Patient weight < 40 kg[5]: Give ~~dextrose 0.5 gram~~Dextrose 10% (D10W) 2 mL/kg (MAX: 5 mL/~~dose~~
         ~~i. Dextrose 10% (D10W) 5 mL/kg OR~~
         ~~ii. Dextrose 25% (D25W) 2 mL/kg IV Push~~
      kg)
      ii. Patient weight ≥ 40 kg
         i. Give Dextrose 50% (D50W) 1 mL/kg
         ii. Maximum dose = 25 gm/50 mL
   3. If patient unresponsive and patent IV not present
      a. Patient weight[6] ≤ 25 kg: Give glucagon 0.5 mg intramuscularly (IM) or subcutaneous (subcut)
      b. Patient weight[6] > 25 kg: Give glucagon 1 mg IM or subcut
      c. Attempt IV access
      d. Turn patient on side, as nausea and vomiting frequently occur with glucagon administration

C. Reassess:
   Recheck blood glucose 15 minutes after treatment. If blood glucose is still < 70 mg/dL, repeat treatment, and recheck blood glucose in 15 minutes to confirm target glucose has been reached.[3]

D. Prevent Recurrence:

1. For patients taking orals: Once blood glucose is above 70 mg/dL, provide snack containing both carbohydrates and protein, without insulin coverage.
2. For patients unable to take orals: Call Provider for orders to prevent recurrence.
    a. Initiate intravenous fluids (NS, ½ NS, ¼ NS) with 10% dextrose at rate of 1.2-3 mL/kg/hr *or* 5% dextrose at rate of 2.5-6 mL/kg/hr (2-5 mg/kg/min glucose infusion rate)[1]

E. Document all events in the electronic health record. Notify Licensed ~~Independent~~ Practitioner.

REFERENCES:

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	2/2/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/12/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/13/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/13/2025
Diabetes Management	Hugo Ortiz: Diabetes Nurse Educator	3/11/2025

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References:	

L.52 Laboratory Response To Hospital Emergency Call Codes

POLICY

The Department of Laboratory Services at Ventura County Medical Center and Santa Paula Hospital shall have a defined process for laboratory staff's response to hospital emergency call codes that require specimen collection and processing.

MATERIALS

1. Specimen collection tubes
    - Light blue (sodium citrate)
    - Red (no additive)
    - Gold (SST)
    - Green (lithium heparin)
    - Lavender (EDTA)
    - Pink (EDTA)
    - Gray (Sodium fluorite)
    - Blood culture bottles
2. Blood collection needles, multi-sample
3. Blood collection needle, butterfly
4. Blood collection single-use tube holder
5. Tourniquet
6. Alcohol pads
7. Chlorhexidine (Chloraprep pads and swabstick)
8. Disposable gloves
9. Blood bank armband
10. Disposable plastic biohazard bags

PROCEDURE

To ensure that patients are accurately diagnosed in the most expedient way possible, the hospital developed the following codes to ensure responders are activated promptly:

1. CODE STROKE (brain stroke): patients affected with central nervous system infarction
2. CODE BLUE/RAPID RESPONSE
3. CODE LAB (ICU ONLY for near-death situations)
4. CODE MATERNITY
5. CODE YELLOW (Tier 1 and Tier 2)
6. CODE SEPSIS

RESPONSIBILITIES

1. The laboratory is responsible for:
    a. Provision of laboratory services to support the hospital life-threatening codes
    b. Immediate attention and support for safe and timely patient care through accurate diagnostic testing.
    c. Communication is vital when responding to hospital codes.
        i. Central Processing Coordinator is responsible for all communications with Certified Phlebotomy Technicians (CPTs).
        ii. Immediately communicate with the ordering department when there are delays in provision of services.
        iii. Document dialogue in ED log or shift report log, or more appropriately on the specimen's accession number.
2. `All Certified Phlebotomy Technicians are provided with cellular phones and receive messages ~~at the same time during code announcements~~simultaneously when codes are announced.
3. Two CPTs respond to the CODE: The CPT assigned to the unit (ED, ICU, MED SURG, etc.) and the CPT assigned as "FLOAT CPT."
    a. Immediate response to the CODE announced.

CODE	ACTION
CODE STROKE	Draw specimens per protocol (4 lithium heparin, 2 lavenders, 1 blue, 2 gold, 1 pink) ~~Tube~~DO NOT TUBE Deliver specimens ~~Call laboratory coordinator~~ to CLS/MLT in Chemistry
CODE LAB	Draw specimens per protocol DO NOT TUBE Deliver specimens to the lab
CODE YELLOW - TIER 1	Draw specimens per protocol (3 lithium heparin, 1 lithium heparin for RT, 1 lavender, 1 blue, 1 gold, 1 pink, 1 gray) Tube specimens Call ~~lab coordinator~~Central Processing Coordinator

CODE	ACTION
CODE YELLOW - TIER 2	Draw specimens per protocol (4 lithium heparin, 1 lithium heparin for RT, 1 lavender, 1 blue, 1 gold, 1 pink, 1 gray) Tube specimens Call ~~lab coordinator~~Central Processing Coordinator
CODE MATERNITY	
~~CODE SEPSIS~~	~~Draw specimens per protocol (2 lithium heparin, 1 lavender, 1 blue, 2 gold)~~ ~~Tube specimens~~ ~~Call lab coordinator~~
CODE SEPSIS	Draw specimens per protocol (2 lithium heparin, 1 lavender, 1 blue, 2 gold) Tube specimens Call Central Processing Coordinator For specimens drawn for Lactate (test performed by Respiratory Therapy), draw within fifteen (15) minutes of order time. Notify Respiratory Therapist (RT) that specimen has been drawn. Call Central Processing Coordinator to receive specimen with the appropriate collector's Cerner ID, date and time of collection, and RT notification.

~~Collect specimens following established protocol: A pre-assembled "CODE STROKE" packet (contains lavender, pink, green, blue, red top tubes, and gray (on ice), butterfly, blood bank armband, blood cultures, chlorhexidine pads and swabstick).~~

~~Immediately bring the specimens to the laboratory. DO NOT USE PNEUMATIC TUBE SYSTEM.~~

~~Hand deliver the specimens to the Clinical Laboratory Scientist or Medical Laboratory Technician assigned to Chemistry.~~

4. Collect specimens following established protocol: CODE STROKE: A pre-assembled "CODE STROKE" packet (contains lavender, pink, green, blue, red top tubes, and gray (on ice), butterfly, blood bank armband, blood cultures, chlorhexidine pads and swabstick). Immediately bring the specimens to the laboratory. DO NOT USE PNEUMATIC TUBE SYSTEM. Hand deliver the specimens to the Clinical Laboratory Scientist or Medical Laboratory Technician assigned to Chemistry.

1.

TUBE COLOR	TESTING AREA	ACTION	
Phlebotomist	**Clinical Lab Scientist Medical Lab Technician**		
Pink	Blood Bank	Centrifuge specimen	◦ Load specimens into analyzer. ◦ Monitor test completion. ◦ Communicate critical results to ordering provider. ◦ Document notification in Laboratory Information System.
Green	Chemistry	Centrifuge specimen	
Gray	Chemistry	Centrifuge specimen	
Purple	Hematology	◦ Mix sample. ◦ Load in analyzer.	

TUBE COLOR	TESTING AREA	ACTION	
Phlebotomist	**Clinical Lab Scientist Medical Lab Technician**		
Blue	Coagulation	Centrifuge specimen	
Blood Cultures	Microbiology	Follow instructions for loading.	

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Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	1/24/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	10/7/2025

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References:	

S.16 Patient Death in the Operating Room

POLICY:

A patient who expires in the Operating Room (OR) shall be considered a ~~Coroner~~Medical Examiner's ~~Case~~(ME) case. The ME must be notified ONLY if ~~the Coroner's~~ME criteria are met. At all times, the OR ~~Staff~~staff will provide death with dignity for patients who expire. Additionally, the OR ~~Staff~~staff will comply with ~~State~~state and local guidelines.

PROCEDURE:

A. In the event a patient expires in the Operating Room, a pronouncement of death must be made by the surgeon.

B. Physician responsibilities include notification of:

1. Family or next of kin
2. The ~~Coroner~~ME must be notified of a patient death in the Operating Room when the deceased falls into one of these categories:
   - i. Death occurring within 24 hours of admission to Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH)
   - ii. Deaths involving criminal action or suspicion of a criminal act
   - iii. Deaths involving known or suspected homicide, suicide, and accidents
   - iv. Deaths of unidentified persons
   - v. Deaths involving communicable diseases constituting a public hazard
   - vi. Deaths involving poisoning or related to substance abuse
   - vii. Deaths occurring in jail or police custody
   - viii. Deaths related to occupational diseases or hazards
   - ix. Deaths where the physician cannot state the cause of death
   - x. Deaths suspected to be from sudden infant death syndrome (SIDS)
   - xi. Deaths wherein no physician has attended the patient for 20 days
   - xii. Deaths at state mental hospitals
3. The ~~Coroner~~ME will decide whether to come and inspect the body before post-mortem care is done

and will advise the OR staff when the body may be released for post-mortem care. ~~The Coroner will advise the OR Staff.~~

C. Nursing responsibilities include notification of appropriate personnel:

1. OR Clinical Nurse Manager and the Nursing Supervisor
2. Patient unit
3. Clergy (if appropriate)
4. Admitting Department
5. The Registered Nurse (RN) must notify the Organ/~~tissue~~Tissue Recovery Hotline (per Admin Policy 100.048). All patient deaths require a referral within one hour, regardless of medical suitability.
6. Notify Medical ME Office if criteria are met

~~Post-mortem care shall be completed in the OR after the Coroner has released the body. A nurse or nursing assistant may perform post-mortem care per policy.~~

DOCUMENTATION

A. It is the responsibility of the physician to:

1. Complete the death certificate or ~~Medical Examiner's~~ME form, whichever is appropriate.
2. Complete patient's electronic health record (EHR).
3. Obtain autopsy permit if applicable.

B. It is the responsibility of the Registered Nurse to:

1. ~~Complete OR EHR.~~Complete documentation in the electronic health record (EHR).
2. Complete patient care note including sequence of events, time of death, name of physician who pronounced the patient, name of ~~Medical Examiner~~the ME who gave approval for post-mortem care to proceed, or time ~~Medical Examiner~~ME took body to ~~Morgue~~morgue.
3. Complete blue Incident Notification Form.

C. Post-mortem care must NOT be performed until or unless approval is obtained from the ~~Medical Examiner's~~ME office.

D. Until approval is granted, the patient's body ~~**must remain on the operating table**~~ must remain on the operating table in the Operating Room with all IV tubes, lines and drains intact.

E. All invasive devices must remain undisturbed until the ME authorizes the release. This includes airway devices, nasogastric/orogastric tubes, Foley catheters, chest tubes, surgical drains, wound packing, or any device or material placed within a body cavity.

References: Centers for Medicare & Medicaid Services. (2024). *42 C.F.R. § 482.45: Condition of participation—Organ, tissue, and eye procurement*. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.45

California Government Code § 27491. (n.d.). https://law.justia.com/codes/california/code-gov/title-3/division-2/part-3/chapter-10/article-2/section-27491/

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Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/11/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/11/2025
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S.24 Environmental Cleaning in Sterile Processing Department Areas

POLICY:

To provide guidance to staff performing environmental cleaning in Sterile Processing Department (SPD) areas. The expected outcome is that the patient is free from signs and symptoms of infection.

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

- Cleaning procedures and frequencies (ie, terminal, scheduled) in sterile processing areas, including extent of cleaning required when areas are not occupied, will be determined by a multidisciplinary team composed of **the Infection Control Committee, Infection Control Manager, Medical Director of Infection Control, Surgery Director, Chief ~~of Hospital Operations~~Nurse Executive, Housekeeping Manager and Sterile Processing Manager** .
- Cleaning chemicals, materials, tools, and equipment used in sterile processing areas will be approved by **the Infection Control Committee** and product selection committees.
- Cleaning responsibilities for sterile processing areas and equipment will be assigned by **the Surgery Director and the Housekeeping Manager** .
- All staff will take precautionary measures to limit transmission of microorganisms when performing environmental cleaning and handling waste materials.
- All staff must follow standard precautions to prevent contact with blood, body fluids, or other potentially infectious materials.

PROCEDURE:

Terminal Cleaning

- Perform terminal cleaning and disinfection of sterile processing areas daily when the areas are being used.
  - When sterile processing areas are not occupied (e.g., weekends, holidays), cleaning and disinfection will be performed by **Housekeeping staff** .
- Do not initiate terminal cleaning when staff are actively decontaminating instruments.
- Clean work areas that are clean (e.g., packaging area) before work areas that are dirty (e.g., decontamination area).
- Damp dust all horizontal surfaces (e.g., sterilizers, counter tops, furniture, shelving) with a facility-approved disinfectant and low-linting cloth.

- Clean and disinfect all work surfaces and high-touch objects with a facility-approved disinfectant and low-linting cloth according to the manufacturer's written instructions for use, including:
  - work tables,
  - counter tops,
  - sinks,
  - pass-through windows,
  - sterilizer control panels and handles,
  - automated washer control panels and handles,
  - ultrasonic washer control panels and handles,
  - light switches,
  - door handles and push plates,
  - chairs and stools,
  - computer accessories,
  - telephones and mobile communication devices, and
  - trash and linen receptacles.
- Disinfect all floors with either a wet vacuum or a single-use mop and a facility-approved disinfectant, including areas under mobile equipment.
- Remove trash from receptacles daily or when they are full.

Scheduled Cleaning

- Clean all areas and equipment that are not terminally cleaned according to an established schedule, as shown in the table below.

Area/Equipment	**Frequency (e.g., weekly, monthly, quarterly, semiannually)**	**Personnel Responsible (e.g., Environmental Services (EVS), sterile processing, facilities)**
Sterile Processing	**Daily**	~~**Environmental Services (EVS)**~~**EVS**
Clean storage areas	**Weekly**	**SPD**
Soiled storage areas	**Weekly**	**EVS**
Sterile storage areas	**Weekly**	**SPD**
Shelving and storage bins	**Weekly**	**SPD**
Corridors (eg, stairwells, elevators)	**Weekly**	**EVS**
Walls and ceilings	**[facility specific]**	**EVS**
Sterilizers (outside) and loading carts	**Daily**	**SPD**
Sterilizer service access area	**Weekly**	**SPD**
Ultrasonic washers	**Daily**	**SPD**
Automated washers (outside)	**Daily**	**SPD**
Unrestricted areas (eg, lounges, offices)	**Daily**	**EVS**
Environmental services closets	**Weekly**	**EVS**

Ventilation ducts	**Quarterly**	**Facilities**
Air vent and grille plates	**Monthly**	**Facilities**
Sinks and wash basins, including eye wash stations and faucet aerators	**Weekly**	**EVS**

Documentation

Staff performing environmental cleaning of the sterile processing areas will document terminal and scheduled cleaning procedures on the **VCMC/SPH** cleaning checklist for the sterile processing areas.

Competency

Perioperative staff performing environmental cleaning of the sterile processing areas will receive education and complete competency verification activities on the principles and processes of environmental cleaning, including:

- standard cleaning and disinfection procedures
- preparation, handling, storage, and disposal of cleaning chemicals
- required personal protective equipment.

Quality

Perioperative staff performing environmental cleaning of the sterile processing areas will participate in quality assurance and performance improvement activities related to environmental cleaning.

Glossary

Clean: The absence of visible dust, soil, debris, blood, or other potentially infectious material.

Disinfection: A process that kills most forms of microorganisms on inanimate surfaces. Disinfection destroys pathogenic organisms (excluding bacterial spores) or their toxins or vectors by direct exposure to chemical or physical means.

Personal protective equipment (PPE): Specialized equipment or clothing for eyes, face, head, body, and extremities; protective clothing; respiratory devices; and protective shields and barriers designed to protect the worker from injury or exposure to a patient's blood, tissue, or body fluids. Used by health care workers and others whenever necessary to protect themselves from the hazards of processes or environments, chemical hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation, or physical contact.

Terminal cleaning: Thorough environmental cleaning that is performed at the end of each day when the area is being used.

References

Petersen C, ed. Infection. In: *Perioperative Nursing Data Set* . 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Guideline for environmental cleaning. In: *Guidelines for Perioperative Practice* . Denver, CO: AORN, Inc; 2019.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/11/2025
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UR.06 Patient Status Orders

SCOPE:

This policy applies to Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). (See policy ~~*100.281 for Assignment of Patient Status for Obstetrical Patients)*~~ *100.281 for Assignment of Patient Status for Obstetrical Patients)*

POLICY:

VCMC and SPH have a process to ensure that Patient Status Orders (PSO) with the appropriate accommodation are entered timely for all hospitalized patients and are reviewed daily to ensure ongoing accuracy. All PSOs must be co-signed by an attending physician. PSOs are reflected in the electronic health record (EHR) and on all claims documentation to ensure proper billing to all payers and to be in compliance with third party payer requirements, including those issued by the Centers for Medicare & Medicaid Services (CMS).

DEFINITIONS:

A. **Patient Status** means Inpatient, Outpatient with Observation Services (OBS), or Outpatient in a Bed (OPIB).

B. **Inpatient** status means a set of clinical criteria has been met and that a patient has been admitted to VCMC or SPH for the purpose of receiving medically necessary hospital services that can only be provided in an inpatient setting. Inpatient status must be supported by appropriate documentation.

C. **Outpatient with OBS** status means a patient is receiving clinically appropriate services which include ongoing short-term treatment, assessment and reassessment to determine whether a patient will require further treatment as an Inpatient or if the patient can be discharged from the hospital. Outpatient with OBS status must be supported by appropriate documentation.

D. **OPIB** status means a patient is occupying an acute care bed to receive outpatient treatment but without meeting medical necessity for Inpatient or OBS.

E. **Admitting or Attending Physician** means, in the context of this policy, a physician who is legally accountable for establishing the patient's diagnosis and has been granted admitting privileges by VCMC and SPH Medical Staff.

F. **PSO** means an order signed by the physician, nurse practitioner (NP), physician assistant (PA), or resident admitting the patient or by the physician responsible for the patient's general medical

management during the admission. The order may be electronic, in writing, or a telephone order as allowed by VCMC and SPH Medical Staff bylaws. If the PSO is entered by a resident physician, NP or PA, it must be authenticated and co-signed by an attending physician. Telephone orders for PSO may only be entered by Registered Nurses (RN) in Case Management or in some specialty areas (i.e. NICU)

G. **Accommodation** means the level of care a patient receives regardless of their location in the hospital. Accommodation may include but is not limited to: Observation, Med Surg, Telemetry, Intensive Care Unit (ICU), ICU Trauma, Direct Observation Unit/Stepdown, Newborn/Nursery, Pediatrics, Pediatric Intensive Care Unit, Obstetrics, Psychiatry, and NICU (I,II,III,IV).

H. **Utilization Review (UR) Registered Nurse (RN)** means, for the purpose of this policy, a case manager appropriately trained in the accurate application of Milliman Care Guidelines (MCG) or other approved clinical screening criteria.

I. **MCG** refers to clinical decision support guidelines used by UR RNs and Physician Advisors to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

J. **Authorization** means a process by which the hospital contacts the payor to seek preauthorization/ precertification/authorization for patient status and accommodation as ordered by the Admitting/Attending Physician, resident physician, NP, or PA.

K. **Two Midnight Rule** provides that inpatient services are generally payable under Medicare Part A if a physician/resident physician, NP, or PA expects a patient to require medically necessary hospital care that spans at least two midnights and is supported by clinical documentation.

PROCEDURE:

It is the responsibility of the Admitting/Attending Physician/resident physician, NP, or PA to determine the appropriate patient status and accommodation and enter the PSO on admission. Orders entered by resident physician, NP, or PAs must be authenticated and co-signed by an attending.

A. Nursing and Case Management staff are responsible for ensuring that appropriate electronic or telephonic PSOs have been entered by the physician.

B. If a PSO has not been entered, Nursing or Case Management should contact the physician/resident physician, NP, or PA to obtain the order. The PSO must clearly indicate the patient's status by explicitly using the terms "Inpatient" or "Outpatient," along with the appropriate level of care or accommodation.

C. All staff are prohibited from leading the physician to a certain PSO or accommodation or from attempting to influence the physician/resident physician, NP, or PA's order. A UR RN or Physician Advisor may educate the physician/ resident physician, NP, or PA on the differences between Inpatient, OPIB, the Two Midnight Rule and Outpatient with OBS based on regulatory guidance and/or clinical screening criteria.

D. For payors with an authorization process the UR Nurse will follow the payor's authorization process and utilize MCG when there is a dispute with the payor regarding patient status, accommodation and/or length of stay as ordered by the physician/resident physician, NP, or PA.

E. All PSOs must be signed before discharge. Acceptable exceptions are patient death, elopement, or transfer to a higher level of care. In the event of an exception, the PSO should be signed as soon as possible.

Physicians/resident physician, NP, or PA should enter a PSO to "Admit to Inpatient" if:

A. The patient needs a level of care based on the severity of illness and intensity of services required for an episode of illness or condition that is the result of disease, trauma, and/or recovery from major surgery. Inpatient care is often used for patients with serious medical conditions, acute illnesses, or severe trauma.

B. The physician/resident physician, NP, or PA expects the patient to require Inpatient hospital care for two or more midnights from the onset of care including care received in the Emergency Department (ED), or the patient requires a procedure that is specified as inpatient-only on the CMS Inpatient Only List for the current year. The medical record documentation must support the expectation.

C. The Admitting/Attending Physician must enter a PSO for inpatient status in the EHR prior to discharge, but entering the order upon admission is the expectation.

Physicians/resident physician, NP, or PA should enter a PSO for "Place in Observation" if:

A. The patient requires a period of treatment or monitoring, usually within 24 hours, before a decision is made whether to admit the patient as an Inpatient or discharge. The medical record documentation must support the expectation.

B. The physician/resident physician, NP, or PA cannot reliably predict a Medicare beneficiary to require a hospital stay of two or more midnights from the onset of care, inclusive of ED services. The medical record documentation must support the expectation.

Requirements for OBS are as follows:

A. The observation period begins at the time the PSO for observation is signed.

B. OBS time ends when all medically necessary services related to observation care are completed.

C. OBS time ends with the physician/resident physician, NP, or PA's order to change the patient status from OBS to inpatient or when the patient status changes from OBS to discharged.

D. These timestamps serve as the official start and stop times and are clearly documented and retrievable in the medical record to ensure compliance with regulatory and billing requirements.

E. The medical record must include documentation that the physician assessed patient risk to determine that the patient would benefit from OBS care.

F. Clinical findings must justify the need for OBS care and must be documented. For patients whose payors do not have an authorization process, medical necessity for OBS must be documented in a manner consistent with federal or state requirements, the Two Midnight Rule, or MCG.

G. For Medicare beneficiaries in Observation, the Medicare Outpatient Observation Notice (MOON) is required in accordance with Policy UR.03 Patient Notification of the Provision, Discontinuation, Reclassification, or Non-Coverage of Care

H. Status changes between Observation and Inpatient for Medicare beneficiaries are governed by the Condition Code 44 process outlined in Policy UR.02 Condition Code 44

Situations not appropriate for OBS are as follows:

A. The convenience of the patient, the patient's family, or the physician (e.g., physician is unavailable when the patient is clinically ready for discharge, or the patient is awaiting placement in a long-term care facility), lack of staff, scheduling of transportation, or coordination of post-acute care services are not appropriate for OBS unless a payer with an authorization process preauthorizes OBS for these reasons.

B. Medically appropriate inpatient admission.

C. For patients whose payers do not have an authorization process, services included in the payment for another service, such as:

   i. Routine preparation services furnished prior to diagnostic testing and/or therapeutic services in a hospital outpatient department and routine recovery afterwards.

   ii. Scheduled therapeutic services such as blood transfusions.

   iii. Routine postoperative or post procedure monitoring during a standard recovery period.

      1. A patient must not be placed in OBS status following an outpatient procedure based on a standing order, an order given prior to the procedure, or an order that does not articulate patient-specific findings justifying the need for OBS. Notwithstanding the foregoing, if a payer with an authorization process pre-authorizes OBS pursuant to a standing order, an order given prior to the procedure or without patient-specific findings, the hospital may provide OBS care to the patient as authorized. Documentation must support this level of care.

Physicians/resident physician, NP, or PA should enter a PSO for "Place in OPIB" in the following situations:

A. **Post-Outpatient Procedure Monitoring**
After an outpatient surgery or procedure requiring post-op monitoring or short-term treatment, without complications and not meeting observation or inpatient criteria.

B. **Outpatient Therapeutic Treatments**
For patients receiving outpatient treatments such as blood transfusions, chemotherapy, hemodialysis, or infusions—when no observation or inpatient services are required.

C. **Social or Convenience Admissions**
When a patient is placed in a bed for non-medical reasons (e.g., social, family convenience, transportation issues, overnight travel concerns) and does not require clinical observation or inpatient-level care.

D. **Short-Term Pre- or Post-Treatment Monitoring**
When a patient needs brief pre- or post-procedure recovery (e.g., pre-procedure hydration, post-sedation recovery) but does not meet criteria for observation or inpatient care.

E. **Extended Recovery After Ambulatory Surgery**
For patients who need a longer-than-usual recovery period (e.g., pain control, nausea, delayed discharge) following outpatient surgery but do not meet clinical criteria for OBS or Inpatient status.

PSO considerations specific to obstetric patients see policy ~~100.281 Assignment of Patient Status for Obstetrical~~

~~Patients~~100.281 Assignment of Patient Status for Obstetrical Patients

PSO considerations specific to General Inpatient Hospice see policy *100.284 General Inpatient Hospice Care*

PSO considerations specific to Newborns and the Neonatal Intensive Care Unit (NICU)

Newborn Inpatient PSO: The admitting or attending physician has primary responsibility for entering the PSO for newborns however, the PSO may be entered by nursing by protocol at the time of birth or admission. The order must be entered as "Inpatient" status with the appropriate level of care (e.g., Routine Nursery). A licensed provider is required to cosign the order per organizational policy to meet regulatory requirements.

NICU PSOs, Accommodations, and Workflow

A. PSOs in the NICU will be placed by the physician upon admission. The order and accommodation code will be reviewed daily during rounds. If it is identified that the accommodation code or status needs to be changed, the physician will change the order during rounds.

B. If changes need to be made outside of daily rounds, the NICU RN will notify the physician and modify the order using the telephone order read back order type. Any diagnosis must be provided by the physician.

C. Accommodation codes in the NICU are defined as follows:

   i. Level I: (Newborn Nursery) - Routine care of apparently normal full-term or pre-term neonates

   ii. Level II: (Continuing Care) - Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates

   iii. Level III: (Intermediate Care) - Sick neonates, who do not require intensive care, but require 6-12 hours of nursing each day

   iv. Level IV: Intensive Newborn Care (ICU or 1:1) - Babies at this level are the sickest of all and require constant one to one nursing care.

Physicians/resident physician, NP, or PA should enter a PSO "Change Accommodation Order" when the physician/resident physician, NP, or PA determines the need for a change in level of care.

A. Example, a change from Telemetry to Med-Surg.

B. The order should be placed prior to the patient's location change.

Patient Status Adjustment Orders

A. Adjustment Orders may be used to align patient status with the UR Nurse or Physician Advisor review when it is determined that the patient did not meet criteria for the PSO entered by the physician/resident

physician, NP, or PA.

B. Only UR Nurses trained in the use of Adjustment Orders and Physician Advisors shall be able to enter Adjustment Orders.

C. All adjustment orders shall be sent to an attending physician for co-signature.

D. Adjustment orders shall not be used when it is known that the primary payer is Original Medicare unless in the instance of a documented clerical error.

   a. CMS allows corrections to a PSO only if:

      i. The initial order was a clear clerical mistake (e.g., "Outpatient" selected when "Inpatient" was intended).

      ii. The provider documents the reason for the correction (e.g., "Clerical error: patient met inpatient criteria at the time, incorrect status selected.")

      iii. The adjusted order reflects the original intent as documented in the EHR at the time of admission, not based on hindsight or how the stay progressed.

Workflows to Ensure Accurate Accommodation

Bed Board Monitoring for Patient Status and Accommodation Accuracy

A. Nursing is responsible for monitoring the bed board throughout their shift to ensure each patient has an active PSO and that the patient is assigned the correct accommodation (e.g., med/surg, telemetry, ICU).

B. Nursing is responsible for reconciliation of PSO orders and accurate accommodation on the bed board prior to midnight to support accurate patient classification, regulatory compliance, and proper billing. Any missing or incorrect status orders must be escalated promptly to the physician or LP for correction.

C. If an error is found after midnight, Case Management staff should be notified.

Clinical Review of OBS Encounters

A. UR RNs and/or Physician Advisors must review all OBS for medical appropriateness prior to releasing the billing hold.

B. UR RNs and/or Physician Advisors must closely monitor the entire OBS census by the end of each business day.

C. A summary report of OBS must be presented to the Utilization Management Committee at regular intervals.

DOCUMENTATION

A. Patients with Observation or Inpatient status orders require complete documentation to include all regulatory elements, including full admission documentation.

B. Patients under Outpatient in a Bed status do not require a full admission intake but do require a focused clinical assessment, physician orders, and discharge orders. Complete documentation is required if patient status changes to Observation or Inpatient.

COMPLIANCE

Randomized audits will be conducted by the Case Management as well as external agencies.

REFERENCES:

CMS Benefit Policy Manual, Ch. 1, §10:

All revision dates: 1/23/2026, 9/16/2025

Attachments

- Access Manangement Office
- Admit to Inpatient
- Changing from Inpatient to Observation
- PSO Instructional Job Aid
- VCHCA Patient-Status-Outpatient-In-A-Bed

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	1/29/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/24/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/23/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/23/2026
Policy Owner	Laura Zarate: Clinical Nurse Manager, Case Management	1/23/2026

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*1/10/2023*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*1/14/2026*
Next Review:	*3 years after approval*
Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Nursing Practice Protocols*
References:	

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

Purpose

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

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

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

Function to Be Performed

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

Applicable Departments

This standardized procedure is applicable in all areas where RNs practice and patients are aged 14 and over in the hospital setting.

Roles and Responsibilities

A. Scope of supervision required

1. The RN performing these functions is responsible and accountable to the nursing director in their

department.

2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the RN by phone or in person.
3. Provider consultation is to be obtained under the following circumstances
    a. Emergency conditions requiring prompt medical intervention
    b. Upon the request of the patient, RN or physician
    c. Anytime any deviation from this protocol is necessary

B. Requirements for the RN

1. Active California RN license
2. Basic life support (BLS) or Advanced cardiovascular life support (ACLS) if indication
3. Orientation to this policy and the attachments

C. Evaluation of the RN competence

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

Procedure

A. Catheter Use

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

B. Indications for Indwelling Catheter Use

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

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

Houdini Protocol.

a. Nursing will place the discontinuation order as a standardized protocol order type.

3. Once removed, the RN will use the Post-Urinary Catheter Management Algorithm as a standardized procedure. *Please see Attachment B: Post-Urinary Catheter Management Algorithm.*

C. Indwelling Urinary Catheters- Miscellaneous

~~1. If an indwelling urinary catheter is present on admission from an outside facility, the RN will: 1) document presence, 2) obtain a urine culture, 3) remove the urinary catheter, and 4) insert a new urinary catheter if warranted. The RN will consider alternatives to the indwelling urinary catheter.~~

~~2. If an indwelling urinary catheter is placed emergently, it must be removed as soon as possible, but no later than 24 hours, a baseline urine culture obtained, and a new indwelling urinary catheter inserted if warranted.~~

~~3. If an indwelling urinary catheter is placed in the Operating Room, the RN will remove the foley catheter as soon as possible but no later than 24 hours after surgery, unless continuation is clinically indicated.~~

1. If an indwelling urinary catheter is present on admission from an outside facility, the RN will document presence.
    1. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as:
        a. Infection,
        b. Obstruction, or
        c. When the closed system is compromised.
    2. At LP discretion when none of the above criteria are met, the indwelling catheter may remain in place. RN to ensure Foley care order is in place.
    3. If the LP determines a need to replace an indwelling catheter from an outside facility, the LP will place an order for a new catheter placement.
    4. If a urine sample is ordered, RN will not obtain from the collection bag and instead obtain from the sampling port.
2. If an indwelling urinary catheter is placed in the Operating Room, the RN will remove the Foley catheter as soon as possible, but no later than 24 hours after surgery, unless continuation is clinically indicated. If clinically indicated, an LP must order the placement of the catheter.

D. Indwelling Urinary Catheter Insertion

1. Personnel who insert indwelling urinary catheters must have demonstrated competency in proper insertion technique.
2. The Lippincott procedure will guide the specific details of insertion.
3. Indwelling urinary catheters should be properly secured after insertion to prevent movement and urethral traction.
4. If a Coude catheter is required, nursing is to contact the critical care clinical nurse specialist or superuser.
    a. Superusers: critical care RNs and rapid response team (RRT) nurses

E. Documentation for Catheter Insertion

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

F. Closed Sterile Drainage

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

G. Irrigation

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

H. Urinary Flow and Collection Bag

1. Unobstructed flow should be maintained
2. To achieve free flow of urine:
    a. Avoid any kinks in the catheter and collection tubing
    b. The collection bag should be emptied as needed and prior to ambulation and/or transport.
    c. A separate collection container to empty the urine should be utilized. The drainage spigot should never come in contact with the urine collection container.
    d. Collection bags should always be kept below the level of the bladder but should never touch the floor.

I. Perineal Care

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

Documentation

A. The RN will document the following in the EHR:
    1. Insertion or removal of any indwelling catheter
    2. Accurate output
    3. Patient tolerance

REFERENCE(S):

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

Centers for Disease Control (CDC) (n.d.) Guideline for prevention of catheter-associated urinary infections.

https://www.cdc.gov/infectioncontrol/guidelines/cauti/recommendations.htmlhttps://www.cdc.gov/infectioncontrol/guidelines/cauti/recommendations.html

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

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

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

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

All revision dates:	1/14/2026, 8/15/2025, 4/16/2025, 11/19/2024, 1/10/2023

Attachments

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	1/14/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/17/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/17/2025
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/17/2025
Protocol Author	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/17/2025

Ventura County Medical Center

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Basic Criteria: a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology* b. Current board certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology **OR**: c. Active participation in the examination process leading to certification within 5 years of completion of training d. Completion of BETA annual obstetrical module requirements (for obstetric privileges only) e. Documentation of case volumes as outlined in each requested privilege section **Evaluation Criteria:** A minimum of 5 cases representative of requested privileges, specific requirements outlined in each privilege section **Renewal Criteria:** a. Documentation of case volumes as outlined in each requested privilege section for renewal of privileges b. Compliance with BETA annual obstetrical module requirements ** Advanced obstetrics may be requested by family medicine physicians with the appropriate obstetrics fellowship training* *If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity. The Return to Practice Plan policy may be used to guide monitoring and/or training requirements.* *If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.*		
OBSTETRICS		
Low-Risk Obstetrics Core Privileges **Initial Criteria**: a. Documentation of a minimum of 40 deliveries in the previous 24 months **OR;** b. Documentation of a minimum of 20 deliveries in the previous 24 months **AND** a minimum of 40 during residency training E**valuation Criteria:** A minimum of 1 vaginal delivery **Renewal Criteria:** Documentation of a minimum of 20 deliveries in the previous 24 months		
Low-Risk Obstetrics Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any low risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Prenatal care Perform history and physical examination Vaginal delivery Fetal monitoring Vacuum extraction Episiotomy and/or other vaginal laceration repairs (up to 3rd-degree laceration repair) Limited obstetric ultrasound Resuscitation of infant	___	___

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Advanced Obstetrics Core Privileges **Initial Criteria:** a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology **OR**; b. Completion of an ACGME or AOA approved family medicine residency program and an obstetrics fellowship c. Documentation of a minimum of 100 cesarean sections during fellowship **AND** 20 within the previous 24 months **Evaluation Criteria:** a. A minimum of 2 cesarean sections (1 primary and 1 repeat) b. Management of 1 complicated prenatal patient (desired but not required) **Renewal Criteria:** A minimum of 20 patients in the previous 24 months, including a minimum of 20 cesarean sections if requesting c-section privileges		
Advanced Obstetrics Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any high-risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Perform history and physical examination Breech delivery Forceps delivery Cerclage placement Amniocentesis and other procedures related to normal and complicated deliveries Multiple pregnancies Postpartum tubal ligation Obstetric ultrasound 4th-degree laceration repair Dilation and curettage (for pregnancy	___	___
Cesarean section (including tubal ligation done at c-section)	___	___
Special Privileges **Initial Criteria:** a. Completion of an Obstetrics and Gynecology residency program b. A minimum of 2 cases in the previous 24 months **Evaluation Criteria:** A minimum of 1 case evaluated **Renewal Criteria:** A minimum of 1 case in the previous 24 months		
2nd Trimester dilation and evacuation	___	___
~~Use of Laser - *CO2 Laser Surgery course certification required*~~	___	___
GYNECOLOGY **Initial Criteria:** a. Completion of an Obstetrics and Gynecology residency program b. Documentation of a minimum of 100 patients within the previous 24 months, including 20 surgical cases, unless only requesting outpatient privileges **Evaluation Criteria:** a. A minimum of 1 major gynecology procedure b. A minimum of 1 minor gynecology procedure (may be fulfilled by satisfactory completion of a major procedure) **Renewal Criteria:** A minimum of 20 patients, including 10 surgical cases, unless only requesting outpatient privileges		

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Gynecology Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, diagnosis, pre, intra-, and post-operative care and treatment of female patients of all ages presenting with illnesses, injuries, and disorders of the gynecological system and nonsurgical treatment of illnesses, and injuries of the mammary glands and urinary tract, and include: Perform history and physical examination Outpatient management Diagnostic and operative hysteroscopy Operative laparoscopy Cautery of endometriosis Hysterectomy, including cesarean hysterectomy Repair of bladder injury Repairs for pelvic relaxation and evaluation and treatment of stress urinary incontinence (suspension techniques) Endometrial ablation Reconstruction of vagina/vulva Myomectomy Bartholin cystectomy and catheter placement Biopsy (cervix, vulva, vagina, endometrium) Cervical conization Dilation and curettage Hymenotomy, Hysteroscopy I&D of abscess Oophorectomy Ovarian cystectomy Perineorrhaphy Removal of cervical polyps Repair of recto-vaginal fistula Pelvic ultrasound Presacral neurectomy Salpingectomy Suction curettage Trachelectomy Incidental cystoscopy IUD placement/removal and other contraceptive procedures Tubal ligation Uterine suspension Vaginal exam under anesthesia Simple vulvectomy	___	___
GYNECOLOGIC ONCOLOGY **Initial Criteria:** a. Completion of a gynecologic oncology fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months **Evaluation Criteria:** a. A minimum of 1 major procedure b. A minimum of 1 laparoscopy procedure **Renewal Criteria:** A minimum of 20 patients within the previous 24 months		

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Gynecologic Oncology Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admission, evaluation, consultation, work-up, diagnosis, and provision of surgical and therapeutic treatment to patients of all ages with malignant diseases, including carcinomas of the cervix, fallopian tubes, ovaries, uterus, vulva, and vagina, and include: Perform history and physical examination Outpatient management Radical hysterectomy with or without lymph node dissection Sentinel node biopsy Operative laparoscopy Retroperitoneal surgery for cancer Microsurgery Chemotherapy Pelvic exenteration Vulvectomy Procedures on the bowel, urethra, and bladder as indicated	___	___
MATERNAL AND FETAL MEDICINE **Initial Criteria:** a. Completion of a maternal and fetal medicine fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months **Evaluation Criteria:** A minimum of 1 complicated patient, procedure, or ultrasound **Renewal Criteria:** A minimum of 20 patients in the previous 24 months		
Maternal and Fetal Medicine Core Privileges ***Indicate in the comment section below, any portion of the core privileges NOT being requested*** **Privileges include but are not limited to the following:** Admit, evaluate, diagnose, treat and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications, connective tissue disorders, and fetal malformations, conditions, or disease, and include: Perform history and physician examination Chorionic villus sampling Intrauterine transfusion Transuterine fetal procedures Ex Utero Intrapartum Treatment (EXIT) procedures Fetal umbilical cord blood sampling Level II ultrasound	___	___
ADDITIONAL PRIVILEGES		
Provider Performed Microscopy (PPM) - ***Annual competency modules required for each exam*** ***Indicate in the comment section below, any portion of PPM privileges NOT being requested*** Fecal WBC Fern Test Pinworm Preparations Qualitative Semen Skin KOH Urine Sediment Vaginal KOH Prep Vaginal Wet Prep	___	___

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested	Granted
Adult Moderate or Deep Sedation and Analgesia **Initial Criteria:** a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) **Evaluation Criteria:** A minimum of 3 cases evaluated **Renewal Criteria:** a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months *- If volume not met, the next case evaluated*		
Light to moderate sedation	___	___
Deep sedation	___	___
ACKNOWLEDGEMENT OF PRACTITIONER: *I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital, and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.* Applicant's electronic signature on file **TEMPORARY PRIVILEGE APPROVAL** Department Chief's Signature: _____ Date: _____ Evaluator Assignment: _____ **[ ] PROVISIONAL [ ] RENEWAL APPROVAL** _____ Chief, Department of Obstetrics & Gynecology Date		

VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

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Medical Executive Committee Document Approvals

February 2026

a. Policies & Procedures / Forms / Orders

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

#	Title	Summary	Frequency	Page
1.	100.001 Hospital Mission Statement	No changes	Triennial	2
2.	100.009 Sterilization Regulations, Required Consent and Waiting Periods	No changes	Triennial	3-7
3.	100.014 Patient Transfer to Ventura County Medical Center and Santa Paula Hospital	Corrected minor typographical error	Triennial	8-9
4.	100.019 Release of Patient Information	Revised to incorporate verbiage from AB 81 regarding sensitive personal information. Added references	Triennial	10-16
5.	100.022 Withdrawal of Patient Life Support	No changes	Triennial	17-21
6.	100.026 Declaration of Brain Death and Apnea Testing	Defined abbreviations	Triennial	22-25
7.	100.033 Blood Alcohol Test Procedures	No changes	Triennial	26-28
8.	100.049 Advance Healthcare Directives	No changes	Triennial	29-32
9.	100.085 Tissue Acquisition, Receipt, Storage and Issuance	Defined abbreviations	Triennial	33-36
10.	100.236 Patient Safety Plan	Complete policy re-write. Revised to include AB 3161 requirements.	Annual	37-45
11.	100.284 General Inpatient Hospice Care	New policy	Triennial	46-47
12.	106.028 Isolation Precautions	Revised C.Auris screening consideration and duration of precautions.	Triennial	48-53
13.	108.057 Clostridium Difficile Screening and Testing	Revised inpatient c.difficile infection testing algorithm for clarity	Triennial	54-57
14.	AC.01 Ambulatory Care Emergency Response Equipment and Supplies	Revised to align emergency cart contents and monthly inspections with Gold Coast guidelines	Triennial	58-62
15.	AC.10 Chemotherapy / Immunotherapy Nurse Certification	Updated reference of biotherapy with immunotherapy. Updated to include initial training requirement for newly hired RNs, and defined grace period for expired certifications.	Triennial	63-64
16.	AC.30 Timeliness of Documentation	Revised to reflect correct term of LP per TJC throughout. Updated reference of 3 days to 72 hours for consistency. Corrected minor typographical errors throughout. Expanded definitions.	Triennial	65-69
17.	DM.002 Pediatric Inpatient Diabetes and Hyperglycemia Management	Minor revisions throughout that does not impact content of policy	Triennial	70-74
18.	DM.003 Pediatric Hypoglycemia	Updated dextrose dosing, defined abbreviations, and updated policy to reflect applicability to ambulatory care clinics.	Triennial	75-78
19.	L.52 Laboratory Response To Hospital Emergency Call Codes	Updated action plan for multiple codes called; outlined plan for code sepsis. Defined abbreviations.	Biennial	79-82
20.	S.16 Patient Death in the Operating Room	Updated policy verbiage to align with CMS 482.45 and California Government Code § 27491. Defined abbreviations	Triennial	83-85
21.	S.24 Environmental Cleaning in Sterile Processing Department Areas	Revised multidisciplinary team composition responsible for determining cleaning procedures/frequencies.	Triennial	86-89
22.	UR.06 Patient Status Orders	Updated to include attending signatures on adjustment orders and exceptions to attending signature on PSO prior to discharge.	Triennial	90-96
23.	NPP. 07 Urinary Catheter Insertion/Maintenance/De-escalation	Revised to include guidance regarding if and when to remove a catheter when the patient comes into the hospital with one or after	Triennial	97-101

		placement in the OR. Defined who would be considered a superuser for insertion of Coude catheters.		

b. Medical Staff Forms

1.	Obstetrics & Gynecology Privilege Checklist	Removed privilege/equipment no longer available within the hospital. (Revision approved by OB/GYN and MEC).	102-106

VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Compliance Policies Presented to

Oversight Committee

February 25, 2026

Policies & Procedures

The following revised policies are recommended by Compliance Committee for approval.

1. HCA.01 Code of Conduct
2. 109.056 Compliance Training Policy
3. 109.057 HCA Corporate Integrity Agreement Certification

VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Compliance Policies and Procedures
presentation to
Oversight Committee
February 25, 2026

Policies & Procedures / Forms / Orders

The following were reviewed and are recommended for approval by the appropriate departments and Compliance Committee.

#	Title	Summary	Frequency	Page
1.	**HCA.01** Code of Conduct	Updated to align with current best practices and the California Hospital Association model. Revisions clarify applicability to all workforce members, including employees, medical staff (as applicable), vendors, contractors, and agents. Language strengthened to reinforce nondiscrimination, privacy and confidentiality expectations across all care settings, appropriate use of HCA systems and assets, reporting mechanisms and non-retaliation protections and accountability for violations. Conflict of interest and gifts language was refined to prohibit improper influence while preserving lawful employment compensation and approved business practices. Contact information for the Office of Compliance and Privacy and the Compliance Helpline was added. Updated approval workflow to include HR and MEC.	Annual	3-9
2.	**109.056** Compliance Training Policy, with Attached Exhibit C: Vendor and Contractor CIA	Updated to clarify ownership and expectations for Compliance Training: Compliance now defines system-wide training requirements while the HCA training/LMS function assigns and tracks them, and departments are responsible for role-based training with Compliance as a resource. The policy now requires completion of systemwide Compliance Training within 30 days of hire, sets an annual training cycle with a 90-day rule for new hires, tightens minimum content (Code of Conduct, reporting/non-retaliation, FWA, HIPAA privacy, CIA), removes IT security from Compliance Training, formalizes when external/primary organization training can be accepted (with annual proof), and clarifies documentation, retention in the LMS, and expectations for Oversight Committee, Compliance Committee, and Certifying Employees. Added: Attachment C: Vendor and Contractor CIA Expectations.	Annual	10-19
3.	**109.057** HCA Corporate Integrity Agreement Certification and 3 Exhibits	Includes Attachments: A: Information for Certification Review; B. Certifying Person Attestation; and C. Vendor and Contractor CIA Expectations	Annual	20-29

Status **Pending** PolicyStat ID **19488687**

Origination	6/23/2024	Owner	Rhondi Shannon: Compliance Officer
Last Approved	N/A	Policy Area	Administrative - Compliance
Effective	Upon Approval		
Last Revised	2/13/2026		
Next Review	1 year after approval		

HCA.01 Code of Conduct

MISSION

Provide comprehensive, cost effective, compassionate health care for our diverse community, especially those facing barriers, through an exceptional workforce, education, and forward thinking leadership.

VISION

Setting the standard in health care excellence. Healthy people in healthy communities throughout Ventura County

PURPOSE AND EXPECTATIONS

Ventura County Health Care Agency (HCA) is committed to conducting its operations with integrity, accountability, and respect for the patients, clients, communities, and partners we serve. This Code of Conduct establishes the standards of behavior and ethical expectations that guide how we perform our work across all HCA programs and settings, including Public Health (PH), Behavioral Health (BH), Ambulatory Care (AC), and hospital operations.

No code can anticipate every situation. Workforce Members are expected to use good judgment, comply with applicable laws and HCA policies, and ask questions or raise concerns when something does not seem right.

Training and education will be provided as required based on role, responsibilities, and regulatory requirements.

WHO MUST FOLLOW THIS CODE

This Code applies to all individuals and entities acting on behalf of HCA, including employees, temporary or registry staff, medical staff members where applicable, residents, students, interns, volunteers, contractors, consultants, vendors, and agents ("Workforce Members").

Vendors and contractors are expected to comply with this Code and all applicable contractual obligations, including confidentiality, privacy, security, and Business Associate requirements where applicable. Failure to comply may result in corrective action up to and including termination of the business relationship.

CODE OF CONDUCT

SERVICE EXPERIENCE

HCA Workforce Members shall strive to deliver quality, patient- and client-centered services.

- Patients and clients have the right to participate in decisions regarding their care to the greatest practical extent possible.
- No person shall be denied services, excluded from participation, or otherwise treated differently in HCA programs or activities on the basis of race, color, national origin, sex, age, or disability. Consistent with HCA and County policy, HCA also prohibits discrimination based on religion, ancestry, medical condition, gender identity, sexual orientation, marital status, economic status, source of payment, or any other status protected by applicable law.
- Workforce Members shall treat all patients and clients with dignity, respect, courtesy, and cultural sensitivity.
- Patients and clients have the right to receive information necessary to make informed decisions regarding their care, including the nature of the proposed care, material risks, and reasonable alternatives.
- Patients and clients have the right to receive information regarding applicable HCA policies and charges.
- Services will be provided by qualified, competent individuals acting within the scope of their role.
- HCA will maintain accurate, complete, and timely records in accordance with law and policy.

COMPLIANCE WITH LAWS AND ETHICAL BUSINESS PRACTICES

HCA Workforce Members shall comply with all applicable federal, state, and local laws, regulations, standards, and HCA policies.

- Billing and coding must be accurate, timely, and fully supported by documentation.
- HCA will bill only for services actually rendered and documented.
- False, fraudulent, misleading, or inaccurate claims or records are prohibited.
- Errors or overpayments must be promptly reported and corrected in accordance with

applicable law.

- Required reports to government agencies must be accurate, complete, and timely.
- HCA will not knowingly employ or contract with individuals or entities excluded from participation in federal or state health care programs.
- No Workforce Member may enter into joint ventures, partnerships, or risk-sharing arrangements involving referral sources without proper review and approval.

PRIVACY AND CONFIDENTIALITY

HCA is committed to protecting the privacy and confidentiality of patient, client, and proprietary information.

- Confidential information may be accessed, used, or disclosed only as necessary to perform authorized duties and in accordance with law, contract requirements, and HCA policy.
- These obligations apply in all settings, including hospitals, clinics, field work, home visits, outreach activities, remote work, and public areas.
- Certain Behavioral Health and substance use disorder information may be subject to additional confidentiality protections. When in doubt, Workforce Members must seek guidance before sharing information.
- Unauthorized access, use, or disclosure of confidential information is prohibited.

USE OF HCA/COUNTY PROPERTY, SYSTEMS, AND TECHNOLOGY

HCA and County property, funds, systems, and equipment are to be used for authorized business purposes only.

- Workforce Members must obtain appropriate authorization before committing or spending HCA funds.
- Personal use of HCA or patient resources is prohibited.
- HCA systems, including email, electronic health records, applications, devices, and networks, must be used in accordance with policy.
- Personal email accounts, unapproved messaging platforms, or unapproved cloud services must not be used to create, store, or transmit HCA confidential information or protected health information.
- PHI may be shared externally only when authorized and through approved secure methods.
- Workforce Members should have no expectation of privacy on HCA or County systems or devices, consistent with applicable law.
- Misuse of systems or assets may result in disciplinary or contractual action.

BUSINESS RELATIONSHIPS AND PROFESSIONAL CONDUCT

Workforce Members shall act honestly, professionally, and in a manner that maintains public trust.

- Misrepresentation, dishonesty, or unethical conduct with patients, vendors, payers, regulators, or the public is prohibited.

- Workforce Members must not subordinate professional judgment to personal interests.
- Significant differences in professional judgment should be referred to management for resolution.
- Workforce Members are expected to safeguard HCA and County assets and report misuse or theft.

CONFLICTS OF INTEREST AND GIFTS

Workforce Members must avoid situations in which personal interests conflict, or appear to conflict, with HCA's interests.

- Actual or potential conflicts of interest must be disclosed in accordance with County and HCA policy.
- Outside employment or activities must not interfere with HCA duties or create conflicts.
- Workforce Members must not accept or provide gifts, meals, entertainment, or benefits that could influence, or appear to influence, business decisions.
- Gifts, benefits, or anything of value may not be offered, provided, or accepted if they are intended to influence, or could reasonably be perceived as influencing, clinical judgment, referrals, or business decisions. This does not prohibit lawful compensation, benefits, or recognition provided to employed clinicians or Workforce Members as part of their employment or pursuant to approved HCA policies and agreements.
- Vendors and contractors must disclose relationships or arrangements that could influence their work for HCA.

HUMAN RESOURCES AND WORKPLACE CULTURE

HCA is committed to a respectful, inclusive, and professional work environment.

- Equal employment opportunity is provided in accordance with law.
- Discrimination, harassment, intimidation, or abusive behavior will not be tolerated.
- Sexual harassment or misconduct is prohibited.
- Reasonable accommodations will be provided as required by law.
- Workforce Members are expected to maintain professional standards and exercise sound judgment.
- Retaliation against individuals who raise concerns in good faith is prohibited.

HEALTH, SAFETY, AND SECURITY

The health and safety of patients, clients, visitors, and Workforce Members is a priority.

- Workforce Members must comply with safety rules and procedures.
- HCA is a drug- and alcohol-free workplace.
- Controlled substances and hazardous materials must be handled and disposed of properly.
- Threats, violence, intimidation, or possession of weapons on HCA premises or while

conducting HCA business are prohibited except as authorized by policy and law.

- Unsafe conditions must be reported promptly.

REPORTING CONCERNS AND NON-RETALIATION

Workforce Members must promptly report suspected violations of this Code, HCA policies, laws or regulations, safety concerns, fraud, waste or abuse, privacy incidents, or unethical conduct.

Concerns may be reported to:

- A supervisor or manager
- The Office of Compliance and Privacy at **805-677-5241**
- The confidential Compliance Helpline at **(833) 823-6631** (available 24/7)

HCA prohibits retaliation against anyone who, in good faith, reports a concern or participates in an investigation.

INVESTIGATIONS, CORRECTIVE ACTION, AND DISCIPLINE

HCA will review reported concerns promptly and take appropriate action.

- Workforce Members are expected to cooperate with investigations and provide truthful information.
- Violations of this Code, HCA policy, contractual obligations, or law may result in corrective action up to and including discipline, termination of employment, termination of access, or termination of a vendor or contractor relationship.
- Corrective actions may include education, policy changes, monitoring, or other measures to prevent recurrence.

ATTESTATION OF COMPLIANCE

I acknowledge that I have received, read, and understand the Ventura County Health Care Agency Code of Conduct. I agree to comply with this Code, applicable HCA and County policies, and all applicable laws and regulations as they relate to my role.

I understand that violations may result in corrective action up to and including termination of employment or termination of my contract or access.

I represent that I am not excluded from participation in any federal or state health care program and will notify HCA if my status changes.

Signature _____ **Date** _____

Printed Name: _____

Department / Company: _____

References

Conflict of Interest - Code found at www.ventura.org/county-executive-office/clerk-of-the-board

Conflict of Interest - Code Health Care Agency found at vcportal.ventura.org/CEO/COB

All Revision Dates

2/13/2026, 7/1/2025, 6/23/2024

Approval Signatures

Step Description	Approver	Date
Compliance & Privacy Office	Rhondi Shannon: Compliance Officer	Pending

History

Draft saved by Shannon, Rhondi: Compliance Officer on 12/15/2025, 2:06PM EST

Edited by Shannon, Rhondi: Compliance Officer on 12/15/2025, 2:08PM EST

> Updated the Code of Conduct to align with current best practices and the California Hospital Association model. Revisions clarify applicability to all workforce members, including employees, medical staff (as applicable), vendors, contractors, and agents. Language was strengthened to reinforce nondiscrimination, privacy and confidentiality expectations across all care settings, appropriate use of HCA systems and assets, reporting mechanisms and non-retaliation protections, and accountability for violations. Conflict of interest and gifts language was refined to prohibit improper influence while preserving lawful employment compensation and approved business practices. Contact information for the Office of Compliance and Privacy and the Compliance Helpline was added.

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> updated signature line

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> Submitting draft with new approval workflow which now includes HR and MEC. Draft reviewed by Compliance Committee 2/3/26.

Administrator override by Arimura, Jason: Associate Hospital Administrator, VCMC & SPH on 2/13/2026, 5:03PM EST

> Modifying approval workflow.

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> Restarting approval workflow.

Status **Pending** PolicyStat ID **19407289**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	9/1/2022
Last Approved	N/A
Effective	Upon Approval
Last Revised	2/4/2026
Next Review	1 year after approval
Owner	Rhondi Shannon: Compliance Officer
Policy Area	Administrative - Compliance

109.056 HCA Compliance Training

PURPOSE

To establish minimum requirements for Compliance Training for the Ventura County Health Care Agency (HCA) and its Covered Persons, consistent with:

- Federal and State laws and regulations;
- The Corporate Integrity Agreement (CIA) between HCA and the U.S. Department of Health and Human Services Office of Inspector General (OIG); and
- Applicable accreditation, contractual, and payer standards.

Compliance Training is a core element of HCA's Compliance Program and is required to support ethical, lawful, and compliant operations.

SCOPE

This Policy applies to HCA, its affiliates, and all locations subject to the HCA Compliance Program.

It covers all **Covered Persons**, including but not limited to:

- Employees (full-time, part-time, per diem);
- Medical staff (physicians and non-physician practitioners);
- Residents, fellows, students, and trainees;
- Volunteers; and
- Contractors, agency staff, and other individuals who provide services, furnish patient care items or services, or perform billing or coding functions on behalf of HCA.

DEFINITIONS

Covered Person
Any New Covered Person or Current Covered Person as defined below.

New Covered Person
An individual newly affiliated with HCA who is a Covered Person (including employees, medical staff, residents, students, volunteers, contractors, and agency staff).

Current Covered Person
Any Covered Person after the initial thirty (30) days of hire or association.

Compliance Training
Training and attestations required under this Policy, consisting of:

A. Compliance modules designated by the HCA Office of Compliance and Privacy (for example, Fraud, Waste and Abuse; General Compliance; HIPAA Privacy; and other risk-based modules); and

B. Review and attestation that the Covered Person has read and understood:
   - the HCA Code of Conduct; and
   - the HCA policy summarizing the CIA and related obligations (see Attachment C, Vendor and Contractor CIA Expectations, as applicable).

Annual Compliance Training
Compliance Training assigned on an annual cycle to all Current Covered Persons.

Certifying Employee
An individual designated as a "Certifying Employee" under the CIA (for example, HCA Director, facility CEO, CFO, COO, Compliance Officer, and County CEO, as specified in the CIA).

POLICY

A. Required Training and Timing

I. **New Covered Persons**
   - Must complete all required Compliance Training and related attestations **within thirty (30) days** of hire or association.
   - Completion of Compliance Training within thirty (30) days does **not** waive the obligation to participate in the Annual Compliance Training cycle when due.

II. **Current Covered Persons**
   - Must complete Annual Compliance Training and required attestations **each year** according to the schedule established by the Office of Compliance and Privacy.

III. **New Hires and Annual Training Cycle**
   - All Covered Persons must complete required Compliance Training within thirty (30)

days of hire or association.

- HCA will establish an annual Compliance Training cycle and due date for Current Covered Persons.
- Covered Persons hired or affiliated **more than ninety (90) days before** the annual Compliance Training due date are included in that year's annual assignment and must complete both:
    - the initial Compliance Training required within thirty (30) days of hire/association; and
    - the Annual Compliance Training assigned for that training year.
- Covered Persons hired or affiliated **within ninety (90) days before** the annual Compliance Training due date are required to complete the initial Compliance Training within thirty (30) days of hire/association. When the content of the initial Compliance Training is comparable to that year's Annual Compliance Training, completion of the initial Compliance Training will be accepted as satisfying the annual requirement for that training year. These Covered Persons will be included in the next annual Compliance Training cycle.

IV. **HR / Departmental Orientation**

- Attendance at Human Resources orientation (including New Employee Orientation/NEO) or departmental orientation **does not, by itself, satisfy** Compliance Training requirements unless the designated Compliance modules and required attestations are assigned, completed, and documented as part of that process.

V. **System Access**

- Access to systems containing PHI and independent duties involving patient care or federal or state program billing may be conditioned on completion of required Compliance Training and applicable Information Security training, in accordance with HCA policies.

B. Minimum Content Requirements

Compliance Training will be role-appropriate and, at a minimum, will address:

I. **Code of Conduct and Compliance Program**

- HCA Code of Conduct, standards of behavior, and expectations for integrity;
- Structure and purpose of the HCA Compliance Program;
- Roles of the Compliance Officer and Compliance Committee;
- How to ask questions or seek guidance.

II. **Reporting and Non-Retaliation**

- Available mechanisms to report concerns (for example, helpline, email, direct reporting);
- Duty to report suspected violations;

- Non-retaliation protections and examples of prohibited retaliation.

III. **Fraud, Waste, and Abuse / Billing Integrity**

- Overview of applicable fraud and abuse laws (for example, False Claims Act, Anti-Kickback Statute, Stark Law, Civil Monetary Penalties);
- Expectations for accurate documentation, coding, and billing;
- Examples of fraud, waste, and abuse and how to report concerns.

IV. **HIPAA Privacy**

- HIPAA Privacy requirements and applicable State privacy laws;
- Permitted uses and disclosures of protected health information (PHI);
- Minimum necessary standard and patient privacy rights;
- How to report suspected privacy incidents and breaches.

V. **Corporate Integrity Agreement (CIA)**

- Purpose of the CIA and key obligations;
- Workforce responsibilities, including cooperation with audits and investigations, and accuracy of certifications where applicable.

VI. **Additional Risk-Based Topics**

- Additional topics identified through risk assessments, audits, investigations, regulatory or contractual changes, CIA requirements, or survey results, including but not limited to EMTALA, cost reporting, quality of care, and vendor and physician relationships, as applicable to the Covered Person's role.

VII. **Information Security Training (Separate Program)**

- Information security awareness training is administered and managed by HCA Information Technology (IT). Covered Persons are required to complete information security training in accordance with IT policies and schedules.
- The Office of Compliance and Privacy does not administer information security training but may rely on documentation and attestations maintained by IT to demonstrate compliance with applicable HIPAA Security Rule, CIA, regulatory, accreditation, and contractual requirements.
- Completion of required information security training does not replace Compliance Training required under this Policy.

C. External (Primary Organization) Training

In limited circumstances (for example, residents, students, contracted or agency staff), Compliance Training completed through a Covered Person's primary organization may be accepted instead of duplicative HCA Compliance modules if the HCA Compliance Officer determines that the external training is comparable and meets all applicable HCA, CIA, regulatory, accreditation, and payer requirements.

To be approved as comparable, external training must cover, at a minimum:

Fraud, Waste, and Abuse;

- General compliance expectations and reporting obligations;
- Privacy and security of PHI; and
- Non-retaliation.

When external training is approved, HCA may rely on the primary organization to:

- Deliver the required training to all Covered Persons assigned to HCA;
- Maintain detailed, individual-level records of training completion; and
- Provide HCA, at least annually, with a written certification and roster confirming that all such personnel have completed the required training within the previous 12 months and that underlying training records will be made available to HCA upon request.

Even when external training is accepted, Covered Persons employed by external organizations must still, at least annually:

- Receive and acknowledge the HCA Code of Conduct;
- Receive and acknowledge information on how to report a compliance concern or privacy/security breach related to HCA; and
- Receive and acknowledge a summary of the CIA and related obligations applicable to their work for HCA.

The primary organization may administer these acknowledgements on HCA's behalf, provided that it:

- Obtains individual acknowledgements from each Covered Person assigned to HCA;
- Maintains those acknowledgements; and
- Provides HCA, at least annually, with a written certification and roster confirming completion and agrees to provide underlying acknowledgements upon request.

The responsible HCA department (for example, Medical Staff Services, GME, contract owner) must ensure that the contractual agreement with the primary organization includes these obligations, must obtain and retain copies of all vendor certifications and rosters at least annually, and must make such documentation available to the Office of Compliance and Privacy upon request.

D. Specialized / Role-Based Compliance Training

I. The Office of Compliance and Privacy will identify system-wide risk themes and recommended Compliance Training topics based on risk assessment, audit findings, investigations, regulatory and contractual developments, CIA requirements, and survey results.

II. **Department leaders** are responsible for assigning and ensuring completion of **role-based Compliance Training** for Covered Persons in their areas (including contractors and trainees), based on job duties and identified risks (for example, claims coding, registration, EMTALA-exposed clinical areas, cost reporting, high-risk clinical services).

III. Role-based Compliance Training is **in addition to**, and does not replace, Compliance Training required under this Policy (initial 30-day requirement and Annual Compliance Training, including Code of Conduct and policy attestations).

E. Special Groups

I. **Oversight Committee Members**

- Must receive Compliance Training within thirty (30) days of appointment and at least annually thereafter regarding their oversight responsibilities for the HCA Compliance Program, including applicable OIG guidance on board and governing body duties.

II. **Compliance Committee Members**

- Must receive orientation to the Compliance Program and Committee charter within sixty (60) days of appointment and at least annually thereafter regarding their responsibilities for risk assessment, policy and procedure oversight, monitoring, and corrective action.

III. **Certifying Employees**

- Must receive training within thirty (30) days of designation and at least annually thereafter—and before executing any CIA-required certification—on their certification responsibilities, oversight duties in their areas, and relevant CIA obligations.

IV. **Volunteers**

- Volunteers must complete HCA-designated Volunteer Compliance Training within thirty (30) days of onboarding and at least annually thereafter.
- Volunteer training will be tailored to the volunteer role and risk level and will include, at a minimum, confidentiality and privacy expectations, appropriate patient and visitor interactions, how to report compliance or privacy concerns, and non-retaliation.
- Volunteers will not be provided access to HCA electronic health records or other applications that store PHI unless expressly approved and documented. If such access is approved, the volunteer must complete the same Compliance Training and attestations required for Covered Persons with comparable access.
- Because volunteers do not have access to HCA information systems that store PHI, they are not required to complete Information Security training unless their role or access changes.

PROCEDURE

A. Planning and Content

I. The Office of Compliance and Privacy will:

- **Establish system-wide Compliance Training requirements each year**, including required modules, target audiences, and deadlines for Covered Persons;
- Design or approve the content of required **system-wide** Compliance modules and

attestations; and

- Review and update system-wide Compliance Training content at least annually to reflect changes in laws, regulations, CIA obligations, contractual and accreditation requirements, survey findings, and identified risks.

II. The Office of Compliance and Privacy will provide **consultation and guidance** to departments on appropriate **role-based** Compliance Training topics and resources, upon request. Responsibility for designing, assigning, and tracking role-based training remains with the departments.

B. Assignment and Tracking

I. **Employees**

- Compliance, in coordination with Human Resources, will:
    - Assign required **system-wide** Compliance Training to New Covered Persons;
    - Assign **Annual Compliance Training** to Current Covered Persons; and
    - Monitor completion of system-wide Compliance Training through the learning management system or other approved mechanism.
- Human Resources and managers will ensure system-wide Compliance Training assignments are incorporated into on-boarding processes and ongoing performance expectations.

II. **Non-Employees (for example, medical staff, residents, students, contractors, volunteers)**

- Compliance, in coordination with Medical Staff Services, GME, contract owners, and other applicable leaders, will:
    - Define required **system-wide** Compliance Training for non-employees;
    - Establish mechanisms to assign and track completion of system-wide requirements; and
    - Identify when external (primary organization) training may be accepted, subject to Compliance Officer approval.

III. **Role-Based Training Tracking**

- Department leaders are responsible for tracking and documenting completion of **role-based** Compliance Training assignments within their areas and must be able to demonstrate such training during audits, surveys, or compliance reviews.

IV. **External Training Documentation**

- When external system-wide Compliance Training is approved, the responsible department must:
    - Obtain proof of completion at least annually;
    - Retain documentation in accordance with this Policy; and
    - Ensure the Covered Person completes HCA's annual Code of Conduct and

policy attestations.

C. Leaves of Absence

Employees on an approved leave of absence when Annual Compliance Training is due must complete that training within thirty (30) days of returning from leave or before resuming independent duties involving patient care, PHI access, or federal/state program billing, whichever is sooner.

D. Record Retention

The Office of Compliance and Privacy will maintain records of required system-wide Compliance Training completion and attestations, as documented in the HCA learning management system (LMS) or other approved platform, in a readily retrievable format for supervisory review, internal committees, and government or third-party review, for at least the period required by the CIA and applicable law, and not less than six (6) years.

Department leaders must retain records of role-based Compliance Training consistent with applicable departmental, regulatory, and record retention requirements.

E. Monitoring and Enforcement

I. The Office of Compliance and Privacy will routinely monitor completion of required **system-wide** Compliance Training and notify supervisors and department leaders of deficiencies.

II. Supervisors and department leaders are responsible for taking timely corrective action regarding non-completion of system-wide and role-based Compliance Training, which may include progressive discipline or other remedial measures.

III. Failure by supervisors or leaders to address non-completion or to implement corrective action may be escalated to the HCA Director and senior leadership.

IV. Covered Persons who do not complete required system-wide Compliance Training may be subject to progressive discipline and may have duties involving patient care, PHI access, or federal/state program billing restricted until system-wide training requirements are met.

F. Communication of Changes

Material changes to the HCA Code of Conduct, system-wide Compliance Training requirements, or related policies will be communicated through appropriate channels (for example, email, intranet, leadership meetings). Managers must ensure that staff in their areas are aware of, and comply with, such changes.

All Revision Dates

2/4/2026, 4/22/2025, 6/23/2024

Attachments

Attachment C Vendor Contractor CIA Expectations.pdf

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Rhondi Shannon: Compliance Officer	Pending
Compliance & Privacy Office	Rhondi Shannon: Compliance Officer	2/4/2026

History

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> Updated to clarify ownership and expectations for Compliance Training: Compliance now defines system-wide training requirements while the HCA training/LMS function assigns and tracks them, and departments are responsible for role-based training with Compliance as a resource. The policy now requires completion of system-wide Compliance Training within 30 days of hire, sets an annual training cycle with a 90-day rule for new hires, tightens minimum content (Code of Conduct, reporting/non-retaliation, FWA, HIPAA privacy, CIA), removes IT security from Compliance Training, formalizes when external/primary-organization training can be accepted (with annual proof), and clarifies documentation, retention in the LMS, and expectations for Oversight Committee, Compliance Committee, and Certifying Employees.

Last Approved by Shannon, Rhondi: Compliance Officer on 12/2/2025, 4:57PM EST

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> removed word that was out of place

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> updated external training section

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Edited by Shannon, Rhondi: Compliance Officer on 12/16/2025, 3:53PM EST

> updated required attestations

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> Added attachment C

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Edited by Shannon, Rhondi: Compliance Officer on 12/23/2025, 2:47PM EST

> Added language for Security Training requirements and Volunteers

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Last Approved by Shannon, Rhondi: Compliance Officer on 2/4/2026, 1:34PM EST

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Next Review	1 year after approval

Owner	Rhondi Shannon: Compliance Officer
Policy Area	Administrative - Compliance

109.057 HCA Corporate Integrity Agreement Certification

SCOPE

This policy is applicable to all Ventura County Health Care Agency (HCA) Certifying Employees as defined.

PURPOSE

To define the process required for Certifications for each of the five annual Reporting Periods under the Corporate Integrity Agreement (CIA) between the Office of Inspector General of the Department of Health and Human Services and Ventura County.

CIA Responsibilities of HCA Workforce Members

Employees, associates, and other individuals affiliated with Ventura County Health Care Agency (HCA) are expected to comply with all applicable HCA and Ventura County Medical Center (VCMC) policies and procedures that support the CIA, including participation in required training, cooperation with audits, reviews, reporting compliance concerns, and supporting accurate documentation and oversight activities. Certain designated senior leaders ("Certifying Employees"), as defined by this policy and the CIA, have additional responsibilities to monitor compliance within their areas of authority and to provide annual certifications to the United States as required by the CIA.

Vendors, contractors, and other non-employee workforce members may be provided with Attachment A for awareness of Corporate Integrity Agreement expectations applicable to their role.

DEFINITIONS

A. ***"Certifying Employees"*** Identified Ventura County employees who are expected to monitor and oversee activities within their areas of authority. This includes, at minimum, HCA Director, VCMC Chief Executive Officer, VCMC Chief Financial Officer, VCMC Chief Operating Officer, Ventura County Chief Executive Officer, HCA Chief Financial Officer and the HCA Compliance Officer as well as other members of senior management with operations that are related to Federal health care programs as defined by the CIA dated August 11, 2022.

B. ***"Certification"*** A written assurance provided by each Certifying Employee that includes:

    1. *"I have been trained on and understand the compliance requirements and responsibilities as they relate to [insert name of department], an area under my supervision. My job responsibilities include ensuring compliance with regard to the [insert name of the department] with all applicable Federal health care program requirements, requirements of the Corporate Integrity Agreement, and Ventura County Health Care Agency policies, and I have taken steps to promote such compliance. To the best of my knowledge, the [insert name of department] of Ventura County Health Care Agency is in compliance with all applicable Federal health care program requirements and the requirements of the Corporate Integrity Agreement. I understand that this certification is being provided to and relied upon by the United States."*

C. ***"Corporate Integrity Agreement (CIA)"*** The Corporate Integrity Agreement is a formal agreement between the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and Ventura County that establishes specific compliance, oversight, training, reporting, and certification requirements related to participation in Federal health care programs. The CIA is intended to promote adherence to applicable Federal health care program requirements and to strengthen VCMC's compliance program.

D. ***"Reporting Periods"*** Each of the five annual periods following the effective date of the CIA.

POLICY

Certifying employees will complete the Corporate Integrity Agreement (CIA) Certification for each of the five Reporting Periods as required within the specified timeframe. To complete the Certifications, all Certifying Employees must follow the procedure outlined by this Policy.

PROCEDURE

A. Certifying Employees must submit completed Certifications to HCA Compliance Officer within a reasonable time after the end of each annual Reporting Period.

B. If at any time during the Reporting Period, a Certifying Employee becomes aware of any issue that would hinder their ability to complete the Certification, HCA Compliance Officer will be notified immediately.

C. To ensure the Certification is accurate and complete, the Certifying Employees should take the following steps for their areas of responsibility, as applicable:

    1. Determine the individuals for which you will require a sub-certification. At a minimum, sub-certifications should be obtained from individuals with either

departmental supervisory responsibilities or whose work has a direct impact on any of the specific areas covered by the CIA, including coding and billing. The sub-certification should state the following:

a. *"I have been trained on and understand the compliance requirements of the CIA as it relates to my job responsibilities. To the best of my knowledge:*

b. □ *HCA and VCMC are in compliance with all applicable Federal Healthcare Program requirements and the obligations of the Corporate Integrity Agreement; or,*

c. □ *I have disclosed the following matters for investigation and follow-up:*

_____

_____

_____

d. *I understand that this certification is being provided to and relied upon by [insert name and title of Certifying Employee]."*

D. Certifying Employees will review reports to ensure Covered Persons are compliant with the training requirements of the HCA and VCMC CIA.

E. Certifying Employees will review the results of any internal or external audits along with corrective action plans, including validating that any Overpayments are refunded.

F. Certifying Employees will review any disciplinary actions taken related to compliance.

G. Certifying Employees will review disclosures including those received through the HCA Compliance Line and related corrective actions for any identified issues or questions associated with HCA or VCMC policies, procedures, or practices with respect to Federal or State Healthcare Programs.

H. Other information, as applicable, may be added to certification review materials to ensure a comprehensive review.

REFERENCES:

"Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Ventura County California dated August 11, 2022.

All Revision Dates

2/4/2026, 6/23/2024

Attachments

Attachment A.docx

Attachment B.docx

Attachment C Vendor Contractor CIA Expectations.pdf

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Rhondi Shannon: Compliance Officer	Pending
Compliance & Privacy Office	Rhondi Shannon: Compliance Officer	2/4/2026

History

Comment by Shannon, Rhondi: Compliance Officer on 2/4/2026, 1:59PM EST

> did not mean to push to approval for oversight. Only compliance committee has approved at this time.

Sent for re-approval by Shannon, Rhondi: Compliance Officer on 2/4/2026, 1:59PM EST

> added note regarding approval from oversight still required

Last Approved by Shannon, Rhondi: Compliance Officer on 2/4/2026, 1:59PM EST

Attachment A

Corporate Integrity Agreement
Ventura County Health Care Agency (HCA)
Information for Certification Review

Annually, all Certifying Employees will review the following:

- Annual Risk Assessment
- Annual Workplan and quarterly updates on each item's progress
- Annual IRO Audit Results and Report
- Implementation Report (Year One only)
- Biannual OIG Report
- Quarterly Compliance Committee Meeting agendas and minutes
- Quarterly Compliance Program Oversight Committee reports
- Sub-certification by Compliance Officer on monthly Exclusion Reports
- Disclosure Log highlighting significant investigations and remedial measures
- Sub-certification by Compliance Officer on Training assignments
- Training statistics including annual, new hire and targeted
- Non-routine Overpayments
- Reported Conflicts of Interest
- Denial trends
- PEPPER Reports
- Compliance Policies and Procedures (new or revised)
- Office for Civil Rights Privacy Correspondence and Response

In addition to the documentation that all Certifying Employees must review prior to making their Annual Management Certification, it is suggested that the following information be reviewed.

HCA Director

Suggested Sub-certifications

- Chief Medical Officer of Ambulatory Care
- Human Resources Manager
- Chief Information Officer

Suggested Supplementary Information to Review:

- Disciplinary actions for non-compliance
- Delinquent performance reviews
- Clinic audits

VCMC CEO:

Suggested Sub-certifications

- Chief Medical Officer
- Chief Nurse Executive
- Utilization Review Committee Chair
- Risk Manager
- Medical Staff Office Manager
- Physician Contracts

Suggested Supplementary Information to Review:

- HRSA audits
- Credentialing reports
- EMTALA issues
- Patient complaints relative to medical staff
- Exclusion screening for medical staff
- Physician contract monitoring reports
- Conflicts of interest

VCMC COO:

Suggested Sub-certifications:

- Laboratory Services
- Imaging Services
- Pharmacy
- Clinical Regulatory Compliance

Suggested Supplementary Information to Review:

- 340B audits
- Audits of provider documentation including diagnosis and CPT codes
- Pharmacy audits
- Medical Necessity audits
- Compliance investigations and remedial measures specific to patient care
- Two-midnight-short stay processes/audits/errors
- Office for Human Research Protections and FDA correspondence

VCMC CFO:

Suggested Sub-certifications:

- HIM and CDI Manager
- Care Management/Utilization Review Manager
- Charge Description Manager
- Revenue Cycle Manager

- Cost Report Manager
- Person Responsible for 855s
- Patient Access

Suggested Supplementary Information to Review:

- Medicare cost reports
- Disproportionate Share Hospital audits (DSH)
- Recovery Audit Contractors audits and results
- Fiscal Intermediary Inquiries (i.e., Probe and Educate program)
- Coding audits
- Medical Necessity audits (i.e., DHCS TAR-Free audits)

Attachment B

Corporate Integrity Agreement
Ventura County Health Care Agency (HCA)
Reporting Period ____

CERTIFYING PERSON ATTESTATION

"I have been trained on and understand the compliance requirements and responsibilities as they relate to [insert name of department], an area under my supervision. My job responsibilities include ensuring compliance with regard to the _____ [insert name of the department] with all applicable Federal health care program requirements, requirements of the Corporate Integrity Agreement, and Ventura County Health Care Agency policies, and I have taken steps to promote such compliance. To the best of my knowledge, the _____ [insert name of department] of Ventura County Health Care Agency is in compliance with all applicable Federal health care program requirements and the requirements of the Corporate Integrity Agreement. I understand that this certification is being provided to and relied upon by the United States."

_____
Signature

_____
Date

Attachment C

Vendor and Contractor CIA Expectations

Corporate Integrity Agreement (CIA) Overview

Ventura County Health Care Agency (HCA) and Ventura County Medical Center (VCMC) operate under a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services. The CIA establishes compliance, training, reporting, and oversight requirements related to participation in Federal health care programs.

Applicability to Vendors and Contractors

Certain vendors, contractors, and agency staff may be considered "Covered Persons" under the CIA depending on the services they perform. This includes, but is not limited to, individuals or entities that:

- Furnish patient care items or services on behalf of HCA or VCMC;
- Perform billing, coding, or revenue cycle functions;
- Support audits, compliance reviews, or access systems containing protected health information (PHI);
- Provide IT services with access to HCA or VCMC systems or data.

Vendors whose sole connection to HCA or VCMC is the sale or delivery of medical supplies or equipment are generally not considered Covered Persons.

Vendor and Contractor Responsibilities

Vendors and contractors working with HCA or VCMC are expected to:

- Comply with applicable HCA and VCMC policies, including the Code of Conduct;
- Complete required training, including HIPAA and Fraud, Waste, and Abuse (FWA) training;
- Cooperate with audits, reviews, and monitoring activities as applicable;
- Protect patient privacy and the security of HCA and VCMC information and systems;
- Promptly report suspected compliance, privacy, or ethical concerns.

Reporting Compliance Concerns

Suspected violations may be reported without fear of retaliation through the HCA Compliance Line or directly to the HCA Compliance Officer.

Ineligible Persons

Vendors and contractors who qualify as Covered Persons must not be excluded from participation in any Federal health care program. Individuals must promptly disclose if they are excluded, proposed for exclusion, or otherwise become ineligible to participate in Federal health care programs.

Acknowledgment

By signing below, I acknowledge that I have received and reviewed this document and understand my responsibility to comply with applicable HCA and VCMC policies and to support compliance with the Corporate Integrity Agreement.

Name: _____

Organization/Vendor: _____

Title/Role: _____

Signature: _____

Date: _____