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

Ventura County Health Care System Oversight Committee
Administrative Policies - March 25, 2026
Summary of Changes

#	Title	Review Period	Summary of Changes
1	100.005 Patient/Visitor Complaints and Grievances	Trienniel	Trienniel review. Clarified processes in hospital and clincis. Clarified and revised timelines on responses to grievances
2	106.004 Smoking Policy	Trienniel	Trienniel review. No changes. Removed box around policy.
3	107.078 Review and Approval of Fixed Assets Equipment Over $10,000.00	Trienniel	Updated title to reflect fixed asset threshold increase from 5k to 10k
4	IS.01 Radiation Safety & Protection Program	Annual	Minor update to dosimetry reports section. Revised review timeframe to reflect need for annual review to occur each Nov.
5	IS.23 Imaging Services Hours of Operation	Trienniel	Policy updated Echo on call times and added expected response time.
6	RS.28 Rehab Services Employee Education	Trienniel	Trienniel review. Edited for clarity
7	F.117 Sick Leave and Vacation Requests	Trienniel	New Policy
8	F.024 Emergency Power Vendor Maintenance	Trienniel	Trienniel review. No changes. Revised policy number
9	F.027 Facilities Maintenance Safety	Trienniel	Trienniel review. No changes. Revised policy number
10	F.028 Sprinkler Drop Test	Trienniel	Trienniel review. No changes. Revised policy number
11	F.029 Smoke Detector Inspection Procedures	Trienniel	Trienniel review. No changes. Revised policy number
12	F.030 Dry Standpipe and Sprinkler System Test	Trienniel	Trienniel review. No changes. Revised policy number
13	F.031 Fire Alarm Disconnection	Trienniel	Trienniel review. No changes. Revised policy number
14	F.032 Fire Extinguisher Service	Trienniel	Trienniel review. No changes. Revised policy number
15	F.035 Compressed Gas and Oxygen Use	Trienniel	Trienniel review. No changes. Revised policy number
16	F.036 Firing Up and Shutting Down Boilers	Trienniel	Trienniel review. No changes. Revised policy number
17	F.037 Starting Boiler from Standby	Trienniel	Trienniel review. No changes. Revised policy number
18	F.042 Above Ceiling Access/Work	Trienniel	Trienniel review. No changes. Revised policy number
19	F.050 Facilities Maintenance Work-Related Injuries	Trienniel	Trienniel review. No changes. Revised policy number
20	F.052 Equipment and Bloodborne Pathogens	Trienniel	Trienniel review. No changes. Revised policy number
21	F.053 Inventory and Inspection of New Equipment	Trienniel	Trienniel review. No changes. Revised policy number
22	F.056 Medical Refrigerators and Freezers	Trienniel	Trienniel review. No changes. Revised policy number
23	F.057 Failure of the Nurse Call System	Trienniel	Trienniel review. No changes. Revised policy number
24	F.059 Utility Systems Emergency Shutoff Labels	Trienniel	Trienniel review. No changes. Revised policy number
25	F.061 Natural Gas Supply Failure	Trienniel	Trienniel review. No changes. Revised policy number
26	F.068 Medical Gas System	Trienniel	Trienniel review. No changes. Revised policy number
27	F.071 Emergency Power Operations	Trienniel	Trienniel review. No changes. Revised policy number
28	F.072 Inventory of Utility Systems	Trienniel	Trienniel review. No changes. Revised policy number
29	F.073 Equipment Management Plan	Trienniel	Trienniel review. No changes. Revised policy number
30	F.074 Maintenance and Monitoring of Water Systems for Legionella	Trienniel	Trienniel review. No changes. Revised policy number
31	F.077 Medical/Surgical Air and Vacuum System Maintenance	Trienniel	Trienniel review. No changes. Revised policy number
32	F.078 Drinking Fountain Inspection	Trienniel	Trienniel review. No changes. Revised policy number
33	F.079 Resetting Fire Alarms	Trienniel	Trienniel review. No changes. Revised policy number
34	F.084 Fire Alarm Pull Station Test	Trienniel	Trienniel review. No changes. Revised policy number
35	F.085 Air Handling and Ventilation Systems	Trienniel	Trienniel review. No changes. Revised policy number
36	F.086 Failure of Medical Air System	Trienniel	Trienniel review. No changes. Revised policy number
37	F.087 Electrical Distribution System Shutdown	Trienniel	Trienniel review. No changes. Revised policy number
38	F.088 Medical Air Alarms	Trienniel	Trienniel review. No changes. Revised policy number
39	F.091 Maintenance of the HVAC System	Trienniel	Trienniel review. No changes. Revised policy number
40	F.092 Oxygen Emergency Procedure	Trienniel	Trienniel review. No changes. Revised policy number
41	F.093 Oxygen Alarms Testing	Trienniel	Trienniel review. No changes. Revised policy number
42	F.094 Electrical Equipment Safety	Trienniel	Trienniel review. No changes. Revised policy number
43	F.096 Bulk and Piped Oxygen System	Trienniel	Trienniel review. No changes. Revised policy number
44	F.097 Heating, Ventilation, and Air Conditioning System Shutdown	Trienniel	Trienniel review. No changes. Revised policy number
45	F.098 Ice Machines	Trienniel	Trienniel review. No changes. Revised policy number

Status **Pending** PolicyStat ID **16463577**

Origination	5/1/1983	Owner	Imelda Reyes-Jay: Clinical Reg. Compliance & Patient Safety Mgr
Last Approved	N/A		
Effective	Upon Approval	Policy Area	Administrative - Patient Care
Last Revised	7/2/2025		
Next Review	3 years after approval		

100.005 Patient/Visitor Complaints and Grievances

PURPOSE

The purpose of this policy is to describe the roles and responsibilities of Ventura County Medical Center (VCMC) / Santa Paula Hospital (SPH), and Ambulatory Care (AC) staff in assuring that patient/visitor complaints/grievances are processed in a timely manner.

DEFINITIONS

- ***"Grievant":*** person who initiates a patient grievance.
- ***"Patient Grievance":*** a formal or informal written or verbal complaint made to the hospital by a patient or the patient's representative regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation, or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.
- ***"Resolved":*** the grievant is satisfied with the actions taken on their behalf.
- ***"Staff Member":*** a permanent, part-time or temporary hospital or clinic employee. A member of the Medical Staff is not a *Staff Member* as used in this policy.
- Billing issues are not usually considered grievances for the purposes of these requirements. (See Policy 109.069 Patient Billing and Collection Policy).

POLICY

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and the Ambulatory Care (AC) will make every attempt to resolve complaints, at the point they are first expressed. If staff is unable to resolve a complaint to the patient/visitor's satisfaction within the same business day, the complaint

becomes a grievance and shall be tracked internally via notification system.

The Governing Body delegates responsibility for oversight of the grievance process (review, resolution, and evaluation) to the Grievance Committee. The Grievance Committee meets at least quarterly.

STANDARDS

- Patients and visitors shall be advised of the method by which they may express complaints and grievances.
- Complaints/grievances related to HIPAA Privacy Standards will be referred to the Compliance an Privacy Officer immediately. (See Policy 109.045).
- Grievances shall be acknowledged within seven (7) business days of receipt date. The patient must receive a written response no more than 45 days after receipt of the complaint.

PROCEDURE

Patients Informed of Complaint Process

Patients and their authorized representatives are encouraged to provide feedback to VCMC/SPH/AC staff regarding the care received. Patients and their authorized representatives have the right to file a complaint or grievance with their health care provider, health plan, and/or the institution in which they receive care without being subject to coercion, discrimination, reprisal or unreasonable interruption in care. Upon admission to an inpatient unit or registration in an outpatient program, patients shall be given information describing the complaint and grievance process.

When a complaint or grievance is filed by an individual other than the patient, the staff must ensure that the individual has been authorized by the patient to act on the patient's behalf. If the patient is unable to provide authorization, or there is insufficient documentation to demonstrate the individual has the authority to act on behalf of the patient, the staff will notify the individual making the complaint or grievance of the pertinent privacy regulations that may prevent any further action.

Submission of Complaints

- Patients/visitors may submit complaints in writing, in person, by telephone or by email.
    - Hospital-related grievances: the VCMC/SPH Patient Advocate at 1-805-652-6691 or at hospitalcomplaints@ventura.org.

      Ambulatory Care-related grievances: the Ambulatory Care dedicated telephone complaints line, 1-805-339-1111 or ACcomplaints@ventura.org.
- Patients/Visitors have the right to contact regulatory or accrediting agencies.

Receiving Complaints

Every attempt must be made by hospital or clinic staff to resolve complaints immediately or within the same business day at the point of origin. Grievances about situations that **endanger the patient, such as neglect or abuse, must be reviewed immediately.** If unable to resolve the

complaint, employees will promptly refer patients/visitors to their direct supervisor and follow the chain of command for addressing the complaint. If the highest-level administrator/clinician is unable to resolve the complaint by the end of the business day, the complaint will be converted to a grievance and resolved accordingly..

A. **Investigation and Resolution:**

1. **Grievant Initial Notification:**
    a. Upon receipt of a grievance, the VCMC/SPH QAPI Team will notify the grievant of receive using the *Letter of Receipt of Patient Grievance.* The Ambulatory Care Quality Assessment/Performance Improvement (QAPI) team will contact the grievant by phone or email depending on their preference. If unable to resolve the matter within 1 business day, will send a *Letter of Receipt of Patient Grievance.*

2. **Investigation:**
    a. The hospital's Patient Advocacy Unit or Ambulatory Care clinic manager may include others as necessary in the investigation of the patient grievance. To the extent possible, the grievant and the patient (when the patient is not the grievant) should be contacted as part of the investigation and attempts to resolve the issue should be made.
        - It may not be possible to conclude the investigation or take actions in a manner that satisfies the grievant.

3. **Grievance Committee**:
    a. When it is not possible to conclude the investigation or take actions in a manner that satisfies the grievant, the governing body has established a Grievance Committee to act in these matters.
    b. The Grievance Committee shall consist of two or more individuals:
    c. The conclusions of each grievance investigation shall be reviewed by the Grievance Committee.
    d. The Grievance Committee may allow the QAPI team to reach a mutually agreeable resolution of grievances between committee meetings

4. **Timeliness**:
    a. Each patient’s grievance must be reviewed, investigated, and resolved within a reasonable time frame.
    If the grievance is not resolved, or if the investigation will not be completed within 7 days, the hospital will inform the patient or the patient's representative that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within 45 days. If the investigation requires additional time for review, the grievant shall be notified in writing.

5. **Conclusion of Investigation**: At the conclusion of the investigation, the grievant shall be sent a resolution letter briefly describing the conclusion of the investigation and,

when appropriate, steps taken to resolve the matter.

a. VCMC/SPH - The grievant shall also receive a copy of the document provided as part of the admission process explaining the Patient Complaints and Grievances process. This document describes various options for contacting external agencies. The Governing Body has determined that this language provides sufficient encouragement to contact regulatory and accrediting bodies.

b. Ambulatory Care - The grievant shall receive a list of options for contacting external agencies.

B. **Patient grievances shall be included in the VCMC/SPH and Ambulatory Care QAPI program.**

If the grievant still has concerns or complaints, they may be sent to:

- Hospital Administration, Ventura County Medical Center/Santa Paula Hospital, 300 Hillmont Avenue, Ventura, CA 93003
  1-805-652-6058 OR 1-805-652-6001
- Ambulatory Care Administration, 800 South Victoria Avenue, L#4615, Ventura, CA 93009
  1-805-677-5223
- California Department of Public Health, 1889 N. Rice Avenue, Suite 200, Oxnard, CA 93030
  1-805-604-2926, TTY -- 1-800-735-2929/Voice -- 1-800-735-2922
- The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181
  1-630-792-5000
- The Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815
  1-800-633-2322
- Livanta, LLC, BFCC-Q10 Area 5, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105
  1-877-588-1123

All Revision Dates

7/2/2025, 10/15/2021, 8/6/2018, 6/22/2018, 8/1/2015, 11/1/2012, 6/1/2008, 6/1/2006, 8/1/2004, 5/1/1995, 10/1/1986

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Marisela Luna: Program Administrator	Pending
Ventura County Medical System Administration	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	2/4/2026

Ventura County Medical System Administration	John Fankhauser, MD: Chief Executive Officer, VCMC & SPH	12/26/2025
Ventura County Medical System Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	11/20/2025
Ventura County Medical System Administration	Vikram Kumar: Chief Executive Officer, Ambulatory Care	11/17/2025
Quality	Rachel Stern: Chief Medical Quality Officer	11/13/2025
Quality	Imelda Reyes-Jay: Clinical Reg. Compliance & Patient Safety Mgr	7/2/2025

Status **Active** PolicyStat ID **19798041**

Origination	1/2/2018	Owner	Ian McGraw: Manager Facility Operation
Last Approved	2/26/2026	Policy Area	Administrative - Environment of Care
Effective	2/26/2026		
Last Revised	2/26/2026		
Next Review	2/25/2029		

106.004 Smoking Policy

POLICY:

It is the policy of Ventura County to prohibit smoking on all County property.

PROCEDURE:

BACKGROUND

The Ventura County Board of Supervisors adopted the Ventura County Comprehensive Smoke-Free ordinance on January 10, 2017. This policy states in Section 6707 - Policy:

> Prohibits smoking and the use of tobacco products in all vehicles, buildings and other areas owned or under the legal control of the County of Ventura, except for smoking areas designated by the Ventura County Executive Officer or Public Health Department Director.

Section 6713 states – Policy:

> Each incident of smoking in violation of the Ordinance is an infraction subject to warning for the first violation, $50 fine for a second violation within one year, $100 fine for a third violation within one year, and $200 fine for a fourth or subsequent violation within one year.

Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and hospital-based clinics, as part of the County-wide policy, prohibit smoking on both campuses. Smoking is prohibited anywhere on either hospital campus, including all parking areas. Smoking includes the use of cigarettes, cigars, water pipes, pipes, hookahs, marijuana (including medical marijuana) and electronic smoking devices, such as e-cigarettes and vaping pens. There are no designated smoking areas at VCMC/SPH or hospital-based clinics.

PURPOSE

In recognition of the health, safety and comfort benefits of smoke-free air, and in recognition of the hospital's special responsibility to establish and maintain an optimally healthy, safe environment for its patients, employees and visitors, the policy is adopted by VCMC/SPH and hospital-based clinics effective August, 10, 2017 and applies to all areas.

No Smoking signs will be posted conspicuously throughout the facilities.

SCOPE

This policy covers all individuals working, visiting or receiving medical care in space within the boundaries of the hospital and its outpatient clinics, as well as all space leased by the hospital. It includes both private and public offices and rooms.

Smoking is not permitted on hospital grounds by either staff or patients. Second-hand smoke may not interfere with patients, visitors and staff entering or exiting the building.

VCMC/SPH and hospital-based clinics will discourage smoking by patients and provide education options on smoking cessation. The hospitals prohibit smoking or the use of any electronic nicotine delivery systems including electronic cigarettes or any electronic nicotine delivery systems in addition to "vapor" delivered nicotine or other substances such a marijuana for all hospital based ambulatory care patients and for all child or adolescent patients. There are no medical exceptions to this rule.

ENFORCEMENT

1. Hospital employees and medical staff members are expected to respect and assist in enforcing the policy.
2. Enforcement of this policy among employees will be the responsibility of the individual department heads. All departments are expected to enforce the policy fully and consistently.
3. Enforcement of the policy among the medical staff members is the responsibility of each department chairman.
4. Enforcement of this policy among patients is a shared responsibility of Security, the Nursing Department, Medical Staff and Hospital Administration.
5. Enforcement of this policy among visitors is a shared responsibility of all hospital employees. Persons refusing to comply with policy will be escorted from the hospital by Security.
6. Any employee who observes patients or visitors smoking inside the building or on campus should advise the individual of the No Smoking policy and request that they cease smoking.

As health care workers, we should all participate in making VCMC and SPH a smoke-free environment.

All Revision Dates

2/26/2026, 1/2/2018

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/26/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/30/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/30/2026
Environment of Care Committee	Ian McGraw: Manager Facility Operation	1/30/2026
Policy Owner	Ian McGraw: Manager Facility Operation	1/30/2026

Status **Active** PolicyStat ID **19166136**

Origination	1/21/2021	Owner	Gabriel De La Rosa: Director, Supply Chain & Logistics
Last Approved	1/29/2026		
Effective	1/29/2026	Policy Area	Administrative - Operating Policies
Last Revised	1/29/2026		
Next Review	1/28/2029		

107.078 Review and Approval of Fixed Assets Equipment Over $10,000.00

POLICY:

To identify and confer responsibility upon those individuals who are Health Care Agency (HCA) employees for obtaining quotes for products or equipment for HCA facilities.

Procedure:

Identify the need for equipment or product.

1. Review the Fixed Assets form, complete and send to Director of supply chain.
    a. If a proposed vendor is identified, forward a formal proposal/quote to Director of supply chain.
    b. Current contractual obligations for this type of equipment or products are vetted by Director of supply chain.
    c. Competitive vendors are engaged if applicable.
    d. Group Purchasing Organization resources are engaged.
    e. Conflict of interest declaration must be completed.
2. Product or equiptment is placed on the Fixed Assets Committee list for review.
    a. Requested equipment & proposed time line (merits) reviewed by committee.
3. Equipment placed on list (if approved)
    a. Timeline based on merits of request discussed.
4. Final decision is made by Fixed Assets Committee.

5. Once request is approved then purchasing process will begin, if the item is rejected, the request will be cancelled.

All Revision Dates

1/29/2026, 10/14/2025, 1/21/2021

Attachments

Fixed Asset Request Form

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	1/29/2026
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	1/21/2026
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	10/23/2025
Policy Owner	Gabriel De La Rosa: Director, Supply Chain & Logistics	10/23/2025

Status **Active** PolicyStat ID **19741084**

Origination	1/26/2023	Owner	Matt McGill: Director, Imaging Services
Last Approved	1/23/2026	Policy Area	Imaging Services
Effective	1/23/2026		
Last Revised	1/23/2026		
Next Review	11/9/2026		

IS.01 Radiation Safety & Protection Program

POLICY:

In California, all radiation sources, either radiation (X-ray) machines or radioactive material, are subject to State laws and regulations. The statutes are found in the Health and Safety Code, Division 104-Environmental Health. The regulations are found in the California Code of Regulations (CCR), Title 17, Div. 1, Chapter 5, Subchapters 4, 4.5, and 4.7. Title 17 CCR 30253 incorporates by reference the federal regulations specified in Title 10, Code of Federal Regulations (CFR), Part 20. Requirements in 10 CFR 20 apply to all registrants.

This medical imaging facility is required to develop, document, and implement a radiation protection program commensurate with the scope and extent of use of X-ray machines and sufficient to ensure compliance with the above regulations. Additionally, the medical imaging facility shall use, to the extent practical, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are **a**s **l**ow **a**s **r**easonably **a**chievable (ALARA). The Radiation Safety Officer will audit the radiation protection program on an annual basis to ensure it remains within the scope and extent of activities required to ensure compliance with the said regulations.

All components of the Radiation Safety and Protection Program do not have to be contained in one consolidated document. However, all components do have to be documented and identified as being part of the Radiation Protection Program and will be duly listed and described. Records of the Radiation Safety and Protection Program content, implementation and audits must be maintained for inspection by the Department.

The regulatory agency for radiation safety is the Radiologic Health Branch of the Department of Public Health and can be contacted at the following addresses and phone number:

Department of Public Health

Radiologic Health Branch
P.O. Box 997414, MS-7610
Sacramento, CA 95899-7414
Email: RHBInfo@cdph.ca.gov
(916) 327-5106
www.cdph.ca.gov

Access to Title 17 is available for all staff through PolicyStat and can be found within the Imaging Services policy section or directly as policy *IS.17 Title 17 California Code of Regulations*.

PROCEDURE:

Organization and Administration

The delegation and responsibility for each aspect of the radiation program and provisions for ensuring enforcement of radiation safety policies and procedures are as follows:

A. **Facility Radiation Safety Officer, qualifications and responsibilities.**

1. VCMC/SPH's designated Radiation Safety Officer is Miguel Jimenez in partnership with our medical physicist, Therapy Physics Inc.
2. The primary responsibility of the Radiation Safety Officer's (RSO) is implementing the Radiation Safety Program. The RSO shall ensure that radiation safety activities are performed with approved procedures, meeting all regulatory requirements in the daily operation of the licensee's radioactive materials program.
3. The Radiation Safety Officer shall promptly investigate and implement corrective actions as necessary regarding:
    a. Overexposures
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Accidents
    d. Spills
    e. Losses
    f. Thefts
    g. Unauthorized receipts, uses, transfers, and disposals; and
    h. Other deviations from approved radiation safety practice. A written report of these investigations and the corrective actions taken shall be given to management.
4. The Radiation Safety Officer shall implement written policies and procedures to:
    a. Authorize the purchase of radioactive material
    b. Use of ionizing radiation as defined by State and Federal guidelines
    c. Receive and open packages of radioactive material
    d. Store radioactive material

e. Keep an inventory record of radioactive material
f. Use radioactive material safely
g. Take emergency action if control of radioactive material is lost
h. Perform periodic radiation surveys
i. Perform checks of survey instruments and other safety equipment
j. Dispose of radioactive material
k. Train personnel who work in or frequent areas where radioactive material is used or stored; and
l. Keep a copy of all records and reports required by department regulations, a copy of these regulations, a copy of each licensing request and license including amendments, and the written policies and procedures required by the regulations.

5. The Radiation Safety Officer shall:
    a. Approve radiation safety program changes for medical use not at a medical institution with the consent of management prior to sending to the department for licensing action. assist the radiation safety committee for medical use at a medical institution.
    b. review, sign and date, at least every 3 months the occupational radiation exposure records of all personnel working with radioactive material.

ALARA Program

VCMC/SPH uses, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA) and documents procedures addressing this requirement. Staff resources and educational materials are available within PolicyStat and through annual education.

Dosimetry Program

All registrants are responsible for the protection of individuals that enter the registrants' controlled areas. The registrant is also responsible for ensuring that the public is protected and that the public dose does not exceed the limits found in 10 CFR 20.

A. Each facility must evaluate whether or not personnel monitoring for occupational exposures is required. If a facility chooses to or is required to monitor, then those who are occupationally exposed to radiation should be instructed in the following:
    1. Types of individual monitoring devices used and exchange frequency.
        - Landauer Film badges (and TLD finger rings for Nuclear Medicine): Monthly
    2. Use of control badges.
        - The use of the control badge is used to maintain a base reading of non-occupational exposure. Control badges are kept in the respective

departments until ready to be sent back with appropriate dosimetry badges for reading.

3. Instructions to employees on proper use of individual monitoring devices, including consequences of deceptive exposure of the device.
    - See Radiation Safety Policy "IS.19 Staff Radiation Safety and Dosimetry Monitoring"

4. Procedures for ensuring that the combined occupational total effective dose equivalent (TEDE) to any employees receiving occupational exposure at this facility and at other facilities does not exceed 5 rem per year.
    - Employee dosimetry reports are monitored at specified intervals (see #1 above) to ensure their combined occupational total effective dose equivalent does not exceed 5 rem per year. An employee's exposure is investigated further if his/her monthly deep dose equivalent is greater than 125 mrem (ALARA Level 1) or quarterly deep dose equivalent is greater than 375 mrem (ALARA Level 2) in a quarter.

5. Procedures for obtaining and maintaining employees' concurrent occupational doses during that year.

    Employees are required to self-disclose any and all concurrent occupational doses received during the previous year in January of the subsequent year or upon being employed. Their doses will be sent to Landauer for inclusion in their dose record. The RSO and designate will investigate in a timely manner the cause(s) of all personnel exposures equaling or exceeding Investigation Level II and, if warranted, will take action. A notice of exposure and a questionnaire will be sent to the affected staff to determine the source of exposure. An acknowledgement letter will be obtained from the affected staff. A report of the investigation and actions taken will be presented to the Radiation Safety Committee at the first Radiation Safety Committee meeting following completion of the investigation. The details of these reports will be recorded in the Radiation Safety Committee minutes.

6. Procedures for ensuring that if minors are employed, their occupational TEDE does not exceed 500 millirem per year
    - N/A. We don't employ nor have any intentions of employing minors.

7. Procedures for addressing a declaration of pregnancy.
    - See policy *IS.56 Radiation Protection*. Declaration by employees and withdrawal is a voluntary process.

8. Procedures for maintaining documentation of dose to the embryo/fetus and associated documentation for the declared pregnant worker.
    - If an employee declares a pregnancy, she will be required to wear a fetal badge at the waist level and her dosimetry badge at the collar level. The fetal badge will be submitted and processed once a month to ensure fetal readings do not exceed the set dose limits. The employee's occupational dosimetry badges will be submitted monthly or quarterly based on the

department (see item #1). All dosimetry reports are evaluated by the RSO and/or designate to ensure compliance with state/federal regulations concerning dose limits.

Area Monitoring and Control

A. **Radiation Area Monitoring**

The need for area monitoring shall be evaluated and documented.

- Any area regulated through protective measures and safety provisions is considered a "Controlled Area". Access is restricted to controlled areas with warning signs specified in 17 CCR and incorporated sections of 10 CFR 20.
- Any area accessible to personnel in which there exists radiation at such levels that a major portion of the body (whole body, head and trunk, active blood-forming organs, gonads, or lenses of the eye) could receive in any one hour a dose equivalent in excess of 5 mrem or in 5 consecutive days a dose equivalent in excess of 100 mrem is considered a "Radiation Area"

B. **Instrument Calibration and Maintenance**

Instruments used to verify compliance with regulatory requirements must be appropriate for use and calibrated at required frequencies.

Maintenance of the machine should be addressed. This may be addressed in part by the operator's manual from the manufacturer.

All maintenance and calibration is completed by:

- G.E. Healthcare
- Phillips Healthcare
- Konica
- Siemens Medical
- Hologic
- Varian
- In-house Biomedical Engineering: Contracted to the above vendors for all radiation producing and radiation detection instrumentation on campus. All non-PM based services are coordinated with above vendors and completed by qualified field service engineers to meet current regulatory and manufacturer recommendations.

Radiological Controls

A. **Entry and Exit Controls**

Entry and exit from controlled areas must be adequate to ensure radiation safety. Design of emergency escape routes shall comply with applicable building codes. Document procedures

addressing this requirement.

- All applicable building codes were followed in the design of emergency escape routes of our facility.

B. **Posting**

1. Areas that are required to be posted should be identified in the Radiation Protection Program, in addition to procedures for ensuring that such areas are properly posted. Also, include procedures for ensuring that areas or rooms containing as the only source of radiation are posted with a sign or signs that read "CAUTION X-RAY". Identify who is responsible for maintaining those signs and/or labels. In addition, certain documents must be posted. This requirement is found in 17 CCR 30255(b).
    a. Entrances to X-ray suites are posted with signs that read "CAUTION X-RAY".

2. Conspicuously post:
    a. A current copy of the 17 CCR, incorporated sections of 10 CFR 20, and a copy of operating and emergency procedures applicable to work with sources of radiation (If posting of documents specified above is not practicable, the registrant may post a notice which describes the document and states where it may be examined.)
        - A current copy of 17 CCR and incorporated sections of 10 CFR 20 can be found on PolicyStat within policy "IS.17 Title 17 California Code of Regulations"

    b. A current copy of Department Form RH-2364 (Notice to Employees) in a sufficient number of places to permit individuals working in or frequenting any portion of a restricted area to observe a copy on the way to or from such area.
        - A current copy of RH-2364 (Notice to Employees) is posted in each department where ionizing radiation is utilized.

    c. Any notice of violation involving radiological working conditions, or any order issued pursuant to the Radiation Control Law and any required response from the registrant.
        - Notice of violation and any response will be posted in the cited department.

C. **Disposal of Equipment**

Registrants shall report in writing to the Department the sale, transfer, or discontinuance of use of any reportable source of radiation. See the Guidance for Disposal of X-ray Machines available http://www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx.

D. **Other Controls**

The registrant should evaluate the need for other controls in addition to those mentioned above.

1. The following items should be considered :
    a. Types of controls used to reduce or control exposure to radiation, such as positioning aids, gonadal shielding, protective aprons, protective gloves, mobile shields, etc.
        - Refer to the "Apron Inventory" listing all of the above in each department utilizing radiation or radiation-producing devices.
    b. Procedures for routine inspection/maintenance of such controls.
        - Refer to the policy "IS.24 Lead Apron and Glove Survey" on PolicyStat

Emergency Exposure Situations and Radiation Accident Dosimetry

Identify any possible emergency exposure situations or radiation accidents and document procedures to address such, to include dose assessment.

- An established process to address and manage high radiation dose fluoroscopically guided procedures to ensure proper patient follow-up and follow-ups on suspicious readings has been developed and is followed.
- All exposure situations or radiation accidents that have occurred are reported immediately to the RSO and reviewed quarterly by the Radiation Safety Committee for trends and performance improvement.

Record Keeping and Reporting

All record keeping and reporting requirements are specified in regulations. Document the applicable requirements and commitments to compliance. The facility must also maintain all records of the Radiation Protection Program, including annual program audits and program content review. The following items should also be identified:

The person responsible for maintaining all required records.

- The RSO and/or delegate are responsible for maintaining all required records.

Where the records will be maintained.

- For the most part, all records will be located in Radiology or online.

The format for maintenance of records and documentation.

- Documentation of policies and procedures are online, with a hard copy for specific departments. Film Badge reports are located in their respective departments, and online with Landauer.

Procedures for record keeping regarding additional authorized sites (mobile providers).

- N/A

Reports to Individuals

The Registrant shall provide reports of individual exposure when requested in accordance with 17 CCR 30255. Document procedures addressing this requirement.

- Employees are provided, free of charge, dosimetry badges throughout the duration of their employment. Dosimetry badges must be submitted on a department specific basis. Monthly badges are available on the first of each month, quarterly badges are due on the 15th of each quarter. The dosimetry pick-up/drop-off container is located in each department utilizing badges. The most current dosimetry report is available through the "myLDR.com" web portal. Individual reports (IDR) are also sent quarterly via email following review from the myLDR dashboard prior to Radiation Safety Committee meetings.
- User: VCMCDOSEREPORTS
- Pass: Radiation1
- The RSO or delegate reports Level 1 or higher exposure levels to the Radiation Safety Committee. A termination radiation dosimetry summary report is available to each employee once their employment has ended. Annual summary reports are kept indefinitely, available on-line from Landauer Inc.

Radiation Safety Training

A. **Operating and Safety Procedures**

1. All registrants are required to have a written operating and safety procedure manual. This may be the operating manual that comes with a radiation unit which may include safety procedures. However, if safety procedures are not included in the manual they must be developed. These safety procedures must be posted on the machine or where the operator can observe them while using the machine.
2. Document all training your employees, both occupationally exposed and non-occupationally exposed workers, are required to have before using radiation machines including continuing education. Also, document other training you provide to your employees or visitors such as radiation safety and protection program review, safety meetings, formal classroom training, etc.
3. Some of these requirements are found in the 17 CCR 30255(b) (1). Specifically, each registrant shall:
    a. Inform all individuals working in or frequenting any portion of a controlled area of the use of radiation in such portions of the controlled area.
    b. All new employees are required to attend a departmental orientation where he/she is orientated to the various components (policies & procedures) of our radiation protection plan.
    c. Instruct such individuals in the health protection problems associated with exposure to radiation, in precautions or procedures to minimize exposure, instruct such individuals in, and instruct them to observe, to the extent within their control, the applicable provisions of Department regulations for the protection of personnel from exposures to radiation occurring in

such areas.

i. This facility has adopted the Radiation Right policies as a guide to effective Radiation Safety.

ii. Annual Radiation Safety review is mandated for all staff dealing with radiation and/or radiation producing devices.

iii. Staff meetings are held routinely, and Radiation Safety incidents are reviewed for best practice.

d. Instruct such individuals of their responsibility to report promptly to the registrant any condition which may lead to or cause a violation of department regulations or unnecessary exposure to radiation, and of the inspection provisions of 17 CCR 30254.

i. Staff are encouraged to report any causes for concern promptly as it relates to department regulation violations or unnecessary radiation exposure. Excessive Fluoroscopy is reported and documented per policy and procedures.

4. Instruct such individuals in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation and advise such individuals as to the radiation exposure reports which they may request pursuant to 17 CCR 30255.

5. Any unusual occurrence or malfunction involving exposure to radiation will be promptly reported to the Equipment Service Coordinator who notifies the vendor and administration. Excessive radiation exposure reports will be documented and presented to the Radiation Safety Committee.

Quality Assurance Programs

Quality assurance program testing and frequency will conform with CCR Title 17 and accreditation requirements. Examples include but are not limited to:

Radiographic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
AEC	**Annual**		**None**	**Exposure meter**
Collimation	**Annual**		**<2% SID**	**IR + metal markers**
Exposure Linearity	**Annual**		**Greater or less than 10%**	**Exposure meter or ion chamber**
Exposure Reproducibility	**Annual**		**Greater or less than 5%**	**Exposure meter or ion chamber**
Exposure time	**Annual**		**<10 ms, greater or less than 20%**	**Exposure meter**
			>10 ms, greater or less than 5%	

Filtration	**Annual**		**>2.5 mm Al**	**Aluminum sheets**
Focal Spot Size or Spatial Resolution	**Annual**		**± 50% stated FSS - <0.8 mm 40% larger – 0.8 mm – 1.5 mm 30% larger – >1.5mm**	**Slit/pinhole camera or star pattern phantom**
kVp	**Annual**		**Greater or less than 10%kVp**	**kVp meter**

Fluoroscopic QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits	Test Tool
ABC	**Annual**		**None**	**Exposure meter**
Exposure rate	**Annual**		**<10 rad/min**	**Exposure meter**
Protective apparel	**Annual**		**No cracks or gaps**	**Fluoroscope, IR**
Resolution	**Annual**		**None**	**Resolution phantom**

CT Scanner QC Tests

Factor	Monitoring Frequency	Responsible Party	Limits
Contrast resolution	**Semiannual**		**Resolve 5mm objects at 0.5% contrast**
Linearity	**Annually**		**coefficient correlation between the densities & HU should equal or exceed 0.96%**
CT number Accuracy, Noise	**Daily**	**CT Technologist**	**0 +/- 5HU for CT number of water, Noise is dependent on scan parameter (mAs)**
Slice thickness <5mm	**Semiannual**		**0.5 mm**
Slice thickness >5mm	**Semiannual**		**±1.0 mm**
Spatial resolution	**Annual**		**greater or less than 20%**
Table increment accuracy	**Annually**	**Field Service Engineer (PM)**	**Expected table movement should be within ±2 mm**
Uniformity	**Daily**	**CT Technologist**	**<±10 HU across the image**

Nuclear Medicine QC Tests

Factor	Monitoring Frequency	Mfr	Model	Serial Number
Accuracy	Annual	Capintec	CRC-55tW	560257
ALARA	Quarterly			
Linearity-200	Quarterly	Capintec	CRC-55tW	560257
Chi-Square	Annual	Capintec	CRC-55tW	560257
Eff Co-57	Annual	Capintec	CRC-55tW	560257
Eff Ba-133	Annual	Capintec	CRC-55tW	560257
Eff Cs-137	Annual	Capintec	CRC-55tW	560257
Eff Na-22	Annual	Capintec	CRC-55tW	560257
Geometry	Annual	Capintec	CRC-55tW	560257
Inv of SS	Semi-Annual			
Leak Test	Semi-Annual	NEN	DCRS	S356009-10
Leak Test	Semi-Annual	EZIP	DCRS	1618-60-12
Leak Test	Semi-Annual	EZIP	Flood Disk	2183-047
LLRW Report	Annual			
Waste Monitor x1	Annual		Loading Dock	

Factor	Monitoring Frequency	Responsible Party
Area Survey	Daily	Technologist
Wipe Test	Weekly	Technologist
DOT Receipt	Daily	Technologist

Regulations

Maintenance of all applicable regulations is required.

Acceptance testing performed on all newly acquired equipment prior to usage. Acceptance testing performed by qualified medical physicist. All acceptance testing procedures are to meet ACR, TJC, IAC, CDPH and Federal Requirements (i.e. MQSA).

Internal Audit Procedures

The Registrant must audit the Radiation Protection Program on an annual basis. Documentation of the annual audits may be requested during inspection. The following items should be addressed depending on the scope of the radiologic health protection problems:

A. Identification of inspection types and program audits conducted, to include radiation machines, personnel and procedures.

1. Each piece of radiation producing and or radiation detecting device shall be inspected by a qualified medical physicist on an annual basis. All annual testing shall be performed within the confines of current state regulations.
2. Notification of failure to pass performance-based testing shall be documented and remedied within the allowable time period as dictated by current state regulations.
3. In certain circumstances equipment must be retested by a qualified medical physicist. Vendor qualified field service engineers shall remedy all deficiencies noted in testing results, and their remedies shall be communicated to the qualified medical physicist.

B. Identification of the individual(s) who are responsible for performing inspections and/or audits.
    1. Only qualified medical physicists shall perform inspections/audits. These individuals must meet requirements as outline by the accreditation body (The Joint Commission diagnostic imaging requirements) and be authorized by the State of CA to provide mammography services.
    2. As a Technologist:
        a. If the test indicates that the x-ray equipment is not functioning within specified standards, I will contact the department Director, equipment vendor, or in-house biomedical engineering to ensure that the equipment is repaired as soon as possible.
        b. If other image quality is not satisfactory, I will contact Therapy Physics, Inc (the medical physicist) to evaluate the system and correct the problem as soon as possible.
        c. All corrective actions will be carried out as soon as possible (within regulatory limits).

C. Identification of where and at what intervals the inspections and/or audits are conducted.
    1. The program is to be valid for VCMC/SPH
    2. Intervals of testing are to be annual. Testing in between annual periods will be dictated by equipment purchases, major component changes in particular systems or the movement of fixed equipment into areas that they do not normally occupy. Acceptance testing will be conducted at purchase and prior to clinical use for newly acquired equipment. All acceptance testing is designed to satisfy current CDPH, Federal, TJC, ACR, IAC standards.

D. Procedures for conducting the inspections and/or audits.
    1. We are contracted with qualified field service engineers as well as qualified medical physicists. Their contractual obligations are such that they are to make certain that all equipment is compliant with current state and OEM standards and specifications.
    2. The compliance is dictated by the frequency of visits and the legal mandate for frequency of testing. Deficiencies or fail items resulting from testing are remedied within the time confines of current state regulations.

E. Instructions on identification of proper use of instrumentation if staff performs machine

maintenance or fluoroscopic monitoring.

1. The quality control (QC) technologist is responsible for all quality assurance duties not assigned to the lead interpreting physician or the medical physicist. Normally, he or she is expected to perform these duties, but may also assign other qualified personnel or may train and qualify others to do some or all of the tests. When these duties are assigned to others, the QC technologist retains the responsibility to ensure they are performed in accordance with the regulations.
2. "Other personnel qualified" means persons with technical training appropriate for the task(s) assigned to them. Examples include a radiological technologist qualified under state regulations with appropriate training, a technologist who is trained to do the QC test(s) by the QC Technologist, or other persons appropriately trained to do the task(s) and supervised by the QC technologist. A receptionist or a secretary whose sole qualification is to copy documents, type, or answer the phone is not included under "other" qualified personnel.

All Revision Dates

1/23/2026, 6/5/2024, 3/4/2024, 1/23/2024, 5/12/2023, 1/26/2023

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	1/23/2026
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	1/23/2026
Imaging Services	Matt McGill: Director, Imaging Services	1/22/2026

Status **Active** PolicyStat ID **20111512**

Origination	1/18/1992	Owner	Matt McGill: Director, Imaging Services
Last Approved	3/17/2026	Policy Area	Imaging Services
Effective	3/17/2026		
Last Revised	3/17/2026		
Next Review	3/16/2029		

IS.23 Imaging Services Hours of Operation

POLICY:

The Imaging Services Department offers emergency and inpatient services 24 hours per day, 7 days per week (24/7).

PROCEDURE:

- The Ultrasound Department is staffed 24/7 at Ventura County Medical Center (VCMC).
- The Ultrasound department at Santa Paula Hospital (SPH) is staffed from 8:00 a.m. to 4:30 p.m. Monday - Friday. On call coverage is available at Santa Paula Hospital Ultrasound from 4:30 p.m. - to 7:00 a.m. Monday - Friday. On call coverage is available starting Friday at 4:30 p.m. to 7:00 a.m. Monday.
- Outpatient Ultrasound is available from 8:00 a.m. to 4:30 p.m. Monday - Friday at SPH.
- Outpatient Ultrasound is available from 8:00 a.m. to 5:00 p.m. at VCMC.
- The Nuclear Medicine Department is open Monday through Friday, 8:00 a.m. to 5:00 p.m. with standby coverage 5:00 p.m. to 10:00 p.m. Standby call coverage is available on Saturday, Sunday and holidays from 9:00 a.m. to 5:00 p.m. ONLY.
- CT and diagnostic x-ray services are provided 24/7 at Ventura County Medical Center.
- CT coverage at SPH is Monday - Friday around the clock; Weekend call coverage at SPH starts at 11:00 p.m. Friday to 7:00 a.m. Monday.
- X-ray coverage is available 24/7 at SPH.
- Routine (not scheduled) outpatient diagnostic services are offered between the hours of 8:00 a.m. and 5:00 p.m. Monday - Friday at both VCMC and SPH.
- Echocardiology services are provided Monday - Friday from 7:30 a.m. to 4:30 p.m. Call coverage for Echocardiology starts at 4:30 p.m. until 7:30 a.m. Monday - Friday. Weekend call

coverage starts 4:30 p.m. Friday to 7:30 a.m. Monday. Echocardiology has a 60 minute response time for all Emergency Room and Inpatient STAT exams.

- MRI services are provided at VCMC Monday - Friday from 7:00 a.m. to 8:00 p.m. Call coverage is from 8:00 p.m. to 7:00 a.m. Monday - Friday and on weekends beginning 8:00 p.m. Friday to 7:00 a.m. Monday. MRI has a 60 minute response time for all Emergency Room and Inpatient STAT exams. This time frame is taken directly from the Trauma Gray book.

All Revision Dates

3/17/2026, 1/23/2026, 7/14/2020, 3/8/2018, 4/1/2015, 9/1/2013, 5/26/2006, 3/14/2006

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/17/2026
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	3/16/2026
Imaging Services	Matt McGill: Director, Imaging Services	3/10/2026

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Last Revised	3/13/2026
Next Review	3/12/2029
Owner	Marcos Rodriguez: Manager, Rehabilitation Services
Policy Area	Rehab Services

RS.28 Rehab Services Employee Education

The Rehab Services staff participates in a variety of educational activities. Rehab Staff members are available to provide in-service programs on topics within their scope of practice.
Topics may include, but not limited to:

1. Range of Motion
2. Bed Positioning
3. Body Mechanics
4. Transfer Techniques
5. Ergonomics
6. Gait Training/ Crutch Adjustment
7. Musculo-Skeletal Assessment
8. Education and Instruction on new equipment relating to transfers.

The Inpatient Rehab Department regularly provides ergonomic and back care instruction at New Employee Orientations, and is available to provide in-services to individual departments as requested. Individualized ergonomic instruction occurs during work-site assessments and in the course of treatment programs as indicated.

As a part of the department's mission to promote a better understanding of the role of Physical, Occupational & Speech Therapy within the health care system, individual residents receive an orientation to the department and workshops are provided as requested. The workshops discuss the scope of practice and proper utilization of Physical, Occupational & Speech Therapy Services. Other educational activities may include the sponsoring of conferences on topics of interest to rehab staff, providing volunteers guided tours and a brief orientation to Rehab Services, and assignment of nursing students to the department for a day of orientation.

Therapists are involved on a daily basis as part of patient care in the education of hospital personnel on the role of Physical, Occupational & Speech Therapy.

All Revision Dates

3/13/2026, 5/29/2020, 12/1/2010, 12/1/2004, 12/1/2001, 12/1/1998, 2/1/1998, 12/1/1995, 10/1/1992, 10/1/1990

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/13/2026
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	3/10/2026

Status **Active** PolicyStat ID **8249216**

Origination	2/26/2026	Owner	Ian McGraw: Manager Facility Operation
Last Approved	2/26/2026	Policy Area	Facilities Maintenance/ Biomed/Support Services
Effective	2/26/2026		
Last Revised	2/26/2026		
Next Review	2/25/2029		

F.117 Sick Leave and Vacation Requests

POLICY:

To delineate the criteria used to authorize sick and vacation leave within the Department of Facilities Maintenance.

PROCEDURE:

SICK LEAVE

A. All policies established by Health Care Agency (HCA) policy pertaining to the use of sick leave are in force within the Department of Facilities Maintenance.

B. Call-in sick leave requests shall be made within 30 minutes of the start of the first shift of the day, or no later than two (2) hours prior to the start of any shift thereafter.

C. Call-ins are to be made by the employee (not by family members) to the On Call Supervisor, Immediate Supervisor or Department Manager. Call-ins for sick leave requests not made by the employee or outside of the specified time frames will be denied, and time off will be listed as leave without pay.

D. The Supervisor or Department Manager shall retain the right to request physician documentation of injury or illness at any time.

VACATION REQUESTS

A. All policies established by Ventura County Medical Center (VCMC) Administrative Employee Policy (101.023) pertaining to the use of vacation time are in force within the Department of Facilities Maintenance.

B. All vacation requests shall be made in writing on the approved vacation request form no later than two (2) weeks prior to the end of the posted schedule. Any requests not conforming are

subject to being denied.

C. Employees will not be required to submit a long-range plan of annual vacation. They are encouraged to submit requests as soon as possible. Vacation slots are granted on a first come, first serve basis.

D. Not more than one employee from a classification will be granted vacation at any one time if the request created a staffing shortage.

All Revision Dates

2/26/2026

Attachments

TIME OFF REQUEST.pdf

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/26/2026
Facilities Department	Ian McGraw: Manager Facility Operation	2/2/2026

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Last Revised	2/26/2026
Next Review	2/25/2029
Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.024 Emergency Power Vendor Maintenance

POLICY:

To state the vendors who provide emergency generators for Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

Quinn Company, manufacturer's representative for generators, are and have been under contract to provide quarterly and annual service and parts for preventative maintenance for the following:

2 – 1500 KW Caterpillar – Hospital and Complex

1 – 1500 KW Caterpillar- Hospital Replacement Wing

1 – 250 KW Onan – Inpatient Psychiatric Unit

1 – 375 KW Caterpillar – Santa Paula Hospital

All Revision Dates

2/26/2026, 7/1/2016, 12/9/2013, 8/25/2009, 12/4/2004, 12/10/1992

Approval Signatures

Step Description	Approver	Date

Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	2/26/2026
Facilities Department	Ian McGraw: Manager Facility Operation	2/2/2026

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Effective	2/26/2026		
Last Revised	2/26/2026		
Next Review	2/25/2029		

F.027 Facilities Maintenance Safety

POLICY:

The Facilities Maintenance Department of Ventura County Medical Center/Santa Paula Hospital will support all facilities, spaces and shops that are involved in electrical, painting, heating, ventilation/air conditioning, carpentry, plumbing, steam generation, emergency power generation and grounds. The safety activities will extend throughout the total physical location. The staff in Facilities Maintenance shall be thoroughly familiar with equipment, devices, controls, machines and work procedures. It is a constant responsibility of all concerned to maintain the hospital so that it is a clean and safe environment. Staff shall be vigilant for hazardous situations involving fire, staff, electrical, mechanical and plumbing situations which will directly affect the operation of the hospital to meet its mission. Staff is expected to be knowledgeable in the fundamentals of safety and emergency procedures. The primary function is to be one of **preventative** rather than corrective maintenance.

PROCEDURE:

FORMALIZED MAINTENANCE PROGRAMS:

The formalized maintenance program consists of specific preventative maintenance, inspections, tests and requirements in the form of schedules, specially prepared for the hospital equipment.

MAINTENANCE, TEST AND INSPECTION SCHEDULES:

All Facilities Maintenance tests and inspection schedules are prepared for the HCA/hospital by the Facilities Maintenance Department. These schedules are procedures and listed in detail. These records are kept in the Support Services Department.

SIX CARDINAL PRINCIPLES:

- Have the right tool for the job. Do not use a substitute.
- Use the right tool correctly.
- Maintain tools in good operating condition.
- Store tools in the proper manner.
- Safety goggles, shields and respirators will be worn, as well as protective clothing, as required.
- Support Services staff will thoroughly familiarize themselves with the proper methods of lifting and carrying materials.

HAND TOOLS AND EQUIPMENT:

In conjunction with the hospital Safety Officer and the Safety Management and Education chair, all Facilities Maintenance Department staff will be instructed in the proper and safe use of hand tools and equipment by the Field Operations Specialists.

REFERENCE: ISSUANCE OF TOOLS AND EQUIPMENT, POLICY # 2.25

Personal hand tools and equipment are not to be used at any County job sites. All hand tools and equipment are to be provided by the Facilities Maintenance Department and will be issued based on a standardized list as determined for each of the trade groups. Additional tools will be issued on an as-needed basis as determined by the Facilities Maintenance Manager or Facilities Operations Specialist responsible for that craft.

Tool replacement must be validated as replacement. Old or damaged tools must be returned prior to purchase of replacement tools.

Lost or missing tools will be replaced at the sole discretion on the Facilities Manager. Every effort must be made to determine the cause of the loss. Evaluation must be made toward the prevention of further loss.

SAFETY

POWER TOOL SAFETY:

- Power tools will be operated by authorized staff only. Such tools will be inspected before each use.
- Any defect, such as frayed cord or a broken plug, will be reported immediately and repaired as soon as possible. In the interim, the equipment will be tagged "DO NOT USE."
- Never use an un-grounded tool, especially in a wet location or when in contact with metal. (Un-grounded tools are only permitted if double-insulated under standards of OSHA.)
- Never use ordinary hand tools in explosive or extremely dusty atmospheres; use only non-

sparking tools, including explosion-proof flashlights.

- Extension cords will be used in a safe manner (in accordance with OSHA).
- Cords will be suspended overhead if there is traffic that might cause a hazard, will be yellow in color, and of proper amperage rating for tool being used.
- Guards will be kept in place at all times on portable equipment such as grinders and saws.
- Safety glasses will be worn when using portable power equipment as well as when using shop equipment.
- Power tools will be cleaned with high flash solvents. When using compressed air, the line will have less than 30 PSI pressure. Wear facial protection.
- Disconnect the plug from the receptacle when changing guards or accessories on a tool being used.
- Power tools will be used and maintained in strict accordance with the manufacturer's instructions. The instruction will be maintained on file in the office of the Facilities Maintenance Manager, and shall be referred to as needed. Repairs on equipment will be made only by qualified persons or by the manufacturer.
- Extra caution will be used when tools of any kind are being used on a ladder or a scaffold. Only ladders approved by Underwriters' Laboratories (UL) will be used when doing electrical repairs or lamp replacement.
- When working on electrical switches or systems, follow energy isolation safe practices.
- Electrical wiring will be installed and serviced by qualified electricians who follow recommended codes and use materials and techniques approved by UL.

LADDER SAFETY:

- Portable ladders will be equipped with nonslip bases. The bottom should be held, tied or otherwise secured to prevent slipping. If a stepladder is used on a polished floor, a nonslip material shall be applied to the front feet.
- Straight ladders will be placed so that the horizontal distance from the base of the plane of the support is about one-fourth the ladder length between the ground and the top support. A minimum of three feet of ladder should extend above the support, in accordance with OSHA requirements.
- Ladders will never be used as runways or scaffolds.
- Ladders will not be placed in front of a door that opens towards the ladder unless the door is locked, blocked or guarded.
- Never lean ladders against glass or plastic.
- Ladders will have solid footing and shall be equalized on both sides so that they cannot sink or overturn.
- Ladders will be climbed with both hands on the rails or rungs. If materials must be handled, they will be hauled up by rope and bucket. Paint buckets will be held to the ladder rung by "S" hooks rather than by one hand.
- The ladder will always be faced by the user. The worker will not lean too far out to the side of the ladder or too far overhead; he/she will never stand higher than the third highest rung of a

single or extension ladder.

- Routines for ladder inspection will be maintained, and ladders will be inspected before each use. Defective ladders will be tagged for immediate repair or destruction.
- Short ladders will never be spliced to provide additional length.
- Loose tools and materials will not be placed on the top step of folding ladders, but on a folding shelf. Screwdrivers and small tools can be set in holes drilled into the top of folding ladders, where they are handy but will not roll or drop off.
- Metal ladders will never be used around electrical circuits or in places where they might come into direct contact with electricity.
- Public areas where ladders are being used will have warning signs or be roped off.

MACHINE EQUIPMENT:

The kinds of machine equipment found in a health care facility are those that present most of the hazards encountered in a manufacturing industry. Protection against these hazards lies in intelligent use of such machines and, primarily, in well-engineered guarding. The hospital must put its own house in order before it can expect Facilities Maintenance Department staff to perform their part of the safety job. The following guidelines will help it do this.

- Proper guarding will be provided for all machines. Equipment shall never be operated after guards have been removed.
- Any rotating part of a machine must be guarded against contact. Even smooth, slowly rotating shafts may grip clothing or hair. The danger is increased if collars, keys or belts are exposed. Rotating mechanisms usually need complete enclosure.
- Exposed shaft ends will present smooth surfaces. They shall not project more than one-half the shaft diameter beyond the bearing or hub unless they are guarded by caps or sleeves.
- Gears shall be enclosed on all sides and have no opening that exceeds one-half inch if the guard is within four inches of the gear. Gear guard will be made of metal.
- A conventional air-circulating fan on the floor or suspended below seven feet from the floor will have a mesh guard, with a mesh of not more than one-half inch, completely covering the blades. Fans set above floor level shall have the bases securely fastened.
- Circular saws will be guarded by a hood that will cover the teeth at all times. The hood shall adjust itself automatically to the thickness of material being cut and remain in contact with the material.
- Table saws shall be equipped with a spreader, splitter or riving knife to keep materials from the back edge of the saw. Material kicked backed from table saws is a frequent cause of serious injury. Also, many injuries occur in the cutting of short lengths of stock.
- A guard that adjusts itself as the stock strikes against it will cover the table opening on the working side of the cage.
- Unused parts of sanders will be enclosed. Discs will be enclosed under the table. Plane drums will be fenced behind and partially covered by an exhaust hood. The ends of belt sanding machines will be enclosed with metal guards that should also serve as part of the exhaust system.

- Grinding and buffing wheels will be standard equipment. A transparent shield shall be fixed to the grinder to help protect the eyes, and eye protections shall be worn. Wheels will be inspected daily for cracks and scaling.
- All saws, planners, lathes and grinders will have excellent lighting at the point of contact and shall conform to ANSI Standards, "Practice for Industrial Lighting" and "Practice for Protective Lighting."

SAFETY

- The Facility Operations Specialists will see that power machines are not abused and are used only by trained, authorized staff.

MACHINE GUARDS:

Too frequently, the purpose of guarding is misunderstood in that it is thought to concern only the point of operation or a power transmission part. However, guarding is also necessary to prevent injuries from other causes on or around machines. Specifically, machine guarding protects against or prevents injury from these sources:

- Direct contact with the moving parts of a machine
- Work in progress, kickbacks on a circular ripsaw, metal chips from a machine tool, splashing of hot metals or chemicals, and so forth)

Any guard must:

- Conform to the standards of OSHA or the state inspection department that has jurisdiction.
- Be considered a permanent part of the machine or equipment.
- Afford maximum positive protection.
- Prevent access to the danger zone during operation.
- Not weaken the structure of the machine.
- Be convenient, not interfere with efficient operation of the machine and cause no discomfort to the operator.
- Be designed for the specific job and specific machine, with provision for oiling, inspections, adjustment and repair of the machine parts.
- Be durable, resistant to fire and corrosion and easily repaired.
- Be constructed strongly enough to resist normal wear and shock, and withstand long use with a minimum of maintenance. The guard shall not itself prevent hazards, such as splinters, pinch points, shear points, sharp corners or rough edges.

FLAME CUTTING, WELDING AND SOLDERING:

The following standards will prevail in the use of acetylene torches for flame cutting and welding.

- Acetylene gas tanks will be capped at all times when not in use. They will be stored upright and secured with a chain or other form of holding device. They will be kept from heat and flame, in a space designed for flammable gas storage. Never store with oxidizing gas.

- Flame cutting and welding will be accomplished in maintenance areas. If it is vital that such work be done elsewhere in the hospital adjacent areas and their equipment (pipelines, combustible, structural materials and so forth) must be properly inspected beforehand. Smoking will be **prohibited** in areas where acetylene gas tanks or flammable liquids are located. Hot work permit must be issued by support services prior to any open flame work within campus facilities.

SAFETY

- Staff will wear proper protective equipment including gloves, hoods, goggles, and aprons. Also they will wear ankle-high shoes, with trousers secured outside them to prevent molten material from falling into the shoes.
- Adequate screening and warning devices will be set up to prevent eye injuries to workers nearby.
- Before welding is done on containers of flammable liquids or on empty containers that previously contained flammable liquids, the containers shall be thoroughly decontaminated. Such procedures are described in **Safe Practices for Welding and Cutting Containers** that have held combustibles, published by the American Welding Society.
- It is hazardous to flame-out sanitary risers used for flammable liquids. If cutting is required, staff shall flush the risers with water, restrict their use during the cutting period and make an explosive meter test prior to the cutting operation. If doubt exists, work shall be delayed or the system shall be purged with nitrogen.

In addition, staff shall:

- Wear gloves and either goggles or a face shield while welding and soldering; keep their sleeves rolled down, shirt collars buttoned and trouser legs over the shoe tops.
- Melt solder only in a thoroughly dry hot solder pot or ladle.
- Never put chilled solder or a moist object into a hot solder pot or ladle.
- Make sure that all explosive vapors have been removed from containers before working on them.
- Place hot irons on racks or holders away from all combustible materials.
- Disconnect electrical soldering irons immediately after use. Keep the cord and connections in good condition.
- Never test the temperature of an iron by holding it near the hands or face.
- Never snap or throw solder to get it off a hot iron.

PAINTING AND SPRAYING:

- A "NO SMOKING" rule must be enforced in **paint and wood shops** and other locations where **paints, thinners, lacquers and turpentine** are used or stored.
- Proper and adequate fire extinguishers must be available in the paint shop.
- All lacquers and thinners shall be kept only in a safety can approved by UL. They will be stored in accordance with state and local fire codes.

- Adequate protective equipment- face masks, goggles, gloves and so forth- will be worn by Maintenance Department staff when they spray paint. Tools shall be nonferrous and non-sparking.

ELECTRICAL SAFETY:

Before machinery is worked on, the electrical controls will be de-energized, tagged and locked. Tags and one-key locks shall be removed only by the person who originated their use. Lockout/Tagout (LOTO) equipment is located in the Facilities Maintenance Department and shops.

SAFETY

Electricians will not repair, service or perform any operations on energized electrical lines or equipment except for these purposes or under these conditions:

- Line voltage and current tests with approved equipment.
- Cutting off power lines when they present an immediate hazard to life.
- Replacement of fuses in circuits of 150 volts or less. Only journeymen electricians should replace higher rated fuses.
- After a determination that power cannot be interrupted, work on circuits of more than 440 volts shall be performed by a public utility contractor; work on circuits of 440 volts or less may be performed by a qualified electrician.
- If the voltage adjacent to equipment being worked on exceeds 250 volts, two or more electricians shall be present.
- If it is necessary to switch off high-voltage circuit breakers or disconnect switches or other equipment to clear a supply feeder or apparatus, two qualified electricians shall be present while switching is in progress.
- All electrical workers will be trained in artificial respiration techniques.
- Electrically operated vending machines will be provided with a grounding cord and cap.
- Panel board schedules will be kept updated.
- The wattage rating for lamps will be limited to the design value. Bulbs extending past the rim of the reflector present hazards of burns, fire and shattering glass.
- Safe electrical equipment must be provided. Where permanent operations are to be performed, an outlet will be installed directly at the site. Extension cords used in operating rooms must comply with National Fire Protection Association Standards. Cord caps (plugs) will be purchased with hand plugs to eliminate strain on the wing connections. Wiring and all other electrical equipment shall bear the UL label.
- In non-fixed electrical equipment furnished with power cords, any exposed metal parts not carrying current shall be grounded through a special cord and plug. Adapters shall be provided until all outlets can be converted to the grounding type. Equipment that is especially critical includes the following:
- Equipment used around moisture. This includes water baths, physiotherapy equipment, drinking fountains, stirrers and water pick up machines.
- Readily moveable equipment used with or around moisture. This includes centrifuges, ovens

and hot plates.

- An electrical supply of more than 150 volts.
- Hand held and motor operated equipment.
- Television installations will be approved by the Maintenance Department, who will determine the need for grounding and for lighting of protective devices.

BOILER AND HEATER ROOMS:

The greatest single safety-need in a boiler room is a qualified individual in charge, with competent helpers on the off-shifts. Boilers can be operated efficiently and safely for many years, but only if the boiler and piping system is kept in proper operating condition through regularly scheduled inspections, proper maintenance and repair. A boiler will not be placed in service until an operating certificate has been obtained from the governing authority. After a new or used boiler installation has passed inspection by a qualified engineer, the custom in states having boiler laws is to stamp a state number on the boiler and to send a report to the state department having jurisdiction.

SAFETY

Definite characteristics mark a good boiler installation:

- There will be ample room for proper maintenance and for any expansion required by additions to the health care facility.
- Lighting will be ample for reading of the water solemn, pressure gauges, valves and so forth.
- Two or more exits shall be provided, one at either end of the boiler. Exit doors will always open outward.
- Stacks, whether of brick, concrete or steel shall be equipped with grounding lighting arresters. Never will a stack be mounted directly on the boiler.
- Boiler safety valves must be set in accordance with the code specifications of the American Society of Mechanical Engineers. Only a qualified boiler inspector or a person specifically trained shall change the setting of a safety valve.
- Steam safety valves of hot water-heating boilers shall be set at 15 pounds above the working pressure of boilers in which such pressure is not greater than 50 PSI.
- Glass on water gauges shall have guards if not made from safety glass.
- Boiler blow down in-service shall be accomplished in accordance with chemical water treatment service. On small installations, the blow downs shall be done at least once during each shift or each eight hour period.

INSPECTION AND MAINTENANCE SCHEDULES:

A well-kept schedule of periodic inspection and testing, together with appropriate criteria and a system for recording, shall be based on these standards:

BOILERS – Every steam boiler will be inspected in accordance with applicable sections of the ASME Boiler Construction Codes and possibly more stringent local codes. The inspections will include any

steam boiler used for hot water supply if:

1. It's pressure exceeds 15 PSI or
2. Pressure is below 15 PSI but its gravity return is unassisted

Inspections will be made by qualified staff commissioned by the National Board of Boiler and Pressure Vessel Inspectors (NBBPVI) of The American Society of Mechanical Engineers. They will be performed by an outside firm rather than by hospital staff engineers. A certificate of approval shall be posted at the boiler.

- **Unfired Pressure Vessels** – Every unfired pressure vessel operating at a pressure above 60 PSI and having a capacity of 15 gallons will be inspected annually by a person qualified by NBBPVI and in accordance with the ASME Boiler Construction Codes. The inspectors will make an external observation of safety devices and other apparatus. If the vessel has a manhole, they will also make an internal inspection. A certificate shall be posted at the vessel.
- **Hot Water Tanks and Heaters** – Temperature and pressure- relief devices on hot water tanks and heaters will be inspected monthly.
- **Steam-Heated Boiler Equipment** – Urns, kettles, vegetable steamers, autoclaves and the like will be inspected quarterly for operation of thermostats, steam traps, safety valves, control or pressure- reducing valves and vacuum breakers.

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2/26/2026, 7/1/2016

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Policy Area	Facilities

F.028 Sprinkler Drop Test

POLICY:

The sprinkler drop test is conducted to check the sprinkler alarm audible signals as well as to flush the sprinkler system out. This test will be performed quarterly for the audible alarm signal. All valve tamper switches and water flow devices shall be tested semi-annually.

PROCEDURE:

- Notify alarm company of test
- Open inspectors test valve.
- Note length of time required to activate alarm

When drop test is complete, test flow and tamper switch, close OSY valve. Check with alarm company to verify that alarm was transmitted. Re-secure system, make appropriate calls, and fill out written report. If repairs/corrections required, reports any deficiencies to the Facilities Maintenance Manager (1-805-652-6514) who shall immediately take steps to correct them.

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Policy Area	Facilities

F.029 Smoke Detector Inspection Procedures

POLICY:

To define the appropriate manner in which smoke detector inspections will be conducted at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

- Detectors shall be smoke-tested and visually inspected for damage, lamp indicators and loose mounts.
- All findings shall be entered on the log and initialed. Any deficiencies shall be reported to the Facilities Maintenance Manager at 1-805-652-6514, who shall immediately take steps to correct them.
- NOTE: Twenty-five percent (25%) or one quarter of all tested smoke detectors per zone sequence will be checked quarterly and alternated to ensure that each detector in each zone is tested on a regular cycle, but at least annually. The Alarm Company shall be notified of the test.
- Inspect annunciator panel during test, located in the hospital basement in the chart room, as well as the PBX to ensure proper warning light and buzzer are activated.
- Check to ensure fire alarm, bells, and chimes are activated.
- Check to ensure all fire doors close and latch.
- Check to ensure alarm was transmitted and received. This check shall be noted under the remarks section of the work order.

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F.030 Dry Standpipe and Sprinkler System Test

POLICY:

It is a legal requirement that the dry standpipe and sprinkler system test be performed by a licensed contractor in possession of a C-16 or smaller license. The contractor shall certify (in writing) that the equipment is operable to the Ventura City Fire Department.

PROCEDURE:

Dry Standpipe and Sprinkler System

1. **Air Test** – Air test the system at 25 PSI to determine if the system leaks. This is to avoid water damage to the building in the event that piping has been broken or disconnected.
2. **Hydrostatic Test** – Fill system completely with water and note the static pressure (head on the test gauge installed on the lowest inlet connection). Hydrostatically test the system at a pressure of 50 PSI greater than the head pressure.
3. **Flow Test** – Flow 100 GPM of water through the standpipe system to the roof outlet. A separate flow test shall be conducted through each inlet. Install a test gauge at the inlet being used to measure the inlet pressure. The maximum allowable pressure-loss within the system, due to friction, shall be 15 PSI. Friction loss shall be determined by subtracting the static pressure (head) and the outlet pressure from the inlet pressure, while 100 GPM is flowing.
4. Operate each outlet valve in the system to determine if functioning properly.

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Policy Area	Facilities

F.031 Fire Alarm Disconnection

POLICY:

In the event of a false fire alarm at Ventura County Medical Center, including the Inpatient Psychiatric Unit (IPU), Facilities Maintenance Department office staff shall contact:

SAS Alarm: (805) 659-1711, code 14-594
Ventura Fire Department: (805) 339-4399

PROCEDURE:

While working on or around the fire alarm system, at no time shall any Facilities Maintenance Department staff contact the above services for the purpose of suspending the alarms to prevent sounding in Ventura County Medical Center or the IPU. All contact with the above, and disconnection of fire alarms, must be authorized by the Facilities Maintenance Department Manager or a designee.

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Policy Area	Facilities

F.032 Fire Extinguisher Service

POLICY:

The Ventura County Health Care Agency (HCA) Facilities Maintenance Department will service the fire extinguishers in the HCA complex, Ventura County Medical Center and Santa Paula Hospital. This will be accomplished with the contractual services of a licensed fire extinguisher company.

PROCEDURE:

Assigned Facilities Maintenance Department staff will be responsible for servicing the fire extinguishers in the HCA complex and Ventura County Medical Center/Santa Paula Hospital on a monthly basis.

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Policy Area	Facilities

F.035 Compressed Gas and Oxygen Use

POLICY:

Staff that handle medical gases shall be educated about the possible hazards associated with medical gas use. All staff concerned with the use and transport (handling) of compressed gas shall be trained in the proper handling of cylinders (vessels), cylinder trucks and supports, and cylinder-valve protection caps. All cylinder storage areas, outside and inside, shall be protected from extremes of heat and cold and from access by unauthorized individuals.

PROCEDURE:

General Standards:

- All staff handling medical gases will be trained to recognize various types of medical gas labels.
- With use of 360-degree wrap-around labels to designated medical oxygen provided on oxygen cylinders from the medical gas supplier, staff will be trained to ensure that every vessel to be connected to oxygen systems bears the 360-degree wrap-around label.
- All staff responsible for changing or installing cryogenic vessels will be trained and proved competent to connect medical gas vessels properly. Included in the training will be information on how vessels are connected to the oxygen supply system and the serious consequences of changing connections.
- Containers must be marked clearly with the name of the contents. Tanks with wired on tags or color codes shall **not** be accepted.
- **Medical grade** products such as oxygen cylinders must be stored separately from **industrial grade** products.
- The use of oil, grease or lubricants on valves, regulators or fittings is prohibited.

- Plastic crush gaskets shall **never** be reused for oxygen cylinders.
- Fittings (adapters) on medical gas cylinders should never be changed. If a cryogenic vessel fitting does not seem to connect to the oxygen supply system fitting, immediately notify the medical gas supplier. The cylinder will be returned to the supplier to determine the fitting or connection problem.
- Do not attempt to repair damaged cylinders or to force frozen cylinder valves.
- Cylinders must be moved using a proper cylinder cart having the appropriate restraint mechanisms in place. Do not roll or drag cylinders.
- Cylinders must be secured at all times to prevent falling.
- Cylinders shall be transported, stored and used in an upright position.
- Valve safety covers shall be left on until pressure regulators are attached.
- Once an oxygen vessel is connected to the oxygen supply system, but prior to introducing the product into the system, the _____ (name of individual trained and proved competent in the management of medical gases at this facility) will inspect the connection to the system to ensure the correct vessel has been connected properly.
- Any patient injury felt to be related to the use of medical gases will be immediately reported to the Performance Improvement Director and the manufacturer of the medical gas.

Flammable Gases:

- Special care must be used when gases are used in confined spaces.
- No more than two (2) cylinders shall be manifolded together; however, several instruments or outlets are permitted for a single cylinder.
- Cylinders must not be stored near heat sources or combustible materials, lubricants, electrical wiring, ignition sources or other non-compatible compressed gases.
- Storage areas must be well ventilated, well protected, dry and at least 20 feet from highly combustible materials.

Pressure Regulators and Needle Valves:

- Needle valves and regulators are designed specifically for different families of gases. Use only the properly designed fittings.
- Always follow the regulators manufacturer's instructions for attaching the regulator to an oxygen cylinder.
- Always use the sealing gasket specified by the regulator manufacturer.
- Throats and surfaces must be clean and tightly fitting. Do not lubricate.
- Always inspect the regulator and CGA 870 seal before attaching it to the valve to ensure that the regulator and seal are in good condition, and the regulator is equipped with only one (1) integral metal and rubber seal that is in good condition. **Avoid** plastic seals.
- Tighten the T-handle firmly by hand, but do not use wrenches or other hand tools that may over-torque the handle.
- Tighten regulators and valves firmly with the proper sized wrench. Do not use adjustable

wrenches or pliers. Do not force tight fits.

- Open the post valve slowly, while maintaining a grip on the valve wrench, so that it can be closed quickly if gas escaped at the juncture of the regulator and valve.
- Do not stand directly in front of gauges (the gauge face may blow out). Do not force valves that stick.
- Check for leaks at connections. Leaks are usually due to damaged faces at connections or improper fittings. Do not attempt to force an improper fit. (It may only damage a previously undamaged connection and compound the problem.)
- Valve handles must be left attached to the cylinders.
- The maximum rate of flow shall be set by the high-pressure valve on the cylinder. Fine-tuning of flow shall be regulated by the needle valve.
- Shut off cylinder when not in use.

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F.036 Firing Up and Shutting Down Boilers

POLICY:

To provide an operating procedure for Stationary Engineer trainees to follow when firing up or shutting down steam boilers. The provisions of this procedure apply to all personnel assigned to the Central Heating Plant whether on a permanent or temporary basis.

PROCEDURE:

STARTING COLD BOILERS FROM "0" PSI:

Boilers number 1 and 2 (Babcock & Wilcox) and 3 (Cleaver Brooks):

1. Check for a minimum ¼ glass of water level in water gauge glass. If below that level, open copes bypass valve ½ turn and fill to ¼ to ½ glasses.
2. Blow down gauge glass and water column. Observe the fall of water from glass and return of water level after blow-down valves are closed.
3. Check that downstream valve from copes regulator is closed on the feed water line.
4. Check that both steam stops are closed and that steam line drain valve is opened.
5. Check that steam drum vent valve is opened.
6. On the boiler electrical panel, place AUTO-MANUAL switch in the MANUAL position.
7. Make sure the firing rate potentiometer is in the LOW FIRE position.
8. Turn the POWER and BURNER switches to "ON" and observe FIRE-EYE readout on screen. Readout will show "BURNER ON," "HRS," "CYCLES," "HOLD D-8" and "HIGH PURGE OPEN." Purge will last one (1) minute.
9. Observe start up on flame through sight glass in front panel of burner. Fire-eye readout will

show "FLAME SIGNAL." A readout of 40 to 70 is normal. Allow boiler to run for five (5) minutes.

10. Run boiler for five (5) minutes and let set for 10 minutes for the first 30 minutes.
11. Increase run time to 10 minutes for 30 minutes.
12. When steam pressure reaches 10 PSI, close steam drum vent valve.
13. When pressure reaches approximately 75 PSI, blow down steam and water legs of copes regulator separately.
14. When pressure reaches approximately 80 PSI, crack open outboard steams stops and allow steam to come out of steam line drain valve for three (3) to five (5) minutes to drain water and warm up line.
15. Close steam line drain valve and open outboard steam stop all the way, slowly.
16. Open inboard "non-return" steam stop and allow boiler to come up to 125 PSI operating pressure.
17. Allow boiler to idle on low fire with a stack temperature around 325 degrees for two (2) hours to spread heat evenly.
18. Remember to control water level manually until copes regulator settles in. When copes is ready to take over feed water control, open downstream feed water valve.
19. Make all safety checks and test during two (2) hour, 125 PSI warm-up period (lockouts, interlocks, starting interlocks).
20. After boiler has been running at operating pressure for two (2) hours, place the AUTO-MANUAL switch in AUTO position.
21. Observe that boiler and feed water regulator are working automatically and note boiler in service time and date in Operator's Log Book.
22. Test boiler water residual and add chemical if necessary.

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VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area	Facilities

F.037 Starting Boiler from Standby

POLICY:

1. Check to see if water level is between ½ and ¾ in sight glass. If not, add or blow down water to correct level.
2. Blow down gauge glass and water column. Observe the fall of water from glass and return of water level after blow-down valves are closed.
3. Check that feed water valves are closed.
4. On the boiler electrical panel, place the AUTO-MANUAL switch in the "MANUAL" position.
5. Make sure the firing rate potentiometer is in the LOW FIRE position.
6. Turn the POWER and BURNER switches to "ON" and observe "Fire-eye" readout on screen. Readout will show "BURNER ON," "HRS," "CYCLES," "HOLD D-8" and "HIGH PURGE OPEN." Purge will last one (1) minute.
7. Observe start up flame through sight glass in front panel of burner. Fire-eye readout will show "FLAME SIGNAL." Readout of 40 to 70 is normal. Allow boiler to warm up on Low Fire.
8. Water level in glass will rise due to expansion. When water level starts to fall, boiler is making steam.
9. Cut in feed water to feed water regulator and watch gauge glass to make sure water level is being controlled automatically.
10. Allow boiler to warm up for ½ hour on Low Fire and then place the AUTO-MANUAL switch in the "AUTO" position.
11. Observe that boiler is working automatically and note boiler in-service time and date in Operator's Log Book.
12. Test boiler water residual and all chemicals if necessary.

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Next Review	2/25/2029		

F.042 Above Ceiling Access/Work

POLICY:

Ventura County Medical Center/Santa Paula Hospital shall ensure that all fire and smoke partitions are sealed and wires are properly supported in above ceiling spaces. The penetrations and improperly supported wires are the result of utilities, such as conduit, pipe, duct work, communication lines, phone lines and television/cable lines, being installed without being properly supported and the penetrations in walls not being properly sealed. The following procedure outlines the above ceiling work program.

PROCEDURE:

- Anyone performing work above the ceiling must secure an Above Ceiling Work Permit prior to beginning any work. Contact the Facilities Maintenance Department Manager or his/her designee to obtain permit. For work scheduled in advance, please submit Ceiling Access Permit Request Form to Facilities Maintenance Department (see policy 3.14).
- Completion of the permit must be done by those requesting the permit and it must be authorized by the Facilities Maintenance Department Manager or his/her designee. The person performing the work must keep the permit in his/her possession at all times while work is in progress.

Facilities Operation Specialists are qualified inspectors for:

Electrical:

- Electrical, telephone, computer, intercom, video, audio, fire alarm, security

Plumbing:

- Domestic or fire, water, sewer, steam, drains, compressed air

HVAC:

- Hydronic system, heating, water ducts, HVAC controls, control air

Building:

- Roof penetrations, ceiling mounted items, wall penetrations, other items

All penetrations and attachments must be made in accordance with local and state building codes. A copy of these resources is available in the Facilities Maintenance Office.

Supporting work from the ceiling grid is strictly prohibited.

Damage to the ceiling or other structures shall be repaired prior to the work being approved for completion.

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Policy Area	Facilities

F.050 Facilities Maintenance Work-Related Injuries

POLICY:

To state the process for Facilities Maintenance staff to follow in case of a work-related injury.

PROCEDURE:

Work-related injuries at Ventura County Medical Center/Santa Paula Hospital must be reported immediately to the Facilities Maintenance Supervisor. In the absence of a Supervisor, the injury should be reported to the Administrator on Duty (AOD) and/or the Nursing Supervisor.

If treatment is required, the Facilities Maintenance staff member shall be immediately sent to the VCMC Emergency Department, Urgent Care or the Ventura County Employee Health Center. Depending on the physician's order as recorded on the Physicians Notice of Return to Work or Temporary Medical Restrictions form, every attempt to accommodate the injured employee will be made.

The Supervisor is responsible for completing the RM75 – Injury First Report (available online). This step is to be completed within 24 hours of injury.

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Step Description	Approver	Date

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.052 Equipment and Bloodborne Pathogens

POLICY:

To give direction to Facilities Maintenance staff regarding the treatment of equipment that has been contaminated with bloodborne pathogens.

PROCEDURE:

In order to comply with Ventura County Health Care Agency's hospital and clinic policy on blood borne pathogens, equipment that has been contaminated with blood or other potentially infectious materials shall be decontaminated by authorized Housekeeping staff before being serviced or shipped, unless it can be shown that decontamination of the equipment is not feasible. Equipment or any portion thereof that is not decontaminated will require a warning label in accordance with OSHA standards on bloodborne pathogens.

All Revision Dates

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F.053 Inventory and Inspection of New Equipment

POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital to take all necessary safety precautions when new equipment is purchased for installation. All new equipment shall be inventoried and inspected prior to use, including Radiology equipment, ultrasound and nuclear imaging equipment and clinical laboratory equipment. New equipment that fails electrical safety tests shall not be approved for use until the deficiencies have been corrected.

PROCEDURE:

- All requests for new equipment shall be reviewed and approved by the Facilities Maintenance Department for proper safety features, including electrical needs, space consideration, OSHA requirements, etc.
- After receipt of any new equipment, but prior to its installation, equipment must be inspected. Electrical and mechanical tests shall be performed and the Facilities Maintenance Department shall determine that the equipment meets all appropriate safety standards. After passing inspection, the new equipment is assigned an identification number (asset ID) and is placed on a maintenance schedule.
- When equipment is assigned an identification number (asset ID), the engineer performing the inspection will document the inspection and the date the inspection was performed in the comment section of the equipment form.
- If the equipment fails to pass the required tests and inspection, the engineer will return the equipment to the Facilities Maintenance shop or vendor until the equipment is fixed. The equipment is not assigned an identification number (asset ID) until the equipment has passed all the requirements.
- In the event that items of equipment not belonging to the hospital are brought into the hospital for use, they must be inspected and determined to be safe by the Facilities Maintenance

Department. This would apply to items brought in by patients, visitors, or employees (radios, televisions, coffee makers, etc.). The Facilities Maintenance Manager is authorized to remove any item which is found to be unsafe for use in the hospital. This will include any and all demonstration equipment brought in by any vendor.

- It shall be the responsibility of the Facilities Maintenance Department to routinely inspect all pertinent hospital equipment to determine its safe operation. If deficiencies are found, the Facilities Maintenance Department shall notify the affected department manager and implement corrective measures.

All Revision Dates

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VENTURA COUNTY HEALTH CARE AGENCY

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.056 Medical Refrigerators and Freezers

POLICY:

To ensure pharmaceuticals in patient care areas are stored in refrigerators/freezers under proper conditions and temperature requirements as mandated by VFC and other compliance agencies.

PROCEDURE:

1. **Medication/Vaccine Storage Temperatures:**
   Medication refrigerator temperatures are maintained with in a range of 2°C to 8°C (36°F to 46°F) and medication freezers are maintained within a range of -15°C to -38°C (+5° to -36.4°F) in accordance with CDC, VFC, and as recommended by the Pharmacy Department. Appropriate measures are to be taken if the temperatures are out of range, such as re-checking the temperature and notifying Facilities Maintenance Department for corrective action.
2. **Each Clinical Manager is responsible for the following:**
   Temperatures for both refrigerators and freezers are read and recorded twice each workday, at the beginning of the day and before closing. The temperature log shall contain acceptable temperature range for the storage unit, date and time of the reading, temperature observed, and initials or signature of person reading. For areas that are not open 24/7, a memory thermometer must be used that records the minimum and maximum temperatures during the defined period of time (Example – Fisher Scientific memory thermometer). The procedure for use of memory thermometer is listed below:
   a. When the area is ready to close, erase the thermometer memory by pressing reset. The thermometer will now record the maximum and minimum temperature reached from that point forward until reset is pressed again. Areas that are closed on the weekends will erase the thermometer on Friday, and check for minimum/maximum temperatures on Monday morning and reset the thermometer.
   b. When the area opens, the maximum and minimum temperatures should be checked

by pressing "min" and "max" recorded.

3. **Temperature Records:**
   Medication refrigerators and freezers are connected to the Remote Temperature Monitoring System (RTMS). Facilities Maintenance is responsible for monitoring this system and ensuring continual temperature monitoring and necessary documentation of these units. In the event the RTMS fails, Facilities Maintenance will be notified and will respond immediately (24/7). Daily data entry logs are maintained on site by the department manager.
4. **Service and Inspection Standards:**
   Facilities Maintenance is responsible for performing routine maintenance and upkeep on medical refrigerators/freezers and should be notified whenever problems arise. Equipment inspections and preventative maintenance are performed a minimum of twice per year.
5. **Emergency Response for Medication or Vaccine Refrigerator/Freezer Failure:**
   In the event that a medication or vaccine refrigerator/freezer fails to maintain temperature due to:
   a. Power outage
   b. Equipment failure (i.e., high/low temperature)
   c. Human error (i.e., door ajar)
      And or loss of device signal, HCA Facilities maintenance is notified within 15 minutes of failure. VCMC Facilities Maintenance will respond with a portable generator in the event of a power outage as well as a back-up refrigerator/freezer if needed. Staff should notify their department manager or designee and follow department procedures for safe handling and transferring of medication into the back-up refrigerator/freezer. Upon power being restored and/or equipment failure being corrected, HCA Facilities Maintenance will verify temperature recordings have returned to normal and retain these records.

THERMOMETERS:

1. Providers have two (2) electronic thermometers in each unit, a primary and a back-up thermometer. According to CDC and VFV, thermometers:
   a. Are accurate within +/- 0.5° C (+/- 1° F)
   b. Digital with the display placed outside the unit to allow for temperature monitoring without opening the unit door.
   c. Have a biosafe, glycol-encased probe placed in proximity of the products nearest to the center of the product storage area whenever possible.
   d. Display current temperature, as well as the minimum temperatures, and have an audible alarm.

THERMOMETER CALIBRATION & CERTIFICATION:

Primary and back-up thermometers are calibrated annually (or every other year at the most as recommended by the manufacture), and each device should be covered by a Certificate of Traceability and Calibration Testing, also known as Certificate of Calibration.

Valid Certification of Calibrations are kept on file and readily available for review.

TEMPERATURE MONITORING

1. **Beginning and end of each shift:**

   Temperatures for each unit must be read and documented twice each workday, at the beginning of the day and before closing. Additionally, minimum and maximum temperatures must also be read and documented each workday.

   - Thermometer temperatures must be cleared after documenting each daily MIN/MAX readings.
   - Temperatures must be recorded on VFC-provided temperature logs even though temperature recordings device is maintained.
   - Temperature logs must be posted in a visible location.
   - Temperature logs must be maintained for three years.

2. **24/365 Temperature recording/monitoring:**

   Temperature, equipment performance, device signal and power (electricity) are ALL monitored by the HCA Facilities Maintenance Clinical Division RTMS (Remote Temp Monitoring System). This system is called "Temp Alert." Equipment that does not have "Temp Alert" (Academic Family Medicine and Santa Paula Hospital Clinic) shall have two (2) Fisher Scientific Digital Electronic Temperature Monitoring units.

All Revision Dates

2/26/2026, 1/17/2014

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.057 Failure of the Nurse Call System

POLICY:

To give direction to the Facilities Maintenance and nursing staff if there is a malfunction/failure of the Nurse Call System at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

GENERAL INFORMATION:

1. Warning signs or indicators of failure:
    - Individual component failure
    - Lack of system response
2. Possible reasons for failure:
    - Individual component failure
    - Power supply failure in call system control panel
    - Circuit breaker trip

1. When notified by the nursing unit(s) of a failure in the Nurse Call System, instruct staff members to set up an alternative method of communication.
2. Try to identify the cause of the malfunction and repair it.
3. If the problem cannot be resolved within a reasonable time frame, contact Pacificom at (805) 978-1350 for immediate service.

NURSING RESPONSIBILITIES:

1. All patients will be immediately informed of call system outage.
2. Patient care units will assign runners to circulate halls listening for patients who can vocalize.
3. Patients who are unable to vocalize will be provided with table top bells located in the maintenance department.
4. Patients unable to use hand bells will be moved and closely observed, as per nursing policy.
5. After repairs are made, notify the departments that the Nurse Call System is operating.

All Revision Dates

2/26/2026, 12/9/2013, 8/25/2009, 12/13/2001

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.059 Utility Systems Emergency Shutoff Labels

POLICY:

To provide direction to Facilities Maintenance staff regarding the proper labeling and monitoring of emergency shutoff labeling of utility systems throughout Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

All emergency shutoff controls of utility systems throughout the facility shall be clearly and permanently labeled. These utility systems include, but are not limited to:

- Natural Gas
- Electricity
- Water Distribution
- Steam
- Medical Air and Vacuum
- Piped Gases
- Nitrous
- Deionized Water
- Oxygen
- Fuel oil
- Diesel
- Soft water
- Chilled water

- Domestic hot water
- Heating system
- Ethylene Oxide

The Facilities Manager will make periodic, but at least monthly, rounds to ensure that main supply valves and all area emergency shutoff labels are visible, in place and accessible.

During orientation and annually thereafter, Facilities Maintenance staff will be in-serviced in the proper locations and operations of the controls for complete or partial shutoff of utilities.

All Revision Dates

2/26/2026, 12/9/2013, 8/25/2009

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.061 Natural Gas Supply Failure

POLICY:

To state the procedure for Facilities Maintenance staff to follow when there is a failure of the natural gas supply at Ventura County Medical Center.

PROCEDURE:

Natural gas is the primary source of fuel that drives the steam boilers located in the central plant. Steam is the only source of energy that provides heat and hot water. Steam is also used for sterilization.

While #1 and #2 boilers run exclusively on natural gas, as a backup to a loss of natural gas, the #3 boiler can be fired by fuel oil that is stored in an underground tank,.

When there is a loss of natural gas, Facilities Maintenance staff should contact the Southern California Gas Company and inform them of the loss of service. If the restoration of service will exceed 30 minutes but is less than one (1) hour, the central plant engineer on duty shall determine if a changeover to fuel oil would be effective.

SOUTHERN CALIFORNIA GAS COMPANY
24-Hour Emergency Line: (310) 803-7339

For Emergency Fuel Delivery, call:
SC FUELS at (805) 339-0370

All Revision Dates

2/26/2026, 7/1/2016, 12/9/2013, 3/31/2011, 10/25/2004

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.068 Medical Gas System

POLICY:

The Facilities Maintenance Department is responsible for maintaining the medical gas system at Ventura County Medical Center, including all medical gas alarms.

PROCEDURE:

When Paging/Admitting receives an alarm on any of the medical gases, the Facilities Maintenance Department shall be notified immediately in the following manner:

- Monday through Friday, between the hours of 7:00 AM and 5:00 PM, call the Facilities Maintenance office at 1-805-652-3219.
- Monday through Friday, between the hours of 5:00 PM and 7:00 AM, contact the Hospital Maintenance Engineer on duty.
- On Saturday and Sunday contact the Hospital Maintenance Engineer on duty.

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F.071 Emergency Power Operations

POLICY:

To state the proper process for Facilities Maintenance staff to follow in the event of a loss of utility power on the campus of Ventura County Medical Center.

PROCEDURE:

SEQUENCE OF OPERATION FOR "EMERGENCY POWER"

In the case of a utility (Southern California Edison) power failure, the following occurs:

1. Both generators start after one (1) second of detecting a power loss.
2. Generators synchronize (both units must have same voltage, frequency, and polarity).
3. Power available to ATS's (Automatic Transfer Switches).
4. The following transfer switches begin to transfer. This is based on the determined "priority."

Priority 1

ATS CR – this is "critical care circuits and lighting"

1. Emergency lighting
2. Red plugs

ATS LS – this is "Life Safety circuits"

1. Egress lighting
2. Exit lights
3. Fire alarms/general alarms

4. Emergency lighting

ATS MX – Mixed load (non-segregated)

1. Medical Air
2. Vacuum
3. Elevators 1-2-3-4
4. All other circuits

Priority 2

ATS EQ – Essential Equipment

1. Cat Scan
2. Elevators 5 and 6
3. Telephone systems
4. Outlying buildings including Public Health, Medical Examiner, Colston, AFMC, Facilities Maintenance, the Laundry/Boiler and CRT

NOTE:

Under existing load demand, two (2) generators will be able to provide power to all areas.

It is only in the event that one of the two generators fail and the load exceeds the capacity of two generators that the "Load-Shed" program becomes active. I f we do begin to load-shed, we will begin to load-shed staring with Priority 2, but not all priority 2 will deactivate. There are 6 levels of activation within the Priority 2 distribution system.

During the weekly testing of the emergency generators, only one is required to do the Electrical Load. In both scenarios, all two generators start up, because only two are needed, while the others shut down.

All Revision Dates

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Policy Area	Facilities

F.072 Inventory of Utility Systems

POLICY:

All utility equipment and systems listed in the inventory shall have a written testing and preventative maintenance procedure as required by codes, regulations, and/or manufacturer specifications.

PROCEDURE:

1. All utility equipment, regardless of type or use, shall be inventoried and tagged.
2. All utility equipment shall be tested and assessed for operation, electrical safety (as applicable) and general safety.
3. There shall be written criteria that identify critical operating components of the utility systems that play a role in:
    1. Life Support Systems
        1. Emergency Power
        2. Medical Air
        3. Medical/Surgical vacuum
        4. Medical Gas Systems
    2. Infection Control Systems
        1. Boiler/Steam Distribution
        2. Heating, Ventilation, Air Conditioning
        3. Air Filtration
        4. Plumbing (potable and non-potable)
    3. Environmental Support Systems

1. Boiler/Steam Distribution
2. Electrical Distribution
3. Heating, Ventilation, Air Conditioning
4. Plumbing (potable and non-potable)

4. Equipment Support Systems
    1. Electrical Distribution
    2. Elevators
    3. Plumbing (potable and non-potable)
5. Communications
    1. Paging System
    2. Nurse Call System
    3. Code Blue System
    4. Alarm Systems
    5. Fire Detection and Extinguishing systems

4. All utility equipment systems shall have a testing, calibration and preventative maintenance program set up as soon as possible.
    1. The complete program shall be based on the following guidelines:
        1. Manufacturer specifications
        2. Local, state, and federal codes/regulations
        3. Established hospital standards
    2. All equipment shall be tested and operated prior to use and at least annually thereafter.
    3. This program is kept and recorded in the Preventative Maintenance System, in the Engineering department.

All Revision Dates

2/26/2026, 7/1/2016, 12/9/2013, 8/25/2009

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Policy Area	Facilities

F.073 Equipment Management Plan

POLICY:

The Facilities Maintenance Department Equipment Management Plan will provide and maintain an equipment management program that promotes the safe and effective use of equipment.

PROCEDURE:

The Facilities Maintenance Department Equipment Management Plan encompasses the following:

- THE SELECTION AND ACQUISITION OF EQUIPMENT

  All requests for electrically-operated equipment shall be reviewed by the Facilities Maintenance Manager prior to purchase to determine if the equipment meets appropriate space requirements, load and phase requirements, Underwriters Laboratory requirements, minimum safety standards of 3-wire line cords with hospital grade plugs, appropriate warranties and manufacturer reliability.

- ESTABLISHING CRITERIA FOR IDENTIFYING, EVALUATING AND TAKING INVENTORY OF MEDICAL EQUIPMENT TO BE INCLUDED IN THE EQUIPMENT MANAGEMENT PROGRAM

  All mechanical and electrical patient care equipment will be evaluated prior to use based on function, physical risks associated with clinical use, maintenance requirements and equipment incidents. All incoming and existing equipment meeting the evaluation criteria are included in the Equipment Management Program.

  There is a current inventory of equipment included in the Equipment Management Program.

  See Equipment Management Numbers Formula, Equipment Management Inventory Policy, Equipment Management Inventory Form, Additions to Equipment Management Inventory Form

and deletions from Equipment Management Inventory Form.

- ASSESSING AND MINIMIZING CLINICAL AND PHYSICAL RISKS OF EQUIPMENT THROUGH INSPECTION, TESTING AND MAINTENANCE

  All mechanical and electrical patient care equipment will be evaluated prior to use. Quarterly, semiannual and annual preventative maintenance and safety inspections will be completed on all equipment in the Program. The results of inspections and maintenance will be kept in the Facilities Maintenance Department. Incident history is documented and maintained in the Facilities Maintenance Department office. Equipment displaying an unusual repair history or unusual incidence of injury to staff or patients, will be evaluated for necessary changes/ replacement.

All Revision Dates

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.074 Maintenance and Monitoring of Water Systems for Legionella

POLICY:

To reduce the potential for nosocomial infections caused by biological agents in aerosolizing water systems, the Utilities Management Program will include the maintenance and monitoring of the facility's water system for the **Legionella bacterium.**

In conjunction with Ventura County Medical Center/Santa Paula Hospital's Infection Control Committee, the Plan will include:

- Prevention
- Surveillance
- Environmental Culturing
- Remediation (if and necessary)
- Reporting

PROCEDURE:

PREVENTION:

- Cooling towers are constructed so that tower drift is directed away from the hospital's air intake system and shall have drift eliminators installed. Manufacturer's recommendations for tower maintenance will be followed with documentation of all maintenance procedures.
- A biocide (such as monochloramine), approved for use by the Infection Control Committee, will be used in the facility's water system on a regular basis.
- All shower hose, heads, and sinks shall be flushed weekly by Housekeeping.

- Older hot water storage tanks and water heaters are cleaned on a routine basis to remove accumulated scale and sediment.
- Where practical, the following engineering measures will be incorporated into the design and operation of the system.
- Instantaneous or semi-instantaneous water heaters should be used instead of tanks. If tanks are used, horizontal tanks are preferred over vertical tanks, and steps should be taken to maintain adequate circulation to minimize cool spots within tanks. Hot water system recirculation pumps should run continuously.
- Hot water should be generated or stored at 140° F (60° C) and reduced as required for distribution.
- Installation of fail-safe thermostatic mixing valves and pressure independent mixing valves permit maintaining a higher temperature while minimizing the risk of scalding.
- The design should eliminate "dead legs" and other areas of stagnant water. Standby pumps and piping connections should be cycled regularly. The hot water recirculating system should be installed to serve the fixture farthest from the supply.
- Copper piping materials should be used whenever possible, since it is the most resistant to Legionella colonization. Natural rubber gaskets should be avoided.
- Appropriate materials should be used for pipe insulation to ensure that hot water stays hot and cold water stays cold.
- Potable water piping should be disinfected in accordance with the method recommended by the local plumbing authority.
- Physicians and other healthcare dysgg are educated to maintain a heightened suspicion for Legionella as a cause of nosocomial pneumonia.
- Sterile water will be used in all respiratory equipment including devices that nebulize. Limited use of humidifiers allowed; eliminate when possible.
- Nasogastric tubes should be flushed with bottled or sterile water.

SURVEILLANCE:

- All sputum obtained from high-risk patients (solid organ transplants, bone marrow transplants, patients undergoing chemotherapy, other immunocompromised patients) with pneumonia will be sent for Legionella culture or urine sent for antigen detection.

All bronchoscopy specimens obtained from patients with pneumonia will be sent for culture and appropriate antigen tests.

ENVIRONMENTAL CULTURING:

Environmental sampling of water cooling towers and potable hot water systems shall be conducted regularly; more frequently is areas that house high-risk patient populations including shower heads and Risk factors may include:

- Engineering, age and complexity of the hospital's hot water system
- Remediation history and frequency

- Number of high-risk patients (i.e., transplant, chemotherapy and other immuno-compromised patients) and patient mix
- Prior history of Legionnaire Disease.

REMEDIATION:

Should a culture show positive for Legionella bacterium:

- The Infection Control Practitioner will be notified.
- Decontamination of the affected system will be implemented, preferably with monochloramine.
- Consideration will be given to further restriction on the use of potable water for high-risk patients.
- Restrictions on showering.
- Use bottled or sterile water for drinking and bathing.
- Cultures will be monitored every 2 weeks for 3 months and, if negative, monthly samples for another 3 months.

REPORTING:

All cases of confirmed Legionella infection will be reported to the Public Health Department following established procedures.

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Policy Area	Facilities

F.077 Medical/Surgical Air and Vacuum System Maintenance

POLICY:

The Computerized Maintenance Management System (CMMS) is used to schedule, monitor and document the testing and maintenance of the medical/surgical air and vacuum systems at pre-determined frequencies.

PROCEDURE:

- Work orders are generated for each key component of the medical/surgical air and vacuum systems as per above maintenance strategy.
- The medical/surgery air and vacuum system is inspected, tested and maintenance is completed according to the established maintenance strategy.
- The work orders are assigned by priority.
- The Facilities Maintenance Department will perform preventive and corrective maintenance (as needed), inspection of the system and testing as pre-determined.
- A corrective maintenance work order is generated for any repair work that exceeds 30 minutes to complete or for which tools or parts are not readily available.
- A scheduled maintenance work order is completed, indicating specific preventative or corrective actions taken. The date the scheduled maintenance was completed is entered on the work order as well as entered into the CMMS.
- All system flow rates will be inspected by a cardiopulmonary representative prior to procedure being performed. Any malfunction will be reported to the Facilities Maintenance Department.
- After repairs or modifications, the medical/surgical air and vacuum system shall be tested by the Facilities Maintenance third party contractor to ensure proper connection and sufficient

volume of vacuum air at each outlet. Documentation of the testing will be kept in the Facilities Maintenance Department.

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.078 Drinking Fountain Inspection

POLICY:

To describe the preventive maintenance process for all drinking fountains within Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

A number of departments within Ventura County Medical Center/Santa Paula Hospital are supplied with one or more drinking fountains. Some are provided with a sealed motor/compressor element, while others may have the conventional separated, exposed motor/compressor unit. Most are recessed within a cupboard/panel system and must be removed for the inspection service function.

All drinking fountains shall be inspected and equipment cleaned on a regularly scheduled, quarterly cycle. This inspection will be accomplished within the department without the unit's removal from service and in accordance with the inspection procedure contained within. If inspection reveals items requiring repair, the unit shall be removed from service. The Facilities Maintenance department will be notified for evaluation, scheduling and repair. The inspection check list, upon completion, shall be filed in the Facilities Department as a permanent record.

Refrigerated fountain temperature not to exceed 20° Fahrenheit from ambient temperature and no lower than 50° Fahrenheit.

The following is the procedure for inspection of drinking fountains:

1. Inspect the control to ensure satisfactory operation. Adjust the flow so that the water fountain does not exceed four (4) inches projection. If there is a continued leak, replace the washer.
2. Remove the fountain from cove to permit inspection of the rear area. Remove the access panel to permit cleaning of the motor/compressor area. Use a vacuum and brush to remove accumulated lint. A cleaning biodegradable soap/water solution with rags shall be used to

dislodge heavily encrusted sludge. All components shall be cleaned in a manner that will ensure operation at the highest acceptable level.

3. Before the unit is returned to the installed location, examine the power cord. If the blades are bent, cracked or broken, the plug shall be replaced. If the cord shows cracked surfaces or missing sections in the insulation, it shall be replaced with an acceptable cord.

All Revision Dates

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F.079 Resetting Fire Alarms

POLICY:

To describe the process for resetting the fire alarms at Ventura County Medical Center.

PROCEDURE:

The following is the procedure for resetting the fire alarms (follow Code Red procedures at all times):

Step 1. Report to Admitting (first floor) where the fire alarm panel is located.

a. Identify fire zone on panel.
b. Report to fire zone area identified on panel.
c. Determine if alarm is valid or if false.

Step 2. Report to hospital basement (fire alarm control panel).

a. Push acknowledge button. **TO RESET (PUSH BUTTON STATIONS).**

Step 3. Locate pull-station(s)

a. Open stations, clear and lock.
b. Return to basement and push reset button on both: Simplex and Auto-Call panels.
c. When pushing reset buttons (HOLD!) button for 3 to 5 seconds each.

Step 4. After panels are clear:

a. Contact Facilities Maintenance Department at 1-805-652-3219 to inform them that the system is all clear and back in operation.
Between the hours of 4:30 PM and 8:00 AM only, contact: Admitting – Extension 6071, and the Security Alarm Service: 1-805-659-1711, use Code No. 14-594.

Step 5. Air handlers and smoke detectors, repeat steps 1 through 3.
Air handler locations:1 to 4 on Fainer Wing roof. Number 5 in Fainer Wing basement.

Step 6. Air handlers reset automatically, but resets should be physically checked.

Step 7. Repeat steps 3 to 4.

Step 8. Fainer Wing detectors located in CCU and Central Supply must be removed to clear and then replaced.

Step 9. Repeat steps 3 to 4.

Step 10. Water flow and tamper switch. Follow steps 1 to 4.

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Policy Area	Facilities

F.084 Fire Alarm Pull Station Test

POLICY:

To guide Facilities Maintenance staff in the testing of fire alarms. One fire alarm pull station per zone shall be tested per quarter and each will be tested annually. Testing ensures the proper operation of all signaling devices related to the pull station and to fire prevention equipment.

PROCEDURE:

- Check the physical condition of the station and glass. Repair or replace glass bar as required.
- Vacuum or clean with contact cleaner.
- During the test, do not break glass. Remove cover using proper sized Allen wrench.
- Check to ensure alarm is activated.
- Ensure annunciator panel is activated.
- Ensure fire doors close and latch.

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Policy Area	Facilities

F.085 Air Handling and Ventilation Systems

POLICY:

The Utility Systems Management Program policies shall include the correct design, installation and maintenance of the hospital's air handling and ventilation system areas specifically designed to control airflow.

Areas of paramount concern include pressure relationships, air exchange rates and filtration efficiencies. Specifically designed areas include operating rooms, special procedure rooms for patients who have been diagnosed or suspected of having an airborne communicable disease, protective environment rooms, clinical laboratory, pharmacy and sterile supply rooms.

The design parameters will follow the American Institute of Architects (AIA) Guidelines for Design and Construction of Hospital and Health Care Facilities, "Ventilation Requirement for Affecting Patient Care in Hospitals and Outpatient Facilities," and "Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals."

PROCEDURE:

STRATEGIES TO REDUCE CONTAMINATION

Maintenance and System Cleaning:

- HVAC (Heating, Ventilation, and Air Conditioning) systems are cleaned utilizing methods to prevent "blowback" of loosened debris. Relative humidity should be controlled at a level of generally no higher than 60 to 70 percent as recommended by American Society of Heating, Refrigerating and Air-Conditioning Engineering (ASHRAE). Eliminate or reduce areas of standing water within the HVAC system.

Increased Ventilation:

- Ventilation rates follow ASHRAE recommended ventilation rates. Periodically test and calibrate negative pressure alarms.
- Maintain a pressure differential log for all negative pressure rooms.
- Isolation rooms and reverse isolation rooms shall be compliant with federal and state laws and regulations.

Source Control:

- Centers for Disease Control and Prevention (CDC) recommended Transmission-Based Precautions (Isolation Precautions) are utilized for appropriate patients.

Ultraviolet Germicidal Irradiation (UVGI):

- UVGI may be used in return air duct systems to irradiate organisms in the return air stream.

Filtration:

- High-Efficiency Particulate Absorbing (HEPA) filters and Ultra Low Penetration Air (ULPA) filters (for use in critical areas such as transplant units, operating rooms, special procedure rooms, etc.) are used with less expensive pre-filters.
- Filters are changed on a pre-determined frequency to ensure proper air filtration performance and proper air flow rates. Clogged air filters will reduce airflow. Follow AIA guidelines for filter efficiencies.

Ducts:

- If ducts become contaminated, they should be thoroughly cleaned thoroughly. Work should be conducted via a corrective maintenance work order and then filed for record.

NOTE

See manufacturer's recommendations for guidelines for your facility's specific equipment.

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F.086 Failure of Medical Air System

POLICY:

To define the steps which should be taken by Facilities Maintenance staff in the event of a medical air system failure.

PROCEDURE:

1. Possible reasons for a medical air system failure:
    a. Equipment malfunction
    b. Rupture of gas lines
    c. Contamination of system
2. Warning signs or indicators of failure:
    a. Audible alarm
    b. Drop in pressure
    c. Call from one or more affected areas
3. Back-up mechanisms or reserves:
    a. Standby compressor(s) – entire system is redundant
    b. "H" cylinders with regulators (for use by Respiratory Therapy staff)
4. Areas which may be affected:
    a. All nursing units
    b. Operating Room/Recovery Room
    c. Special Procedure Rooms

d. Emergency Department

5. Check to see if compressors are running. If one compressor has failed, switch valves and isolate the defective unit.
6. Check to be sure that the filters are not plugged.
7. Check to be sure that the dryers are functioning properly.
8. If the main supply line has ruptured, request emergency outside assistance (refer to Emergency Telephone List).
9. In the event of a total loss of medical air notify:
    - Respiratory Therapy Department
    - Facilities Maintenance Manager or on-call Supervisor
    - Nursing Supervisor
10. Begin repairs, if possible, while waiting for assistance.

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F.087 Electrical Distribution System Shutdown

POLICY:

To provide guidance to Facilities Maintenance Department staff in the event of a complete or partial shutdown of the electrical distribution system. There will be current documentation that identifies the electrical distribution system and the location of the ATS switches. All ATS switches shall be labeled.

PROCEDURE:

Comprehensive drawings for all hospital buildings are located in the Facilities Maintenance Building. The Facilities Maintenance Manager shall ensure that the drawings are organized and are readily available for quick access and reference in the event of an emergency causing a partial or complete shutdown of the electrical distribution system. In the event of an emergency, there may not be time for use of the architectural drawings and plans. Therefore, the following shall be a requirement to address this need:

- Additional drawings of the generalized plot plan of the Hospital shall be maintained by the Facilities Maintenance Department. This plan shall show the main electrical ATS switches.
- In addition to the plot plan, there shall be a detailed written listing of ATS switches. For each item, the list shall include the following:
    - A description of the location where the switch can be found (i.e., room, area, etc.)
    - Type of switch and the current rating
    - The area supported by the switch
    - Any important equipment that would be adversely affected by the shutdown of the switch (i.e., life support equipment, surgery equipment, telephone systems, etc.)
- A copy of the plot plan and the detailed written listing of ATS switches shall be kept in the Facilities Maintenance Building.
- List of all areas/circuits that are controlled by ATS switches.

All Revision Dates

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VENTURA COUNTY HEALTH CARE AGENCY

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F.088 Medical Air Alarms

POLICY:

Facilities Maintenance staff will test and document testing of the medical air alarms on a quarterly basis. All modifications and repairs on any part of the medical air system are to be documented.

PROCEDURE:

1. Before testing medical air alarms, notify hospital Paging, Nursing office and the Facilities Maintenance Department.
2. Put medical air system to be tested in "ALARM" mode.
3. Check all pressure gauges, lights and audio alarms.
4. Put the system back in "NORMAL" mode.
5. Check system, making sure all valves are in proper position and there is proper line pressure.
6. Document the test and all repairs.

All Revision Dates

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Policy Area	Facilities

F.091 Maintenance of the HVAC System

POLICY:

The Facilities Maintenance Computerized Maintenance Management System (CMMS) is used to schedule, monitor and document the testing and maintenance of the HVAC systems at pre-determined frequencies. These frequencies are based on risk assessment, application as well as individual equipment history.

PROCEDURE:

- Work orders are generated for each key component of the HVAC system.
- The HVAC System is inspected, tested and maintenance is completed according to the established maintenance strategy
- The work orders are assigned by priority.
- The Facilities Maintenance Department personnel or its contractors will perform preventative and corrective maintenance (as needed), as well as perform inspections and testing of the system.
- A Corrective Maintenance work order is submitted for any repair work that exceeds 30 minutes to complete or for which tools or parts are not readily available.
- A scheduled maintenance work order is completed by the engineer, indicating specific preventative or corrective action taken. The date the scheduled maintenance was completed is entered on the work order and it is submitted to the Facilities Maintenance Department.

NOTE: See Manufacturer's recommendations for guidelines of your facility's specific equipment.

All Revision Dates

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Owner	Ian McGraw: Manager Facility Operation
Policy Area	Facilities

F.092 Oxygen Emergency Procedure

POLICY:

To state the procedure for Facilities Maintenance staff to follow in case of oxygen tank depletion alarm.

PROCEDURE:

If the bulk oxygen tank is depleted for any reason and the oxygen alarms indicate that the system has switched to the back-up manifolds, the following steps should be taken;

1. Notify Supervisor on-call.
2. Determine whether the main oxygen line from the bulk storage tank to the hospital is supplying oxygen to the system. If not, close the main valve from the tank where the feed line goes through the cement slab.
3. Verify that the secondary back-up manifold in the hospital is supplying oxygen to the system. If not, silence the alarm and deliver full cylinders from the medical gas storage dock to the manifold as needed.
4. If the tank is depleted and there is no breach of the main line, contact Air Gas.

24 hour service	800-931-4327
Delivery	800-323-1970
Delivery	805-642-0218

   Ask for an emergency delivery and inform them as to the cause and the reason.
5. Be prepared to put the emergency recall program into effect if so directed by the supervisor on-call.
6. Inform the Nursing Supervisor as to condition of system and action underway.

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Policy Area	Facilities

F.093 Oxygen Alarms Testing

POLICY:

The oxygen alarms are to be tested quarterly and documentation of testing completed. In addition, all modifications and repairs on any part of the oxygen system are to be documented. The oxygen alarm is set on a minimum of 55 lbs. All monitoring panels are to be "alarm tested" for each zone alarm and for audibility on a monthly basis.

PROCEDURE:

1. Before testing the oxygen alarm, notify hospital Paging, Nursing Administration and the Facilities Maintenance Department.
2. Set the oxygen system to be tested in "ALARM" mode.
3. Check all pressure gauges, lights and audio alarms.
4. Set the system back in "NORMAL" mode.
5. Check the system, making sure all valves are in proper position and there is proper line pressure.
6. Document the test and all repairs.

ALARM LOCATIONS:

1. Manifold System E- end of clinic – visual
2. Surgery office – visual

MEDICAL AIR ALARM LOCATIONS:

1. ICN	Visual	Audio

2. Admitting	Visual	Audio
3. CCU	Visual	Audio
4. EM Manifold- basement	Visual	Audio

All Revision Dates

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Policy Area	Facilities

F.094 Electrical Equipment Safety

POLICY:

All appropriate Facilities Maintenance Department staff will be responsible for assessing the condition of electrical equipment in their use.

PROCEDURE:

Electrical equipment and devices with electrical components shall be evaluated as follows:

- Cables, cords and internal wiring must be of an approved type and of proper wire size to safely handle the required current.
- All cables, cords and internal wiring must be of sufficient length. All cables, cords and internal wiring must be free of unsafe or unsightly splices, and of frayed, cracked, abraded or brittle insulation.
- Cables, clips, studs and terminals must be fee of dirt, rust, corrosion and other deposits.
- Switches, circuit breakers, relay points and selectors must not be dirty, corroded, excessively worn or pitted.
- Grounding systems must be of an approved type and properly installed.
- Batteries must be properly charged and free of cracks, breaks, or leaks.
- Electrolyte or wet cell batteries must be charged at the proper level.
- Electrical leakage currents must be within acceptable limits.

Electric Motors:

- The electric motor must operate under load without excessive variation/hunting (varying speed), or noise.
- The electric motor must operate without excessive temperature rise when operated at the

rated duty cycle and mechanical load.

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F.096 Bulk and Piped Oxygen System

POLICY:

The primary and secondary bulk oxygen vessels are located approximately 50 feet south of the hospital (the oxygen bulk site). Oxygen is supplied to the buildings by an underground piping system at a normal operating pressure of approximately 55 PSI.

PROCEDURE:

Both the primary and secondary bulk oxygen vessels have check valves and alarms. If the primary oxygen vessel is incapable of feeding the building due to loss of liquid content or loss of pressure, the secondary system would automatically cut in and supply oxygen to the hospital, at which time alarms would sound at the general panels.

If the primary and secondary bulk oxygen systems both fail to supply oxygen pressure to the hospital, an emergency in-building reserve system is in place that will automatically feed the building (at the lower line pressure of 40-50 PSI). This in-building reserve consists of two separate manifolds that are each fed by 8 (eight) oxygen "H" size (large) cylinders. At this point, multiple alarms will sound at the general panels, and area alarm panels located throughout the building may sound.

The oxygen system has the ability to be fed from a specific location near the Emergency Department on the west wall of the building. This location is a green cabinet labeled Emergency Oxygen Supply Connection (EOSC). The EOSC is designed to feed the building during a planned shutdown of the oxygen system and **will not feed the building automatically**. Specialized equipment will have to be attached to the EOSC before it can feed the oxygen system.

As a final back-up to the system, specific regulators are designed so cylinders can plug into wall outlets in critical care areas and supply those areas by closing zone valves.

ALARMS:

The general alarm panels will sound in the event of a malfunction of the bulk system.

Area alarm panels are located throughout the building and will sound if the line pressure increases beyond 65 PSI or decreases below 45 PSI. Some of the locations that have an area alarm panel are CCU, DOU, Emergency Department, OR, and Recovery Room.

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F.097 Heating, Ventilation, and Air Conditioning System Shutdown

POLICY:

The documentation that identifies the Heating, Ventilation, and Air Conditioning (HVAC) Systems and the location of their shutdown controls is located in the Facilities Maintenance Office. All shutdown controls shall be labeled. In the event of a partial or complete shutdown of the HVAC System, the following procedures will be followed by Facilities Maintenance Department personnel.

PROCEDURE:

Comprehensive drawings for all buildings of this Hospital are located in the Facilities Maintenance Office. The Facilities Manager shall ensure that the drawings are organized and are readily available for quick access and reference in the event of an emergency causing a partial or complete shutdown of the HVAC System. In the event of an emergency, there may not be time for use of the architectural drawings and plans. Therefore, the following shall be a requirement to address this need;

- Additional drawings of the generalized plot plan of this Hospital shall be maintained by the Architect. This plan shall show the main shutdown valves or switches for the HVAC equipment, for each HVAC System of the hospital.
- In addition to the plot plan, there shall be a detailed written listing of shutdown valves and switches. For each item, the list shall include the following:
    - A description where the valve or switch can be found, (i.e., room, cage)
    - Type of control
    - The area handled by the control
    - Any important or critical equipment that would be adversely affected by the shutdown

- A copy of the plot plan and the detailed written listing of shutdown switches shall be kept in the Architect office.

List all the areas that are controlled by automatic shutdown devices.

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F.098 Ice Machines

Ice machines conducted by service agreement quarterly see work order for tasks list.

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2/26/2026, 7/24/2017

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VENTURA COUNTY MEDICAL CENTER

Property of the Medical Staff, Privileged and Sensitive Information

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Medical Executive Committee Document Approvals

March 2026

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VENTURA COUNTY
HEALTH CARE AGENCY

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

100.030 Critical Tests and Critical Results

POLICY:

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

DEFINITIONS:

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

B. **Critical Results**: test results even from routine tests that represent a life threatening state that require rapid communication to the physician or responsible licensed caregiver.

C. Time Sensitive Results: Results which warrant urgent communication with the referring provider in the time frame of 1-2 days.

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

PROCEDURE:

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

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

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

D. New diagnosis of cancer are considered time-sensitive and should be communicated within two business days via electronic health record Message center, a phone call, or secure messaging with acknowledgement.

E. Nursing is responsible for documenting critical results in Cerner and ensuring that the licensed practitioner is notified of any critical lab results within thirty (30) minutes of receipt from lab.

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

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

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

GUIDELINES:

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

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

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

1. For Inpatients and Emergency Department (ED) Hold Patients
    a. Testing personnel shall contact bedside nurse. The bedside nurse shall communicate the critical test/result to the licensed practitioner.
2. For Patients in the ED or Discharged from the ED
    a. Testing personnel shall contact the patient's nurse in the ED. ED nurse shall communicate the critical test/result to the ED licensed practitioner.
3. For Patients Discharged from the Hospital
    a. Testing personnel to call the ordering licensed practitioner.
    b. If there is no response, retry a second time within two hours of the result.
    c. If there is still no response, TigerText the Chief Medical Officer.
4. For Patients Seen in Ambulatory Care Clinic
    a. During clinic hours: Testing personnel shall contact a licensed responsible caregiver or the ordering licensed practitioner. See *Attachment A Ambulatory Care Critical Values Phone Lines*.
        i. In the event a licensed responsible caregiver other than the ordering licensed practitioner receives the critical test result, the ordering or covering licensed practitioner shall be contacted by the licensed responsible caregiver to report results.
    b. After hours and weekends: A critical result may NOT be left with an answering service. Critical values shall be reported to the on-call licensed practitioner by calling the clinic and following the phone tree.

D. Chain of Command for Communication

1. Hospital chain of command for communication to nursing
    a. If bedside or ED nurse is not immediately available, communication will be made via phone to the unit charge nurse. If no charge nurse is available, communication will be made via phone to the nursing supervisor.
2. Hospital chain of command for communication to licensed practitioners
    a. If the licensed practitioner is not available within ten (10) minutes, a second attempt will be made via phone to the licensed practitioner. If there is no response within 15 minutes of the initial attempt, the supervising attending physician shall be contacted. If there is no response from the supervising attending physician after 15 minutes, then the on-duty Emergency Department Attending Physician shall be contacted. If the on-duty Emergency Department Attending Physician does not respond within 15 minutes, the Chief Medical Officer (CMO) shall be contacted.
    b. The licensed responsible registered nurse shall document notification including time, date, verification of "read back" and the name and title of the provider who received the critical test/ result.
    c. Final notification to a provider must occur within thirty (30) minutes from the time the critical test result became available.
3. Ambulatory Care chain of command to licensed practitioners
    a. If the ordering or covering licensed practitioner does not respond within ten (10) minutes, a second attempt to contact the licensed practitioner shall be made. If there is no response within 15 minutes of the initial attempt, the Clinic Medical Director shall be contacted.
    b. If there is no response from the Clinic Medical Director after 15 minutes, then the Ambulatory Care Chief Medical Officer (CMO) shall be contacted.
    c. After office hours and on weekends, if the on-call licensed practitioner fails to respond to their page within 15 minutes, the on-call satellite licensed practitioner shall be contacted.

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

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

1. **Radiology/Nuclear Medicine New or Unsuspected Critical Results**
    a. Carotid or vertebral artery dissection
    b. Ectopic pregnancy
    c. Hemoperitoneum
    d. Intracranial tumor, mass effect, midline shift
    e. Ischemic stroke, acute
    f. Testicular or ovarian torsion
    g. Upper or lower extremity deep venous thrombosis (DVT)
    h. Acute aortic dissection, rupture or leak
    i. Intracranial hemorrhage (traumatic, non-traumatic)

j. Pneumothorax
k. Pneumoperitoneum
l. Acute pulmonary embolism
m. Acute spinal cord compression
n. Placental Abruption

2. **Adult Echocardiogram Critical Results**
   a. Pericardial effusion, moderate to large with echocardiographic signs of tamponade
   b. Acute aortic dissection
   c. Myocardial rupture
   d. Ruptured chordae tendinae
   e. Valvular vegetation
   f. Visible abnormalities with prosthetic valves
   g. Large Ventricular septal defect (VSD) or Atrial septal defect (ASD)
   h. Myxomas or other cardiac tumors
   i. Atrial or ventricular thrombus
   j. Decrease in ejection fraction (EF) ≤ to 40% if new finding
   k. New wall motion abnormalities
   l. History of acute trauma associated with myocardial contusion
3. **Pediatric Echocardiogram Critical Results**
   a. Pericardial effusion, moderate to large with echocardiographic signs of tamponade
   b. Transposition of the great vessels
   c. Severe obstruction of the right/left ventricular inflow or outflow
   d. Hypoplastic left or right heart
   e. Severe coarctation of aorta
   f. Tetralogy of Fallot
   g. Severe right or left ventricular hypokinesis
4. **Electrocardiogram/Holter/Event monitor Critical Results (For patients not on a cardiac monitor)**
   a. Sustained ventricular tachycardia
   b. Sinus pause > 3 seconds
   c. New second or third degree atrioventricular (AV) block
   d. Acute localized ST segment elevation suggesting myocardial infarction (MI)

G. **Blood Bank Critical Results**

1. A positive antibody screen, a positive direct antiglobulin test, or a positive crossmatch on a patient receiving blood that was emergency-released.
2. A positive antibody screen or a positive direct antiglobulin test on a pre-surgery patient. The

physician will be told that the antibody could cause a delay in the availability of compatible blood.

3. Verify that a physician is aware of any suspected transfusion reaction.
4. Coombs positive infants on screening for hemolytic disease of the newborn.

H. **Microbiology Critical Results**

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

I. ~~**Pathology Results**~~

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

Time Sensitive Pathology Results

1. New pathologic diagnosis of cancer, excluding non-invasive skin cancer (basal cell and squamous cell). All newly identified cancer diagnoses shall be communicated promptly to the ordering provider (or appropriate covering provider) to support timely patient care planning. These results are considered **time-sensitive** and require **urgent notification** and documentation within two business days from the date of identification. Primary mode of communication will be messages through the electronic health record, but depending on clinical urgency, this may be supplemented with secure text messaging or a phone call.

Laboratory Critical Results

Test	Low Critical Result	High Critical Result
Hemoglobin	≤ 6.9 g/dL	≥ 23.0 g/dL
Hemoglobin if > 65 years old	< 6.9	

Test	Low Critical Result	High Critical Result
Hematocrit	≤ 18%	≥ 70%
Platelets	20 x 10^3/mcL	
White Blood Cell (WBCs)	≤1.0 x 10^3/mcL	≥50K
Neutrophil # (ANC or absolute neutrophil count)	< 0.5 x 10^3/mcL	
International normalization ratio (INR)		≥ 4.0
Partial Thromboplastin Time (PTT)		> 118 sec.
Anti-Xa, unfractionated	All results to be communicated to the responsible licensed caregiver.	
Anti-Xa, low molecular weight	All results to be communicated to the responsible licensed caregiver.	
Bilirubin - Newborn		> 18 mg/dL
Calcium	< 6.0 mg/dL	> 13.0 mg/dL
Fibrinogen	< 100	
Glucose	< 60 mg/dL	> 500 mg/dL
Glucose – Newborn	< 40 mg/dL	> 300 mg/dL
Lactic Acid		≥ 4
Phosphorus	< 1.0 mg/dL	
Potassium	< 2.9 mEq/L	> 5.7 mEq/L
Sodium	< 128 mEq/L	> 155 mEq/L
Magnesium	< 1 mEq/L	> 8 mEq/L
Troponin I, high-sensitivity		Females: ≥120 ng/L Males: ≥120 ng/L
Ethanol		≥ 400 mg/dL
Iron (less than 12 years)		> 350 mcg/dL
Thyroid stimulating hormone (TSH)		> 50 milli-International units/L
Cerebrospinal fluid (CSF) White Blood Cell count		≥ 10
Vancomycin trough, if > 1 month age		≥ 20 mcg/mL
Vancomycin trough, 0-1 month age		≥ 15 mcg/mL
Lead		≥ 3.5 mcg/mL

Respiratory Critical Values

Critical Value	Arterial Blood Gas (ABG)		Capillary Blood Gas (CBG)		Neonatal Arterial Blood Gas		Neonatal Capillary Blood Gas		Venous Blood Gas (VBG)		pH Cord
	Low	High	Low	High	Low	High	Low	High	Low	High	Low

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

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

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Attachments

Attachment A Ambulatory Care Critcial Values Phone Lines

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED, Medicine & Pediatrics	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/24/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/24/2025
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH	11/24/2025

VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*2/1/2013*
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Owner:	*Melody Donate: Stroke Coordinator*
Policy Area:	*Administrative - Patient Care*
References:	

100.226 Acute Stroke Management/Code Stroke

POLICY:

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

Scope of Responsibility:

Registered Nurse (RN)

Medical Provider

Lab Personnel
Radiology Personnel
Pharmacist

Definitions:

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

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

10. Visual Field defect

Types of Stroke:

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

Code Stroke:

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

Purpose:

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

Guidelines:

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

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

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

PROCEDURE:

Patients experiencing sudden stroke-like symptoms:

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

Patients last known well less than 4.5 hours consider for:

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

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

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

Patients last known well onset 24 hours or more:

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

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

Additional Considerations:

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

Stroke performance standards and quality measures:

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

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

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

K. Smoking cessation education/referral if indicated.

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

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

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

REFERENCES:

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Attachments

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED & Medicine	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/5/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/21/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/21/2025
Policy Owner	Melody Donate: Stroke Coordinator	10/21/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
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100.227 Telestroke Neurology Consultations

POLICY:

To establish a policy for the provision of telestroke/neurology consultations at Ventura County Medical Center/ Santa Paula Hospital. This policy will contribute to a standardized communication procedure for initiating an emergency telestroke/neurology consult for acute stroke/neurology patients.

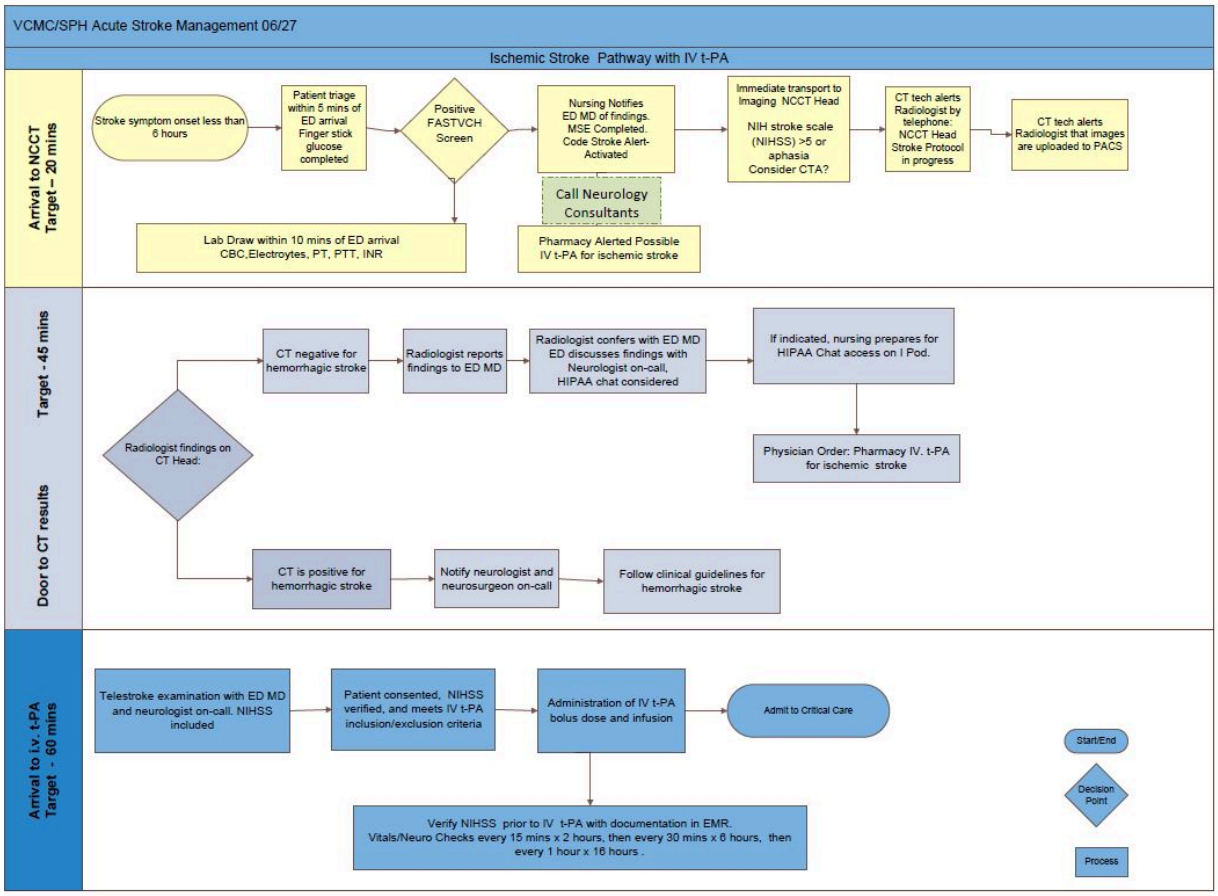
Telemedicine allows a link between a referring and consulting health care provider (i.e. neurology), thereby accommodating real-time assessment and the management of /stroke/neurology patients. With the use of a secure, HIPAA Compliant, 24/7 telemedicine portal, health providers are able to exchange patients' clinical findings and expedite interventions required in acute stroke management.

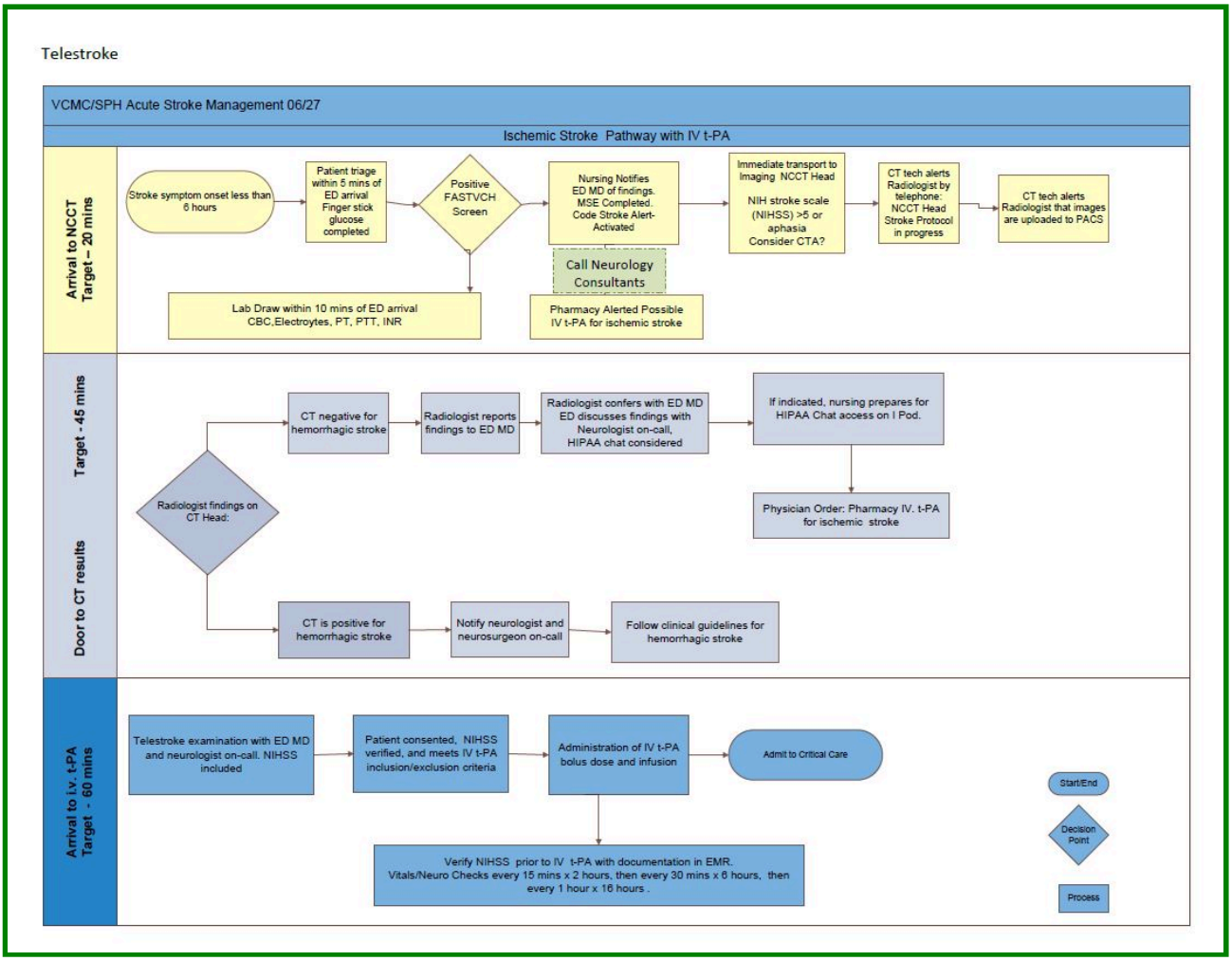
PROCEDURE:

a. Patient evaluated for symptoms consistent with acute stroke.
b. Work up and testing by Emergency Department (ED) health care provider (HCP)
c. ED HCP identifies need for telestroke/neurology consultation.
d. ED physician consults neurology through typical channels, discusses case.
e. Decision made that a telestroke/neurology consult might be valuable in specific case.
f. ED physician describes telestroke/neurology consult to patient and gets patient's verbal consent (written consent already obtained at registration includes telehealth).
g. Patient identifiers, name, medical record number, and date of birth entered into telemedicine portal by one of the following: medical office assistant, primary nurse, or health care provider.
h. Telestroke/neurology consult, audio and/or visual is initiated via telemedicine from ED physician to consulting neurologist.
i. ED nurse assists patient with the telestroke/neurology consult.
j. Telestroke/neurology consult concludes.
k. Consulting neurologist confers with ED physician on recommendations.
l. Clinical findings and decision-making from the telestroke/neurology consult documented and accessible in the electronic health record.

Appendix 1

Telestroke





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All revision dates: 9/27/2018, 7/1/2015

Attachments

Appendix 1

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED & Medicine	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
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	Melody Donate: Stroke Coordinator	11/25/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Melody Donate: Stroke Coordinator*
Policy Area:	*Administrative - Patient Care*
References:	

100.232 Code Stroke - Intravenous t-PA (Alteplase) Administration

POLICY:

To improve patient outcomes by establishing guidelines for the prompt treatment of strokes, including Ischemic stroke, with consideration of Intravenous t-PA (alteplase) for patients who present to Ventura County Medical Center (VCMC) or Santa Paula Hospital (SPH). A Registered Nurse (RN) from the Emergency Department (ED) or Intensive Care Unit (ICU) is responsible for the timely administration of t-PA. An RN may prepare intravenous t-PA (alteplase) at SPH if the pharmacy is closed.

PROCEDURE:

Critical Elements

Usual Dosage Range and Route:

1. Verify that the attending physician has reviewed the inclusion/exclusion criteria and consulted with VCMC Neurology attending and/or telemedicine neurology consultant.
2. Verify that administration will start within 4.5 hours of symptom onset or time last known well.
3. t-PA (alteplase) dose is 0.9 mg/kg to a maximum of 90 mg.
    - First 10% of calculated dose given as intravenous bolus dose.
    - Remaining 90% of calculated dose given in an infusion over 1 hour.
4. Document NIH Stroke Score before and after t-PA.
5. During t-PA infusion: Vital signs/neuro checks every 15 minutes for 2 hours, then every 30 minutes for 6 hours, then every hour for 16 hours (24 hours total).
6. If the patient's neurologic status declines during the t-PA infusion, stop infusion and page the Stroke Neurologist and/or attending physician (prepare for emergent CT as ordered).

Equipment:

1. One (1) vial of t-PA (alteplase)100 mg or two vials of t-PA (alteplase) 50 mg each
2. One (1) 10 mL syringe
3. Two (2) 19-guage needles

4. One (1) blunt cannula
5. One (1) mini-spike
6. Standard pump tubing
7. Intravenous infusion pump
8. 50 mL bag of 0.9% sodium chloride
9. Alcohol wipes
10. Two (2) patient labels
11. Two (2) medication labels

Administration Protocol:

1. It is appropriate to mix t-PA prior to CT even if not used: See below procedure for return t-PA that is mixed but not administered.
2. Verify the bolus dose, infusion dose and discard dose with the Stroke Neurologist or attending physician.
3. For patients at SPH, reconstitute the vial of t-PA with the supplied preservative-free water.
    a. Direct stream of water into lyophilized cake
    b. Swirl but DO NOT SHAKE (slight foaming is common)
    c. Let stand several minutes to allow large bubbles to dissipate
    d. Final concentration is 1 mg/mL
        - Using a 10 mL syringe, withdraw the bolus dose directly from the alteplase bottle. See attached dosing sheet (Attachment A) for bolus dose based on patient weight. Fill out patient/medication label with all required information (patient name, medication, dosage, time, date, RN Signature). Write “BOLUS DOSE” and affix label to syringe.
        - Enlist a second RN to complete an Independent Double Check of medication, bolus dose, infusion dose, infusion rate and discard dose.
        - Administer bolus dose via intravenous push method over one minute
        - Document administration of bolus dose on Medication Administration Record in EMR including time, dose, route, initials and signature.
        - Fill out patient/medication label with all required information (patient name, medication, dosage, time, date, RN signature). Write “INFUSION DOSE” and affix label to alteplase bottle.
        - Draw waste dose from bottle and verify waste amount by verifying with second RN completing an Independent Double Check.
        - Connect alteplase bottle to IV Pump tubing, carefully priming to avoid discarding any medication.
        - Verify patency of IV site and tubing connections.
        - Verify that all ordered blood work has been drawn and sent.
        - Attach noninvasive blood pressure cuff to other arm.
        - Set infusion pump rate according to dosing sheet and start infusion with a total infusion of 1 hour. Document infusion start time and name of ordering neurologist/attending physician.

- When pump alarms “no flow above”, there is still some t-PA left in the tubing which must be infused. Remove the IV Tubing connector from the alteplase bottle and attach it to a newly spiked 50 mL bag of 0.9% sodium chloride. Continue the infusion until the preset volume is completed.
- Document the end time of infusion. Expect to see significant volume remaining in 50 mL 0.9% sodium chloride bag.

4. For patients at VCMC, the Pharmacy will provide the reconstituted and labeled bolus dose and infusion dose of t-PA.
    - Enlist a second RN to complete an Independent Double Check of medication, bolus dose, infusion dose and infusion rate.
    - Administer bolus dose via intravenous push method over one minute.
    - Document administration of bolus dose on Medication Administration Record in EMR including time, dose, route, initials and signature.
    - Connect alteplase infusion dose to IV Pump tubing, carefully priming to avoid discarding any medication.
    - Verify patency of IV site and tubing connections.
    - Verify that all ordered blood work has been drawn and sent.
    - Attach noninvasive blood pressure cuff to other arm.
    - Set infusion pump rate according to dosing sheet and start infusion with a total infusion of one (1) hour. Document infusion start time and name of ordering neurologist/attending physician.
    - When pump alarms “no flow above”, there is still some t-PA left in the tubing which must be infused. Remove the IV Tubing connector from the alteplase bag and attach it to a newly spiked 50 mL bag of 0.9% sodium chloride. Continue the infusion until the preset volume is completed.
    - Document the end time of infusion. Expect to see significant volume remaining in 50 mL 0.9% sodium chloride bag.

Precautions and Side Effects:

1. Hemorrhage (gastrointestinal, genitourinary, catheter puncture site, intracranial, retroperitoneal, pericardial, gingival, epistaxis)
2. New ischemic stroke
3. Bruising
4. Anaphylaxis
5. Laryngeal edema
6. Rash, urticaria

Protocol for Returning Unused Medication:

When t-PA is mixed, but not administered, or the packaging is damaged, the reconstituted and unused t-PA shall be returned to the Pharmacy for credit from the drug manufacturer.

- If t-PA is removed from Pyxis but not reconstituted and the packaging is intact, place in unit bin for return to Pharmacy.
- If t-PA is reconstituted or the packaging is not intact and the medication was not used, place a patient

identification label on any container holding reconstituted drug (t-PA bottle, syringe, IV bag or IV tubing. Remove blunt cannula or needles from syringes). Place containers in a plastic bag if necessary to prevent spillage and place in Pharmacy bin on unit for return.

Monitoring and Care during after t-PA Infusion:

1. Vital signs and neurological checks:
    - Every 15 minutes for 2 hours after starting infusion
    - Then every 30 minutes for 6 hours
    - Then every 60 minutes for 16 hours
2. Monitor blood pressure closely and notify physician of systolic blood pressure above 180 mmHg and/or diastolic blood pressure above 105 mmHg.
3. Nothing by mouth (NPO) until swallow screen has been performed and patient passes the swallow screen.
4. Bed rest.
5. Strict recording of intake and output.
6. Avoid placement of nasogstric tubes, bladder catheters or intra-arterial lines within 24 hours of t-PA treatment.
7. Intramuscular injections should be avoided in the immediate 24 hours after completing t-PA infusion.
8. Follow physician order for follow-up non-contrast head CT scan at 24 hours post treatment before starting anticoagulants or antiplatelet drugs.

Competency to Respond to a Call for t-PA:

Competency of each nurse to be completed as follows:

1. Prior to responding to a Code Stroke, ED and ICU RNs will be oriented on the preparation and administration procedure for t-PA during a Code Stroke.
2. After the orientation, each RN will complete a skill competency, successfully demonstrating and understanding the procedure (see Attachment B).
3. t-PA competency will be re-evaluated yearly.

All revision dates: 3/19/2025, 3/8/2022, 8/12/2019

Attachments

- Attachment A: t-PA Dosing Chart for Stroke Patients
- Attachment B: t-PA Assessment and Competency

Approval Signatures

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

Step Description	Approver	Date
Medical Staff Committees: ED & Medicine	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/5/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/21/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/21/2025
Policy Owner	Melody Donate: Stroke Coordinator	10/21/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Administrative - Patient Care*
References:	

100.235 Patient-Controlled Analgesia (PCA)

POLICY:

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

PURPOSE:

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

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

BACKGROUND:

Indication:

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

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

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

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

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

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

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

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

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

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

PROCEDURE:

Equipment

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

B. Nasal cannula ETCO2 tubing

C. PCA Medication in standardized concentrations

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

Roles and Responsibilities

Licensed Practitioner (LP)

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

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

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

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

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

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

C. Remifentanil PCA

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

Pharmacy

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

A. PH.55 Medication Order Management

B. PH.88 Controlled Substances

Nursing

A. Set up

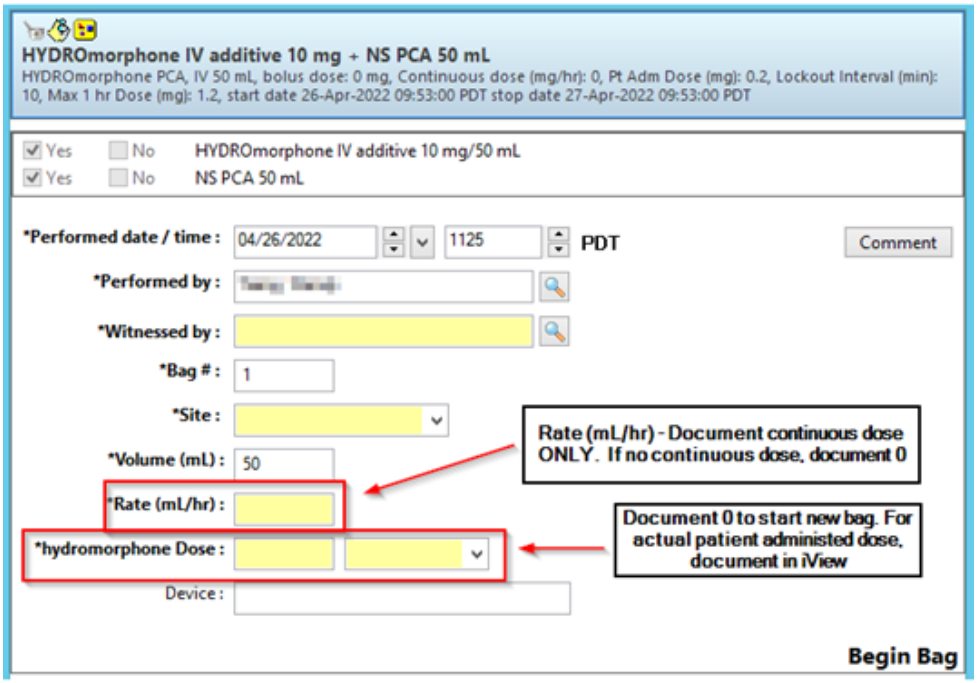
1. The nurse (RN) will call the charge nurse/nursing supervisor to inform them before starting a PCA.
2. The RN will obtain the necessary equipment.
3. The RN will assemble the PCA pump and ETCO2 module with nasal canula tubing attached.
4. The RN shall retrieve the PCA medication from the Automated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

B. Patient education

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

C. Administration

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



D. Monitoring and Documentation

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

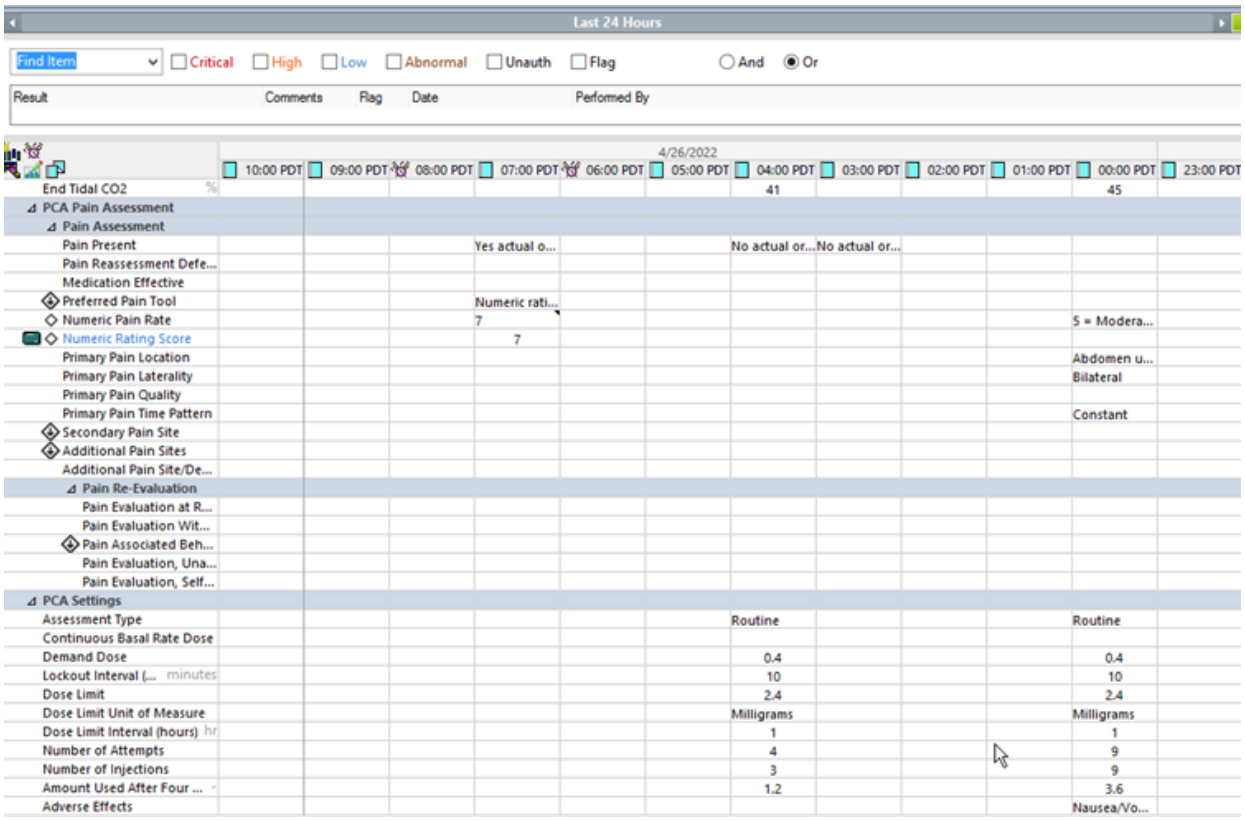
Table 4 Monitoring Frequencies based on Clinical Scenarios

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

1. The nurse shall notify the LP in the event the patient is over sedated and/or their clinical condition

deteriorates.

2. The nurse shall document total PCA amount infused in mg and total number of attempts at administration every 4 hours in the EHR (See screen shot below).



1. The nurse shall clear the medication history stored on the PCA every four (4) hours, at patient hand off, and at shift change.
2. Upon discontinuation of the PCA, any unused medication remaining in the syringe shall be wasted and documented in the Automated Dispensing Cabinet with a witness (see policy PH.88 Controlled Substances).

E. Management of Change in Condition

1. The nurse shall troubleshoot and provide interventions as indicated.
2. Emergent situations (e.g., severe respiratory depression: RR <7, SpO2<85%, ETCO2 ≥ 60 mmHg, or unresponsive patient)
   a. Stop the infusion. Do NOT leave the patient unattended.
   b. Immediately check the patient's O2 saturation, ETCO2, blood pressure, and heart rate.
   c. Notify the LP.
   d. Call a Rapid Response or CODE Blue if indicated.
   e. Assemble manual resuscitation bag/mask; attach to oxygen flowmeter; and turn flowmeter to greater than 15 liters; provide manual breaths if appropriate.
   f. Re-assess every hour x 12 hours: RR, O2 saturation, pain score, and level of consciousness.
   g. Check PCA pump for drug total and programmed settings once patient is stable.

3. Urgent situations
    a. Inadequate pain control
        i. Check the tubing connection for looseness and wetness.
        ii. Check the IV catheter site for patency and signs of infiltration.
        iii. Check the PCA pump.
    b. Respiratory depression
        i. Check the nasal cannula for disconnect from the flowmeter.
        ii. Check the PCA pump.
        iii. Assess lung capacity. Have the patient use an incentive spirometer if able.
    c. Somnolence
        i. Check the PCA pump settings and total dose infused.
        ii. Review level of consciousness trend over the past 24 hours and notify the LIP of declining condition.
    d. Severe itching unrelieved by ordered as needed (PRN) medication.
    e. Excessive nausea unrelieved by ordered PRN medication.
4. The PCA pump and ETCO2 module is programmed with PCA alarms and pause functionality (See Table 5). Once paused, the PCA pump will require clinical assessment to restart. That is, the PCA pump will not automatically resume regardless of the ETCO2 module readings.

Table 5. PCA pump and ETCO2 module settings

PCA Alarm setting	**Value**
EtCO2 High (mmHg)	60 mmHg
EtCO2 Low (mmHg)	10 mmHg
RR High (bpm)	48
RR Low (bpm)	7
No CO2	30 seconds (sec)
FiCO2 High (mmHg)	10
PCA Pause Protocol	**Value**
RR Lower Limit (bpm)	*5*
Initial value (bpm)	6

References

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

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Attachments

Attachment A: Alaris™ System with Guardrails™ Suite MX

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Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	1/5/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/12/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/12/2025
Policy Owner	Sul Jung: Associate Director of Pharmacy Services	12/12/2025

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

100.266 Penicillin VK Oral Desensitization Protocol

Purpose

There is a high prevalence of reported penicillin allergy. Penicillin desensitization may be required when there is no alternative antimicrobial therapy. This policy outlines the work flow for completing oral penicillin desensitization.

Procedure

- Consult Infectious Disease/Stewardship to discuss possible alternative therapies before initiating this protocol.
- If pregnant, consult Obstetric.
- Obtain informed consent.
- Admit patient to ICU.
- Patient MUST be full code for the desensitization procedure and thru the next full dose is administered. If patient is DNR/DNI, the primary team should discuss with the patient or legal guardian whether they are willing to reverse the status to FULL CODE for the duration of the procedure.
- If patient is taking a beta blocker, HOLD beta blocker for 24 hours before protocol is administered.
- Locate hospital approved Anaphylaxis Kit and Crash Cart. Review policy and procedures prior to starting desensitization protocol if needed.
- Obtain IV access.
- Must administer the therapeutic penicillin dose within 24 hours of desensitization or else the desensitization procedure must be repeated.

Monitoring Requirements

A. Monitor and document vital signs and oxygen saturation prior to the first dose, prior to each dose escalation, and every 5 minutes after each dose x 2 measurements.

B. Assess breath sounds prior to first dose, prior to each dose escalation, and upon complaints of respiratory symptoms including dyspnea or chest tightness.

C. Notify licensed ~~independent~~ provider (~~LIP~~LP) and hold subsequent dose if following occurs:

1. Neurological: Change in activity level, anxiety, “light headedness”, feeling “impending doom”, loss of consciousness
2. Oral: Pruritus of lips, tongue, and palate, oral “tingling”, edema of lips and tongue, metallic taste in the mouth

3. Respiratory: Nasal congestion or sneezing, rhinorrhea, tightness in the throat, hoarseness, “barky” cough, difficulty swallowing, dyspnea, chest tightness, wheezing, stridor, drop in oxygen saturation, cyanosis, respiratory distress
4. Cardiovascular: Tachycardia (increase > 15 beats/min), dysrhythmia, mild hypotension, bradycardia, profound hypotension, cardiac arrest
5. GI: Abdominal cramps or pain (colic), nausea, vomiting, diarrhea, loss of bowel control
6. Skin: Localized or generalized itching, flushing, hives, swelling (angioedema), morbilliform rash

D. If anaphylactic reaction occurs call LIP immediately and follow CPG.73 Acute management of Anaphylaxis.

Pharmacy Compounding Instruction

- Use Pharmacy Department Oral Compounding Recipe for Penicillin VK Oral Suspension – Desensitization Protocol
- Pharmacist must be present during compounding and verify/initial each step of dilution.

References

1. Workowski K, Bachmann L, Chan P, et al. Sexually Transmitted Infections Treatment Guidelines, 2021 MMWR Recomm Rep 2021; 70(4):1-187.

2. Wendel G, Stark B, Jamison R, et al. Penicillin allergy and desensitization in serious infections during pregnancy. New Eng J Med 1985; 12(19):1229-1232.

All revision dates: 10/28/2025, 12/14/2022

Attachments

Penicillin V ORAL Suspension Desensitization Protocol.pdf

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/5/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	12/5/2025
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Owner:	*Kelly Valenzona: Director, ICU/ DOU/Telemetry*
Policy Area:	*Administrative - Patient Care*
References:	

100.283 Education for Chemotherapy Patients

POLICY:

To provide guidelines for educating chemotherapy patients and their families.

PROCEDURE:

A. Assess patient's knowledge base regarding treatment plan and disease process.

B. Assess patient's and family members' readiness to learn.

C. Gather appropriate written material specific to each patient's treatment.

D. Educate patient and family.

E. Have patient verbalize understanding of information.

EQUIPMENT

Appropriate written material and resources.

DOCUMENTATION

Document on Patient/Family Education Teaching Record and electronic health record. Document patient education and educational materials given to patient. Also note patient response and stated understanding.

KEY POINTS

A. Patient and family education is essential in the care of patient receiving chemotherapy. The nurse plays a key role in providing information to patients and their families.

B. All patients receiving chemotherapy are educated regarding the administration and side effects of the drugs they are receiving, as well as the actions which may be taken to minimize the side effects of the drugs.

C. Patients will be educated on the 0-10 scale for Reporting Pain. To include intravenous site or any other unusual sensations (i.e., symptoms of an allergic reaction) during the administration of chemotherapy.

D. The educational process will vary depending on each patient's knowledge base, treatment plan and individualized learning needs. Keep in mind their readiness to learn, reading level and language.

E. Verbal, written and video information may be used in the teaching process.

F. It is vital that teaching is an ongoing process of assessing education needs, meeting those needs and reinforcing throughout the treatment period.

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

All revision dates: 9/3/2025, 7/13/2022, 8/1/2003, 12/1/2001, 12/1/1998, 12/1/1995

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	2/26/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/28/2025
Policy Owner	Kelly Johnson: Director, ICU/DOU/Telemetry	10/28/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services*
Policy Area:	*Administrative - Patient Care*
References:	

100.284 Whole Blood Transfusions

Purpose:

Whole blood (WB) has re-entered hospital practice as a lifesaving therapeutic procedure. Previously, component therapy has been mainstay. Whole blood has less compatibility across blood groups than group O RhD-negative red blood cells (RBC). As data has shown both efficacy and safety, prior restrictions on sex and age have been removed. As transfusions cross the health care enterprise, a single updated policy is needed for all to review.

Indications:

Whole blood may be indicated in life-threatening hemorrhage where oxygen-carrying capacity, non-labile coagulation factors, platelets, and volume expansion are needed. (AABB Circular of Information). Nationally, low Anti-A, low Anti-B titer Group O whole blood (LTOWB) may be used in life-threatening hemorrhage. Vitalant is the sole source of LTOWB for Ventura County Medical Center (VCMC), Vitalant defines and supplies low titer as 1:200. At VCMC, titer shall not be more than 1:256, and we allow maximum two (2) units of LTOWB to non-O recipients.

Background:

Fresh warm whole blood, directly from a live donor in the room has been the first type of successful transfusion. During World War II, blood split into components allowed the United States to send plasma to England with less concern about spoilage and blood type. Component blood became routine, but traumatic blood loss highlighted the need for the plasma components of blood. During the wars in Iraq and Afghanistan, fresh whole blood from fellow servicepeople was readily available. Donor blood types and infectious status were known. Benefits in survival over component replacement were notable. However, in the civilian population, trauma victims' blood types are unknown, and live volunteers are not readily available. Group O cold stored (not fresh) whole blood has been used for emergency management of traumatic hemorrhage. To offset potential hemolytic reaction, donors are chosen for low anti-A and anti-B titers.

A. **RISK:** LTOWB units are RhD-positive which may allow for anti-D antibodies developing in the recipient. Women of childbearing potential would have the risk of Hemolytic Disease of the Fetus and Newborn (HDFN)and kernicterus in future pregnancies and children.
    1. The risk can be mitigated with Rho(D) immune globulin (WinRho),
    2. The risk is counterbalanced by the life saving potential of Whole Blood at VCMC.

B. **RISK:** Units have anti-A and anti-B antibodies, compared to no antibodies in Group O RBC and only anti-B in Group A plasma. Those antibodies pose a risk of hemolysis of recipient blood in Group A, B and AB recipients. The low titers minimize the impact of this type of hemolysis.

C. **RISK**: Units are not leukoreduced. Leukoreduction has been shown to reduce the following risks:

   1. Recurrent febrile, non-hemolytic transfusion reaction (i.e., patients with a history of two or more febrile reactions to transfusion);
   2. Alloimmunization to leukocyte antigens that may complicate care of patients who undergo transplantation or chronic transfusion therapy (e.g., patients with aplastic anemia or hematologic malignancies); and
   3. Transmission of cytomegalovirus (CMV) to patients at increased risk of CMV disease (e.g., chemotherapy recipients for whom severe neutropenia is expected, recipients of hematopoietic progenitor cell replacement therapy, and CMV seronegative recipients of CMV seronegative solid organ grafts)

Donors: Vitalant manufactures whole blood from volunteer donors

1. Vitalant collects from selected Low titer Group O RhD-positive male, and female donors who have not been pregnant or have tested negative for anti-HLA antibodies.
2. Unit is tested for standard infectious disease markers but is not leukoreduced
3. RhD-positive blood is more abundant and does not impact the supply of true universal donor Group O RhD-negative RBC units.
4. The whole blood unit volume with anticoagulant is 500 mL.
5. Units expire in 21 days.
6. Delivery to VCMC Blood Bank is made weekly as small ration (2-5 units).

Blood Bank: Maintains inventory and dispenses whole blood units

1. To Ventura County Fire for prehospital transfusion,
2. Emergency release for Tier 1 activations,
3. Emergency release for massive transfusion protocol (MTP),
4. Emergency release for pediatric massive transfusion, and
5. As ordered by attending physician.
6. Inventory management is a continuous process.
7. Units used in hospital are retrospectively crossmatched.

Traumatic Hemorrhage: Adult, pediatrics, Code Yellow Tier 1

1. a. Massive Transfusion Protocol: T.02 details all aspects of MTP in adults. 2 units emergency release

Whole blood is the first line to mitigate the lethal triad. As in T.02 MTP will be initiated by the attending physician when immediate transfusion of six (6) or more units of Red Blood Cells is anticipated,

i. Adult women are also indicated for O+ whole blood. Those that are RhD-negative shall be informed by responsible physician of the risk of RhD alloimmunization because they received RhD-positive blood.

ii. Rho(D) immune globulin (WinRho and similar) is indicated to mitigate risk of alloimmunization against the RhD antigen. Given the volume transfused and the risk of anemia, that decision is managed by treating physician.

b. Pediatric Massive Transfusion Protocol T.15 : has been the latest expansion of use of Whole Blood as part of MTP. At VCMC, children greater than 12 months or 1 year old are eligible for LTOWB. MTP is considered when the immediate transfusion of 15 to 20 mL/kg of Red Blood Cells is anticipated. The Pediatric Intensivist should manage the MTP volumes, including LTOWB volumes. A unit of LTOWB is 500 mL.

i. At VCMC, Female children are also indicated for O+ whole blood. If they are RhD-negative, the patient and guardian shall be informed by responsible physician of the risk of RhD alloimmunization because they received RhD+ blood.

c. Tier 1 Trauma: T.01 Trauma Response Plan and T.13 Multiple Casualty Incident (MCI) Indicate blood products and blood bank personnel are to arrive for Trauma activations likely to need immediate surgical intervention. Many of those will also need emergency blood and are indicated for massive transfusion.

i. Adults and children older than 12 months or 1 year old and > 20 kg will have 2 units LTOWB delivered

ii. Children less than 12 months or 1 year old will have 1 (one) unit **group O RhD negative RBC** and 1 unit AB plasma delivered to trauma suite.

iii. Children >12 months or 1 year old but less than 20 kg will have 1 (one) unit LTOWB delivered

2. a. Post Partum Hemorrhage: Do NOT give LTOWB

a. OB.09 Code Maternity covers all obstetric hemorrhage.

i. Stage 2 (ongoing bleeding with <1500 mL loss) consideration for Emergency Release group O negative red blood cell (RBC).

ii. Stage 3 (>1500 mL blood loss) MTP is activated, and 2 units **group O RhD negative RBC** and 2 units AB plasma will be dispensed

3. Non-traumatic hemorrhage

a. It is acknowledged that LTOWB use outside of traumatic hemorrhage is practice specific

b. The AABB states, whenever life-threatening hemorrhage occurs and correction of oxygen carrying capacity, coagulopathy, and volume loss are paramount, LTWOB may be used. Variceal bleeding presents a counterweight as increased blood volume can lead to continued bleeding.

c. LTOWB would be used whenever the MTP is activated, except Code Maternity

d. LTOWB is allowed at physician discretion with post transfusion review by either Director of Blood

Bank, Blood Committee, or respective medical staff committee (e.g., Surgery, Medicine, Emergency Medicine).

i. Case may be forwarded to medical staff office for peer review

ii. This process avoids delaying transfusion

4. **Non-emergency Group O recipient**

a. LTOWB has a short shelf life and has expired at VCMC without use. One measure to avoid waste is to substitute for component therapy in non emergent patients. This use is outside of general indications

b. A patient that requires increase in oxygen carrying capacity and correction of coagulopathy/volume loss that is not life-threatening, would be a candidate.

i. For example, a patient ordered both RBC and plasma transfusion

ii. Use solely for volume expansion is contraindicated

c. Recipient must be Group O RhD-positive. Unit must be crossmatch compatible.

d. The blood bank would offer a LTOWB that is near expiration and above par level.

Pre-Hospital Transfusion

The Ventura County Fire Department (VCFD) provides pre-hospital LTOWB transfusion. As part of a California-wide state project, VCFD transfuses under specific parameters for traumatic and medical hemorrhage. Pre-hospital transfusion is thought to improve survival of the critically ill and injured. Those program, policies, and standard operating procedures are under VCFD governance. VCFD, VCMC, and Ventura County Local Emergency Medical Services Agency (VC LEMSA) collaborate to ensure compliance with national blood banking standards for pre-hospital transfusion.

A. VCMC is the Transfusion Service responsible for compatibility testing, ABO/Rh confirmatory testing of whole blood prior to issue, storage, selection and issuing of whole blood.

1. VCMC Blood Bank issues units to VCFD rigs on a planned basis. In addition, ad hoc/as needed dispensing when VCMC inventory is adequate and there is VCFD need.

2. This process is independent and separate from hospital to hospital transfer of blood products.

B. VCFD shall act as the Transfusion Administration Service (TAS) responsible for receiving and transmitting orders of blood for transfusion, transporting blood to the transfusion site, performing the transfusion, collecting and reporting outcomes, and ensuring the traceability of the unit is maintained.

1. Patients brought by VCFD to VCMC would have later outcomes readily available

2. Patients brought by VCFD to other regional hospitals, outcomes would depend on those hospitals' cooperation, which is standard

C. The unit given in pre-hospital transfusion would be one of the 2 (two) emergency release LTOWB units. No more than 2 units are given to the same recipient for the same incident.

D. An agreement between the two seeks to maintain units in emergency vehicles and at VCMC

1. Avoiding shortage at VCMC is primary over VCFD, but supply from Vitalant will be "right-sized" based on inventory/use

2. Avoiding expiration is managed by having units returned with a window before expiration (e.g. 7

days). Supply from Vitalant will again be right-sized.

E. VCFD and VCMC shall share data to monitor safety and efficacy of pre-hospital transfusion program and provide accurate information to the state-wide project. VC LEMSA provides oversight.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Blood Usage Committee	Francisco Bracho: MD	3/3/2026
Blood Usage Committee	Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services	2/5/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	1/23/2026
Laboratory Services Department	Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services	1/7/2026
Laboratory Services Department	Linda Lee: Medical Director, VCMC Blood Bank	12/16/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.035 Medi-Cal Enrollment Validation

POLICY:

This policy applies to the initial credentialing/appointment and re-credentialing/reappointment of practitioners under the County of Ventura's health plan delegation agreement to meet validation requirements for Medi-Cal payors ~~to meet validation requirements~~.

PROCEDURE(S):

Initial Credentialing/Appointment Process:

The Medical Staff Office will query the California Department of Health Care Services (DHCS) ~~Ordering, Referring and Prescribing (ORP) Enrollment Validation Lookup at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/orp and~~ Enrolled Medi-Cal Fee-for-Service (FFS) Providers list at https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers/resource/d652b210-ec3d-4a92-b7e0-e55c3dcbc7dc during the initial credentialing process.

Practitioners not enrolled in Medi-Cal will be enrolled by the County's enrollment vendor. Practitioners currently enrolled in Medi-Cal will be linked to the County during the enrollment process.

Re-credentialing/Reappointment Process:

The Medical Staff Office will validate continued enrollment during the re-credentialing/reappointment process.

Documentation:

Validation evidence will be maintained in the electronic practitioner credentialing file. The documentation will include the date and time of the verification, the user name of the team member completing the verification, and must be completed within ~~180~~120 days of the credentialing/appointment or re-credentialing/reappointment approval date.

REFERENCE(S):

Gold Coast Health Plan Practitioner Credentialing Policy QI-025

DHCS All Plan Letter (APL) 22-013

DHCS All Plan Letter 22-013 FAQ

All revision dates: 2/24/2026, 9/30/2024

Attachments

- DHCS All Plan Letter 22-013
- DHCS All Plan Letter 22-013 FAQ
- Gold Coast Health Plan Practitioner Credentialing Policy QI-025

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	2/27/2026
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	2/27/2026
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	2/24/2026

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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.037 Medical Staff Initial Credentialing/ Appointment & Recredentialing/Reappointment Guidelines

Purpose:

To establish a mechanism for obtaining, verifying and assessing relevant information to validate qualifications including but not limited to individual character, clinical competence, training, experience and judgment of practitioners eligible for membership and/or privileges within the Ventura County Health Care System.

Policy Statement:

It is the policy of the Ventura County Health Care System to ensure practitioners eligible for medical staff membership and/or clinical privileges (credentialing) meet the minimum requirements outlined in the Bylaws, Rules & Regulations, Department Rules & Regulations, and established privileging criteria prior to approval by the governing board. All applications will be processed and reviewed in a non-discriminatory manner as outlined in policy 102.034 Non-Discriminatory Credentialing & Recredentialing Process.

Procedure:

Initial Credentialing/Appointment and Recredentialing/Reappointment

Upon receipt of a complete electronic application, including all supporting documentation, the Medical Staff Administration credentialing team will review the application, including the attestation responses and will begin the verification process. The applicant will be notified in writing of any missing information, clarifications or discrepancies, and the applicant will have 14 days to provide a written response or correction.

Processing and Verification:

The following items will be primary source verified (PSV) or verified via the approved designated equivalent sources (refer to Attachment A for a list of links). Verifications must be completed within 120 days of the board approval date, expiring verifications will be reverified. Exceptions to the 120-day requirement include the application, attestation and verifications of education and training, work history, and background screening which must be completed within 180 days of the board approval date.

A. **Practitioner Identification (initial application):** Face to face or via video meeting and a valid driver's license/government issued identification. A valid driver's license or state issued identification is required for health plan enrollments.

B. **Criminal Background Check (initial application):** Verifications will be completed via PreCheck.

C. **Education and Training (initial and any additional training completed since last appointment or if required for requests for additional privilege):** Education and training will be verified directly with the program, American Medical Association (AMA) Profiles, American Osteopathic Association (AOA) Profile, National Student Clearinghouse, and Educational Commission for Foreign Medical Graduates (ECFMG) as appropriate.

D. **Medical/Professional License (initial/reappointment/license renewal/requests for additional privileges):** All current and previously held state licenses will be verified through the state licensing agencies and reviewed for disciplinary actions.

E. **Drug Enforcement Administration (DEA) Registration and out of state Controlled Dangerous Substance Certifications (CDS) (initial/reappointment/renewal of registration):** Verified via the DEA, issuing state CDS, or applicable state Department of Public Safety.

F. **Board Certification(initial/reappointment/renewal):** Verified through the issuing board, American Board of Medical Specialties (ABMS) CertiFACTS report, or AOA Profile, Nurse Practitioners (NP) are verified directly through the issuing board, and Physician Assistants (PA) via the National Commission on Certification of Physician Assistants.

G. **Peer/Professional References (initial credentialing/appointment, recredentialing/reappointment, request for additional privileges):** A minimum of 3 peer references will be obtained at initial credentialing/appointment, and a minimum of 2 peer references will be obtained at recredentialing/ reappointment.

H. **Affiliations, practice/work/employment history, including military history (initial credentialing/ appointment, recredentialing/reappointment):** The credentialing team will query the reported hospital, clinic, employer or other health care entity directly. If the entity uses NAMSS PASS, this will be accepted as PSV. At the initial appointment the credentialing team will query affiliations from completion of professional training to current. At reappointment the credentialing team will query current affiliations and any new affiliations since the last appointment. Applicants applying for tele-medicine privileges with excessive affiliations a sampling approved by the Credentials Committee will be verified.

I. **National Practitioner Database (NPDB) (initial credentialing/appointment, recredentialing/ reappointment, request for additional privileges):** All practitioners will be enrolled in the NPDB Continuous Query for ongoing monitoring and notifications. Practitioners are automatically re-enrolled annually. The reports will be reviewed at initial credentialing/appointment, recredentialing/reappointment, requests for additional privileges, and at any time a notification is received from the NPDB of activity related to the enrolled practitioner.

J. **History of Malpractice Claims (initial credentialing/appointment, recredentialing/reappointment):** The credentialing team will query the malpractice carrier(s) directly for the practitioner's claims history report. In the absence of a response, the NPDB report may be used to document the claims history. A minimum of 10 years will be reviewed.

K. **Department of Health & Human Services, Office of Inspector General (OIG) (initial credentialing/ appointment, recredentialing/reappointment, monthly):** Medicare/Medicaid exclusions and sanctions verified by querying the OIG website.

L. **Medi-Cal Provider Suspended and Ineligible List (initial credentialing/appointment, recredentialing/reappointment, monthly):** Verified directly through the most current published list of suspended and ineligible providers posted on the Medi-Cal website.

M. **Medicare Opt-Out Reports (initial credentialing/appointment, recredentialing/reappointment, monthly):** Verified by querying the CMS Opt-Out website.

N. **U.S. General Service Administration Exclusion List (initial credentialing/appointment, recredentialing/reappointment, monthly):** Verified by querying the Sam.gov exclusions website.

O. **Social Security Administrations' Death Master File (initial credentialing/appointment, recredentialing/reappointment, monthly):** Verified by querying the National Technical Information Service (NTIS).

P. **Medi-Cal Enrollment Validation (initial credentialing/appointment, recredentialing/reappointment):** Verified by querying the Department of Health Care Services (DHCS) ordering, referring and prescribing (ORP) enrollment validation look up and the enrollment Medi-Cal Fee-for-service (FFS) providers list, refer to policy 102.035 Medi-Cal Enrollment Validation.

Q. **Time gaps (initial credentialing/appointment, recredentialing/reappointment if identified):** Any time periods or gaps in training or professional work history that have occurred since graduation from medical/ professional school greater than 3 months must be reported and explained in full on the application and must be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences, or activities. For current gaps in professional work history greater than 1 year refer to policy 102.022 Return to Practice Plan.

Additional Credentialing Information:

A. **Resume/curriculum vitae (CV):** The CV will be reviewed during the application review process and compared to the electronic application for accuracy in work history, gaps, or discrepancies. Review of the CV is not intended to be used as a substitute for PSV of work history.

B. **Quality Data (recredentialing/reappointment):** The practitioner's ongoing professional practice evaluation (OPPE) data is reviewed and factored into the recredentialing/reappointment decisions. Quality data that does not meet the established thresholds for OPPE will trigger a focused professional practice evaluation (FPPE), which may include peer review.

C. **Patient Complaints/Grievances (recredentialing/reappointment/ongoing):** Complaints/grievances from patients and staff are included in the practitioner's ongoing professional practice data and reviewed every 6 months, and factored into the recredentialing/reappointment decisions. Complaints/grievances related to quality of care may be referred for peer review. For patient complaints regarding practitioner office sites please refer to AC.27 Patient Complaints at Clinic Facilities.

D. **Continuing Medical Education (CME)/Continuing Education (CE) (initial credentialing/appointment, recredentialing/reappointment):** The credentialing team will review documentation of the required continuing education, including any privilege specific requirements.

E. **Health Status Requirements:** According to hospital policy EHS.02 Pre-employment and Ongoing Staff Health Requirements.

F. **Additional Privileging or Practice Requirements (initial/reappointment/renewal of registration, license or certification):** Examples include but not limited to x-ray/fluouroscopy certification, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Advanced Trauma Life Support (ATLS), privilege/program specific training certificates or clinical activity reports. If the additional requirements has a mechanism for PSV, the source will be queried.

Requests for application status/updates:

Applicants may request in writing the status of their application. The credentialing team will provide a written response within 7 business days and the response will include a list of outstanding queries or missing information necessary to complete the credentialing process.

Application Review and Recommendation Process:

Initial:

Physicians: Credentials Committee, Department Committee, Medical Executive Committee, and Governing Board.

Allied Health Professionals (AHP): Interdisciplinary Practices Committee, Department Committee, Medical Executive Committee, and Governing Board.

Renewal:

Physicians/AHPs: Department Committee, Medical Executive Committee, and Governing Board.

Notification of Credentialing Decision:

Applicants will be notified in writing of appointment/reappointment decisions within 30 days of approval.

Adverse Recommendations:

Applicants to the Medical Staff shall be, if applicable, entitled to the procedural rights outlined in the Medical Staff Bylaws Article 14. Allied Health Professionals refer to policy 102.033 Allied Health Professionals.

Requirements:

A practitioner who does not meet the general and/or basic qualifications outlined in the Medical Staff Bylaws, or privileging requirements is ineligible to apply and the application shall not be accepted. There is no obligation to release an application to a practitioner who does not meet the requirements. If it is identified after the application has been accepted or during the credentialing process that the applicant failed to meet these requirements, the practitioner will have the opportunity to submit additional information or documentation to support their qualifications within 14 days of the notification. If the applicant still does not meet the criteria, the credentialing process will be discontinued, considered withdrawn, and reported to the Credentials Committee or Interdisciplinary Practices Committee (APPs).

Definitions/Clarifications:

Credentials Committee: A multidisciplinary peer review committee responsible for the review and recommendations of physician initial credentialing/appointment applications. Accountable to the Medical Executive Committee and Governing Board.

Interdisciplinary Practices Committee (IPC): A California required (Cal. Code Regs. Tit. 22, § 70706 and 70706.1) multidisciplinary peer review credentials committee responsible for review and recommendations of advanced practice providers (APP) initial credentialing/appointment applications. Accountable to the Medical Executive Committee and Governing Board.

Medical Executive Committee (MEC): A multidisciplinary peer review committee responsible for all medical staff activities, including the approval of credential files. The MEC serves as the credentials committee for recredentialing/reappointment files. Accountable to the Governing Board.

Complete application: All required electronic application fields are completed and all required supporting documents have been submitted.

Completed application: All credentialing queries have been received, and no further information has been requested by the Credentials Committee or any other approval body.

In writing/written response: may include email correspondence.

Attachments and Additional Document References:

A. Health Plan Audit Ongoing Monitoring Websites 2024

B. 102.029 Ongoing Monitoring and Interventions

C. 102.031 Confidentiality of Medical Staff/Allied Health Professional Staff Records

D. 102.027 Medical Staff Credentialing Information Integrity (CII) and Database User Access

E. Medical Staff Bylaws

F. Medical Staff Rules & Regulations

All revision dates: 2/11/2026, 6/10/2025

Attachments

Ongoing_Monitoring_Websites_June_20-2024_.cleaned (1) (1).pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	2/24/2026
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	2/11/2026

VENTURA COUNTY
HEALTH CARE AGENCY

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

108.000 Plan for Provision of Nursing Care

POLICY:

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

PROCEDURE:

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

SCOPE OF NURSING SERVICE:

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

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

PROCEDURE:

The Nursing department consists of an Administrative Function, Clinical Function, Educational Function, and an Infection Control Function, which are under the jurisdiction of the CNO. The CNO is a Registered Nurse licensed in the state of California with appropriate education and experience. The CNO is employed on a full

time basis and reports to the Hospital Administrator. The CNO is accountable for providing an optimal level of patient care in an environment conducive to professional practice. The CNO will oversee the provision of nursing care that is in compliance with requirements of Title 22, Joint Commission Standards and other regulatory agencies. The CNO is responsible to the Chief Executive Officer for meeting the staffing standards of the Nursing Units.

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

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

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

MISSION

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

VISION

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

PHILOSOPHY

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

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

STAFFING

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

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

PERFORMANCE IMPROVEMENT

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

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

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

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

NURSING STANDARDS

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

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

Attachments

No Attachments

Approval Signatures

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/24/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/24/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/24/2026

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.01 Cancer Program Goals and Objectives

POLICY:

The major goal of the Cancer program at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) is to improve its cancer control through use of the following methods:

- Cancer prevention.
- Early diagnosis.
- Evaluation of pre-treatment work-ups
- Accurate staging of the disease.
- Evaluation of treatment against national standards.
- Availability of rehabilitation programs.
- Surveillance of recurrent disease and multiple primaries.
- Enhancement of care for the terminally ill patient.
- Contribute accurate data to the:

1. National Cancer Institue (NCI) Surveillance Epidemiology and End Results (SEER) population-based cancer registry.
2. State of California Cancer Registry.
3. Regional Cancer Surveillance Program Cancer Registry.
4. National Cancer Data Base.
5. American College of Surgeons Commission on Cancer quality of cancer patient care studies and other projects as approved by the Cancer Committee and Hospital Administration.
6. Medical staff and Hospital Administration for statistical studies and reports as requested and approved.

CANCER COMMITTEE OBJECTIVES AND RESPONSIBILITIES:

- Develop and evaluate the annual goals and objectives for the clinical, educational, programmatic activities related to cancer.
- Promote a coordinated, multidisciplinary approach to patient management.
- Ensure that educational and consultative cancer conferences cover all major sites and related issues.
- Assure that an active supportive care system is in place for patients with cancer, their families, and oncology staff.
- Monitor quality management and improvement through completion of quality management studies that

focus on quality, access to care and outcomes.
- Promote clinical research
- Supervise the cancer registry, and ensure accurate and timely abstracting, staging, and follow-up reporting.
- Perform quality control for the cancer registry.
- Encourage data usage and accurate data reporting.
- Cancer Committee analyzes patient outcomes and disseminates the results of the analysis.
- Uphold medical ethical standards.

CANCER REGISTRY OBJECTIVES AND RESPONSIBILITIES:

- Meet and maintain the standards defined in Facility Standards for Oncology Registry Entry(STORE) for collecting and analyzing data on all reportable cancer cases seen at VCMC/SPH.
- Ensure that cancer registry is staffed by personnel who are trained and knowledgeable in cancer registry operations including at least one oncology data specialist (ODS)
- Ensure that the maximum abstracting delay is six months and is calculated from the date of initial cancer diagnosis or first cancer admission to the time the data are available for analysis.
- Maintain patient and hospital staff confidentiality as established by the cancer committee and legally required.
- Collect the required data set, and utilize the data definitions and codes in STORE.
- Obtains systematic follow-up information for all analytic patients in the registry and ensure the required follow-up rates are met,
- Submit registry data to the National Cancer Data Base (NCDB) and Cancer Committee approved Commission on Cancer patient care evaluation studies.
- Provide registry data and information to the Medical Staff, Cancer Committee, Administration, other hospital health care professionals in the form of special studies, cancer conference presentations, and quality improvement studies.
- Comply with SEER and State of California Cancer Registry data submission requirements.

Reference:

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

All revision dates: 2/14/2024, 3/9/2021, 3/21/2019, 4/28/2016

Attachments

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Cancer Committee	Jennifer Ferrick: Cancer Program Coordinator	2/10/2026
Cancer Program Manager	Jennifer Ferrick: Cancer Program Coordinator	2/6/2026

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Policy Area:	*Cancer Program*
References:	

CA.06 Cancer Registry Abstracting

POLICY:

Reportable cases must be abstracted within six months from their date of diagnosis if they are analytic cases, or six months from the date they were first admitted to Ventura County Medical Center/Santa Paula Hospital as either an inpatient or outpatient if they are non-analytic cases. Abstract information is entered and maintained using the CNExT software application. ~~Both the software and database are stored in the Cancer Registry computer network located in the Cancer Registry office.~~ If a patient has multiple primaries, a separate abstract must be prepared for each primary. The ~~Cancer Committee~~Lead ODS0C or Quality Control Coordinator must review and approve any changes in abstract form and/or content.

PROCEDURE:

A. Data items that must be included in each CNExT abstract and are required by the Commission on Cancer, the State of California Cancer Registry and/or SEER:

1. Accession Number
2. Sequence Number
3. Medical Record Number
4. Social Security Number
5. Military Medical Record Number Suffix
6. Last Name
7. First name
8. Middle Name (Middle Initial)
9. Patient Address (Number and Street) at Diagnosis
10. Patient Address (Number and Street) at Diagnosis-Supplemental
11. City/Town at Diagnosis (City or Town)
12. State at Diagnosis (State)
13. Postal Code at Diagnosis(Zip Code)
14. County Code at Diagnosis
15. Patient Address (Number and Street) - Current

16. Patient Address (Number and Street) - Current Supplemental
17. City/Town Current
18. State- Current
19. Patient Identification (continued)
20. Postal Code-Current (Zip Code)
21. Telephone
22. Place of Birth
23. Date of Birth
24. Age at Diagnosis
25. Race
26. Spanish Origin
27. Sex
28. Primary Payer at Diagnosis
29. Comorbidities and Complications
30. Following Physician (Follow-up Physician)
31. Primary Surgeon
32. Physician #3 (Other Physician)
33. Physician #4 (Other Physician)
34. Cancer Identification
35. Class of Case
36. Facility referred From
37. Facility Referred to
38. Date of First Contact
39. Date of Initial Diagnosis
40. Primary Site
41. Laterality
42. Histology
43. Behavior Code
44. Grade/Differentiation
45. Diagnostic Conformation
46. Tumor Size
47. Regional Lymph Nodes Examined
48. Regional Lymph Nodes Positive
49. Stage of Disease at Diagnosis
50. Date of Surgical Diagnostic and Staging Procedure

51. Surgical Diagnostic and Staging Procedure
52. Surgical Diagnostic and Staging Procedure at This Facility
53. Clinical T ~~2018~~
54. Clinical N ~~2018~~
55. Clinical M ~~2018~~
56. Clinical Stage Group ~~2018~~
57. Clinical Stage (Prefix/Suffix) Descriptor
58. Staged By (Clinical Stage)
59. Pathologic T ~~2018~~
60. Pathologic N ~~2018~~
61. Pathologic M ~~2018~~
62. Pathologic Stage Group ~~2018~~
63. Pathologic Stage (Prefix/Suffix) Descriptor
64. Staged By (Pathologic Stage)
65. SEER Summary Stage ~~2000~~
66. Mets at Diagnosis- Distant Lymph Nodes
67. Mets at Diagnosis - Bone
68. Mets at Diagnosis - Brain
69. Mets at Diagnosis - Liver
70. Mets at Diagnosis - Lung
71. Mets at Diagnosis - Other
72. Site Specific Data Items
73. TNM, Mixed Stage AJCC T Code
74. TNM Mixed Stage T Descriptor
75. TNM Mixed Stage AJCC N Code
76. TNM Mixed Stage N Descriptor
77. TNM Mixed Stage AJCC M code
78. TNM Mixed Stage AJCC M Descriptor
79. TNM, Mixed Stage AJCC Stage Group

    ~~Derived SS1997~~

    ~~Derived SS2000~~
80. First Course of Treatment
81. Date of First Course of Treatment
82. Date of First Surgical Procedure
83. Date of Most Definitive Surgical Resection of Primary Site

84. Surgical Procedure of Primary Site
85. Surgical Procedure of Primary Site at This Facility
86. Surgical Margins of the Primary Site
87. Scope of Regional Lymph Node Surgery
88. Scope of Regional Lymph Node Surgery at This Facility
89. Surgical Procedure/Other Site
90. Surgical Procedure/Other Site at This Facility
91. Date of Surgical Discharge
92. Readmission to the Same Hospital within 30 days of Surgical Discharge
93. reason for No Surgery of Primary Site
94. Date Radiation Started
95. Location of Radiation Treatment
96. Radiation Treatment Volume
97. Regional Treatment Modality
98. Regional Dose: cGy
99. Boost Treatment Modality
100. Boost Dose: cGy
101. Number of Treatments to This Volume
102. Radiation/Surgery Sequence
103. Date Radiation Ended
104. Reason for No Radiation
105. Date systemic Therapy Started
106. Chemotherapy
107. Chemotherapy at This Facility
108. Hormone Therapy (Hormone/Steroid Therapy)
109. Hormone Therapy at This Facility (Hormone/Steroid Therapy)
110. Immunotherapy
111. Immunotherapy at This Facility
112. Hematologic Transplant and Endocrine Procedures
113. Date Other Treatment Started
114. Other Treatment
115. Other Treatment at This Facility
116. Palliative Care
117. Palliative Care at This Facility
118. Outcomes

119. Date of First Recurrence
120. Type of First Recurrence
121. Date of last Contact of Death
122. Vital Status
123. Cancer Status
124. Following Registry
125. Follow-Up Source
126. Next Follow-Up Source (Next Follow-up Method)
127. Case Administration
128. Abstracted By
129. Facility Identification Number (FIN)
130. Archive FIN
131. Commission on Cancer (CoC) Coding System- Current

B. Additional data items that must be included per Cancer Committee request and approval are:
   1. Current oncology indicators defined and approved by Cancer Committee.
   2. Additional site-specific information currently requested and approved by the Cancer Committee.

C. Coding and Staging Manuals:
   Coding and staging manuals used to abstract include:
   1. Surveillance Epidemiology and End results (SEER) Summary Staging Guide
   2. American Joint Committee on Cancer (AJCC) TNM Staging Guide, 8th/9th Edition
   3. International Classification of Diseases for Oncology, 3rd Edition, ICD-O 3.2/International Classification of Diseases, 4th Edition (ICD-O-4)
   4. Standards for Oncology Registry Entry (STORE)
   5. SEER extent of Disease ~~2018~~ Coding and Coding Instructions~~, 3rd Edition~~

D. Detailed definitions for the data items can be found in (STORE)

E. The specific procedures and codes for entering data items into CNExT can be found in Standards for Oncology Registry Entry(STORE)

F. The following staging systems are used for all primaries:
   1. SEER Summary Stage, ~~version~~ v3.~~1~~3

      ~~SEER Extent of Disease, 3rd Edition~~
   2. AJCC Manual for Cancer Staging, 8th/9th Edition

~~In addition to the above, the following site specific staging systems are also used:~~

~~1. Female genital cancer : International Federation of Gynecology and Obstetrics (FIGO) staging system~~

~~2. Colorectal cancer: Duke's Staging system~~

~~3. Prostate Cancer: Urologists prostate staging system.~~

G. If the entire first course of treatment is not documented in the patient chart, a "first course of treatment summary" letter must be sent to the appropriate physician(s) and/or facility to obtain this information. Complete first course treatment information must be entered into the abstract.

Reference:

Standards for Oncology Registry Entry

All revision dates: 2/5/2026, 1/12/2024, 2/9/2021, 4/24/2018, 4/28/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Jennifer Ferrick: Cancer Program Coordinator	2/5/2026
Cancer Program Manager	Jennifer Ferrick: Cancer Program Coordinator	2/5/2026

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area:	*Cancer Program*
References:	

CA.08 Cancer Registry Quality Control Procedures

POLICY:

To ensure compliance with the Commission on Cancer Standard 6.1 as follows:

High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival. Each calendar year, the cancer committee implements a policy and procedure to annually evaluate the quality of cancer registry data and activity, including procedures to monitor and evaluate each required control component.

PROCEDURE:

The Cancer Committee will conduct a quality review of Cancer Registry data by reviewing abstracts with comparison to Medical Records. The Cancer Committee shall designate a physician, physician resident, fellow, advanced practice nurse(APN), physicians assistant (PA) or an Oncology Data Specialist (ODS) to perform Quality Activities of the hospital's analytic cases (Class 10's and 20's). A non-Committee physician can also be involved in Quality Improvement activities depending upon the need.

Accuracy rates:

The accuracy rates have been approved by the Cancer Committee as follows:

CASEFINDING	90%
ACCURACY OF DATA COLLECTION (ABSTRACTING: Class of case, primary site, date of diagnosis, histology, residual tumor, first course of treatment, follow-up information, first recurrence and cancer status, percentage of information coded as unknown)	97%
FOLLOW-UP (The documented follow-up contacts and/or physicians are correct)	~~100%~~90%

Quality review of randomly selected abstracts for the top five (5) sites in the cancer database will be compared to the documentation in the medical record.

A minimum of 10% of all analytic cases will be reviewed annually by the designated member of the Cancer Committee.

The cancer registrar randomly selects 10% of the quarterly abstracted cases based on the analytic caseload.

For the cases selected, a CoC Quality Control (QC) form containing the abstracted data will be printed using CNExT software. The abstract will be provided to the designated reviewer.

REVIEW BY COORDINATOR OF QUALITY OF CANCER REGISTRY DATA:

The Coordinator will conduct periodic quality review of the cases abstracted by the staffed Cancer Registrar and outside consultants.

REPORTING TO CANCER COMMITTEE:

The Coordinator of Cancer Registry Data Quality will report the audit results at least annually to the Cancer Committee.

Reference:

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

All revision dates: 2/5/2026, 2/14/2024, 3/9/2021, 2/12/2020, 4/28/2016

Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Jennifer Ferrick: Cancer Program Coordinator	2/5/2026
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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.10 Cancer Registry Conferences

POLICY:

It is the policy of Ventura County Medical Center/Santa Paula Hospital to have a multi-disciplinary team approach to planning, providing and evaluating the care of patients with cancer. To this end, Cancer Conferences and Committee meetings are held on a regular basis.

PROCEDURE:

Cancer Committee:

The Cancer Committee is a standing committee which reports to the Medical Executive Committee. Committee minutes are maintained and meetings scheduled by the Cancer Registrar and maintain legal confidentiality. The Cancer Committee meets quarterly and is the leadership component of the Cancer Program. It is multidisciplinary in nature, and includes representatives from all the medical specialties and allied health professionals. The Committee's physician composition includes at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology, as well as the cancer liaison physician and other specialty physicians as appropriate. Non-physician members must include administration, nursing, social services, ~~Cancer Registry~~cancer registry, clinical research, and other department/service representatives, as appropriate.

A. Cancer Committee responsibilities include:

1. Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.
2. Promote a coordinated, multidisciplinary approach to patient management.
3. Ensure that educational and consultative cancer conferences cover all the major sites and related issues.
4. Assure that an active supportive care system is in place for patients with cancer, their families, and oncology staff.
5. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes.
6. Promote clinical research.
7. Develop and monitor the Cancer Survivorship Program

8. Supervise the cancer registry, and ensure accurate and timely abstracting, staging, and follow-up reporting.
9. Perform quality control for the cancer registry.
10. Encourage data usage and accurate data reporting.
11. Uphold medical ethical standards.

Cancer Conferences (Tumor Boards):

1. Multidisciplinary Tumor Board Cancer Conferences are held the first, second and third Monday's each month. The first and third Tumor Board Cancer Conference meetings are dedicated to colon/rectal cases and the second Monday meeting is dedicated to all other cancer cases.
2. ~~Multidisciplinary Tumor Board Cancer Conferences~~A minimum of two cases are ~~held the first and third Monday's~~presented at each ~~month. A minimum of two cases are presented at each~~ meeting for consultative and educational purposes.
3. The Cancer Committee establishes the Multidisciplinary attendance requirements to include physician representatives from Medical Oncology, General Surgery, Diagnostic Radiology, Pathology, Radiation Oncology, and other appropriate disciplines, attend/participate in this activity. These physician specialties are expected to attend at least 80% of the meetings each year.
4. The number of cases presented is a minimum of 15% of the annual analytic case load with at least 80% of the presented cases being prospective. Prospective cases include:
    - Newly diagnosed and treatment not yet initiated
    - Newly diagnoses and treatment initiated, but discussion of additional treatment is needed.
    - Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed.
    - Previously diagnosed, and discussion of supportive or palliative care is needed.
5. The Cancer Conference Coordinator monitors discussion of the required areas:
    - Discussion of clinical and/or pathological stage
    - Treatment planning using evidence-based national guidelines
    - Options and eligibility for research study enrollment
    - Options and eligibility for genetic testing
    - Options and eligibility for supportive care services
6. Purely didactic lectures are limited to 25 percent of conference frequency. ~~Copies of the agenda and sign-in sheets are kept in the Cancer Registry.~~
7. Copies of the agenda and sign-in sheets are kept in the Cancer Program Coordinator's office.
8. The Cancer Conference Coordinator must evaluate and report annually to the Cancer Committee the following required elements 1) Cancer case conference frequency 2) Multidisciplinary physician specialty attendance 3) Number of cases presented and percentage of prospective cases 4) Elements of discussion for each case, including, but not limited to Staging, Treatment planning, options for clinical study enrollment, options or genetic testing, options and eligibility for supportive care services. 5) An action plan to resolve any areas that do not meet the requirements of the program's policy and procedure.

Reference:

Optimal Resources for Cancer Care 2020 Standards

All revision dates: 2/6/2026, 7/10/2024, 8/23/2021, 2/9/2021, 2/12/2020, 4/28/2016

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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.11 Cancer Registry Policy Statement on Confidentiality

POLICY:

It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) to maintain confidentiality of patient information in compliance with federal, state and local laws governing the release of information, and to ensure that each patient's right to privacy is preserved. Cancer Registry patient data are treated in the same confidential manner as other patient specific information in the Hospital. Other data maintained in the registry database specific to physicians and additional individuals are also treated in this same confidential manner.

PROCEDURE:

The purpose of the cancer data gathering process at VCMC/SPH is to provide information for both internal VCMC/SPH needs and to fulfill reporting standards as required by specific outside agencies.

Definition:

A. Release of data to external organizations must be approved by the Cancer Committee, and is limited to:
    1. The American College of Surgeons Commission on Cancer as needed to meet standards for hospital Cancer Program approval.
    2. The National Cancer Data Base.
    3. State of California Cancer Registry as needed to meet state reporting requirements.
    4. The National Cancer Institue(NCI) Surveillance Epidemiology and End results (SEER) Regional Registry Program as needed to meet regional and NCI reporting requirements.
    5. Legitimate requests for patient follow-up received from other hospital cancer registries that are following the same patients.

B. Any other requests for patient and/or physician specific information must be individually reviewed and approved by the Cancer Committee and Hospital Administration to ensure confidentiality standards are maintained as required by Hospital policy and the law. ~~All requests are documented in the Cancer Registry request log including the date of the request, topic, and study period, source of the request, intent and final use of the data.~~

C. Any release of data must also follow the confidentiality guidelines as they are defined in the VCMC/SPH

Administrative policies and procedures.

Reference:

Registry Operations and Data Standards

VCMC/SPH Policy 100.18 Confidentiality of Medical Records

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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.16 Cancer Registry Guidelines for Patient Management and Treatment

POLICY:

To ensure compliance with the American College of Surgeons Commission on Cancer 2020 Program Standard 5.1 *Optimal Resources for Cancer Care*, which are guidelines for patient management and treatment that provide an organized approach to quality care.

In addition, Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologists (CAP) cancer protocols, including containing all core data elements within the synoptic format.

Eligible cancer pathology reports are defined as:

- Definitive surgical resection of primary invasive malignancies and ductal carcinoma in situ (DCIS), and
- Definitive surgical resection in patients who have received neoadjuvant therapy AND who have residual tumor

Please refer to the CAP Cancer protocols for specific guidance and examples by primary site.

PROCEDURE:

The Commission on Cancer site reviewer will review the standardized synoptic pathology reports for eligible patients.

All revision dates: 3/9/2021, 3/21/2019, 4/28/2016

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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.25 Cancer Program Psychosocial Distress Screening

POLICY:

Ventura County Medical Center/Santa Paula Hospital serves the psychosocial needs of cancer patients by utilizing a multidisciplinary approach to care, and integrating psychosocial care and distress screening into the assessment, planning, implementation and evaluation of cancer care on the patients' care continuum.

PROCEDURE:

The National Comprehensive Cancer Network (NCCN) Distress Screening Tool ~~Version 2.2023~~ is ~~utilized for cancer patient distress~~an evidenced based screening ~~in the Ventura County Hematology-Oncology Outpatient Clinic during, or proximal to, the initial patient visit. The purpose of the Distress Screening Tool is to~~too to assess and best determine the severity of the patient's distress as well as the nature of the individual ~~patient's~~ needs for distress reduction through the provision of services. The Distress Screening Tool is utilized during, or proximal to, the initial patient visit.

~~The NCCN Distress Screening Tool measures patients' distress with regard to relevant social work issues. Most notably measured include Physical Concerns: (1) Pain; (2) Sleep; (3) Fatigue; (4) Tobacco use; (5) Substance use (6) Memory or Concentration; Sexual Health (7) Changes in eating (8) Loss or change of physical abilities: Emotional Concerns (1) Worry or anxiety; (2) Sadness or depression; (3) Loss of interest or enjoyment; (4) Grief or loss (5) Fear (6) Loneliness (7) Anger (8) Changes in appearance (9) Feelings of worthlessness or being a burden . Social Concerns: (1) Relationship with spouse or partner (2) Relationship with children (3) Relationship with family members (4) Relationship with friends or coworkers (5) Communication with health care team (6) Ability to have children. Most notably measured Practical Concerns: (1) Taking care of myself (2) Taking care of others (3) Work(4) School (5) Housing (6) Finances (7) Insurance (8) Transportation (9) Child Care (10) Having enough food (11) Access to medicine (12) Treatment decisions. Spiritual or Religious concerns: (1) Sense of meaning or purpose (2) Changes in faith or beliefs (3) Death, dying, or afterlife (4) Conflict between beliefs and cancer treatments (5) Relationship with the sacred (6) Ritual or dietary needs.~~

The NCCN Distress Screening Tool measures patients' distress with regard to relevant social work issues. Most notably measured include:

- Physical Concerns: (1) Pain; (2) Sleep; (3) Fatigue; (4) Tobacco use; (5) Substance use (6) Memory or Concentration; Sexual Health (7) Changes in eating (8) Loss or change of physical abilities

- Emotional Concerns: (1) Worry or anxiety; (2) Sadness or depression; (3) Loss of interest or enjoyment; (4) Grief or loss (5) Fear (6) Loneliness (7) Anger (8) Changes in appearance (9) Feelings of worthlessness or being a burden
- Social Concerns: (1) Relationship with spouse or partner (2) Relationship with children (3) Relationship with family members (4) Relationship with friends or coworkers (5) Communication with health care team (6) Ability to have children
- Practical Concerns: (1) Taking care of myself (2) Taking care of others (3) Work(4) School (5) Housing (6) Finances (7) Insurance (8) Transportation (9) Child Care (10) Having enough food (11) Access to medicine (12) Treatment decisions
- Spiritual or Religious concerns: (1) Sense of meaning or purpose (2) Changes in faith or beliefs (3) Death, dying, or afterlife (4) Conflict between beliefs and cancer treatments (5) Relationship with the sacred (6) Ritual or dietary needs.

Nurse Navigators assist the patient to complete the NCCN Guideline Distress Screening Tool. The physician will also completes a distress assessment with the patient. Patients who score five (5) or greater on the NCCN Distress Screening Tool are flagged and further assessed for psychological (emotional) problems, social work (practical problems and family problems) issues and medical (physical) problems. ~~Patients with more indicators of practical and family problems indicate the need for social work intervention; more indicators of emotional problems indicate the need for psychological or psychiatric referrals; and more indicators of physical problems indicate the need for medical referral to oncologist or nursing staff.~~

- Patients with more indicators of practical and family problems indicate the need for social work intervention.
- Patients with more indicators of emotional problems indicate the need for psychological or psychiatric referrals.
- Patients with more indicators of physical problems indicate the need for medical referral to oncologist or nursing staff.

Each year, the Psychosocial Services Coordinator presents a report to the Cancer Committee which includes:

- Number of patients screened
- Number of patients referred for distress resources or further follow-up
- Where patients were referred (on-site or by referral)
- The screening process
- Timing of screening
- Identified tool
- Distress level triggering referral service
- Distress Screening(s) results
- Referral for provision of care
- Follow-ups documented in patients' medical records to facilitate integrated, high-quality care

All revision dates: 2/5/2026, 1/12/2024, 1/1/2012

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Cancer Committee	Jennifer Ferrick: Cancer Program Coordinator	2/5/2026
Cancer Program Manager	Jennifer Ferrick: Cancer Program Coordinator	2/5/2026

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Jennifer Ferrick: Cancer Program Coordinator*
Policy Area:	*Cancer Program*
References:	

CA.26 Cancer Program Survivorship Program

POLICY:

The Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) Cancer Program is in accordance of American College of Surgeons Commission on Cancer by the development of a Survivorship Program. The ~~program will be developed and implemented by a~~ Survivorship Program is to promote a healthy lifestyle and lower the risk of future cancers by focusing on screening, monitoring, and addressing long-term problems through coordination of care after completion of the patient's first course of treatment. The Committee~~. The Committee includes, but~~ is ~~not limited to, a team of Physicians, nurses, social worker, and other allied health care workers. The Committee is~~ responsible for the referral of Cancer Survivors to one or more of three selected programs as advised by the American College of Surgeons (ACS) Commission on Cancer (CoC)

PROCEDURE:

The Survivorship Committee is an intradisciplinary committee that includes but is not limited to a team of physicians, nurses, social workers, and other allied health care workers.

Adult cancer patients will be referred to the Survivorship Program Coordinator by infusion nurses, physicians, or other allied health workers.

A Survivorship Program Team determines a list of services and programs offered on-site or by referral that addresses the needs of cancer survivors who have completed their first course of treatment and/or may utilized by patients in active treatment.

The program coordinator will arrange for referrals to one or more of the three services chosen by the Survivorship Program Committee.

The Survivorship Committee will meet ~~Monthly~~quarterly to continue program development, review progress, and discuss data to identify achievements and areas for improvement.

The Survivorship Program will document and evaluate a minimum of three survivorship services offered each year. Services utilized by the survivorship programs may include, but are not limited to the following:

- Financial support services
- Formalized referrals to experts in cardiology, pulmonology, sexual dysfunction, or fertility counseling.
- Treatment Summaries
- Survivorship Care plans

- Screening Programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support Groups
- Physical Activity programs

~~Adult cancer patients will be referred to the Survivorship Program Coordinator by infusion nurses, physicians, or other personnel. The program coordinator will arrange for referrals to one or more of the three services chosen by the Survivorship Program Committee.~~

Data will be collected by nurses, physicians, and social workers to monitor participation in the program. The Survivorship Committee will evaluate the program annually to monitor progress, and identify any modifications needed to improve fulfilling the needs and barriers for our patient population.

Findings from the annual program evaluations will be reported to the Cancer Committee by the Survivorship Program Coordinator. The report will include the estimated number of cancer patients who participated in the referred services, identification of barriers that prevented the participants from utilizing the referred services, and evaluation of additional resources needed to improve the program.

~~During 2024 The Survivorship committee plans to refer Survivors to the Following 3 services:~~

- ~~Nutrition Services~~
- ~~Financial Support Services~~
- ~~Psychological support/Psychiatric services.~~

~~Referral Goal to initiate Program is to refer 100% of all Breast cancer Survivors to one or more of these services.~~

REFERENCE: *American College of Surgeons Commission on Cancer: Optimal Resources for Cancer Care 2020 Standards*

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Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Diabetes Management*
References:	

DM.004 Adult Intravenous (IV) Insulin Infusion Policy

POLICY:

A. Continuous IV insulin infusion is utilized at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to control hyperglycemia in the acutely ill patient.

B. VCMC/SPH shall use approved IV insulin software for all continuous IV insulin infusions.

C. Insulin software will only be initiated with a ~~prescriber~~Licensed Practitioner's (LP) order.

D. ~~Prescribers~~LPs will order IV Insulin infusion using one of the IV insulin order-sets for IV insulin software in the electronic health record (EHR).

E. Only regular insulin at a standard concentration of 1 unit insulin to 1 mL 0.9% normal saline will be used.

F. IV insulin infusion will be titrated by Registered Nurses (RN) who have been trained to use the current IV insulin software. ~~The RN~~Staffing will ~~have no more than three (~~be adjusted whenever possible to maintain a 1:3~~)~~ ratio for patients on IV insulin infusions.

G. Glucose is monitored per IV insulin software instruction, or ~~prescriber~~LP's order. IV insulin software will alert RN of need for glucose check.

H. Hypoglycemia is defined as glucose <70mg/dL and will be treated per IV insulin software instructions. If IV insulin software downtime occurs, hypoglycemia is treated per policy 100.095 Hypoglycemia Management in Adults or policy DM.003 Pediatric Hypoglycemia.

I. When IV insulin software downtime occurs: use the paper protocol which is available on each unit in "downtime" binders.

J. To transition a patient off of IV insulin infusion software, the ~~prescriber~~LP will submit an order using the "MED Transition Intravenous to SubQ Insulin (multi-phase order)" in the EHR.

Principles:

A. The IV insulin software is a glycemic management tool intended to evaluate current and cumulative patient blood glucose values, and based on the aggregate of these measurements, recommends an intravenous dosage of regular insulin to maintain blood glucose levels towards a clinician-determined range.

B. Default settings for the IV insulin software are as follows:

1. Target glucose range: non-pregnant adult 120-180 mg/dL
2. Target glucose range: pregnant woman in labor, 80-120 mg/dL
3. Target glucose range: pregnant woman, not in labor, 100-140 mg/dL
4. Initial multiplier adult: 0.01
5. Maximum time between glucose checks when patient is first placed on IV infusion: 60 minutes
6. Maximum time interval between glucose checks once patient is stable: 120 minutes

PROCEDURE:

A. Use IV insulin software manufacturer's most current manual and tip sheets for the basic procedure to place a patient on IV insulin infusion and for ongoing management of patient on IV insulin infusion.

B. With ~~a prescriber~~an LP order, transition from IV insulin to subcutaneous insulin can begin ~~if glucose values~~when the following criteria are ~~in goal range for 4 hours, with a stable insulin software multiplier, and if patient's clinical condition is appropriate for SQ insulin.~~met:

1. Blood Glucose (BG) is < 200 mg/dL
2. BG is stable for 8 hours with a stable insulin software multiplier
3. Patient is tolerating orals
4. The underlying reason for insulin drip is resolved

C. To transition patient off of IV insulin infusion software, RN will receive an order from ~~a prescriber~~an LP.

D. Document ~~Blood glucose~~BG values and IV insulin titrations in the EHR.

References:

Diabetes Care 2018;41(Suppl. 1):S144–S151 | https://doi.org/10.2337/dc18-S014

"Clinical Guide for GlucoStabililizer," version 3.5. Healthways for Hospitals, 2015.

"Guidelines for the use of an insulin infusion for the management of critically ill patients." Crit Care Med 2012; 40:3251-3276.

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Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/12/2025
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
Diabetes Management	Hugo Ortiz: Diabetes Nurse Educator	11/25/2025

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Owner:	*Hugo Ortiz: Diabetes Nurse Educator*
Policy Area:	*Diabetes Management*
References:	

DM.008 Hypoglycemia Management in Adults

POLICY:

It is the policy of Ventura County Medical Center ~~and~~, Santa Paula Hospital, and Ambulatory Care Clinics that hypoglycemia will be identified and immediately treated according to evidence-based standards.

BACKGROUND:

Hypoglycemia is not defined by a blood glucose (BG) value alone. For the purpose of identifying those whom treatment should be rendered, hypoglycemia is defined as a blood glucose less than 70 mg/dL or less than 80 mg/dL with symptoms of hypoglycemia in the following types of adult patients:

- All patients with any type of diabetes mellitus
- Patients with critical illness
- Patients with sepsis
- Patients with clinically significant malnourishment and/or cachexia
- Patients thought to have alcohol induced hypoglycemia
- Patients with End Stage Renal Disease (ESRD) and/or advanced cirrhosis
- Patients with a confirmed or suspected hypoglycemic disorder diagnosed by Whipple's triad:
  - Patient has symptoms of hypoglycemia
  - The plasma glucose concentration is confirmed and documented to be low when patient has the symptoms
  - The symptoms are relieved by elevating the plasma glucose with administering glucose or glucagon
- A patient on a medication known to have significant risk of causing hypoglycemia (see Table 1)

Table 1. Formulary drugs that can cause hypoglycemia other than anti-hyperglycemic agents and alcohol	
Moderate Quality of Evidence	Pentamidine isethionate Quinine sulfate Indomethacin Glucagon (during endoscopy)
Low Quality of Evidence	Hydroxychloroquine sulfate Lithium
Very Low Quality of Evidence	Angiotensin-converting enzyme inhibitors Angiotensin-receptor antagonists Beta-blockers Levofloxacin Mifepristone Disopyramide Trimethoprim-sulfamethoxazole Heparin 6-mercaptopurine
Adapted from M. Hassan Murad, et al. Drug Induced Hypoglycemia: A Systematic Review. J Clin Endocrinol Metab, March 2009, 94(3): 741-745	

DEFINITIONS

A. **Blood Glucose (BG):** Glucose measurement in the blood. Glucose monitoring can be performed by capillary or fingerstick devices or by continuous glucose monitoring devices. Target BG range is greater than 70 mg/dL to 180 mg/dL for non-pregnant patients with diabetes.

B. **Critical result:** Test results, including routine tests, that represent a life-threatening symptom that require rapid communication to the Licensed Provider (LP) or responsible licensed caregiver. The BG value for low critical result is <60 mg/dL. The high critical result for BG is >500 mg/dL. See policy 100.030 Critical Tests and Critical Results

INPATIENT PROCEDURE:

A. Assessment:

1. Licensed Practitioner (LP) should assess patient's risk for clinically defined hypoglycemia as above and order appropriate glucose monitoring and the PHA Adult Hypoglycemia Treatment PowerPlan.
2. In any patient with symptoms of hypoglycemia (e.g., shakiness, dizziness, headache, confusion, irritability, weakness, decreasing level of consciousness, hunger, tachycardia, pallor and/ or diaphoresis) then get a STAT bedside capillary Point of Care (POC) glucose level with a hospital approved glucometer to screen for hypoglycemia.
3. In patients meeting above clinical definition of hypoglycemia, treat per protocol below.
4. In patients without any of the known clinical conditions above and
    a. an incidental BG <70 mg/dL but >40 mg/dL with no symptoms of hypoglycemia no further assessment or monitoring is needed.
    b. an incidental BG <70 mg/dL but >40 mg/dL with symptoms of hypoglycemia, then further workup to confirm clinical hypoglycemia is recommended
    c. an incidental BG <40 mg/dL with or without symptoms of hypoglycemia, then repeat confirmatory BG is recommended and if still <40 mg/dL then further workup to confirm clinical hypoglycemia is recommended.

B. Treatment protocol for those that meet criteria:

1. Have patient stop all activity
2. If patient responsive and able to take orals, give 15 grams of carbohydrates:
    a. 120 mL (4 oz) apple/cranberry/orange juice, do not give orange juice to patients with renal insufficiency. **OR**
    b. 120 mL (4 oz) non-diet soda **OR**
    c. Glucose gel equal to 15 grams carbohydrates
3. If patient unresponsive, nothing by mouth (NPO), or unable to swallow:
    a. Patent intravenous (IV) line present:
        i. Blood glucose ≤ 40 mg/dL give 50 mL of D50.
        ii. Blood glucose > 40 mg/dL give 25 mL of D50.
    b. Patent IV line not present:
        i. Give 1 mg glucagon intramuscular (IM) or subcutaneous (SubQ).
        ii. Attempt IV access.
        iii. Turn patient on side as nausea and vomiting frequently occur with glucagon.
4. Document all events in the electronic health record (EHR) and notify the LP.
5. Recheck blood glucose 15 minutes after treatment. If blood glucose is still <70 mg/dL, repeat treatment, and recheck blood glucose in 15 minutes.
6. Consider measures to prevent recurrence:
    1. For patients taking orals: Once blood glucose has come up >70 mg/dL, provide snack containing carbohydrates ~~and protein~~.
    2. For patients unable to take orals: call the LP for orders to prevent recurrence.
7. Initiate a notification form for all blood glucose <40 mg/dL.

AMBULATORY CARE CLINIC PROCEDURE

A. Patient History and Assessment

1. All patients with symptoms of hypoglycemia shall be screened and a history of hypoglycemia shall be reviewed at each patient encounter.
2. Identify signs and symptoms of hypoglycemia (i.e., shakiness, dizziness, headache, confusion, irritability, weakness, decreasing level of consciousness, hunger, tachycardia, pallor, and/or diaphoresis).
3. If symptoms are present, the following should be initiated:
    a. Have patient stop all activity
    b. Perform a STAT point of care blood glucose (POC BG)
    c. Notify clinic practitioner and obtain treatment orders if indicated (e.g., BG less than or equal to 70 mg/dL).

B. Treatment

1. If patient is responsive and able to take oral medications, an order for 15 grams of fast acting carbohydrates is indicated:
    a. 120 mL (4 oz) of apple juice, cranberry juice, or orange juice. Do not give orange juice to patients with renal insufficiency. **OR**
    b. 120 mL (4 oz) of non-diet soda **OR**
    c. 15 grams of glucose gel **OR**
    d. 4 glucose tablets
2. If patient is unresponsive and/or unable to swallow, call 911
    a. If ordered, give glucagon 1 mg intramuscularly (IM) or subcutaneously (subcut)
    b. Turn the patient on their side as nausea and vomiting frequently occur with glucagon administration.

C. Monitoring
1. Recheck POC BG in 15 minutes after treatment
2. If BG remains less than 70 mg/dL, repeat the above treatment and recheck BG in 15 minutes
3. Repeat this process until BG is above 70 mg/dL

D. Document all interventions including signs and symptoms and BG levels and treatment into the electronic health record (EHR).

E. Consider measures to prevent re-occurrence: Once BG has returned above 70 mg/dL, provide a snack containing carbohydrates.

F. Long term strategies
1. Patients at risk shall be made aware of symptoms and prevention strategies to mitigate hypoglycemia occurrences.
2. Clinicians should evaluate the patient's risk of hypoglycemia prior to prescribing medications to treat diabetes in high risk patients in the outpatient setting.
3. Clinicians should prescribe glucagon to high risk patients and patients on insulin with accompanying education for close contacts on how to administer.[1]
4. Clinicians may consider Continuous Glucose Monitoring (CGM) for individuals at risk of hypoglycemia for maximal outpatient control.

REFERENCES:

~~American Diabetes Association. Diabetes Care 2021 Jan; 44 (Supplement 1): S211-S220.~~

~~Cryer, Philip E. M.D. "Management of hypoglycemia during treatment of diabetes mellitus" UpToDate, April 2018. Last Accessed 11/6/2022.~~

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5. Lee W, Neumiller J, Hypoglycemia Prevention and Treatment in the Ambulatory Care Setting. US Pharm. 2020; 45(11): 24-30. Hypoglycemia Prevention and Treatment in the Ambulatory Care Setting. Last Accessed 2/24/2025.
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Attachments

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Medical Staff Committees: Family Medicine & Medicine	Stephanie Denson: Manager, Medical Staff Office	2/26/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	12/3/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/7/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	10/7/2025
Diabetes Management	Hugo Ortiz: Diabetes Nurse Educator	10/7/2025

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Owner:	*Julia Feig: Nurse Director, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.07 Death of Patient in the Emergency Department

POLICY:

To facilitate proper care of deceased patients and their families and to assist the Coroner's office with collection of appropriate data.

PROCEDURE:

All deaths in the Emergency Department (ED), whether the death occurred in the ED or the patient was dead on arrival (DOA), are under the Coroner's jurisdiction. ED staff will immediately notify the Coroner's office. The patient's physician will give report to the Coroner.

In the case of a DOA, the patient is not to be undressed nor is this person to be searched for identification until arrival of the Coroner's representative.

No medical devices inserted during resuscitation will be removed unless directed by the Coroner.

It is the responsibility of the Coroner to collect any possible evidence, to notify the next of kin, to make arrangements for autopsy as indicated or for a funeral home to pick-up of the body, and to dispose of the patient's valuables and personal effects. If the patient is not a Coroner's case, these arrangements will be made by the Nursing Supervisor and/or Patient Advocate and family.

Relatives will be asked to remain in the appropriate waiting area until interviewed by the Coroner.

When immediate pick-up cannot be arranged, the ED is busy or the Coroner releases the body, the body may be identified by placing a tag with the patient's name and chart number, if available, on right ankle and taken to the Morgue located in the Hospital basement.

The Nursing Office, the Coroner's office and the Admitting office will be notified of any DOA or death occurring in the ED.

All imminent brain deaths and all cardiac deaths must be reported to One Legacy's 24-hour Donor Referral Line within one (1) hour. **One Legacy: 800-338-6112**

All deaths shall be called in to the One Legacy referral line within (1) hour of death or (1) hour of the patient meeting clinical triggers for referral. **One Legacy: 800-338-6112**

All patients meeting **CLINICAL TRIGGERS,** including cardiac death, must be reported within one hour to One

Legacy.

Clinical Triggers - include ANY Ventilator Dependent patient with a non-survivable injury, **and** either 1 of the below instances:

- Loss of one or more brainstem reflexes (fixed & dilated pupils, no cough, no gag, no involuntary blinking of the eyelids elicited by stimulation of the cornea, doll's eyes reflex, etc.)
- Or an anticipated discussion of DNR, withdrawal of life-sustaining therapies, or withdrawal of ventilator.

Referrals to One Legacy must be documented in the patient's Progress Notes, and noted directly in the patient's medical record; the One Legacy Referral Number becomes part of the permanent record.

All Cardiac deaths MUST be reported to One Legacy for tissue donation evaluation. Even if the patient was previously ruled out for organ donation, as they may still be eligible for tissue and/or cornea donation.

Provide post-mortem eye care per hospital policy to preserve the opportunity for cornea donation.

Admitting will be notified of patient's name, time of death and name of physician. The ED chart will be completed via Electronic Health Record (EHR).

A Notification form must be filled out by RN.

All deaths within the ED or within 48 hours of admission to the Hospital through the ED will be reviewed on a periodic basis.

All revision dates: 11/17/2022, 11/13/2019, 5/1/2009, 5/1/2006, 1/1/2005, 11/1/2001, 1/1/1995, 10/1/1992, 12/1/1989

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	10/7/2025
Policy Owner	Julia Feig: Nurse Director, Emergency Services	10/7/2025

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Owner:	*Julia Feig: Nurse Director, Emergency Services*
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References:	

ER.36 Paramedic Base Hospital Designation

POLICY:

To establish guidelines for the designation of Ventura County Medical Center (VCMC) as a Paramedic Base Hospital.

PROCEDURE:

A. The guidelines for an ambulance policy will be developed by the Ventura County Health Care Agency (VCHCA) through the Pre-Hospital Services Committee. Such guidelines will be approved by the Board of Supervisors. The VCMC Pre-Hospital Care Coordinator and Base Hospital Medical Director will participate in these procedures as a member of the Pre-Hospital Services Committee or as requested by the Administration of Emergency Medical Services (EMS) Agency.

B. According to EMS policy 410, VCMC is a Paramedic Base Hospital as designated and approved by the Ventura County Health Care Agency. Copies of the Ventura County EMS Policy and Procedure Manual are available on the County of Ventura Emergency Medical Services website. The function of the base hospital will be based on these policies and procedures.

C. Continuous Performance Improvement surveys will include, but not be limited to, field care audit and review, endotracheal intubation, base communication problems and cardiac tracing studies. Additional short-term surveys will continue and will be initiated by the Pre-Hospital Care Coordinator as situation or need dictates.

D. Items left with the patient in the Emergency Department such as back boards, special collars, splints, etc., will be secured for a return pick-up.

E. A copy of the patient's ambulance record will be available to the Base Hospital within 24 hours and will be filed with the patient's chart according to EMS Policy 1000.

All revision dates: 1/28/2020, 6/1/2011, 12/1/2004, 11/1/2001, 12/1/1998, 1/1/1995, 10/1/1992, 12/1/1989

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/25/2025
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ER.43 Sudden Infant Death Syndrome (SIDS)

POLICY:

To provide a guide for Emergency Department (ED) staff to use when faced with the arrival of a Sudden Infant Death Syndrome (SIDS) patient and family and to ensure the needs of the family are compassionately and adequately met.

PROCEDURE:

A. After resuscitative measures have been stopped (or if the decision to declare an infant dead on arrival (DOA) has been made by the physician in charge), SIDS must be considered one of the possible causes of death. Any diagnosis at this point is tentative pending autopsy.

B. If the case is declined by the Medical Examiner's Office,* support the family and offer them the opportunity to hold their baby under direct supervision of a member of the hospital staff in a quiet, private place for no more than one (1) hour. If the family declines, it may be helpful to obtain a photo of the infant to be given to the deputy coroner and to let a member of the family know it is available to them at a later date, if they choose to obtain it.

C. Keeping the above point in mind, it is vital to attend to the family members and/or child care providers. Ideally a nurse should stay with the family. This can be an ED nurse, ED social worker or the Nursing Supervisor.

D. The physician in charge of the resuscitation and the nurse assigned to support the family should ideally inform the family of the expiration of the child together.

E. Attempt to contact individuals whose presence would be helpful to the family, i.e. clergymen, a neighbor, family. Ask if they desire a baptism and document if it is performed.

F. The on-call Deputy Coroner should be informed as soon as possible and arrangements made to allow privacy for an interview with family.

G. Be available to answer questions regarding subsequent procedures such as autopsy and availability of local support groups.

*Please note California Statute 27491.2 - Body shall not be disturbed or moved from the position or place of death without permission of the coroner or coroner's appointed deputy. Any violation of this subdivision is a misdemeanor.

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Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/25/2025
Nursing Administration	Sherri Block: Associate 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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Last Revised:	*11/26/2025*
Next Review:	*3 years after approval*
Owner:	*Julia Feig: Nurse Director, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.49 Documentation Standards in the Emergency Department

POLICY:

To establish documentation requirements for Emergency Department (ED) patients at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH).

PROCEDURE:

A. An ED record shall be kept for every patient receiving emergency service in the patient's electronic health record (EHR), which shall be part of the official hospital record. All Emergency Department documentation shall be completed and entered into the patient's EHR within 24 hours of patient discharge or transfer. Late entries must be clearly identified as such and include the date and time of entry. This record shall contain:

1. Adequate patient identification and hospital medical record number, date of birth and consents for treatment. When consents are not available or when unable to obtain, documentation will be made. All the paperwork shall be labeled and scanned into the patient's EHR.
2. Date and time of patient arrival and discharge from the ED.
3. Means of arrival and by whom transported.
4. The patient's chief complaint.
5. Physician Charting Will Include:
    a. History of injury or illness including emergency care given prior to arrival
    b. Physical findings with diagrams of injury, if indicated and vital signs.
    c. Laboratory and radiographic studies ordered and results.
    d. Impressions, diagnosis, treatment orders and the results of the treatment.
    e. Instructions in the language understood by patient for after-care given to the patient or relatives, and appointments in writing for return visits to the ED or to other clinics or physicians. When after-care sheets are given to patients, it shall be noted on the chart, in the patient's EHR. After-care instructions in patient's language, with interpreter documentation, must be provided when non-English speaking. When interpreter services are used, document in the EHR: language, interpreter ID, mode and confirmation that the patient or family understood the information

provided.

f. Disposition, means and condition of the patient on discharge.

6. Nurses Charting to include:
   a. Nursing Assessment to include nursing history (emotional and physical) based on ED "Standards of Care."
   b. ~~Vital~~Initial vital signs to include blood pressure, pulse, temperature, respiratory rate, oxygen saturation, and level of pain on admission as part of the Emergency Severity Index (ESI) scoring assessment. Vital signs per ESI triage level, with abnormal findings promptly reported.
      i. ESI 1 patients or critical patients including traumas, vital signs should be repeated every 5 to 15 minutes until patient's status stabilizes, then every 2 hours after that.
      ii. ESI 2-3 patients vital signs should be repeated every 2 hours.
      iii. ESI 4-5 patients with abnormal vital signs should have then repeated every 2 hours until they normalize, then every 4 hours after that.
      iv. ESI 4-5 patients with normal vital signs should have vital signs repeated every 4 hours.
      v. Rectal temperatures are required for all infants less than 60 days of age.
      vi. Rectal or axillary temperatures should be taken on all pediatric patients ~~under the age of~~sixty (60) days to two (2) years depending on chief complaint.
      vii. Any abnormal vital signs should be promptly reported by the nurse or technician who takes them to the attending physician. (See Attachment A).
      viii. Once a patient is medically cleared for placement at a psychiatric facility vital sign frequency can be reduced to once per shift.
   c. Weight in kg on all patients, naked weight on all children under one (1) year old.
   d. Head circumference on pediatric patients when deemed appropriate by attending physician.
   e. Fetal heart tones (FHTs) on all pregnant patients over 12 weeks gestation.
   f. Allergies, medications currently used and tetanus immunization status.
   g. Medication Reconciliation form on all patients in the ED shall be completed by the RN.
   h. Document patient's level of pain initially and any changes in the level or severity as applicable. Document of pain assessment and at triage and reassessment after interventions, at intervals, and prior to discharge.
   i. If medications are administered in the ED, note name, dosage, route of administration, site of administration if parental, time administered and results. Document in the patient's EHR.
   j. Any change in patient's condition.
7. Conclusions and documentation if the patient leaves against medical advice, label against medical advice (AMA) form and have scanned into patient's EHR.
8. Psychiatric patients: behavioral observations, restraint/seclusion documentation, patient rights notifications.
9. Patients, patient's relatives, guardians, law enforcement or other responsible person's signature on receipt of discharge instructions.
10. Document in EHR if a patient leaves without being seen or leaves before treatment is completed (per

policy 100.211).

11. All patient records are confidential. Refer to Administrative policy 100.018 and HIPAA. Hospital maintains audit trails, access controls, and breach reporting procedures. Staff complete annual HIPAA training.
12. Patient authorization to release information for follow up care to his or her physician or health care organization is addressed.

B. Trauma Flow Sheet to be used on all Code Yellow Tier I and Tier II patients.

DOCUMENTATION

As above

REFERENCES:

Title 22, California State requirements
The Joint Commission Standards
Emergency Nurses Association - Standards of Care

CDPH CMIA (Health & Safety Code §56 et seq.), CMS §482.24(b)

All revision dates:	11/26/2025, 3/20/2025, 9/13/2024, 1/28/2020, 11/1/2016, 12/1/2013, 11/1/2011, 8/1/2011, 1/1/2011, 12/1/1998, 1/1/1995, 10/1/1992

Attachments

ER.49 Attachment A.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	11/19/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	11/19/2025
Policy Owner	Julia Feig: Nurse Director, Emergency Services	11/19/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Julia Feig: Nurse Director, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.55 MED CODE

Policy:

To facilitate and expedite the care and stabilization of nontrauma patients at high risk for rapid deterioration who present to the Emergency Department.

Purpose:

A "MED CODE" is called so that the staff needed to care for critically ill nontrauma patients responds rapidly to the Emergency Department (ED). The med code response is to ensure a rapid and orderly assessment of patients with significant physiologic impairments. Patients who fall under the guidelines for a code stroke, code yellow (trauma) or code blue should be called and cared for as per those previously established guidelines and should not be called as a med code.

Criteria:

1. Hemodynamic instability
    1. Adults with systolic blood pressure <80 mm Hg
    2. Children with age specific hypotension
        1. ≤ 1 year: <60mm Hg
        2. 1-10 years: <70 mmHg + 2X age in years.
2. Respiratory compromise
    1. CPAP in field
    2. Persistent 02 sat < 90% despite oxygen supplementation
3. Patient who is unresponsive to painful stimulus.
4. Judgment of ED Physician/Nursing. Examples:
    1. Concern for acute vascular dissection or rupture
    2. Concern for pericardial tamponade
    3. Concern for imminent decompensation from severe electrolyte derangement
    4. Concern for impending airway disaster

Procedure:

1. The MICN or designee will notify the Emergency Department charge nurse.
2. The MICN or designee will notify the page operator (x7-6666 at VCMC or x7-8666 at SPH) who will send an alphanumeric page stating "*Med Code ER, adult/peds/infant ETA …minutes"* to all required team members including:
    a. nursing supervisor when available
    b. certified phlebotomy technician when available
    c. x-ray technician
    d. respiratory therapist
    e. rapid response nurse
    f. VCMC only: ICU (adult patient) or PICU attending (pediatric patient)
    g. VCMC only: for pediatric med codes PICU respiratory therapist should also be paged in addition to the emergency department respiratory therapist
3. A Med Code is a silent page at VCMC. At VCMC, charge nurse, MOA or designee will announce Med Code overhead in department only. At Santa Paula Hospital, charge nurse, MOA or designee will call x7-8666 to ask for overhead page.
    a. Announcement/page will state, *"Med Code ER, adult/peds/infant ETA …minutes."*
    b. If the patient self presents to the ER via triage the overhead page will state *"Med Code ER, adult/peds/infant Now."*
4. The following people are to arrive immediately to the Resuscitation Room in the ED:
    a. Physicians: Attending ED physician, ED residents
    b. Nurses: Two ED nurses (or more if requested), Nursing Supervisor, Rapid Response Nurse
    c. Ancillary Staff: certified phlebotomy technician, X-ray technician, Respiratory therapist, ER technician

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Attachments

No Attachments

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Emergency Department Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	1/16/2026

Step Description	Approver	Date
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	1/16/2026
Policy Owner	Julia Feig: Nurse Director, Emergency Services	1/16/2026

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

HIM.08 Health Care Agency Use of Scribes

POLICY:

To provide guidelines for the procurement and utilization of medical documentation scribes by clinicians in the inpatient and ambulatory workplace of the Ventura County Healthcare Agency (HCA). Scribes are defined as employed or contracted individuals who work side-by-side with a ~~medical provider~~clinician as a "clinical information assistant." Scribes only provide assistance by direct documentation of a medical visit as it is verbalized by the ~~provider~~clinician at the time of the medical visit. The use of contracted services from outside of the United States will be excluded.

PROCEDURE:

Scribes SHALL:

1. Obtain proper credentials and training for electronic health record (EHR) use which includes compliance with continuing education and regulations concerning documentation within the Healthcare Agency EHR.
2. Document the medical encounter with accuracy.
3. Provide their name, title, time of documentation, date of documentation, and electronic signature on each medical document created.
4. Provide an attestation with each document created at the time of chart completion and forward to the ~~medical provider~~clinician for co-signature:
   ~~a. "I, _____, transcribed the note for _____."~~
   "I, _____, transcribed the note for _____."
5. Abide by all rules and regulations concerning HIPAA, The Joint Commission, and CMS guidelines, as well as Hospital policies ~~and~~, procedures and bylaws.

Scribes SHALL NOT:

1. Act independently and/or create documentation which does not originate from the ~~medical provider~~
   ~~a. Review of systems (ROS) and Past Family/Social History (PFSH) is exempt as it can be obtain by ancillary staff or transcribed from a form completed by the patient.~~
   clinician. Review of systems (ROS) and Past Family/Social History (PFSH) is exempt as it can be obtained by ancillary staff or transcribed from a form completed by the patient.

2. Engage in physical patient contact of any kind.
3. Interpret information in the patient record.
4. Discuss any aspect of a patient's care with the patient's family members.
5. Enter orders or electronically prescribe on behalf of a ~~medical provider~~clinician.
6. Use anyone else's login credentials to document patient encounters or other forms of documentation
   a. ~~Scribes must have their own unique login and profile credentials as established by HIM and HCA IT.~~ . Scribes must have their own unique login and profile credentials as established by HIM and HCA IT.

~~Medical Providers SHALL:~~

Clinicians SHALL:

1. Engage the services of a scribe solely for the purposes of medical documentation.
2. Maintain appropriate ~~provider~~clinician credentials, including compliance with continuing education and meaningful use within the Healthcare Agency ~~Electronic Health Record~~EHR in the event a scribe is unavailable for use.
3. Provide information for ~~the~~a scribe which accurately ~~reflect~~reflects what is obtained or performed during the medical encounter.
4. Review all forms of documentation created by a scribe and provide an attestation with each document at the time of chart completion:
   a. ~~"I, _____, personally performed the history, physical examination and medical decision making and confirmed the accuracy of the information in the transcribed note."~~
   "I, _____, personally performed the history, physical examination and medical decision making and confirmed the accuracy of the information in the transcribed note."
5. Abide by all rules and regulations concerning HIPAA, The Joint Commission, and CMS guidelines, as well as Hospital policies and procedures and bylaws.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Health Information Management Committee	Vibha Gune: HIM Manager	2/16/2026
Health Information Management	Vibha Gune: HIM Manager	2/16/2026

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Owner:	*Kelly Valenzona: Director, ICU/ DOU/Telemetry*
Policy Area:	*Intensive Care Unit*
References:	

ICU.07 Intensive Care Unit Nursing Admission/ Transfer Procedures

POLICY:

Patients will be admitted ~~to the~~with a patient status order (PSO) of Intensive Care Unit on physician's order.

PROCEDURE:

1. ~~Prior to patient coming to the room set up room with suction, monitor, zero bed with assorted linen and waffle mattress and sequential compression device (SCD).~~Prior to patient coming to the room staff will ensure that it is set up appropriately including all emergency and life-saving equipment. .
2. ~~Assist~~Upon patient arrival, staff will assist with transferring patient safely into bed.

   ~~Attach electro cardio gram(ECG) electrodes to patient and record rhythm strip. Lead II and MCL I are preferred while in the unit (refer to lead placement.)~~

   ~~Weigh patient within an hour on the current critical care bed.~~

   ~~Orient the patient and family to surroundings.~~
3. The patient will be transferred to the cardiorespiratory monitor and a baseline strip will be obtained.
4. Within one hour of arrival, the patient is to be weighed. (actual weight and not estimated weight).
5. When appropriate staff will orient the patient and family to the intensive care unit, visitation policy, and waiting room locations.
6. ~~Send~~If the patient is unresponsive, the patient's belongings will be sent home with family. If the patient has no family member, personal belongings will be properly labeled and ~~belongings form filled out/ updated~~documented in the electronic medical record (EMR) (eyeglasses, hearing aid, and dentures may be kept at the bedside.) Any valuables should be sent to the safe.
7. ~~Complete nursing~~The admission history assessment ~~with proper documentation~~will be completed in the electronic health record within 4~~1~~2 hours.

   ~~Initiate patient care plan using nursing diagnosis with interventions.~~

   ~~Enter patient's admission in the unit log.~~
8. An interdisciplinary plan of care (IPOC) should be initiated and be specific to the patient's diagnosis and risk factors.

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Attachments

No Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Intensive Care Unit Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/26/2025
Intensive Care Unit	Tara Paterson: Medical Director, Critical Care Services	12/26/2025
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	8/18/2025

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Owner:	*Tess Slazinski: Clinical Nurse Specialist, Critical Care*
Policy Area:	*Intensive Care Unit*
References:	

ICU.32 EKOS 4.0 Ultrasonic Device for Infusion of Thrombolytic Agents

PURPOSE:

Provide guidelines for infusion of thrombolytic agents into peripheral vasculature using the EKOS® 4.0 ultrasonic device. The catheters used with the device are inserted in Intervention Radiology (IR).

PROCEDURE(S):

Equipment:

A. Two BD Alaris continuous infusion pump modules. The EKOS device does not control the rates of infusion.

B. Infusion pump tubing

C. Sterile central line dressing

D. Three way Luer lock stopcocks

E. Medication and Fluids

1. Alteplase (tPA) 10 mg/~~100~~250 mL compounded by Pharmacy (Thrombolytic)
2. Heparin ~~5~~25,000 units/500 mL premixed bag (Sheath maintenance)
3. Sodium chloride 0.9% 1000 mL premixed bag~~ at 35 mL/hr~~ (Coolant)

F. EKOS 4.0 Control Unit (CU)

G. Connector Interface Cables (CIC)

Personnel:

Adult ICU Registered Nurses (RNs) who have received the appropriate training and one-time competency.

Catheter placement and device:

A. The EKOS 4.0 catheter/introducer is placed in IR.

B. Adult ICU RN responsibilities upon patients arrival to ICU

1. Plug in EkoSonic (EKOS) CU into a hospital grade outlet.

2. Confirm medications and coolant fluid are infusing at provider specified rates (e.g., green "running indicator surrounded by white bands).
3. Confirm CIC cables are connected properly (e.g., **Black to Black and Δ to Δ; Gray to Gray and O to O**). Keep CIC above the patient bed covers.
4. Confirm orders for vital sign (VS), Doppler/Color, motor, sensation (CMS) checks (e.g., pedal and posterior tibial pulses), puncture site checks, and laboratory values.
5. **DO NOT USE THE CATHETER FOR BLOOD DRAWS**
6. **NEVER** aspirate from the drug lumen. Aspiration of blood will occlude the micropores in the infusion catheter.
7. **ONLY** infuse heparinized saline, normal saline, and/or therapeutic agent via the **COOLANT** or **DRUG** ports.
8. **ENSURE** proper procedure for Doppler checks (e.g., push the red STOP button when performing Doppler checks or Echocardiograms) and Green button to restart.

Provider responsibility for EKOS therapy management

A. Enters orders for alteplase, heparin for sheath maintenance, and coolant fluid using the approved order set - RAD EKOS Catheter Thrombolysis.

B. Indicates duration of therapy (e.g., up to 24 hours)

C. If alteplase must be discontinued for any reason, request a physician order to infuse sodium chloride 0.9% Keep Vein Open (KVO) through the DRUG and COOLANT ports.
   1. **DO NOT** completely stop infusing through the **DRUG** and **COOLANT** ports.
   2. This will maintain patency of the catheter if the thrombolytic drug and ultrasound needs to be restarted.
   3. Turn ultrasound **OFF** by pressing and holding the power button for at least 10 seconds on the CU and disconnect the black and grey cables from the CIC.

D. Enters orders for lab tests, sedation, sheath maintenance, frequency of vital signs, IV/intra-arterial (IA) site checks, and Doppler/CMS checks (e.g., pedal and posterior tibial pulses). See below for order set example:
   1. Doppler/CMS checks every 15 min x 4, then every 1 hour
   2. Check puncture site and dressing every 15 minutes x 4, then every 1 hour.
   3. ~~VS~~Vital Signs every 15 minutes x 4, then every 1 hour
   4. Check infusion lines, flow rates, tubing, and connections every 1 hour throughout the treatment. Notify the provider immediately if there is any leakage, excessive bleeding or difficulty with the infusion flow.
   5. Avoid intra-artieral punctures and intramuscular injections
   6. HOB at 30 degrees.

Troubleshooting:

A. If the CU generates an audible alert, press the audio silence button. Silence is for 5 minutes.

B. Follow the on screen prompts.

C. If the audible alert continues, call the EKOS Helpline (1-888-356-7435; 24/7). Please have error code ready to give the helpline team.

D. Call EKOS Helpline for any issues with the CU, Cart, Device, or Infusions

E. If issue is not resolved after contacting the Helpline, contact the interventional radiologist.

Intrahospital Transport:

A. Unplug the EKOS cart from the AC outlet (battery life = 1 hour)

B. Transport the patient to desired location

C. Plug EKOS cart into a red AC outlet.

Device Removal:

A. Follow intrahospital transport instructions

B. Device and sheath will be removed in interventional radiology department.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Intensive Care Unit & Medicine	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/11/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	12/26/2025
Intensive Care Unit	Tara Paterson: Medical Director, Critical Care Services	12/26/2025
Intensive Care Unit	Kelly Johnson: Director, ICU/DOU/Telemetry	10/28/2025
Intensive Care Unit	Tess Slazinski: Clinical Nurse Specialist, Critical Care	10/7/2025

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Owner:	*Christian Press: Supervisor-LIS, Laboratory Services*
Policy Area:	*Laboratory Services*
References:	

L.BB.109 Prehospital Blood Transfusion Procedure

PURPOSE:

To establish a standardized and documented procedure for the Ventura County Medical Center Blood Bank Department (VCMC BB) to ensure compliance with **AABB Standard 6.2.4** and **FDA 21 CFR 606.160(a)(b)**. This policy supports proper documentation and traceability of ~~blood products~~Low Titer Group O Whole Blood handled by Ventura County Fire Department (VCFD) /Emergency Medical Service (EMS) personnel in the ~~pre-hospital transfusion program~~**Prehospital Blood Transfusion Program (PHBT)**. It also ensures that all field use of blood products is securely recorded, electronically tracked, and reconciled in the Laboratory Information System (LIS).

POLICY:

~~VCMC~~Ventura County Medical Center shall maintain a controlled process for the release, documentation, and reconciliation of blood products used in the field by VCFD/EMS personnel. A dedicated, auditable login (VCFIREEMS) has been created in Cerner PathNet, which is limited to acknowledging receipt and return of blood components by VCFD/EMS personnel.

Ventura County Medical Center Blood Bank staff are responsible for:

- Receiving all blood products from the ~~vendor~~blood supplier (Vitalant, Red Cross etc.).
- Documenting all ~~pre-transfusion~~pretransfusion testing typing blood product antigen type screening ("regrouping" after delivery from vendor), proper storage of blood products, and transfers of blood products to VCFD~~,~~
  - ~~Logging the physical handoff and/or receipt or the blood products, whether on paper or electronically in the Laboratory Information System (LIS).~~

  /EMS.
- Logging the physical hand off and/or receipt of the blood products, whether on paper or electronically in the Laboratory Information System (LIS).
- Reconciling transfused units in the LIS if units are administered by VCFD/EMS.
- Ensuring traceability for regulatory and clinical safety purposes.

This policy ensures that all EMS-related blood handling is compliant with applicable AABB and FDA standards, supports post-transfusion testing when needed, and maintains the integrity of the VCMC/VCFD ~~pre-hospital transfusion service~~'Prehospital Blood Transfusion Program's quality system.

PROCEDURE

1. VCFD/EMS Arrival and Verification

A. VCFD/EMS personnel arrive at the VCMC Blood Bank to retrieve assigned blood products for ~~pre-hospital~~prehospital blood transfusion use.

- VCMC Blood Bank staff must **verify VCFD/EMS identification** (e.g., badge or credentials).
- The name and ID number of the VCFD/EMS personnel handling the blood products shall be **documented in the Prehospital Whole Blood Log**.

B. **Electronic Transfer of Blood Product to EMS Inventory**
After the VCFD/EMS personnel has their unit(s), the Blood Bank staff shall document the handoff of blood product(s) in Cerner using the **"Transfer Products"** function.

The following fields must be completed with the following information: (see image below)

- **To Owner Area =** VCMC
- **To Inventory Area =** VCFD
- **Reason =** Pre-Hospital Transfusion
- **Product Number** of the whole blood unit
- Click **Save** to complete the transfer

C. **Manual Documentation and Handoff**

- Ventura County Medical Center Blood Bank staff shall complete the **~~VCFD~~PHBT Whole Blood Log**.
- The blood unit is physically released to VCFD/EMS personnel for ~~pre-hospital~~prehospital storage or administration.

D. **Post-Transfusion Notification and Return of Blood Unit**

- If a transfusion occurs in the field, VCFD will notify the VCMC ~~ED~~Emergency Department and **return the empty blood unit** to the VCMC Blood Bank.
  - The returned empty unit will be stored temporarily in the VCMC Blood Bank in case **residual testing or blood culture** is required due to a suspected **transfusion reaction**.

E. **Reconciliation of Transfused Blood Product in Cerner after transfused patient is registered at VCMC, and identified as the transfusion recipient - Blood Bank staff shall:**

1. Open the **"Dispense and Assign Products"** application in Cerner.
2. Select **VCFD** as the inventory source.
3. Choose **Emergency Release** as the release method.
4. Enter the **Product ID** of the transfused blood unit~~.~~
5. Ensure the **Start Time** of the Transfusion is **Backdated**
6. If a **reason override** is requested, select **"Pre-Hospital Transfusion"** as the reason.

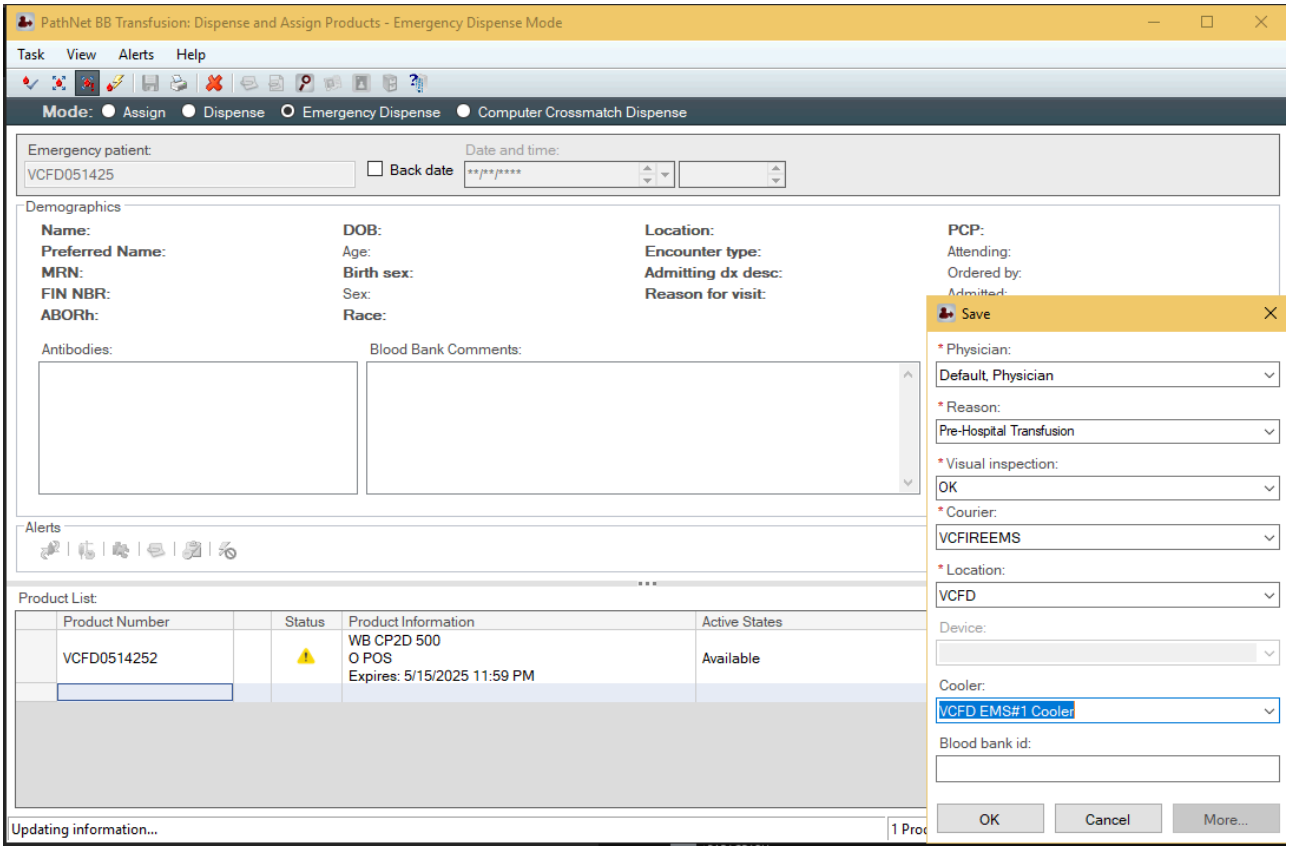
7. Complete the required fields as follows:

   - ~~**Emergency Patient: Unique Identifier for the trauma patient given by registration department**~~**Emergency Patient:** Unique Identifier for the trauma patient given by registration department
   - **Physician**: Canby, Niel M.D.
   - **Reason ~~=~~: Pre-Hospital Transfusion**
   - **Visual Inspection ~~=~~: OK (If acceptable)**
   - **Courier**: VCFIREEMS
   - ~~Location =~~**Location:** VCFD
   - ~~Cooler =~~**Cooler:** VCFD EMS#1 Cooler (#1, 2, 3, or 4)

~~Click **Save** to assign the unit to the specified trauma patient.~~

F. ~~Once the trauma patient is registered at VCMC and identified as the transfusion recipient, Blood Bank staff shall:~~

Click **Save** to assign the unit to the specified trauma patient.



~~Example for how to dispense an emergency pre-hospital transfusion blood product to a trauma patient when reconciling the pre-hospital transfusion~~

Example for how to dispense an emergency pre-hospital transfusion blood product to a trauma patient when reconciling the pre-hospital transfusion

REFERENCE(S):

https://marketplace.aabb.org/PRODUCTFILES/13763269/183142_sam.pdf

https://www.ecfr.gov/current/title-21/chapter-I/subchapter-F/part-606/subpart-I/section-606.160

All revision dates:

Attachments

PREHOSPITAL BLOOD TRANSFUSION WHOLE BLOOD LOG.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Blood Usage Committee	Francisco Bracho: MD	2/24/2026
Blood Usage Committee	Kathrina Barcena: Supervisor-Blood Bank, Laboratory Services	1/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	1/24/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	10/13/2025
Laboratory Services Department	Linda Lee: Medical Director, VCMC Blood Bank	10/7/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Christian Press: Supervisor-LIS, Laboratory Services*
Policy Area:	*Laboratory Services - Histology*
References:	

L.HIST.12 Preservation of Surgical Pathology and Cytology Specimens and Records (Slide and Block Storage)

PURPOSE:

Ensure that the slides and tissue blocks will be available if needed at a future date. The retention of Surgical Pathology and Cytology specimens and reports and the minimum retention periods suggested by the College of American Pathologists (CAP). The period of retention for Ventura County Medical Center meets the periods required by CAP or the State of California. Slides and tissue blocks are stored at room temperature within the laboratory and hospital storage, temperature is to be maintained between 18-27 degrees C. Storage temperature monitoring, including deviations must be recorded.

POLICY:

Department/Material	VCMC Retention Requirement	CAP Retention Requirement
SURGICAL PATHOLOGY		
Wet Tissue	2 Weeks	2 Weeks
Paraffin Blocks	10 Years	10 Years
Slides	10 Years	10 Years
Reports	10 Years	10 Years
Accession Log	2 Years	2 Years
Records of intra/extra-Departmental consultations	10 Years	10 Years
CYTOLOGY		
Slides negative & positive	5 Years	5 Years
FNA Slides	10 Years	10 Years
Reports	10 Years	10 Years

Accession Records	5 Years	5 Years
Records of intra/extra-Departmental consultations	10 Years	10 Years
AUTOPSY		
Wet Tissue	3 Months	3 Months
Paraffin Blocks	10 Years	10 Years
Slides	10 Years	10 Years
Accession Log	2 Years	2 Years
Autopsy Reports and Consents	10 Years	10 Years

REFERENCE(S):

ANP.23700, CYP.07100

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Stephanie Denson: Manager, Medical Staff Office	pending
Policy Owner	Amanda Lo: Medical Director, SPH Lab	2/26/2026
Policy Owner	Erlinda Roxas: Director, Laboratory Services	2/24/2026
Policy Owner	Christian Press: Supervisor-LIS, Laboratory Services	2/10/2026

VENTURA COUNTY
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References:	

L.POC.5.1 Hemoccult Fecal Occult Blood Test

PURPOSE

A. To establish guidelines for Hemoccult test as a rapid, convenient and virtually odorless qualitative method for detecting fecal occult blood, this may be indicative of gastrointestinal disease. It is not a test for colorectal cancer or any other specific disease.

1. To define the nature of laboratory testing that may be personally performed by physicians within their scope of clinical practice. Patient management is often facilitated by immediate and direct physician performance of certain laboratory tests at the time of a patient encounter.
2. Physicians are authorized to perform both waived tests under CLIA'88, Provider Performed Tests (PPT), and Provider Performed Microscopy (PPM) procedures.
    a. Physician Performed Testing (PPT) is defined as testing that is personally performed by a physician
    in conjunction with the physical examination or treatment of a patient.

B. To define an effective quality management program to include:

1. Quality control reagents/materials
2. Review and corrective action of quality control and/or reagent failure
3. Inventory management
    a. Quality control is performed on each new lot or shipment of Hemoccult kits.
    b. Quality control is performed according to manufacturer's instructions.
    c. Quality control records are retained in the Point-of-Care Testing in the Laboratory for 3 years.

POLICIES

A. Hemoccult test shall be used by physicians as a preliminary screening as an aid to diagnosis.

B. Testing shall be performed by the physician, mid-level health care providers (physician assistants and nurse practitioners) with documented initial training and annual competency assessments.

1. Validation of competency among physicians is the responsibility of Medical Staff Credentialing Office.
2. Competency to the specific tests performed by the physicians will be assessed using external proficiency testing samples or blind testing samples and direct observation of occult blood testing.

C. It is the physician's responsibility to provide proof of competency to the Medical Staff Credentialing Office.

D. Proficiency testing and skills assessment is required of all testing personnel.

E. Test results on specific test performed by the physicians are documented in the Fecal Occult Blood Test Workflow in the Hospital Information System.

F. This test should not be interpreted by individual with blue color blindness because it is visually read and requires color differentiation.

EQUIPMENT/MATERIALS NEEDED

A. Hemoccult® Card - Store at room temperature and under low light conditions.

   1. DO NOT REFRIGERATE.

B. Hemoccult® developer- Store at room temperature and under low light conditions

C. Applicator sticks

D. Biohazard container

E. Disposable gloves

F. Stool sample from the patient

PROCEDURE

A. Quality Control Test

   1. Run controls with each batch of patient tests (as in procedure below).
   2. Gather patient's sample, reagent and kit.
   3. Identify patient sample to be tested. Label test kit with patient's name and medical record number.
   4. Apply this smear of fecal sample on Box A + B.
   5. Wait 3-5 minutes before developing.
   6. Apply 2 drops of Hemoccult developer to guiac paper directly over each smear.
   7. Read results within 60 seconds.
   8. Apply one drop of Hemoccult developer between the positive and negative performance uniform areas.
   9. Read results within 10 seconds. If the slide and developer are functional:
      a. Blue color will appear in the positive Performance Monitor area
      b. No blue color will appear in the negative Performance Monitor area

INTERPRETATION OF RESULTS

A. **Negative:** No blue color develops (green is negative)

B. ~~Positive~~**Positive**: Any amount of blue diffusing into the paper around the patient sample within 60 seconds.

REPORTING

Copy the following to a ~~drago~~dragon auto-text or include the information in notes section:

- Patient Result []
- Hemoccult Card QC Result []
- Test Slide Lot Number []
- Test Slide Exp Date []
- Developer Lot Number []
- Developer Expiration Date []

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Attachments

- FECAL OCCULT BLOOD COMPETENCY CHECKLIST.docx
- Hemoccult.pptx
- Hemooccult-1_2-product-instructions.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/24/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	1/30/2026

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References:	

NPP.06 Diuretic Renal Scintigraphy

Policy:

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

It is the policy of Ventura County Medical Center and Santa Paula Hospital that all standardized procedures are developed collaboratively and approved by the Interprofessional Practice Committee (IPC), whose membership consists of Physicians, Registered Nurses (RN), Pharmacists, Advanced Practice Nurses and Administrators. Standardized procedures are reviewed every three years.

To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, all approved standardized procedures will be kept in Policy Stat. The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs 3 and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

Functions to Be Performed:

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

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

Furosemide is a loop diuretic that inhibits reabsorption of sodium and chloride in the ascending loop of Henle and proximal and distal renal tubules, interfering with the chloride binding cotransport system, thus causing its natriuretic effect. By increasing urine flow rate, loop diuretics help distinguish between an obstructed or unobstructed ureter. This is based on the concept that an unobstructed system will clear radiopharmaceutical rapidly because of high urine flow following diuretic administration. Conversely, if an obstruction is present a

high flow rate will not occur and a decrease in clearance of ureteral activity will be seen.[1,5]

Contraindications for the use of pharmacologic diuretics in renal scintigraphy:

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

Roles and Responsibilities:

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

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

A. Scope of supervision required
    1. The RN performing this procedure is responsible and accountable to their Nursing Department Director.
    2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the RN by phone or in person.
    3. Provider consultation is to be obtained under the following circumstances
        a. Emergency conditions requiring prompt medical intervention
        b. Upon the request of the patient, RN or physician

B. Requirements for the RN
    1. Active California RN license
    2. Life support certification: Basic (BLS), Advanced (ACLS), Pediatric (PALS)
    3. Special training: formal orientation to nuclear medicine

C. Evaluation of the RN competence
    1. Initial upon hire to department: the Nurse director/delegate will assess the RN's ability to perform the procedure
    2. Annually: the Nurse director/delegate will evaluate the RN competency annually as part of the performance review process.

Procedures:

A. Order Placement

B. Patient Preparation
    1. Patient should not fast before the procedure.
    2. Chronic diuretic medications shall be held the morning of the study.
    3. Explain procedure to patient, and confirm patient understands process and purpose of this exam.
    4. Intravenous (IV) access shall be established using a 22-24 gauge cannula by the RN or imaging tech.

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

C. Hydration

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

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

E. IV administration guidelines for diuretic agents in renal scintigraphy

1. Monitor for signs and symptoms of anaphylaxis.
2. RN to administer furosemide IV bolus on frame ~~20 of 40~~12 of 30 after radiotracer injection. 1 frame = 1 minute.
3. Adult furosemide dose: 0.5 mg/kg or 40 mg
    a. Higher doses to a maximum (Max) of 80 mg may be administered in those patients with impaired renal function or on chronic diuretic use at home.
    b. Administer the IV push over 1-2 minutes.
4. Pediatric furosemide dose: 1 mg/kg (Max 40 mg)
    a. Pharmacy to dispense furosemide 2 mg/mL in Normal Saline (NS)
    b. Administer the IV push over 5 minutes.

Medications:

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

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

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

	minutes.	Flush immediately after with 10 mL of NS.

Equipment:

Gamma Camera

Low energy high resolution collimator

Documentation:

Document in patient chart the following:

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

References:

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

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Attachments

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending

Step Description	Approver	Date
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Interdisciplinary Practices Committee	Stephanie Denson: Manager, Medical Staff Office	1/20/2026
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
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	12/9/2025
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References:	

NPP.09 Nursing Wound Prevention and Wound Care Protocol

Policy:

To provide a guideline and standardized procedure for the Registered Nurse (RN) for the initiation of standard wound prevention and wound care interventions ~~and wound prevention interventions~~ when patients meet assessment criteria.

It is the policy of Ventura County Medical Center and Santa Paula Hospital that all standardized procedures are developed collaboratively and approved by the Interprofessional Practice Committee (IPC), whose membership consists of Physicians, Registered Nurses (RN), Pharmacists, Advanced Practice Nurses and Administrators. Standardized procedures are reviewed every three years.

To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, all approved standardized procedures will be kept in Policy Stat. The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

~~Function~~Functions to Be Performed:

The RN will perform a detailed skin assessment including Braden score to identify patients at risk of developing a pressure injury. Based on nursing assessment of a Braden score ≤18 and/or identification of a stage I pressure injury, the nurse will initiate the **Wound Prevention Power Plan.**

Based on nursing assessment of a suspected pressure injury of stage II or greater, or impaired skin integrity, nurse will initiate the **Nursing Adult Wound Care Power Plan.** ~~**Wound Care Power Plan.**~~

Applicable Departments:

All adult nursing departments will follow this protocol.

Definitions:

Impaired skin integrity refers to a condition in which the skin's normal structure, function, or protective

barrier is damaged. This may include breaks in the skin (such as wounds, ulcers, abrasions, or tears), inflammation, or alterations in texture, color, or temperature. Impaired skin integrity can result from pressure, moisture, friction, shear, trauma, poor nutrition, decreased mobility, or underlying medical conditions.

Roles and Responsibilities

See policy 108.021 Pressure Injury Prevention and Wound Management for roles of Wound Care Team and Licensed Practitioner (LP).

The Wound Prevention Power Plan for standardized wound prevention interventions and wound care interventions will be initiated by the RN. RN's will review and implement these functions whenever a nursing assessment meets identified criteria.

The wound prevention and adult wound care power plans detailed in this policy are established to expedite the initiation of standardized wound prevention and wound care interventions when pressure injury risk and/or impaired skin integrity is identified. All interventions are to be documented in the Electronic Health Record (EHR).

A. Scope of supervision required
    1. The RN is responsible and accountable to their Nursing Department Director.
    2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the RN by phone or in person.
    3. Provider consultation is to be obtained under the following circumstances
        a. Emergency conditions requiring prompt medical intervention
        b. Upon the request of the patient, RN or physician
        c. Anytime any deviation from this protocol is necessary
    4. Limitations on Settings-**Nursing Adult Wound Care Power Plan** to be used only in **adult** acute care units
B. Requirements for the RN
    1. Active California RN license
    2. Life Support Certification: Basic (BLS)
    3. Introduction to nursing practice protocol via online education with demonstrated competency validation
C. Evaluation of the RN competence
    A. Initial upon hire to department: the Nurse director/delegate will assess the RN's ability to perform the procedure
    B. Annually: the Nurse director/ delegate will evaluate the RN's ability to perform this procedure during performance review cycle
D. A list of RN's who demonstrate competency to perform this procedure is held by the Nurse director/ manager

Procedures:

Skin and Risk Assessment

A. Assessment/Reassessment- ~~*Please refer to Policy 108.021 Pressure Injury Prevention and Wound*~~ *Please refer to Policy 108.021 Pressure Injury Prevention and Wound*

   1. Risk Assessment
      a. Use Braden scale to assess skin breakdown risk.
   2. Skin assessment per unit guidelines. *Please refer to policy Policy* ~~*100.015 Patient Assessment and Reassessment (Attachment A)*~~*100.015 Patient Assessment and Reassessment (Attachment A)*

B. Treatment/Intervention

   1. Initiate Interdisciplinary Plan of Care (IPOC), related to skin integrity, for patients with actual or at risk for impaired skin integrity e.g., Pressure Ulcer Prevention, Pressure Ulcer Management, ~~Pressure Ulcer Prevention,~~ Impaired Skin Integrity.
   2. Implement interventions based on risk assessment and/or identification of skin integrity issue:
      a. Braden Score ≤ 18 (18 or below)
         i. Initiate the **Wound Prevention Power Plan.** This bundle includes:
            a. Wound prevention education
            b. Communication order to implement IPOC- Pressure Ulcer Prevention
            c. Protective Zinc ointment BID and PRN- see policy *PH.69 Medications Stored at Bedside for Self Administration*
      b. Suspected or confirmed pressure injury present greater than stage I:
         i. In addition to Wound Prevention Power Plan, initiate **Nursing Adult Wound Power Plan.** This bundle includes:
            a. Nutrition consult
            b. Juven dietary supplement order
            c. Wound consult order
            d. Skin integrity photos
            e. Wound management education
            f. Communication order to initiate IPOC- Skin integrity issue or Pressure Injury
            g. Protective Zinc ointment order- BID and PRN- see policy *PH.69 Medications Stored at Bedside for Self Administration*

Documentation:

A. The RN will document the following in the electronic health record (EHR)

   1. Skin assessment and Braden Risk assessment per unit guidelines as outlined in ~~*policy 108.021 Pressure Injury Prevention and Wound Management and 100.015 Patient Assessment and Reassessment (Attachment A)*~~ *policy 108.021 Pressure Injury Prevention and Wound Management and 100.015 Patient Assessment and Reassessment (Attachment A)*

2. Initiate and update IPOC
3. Wound Photo
4. Any medication(s) applied in the Medication Administration Record (MAR)
5. Any interventions (prevention dressing, treatments, ~~prevention dressing,~~ nutritional supplements)
6. Patient education

References:

1. Preventing Pressure Ulcers in Hospitals. Content last reviewed February 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/index.html
2. The Joint Commission. (2022, March). *Quick Safety Issue 25: Preventing pressure injuries*. Oakbrook Terrace, IL. Available at: https://digitalassets.jointcommission.org/api/public/content/Quick-Safety-25-UPDATE-3-21-22.pdf (digitalassets.jointcommission.org)

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/13/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/13/2026
Nursing Education	Sharon Waechter: Clinical Nurse Manager, Nursing Education	2/13/2026
Protocol Author	Misty Svestka: VCMC - QAPI	1/14/2026

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PH.115 Medication Boxes and Kits

POLICY:

Medication boxes and kits shall be available upon the approval of the Pharmacy & Therapeutics Committee. Medication boxes and kits shall serve a specific purpose for scenarios where the regular medication distribution process is deemed to be insufficient for patient care. Medications boxes and kits shall be secured with red breakable numbered locks or ties controlled by the Pharmacy Department. Medication boxes and kits shall be stored in agreed upon secure locations as listed in Attachment A Locations of Medication Boxes & Kits.

Exception: This policy does not apply to medication trays stored in crash carts. Refer to policy 100.113 Crash Cart Checks and Restocking Process for information on crash cart medication trays.

PROCEDURE:

A. A list of contents shall be viewable on the exterior surface of each medication box or kit. The attachments to this policy specify the contents of each kit.

B. The expiration date of the earliest expiring medication shall appear on the exterior surface of each medication box or kit.

C. A billing sheet shall be supplied in each medication box or kit.

D. Upon use, the nurse shall document the patient name, medical record number or financial identification number, date of use and medication(s) used on the billing sheet.

E. After use, the nurse shall return the used medication box or kit to the Pharmacy Department. The Pharmacy Department shall provide the nurse with a replacement medication box or kit.

F. The pharmacist shall replenish the used medication box or kit, secure the medication box or kit with a red breakable numbered lock or tie and record the lock or tie number and expiration date of the earliest expiring medication on the exterior surface.

G. Pharmacists shall inspect medication boxes or kits for integrity and the expiration date when performing monthly pharmacy inspections. Any medication box or kit found in an unapproved location shall be removed and returned to pharmacy. Any medication box or kit missing from an approved location shall be replenished.

H. Any medications boxes or kits that do not have a designated location outside of the pharmacy shall be checked out of the pharmacy and returned to the pharmacy after use.

List of Medication Boxes & Kits

Anaphylaxis Kit

Anaphylaxis Kit shall be available in the event a patient has an ~~allergic~~anaphylactic reaction.

Anesthesia and Sedation Medication Box

Anesthesia and Sedation Medication Box shall be available to anesthesiologists for procedures performed outside of the OR setting or to intensivists for moderate to deep sedation procedures. See attachment C for the *Anesthesia and Sedation Medication Box Log Sheet* and *Anesthesia and Sedation Medication Box Medication Administration Record*

A. Only the anesthesiologist or intensivists can sign out an Anesthesia and Sedation Medication Box from the pharmacy.
    1. Change of custody shall be documented on the *Anesthesia and Sedation Medication Box Log Sheet* by both the pharmacist and the anesthesiologist/intensivists. The following shall be documented:
        a. The Anesthesia and Sedation Medication Box number.
        b. The date and time of sign out.
        c. The name and signature of both the anesthesiologist/intensivists and the pharmacist.
        d. The number of fentanyl 100 mcg/2 mL vials and midazolam 2 mg/2 mL vials secured in the Anesthesia and Sedation Medication Box.
        e. The medication box seal number.
B. Only one Anesthesia and Sedation Medication Box may be checked out by one anesthesiologist/ intensivists.
C. The Anesthesia and Sedation Medication box must be with the anesthesiologist/intensivists at all times. It may not change hands and may not be left unattended.
D. The anesthesiologist/intensivist is responsible for all of the contents contained within the Anesthesia and Sedation Medication Box while it is checked out of the pharmacy.
    1. If the Anesthesia and Sedation Medication Box is used, medication administration shall be documented on the *Anesthesiologist Medication Box Medication Administration Record (MAR).*
    2. The anesthesiologist/intensivist shall also document their name, sign and date the *Anesthesia and Sedation Medication Box MAR*.
E. Once the anesthesiologist/intensivist no longer needs the Anesthesia and Sedation Medication Box, it must be returned to the pharmacy by the anesthesiologist/intensivist who signed out the box earlier that day.
    1. Change of custody shall be documented on the *Anesthesia and Sedation Medication Box Log Sheet* by both the pharmacist and the anesthesiologist/intensivist. The following shall be documented:
        a. The date and time of return.
        b. The name and signature of both the anesthesiologist/intensivist and the pharmacist.
        c. The number of fentanyl 100 mcg/2 mL vials and midazolam 2 mg/2 mL vials remaining in the Anesthesia and Sedation Medication Box.
    2. The pharmacist and the anesthesiologist/intensivist shall review the *Anesthesia and Sedation*

Medication Box MAR together.

a. The pharmacist shall also confirm that the anesthesiologist/intensivist has documented their name, signed and dated the *Anesthesia and Sedation Medication Box MAR*.

3. The pharmacist and the anesthesiologist/intensivist shall reconcile the amount at check out with the amount used and/or wasted and the amount returned to the pharmacy. These amounts shall be the same.
    a. Any discrepancy shall be immediately reported to the Director of Pharmacy Services.
4. The pharmacist shall refill the Anesthesia and Sedation Medication Box.
    a. The KitCheck refill record and a new *Anesthesia and Sedation Medication Box MAR* shall be secured in the Anesthesia and Sedation Medication Box once the refill process is complete.
        i. The pharmacist shall document the refill date and sign the new *Anesthesia and Sedation Medication Box MAR*.
        ii. The new *Anesthesia and Sedation Medication Box MAR* shall be on top of the KitCheck refill record.
        iii. The pharmacist shall ensure that the KitCheck refill record and the new *Anesthesia and Sedation Medication Box MAR* do not obstruct the view of the fentanyl and midazolam vials.
    b. The pharmacist shall check the medication box expiration sticker. If needed, the pharmacist shall apply a new medication box expiration sticker.
    c. The pharmacist shall seal the Anesthesia and Sedation Medication Box with a new red breakable numbered lock or tie. The new seal number shall be documented on the *Anesthesia and Sedation Medication Box Log Sheet*.
5. The used *Anesthesia and Sedation Medication Box MAR* and the Narcotic Delivery Signature Receipt (if applicable) shall be filed with Pharmacy Administration.

Cardiac Medication Box

Cardiac Medication Box shall be available in the Emergency Department in the event of a prolonged resuscitation effort.

~~Code Blue Medication Box~~

~~Code Blue Medication Box shall be available to the ICU nurse and Rapid Response Team responding to a medical emergency.~~

Code Blue Pharmacy Medication Box

Code Blue Pharmacy Medication Box shall be available for use by a pharmacist when responding to a medical emergency.

~~Code White Pharmacy Medication Box~~

~~Code White Pharmacy Medication Box shall be available for use by a pharmacist when responding to a pediatric medical emergency.~~

Code Stroke Medication Box

Code Stroke Medication Box shall be available at Ventura County Medical Center for use by a pharmacist

when alteplase is needed for an ischemic stroke. See policy 100.226 Acute Stroke Management/Code Stroke.

~~Epidural Medication Kit~~

~~Epidural Medication Kit shall be available at Santa Paula Hospital for use by an anesthesiologist during the placement of an epidural.~~

~~Extravasation Kit~~

~~Extravasation Kit shall be available in the event of an extravasation or infiltration. See policies 100.250 Management of Extravasation/Infiltration Due to Non-Chemotherapy Medication Administration and 100.251 Administration and Extravasatin of Antineoplastic Agents~~

~~GI Lab Transport Medication Box~~

~~GI Lab Transport Box shall be available in the event a patient needs to be transferred to and from the GI Lab.~~

Hydrofluoric Acid Exposure Kit

Hydrofluoric Acid Exposure Kit shall be available in the event there is a hydrofluoric acid exposure.

~~Infusion Hypersensitivity Kit~~

~~Infusion Hypersensitivity Kit shall be available for use by the Infusion Center Nursing staff in the event there is an infusion related reaction.~~

Intubation Kit

Intubation Kit shall be available in the event a patient needs to be intubated.

~~Neonatal Resuscitation Box~~

Neonatal resuscitation box

Neonatal Resuscitation Box shall be available ~~at Santa Paula Hospital for neonatal resuscitation~~in the event of high risk deliveries.

~~NICU Transport~~OB Epidural Medication ~~Box~~Tray

OB Epidural Medication Tray shall be available in OB Labor and Deliver unit for use by an anesthesiologist during the placement of an epidural.

PICU Intubation and Transport Kit

~~NICU~~PICU Intubation and Transport ~~Medication Box~~Kit shall be available in the event a ~~NICU~~PICU patient needs to be transported to and from the ~~NICU~~PICU.

~~PICU Transport Medication Box~~

~~PICU Transport Medication Box shall be available in the event a PICU patient needs to be transported to and from the PICU.~~

Pyxis Anesthesia Emergency Drug Kit

Pyxis Anesthesia Emergency Drug Kit shall be available to the Anesthesiologist during OR procedures.

All revision dates: 1/29/2026, 5/15/2024, 7/13/2022, 8/10/2021, 8/11/2020, 11/26/2018

Attachments

- Attachment A: Locations of Medication Boxes and Kits
- Attachment B: Medication Boxes and Kits Billing Sheets
- Attachment C: Medication Boxes and Kits Content Label

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/20/2026
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	2/20/2026

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*11/10/2020*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/14/2022*
Next Review:	*3 years after approval*
Owner:	*Jessica Rodriguez: Manager, Cardiopulmonary Services*
Policy Area:	*Respiratory Care*
References:	

R.96 Inhaled Epoprostenol (Flolan)

POLICY

- To establish the standard for safe and effective use of inhaled epoprostenol. Additionally, this Policy and Procedure serves as an educational tool to provide the appropriate indication, administration, management and monitoring of inhaled epoprostenol for physicians, pharmacists, nurses, and respiratory care practitioners.
- Epoprostenol is a synthetic prostacyclin that mimics the actions of natural prostacyclin. Prostacyclin is a substance produced by vascular endothelium that has vasodilating, antiplatelet aggregation and cytoprotective effects.
- Order for epoprostenol should be provided as STAT priority as appropriate. Respiratory care services is responsible for the set up and administration of aerosolized epoprostenol via the Aeroneb Solo System (in the continuous mode) and infusion pump. Infusion pump flow rate is adjusted to deliver prostacyclin solution that will result in a desired aerosolized dose per hour.
- Inhaled epoprostenol will be delivered via nebulization. During continuous nebulization operation, the nebulizer is “ON” continuously and the medication is nebulized on drop by drop basis as it reaches the aerosol generator. The nebulizer will run dry between drops. This does not affect the dosing.

INDICATIONS

A. Treatment of hypoxic respiratory failure in adults with a PaO2/FiO2 ratio of less than 150 and/or has hemodynamic instability that will not tolerate high levels of positive end expiratory pressure (PEEP).

B. Treatment of pulmonary hypertension.

1. Pulmonary hypertension (mPAP > 30 mmHg) and/or right ventricular dysfunction (CVP > 15 mmHg), cardiac index (CI) <2.5 L/min/m2 and/or hypoxia with marginal hemodynamics/oxygenation despite optimal inotropic/mechanical therapy.

EXCLUSIONS

A. Severe hemodynamic instability

B. Patients on mechanical ventilators with high PEEP dependency where breaking the circuit could be detrimental to lung recruitment.

CONTRAINDICATIONS

A. Allergy or sensitivity to epoprostenol or glycine diluent

B. Discontinue if patient develops pulmonary edema during dose initiation.

C. Active pulmonary hemorrhage

D. Pregnancy

E. Pediatrics

F. Neonates

G. Patients with significant bleeding

POTENTIAL RISKS

A risk associated with epoprostenol nebulized through a ventilator is ventilator failure. Epoprostenol may increase the risk of ventilator valves malfunction. This may result in significant auto-PEEP and hypotension. The ventilator must be protected by two disposable filters to alleviate this risk.

SIDE EFFECTS

A. Rebound hypoxemia and pulmonary hypertension from abrupt withdrawal

B. Systematic hypotension

C. Bleeding (decrease in platelet aggregation)

D. Nausea/vomiting, hypotension, chest pain, dyspnea, bradycardia, tachycardia, headache, anxiety or dizziness

E. Facial flushing

ASSESSMENT OF OUTCOME

A. The desired effect is improved oxygenation as measured by PaO2, decrease mean pulmonary artery pressure (mPAP), and decrease central venous pressure (CVP).

B. A 20% increase in PaO2 is recommended as the minimum response. For pulmonary hypertension, a 20% decrease in mPAP at any point indicated a positive response.

C. If minimum response is not achieved in 4 hours, physician will be contacted and discontinuation of inhaled epoprostenol should be considered.

PROCEDURE

EQUIPMENTS

A. Designated infusion syringe pump.

B. Heated high flow nasal cannula (HHFNC) or ventilator

C. Four (4) Iso-Gard HEPA Light filters - two (2) filters for initial set up and two (2) as standby

D. Aeroneb Solo nebulizer cup (keep 1-2 extras at bedside)

E. Epoprostenol prepared by the pharmacy department in a 50 mL syring

F. Aeroneb t-piece

G. Appropriate sticker labels

H. Cardiopulmonary resuscitation (CPR) bag for adult

RESPONSIBILITIES

Attending Physician

A. RESTRICTED TO ADULT INTENSIVE CARE UNITS

B. All orders must be entered by an attending physician via the EHR with specific indication. Indication determines target goal for dose titration.

C. Epoprostenol medication orders will reflect initial dosing, weaning, or maintenance dosing. Upon cessation of therapy, all active orders must be discontinued via the EHR.

D. Patient's nurse and respiratory therapist are notified regarding any therapy initiation, request for dose titration, or therapy cessation.

E. Epoprostenol dosing is based on *ideal body weight* (kg). Round the weight to the nearest 10 kg for dosing. See Table 1.

1. Male: 50 kg + 2.3 kg for each inch over 5 feet
2. Female: 45.5 kg + 2.3 kg for each inch over 5 feet

F. Order arterial blood gas (ABG) as clinically relevant based on patient's clinical status.

Respiratory Therapist

A. The RT will call RT supervisor/manager to inform them before starting epoprostenol.

B. The RT will obtain the necessary parts listed under the EQUIPMENT section.

C. The RT will obtain and manage dedicated syringe infusion pump.

D. The RT will assemble Aeroneb nebulizer and infusion pump set-up.

1. For non-intubated patient, connect the infusion tubing to the luer lock connector on the Aeroneb nebulizer cup that is inline with the circuit on the dry side.
2. For intubated and on ventilator patient, attach nebulizer inline with ventilator set up at the dry side of the heater chamber.

E. The RT will place labels "Inhaled EPOPROSTENOL" on syringe pump and Aerogen Solo Continuous Nebulization Tube Set.

F. First, prime the tubing, connect the pre-filled syringe with a standard concentration of epoprostenol obtained from pharmacy to the syringe infusion pump.

G. RT and RN will perform verification double check for 7-rights of medication administration, and both individual will initial/sign-off on pre-filled epoprostenol syringe *and* on the EHR. See Policy 100.025 Medications: Ordering, Administration and Documentation. and PH.70 High Alert Medication

1. Prior to starting the infusion, RT will document the following in the patients EHR:
    a. Complete ventilator check including plateau pressure, auto-PEEP, airway resistance and compliance as appropriate to ventilator mode.
2. Hemodynamic parameters including heart rate (HR), blood pressure (BP), and Oxygen Saturation and if available, pulmonary artery pressure (PAP).

H. Set the pump to deliver ordered dose using hospital approved guardrail function and set the "Volume to be infused" on the pump to 10 mL below the medication fill-line. Syring must be protected from light during the entirety of infusion.

I. Epoprostenol syringe change will be based on the rate of administration.

1.

Aerosolized Epoprostenol rate	Minimum syringe change frequency
≤ 5 mL/hr	Every 8 hours
6 – 6.9 mL/hr	Every 7 hours
7 – 7.9 mL/hr	Every 6 hours
≥ 8 mL/hr	Every 5 hours

Aerosolized Epoprostenol rate	Minimum syringe change frequency
≤ 5 mL/hr	Every 8 hours
6 – 6.9 mL/hr	Every 7 hours
7 – 7.9 mL/hr	Every 6 hours
≥ 8 mL/hr	Every 5 hours

2. RT must request new syringe from pharmacy at least 1 hour priot to change time.
3. Discard the left-over drug into the appropriate blue co-mingled Pharmaceutical waste bin.

J. Hand off report will be given at bedside verifying medication, dosage, change of the syringe time, change of the filter time, nebulizer set up and which number of syringe is currently in use.

K. For patients on mechanical ventilators, RT will change one of the two HEPA disposable ventilator filters in use connected back to back (one closest to the circuit), every 2 hours. Then rotate the next filter in line to the position nearest ventilator circuit and place the new filter behind it.

L. Filters will be disposed in the regular trash.

M. Humidity level on the ventilator or HHFNC should be kept at optimal level.

N. Change epoprostenol tubing every syringe change.

O. When the drug is discontinued, notify the supervisor/manager.

Nursing

A. Nursing will be part of the verification double check at patient bedside with RT to ensure 7-rights of medication administration. See Policy 100.025 Medications: Ordering, Administration and Documentation, and PH.70 High Alert Medication

B. During initial dosing, nurse will obtain and record:

1. Hemodynamics (HR, mean arterial pressure (MAP), oxygen (O_2) saturation, and when possible, mPAP, and cardiac output (CO)) at baseline, then every 15 minutes for the first half-hour then every 30 minutes for the second half-hour, then every 1 hour thereafter.

C. After any change in dose, nurse will obtain and record hemodynamics (HR, MAP, O_2 saturation, and when possible, mPAP, and CO) at baseline, then every 15 minutes for the first half-hour, then every 30 minutes for the second half-hour, then every 1 hour thereafter.

Pharmacy preparation and hand-off

A. Pharmacy will prepare epoprostenol solution for nebulization (Final concentration = 30,000 ng/mL = 1.5 mg epoprostenol in 50 mL diluent) in a syringe. (ng = nanogram)

1. Pharmacy will protect final compounded preparation in a green/brown, opaque plastic bag to protect from light.
2. The syringe is stable at room temperature for 8 hours and stable in the refrigerator for 48 hours.

3. Pharmacy will adhere auxillary label "INHALED Epoprostenol" on the syringe label.

B. Epoprostenol syringes will be kept in the pharmacy at all times and doses will be dispensed from the pharmacy.

C. Hand off of the syringe must be done by a pharmacy personnel directly to the RT responsible for changing the syringe at bedside.

D. A back-up syringe should be made and kept in the refrigerator in the pharmacy until full discontinuation of therapy.

E. RTs to label the syringe infusion pump and the tubing as “INHALED Epoprostenol” at bedside.

DOSING

******ALL dosing must be done based on ideal body weight rounded to the nearest 10 kg******

Acute Respiratory Distress Syndrome

- Initiate at a dose of 50 ng/kg/min via continuous nebulization. Doses higher than 50 ng/kg/min has not been studied in ARDS.
- The dose of epoprostenol should be decreased by 10 ng/kg/min every 2 hours as tolerated by the patient when weaning off therapy.

Pulmonary Hypertension, Right Heart Failure Following Pulmonary Embolism, Severe Right Heart Failure

- Inhaled epoprostenol therapy may be considered for patients with refractory hypoxemia and mean pulmonary artery pressure >30 mmHg, PaO2/FiO2 <150, or cardiac index less than 2.2 L/min/m^2.
  - Initiate at a dose of 10 ng/kg/min.
  - The dose of epoprostenol may be titrated up by 10 ng/kg/min every two hours to a maximum of 50 ng/kg/min.

Table 1. Aerosolized Epoprostenol rate in **mL/hr** based on 1.5 mg/50 mL syringe (30 mcg/mL = 30,000 ng/mL)

Epoprostenol dose in ng/kg/min	Dosing Ideal Body Weight in kg						
	40 kg	50 kg	60 kg	70 kg	80 kg	90 kg	100 + kg
10	0.8	1	1.2	1.4	1.6	1.8	2
20	1.6	2	2.4	2.8	3.2	3.6	4
30	2.4	3	3.6	4.2	4.8	5.4	6
40	3.2	4	4.8	5.6	6.4	7.2	8
50	4	5	6	7	8	9	10

WEANING

A. The RT, nurse, and attending physician must evaluate and document on EHR the patient's readiness to wean at least twice daily.

B. The patient must be weaned in 2 to 4 hour increments.

C. New order from the attending physician must be entered via EHR prior to each weaning attempt.

D. “Failure to wean” is defined as:

1. An increase in mPAP by 20% or decrease in PaO2 by 20%
2. A return to baseline hemodynamic parameters

3. Patient response should be assessed at 15 and 30 minutes after reducing the dose
4. If dose reduction is successful, continue current dose and readdress need for additional weaning
5. If dose reduction failed, resume previous dose in conjunction with new order placed by attending physician on EHR

DISCONTINUATION

A. May discontinue therapy once the patient has been weaned successfully to 10 ng/kg/min.
B. Remove applicable nebulizer from patient breathing circuit.
C. For intubated patients remove HEPA filter from expiratory limb.
D. Document discontinuation in patients medical record.

Reference

1. Ammar, Mahmoud A., et al. "Noninferiority of inhaled epoprostenol to inhaled nitric oxide for the treatment of ARDS." *Annals of Pharmacotherapy* 49.10 (2015): 1105-1112.

2. Ammar, Mahmoud A., Madhu Sasidhar, and Simon W. Lam. "Inhaled epoprostenol through noninvasive routes of ventilator support systems." *Annals of Pharmacotherapy* 52.12 (2018): 1173-1181.

3. Buckley, Mitchell S., and Jeremy P. Feldman. "Inhaled epoprostenol for the treatment of pulmonary arterial hypertension in critically ill adults." *Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy* 30.7 (2010): 728-740.

4. Davis, Stephanie L., et al. "Use and costs of inhaled nitric oxide and inhaled epoprostenol in adult critically ill patients: A quality improvement project." *American Journal of Health-System Pharmacy* 76.18 (2019): 1413-1419.

5. Epoprostenol [Package Insert]. GlaxoSmithKline. 2019

All revision dates: 12/14/2022, 11/10/2020

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	3/3/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	2/11/2026
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	1/26/2026

VENTURA COUNTY MEDICAL CENTER
A Division ofthe Ventura County Health Care Agency

PEDIATRICS DEPARTMENT
VCMC / SPH - OPPE REPORT

MEDICAL STAFF OFFICE / CONFIDENTIAL INFORMATION					
Practitioner:	Year(s) of Review: 2026-2027				
Specialty: Pediatrics /	Medical Liability Claims since last appointment: No / Yes (circle)				
PATIENT CARE	**Jan - June 2026 (1)**	**July - Dec 2026 (2)**	**Jan - June 2027 (3)**	**July - Dec 2027 (4)**	**Bench-mark / Triggers**
Clinical Activity					
CLINICAL JUDGMENT					
Opportunity for Improvement Identified in Peer Review					
Total # Cases Reviewed					
P1- Prescribed to the wrong patient					
P2- Prescribed a medication with a known allergy to the medication					
MEDICAL / CLINICAL KNOWLEDGE					
CME/ CEU'S (doc. due @ reappt for previous 2 yrs.)	Y	Y	Y	Y	
MOC / Board Certified Y/N	Y	Y	Y	Y	
INTERPERSONAL / COMMUNICATION SKILLS					
Patient Complaints / Dissatisfaction / Comments					
Concerns from Staff					
PROFESSIONALISM					
Documented Interventions (i.e. letters of concern, etc.)					
Peer Reviews - Refusal to participate (i.e. refusing to do peer reviews 2x in 6 months review cycle)					
Administrative Suspension - Including Delinquent Records (cumulative days)					
TECHNICAL / CLINICAL SKILLS *(Pediatrics)*					
Unplanned Extubation w/ Reintubation (PICU/NICU)					>1
Readdmission within 72 hrs - Same dignosis (Inpatient)					>2
Appropriate use of antibiotics in URI (Outpatiemt)					>10%
Well child visits for the first 30 months of life					<72%

☐ No concerns or trends noted:_____ ☐ Concerns or trends identified:_____

_____

_____

_____

_____

Chair Signature:_____ **Date:** _____

Delineation Of Privileges

Pulmonary Medicine Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

Initial Criteria:
a. Successful completion of an ACGME or AOA accredited residency in internal medicine or pediatrics and fellowship in pulmonary medicine
b. Current certification with sub-specialty in Pulmonary Disease or active participation in the examination process leading to certification within 2 years of the first opportunity to take the exam
c. Documentation of a minimum of 100 cases within the previous 24 months related to the requested privileges

Evaluation Criteria:
A minimum of 5 cases (***** Requires concurrent evaluation)
All other cases may be concurrent or retrospective evaluation

Renewal Criteria:
A minimum of 100 cases within the previous 24 months related to the requested privileges

Pulmonary Medicine Core Privileges

Admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment to patients presenting with conditions, disorders, injuries, and diseases of the organs of the thorax or chest, the lungs, cardiovascular and tracheobronchial systems, esophagus and other mediastinal contents, diaphragm, and circulatory system	___	___	___	___
Consultation only	___	___	___	___
Arterial line placement	___	___	___	___
Arterial puncture (blood gases)	___	___	___	___
Insertion of arterial, central venous, and pulmonary artery balloon flotation catheters	___	___	___	___
Endotracheal intubation	___	___	___	___
Pulmonary function tests and interpretation	___	___	___	___
Thoracentesis	___	___	___	___
Ventilator Management Includes: - Ventilatory support to include BiPAP - Weaning, and respiratory care techniques - Maintenance and withdrawal of mechanical ventilatory support	___	___	___	___
Bronchoscopy with or without biopsy*	___	___	___	___
*Direct observation of a minimum of 2 cases to be evaluated for initial bronchoscopy privileges				
Chest tube placement*	___	___	___	___
*Direct observation of a minimum of 2 cases to be evaluated for initial chest tube placement privileges				

Supplemental Privileges
(must also meet criteria above)

Delineation Of Privileges

Pulmonary Medicine Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

Adult Moderate or Deep Sedation ___ ___ ___ ___

Initial Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria:
A minimum of 3 cases evaluated

Renewal Criteria:
a. Current ACLS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If the volume is not met, the next case evaluated

Pediatric Moderate or Deep Sedation
Initial Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)

Evaluation Criteria:
A minimum of 3 cases evaluated

Renewal Criteria:
a. Current PALS
b. Completion of Sedation Module (minimum score of 80%)
c. A minimum of 6 cases within the previous 24 months
- If the volume is not met, the next case evaluated

Endobronchial Ultrasound (EBUS)* ___ ___ ___ ___

Initial Criteria:
Certificate of training from endobronchial ultrasound vendor course **OR** documentation of training and competency from fellowship program

Evaluation Criteria:
A minimum of 2 cases evaluated via direct observation

Renewal Criteria:
A minimum of 20 cases in the previous 24 months

Delineation Of Privileges

Pulmonary Medicine Privileges

Name:

Privilege	Requested	Granted	Deferred	Suspended

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 ambulatory clinics. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.

Applicant's electronic signature on file

TEMPORARY PRIVILEGE APPROVAL

Department Chief's Signature: _____ Date: _____

Evaluator Assignment: _____

[ ] PROVISIONAL [ ] RENEWAL APPROVAL

_____
Chief, Department of Medicine Date