

#	Title	Review Period	Summary of Changes
1	107.050 Recognition and Evaluation of Abuse	Triennial	Added ambulatory care to policy line
	L.HIST.35 Processing a Death	Biennial	Adding hyperlink to referred policy; removing duplicative information.
3	L.BB.32 Blood Bank Issue of Blood Products	Biennial	Bennial review. Revised references
4	L.O5 Laboratory Document Control	Biennial	Biennial review. Revised to include process for document control of manual logs and forms.
5	L.O4 Medical Direction of the Laboratory	Biennial	Biennial review. Revised to update laboratory medical directorship, attached site visit log, and added references.
6	L.BG.01 ABG Logs and Record Keeping	Biennial	Changed policy area and policy number. No content change.
7	L.BG.02 Analytical Measurement Range Validation	Biennial	Changed policy area and policy number. No content change.
8	L.BG.03 Analyzer Calibrations	Biennial	Changed policy area and policy number. No content change.
9	L.BG.04 Arterial Blood Gas Laboratory Chemical Hygiene Plan	Biennial	Changed policy area and policy number. No content change.
10	L.BG.05 Arterial Blood Gas Laboratory Safety Policy	Biennial	Changed policy area and policy number. No content change.
11	L.BG.06 Arterial Blood Gas Sample Analysis	Biennial	Changed policy area and policy number. No content change.
12	L.BG.07 Arterial Blood Gas Sampling and Testing Proficiency Program	Biennial	Changed policy area and policy number. No content change.
13	L.BG.08 Arterial Blood Gas Sampling	Biennial	Changed policy area and policy number. No content change.
14	L.BG.09 Arterial Line Blood Draws	Biennial	Changed policy area and policy number. No content change.
15	L.BG.10 Availability of Blood Gas Test Procedures to Clients	Biennial	Changed policy area and policy number. No content change.
16	L.BG.11 Biennial Review of Respiratory Care Manuals and Documents	Biennial	Changed policy area and policy number. No content change.
17	L.BG.12 Respiratory Care Refrigerator and Room Temperature Quality Control	Biennial	Changed policy area and policy number. No content change.
18	L.BG.13 Blood Gas Laboratory Quality Assurance Program	Biennial	Changed policy area and policy number. No content change.
19	L.BG.14 Blood Gas Laboratory RapidPoint 500 Analyzer Quality Control Program	Biennial	Changed policy area and policy number. No content change.
20	L.BG.15 Blood Gas Test Ordering Options	Biennial	Changed policy area and policy number. No content change.
21	L.BG.16 Rejection of Arterial Blood Gas Samples and Requisitions	Biennial	Changed policy area and policy number. No content change.
22	L.BG.17 Arterial Blood Gas Laboratory Analyzer Calibration Verification	Biennial	Changed policy area and policy number. No content change.
23	L.BG.18 Canceled Requisitions and Rejected Arterial Blood Gas Samples Recordkeeping	Biennial	Changed policy area and policy number. No content change.
24	L.BG.20 Blood Gas Laboratory Report Editing	Biennial	Changed policy area and policy number. No content change.
25	L.BG.21 Handling of Blood Gas Laboratory Samples for Analysis	Biennial	Changed policy area and policy number. No content change.
26	L.BG.22 Blood Gas Laboratory Specimen Labeling Requirements	Biennial	Changed policy area and policy number. No content change.
27	L.BG.23 Time and Dating of Blood Gas Samples	Biennial	Changed policy area and policy number. No content change.
28	L.BG.24 Arterial Blood Gas Sample Turn-Around Time	Biennial	Changed policy area and policy number. No content change.
29	L.BG.25 Central Venous Line Blood Gas Sampling	Biennial	Changed policy area and policy number. No content change.
30	L.BG.26 Blood Gas Laboratory Document Control System	Biennial	Changed policy area and policy number. No content change.
31	L.BG.27 Lactate Sampling for Initial Sepsis Evaluation	Biennial	Changed policy area and policy number. No content change.
32	L.BG.28 Respiratory Care Manual Entry of Test Results	Biennial	Changed policy area and policy number. No content change.
33	L.BG.29 Discontinued Arterial Blood Gas Laboratory Procedures	Biennial	Changed policy area and policy number. No content change.
34	L.BG.30 Post-Analytic Review of Arterial Blood Gas Laboratory Patient Data	Biennial	Changed policy area and policy number. No content change.
35	L.BG.31 Blood Gas Normal Values for Respiratory Care Staff	Biennial	Changed policy area and policy number. No content change.
36	L.BG.32 Designees in the Blood Gas Laboratory	Biennial	Changed policy area and policy number. No content change.
37	L.BG.33 Respiratory Care Certification of ABG Logs and Results	Biennial	Changed policy area and policy number. No content change.
38	L.BG.34 Respiratory Care Arterial Blood Gas Laboratory Scope of Operations	Biennial	Changed policy area and policy number. No content change.
39	L.BG.35 Fire Prevention and Safety in the Blood Gas Laboratory	Biennial	Changed policy area and policy number. No content change.
40	L.BG.36 Respiratory Care Patient Safety During ABG/CBG Sampling	Biennial	Changed policy area and policy number. No content change.
41	L.BG.37 Bleeding of Arterial Blood Gas Analyzer Machines	Biennial	Changed policy area and policy number. No content change.
42	L.BG.38 Respiratory Care Staff Computer Access Levels	Biennial	Changed policy area and policy number. No content change.
43	L.BG.40 Respiratory Care Compliance with CAP Terms of Accreditation	Biennial	Changed policy area and policy number. No content change.
44	L.BG.41 Respiratory Care Communication of Arterial Blood Gas Results	Biennial	Changed policy area and policy number. No content change.
45	L.BG.42 Blood Gas Laboratory Staff Competency Assessment	Biennial	Changed policy area and policy number. No content change.
46	L.BG.43 Respiratory Care EHR Downtime Contingency Plan	Biennial	Changed policy area and policy number. No content change.
47	L.BG.44 Respiratory Care Capillary Blood Gas Sampling	Biennial	Changed policy area and policy number. No content change.
48	L.BG.45 Respiratory Care Department Safety	Biennial	Changed policy area and policy number. No content change.
49	L.BG.46 Biohazardous and Reagent Spill Cleaning for Respiratory Care Staff	Biennial	Changed policy area and policy number. No content change.
50	L.BG.47 Interfacility Transport of Blood Gas Samples	Biennial	Changed policy area and policy number. No content change.
51	L.BG.49 Respiratory Care Venous Blood Gas Sampling	Biennial	Changed policy area and policy number. No content change.

#	Title	Review Period	Summary of Changes
52	L.BG.50 Personal Protective Equipment (PPE) in the Blood Gas Laboratory	Biennial	Changed policy area and policy number. No content change.
53	L.BG.19 CLIA Guidelines	Biennial	Changed policy area and policy number. Updated Medical Director.
54	L.BG.39 CLIA Guidelines for the Respiratory Care Arterial Blood Gas Laboratory	Biennial	Changed policy area and policy number. Updated Medical Director.
55	L.HIST.02 Specimens Requiring Gross Exam Only; Exempt Specimens from Microscopic Examination	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
56	L.HIST.08 Decalcification of Surgical Pathology Specimens	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
57	L.HIST.10 Routine Staining Procedure	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
58	L.HIST.15 Handling of Bone Marrow Specimens Prior to Submission to Pathology	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
59	L.HIST.16 Bone Marrow Specimen Processing	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
60	L.HIST.20 Handling Lymph Nodes For Possible Lymphoma	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
61	L.HIST.21 Techniques For Handling Renal Biopsy Specimens	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
62	L.HIST.22 Processing Tissue For Oncotype DX and OncoExTra Assay	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
63	L.HIST.25 FNA Cross-Contamination and PAP Staining Procedure	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
64	L.HIST.32 Handling, Preparation, and Staining Frozen Sections	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
65	L.HIST.42 Performance Improvement	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
66	L.HIST.44 Self Assessment and Performance Improvement Component of Quality Assurance/Improvement	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
67	L.HIST.61 Guidelines for Examination of the Most Common and Important Surgical Specimens	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
68	L.HIST.63 Competency Assessment of Pathologists	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
69	L.HIST.64 Communication and Recording Significant and Unexpected Surgical Pathology Findings	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
70	L.HIST.66 Special Preparation for Electron, Light, and Immunofluorescence Microscopy	Biennial	Migrated from binder to PolicyStat. Changed owner. Changed policy area. No content changes.
71	L. MIC 7.02 BACT/ALERT® VIRTUO® PROCEDURE	Biennial	Migrated from binder to PolicyStat. No content changes.
72	L.MIC.7.08 Urine Culture	Biennial	Migrated from binder to PolicyStat. No content changes.
73	L.CGL 1.3 Critical Results - Coagulation Department	Biennial	Minor changes in critical result
74	L.CYT.23 Staining Non-Gyn Specimens to Avoid Cross-Contamination	Biennial	Minor edit. Changed owner
75	L.HEM 1.3 Critical Results - Hematology Department	Biennial	Minor edits in the critical results.
76	107.071 Patient Clothing Donations	Triennial	Minor revision for clarity.
77	107.088 Pneumatic Tube System	Triennial	Revised policy number and policy area. Owner changed. Cleaned up formatting. Updated attachment. Added Fainer South Tower units.
78	L.118 Quality Management System Clinical Laboratory Ventura County Medical Center Santa Paula Hospital	Biennial	Reviewed. Revised policy with latest practices
79	L.52 Laboratory Response To Hospital Emergency Call Codes	Biennial	Reviewed. Revised policy with latest practices
80	L.BB.06 Safe-T-Vue® Temperature Indicators	Biennial	Reviewed. Added storage and preparation for Safe Tvue device
81	L.82 Handling and Processing Blood Specimens	Biennial	Reviewed. Added two attachments for Order of draw and mix inversion protocols.
82	L.41 Referral Laboratories	Biennial	Reviewed. Added verbiage for clarity and updated listed laboratories information. Revised reference lab contact info.
83	L.09 Laboratory Staff Roles	Biennial	Reviewed. Minor edit.
84	L.53 Correction and Management of Laboratory Records	Biennial	Reviewed. Revised policy with latest practices
85	L.93 Venipuncture: Winged Blood Collection Sets	Biennial	Reviewed. Revised reference.
86	L.CHEM 3.14 Sweat Chloride	Biennial	Reviewed. Revised to include the new Macroduct advanced collection system and CAP checklist number revision.
87	L.POC.2.2 Clinitek Status Urine hCG Procedures: Quality Control, Patient Testing, and Preventative Maintenance	Biennial	Changed policy area and policy number. No content change.

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88	L.POC.2.1 Clinitek Status UA Dipstick Procedures: Quality Control, Patient Testing, and Preventive Maintenance	Biennial	Revised policy number and policy area. Revised policy with latest practices.
89	L.03 Delegation of Responsibilities in the Laboratory	Biennial	Revised policy with latest practices
90	L.SER.11 Sure-Vue™ RF Test	Biennial	Revised policy with latest practices
91	R.70 Respiratory Care Scope of Operations and Availability of Services	Biennial	Revised policy with latest practices
92	L.HIST.30 Handling of Tissues Containing Radioactive Material (Sentinel Lymph Nodes, Breast Biopsies, Prostatic "Seeds")	Biennial	Changed policy area and policy number. No content change.
93	L.25 Corrected Laboratory Results	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
94	L.CHEM 3.6 Neonatal Urine Drug Screen	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
95	L.LIS.01 Protected Systems User Authentication, Access Control, and Data Security Policy	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
96	L.LIS.04 User Authentication, User Authorization Privileges, Unauthorized Software Installation, and Intake Procedure	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
97	L.LIS.06 Calculated Patient Data Verification	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
98	L.LIS.07 Laboratory Information System Update Validation Verification	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
99	L.SO.02 Uploading of Patient Reports Securely into PowerChart	Biennial	Revised to add CAP inspector recommendations from March 2026 inspection
100	107.004 Purchasing Policy	Triennial	Triennial Review. Allow approvals for \$1,000 - \$5,000 by Associate Chief Nurse Executive (previously Chief Nurse Executive). Allow approvals for \$5,000 - \$10,000 by Chief Nurse Executive (previously not listed). Updated title on linked policy.
101	100.005 Patient/Visitor Complaints and Grievances	Triennial	Triennial review. Clarified processes in hospital and clinics. Clarified and revised timelines on responses to grievances
102	107.061 Legal Health Record and Designated Record Set	Triennial	Triennial review. Deleted verbiage 'only when that medical staff member has reviewed and signed the Ventura County HCA 10.3 Electronic Signature Policy' from Section F 5. This policy does not exist in Policy Stat per Policy Manager report.
103	EVS.11 Cleaning of Vinyl Chairs	Triennial	Triennial review. Formatted for clarity.
104	F.017 Fire Door Inspections	Triennial	Triennial review. Revised policy number. No content change.
105	F.020 Facilities Maintenance Performance Improvement Plan	Triennial	Triennial review. Revised policy number. No content change.
106	F.044 Compressed Gas Cylinders	Triennial	Triennial review. Revised policy number. No content change.
107	F.089 Construction and Renovation Guidelines	Triennial	Triennial review. Revised policy number. No content change.
108	EVS.42 Ultraviolet Germicidal Irradiation (UVGI)	Triennial	Triennial review. Revised policy with latest practices.



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Next Review 4/28/2029

Owner Danielle Gabele:
Chief Nursing
Executive, VCMC
& SPH
Policy Area Administrative -
Operating
Policies

107.050 Recognition and Evaluation of Abuse

POLICY:

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

PROCEDURE:

I. GENERAL EXPECTATIONS:

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

II. SUSPECTED CHILD ABUSE REPORT:

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

The contact information for the local Child Welfare Services Office is:

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

- III. A "child" is a person under the age of 18 years.
- IV. The term "Mandated Reporter" within the context of suspected child abuse includes but is not limited to the following: A social worker, a physician, psychiatrist, psychologist, resident, licensed nurse, marriage, family and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code .

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

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

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

V. REPORT OF SUSPECTED DEPENDENT ADULT / ELDER ABUSE :

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

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

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

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

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

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

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

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

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

- A. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- B. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- C. In the exercise of clinical judgment, the mandated reporter reasonably believes that the abuse did not occur.
- D. When a Report is not made based upon the above circumstances, the clinical record should include notes describing the patient's report, the patient's diagnosis and conservatorship status, if applicable, attempts made to seek evidence of the patient's report and the lack of evidence, and the clinical judgment and decision-making on the part of the mandated reporter.
- E. **SUSPECTED VIOLENT INJURY / SUSPECTED DOMESTIC VIOLENCE INJURY REPORT**

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

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

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

The reporting requirement is as follows:

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

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

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

PHYSICAL ABUSE

PHYSICAL AND BEHAVIORAL OBSERVATIONS THAT MAY SUGGEST ABUSE

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

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

INDICATORS OF PHYSICAL AND PSYCHOSOCIAL ABUSE

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

SEXUAL ABUSE

INDICATORS OF SEXUAL ABUSE/RAPE

PHYSICAL

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

PSYCHOSOCIAL

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

Adapted from Ramsey-Klawnsnik (1993a)

INDICATORS OF SEXUAL ABUSE/RAPE IN THE CHILD

PHYSICAL

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

BEHAVIORAL

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

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

RECOGNIZING AND RESPONDING TO DOMESTIC VIOLENCE IN A HOSPITAL SETTING

STEP BY STEP CHECKLIST

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

1. Look for Clues from the Patient

- the history of the accident is not consistent with the kind of injury
- there is a time delay between injuries and presentation
- the patient may have an accident-prone history
- suicide attempts or depression
- repetitive psychosomatic complaints
- signs and symptoms of alcoholism and drug abuse
- injury during pregnancy
- signs and symptoms of post-traumatic stress syndrome
- patient is frightened, ashamed, embarrassed or evasive

2. Patient's Companion Can Be a Clue

- if batterer has accompanied patient for medical visit, he asks to stay with patient for entire visit
- s/he answers questions for the patient
- patient may seem afraid or reluctant to disagree with her companion's explanation of what occurred.
- patient does not attempt to speak for him/herself
- companion may display hostility or anger directed at patient or medical staff

3. Clues from the Physical Examination

- victims of domestic violence may try to hide injuries by wearing long sleeves or turtlenecks
- they may conceal black eyes with dark glasses or heavy make-up
- whenever possible, have patients change from their street clothes into a hospital gown.

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

4. What to Do When Patient Says Yes to Questions About Abuse

- most important: assess, with the patient, her safety and that of her children
- ask if she has protective friends or family with whom she can stay
- ask where her children or other dependents are and if she thinks they will be safe
- ask if she wants immediate access to a shelter; if not, provide phone numbers in case she needs to go later
- consider whether she needs immediate physical or psychiatric intervention
- if she wants to go home, be sure a definite follow-up appointment is scheduled
- ask if she wants to report the incident to the police (Medical Staff should be familiar with the response of local police and attorney to battering so they can help the victim understand what to expect)
- involve social worker if available

5. Document Findings

- record a description of the abuse as the patient described it
- record all physical findings using a body map
- if the patient agrees, take instant photographs of injuries - documented evidence of injuries sustained by the patient can play an integral part in both prosecuting the batterer and protecting the victim
- name, date, time, medical record number, as well as doctor's name and that of a witness should be recorded at the bottom of the photo or attached, with photo, to the chart
- efforts should be made to have follow-up pictures taken 24-48 hours after bruises are received because their heightened discoloration will make them more apparent
- If actual size and location of the injuries sustained cannot be adequately determined by standard photographs, use Polaroid Spectra GridFilm, which superimposes a grid over the victim's body to provide an accurate scale - or superimposes a grid over the victim's body to provide an accurate scale - or take photos next to a ruler or a familiar household object to indicate actual size
- photograph from different angles, full body and close-up , taking at least two pictures of every major trauma area
- include the patient's face in at least one picture
- preserve all physical evidence - torn or bloodstained clothing or a weapon can be

sealed in an envelope or paper bag.

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

6. Important Messages to Give Patient

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

CHILD ABUSE

CHECKLIST OF PHYSICAL AND BEHAVIORAL

INDICATORS OF CHILD ABUSE/NEGLECT

PHYSICAL ABUSE

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

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

PHYSICAL NEGLECT:

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

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

HUMAN TRAFFICKING

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

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

ELDER ABUSE

PHYSICAL ABUSE POSSIBLE INDICATORS:

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

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

PSYCHOLOGICAL/EMOTIONAL ABUSE POSSIBLE INDICATORS:

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

FINANCIAL ABUSE POSSIBLE INDICATORS:

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

NEGLECT BY CAREGIVER POSSIBLE INDICATORS:

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

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

SELF-NEGLECT POSSIBLE INDICATORS:

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

ABUSE FROM THE CAREGIVER POSSIBLE INDICATORS:

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

All Revision Dates

4/29/2026, 9/5/2025, 5/9/2023, 10/3/2022, 2/1/2016, 12/1/2013, 8/1/2009, 5/1/2006, 2/1/2005

Attachments

 [PEARR Tool.pdf](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/27/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/23/2026

COPY

Status **Active** PolicyStat ID **20140494**



Origination 3/2/2026
Last Approved 3/27/2026
Effective 3/27/2026
Last Revised 3/27/2026
Next Review 3/26/2028

Owner Amanda Lo:
Medical Director,
SPH Lab

Policy Area Laboratory
Services -
Histology

L.HIST.35 Processing a Death

POLICY:

The following ~~protocol~~ policy will be observed for activity involving the morgue: [100.031 Processing a Death & Post-Mortem Exam \(Autopsy\)](#).

ADMINISTRATIVE POLICY No. 100.031 (Formerly Administrative Memorandum No. 4-83)

REFERENCE(S):

• vcmc.policystat.com/policy/14407882/latest

All Revision Dates

3/27/2026, 3/2/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	3/26/2026

COPY



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Last Revised 4/3/2026
Next Review 4/2/2028

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

L.BB.32 Blood Bank Issue of Blood Products

POLICY:

Anyone who delivers blood or blood products to patient locations at Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) must be a member of VCMC/SPH nursing or Medical Staff (i.e., a ~~physician~~Physician, Nursing Assistant, Medical Office Assistant, Registered Nurse ~~or~~, Licensed Vocational Nurse).

PROCEDURE:

The individual who delivers blood or blood products must present the following to the Blood Bank:

- Patient Identification
- A Blood Pickup Request Form with the patient's name, medical record number, and current vitals.
- Documentation of informed consent

Note: A patient registration label can be presented to the Blood Bank if the Blood Pickup Request Form cannot be printed due to computer down procedure or during an emergency where the patient's treatment would be delayed.

SPECIMEN COLLECTION:

N/A

MATERIALS:

1. Blood Pickup Request Form.

2. Patient registration label (used during computer down time procedures and during emergency dispensing of blood products).
3. Printed Blood Component Tag.

PROCEDURE:

1. The individual (transporter), who will deliver the blood product to the patient location, must present a **Blood Pick up Request Form** with the intended recipient's full name and medical record number to the Blood Bank Technologist. This form should also document the current vitals and the documentation of consent forms having been signed.
 - a. A patient registration label may be presented during computer down time procedures or during emergency dispensing of blood products.
2. A Blood Bank Technologist will retrieve the proper product for issue by verifying the patient identification on the unit with the identification provided by the transporter.
 - a. When multiple units are available for issue, the shortest dated unit will be issued first.
 - b. Only one unit of blood will be issued at a time except in an extreme emergency. When more than one unit is issued, it will be transported in a blood transport cooler to the patient's location. (See policy *Supplying Blood in Blood Transport Coolers*).
 - c. A transporter can only pick up blood products for one patient recipient at a time.
3. The Blood Bank Technologist will dispense the unit in the Laboratory Information System as follows:

Health-e-Connect:

- a. Open Dispense and Assign Products application.
- b. Choose a location and click <OK>.
- c. Receive the blood pickup request &/or patient registration label from the courier.
- d. Locate the patient's medical record number on the submitted identification form. Enter this medical record number into the medical record number field in the dispense application.
- e. Press the enter/return key.
- f. The patient's demographic information will load. Compare and verify the loaded information is the same as the submitted identification.
- g. Retrieve the appropriate blood product from storage.
- h. Scan the unit Donor Identification Number under product number in product list below.
- i. Press the enter/return key. The product demographics will load.
- j. Click <Save>.
- k. A dispense dialog box will pop up. Enter the following:
 - Physician

- Patient Location
 - Visual Inspection
 - Reason for Transfusion
 - Courier's user name
 - Blood Cooler (if appropriate)
 - Blood Recipient wristband number.
- I. Click <OK>.
 - m. An output destination box will appear for printing the Dispense packing form and the Blood Component/Crossmatch/Emergency Tag. Print to default printer for both forms.
4. A visual inspection of the retrieved blood component will be performed as outlined in the policy, *Visual Inspection of Blood Components*.
 5. The Blood Bank Technologist, issuing the blood product, will ask the transporter if he/she has performed the blood issue procedure. If the answer is **no**, the Blood Bank Technologist will explain each step of the procedure and then directly observe their performance of the procedure.
 6. The blood product will be handed to the transporter. The Blood Bank Technologist will retain the printed Blood Component/Cross match/Emergency Tag and the read procedure will be performed.
 7. The transporter will read all of the following information from the label of the blood product and the Blood Bank staff member will verify that all information read is the same as the information on the printed Blood Component/Cross match/Emergency Tag:
 - a. Patient's name and medical record number from the Laboratory label placed on the blood unit.
 - b. Patient's Blood Bank wristband number located on the unit. This will be a red or white sticker located next to the Laboratory label. If many units have been dispensed, the wristband number may be written on the Laboratory label because there are no stickers available.
 - c. The description of the blood or blood component.
 - d. The donor's (unit) 13 digit Identification Number.
 - e. The blood type of the donor unit.
 - f. The expiration date of the donor unit.
 8. The Blood Bank technologist will verify that the compatibility testing has been done and the unit is type specific/type compatible with the patient's blood type.
 9. If all the information is correct and complete, the transporter and the Blood Bank Technologist will both sign the Blood Component/Cross match/Emergency Tag using their user name. In addition, the Blood Bank Technologist will:
 - a. Document "Yes" next to IRR (Irradiated) if the unit is irradiated.
 - b. Document "Neg" next to CMV if the unit is CMV negative, as indicated on the label of

the blood unit.

- c. Document the hematocrit value next to HCT for red blood cells aliquoted for NICU babies.

10. At the completion of the reading and verification of information, the Blood Bank Technologist will permanently attached the Blood Component/Cross match/Emergency Tag to the donor unit using a plastic "cable tie." This tag must remain attached to the unit for the duration of the transfusion.

CALIBRATION:

N/A

CALCULATIONS:

N/A

QUALITY CONTROL:

See Daily Quality Control SOP 8.1

RESULTS:

N/A

REFERENCES:

Standards for Blood Banks and Transfusion Services. Bethesda, MD: ~~American~~ Association ~~for the~~ Advancement of Blood ~~Banks and Biotherapies (AABB), Current Edition~~ current edition.

Cohn, Claudia S., ~~et MD, PhD. al.~~ Technical Manual. Bethesda, MD: ~~American~~ Association ~~for the~~ Advancement of Blood ~~Banks and Biotherapies (AABB), Current Edition~~ current edition.

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

All Revision Dates

4/3/2026, 2/27/2024, 8/8/2022, 6/5/2020, 12/1/2016, 12/1/2013, 3/1/2012

Approval Signatures

Step Description

Approver

Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/3/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/1/2026
Laboratory Services Department	Kathrina Barcena: Supervisor- Blood Bank, Laboratory Services	2/5/2026
Laboratory Services Department	Linda Lee: Medical Director, VCMC Blood Bank	1/29/2026

COPY



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Next Review 4/8/2028

Owner Gayle Haider:
Supervisor-
Quality
Assurance,
Laboratory
Services

Policy Area Laboratory
Services

L.05 Laboratory Document Control

POLICIES

1. The Ventura County Medical Center/Santa Paula Hospital Laboratory has ~~a~~PolicyStat, a cloud-based document management system to ensure that all written policies and procedures are current and must match laboratory practices.
2. All staff will read those policies and procedures pertinent to their positions and will document on the proper form. Staff will read and document within 30 days of implementation and as changes occur. A sign-off sheet (see attachment) or electronic acknowledgement of review in PolicyStat will serve as documentation.
3. Approval workflows have been created in PolicyStat to ensure reviews, revisions, and approvals are documented.
4. All new and revised technical policies and procedures will be reviewed and approved by the Laboratory Medical Director before implementation and all existing policies and procedures will be reviewed biennially by the Laboratory Medical Director ~~(COM.10100/COM.10200).~~
 - a. Change in Laboratory Medical Directorship (Clinical Laboratory, Blood Bank/ Transfusion Services, and Anatomical Pathology):: technical policies and procedures are reviewed by the new laboratory medical director, respectively.
5. ~~Discontinued and retired policies and procedures must generally be inaccessible to the working areas of the laboratory. Paper copies or electronic copy of discontinued and retired policies and procedures will be retained for three (3) years after discontinuation. Policies and procedures related to Transfusion Services are retained for five (5) years after discontinuation (COM.10500/GEN.20375).~~
6. ~~Records must be readily available for review.~~

(COM.10100/COM.10200, DRA.11485).

1. Discontinued and retired policies and procedures must generally be inaccessible to the working areas of the laboratory. Paper copies or electronic copy of discontinued and retired policies and procedures will be retained for three (3) years after discontinuation. Policies and procedures related to Transfusion Services are retained for five (5) years after discontinuation (COM.10500/GEN.20375).
2. Records must be readily available for review.

RESPONSIBILITIES

It is the responsibility of the Clinical Laboratory Scientist III (CLS III), Safety Officer, Laboratory Information System (LIS) Coordinator, and Performance Improvement/Quality Assurance Coordinator to maintain the policies and procedures for their areas of responsibilities. ~~The Director of Laboratory Services is responsible for the administrative policies and procedures. The Laboratory Medical Director, along with the associate pathologists and histologists, are responsible for the pathology policies and procedures.~~

The Director of Laboratory Services is responsible for the administrative policies and procedures.

The Laboratory Medical Director will review and approve technical policies and procedures in Chemistry, Coagulation, Hematology, Laboratory Information Systems, Microbiology, Urinalysis, Serology.

Technical policies and procedures related to Blood Bank/Transfusion Services are reviewed and approved by the Transfusion Services Medical Director.

The Medical Director for Anatomical Pathology, along with the associate pathologists and histologists, are responsible for the pathology and histology policies and procedures.

PROCEDURE

1. The following steps will be followed to ensure that the procedures/protocols are complete current and have been reviewed by a knowledgeable person. Also, that all personnel are knowledgeable and familiar about the contents of the procedure manuals relevant to the scope of their testing activities:
 - a. All written administrative policies, procedures and forms will be reviewed by the Director of Laboratory Services or designee at least every two years to ensure that they are current with accrediting and licensing agency requirements and standards.
 - b. All new technical policies and procedures, as well as substantial changes to existing policies, procedures, and documents, shall be reviewed and approved by the Laboratory Medical Director, before implementation (COM.10200).
 - c. Discontinued and retired policies and procedures are removed from the manual, date and initial and place in "Retired Procedure" binder. Include Policy and Procedure History page. Electronic copies will be retained in the sub-folder for retired policies and procedures in the laboratory shared drive.
 - d. All personnel are knowledgeable about the contents of procedure manuals (including changes to existing policies and procedures) relevant to the scope of their testing activities.

- e. Changes in existing policies, procedures, and documents are posted. Within the scope of testing activities, all personnel read and sign policy and procedure cover sheet. See attachment.
2. Communication between shifts, messages, etc. will be done in the communication notebook in each department.
All worksheets, from which patient results have been manually entered into the computer, will be retained for at least two years.

FORMAT

1. Paper forms of document control logs are manually completed by staff or that are manually completed by staff or may involve specialized computer software programs that may involve specialized computer software programs that generate hard copies as necessary.
 - a. Most records are organized and stored in a chronological, numerical, or alphabetical system.
2. ~~Most records are organized and stored in a chronological, numerical, or alphabetical system.~~ Manual logs shall include the document file name and file path in the footer of each page to ensure document traceability and version control. Each log shall be clearly labeled by section and maintained as an attachment or reference to the appropriate and pertinent policy and procedure.

RECORDS RETENTION

Refer to L.42 Preservation of Laboratory Records and Specimens

The standards for record keeping and the length of time records must be retained are established by relevant certification agencies.

1. Federal guidelines should be considered minimum standards and are superseded by the standards established by the state or other certification agencies.
2. Agencies include the following.
 - a. Clinical Laboratory Improvement Amendments (CLIA) of 1967
 - b. CLIA of 1988 & 1990
 - c. State of California Code of Regulations Title 17 and Title 22
 - d. Code of Federal Regulations
 - e. College of American Pathologists (CAP)
 - f. Joint Commission
 - g. American Association of Blood Banks

REFERENCES

1. College of American Pathologists Accreditation Checklist, December 2025.
2. Garcia, Lynne S., **Clinical Microbiology Procedures Handbook**, 2nd edition, 2007, ASM,

Washington, D.C. p. 14.3.1-14.3.6.

3. Wagar, Elizabeth A., **Laboratory Administration for Pathologists**, CAP Press, Northfield, Illinois, 2011, pp121-127.
4. [Section 1053 - Clinical Laboratory Improvement Amendments \(CLIA\) Record Retention Regulations Determined to be Less Stringent than California Law, Cal. Code Regs. tit. 17 § 1053 | Casetext Search + Citator](#). Retrieved October 1, 2022.
5. [Law Section \(ca.gov\)](#). Retrieved October 1, 2022.

All Revision Dates

4/9/2026, 11/15/2024, 10/25/2022, 10/7/2022, 9/27/2022, 7/26/2022, 10/25/2017, 11/1/2016, 4/1/2016, 8/1/2012

Attachments

- [Document Control system Blank Template 082015.xlsx](#)
- [Document Control system histology Cytology 012016.xlsx](#)
- [POLICY REVISED REVIEW SIGNATURE COVERSHEET 112013.xlsx](#)
- [TOC & STAFF REVIEW OF P&P 2026 part 1.xlsx](#)
- [TOC & STAFF REVIEW OF P&P 2026 part 2.xlsx](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/9/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/9/2026
Laboratory Services Department	Gayle Haider: Supervisor- Quality Assurance, Laboratory Services	4/8/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/8/2026



Origination 1/1/2003
Last Approved 4/8/2026
Effective 4/8/2026
Last Revised 4/8/2026
Next Review 4/7/2028

Owner Gayle Haider:
Supervisor-
Quality Assurance,
Laboratory Services

Policy Area Laboratory Services

L.04 Medical Direction of the Laboratory

POLICY:

Laboratory Services at Ventura County Medical Center/Santa Paula Hospital are under the direction of ~~Brad S. Adler~~ Muhammad Anwar Molani, M.D., ~~Pathologist and the Associate Pathologists Melanie Gero, M who is certified by the American Board of Pathology D., Michael Richardson M.D., and Mrugesh Shah, M.D. They are certified by the American Board of Pathology and perform anatomic pathology procedures. The pathologists are active members of the Medical Staff and have established an effective working relationship with Medical Staff, Hospital Administration and other departments.~~

PROCEDURE:

~~The Laboratory Medical Director is certified in anatomic and clinical pathology and is responsible for the administration and overall technical and clinical operation of the Laboratory. These areas include: performance standards, personnel standards, provision of continuing education, quality management, implementation of a safe environment, and planning for hospital and Laboratory needs. There is active participation of the pathologists and Laboratory technologists in the hospital quality assurance program by reviewing and evaluating the quality and appropriateness of the services rendered. The director may delegate administrative, medical and technical responsibilities to qualified physicians, Laboratory managers, supervisors or other qualified Laboratory staff as appropriate. In the event of a change in directorship, the new Director will review all procedures over a reasonable period of time.~~

~~The pathologists are available as needed to provide consultation concerning the medical significance of the Laboratory results, and to assist in obtaining other required professional consultation. Questions regarding Laboratory service, which cannot be answered by a clinical laboratory scientist, or questions regarding interpretation of Laboratory results or policies, should be directed to one of the pathologists.~~

~~Consultation with a pathologist may be obtained by calling during routine office hours. For off-duty hours, an on-call pathologist is available by calling the Laboratory office.~~

~~Transfusion Service: The transfusion service medical director must be involved in physician education and review transfusion practices to ensure the appropriate use of blood components and the ability of the transfusion service to meet patient needs. The monitoring required to do this effectively is met by various mechanisms including reviewing cases not meeting transfusion audit criteria. Monitors include the following: ordering practices, sample collection and usage (including discard of components), and compliance with institutional peer review recommendations. Data from the review and monitoring of transfusion practices will be used to modify blood administration policies and procedures as necessary. The medical director is a member of the blood usage committee.~~

According to standards of Title 22, the director of the clinical ~~Laboratory~~laboratory service will ensure that:

1. Examinations are performed accurately and in a timely fashion.
2. Procedures are established governing the provision of Laboratory services for outpatients.
3. Laboratory systems identify the patient, test requested, date and time of collection, the time that the request reached the Laboratory, the time the Laboratory completed the test and any special handling that was required.
4. Procedures are established to ensure the satisfactory collection of specimens.
5. A communication system to provide efficient information exchange between the Laboratory and related areas of the hospital is established.
6. A quality control system within the Laboratory designed to ensure medical reliability of Laboratory data is established. The results of control tests shall be readily available in the hospital.
7. Reports of all Laboratory examinations are made a part of the patient's medical record as soon as is practical.
8. No Laboratory procedures are performed except on the order of a person lawfully authorized to give such in order.
9. The Laboratory Medical Director for Santa Paula will be an off-site Laboratory Director and shall visit Santa Paula Hospital on a monthly basis to ensure Laboratory function and answer any questions.
10. Site visits shall be documented in Laboratory Medical Director Site Visit Log (see attachment).

The Transfusion Services is under the directorship of Linda Lee, M.D. and is certified by the American Board of Pathology.

The Laboratory Medical Director (Clinical Laboratory) and Transfusion Services Medical Director are certified in anatomic and clinical pathology and are responsible for the administration and overall technical and clinical operation of the Laboratory and Transfusion Services.

The Anatomical Pathology Department, under Amanda Lo, M.D., is staffed with pathologists who are certified by the American Board of Pathology and are active members of the Ventura County Medical Staff and have established an effective working relationship with Medical Staff, Hospital Administration

and other departments.

PROCEDURE:

Laboratory Medical Directors are responsible for the following:

1. Performance standards.
2. Personnel standards.
3. Provision of continuing education.
4. Quality management.
5. Implementation of a safe environment, and
6. Planning for hospital and Laboratory needs.

There is active participation of the pathologists and laboratory personnel in the hospital's quality assurance program by reviewing and evaluating the quality and appropriateness of the services rendered.

The director(s) may delegate administrative, medical and technical responsibilities to qualified physicians, laboratory managers, supervisors or other qualified laboratory staff as appropriate.

In the event of a change in directorship, the new Director will review all procedures over a reasonable period of time.

The pathologists are available as needed to provide consultation concerning the medical significance of the Laboratory results, and to assist in obtaining other required professional consultation. Questions regarding laboratory service, which cannot be answered by a clinical laboratory scientist, or questions regarding interpretation of laboratory results or policies, should be directed to one of the pathologists. Consultation with a pathologist may be obtained by calling during routine office hours. For off-duty hours, an on-call pathologist is available by calling the laboratory.

Transfusion Service:

The transfusion service medical director is involved in physician education and review transfusion practices to ensure the appropriate use of blood components and the ability of the transfusion service to meet patient needs. The monitoring required to do this effectively is met by various mechanisms including reviewing cases not meeting transfusion audit criteria. Monitors include the following; ordering practices, sample collection and usage (including discard of components), and compliance with institutional peer review recommendations. Data from the review and monitoring of transfusion practices will be used to modify blood administration policies and procedures as necessary.

The Transfusion Service Medical Director actively participates in the Blood Usage Committee meetings.

REFERENCES:

1. [Lab Director Brochure](#) Retrieved April 7, 2026.
2. [California Code of Regulations](#). Retrieved April 7, 2026.

All Revision Dates

4/8/2026, 8/8/2022, 10/3/2017, 11/1/2016, 8/1/2012

Attachments

 [Laboratory Director Site Visit Log.doc](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/8/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/8/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/8/2026
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	4/7/2026





Origination 6/1/2009
 Last Approved 4/21/2026
 Effective 4/21/2026
 Last Revised 4/21/2026
 Next Review 4/20/2028

Owner Jessica Rodriguez:
 Manager,
 Cardiopulmonary
 Services
 Policy Area Laboratory-Blood
 Gas

L.BG.19 CLIA Guidelines

POLICY:

The Arterial Blood Gas Laboratories at Ventura County Medical Center/Santa Paula Hospital have established specific policies regarding the implementation of the federal Clinical Laboratory Improvement Act of 1988, to designate testing site and test complexity by site, registration certificates for each testing site, staff responsible for the direction of testing sites, and staff qualified to perform testing.

PROCEDURE:

The Clinical Laboratory Improvement Act of 1988 (CLIA 88) mandated specific requirements for the operation of all facilities performing patient care laboratory testing. The regulations first published in the February 28, 1992 Federal Register (Vol.50,No.40), cover the following areas of laboratory operation:

Subpart A:	General Provisions
Subpart B:	Certificate of Waiver
Subpart C:	Registration Certificate and Certificate
Subpart D:	Certificate of Accreditation
Subpart H:	Participation in Proficiency Testing
Subpart I:	Proficiency Testing Programs
Subpart J:	Patient Test Management
Subpart K:	Quality Control
Subpart M:	Personnel
Subpart P:	Quality Assurance
Subpart Q:	Inspection

Subpart T:	Consultations

Many of these regulations were already being met in laboratories which participated in voluntary or other accreditation programs, such as those conducted by the College of American Pathologists (CAP), The Joint Commission, and the State of California, Departments of Health. The Laboratory at Ventura County Medical Center is accredited by all three of these agencies.

The section of CLIA 88 which this policy will address are those which were not previously required in essentially the same language under the accreditation guidelines of other agencies: Subparts A-D, and Subpart M. Aspects of laboratory operations related to other Subparts of the CLIA regulations (e.g., Subparts H, I, J, K, P) are covered in specific policies and procedures for the affected areas.

Subparts A-D

Ventura County Medical Center and Santa Paula perform Blood Gas testing as defined in CLIA 88 at the following sites:

- I. Ventura County Medical Center: Blood Gas Laboratories located in CCU, NICU, PICU and Emergency Department.
 - A. **CLIA I.D. #05CD0872517**
 - B. Types (s) of testing: Moderate complexity only.
 - C. Director: ~~Brad Adler~~Amanda Lo, MD
- II. Santa Paula Hospital: Respiratory Care Blood Gas Lab.
 - A. **CLIA I.D. #05D0856493**
 - B. Type(s) of testing: Moderate complexity only.
 - C. Director: ~~Brad Adler~~Amanda Lo, MD

SUBPART M

Laboratory Director

The position of Blood Gas Laboratory Director is held by a pathologist (doctor of medicine), licensed in the State of California and board certified in anatomic and clinical pathology by the American Board of Pathology § 493.1498 [(a)(b)(1)(I-ii)]. The Director ensures that all responsibilities describes in section § 493.1445 are discharged. The Blood Gas Laboratories Director also assumes the responsibilities of Technical Supervisor, and Clinical Consultant.

Testing Personnel

The Medical Director designates the Manager of the Respiratory Care Department and key staff as that manager may designate, licensed as Respiratory Care Practitioners by the State of California and qualified under § 493.1423 to manage operations in the Blood Gas Laboratories. Duties delegated include as appropriate:

1. Testing systems

2. Physical environment
3. Test methodologies
4. Proficiency testing
5. Quality control and quality assurance
6. Establishment and maintenance of acceptable levels of analytical performance for each test
7. Remedial action is taken whenever deviations from established laboratory performance characteristics are identified; assuring that patient results are not reported until appropriate corrections are made
8. Reports of test results include pertinent information needed for interpretation
9. Personnel qualifications and skills assessment
10. Employing sufficient qualified personnel
11. Verification of education, credentials and experience of testing personnel
12. Procedures for periodic assessment of competency of all laboratory personnel
13. Approved procedure manuals are available to all personnel for all phases of the testing process
14. Written specifications of the duties of all laboratory personnel

Testing Personnel

All testing personnel meet the minimum qualifications for the type of testing which they perform, moderate complexity as described in § 493.1423 and under the supervision of on-site General Supervisors as designated by the Respiratory Manager.

All Revision Dates

4/21/2026, 3/24/2026, 6/1/2009

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/21/2026
Laboratory Services	Amanda Lo: Medical Director, SPH Lab	4/21/2026
Policy Owner	Jessica Rodriguez: Manager, Cardiopulmonary Services	3/30/2026



Origination 6/1/2009
Last Approved 4/21/2026
Effective 4/21/2026
Last Revised 4/21/2026
Next Review 4/20/2028

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

L.BG.39 CLIA Guidelines for the Respiratory Care Arterial Blood Gas Laboratory

POLICY:

The Arterial Blood Gas Laboratory at Ventura County Medical Center/Santa Paula Hospital has established specific policies regarding the implementation of the federal Clinical Laboratory Improvement Act of 1988 (CLIA 88) to designate testing sites, test complexity by site, registration certificates for each testing site, personnel responsible for the direction of testing sites, and personnel qualified to perform testing.

PROCEDURE:

The CLIA 88 mandated specific requirements for the operation of all facilities performing patient care laboratory testing. The regulations first published in the February 28, 1992 Federal Register (Vol.50, No.40) cover the following areas of laboratory operation:

Subpart A:	General Provisions
Subpart B:	Certificate of Waiver
Subpart C:	Registration Certificate and Certificate
Subpart D:	Certificate of Accreditation
Subpart H:	Participation in Proficiency Testing
Subpart I:	Proficiency Testing Programs
Subpart J:	Patient Test Management
Subpart K:	Quality Control
Subpart M:	Personnel

Subpart P:	Quality Assurance
Subpart Q:	Inspection
Subpart T:	Consultations

Many of these regulations were already being met in laboratories which participated in voluntary or other accreditation programs, such as those conducted by the College of American Pathologists (CAP), The Joint Commission, and the California Department of Public Health. The Laboratory at Ventura County Medical Center is accredited by all three of these agencies.

The section of CLIA 88 which this policy will address are those which were not previously required in essentially the same language under the accreditation guidelines of other agencies: Subparts A-D, and Subpart M. Aspects of laboratory operations related to other Subparts of the CLIA regulations (e.g., Subparts H, I, J, K, P) are covered in specific policies and procedures for the affected areas.

Subparts A-D

Ventura County Medical Center/Santa Paula Hospital perform Blood Gas testing as defined in CLIA 88 at the following sites:

- I. Ventura County Medical Center: Blood Gas Labs located in CCU, NICU, PICU and ED.
 - A. **CLIA I.D #05CD0872517**
 - B. Types (s) of testing: Moderate complexity only.
 - C. Director: ~~Brad Adler~~Amanda Lo, MD
- II. Santa Paula Hospital: Respiratory Care Blood Gas Lab.
 - A. **CLIA I.D #05D0856493**
 - B. Type(s) of testing: Moderate complexity only.
 - C. Director: ~~Brad Adler~~Amanda Lo, MD

SUBPART M

Laboratory Director

The position of Blood Gas Laboratory Director is held by a pathologist (doctor of medicine), licensed in the State of California and board certified in anatomic and clinical pathology by the American Board of Pathology §493.1498 [(a)(b)(1)(I-ii)]. The Director ensures that all responsibilities describes in section §493.1445 are discharged. The Blood Gas Laboratories Director also assumes the responsibilities of Technical Supervisor, and Clinical Consultant.

Testing Personnel

The Medical Director designates the Manager of the Respiratory Care Department and key staff as that manager may designate, licensed as Respiratory Care Practitioners by the State of California and qualified under § 493.1423 to manage operations in the Blood Gas Laboratories. Duties delegated include as appropriate:

1. Testing systems
2. Physical environment
3. Test methodologies
4. Proficiency testing
5. Quality control and quality assurance
6. Establishment and maintenance of acceptable levels of analytical performance for each test
7. Remedial action is taken whenever deviations from established Laboratory performance characteristics are identified; assuring that patient results are not reported until appropriate corrections are made
8. Reports of test results include pertinent information needed for interpretation
9. Personnel qualifications and skills assessment
10. Employing sufficient qualified personnel
11. Verification of education, credentials and experience of testing personnel
12. Procedures for periodic assessment of competency of all Laboratory personnel
13. Approved procedure manuals are available to all personnel for all phases of the testing process
14. Written specifications of the duties of all Laboratory personnel

Testing Personnel

All testing personnel meet the minimum qualifications for the type of testing which they perform, moderate complexity as described in § 493.1423 and under the supervision of on-site General Supervisors as designated by the Respiratory Manager.

All Revision Dates

4/21/2026, 11/7/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/21/2026
Laboratory Services	Amanda Lo: Medical Director, SPH Lab	4/21/2026
Policy Owner	Jessica Rodriguez: Manager, Cardiopulmonary Services	3/30/2026



Origination 1/17/2024
Last Approved 3/27/2026
Effective 3/27/2026
Last Revised 3/27/2026
Next Review 3/26/2028

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

L.CGL 1.3 Critical Results - Coagulation Department

PRINCIPLE:

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

All hematology critical results should be communicated immediately to the ordering physician or licensed responsible caregiver. Report must be verbally communicated no more than thirty (30) minutes from the availability of critical results.

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

PROCEDURE:

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

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

Platelets	$\leq 20 \times 10^3/\text{mm}^3 \text{mcL}$	≥ 700
White Blood Cell (WBCs)	$\leq 1.0 \times 10^3/\text{mm}^3 \text{mcL}$	$\geq 50K$
Absolute Neutrophil Count (ANC/Neutrophil#)	$< 0.5 \times 10^3/\text{mm}^3 \text{mcL}$	
International normalization ratio (INR)		≥ 3.90
Partial Thromboplastin Time (PTT)		$> 118 \text{ sec.}$
D-Dimer		> 7.5
Fibrinogen	$< 100 \mu\text{g/dL}$	
Heparin, Anti-Xa (UF)	Call all result or Tiger Text	
Heparin, Anti-Xa (LMW)	Call all result or Tiger Text	
Cerebrospinal fluid (CSF) White Blood Cell Count	≥ 10	

RESULTS:

1. Under Accession Result Entry in Cerner, go to the appropriate result entry mode (i.e. Instrument Queue, Accession, Worklist) for accepting patient test result.
2. The result would have transmitted from analyzer to patient's accession. If you manually enter result, do not convert result to free text or critical prompt will not appear.
3. Right click the result and select comment.
NOTE: If there are multiple critical results on the same patient's test, uncheck all results from the test except the critical results. Right click one of the critical results and select Batch comments → All selected.
4. Under result comments the following prompt should be present:
"Called to (name):_ Location:_ Time:_ Called results read back to Lab? (Y/N):_"
NOTE: If the above prompt is not present, Press F2 and under Name, type mnemonic LCALL and select ok.
OR : Tiger text to the physician who is in charge for the patient.
5. Call licensed care giver or physician and fill call prompt ensure there is a "read-back" of the critical results. Record FIRST and LAST name of personnel receiving critical results.
*For clinic's (outpatient) results analyzed during off hours (1700-0700) page the operator at x7-6075. The operator will contact the on-call clinic physician and report critical result to on-call physician.
NOTE: Due to CAP regulations, first name alone is NOT sufficient for documenting critical results.
6. Save and close comment box and verify results.

REFERENCES:

Administrative Policy: 100.030 - Critical Test Results

CAP Accreditation Program – Hematology and Coagulation Checklist 08.24.2023

CAP Checklist Requirements

COM.30000 Critical Result Notification

COM.30100 Critical Result Read-Back

All Revision Dates

3/27/2026, 2/24/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	3/25/2026
Laboratory Service Dept	Samah Meshreky: Supervisor- Hematology, Laboratory Services	3/25/2026



Origination 5/1/1991
Last Approved 3/27/2026
Effective 2/25/2026
Last Revised 3/27/2026
Next Review 3/26/2028

Owner Amanda Lo:
Medical Director,
SPH Lab
Policy Area Laboratory
Services -
Cytology

L.CYT.23 Staining Non-Gyn Specimens to Avoid Cross-Contamination

PURPOSE:

The possibility of cross-contamination which might occur from highly cellular fluid sediment smears should be a serious consideration when staining several cases at one time. It is obvious that atypical or malignant cells floating from one patient's slide to another could result in a serious misdiagnosis.

If possible, specimens should be assessed for the potential for cross contamination. The clinical information should be taken into account. Concurrent cytological specimens from patients with known malignant tumors, e.g. ruptured tumor with concurrent washings, pleural fluid or ascites fluid in a patient with a lung carcinoma or an intraabdominal malignancy, should be considered high risk for cross contamination. Gross examination of the cytology specimen can also be helpful with very cellular smear or tissue fragments in the alcohol fixed material.

The following procedure should be followed to avoid this problem:

1. When making sediment smears, apply a few drops of concentrated cellular material and spread this evenly over the slides without excess layering of material.
2. Before staining, rinse each smear well with alcohol fixative from a wash bottle. It may be impractical to stain one case at a time; if so, place slides from different cases in separate staining racks.
3. If one staining rack is used, widely separate slides from different cases. Placing a blank slide on either side of each case may be helpful in containing cells which may detach.
4. When moving slides through the stains and rinses, avoid shaking or agitating the rack to reduce the possibility of loosening the cells from the smears. Highly cellular cases should be stained after the other cases and the staining fluids changed or filtered between each of the highly cellular cases.

5. A rapid stain, e.g., toluidine blue can be done on a wet specimen to detect highly cellular specimens.

All Revision Dates

3/27/2026, 3/2/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Service Dept	Amanda Lo: Medical Director, SPH Lab	3/18/2026





Origination 12/14/2023
Last Approved 3/27/2026
Effective 3/27/2026
Last Revised 3/27/2026
Next Review 3/26/2028

Owner Samah Meshreky:
Supervisor-
Hematology,
Laboratory
Services

Policy Area Laboratory
Services

L.HEM 1.3 Critical Results - Hematology Department

PRINCIPLE:

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

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

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

PROCEDURE:

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

Test	Low Critical Result	High Critical Result
Hemoglobin	≤6.59 g/dL	≥23.0 g/dL
Hemoglobin patient age >65	≤6.89 g/dL	≥23.0 g/dL
Hematocrit	≤18%	≥70%

Platelets	$\leq 20 \text{ Thx}10^3/\text{mm}^3\text{mCL}$	
White Blood Cell (WBCs)	$\leq 1.0 \text{ Thx}10^3/\text{mm}^3\text{mCL}$	$\geq 50\text{K}$
Absolute Neutrophil Count (ANC/ Neutrophil#)	$< 0.5 \text{ Thx}10^3/\text{mm}^3\text{mCL}$	≥ 20.0
International normalization ratio (INR)		≥ 4.0
Partial Thromboplastin Time (PTT)		$> 118 \text{ sec.}$
Fibrinogen	$< 100 \text{ }\mu\text{g/dL}$	
Heparin, Anti-Xa (UF)		$> 0.7 \text{ IU/mL}$
Heparin, Anti-Xa (LMW)		$> 1.2 \text{ IU/mL}$
Heparin, Anti-Xa (UF)	All results to be communicated to the responsible licensed caregiver	
Heparin, Anti-Xa (LMW)	All results to be communicated to the responsible licensed caregiver	
Cerebrospinal fluid (CSF) White Blood Cell Count		≥ 10

RESULTS:

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

2. 

Sample ID
C 233530548A

Name
ZZZTEST, GEORGE B

MRN
0000159773

DOB
08/01/1950

Age
73 years

Sex
Female

Physician
Sammons

Sample Location
IN302

☐ Manual review ☐ PLT

Order: XN362ZWB0

Prev dt: 12/16/2023 15:13:00

OP Alerts

12 items

Critical WBC (w=6.8 or w=23.8)
Call and document critical as per SOP.

MCV Delta - Possible mislabeled sample. Perform critical check. Refuse if necessary.

WBC Delta - Check sample integrity. Patient status/history. Notify provider if necessary.

PLT Delta - Check sample integrity. Add DISEARS if necessary. Check patient status (Trauma? Surgery? OBT Oncoflag? Transfusion?) Notify provider if necessary.

Hypochromia - Run sample.

Blasts/Abn Lympho? - Slide Review. Perform Manual Diff if indicated.

Anisocytosis - Perform slide review. Perform RBC Morph if indicated.

Leukopenia WBC <= 2.0 - Perform manual diff.

Atypical Lympho? - Perform slide review. Manual diff if indicated.

Thrombocytopenia - Check specimen integrity. Run for PLT.F.

PLT Abn Distribution - Run for PLT.F.

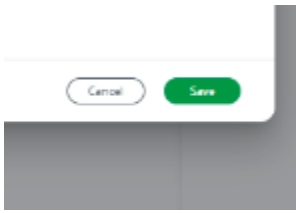
PLT Low Reliability - Check for clot. Refuse PLT.F.

Test	Result	Comment	Run on	Prev Res	Pre
☐ + WBC	6.8				
☐ + RBC	3.29				
☐ + HGB	6.9				
☐ + HCT	22.0				
☐ + MCV	100.0				
☐ + MCH	28.4				
☐ + MCHC	29.5				
☐ + RDW-CV	25.0				
☐ + PLT	10				
☐ MPV	Not Measured				
☐ IPF %					
☐ IPF #					
☐ + NEUT Auto %	40.9				
☐ + LYMPH Auto %	40.9				
☐ + MONO Auto %	14.8				
☐ + EOS Auto %	2.0				
☐ + BASO Auto %	0.7				
☐ + IG Auto %	1.3				
☐ + NEUT Auto #	0.61				
☐ + LYMPH Auto #	0.60				
☐ + MONO Auto #	0.22				
☐ + EOS Auto #	0.03				
☐ + BASO Auto #	0.01				
☐ + IG Auto #	0.02				

3.

The screenshot displays the Cerner Caresphere WS interface. A 'Critical Call Documentation' pop-up window is open, overlaying the main lab results screen. The pop-up contains a form for documenting critical results, with a red box highlighting the 'Patient Name and Department' field. A red arrow points to this field. The background shows the main lab results screen with a table of test results.

4. This pop-up documents the critical/delta results that have been called to the appropriate medical professional.
Press save and result will be verified on Cerner.

	
	Note: Call licensed care giver or physician and fill call prompt ensure there is a "read-back" of the critical results. Record FIRST and LAST name and VOCATION of personnel receiving critical results. *For clinic's (outpatient) results analyzed during off hours (1700-0700) See corresponding Memo.

REFERENCES:

Administrative Policy: 100.030 - Critical Test Results

CAP Accreditation Program – Hematology and Coagulation Checklist 8.24.2023

CAP Checklist Requirements

COM.30000 Critical Result Notification

COM.30100 Critical Result Read-Back

All Revision Dates

3/27/2026, 1/26/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Service Dept	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Service Dept	M. Anwar Molani: Medical Director, Laboratory Services	3/25/2026
Laboratory Service Dept	Samah Meshreky: Supervisor- Hematology, Laboratory Services	3/25/2026



Origination 8/27/2021
Last Approved 4/29/2026
Effective 4/29/2026
Last Revised 4/29/2026
Next Review 4/28/2029

Owner Laura Zarate:
Clinical Nurse
Manager, Case
Management
Policy Area Administrative -
Operating
Policies

107.071 Patient Clothing Donations

POLICY:

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

PROCEDURE:

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

followed.

- Only staff are allowed access to the patient clothes closet. Under no circumstances shall patients be allowed in the patient clothes closet.
- ***Discarded patient clothing shall not be placed in the patient clothes closet. Discarded clothing shall be sent to the Security Department or disposed of with appropriate documentation noted in the electronic health record (EHR).***
- ***VCMC/SPH does NOT accept bedding, sleeping bags, pillows, etc.***

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

DOCUMENTATION:

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

REFERENCES:

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

All Revision Dates

4/29/2026, 9/5/2025, 8/27/2021

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Infection Prevention Committee	Magdy Asaad: Infection Prevention Manager	4/28/2026
Policy Owner	Laura Zarate: Clinical Nurse Manager, Case Management	1/23/2026



Origination 9/1/2016
Last Approved 3/30/2026
Effective 3/30/2026
Last Revised 3/30/2026
Next Review 3/29/2029

Owner Jason Arimura:
Associate
Hospital
Administrator,
VCMC & SPH

Policy Area Administrative -
Operating
Policies

107.088 Pneumatic Tube System

POLICY:

The ~~PNEUMATIC TUBE SYSTEM~~ pneumatic tube system (PTS) is used to transport supplies, specimens, medications, and other small items. The purpose of this policy is to establish procedures and guidelines for the operation of the system including:

- To define the steps for operating the pneumatic tube system.
- To provide guidelines for the types of materials that can be safely transported through the pneumatic tube system.
- To ensure that all authorized materials transported through the pneumatic tube system are done so without damage to the materials or contaminating the pneumatic tube system.

PROCEDURE:

PTS is a computerized carrier technology used to transport patient specimens, blood products, pharmaceuticals, supplies and documents to designated locations at Ventura County Medical Center.

~~1. Cautions~~

- ~~a. In accordance with Universal Precautions and OSHA Blood Borne Pathogen regulations, all blood and body fluids must be handled as potentially infectious materials per Infection Control policy 106.018, Standard Precautions.~~
- ~~b. Personal Protective Equipment must be used when packaging and receiving specimens as applicable.~~
- ~~c. Samples must be properly packed before transport to prevent damage and leakage of potentially infectious materials.~~

2. Roles and Responsibilities

- a. All personnel working in an area where PTS stations are available are authorized to use the PTS **only after successfully completing the competency assessment/ checklist.**

3. Only certain materials are authorized to be transported through the pneumatic tube system. Materials that are specifically prohibited will not be transported through the pneumatic tube system. Precautions will be taken by the shipper to ensure that authorized materials are not damaged during transport and the pneumatic tube system is not contaminated with hazardous chemicals, radioactive materials, blood and body fluids. **NOTE: NO FOOD OR FOOD PRODUCTS ARE TO BE PLACED IN THE TUBE SYSTEM.**

4. The PTS has stations available in:

- Ground Level: Radiology-100, OR Core-100, PACU-200
- 1st Level: ED, Med/Surg, Pharmacy, specimen collection station, ICU 1,2,3
- 2nd Level: PICU, Pharmacy, NICU, Post-Partum, Labor & Delivery, Med/Surg
- 3rd Level: Med/Surg
- Clinical Laboratory Core Lab

5. The PTS will deliver "sent" items in the follow order of priority:

1. STAT Lab
2. ED
3. Laboratory
4. Pharmacy
5. PICU
6. OR
7. ICU
8. OR
9. PACU
10. Labor and Delivery
11. Med/Surg
12. Post-Partum

PROCEDURE

- A. Per the manufacturer's instructions, properly load the carrier and **always** secure the latches.
- B. Consult the **posted** directory for the correct address of the desired destination.
- C. Follow Basic Systems/Operational Instructions.

NOTE: The carrier should arrive at the dialed destination within 3 minutes.

- ~~D. If the carrier does not reach the desired location, contact the Maintenance Department for assistance.~~
- ~~E. Carriers lost in transit will be routed to one of the default destination in the Swisslog Pneumatic Tube System. During normal business hours end users are to contact Facilities Maintenance to report any problems or issues via telephone and or contact paging after hours or on weekends.~~

A. Cautions

1. In accordance with Universal Precautions and Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen regulations, all blood and body fluids must be handled as potentially infectious materials per policy [106.018 Infection Control Standard Precautions](#).
2. Personal protective equipment must be used when packaging and receiving specimens as applicable.
3. Samples must be properly packed before transport to prevent damage and leakage of potentially infectious materials.

B. Roles and Responsibilities

1. All personnel working in an area where PTS stations are available are authorized to use after reviewing this policy and orientation to the PTS.

- C. Only certain materials are authorized to be transported through the pneumatic tube system. Materials that are specifically prohibited will not be transported through the pneumatic tube system (see Attachment A: Do Not Tube List). Precautions will be taken by the shipper to ensure that authorized materials are not damaged during transport and the pneumatic tube system is not contaminated with hazardous chemicals, radioactive materials, blood and body fluids. **NO FOOD OR FOOD PRODUCTS ARE TO BE PLACED IN THE TUBE SYSTEM.**

D. The PTS has stations available in:

: North Tower

- o Ground Floor: Radiology, Operating Room Core (OR Core), Post Anesthesia Care Unit (PACU)
- o 1st Floor: Emergency Department (ED), Intensive Care Unit 1 (ICU1), Intensive Care Unit 2 (ICU2), Intensive Care Unit 3 (ICU3), Medical-Surgical 1 (MS1), Pharmacy, Outpatient Lab Draw Station.
- o 2nd Floor: Pediatrics, Pediatric Intensive Care Unit (PICU), Pharmacy, Neonatal Intensive Care Unit (NICU), Labor & Delivery and Post-Partum.
- o 3rd Floor: Medical-Surgical 3 (MS3)

: Fainer South Tower

- o 1st Floor: Emergency Department
- o 3rd Floor: 3 Fainer South Tower
- o 4th Floor: 4 Fainer South Tower

: Clinical Laboratory

E. The PTS will deliver "sent" items in the follow order of priority:

1. STAT Lab
2. ED
3. Laboratory
4. Pharmacy
5. PICU
6. OR
7. ICU
8. PACU
9. Labor and Delivery
10. Medical-Surgical
11. Post-Partum

E. Per the manufacturer's instructions, properly load the carrier and **always** secure the latches.

1. Clear carriers will be designated for all purpose use.
2. Red carriers will be designated for lab specimen transport.
3. Blue carriers will be designated for medication transport.

G. Consult the **posted** directory for the correct address of the desired destination.

H. Follow Basic Systems/Operational Instructions.

NOTE : The carrier should arrive at the dialed destination within 3 minutes.

- I. If the carrier does not reach the desired location, contact the Facilities Department for assistance.
- J. Carriers lost in transit will be routed to one of the default destination in the Swisslog Pneumatic Tube System. During normal business hours end users are to contact Facilities Department to report any problems or issues via telephone and or contact paging after-hours or on weekends.

BASIC SYSTEMS/OPERATION INSTRUCTIONS

LOADING THE CARRIERS

- ~~1. Label contents of all carriers, identifying sender and destination, by placing the requisition in the carrier. The requisition should be packaged where it will be free from possible contamination.~~
- ~~2. Open the carrier by pressing outward on the clips at both ends.~~
- ~~3. Protect all fragile or breakable items with the foam rubber cushion and/or the bubble wrap envelopes. The users must determine what combination of foam rubber cushions and bubble wrap is needed to keep items firmly in place.~~
- ~~4. Close the carrier firmly. Both latches on the carrier must be closed.~~

- ~~5. Make sure nothing is hanging out of the carrier. If it is, open the carrier and rearrange the packing materials. Close and check again to make sure nothing is hanging out.~~

Weight Limit

Loading the Carriers

- A. Label contents of all carriers, identifying sender and destination, by placing the requisition in the carrier. The requisition should be packaged where it will be free from possible contamination.
- B. Open the carrier by pressing outward on the clips at both ends.
- C. Protect all fragile or breakable items with the foam rubber cushion and/or the bubble wrap envelopes. The users must determine what combination of foam rubber cushions and bubble wrap is needed to keep items firmly in place.
- D. Close the carrier firmly. Both latches on the carrier must be closed.
- E. Make sure nothing is hanging out of the carrier. If it is, open the carrier and rearrange the packing materials. Close and check again to make sure nothing is hanging out.

Weight Limit

The item or items placed in the carrier, together with the carrier, should not weigh more than 7 pounds for a 6-inch carrier.

SENDING THE CARRIER

Sending the Carriers

To send a carrier, make sure it is properly closed; then, follow these easy steps:

- ~~1. Look at the display. If the "Station Ready" message appears, it means your station is ready to send a carrier.~~
- ~~2. Insert either end of the carrier into the dispatcher. Rest the carrier on the bracket (dispatcher arm). Let go.~~
- ~~3. Look up the numerical address on the station directory.~~
- ~~4. Dial these numbers on the keypad and press SEND; or, press one of the programmed pre-programmed speed dial keys. You will see "Selection Accepted" displayed on the screen.~~
- A. Look at the display. If the "Station Ready" message appears, it means your station is ready to send a carrier.
- B. Insert either end of the carrier into the dispatcher. Rest the carrier on the bracket (dispatcher arm). Let go.
- C. Look up the numerical address on the station directory.
- D. Dial these numbers on the keypad and press SEND; or, press one of the programmed pre-programmed speed dial keys. You will see "Selection Accepted" displayed on the screen.

NOTE : If the "Transaction Rejected" message appears, it means that your carrier cannot reach the

address you dialed because:

- The number you dialed does not exist within the system;
- The station may be signed off; or
- The destination station is full and cannot receive more carriers.

When this happens, begin again. Make sure you dial the correct address or press the correct pre-programmed key. If this recurs, remove the carrier from the dispatcher and try again.

CLEARING OR CANCELING A TRANSACTION

Clearing or Canceling a Transaction

If an error is made while entering a transaction, press CANCEL/CLEAR button and begin again.

If any improper keyboard entry is made, press CLEAR and begin again. Will state "Selection Does Not Exist" (no beep).

If you wish to stop a transaction after the SEND button has been pressed and "Selection Accepted" is displayed, press CANCEL/CLEAR. The transaction cannot be cancelled once the dispatcher has started to move.

If the transaction was rejected and "TRANSACTION WAS ABORTED" appears, press CANCEL/CLEAR and begin again.

Read the messages which appear on the display. They will tell you what to do.

RECEIVING CARRIERS

Receiving Carriers

Receiving carriers is easy: when one arrives, just go to your station, and remove contents. If you have too many carriers, empty send carrier.

1. ~~The message "INCOMING CARRIER" or "INCOMING SECURE CARRIER" indicates a carrier will be arriving at your station.~~
2. ~~Remove carriers from the receiving bin. Promptly remove carriers when they arrive to prevent the receiving bin from becoming full and turning off your station.~~
3. ~~Open the carrier and remove the contents.~~
4. ~~Close the carrier. If you do not have your full complement of carriers on the carrier storage rack, place it on the rack until you need it again.~~
5. ~~Put the excess empty carriers you have unloaded back into the system for automatic distribution.~~
6. ~~If "RETURN SURPLUS CARRIERS" is displayed, send extra carriers to station "empty send."~~

EMPTY CARRIER RETURN

- A. The message "INCOMING CARRIER" or "INCOMING SECURE CARRIER" indicates a carrier will

- be arriving at your station.
- B. Remove carriers from the receiving bin. Promptly remove carriers when they arrive to prevent the receiving bin from becoming full and turning off your station.
- C. Open the carrier and remove the contents.
- D. Close the carrier. If you do not have your full complement of carriers on the carrier storage rack, place it on the rack until you need it again.
- E. Put the excess empty carriers you have unloaded back into the system for automatic distribution.
- F. If "RETURN SURPLUS CARRIERS" is displayed, send extra carriers to station "empty send."

Empty Carrier Return

The Empty Carrier Return (ECR) feature is designed to assure that an adequate supply of carriers is available to all stations at all times, thus minimizing demands of your time.

After a carrier arrives in the receive chamber and you have removed the contents, check the empty carrier storage rack. If it does not contain three empty carriers, place the carrier you have just received onto this rack for future use. If you have three or four carriers on the storage rack, all other carriers received should be returned for use within the system by utilizing the ECR feature:

- a. Place the empty carrier onto the bracket (dispatcher arm).
- b. Press "empty send."
- c. Press the **SEND** button.

The computer will automatically distribute carriers to the stations that need them the most. If you receive an empty carrier, the computer recognized your station's need for additional carriers.

Carriers should **NOT** be physically removed from one station and hand-carried to another station. If this occurs, the ECR feature will be compromised. The remote indicator does not turn on when an empty carrier arrives at the station.

REMOTE ANNUNCIATOR

Remote Annunciator

When you cannot see the station from your work area, you may be provided with a remote annunciator to let you know when a carrier arrives at the station.

The annunciator will be turned on when an active (not empty) carrier is received. To cancel the light and/or buzzer, all you have to do is remove the carrier and press Cancel/Clear.

Multiple Address Remote Annunciators

Stations with more than one address are equipped with remote annunciators for each address. The annunciator will be turned on when an active (not empty) carrier is received at the station. To cancel the light and/or buzzer, press **USER OPTIONS**, ## and then # or # depending on which number is assigned to that annunciator.

SENDING A SECURE TRANSACTION

1. ~~Menu~~
2. ~~User special function (press Enter)~~
3. ~~Secure transaction (press Enter)~~
4. ~~PIN code (press Enter)~~
5. ~~Select station you are sending to (press Enter)~~
6. ~~Call destination of carrier and give them the release code, unless you have a set code.~~

Sending a Secure Transaction

- A. Menu
- B. User special function (press Enter)
- C. Secure transaction (press Enter)
- D. PIN code (press Enter)
- E. Select station you are sending to (press Enter)
- F. Call destination of carrier and give them the release code, unless you have a set code.

If the release code cannot be retrieved, please contact Facilities.

RECEIVING A SECURE TRANSACTION

Receiving a Secure Transaction

The message INCOMING SECURE CARRIER is displayed until the carrier reaches the station. Once the carrier reaches the station, the message ENTER SECURITY CODE and SECURED CARRIER PRESENT are displayed.

Once the carrier arrives, a 10-minute timer will start. Once the correct PIN is entered, the station will release the carrier. If the PIN is not entered, the timer will run down to 0 and return the carrier to the sender.

SENDING A STAT TRANSACTION

Sending a STAT Transaction

Sending a "statSTAT" transaction required an authority code. When the function is initiated the user is prompted for the STAT authority code.

1. ~~Key in the code and hit enter.~~
2. ~~Once the code is accepted you will be prompted to enter the destination.~~
3. ~~Enter the destination by pressing the numbers on the numeric key pad or press the "speed" dial key associated with the desired location~~
4. ~~Press send to initiate the transaction.~~

- ~~5. The system will process the carrier through the system.~~
- ~~6. No special procedures are needed to receive a "stat" transaction.~~
- ~~7. When a carrier is inbound to the station an "incoming stat carrier" message will appear on the display.~~
- ~~8. On arrival the bid will be delivered in the receiving bin.~~

MEDICATIONS

- ~~1. Medications sent from the Pharmacy may be tubed.~~
 - ~~2. Make sure primary container is properly sealed and labeled.~~
 - ~~3. Place container and any necessary paperwork in re-sealable bag or equal to bag product.~~
 - ~~4. Secure re-sealable bag or equal to bag product.~~
 - ~~5. Place re-sealable bag in Zip N' Fold pouch or equal to bag product.~~
 - ~~6. Secure pouch and place in carrier.~~
- A. Key in the code and hit enter.
 - B. Once the code is accepted you will be prompted to enter the destination.
 - C. Enter the destination by pressing the numbers on the numeric key pad or press the "speed" dial key associated with the desired location.
 - D. Press send to initiate the transaction.
 - E. The system will process the carrier through the system.
 - F. No special procedures are needed to receive a "stat" transaction.
 - G. When a carrier is inbound to the station an "incoming stat carrier" message will appear on the display.
 - H. On arrival the bid will be delivered in the receiving bin.

Medications

- A. Most medications sent from the Pharmacy may be tubed.
- B. Make sure primary container is properly sealed and labeled.
- C. Place container and any necessary paperwork in re-sealable bag or equal to bag product.
- D. Secure re-sealable bag or equal to bag product.
- E. Place re-sealable bag in Zip N' Fold pouch or equal to bag product.
- F. Secure pouch and place in carrier.

Reasons for NOT delivering selected medications through the Pneumatic Tube System (See **Appendix A for Medications that Shall Attachment A: Do Not be Delivered via PTSTube List)**

- ~~1. Product exceeds pneumatic tube weight and/or size limits

 - ~~▪ Maximum weight capacity = 7lbs~~
 - ~~▪ Large volume bags > 1000 ml~~~~

2. ~~Potential for alteration of the active ingredient or vehicle, such as protein denaturation, cracking of emulsions, etc.~~
 - ~~▪ If a product's package insert contains a statement such as "Do not shake", then it should not be delivered through the PTS~~
 - ~~▪ Carbonated products should be allowed to settle before being transported in a PTS~~
 - ~~▪ Use caution with emulsions, because cracking may occur~~
 3. ~~Use of biohazardous material including chemotherapy, radiopharmaceuticals, or other cytotoxic medications (See exceptions in PHARM Attachment A. "Medications that Should Not be Delivered through PTS").~~
 - ~~▪ Many tubes are not completely liquid-proof. If a container is damaged and the contents leak inside the tube, they may also leak outside the tube, thus contaminating the entire PTS.~~
 4. Breakage
 - Use caution with medications in glass bottles or large containers that cannot be adequately secured or padded during transport. Do not tube glass containers greater than 250 ml.
 5. Living therapeutic modalities that may be harmed during transport
 6. Controlled substances will not be sent via the P-tube system.
 - Security cannot be guaranteed and the risk of diversion is increased.
 7. Explosive or flammable substances
 8. Extremely costly, difficult to procure, or difficult to compound items
 9. In the event of a downtime of the PTS, Pharmacy personnel will deliver medications from the Pharmacy to designated patient care areas.
- A. Product exceeds pneumatic tube weight and/or size limits
- Maximum weight capacity = 7 lbs
 - Large volume bags >1000 mL
- B. Potential for alteration of the active ingredient or vehicle, such as protein denaturation, cracking of emulsions, etc.
- If a product's package insert contains a statement such as "Do not shake", then it should not be delivered through the PTS.
 - Carbonated products should be allowed to settle before being transported in a PTS.
 - Use caution with emulsions, because cracking may occur.
- C. Use of biohazardous material including chemotherapy, radiopharmaceuticals, or other cytotoxic medications.
- Many tubes are not completely liquid-proof. If a container is damaged and the contents leak inside the tube, they may also leak outside the tube, thus contaminating the entire PTS.

D. Breakage

- : Use caution with medications in glass bottles or large containers that cannot be adequately secured or padded during transport. Do not tube glass containers greater than 250 mL.

E. Living therapeutic modalities that may be harmed during transport.

F. Controlled substances will not be sent via the PTS.

- : Security cannot be guaranteed and the risk of diversion is increased.

G. Explosive or flammable substances.

H. Extremely costly, difficult to procure, or difficult to compound items.

I. In the event of a downtime of the PTS, Pharmacy personnel will deliver medications from the Pharmacy to designated patient care areas.

GUIDELINES

Materials that are ***specifically prohibited*** from being transported through the pneumatic tube system include: ***NOTE: NO FOOD OR FOOD PRODUCTS ARE TO BE PLACED IN THE TUBE SYSTEM.***

- Medications listed ~~by Pharmacy (see Appendix A)~~ in Attachment A: Do Not Tube List. Chemotherapy medications should **NEVER** go in the pneumatic tube system.
- ~~CSF~~ Cerebral spinal fluid (CSF)
- Used, hazardous or contaminated sharps/needles*
- Hazardous chemicals*
- Flammable ~~Aerosols~~ aerosols
- Large volume IV fluids greater than 1000~~ml~~ mL
- Surgery specimens or specimens that cannot be replaced
- Paps or other cytology specimens
- Frozen tissue specimens
- Body tissue/organs
- Medical/Legal specimens requiring "chain of evidence"
- All other products having a greater than a **7 lb.** weight limit
- Flammables (requiring special storage)
- Autologous blood
- Contrast media
- No specimens in formalin
- Radiopharmaceuticals
- Shampoo, mouthwash, liquid soap
- Hand lotion
- Alcohol

- Betadine solution
- 24 hour urine specimens
- Stool specimens of any kind
- Non-leak proof containers
- Money or patient valuables
- Batteries

*Hazardous defined as being open or used

A. Packaging - to prevent leakage during transport, all specimens must be properly contained. Specimens and liquids will require both primary and secondary containment.

1. **Primary approved containers** for specimen transport are:

- Culturettes
- Vacutainers
- Specimen cups with screw on lids

2. **Secondary containment and immobilization** approved devices are:

- Clear Plastic Ziploc Bags
- Foam Liners

3. **Material Management** Central Supply is responsible for the purchase and maintenance of adequate numbers of form liners and "Zip N 'Fold" pouches.

B. System Spill Procedure:

- STOP sending carriers from the station where the contamination was first noticed.
- Call Facilities/Engineering office during business hours or page the On Duty Engineer via the PBX Operator to perform emergency shutdown.
- Notify Facility Operations and tell them:
 - The receiving station's number
 - The sending station's number (if known)
 - The type of spill (i.e. specimen type and suspected amount)
 - The time the contaminated carrier arrived, or was first noticed
 - The number of contaminated carriers that have arrived
 - Facility Operations will notify Environmental Services, House Supervisor, to institute decontamination procedures for a hazardous spill.

DISPLAY MESSAGES

The following are other display messages possibilities and the appropriate action required.

MESSAGE	ACTION
1. Station Full	Empty carrier bin

MESSAGE	ACTION
2. Station Scheduled Off	Call Facilities/ Maintenance
3. Station Signed Off	See Special Function - Call Facilities Maintenance
4. Station Not in Service	Call Facilities/ Maintenance
5. Selection does not exist	Confirm selection number and try again
6. Selection Full	Call designation to unclutter PTS receiver
7. Selection Not in Service	Try again later - Call Facilities Maintenance
8. Selection Not Permitted	Call Facilities/Maintenance
9. Selection Aborted	Press" Cancel" and try again
10. Selection Accepted	No action required

POTENTIAL INFECTIOUS ITEMS

Potentially infectious items must be contained and transported in a manner that prevents breakage, leakage or contamination of the system. In accordance with Standard Precautions and OSHA Blood borne Pathogen regulations, all blood and body fluids specimen must be handled as potentially infections. Gloves must be worn when inserting and removing of blood and body fluids specimens from carriers.

Leakage is primarily due to:

- Improper packaging and non-immobilization of contents
- Use of non-leak-tight containers or failure to tighten container lids

To prevent spillage or breakage, remember:

- Containment prevents leakage

DECONTAMINATION INSTRUCTIONS

~~1. The following are instructions for a spill NOT contained in the carrier:~~

- ~~If spillage has occurred that is not limited to the inside of the PTS carrier, immediately stop sending carriers from the station where the contamination was first noticed.~~
- ~~Notify your supervisor.~~
- ~~Contact Facilities Maintenance during business hours or via the PBX Operator and provide:~~
 - ~~The receiving station's number~~
 - ~~The type of spill (i.e. specimen type and suspected amount)~~
 - ~~The time the contaminated carrier arrived (or was first noticed)~~
 - ~~The number of contaminated carriers that have arrived.~~

~~Facilities may authorize an emergency shutdown of the PTS. When the PTS is shut~~

~~down, any carriers in the system will remain undelivered.
Facilities personnel are responsible for decontamination of the system when spills occur within the PTS.~~

- ~~d. Wipe down any spillage on the PTS station with a bleach-based disinfectant.~~
- ~~e. Remove the contents of the carrier using PPE under a biological safety cabinet, if possible.~~
- ~~f. Contact Environmental Services for any spills outside of the station (e.g., carpet decontamination).~~

2. The following are instructions for a spill contained in the carrier:

- ~~a. If a spill has contaminated **only** the inside of the carrier only, remove the contents of the carrier using PPE.~~
- ~~b. Discard the specimen and secondary containment bag in **biohazard trash**.~~
- ~~c. Wash the carrier and liner in hot water to remove debris and biological waste.~~
- ~~d. Spray the contaminated carrier and liner with bleach-based disinfectant.~~
- ~~e. Place the contaminated carrier and liner in a large plastic bag with a note attached that says: **TO BE DECONTAMINATED**.~~
- ~~f. Remove gloves and wash hands.~~
- ~~g. Call the sending station and request another specimen, as needed.~~
- ~~h. Take the carrier and liner that require decontamination to the dirty equipment room in the Sterile Processing department. Personnel will disinfect, clean and put the carriers back into service when decontamination has been completed.~~
- ~~i. File an incident report according hospital policy and contact the hazardous material officer, if necessary.~~

A. The following are instructions for a spill NOT contained in the carrier:

1. If spillage has occurred that is not limited to the inside of the PTS carrier, immediately stop sending carriers from the station where the contamination was first noticed.
2. Notify your supervisor.
3. Contact Facilities Maintenance during business hours or via the PBX Operator and provide:
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4. Wipe down any spillage on the PTS station with a bleach based disinfectant.
5. Remove the contents of the carrier using PPE under a biological safety cabinet, if possible.
6. Contact Environmental Services for any spills outside of the station (e.g., carpet decontamination).

B. The following are instructions for a spill contained in the carrier:

1. If a spill has contaminated **only** the inside of the carrier only, remove the contents of the carrier using PPE.
2. Discard the specimen and secondary containment bag in **biohazard trash**.
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8. Take the carrier and liner that require decontamination to the dirty equipment room in the Sterile Processing department. Personnel will disinfect, clean and put the carriers back into service when decontamination has been completed.
9. File an incident report and contact the hazardous material officer, if necessary.

All Revision Dates

3/30/2026, 9/1/2016

Attachments

 [Attachment A: Do Not Tube List](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	3/30/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/10/2026

Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/10/2026
Pharmacy Department	Sul Jung: Associate Director of Pharmacy Services	3/10/2026
Facilities Department	Ian McGraw: Manager Facility Operation	2/2/2026
Policy Owner	Jason Arimura: Associate Hospital Administrator- Ancillary Services	1/19/2024

COPY



Origination 1/12/2024
Last Approved 4/22/2026
Effective 4/22/2026
Last Revised 4/9/2026
Next Review 4/21/2028

Owner Evan Gamad:
CLS III
Policy Area Laboratory
Services

L.118 Quality Management System Clinical Laboratory Ventura County Medical Center Santa Paula Hospital

Vision

Setting the standard in health care excellence. Healthy people in healthy communities throughout Ventura County.

Mission Statement

Provide comprehensive, cost-effective, compassionate healthcare for our diverse community, especially those facing barriers, through an exceptional workforce, education, and forward-thinking leadership.

Quality Statement

Quality is essential in our services, our workplace environment and in our people. Through our quality program the clinical laboratories at the Ventura County Medical Center and Santa Paula Hospital are committed to accurate test results and high quality-cost effective patient care. Both laboratories will consistently strive to meet and exceed our customers' expectations through our commitment to quality.

Scope

The laboratory will comply with the requirements of the College of American Pathologists (CAP), federal, and state regulatory agencies and continually improve its quality management system.

The Clinical Laboratory will comply with all laws, rules, and regulations, as is consistent with the *Code of Conduct* and *Code of Ethics* for the Ventura County Medical Center and Santa Paula Hospital. The regulating agencies for the clinical laboratory include College of American Pathologists (CAP), the

Centers for Medicare and Medicaid Services (CMS), the Clinical Laboratory Improvement Act (CLIA), Joint Commission, and the State of California. Compliance with local laws and regulations will also be adhered to, as is applicable.

The Laboratory permits performance of accreditation inspections by accrediting agencies. Accrediting agencies may review results of evaluations by publicly recognized bodies. The Laboratory provides accurate information throughout the accreditation process.

This policy is not meant to include an all-inclusive list of the regulations but serve as a guideline for the commitment to comply with the regulations set forth by each agency and directions for finding the specific rules and regulations.

Quality Policy

In support of this policy both laboratories will fully operate to documented standards within the scope. Each laboratory section Clinical Laboratory Scientist III will ensure compliance to Laboratory Policies and Procedures.

- Provide a clear focus on priorities through the establishment of quality objectives.
- Make available the necessary resources for the effective functioning of the quality management system and the achievement of its quality objectives
- Communicate the Quality Policy and objectives to all lab employees.
- Provide the necessary training and skills to lab employees.
- Operate a closed loop performance measurement system by identifying areas for improvement and implementing the necessary corrective actions and preventive measures.

FOCUS-PDCA Methodology



Find a problem/process to improve.

Organize team that knows the process.

Clarify how the process works.

Understand root causes of problems.

Select an improvement strategy.

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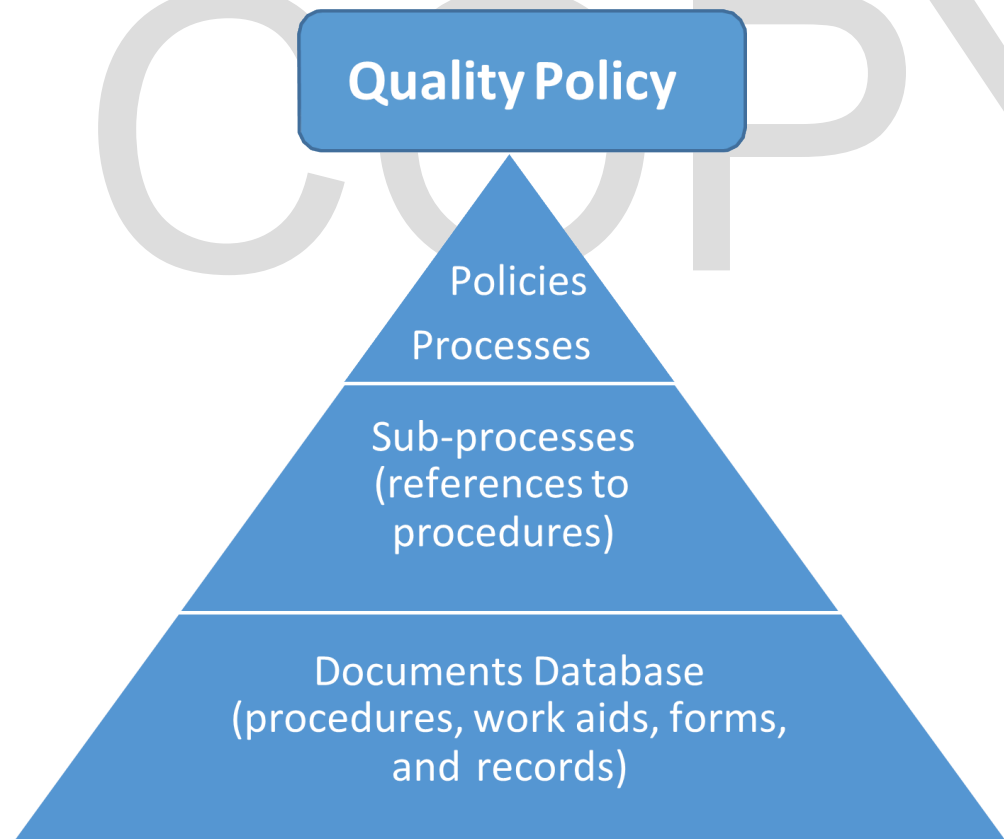
Select an improvement strategy.

The Quality Management System is annually reviewed by the Quality Assurance/Performance Improvement CLS III, the section CLS III, the director of laboratory services, or designee, and clinical laboratory medical director.

The Quality Management System is assessed through the Internal Quality Audits and Management Review Meetings to reaffirm its continued suitability and conformity. Initial training of laboratory staff is done within 90 days of hire.

The quality management system and the structure of the documentation are organized by the following configuration.

Topic	
Quality Policy	
A.Scope of Services	
B. Quality Objective and Metrics	
C. Roles and Responsibilities	
D.Quality System Overview	
E. Ethical Conduct	
F. Management Commitment	
H. Implementation and Monitoring	



Scope of Services

Types of Services Provided

The laboratory offers a full range of clinical laboratory and anatomical pathology services. Testing requiring technology not available within the hospital is forwarded to accredited reference laboratories approved by medical staff. The monitoring of quality for reference laboratories is part of the overall Quality Management System.

- Hours of Operations:
 - 24/7 Laboratory Services (Phlebotomy and Diagnostic Testing)
 - 0800 to 1630(Anatomical Pathology Services)
 - 0700 to 1530

Service	Description
General Laboratory Testing of Individual Laboratory Tests	Perform analytical testing classified by testing methodologies and medical disciplines: Hematology, Urinalysis, Routine and automated chemistry, Immunochemistry, Serology, Coagulation, Transfusion Medicine/Blood Bank, and Toxicology.
Pathology and Cytology Services	Anatomic pathology and Cytopathology (non-gynecologic). Services include autopsy, biopsy,PAP test, interpret fine-needle aspirate, frozen section analysis, pathology consultations, histology processing/staining, and surgical pathology.
Microbiology Testing	Perform services for bacteriology, mycology and molecular testing.
Transfusion Service/Blood Bank	Maintains full-service hospital transfusion service with an active blood management program.

Complexity of Patient Care Needs

Hospital services: Newborn through adult patients of all acuity levels, including those requiring the intensive care involved in emergency services, Level II trauma, neonatal, cardiac and oncology services.

Outpatient services: Specimen collection and POCT is available at outpatient locations. The laboratory serves as referral laboratory to physician offices in the community.

Specific Services Provided

A. Quality Objectives and Metrics

Clinical Laboratory Scientist III, Performance Improvement/Quality Assurance Supervisor, Laboratory Manager, Director of Laboratory Services monitor and measure performance of processes within their

area(s) of responsibility. Each lab section will establish measurable operation level improvement indicators consistent with the quality policy. The following are examples:

Element of Quality Policy	Quality Objective	Metrics
Meeting Customer Needs	Timely test results.	A. STAT turnaround times for Inpatient and emergency department (ED). B. Routine Early Morning Collection. C. Turnaround Time (TAT) for BMP, PT/INR/PTT, CBC, and Troponin-I in ER D. Lactate Turnaround Time (TAT) E. Unacceptable Specimens
	Meet and exceed customer satisfaction.	A. Satisfaction Surveys B. Monitoring and the Resolution of Notifications
	Cost effectiveness	A. Blood Utilization (Usage and Wastage, Crossmatch: Transfusion Ratio) B. Test Utilization
Accurate Test Result	Maintain or improve scores in Proficiency Testing	Proficiency testing survey evaluation trending.
	Perform all defined quality control measures.	A. Blood Culture Contamination Rates B. Corrected Results Report C. Computer Calculation Checks. D. Evaluations of suppliers of critical reagents.
	Retain qualified and competent staff	A. Employee Satisfaction Survey B. Training/Competency Completion Audit A. Professional Development Plans
High Quality Patient Care	Accurately identify all patient and patient samples.	A. Labeling Errors B. Requisition Audits for

		completeness
	Call all defined critical results to an approved health care provider in a timely manner.	A. Critical Value Reporting TAT B. Critical Value Documentation C. Frozen Section TAT
	Accurately report test results.	A. Data transmission checks B. Resulting Clerical Errors.
	Reduce Nosocomial Infections	MRSA/CDIFF testing surveillance audits.
Maintain a safe work environment.	Ensure Employee Safety and Regulatory Safety Requirements are met.	A. Occupational Injuries B. Environmental Audits

A. Roles and Responsibilities

Overall Quality Management System responsibilities for ensuring compliance with the QMS is described below:

Position	Responsibility
Chief Operations Officer and Chief Quality Officer	Responsible for quality affairs at the senior executive level.
Associate Hospital Administrator (Ancillary Services)	Responsible for executive sponsorship of laboratory management and laboratory quality providing oversight and alignment within the Health Care Agency.
Laboratory Medical Director	Responsible for the clinical aspects of laboratory testing, which includes approval of the new tests, test procedures, reference ranges, report format, clinical interpretation, and consultation. Responsible for the approval of overall QMS activities.
Director of Laboratory Services/ Laboratory Manager	Responsible for the business management and strategic direction of the laboratory in support of overall quality

	management. Responsible for activities involved in laboratory operation such as testing, reporting, logistics, facilities, and environmental health and safety. Also, responsible for QMS planning and the provision of resources needed to implement and improve the QMS.
Section Clinical Laboratory Scientist III	Responsible for planning and controlling QMS processes within their area(s) of responsibility, including the implementation of Quality Management objectives and the provision of resources needed to implement and improve these processes. Clinical Laboratory Scientists are responsible for corrective action of product or process non-conformities. Develops a budget for the laboratory and maintains control of laboratory costs.
Quality Assurance/Performance Improvement (CLS III)	Delegated responsibility for ensuring that QMS is established, implemented, monitoring, documenting and continuously improving quality. Also, responsible for periodical reviews by Senior Management for effectiveness and continuing suitability. The Quality Assurance/Performance Improvement (CLS III) provides guidance for staff to develop and document appropriate operational procedures for department activities.
Clinical Laboratory Scientist III	Responsible for supervising the activities of the QMS. Ensures performance of standard biological, microbiological, and chemical tests to ensure their delivery in an accurate and timely fashion using proper safety precautions. Evaluates quality control and quality assurance statistics and maintains policies and procedures. Investigations and root cause analyses for the management of occurrences.
Staff	Responsible for the quality of individual work and the development and implementation of the policy and procedures applicable to the processes performed. Identifying and reporting occurrences.

A. Quality System Overview

All employees are responsible for the quality system. Individual policies and procedures further define specific employee responsibilities. The quality system includes a formal system of planned activities. The quality manual is maintained current by the Quality Assurance/Performance Improvement CLS III to reflect changes to the system. The laboratory defines the key components of quality in a separate quality improvement process document.

The laboratory defines policies for each applicable standard in the quality manual or the general policy

manual. Laboratory policies are maintained in a document control system and approved by the Laboratory Medical Director. The laboratory departments have documented procedures that further describe how the specific policy objectives and goals are implemented within the department.

Technical work instructions are maintained in each department's manuals. The technical procedures specify the equipment, and the required resources needed to produce quality work. Department policies and procedures are maintained in the document control system by each department leadership, section director, and approved by the laboratory medical director.

A. Ethical Conduct

The hospital has a Compliance Program which requires all dealings to be conducted in a lawful and ethical manner. Through adherence to the Code of Conduct all staff members will conduct themselves to protect and promote organization-wide integrity.

A. Management Commitment

Laboratory management provides evidence of commitment to the development and implementation of the quality management system and continually improves its effectiveness by the following activities:

- Laboratory management establishes the quality policy and reviews biannually. Communication to employees of the quality policy is documented during laboratory training/orientation and reviewed annually. It is understood, implemented, and maintained by employees at all levels. This is documented by management through the employee evaluation process and training procedures. The internal audit process and the management review process demonstrate compliance.
- The department leaders and section directors should ensure department policies and procedures are understood and implemented by testing personnel. Documentation is documented through training/competency and maintained in the employee file.
- Laboratory communication is accomplished through Departmental and Quality Management Meetings. Documentation of meetings is maintained.

Implementation and Monitoring

The following calendar has been established to identify when QA reviews should be performed. Each item identified under the QA Review heading must be reviewed at a minimum of once a year.

January	February	March	April
A. Monthly reviews	A. Monthly reviews	A. Monthly reviews	A. Monthly reviews
B. Annual evaluation of QMS	B. Annual review of safe work practices,	B. Annual Water Quality Check	B. Competency #1 OSHA Training/

C. Staff Performance Evaluation	evaluation of accident/injury	C. Annual review of emergency preparedness policy D. Cancer Committee	PPE/Fire Safety C. Annual review of infection/exposure plan/PPE usage
May A. Monthly reviews B. Annual review of policies and procedures	June A. Monthly reviews B. Annual review of chemical hygiene plan C. Biennial review of technical policies and procedures by lab med director	July A. Monthly reviews B. Instrument checks/ Noise level checks C. Cancer Committee	August A. Monthly reviews B. Competency #2 Technical procedures (TS/Micro/ Chem)
September A. Monthly reviews B. Self-inspection C. Vendor qualification reviews by lab medical director	October A. Monthly reviews B. Annual review of ergonomics policy/ assessment	November A. Monthly reviews B. Customer feedback C. Cancer Committee	December A. Monthly reviews B. Competency #3 Technical Procedures (Hema/UA/ Coag/ Serology) C. Purge documents (2 years old)

DEPARTMENTAL MONTHLY QA REPORTS

- QUALITY CONTROL LOGS
- MONTHLY STATISTICS CALCULATION

- PREVENTIVE MAINTENANCE LOGS
- PROBLEM LOGS
- QUALITY ASSURANCE REVIEWS: INDICATORS, INCIDENT REPORTS, CERTIFICATIONS AND LICENSES
- EVALUATIONS OF EFFECTIVENESS OF CORRECTIVE ACTIONS TAKEN OF INVESTIGATIONS AND NON-CONFORMING EVENTS
- CALIBRATIONS/CALIBRATION VERIFICATIONS
- PARALLEL TESTING/LOT-LOT CORRELATIONS
- VALIDATIONS OF NEW TEST/METHOD
- SURVEILLANCE LOGS
- PENDING LOGS
- UNCOLLECTED SPECIMENS LOG
- EXCEPTION REPORTS
- RESULTS REVIEW

QUALITY ASSURANCE Reviews

Pre-Analytical Metrics

Patient Preparation, Specimen Collection, & Handling

(GEN.40016, GEN.40032, GEN.40050, GEN.40100, GEN. 40490. GEN.40491, GEN.40499, GEN.40535)

- Is patient identity properly confirmed prior to collection? (GEN.40490)
- Are specimens only collected when patients have been properly prepared?
- Are specimens properly labelled? (GEN.40491)
- Are appropriate specimen collection containers and procedures followed?
- How is specimen integrity maintained if testing cannot be performed right away?
- If specimens require special preparation or handling prior to testing, is this performed properly?
- If specimens must be transported to another location for testing, are procedures followed to ensure specimen integrity is maintained? If specimens are not suitable for analyses, are they rejected and appropriate notifications made? How are they communicated to clients? (GEN.40535).

• Are preventive measures being applied to decreased the recurrence of errors in the proper collection of specimens? Is accurate documentation of incident details the aid of investigation and counselling of collecting personnels? Are competency, remedials and re-training being practiced to ensure patient safety and reliability of results are achieved? (GEN.40499). • Are policies and procedures (existing and/or modified) reviewed by the lab medical director or designee at least every two years?	
When:	Daily reviews of specimen logs, send out logs, referral lab reports, batch reports
How:	Specimen integrity, reviews of requisition slips
Acceptable Target for Performance:	100% of samples submitted shall be appropriately labeled and packaged for transport, requisitions shall have identical patient information on the specimen label.

Test Ordering & Requisitions

(GEN.40700, GEN.40725, GEN.40750, GEN.40825, GEN.40900, GEN.40930, GEN.43900)

- Do all specimens accompanied by an adequate requisition? (GEN.40700)
- How does the laboratory know what tests have been ordered on which patients, by which health care provider?
- Are orders reviewed to identify any inconsistencies related to age, gender, diagnosis, or relationship with other test requests or results?
- Are all surgical pathology/cytology specimens accurately labeled with source and test requisition
- What serves as the laboratory's test requisition for inpatient and outpatients?
- How does the laboratory evaluate test requisitions to ensure completeness of required information needed for test interpretation? (GEN.40750)
 - If information is missing are proper procedures followed to obtain the needed information?
- Are test requisition data elements entered accurately into the laboratory information system? (GEN.40725)
- How are requisitions stored?
- How long are requisitions retained?
- Can the laboratory produce original or exact copies of requisitions throughout the entire time period for retention?

When:	Daily Checks, Monthly Reviews
How:	Upon receipt of specimen packages, test requisitions are reviewed for

	completeness and are checked against specimen collection vials submitted. Clerical checks of specimen labels. When and if discrepancies are discovered, the specimens are quarantined and held for investigation.
Acceptable Target for Performance:	• All manual requisitions submitted with the specimens shall have an authorized physician and patient signature (as applicable) • Patient demographics are complete • Clinical information and diagnosis are indicated on the requisition • Site of the biopsy is clearly identified

Communication Breakdowns

(GEN.20325, GEN.40535, GEN.61750, GEN.61800)

- How does the laboratory communicate changes in specimen collection requirements, testing, or reporting to health care providers? (GEN.40535)
- Is there any feedback from providers, which indicates a communication problem between the provider and the laboratory may have occurred?
- How were these investigated and resolved?

When:	When there are changes
How:	Laboratory staff will create a memo or a bulletin and have the laboratory medical director approve and sign documents
Acceptable Target for Performance:	All changes pertaining to specimen collection requirements, testing or reporting, including manufacturer recalls, will be communicated to clients within 72 hours of changes or discoveries of recalls.

Analytical Metrics

Performance Specifications

- Have performance specifications been completed for all non-waived test systems?
NOTE: If you have multiple units of the same instrument, each must have performance specifications completed independently.
- Is there any evidence that a test system may no longer be meeting expected performance specifications including accuracy, precision, reportable range? *(This may include discrepancies in the relationship or distribution of test results, discrepancies between in house test results and those obtained by other laboratories, questions or complaints from ordering practitioners regarding test results, patterns related to repetitive*

maintenance, calibration, or QC issues for a given test/test system.)

- You must complete performance specifications on “loaner” instruments.

When:	Annual
How:	Calibration verification
Acceptable Target for Performance:	100% compliance

Instrument and Equipment Record Review

(COM.04200, COM.30550, COM.30575, COM.30600, COM.30625, COM.30650, COM.30675, COM.30680, COM.30680, COM.30685, COM.30700, COM.30725, COM.30750, 30775, COM.30600, COM.30810, COM.30820, COM.30830)

- Is the preventive maintenance performed as scheduled?
- Is there an appropriate corrective action performed for the problems identified?
- Performance verification is performed on all instruments and equipment prior to initial use, after major maintenance or service, and after relocation to ensure that they run according to expectations
- Start-up, operation, and shutdown instructions for all instruments and equipment are available at the workbench or work area

When:	Monthly
How:	Laboratory Director or Designee reviews and assesses instrument and equipment maintenance and function check records. If problems are identified, the reviewer must record corrective action. The review of the records related to tests that have an approved individual quality assurance plan (IQCP) is included in the assessment of whether further evaluation of the risk assessment and quality control plan is needed based on the problems identified.
Acceptable Target for Performance:	100% compliance

Reference Ranges for In House Testing

- How are reference ranges established for all tests performed by the laboratory?
- If a change in test methodology has been implemented, did the laboratory verify the reference range for the new methodology?
- Does the laboratory serve a patient population with characteristics that affect the expected normal range for a given test? (*For example pediatrics, geriatrics, ethnic variations, altitude, etc..*)
- Have you compared results for a sample of “normal” patients from your practice to your

established reference range?

- Does this comparison indicate the need for further review or potentially adjustment of laboratory reference ranges?
- If any need for adjustment of reference ranges was identified, were ordering practitioners notified of the change and reporting methods updated to reflect the new range?

When:	Annual
How:	Monthly statistical analyses of patient data
Acceptable Target for Performance:	100% compliance

Corrective Actions for QC and Calibration

(GEN.30000)

- Is laboratory staff identifying out of range results for QC or calibration?
- Is laboratory staff documenting corrective actions taken when out of range results are obtained?
- Are the corrective actions taken appropriate?
- Can you observe any patterns related to the frequency of out-of-range results, the staff members involved, the cause of out-of-range results?
- *If patterns are identified, further investigation is needed to determine the root cause and identify actions that can be implemented to prevent future occurrences.*

When:	Daily review of QC by testing personnel, monthly QC reviews
How:	Testing personnel, prior to testing patients, will review QC data, investigate out-of-control, perform corrective action
Acceptable Threshold:	100% QC/calibration are within acceptable range, performance of appropriate corrective actions

Proficiency Testing

(COM.01000, COM.01100, COM.01200)

Review of Activity Menu (COM.01200)

PT Attestation Statement (COM.01400)

On the most recent PT event:

- Has the laboratory received any PT scores for any test that were not within the allowable range? (NOTE: the laboratory may pass the PT challenge for a given analyte even though an out-of-range result was received for 1 of the PT samples.)
 - If so, investigate to determine the reason for out-of-range results and take corrective action as needed.

- Were any tests not graded or evaluated?
 - If so, review the PT report to determine the reason it was not graded. If the target values expected for the samples are provided, compare your results to the target. If not within range, conduct split sample analysis to verify the accuracy of your test results.
- Is there a record of actions taken to investigate any PT failures and the above situations?
- On-going evaluation of PT by laboratory director or designee with appropriate corrective action taken for each unacceptable result. (COM.01700)

Compare Current PT Performance to the Two Preceding Events:

- Are there any patterns for a given test? (out of range results, un-graded results)?
 - If so, has performance improved in the most recent PT event?
 - If not, is further investigation and corrective action warranted to ensure accuracy of patient results?

When:	When performance evaluations from each PT event are received.
How:	Quality Assurance/Performance Improvement CLS III or designee will distribute PT evaluations to respective CLS III who will evaluate performance adhering to policy and procedure related to proficiency testing.
Acceptable Target for Performance:	• 80% for all analytes, see CMS changes • 100% for transfusion medicine

Individualized Quality Control Plans

For each test utilizing IQCP:

- Evaluate the effectiveness of the IQCP by reviewing the following:
 - Has the laboratory received any feedback questioning test results?
 - Has the laboratory received any unsatisfactory or unsuccessful PT scores?
 - Have any QA Reviews identified concerns with the given test?
- Review the prior Risk Assessment based on any problems identified and any changes that may have occurred in the past year. This may lead to either an increase or a decrease in the future risk of an incorrect result.
 - Changes related to the specimen, collection and its handling?
 - Changes related to testing personnel?
 - Changes related to the testing environment?

- Changes in reagents used for testing?
- Changes to the test system or its components?
 - Re-assess the potential risk for any changes or identified problems.
- Review the QC Plan.
 - If the risk has increased, determine what additional actions can be implemented to reduce the risk.
 - Add these actions to the QC Plan.
 - If the risk has decreased, determine whether the prior actions in the QC Plan to address the risk should remain or be altered.
 - Make any adjustments to QC plan as needed.
- Approve all changes to the IQCP and re-train staff in the revised IQCP.
- If no changes are needed, record the review noting that the IQCP was determined to be effective.

When:	At least once per year
How:	List of IQCP will be reviewed by responsible CLS III and/or QA/PI CLS III, add or delete as necessary, risk assessment performed for new test, identify risks and implement risk mitigation steps.
Acceptable Target for Performance:	100% adherence to standard

Relationship of Patient Results

- Does the laboratory have a mechanism to detect inconsistencies in the distribution of patient results across your stated reference ranges?
- Does the laboratory have a mechanism to detect inconsistencies in patient results based on relationship with other test results?
- Does the laboratory have a mechanism to detect inconsistencies in patient results based on relevant information such as gender, age, time of collection, symptoms, treatments, diagnosis, clinical history.

For each of the above:

- What inconsistencies have been identified?
 - What actions were taken to investigate the cause of any inconsistencies?
 - What corrective actions were taken?
 - How was the situation communicated to ordering practitioners?

When:	Testing event

How:	• Reviews of anion gaps, delta checks, H/H mismatch, etc. • Pathology correlation reports (monthly/quarterly/semi-annual/annual reports)
Acceptable Target for Performance:	100%

Patient Test Results/Reports

- How does the laboratory report test results?
- How does the laboratory monitor corrected and amended reports?
- How does testing personnel report critical results to healthcare providers?
- How does the laboratory monitor reports for completeness (all required elements are present)?
- Do reports include the name of the laboratory director of the laboratory performing the test?
- Is there any feedback that would indicate a potential problem with content of reports or their distribution?
- How long does the laboratory maintain test reports?
 - Can the laboratory produce the original or an exact copy of test reports throughout the entire time period?
- How does the laboratory evaluate staff compliance with procedures for reporting critical values?
- How does the laboratory evaluate staff compliance with procedures for issuing corrected reports?

When:	Test Results: Daily reviews of departmental activity reports Test Reports: Biennial (Every two years)
How:	VCMC and SPH laboratory provide electronic reports to ordering physicians.
Acceptable Target for Performance:	100% compliance

Laboratory Information System

- How does the laboratory evaluate data entry processes (manual & automated) for patient information?
 - Are there any indications of problems with the accuracy of patient information?

- Are there any indications that some patients or some information may be missing from the lab information system?
- How does the laboratory evaluate data entry processes (manual & automated) for test results?
 - Are there any indications of problems with the accuracy of test results including any interpretive comments?
 - Are there any indications that some test results may be missing from the lab information system?
- Does the Lab Information System perform any calculations?
 (The following items are provided as potential examples of calculations that might be performed: converting birth dates to age groups for evaluating normal values, INR calculations, Anion gap, ratios to compare selected test results (BUN/Creatinine, Total Cholesterol/HDL), and/or conversion of any results to different units or percentages).
 - How does the laboratory validate the correctness of any calculations performed by the LIS?
- How does the laboratory protect the LIS against loss of data?
- Is the laboratory able to retrieve data from the past in a timely manner?
- How far back can the laboratory retrieve data?

When:	Annual
How:	Periodic validation and maintenance of LIS hardware, software, calculations, etc. Transfusion Services: BC Solutions
Acceptable Target for Performance:	100%

Monitoring Turn-Around-Time

In house:

- Has the laboratory established turn-around times for reporting results based on the needs of ordering practitioners?
- How does the laboratory monitor its ability to meet the established turn-around times?
- Has the laboratory received any feedback regarding turn-around time?
- How does the laboratory ensure that all results are reported within a clinically useful period?

Send outs:

- Does the laboratory have a negotiated turn-around time with outside laboratories?

• How does the laboratory monitor the turn-around time? • Does the laboratory provide feedback to the outside laboratory regarding turn-around time? • How does the laboratory ensure that reports are received within a clinically useful period for all tests sent to an outside laboratory? • Does the referral laboratory adhere to all requisition, collection and handling specifications of the referral laboratory?	
When:	Daily reviews Tracking CMP, CBC with Differential, PT/PTT, Troponin, Lactate Monitoring tests-not-performed reports from referral laboratories
How:	• Specimen tracking for all in-house and outpatient draws, referral lab reports • Participation in hospital-wide and laboratory Throughput Committee • Participation in ED TAT Committee
Acceptable Target for Performance:	90% (60 minutes from order time, 45 minutes from door time (CODE STROKE, CODE SEPSIS)

Customer Feedback

Does the laboratory have a method for obtaining feedback regarding laboratory services from patients and ordering providers?

How is this feedback reviewed and acted on?

Does the laboratory have a protocol for handling complaints?

Have all complaints been investigated?

Have corrective actions been taken, as appropriate?

Are there any patterns related to the number or type of complaints received?

When:	Annual
How:	Distribution of customer satisfaction survey Review of the NRC reports techsupport@nationalresearch.com
Acceptable Target for Performance:	Customer (patient and physician) feedback is reviewed, evaluated and corrective action performed within 72 hours of receipt

Water Quality and Glassware

Has the laboratory defined the specific type of water required for each of its testing procedures and water quality is tested at least annually?

Have corrective actions been taken, as appropriate?

When:	Annual
How:	Biomed checks
Acceptable Target for Performance:	100% compliance

Safety Rounds

Policy and procedure current and available to staff, staff training
 Work practices, occupational injury/illness tracking and monitoring
 For any occupational injury or illness that required medical treatment, further evaluate laboratory leadership's responses, corrective actions, follow-up procedures, and additional measures taken to ensure safety in the workplace

When:	Weekly
How:	Weekly rounding in all areas of the laboratory at SPH and VCMC using the hospital's Patient Safety Rounding Tool, weekly report provided by PI/QA
Acceptable Target for Performance:	90% compliance

Attachments

- A. Quality System Management Calendar
- B. Performance Improvement Dashboard
- C. Annual review of quality management system

References

1. Accreditation Checklists, College of American Pathologists, September, 2021.
2. Clinical and Laboratory Standards Institute (CLSI). *A Quality Management System Model for Laboratory Services*. 5th ed. CLSI guideline QMS01. Clinical and Laboratory Standards Institute, Wayne, PA; 2019.
3. Valenstein P. *Quality Management In Clinical Laboratories*. Chicago, IL: CAP Press, 2005.
4. Jhai Q, Siegal GP. *Quality Management in Anatomic Pathology*. Northfield, IL: CAP Press, 2017
5. ISO Standards compendium: ISO 9001:2015, Quality management systems -- Requirements. Geneva, Switzerland: International Organization for Standardization, 2015.
6. ISO 15189:2012 Medical laboratories -- Requirements for quality and competence. Geneva, Switzerland: International Organization for Standardization, 2012.

All Revision Dates
4/9/2026, 3/27/2026, 3/3/2026

Attachments

 [Clinical Lab Investigation Form.pdf](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/22/2026
Laboratory Services Department	Evan Gamad: CLS III	4/21/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/17/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/16/2026





Origination 9/1/2022
Last Approved 2/11/2026
Effective 2/11/2026
Last Revised 2/11/2026
Next Review 2/11/2028

Owner Erlinda Roxas:
Director,
Laboratory
Services
Policy Area Laboratory
Services

L.52 Laboratory Response To Hospital Emergency Call Codes

POLICY

The Department of Laboratory Services at Ventura County Medical Center and Santa Paula Hospital shall have a defined process for laboratory staff's response to hospital emergency call codes that require specimen collection and processing.

MATERIALS

1. Specimen collection tubes
 - Light blue (sodium citrate)
 - Red (no additive)
 - Gold (SST)
 - Green (lithium heparin)
 - Lavender (EDTA)
 - Pink (EDTA)
 - Gray (Sodium fluoride)
 - Blood culture bottles
2. Blood collection needles, multi-sample
3. Blood collection needle, butterfly
4. Blood collection single-use tube holder
5. Tourniquet

6. Alcohol pads
7. Chlorhexidine (Chloraprep pads and swabstick)
8. Disposable gloves
9. Blood bank armband
10. Disposable plastic biohazard bags

PROCEDURE

To ensure that patients are accurately diagnosed in the most expedient way possible, the hospital developed the following codes to ensure responders are activated promptly:

1. CODE STROKE (brain stroke): patients affected with central nervous system infarction
2. CODE BLUE/RAPID RESPONSE
3. CODE LAB (intensive care unit (ICU) ONLY for near-death situations)
4. CODE MATERNITY
5. CODE YELLOW (Tier 1 and Tier 2)
6. CODE SEPSIS

RESPONSIBILITIES

1. The laboratory is responsible for:
 - a. Provision of laboratory services to support the hospital life-threatening codes
 - b. Immediate attention and support for safe and timely patient care through accurate diagnostic testing.
 - c. Communication is vital when responding to hospital codes.
 - i. Central Processing Coordinator is responsible for all communications with Certified Phlebotomy Technicians (CPTs).
 - ii. Immediately communicate with the ordering department when there are delays in provision of services.
 - iii. Document dialogue in emergency department (ED) log or shift report log, or more appropriately on the specimen's accession number.
2. All Certified Phlebotomy Technicians are provided with cellular phones and receive messages ~~at the same time during code announcements~~ simultaneously when codes are announced.
3. Two CPTs respond to the CODE: The CPT assigned to the unit (ED, ICU, MED SURG, etc.) and the CPT assigned as "FLOAT CPT."
 - a. Immediate response to the CODE announced.

CODE	ACTION	
CODE STROKE	Draw specimens per protocol (4 lithium heparin, 2 lavenders, 1 blue, 2 gold, 1	

CODE	ACTION	
	pink) ~~Tube~~<u>DO NOT TUBE</u> <u>Deliver</u> specimens ~~Call laboratory coordinator~~ <u>to CLS/MLT in Chemistry</u>	
CODE LAB	Draw specimens per protocol DO NOT TUBE Deliver specimens to the lab	
CODE YELLOW - TIER 1	Draw specimens per protocol (3 lithium heparin, 1 lithium heparin for RT, 1 lavender, 1 blue, 1 gold, 1 pink, 1 gray) Tube specimens Call ~~lab coordinator~~<u>Central Processing Coordinator</u>	
CODE YELLOW - TIER 2	Draw specimens per protocol (4 lithium heparin, 1 lithium heparin for RT, 1 lavender, 1 blue, 1 gold, 1 pink, 1 gray) Tube specimens Call ~~lab coordinator~~<u>Central Processing Coordinator</u>	
CODE MATERNITY		
CODE SEPSIS	~~Draw specimens per protocol (2 lithium heparin, 1 lavender, 1 blue, 2 gold)~~ ~~Tube specimens~~ ~~Call lab coordinator~~	<u>CODE SEPSIS</u> <u>Draw specimens per protocol (2 lithium heparin, 1 lavender, 1 blue, 2 gold)</u> <u>Tube specimens</u> <u>Call Central Processing Coordinator</u> <u>For specimens drawn for Lactate (test performed by Respiratory Therapy), draw within fifteen (15) minutes of order time. Notify Respiratory Therapist (RT) that specimen has been drawn. Call Central</u>

CODE	ACTION	
		<u>Processing Coordinator to receive specimen with the appropriate collector's Cerner ID, date and time of collection, and RT notification.</u>

- b. ~~Collect specimens following established protocol: A pre-assembled "CODE STROKE" packet (contains lavender, pink, green, blue, red top tubes, and gray (on ice), butterfly, blood bank armband, blood cultures, chlorhexidine pads and swabstick).~~
4. ~~Immediately bring the specimens to the laboratory. DO NOT USE PNEUMATIC TUBE SYSTEM.~~
5. ~~Hand deliver the specimens to the Clinical Laboratory Scientist or Medical Laboratory Technician assigned to Chemistry.~~
6. Collect specimens following established protocol: CODE STROKE: A pre-assembled "CODE STROKE" packet (contains lavender, pink, green, blue, red top tubes, and gray (on ice), butterfly, blood bank armband, blood cultures, chlorhexidine pads and swabstick). Immediately bring the specimens to the laboratory. DO NOT USE PNEUMATIC TUBE SYSTEM. Hand deliver the specimens to the Clinical Laboratory Scientist or Medical Laboratory Technician assigned to Chemistry.

1. TUBE COLOR	TESTING AREA	ACTION	
Phlebotomist	Clinical Lab Scientist Medical Lab Technician		
Pink	Blood Bank	Centrifuge specimen	• Load specimens into analyzer. • Monitor test completion. • Communicate critical results to ordering provider. • Document notification in Laboratory Information System.
Green	Chemistry	Centrifuge specimen	
Gray	Chemistry	Centrifuge specimen	
Purple	Hematology	• Mix sample. • Load in analyzer.	
Blue	Coagulation	Centrifuge specimen	
Blood Cultures	Microbiology	Follow instructions for	

TUBE COLOR	TESTING AREA	ACTION	
Phlebotomist	Clinical Lab Scientist Medical Lab Technician		
		loading.	

All Revision Dates

2/11/2026, 10/3/2025, 7/27/2024, 9/1/2022

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	2/11/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	1/24/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	10/7/2025



Origination 3/18/2010
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Effective 3/25/2026
Last Revised 3/25/2026
Next Review 3/24/2028

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

L.BB.06 Safe-T-Vue® Temperature Indicators

PRINCIPLE:

Safe-T-Vue® is a nonreversible temperature indicator that changes color from white to red when the safe temperature for blood has been reached or exceeded. The indicators are designed to attach directly to the blood bag or product being transported or stored.

SPECIMEN COLLECTION:

N/A

MATERIALS/EQUIPMENT:

1. Safe-T-Vue® 6
2. Safe-T-Vue®10
3. Refrigerator to maintain temperature sensitive blood products between 2°C and 4.5°C and storage of Safe-T-Vue® indicators.
4. Storage and Preparation: Store or ship at room temperature. Refrigerate at the same temperature as blood for at least 24 hours prior to use. Remove from refrigerator and bring to room temperature for 24 to 48 hours every 2 months. Write the refrigeration and removal dates on the box.

Guidelines:

Step	Description
1	Safe-T-Vue® blood temperature indicators will be placed on all red blood cells and thawed plasma issued in a blood transport cooler.

Step	Description
2	- Safe-T-Vue® 6 – placed on all blood products issued in a blood transport cooler for temporary storage for up to 4 hours. These units can be returned to the blood bank for reissue if the indicator color is still white. (Example: ER, OR, ICU) - Safe-T-Vue® 10- placed on all blood products issued in a blood transport cooler for transport to a ward for immediate transfusion. Unit(s) most likely will be transfused and not returned. Units can be returned for reissue if the indicator color is still white. (Example: Hematology/Oncology Infusion Department or Dialysis)

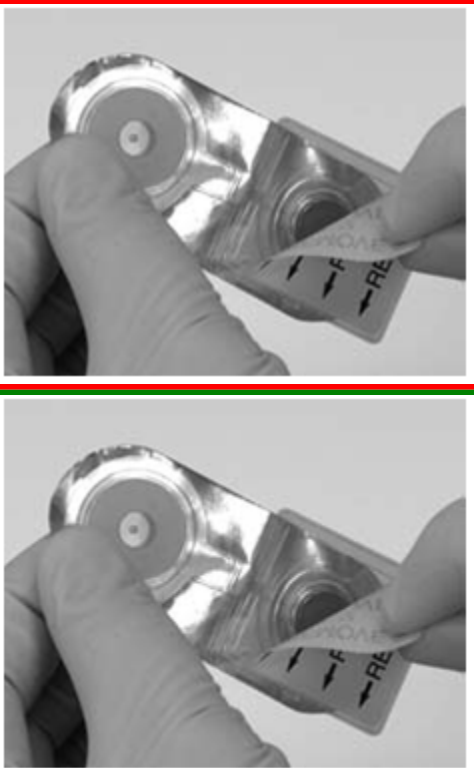
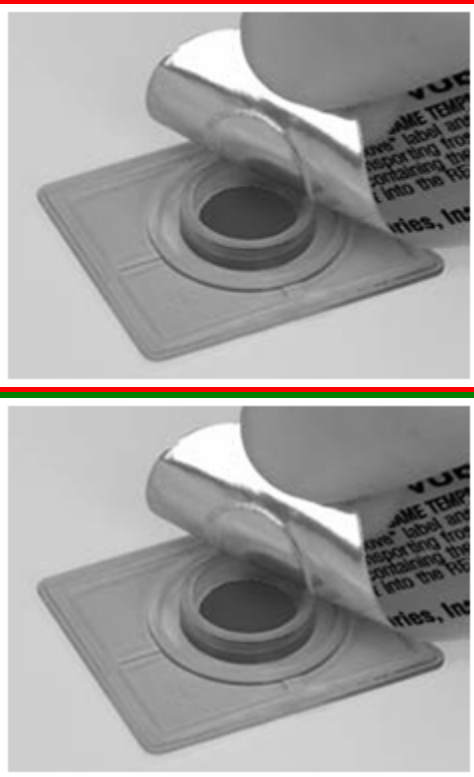
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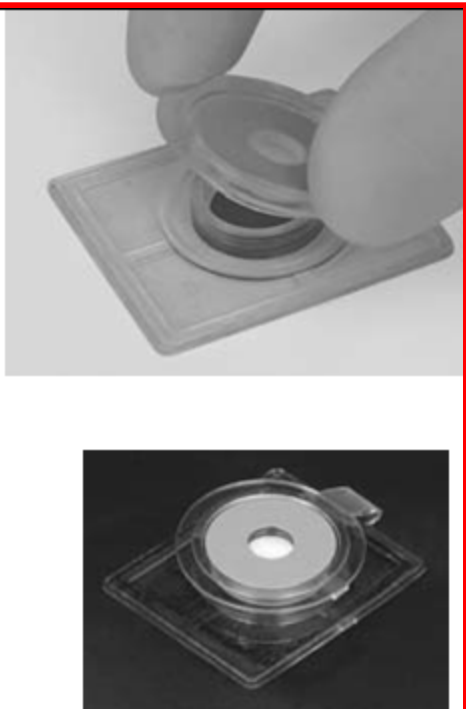
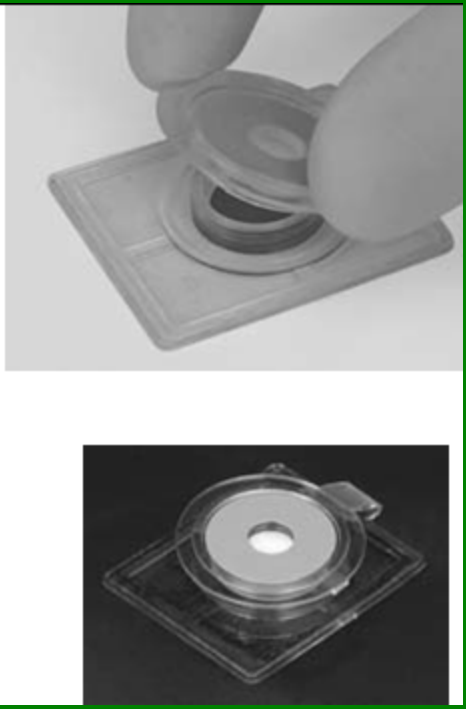
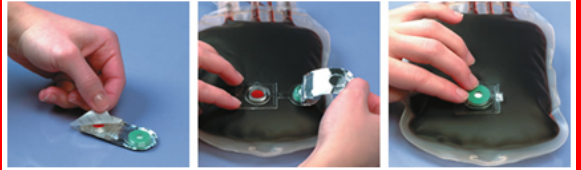
N/A

CALCULATIONS:

N/A

Step	Action	Comment
1	Store indicator boxes of Safe-T-Vue® 6 and Safe-T-Vue® 10 in refrigerator at temperatures below 5°C for 24 hours prior to use.	All received indicator boxes will be stored in the blood product refrigerator upon receipt.
2	Remove one unit of red blood cells or thawed plasma to be issued and monitored and one Safe-T-Vue® 6 or 10 temperature indicator from the refrigerator at the same time and place blood bag on lab bench. Safe-T-Vue® 6 - for red blood cells and thawed plasma that require temporary storage temperatures between 1-6°C for up to a maximum of 4 hours. (ER, OR, ICU) Safe-T-Vue® 10 - for red blood cells and thawed plasma requiring safe transport temperatures between 1-10°C. (Infusion/Dialysis)	Placing a cold pack under the unit will help maintain temperature of blood during dispensing process. Multiple polar gel 16 oz cold packs are located in the bottom left of the blood product refrigerator. <i>Take great care to handle Safe-T-Vue® indicators by the colored label end only.</i>

Step	Action	Comment
3	Remove the adhesive cover and place sticky end of Safe-T-Vue on the bag or temperature-sensitive product being monitored BEFORE peeling off the printed white paper/foil like to expose the white and red rounds.	
4	• Be certain that the Safe-T-Vue® Temperature indicator is completely in contact with the blood bag – no air pockets should be under the indicator due to a fold in the bag or other obstruction. • Place on area of the bag where there is the greatest volume of blood during placement and shipment or storage. • Peel off the printed white paper/foil lid to expose the white and red rounds.	

Step	Action	Comment
5	To Activate, firmly press the white round color-coded label end into the red round until they fully close together. Be careful to press ONLY on the white round color-coded label to activate properly. <i>Safe-T-Vue indicators may remain on units as long as the red color has not been observed.</i>	 
6		

Step	Action	Comment
		

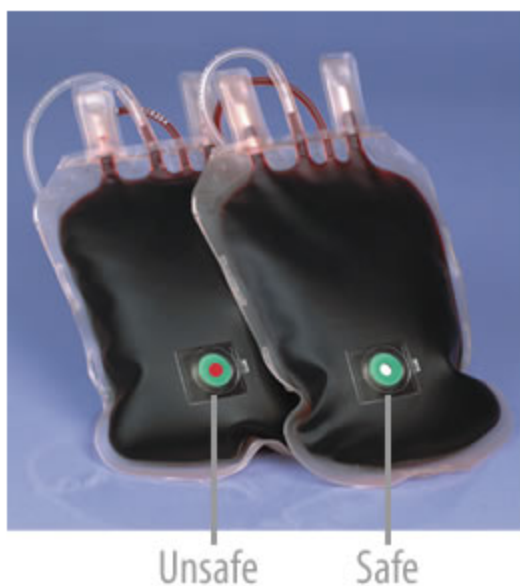
QUALITY CONTROL:

1. Safe-T-Vue® 6 and Safe-T-Vue® 10 lot specific quality assurance documents.
2. Safe-T-Vue® 6 and Safe-T-Vue® 10 Quality Control (SOP BB 8.9)

RESULTS:

Color change Interpretation

1. The color change may start taking place at approximately 1°C below the maximum allowed temperature of the Safe-T-Vue® indicators.
2. The maximum temperature has been reached **ONLY** when the entire white area is colored rose to red.
 - a. Sometimes a pinkish hue or cast can be observed in the white disk at the start. **THIS IS NOT A TEMPERATURE CHANGE.** Depending upon the light source, it is a muted refraction of the bottom red disc. It is clearly distinguishable from the color change of rose to red. Use of a positive control is recommended to ensure correct interpretation.
3. The start of the color change is typically in spots of light rose to red anywhere in the white area but is not completed until the white area has entirely turned to red.



LIMITATIONS:

When you observe a red color indication but are certain the blood or temperature-sensitive product being monitored is below the color-indicating temperature of the Safe-T-Vue® product you are using, please review the following list of actions and/or environmental factors to determine what may be provoking the red indication:

1. **Handling of Safe-T-Vue® at the Wrong end** - Indicator should be handled ONLY by the round, color-coded label end. Safe-T-Vue is extremely sensitive to its environment, and touching or grasping the red end of the indicator will usually provoke the temperature-sensitive materials contained in Safe-T-Vue®.
2. **Improper Activation** - when activating, be sure to press ONLY on the white, color-coded round label end into the red end. Pressing directly on the red end may provoke a color change.
3. **Premature Removal of Paper/Foil Lid** - peel the paper/foil lid only AFTER attaching the Safe-T-Vue® Temperature Indicator to the blood bag. Peeling before attachment may provoke a color change.
4. **Excessive Time Taken to Activate** - for Safe-T-Vue® 10, activation should occur within 15 seconds from the time Safe-T-Vue® is removed from the refrigerator.
5. Since a cold start of less than 4.5°C is required, it is preferable to activate Safe-T-Vue® 6 in the blood refrigerator. Alternately, Safe-T-Vue® 6 can be activated IMMEDIATELY after removing the bag (with applied Safe-T-Vue®) from the blood refrigerator.
6. **Busy Refrigerator** - a high door-count blood refrigerator may warm Safe-T-Vue® if it is located in an area of the refrigerator where it is swept by warm room air. Safe-T-Vue® should be located in a sheltered area to maintain proper start temperature.
7. **Blood Not Cold Enough** - blood received from a supplier is sometimes very close to 10°C on arrival. Be certain blood is cooled in the refrigerator a minimum of 90 minutes before release from the blood bank when a return is likely, such as when sending to the OR.

REFERENCES:

1. William Laboratories, Inc. Product Sheet SAL/0100-2, Rev 01, 11/16/07.
2. Package insert "*Handling/Use Instructions/Frequently Asked Questions (FAQs) and Color change Interpretation Information.*"
3. Use of Cold Packs during Dispensing of Blood; Feb. 27, 2008; Rev 0 ©Copyright, William Laboratories, Inc. 2008.
4. American Association of Blood Banks, *Standards for Blood Banks and Transfusion Services*, Reissue of Blood and Components, 25th edition, 2008.

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

All Revision Dates

3/25/2026, 2/9/2026, 2/27/2024, 12/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/25/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/24/2026
Laboratory Services Department	Linda Lee: Medical Director, VCMC Blood Bank	3/13/2026
Laboratory Services Department	Kathrina Barcena: Supervisor- Blood Bank, Laboratory Services	3/13/2026

COPY



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Owner Evan Gamad: CLS III
Policy Area Laboratory Services

L.82 Handling and Processing Blood Specimens

PROCEDURE

It is imperative that the phlebotomist accurately checks the specimen requirements for the tests that are ordered.

For most tests, the tube required will actually print out on the label with any special requirements noted. However, miscellaneous send out tests are often esoteric tests that are not included in the computer choices. **The phlebotomist must check with a supervisor or the send out department to ensure that the proper tubes are collected.** The phlebotomist may also check in the Specimen Collection Guide by **QUEST Diagnostics** or on the on-line ICON which is on all monitors for Quest Diagnostics

Factors to consider in the handling of specimens:

1. Agitation:

All tubes must be mixed by gentle inversion 5 to 10 times. (Even the yellow top has a clot-activator.)

[Please see attachments for order of draw and inversion mixing protocol.](#)

1. Temperature: **Check test requirements.**

Some tests require a pre-chilled tube or must be kept on ice.i.e. Ammonia, Catecholamines, Gastrin, Lactic Acid, Parathyroid Hormone

Some tests require pre-warmed tubes and must be kept in heel warmers. i.e. Cryoglobulins

Some tests can only be drawn Monday through Friday because of restrictions at the reference lab that performs the test.

i.e. Cryoglobulins, Chromosome Studies

1. Timing of the Draw

Some specimens must be drawn at timed intervals because of medications, fasting requirements, and/or biological variation (circadian rhythm). It is important that collection of specimens for timed tests be obtained at the precisely specified interval. For example, when a creatinine clearance is ordered, the serum creatinine must be drawn within +/- 24 hours of the collection. Patients are encouraged to collect the 24 hour urine first and then come in for the blood draw.

Drug levels are time dependent for trough and peak values used to adjust medication. Examples are shown in the table following.

TEST	TROUGH	PEAK	RANDOM
Digoxin			Draw 6 hours after last Dose
Dilantin (PTN)			Draw Just before next dose
Gentamicin	Draw just before next dose	Draw 30 minutes post infusion	Draw 6-14 hours post last dose
Lithium			12 hours after evening dose
Phenobarbital			Draw just before next dose
Tegretal(CRBAM)			Draw just before next dose
Theophylline	Draw just before next dose		
Tobramycin	Draw just before next dose	Draw 30 minutes post transfusion	Draw 6-14 hours post last dose
Valproic Acid (VLPR)			Draw just before next dose or
Depakote			at least 6 hrs post last dose
Vancomycin	Draw just before next dose	Draw 60 minutes post infusion	Draw 6-14 hours post last dose

1. Delivery to the department and Centrifugation:

Routine specimens should be delivered within 30 minutes with extra labels. STAT specimens should be delivered immediately by the Phlebotomist or designee. Notify Tech when there is a STAT.

Tubes need to be delivered to the appropriate departments ASAP because for many tests, the blood must be centrifuged to separate the cells from the serum/plasma so that chemical reactions do not alter the integrity of the specimen and/or then often frozen to preserve the substances that will be tested.

Blue citrate tubes should be placed in the room temperature Stat Spin Express centrifuge in Hematology and spun for 2 minutes at 120s. If the centrifuge is already on, notify the technologist that there is a tube that needs to be centrifuged.

Lavender EDTA tubes that have CBC or CBCD ordered should be put on the rocker in the Hematology department. But lavender EDTA tubes for other tests must be delivered to Chemistry for processing.

The yellow top with clot activator should be completely clotted before centrifugation so that fibrin does not form in the separated serum.

REFERENCES

All Revision Dates

3/27/2026, 3/2/2026

Attachments

[!\[\]\(830769b31eeeaca920791081939ff8ba_img.jpg\) Blood Tube Order of Draw & Inversion Protocol.pdf](#)

[!\[\]\(0b5e7e25e8775f7e7e80906ada4f0021_img.jpg\) Microtainer Draw & Inversion Protocol.pdf](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/5/2026
Laboratory Services Department	Evan Gamad: CLS III	3/4/2026



Origination 2/1/2006
 Last Approved 3/2/2026
 Effective 3/2/2026
 Last Revised 3/2/2026
 Next Review 3/1/2028

Owner Gayle Haider:
 Supervisor-
 Quality
 Assurance,
 Laboratory
 Services

 Policy Area Laboratory
 Services

L.41 Referral Laboratories

POLICY:

The Laboratory Medical Director, in consultation with the Medical Staff, is responsible for selecting the referral laboratories for Ventura County Medical Center/Santa Paula Hospital. Referred specimens, except for special circumstances, are sent to laboratories accredited by the College of American Pathologists (CAP), or The Joint Commission and CLIA-88 for high complexity testing. Instructions for staff on how to report Reference Laboratory Test Reports can be found in policy L.SO.01 Resulting Reference Laboratory Testing.

PROCEDURE:

1. Selection of reference laboratories must be based primarily upon the quality of performance of such laboratories.
 - a. Quality is assessed during the RFP process and includes utilizing CLIA certified laboratories (see #3).
2. "~~Referred Specimens~~Referred Specimens" includes any for which intermediate processing is performed at another facility, such as histopathology/cytology preparation or nucleic acid sequencing.
3. Laboratories subject to CLIA-88 must refer specimens for testing only to a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CMS.
 - a. Compliance is confirmed by reviewing current CLIA licensure.
4. The Laboratory director or designee monitors the quality of test results received from reference laboratories.

Laboratory	Address	Contact Info.		
Accupath-Diagnostics (US Labs) <u>Accupath Diagnostics (US Labs)</u>	2601 Campus Drive Irvine, CA 92612		No. 185 Technology Dr. Suite 100, Irvine, CA 92618-2412	customer@accupathmed.com

ATHENA DiagnosticsATHENA Diagnostics	Four Biotech Park 377 Plantation Street Worcester, MA 01605	866/284-3623		
California State Dept of HealthCalifornia State Dept of Health				
AFP-OB Screening (General)		AFP-OB Screening (General)	866/ 718-7915	
Case Coordinator		Case Coordinator	877/ 568-9237	
Genetic Disease Lab Branch Genetic Disease Lab Branch : Dr. Ajit Bhandal, Chief	850 Marina Bay Parkway #265 Room 274, Richmond, CA 94804	510/231-1704		
Dr. Ajit Bhandal, Chief	850 Marina Bay Parkway #265 Room 274 Richmond, CA 94804			
Newborn ScreeningNewborn Screening	Kathy Jew, RN 11726 San Vicente Blvd., #220 Los Angeles, CA 90049-5045	310/826-4458		
Cedars Sinai Medical Center	www.CSMC.edu		Cedars Sinai Medical Center	8700 Beverly Blvd. Los Angeles, CA 90078 www.
Central Coast PathologyCentral Coast Pathology • Western Dermatology DivWestern Dermatology Div	2781 Loma Vista Rd, Ventura, CA 93003	800/522-2787		
NeoGenomicsNeoGenomics	www.neogenomics.com 31 Columbia, Aliso Viejo, CA 92656	866/776-5907 neogenomics.com		
Esoterix	3930 East Watkins St, #300 Phoenix, AZ 85040		Esoterix	4301 Lost Hills Rd, Agoura Hills, CA 91301 818/8
Genomic Health, Inc.Genomic Health, Inc.	301 Penobscot Drive Redwood City, CA 94063	650/556-9300		
Genzyme GeneticsGenzyme Genetics	655 East Huntington Drive Monrovia, CA 91016	800/255-1616 www.genzyme.com		

	www.genzyme.com		
Monogram Biosciences Monogram Biosciences	345 Oyster Point Blvd San Francisco, CA 94080	800/777-0177	
Prometheus Diagnostics	9410 Carroll Park Drive San Diego, CA 92121	888/423-5227 858/587-4175	
Prometheus Diagnostics	160 E Tasman Dr San Jose, CA 95134	408/392-0064	
Quest Diagnostics Quest Diagnostics	8401 Fallbrook Avenue West Hills, CA 91304-3226	800/877-7484	
33608 Ortega Hwy. San Juan Capistrano, CA 92675 33608 Ortega Hwy. San Juan Capistrano, CA 92675	33608 Ortega Hwy. San Juan Capistrano, CA 92675	800/642-4657	
UCLA Medical Center Lab UCLA Medical Center Lab	10833 Le Conte Avenue Los Angeles, CA 90095-1732	310/267-2680	
US Labs US Labs	2601 Campus Drive Irvine, CA 92612	800/710-1800	
Viracor Laboratories Viracor Laboratories	1001 NW Technology Drive Lees Summit, MO 64086	800/305-5198	
Blood Systems Laboratories	2424 W. Erie Dr. Tempe, AZ 85282	602/343-7133 602/343-7079 (fax)	
Immunohematology Reference Lab (IRL) Vitalant Immunohematology Reference Laboratory	9305 East Via de Ventura Scottsdale, AZ 85258	877-258-4829	

All Revision Dates

3/2/2026, 2/13/2019, 11/1/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/2/2026

Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/28/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	2/27/2026
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	2/27/2026

OLD



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Next Review 4/2/2028

Owner Gayle Haider:
Supervisor-
Quality Assurance,
Laboratory Services

Policy Area Laboratory Services

L.09 Laboratory Staff Roles

POLICY:

Ventura County Medical Center/Santa Paula Hospital Laboratory perform both waived and non-waived (formerly waived, moderate and high) complexity testing. All staff involved in the analytical performance of clinical Laboratory tests meet the requirements of high complexity testing required by the Clinical Laboratory Improvement Act (CLIA)'88. This policy outlines the staff roles for the Ventura County Medical Center/Santa Paula Hospital Laboratory.

PROCEDURE:

DIRECTOR, HIGH COMPLEXITY TESTING

The Director of the Laboratory is responsible for the overall operation of Laboratory and administration as well as assuring compliance with applicable regulations. The Director, where appropriate, may delegate some duties to qualified individuals, but remains responsible for ensuring all duties are properly preformed. As defined by CLIA, the Laboratory director is responsible for ensuring that:

1. **Testing Systems** are developed and each of the tests performed in the Laboratory provide quality services for all aspects of test performance, which includes the pre-analytic, analytic, and post-analytic phase of testing.
2. The **physical plant and environment conditions** of the Laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical, and biological hazards.
3. The **test methodologies**, equipment and supplies selected have the capability of providing the quality of results required for the patient care.

4. **Verification procedures** used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method.
5. The **competency** of all Laboratory staff performing test methods are assessed as required by CLIA'88 and are adequate for performing accurate and reliable results. The technical details for staff competency is the responsibility of the section Clinical Laboratory Scientist III / Manager.
6. The Laboratory is enrolled in a Health and Human Services (HHS) approved **proficiency testing** (PT) program. Responsibility for the corrective action associated with unacceptable PT is delegated to the Clinical Laboratory Scientist III/Manager.
7. **Quality control and quality assurance programs** are established and maintained assuring the quality of Laboratory testing provided and identifying failures in quality as they occur.
8. There is establishment and maintenance of acceptable levels of **analytical performance** for each test system.
9. All necessary **remedial actions** are taken and documented whenever significant deviations from the Laboratory's established performance characteristics are identified. Patient test results are reported only when test systems are functioning properly.
10. The **reports** of the test results include pertinent information required for interpretation.
11. **Consultation** is available to the Laboratory's clients on matters relating to the quality of the test results and their interpretation concerning specific patient conditions.
12. A **sufficient number of Laboratory** staff are employed with the appropriate education and either experience or training to provide appropriate consultation. Properly supervise and accurately perform tests and report result.
13. Prior to testing patient's specimens unsupervised, all staff have **competency assessed** and documented. It is the responsibility of the Clinical Laboratory Scientist III/ Manager to ensure that the appropriate training for the type and complexity of the testing is offered and that the staff has demonstrated that they can perform all testing reliably in order to provide accurate results. Procedures are established for monitoring individuals who conduct pre-analytical, analytical, and post-analytical phases of testing to assure that they are competent and maintain their competence to process specimens, perform test procedures, and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills.
14. An approved **technical procedure manual**, reviewed bi-annually, is available to staff responsible for all aspects of the testing process. Administrative policies and procedures are reviewed and revised as needed.
15. The **responsibilities and duties** of each consultant and supervisor, and each person, engaged in the performance of the pre analytic, analytic, and post-analytic phases of testing are clearly defined in writing to identify which exams and procedures each individual are authorized to perform, whether supervision is required for specimen processing, test performance, result reporting and whether supervisory, consultant or director review is required prior to reporting patient test results.

CLINICAL CONSULTANT, HIGH COMPLEXITY TESTING

The Laboratory medical director or, as designated, the pathologists serve as Clinical Consultants. The

Clinical Consultant provides consultation regarding appropriateness of the testing ordered and interpretation of test results. In addition, the Clinical Consultant may review department section test methodologies, procedures and proficiency testing. As defined by CLIA, the Clinical Consultant is responsible for ensuring:

1. Availability to assist the Laboratory clients in ensuring the appropriate test are ordered to meet the clinical expectations.
2. Reports of test results include pertinent information required for specific patient interpretation.
3. Consultation is available and communicated to the Laboratory's clients on matters related to the quality of the test results reported and their interpretation concerning specific patient condition.
4. The Clinical Consultant may participate in the following quality improvement/ assurance activities at the Ventura County Medical Center/Santa Paula Hospital Laboratory.
 - a. Monthly review of the section quality control.
 - b. Quarterly quality assurance meetings.

TECHNICAL SUPERVISOR, HIGH COMPLEXITY TESTING

The position titled "*Clinical Laboratory Scientist III*" has been designated by the Medical Director of Laboratory to provide the technical and scientific oversight for each section within the Laboratory. The Clinical Laboratory Scientist III (Technical Supervisor) establishes the quality standards for each section through selecting and monitoring the department section's methods/instrumentation, evaluating and documenting the competency of the staff. As required by the job classification. Clinical Laboratory Scientist III are licensed by the State of California as 'Clinical Laboratory Scientist' hold a Bachelor's degree in medical technology, chemical, physical or biological science and have a 4 years of training/ experience in high complexity testing. As defined by CLIA, the technical supervisor is responsible for ensuring that:

1. The selection of the test methodology is appropriate for the clinical use of the test results.
2. Verification of the test procedures is performed and test performance characteristics, including the precision and accuracy of each test and test system are established.
3. Enrollment and participation in a HHS-approved proficiency testing program is commensurate with services offered.
4. A quality control program is established and is appropriate for the testing performed and includes the parameters for acceptable levels of analytic performance and that these levels are maintained throughout the entire testing process from the initial receipt of the specimen, through sample analysis and reporting of test results.
5. Technical problems are resolved and that remedial actions are taken whenever test systems deviate from the Laboratory's established performance characteristics.
6. Patient test results are not reported until corrective action has been taken and the test system is functioning properly.
7. Training needs are identified. Until training is completed, staff must not perform patient testing unsupervised. Training activities are specific for each job description and function and are listed in the training checklist. In addition, each individual performing tests receives regular in-

service training and education appropriate for the type and complexity of the Laboratory services performed.

8. Competency of all testing staff is evaluated to ensure that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. The procedure for evaluation of the competency of the staff must include 2 methods of evaluation, and may be but not limited to:
 - i. Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing and testing;
 - ii. Monitoring the recording and reporting of test results;
 - iii. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records;
 - iv. Direct observation of performance of instrument maintenance and checks;
 - v. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and
 - vi. Assessment of problem solving skills.
9. The evaluation and documentation of performance of assessment of individuals responsible for high complexity testing is done at least semi-annually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results. The individual's performance must be re-evaluated to include the use of the new test methodology or instrumentations.
10. Quality improvement activities:
 - a. The Clinical Laboratory Scientist III for each section performs monthly review of quality control. In the absence of the Clinical Laboratory Scientist III, the Laboratory Director at Ventura County Medical Center and the Laboratory Manager at Santa Paula Hospital will perform this function.
 - b. Review policies and procedures every two years or as needed.
 - c. Quarterly quality assurance meetings.
 - d. Participation in quality improvement activities.

GENERAL SUPERVISOR, HIGH COMPLEXITY TESTING

The Laboratory Medical Director has designated the position Clinical Laboratory Scientist III (Technical Supervisor) to perform the duties of General Supervisor. The Clinical Laboratory Scientist III, under the direction of the Laboratory medical director, is responsible for the day-to-day supervision or oversight of the section operation, staff performing testing and reporting of test results. In the absence of the Clinical Laboratory Scientist III, the Laboratory Director at Ventura County Medical Center and the Laboratory Manager at Santa Paula Hospital will perform the Clinical Laboratory Scientist III duties.

As required by the job classification, Clinical Laboratory Scientist III and Clinical Laboratory Scientist II are licensed by the State of California as "Clinical Laboratory Scientist" and hold at minimum a bachelor's degree in medical technology, or chemical, physical or biological science.

TESTING STAFF, HIGH COMPLEXITY TESTING

The job classification titled "Clinical Laboratory Scientist I, Clinical Laboratory Scientist II and Clinical Laboratory Scientist III" have been designated by the Laboratory Medical Director to perform all complex testing. These individuals are responsible for specimen processing, test performance and reporting test results and report to the Clinical Laboratory Scientist III who is responsible for the section that the individual is assigned. Laboratory Medical Director/Laboratory Director/Supervisory review is not required prior to reporting patients' test results. As required by the job classification, Clinical Laboratory Scientist I, Clinical Laboratory Scientist II, and Clinical Laboratory Scientist III are licensed by the State of California as Clinical Laboratory Scientist and hold a minimum a bachelor's degree in medical technology or chemical, physical or biological science as defined by CLIA, testing staff are responsible for ensuring:

- a. The Laboratory's procedures for specimen handling and processing, test analyses, reporting and maintaining records of patient test result are followed.
- b. Proficiency testing samples are tested in the same manner as patient specimens.
- c. Adherence to the Laboratory's quality control policies; documentation of all quality control activities, instrument and procedural calibrations and maintenance performed.
- d. The Laboratory's established policies and procedures are followed whenever test systems are not within the Laboratory defined acceptable levels of performance.
- e. Problem that may adversely affect test performance or reporting of test results are corrected and that the General Supervisor, Technical Supervisor, Clinical Consultant or Laboratory Medical Director is notified.
- f. Corrective action when test systems deviate from the Laboratory's established performance specifications is documented.

Certified Phlebotomy Technician I, Certified Phlebotomy Technician II, Certified Phlebotomy Technician III, Medical Office Assistant I, Medical Office Assistant II, Medical Office Assistant III.

These unlicensed staff are responsible for the pre-analytic, and post-analytic phase of the testing and processing. Phlebotomists are certified by the State of California. Refer to the Laboratory organization chart for reporting responsibilities.

RESPONSIBILITIES:

1. Pre and Post-Analytical Area:

Support Services is responsible, but not limited to the following:

- Department Procedures.
- Specimen Collection Manual.
- Specimen Manifest Storage.
- Client Services and Support Training Records.
- Test Request forms are scanned into the patient's electronic health record.
- Documenting Client Complaints.

- Client Feedback/Communication.
- Collecting Departmental Quality Metrics for Quality Improvement.
- Orientation, training and competency of staff.

2. Analytical Area:

Responsible for, but not limited to the following:

- Technical / General Laboratory Manual.
- Laboratory Operations Procedures.
- Training and Competency Records.
- Equipment and Instrument Procedures and Documentation.
- Quality Control Monitoring.
- Assay Protocols.
- Meeting Turnaround Time.
- Workflow Analysis.
- Collecting Quality Indicators for Quality Improvement.
- Orientation, training and competency of staff.

3. Quality Assurance Area:

Quality management is responsible, but not limited to the following:

- Audit analysis, and follow-up
- Maintain Proficiency Testing Program includes: Ordering, submission of the results, review the evaluation with technical supervisors, document corrective actions in timely manner and review evaluation with the Laboratory Medical Director.
- Quality Assurance Policies/Procedures.
- Quality Indicators.
- QA Training Documents.
- Follow-up on all QA issues.

4. Laboratory Safety:

Responsible for, but not limited to the following:

- Laboratory Safety Program.
- Documenting and monitoring Laboratory accidents / incidents.
- Monthly reporting of the environment observation report electronically.

5. Laboratory Management Area:

Responsible for, but not limited to the following:

- Audit Schedules for VCMC – VCMC Laboratory Director and for SPH – SPH Laboratory Manager.
- Workload Analysis for VCMC – VCMC Laboratory Director
- Workload Analysis for SPH – SPH Laboratory Manager.

- Workload Analysis – inpatient, outpatient, and emergency room for VCMC – VCMC Laboratory Director
- Workload Analysis for SPH – SPH Laboratory Manager.
- Retired and revised documents.
- Regulatory Documents.
- Maintaining, Renewing, or Updating Regulatory Licenses or Certificates.
- Compliance Program – Target Solutions, for VCMC – VCMC Laboratory Director, and for SPH – SPH Laboratory Manager.
- Compliance, Orientation, training and competency of staff.
- Maintain Regulatory Accreditation for VCMC – VCMC Laboratory Director and for SPH – SPH Laboratory Manager.

All Revision Dates

4/3/2026, 11/1/2016, 7/2/2015, 7/1/2015

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/3/2026
Laboratory Services Department	Gayle Haider: Supervisor-Quality Assurance, Laboratory Services	4/2/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/1/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/1/2026



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Owner Erlinda Roxas:
Director,
Laboratory
Services
Policy Area Laboratory
Services

L.53 Correction and Management of Laboratory Records

Policies

- A. All laboratory data must be recorded in black or blue indelible ballpoint ink to ensure permanence and traceability.
- B. Entries must be clear, legible, and completed at the time the activity is performed.
- C. Laboratory prohibits the use of pencil or erasable ink in recording data in laboratory records such as quality control logs, preventive maintenance logs, manual test worksheets, etc.
- D. Corrections made to both paper and electronic laboratory records must be legible and indelible.
- E. Original (erroneous) entries must not be obliterated, be visible or accessible (audit trail for electronic records),
 - 1. Correction of laboratory records such as temperature logs, preventive maintenance logs, test results worksheets, etc. are handled by drawing one ink line through the incorrect documentation and writing the correct documentation next to it. The incorrect documentation should be legible through the strike-out line.
 - 2. Erasures and liquid "white-out" corrections are unacceptable.
- F. The person performing the correction will initial and date next to the corrected documentation.
- G. Corrections may also be documented on the Corrective Action Section of the appropriate log.

Reference

GEN.20450	Correction of Laboratory Records. Laboratory General Accreditation Checklist, College of American Pathologists, August 2023.

All Revision Dates

4/3/2026, 11/15/2024, 9/26/2022

Approval Signatures

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Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/3/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/3/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/3/2026

COPY



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Last Revised 4/22/2026
Next Review 4/21/2028

Owner Evan Gamad:
CLS III
Policy Area Laboratory
Services

L.93 Venipuncture: Winged Blood Collection Sets

PRINCIPLE

The BD Vacutainer Push Button winged blood collection set with the BD One Use Vacutainer holder is used in special circumstances with infants and small children, elderly people with fragile skin, and for combative patients. The venipuncture should be completed following the procedures for the vacutainer or syringe instructions with the following adaptations.

PROCEDURE

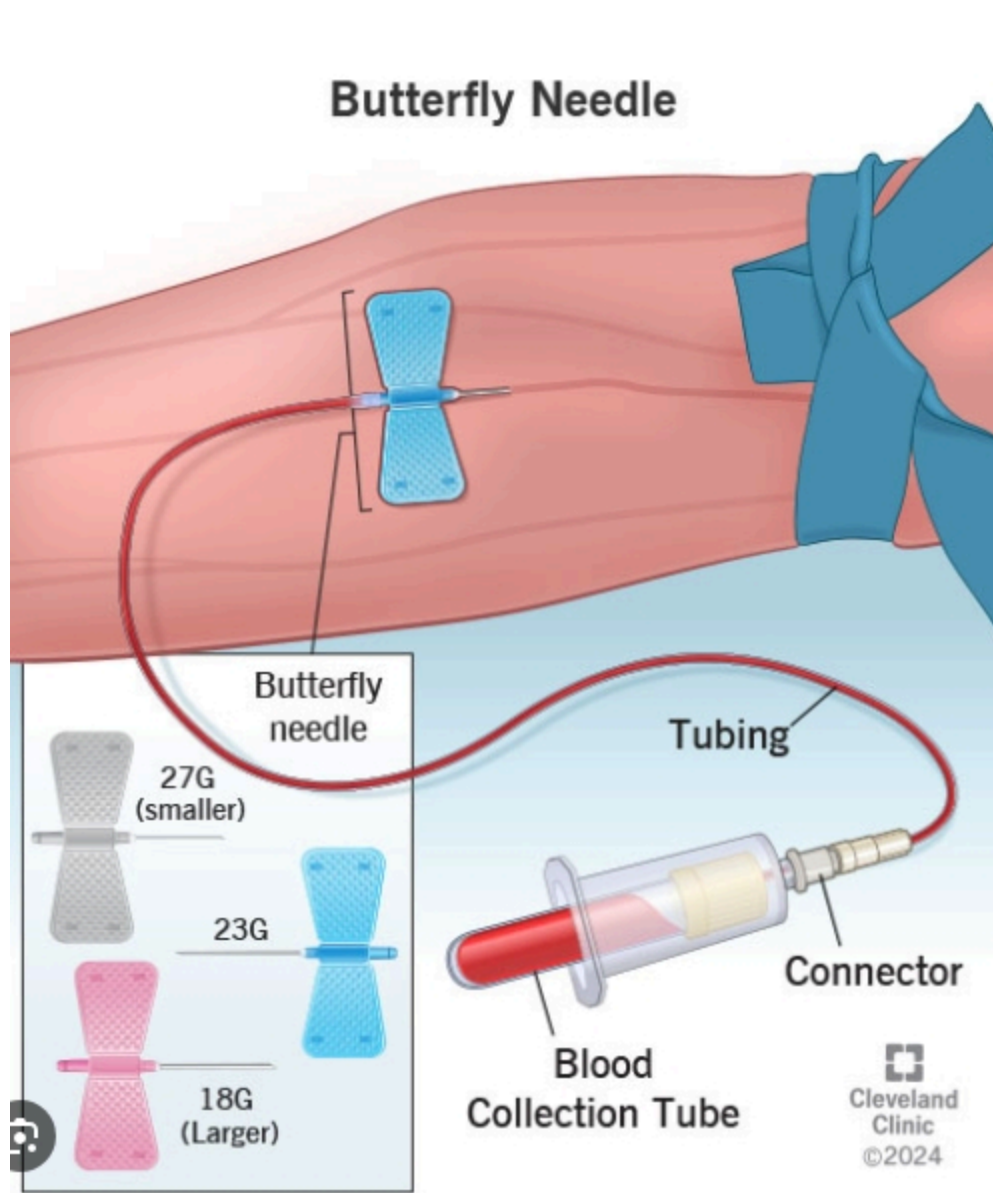
Using the BD Vacutainer Push Button winged blood collection set with the BD One Use Vacutainer holder:

1. Peel blister pouch by peeling back the arrowed corner of the package and remove device, allowing the tubing to relax.
2. Firmly thread the Luer Adapter into the one use vacutainer holder.
3. Carefully remove needle sheath away from needle, grasping the wings pinched together or holding one wing and insert the needle..
4. After observing the presence of blood in the chamber, collect blood into an evacuated tube by placing tube into holder, then puncture the stopper by pushing the tube and replace additional tubes as appropriate.
5. Using one hand, retract the needle by gently depressing the button. The needle will slide out of the venipuncture site and lock into place. Do not impede device retraction.
6. Immediately cover the puncture site with a sterile gauze pad and apply pressure.
7. Dispose of all used materials in appropriate containers.

8. Using a 23 gauge butterfly with a 12 inch tubing causes a draw loss of 0.350 ml when collecting the initial tube.

Using The BD Vacutainer Push Button winged blood collection set with the BD One Use Vacutainer with a Syringe:

1. Peel blister pouch by peeling back the arrowed corner of the package and remove device, allowing the tubing to relax.
2. Detach the luer multi-sampler collection device from the end of the tubing so that the female luer will fit onto the syringe tip.
3. Carefully remove needle sheath away from needle, grasping the wings pinched together or holding one wing and insert the needle.
4. After observing the presence of blood in the chamber, collect blood in the syringe.
5. Using one hand, retract the needle by gently depressing the button. The needle will slide out of the venipuncture site and lock into place. Do not impede device retraction.
6. Immediately cover the puncture site with a sterile gauze pad and apply pressure.
7. Remove winged device from syringe and place immediately in Sharp's container.
8. Attach opened BD Blood Transfer Device Holder with Pre-Attached Multiple Sample Female Luer Adapter by rotating clockwise to secure the syringe to the hub. Collect blood into an evacuated tube by placing tube into holder, then puncture the stopper by pushing the tube and replace additional tubes as appropriate.
9. Dispose of all used materials in appropriate containers.
10. Using a 23 gauge butterfly with a 12 inch tubing causes a draw loss of 0.350 ml when collecting the initial tube



REFERENCES

[BD Vacutainer® UltraTouch™ Push Button Blood Collection Set Product Training | BD Learning Academy. Retrieved April 15, 2026.](#)

[BD Vacutainer® Safety-Lok™ Blood Collection Set Product Training | BD Learning Academy. Retrieved April 15, 2026.](#)

All Revision Dates

4/22/2026, 3/2/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/22/2026
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Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/16/2026
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Owner Yewubdar Argaw:
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L.CHEM 3.14 Sweat Chloride

Policy

Sweat Chloride

Principle

Sweat chloride analysis provides laboratory confirmation of the clinical diagnosis of cystic fibrosis. Patients with cystic fibrosis have a normal sweat rate with an increased concentration of sweat chloride. The quantitative determination of chloride concentration in sweat is a three step procedure involving stimulation of the sweat gland by pilocarpine iontophoresis and collection of induced sweat into a micro-bore capillary tubing. These first two steps utilize the ~~Wescor~~ Macroduct ® Advanced Sweat Collection System. The third step involves quantitative analysis of the chloride concentration in the collected sweat utilizing a Labconco Digital Chloridometer.

Specimen Collection and Handling

Specimen requirement; 20 µL of sweat.

* The minimum volume of sweat collected to insure proper sweat rate is 15 µL (CHM.30000). The minimum volume required to perform the analysis is 20 µL.

Reagents

- Pilogel iontophoretic discs
- Chloridometer Acid Reagent
- Chloride Standard, 100 mEq/L

- Silver wire
- Macroduct ® Advanced Sweat Collection kit System

Procedure

Disinfection of Equipment

- The induction electrodes and wires are cleaned with alcohol wipes before and after each patient use. The entire surface of the electrode must be wiped thoroughly.
- The induction electrode straps and the Macroduct straps are disinfected after each patient use.
- Soak straps in 70% Isopropyl alcohol for 1 - 5 minutes.
- Rinse the soaked straps thoroughly 2 to 3 times in de-ionized water.
- Allow to air dry before next use.
- The sweat collection device is one time use only.
- All other reusable equipment such as scissors, nippers, and sweat dispensers should be rinsed with distilled or deionized water and dried with each use to ensure they are not contaminated with sweat.
- The procedure for disinfection of the sweat chloride equipment is reviewed ~~biennially~~biennially by the Laboratory Medical Director, and/or designee to assure continued effectiveness (CHM.29150).

Sweat Stimulation and Collection

- Assemble the Macroduct Sweat Collection System and perform the iontophoresis for sweat stimulation. Use the ~~Wescor~~Macroduct ® Advanced Sweat Collection System Instruction Manual for complete details, including instructional photos, of this procedure. Always follow the manufacturer's listed recommendations. To minimize sample evaporation or contamination (CHM.29200), emphasis is placed on the following steps:
- Wash the patient's skin stimulation site thoroughly first with alcohol and then De-ionized water to remove any accumulated sweat before the stimulation. Also wash with De-I water after the stimulation to remove any pilocarpine and thoroughly dry before placing the collection coil on the site.
- Avoid touching the stimulation site and the collecting surface of the coil.
- Attach the collection device on the stimulation site with firm strap pressure. Recheck for firm attachment once sweat appears in the coil.
- Do not remove the collection device from the patient's extremity before separating the coil from the main body. Doing so may result in a loss of sweat sample.
- Clean the nipper device and the sweat dispensing needle with an alcohol wipe before and after using, to avoid any contamination with sweat sample.
- **NOTE:** The electrodes used for stimulation must be placed only on the patient's lower arm or upper leg that is free from any rashes or diffuse inflammation (CHM.29300), and **never in a position that would cause the current to cross the patient's trunk** (CHM.29500).

- If the patient should exhibit an allergic reaction to the pilocarpine, such as urticaria (hives), redness and swelling or burns exhibited by redness and blistering, discontinue the stimulation and notify the Pathologist immediately (CHM.30300). The stimulation must be performed for 5 minutes and not longer using the manufacturer's (~~Wescor~~Macroduct ® Advanced Sweat Collection System) battery powered device. This equipment is checked annually by the Biomed Dept. (CHM.29600).
- **Do not attempt stimulation on a patient receiving oxygen by an open delivery system. This could cause an explosion** (CHM.29700).
- Make sure the collection device is placed over the exact area of stimulation (the area under the red electrode). It is important that the stimulation area and collection area are equivalent (CHM.29800).
- Once the induction is complete perform the collection phase. Use the ~~Wescor~~Macroduct ® Advanced Sweat Collection System Instruction Manual for complete details of this part of the procedure. Use only the ~~Wescor~~Macroduct ® Advanced Sweat Collection System device with the provided collection~~device provided with the kit. No other devices~~The sweat collection device must be designed for use with the appropriate iontophoresis system so that the stimulation and collection area are acceptable equivalent (CHM.29850).
- The collection period must be for a minimum of, but no longer than, 30 minutes (CHM.29900).
- Once the sample is obtained, it must be placed immediately into a plastic ~~microcup~~microcentrifuge tube with ~~lid~~a tight fitting cap and labeled with the patient's identification label ~~(CHM.30200)~~. The minimum volume of sweat collected to insure proper sweat rate is 15 µL (CHM.30000), however 20 µL or more is required for analysis. Samples that are less than 20 µL must be rejected and **not pooled** for analysis (CHM.30100). If there is a significant delay between collection and analysis, appropriate storage conditions must be followed:
- Sweat collected in macroduct is stable at refrigeration or room temperature for up to 72 hours in a 0.2 mL microcentrifuge tube with a tight fitting cap. (CHM.30250). Proceed immediately to the analysis portion of the procedure. The analysis should be run in duplicate if enough sample is collected.
- If an insufficient volume is obtained after two attempts, it must be reported in the computer and in the Sweat Chloride Log Book. Reschedule the patient for another appointment in two weeks. Inform the patient to drink sufficient water in order to be well hydrated before the next appointment.
- The incidence of insufficient sweat samples is monitored and recorded on a form (Annual Insufficient Sweat Rate). The annual insufficient sweat rate should not exceed 5% for patients older than three months of age. For patients up to three months of age, the rate should not exceed 10% (CHM.30150). If these rate are exceeded, the collection procedure should be reevaluated for consistency with the CLSI guideline C34 4th ed.

Chloride Analysis

- Place Titration switch in Standby and Range switch to Low. Using the ~~Brinkmann~~ Dispenser, pipet 4.0 ml of Acid Reagent into glass vials for controls and patient specimen each ~~of three vials-labeled patient, normal control and abnormal control~~at a time.
- Pipette 20 µL of controls and the collected patient sweat sample, ~~normal level control and~~

~~abnormal level control~~ each at a time into the appropriate vials of Acid Reagent. ~~If there is adequate patient sample to run in duplicate, then do so and report the average of the two results.~~

- Place each vial in turn in holder, raise holder, and depress the Titration switch to Start.
- Use the values obtained to calculate the patient's chloride and control results in mEq/L, using the formula provided.
- If there is adequate patient sample to run in duplicate, then do so and report the average of the two results.

Calculation:
$$\frac{\text{Patient (Control) Value}}{\text{Standard (Avg Value)}} \times 100 \text{ mEq/L} = \text{Sweat Cl}^- \text{ mEq/L}$$

Calibration

Frequency: Calibration must be done each time a new patient sweat sample is to be analyzed.

1. Set the toggle switch on the rear of the instrument to the Standard position (down). Place the Titration switch in Standby and the Range switch to Low.
2. Using the ~~Brinkmann~~ Dispenser, pipet 4.0 ml Acid Reagent into each of two vials. These serve as blanks.
3. Place each vial in turn on the vial holder, raise the holder and depress the Titration switch to start.
4. Calculate the average of the two blank determinations and enter that number on the Blank thumbwheel switch.
5. Using the ~~Brinkmann~~ Dispenser, pipet 4.0 ml of Acid Reagent into each of two vials and pipet 20 μ L of 100 mEq/L Standard into each vial.
6. Place each standard vial in turn in the vial holder, raise the holder and depress the Titration switch to Start.
7. Calculate the average of the two standard determinations and use this value in the formula to calculate sweat chloride control and patient results.

Quality Assurance

Daily maintenance is performed per schedule and per manufacturer's recommendations. Maintenance includes the disinfection of the equipment. See the Disinfection Procedure below. The schedule is reviewed monthly by the Chemistry Dept. Supervisor.

See the Labconco Digital Chloridometer Instruction Manual and the ~~Wescor~~ Macroduct [®] Advanced Sweat Collection System Manual for details of these procedures.

Three levels of controls, normal and abnormal low and abnormal high, are run along with each patient tested (CHM.30600). Established $\pm$ 2 SD ranges are posted. New lots of un-assayed controls are run concurrently with the old established lot to obtain new ranges before they are put in use. For assayed controls, the lab must verify the acceptability ranges supplied by the manufacturer.

The analytical method has been validated by this laboratory and includes studies of accuracy, precision, and linearity to determine the upper and lower limits of the analytical measurement range (CHM.~~30650~~)

~~The analytical method has been validated by this laboratory and includes studies of accuracy, precision, and linearity to determine the upper and lower limits of the analytical measurement range (CHM.30400). Linearity check is performed every six months.~~

Results

~~Conductivity is a non-selective method for sweat analysis that has its own unique set of reference intervals. When sweat conductivity is expressed as units of Aqueous sodium chloride solution, the values are approximately 15 mmol/L higher than when chloride is measured directly. A patient having a sweat conductivity greater than equal to 50 mmol/L should be referred to a specialized cystic fibrosis center for a quantitative analysis of sweat chloride with or without sweat sodium.~~

Reference Values

- 29 or less mEq/L : Negative
- A range of 30 – 59 mEq/L: Intermediate
- 60 mEq/L or greater: Consistent with CF
- The Cystic Fibrosis Foundation reference intervals for chloride (Farrell PM et al ~~2007~~2017) are:

Test	Result	Interpretation
Sweat Chloride	<30 mmol/L	Newborns with a positive newborn screen: CF unlikely
Sweat Chloride	30-59 mmol/L	All populations: intermediate range- need further study to establish or rule out a CF diagnosis
Sweat Chloride	≥60 mmo/L	~~All populations: indicative of CF for individuals presenting consistent with CF, or a positive family history~~ <u>All populations: indicative of CF for individuals presenting consistent with CF, or a positive family history</u>

Conductivity is a non-selective method for sweat analysis that has its own unique set of reference intervals. When sweat conductivity is expressed as units of Aqueous sodium chloride solution, the values are approximately 15 mmol/L higher than when chloride is measured directly. A patient having a sweat conductivity greater than equal to 50 mmol/L should be referred to a specialized cystic fibrosis center for a quantitative analysis of sweat chloride with or without sweat sodium (CHM.30700).

Limitation of Procedure

Sweat electrolyte concentration is related to sweat rate. At low sweat rates, sweat electrolyte concentration decreases. The average sweat rate must exceed 1 gm/m² per minute. The minimum acceptable sample size to assure proper rate is 15 µL collected in 30 minutes (CHM30000). If collection is less than this then patient sweat induction must be repeated. Multiple insufficient samples may not be pooled for analysis (CHM.30100).

Patient must be older than 48 hours before performing the testing to assure that proper sweat

stimulation and collection takes place (CHM.29100).

- Lower Limit of Reportable Results: Results less than 10 mEq/L will be reported as < 10 mEq/L (CHM.30550).
- Upper Limit of Reportable Results: Results greater than 160 mEq/L will not be reported, because chloride results > 160 mEq/L are not physiologically possible. The patient must be retested. Results must be less than or equal to 160 mEq/L of chloride. (CHM.~~30900~~30575).

To ensure proficiency with collection and analysis two CLS personnel are certified to perform sweat chloride testing. Testing is divided equally between these two personnel in order to provide a sufficient number of collections and analyses to remain proficient-(CHM.31000).

References

1. Sweat Testing: Sample Collection and Quantitative Analysis; Approved Guideline, NNCLS Document C34-A, December 1994.
2. Macroduct ® ~~Advanced~~ Sweat Collection System Instruction Manual, ~~Wescor Inc~~ELITechGroup., ~~M2551-4, 1995~~ 57-0192-01E 2018.
3. Digital Chloridometer Instruction Manual, Labconco Corp., 1997.
4. ~~Wescor Product Bulletin, Disinfection Options for Macroduct and Nanoeduct Straps, 10 October 2005, DOC-00291A.doc.~~
5. Farrell PM, et al. Diagnosis of Cystic Fibrosis: Consensus Guidelines from the Cystic Fibrosis Foundation. J. Pediatr. February 2017;181S; S4-15.
6. Clinical and Laboratory Standards Institute (CLSI). Sweat Testing: Sample Collection and Quantitative Analysis; Approved Guideline-Third Edition, CLSI document C34-A3 (ISBN 1-56238-713-8. Clinical and Laboratory Standards Institute, 940 West Valley Road, Wayne, PA, 19087-1898, USA, 2009.
7. CHM.30700, ~~CHM.30900~~, CHM.30100, CHM.29100, CHM.30550, ~~CHM.31000~~

All Revision Dates

1/23/2026, 10/3/2025

Approval Signatures

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COPY



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L.POC.2.1 Clinitek Status UA Dipstick Procedures: Quality Control, Patient Testing, and Preventive Maintenance

PURPOSE:

The **Siemens Clinitek Status Analyzer** is a portable, benchtop instrument powered by an electrical outlet, designed for in-vitro diagnostic use. It enables the semi-quantitative or qualitative detection of multiple analytes in urine samples, including protein, blood, leukocytes, nitrite, glucose, ketone, pH, specific gravity, bilirubin, and urobilinogen.

System Functionality

The system uses **reflection from six LEDs** to quantify urine constituents. This reflected light is converted into electrical impulses, processed by the analyzer's microprocessor, and translated into clinically meaningful results.

Siemens Multistix Reagent Strips

- **Purpose:** Multistix reagent strips aid in diagnosing kidney function, urinary tract infections, carbohydrate metabolism (e.g., diabetes mellitus), and liver function.
- **Physical Characteristics:** The strips also evaluate acid-base balance and specific gravity of urine.
- **Clinical Application:** Results may be used alongside other diagnostic information to rule out certain disease states and to determine the need for microscopic evaluation.

Multistix reagent strips are ready to use upon removal from the bottle and are fully disposable after use. These reagent strips are intended for in vitro diagnostic use only and have been classified as nonhazardous under OSHA guidelines in 29 CFR 1910.1200(d).

POLICY:

To establish a policy for the Siemens Clinitek Status Analyzer regarding:

- **Performance of Urinalysis**
- **Quality Control (QC)**
- **Proficiency Testing**
- **Instrument Maintenance**
- **Infection Control Measures**
- **Training of Personnel**
- **Competency Validation**

The following policy adheres to guidelines from the laboratory accrediting agency, **The College of American Pathologists (CAP)**, and **Clinical Laboratory Improvement Amendments (CLIA)** standards for point-of-care testing.

- The Clinitek Status Analyzer (FDA approved waived test) shall be used to screen patient urine for Glucose, Ketone, Specific Gravity, Blood, pH, Protein, Nitrite, Bilirubin, Uro-Bilinogen, and Leukocytes. Results obtained shall not be used for definitive diagnostic and further testing from the main lab shall be up to the discretion of the attending physician.
- Daily QC of the reagent test strip shall be performed by testing known negative and positive controls.
- Proficiency testing will be completed as required by the laboratory department's accrediting agency, CAP.
- The maintenance of the instrument shall be performed to provide accurate test results and operate correctly. (Procedure in the "Preventative Maintenance" section) This includes periodic checking of the white calibration bar in the test table for dirt or discoloration, especially after a strip jam. Adherence will enhance the instrument's ability to provide reliable results.
- To ensure safety and compliance with infection control guidelines, gloves must be always worn during testing. After testing, store specimens appropriately, clean any spills in the work area, remove gloves and clean hands immediately.
- Training and signing off initial and recurring competency evaluations of personnel must occur prior to live patient testing before testing privileges are granted.
- Urinalysis by Clinitek Status shall be performed by trained personnel, their skills must be validated annually per CAP guidelines

STORAGE:

STORAGE:

- Store Multistix 10 reagent strips at room temperature (15°-30°C), away from direct sunlight.
- Keep all unused strips in the original bottle; transferring strips to another container may cause deterioration.
- Do not use strips past their expiration date or remove the desiccant from the bottle.
- Protect strips from light, heat, and moisture to maintain reagent activity.

- Avoid touching the test areas of the strips. Discard any strips showing discoloration or darkening of reagent areas, as this indicates deterioration.

EQUIPMENT AND MATERIALS

EQUIPMENT AND MATERIALS

- Siemens Clinitek Status Analyzer
- Siemens Multistix 10SG Reagent Test Strip
- CLINIQA Level 1 and 2 QC Material
- CLINIQA Urinalysis Control Assigned Value Chart package insert
- Personal Protective Equipment (PPE): Gloves, lab coat, safety glasses
- Biohazard waste container
- Quality Control Test Result Log Sheet
- Clean-catch Midstream, random urine sample from the patient
- Paper Towels
- Sani-Cloth Disinfectant Wipes

SPECIMEN COLLECTION:

SPECIMEN COLLECTION:

- Obtain 10 mL (optimal) freshly voided, well mixed urine.
- Do not centrifuge urine. Minimum volume = 1mL.
- Specimen must be labeled with patient identification.
- If using an addressograph label, affix label to urine cup not on the lid.
- Collect the urine in an approved sterile urine collection container.
- Work areas and specimen containers should always be free of detergents and other contaminating substances
- Specimen should be at room temperature for less than 2 hours.
- If the test cannot be performed within 30 minutes, the urine sample should be refrigerated.
- Refrigerated specimens must be analyzed within 24 hours.
- Refrigerated urines must be brought to room temperature before analysis.

SPECIMEN REJECTION:

SPECIMEN REJECTION:

If an unacceptable specimen is received, document the issue in the Electronic Medical Record and promptly notify the patient's care team. A new sample should be recollected if necessary.

The following conditions warrant specimen rejection:

- **Improperly Labeled Specimen**

- Any specimen not correctly labeled with the patient's identification details must be rejected, and a new sample requested.
- **Specimen Left at Room Temperature for More Than 2 Hours**
 - Urine samples kept at room temperature for over 2 hours are unsuitable for testing and must be discarded.
- **Refrigerated Specimens Older Than 24 Hours**
 - Urine samples stored in the refrigerator for more than 24 hours may have deteriorated and should not be used for testing.
- **Grossly Bloody Specimens**
 - Visibly bloody urine samples should be sent to the main laboratory for further analysis, as blood could interfere with hCG test results.
- **Specimens Containing Urine Preservatives**
- **Samples containing preservatives are unsuitable for hCG testing, as these chemicals can affect test accuracy.**
- **Grossly Bloody or Pus-Filled Specimens with Visible Clots**
 - Any grossly bloody or pus-filled sample, especially with visible clots, should be sent to the main laboratory for analysis. (Refer to the manufacturer's insert for additional details.)

HANDLING THE MULTISTIX REAGENT TEST STRIP

- Store at room temperature between 15 to 30 degrees C.
- Initial and date the reagent bottle after opening.
- Do not use beyond the expiration date indicated on the bottle.
- Do not store the bottle in direct sunlight.
- Do not remove the reagent strip from its bottle until immediately before use.
- Store the bottle tightly always capped.
- Do not touch the test areas of the reagent strip.
- Do not use reagent test strips that showed discoloration and darkening of the reagent areas which may indicate deterioration.

HANDLING OF CONTROL SOLUTIONS

- A. Stable until expiration date when stored unopened at 2-8° C.
- B. Once control is opened, it is stable for 31 days when stored tightly capped at 2-25° C.
- C. Write the opening date, new expiration date, and user's initials after opening control vials.
- D. After each use, promptly recap vial and store at 2-8° C
- E. Controls should never be frozen.
- F. Never use past the expiration date.

DEFINITION(S):

DEFINITIONS:

Chemical Principles of the Reagent Strips	
Test Name <u>Test Name</u>	Chemical Principle <u>Chemical Principle</u>
Glucose	Glucose oxidase catalyzes the formation of gluconic acid and hydrogen peroxide from the oxidation of glucose. Peroxidase catalyzes the reaction of hydrogen peroxide That couples 4-aminoantipyrine and 4-methylcatechol to create an orange to dark red color reaction.
Bilirubin	Bilirubin couples with diazotized dichloroaniline in a strongly acid medium. Colors range through various shades of tan.
Protein	At a constant pH, the development of any green color is due to the presence of protein (Protein error-of-indicators principle). Colors range from yellow for negative through yellow-green and green to green-blue for positive reactions.
pH	The double indicator principle gives a broad range of colors covering the entire urinary pH range. Colors range from orange through yellow and green to blue.
Blood	Hemoglobin catalyzes the reaction of diisopropylbenzene dihydroperoxide and 3,3',5,5'-tetramethylbenzidine. Colors range from orange through green; very high levels of blood may cause the color development to continue to blue.
Ketone	Acetoacetic acid reacts with nitroprusside. Colors range from pink, for a negative reading, to maroon for a positive reading.
Urobilinogen	In a modified Ehrlich reaction, p-diethylaminobenzaldehyde in conjunction with a color enhancer reacts with urobilinogen in a strongly acid medium to produce a pink-red color.
Nitrite	Nitrate (derived from the diet) is converted to nitrite by the action of Gram-negative bacteria in the urine. At the acid pH of the reagent area, nitrite in the urine reacts with p-arsanilic acid to form a diazonium compound. This diazonium compound couples with 1,2,3,4-tetrahydrobenzo(h)quinolin-3-ol to produce a pink color.
Leukocyte	Esterases in granulocytic leukocytes catalyze the hydrolysis of the derivatized pyrrole amino acid ester to liberate 3-hydroxy-5-phenyl pyrrole. This pyrrole then reacts with a diazonium salt to produce a purple product.
Specific	pKa changes occur for certain pretreated polyelectrolytes in relation to ionic

Gravity	concentration. In the presence of an indicator, colors range from deep blue-green in urine of low ionic concentration through green and yellow-green in urines of increasing ionic concentration

~~VCMC/SPH Urine Dipstick Point of Care Normal Values~~

VCMC/SPH Urine Dipstick Point of Care Normal Values

<u>Assay</u>	<u>Normal Value</u>	<u>Units of Measurement</u>	<u>Range of Results</u>
<u>Assay</u>	<u>Normal Value</u>	<u>Units of Measurement</u>	<u>Range of Results</u>
pH	4.6-8.0	pH	5.0 - 8.5
Specific Gravity	1.001-1.035	SG	1.000 – 1.030
Leukocytes	Negative	Grading	Trace, Small, Moderate, Large
Protein	Negative	mg/dL	Negative, Trace, 30 - 2000
Glucose	Negative	mg/dL	Negative, 100 - 2000
Ketones	Negative	mg/dL	Negative, 5 - 160
Blood	Negative	Grading	<u>Non-Hemolyzed:</u> • Trace • Moderate <u>Hemolyzed:</u> • Trace • Small • Moderate • Large
Bilirubin	Negative	Grading	Small, Moderate, Large
Nitrite	Negative	Grading	Negative, Positive
Urobilinogen	0.2	mg/dL	0.2 – 8.0

Urine samples with test results indicating the need for microscopic examination and/or Culture & Susceptibility (C&S) testing will have lab orders automatically generated via reflex rules in the electronic medical record (EMR) if the initial dipstick test results warrant further workup. The rules for dipstick order reflexing are outlined in the following table.

VCMC/SPH Urine Dipstick Point of Care Reflex Rules

Test	Reflex	Analytes	Criteria
Urinalysis Dipstick w/Reflex	UA microscopy	PRO: Protein	≥ 70 mg/dL
		NIT: Nitrates	≥ 1+
		LEU: Leukocytes	Trace - Large
		BLO: Blood	Trace - Large
	Urine culture	NIT: Nitrates	≥ 1+
		LEU: Leukocytes	Trace - Large
		WBC: White blood cells	≥ 6 cells/HPF
		WBCC: White blood cells	≥ 1 cells/HPF
		BACT: Bacteria	≥ 3+/HPF

PROCEDURE(S):

VCMC/SPH Urine Dipstick Point of Care Reflex Rules

Test	Reflex	Analytes	Criteria
Urinalysis Dipstick w/Reflex	UA microscopy	PRO: Protein	≥ 70 mg/dL
		NIT: Nitrates	≥ 1+
		LEU: Leukocytes	Trace - Large
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	Urine culture	NIT: Nitrates	≥ 1+
		LEU: Leukocytes	Trace - Large
		WBC: White blood cells	≥ 6 cells/HPF
		WBCC: White blood cells	≥ 1 cells/HPF
		BACT: Bacteria	≥ 3+/HPF

PROCEDURES:

CALIBRATION PROCEDURE

The Clinitek Status Analyzer performs a “self-test” and calibration each time it is turned on. In addition, the analyzer performs an automatic calibration each time a test is run. The white calibration bar (on the test Table) provides traceable calibration approved by the National Institute of Standards and Technology.

QUALITY CONTROL TESTING PROCEDURE

1. **At the main Select screen, touch “QC Test/Due”.**
2. This will appear after 24 hours since the last QC analysis.
3. **Select “QC Strip Test Required”. “Required” appears on screen after 24 hours since the last Quality Control analysis.**
4. **Screen then prompts for Operator ID. This should be the user’s Ventura County Employee ID as specified in Telcor QML Point of Care database. Press Enter.**
 - The employee number can also be entered via custom barcoded provided by nursing management.
 - This screen will prevent non-certified staff from using the device.
5. **The next screen requires the operator to enter their name. Use the alpha keyboard and enter your name. Press Enter. (? Not sure if this happens, check after setup)**
6. **Select QC 1 Level 1 appears on the Screen.**
 - Scan the QC Level 1 **Lot Number**. Press **Enter**. You must scan the barcode to proceed.
 - Enter the QC Level 1 **Expiration Date**. Press **Enter**.
7. **Select “Enter new Lot and Expiration date” for the Multistix reagent strips.**
8. **Scan the barcode on the side of the round Siemens Multistix 10SG container.**
9. **BEFORE you press START, take one Multistix out of the vial and have the Level 1 QC ready to dose the reagent strip.**
 - Once you press START you have 8 seconds to apply QC 1 drop to each pad, starting at the bottom of the strip.

Follow the steps in this order:

1. Prepare QC material
2. Prepare reagent strip
3. Press “START”. Table may retract quickly and come back out for the strip. Ignore this, it is pretty quick.
4. Dip strip into QC
5. Remove excess urine from strip. Blot strip gently by turning on edge against a paper towel.
6. Place strip on Clinitek Status strip table.
7. **WARNING: Do not push or pull the test table.** This will cause damage

10. After the 8-second countdown, the test table will retract, pulling the placed strip into the instrument.
11. The analyzer will perform an automatic calibration and then analyze the QC.
12. Once the analysis is complete the Results screen will be displayed as **"PASS"** or **"FAIL"** the quality control. If the QC passed, select the PRINT button and results will be printed.
 - **If QC results are stored in an interfaced database they don't need to be printed.**
 - **If there's network downtime, QC results must be printed.**
13. A summary of the QC performed will be displayed on the next screen.
14. Store paper QC results in the "Quality Control Log" section the POCT binder.
15. Results are entered manually after network downtime.
16. The Clinitek Status knows the QC status whether it is pass or fail and will not allow patient testing until QC Levels 1 & 2 have **"PASSED"**.
17. Select Done. Clinitek then prompts for QC Level 2. **Repeat steps 6-15.**
 - Note: QC **Level 2 Strip Lot** is the same lot number of Multistix used for running **QC Level**
18. When one or both levels of the QC **"FAIL"** the instrument will prompt you to repeat the failed QC test.
19. Follow these steps when a QC run fails.
20. After the **1st QC Failure**, Inspect the calibration bar. Ensure it is clean. Then, Rerun QC with newly opened QC Material.
21. After the **2nd QC Failure**, contact the laboratory for assistance. contact the laboratory for assistance.

Quality Control (QC) Testing

A. QC Frequency:

1. Perform QC testing:
 - a. When opening a new lot or shipment of test cassettes.
 - b. At the start of each day before patient testing.
 - c. If the analyzer has been moved or serviced.
 - d. If test results are questionable (multiple patients with similar results, likely carryover from previous run).

B. Running QC Tests:

1. Use both positive and negative control solutions.
2. Follow the same steps as patient testing, substituting control solution for the urine sample.

C. Acceptance Criteria:

1. QC results must fall within the manufacturer's acceptable range.
2. If QC results fail, troubleshooting must be done, and the analyzer should not be used for patient testing until resolved.

PATIENT UA DIPSTICK POC TEST PROCEDURE:

-Run the test using full test mode-

1. At the main screen, touch Strip Test.
2. Enter your Operator ID as defined in the QML Database.
3. Select Enter New Patient.
4. Use patient's financial number (FIN) as patient's ID.
5. Enter Strip Lot by scanning the barcode on the side of the Multistix 10 SG container.
6. After you press START you have 8 seconds to dip the test strip into urine specimen and place it on the test table. Ensure the strip is placed all the way back on the table or you will get an error right away and have to repeat the testing.
7. BEFORE you press START, take one Multistix out of the container and have the sample ready to dose the reagent strip.

-Follow these steps exactly-

8. Prepare urine specimen for dipping.
9. Prepare reagent strip.
10. Press "START" (Table may retract briefly and come back out. Ignore this, it is quick.)
11. Dip strip into urine
12. Remove excess urine from strip by blotting strip edge gently against a paper towel.
13. Place strip on Clinitek Status strip table.
 - **WARNING: Do not push or pull the test table****WARNING: Do not push or pull the test table.**
This will cause damage
 - **If a urine sample is extremely abnormal (turbid, red, orange, etc) clean the strip tray with an alcohol pad before testing the next patient sample.**
14. After the 8-second countdown, the test table will retract, pulling the placed strip inside the instrument.
15. The analyzer will perform an automatic calibration and analyze the urine.
16. Once analysis is complete the Results screen will display on the analyzer and may print if printing is activated. Record results manually on paper, and results in the electronic medical record if analyzer is not connected, or you are printed. Record results in the electronic record if there is no interface or you are experiencing network downtime. Interfaced analyzers should send results to Cerner and post in the patient's chart after 3-5 ~~minute~~minutes.
17. Manual results are entered in Power Chart via the "Point of Care Result Entry" tool bar application by the testing personnel.
18. Results during network downtime results are taped ~~onto~~on to a designated page in the POCT binder.
19. Remove the test strip and dispose of it in biohazard container.
20. Touch ~~Done~~Done on the Clinitek Screen to complete the test and return to the main ~~Select screen~~menu.

21. ~~Wipe any urine left on the table with a paper towel.~~ Wipe any urine left on the table with a paper towel.
- If a urine dipstick result indicates a microscopic analysis or culture order is required, an order will generate automatically within 2 minutes, and ~~a Culture labels should print out at the label~~ should print out at the label printer next to the Clinitek Status. Rules for reflex testing are described in the next section.
 - If a label does not print out or the reflex testing, but should, contact the laboratory for assistance in getting the reflex testing completed. Ensure you have a yellow and grey top urine container filled.
 - For difficult patients, if specimen volume is low, fill the yellow urine tube only and instruct the lab that the volume is low so that a culture can be plated before any other testing is performed on the specimen.

~~TEST REPORTS:~~

TEST REPORTS:

1. Attach the instrument printout to the patient result log.
2. Record results in Cerner.
3. During Computer Downtime
4. Affix the patient's label that contains the patient's name and medical record number, account number as well as ordering provider's name and location in the space provided in the upper right hand corner during computer downtime.
5. Attach or transcribe the printed test results from the instrument tape to the form.
6. Enter the date and time of testing and initials or signature.
7. All patients' test results printouts shall be retained for three years together with the QC records.

~~PREVENTIVE MAINTENANCE:~~

~~CLINITEK Status®+ Analyzer Maintenance Procedure~~

PREVENTIVE MAINTENANCE:

CLINITEK Status®+ Analyzer Maintenance Procedure

Daily Maintenance

- Wipe down the external surfaces of the analyzer with a disinfectant wipe, ensuring the test table and cassette insert are clean.
- Clean the screen with a mild glass cleaner and a lint-free cloth.

Weekly Maintenance: Cleaning the Test Table and Insert

- Moisten a cotton-tipped swab with distilled water and gently clean the test table and insert.
 - **Caution:** Avoid touching the white calibration bar during cleaning.

- Wear appropriate personal protective equipment (PPE) throughout this process.
- Follow your facility's standard operating procedure for cleaning frequency.

As-Needed Maintenance: Cleaning the Calibration Bar

- Inspect the white calibration bar regularly, particularly after a strip jam.
- If dirty or discolored, gently wipe it clean with a cotton-tipped swab or lint-free cloth moistened with distilled water.
 - **Caution:** Do not scratch or use any solvent on the calibration bar.

Decommission Maintenance: Disinfecting Test Table and Insert (For removal from service)

- Disinfection is necessary if the test table or insert is relocated, especially if moved through non-biohazardous areas.
- Use deionized water mixed with 5% sodium hypochlorite (bleach) as a disinfectant.
- Soak the test table and insert in the disinfecting solution for 2–10 minutes.

Caution: Ensure the white calibration bar is not exposed to any disinfectant.

REFERENCE(S):

REFERENCES:

- Siemens Multistix Reagent Strips Product Insert, AN30516C, Rev. 4/99.
- Freeman, J.A. and M.F. Beeler: *Laboratory Medicine - Clinical Microbiology*, Lea and Febiger, Philadelphia, PA, 1974.
- Graff, S.L., *A Handbook of Routine Urinalysis*, J.B. Lippincott
- Henry, John, *Clinical Diagnosis and Management by Laboratory Methods*, W.B. Saunders Co., 16th ed., 1979.
- Race, G.L. and M.G. White: *Basic Urinalysis*, Harper and Row, Hagerstown, MD, 1979.
- Siemens Medical Solutions Diagnostics Clinitek Status Analyzer Operator's Manual 13287. rev. T, 2008-05.: [ad](#)
- [VA Salt Lake City Health Care System, Pathology & Laboratory Medicine. \(n.d.\). Clinitek status urinalysis procedure \(SOP-0995\) \[Policy\].](#)

All Revision Dates

5/15/2026, 2/9/2026, 10/3/2025

Attachments

[Clinitek QC Log Sheet UA + hCG.docx](#)

[Clinitek Status A Maintenance Log.docx](#)

[!\[\]\(50ba758255c5d7cec2761495a31c7c80_img.jpg\) Clinitek Status B Maintenance Log.docx](#)

[!\[\]\(529949c2c3dadbaa4e538e8c643454bc_img.jpg\) HEM 3.5.1 Clinitek Status UA SOP.docx](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/15/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	5/14/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/13/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	4/10/2026

COPY



Origination 4/2/2004
Last Approved 4/9/2026
Effective 4/9/2026
Last Revised 4/9/2026
Next Review 4/8/2028

Owner Gayle Haider:
Supervisor-
Quality
Assurance,
Laboratory
Services

Policy Area Laboratory
Services

L.03 Delegation of Responsibilities in the Laboratory

POLICY:

While the Ventura County Medical Center (VCMC) Laboratory Medical Director is responsible for the overall technical and clinical operation and the administration of the Laboratory, some of these responsibilities have been delegated to others. Any reports, problems or medical decisions are given to the Medical Director for assistance or approval.

There are programs throughout the hospital which require a pathologist's oversight and involvement. The transfusion service medical director should be involved in, aware of and participate in the development and establishment of the policies and procedures for blood recovery and to ensure the safety and efficacy of the recovered blood components as part of the transfusion medicine service. The medical director will interact with the surgeons/physicians responsible for ordering the use of the cell-saving ~~devices~~ devices and oversee the appropriate use at surgery.

PROCEDURE:

Clinical Consultants (Pathologists) Responsibilities:

1. All responsibilities of the Laboratory Medical Director when the Laboratory Medical Director is off duty.
2. All responsibilities in Anatomic and Clinical Pathology as needed or assigned per CLIA guidelines.

General Supervisor (Laboratory Manager) Responsibilities:

1. Laboratory operations including scheduling staff and hiring new employees, budget, contracts,

- overall quality assurance and oversee all technical supervisors and other testing staff.
2. Other administrative responsibilities.
 3. Share responsibilities designated to technical supervisors and testing staff as needed.
 4. Review compliance related documents and oversee all regulatory requirements.
 5. Maintain Policy manuals. Write new and revised policies for Laboratory Medical Director to review and sign. Review and sign policy manuals every other year.
 6. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Technical Supervisors, Interim Supervisors, Acting Supervisors.

Chemistry (CLS III):

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing staff) of proficiency testing, exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for the Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Staff: Staffing, training, competency assessments, evaluations and discipline of testing staff.
7. Quality improvement and safety specific to assigned area.
8. Computer, software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing staff (CLS II) as needed.
10. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.
11. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Hematology (CLS III):

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational

- and other ungraded test results. Completion and/or review (if completion delegated to testing staff) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
 5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
 6. Staff: Staffing, training, competency assessments, evaluations and discipline of testing staff.
 7. Quality improvement and safety specific to assigned area.
 8. Computer, software and hardware issues specific to assigned area.
 9. Responsibilities assigned to testing staff (CLS II) as needed.
 10. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.
 11. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Microbiology (CLS III):

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.
2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing staff) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Staff: Staffing, training, competency assessments, evaluations and discipline of testing staff.
7. Quality improvement and safety specific to assigned area.
8. Computer, software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing staff (CLS II) as needed.
10. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.
11. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Blood Bank (CLS III):

1. Standards of performance including review all quality control, instrument functions checks, temperature monitoring.

2. Inventory and ordering of reagents, calibrators, controls, and other supplies.
3. Perform and/or review proficiency testing including attestation statement and preliminary review of all proficiency testing evaluations including highlighting of unacceptable or unexpected results and comparison of reported results with expected results for educational and other ungraded test results. Completion and/or review (if completion delegated to testing staff) of proficiency testing exception investigation report.
4. Equipment: Review routine and preventive maintenance, and resolution of maintenance issues.
5. Maintain Procedure Manuals: Write new and revised procedures for Laboratory Medical Director to review and sign. Review and sign procedure manuals every other year.
6. Staff: Staffing, training, competency assessments, evaluations and discipline of testing staff.
7. Quality improvement and safety specific to assigned area.
8. Computer, software and hardware issues specific to assigned area.
9. Responsibilities assigned to testing staff (CLS II) as needed.
10. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.
11. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Laboratory Information System (CLS III):

1. Monitor and oversees the performance of the Laboratory information system to ensure that it is functioning correctly and meeting the needs of the department.
2. Implements all aspects of system requirements, including system analysis, policy and procedure documentation, test plans, system performance, and user training.
3. Monitors the development and installation of software upgrades, which includes testing, quality control, and acceptance.
4. Oversees the computer operations to ensure data is processed according to the program and to ensure timely communication of results.
5. Monitor interfaces, both instrument and hospital related computer system to ensure optimum accuracy, appropriate flow of data and timely turnaround of results.
6. Ensure that the LIS is in compliance with regulatory requirements.
7. Acts as liaison with vendors and attends vendor training.
8. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.
9. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Quality Assurance Coordinator (CLS III):

1. Monitor and oversees the performance of the Laboratory proficiency specimen. Monitor the data from receive to submission. Review the proficiency evaluation received from College of

- American Pathology. Tabulate and compile the data from the monthly workload.
2. Verify the documentation of completed preventive maintenance of all equipment.
 3. ~~Monthly audition of the blood culture log sheet, time draw study, turnaround time study draw, critical value reporting, and responses to the regulatory agencies.~~ Monthly audits of the key performance indicators being monitored: anti-Xa turn-around-time, CODE STROKE, blood culture contamination, lactate draws, early morning laboratory turn-around-times, specimen integrity, ED Throughput turn-around-time, licenses, critical tests and critical value reporting compliance, and certification of laboratory personnel and clinical laboratories at Ventura County Medical Center and Santa Paula Hospital.
 - a. Log sheet, time draw study, turnaround time study draw, critical value reporting.
 - b. Responses to the regulatory agencies.
 4. Monitors, evaluates, and maintains quality indicators.
 5. Ensures that the Laboratory and staff are survey ready at all times for regulatory agencies; California department of Public Health, Collage of American Pathologists.
 6. Compiles and reviews self-inspection conducted by section supervisors, evaluates findings prior to internal and/or external surveys.
 7. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Laboratory Safety Coordinator (CLS III):

The Laboratory Safety Coordinator is appointed by the Department to facilitate the implementation of the various safety requirements and assist in establishing a safe work environment by collaborating with EH&S, Laboratory medical director, administration, and lab staff. The Lab Safety Coordinator is familiar with their department operations, has management support and has an understanding of Laboratory safety requirements.

The Lab Safety Coordinator responsibilities include:

1. Coordinate Laboratory safety and environmental compliance efforts based on EH&S programs.
2. Serve as liaison between the Laboratory and EH&S in helping maintain safety and regulatory information, including Safety Data Sheets
3. Attend training sessions provided by EH&S, sharing information with department staff. Distribute and communicate safety, hazardous material, precaution information to all lab staff.
4. Assist EH&S in evaluating program effectiveness.
5. Conduct or coordinates periodic Laboratory self-inspections
6. Document and report all safety and injury incidents to the appropriate department. Maintain all records as appropriate.
7. Provide guidance on Laboratory safety compliance to other Laboratory members.
8. Request information and clarification on regulatory requirements from EH&S.
9. Assist in responding to any regulatory actions or investigations.

10. Participate in the development of the Laboratory Emergency Plans and assists with emergency management planning and response as needed.
11. Ensure that lab staff receive all required EH&S training and lab specific information. Maintain all training documents as required by College of American pathologist.
12. Oversight that safety conditions in the laboratories are met.
13. Maintain Laboratory safety postings
14. Assist in developing, implementing, and communicating departmental safety policies and programs.
15. Coordinate Laboratory submissions of hazardous materials inventories to EH&S for annual updates and storage relocations.
16. Communicate with the institute safety officer on facility issues related to safety.
17. Maintain Policy manuals. Write new and revised policies for Laboratory Medical Director to review and sign. Review and sign policy manuals every other year.
18. Conducts a thorough self-inspection and implements corrective actions for findings prior to internal and/or external surveys.

Testing Staff

Phlebotomy Supervisor (CPT III):

1. Staff scheduling, staffing, education, training of phlebotomist and office standards.
2. Quality assurance including timeliness of draws.
3. Environmental digital thermometer temperature monitoring.
4. Maintain adequate phlebotomy supplies.
5. Ensures that all licenses and certifications are current for all certified phlebotomy technicians.
6. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

Testing Staff (CLS II):

1. Analyzing and reporting of patient and proficiency specimens.
2. Equipment, operations, maintenance, and function checks.
3. Perform Quality control.
4. Maintains license current at all times.
5. Other responsibilities as deemed appropriate by the Laboratory Medical Director per CLIA guidelines.

CLIA Guidelines:

Laboratory Medical Director:

The Laboratory Director is responsible for the overall operation and administration of the Laboratory, including the employment of staff who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations.

- a. The Laboratory director, if qualified, may perform the duties of the technical supervisor, clinical consultant, general supervisor, and testing staff, or delegate these responsibilities to staff meeting the qualifications under §§493.1447, 493.1453, 493.1459, and 493.1487*, respectively.
- b. If the Laboratory director reapportions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed.
- c. The Laboratory director must be accessible to the Laboratory to provide onsite, telephone or electronic consultation as needed.
- d. Each individual may direct no more than five laboratories.

The Laboratory director must:

1. Ensure that testing systems developed and used for each of the tests performed in the Laboratory provide quality Laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing;
2. Ensure that the physical plant and environmental conditions of the Laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical, and biological hazards;
3. Ensure that:
 - i. The test methodologies selected have the capability of providing the quality of results required for patient care;
 - ii. Verification procedures used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method; and
 - iii. Laboratory staff are performing the test methods as required for accurate and reliable results;
4. Ensure that the Laboratory is enrolled in an HHS-approved proficiency testing program for the testing performed; and that
 - i. The proficiency testing samples are tested as required under subpart H of this part;
 - ii. The results are returned within the timeframes established by the proficiency testing program;
 - iii. All proficiency testing reports received are reviewed by the appropriate staff to evaluate the Laboratory's performance and to identify any problems that require corrective action; and
 - iv. An approved corrective action plan is followed when any proficiency testing result is

found to be unacceptable or unsatisfactory;

5. Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of Laboratory services provided and to identify failures in quality as they occur;
6. Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system;
7. Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the Laboratory's established performance characteristics are identified, and that patient test results are reported only when the system is functioning properly;
8. Ensure that reports of test results include pertinent information required for interpretation;
9. Ensure that consultation is available to the Laboratory's clients on matters relating to the quality of the test results reported and their interpretation concerning specific patient conditions;
10. Ensure that a general supervisor provides on-site supervision of high complexity test performance by testing staff qualified under §493.1489(b)(4);
11. Employ a sufficient number of Laboratory staff with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests and report test results in accordance with the staff responsibilities described in this subpart;
12. Ensure that prior to testing patients' specimens, all staff have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results;
13. Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and ~~postanalytical~~ post analytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills;
14. Ensure that an approved procedure manual is available to all staff responsible for any aspect of the testing process; and
15. Specify, in writing, the responsibilities and duties of each consultant and each supervisor, as well as each person engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or result reporting and whether supervisory or director review is required prior to reporting patient test results.

Clinical Consultants (Staff Pathologists):

The clinical consultant provides consultation regarding the appropriateness of the testing ordered and interpretation of test results. The clinical consultant must:

- a. Be available to provide consultation to the Laboratory's clients;

- b. Be available to assist the Laboratory's clients in ensuring that appropriate tests are ordered to meet the clinical expectations;
- c. Ensure that reports of test results include pertinent information required for specific patient interpretation; and
- d. Ensure that consultation is available and communicated to the Laboratory's clients on matters related to the quality of the test results reported and their interpretation concerning specific patient conditions.

General Supervisor (Laboratory Manager):

The General Supervisor is responsible for day-to-day supervision or oversight of the Laboratory operation and staff performing testing and reporting test results.

The General Supervisor:

- 1. Must be accessible to testing staff at all times testing is performed to provide on-site, telephone or electronic consultation to resolve technical problems in accordance with policies and procedures established either by the Laboratory director or technical supervisor;
 - 2. Is responsible for providing day-to-day supervision of high complexity test performance by a testing staff qualified under §493.1489;
 - 3. Except as specified in paragraph (c) of this section, must be onsite to provide direct supervision when high complexity testing is performed by any individuals qualified under §493.1489(b)(5); and
 - 4. Is responsible for monitoring test analyses and specimen examinations to ensure that acceptable levels of analytic performance are maintained.
- a. The director or technical supervisor may delegate to the general supervisor the responsibility for:
 - 1. Ensuring that all remedial actions are taken whenever test systems deviate from the Laboratory's established performance specifications;
 - 2. Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is properly functioning;
 - 3. Providing orientation to all testing staff; and
 - 4. Annually evaluating and documenting the performance of all testing staff.
 - b. Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (a)(3) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general supervisor qualified under §493.1461.

Technical Supervisors (CLS III, Chemistry, Hematology, Microbiology, and Blood Bank Supervisors, Acting Supervisors,

and Interim Supervisors):

The technical supervisor is responsible for the technical and scientific oversight of the Laboratory. The technical supervisor is not required to be on site at all times testing is performed; however, he or she must be available to the Laboratory on an as needed basis to provide supervision as specified in (a) of this section.

- a. The technical supervisor must be accessible to the Laboratory to provide on-site, telephone, or electronic consultation; and
- b. The technical supervisor is responsible for:
 1. Selection of the test methodology that is appropriate for the clinical use of the test results;
 2. Verification of the test procedures performed and establishment of the Laboratory's test performance characteristics, including the precision and accuracy of each test and test system;
 3. Enrollment and participation in an HHS approved proficiency testing program commensurate with the services offered;
 4. Establishing a quality control program appropriate for the testing performed and establishing the parameters for acceptable levels of analytic performance and ensuring that these levels are maintained throughout the entire testing process from the initial receipt of the specimen, through sample analysis and reporting of test results;
 5. Resolving technical problems and ensuring that remedial actions are taken whenever test systems deviate from the Laboratory's established performance specifications;
 6. Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is functioning properly;
 7. Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the Laboratory services performed;
 8. Evaluating the competency of all testing staff and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to:
 - i. Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing and testing;
 - ii. Monitoring the recording and reporting of test results;
 - iii. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records;
 - iv. Direct observation of performance of instrument maintenance and function checks;
 - v. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing

samples; and

vi. Assessment of problem solving skills; and

9. Evaluating and documenting the performance of individuals responsible for high complexity testing at least semiannually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be reevaluated to include the use of the new test methodology or instrumentation.

Testing Staff (CLS II):

The testing staff are responsible for specimen processing, test performance and for reporting test results.

- a. Each individual performs only those high complexity tests that are authorized by the Laboratory director and require a degree of skill commensurate with the individual's education, training or experience, and technical abilities.
- b. Each individual performing high complexity testing must:
 1. Follow the Laboratory's procedures for specimen handling and processing, test analyses, reporting and maintaining records of patient test results;
 2. Maintain records that demonstrate that proficiency testing samples are tested in the same manner as patient specimens;
 3. Adhere to the Laboratory's quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed;
 4. Follow the Laboratory's established policies and procedures whenever test systems are not within the Laboratory's established acceptable levels of performance;
 5. Be capable of identifying problems that may adversely affect test performance or reporting of test results and either must correct the problems or immediately notify the general supervisor, technical supervisor, clinical consultant, or director;
 6. Document all corrective actions taken when test systems deviate from the Laboratory's established performance specifications; and
 7. Except as specified in paragraph (c) of this section, if qualified under §493.1489(b)(5), perform high complexity testing only under the onsite, direct supervision of a general supervisor qualified under §493.1461.
- c. Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (b)(7) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general supervisor qualified under §493.1461.

*All Alphanumeric references are to CLIA.

REFERENCE:

[GEN.23584 College of American Pathologists Laboratory Accreditation Checklist, December 2025.](#)

All Revision Dates

4/9/2026, 4/3/2026, 11/1/2016, 3/1/2016, 2/1/2016, 1/1/2016, 7/1/2015, 11/1/2013, 8/1/2012

Attachments

[Self_Evaluation_form.doc](#)

[Template self-inspection-deficiency-corrective.docx](#)

[TIPSELF-INSPECTION CAP \(1\).pdf](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/9/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	4/9/2026
Laboratory Services Department	Gayle Haider: Supervisor- Quality Assurance, Laboratory Services	4/8/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	4/8/2026



Origination 8/30/2001
Last Approved 3/2/2026
Effective 3/2/2026
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Next Review 3/1/2028

Owner Kathrina Barcena:
Supervisor-
Blood Bank,
Laboratory
Services

Policy Area Laboratory
Services -
Serology

L.SER.11 Sure-Vue™ RF Test

PRINCIPLE:

Sure-Vue™ RF latex reagent is a suspension of polystyrene latex particles of uniform size coated with human immunoglobulin. Latex particles allow visual observation of the antigen-antibody reaction. When a serum containing rheumatoid factor is mixed with the Sure-Vue RF latex, the uniform appearance of the latex suspension will convert to a clear agglutination. This change occurs because the rheumatoid factor present in the serum reacts with the IgG coated latex particles forming a web between them.

SPECIMEN COLLECTION:

Use fresh serum collected by centrifuging clotted blood. If the test cannot be performed the same day, serum may be stored at 2-8°C for up to 8 days after collection. **Do Not Use Plasma. DO NOT USE PLASMA.**

EQUIPMENT AND MATERIALS:

Materials Required:

- Normal Saline (0.9% NaCl, for semi-quantitative test)
- Serological or automated pipettes
- Rotator
- Timer
- Disposable stirrers
- RF TITER – Control (For semi-quantitative test). Ready to use. Store 2-8°C. Do not use after the

expiration date shown on the vial label. Discard if it becomes contaminated.

Materials Provided:

- Sure-Vue RF latex reagent – Suspension of human IgG coated polystyrene latex particles in a buffer.
- Positive control – Diluted human serum containing more than 10 IU/mL of rheumatoid factor. Ready to use.
- Negative control – Diluted human serum containing less than 10 IU/mL of rheumatoid factor. Ready to use.
- Disposable slides
- The reagents will remain stable through the expiration date shown on the label, if stored between 2 and 8°C. Do not freeze.

QUALITY CONTROL:

Qualitative Procedure:

1. Before performing a set of determinations check the latex reagent with the positive and negative controls included in the kit.
2. Both controls should be used following the steps outline in the Qualitative Test.
3. The reaction between the positive control and reagent should show a clear agglutination, different than the uniform appearance of the negative control. If no agglutination takes place, the test should be repeated; if there is still no agglutination the kit should be discarded.

Semi-Quantitative Procedure:

1. A negative control and a positive control with graded or titered reactivity will be tested using the Semi-Quantitative test procedure.
 - a. The RF T-Control should be run each time semi-quantitative tests are performed.
 - b. The RF T-control should be handled as a serum specimen following the test procedure.
 - c. Results should be read after the period of time indicated in the reagent package insert.
2. **INTERPRETATION OF RESULTS:** The approximate concentration of rheumatoid factor in the RF T-control will correspond to the highest dilution which still presents a clearly visible agglutination.
3. **EXPECTED VALUES:** The obtained concentration should be within one (1) dilution of the concentration indicated on the vial label.
 - a. If results obtained are not within one dilution of the RF concentration indicated on the vial label, the test should be repeated. If results remain discrepant, the reagent should not be used and the reagent manufacturer technical services should be contacted.

- a. Prolonged time in reading may lead to incorrect results.
- b. Alternately, the positive and negative kit controls can be utilized as the control material. A positive control titer result of >10 IU/mL is acceptable.

PROCEDURE: Qualitative

1. Allow reagents and controls to reach room temperature (20-30°C).
2. Gently shake the reagent vial to disperse and suspend the latex particles. Vigorous shaking should be avoided.
3. Place 50 μ L of neat serum in one labeled section of the disposable slide.
4. Place one drop of reagent next to the drop of serum.
5. Mix both drops with a stirrer, covering the whole surface of the slide section.
6. Gently rotate the slide for two (2) minutes manually or on a rotator set at 80-100 rpm.
7. Look for the presence or absence of agglutination after the two (2) minute time period.

PROCEDURE: Semi-Quantitative

1. Allow reagents and controls to reach room temperature (20-30°C)
2. Place 50 μ L of 0.9% NaCl on slide sections 2 through 6.
3. Using an automated pipette, place 50 μ L of neat serum in sections 1 and 2.
4. Using the same pipette, take in and release the serum and normal saline in section 2 several times until well mixed.
5. Take 50 μ L of the mixture made on section 2 and transfer to section 3.

Section	1	2	3	4	5	6
Saline μ L	None	50	50	50	50	50
Serum μ L	50	50	-	-	-	-
Mix and Transfer		50→	50→	50→	50→	50→ Discard
Dilution	1:1	1:2	1:4	1:8	1:16	1:32
I.U./mL	10	20	40	80	160	320

6. Repeat steps 5 and 6 for the rest of the remaining sections of the slide, discarding the last 50 μ L of sample from section 6.
7. Gently shake the reagent vial to disperse and suspend the latex particles. Vigorous shaking should be avoided.
8. Place a drop of reagent on sections 1 through 6 of the slide.
9. Mix both drops with a stirrer, covering the whole surface of the slide section.
10. Gently rotate the slide for two (2) minutes manually, or on a rotator set at 80-100 rpm.
11. Look for the presence or absence of agglutination after the two (2) minute time period.

RESULTS:

Qualitative – The presence of agglutination indicates a titer of rheumatoid factor greater than or equal to 10 IU/mL. The absence of agglutination indicates a content of rheumatoid factor less than 10 IU/mL.

Semi-Quantitative – The approximate titer corresponds to the highest serum dilution that still presents a clearly visible agglutination.

- If section 6 (1:32 or 320) has clearly visible agglutination present, continue to titer out the sample until a negative end point result is obtained.

LIMITATIONS:

- ~~1. Results should be read within two (2) minutes after completion of rotation of the slide. Reading results more than two (2) minutes after rotation may give false positive results.~~
- ~~2. The strength of agglutination is not necessarily indicative of relative rheumatoid factor concentration.~~
1. Results should be read within two (2) minutes after completion of rotation of the slide. Reading results more than two (2) minutes after rotation may give false positive results.
2. The strength of agglutination is not necessarily indicative of relative rheumatoid factor concentration.
3. In order to obtain reliable consistent results, the instructions in the package insert must be strictly followed. Do not modify the handling and storage conditions for reagents and samples.
4. Do not use past the expiration date indicated on the kit.
5. Do not interchange components of one kit with those of another kits.
6. False positive tests may occur using samples from patients with systemic lupus erythematosus, hepatitis, scleroderma, lymphomas, cirrhosis of the liver and other infections. The frequency of false positive results is not high under these conditions but the possibility does exist.
7. Contaminated, lipemic, or grossly hemolyzed sera should not be used because of possibility of nonspecific results.
8. plasma samples should not be used because of the possibility of nonspecific results.
9. Temperature of the reagents and samples is crucial to test outcome. It should be between 20°C and 30°C.

REFERENCES:

Current Sure-Vue RF manufacturer's instructions for use.

All Revision Dates

3/2/2026, 12/1/2016, 1/1/2016, 10/1/2013

Attachments

 [L.SER.11 - Attachment A - RF Titer Control.docx](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/2/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/28/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	2/9/2026
Laboratory Services Department	Kathrina Barcena: Supervisor- Blood Bank, Laboratory Services	2/9/2026

COPY



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Next Review 3/29/2028

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

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

POLICY:

To outline the services offered by the Respiratory Care Department of Ventura County Medical Center/ Santa Paula Hospital ~~and the availability of such.~~ The Respiratory Care Department provides comprehensive cardiopulmonary diagnostic, therapeutic, and consultative services as directed by a licensed practitioner to patients across the lifespan (neonatal through geriatric), in accordance with orders from a Licensed Practitioner (LP) and in compliance with the California Respiratory Care Board. ~~The practice typically focuses on:~~

Services are delivered to support the assessment, treatment, stabilization, and management of acute and chronic respiratory conditions in all care settings.

PROCEDURE:

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

- B. Education and instruction to patients
- C. Application of therapeutics to respiratory care
 - a. Medical gas therapy
 - b. Humidity therapy
 - c. Hyperinflation therapy
 - d. Aerosol therapy
 - e. Artificial airway insertion, management and care
 - f. Airway clearance
 - g. Invasive and non-invasive mechanical ventilation
- D. Implementation of ventilator support
 - a. Invasive
 - b. Non-invasive
- E. Assist and/or perform endotracheal intubation
- F. Administration of aerosol medication
 - a. Metered dose inhalers
 - b. Large and small volume nebulizers
- G. Assistance with bronchoscopies
- H. Collection of Sputum Samples for processing by the Laboratory
- I. Pulmonary function testing
 - a. Peak Flows
 - b. Pulmonary Function Test
 - c. Bedside Spirometry
- J. Documentation of oxygen saturation by non-invasive pulse oximetry
- K. Assistance during placement, replacement, downsizing or removal of tracheostomy tubes
- L. Administration of surfactant
- M. Assessment of therapies
- N. Provision of emergency, acute, critical, and post-acute care, including
 - a. Patient and environmental assessment
 - b. Therapeutic interventions
 - c. Patient transports
- O. Disease management of acute and chronic diseases
- P. The following services are available (management should be notified to ensure services):

1. ~~Operation of nitric oxide~~
2. ~~Operation of Flo-lan~~
3. ~~Operation of Heliox~~
4. ~~Assistance with ventilator in surgical suite~~
5. ~~Out-of-facility ventilator transports~~

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

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

a. ~~Arterial Blood Gases~~

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

b. ~~Venous Blood Gases~~

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

c. ~~Mixed Venous Blood~~

1. ~~PO₂~~
2. ~~Hgb~~
3. ~~Oxygen Hemoglobin~~

R. ~~Patients across the age spectrum- neonatal through geriatric~~

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

3. ~~Availability of Services:~~

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

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

1. ~~Complete Pulmonary Function Test~~

a. ~~Available by appointment only~~

- ~~b. Contact scheduling desk to arrange an appointment~~
- ~~2. Chronic Obstructive Pulmonary Disease (COPD) assessments and consultation~~
- ~~3. Smoking cessation consultations~~

Medical Consultation Services

- 1. Medical consultation by the Medical Director, including:
 - 1. Inpatient care management
 - 2. Bronchoscopy support
 - 3. Interpretation of Pulmonary Function Tests (PFTs)
- 2. Consultation provided by the Licensed Practitioner directly responsible for patient care

Therapeutic and Clinical Services

The Respiratory Care Department provides, but is not limited to, the following services as ordered by an LP:

- 1. Patient Assessment
 - 1. Patient assessment and reassessment
 - 2. Physical examination
 - 3. Interpretation of diagnostic data
 - 4. Development and modification of respiratory care plans
 - 5. Documentation of care provided
- 2. Patient Education
 - 1. Education and instruction on respiratory conditions and therapies
 - 2. Device use (e.g., inhalers, home equipment)
- 3. Respiratory Therapeutics
 - 1. Medical gas therapy (oxygen, heliox, nitric oxide)
 - 2. Humidity and aerosol therapy
 - 3. Hyperinflation therapy
 - 4. Airway clearance techniques
- 4. Airway Management
 - 1. Endotracheal intubation (assist and/or perform per scope)
 - 2. Artificial airway insertion assistance
 - a. Esophageal-Tracheal Tube
 - b. Endotracheal Tube
 - c. Laryngeal Mask Airway

- 3. Bag-Mask Ventilation
- 4. Airway maintenance and suctioning
- 5. Tracheostomy care, including:
 - a. Placement assistance
 - b. Downsizing support
 - c. Decannulation support
 - d. Speaking Valve assistance
- 5. Mechanical Ventilation
 - 1. Initiation, management, and monitoring of:
 - a. Invasive mechanical ventilation
 - b. Non-invasive ventilation (BiPAP/CPAP)
 - 2. Ventilator management during:
 - a. Routine care
 - b. Emergency response
 - c. Patient transport (intra- and inter-facility)
- 6. Medication Administration
 - 1. Aerosolized medications via:
 - a. Metered Dose Inhalers (MDIs)
 - b. Small and Large Volume Nebulizers
 - c. Continuous administration
 - 2. Administration of specialty medications:
 - a. Surfactant
 - b. Flolan (Epoprostenol)
 - c. Nitric Oxide
 - d. Tranexamic Acid
- 7. Procedural Support
 - 1. Assistance with bronchoscopies
 - 2. Support in surgical suite for ventilator management
 - 3. Mini Bronchoalveolar Lavage (Mini BAL) collection for microbiological and diagnostic analysis
 - 4. Sputum Induction
 - 5. Arterial Blood Gas Collection
 - a. Puncture
 - b. Arterial line blood draw

Diagnostic Services

1. Pulmonary Function Testing
 1. Complete Pulmonary Function Testing (PFT) – by appointment
 2. Bedside spirometry
 3. Peak expiratory flow measurements
2. Laboratory Diagnostics
 1. Arterial Blood Gases (ABG)
 - a. pH
 - PaCO₂
 - PaO₂
 - HCO₃
 - Base Excess
 - Lactate
 - Electrolytes
 - Glucose
 - Hemoglobin
 2. Venous Blood Gases (VBG)
 - a. pH, PCO₂, PO₂
 - HCO₃, Base Excess
 - Lactate
 - Electrolytes
 - Glucose
 - Hemoglobin
 3. Mixed Venous Samples
 - a. PO₂
 - Hemoglobin
 - Oxygen saturation
 4. Lactate
 5. Umbilical Cord Gas
3. Monitoring
 1. Pulse oximetry (non-invasive oxygen saturation monitoring)
4. Specimen Collection
 1. Sputum collection for laboratory analysis

Specialized and High-Acuity Services

Requires notification of Respiratory Care leadership/management

1. Nitric Oxide therapy
2. Flolan (Epoprostenol) administration

3. [Heliox therapy](#)
4. [Ventilator management in surgical suite](#)
5. [Endobronchial Ultrasound \(EBUS\)](#)
6. [Outpatient Bronchoscopy](#)
7. [Out-of-facility ventilator transports](#)

Emergency and Critical Care Services

1. [Participation in emergency response \(Code Blue, Rapid Response\)](#)
2. [Management of critically ill patients](#)
3. [Support during patient transport](#)
4. [Acute and chronic disease management \(e.g., COPD\)](#)

Population Served

- : [Neonatal](#)
- : [Pediatric](#)
- : [Adult](#)
- : [Geriatric](#)

Performance Improvement & Safety

1. [Participation in departmental and hospital-wide Performance Improvement \(PI\) initiatives](#)
2. [Compliance with infection control, safety, and regulatory standards](#)
3. [Participation in Emergency Preparedness activities](#)

AVAILABILITY OF SERVICES

1. [**Critical Care Services:** Available 24 hours/day, 7 days/week](#)
2. [**Non-Critical Services:** Available during day shift hours](#)
3. [**Pulmonary Function Testing:** By appointment only \(via scheduling department\)](#)

ADDITIONAL PROGRAMS

- A. [Chronic Obstructive Pulmonary Disease \(COPD\) assessment and management](#)
- B. [Smoking cessation counseling and education](#)
- C. [Cystic Fibrosis Clinic](#)
- D. [Resident Training](#)
- E. [Nurse Education](#)

All Revision Dates

3/30/2026, 4/3/2024, 11/10/2020, 7/1/2015, 1/1/2014, 2/1/2012, 2/1/2010

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/30/2026
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	3/30/2026

COPY



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Next Review 3/26/2028

Owner Gayle Haider:
Supervisor-
Quality Assurance,
Laboratory Services

Policy Area Laboratory Services

References GEN.41307,
GEN.41310,
GEN.41312

L.25 Corrected Laboratory Results

POLICY:

It is the policy of the Ventura County Medical Center/Santa Paula Hospital Laboratory to have an established system of handling patient testing information when revisions are made to the original report. Revision means reports that contain any changes to patient results, accompanying reference intervals and interpretations, or patient identifiers, but not minor typographical errors that are of no clinical consequence.

Report Errors:

When errors are detected in patient test reports, the laboratory promptly notifies responsible clinical personnel or referring laboratory as applicable and issues a corrected report.

NOTE: Notification should include the department of health or other legal entity as required by local regulations.

Corrected Report:

All corrected reports of previously reported, incorrect patient results are identified as corrected, and both the corrected and original data are clearly identified as such.

Clinical decisions or actions may have been based on the previous report, it is important to replicate previous information (test results, interpretations, reference intervals) for comparison with the corrected information. The previous information and the corrected information must be identified as such, and the

original data must be present in the corrected report (for paper reports), or linked electronically or logically to the corrected information (in electronic reports).

This requirement applies to electronic reports in the laboratory information system and to the data systems interfaced to the laboratory information system either directly or through middleware or an interface engine (but not to systems that are further downstream in the interface chain).

Displays in an electronic medical record (EMR) downstream from the laboratory should include the original report as well as the corrected report. The correction should add explanatory language if an explanation would be helpful to the user. For example, a comment about transport or sample storage conditions uncovered post-analysis can help frame an original, invalid result.

Multiple Corrections:

When there are multiple sequential corrections of a single test result, all corrections are referenced in sequential order on subsequent reports. When there are multiple sequential corrections of a previously reported result, it is considered inappropriate to note only the last correction made, as the clinician may have made a clinical decision based upon erroneous data rather than the "true" result. All corrections should be referenced in the patient report.

PROCEDURE:

1. All corrected reports must be communicated by TigerText or phoned to licensed staff (physician, physician's office, or the nurse) by a Clinical Laboratory Scientist (CLS). These text messages or calls must be documented in the Hospital LIS system (see step #2).
NOTE: If the Clinic is closed, then do not call unless the correct result is a Critical Value or Critical Test.
2. Entering a Corrected Result in the Laboratory Information System (LIS):
 - a. In Cerner Accession Results Entry, choose the "Corrected" option. Select the result to be corrected and enter the corrected result.
 - b. Right click on the result and select "Comment." Use the "LCALL" comment and document who was notified of the corrected result, along with the date and time.
 - c. Once the comment is entered, close the comment box.
 - d. Verify the results.
3. The Laboratory Information System documents changes in the following manner:
 - a. The LIS automatically flags corrected results on the patient's report as corrected.
 - b. The LIS provides a verified result history which includes the date and time of the specimen order, collection, log in as received in the Laboratory and person/s performing each activity.

All Revision Dates

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	Gayle Haider: Supervisor- Quality Assurance, Laboratory Services	3/24/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/18/2026

COPY



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Owner Yewubdar Argaw:
Supervisor-
Chemistry,
Laboratory
Services

Policy Area Laboratory
Services -
Chemistry

L.CHEM 3.6 Neonatal Urine Drug Screen

Policy

Neonatal Urine Drug Screen ([Chain-of-Custody](#))

Principle

Neonatal Urine Drug Screens are run on the Siemens Dimension VISTA. This system provides reagents for determining the qualitative presence of Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Opiates, PCP, and THC. These methods provide only a preliminary result. All positive results are sent to the NIDA Laboratory at Quest Laboratories for confirmation by GCMS.

Specimen Collection and Handling

A minimum of 10 mL of urine is required, which allows for the screening of the above drugs and confirmation of one (1) positive. It is advised that as much urine as possible be collected on the first void, as subsequent voids may produce different results and more than one positive drug requires additional specimen for each confirmation.

Reagents

Refer to individual assay procedure manuals for detailed information.

CALIBRATION:

The Urine Drugs of Abuse assays use a single level multi-analyte calibrator. The calibration results for each assay are normalized to provide a reference value of 1000. See the Dimension VISTA Operator's Manual for details.

QUALITY CONTROL:

Positive and Negative Urine Toxicology Controls are run, once each day of use.

Procedure

Specimen Collection (Nursing Personnel)

1. A urine drug screen is ordered in Laboratory Information System and the specimen is collected by nursing personnel. Place the specimen in a tamper-proof container labeled with the patient's name, chart number, and date and time of collection.
2. Obtain a security tape, peel off the tape backing and place over the top of the urine container.
3. Complete the Internal Chain of Custody form. Fill out all information in Section 1 & 2. The collector (nursing) must sign Section 3 Part A, on the "Released By" line when the specimen is turned over to transport or to the party delivering the specimen to the laboratory. The collector must also make sure that the person who received the specimen signs the "Received By" line at that time. The Internal Chain of Custody form must accompany the specimen.
4. Deliver the specimen and the Chain of Custody form to the Chemistry Laboratory immediately. Hand the specimen directly to a Clinical Laboratory Scientist. The CLS must then have the person delivering the specimen sign Section 3 Part B on the "Released" by line and the CLS must sign the "Received By" line on the Chain of Custody form.

Laboratory Specimen Processing (Clinical Laboratory Scientist)

1. Verify that the Urine drug screen has been ordered into the Laboratory Information System. If the specimen has not yet been entered in the computer, contact the unit submitting the specimen, and have them enter it ASAP. Make sure that the specimen has a minimum volume of 10ml to be acceptable and must be in a tape sealed tamper proof container with patient's information, date and time of collection and collector's name. Complete section 4 of the Internal Chain of Custody form.
2. **If the specimen does not meet the criteria for acceptability.** List reasons on form (Sec.4) and call Nursery and notify them of unacceptability. Document name of the person, date and time notified on the form. ***The drug screen can be run as non-medicolegal specimen if ordered or requested by the Nurse or Clinician and report results with a comment not a chain of custody specimen.*** Minimum volume for a non-medicolegal urine drug screen is 7ml. If a result is positive, then the specimen must be sent out for GCMS confirmation. ***Use a regular send out requisition instead of chain of custody requisition.***
3. **If the specimen is acceptable** remove the tape seal from the specimen container and removes a 0.5 mL aliquot, centrifuge in a labeled tube and run a drug screen on the Siemens Dimension Vista. See the Vista Operator's Manual for detail on processing specimens on Vista Analyzers.
4. Record patient and QC result. QC must be run once per 24 hours.
5. Complete the Certifying Review Document and if all conditions are met, results may be entered into the Laboratory Information System according to the following options.

If the drug, screen is NEGATIVE:

- Enter the results into the computer and verify.
- Attach the Vista result printout, QC result and the Internal Chain of Custody form to the Certifying Review Document.
- Place in the Supervisor's desk for review and documents should be filed in the Neonatal drug screen file.

If the drug screen is POSITIVE:

- Enter only the negative drug results into the computer and verify
- Enter: Result "**Preliminary Positive**" and Add comment "**Pending GCMS Confirmation**" for the drug or drugs that were positive.
- Fill out Section 5 on the Internal Chain of Custody form.
- Reseal the specimen with new pre-labeled security tape.
- Order Quest "**SO Misc-GL**" (Sendout Miscellaneous General- lab) in the computer for each drug that tested positive.
- Fill out a Quest's [external](#) Chain of Custody Requisition
- Attach a photocopy of the Internal Chain of Custody form to the Quest Chain of Custody requisition to be sent with specimen to Quest.
- Request GCMS Confirmation for drugs that tested positive on screen and prepare specimen for send out.
- Attach *collector's copy of Quest requisition*, the Vista result printout, QC/Cal printout and the original copy of the Internal Chain of Custody form to the Certifying Review Document and place in the Chemistry Supervisor's desk for review. The documents will be stored and locked for safekeeping.
- When GCMS Confirmation results come back attach a copy to the previous paperwork in the Drug Screen file and complete the appropriate section on the Certifying Review Document for confirmation.
- Enter the final result in the computer: "PGC" Positive with GCMS CONFIRMATION or LPGC - Found to be Negative after GCMS Confirmation. Remove the Pending confirmation comment originally entered.

Specimen Storage

If the drug screen is NEGATIVE: the remaining urine specimen in the original collection container will be stored in freezer for a year.

If the drug screen is POSITIVE: the remaining urine specimen in the original container will be resealed with tamper proof seal and sent to Quest for GCMS confirmation. Appropriately labeled aliquots will be maintained in freezer for a year.

Record Keeping

The chain of custody collection records, security logs, and testing records are retained for at least five years in a limited-access, secured area that is only accessible to authorized laboratory personnel.

References

Quest - Nichols Clinical Laboratories of Custody Collection-Submission Procedures. Publication

DADC Dimension RXE Operator's Guide. f997. Dade International- al. PN: 7731904.9117

[CAP Lab General Checklist: GEN. 40502, GEN. 40503, GEN. 40504, GEN. 40506, GEN. 40507 and GEN. 40509](#)

All Revision Dates

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Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/2/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	2/28/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	2/26/2026
Laboratory Services Department	Yewubdar Argaw: Supervisor- Chemistry, Laboratory Services	2/26/2026



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Next Review 3/26/2028

Owner Christian
Press:
Supervisor-
LIS,
Laboratory
Services

Policy Area Laboratory
Services -
Lab
Information
Systems

References GEN.43150,
GEN.43200,
GEN.43262
+ 3 more

L.LIS.01 Protected Systems User Authentication, Access Control, and Data Security Policy

PRINCIPLE:

The purpose of this document is to provide information about security measures on the Laboratory information System (LIS). This involves who may access the computer system, how the access is obtained, and how the security of access is maintained. This document also provides information on the security maintenance of the LIS . When dealing with the computerized health care records, specific confidentiality and security issues must be followed to protect the patient. ~~There are also increasing Health insurance Portability and Accountability Act (Compliance with HIPAA) and Joint commission that dictate how these records are handled~~ Commission standards is required to ensure confidentiality, integrity, and security of patient information.

POLICY:

Personnel follow explicit written policies that define who may access the system, how access is obtained, and how security is maintained. Violations of access or security policies may result in disciplinary action. Accounts are deactivated when personnel leave the organization, and employee account user names and passwords are not posted on terminals. Violations of access or security

[policies may result in disciplinary action.](#)

Mechanisms for Security and Data Protection

1. User Authorization Privileges

A. Passwords

Laboratory staff are assigned passwords in order to log into Cerner PathNet. Passwords are managed by the IT Service Desk at **805-677-5119**.

Passwords requirements:

- 7-14 characters in length AND
- At least one number AND
- At least one special character AND
- At least one uppercase letter AND
- At least one lowercase letter AND
- Common people names are blacklisted and will therefore likely show as invalid passwords.

The employees are not to tell anyone their password or post them on computer terminals. The system also requires employees to change their passwords at regular intervals. If employee forgets their password or gets lock out, they may call the Help desk at (805) 677-5119 option 1 to reset their password.

B. User access

Access to the computer system in the laboratory for a new employee is obtained through the Help desk services. All employees will obtain access to the computer terminals in the laboratory, Cerner PathNet General lab, the Ventura County email portal, and Oracle Peoplesoft. Not every employee will be allowed to see or perform every activity on the computer. Table 1 below list the user access levels in the laboratory.

Employee user rights is limited to only the level needed to execute assigned responsibilities. Other departments in the hospital for example, such as pharmacy or the emergency department do not have direct access to the LIS and are not permitted to view or alter programs within the LIS. They may view patient results in PowerChart. Access is maintained by discouraging employees to post their personal passwords on their computer terminals. The system keeps an audit trail of the person who enters the chart and when they have entered the chart. When an employee resigns, their computer access is immediately inactivated.

Table 1 User access information

User	Able to view patient's charts and log in specimens	Able to result and correct patient results	Able to view laboratory data reporting and statistics

Medical-office assistant/ CPT I/II	Yes	No	No
Certified Phlebotomy Technician I/II	Yes	No	No
AP Transcriptionist	Yes	Yes	No
Histologists /Histotechnician	Yes	No	No
Certified Phlebotomy Technician III	Yes	No	No
Clinical Lab Scientist I/II and Medical Lab Technician	Yes	Yes	No
Clinical Lab Scientist III	Yes	Yes	Yes
Pathologists	Yes	Yes	No
Laboratory Director	Yes	Yes	Yes

2. Computer Training

1. User Authorization and Privileges

A. Passwords:

Laboratory staff are assigned passwords in order to log into Cerner. Passwords are managed by the IT Service Desk at 805-677-5119.

B. Passwords requirements:

- : 7-14 characters in length AND
- : At least one number AND
- : At least one special character AND
- : At least one uppercase letter AND
- : At least one lowercase letter AND
- : Common people names are blacklisted and will therefore likely show as invalid passwords.

The employees are not to tell anyone their password or post them on computer terminals. User authentication is unique to each individual and shared accounts are prohibited. The system also requires employees to change their passwords at regular intervals. Accounts are locked after 3 failed login attempts. If employee forgets their password or gets lock out, they may call the Help desk at (805) 677-5119 option 1 to reset their password.

C. User access

Access to the computer system in the laboratory for a new employee is obtained through the Help desk services. All employees will obtain access to the computer terminals in the laboratory, Cerner PathNet General lab, the Ventura County email portal, and Oracle Peoplesoft. Not every employee will be allowed to see or perform every activity on the computer. Table 1 below list the user access levels in the laboratory.

Employee user rights is limited to only the level needed to execute assigned responsibilities. Other departments in the hospital for example, such as pharmacy or the emergency department do not have direct access to the LIS and are not permitted to view or alter programs within the LIS. They may view patient results in PowerChart. Access is maintained by discouraging employees to post their personal passwords on their computer terminals. The system keeps an audit trail of the person who enters the chart and when they have entered the chart. Audit logs are monitored by Ventura IT Security for inappropriate access or activity. When an employee resigns, their computer access is immediately inactivated.

Table 1 User access information

<u>User</u>	<u>Able to view patient's charts and log in specimens</u>	<u>Able to result and correct patient results</u>	<u>Able to view laboratory data reporting and statistics</u>
<u>Medical office assistant/CPT I/II</u>	<u>Yes</u>	<u>No</u>	<u>No</u>
<u>Certified Phlebotomy Technician I/II</u>	<u>Yes</u>	<u>No</u>	<u>No</u>
<u>AP Transcriptionist</u>	<u>Yes</u>	<u>Yes</u>	<u>No</u>
<u>Histologists /Histotechnician</u>	<u>Yes</u>	<u>No</u>	<u>No</u>
<u>Certified Phlebotomy Technician III</u>	<u>Yes</u>	<u>No</u>	<u>No</u>
<u>Clinical Lab Scientist I/II and Medical Lab Technician</u>	<u>Yes</u>	<u>Yes</u>	<u>No</u>
<u>Clinical Lab Scientist III</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
<u>Pathologists</u>	<u>Yes</u>	<u>Yes</u>	<u>No</u>
<u>Laboratory Director</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>

2. Computer Training

Each **lab-department** section supervisor of the laboratory is responsible for the training of employees on how to use Cerner and to protect patient information. Training is department specific and signed off by a

CLS II or CLS III before ~~performing~~ staff perform the duties without observation. Training and competency are documented and maintained per laboratory policy.

~~3. Unauthorized Software Installation~~

~~Employees are restricted from installing software to instruments and computers in the laboratory in order to prevent malware and computer viruses. Installation is monitored by the Information Technology Department and is installation requires administrative access by the Information Technology Department.~~

~~4. Public Network Security~~

3. Unauthorized Software Installation

Installation is controlled by the Ventura County Information Technology Department and installation requires administrative access by authorized Information Technology Department Specialists. Unauthorized employees are restricted from installing software to instruments and computers in the laboratory in order to prevent malware and computer viruses. Periodic audits may be performed by IT Security to ensure no unauthorized software is present.

4. Public Network Security

~~The~~ There are network security measures to ensure confidentiality of patient/client data sent over the public networks. Emails are encrypted when recipients are within the organization. Messages containing Protected Health Information are encrypted with the addition of #SECURE# to the Subject Line when recipient emails are outside of the organization. PHI sent by methods other than email are send via an encrypted portal (eg. CDPH Newborn Screens, Quest Quantum). The Ventura County Information Technology department is responsible for installing firewalls, anti-virus software, and data encryption schemes for every computer terminal. Employees have access to OneDrive that is located in the app bar when they log into their email. OneDrive is ~~aan approved secure storage solution configured to meet HIPAA compliant cloud storage software where employees can save and share files with other hospital employees~~ requirements by the Information Technology Department. OneDrive is protected by data encryption schemes that are maintained by the Information Technology department.

~~5. Email and Tigertexting~~

5. Email and Tigertexting

Employees are instructed to use #secure# in the subject line if the email contains sensitive patient information. Employees are also discouraged to open email or click on links from unknown sources. Employees are able to use Tigertexting as method of communicating patient information. Transmission of protected health information through unapproved communication methods is prohibited. TigerConnect app is a cloud-based clinical communication and collaboration tool that was developed for the enterprise market. It allows patient information and other secure messages to be sent HIPAA compliantly. ~~The app claims users cannot save~~ TigerConnect is configured to support secure, copy or forward the messages because TigerText stores the HIPAA compliant communication, including message on a company server, not the receiving and sending device, and deletes when the expiration

~~conditions are met~~ encryption and controlled message retention.

REFERENCE(S):

6. Data Preservation and Destructive Event Procedures

The laboratory maintains written procedures for preservation of LIS and analyzer data in the event of fire, flood, malicious activity, cyberattack, software failure, hardware failure, or power interruption, including complete loss of electrical power affecting LIS availability.

These procedures:

- : Allow timely restoration of service and verification of data integrity in compliance with CAP GEN.43946.
- : Address protection of the physical environment, including LIS servers, analyzers, and associated laboratory equipment.
- : Include steps to limit the extent of the destructive event, including system isolation, shutdown protocols, and coordination with Information Technology security.

A. Analyzer Data Backup Responsibility and Frequency

Each laboratory section is responsible for backing up data from all analyzers within their section. Paper test analysis data shall be stored in a binder or other appropriate test analysis storage location and are retained according to the requirements of the record retention policy. Electronic test analysis data shall be backed up to secure, laboratory approved data storage drives at a minimum frequency of once per month. Backups must be performed monthly. Each section Supervisor is responsible for ensuring the backup is completed for their respective sections. Flash drives shall be stored in a secure, access controlled location within the laboratory and must not be removed from the facility unless authorized by Laboratory Administration until the record retention period has elapsed.

B. LIS System Backups

The Information Technology Department performs routine automated backups of LIS programs and patient data. Backup systems include daily incremental backups and scheduled full backups. Backup data are stored onsite and at secure off site locations. Backup systems include protections against corruption and unauthorized modification. Backup systems are periodically validated by Informatics and IT to ensure data recoverability.

C. Data Restoration and Integrity Verification

Restoration procedures are coordinated between Laboratory Administration and Information Technology. Restored data must undergo integrity verification to ensure completeness and accuracy. Patient demographics, results, audit trails, and reporting functions must be validated after restoration.

D. Downtime and Interruption Procedures

Procedures address both scheduled and unscheduled interruptions. Paper requisitions and

manual result documentation shall be used during downtime. All downtime entries must be reconciled in the LIS once functionality is restored. Downtime procedures are periodically reviewed and tested.

E. Review and Reevaluation

Data preservation procedures are reviewed annually. Any changes to hardware, software, middleware, or analyzer interfaces require reevaluation of backup and recovery procedures. Testing of recovery procedures is performed periodically and results are documented.

These procedures are aligned with the Ventura County Medical Center disaster recovery and emergency operations plan.

REFERENCES:

- A. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.43150 *User Authentication*. 2020 (Jun 4) page 60.
- B. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.43200 *User Authorization Privileges* 2020 (Jun 4) page 61.
- C. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.43262 *Unauthorized Software Installation*. 2020 (Jun 4) page 61.
- D. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.43150 *User Authentication*. 2020 (Jun 4) page 60.
- E. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.43325 *Public Network Safety*. 2020 (Jun 4) page 60.

All Revision Dates

3/27/2026, 2/9/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/18/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	3/18/2026

References

GEN.43150, GEN.43200, GEN.43262, GEN.43325, GEN.43450, GEN.43946

COPY



Origination 3/2/2026
Last Approved 3/27/2026
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Last Revised 3/27/2026
Next Review 3/26/2028

Owner Christian Press:
Supervisor- LIS,
Laboratory Services
Policy Area Laboratory Services - Lab Information Systems
References GEN.43150, GEN.43200

L.LIS.04 User Authentication, User Authorization Privileges, Unauthorized Software Installation, and Intake Procedure

PRINCIPLE:

This document fulfills CAP ~~guideline~~guidelines GEN.43150 and GEN.43200 by defining who may access computer systems, how access is obtained, ~~and~~ how security is maintained, and how unauthorized software installation is controlled. This policy defines authorized users for any computer, laboratory information system application, or analyzer system at Ventura County Medical Center and Santa Paula Hospital Laboratories ~~in accordance with CAP guidelines GEN.43150 and GEN.43200.~~

Access privileges are restricted by job role within individual applications in Cerner Millennium and other laboratory systems, limiting user access to only those functions necessary to perform assigned responsibilities. ~~There are no data centers located on site, as all systems are hosted by the LIS vendor, and laboratory staff are not permitted~~User access to the servers hosting the LIS is granted according to the principle of least privilege and is reviewed periodically to ensure appropriateness for current job responsibilities.

This policy also provides instructions for obtaining new user access to computers, Cerner Millennium, and other required applications. ~~Application~~User authentication is unique to each individual, shared accounts are prohibited, and application assignments may be modified with Laboratory Director approval, ~~and access.~~ Access requests are submitted through the Help Desk at **(805) 677 5119**.

POLICY:

User Access Issuance

Employees of the Ventura County Medical Center and Santa Paula Hospital Laboratory Departments receive computer and network access upon hire or after an internal transfer. HCA IT Security assigns unique **usernames** **user names** and passwords for approved computers and the secured Ventura County network. Accounts are deactivated when personnel leave the organization or no longer require access.

- **Accounts lock after five failed login attempts.**
- **Passwords must be changed periodically and must meet current complexity requirements.**
- **For password rule updates, contact the Help Desk at (805) 677 5119.**

Access Governance

Control of the following is managed by IT, Informatics, or the LIS vendor, not the Laboratory Department:

- **Physical entry to data centers housing the LIS**
- **Access to server operating systems hosting the LIS**
- **Access to software systems that comprise the LIS**

Laboratory leadership coordinates with Information Technology and Informatics to ensure access is appropriate, approved, and compliant with CAP requirements. User access is reviewed periodically and adjusted when job duties change.

Application Access by Role

The following positions receive access to Cerner Millennium, Microsoft Office, and any other systems required for their job duties:

- **Laboratory Medical Director**
- **Laboratory Director**
- **Assistant Laboratory Director**
- **Pathologist (Not a position managed by the laboratory staff)**
- **Pathologist Assistant**
- **Clinical Laboratory Scientist**
- **Medical Laboratory Technician**
- **Histology Technician**
- **Histologist**
- **Certified Phlebotomy Technician**
- **Medical Office Assistant**
- **Pathology Transcriptionist**

Assignment of application access is based on job role, training, competency, and operational need. Not all users receive the same functionality within the same application.

Password and Workstation Security

- ~~A. Password sharing is prohibited except during true emergencies. In those situations:~~
- ~~▪ Assay results must include an internal note identifying the actually performing user, or~~
 - ~~▪ A signed analyzer printout must include the performing user's initials, time, and date.~~
- ~~B. All staff must log out or secure their workstations whenever they step away from direct view, including during:~~
- ~~▪ Assay results must include an internal note identifying the performing user, or~~
 - ~~▪ A signed analyzer printout must include the performing user's initials, time, and date.~~

Password sharing is prohibited. Users shall not disclose passwords, post passwords at workstations, or use another individual's credentials to access laboratory systems.

If delayed documentation becomes necessary during urgent operations, the work performed must remain traceable to the actual performing user through appropriate documentation, such as:

- Assay results that include an internal note identifying the performing user, or
- A signed analyzer printout that includes the performing user's initials, date, and time, when applicable.

All staff must log out of or secure their workstations whenever they step away from direct view. Workstations shall not be left open and unattended in a manner that allows unauthorized viewing or access to patient information. Workstations automatically lock after 10 minutes of inactivity.

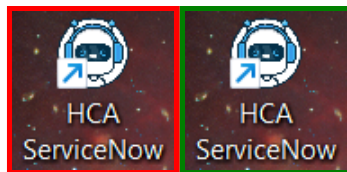
New Account Creation

To request a new account with access to Windows, Microsoft Office, and Cerner Millennium, follow the instructions outlined below.

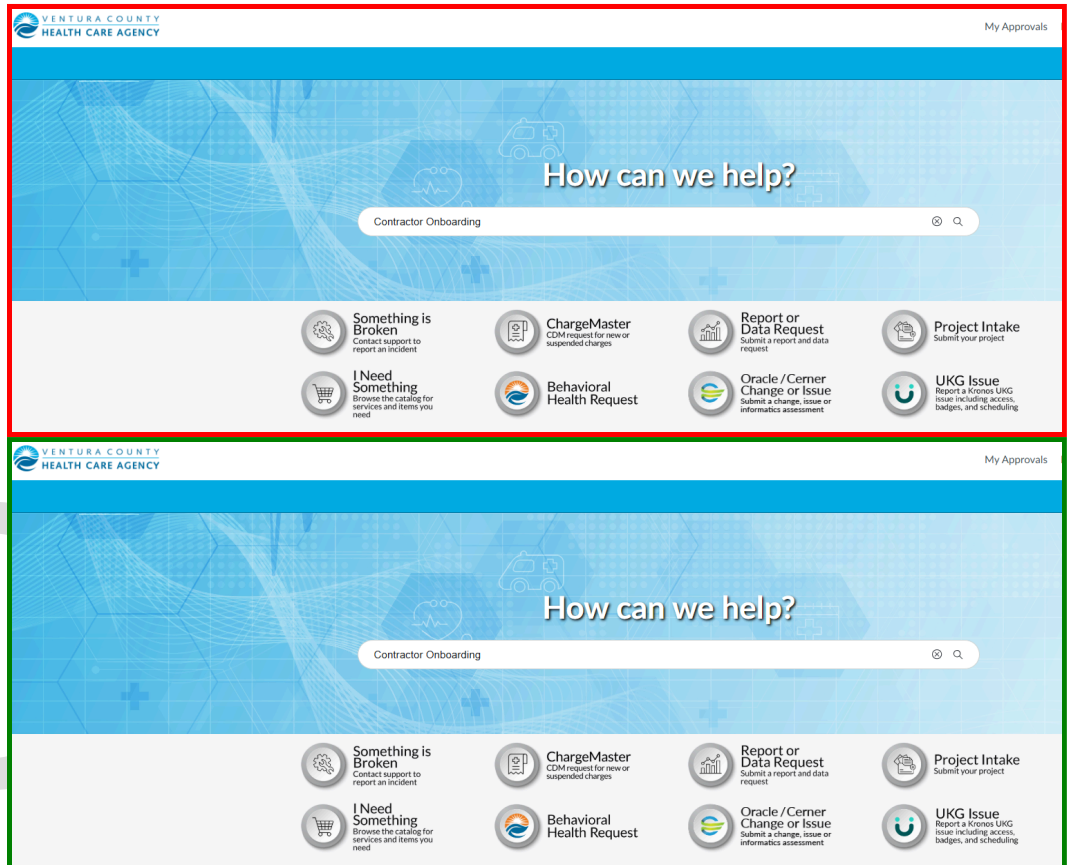
New hires at VCMC and SPH follow a standardized intake process that provides consistent onboarding and ensures they receive foundational training on employee resources, laboratory operations, the laboratory information system, analyzers, and middleware technologies used at VCMC and SPH.

Over time, applications may be added to users' roles depending based on the operational need and users' ability to perform, training, competency, and approval for additional duties. Below is a general outline of applications for each main job classification in Cerner Cerner. All access additions or changes must be approved and documented through the appropriate workflow.

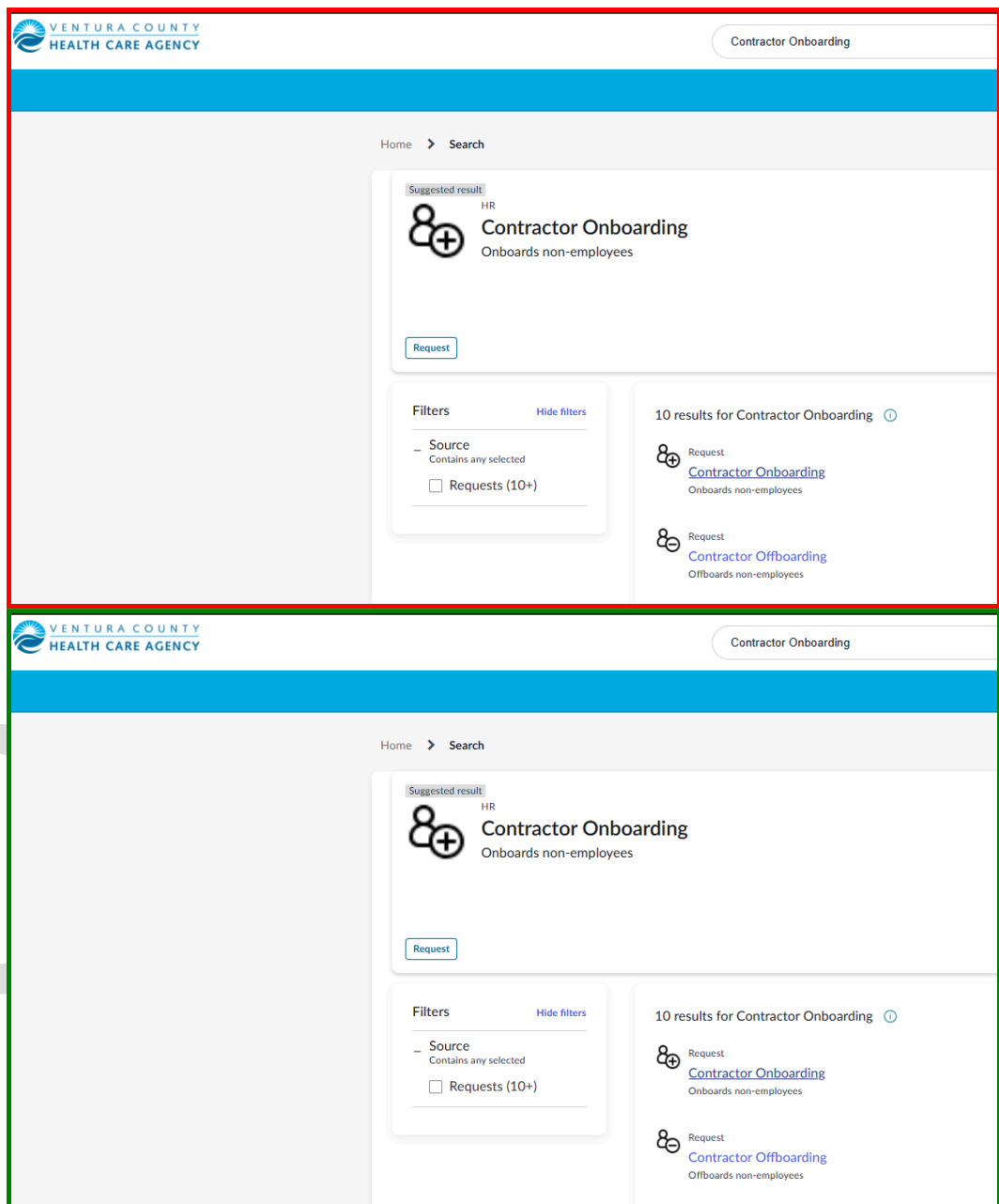
- A. The Laboratory Director, Assistant Laboratory Director, or other manager in charge of hiring will notify the appropriate party of the **starting start** date of any new hire **at least one week prior to starting start date**. Two weeks' notice or more is ideal.
- B. **Contractor Accounts:** Upon notification, the party in charge of ordering an account creation will create an account using the account creation order form on the HCA ServiceNow Portal:
<https://vchca.service-now.com/esc>



1. From the main ServiceNow Portal page type: “Contractor Onboarding” into the search bar.



2. Click on/offboarding and complete the form.



- C. **Employee Orientation** - After the employee arrives for ~~their~~^{the} first day of work. ~~The laboratory director or their, the Laboratory Director or~~ designee will ~~be assigned to give the new hire~~^{provide or arrange} a tour of the hospital and laboratory. ~~Ensure to point all the criteria~~^{The orientation shall include the elements required} for a proper safety orientation. ~~Including safety~~^{Safety} features ~~in reviewed during~~^{like all} shall include eye wash stations, fire alarms, fire extinguishers, emergency exits, and information regarding ~~the “commonly announced emergency codes” that are frequently announced.~~
- D. The next phase of the staff members' training will be either **Laboratory Information System (LIS) Training** or **Policy and Procedure Review** to increase their base knowledge prior to starting. Regardless of which training phase is completed first, both are required training phases before the staff can treat patients.

- E. **LIS Training** ~~must~~ **Must** be coordinated 2 weeks prior to the desired date. The training is completed by the Informatics Department and appointments can be created by emailing the Help Desk at HCA.Helpdesk@ventura.org. **The following two points shall be considered. The length of training will vary depending on whether the new hire has prior experience with Cerner.**

The new hire will be signed off for the Cerner applications relevant to the position and will attest to the required knowledge. The following two points shall be considered. The length of training will vary depending on whether the new hire has prior experience with Cerner. New hire will be signed off and attest to their knowledge with Cerner applications relevant to their position.

- F. **Policy and Procedure Review** takes place in front of the Laboratory Director's Office, or at the new hire's desk/office if they are assigned one. The full review should take no more than ~~1-3~~ **1 to 3** days depending on the new hire's experience with VCMC and SPH.
- G. If the new hire is for SPH, the policies and procedures specific to SPH are present in the Pathology Office at SPH Laboratory and/or on PolicyStat. However, the VCMC policies and procedures will apply when SPH must send samples to VCMC, so it is important to be familiar with both.
- H. The employee may now proceed to assigned training rotations respective to their job position.

Assignment of Applications

Laboratory staff may ~~be responsible for a robust~~ **require working** knowledge ~~in many of multiple~~ **Cerner Applications** ~~applications~~. Depending on the needs of the hospital, staff can take on new applications as needed. Therefore, ~~all positions may require~~ **be assigned** the following applications ~~and more, as applicable to job duties and operational need:~~

Below is a general outline of applications that may be assigned for each main job classification in Cerner.

Certified Phlebotomy Technician I/II/III
Collection List
Collections Inquiry
Container Inquiry
Department Order Entry
Label Reprint
Modify Collections
Order Result Viewer
Pending Inquiry
PowerChart
Specimen Log-In
Storage Tracking
Transfer Specimens
AP Transcriptionist/Histotechnician/Histologist
Collection List
Collections Inquiry

Container Inquiry
Department Order Entry
Label Reprint
Modify Collections
Order Result Viewer
Pending Inquiry
PowerChart
Specimen Log-In
Storage Tracking
Transfer Specimens
Transcription
Online Review
Case Management
Document Scanning
<u>Medical Laboratory Technician</u>
Accession Result Entry
Batch Result Entry
Charge Viewer
Collection List
Collections Inquiry
Container Inquiry
Daily Reports
Department Order Entry
Explorer Menu
Label Preprint
Label Reprint
Modify Collections
Multiple Accession Result Verification
Order Result Viewer
Pending Inquiry
Point of Care Result Entry
PowerChart
QC Inquiry
Quality Control Result Entry
Report Selection
Specimen Log-In
Storage Tracking

TAT Monitor
Transfer Specimens
Worklist Request
<u>Clinical Laboratory Scientist I/II</u>
Access Management Office
Accession Audit
Accession Result Entry
Batch Result Entry
Charge Viewer
Collection List
Collections Inquiry
Container Inquiry
Correct Inventory
Daily Reports
Department Order Entry
Dispense and Assign Products
Explorer Menu
Final Disposition
Generate Tags and Labels (BB)
Instrument Accession Queue Viewer
Instrument Activity Monitor
Inventory Search
Label PrePrint
Label Reprint
Label Verify
Lot Maintenance
Media Label Reprint
Modify Collections
Modify Crossmatch
Modify Products (BB)
Multiple Accession Result Verification
Order Result Viewer
Patient Product Inquiry
Pending Inquiry
Point of Care Result Entry
PowerChart
Product History Review

QC Inquiry
Quality Control Result Entry
Quarantine Products (BB)
Receive Products (BB)
Release Products
Report Selection
Result Entry Blood Bank
Result Entry Microbiology
Return Products
Specimen Log-In
Storage Tracking
TAT Monitor
Transfer Specimens
Worklist Request
<u>Clinical Laboratory Scientist III</u>
Access Management Office
Accession Audit
Accession Result Entry
Batch Result Entry
Charge Viewer
Collection List
Collections Inquiry
Container Inquiry
Daily Reports
DB Collection Requirements Inquiry
DB QC Maintenance
DB QC Patient Data Monitoring
DB QC Reference Build
DB QC Templates
DB Worklist Build
Department Order Entry
Explorer Menu
Instrument Accession Queue Viewer
Instrument Activity Monitor
Label PrePrint
Label Reprint
Modify Collections

Multiple Accession Result Verification
Order Result Viewer
Pending Inquiry
Point of Care Result Entry
PowerChart
QC Inquiry
Quality Control Result Entry
Report Selection
Specimen Log-In
Storage Tracking
TAT Monitor
Transfer Specimens
Worklist Request
Document Scanning

Plus any other respective department-specific applications available in Cerner

Adding Applications to the Appbar

AppBar -> Customize -> Buttons -> Sort -> View all available apps for department

Click the "A"



-
- Click **Customize** → **Buttons** → Click **Product** to sort the applications by Department.
- View Sorted Applications by department. Note that many applications are shared and will not be in a department specific location. But for a department supervisor, this step will help them ensure that they have all relevant applications at their disposal.
- ~~Click **OK** to save your applications.~~
Click **OK** to save application display changes.

~~**Policy and Procedure Review** takes place in front of the Laboratory Director's Office, or at the new hire's desk/office if they are assigned one. The full review should take no more than 1-3 days depending on the new hire's experience with VCMC and SPH.~~

If the new hire is for SPH, the policies and procedures specific to SPH are present in the Pathology Office at SPH Laboratory and/or on PolicyStat. However, the VCMC policies and procedures will apply when SPH must send samples to VCMC, so it is important to be familiar with both.

The employee may now proceed to assigned training rotations respective to their job position.

Access to laboratory workstations (PCs) and laptop devices is granted only to the following:

- Current authorized Ventura County employees.
- Current authorized Ventura County contracted employees.

Access to laboratory is granted only to the following:

- Current ~~Qualified~~authorized Ventura County employees.
- Current ~~Qualified~~authorized Ventura County contracted employees.
- Individuals or representatives of organizations ~~approved~~authorized by management to enter the laboratory.

Access to laboratory analyzers is granted only to the following:

- Current Qualified Ventura County employees
- Current Qualified Ventura County contracted employees
- Current ~~Qualified~~authorized and qualified Ventura County contracted analyzer vendor technical support personnel, when necessary and approved.

For ~~a~~ detailed application ~~list~~per assignment by job role, the Informatics Department ~~is responsible for~~supports application assignment within Cerner in coordination with management. ~~A request~~Requests for information ~~can~~may be submitted ~~to~~through the Help Desk at (805) ~~677-5119~~677 5119.

All Revision Dates

3/27/2026, 3/2/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/18/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	3/18/2026



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Last Revised 3/27/2026
Next Review 3/26/2028

Owner Christian Press:
Supervisor- LIS,
Laboratory Services

Policy Area Laboratory Services - Lab Information Systems

References GEN.43450

L.LIS.06 Calculated Patient Data Verification

PRINCIPLE:

The purpose of this document is to ~~provide information of using and maintaining~~ define the requirements for verification and periodic review of calculations that use patient results to produce other reported results within the Laboratory Information System (LIS) to perform, middleware, or analyzer calculation logic modifiable by the user. These calculations ~~on various assays that use patient results to produce other reported results. These calculations~~ are reviewed at least every two years, or ~~when~~ whenever a system change is made that may affect the ~~calculations~~ calculation. The template for completing the calculation verification is attached below to this policy.

This requirement applies to user modifiable calculations that generate reported patient results. It does not apply to preset calculations provided by instruments as final results or to routine age or sex stratified reference intervals implemented by the LIS. When calculations are performed by a shared LIS used by multiple laboratories, the review may be completed at one location, provided each affected laboratory has access to the review records. Calculations specific to an individual laboratory's methodology must be reviewed by that laboratory and the record of review must be available.

POLICY:

- ~~1. In order for the LIS to perform calculations on patient results, a help-desk ticket must initially be requested in order for the calculation to be built into the LIS.~~

- ~~2. The initial calculation verification must be tested using all flagging scenarios (e.g., low values, high values) and must perform as expected before use.~~
- ~~3. After the calculation has been validated in non-production and production domains of the LIS, the calculation will be reviewed at least every two years or when a system change is made that may affect the calculation.~~
- ~~4. Documents of the validations will be retained for two years to ensure accuracy of the calculation.~~
- ~~5. The review verification of the calculation can consist of Linear Low/High, Normal, Low/High and Critical Low/High(if applicable) and the manual calculation will be performed to prove the calculation is performed accurately by the LIS. At least one example of either parameter is acceptable for review.~~
- ~~6. If there is a discrepancy, the calculations performed by the LIS will not be accepted and a manual calculation will be performed until resolved. Autoverification will be suspended for that assay and a help desk ticket will be made to resolve the issue.~~

- In order for the LIS to perform calculations on patient results, a help desk ticket must be submitted so that the calculation may be built, modified, or reviewed within the LIS or other applicable system.
- The initial calculation verification must be tested using all flagging scenarios (e.g., low values, high values) and must perform as expected before use.
- After the calculation has been validated in non production and production domains of the LIS, the calculation shall be reviewed at least every two years, or whenever a system change is made that may affect the calculation. System changes may include changes to LIS build, middleware logic, analyzer interfaces, formulas, result mapping, or other calculation related configuration.
- Records of validation and periodic review of calculated test results shall be retained and made available upon request in accordance with laboratory document retention requirements.
- Review verification of the calculation may include representative examples of linear low, linear high, normal, low, high, critical low, and critical high results, as applicable to the assay. Manual calculation shall be performed to verify that the result produced by the LIS matches the expected calculated value. At least one representative example of each applicable parameter category is acceptable for review.
- When a calculation is performed by an LIS shared by multiple laboratories, the review may be completed at one location, provided each laboratory has access to the review records. Any calculation specific to this laboratory's methodology shall be reviewed by this laboratory and the review record shall be available.
- This policy applies to calculations that use patient results to produce other reported results and that are modifiable by the user. This policy does not apply to preset calculations provided by instruments as final reported results or to routine age or sex stratified reference intervals

implemented by the LIS.

- : If a discrepancy is identified, results produced by the LIS calculation shall not be accepted for reporting until the issue is resolved. Manual calculation shall be performed when appropriate until correction is completed. Autoverification for the affected assay shall be suspended when applicable, and a help desk ticket shall be submitted for investigation and resolution.

Assays ~~that currently results~~ calculated by the LIS as of ~~2-8-2026~~ 3-18-2026:

Anion Gap
Cholesterol/High Density Lipoprotein
Cholesterol/High-Density Lipoprotein Ratio
<u>Corrected Calcium</u>
Creatinine Clearance
Estimated Average Glucose
<u>Estimated Glomerular Filtration Rate</u>
24 HR Urine Amylase
Urine Uric Acid
12 HR Urine Creatinine
24 HR Chloride
24 HR Uric Acid Urine
24 HR Urine Calcium
24 HR Urine Creatinine
24 HR Urine Magnesium
24 HR Urine Phosphorous
24 HR Urine Potassium
24 HR Urine Sodium
24 HR Urine Urea
Microalbumin/Creatinine Ratio
Glucose 24H Urine
Iron Saturation
Protein Creatinine Ratio
Protein Urine 24H

Example of Calculated Patient Data Verification Report Format:

Calculated Patient Data Verification

Assay:

Date tested:

Instrument:

Manual calculation formula:

- : Assay:
- : Date tested:
- : Instrument or system:
- : LIS equation:
- : Actual LIS result:
- : Manual calculation formula:
- : Acceptability Status:

Paste NOTE: Include the equation using the "Show Equation" function when available, and also include screenshots of the result Calculation calculation screen shots from Accession Result Entry in the LIS and perform, and documentation of the manual calculations to prove the calculation is demonstrating satisfactory performance. Attach the signed, complete audit to this policy after Medical Director Approval.

All Revision Dates

3/27/2026, 2/9/2026

Attachments

- [Calculated Patient Data Verification Template.docx](#)
- [eGFR Calculated Result Rule Script.docx](#)
- [SIGNED 2026_Calculated_Patient_Data_Verification.pdf](#)

Approval Signatures

Step Description

Approver

Date

Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	3/26/2026

COPY



Origination 2/9/2026
Last Approved 3/27/2026
Effective 3/27/2026
Last Revised 3/27/2026
Next Review 3/26/2028

Owner Christian Press:
Supervisor-LIS,
Laboratory
Services
Policy Area Laboratory
Services - Lab
Information
Systems
References GEN.41440,
GEN.43750,
GEN.43800
+ 3 more

L.LIS.07 Laboratory Information System Update Validation Verification

PRINCIPLE:

The purpose of this document is to provide information for testing the interface. This procedure will ensure that results from laboratory analyzers are transmitted accurately into the Laboratory Information systems.

POLICY:

Interface verification must be performed before implementation of an interface and whenever any change is made to an existing interface that could affect the accuracy of transmission of patient results.

1. The interface verification must include the Incident Number (INC), a brief description of the testing, the date performed, the domain used to test, and the accession number and/or financial number that was used for testing. A screenshot of each testing phase shall be provided in the report.
 - Department Order Entry
 - Order Result Viewer
 - Accession Result Entry

- PowerChart
 - Lab Label (new assays only)
 - Charge Viewer
2. Testing is done initially in the CERT domain. Access to CERT is granted by the Information Technology department.
 3. The test to be validated must be ordered under the **Department order entry**.
 4. The test order label will be printed out and checked for the correct test order, specimen type, location of patient testing, date and time of collection, and patient information (medical record number, accession number, date of birth).
 5. The test order name and other parameters (collection time/date, specimen type, ordering physicians etc.) shall be checked in PathNet general lab and PowerChart.
 6. The test shall be resulted in Accession Result Entry. Depending on the test, several parameters (eg. Critical values, Delta checks, low and high values, normal values, reference ranges) should be tested to see if the correct values and flags appear in PathNet general and in PowerChart.
 7. Procedure information should also be checked and evaluated for errors. This is accessed through Accession Result Entry, right click the result, and then choose Procedure Information. The Procedure information contains the following information:

Procedure Information

Procedure Short description: Potassium Lvl Test site: VCMC Easylink Default result type: Numeric Current result type: Numeric		Delta Type: Percent Value: 50 Minutes: 0
Numeric Units of measure: mEq/L Normal low: 3.5 Normal high: 5.1 Critical low: 2.6 Critical high: 5.9 Review low: 2.6 Review high: 5.9 Linear low: (Not Applied) Linear high: (Not Applied) Feasible low: (Not Applied) Feasible high: (Not Applied)		Alpha Normal: (Not Defined) Responses: (None)

8. If testing appears satisfactory in the CERT testing domain, the validation will get approved to

move forward to the PROD domain testing site.

9. Follow the above steps from 1-7 and include screen shots of each phase of testing.
10. If the test is autoverified or interfaced, follow the Autoverification procedure to test for Autoverification functionality.
11. To generate a Laboratory report, go to Manual expedite under order result viewer and choose laboratory Report. Check Report if it meets reporting elements parameters.
12. If the testing appears satisfactory in the PROD Domain and is approved by the medical director, the test is ready to go live.

Validation Templates are attached below.

The Validation Templates are also found at the following shared drive location:

V:\Lab Shared\Laboratory Information Systems\BLANK Forms

Summary of Reviewed Items during a validation

1. Department order entry

- Correct test name
- Ability to order test
- Correct specimen type
- Specimen log-in
- Screen shot

1. Order labels

- Test name
- Patient information
- Container type
- Location (Ex. VCMC, SPH, public health)
- Screen shot or indication that each parameter was checked
- Check if special handling label note required by lab

1. Accession result entry

- Format of Procedure column and Result column
- Procedure and Test site
- Procedure information parameters (units of measure, normal low, normal high,

~~critical low, critical high, review low, review high, linear low, linear high, delta checks)
if applicable. Screen shot of Procedure information.~~

- ~~• Test each parameter and obtain screen shot example of each.~~
- ~~• Appropriate flags associated with each parameter if applicable (critical flags, delta flags, review high flags)~~
- ~~• Check linear low and linear high results. Use values below the linear low, at the linear low, at the linear high, and above the linear high. Take a screen shot of linear low value and linear high value. Indicate in the report that the rest of the linear values are satisfactory.~~
- ~~• For PROD domain, check Autoverification parameters (Refer to Autoverification policy for validation)~~
- ~~• Test Correction Mode~~

Main Items Reviewed During a LIS Update Validation

- : Ability to Order Test (Location: Department Order Entry)
- : Test Name (Location: Department Order Entry, Order Result Viewer, Power Chart, Specimen Label, Charge Viewer)
- : Correct Specimen Type (Location: Department Order Entry)
- : Correct Service Resource (Location: Container Details → Routing)
- : Specimen Log-In view
- : Order Result Viewer
- : Specimen Label
- : Power Chart Order Entry
- : Reportable Comments Post Correctly in the Chart

Items to review in each section when LIS updates are made:

1. Specimen Labels

- : Test name
- : Patient information
- : Container type
- : Performing Location (Ex. VCMC, SPH, public health)
- : Screen shot or indication that each parameter was checked
- : Check if special handling label note required by lab

2. Accession result entry

- Procedure and Result column formats.
- Procedure and Testing Site(s).
- Procedure information parameters:
 - Units of measure
 - Normal low/high (if applicable)
 - Critical low/high (if applicable)
 - Review low/high (if applicable)
 - Linear low/high (if applicable)
 - Delta Checks (if applicable)
 - Autoverification (If applicable) of results. Refer to **Autoverification policy L.LIS.103** for validation requirements.
 - Corrected Results
- **NOTE:** Use values below the linear low, at the linear low, at the linear high, and above the linear high, and beyond the critical value setting to test the LIS's ability to flag appropriately in each scenario.

3. **Order result viewer**

Order Result Viewer

- Collection
- Accession
- Order test name
- Specimen type
- Priority
- Status
- Comment
- General lab results (Check flags, interpretative comment, result comments, Reference ranges)
- Manual Expedite (Refer to Reporting elements to check parameters)
- **Screen-shot**

4. Powerchart

- Result Review format and Orders (laboratory)
- Order name
- Results
- Result parameters (Reference ranges)
- Result flags
- Result comments
- Interpretative comments
- Order information (Collection time/date, specimen type, Ordering physician, Resulting CLS, Resulting site)
- Orders (laboratory): Check status of test (ex. Dispatched, In-lab, Completed)
- ~~Screen shots where applicable~~

Result Categories

REFERENCES:

- A. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.46000 *Reference Interval/Units Transmission* . 2020 (Jun 4) page 67
- B. College of American Pathologists, CAP Accreditation Program. Laboratory General Checklist. GEN.46000 *Interface Result Integrity*. 2020 (Jun 4) page 67

All Revision Dates

3/27/2026, 2/9/2026

Attachments

 [BLANK Interface Validation Template.xlsx](#)

 [BLANK Validation Template.docx](#)

 [Gen Lab and Blood Bank Reference Ranges 1.22.2026.xlsx](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/18/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	3/18/2026

References

GEN.41440, GEN.43750, GEN.43800, GEN.43875, GEN.43876, L.LIS.103

COPY



Origination 2/9/2026
Last Approved 3/27/2026
Effective 3/27/2026
Last Revised 3/27/2026
Next Review 3/26/2028

Owner Christian
Press:
Supervisor-
LIS,
Laboratory
Services
Policy Area Laboratory
Services -
Sendouts
References GEN.41440

L.SO.02 Uploading of Patient Reports Securely into PowerChart

PRINCIPLE:

POLICY:

Some laboratory test results come from outside laboratories and will require to be uploaded into the Electronic Medical Record so the providers can view the report. This procedure details the process of uploading reports using the EPSON scanner and uploading of a PDF into the Electronic Medical Record. All reports must be reviewed for accuracy after scanning into the patient chart. Proof of review is required as a final step, requiring the reviewing CLS to physically initial and date each patient report after verification of scanning accuracy.

PROCEDURE:

1. Open **Accession Result Entry**
2. Enter the Accession Number (Example: 240430555) to bring up the result entry for the accession number

PathNet General Lab: Accession Result Entry

Task Mode View Help

Results Accession: 24-043-0555 Retrieve Procedure: All Test site: All

Procedure	Result	Flags	Status	Reference Range	Service Resource Display	AV Codes	Prev	Tl...
SO Misc GL	Scanned Report		Pending					

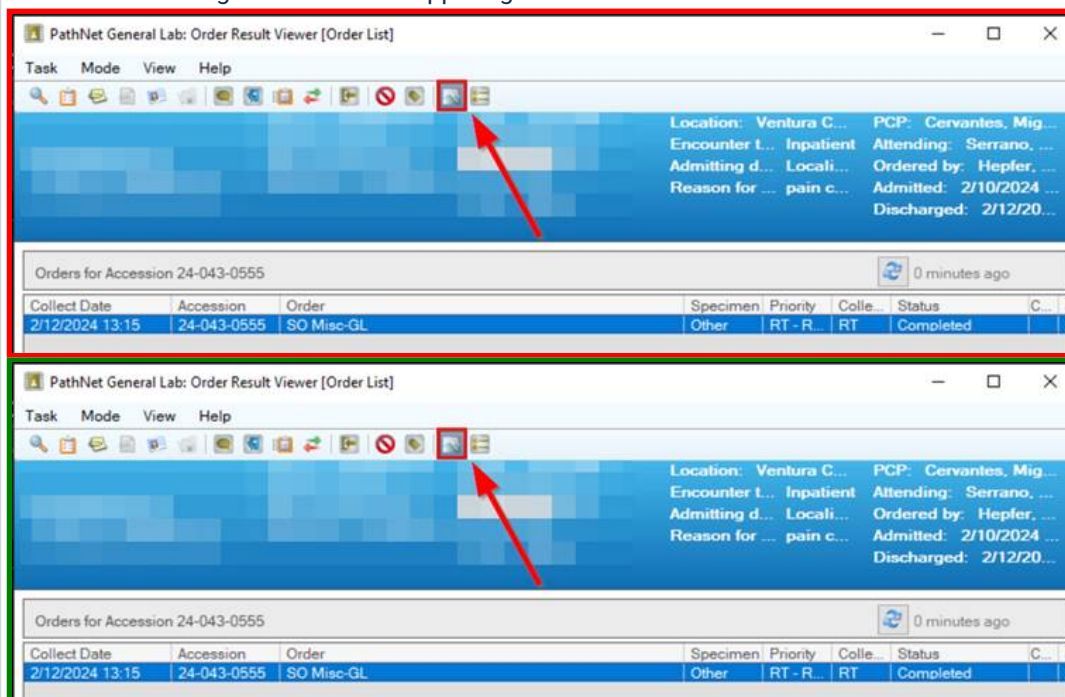
Priority: RT - Routine Performing loc: Hierarchy:

Perform... Verify...

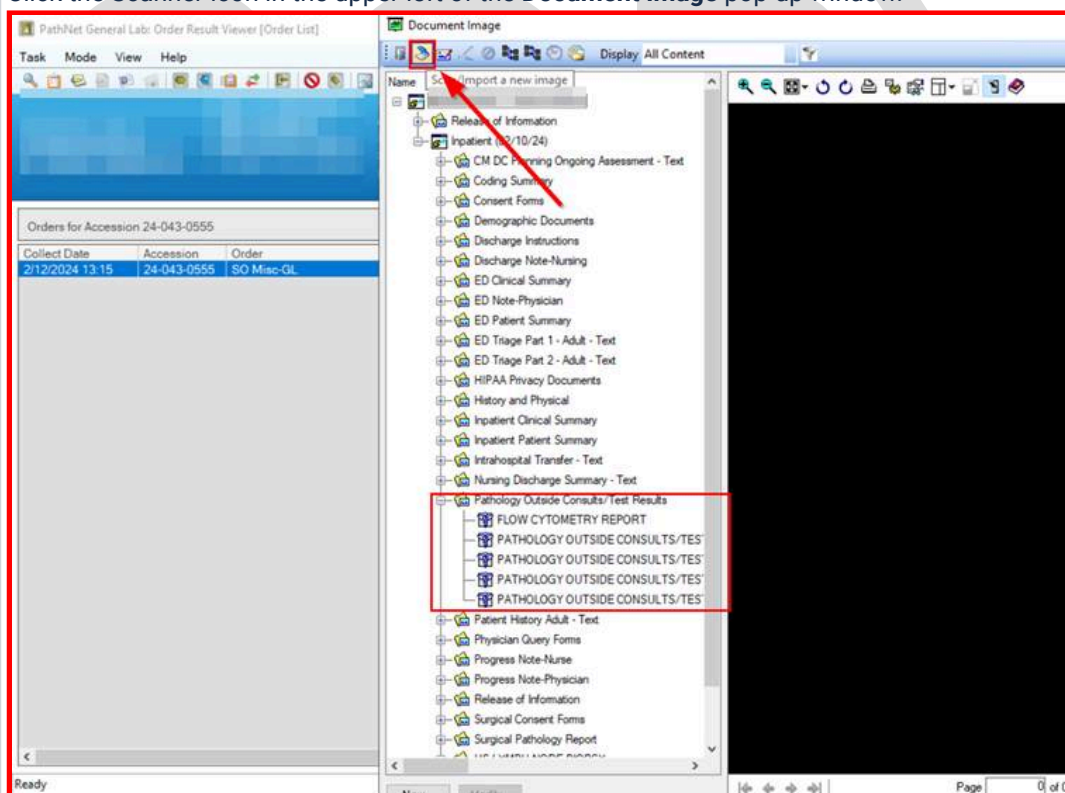
Order: SO Misc-GL; Status: Ordered; Procedure: SO Misc GL; Location: VCMC Misc SO; Collected: 2/12/2024 13:15 P441 PRESSCH 2/16/2024 10:22

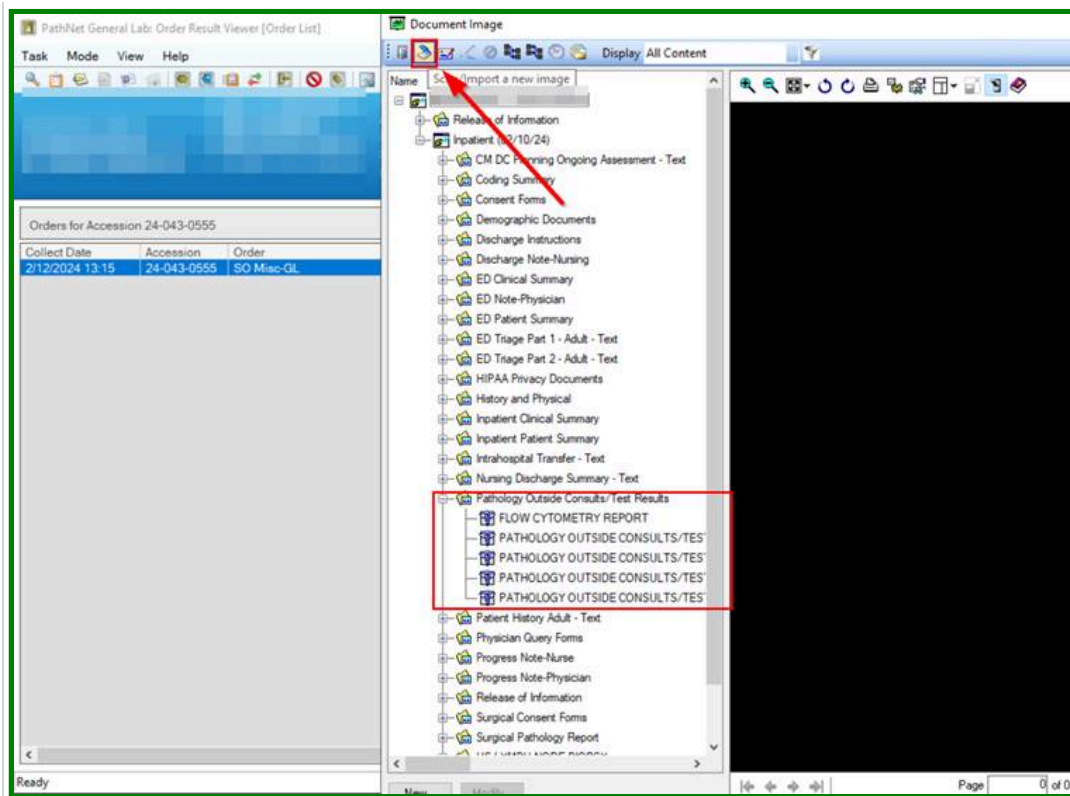
- There must be a test result in the "Performed" status before uploading a report. If there is no result present then enter "Scanned Report" as a Freetext general placeholder.

4. Click the View Images button in the upper right of the toolbar in ARE

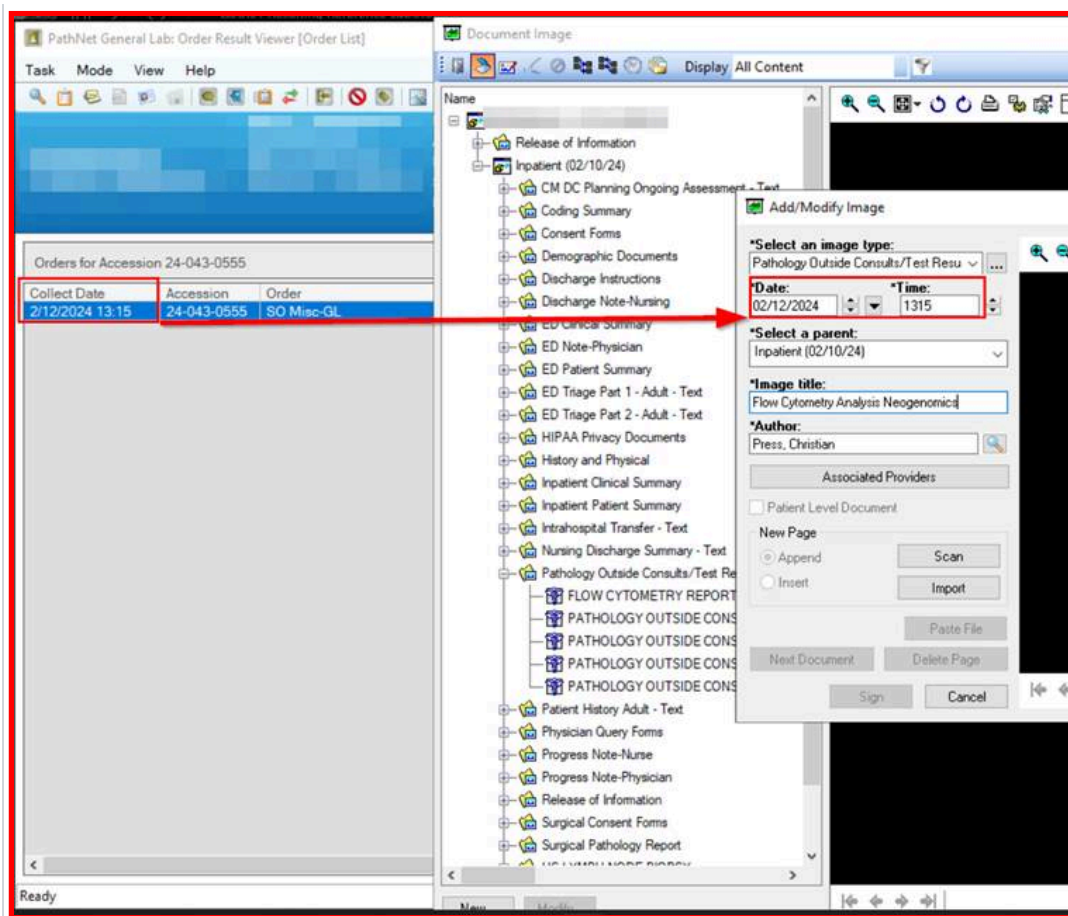


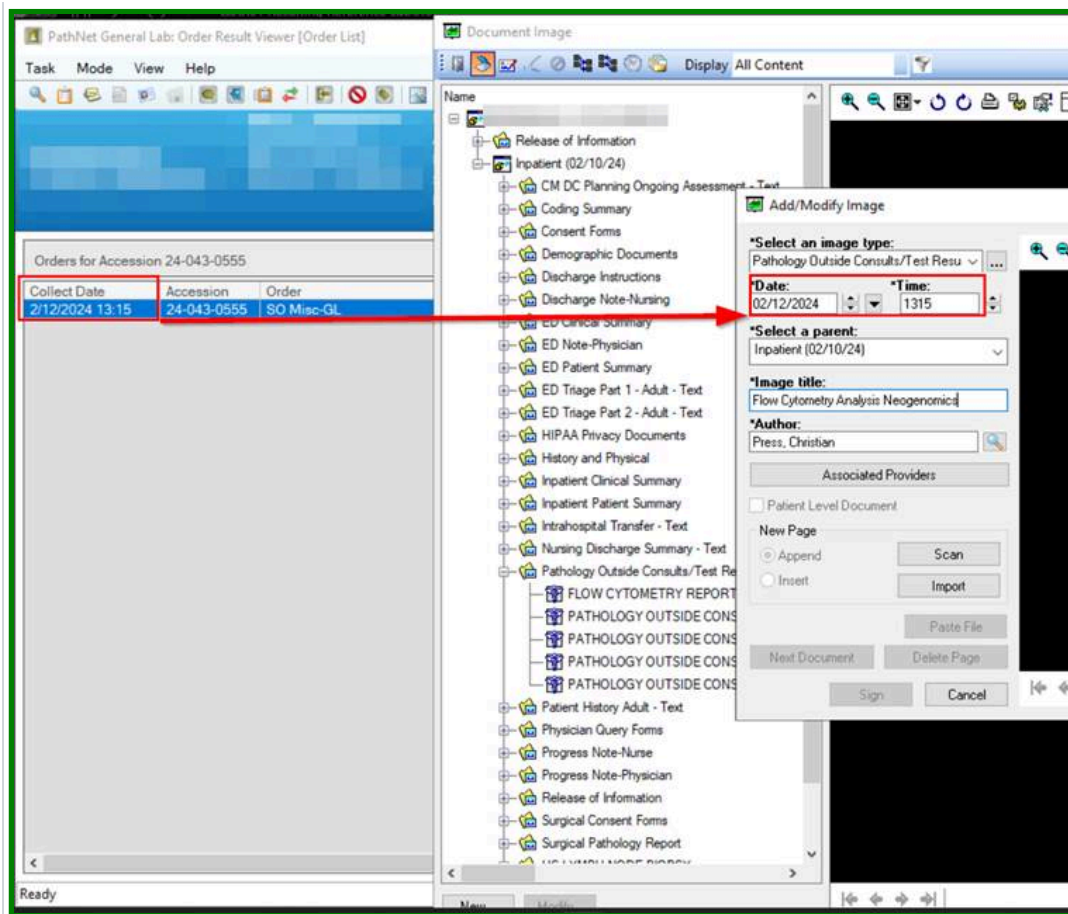
5. Click the Scanner icon in the upper left of the Document Image pop-up window.



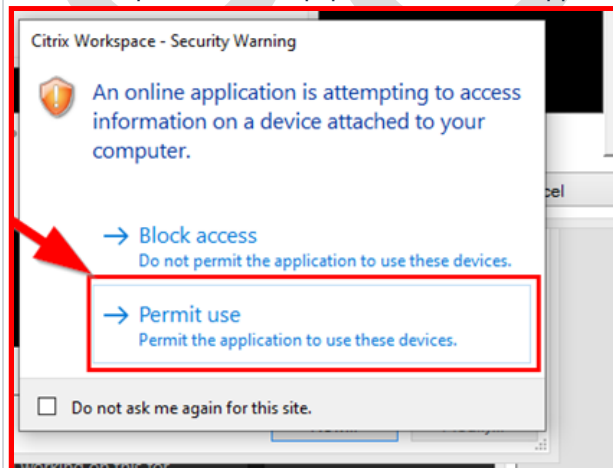


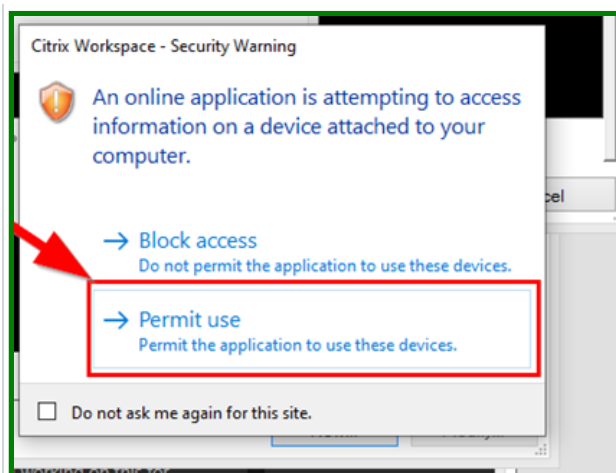
6. Turn on the scanner.
7. The Add/Modify Image window will pop up and use the image below as a template.
 - **Select an image type:** Either **"Reference Lab Documents"** or **"Pathology Outside Consults/ Test Results"**
 - **Date/Time:** Actual Collection Date and Time for the accession in Cerner.
 - **Image Title:** Enter the Test Name and the Performing Laboratory's Name



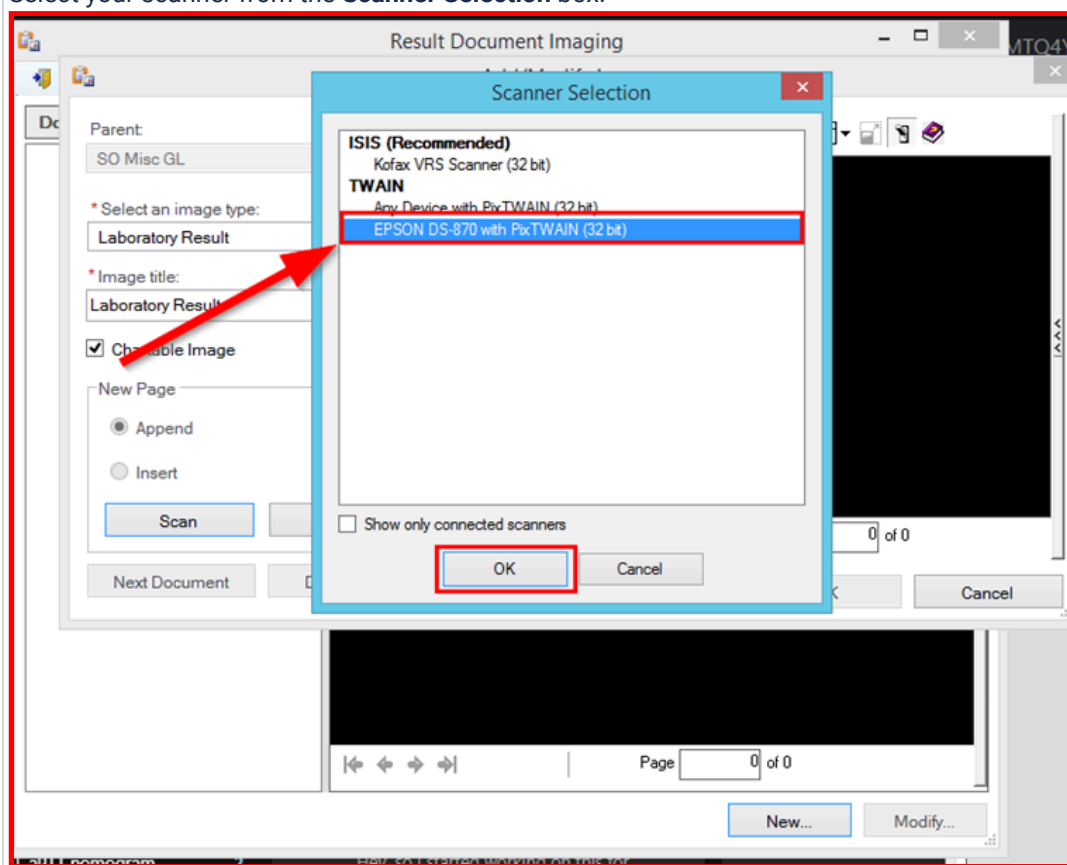


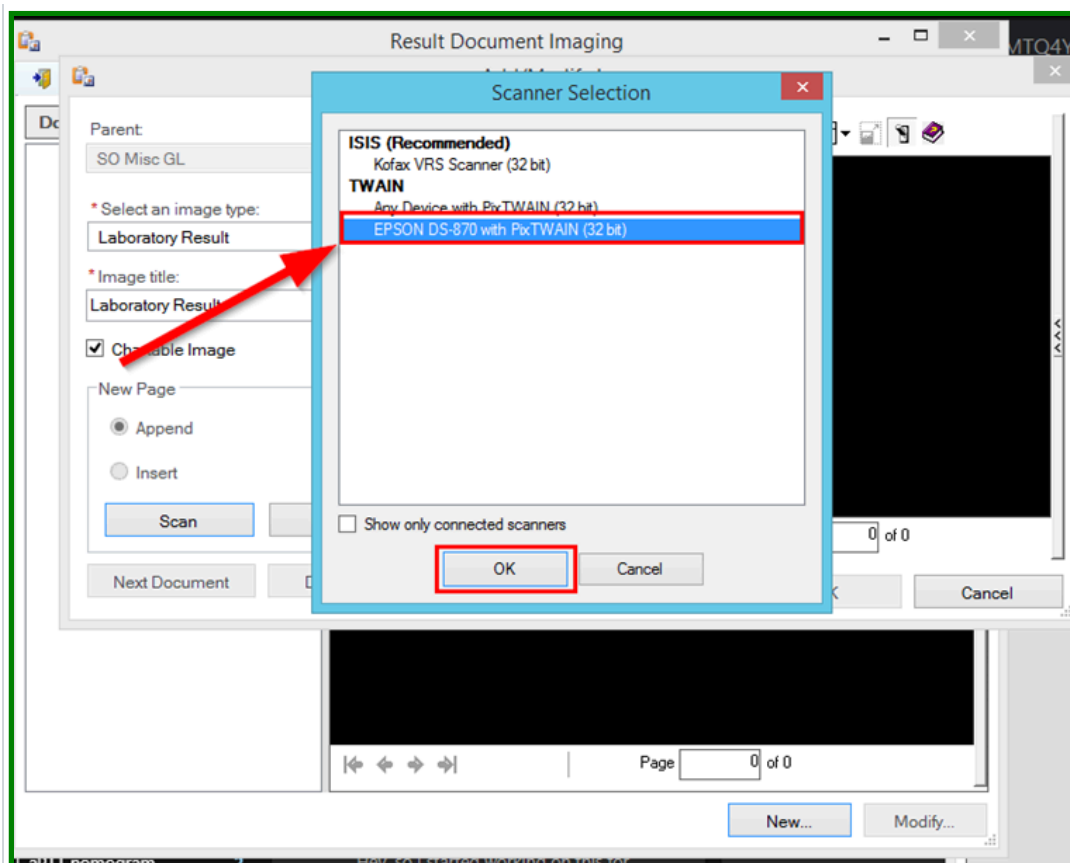
8. If you get a security pop-up, click **Permit Use** or **Allow** or whatever will allow the scanner access to the Citrix. This process and equipment have been approved by IT.



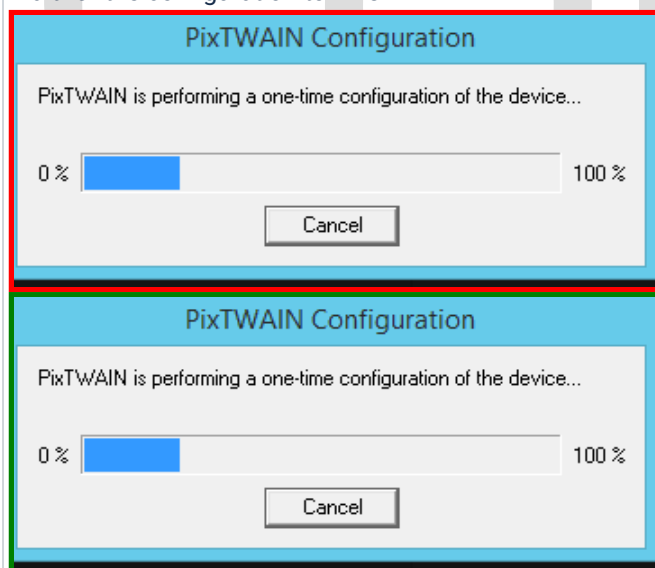


9. Select your scanner from the **Scanner Selection** box.

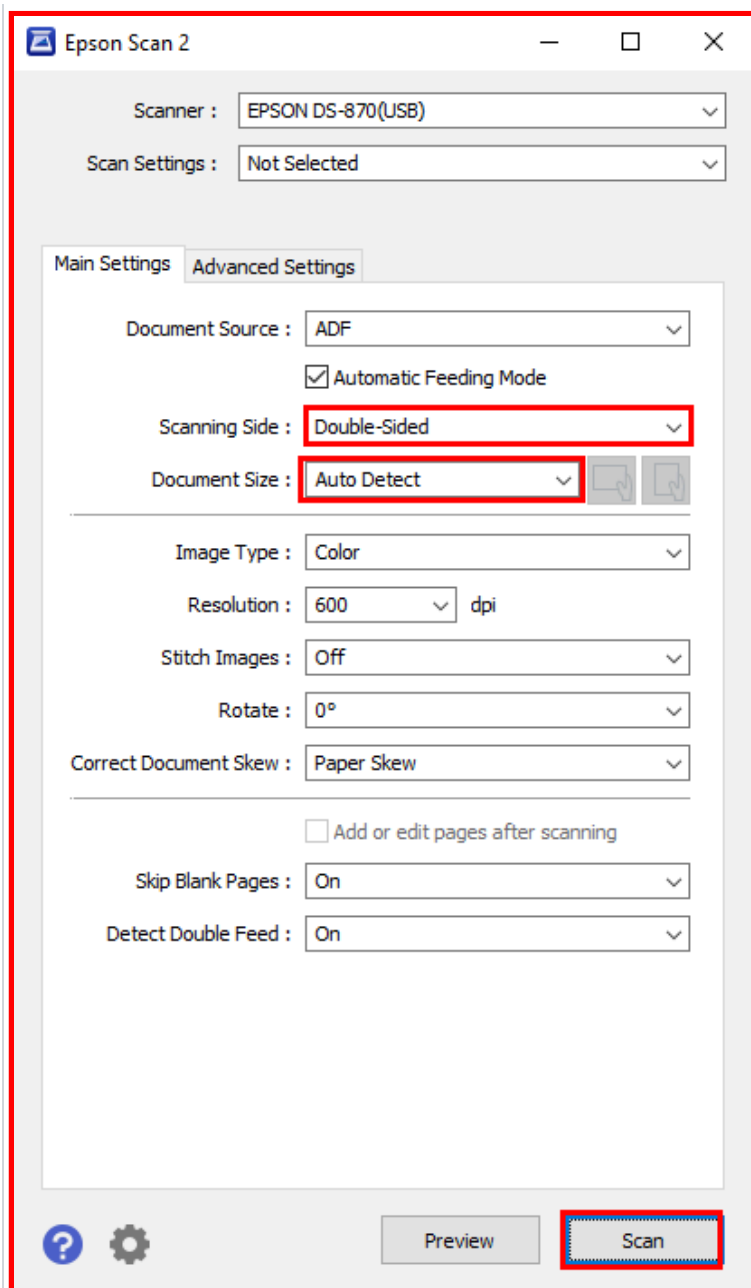


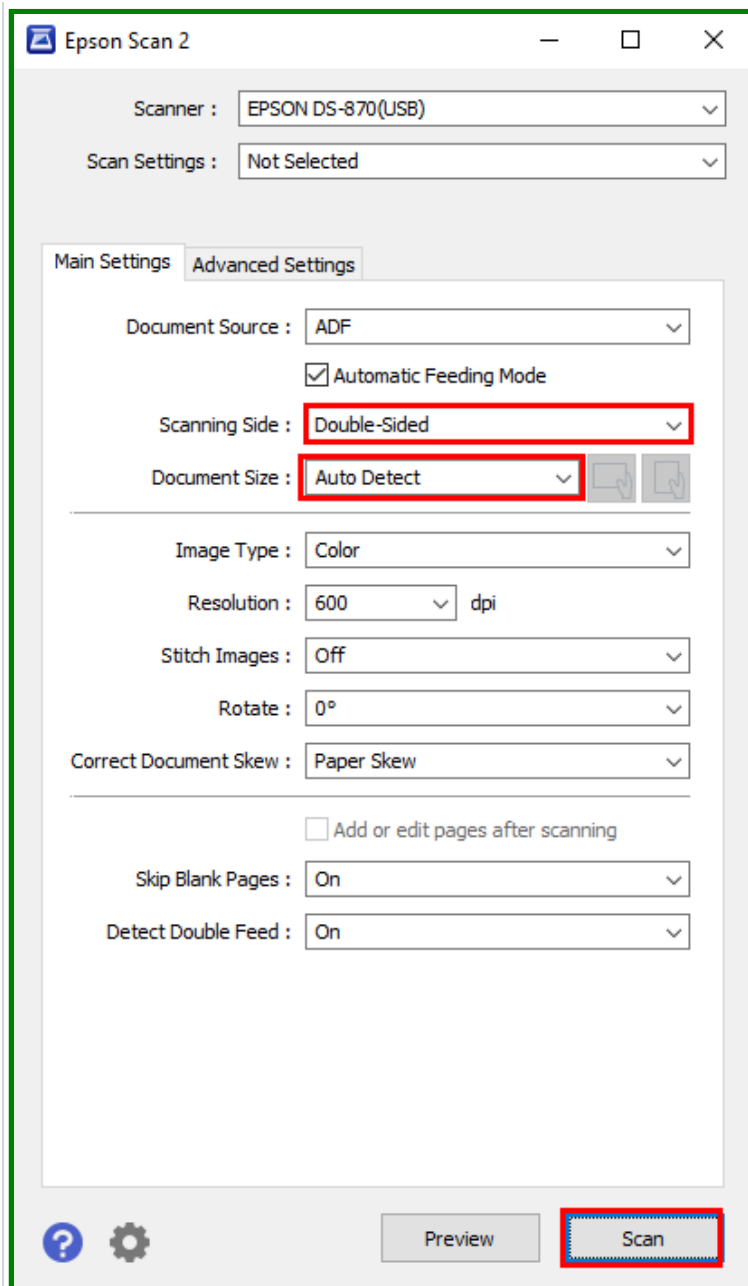


10. Wait for the configuration to finish.

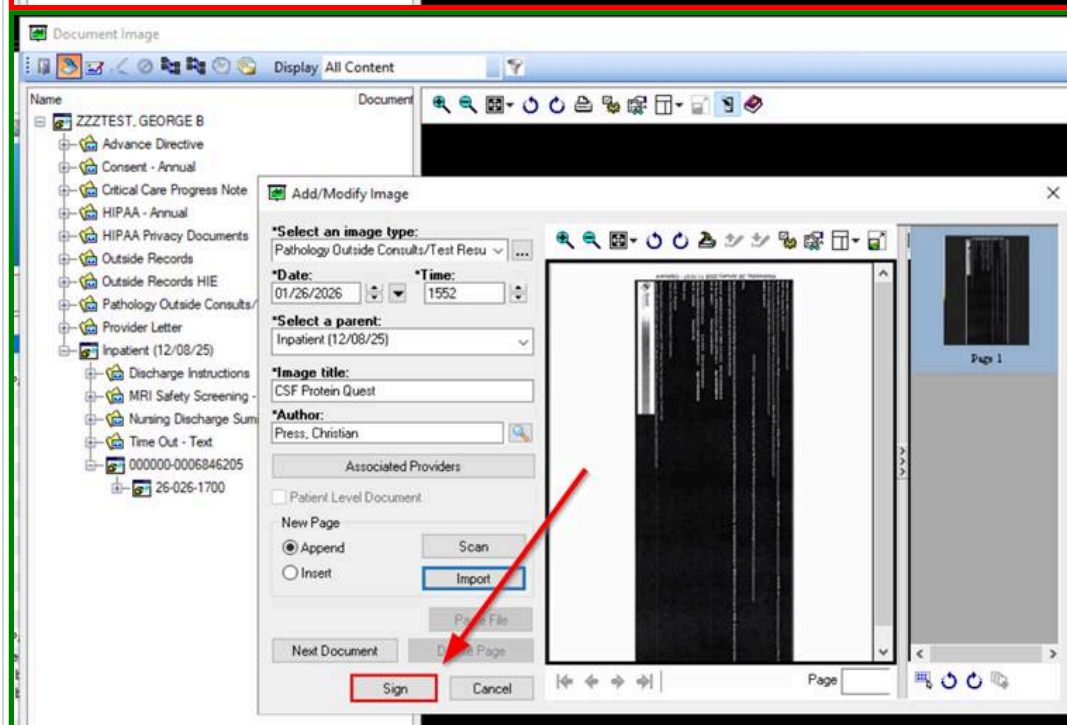
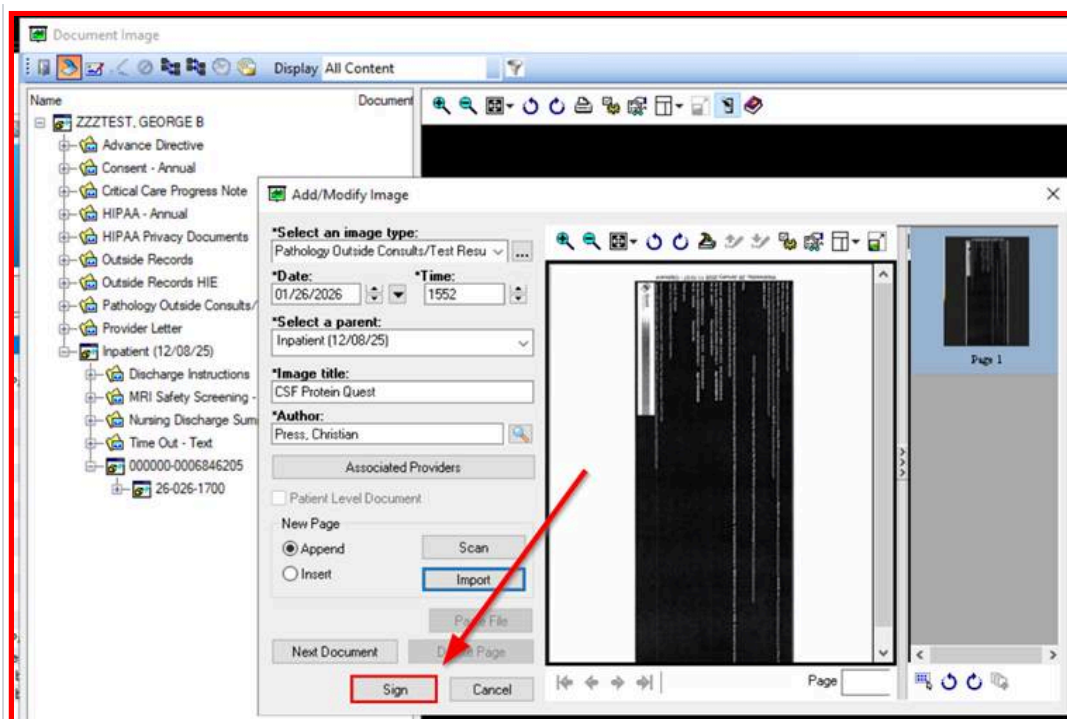


11. If you are using an EPSON scanner, ensure the **Double-Sided** and **Detect Blank Pages** are enabled then click **Scan**.





12. Review the Pages that you have entered by scrolling through and making the window bigger view the page(s) in its/their entirety.
You can also **Rotate**, **Delete**, and **Move** up/down scanned pages if they should not be included in the upload. You can do this by clicking the buttons in the lower right panel as seen below.
Click **Okay** **Sign** when you are finished.



13. Click the **Verify** button in the bottom right of **Accession Result Entry** to complete the accession.

PathNet General Lab: Accession Result Entry

Task Mode View Help

Accession: 24-043-0555 Retrieve Procedure: All Test site: All

Procedure	Result	Flags	Status	Reference Range	Service Resource Display	AV Codes	Prev	Ti...
SO Misc GL	✓ Scanned Rept	I	Pending					

Priority: RT - Routine Performing loc: Hierarchy:

Perform... Verify...

Order: SO Misc-GL; Status: Ordered; Procedure: SO Misc GL; Location: VCMC Misc SQ; Collected: 2/12/2024 13:15 P441 PRESSCH 2/16/2024 11:02

PathNet General Lab: Accession Result Entry

Task Mode View Help

Accession: 24-043-0555 Retrieve Procedure: All Test site: All

Procedure	Result	Flags	Status	Reference Range	Service Resource Display	AV Codes	Prev	Ti...
SO Misc GL	✓ Scanned Rept	I	Pending					

Priority: RT - Routine Performing loc: Hierarchy:

Perform... Verify...

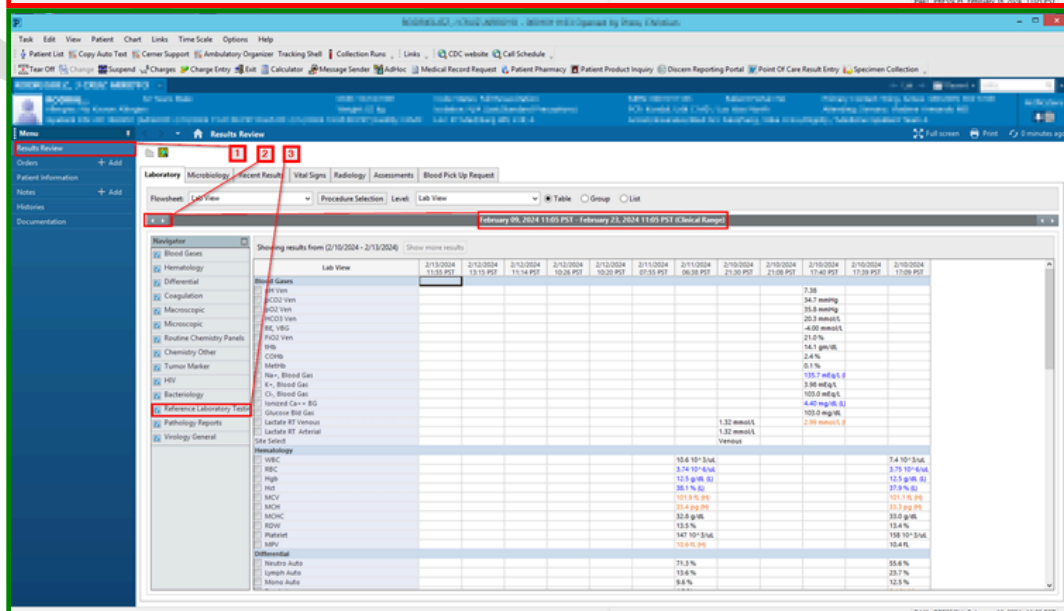
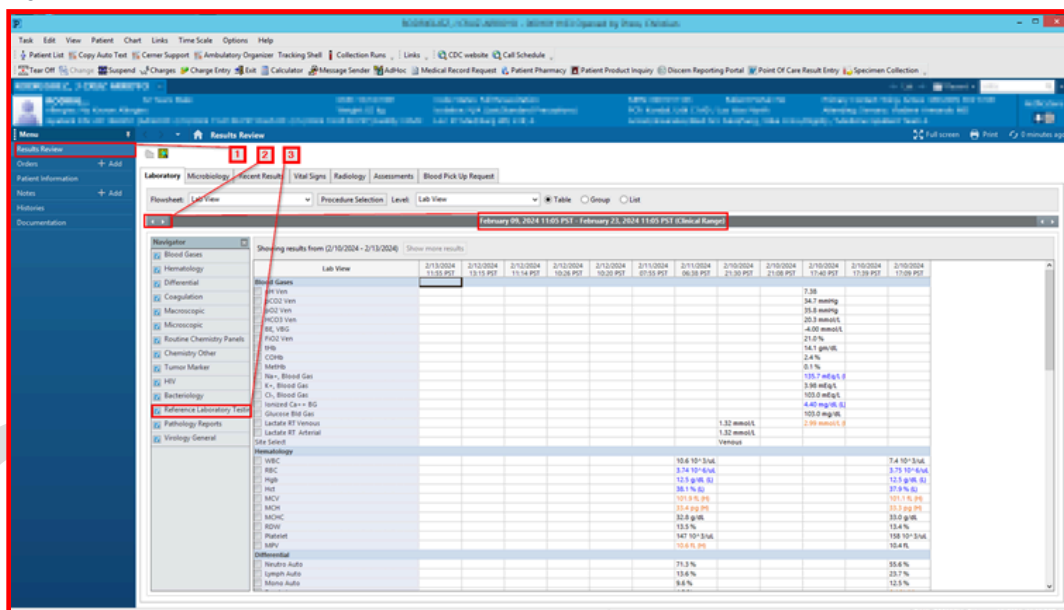
Order: SO Misc-GL; Status: Ordered; Procedure: SO Misc GL; Location: VCMC Misc SQ; Collected: 2/12/2024 13:15 P441 PRESSCH 2/16/2024 11:02

Now you must verify the record is in the patient chart.

14. Open **PowerChart**

15. Click:

- Results Review**
- The Left/Right Date-Change Arrows** until you get to the collection date of the specimen.
- Reference Laboratory Testing** or the VCMC/SPH department of which your result is resulted from.



16. The goal is to search for your test result. Once you have located it, double-click it to bring up the **Result Details**.

ZZZTEST, GEORGE B - 0000159773 Opened by Press, Christian

Task Edit View Patient Chart Links Time Scale Options Help

Patient List Copy Auto Text Cerner Support Ambulatory Organizer ED LaunchPoint Tracking Shell Collection Runs DSI Ref

Links

CDC website UpToDate Call Schedule

Tear Off Change Suspend Charges Charge Entry Exit Calculator Message Sender AdHoc Medical Record Reque

ZZZTEST, GEORGE B

ZZZTES... 75 Years Male 'NOAH' He/Him/His DOB: 8/1/1950 Code Status: Full Resuscitation
 Allergies: **Brilinta, cephalosporins, iodine, Mold, Doxycycline Hy...** Weight: 85 kg Isolation: N/A (Last: Standard Pre
 Outpatient FIN: 2013972587 [Visit Dt: 12/23/2025 13:50:00 PST] Visit Reason: test Loc: VCMC Cardiology

Menu Results Review

Orders + Add

Patient Information

Notes + Add

Histories

Documentation

Laboratory Microbiology Recent Results Vital Signs Radiology Assessments Blood Pick Up Reque

Flowsheet: Lab View Procedure Selection Level: Lab View

December 31, 2025 18:43

Navigator

Blood Gases

Routine Chemistry Panels

Urine Toxicology

Immunology General

Showing results from (1/5/2026 - 1/26/2026) Show more results

Lab View 1/26/2026 15:52 PST

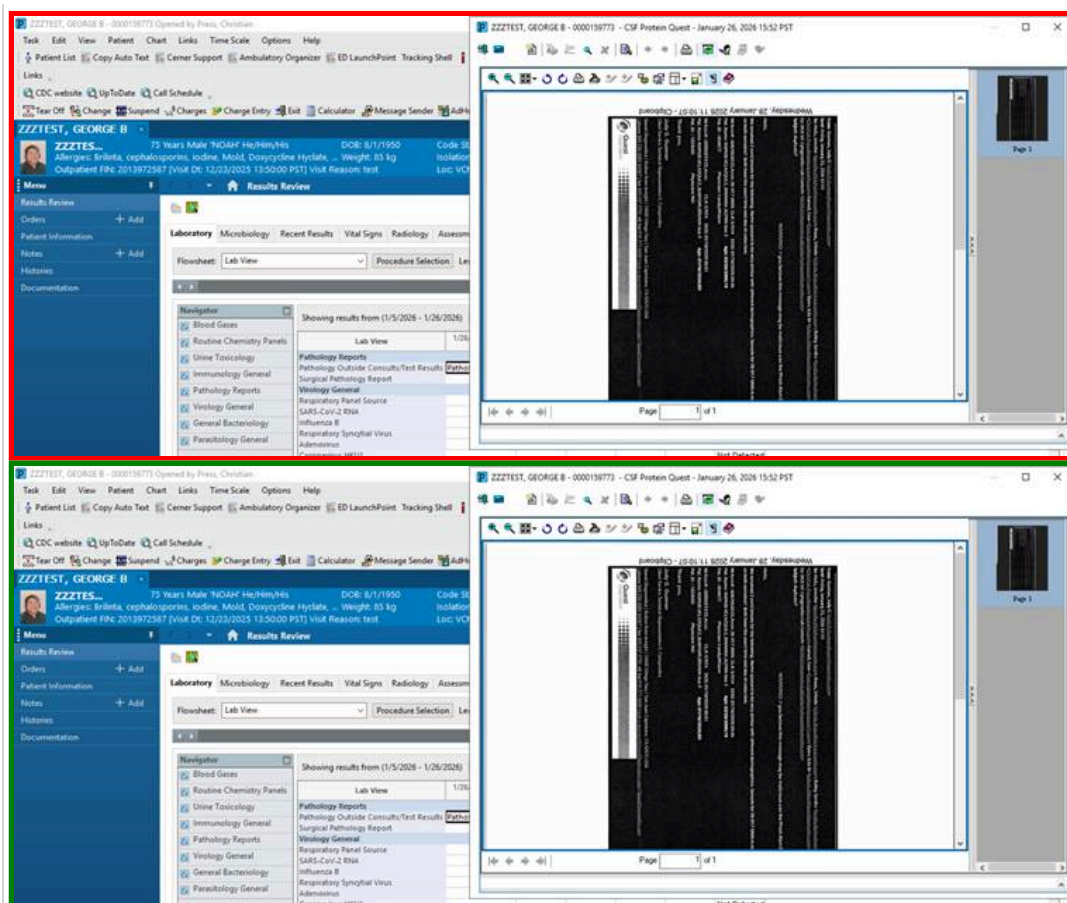
Pathology Reports

Pathology Outside Consults/Test Results

Surgical Pathology Report

Pathology Outside

17. Verify your document looks as intended for the provider.



18. You have completed the Uploading of Patient Reports Securely into PowerChart Procedure. To upload a report via the **Import** function from **Step 7** proceed to the next step
19. Click **Import** to import your report from the **Shared Drive**.

Add/Modify Image

***Select an image type:**
Pathology Outside Consults/Test Resu

***Date:** 01/28/2026 ***Time:** 1851

***Select a parent:**
Inpatient (12/08/25)

***Image title:**
Test Import File

***Author:**
Press, Christian

Associated Providers

☐ Patient Level Document

New Page

☒ Append ☐ Insert

Scan

Import

Paste File

Next Document Delete Page

Sign Cancel

Add/Modify Image

***Select an image type:**
Pathology Outside Consults/Test Resu

***Date:** 01/28/2026 ***Time:** 1851

***Select a parent:**
Inpatient (12/08/25)

***Image title:**
Test Import File

***Author:**
Press, Christian

Associated Providers

☐ Patient Level Document

New Page

☒ Append ☐ Insert

Scan

Import

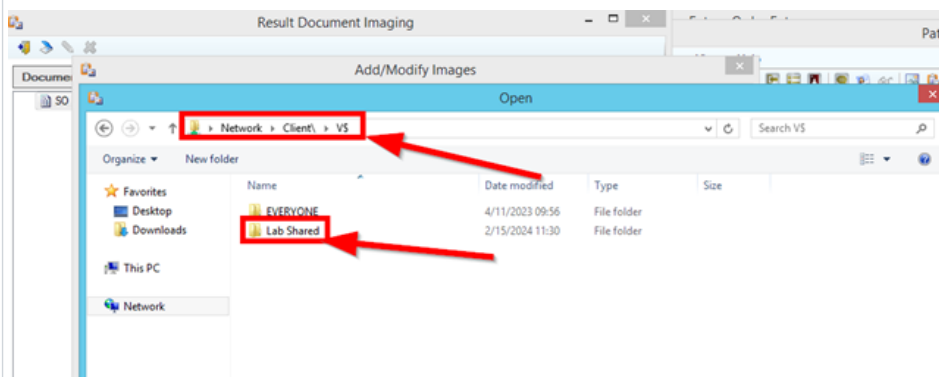
Paste File

Next Document Delete Page

Sign Cancel

20. Click in the following order to get to the **shared drive** where your document must be stored. Citrix cannot access the PC desktop.

- A. **Network**
- B. **Client**
- C. **V\$** (if there is a security pop-up from Citrix, click Permit or approve)
- D. **Lab Shared**



21. Once you have located your file. Click on it once, then click **Open**.

22. Proceed to **Step 12** until you have completed the secure upload.

All Revision Dates

3/27/2026, 2/9/2026

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	3/27/2026
Laboratory Services Department	Erlinda Roxas: Director, Laboratory Services	3/26/2026
Laboratory Services Department	M. Anwar Molani: Medical Director, Laboratory Services	3/3/2026
Laboratory Services Department	Christian Press: Supervisor-LIS, Laboratory Services	3/3/2026



Origination 5/1/1983
Last Approved 3/30/2026
Effective 3/30/2026
Last Revised 3/30/2026
Next Review 3/29/2029

Owner Jill Ward: Chief Financial Officer, VCMC & SPH
Policy Area Administrative - Operating Policies

107.004 Purchasing Policy

POLICY:

To delegate authority for approval of requests for purchases of supplies, services, equipment and furnishings to facilitate efficient, effective and compliant procurement practices.

All purchases made by or on behalf of Ventura County Medical System (VCMS) staff must be supported by a Purchase Requisition that was reviewed and approved by appropriate authority to assure the legitimacy and cost effectiveness of the requisition. Purchases are confirmed and binding only upon completion of an approved requisition and issuance of a purchase order (PO) by the General Services Agency (GSA) of the County of Ventura.

PROCEDURE:

- A. Purchase request equal to or less than \$1,000.00:
 - 1. Request for purchase of supplies, services or equipment with a total value, tax included, equal to or less than \$1,000.00 needs approval by the department manager.
- B. Purchase request greater than \$1,000.00, but equal to or less than \$5,000.00:
 - 1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than \$1,000.00, but equal to or less than \$5,000.00 needs approval by the Associate Hospital Administrator, Associate Chief Nurse Executive or Ambulatory Care Regional Administrative Director.
- C. Purchase request greater than \$5,000.00, but equal to or less than \$10,000.00:
 - 1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than \$5,000.00, but equal to or less than \$10,000.00 needs approval by the Chief Operations Officer ~~or~~, Chief Nurse Executive or Chief Executive

Officer.

D. Purchase requests greater than \$10,000.00:

1. Request for purchase of supplies, services or equipment with a total value, tax included, greater than \$10,000.00 needs approval by the Chief Financial Officer.

E. Fixed Assets Equipment:

1. Request for fixed asset equipment will be reviewed and approved by the Fixed Assets Committee. See policy [107.078 Review and Approval of Fixed Assets Equipment Over \\$~~5000~~10,000.](#)

All Revision Dates

3/30/2026, 5/9/2023, 4/25/2023, 8/11/2021, 1/1/2008, 5/1/2006, 1/1/2005

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	3/30/2026
Finance	Michael Taylor: Chief Financial Officer, Health Care Agency	3/24/2026
Finance	Jill Ward: Chief Financial Officer, VCMC & SPH	2/9/2026
Policy Owner	Jill Ward: Chief Financial Officer, VCMC & SPH	2/9/2026



Origination 5/1/1983
Last Approved 3/25/2026
Effective 3/25/2026
Last Revised 3/25/2026
Next Review 3/24/2029

Owner Imelda Reyes-Jay: Clinical Reg. Compliance & Patient Safety Mgr
Policy Area Administrative - Patient Care

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

~~It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) and the Ambulatory Care clinics to implement an effective system to address any patient concerns about care or service.~~

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 and 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.
 - o 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. ~~Grievance Process Education of Patients, Family and Staff Members:~~

- ~~1. **Written Education:** Patients and family members shall be notified in writing of the complaint and grievance process, which includes the method of reporting concerns regarding care, treatment, service and patient safety at the time of admission to VCMC/SPH inpatient service or at the time of service at an Ambulatory Care clinic.~~
- ~~2. **Assessment for Follow-up Education:** Staff members shall include the patient's/ family member's knowledge of the process for reporting concerns over care, treatment, services and safety when plans for general education are developed.~~
- ~~3. **Orientation of Staff:**~~
 - ~~a. Staff members and members of the medical staff shall be oriented to the patient complaint and grievance process and their responsibilities for assessing and, as necessary, educating patients about this process.~~
 - ~~b. All staff members and members of the medical staff shall also be encouraged to forward any of their quality, safety or other concerns to:~~
 - ~~• VCMC/SPH: The Patient Advocate at 1-805-652-6691~~
 - ~~• Ambulatory Care Clinics: Ambulatory Care Administration at 1-805-339-1111~~
 - ~~c. Staff will also be informed of their right to contact The Joint Commission with any quality concerns without reprisal.~~

B. ~~Early Complaint Resolution:~~ Any staff member receiving a patient complaint shall attempt to resolve the issue on the spot.

C. ~~Reporting Grievances:~~ Any verbal or written patient complaint/grievance that cannot be promptly resolved by staff at the time of the complaint/grievance shall be referred to:

- ~~• Hospital-related grievances: the VCMC/SPH Patient Advocate at 1-805-652-6691.~~
- ~~• Ambulatory Care-related grievances: the Ambulatory Care dedicated telephone complaints line, 1-805-339-1111.~~

1. ~~Options and Time Frame for Referral~~

~~**Written:** An official Patient Grievance form or complaint/grievance in the original format received from the patient shall be completed and transmitted to the Patient Advocate or Ambulatory Care Administration.~~

- ~~a. **Verbal :** A verbal patient grievance may be transmitted verbally to the Patient Advocate or Ambulatory Care Administration as long as the information transmitted includes the details required on the patient grievance form.~~
- ~~b. **Timeliness :** Any patient grievance related to quality of care or patient safety shall be reported as soon as possible (for~~

example, via an immediate person-to-person conversation with the appropriate manager, Patient Advocate or Ambulatory Care Administration). Other patient grievances shall be referred to the appropriate manager by the end of the staff's shift.

D. **Receipt, Investigation and Resolution:**

1. **Grievant Initial Notification:** Upon receipt of a grievance, the VCMC/SPH or Ambulatory Care Quality Assessment/Performance Improvement (QAPI) team shall contact the grievant using the letter of receipt of patient grievance.
 - a. Upon receipt of a grievance, the VCMC/SPH QAPI Team will notify the grievant of receipt 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:** The hospital department 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.
 - 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:** The governing body has established a Grievance Committee to act in these matters on its behalf. The Grievance Committee shall consist of two or more individuals:
 - 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~~committee meetings.
4. **Timeliness:** ~~Most grievances shall be completed within seven (7) days of receipt. If,~~

~~however, it will take more than seven (7) days to conclude the investigation, the grievant shall be notified and an approximate date of resolution communicated to the grievant, generally between 30 to 45 days of the initial notification of grievance receipt. If the investigation requires additional time for review, the grievant shall be notified in writing.~~ **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.

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

DEFINITIONS

- A. ~~"Grievant": person who initiates a patient grievance.~~
- B. ~~"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.~~
1. ~~"Staff present" includes any hospital or clinic staff present at the time of the complaint or who can quickly respond to the patient's location (i.e., supervisor, manager, patient advocate).~~
 2. ~~A billing issue is not a patient grievance. Such matters should be referred to the Billing Department for investigation and resolution.~~
- C. ~~"Resolved": the grievant is satisfied with the actions taken on their behalf.~~
- D. ~~"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.~~

All Revision Dates

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Approval Signatures

Step Description	Approver	Date
Oversight Committee	Marisela Luna: Program Administrator	3/25/2026
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

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Owner Vibha Gune: HIM Manager
Policy Area Administrative - Operating Policies

107.061 Legal Health Record and Designated Record Set

POLICY:

This policy identifies the Legal Health Record and Designated Record Set of Ventura County Health Care Agency (HCA) for business and legal purposes. It establishes guidelines for the contents, maintenance, and confidentiality of patient medical records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record.

DEFINITIONS:

Legal Health Record (LHR): a collection of information concerning a patient, and his or her health care, which is created and maintained in the regular course of business, in accordance with Ventura County HCA policies. This information is completed by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and entered at or around the time indicated in the documentation.

- The medical record may include records maintained in an Electronic Medical Records (EMR) system.
- The medical record excludes health records that are not official business records of Ventura County HCA, unless the records were used to make medical decisions for the patient.

Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results of their treatment, and promote continuity of care among health care providers. The information may be from any source and in any format, including but not limited to print and/or electronic display.

The medical record may also be known as the "Legal Health Record" or "LHR." The LHR is the record that will be released for legal proceedings or in response to a request to release patient medical records.

Designated Record Set (DRS): A group of records that includes protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity (e.g. Ventura County Medical Center (VCMC)) for each individual that received care from a covered individual or institution.

The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;
2. The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or
3. The information used, in part or in whole, to make decisions about individuals (these may be outside records that have been used to make care decisions for the patient).

Any research activities that create PHI should be maintained as part of the DRS and are accessible to research participants, unless there is a HIPAA Privacy Rule permitted exception.

Protected Health Information: PHI is individually identifiable health information that is transmitted or maintained in any form, including oral statements.

PROCEDURE:

A. Maintenance of the Medical Record

1. The current electronic components of the medical record consist of patient information from multiple Electronic Health Record (EHR) source systems. The intent of Ventura County HCA is to integrate all electronic documents into a permanent electronic repository.
2. A medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient or emergency patient through Ventura County HCA.
3. Documentation that comprises the medical record may exist in both paper and electronic formats. Upon discharge of a patient (24 hours inpatient and 48 hours outpatient), the paper-based medical records will be scanned (within 24 hours for inpatient and 48 hours for outpatient).
4. Original medical record documentation in paper format must be scanned into the EHR by utilizing the single document scanner or sent to the Health Information Management Department of VCMC within 24 hours of a patient's discharge or visit.
5. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images and fetal monitor strips, and/or a written or dictated summary or interpretation of findings.

B. Confidentiality

The medical record is confidential and is protected from unauthorized disclosure, by law. The circumstances under which Ventura County HCA may disclose confidential medical record information is set forth in the Notice of Privacy Practices Form VCMC-546-039.

C. Content

1. Medical record content shall meet all State and Federal, legal, regulatory and accreditation requirements, including, but not limited to, California Code of Regulations 22 CCR § 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 CFR § 482.24. Appendix A contains a listing of required medical record documentation content and current electronic or paper format status.
2. Additionally, all hospital records and hospital-based clinic records must comply with the applicable hospital's Medical Staff rules and regulation requirements for content and timely completion.
3. All documentation and entries in the medical record, both paper and electronic, must be identified with two (2) patient identifiers.
4. All medical record entries should be made as soon as possible, after the care is provided, or after an event or observation is made. An entry should never be made in the medical record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

D. Legal Health Record (LHR) vs. Designated Record Set (DRS)

Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, Ventura County HCA has defined a DRS to mean the group of records maintained for each individual who received healthcare services delivered by a healthcare provider, which is comprised of the following elements:

1. The medical record whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips, when a written or dictated summary or interpretation of finding has not been prepared;
2. Billing records including claim information; and
3. All physicians or other provider notes, written or dictated, in which medical decision making is documented, and is otherwise not included in the Legal Medical Record (i.e., outside records applicable for treatment).
4. The medical record generally excludes records from non-Ventura County HCA providers (i.e., health information that was not documented during the normal course of business at Ventura County HCA). However, if information from another provider or healthcare facility or personal health record is used in providing patient care or in making medical decisions, it may be considered part of the Ventura County HCA DRS, and may be subject to disclosure upon a specific request or in the event of a subpoena. Information that was not documented during the normal course of business at Ventura County HCA, but was used to make medical decisions for the patient, shall be signed and dated by the person who used the information for patient care.

E. Who may document entries in the Medical Record: Multidisciplinary Notes

Only the following types of Ventura County HCA employees or Ventura County HCA contracted clinical and social services providers may document entries in the multidisciplinary notes section of the medical record:

1. Clinical Social Workers;
2. Dietitians/Diet Technicians;
3. Emergency Trauma Technicians;
4. Home Health Coordinators;
5. Clinical Care Partners;
6. Interpreters;
7. Lactation Specialists;
8. Licensed Vocational Nurses;
9. Medical Assistants;
10. Nurse Practitioners;
11. Occupational Therapists;
12. Pastoral Care Providers;
13. Pharmacists;
14. Physical Therapists;
15. Physician Assistants;
16. Physicians including MD's and DO's;
17. Podiatrists;
18. Psychologists;
19. Registered Nurses;
20. Mental Health Practitioners;
21. Licensed Psychiatric Technicians;
22. Respiratory Therapists;
23. Speech Pathologists;
24. Students, e.g., physician, RN, Occupational Therapy, etc. (notations in the record must be co-signed by a supervising clinician)
25. Others as designated by Medical Center Policies and/or Medical Staff Bylaws

F. Completion, Timeliness and Authentication of Medical Records

1. All inpatient medical records must be completed within 14 days from the date of discharge (California Code of Regulations, 22 CCR § 70751). Additional requirements may also be included in the applicable Medical Staff Bylaws, Rules and Regulations, and/or policies.
2. All operative and procedure reports must be completed immediately after surgery.

3. Daily documentation of care provided must be timely, completed daily and no later than midnight on each calendar day. Daily documentation includes, but not limited to, progress notes and/or procedure notes.
4. All medical record entries are to be dated, the time entered and signed. Physician's entries must be authenticated followed by the physician's ID number and/or legibly printed name.
5. Certain electronic methods of authenticating the Medical Record, including methods such as access codes, may be allowed, provided certain requirements are met. The methodology for authenticating the document electronically, must comply with Ventura County HCA electronic signature standards (see section L below: Authentication of Entries). The entries may be authenticated by a signature stamp or computer key, in lieu of a medical staff member's signature, ~~only when that medical staff member has reviewed and signed the Ventura County HCA 10.3 Electronic Signature Policy.~~
6. Fax signatures are acceptable.

G. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations, aka TPO

The Health Information Management Department will process routine requests for medical records. All charts physically removed from the medical record storage areas will be logged into an electronic tracking system. Only authorized Ventura County HCA employees may access medical records.

Ventura County HCA employees who access medical records for payment or healthcare operations are responsible to access only the amount of information in medical records, that is necessary to complete their job responsibilities and include:

1. Access to medical records for treatment purposes

Healthcare providers who are directly involved in the care of the patient may access the full medical record.

2. Payment Purposes

Authorized and designated Ventura County HCA employees may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

- a. Coding and abstracting;
- b. Billing, including claims preparation, claims adjudication and substantiation of services;
- c. Utilization Review; and
- d. Third Party Payer Reviews (including Quality Improvement Organization reviews).

3. Healthcare Operations

Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

- a. Peer Review Committee activities;
- b. Quality Management reviews including outcome and safety reviews;
- c. Documentation reviews;
- d. Teaching; and
- e. Accreditation/Licensure surveys.

4. Requests for Electronic Components of the Medical Record

Personnel who access the EMR are required to have a unique User ID and password, and access to information is limited according to the minimum necessary role (filed and managed), as approved by designated management personnel.

H. Ownership, Responsibility and Security of Medical Records

1. All medical records, patient lists and billing information of Ventura County HCA patients, whether they are created at or received by Ventura County HCA, are the property of Ventura County HCA. The information contained within the medical record must be accessible to the patient and thus made available to the patient and/or his or her legal representative, upon appropriate request and authorization by the patient or his or her legal representative.
2. The Ventura County HCA Director of Health Information Management is the designated person responsible for ensuring that there is a complete and accurate medical record for every patient through the discharge analysis process for all medical records. The medical staff and other health care professionals are responsible for the documentation within the medical record, within required and appropriate time frames, to support patient care.
3. Original records may not be removed from Ventura County HCA facilities and/or offices, except by court order, subpoena, or as otherwise required by law. If an employed physician or provider separates employment or is terminated by the Ventura County HCA for any reason, he or she may not remove any original medical records, patient lists, and/or billing information from Ventura County HCA facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written or verbal request to Ventura County HCA.
4. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering, will be maintained as appropriate. Records will be released from the Health Information Management department only in accordance with the provisions of this policy and other Ventura County HCA privacy policies and procedures.
5. Special care must be exercised with medical records protected by the State and Federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing and AIDS research. Refer to Administrative Compliance

Policy [109.010, Obtaining Authorization for Use or Disclosure of Protected Health Information](#).

6. Chronology is essential and close attention shall be given to ensure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

I. Retention and Destruction of Medical Records

All medical records are retained for at least as long as required by State and Federal laws and regulations, and Ventura County Health Care Agency policies and procedures. The electronic version of the record must be maintained per the legal retention requirements as specified in Administrative Operating Policy [107.013, Record Retention](#).

J. Maintenance and Legibility of Record

All medical records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the Administrative Operating Policy [107.013, Record Retention](#).

Handwritten entries should be made with permanent black or blue ink, medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

K. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, with the inaccurate information still being viewable/accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. An example of changing an incorrect entry may include writing/entering, "wrong patient," etc.

The contents of a medical record must not otherwise be edited, altered or removed. Patients may request a medical record amendment and/or a medical record addendum (refer to *Form 800-012 Request to Amend Protected Health Information*).

1. Documents created in a paper format:
 - a. Do not place labels over the corrected information entries.
 - b. If information, in a paper record, must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and include the signature of the person making the revision.
 - c. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the document, correcting as described above, and rescanning it into the patient's EMR.

2. Documents that are created electronically must be corrected by one of the following mechanisms:

- a. Adding an addendum to the electronic document, indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
- b. Preliminary versions of transcribed documents may be edited by the author, prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered, prior to signing (i.e., wrong work type, wrong date, wrong attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.
- c. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy, as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.
- d. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.

3. When a pertinent entry was missed or was not written in a timely manner, the author must meet the following requirements:

- a. Identify the new entry as a "late entry."
- b. Enter the current date and time; do not attempt to give the appearance that the entry was made on a previous date or at an earlier time. The entry must be signed.
- c. Identify and document the date and circumstance for which the late entry or addendum was written.
- d. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

4. An addendum is another type of late entry that is used to provide additional information, in conjunction with a previous entry.

- a. Document the date and time on which the addendum was made.
- b. Write "addendum" and state the reason for creating the addendum, referring back to the original entry.
- c. When writing an addendum, complete it as soon as possible after the original note.

5. Errors in Scanning Documents

If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

- a. Copy the incorrectly scanned documents
 - b. Rescan the document to the correct date or patient's encounter number. Mark the incorrectly scanned documents with the term, In-error.
6. Electronic Documentation Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

- a. In general, correcting an error in an electronic/computerized medical record follow the same basic principles as corrections to the paper record.
- b. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
- c. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

L. Authentication of Entries

1. Electronic signatures must meet standards for:
 - a. Data integrity to protect data from accidental or unauthorized change (for example, locking of the entry so that once signed, no further untracked changes can be made to the entry);
 - b. **Authentication** to validate the correctness of the information and confirm the identity of the signer (for example requiring the signer to authenticate with a password or other mechanism);
 - c. **Non-repudiation** to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).
2. At a minimum, the **electronic signature** must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.*
3. Electronic signatures must be affixed only by that individual whose name is being affixed to the document, and no other individual.
4. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.
5. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.
6. Rubber stamp signatures: *Refer to Section F(4).*

* Acknowledge that there may be older systems that do not have this capability. There are future plans for all systems to meet this minimum requirement.

7. Documents with multiple sections or documents completed by multiple individuals, should include a signature area on the document for all applicable staff to sign and date. Staff who have completed sections of a form, should either indicate the sections they completed at the signature line or initial the sections they completed.

8. No individual shall share electronic signature keys with any other individual.
9. **Macros and Checklists.** Pre-printed forms, checklists, patient questionnaires and word-processing macros can be used to supplement written or dictated notes. When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation, if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized, patient specific information that is sufficient to support a medical necessity determination. The note in the record must sufficiently describe the specific services furnished to the specific patient, on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros which do not contain patient specific information, Medical record macros and checklists may be used to supplement provider written or dictated notes.
10. **Authentication of Entries for paper signatures** must include signature, name, credentials or unique identifier, date and time.

M. Designation of Secondary Patient Information

The following categories of data contain secondary patient information and must be afforded the same level of confidentiality as the legal health record, but are not considered part of the legal health record.

1. Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They often are maintained at the department level in a separate location or database, and are retrievable only upon request. Examples include:
 - a. Photographs for identification purposes;
 - b. Audio recordings of dictation notes or patient phone calls;
 - c. Video recordings of an office visit, if taken for other than patient care purposes;
 - d. Video recordings/pictures of a procedure, if taken for other than patient care purposes;
 - e. Video recordings of a telemedicine consultation;
 - f. Communication tools (i.e., work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes or summary reports prepared by clinicians, etc.);
 - g. Protocols/clinical pathways, best practice alerts and other knowledge sources;
 - h. A patient's personal health record provided by the patient to his or her care provider;
 - i. Alerts, reminders, pop-ups and similar tools used as aids in the clinical decision making process. The tools themselves are not considered part of the legal health record, however, the associated documentation of subsequent actions taken by the provider, including the condition acted

upon, and the associated notes detailing the exam, are considered a component of the legal health record. Similarly, any annotations, notes and results created by the provider, as a result of the alert, reminder or pop-up, are also considered part of the legal health record.

2. **Administrative Data** is patient-identifiable data used for administrative, operations and payment purposes. Examples include:
 - a. Authorization forms for release of information;
 - b. Correspondence concerning requests for records;
 - c. Birth and death certificates;
 - d. Event history/audit trails;
 - e. Patient-identifiable abstracts in coding system;
 - f. Patient identifiable data reviewed for quality assurance or utilization management;
 - g. Administrative reports.
3. **Derived Data** consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples include:
 - a. Accreditation reports;
 - b. Best practice guidelines created from aggregate patient data;
 - c. ORYX reports, public health records and statistical reports.
4. **Draft Documents/Work in Progress.** Electronic processes and workflow include:

These work in progress documents often are available in the system as "draft documents," viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until signed by an authorized signer.

N. Enforcement, Corrective and Disciplinary Actions

Compliance with the above policy is monitored by Ventura County HCA. Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with Ventura County HCA, Medical Staff Bylaws, and Human Resource/Personnel policies.

APPENDIX A

Documentation Contents of the Medical Record

The medical record shall include, at a minimum, the following items (if applicable):

- A. Identification information, which include but are not limited to the following:
 1. Name;

2. Address on admission;
3. Identification number (if applicable);
 - Medicare
 - Medi-Cal
 - Hospital medical record number
 - Social security number
4. Age;
5. Sex;
6. Race (with option to decline);
7. Ethnicity (with option to decline);
8. Marital status;
9. Legal status;
10. Mother's maiden name;
 - Patient's mother's maiden name
 - Place of birth
11. Legal authorization for admission (if applicable);
12. School grade, if applicable;
13. Religious preference;
14. Date and time of admission (or arrival for outpatients);
15. Date of time discharge (departure for outpatients);
16. Name, address and telephone number of person or agency responsible for patient;
17. Name of patient's admitting/attending physician;
18. Initial diagnostic impression;
19. Discharge or final diagnosis and disposition;
20. Allergy records;
21. Advance directives (if applicable);
22. Medical history including, as appropriate: Immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients, a neonatal history;
23. Physical examination;
24. Consultation reports;
25. Orders including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services;
26. Progress notes including current or working diagnosis (excluding psychotherapy notes);

27. Nurses' notes, which shall include, but not be limited to, the following:
- Nursing assessment including nutritional, psychosocial and functional assessments.
 - Concise and accurate record of nursing care administered.
 - Record of pertinent observations including psychosocial and physical manifestations and relevant nursing interpretation of such observations.
 - Name, dosage and time of administration of medications and treatment, route of administration and site of injection shall be recorded if other than by oral administration.
 - Record of type of restraint and time of application and removal.
 - Record of seclusion and time of application and removal, (NPH).
28. Graphic and vital sign sheet;
29. Results of all laboratory tests performed;
30. Results of all radiologic examinations performed;
31. Consent forms for care, treatment and research, when applicable;
32. Problem list (outpatient records only);
33. Emergency Department record;
34. Anesthesia record including preoperative diagnosis, if anesthesia has been administered;
35. Operative and procedures report including preoperative and postoperative diagnosis, description of findings, technique used and tissue removed or altered, if surgery was performed;
36. Pathology report, if tissue or body fluid was removed;
37. Written record of preoperative and postoperative instructions;
38. Labor record, if applicable;
39. Delivery record, if applicable;
40. Physical, occupational and/or respiratory therapy assessments and treatment records, when applicable;
41. Patient/family education plan (NPH only);
42. Clinical data set from other providers;
43. Master data sets (as applicable to record type) including, but not limited to: MDS (Skilled Nursing), OASIS (Home Health), IRF and PAI (Rehabilitation);
44. Patient photographs when used for identification or treatment;
45. Master Treatment Plan and Reassessment (NPH only);
46. Discharge instructions;
47. A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on

discharge and the recommendations and arrangements for future care and if applicable, it shall include diet and self-care instructions;

48. Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:

- Provide new or renewal of prescription for medications.
- Alter the current plan of care, including treatments and medications.
- Identify a new system or problem and provide a plan of care.
- Provide home care advice for symptom/problem management.
- Provide authorization for care.
- Provides or reinforces patient education.

Documentation should include:

- a. the date and time of the call;
- b. the name of the caller and the relationship to the patient (if different from the patient);
- c. date and time of the response (or attempts to return call);
- d. the response given; and
- e. the signature and professional title of provider or clinic staff handling the call.

49. Primary language;

50. Copies of letters to patients.

All Revision Dates

3/30/2026, 3/16/2023, 5/26/2022, 2/8/2016

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	3/30/2026
Chief Financial Officer	Michael Taylor: Chief Financial Officer, Health Care Agency	1/21/2026
Policy Owner	Vibha Gune: HIM Manager	11/15/2025



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Next Review 4/27/2029

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

EVS.11 Cleaning of Vinyl Chairs

POLICY:

To aid in the elimination of the spread of infection, vinyl chairs should be cleaned and disinfected on a bi-weekly or as needed basis.

PROCEDURE:

~~When cleaning vinyl chairs, use a hospital-approved cleaner/disinfectant according to the manufacturer's directions. Using gloves and a clean cloth, wipe the back of the chairs, top, sides, and bottom edges, including the seat and legs. Allow cleaner/disinfectant to air dry. Do not wipe dry.~~

~~If vinyl is ripped or cracked, remove chair from service and notify the Housekeeping Supervisor/Lead who will notify the charge nurse. A work order will be submitted to have the chair replaced.~~

- When cleaning vinyl chairs, use an Environmental Protection Agency (EPA) hospital-approved cleaner/disinfectant according to the manufacturer's instructions.
- Using personal protective equipment (PPE) as indicated, such as gloves, with a clean cloth, wipe the back of the chairs, top, sides, and bottom edges, including the seat and legs.
- Allow cleaner/disinfectant to air dry. Do not wipe dry.
- If vinyl is ripped or cracked, remove chair from service and notify the Housekeeper Supervisor/Lead. The chair will be replaced in in stock, or a work order will be submitted for its repair or replacement.

All Revision Dates

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Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/28/2026
Infection Prevention	Magdy Asaad: Infection Prevention Manager	4/28/2026
Housekeeping Manager	Michael Lopez: Supervisor, Environmental Services	3/11/2026
Housekeeping Manager	Fernando Medina: Director, Support Services	3/5/2026

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

EVS.42 Ultraviolet Germicidal Irradiation (UVGI)

Ultraviolet Light Disinfection System (Tru-D) Usage and Safety Policy

Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) will utilize Ultraviolet (UV) light disinfection as an additional disinfection process after standard cleaning and disinfection of areas has been completed. Trained staff from the VCMC/Santa Paula Hospital Environmental Services (EVS) department will administer the UV disinfection process.

VCMC and SPH Environmental Services management is responsible and accountable for the safety, training and maintenance of the UV device. Annual training is required, and remedial/refresher training is provided as needed. Inspections should be conducted per the contractual agreement by the vendor and coordinated by Engineering. The EVS Manager and Supervisors are responsible for working directly with the vendor for arranging replacement supplies such as bulbs.

Purpose

To establish a standard procedure for the safe use of UV for disinfection. The addition of germicidal irradiation technology as an effective means to eradicate the residual germicidal contamination that can persist on surfaces in the ~~healthcare~~ **health care** environment after standard cleaning and disinfection has been completed, in order to improve patient safety, patient outcomes and quality of care.

Scope/Coverage

Ultraviolet germicidal irradiation (UVGI) is a disinfection method that uses short-wavelength ultraviolet (ultraviolet C or UV-C) light to kill or inactivate microorganisms by destroying nucleic acids and

disrupting their DNA, leaving them unable to perform vital cellular functions. UVGI is used in a variety of applications, such as food, air, and water purification.

The Tru-D Ultraviolet Light Disinfection System is an automated, remotely operated system that self-adjusts to the size and content dynamics of a room to deliver the proper dose of ultraviolet-C (UVC) light energy.

Ultraviolet (UV) light is a form of light, invisible to the human eye. UVC wavelengths are between 200 and 300 nanometers, making them germicidal – meaning they are capable of inactivating microorganisms, such as bacteria, viruses and protozoa.

Procedure

This policy and procedure applies to every use of the UV device at VCMC and SPH areas that requires enhanced disinfection as directed by Infection Prevention.

Areas ~~targeted~~identified by Infection Prevention for disinfection with the UV device, ~~after~~following standard cleaning and disinfection, include ~~at a minimum~~:

- ~~A. Isolation rooms after each discharge – REQUIRED and Prioritized as following:~~
 - ~~1. Coronavirus (COVID-19) Rooms~~
 - ~~2. Clostridium difficile (CDIFF) Rooms~~
 - ~~3. Norovirus Rooms~~
 - ~~4. Carbapenem-resistant Enterobacteriaceae (CRE)~~
 - ~~5. Vancomycin-resistant Enterococcus (VRE)~~
 - ~~6. Other significant Multi-Drug Resistant Organisms (MDROs)~~
 - ~~7. All inpatient rooms quarterly, if not already UV-disinfected during that period – (as feasibly possible)~~
- ~~A. Operating Rooms (ORs) and Interventional Radiology (IR) Rooms after daily terminal clean.~~
- ~~B. Library, Lobbies, waiting rooms every 3-6 Month – After all of the above priorities have been met.~~
- A. Isolation rooms after each discharge
- B. High-risk patient care areas identified by Infection Prevention
- C. Patient rooms associated with outbreak investigations or clusters of healthcare-associated infections
- D. Any additional areas identified by Infection Prevention or hospital leadership requiring enhanced environmental disinfection

Before using a UV device, please follow ~~your facility~~VCMC & SPH's standard cleaning and disinfection policies and procedures. Consult *Centers for Disease Control* (CDC) and *Association for Professionals in Infection Control and Epidemiology* (APIC) guidelines for additional steps to take as part of a bundled cleaning and disinfection approach.

Provisions/Note: UV disinfection should be used as a supplement--not as a replacement--to standard cleaning policies and procedures. Process which includes, but may not be limited to:

- A. Ensure that the area/room to be disinfected using the UV device has first been cleaned and disinfected as per applicable EVS standard cleaning policies and procedures.
- B. Ensure the room is unoccupied by all persons, service animals, and plants prior to operating the UV device, in accordance with manufacturer guidelines.
- C. Perform hand hygiene prior to operating the UV device, and utilize appropriate personal protective equipment (PPE). Retrieve the UV device and safety signs from the designated storage location and bring to the area/room to be UV disinfected. ~~The device comes with a Door Monitor safety feature that will interrupt the disinfection cycle if the door sensor is activated.~~ The UV-C energy will not penetrate walls, plastic, cloth or standard glass.
- D. Always follow all operating steps and safety procedures that apply to the area/room to be disinfected, including:
 - The Tru-D device is not to be used in open areas (e.g. curtained bays).
 - Use caution when rolling the device from one location to another, over uneven or sloped flooring.
 - Do not touch the UV bulbs unless replacing.
 - After arriving at the area/room designated for disinfection, remove the UV device bulb covers prior to entering the area/room.
 - If a room has two entrances, always lock one of the entrances from the inside of the room to be disinfected to prevent anyone from entering the room while disinfection is in process. If a lock is unavailable, use extra safety barriers for those entrances.
 - In preparing the area/room for UV disinfection, (Remove ~~linen removed~~ from bed, curtain pulled back, bed rails are placed up, hang call button/phone/high-touch items for maximum exposure, cabinets/drawers open, movable items pulled away from wall, monitors and surgical lights facing away from direct light etc.).
 - Place the UV device in the appropriate location and secure wheels so that the device does not roll inadvertently during the disinfection process.
 - Plug the electrical cord into the nearest red electrical outlet. Do not use an outlet where other electrical equipment is already plugged in.
- A. Operation of the Tru-D:
 1. Turn on the Tru-D remote.
 2. Tap the Tru-D icon.
 3. Select "Disinfect" on the tablet screen.
 4. Choose an Operator.
 5. Tap the box below the operator list labeled "PIN"
 6. Display the keyboard, and the operator will enter a personal activation password.
 7. Enter Room Number.
 8. Select a pathogen.

9. Select a Cycle Type.
10. Conduct a safety check:
11. Ensure that the following requirements are met and tap each item on the checklist:
 - Room Clear: Is the door barrier signage in place?
 - Sound Check: You heard the Tru-D do its volume check?
 - ~~Door Monitor has been properly placed?~~
 - Tap "Start"
1. If Tru-D needs to be stopped for any reason during the cycle, press the "abort" button on the Tru-D remote ~~or Door Monitor~~.
2. The Tru-D remote must be within 25 meters of Tru-D during operation or Tru-D may lose wireless communication with the remote and terminate the disinfection cycle.
3. Cycle will run until the Disinfection Status shows 100% complete.
4. At this point the Tru-D will turn off.

Operating Rooms (ORs)

- ~~1. Face surgical lights and monitors away from direct light (UVC indirect light is suggested)~~
- ~~2. Remove any materials labeled "Do not expose to sunlight"~~
- ~~3. Disconnect all support straps that remain on the procedure table and allow them to hang off the side of the table, but not touching the floor.~~

Other Rooms

Placement

1. Placement of UV device is determined by the size and configuration of the room. Refer to the manufacturer's specification and vendor representative to determine appropriate placement of UV device for specific room types if there are any questions. (Use Positioning Coach on Tru-D remote to ensure optimal placement.)
- ~~2. If there are any operational difficulties or malfunctions with the UV device, purple tag the equipment to place it out of order and report the discrepancy with local EVS management immediately. The EVS Manager/Supervisor will notify The Biomedical Department of the equipment failure.~~

UV Equipment failure procedure

1. Remove the device from service immediately.
If the UV device is not functioning properly, discontinue use to prevent improper disinfection or potential safety hazards.
2. Secure the equipment.
Place an "Out of Order" sign on the device to ensure staff are aware the equipment is not to be

used.

3. Notify supervision.

Report the issue promptly to the EVS Supervisor or EVS Manager and provide details regarding the malfunction or observed issue.

4. Vendor notification and service.

The EVS Manager or Supervisor will contact the Tru-D vendor to report the malfunction and arrange for inspection, troubleshooting, and repair of the device.

5. Return to service.

The UV device may only be returned to service after the malfunction has been corrected and the unit has been verified to be functioning properly.

References/Appendices:

1. U.S Centers for Disease Control and Prevention. Guidelines for Environmental Infection Control in Health-Care Facilities at: <http://www.cdc.gov/MMWR/preview/MMWRhtml/rr5210a1.htm>
2. U.S Centers for Disease Control and Prevention. Hand hygiene in healthcare settings, hand hygiene basics. Available at: <http://www.cdc.gov/handhygiene/Basics.html>.
3. Rutala WA, Weber DJ. Understanding and preventing transmission of healthcare-associated pathogens due to the contaminated hospital environment. ICHE 2011;32:743-747.
4. Anderson, D et al. Decontamination of targeted pathogens from patient rooms using an automated ultraviolet-C-emitting device. ICHE 2013;34(5):466-471.

All Revision Dates

4/3/2026, 10/27/2020

Attachments

 [Attachment A: Room Cleaning Protocol for Patients with Known or Suspected COVID](#)

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	4/3/2026

Infection Prevention	Magdy Asaad: Infection Prevention Manager	4/1/2026
Housekeeping Manager	Fernando Medina: Director, Support Services	3/27/2026
Housekeeping Manager	Michael Lopez: Supervisor, Environmental Services	3/16/2026

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VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

May 2026

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

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2.	100.223 Discharge Against Medical Advice (AMA)	page	5-7
3.	100.224 Emergency Medical Treatment and Labor Act (EMTALA)	page	8-12
4.	100.237 Elopement & Left Without Being Seen (LWBS) Policy	page	13-20
5.	100.278 Surge Plan	page	21-31
6.	100.279 Responsible Use of Health-Related Artificial Intelligence Technology	page	32-36
7.	100.285 Pronouncement of Death by a Registered Nurse	page	37-39
8.	102.024 Non-affiliated Physicians and Assistant or Proctor	page	40-42
9.	CA.PRC.013 Watch and Wait Management for Rectal Cancer: NAPRC Standard 5.13	page	43-47
10.	IS.38 MRI Pre-Screening Process	page	48-49
11.	IS.56 Radiation Protection	page	50-52
12.	IS.57 Computerized Tomography Enterography	page	53-54
13.	PH.088 Controlled Substances	page	55-62
14.	PH.096 Medication Override from Automated Dispensing Cabinets	page	63-66
15.	R.51 Non-Invasive Ventilation	page	67-76
16.	R.57 Respiratory Care Invasive Mechanical Ventilation	page	77-85
17.	R.104 Tranexamic Acid For Nebulization	page	86-88
18.	RS.13 Outpatient Rehab Services Use of Dexamethasone	page	89-90
19.	HIPAA Privacy Policy: General Use, Disclosure, and Confidentiality of Protected Health Information (PHI)	page	91-97

b. Medical Staff Forms

1.	Cardiology Privilege Checklist (approved by Medicine Committee)	page	98-102
2.	Family Medicine Privilege Checklist (approved by Family Medicine Committee)	page	103-105
3.	OB/GYN Privilege Checklist (approved by OB/GYN Committee)	page	106-110
4.	Podiatry Privilege Checklist (approved by Surgery Committee)	page	111-112



VENTURA COUNTY HEALTH CARE AGENCY

Origination: 11/8/2016
 Effective: Upon Approval
 Last Approved: N/A
 Last Revised: 3/6/2026
 Next Review: 3 years after approval
 Owner: Erin Olivera: Clinical Nurse Manager, IPU/CSU
 Policy Area: Administrative - Patient Care
 References:

100.203 Patient Transport/Escort To and From the Inpatient Psychiatric Unit (IPU), the Crisis Stabilization Unit (CSU), the Emergency Department (ED) and Inpatient Acute Care Units

POLICY:

This policy outlines the proper procedure for the transport and escort of patients to and from Ventura County Medical Center (VCMC) hospital acute care inpatient units, the Emergency Department (ED), the Inpatient Psychiatric Unit (IPU) and the Crisis Stabilization Unit (CSU).

Staff caring for patients who are actively suicidal, homicidal, assaultive, or an elopement risk and who require transport to and from VCMC ED, acute care inpatients units, IPU or CSU must be assisted and escorted by Security and a VCMC ~~icensed~~ licensed health care professional. ~~Staff should call the Crisis Team to assess if a patient prior to transport to determine if the patient needs to be placed on a 5150 hold as appropriate. For patients on a 5150 hold, Security staff will have the training and authority to give staff "hands on" assistance. If a patient~~ is highly volatile and high risk, VPD (Ventura Police Department) personnel ~~will~~ may be requested to assist with the patient transport.

PROCEDURE:

~~All staff caring for a patient that requires transport/escort should take the following steps regardless of the patient's legal status (voluntary, involuntary etc.):~~

All staff caring for a patient that requires transport/escort should take the following steps regardless of the patient's legal status (voluntary, involuntary etc.):

1. ~~Transport of a patient needing psychiatric care:~~

Transport of a patient needing psychiatric care:

The Transferring Unit Physician determines the need for restraints during transport and places the order in the electronic health record(EHR).

~~After a 5150 hold has been placed (if appropriate), staff should:~~

- ~~◦ The physician will assess necessity of restraints for transport with the goal of ensuring patient safety. If indicated, a one-time order for restraints shall be used during the transport of the patient. The licensed staff member shall monitor and document the patient's restraints per policy.~~
- ~~◦ Upon arrival at the receiving department, the patient's restraints shall be removed as soon as safely possible.~~
- ~~◦ ~~Call~~Staff call Security at ext. 6283 and request a patient escort.~~
- ~~◦ All patients will be transported via ~~Stryker~~ Transport gurney.~~

~~The physician will assess necessity of restraints for transport with the goal of ensuring patient safety. If indicated, a one-time order for restraints shall be used during the transport of the patient. Upon arrival at the receiving department, the patient's restraints shall be removed. The licensed staff member shall monitor the patient's restraints at all times.~~

- ~~◦ A licensed healthcare professional will complete the SBAR form (Situation, Background, Assessment, Recommendation) which is to be handed to staff in the receiving department.~~
- ~~◦ A licensed health care professional shall accompany the patient and the Elite Security Officer to the IPU or CSU designated unit.~~

2. ~~Transport of a patient who is highly volatile/high risk currently on a 5150 hold:~~

- ~~◦ Staff shall call the VPD officer stationed in the VCMC ED and request assistance with a patient escort.~~
- ~~◦ All patients will be transported via Stryker Transported gurney.~~
- ~~◦ The physician shall assess the necessity for restraints for transport with the goal of ensuring patient safety. If indicated, a one-time order for restraints shall be used during the transport of the patient. Upon arrival at the receiving department, restraints shall be removed. The licensed staff member shall monitor the patient's restraints at all times.~~
- ~~◦ A licensed health care professional shall complete the SBAR form which is to be handed to staff in the receiving department.~~
- ~~◦ A licensed health care professional shall accompany the patient and the VPD officer to the IPU or CSU.~~

Transport of a patient who is highly volatile/high risk currently on a 5150 hold:

- Staff may call the VPD officer and extra security to request assistance with a patient escort when warranted.
- The physician will assess necessity of restraints for transport with the goal of ensuring patient safety. If indicated, a one-time order for restraints shall be used during the transport of the patient. The licensed staff member shall monitor and document the patient's restraints per policy.
- Upon arrival at the receiving department, the patient's restraints shall be removed as soon as safely possible.
- Staff call Security at ext. 6283 and request a patient escort.
- All patients will be transported via Transport gurney.

- A licensed healthcare professional will complete the SBAR form (Situation, Background, Assessment, Recommendation) which is to be handed to staff in the receiving department.
- A licensed health care professional shall accompany the patient and the Elite Security Officer to the designated unit.

Guidelines:

1. Acquire a ~~Stryker~~ Transport gurney.
2. Apply restraints if needed and appropriate, ensuring a one-time order is placed.
3. ~~Cover~~Offer and cover the lower half of the patient's body with a sheet or blanket if they consent.
4. Transport the patient from VCMC inpatient units (including the ED) to IPU/CSU (or vice versa).

Note: Elite Security is available 24 hours a day, 7 days a week. The Elite Security Officers have received additional training in de-escalation techniques and crisis prevention interventions. In addition, Elite Security Officers are trained to provide hands-on detention as appropriate.

All revision dates:

3/6/2026, 3/26/2019, 3/22/2019, 11/9/2016, 11/9/2016, 11/8/2016, 11/8/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: ED & Psychiatry	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/6/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/6/2026
Policy Owner	Erin Olivera: Clinical Nurse Manager, IPU/CSU	3/6/2026



VENTURA COUNTY HEALTH CARE AGENCY

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

100.223 Discharge Against Medical Advice (AMA)

~~POLICY:~~

~~This policy is to establish the procedure for discharging a patient Against Medical Advice (AMA).~~

~~PROCEDURE:~~

~~When a patient does not meet the criteria for a legal hold, is released by the courts or requests to be discharged AMA, the procedure for discharge is as follows:~~

- ~~1. Nursing staff should notify the treating physician of a patient's request to be discharged.~~
- ~~2. The treating physician will meet with the patient to explain the risks involved in failing to continue treatment.~~
- ~~3. If the patient continues to request discharge, staff will begin the process of discharge.~~
- ~~4. All patients will be encouraged to continue with medication regimen and to follow up with outpatient services upon discharge. Social Services staff or designee will provide resource information or arrange for follow up appointments if patient consents.~~
- ~~5. Patients will be offered drug prescriptions and medical follow up appointments. Aftercare Plan and chart will document patient refusal of medications and/or follow up appointments.~~
- ~~6. Staff will follow discharge procedure according to Administrative policy 100.038.~~
- ~~7. Patients with known reportable infectious diseases or other reportable conditions will be reported to the Public Health Department.~~

~~After Hours or When Responsible Physician is Not Available~~

- ~~1. Patient will be evaluated for change in legal status by certified unit staff. If patient was not on 5150 hold, initiate 5150 if criteria is met.~~
- ~~2. On call physician will document discussion and outcome in the chart. A Discharge Summary shall be dictated by the responsible physician post discharge for patient stay greater than 48 hours.~~
- ~~3. Patient will be released or notified of change in legal status and detained. Patient will sign AMA form. Patient will be given referrals for follow up treatment. All belongings will be returned except items kept in the locked unit safe. Patient will be required to return to obtain these items.~~

Purpose:

To provide clear guidance for safely discharging patients who choose to leave Against Medical Advice (AMA), in both the **Emergency Department (ED)** and **Inpatient units**. This policy provides guidance to ensure that patients receive required information on risks, alternatives, follow-up options (if appropriate), and documentation requirements.

Definition:

Discharge Against Medical Advice: a situation in which a patient chooses to leave the hospital or health care facility before the treating provider recommends discharge, despite being informed of and understanding the medical risks of leaving.

Procedure: Applies to All Areas

1. Notify Provider

- Nursing staff must notify the treating provider as soon as a patient requests to leave AMA

2. Provider - Evaluation, Discussion & Documentation

The provider must meet with the patient/legal representative to (and document):

- Assess the patient's decision-making capacity
 - If the patient's decision-making capacity is not adequate, contact and attempt to involve an appropriate legal representative.
- Explain medical concerns, risks of refusing treatment, and possible negative outcomes
- Offer alternatives and review available therapies (if applicable)
- Confirm the patient's/legal representative's understanding
- Encourage the patient to return at any time for further evaluation or treatment
- Provide all applicable discharge resources—such as prescriptions, follow-up referrals, and patient education—when clinically appropriate and feasible.
- Enter discharge order with disposition "Left Against Medical Advice" selected.

3. Nurse- Documentation

- Nurse to document patient behavior
- Nurse to complete discharge documentation in EHR

4. Forms & Signatures (after provider evaluation and discussion)

- Use the AMA form to obtain the patient/legal representative's signature. See attachment A
- If unable to obtain signature prior to patient leaving, document on form:
 - Reason unable to obtain signature (for example, "*Patient refused to sign*") in the patient signature area
 - Date and time
 - MD signature
- A **copy** of the AMA form will be provided to the patient/legal representative

- The completed AMA form must be scanned into the patient's EHR

Inpatient Considerations (In addition to the above process)

1. AMA form (process outlined above)
2. Follow inpatient discharge procedure per **Administrative Policy 100.038 Discharge Requirements**.
3. Document any patient (or representative) refusal and reason (if known). If patient stay has exceeded **48 hours**, a **Discharge Summary** must be dictated after discharge by treating physician.

Reference:

Department of Health Care Access and Information. (2025). *Patients leaving California hospitals against medical advice (AMA), 2019-2020*. HCAI. Retrieved November 15, 2025, from <https://hcai.ca.gov/visualizations/patients-leaving-california-hospitals-against-medical-advice-ama/>

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4/28/2026, 3/14/2024, 1/10/2023, 2/1/2016, 5/1/
2014, 3/1/2009, 2/1/2008, 3/1/2007, 10/1/2006

Attachments

 [FINAL 3.2026 AMA.pdf](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/29/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/28/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/28/2026
Policy Owner	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/28/2026



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

100.224 Emergency Medical Treatment and Labor Act (EMTALA)

POLICY:

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted both by Congress to regulate and restrict the transfer, for economic or other non-medical reasons, all patients presenting for emergency services. The primary focus of EMTALA is to ensure access for all patients to emergency services and to prohibit discrimination in the provision of emergency services. This policy aligns with the EMTALA definition of hospital campus which refers to the areas located within 250 yards of the main campus buildings.

This policy provides for:

- A. The Medical Screening Examination (MSE) conducted by a physician or Qualified Medical Person (QMP) will be provided to all patients presenting to the Emergency Department (ED).
- B. The transfer of patients with emergency medical conditions.

PROCEDURE:

- A. A medical screening examination (MSE) will be offered to any individual presenting for examination or treatment of a medical condition. The examination will be the same appropriate screening examination that would be performed on any individual with similar signs and symptoms, regardless of the individual's ability to pay for medical care.
- B. The medical screening examination or necessary stabilizing treatment shall not be delayed in order to inquire about an individual's method of payment or insurance status. Prior authorizations will not be requested for emergency services until the medical screening examination has been conducted.
- C. The hospital will not transfer any patient with an unstable emergency condition (including a pregnant patient having contractions or a patient with severe pain) unless a physician certifies that the medical benefits reasonably expected from the provision of treatment at the receiving facility outweigh the risks of the transfer.
 - 1. Prior to transfer, the receiving hospital and physician have agreed to accept the patient and to provide appropriate medical treatment.
 - 2. The hospital shall send to the receiving facility all medical records (or copies thereof) available at the time of transfer related to the emergency condition of the patient, including:
 - a. Records related to the patient's emergency condition, observations of signs or symptoms,

preliminary diagnosis, treatment provided, results of any tests and vital signs at the time of transfer; other records (including pending test results or records not available at the time of transfer) must be forwarded as soon as practicable after the transfer;

- b. The patient's informed written consent to transfer or the physician's certification (or copy thereof); and
 - c. The name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.
3. The transfer is effected using proper staff and equipment, as well as necessary and medically appropriate life support measures.

If a patient who has or may have an emergency medical condition is transferred to another facility for a test with the intention of the patient returning to the Hospital after the test, the Hospital will transfer in accordance with EMTALA standards.

PATIENT REFUSAL OF EMERGENCY SERVICES OR TRANSFER

- A. Under EMTALA the patient retains the right to refuse necessary stabilizing treatment and further medical examination, as well as a transfer to another facility.
- B. If a patient leaves the hospital before receiving a medical screening examination, either with or without notice to staff, staff should document the circumstances and reasons (if known) for the patient's departure and the time of departure.
- C. If a patient refuses stabilizing treatment after receiving a medical screening, the physician or QMP at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) will offer examination and treatment, and inform the patient of the risks and benefits of the examination and treatment and request that the patient sign an *Against Medical Advice (ADA)* form that he/she has refused further treatment. A summary of the risks of not receiving treatment as describes to the patient shall be documented in the medical record.

SIGNAGE

Signs will be posted in lobbies and other appropriate locations where patients may be waiting for treatment or where examination may occur specifying the rights of individuals to examination and treatment for emergency medical conditions and indicating the participation in the Medi-Cal program. The signs will also explain how to contact the State Department of Health Services. The signs will be posted in English and Spanish in the ED and Labor and Delivery.

DOCUMENTATION LOG

Each location that provides medical screening examination will maintain a central log recording the name of the person who presents for emergency services and whether the person refused treatment, was refused treatment or whether the patient was transferred, admitted and treated, stabilized and transferred or discharged.

ON-CALL RESPONSE

A list of on-call physicians is maintained in the ED. These physicians are to provide consultation or treatment necessary to stabilize a patient with an emergency medical condition. See Physician On-Call Administrative

policy 100.107.

MAINTENANCE OF RECORDS

Transfer logs, on-call lists and changes to the on-call list and central logs shall be maintained for five (5) years.

DISPUTES

In the event of any concern over emergency services to a patient, a dispute with another hospital regarding a patient transfer or a concern about VCMC/SPH's compliance with EMTALA, the Hospital Administrator on duty and the Medical Director are to be notified immediately.

AMBULATORY SETTING (ACADEMIC FAMILY MEDICAL CENTER)

The campus of VCMC encompasses additional areas beyond the hospital proper. Patients who present to the Academic Family Medical Center (AFMC) and require transport to the VCMC ED will follow the workflows in Attachment A and Attachment B.

REPORTING

VCMC/SPH will report to the Health Care Finance Administration (HCFA) or State Licensing within 72 hours if it concludes that it has received an individual who has been transferred in an unstable emergency condition from another hospital. All hospital staff who believe an EMTALA violation has occurred shall report the violation to the Hospital Administrator on duty and Medical Director.

The hospital shall not retaliate, penalize or take adverse action against any Medical Staff member or employee for reporting violations of EMTALA or State laws to the proper authorities.

DEFINITIONS

Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of the individual in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before the delivery or the transfer may pose a threat to the health or safety of the woman or her unborn child.

Hospital Campus The physical area immediately adjacent to the hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers for Medicare & Medicaid Services ("CMS") Regional Office to be part of the hospital's campus.

Medical Screening Exam (MSE)

An MSE is the process required to reach, within reasonable clinical confidence, the point at which it can be determined whether the individual has an emergency medical condition (EMC) or not. An appropriate MSE is

dependent on the presenting signs and symptoms and may involve a wide spectrum of actions ranging from a simple process involving only a brief history and examination of the presenting symptoms to a complex process that includes ancillary studies and procedures. Medical includes both physiological and psychological symptoms.

Qualified Medical Person (QMP)

A Qualified Medical Person is a physician, nurse practitioner, physician assistant, and a specialty trained nurse such as obstetrics nurse who performs the examination and communicates the findings to an attending physician to determine if an EMC exists.

Transfer is defined as the movement of an individual outside of a hospital's facility at the direction of any person employed by the hospital, but does not include such movement of an individual who has been declared dead or leaves the facility without permission of any such person.

Labor is defined as the process of childbirth beginning with the latent or early phase of labor and continuing through delivery of the placenta. A woman is in true labor unless the physician certifies that after a reasonable time of observation, the woman is in false labor.

Stabilization is defined as follows:

Labor and Delivery patients. Stabilization is defined as delivery of the child and the placenta. A women having contractions "may not be transferred unless she, or a legally responsible person acting on her behalf, request a transfer or if a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the condition of the woman and/or unborn child out weigh the risks associated with the transfer."

Medical patients. Stabilization is defined as no material deterioration of the condition is likely, within reasonable medical probability, to result for or occur during transfer. A patient is deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

Capacity refers to the ability of the hospital to accommodate the individual requesting examination or treatment of a transfer patient. Capacity encompasses adequacy of staff, beds, equipment and past practices in accommodating additional patients beyond occupancy limits.

Psychiatric Patients

Stable for transfer. A psychiatric patient is considered "stable for transfer" if the patient has been assessed by the treating physician and determined to have no underlying organic basis for the presenting psychiatric symptoms; initial treatment has been provided as indicated; the patient has been treated sufficiently so that he/she is stable for transfer.

Stable for discharge. A psychiatric patient is considered "stable for discharge" if the patient no longer considered to be a threat to himself/herself or others.

All revision dates: 4/3/2026, 11/12/2025, 1/28/2020, 11/8/2016, 9/1/2015, 5/1/2006, 4/1/2000

Attachments

 [Attachment A](#)

 [Attachment B](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/6/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/6/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/3/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/3/2026



VENTURA COUNTY HEALTH CARE AGENCY

Origination: 8/10/2021
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Next Review: 3 years after approval
Owner: Fernando Medina: Director,
Support Services
Policy Area: Administrative - Patient Care
References:

100.237 Elopement & Left Without Being Seen (LWBS) Policy

~~POLICY:~~

~~To ensure that necessary Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) departmental personnel and appropriate outside agencies are notified, as well as provide an appropriate response in the event of a missing or eloping patient who has been identified to be a danger to self or others, or who is identified as an at risk patient (e.g., minors, patients who are confused or otherwise appearing to lack mental capacity/cognitive ability, etc.).~~

Purpose:

To outline the steps to be taken for patients who leave before treatment has been completed, have eloped, or are missing.

Every reasonable measure shall be taken to prevent the elopement of high-risk patients from the Hospital. The Hospital staff shall take all reasonable steps necessary, to safely retrieve or locate an eloped patient, as soon as possible.

Definitions:

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

~~**High-Risk Patient for Elopement and/or Patient Elopement:** A patient who fits the following criteria or who leaves the patient care unit without permission, who is:~~

- ~~1. On a legal hold (danger to themselves or others);~~
- ~~2. Having active suicidal/homicidal ideation and may be on a voluntary status;~~
- ~~3. Gravely disabled—unable to provide food, shelter or clothing;~~
- ~~4. On a "patient watch" or has a safety attendant/sitter;~~
- ~~5. Confused, disoriented or otherwise appearing to lack mental capacity/cognitive ability;~~
- ~~6. Have an adult protection, public trustee or court-appointed legal guardian;~~
- ~~7. Minors;~~

~~8. On-Lanterman-Petris-Short (LPS) conservatorship.~~

Left Without Being Seen (LWBS): A patient who leaves the care area prior to the initiation of the Medical Screening Exam (MSE).

Elopement: A patient who leaves their care area after MSE has been initiated, before treatment is complete, and/or before having an informed discussion with a provider.

Types of Elopement:

A. **Elopement- Low Risk:** A patient who **does not meet** the high-risk criteria outlined below and leaves the unit before treatment is complete.

B. **Elopement- High Risk:** A patient who meets **any** of the criteria below **and leaves the unit before treatment is complete:**

- On a legal hold (danger to self or others) or LPS conservatorship
- Active suicidal or homicidal ideation (voluntary or involuntary status)
- Gravely disabled (unable to provide food, shelter, or clothing)
- On "patient watch" or has a sitter
- Confused, disoriented, or lacking decision-making capacity
- Has an adult protective services case, public conservator, or court-appointed guardian
- Minors (without a legal guardian present)
- Other criteria at provider discretion

Code Green: A facility-wide alert for a missing high-risk patient requiring immediate search and safety actions.

PROCEDURE:

- ~~1. At no time during an elopement, will anyone without a valid "need to know" notification, be informed of the incident.~~
- ~~2. No hospital employee or volunteer is authorized to make a public statement concerning this incident or communicate with the news media or any other public agency about this incident.~~
- ~~3. The Hospital's response is limited to the hospital campus, as defined by policy.~~
- ~~4. The AOD or designee will notify Law Enforcement for assistance beyond the hospital campus.~~
- ~~5. Patients, other than those that are involuntary patients, have the right to leave the hospital against medical advice. The Hospital ensures the patient is safely discharged per VCMC/SPH discharge policy 400.038.~~

Left Without Being Seen

If staff become aware that a patient intends to leave before initiation of the MSE, reasonable efforts shall be made to encourage the patient to remain for evaluation.

When a patient who has not had an MSE initiated leaves the immediate care area without notice, staff will make a reasonable attempt to locate the patient by searching the last known location.

If the patient leaves and/or staff are unable to locate the patient **prior to initiation of the MSE**, staff will document **Left Without Being Seen** in the EHR.

PROCEDURE:

NOTE: Patients who have expressed their intention to leave after receiving an MSE, but before treatment is complete and/or before having an informed discussion with a provider, are encouraged to remain for continued evaluation. If the patient still leaves, proceed with the elopement response based on the patient's risk level.

Elopement-Low Risk Response

Upon discovery of a patient who is missing or suspected of elopement:

- A. ~~Staff shall notify the Hospital operator immediately and provide the following information:~~
 - 1. ~~The time and location the patient was last seen;~~
 - 2. ~~A description of the eloped patient;~~
 - 3. ~~The patient's assigned patient care unit.~~
- B. ~~The operator will announce a "Code Green" via the overhead paging system and ensure notifications are made to the Administrator on Duty (AOD), Security Services and the Safety Officer.~~
- C. ~~If a patient is missing from the patient care area and does not meet the criteria of a missing or eloping patient, the Charge Nurse and Security Services are notified to assist with locating the patient.~~

Code Green Response:

- A. ~~**Code Green Team:**~~
 - 1. ~~The Security Director, Nursing Supervisor and Safety Officer are used as the incident's management team structure, in response to a "Code Green."~~
 - 2. ~~The Nursing Supervisor on duty assumes the role, along with the Security department, during non-business hours, (e.g., weekends, holidays, after hours).~~
 - 3. ~~In order to obtain pertinent information, each member of this team will report to the area in which the patient was reported missing. In addition, notification will be paged overhead.~~
 - 4. ~~The most qualified member of the team will assume the role of team leader. The team leader will coordinate with the senior member of the patient care unit from which the patient eloped.~~
- B. ~~**The incident action plan objectives may include:**~~
 - 1. ~~Each team member performs specific functions assigned by the team leader, in support of the incident objectives.~~

~~**Initial Incident Objectives:**~~

- ~~a. Conduct a facility-wide search;~~
- ~~b. Make appropriate notifications;~~
- ~~c. Locate the eloped patient;~~
- ~~d. Review video monitoring system.~~

- e. ~~Security conducts a campus-wide search for the missing patient. Law enforcement is notified for assistance beyond the hospital campus. Security Director, Safety Officer or Nursing Supervisor to provide pertinent information to Law Enforcement using the following script(s):~~
- f. ~~***Attempt to Locate:** "This is VCMC/SPH, my name is _____, my title is _____. I am located at _____. I am notifying you that patient (state name) with a date of birth of (state DOB) has eloped from the hospital at (estimate approximate time of departure). Attempt to locate."~~ (Be prepared to describe patient and last known attire.)
- g. ~~***Danger to Self or Others:** "This is VCMC/SPH, my name is _____, my title is _____. I am notifying you that patient (state name) with a date of birth of (state DOB) has left the hospital (estimate approximate time of departure). This patient is A DANGER TO SELF AND/OR OTHERS."~~ (Be prepared to describe patient height, weight, build, last clothing attire).

C. Security:

- 1. ~~Secure hospital perimeter utilizing the Hospital's access control system, if applicable.~~
- 2. ~~Notify law enforcement, if applicable.~~
- 3. ~~All surrounding entrances and exits to the hospital are monitored until the situation has been resolved or unless otherwise directed by either the Director of Security, AOD, Nursing Supervisor or Safety Officer.~~
- 4. ~~Announce the missing/eloping patient's description to the checkpoint screener(s) and hospital staff.~~
- 5. ~~Provide further information regarding the incident, including a detailed description of the patient's clothing, medical conditions relevant to their safety or the safety of others, other parties involved, and any other pertinent information.~~
- 6. ~~Initiate continuous searches on campus until the missing/eloping patient is located. Notify surrounding buildings of the "Code Green" and provide those staff the patient's description.~~
- 7. ~~Secure video, if applicable.~~

D. Safety Officer:

- 1. ~~The Safety Officer serves to advise, coordinate and act as a liaison with Administration, as well as regulatory agencies.~~
- 2. ~~Will notify family, in collaboration with the AOD/Nursing Supervisor and or patient care staff. Family is provided ongoing information of the progress of the search and the measures the facility is taking to locate the patient.~~
- 3. ~~Assign a facility contact person who the family can call to obtain updated search information.~~

E. Patient Care Staff:

- 1. ~~All relevant medical information pertaining to the patient is made available to the appropriate person(s) or as authorization allows.~~
- 2. ~~The patient care staff notifies the attending physician of the incident.~~

F. Public Information Officer (if required):

- 1. ~~Drafts a press release for approval by the Chief Operations Officer and Chief Executive Officer (CEO).~~

- ~~2. Coordinates with law enforcement regarding the type of information that can be released to the news media, and when it is appropriate to do so.~~
- ~~3. Establishes a media briefing area and briefing time, if appropriate.~~

G. All Personnel:

- ~~1. Upon hearing "Code Green," monitor all points of exit and surrounding areas in their vicinity, for persons appearing to be a patient from another unit, leaving the facility.~~
- ~~2. Communicate any suspicious activity to security staff immediately.~~

H. Recovery:

- ~~1. The Safety Officer/Security and Law Enforcement (if applicable) determine when the "Code Green" event is concluded and then releases the site, to resume normal operations.~~
- ~~2. The Safety Officer or Director of Security will notify the operator to page, "Code Green, all clear" two (2) times.~~
- ~~3. Management will conduct a root cause analysis (RCA) or similar review of the incident, to identify areas for improvement and then implement those improvements.~~

I. When the Patient Returns:

- ~~1. Nursing to note the time of the patient's return in the EHR after confirming patient's identify using two patient identifiers.~~
- ~~2. Patient to be medically cleared in the Emergency Department prior to returning to unit of origin if missing for one hour or more and/or patient believed to have suffered injury or with significant behavior/physical status change/discretion of attending physician.~~
- ~~3. The Safety Officer/Director of Security or Nursing Supervisor will notify hospital personnel, Law Enforcement, etc. that the emergency response has ended.~~
- ~~4. Nursing to notify the attending physician of the patient's return.~~
- ~~5. Nursing Supervisor, Safety Officer and/or facility contact person will notify the family of the patient's return.~~
- ~~6. Nursing to perform a comprehensive physical assessment, focusing on the patient's level of consciousness, behavior, degree of distress, injuries, skin bruising or lacerations, or pain.~~
- ~~7. Nursing to interview patient to find out the reason for leaving the unit or facility and the events that occurred while the patient was away.~~
- ~~8. Nursing to notify attending physician of assessment findings and intervene, as ordered.~~
- ~~9. Nursing or attending physician to request that a pharmacist review the patient's medications to determine whether any prescribed medication could have caused an adverse reaction or drug interaction that resulted in a behavior change responsible for the elopement.~~
- ~~10. Nursing to provide reassurance about the patient's safety because elopement can cause stress, anxiety and fear.~~
- ~~11. Nursing to reorient the patient to the surroundings, as necessary. Reinforce the physical boundaries.~~
- ~~12. Monitor the patient closely for at least 72 hours after elopement. Note further exit seeking attempts or behaviors, alterations in sleep and eating patterns, and anxiety.~~
- ~~13. Nursing to ensure bed alarms are in use, functioning properly and audible to staff.~~

J. Documentation:

- ~~1. Involved staff to document the entire elopement episode, including the time the patient was found to be missing, measures taken to activate the emergency response, the process of the search, areas of the facility that staff members searched and the result of the search. Provide a sequential presentation of events.~~
- ~~2. When the patient returns to the facility, document assessment findings, including bruises and other injuries; notification of the attending physician, the patient's family and other appropriate individuals; prescribed interventions and the patient's response to such.~~
- ~~3. Document teaching provided to the patient and family (if applicable), their understanding of that teaching and any need for follow-up education.~~

K. Training and Education:

- ~~1. Patient care staff receive appropriate orientation and training relative to working with high-risk, elopement patients.~~
- ~~2. The Security Director, Safety Officer, AOD and Nursing Supervisor members will conduct an **After Action Report**, after each "Code Green" response, in order to discuss performance improvement efforts.~~

A. Staff to notify treating physician/clinician, nursing supervisor, and security

B. Staff & security personnel to assist in attempts to locate the patient

C. Nursing Documents:

- Time the staff became aware of the patient missing
- Circumstance(s)/reason(s) (if known)
- All efforts made to locate the patient
- Notifications:
 - Inpatient: Physician/clinician and nursing supervisor were notified
 - ED: Physician/clinician notified
- Time family notified (if applicable)
- Complete the discharge documentation in EHR
- If the patient is located and/or returns, document any education provided to the patient/family and their understanding

D. Physician documents:

- Risk level
- Patient's decision-making capacity
- Pertinent information
- Select discharge disposition "**Eloped.**"

E. Complete an Incident Report.

Elopement-High-Risk / Code Green Activation &

Response:

A **Code Green** is activated when a **high-risk** patient is discovered missing. The goal is to locate the patient quickly and safely through a coordinated campus-wide response.

Upon discovering that a high-risk patient is missing, staff will:

A. Immediately call the hospital operator and provide:

- Last known time and location
- Patient description
- Unit/department

B. The operator will announce “Code Green” overhead and notify:

- Nursing Supervisor
- Security Services
- Safety Officer

C. Initiate Code Green response actions:

- Notify treating physician/clinician
- Notify department nursing director
- Share the patient’s description with all staff and checkpoint screeners
- Conduct a facility-wide and continuous campus search to locate the patient
- Secure and monitor all hospital entrances and exits, with checkpoints as needed
- Review available video footage and surveillance systems as needed
- Notify law enforcement when the patient is not located on campus

D. Clear Code Green (by calling the hospital operator) once the patient is located and safely returned to the unit and/or when the Nursing Supervisor or designee determines the situation has been resolved.

Note: If the patient is not located, the nursing supervisor/designee will call law enforcement within 24 hours of the original report to obtain an update on whether the patient was located.

Elopement-High-Risk and Code Green Documentation:

A. Nursing documentation

- Time and date Code Green was activated
- Search actions and areas checked
- If the patient is located and returns, document the patient’s condition upon return
- Time law enforcement notified
- Law enforcement’s successful location of the patient
- Complete the discharge documentation in EHR

B. Physician documentation

- Risk level

- Patient's decision-making capacity
- Pertinent information

REFERENCES:

- ~~1. Hospital Incident Command System (HICS) Guidebook.~~
- ~~2. The Joint Commission, Emergency Management Codes.~~
- ~~3. Hospital Association of Southern California, Health Care Emergency Codes. May 2014.~~
1. **California Department of Public Health.** Reportable adverse events. California Department of Public Health. <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Reportable-Adverse-Events.aspx>
2. **The Joint Commission.** **Sentinel event data 2024 annual review.** Published 2025. <https://digitalassets.jointcommission.org/api/public/content/eac7511986c0442a9c1ae04b1aa02cc0?v=ad34daa0>

All revision dates:

4/9/2026, 8/10/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/29/2026
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/28/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/28/2026
Policy Owner	Fernando Medina: Director, Support Services	4/28/2026



VENTURA COUNTY HEALTH CARE AGENCY

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

100.278 Surge Plan

PURPOSE:

To coordinate hospital-wide efforts to manage patient surges, reduce emergency department (ED) boarding, and maintain safe care.

POLICY:

The surge plan establishes a hospital-wide approach for Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to manage fluctuations in patient demand. When demand exceeds normal capacity and inpatient beds are unavailable, patients board in the ED— a situation linked to increased mortality, morbidity, and length of stay. The Ventura County diversion protocol requires hospitals to have a surge plan. This plan proactively identifies resources and adjusts workflows to respond to surges, providing a daily operational framework with escalating actions to maintain safe patient care.

Note: This policy is exclusive of any procedures related to emergency management. In the case of internal disaster or other such emergency events that may trigger surge, refer also to this policy: [Policy 106.034 Emergency Management Plan](#).

DEFINITIONS:

Shared Responsibility: Surge management is a team effort—physicians, advanced practice providers (APP), nursing, ancillary staff, and leadership all play active roles.

Physicians as Key Drivers: ED physicians, hospitalists, and specialists lead patient flow by making timely discharge, transfer, and level-of-care decisions.

Real-Time Communication: ED and hospitalist directors coordinate directly with hospital leaders and managers to quickly identify barriers and improve throughput.

Team Support: Leadership, APPs, nursing, and ancillary staff redirect energy to assist physicians and streamline processes.

Coordinated Communication: Surge huddles and Tiger Text threads provide rapid updates and decision-making.

Surge Levels: Green (normal), Yellow (moderate overcrowding), Red (severe overcrowding) with escalating team interventions.

Goal: A unified, collaborative approach to safely improve patient flow and reduce capacity strain.

ED Crowding: a situation in which the identified need for emergency services exceeds available resources for patient care in the ED.

Mass Casualty Incident (MCI): an event that exceeds the healthcare capabilities of the response. An MCI exists when healthcare needs exceed resources.

Surge: a sizeable increase in demand for resources compared with a baseline demand. Components include Influx (volume, rate), Event (type, scale, duration), and Resource Demand (consumption, degradation).

Against Medical Advice (AMA)- The patient chooses to leave the hospital before the treating clinician has the opportunity to complete the assessment and diagnostic testing necessary to reach a clinical impression or diagnosis. As such, the treating clinician advises the patient of the risks of leaving before the determination of a clinical impression and the benefits of remaining until crucial differential diagnoses have been ruled out.

Boarding- The process of holding an admitted patient in the ED while waiting for an inpatient bed.

Capacity- The ability to accommodate the patient including the availability of qualified staff, beds, and equipment.

Early Warning System- A real-time process to assess for and anticipate a forthcoming and imminent overcrowding crisis in the ED and alert administrators so that strategies may be promptly implemented to avert a breach in the ED's capacity to evaluate and treat patients in a timely manner.

Left without Being Seen (LWBS)- The patient checks into the ED and may or may not have been triaged. Ultimately the patient decides to leave the ED before being evaluated by the treating medical clinician.

Seen by Physician- When the medical clinician (including APP) first makes contact with the patient to begin evaluation and treatment. Simply noting that the patient walked through the door does not constitute being "seen."

PROCEDURE:

Surge Level Assessment

Hospital capacity is calculated by evaluating current bed occupancy against incoming bed needs. As hospital capacity reaches or exceeds maximum utilization, clinical and administrative leaders are to follow a process of escalating communication/notification and initiate actions to alleviate high surge level and overcrowding. Actions that will be taken are appropriate to the situation and maybe modified according to specific challenges. See surge level thresholds below; there are three levels of resource consumption indicating when the demand increases, thereby meeting and/or exceeding capacity. The table below is associated with communication and action steps to be taken according to resources utilized. The thresholds assist in identifying the three surge levels for the hospital demand and capacity providing guidance on recommended actions from department leadership to alleviate congestion within the hospital.

The nursing supervisor assesses the surge level status every six hours and more frequently as needed to promote patient flow, increase capacity and avoid bottlenecks. When we meet the thresholds outlined below

to move up or down a surge level the nursing supervisor will contact the Administrator on Duty (AOD). The AOD is responsible for considering the number of patients boarding in the ED, anticipated discharges, pending admissions and time of day to determine whether it is appropriate to change the surge level status. Given the time required to call in additional staff and to change workflows, the surge plan should be activated during daytime hours (7 am to 9 pm) if it is anticipated that the current level of patient demand will be over 4 hours. Between the hours of 9 pm and 7 am, the surge plan will be activated at 7 am the following morning.

Determining Surge Levels

Surge levels for VCMC are determined using the National Emergency Department Overcrowding Scale (NEDOCS) score located on the ED Real Time Dashboard. Cutoffs are as follows:

- < 100 Surge level Green (i.e. normal operations)
- 101 - 180 Surge level Yellow (moderately overcrowded)
- >181 Surge level Red (severely overcrowded)

Santa Paula Surge Plan:

Due to the unique characteristics of SPH (size and patient levels of care), the NEDOCS score is not used to determine surge status at SPH. Rather, the SPH nursing director or nursing supervisor identifies surge at SPH when the composition of patients outpaces available staffing. When this circumstance occurs, the director or nursing supervisor notifies the nursing supervisor at VCMC to make plans for additional staffing and/or VCMC transfers.

Communications plan

1. The nursing supervisor will monitor the surge level criteria defined above and notify the AOD when we meet criteria to move to a different surge level. The AOD is responsible for directing a change to the surge level. When the AOD has determined that the hospital should move either up or down a surge level, the AOD will call paging to send out a Pagegate notification and they will contact the IT department leadership or trained designee to send a SnapComms message. The managers will communicate the surge level with floor staff via radio when the Pagegate communication is sent, for all departments that communicate with floor staff via radio including but not limited to, security, environmental services (EVS), and ED. Since the notice to change the surge level will be announced at the time the surge level is changed and will not be repeated at every change of shift, it is the responsibility of managers and charge nurses to notify the oncoming teams at change of shift about the current surge level.
2. The surge plan will be readily available in the departments so that staff can reference it and are familiar with their responsibilities at the different surge levels.

SURGE LEVEL GREEN: NORMAL OPERATIONS

System:

1. Administration:
 - a. Patient flow discussion occurs in the daily safety huddle.
2. Admissions: Inpatient beds assigned per protocol
3. Diagnostic Services: follows standard operations

Staff, Supplies, Space:

1. Standard operating procedures in effect.

Medical Center Response:

1. Standard operating procedures in effect.
2. ED Status: Open
 - a. ED Diversion Status: Open.
 - b. ED Transfer Status: Open.
 - c. Base Station mobile intensive care nurse (MICN) will update ReddiNet as needed.
3. Daily Operations Huddle:
 - a. All hospital department directors and managers/designees and executive team

SURGE LEVEL YELLOW: Moderately Overcrowded**System:**

1. Daily Operations Huddle: normal operations
2. ED Status:
 - a. Consider ambulance diversion criteria based on Emergency Medical Services (EMS) policies.
 - b. MICN will update the ReddiNet as needed.
3. Level of Care Re-evaluation:
 - a. Resident physician and attending physician will speak by phone and run the list of every admitted patient boarding in ED or pending admit. Attending physician will identify patients that require a lower level of care than currently ordered, and resident physician will immediately write orders to downgrade those patients. Results of that conversation will be communicated by medicine resident to ER charge nurse. ER charge nurse will document these downgrades on report sheet.
 - b. Create Tiger Text Surge Thread with AOD, Chief Medical Officer (CMO), Chief Nurse Executive (CNE)/Associate Chief Nursing Officer (ACNO), SPH nursing supervisor and VCMC nursing supervisor.
 - a. SPH nursing supervisor to reply with available staffed beds. Nursing supervisor to contact hospitalists for transfers if indicated.
 - c. Charge nurses to identify patients for potential downgrade or discharge and report to nursing supervisor. Nursing supervisor will request re-evaluation of care level for patients and medicine team will respond within 30 minutes.
 - d. CNE will assign a nurse manager to reassess if all patients on telemetry meet such level of care indications.
4. Psychiatric patients
 - a. Nursing supervisor to create sign up sheet for nursing assistants willing to work overtime as safety attendants. Sheet will be posted on nursing supervisor office door. Nursing supervisor will deploy additional patient safety attendants or security to psychiatric patients boarding in the ER.
 - b. If no nursing assistants are available, security may be utilized with AOD approval. Alternatives also

include any registered nursing staff or ED Technicians.

Space, Staff, Supplies

1. Med/Surg admission handoffs:
 - a. If patients have beds assigned but primary registered nurse (RN) is not available, the charge nurse will take report if the charge RN does not have a full patient assignment.
 - b. If there is greater than 30-minute delay from bed assignment to hand off for med/surg patients and the charge nurse does not have a full patient assignment, then the patient can be transported to the floor for face-to-face handoff with the charge nurse. The sending unit RN will call the receiving unit to notify of their impending arrival.
2. Monitored patient admission handoffs:
 - a. If handoff is complete, but no additional RN is available for transport, then nurse manager, charge nurse, nurse educator, resident or attending may accompany the nursing assistant or RN to transport the patient upstairs.
3. Off duty staff:
 - a. Department leaders to review and ensure call back trees are updated.
 - b. Managers to notify staff of potential to be called in to work.
 - c. Refer to Policy 108.010 for nursing alternative staffing: [Policy 108.010 Alternate Nurse Staffing Assignments](#)
4. Education / Classes:
 - a. AOD will contact the CNE or ACNO to determine which classes and meetings may be canceled to return staff to patient care.
5. Charge nurses:
 - a. Will assume patient assignments.
6. Additional Staff:
 - a. Exempt staff can be placed into work units to assist (example: educators, supervisors) within their scope of practice.
 - b. CNE or ACNO to approve and utilize supplemental agency staff.
 - c. Nursing supervisor or staffer to send out mass text offering extra shifts.
 - d. Consider when staffing allows to utilize an RN as admit and discharge nurse (can consider modified duty staff if restrictions permit).
7. Central Supply:
 - a. Will stock extra carts including but not limited to linen, crash carts and supply carts so that they are available for staff to grab after hours as needed
8. Dietary:
 - a. Nursing supervisor to call the dietary manager to arrange sack lunches to expedite discharges.

Medical Center Response

1. Inpatient teams:

- a. Prioritize discharges.
- 2. Nursing directors:
 - a. Open any closed beds if possible.
- 3. Patient Transportation Home:
 - a. Patients needing to wait more than 4 hours at any time for a ride home will be sent by Uber Health if appropriate. If not appropriate for Uber Health, the nursing staff will contact case management for alternative options.

SURGE LEVEL RED: SEVERELY OVERCROWDED

System:

- 1. Daily Operations Huddle (930 am):
 - a. All directors, managers, executive team, hospitalist member, chief of surgery and/or anesthesia to attend.
- 2. ER status:
 - a. Consider closing to ED Saturation, criteria based on Emergency Medical Services (EMS) policies.
 - b. MICN will update the ReddiNet as needed.
- 3. Level of Care Re-evaluation:
 - a. Resident physician and attending physician will speak by phone and run the list of every admitted patient boarding in ED or pending admit. Attending physician will identify patients that require a lower level of care than currently ordered, and resident physician will immediately write orders to downgrade those patients. Results of that conversation will be communicated by medicine resident to ER charge nurse. ER charge nurse will document these downgrades on report sheet.
 - b. Create Tiger Text Surge Thread with AOD, CMO, CNE/ACNO, SPH nursing supervisor and VCMC nursing supervisor.
 - i. SPH nursing supervisor to reply with available staffed beds. Nursing supervisor to contact hospitalists for transfers if indicated.
 - c. Charge nurses to identify patients for potential downgrade or discharge and report to nursing supervisor. Nursing supervisor will request re-evaluation of care level for patients and medicine team will respond within 30 minutes.
 - d. CNE will assign a nurse manager to reassess if all patients on telemetry meet such level of care indications.
- 4. Psychiatric patients
 - a. Nursing supervisor to create sign-up sheet for nursing assistants willing to work overtime as safety attendants. Sheet will be posted on nursing supervisor office door. Nursing supervisor will deploy additional patient safety attendants or security to psychiatric patients boarding in the ER.
 - b. If no nursing assistants are available, security may be utilized with AOD approval. Alternatives also include any registered nursing staff or ED Technicians.
 - c. AOD, CNE or ACNO will contact inpatient unit (IPU) manager to evaluate if other resources are available.

5. Post-Anesthesia Care Unit (PACU):

- a. Notify perioperative services director to arrange for after hours PACU staffing coverage.
- b. PACU may hold patients until an inpatient bed is obtained. Nursing supervisor to call perioperative services director if patients are holding in PACU. Appropriate level of care for PACU is med/surg and telemetry level of care. Intensive care unit 2 (ICU2) and direct observation unit (DOU) can be used as DOU and ICU overflow instead.

Space, Staff, Supplies

1. Med/Surg admission handoffs:

- a. If patients have beds assigned but primary RN is not available, the charge nurse will take report if the charge RN does not have a full patient assignment.
- b. If there is greater than 30-minute delay from bed assignment to hand off for med/surg patients and the charge nurse does not have a full patient assignment, then the patient can be transported to the floor for face-to-face handoff with the charge nurse. The sending unit RN will call the receiving unit to notify of their impending arrival.

2. Monitored patient admission handoffs:

- a. If handoff is complete but no additional RN is available for transport, then nurse manager, charge nurse, nurse educator, resident or attending may accompany the nursing assistant or RN to transport the patient to the floor.

3. Off duty staff

- a. Department leaders to review and ensure call back trees are updated.
- b. Managers to notify staff of potential to be called in to work.
- c. Refer to Policy 108.010 for nursing alternative staffing: [Policy 108.010 Alternate Nurse Staffing Assignments](#)

4. Education / Classes:

- a. AOD will contact the CNE or ACNO to determine which classes and meetings may be canceled to return staff to patient care.

5. Charge nurses:

- a. Assume patient assignments.

6. Additional staff:

- a. Exempt staff will be placed into work units to assist (example: educators, supervisors) within their scope of practice.
- b. CNE or ACNO to approve and utilize supplemental agency staff.
- c. Nursing supervisor or staffer to send out mass text offering extra shifts.
- d. Consider when staffing allows to utilize an RN as admit and discharge nurse (can consider modified duty staff if restrictions permit).
- e. ED director may alert CNO/ACNO to request additional personnel from other areas of clinic or hospital.
- f. Nursing supervisor may activate available inpatient staff to report to ED charge nurse to assist with non-emergency care including sitter duties, care of admitted boarding patients and monitored patient

- transport.
- g. AOD to email hospital department directors to identify staff available for helping hands.
- h. Any staff members working on special projects will be pulled into direct care staffing as needed.
- 7. Case Management:
 - a. Case management director to call in per diem staff if available. Their role will be to go to the ED to reevaluate admissions, determine need for transfers to capitated hospitals and transfers for decompression and or lower level of care.
 - b. Discharge planning staff are expected to round prior to 10 am and again before 4 pm to evaluate barriers to discharge and patient needs.
 - c. Case management leadership to give overtime to discharge planning staff (authorize 12-16 hour shifts as needed to assist with late discharges).
 - d. Case management to arrange transportation for discharges prior to 4 pm.
- 8. Radiology:
 - a. AOD will notify the in house radiologist of the surge level 3 (red) status so they can prioritize ER reads and pending discharges.
- 9. Central supply:
 - a. Will stock extra carts including but not limited to linen, crash carts and supply carts so that they are available for staff to grab after hours as needed
- 10. Dietary:
 - a. Nursing supervisor to call the dietary manager to arrange sack lunches to expedite discharges.
- 11. Physician Huddle:
 - a. 4pm huddle will occur with attending physicians, residents and their respective case managers to proactively identify potential discharges for the next day and address any remaining barriers to discharge.
- 12. Residents:
 - a. CMO/Associate Chief Medical Officer (ACMO) to contact residency director to evaluate for any additional support options available
- 13. Biomed:
 - a. Contact head of biomed as needed for daily rental of tele units, ventilators, and beds. Decision to rent will be made by AOD and CNE.
 - b. Critical items out for repair will be reported out at huddle.
 - c. If necessary there are two rooms of equipment that can be brought over from SPH.
- 14. Facilities:
 - a. If surge is predicted to be prolonged, request can be sent to California Department of Public Health (CDPH) for permission to set up alternative patient care locations.
- 15. Staffing:
 - a. Leadership will work to ensure adequate staffing by holding over and/or calling in staff as needs dictate.

- b. Relevant policies: #101.007: Mandatory Overtime: [Policy 101.007 Overtime](#)
- c. #108.010 Alternate Nursing Staffing Arrangements: [Policy 108.010 Alternate Nurse Staffing Assignments](#)
- d. #108.006 Nurse Staffing and Scheduling: [Policy 108.006 Nurse Staffing and Scheduling](#)

Medical Center Response:

1. Inpatient teams:
 - a. Prioritize discharges.
2. Nursing Directors:
 - a. Open any closed beds if possible.
 - b. NOTE: if surge of monitored patients, consider increasing telemetry capacity from 4 to 8 beds on MS3.
 - c. Consider closing off 3S addiction medicine elective admissions until surge ends.
3. Leadership:
 - a. Available leadership will assist medicine teams with contacting consultants to expedite consults.
4. Cohorting:
 - a. Pair any appropriate non-suicidal, non-homicidal patients with sitters where possible to consolidate resources.
 - b. Ensure all 4S rooms have double occupancy (ie move isolation patients to next available single rooms) to create capacity.
5. Bed Huddle activation:
 - a. CNE/ANCO will activate 4pm bed huddle to included department directors who will report on pending discharges and their remaining barriers, as well as follow up on patients identified at the 9am huddle as discharging who did not discharge. Reasons for failure to discharge must be provided.
6. Administration:
 - a. May consider implementing medical center emergency response plan if indicated.
7. Surgery:
 - a. Chief of Surgery and Chief of Anesthesia will look ahead at the next 2 days to evaluate if rescheduling some cases may be beneficial.
 - b. Surgery, anesthesia and hospital leadership may consider canceling non-emergent inpatient cases with CEO approval.
8. Anesthesia:
 - a. Evaluate the surgical schedule especially for cases requiring postop admission to determine if needed or if able to postpone.
9. Consulting Physicians:
 - a. Medicine attendings to identify which patients have pending consults as a barrier to discharge and relay list to CMO/ACMO who will assist with contacting consultants to prioritize those patients.
10. Utilization Management (UM):

- a. UM physician will review ED admits to ensure that hospitalization is medically necessary and patient needs can not be met as an outpatient.
- b. UM physician will also assist with identifying appropriate patient to transfer to SPH.

11. EVS:

- a. Offer double shifts for EVS to increase coverage especially for afternoon (second) shift.
- b. EVS dispatch to discuss prioritization of room cleaning with nursing supervisor.

12. Patient transportation home:

- a. Patients need to wait more than 4 hours at any time for a ride home will be sent by Uber Health if appropriate. If not appropriate for Uber Health the nursing will contact case management for alternative options.

13. Chain of Command:

- a. AOD to notify hospital CEO that we are in surge level red. AOD to notify ED to ensure status is logged into Reddinet.

DOCUMENTATION:

- A. Each time the surge plan is initiated, the nursing supervisor is responsible for ensuring proper documentation.

1. Time surge level was initiated and concluded in RL Datix.
2. Start and end times of any diversion. Note: Trauma diversion cannot be implemented without documented discussion between AOD and Trauma Medical Director/Deputy Trauma Medical Director with subsequent CEO approval.
3. Time AOD was notified and CMO if applicable.
4. Log of any surgeries or procedures cancelled secondary to surge. Log to be provided to Perioperative Service Director to ensure timely rescheduling.

REFERENCES:

[Policy #107.003 Emergency Department Saturation and Ambulance Diversion](#)

All revision dates:

3/18/2026, 12/9/2025, 11/20/2025

Attachments



106-034 Emergency Management Plan.pdf



image1.jpg

Approval Signatures

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

Step Description	Approver	Date
Committee		
Medical Staff Committees: ED, Surgery & Medicine	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/18/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/18/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/18/2026



Origination: N/A
Effective: Upon Approval
Last Approved: N/A
Last Revised: N/A
Next Review: 3 years after approval
Owner: Stanley Patterson: Chief Medical Information Officer
Policy Area: Administrative - Patient Care
References:

100.279 Responsible Use of Health-Related Artificial Intelligence Technology

Introduction:

The Ventura County Health Care Agency (VCHCA) recognizes the transformative potential of artificial intelligence (AI) in healthcare yet acknowledges the importance of ethical and responsible deployment to ensure patient and medical provider trust, data security, and privacy. This policy aims to establish principles and guidelines for the ethical and responsible utilization of health-related artificial intelligence to uphold patient trust, ensure data security and privacy, and foster innovation in healthcare delivery within VCHCA. This includes comprehensive guidelines for adoption and application of AI technologies across VCHCA subsidiaries to align with the mission of culturally sensitive, high-quality care while ensuring regulatory compliance and safeguarding patient trust.

This policy shall be implemented and enforced in compliance with the **Health Insurance Portability and Accountability Act (HIPAA)** (45 CFR Parts 160 and 164), the California Confidentiality of Medical Information Act (Cal. Civ. Code §56 et seq.), 42 CFR Part 2 (where applicable), CMS Conditions of Participation (42 CFR §482.24(c)), OIG Compliance Program Guidance, and Joint Commission information-management standards.

1. Scope:

This policy applies to all VCHCA personnel, contractors, and third-party entities involved in the development, deployment, or utilization of health-related AI technologies within VCHCA facilities and operations.

All third-party vendors or AI tools that access, process, or generate PHI must operate under a current, executed Business Associate Agreement (BAA) approved by IT Security and Compliance in accordance with 45 CFR §164.314(a).

The scope of artificial intelligence in healthcare encompasses a wide range of applications, from enhancing clinical documentation and reducing clinician burnout to optimizing resource allocation and automating medical coding and billing processes. By leveraging AI technologies, healthcare organizations can drive operational efficiencies, improve patient outcomes, and deliver more personalized and efficient care while addressing the evolving challenges and demands of the healthcare landscape and the scope of AI in healthcare encompasses the following key areas:

- a. **Reporting and Documentation:** AI-powered natural language processing (NLP) algorithms can streamline clinical documentation processes by automatically transcribing and summarizing patient encounters, reducing the burden of manual data entry on clinicians. These AI systems can accurately

extract relevant information from electronic health records (EHRs), enabling clinicians to focus more on patient care rather than administrative tasks. Additionally, AI-driven predictive analytics can identify patterns in patient data to generate real-time alerts for potential adverse events or clinical deteriorations, facilitating timely interventions and improving patient safety and effectively reducing cognitive load and decision-making fatigue among clinicians. All AI-generated documentation must be reviewed, corrected as necessary, and authenticated by the responsible provider before being entered into or used as part of the legal medical record, consistent with **CMS 42 CFR §482.24(c)** and **Joint Commission RC.01.01.01**.

- b. **Automation and Resource Optimization:** AI-enabled predictive analytics and optimization algorithms can optimize healthcare resource allocation by forecasting patient admission rates, predicting equipment maintenance needs, and identifying operational inefficiencies. Furthermore, robotic process automation (RPA) solutions can automate repetitive tasks such as claims processing, billing, and revenue cycle management, streamlining administrative workflows and reducing processing times.
- c. **Medical Coding and Billing:** AI-powered coding and billing solutions utilize machine learning algorithms to automate the assignment of accurate medical codes based on clinical documentation, reducing coding errors and claim denials. These AI systems analyze unstructured clinical notes, diagnostic reports, and procedure descriptions to generate comprehensive coding suggestions, ensuring compliance with coding guidelines and regulatory requirements in efforts to accelerate revenue cycle management, optimize reimbursement rates, and minimize revenue leakage.

2. Principles of Ethical and Responsible AI Use:

- a. **Patient-Centric Care:** VCHCA shall prioritize AI applications that enhance patient outcomes, improve care quality, and promote patient safety.
- b. **Ethical and Responsible AI:** VCHCA shall adhere to ethical guidelines ensuring that AI technologies are designed, deployed, and utilized in a manner that respects human dignity, autonomy, and privacy.
- c. **Transparency and Accountability:** VCHCA shall prioritize the adoption of AI technologies that are transparent and explainable in their operations, decision-making processes, and potential limitations.
- d. **Fairness and Non-Discrimination:** VCHCA shall ensure that AI algorithms and models are designed and trained to mitigate biases and ensure equitable outcomes for all patients, regardless of demographic characteristics or health conditions. Fair and non-discriminatory AI promotes inclusivity and reduces disparities in healthcare delivery.
- e. **Privacy and Data Security:** VCHCA shall implement robust measures to protect patient data and ensure compliance with applicable privacy regulations, such as the Health Insurance Portability and Accountability Act (HIPAA). AI systems utilized within VCHCA shall adhere to strict data security protocols, encryption standards, and access controls to prevent unauthorized access or breaches.
Health-related AI applications require a Business Associate Agreement (BAA) and all BAA's must be negotiated and approved by HCA IT prior to any application use. This may include HCA Compliance and/or Legal consultation. AI systems shall also comply with the HIPAA Security Rule (45 CFR §§ 164.308 – 164.312), including risk analysis, access controls, audit logging, transmission security, and encryption in transit and at rest. Each system must undergo a documented Security Risk Assessment prior to implementation, and all BAAs must prohibit secondary use of PHI for model training unless the data are de-identified in accordance with 45 CFR § 164.514(b).
- f. **Human Oversight and Autonomy:** AI technologies shall complement, rather than replace, the role of healthcare professionals in clinical decision-making. Human oversight is essential to validate AI-generated insights, interpret results, and ensure that patient care remains individualized and patient-

centered.

3. Restrictions on AI Use:

- a. **Medical Decision-Making:** AI technologies shall not autonomously make medical decisions without human oversight or intervention. The ultimate responsibility for patient care rests with qualified healthcare professionals, who shall leverage AI insights to inform clinical decision-making in a collaborative manner.
- b. **Experimental Use:** The deployment of experimental or unvalidated AI technologies within clinical settings requires approval from the VCHCA IT Department, the HCA IT Steering Committee, Ventura County General Counsel, and Compliance. Prior to implementation, comprehensive risk assessments, ethical reviews, and stakeholder consultations shall be conducted to evaluate the potential benefits and risks associated with the use of such technologies.
- c. **Privacy and Data Security:** AI systems utilized within VCHCA shall adhere to stringent data privacy and security standards, in accordance with recommendations from State and Federal Privacy Laws. Patient data shall be anonymized, encrypted, and protected against unauthorized access or breaches to safeguard patient privacy and confidentiality.
- d. **Unauthorized Use of Healthcare-Related AI Applications:** The Ventura County Health Care Agency (VCHCA) strictly prohibits the unauthorized use of healthcare-related artificial intelligence (AI) applications in clinical or operational settings. Any use of AI applications outside those authorized by VCHCA confers full responsibility and liability to the end user. VCHCA assumes no responsibility for errors, adverse outcomes, or other detrimental results arising from the use of unauthorized AI. End users engaging in unauthorized AI use may be held personally liable for any resulting violations of privacy, breaches of compliance standards (including but not limited to HIPAA), or improper clinical decisions influenced by such AI tools. Furthermore, they may bear financial responsibility for any monetary penalties, damages, or legal consequences that result from these actions. **All staff and personnel must adhere to this policy to protect patient safety, ensure compliance with regulatory standards, and maintain the integrity of care provided by VCHCA.**
- e. **Agentic AI Systems:** Agentic Artificial Intelligence (Agentic AI) refers to AI technologies capable of autonomous goal-driven action within defined parameters, such as dynamically prioritizing tasks, initiating workflows, or adapting care coordination pathways. Within VCHCA, Agentic AI systems may be utilized only when their autonomy is bounded by explicit human oversight and when their operations are transparent, auditable, and explainable.
 - **Human-in-the-Loop Oversight:** All Agentic AI applications must include human review and authorization prior to executing or finalizing any clinical, operational, or financial actions that may directly affect patient care, documentation, or resource allocation.
 - **Defined Scope and Guardrails:** Agentic AI shall operate only within pre-approved functional boundaries that have been validated through risk assessment, cybersecurity review, and IT Steering Committee approval.
 - **Accountability and Traceability:** Every autonomous or semi-autonomous action performed by Agentic AI systems must be logged with full traceability to ensure accountability, auditability, and reproducibility.
 - **Ethical Alignment:** Agentic AI shall adhere to the same ethical standards, privacy protections, and fairness requirements outlined in this policy, ensuring that automation augments rather than replaces human judgment and compassion in clinical care.

- f. **Unauthorized or Unapproved Use:** Any existing use of unapproved AI applications involving PHI must cease immediately. Future use of AI applications shall only occur after full review and approval under this policy.
- g. **FDA-Regulated Applications:** Any AI application intended to support diagnosis or treatment must comply with FDA regulations for clinical decision support (21 U.S.C. §360j) and applicable FDA Guidance for Clinical Decision Support Software (2022). Unapproved or experimental tools shall not be used for these purposes.
- h. **Information Blocking:** AI tools shall not be used in any manner that delays, distorts, or prevents required patient access to their medical records under the 21st Century Cures Act.

4. Evaluation and Approval Process:

- a. **IT Department Evaluation:** Any proposed use of health-related AI within VCHCA shall undergo thorough evaluation by the VCHCA IT Department in conjunction with the HCA IT Steering Committee (VIGO). This evaluation shall assess technical feasibility, security implications, and potential impact on patient care and operational workflows. **No health-related AI applications shall be permitted for use in any capacity without this evaluation. Any existing use of unauthorized health-related AI applications must cease immediately.** Each proposed AI use case must include a documented Security and Privacy Risk Assessment consistent with HIPAA 45 CFR § 164.308(a)(1)(ii)(A) and NIST SP 800-30 prior to approval.
- b. **Legal and Risk/Compliance Review:** All AI applications intended for use within VCHCA shall undergo legal and compliance review by the Ventura County General Counsel and Compliance when deemed necessary after initial evaluation. This review shall ensure compliance with relevant laws, regulations, and ethical standards governing the use of AI in healthcare. Reviews must confirm that breach-notification procedures comply with 45 CFR §§ 164.400 – 164.414 and Cal. Civ. Code § 1798.82.
- c. **Ethical Review:** All AI applications intended for use within VCHCA shall undergo ethical review by designated ethics committees to ensure autonomy, beneficence, nonmaleficence, and justice otherwise in alignment with established ethical guidelines.

5. Enforcement and Compliance:

- a. **Training and Education:** VCHCA shall provide regular training and educational programs to ensure that all personnel involved in the use of health-related AI are aware of their responsibilities, ethical obligations, and compliance requirements under this policy. Documentation of training completion shall be maintained for a minimum of six (6) years in compliance with 45 CFR § 164.530(j).
- b. **Monitoring and Auditing including Compliance:** VCHCA shall establish mechanisms for ongoing monitoring, auditing, and review of AI systems to ensure compliance with this policy and any relevant regulations. Any deviations or breaches shall be promptly investigated, and corrective actions shall be taken as necessary. Monitoring shall include periodic auditing of AI outputs for accuracy, bias, and regulatory compliance, with results reported to the **Compliance and Privacy Offices** and retained for a minimum of six (6) years.
- c. **Oversight:** HCA IT Steering Committee shall serve as oversight. The Committee shall coordinate with the Office of Compliance and Privacy to ensure corrective action plans are implemented for any identified deficiencies.

6. Revision and Review:

- a. **Periodic Review:** This policy shall be subject to periodic review and revision to incorporate emerging best practices, technological advancements, and regulatory changes in the field of health-related AI. Review must occur at least annually or upon any material change in federal or state regulation governing AI in healthcare, including guidance issued by CMS, HHS OCR, or DHCS.
- b. **Stakeholder Engagement:** VCHCA shall engage relevant stakeholders, including healthcare professionals, patients, institutional review board, and regulatory stakeholders, in the review and revision process to ensure that this policy reflects the evolving needs and concerns of the community.

7. Conclusion:

By adhering to the guidelines and restrictions outlined in this policy, VCHCA reaffirms its commitment to alignment and leveraging of AI technologies in a manner that centers on the "FAVES" principles, resulting in healthcare outcomes that are Fair, Appropriate, Valid, Effective, and Safe, yet also maximizes trust, security, privacy, and patient-centered care.

References

- HIPAA Privacy, Security, and Breach Notification Rules (45 CFR Parts 160 and 164)
- CMS Conditions of Participation – Medical Record Services (42 CFR §482.24(c))
- California Confidentiality of Medical Information Act (Cal. Civ. Code §56 et seq.)
- California Data Breach Notification Law (Cal. Civ. Code §1798.82)
- 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records
- FDA Guidance for Clinical Decision Support Software (2022)
- OIG Compliance Program Guidance for Hospitals
- The Joint Commission Standards RC.01.01.01 and IM.02.02.01
- NIST SP 800-30 – Guide for Conducting Risk Assessments

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Information Technology	Bach Nguyen: Chief Information Officer	4/20/2026
Information Technology	Stanley Patterson: Chief Medical Information Officer	3/10/2026



Origination: N/A
Effective: Upon Approval
Last Approved: N/A
Last Revised: N/A
Next Review: 3 years after approval
Owner: Danielle Gabele: Chief Nursing Executive, VCMC & SPH
Policy Area: Administrative - Patient Care
References:

100.285 Pronouncement of Death by a Registered Nurse

POLICY

Purpose

The purpose of this policy is to outline the circumstances that allow a registered nurse (RN) to pronounce a patient a time of death. This task may only be performed by RNs who have received specialty training and demonstrated competency in this procedure. An order from a licensed practitioner (LP) is not required for the RN in the specific circumstances allowing RN pronouncement of death.

Definition

Death is "an irreversible cessation of cardiopulmonary function".

California law recognizes two means by which death can be determined.

- Total cessation of *circulatory and pulmonary functions* **OR**
- The total cessation of all brain functions including the brain stem i.e. brain death)

Note: Because Brain death must be independently confirmed by 2 licensed physicians, it cannot be performed by a RN.

Death Pronouncement Criteria

All of the following criteria **must** exist before the registered nurse is authorized to pronounce the death of a patient:

- Physician documentation on the patient reflects that the patient is likely to die during this hospital admission.
- A Do Not Resuscitate (DNR) order is present in the medical record.
- The patient has been enrolled in the General inpatient hospice program (GIP) or has an active order for comfort care.

Excluded Areas

- Emergency Department
- ICU's
- Dialysis
- Mother/Baby Unit
- Pediatrics and PICU - up to 18 years of age
- Perioperative Areas
- Post Anesthesia Care Unit
- Obstetrics Areas
- Neonatal Intensive Care Unit (NICU)
- All Outpatient areas

PROCEDURE

- A. Please refer to "Inpatient Death Workflow for Nurses" flowsheet (Attachment 1).
- B. Verify that the patient meets the criteria for patient selection outlined above (Death Pronouncement Criteria).
- C. Inform the family, if present, of the procedure for death pronouncement. Note: The family may remain in room if they wish.
- D. Confirm identity of patient (2 patient identifiers) with ID band.
- E. Observe the patient for three (3) minutes to verify the following clinical findings:
 - Absence of pulse
 - Absence of spontaneous respirations
 - Pupils fixed/non-reactive and dilated
 - Unresponsive to verbal and tactile stimuli

Note: Normally gentle tactile stimuli (such as squeeze of hand) are adequate. Rarely would more aggressive stimulation such as pressing under orbital rim with fleshy portion of thumb be needed.)

- F. Note time of death at the end of three minutes.
- G. Inform family, if present, of the patient's death.

Note: If family is not present, the RN will contact the attending physician (or the contracted hospice nurse liaison if the patient was enrolled in Inpatient Hospice at the time of their death) who will notify the family.

- H. Nurse will document in a ~~CS-Link~~ Progress Note the following:
 - Time of death pronouncement
 - Clinical findings of absence of pulse, spontaneous respirations, fixed/non-reactive and dilated pupils and unresponsiveness.
 - Physician (or hospice nurse liaison) who was notified about the death.;

All revision dates:

Attachments

 [Attachment 1 - Pronouncement of Death by a Registered Nurse Policy.docx](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	4/29/2026
Hospital Administration	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/6/2026
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/6/2026
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/2/2026
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/2/2026



Origination: 7/26/2017
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Last Revised: 6/14/2023
Next Review: 3 years after approval
Owner: Tracy Chapman: Director, HCA
Medical Staff Administration
Policy Area: Administration - Medical Staff
References:

102.024 Non-affiliated Physicians as Assistant or Proctor

POLICY:

The intent of this document is to establish the process for issuing limited temporary privileges under special circumstances for a non-affiliated physician to serve as the assistant or proctor. The services of non-affiliated physicians may be enlisted when there is no other qualified member of the medical staff to provide the service for cases involving new technology.

PROCEDURE:

A. Requirements

1. A formal request for temporary privileges must be submitted by a member of the Medical Staff, at least 2 weeks prior to the scheduled procedure. Requests must include documentation to support the expertise of the non-affiliated physician.
2. The non-affiliated physician must meet the basic qualifications to perform the requested duties/privileges.
 - a. Refer to the Robotic Assisted Surgery Credentialing & Privileging Requirements policy for requests related to robotic cases.
3. Requests for a non-affiliated assistant or proctor must be approved by the Department Chief and the Chief of Staff or the Chief Medical Officer, prior to final approval by the Chief Executive Officer.

B. Required Documentation

- Non-affiliated Assistant or Proctor Application - Attachment A
- Evidence of equivalent privileges at another hospital
- Current Curriculum Vitae
- Current malpractice coverage (Limits: \$1 Million per claim/ \$3 Million aggregate)
- Signed release of information form - Attachment B
- Confidentiality Agreement - Attachment C
- Copy of current government issued identification

C. Verifications

1. The Medical Staff Office will primary source verify the necessary information to ensure evidence of current clinical competence is available prior to the decision to approve temporary privileges to assist or proctor. The following will be verified.
 - State medical license (includes sanctions)
 - Board certification
 - National Practitioner Data Bank
 - Office of the Inspector General
 - Systems Award Management (SAMS)
 - Current, unrestricted hospital privileges equivalent to those being requested (primary hospital)
 - Current competence to perform the privilege(s) being requested or proctored (this may be obtained verbally or by vendor confirmation for robotics cases)
2. The appropriate hospital staff will be notified of the approval and date(s) of service.

D. Limitations

1. The non-affiliated physician assistant or proctor is not allowed to take over patient care or act as the primary physician for any patient.
2. Temporary privileges are limited to the specified procedure(s) and/or patient(s) and are not to exceed 30 procedures within 120 days of approval or the non-affiliated physician will be required to apply for full membership and/or privileges.

E. Responsibilities

1. The Medical Staff member being assisted or proctored by a non-affiliated physician, in collaboration with Hospital Administration, is responsible for any monetary reimbursement for services rendered and ensures there is no direct or indirect compensation from any patient for this service to the non-affiliated physician.

Definitions

Non-affiliated assistant or proctor: a licensed physician who is not currently privileged by the Hospital and has been deemed qualified as an expert in his/her area of practice.

All revision dates:

6/14/2023, 6/9/2020, 7/26/2017

Attachments

-  [Attachment A - Non-Affiliated Physician Assistant or Proctor Request Form](#)
-  [Attachment B - Information Release/Acknowledgments](#)
-  [Attachment C - Confidentiality Agreement](#)

Approval Signatures

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

Step Description	Approver	Date
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH [AB]	4/27/2026
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	4/16/2026
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	4/9/2026



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Owner: Jennifer Ferrick: Cancer Program Coordinator
Policy Area: Cancer Program – Rectal Cancer
References:

CA.PRC.013 Watch and Wait Management for Rectal Cancer: NAPRC Standard 5.13

Ventura County Medical Center (VCMC)

American College of Surgeons (ACS)-National Accreditation Program Rectal Cancer (NAPRC) 2026 Guidelines

Standard 5.13 Watch and Wait Management for Rectal Cancer

I Purpose

Define Rectal Cancer-Multidisciplinary Team (RC-MDT) requirements for selecting, approving, and monitoring patients managed under watch and wait (W&W) surveillance after favorable response to neoadjuvant therapy, in alignment with the 2026 ACS/NAPRC Optimal Resources for Rectal Cancer Care standards.

II Scope

- Applies to all rectal cancer patients considered for or managed under watch and wait who are treated within VCMC's NAPRC program.
- Addresses eligibility determination, RC-MDT presentation and approval, imaging and endoscopy requirements, follow-up protocols, and documentation.

III Procedures

1. Patients being considered for the Watch and Wait Protocol are to be presented at RC-MDT Cancer Conference for review and approval.
 - **Microsatellite Instability (MSI)-high/deficient Mismatch Repair (dMMR) tumors:** Checkpoint inhibitor therapy for up to 6 months (dostarlimab, nivolumab, or pembrolizumab). If checkpoint therapy is contraindicated, then can follow protocol below as if microsatellite stable.
1. Re-evaluation of disease status every 2-3 months is preferred. This will involve re-staging with digital rectal exam (DRE), magnetic resonance imaging (MRI) and computed tomography (CT) of the chest, abdomen, and pelvis. Endoscopic examination should also be considered but is not required until 6 months of therapy have been completed. Responses will be graded as complete, near complete or incomplete (see Definitions Table).
2. After 6 months of checkpoint therapy if there is not a complete response, then long course

chemoradiation (using either capecitabine or infusional 5-FU) or radiation alone should be completed. Re-evaluate disease 8(+/- 4) weeks later and if complete response is subsequently achieved patient can enter surveillance with watchful waiting protocol as described below or undergo total mesorectal excision (TME).

Please note, there is an option to evaluate clinical response during Total Neoadjuvant Therapy (TNT) if there is suspicion that therapy is not effective.

- **Microsatellite stable tumors:** Long course chemoradiation (using either capecitabine or infusional 5-FU) or short course radiation alone should be completed. When long course chemoradiation is being pursued, higher rates of organ preservation have been achieved in patients who pursue chemoradiation followed by consolidative chemotherapy. Therefore, consolidative chemotherapy following long course chemoradiation is preferred over induction chemotherapy in patients intended for non-operative management, but either option is acceptable. During the chemotherapy alone portion of treatment, FOLFOX or CAPEOX are preferred. Can consider FOLFIRINOX per National Comprehensive Cancer Network (NCCN) guidelines, but current data is weak.
1. Clinical response evaluations should be undertaken within 8 (+/- 4) weeks of the completion of TNT. This will involve re-staging with DRE, endoscopic examination, MRI and CT of the chest, abdomen, and pelvis. Responses will be graded as complete, near complete or incomplete (see Definitions Table). At the end of treatment, incomplete responses are recommended for total mesorectal excision (TME). Complete and near-complete responses will enter a watchful waiting protocol as described below.

Again note, there is an option to evaluate clinical response during TNT if there is suspicion that therapy is not being effective.

Watchful waiting protocol

Years 1-2

- DRE and proctoscopy +/- flexible sigmoidoscopy every 3-4 months.
 - Flexible sigmoidoscopy performed by the surgeon is highly recommended.
 - At the one year interval, colonoscopy would replace proctoscopy/flexible sigmoidoscopy
- Rectal MRI every 6 months – or endoscopic ultrasound (EUS) if unable to undergo MRI (i.e. non-compatible cardiac devices such as older pacemaker (PPM)/implantable cardioverter-defibrillators (AICD)).
- CT Chest Abdomen every 6-12 months.
- Carcinoembryonic Antigen (CEA) blood test every 3-6 months
- DRE and flexible sigmoidoscopy every 6 months.
- Rectal MRI every 6 months during year 3 – or EUS if unable to undergo MRI (ex PPM/AICD)
- CT Chest Abdomen every 6-12 months, CT pelvis to be included once no longer doing rectal MRI
- CEA every 6 months

Years 3-5

- DRE and flexible sigmoidoscopy every 6 months.
- Rectal MRI every 6 months during year 3 – or EUS if unable to undergo MRI (ex PPM/AICD)
- CT Chest Abdomen every 6-12 months, CT pelvis to be included once no longer doing rectal MRI
- CEA blood test every 6 months

Evaluations can be more frequent than listed above. If there is a sustained clinical response compared with

the previous evaluation, then the patient may continue the watch and wait protocol. If there are signs of tumor regrowth or lack of ongoing response, then TME is recommended. Biopsy is not required to exit the protocol. Patients who undergo TME revert to standard surveillance guidelines.

Patients are not required to be presented to RC-MDT after follow-up assessment. However, patients managed under Watch and Wait Protocol must be re-presented to RC-MDT for discussion in the event of a significant clinical finding from any follow-up assessment or imaging study.

All specific clinical processes associated with watch and wait surveillance are to be documented in the patient medical record.

DEFINITIONS

Response evaluation *after* TNT (i.e. 4-12 weeks after radiation or 4-12 weeks after chemotherapy).

	Incomplete Response	Near Complete Response	Complete Response
Endoscopic Exam	Visible tumor	Irregular mucosa	- Flat, white scar - Telangiectasia
Digital Rectal Exam (DRE)	Palpable tumor nodules	Smooth induration or minor mucosal abnormalities	Normal
MRI – T2W	- More intermediate than dark T2 signal, no T2 scar AND/OR - No regression of lymph nodes	- Mostly dark T2 signal, some remaining intermediate signal AND/OR - Partial regression of lymph nodes	- Normal appearing bowel wall without any fibrosis in the tumor bed; - Only dark T2 signal, no intermediate T2 signal - No visible lymph nodes or very few, small nodes (<5mm)
MRI – DW	Insignificant regression of signal on B800-B1000	Significant regression of signal on B800-B1000	- No visible signal on B800-B1000 AND/OR - Uniform, linear signal in wall above tumor is acceptable

Optional response evaluation *during* TNT (i.e. 2-6 weeks after radiation or 2-6 weeks after chemotherapy).

	Progressive Disease	Stable Disease or Partial Response	Near Complete Response	Complete Response
Endoscopic Exam	Increase	Partial Response	Irregular	Flat, white scar

	in tumor size	No change in size	mucosal nodules or minor mucosal abnormality - Superficial ulceration - Mild persisting erythema of the scar	- Telangiectasia - No ulcer - No nodularity
Digital Rectal Exam (DRE)	Palpable tumor nodules	Palpable tumor nodules	Smooth induration or minor mucosal abnormalities	Normal
MRI – T2W		- Mostly dark T2 signal, some remaining intermediate signal AND/OR - Partial regression of lymph nodes	- Mostly dark T2 signal, some remaining intermediate signal AND/OR - Partial regression of lymph nodes	- Normal appearing bowel wall without any fibrosis in the tumor bed - Only dark T2 signal, no intermediate T2 signal - No visible lymph nodes or very few, small nodes (<5mm).
MRI – DW		Stable or continued diminution in signal (no new focal signal)	Significant	- No visible signal on B800-B1000 AND/OR - Uniform, linear signal in wall above tumor is acceptable

IV References:

- Lynn, P. B., et al. (2017). "Organ-Preserving Strategies for the Management of Near-Complete Responses in Rectal Cancer after Neoadjuvant Chemoradiation." Clin Colon Rectal Surg 30(5): 395-403
- Cercek, A. et al. (2022). "PD-1 Blockade in Mismatch Repair–Deficient, Locally Advanced Rectal Cancer." NEJM 386(25): 2363-2376
- Conroy, T., et al. (2021). "Neoadjuvant chemotherapy with FOLFIRINOX and preoperative chemoradiotherapy for patients with locally advanced rectal cancer (UNICANCER-PRODIGE 23): a multicentre, randomised, open-label, phase 3 trial." Lancet Oncology 22(5): 702-715

- Verheij et al. (2024). "Long-Term Results of Organ Preservation in Patients With Rectal Adenocarcinoma Treated With Total Neoadjuvant Therapy: The Randomized Phase II OPRA Trial." JCO 42(5): 500-506

All revision dates:

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	4/24/2026
Cancer Program Manager	Jennifer Ferrick: Cancer Program Coordinator	4/24/2026



VENTURA COUNTY HEALTH CARE AGENCY

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Last Revised: 3/14/2023
Next Review: 3 years after approval
Owner: Matt McGill: Director, Imaging Services
Policy Area: Imaging Services
References:

IS.38 MRI Pre-Screening Process

POLICY:

To ensure patient safety, all patients that are scheduled for an Magnetic Resonance Imaging (MRI) exam shall be pre-screened for any metallic devices that will contraindicate the patient entering the MRI magnet room, Zone IV and for any issues related to claustrophobia or anxiety.

PROCEDURE:

All initial screenings should begin at the ordering physician's office and/or at the time of scheduling the MRI exam appointment. Patients with contraindications shall not be scheduled. Patients with claustrophobia and/or anxiety can review options for management with their ordering physician as necessary.

Contraindications

Contraindications may include, but are not limited to the following:

- Cardiac pacemaker
- **Individual devices may be cleared through the website: www.mrisafety.com**
- Implanted cardioverter device (ICD)
- Electronic implant or device, neurostimulator device, aneurysm clip
- Magnetically activated implant or device
- Internal electrodes or wires
- Bone growth stimulator
- Cochlear or other ear implant
- Implanted insulin pump
- Any metallic fragment or foreign body
- EKG/cardiac monitoring electrodes that are not MRI approved

A positive response to any item on the pre-screening form must be checked and approved by the Radiologist or MRI Technologist before the MRI can be done.

Patients shall be screened upon arrival at VCMC for their scan. Each patient shall have a complete MRI Patient History and Screening Form (see Attachment A).

If applicable, patients will be asked if they feel their claustrophobia or anxiety has been appropriately managed prior to bringing them into the MRI scan room.

In addition to the screening form, a pre-MRI TIMEOUT Form will be completed by the MRI Technologist

before any MRI exam is performed (see Attachment B).

The pre-screening form shall be reviewed by the MRI Technologist with the patient before the patient is allowed to enter the MRI scan room.

Patients who are unconscious or unable to answer questions shall be screened through one of the following ways:

- A family member, surrogate, or physician who is familiar with the patient's medical record
- Review of the patient's medical history and medical record
- Use of plain film radiography
- Visual inspection looking for scars, deformities or devices

If the patient cannot be screened to the satisfaction of the technologist, the technologist shall consult with the Radiologist. If the Radiologist is unavailable, the MRI exam shall be canceled and rescheduled.

The pre-screening form shall be scanned into the electronic health record and become part of the patient's permanent medical record.

All revision dates:

3/14/2023, 9/17/2019, 10/1/2015

Attachments

 [Attachment A.pdf](#)

 [Attachment B - Pre-MRI Time Out Form.xlsx](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Imaging Services	Matt McGill: Director, Imaging Services	2/26/2026
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/26/2026



VENTURA COUNTY HEALTH CARE AGENCY

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

IS.56 Radiation Protection

POLICY

It is the policy of the Radiology Department to obtain satisfactory diagnostic radiographs. This must be done with the minimum amount of exposure to the patient at all times. Technique charts are posted in each room provided annually by a Radiologic Health Physicist.

PROCEDURE

1. Patient identification will be made by verifying name and date of birth on every neonate, pediatric, adolescent and adult patient by checking the identification band and verbally to patient and/or patients' nurse.
2. Verification of physicians order in the patients' CERNER Powerchart for accuracy of order and reason for exam.
3. In general, the relatives and friends of patients being examined are to be kept out of the diagnostic room.
4. When absolutely necessary, the parent, friend, nurse, etc., may be used to help hold the patient being examined. Pregnant women should not be used in this capacity.
5. When applicable, such individuals will be given appropriate protection equipment to use, i.e., lead aprons
6. Special restraints for neonates, pediatric and adolescent patients are expected to be used as the patient's condition allows, such as sandbags, lead aprons or an appropriate pediatric immobilizer/positioner.
7. Lead Aprons are to be used where indicated.

SHIELDING

POLICY:

To provide maximum measures of radiation protection, and to establish procedure in the interest of protecting the patients and the hospital. Maximum efforts should be made to minimize radiation received by all patients and personnel.

PATIENT PROTECTION: Utilization of various coning devices, collimation devices, and lead shielding devices should be practiced at all times and extreme care should be utilized as to not obscure or compromise clinical information in the area of interest. **PRODUCTIVE AGE GROUP:** To include, but not limited to, neonates, pediatric gonads, a 0.5mm of lead shielding is to be placed between the patient and the primary

beam, taking care not to obscure clinical information.

GENERAL RULES: Personnel operating various X-ray equipment are to use all means available to enhance detail and reduce radiation.

1. Restrict beam size to the size of the image receptor.
2. Utilize cones.
3. Utilize fluoroscopy field limiting devices, exposing only areas with good fluoroscopy practice.
4. Exposure switches are to be located as not to allow operation beyond the primary protective field.

RADIATION PROTECTION FOR PERSONNEL WORKING IN RADIOLOGY

Per Title 17, section 30308 (b.)(l.): No individual occupationally exposed to radiation shall be permitted to hold patients during exposures except during emergencies, nor shall any individual be regularly used for this service. If the patient must be held by an individual, that individual shall be protected with appropriate shielding devices such as protective gloves and apron and shall be so positioned that no body part will be struck by the useful beam.

Only those persons required to perform fluoroscopy procedures are allowed beyond the primary protections barrier. These individuals are to utilize proper procedures at all times.

1. Utilize lead fluoroshield.
2. Wear lead aprons.

PROPER PLACEMENT OF RADIATION MONITORING DEVICE

During fluoroscopy, the radiation dosimeter badge is to be worn as close to the individual's eyes as conditions permit. Preferably on the collar next to the clavicle.

PREGNANT EMPLOYEES:

All staff members that become pregnant will fill out and sign a Declaration of Pregnancy form letter. This letter will be signed by the Radiation Safety Officer. The pregnant employee will be given information related to radiation safety for pregnant employees.

The pregnant employee will also fill out a pregnancy policy acknowledgement. This form contains the acknowledgement of radiation risk during pregnancy and the ability to withdraw the declaration of pregnancy.

Every effort must be taken to minimize exposures for pregnant employees. Under no circumstances should a pregnant employee be allowed to hold a patient during an X-ray exposure. Job assignments within the radiology department will incorporate minimal radiation risk to the employee. Normal daily job assignments will be altered in order to minimize and reduce the risk of an accidental overexposure.

The following job assignments will not be assigned:

1. Surgery assignments involving use of the C-arm
2. Fluoroscopy assignments

A second film badge shall be ordered for the employee and shall be worn at belt level to monitor the fetal dose.

RADIATION PROTECTION FOR EMPLOYEES OUTSIDE RADIOLOGY DEPARTMENT

The following areas/individuals are provided with radiation dosimeter badges and rotated on a routine/monthly basis. The records are retained in with the records for the Radiology Department.

At present, the following areas are monitored:

1. Same Day Surgery Staff
2. Surgery-nursing and physicians
3. Doctors who perform ERCP's

All revision dates:

3/14/2023, 9/17/2019, 12/1/2015, 4/1/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medicine Committee	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Imaging Services	Matt McGill: Director, Imaging Services	2/26/2026
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/26/2026



VENTURA COUNTY HEALTH CARE AGENCY

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

IS.57 Computerized Tomography Enterography

POLICY:

Nursing staff will be provided with guidelines and dosing instructions for the administration of oral contrast, Barium Sulfate 0.1% oral suspension with the order of CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST.

PROCEDURE:

Upon receiving a order for a CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST examination for an inpatient at Ventura County Medical Center (VCMC) or Santa Paula Hospital (SPH), a specific time frame for the administration of the the Barium Sulfate 0.1 % oral suspension shall be followed by the Registered Nurse (RN) providing the daily care of the patient. In addition, Computerized Tomography (CT) staff and nursing staff will need to be in communication with each other to properly time the administration of the oral contrast and the performance of the CT exam following the administration of the oral contrast to the patient.

When the order for CT ENTEROGRAPHY ABD/PELV W/IV CONTRAST AND ORAL CONTRAST is entered, a pharmacy order will automatically generate for the Barium Sulfate 0.1% oral suspension. There will be four orders for the different amounts of Barium Sulfate and the time frames that the oral contrast needs to be taken orally by the patient.

The oral contrast will need to be given to the patient at the following dose amounts and time frames.

1. 450 mL of Barium Sulfate, 0.1% oral suspension at 60 minutes prior to scanning.
2. 450 mL of Barium Sulfate, 0.1% oral suspension at 40 minutes prior to scanning.
3. 225 mL of Barium Sulfate, 0.1% oral suspension at 20 minutes prior to scanning.
4. 225 mL of Barium Sulfate, 0.1% oral suspension at 10 minutes prior to scanning.

After the final dose of oral contrast is given to and consumed by the patient, patient will be transported to the CT department where the CT scan will be completed. Nursing staff and CT Technologists will be in communication to coordinate the time of the exam.

All revision dates:

3/14/2023

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	5/6/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/10/2026
Imaging Services	Matt McGill: Director, Imaging Services	2/26/2026
Imaging Services	Michael Hepfer: Medical Director, Imaging Services	2/26/2026



VENTURA COUNTY HEALTH CARE AGENCY

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

PH.088 Controlled Substances

POLICY:

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

PROCEDURE:

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

~~Definition of Controlled Substances~~

Definition of Controlled Substances

- A. Controlled substances includes all drugs listed on Schedules CII, CIII, CIV, and CV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, or the California Uniform Controlled Substances Act, as amended.
- B. The disposition of these medications shall be regulated as outlined in these acts.
- C. Violation of these laws can lead to dismissal, license revocation, and/or criminal prosecution.

~~I. Procurement of Controlled Substances~~

- ~~A. All orders for Schedule CII controlled substances shall be authorized by the Director of Pharmacy Services or designee (through the "Power of Attorney"). Such orders shall be completed on the Drug Enforcement Agency (DEA) form 222.~~
- ~~B. All orders for Schedule CIII, CIV, and CV controlled substances may be ordered directly from drug wholesaler or direct from the manufacturer.~~

~~II. Receiving Controlled Substances~~

- ~~A. All Schedule CII controlled substances received by the pharmacy shall be checked in immediately and placed in the narcotic vault.~~
- ~~B. All Schedule CII controlled substances shall be received and checked in by a pharmacist.~~
 - ~~a. The pharmacist shall document the receipt of all CII medications on DEA Form 222, under the column titled "to be filled by purchaser".~~

- ~~b. The pharmacist shall record the number of packages received, the date of shipment and the pharmacist's initials.~~
- ~~C. Schedule CII, CIII, CIV, and CV medications shall be placed in the narcotic vault after receiving the medications.~~
- ~~D. All controlled substances in the hospital shall be stored in locked conditions at all times. The Pharmacy Department shall assume overall responsibility for the storage of all controlled substances throughout the Hospital.~~
- ~~III. Dispensing Controlled Substances in Automated Dispensing Cabinets (ADCs)~~
 - ~~A. See policy [PH.02 Automated Drug Cabinet Usage and Documentation](#).~~
- ~~IV. Dispensing Controlled Substances in Adult Infusion Center~~
 - ~~A. Dispensing of controlled substance for patients receiving treatment at the Infusion Center requires a valid prescription.~~
 - ~~a. Controlled substance class II: Prescriber must submit a valid prescription using tamper evident security prescription pad. The prescription is valid for 30 days from the written date and for one dispense. Refills are not allowed.~~
 - ~~b. Controlled substance class III-V: Prescriber may submit a valid prescription using tamper evident security prescription pad or called in to the Infusion Center Pharmacy. All orally transmitted prescriptions shall be produced in hard copy form by the pharmacist receiving the order including initials of the pharmacist. This prescription is valid up to 180 days from date written or up to 6 dispenses which ever comes first.~~
 - ~~c. Infusion Center pharmacist will transcribe the prescription order details into the electronic health record (EHR) system and label individual medication dispensed to nursing staff for patient administration during the visit. See [Policy PH.55 Medication Order Management](#) for details on labeling requirements.~~
 - ~~d. All controlled substances (class II-V) will be kept and dispensed by the infusion center pharmacy and perpetual inventory shall be maintained.~~
 - ~~e. All dispense must be reported to Controlled Substance Utilization Review and Evaluation System (CURES) within 24 hours of dispense.~~
 - ~~B. No controlled substance (class II-V) shall be dispensed directly to patient for home use.~~
- ~~V. Nursing Administration and Documentation~~
 - ~~A. A current physician's order for administration of controlled drugs is required prior to administration of any controlled substance.~~
 - ~~B. Administered doses shall also be recorded on the respective patient's Medication Administration Record (MAR).~~
 - ~~C. Discrepancies: Any discrepancy in the controlled drugs must be reported immediately to the charge nurse on duty. A nurse whose shift involved discrepancy shall not leave the facility until the discrepancy is resolved or thoroughly investigated. A notification form shall be completed if the discrepancy cannot be resolved.~~
 - ~~a. The Department of Pharmacy Services shall be notified if any discrepancy cannot be accounted by nursing staff.~~
 - ~~D. Lockboxes and portless IV tubing shall be used for the following controlled substance infusions:~~

- ~~a. All controlled substance infusions in the ICU shall be placed in a lock box and portless IV tubing used.~~
- ~~b. All end-of-life controlled substance infusions (e.g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL).~~
- ~~c. Patient controlled analgesia (PCA) locked in the Alaris Pump PCA module~~
- ~~d. Epidural infusions locked into the appropriate pump~~
- ~~e. Other controlled substance infusions (e.g. fentanyl drip) may be placed in lockboxes with portless IV tubing at the discretion of the care team.~~

~~VI. Nursing: Discontinuation of Controlled Substance Infusion~~

- ~~A. In the event a controlled substance infusion is discontinued, stopped or titrated off, the nurse shall immediately perform one of the following:~~
 - ~~a. Remove the controlled substance infusion bag from the patient room and waste the controlled substance, OR~~
 - ~~b. Disconnect the tubing from the patient's intravenous line and secure the bag and tubing in the medication room if the nurse anticipates the controlled substance infusion may be restarted.~~
 - ~~i. Controlled substances in a bag and tubing secured in the medication room under this circumstance shall be wasted if order is not restarted within 2 hours or at shift change, which ever is shorter.~~

~~VII. Disposal of Controlled Substances~~

- ~~A. Controlled substances shall be disposed of in a controlled substance waste container.~~
- ~~B. Disposal of controlled substances shall be performed by a licensed individual, with disposal activity witnessed by another licensed individual. Both individuals shall record all disposal/waste events in the automated dispensing cabinets in patient care areas.~~
- ~~C. Fentanyl Patches shall be disposed of in the following manner:~~
 - ~~a. All fentanyl patches removed from patients shall be disposed of in such a manner to prevent the diversion of the fentanyl patches.~~
 - ~~b. After being removed from the patient, the patches shall be folded in half so that the adhesive parts are attached together.~~
 - ~~c. Steps A & B of this section shall be completed thereafter.~~
- ~~D. Pharmacy Only: Expired controlled substances which are intact may be removed from hospital premises by a reverse distributor. All controlled substances removed in this manner shall be itemized for proper documentation.~~

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

- ~~A. Documenting Controlled Substance wasted from ADC's:~~
 - ~~a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste.~~
 - ~~b. Witness must observe the wasting and cosign in the ADC. The witness must have an existing user account.~~
 - ~~c. Controlled Substance waste shall be rendered unusable by dumping into a locked~~

~~pharmaceutical waste container and removed from the medication area in a timely manner.~~

~~IX. Returned Controlled Substances~~

- ~~A. When narcotics are returned to the Pharmacy, the pharmacist shall verify the quantity received immediately.
 - ~~a. Physical inspection shall be made of the items to be returned, particularly noticing whether vials or pre-filled syringes have been tampered or resealed.~~
 - ~~b. The returned medication shall be returned to the Pharmacy inventory.~~~~
- ~~B. Controlled substances that are not usable shall be disposed in the appropriate controlled substance waste container and documented in the ADCs with another licensed witness.
 - ~~a. If the controlled substance is wasted in the Pharmacy, Pharmacy must document waste in the Controlled Substance Waste Log with licensed witness.~~~~
- ~~C. Controlled substances may also be surrendered to a pharmaceutical waste management company for proper disposal.~~

~~X. Nursing Inventory of controlled substances~~

- ~~1. Two charge nurses shall complete at least weekly inventory count on ADCs of all controlled substance class II to V.~~
- ~~2. If charge nurses are unavailable, any licensed nurse (RN) may perform this function.~~

~~XI. Controlled Substances for Transport~~

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

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

- ~~A. Physical Count Inventories of controlled substances shall be performed by Pharmacist(s).
 - ~~1. C-II controlled substances shall be inventoried quarterly.~~
 - ~~2. C-III to C-V controlled substances shall be inventoried yearly.~~
 - ~~3. The inventory report shall be signed by the involved Pharmacist(s) and the Pharmacist in Charge.~~~~
- ~~B. Quarterly reconciliation report shall be prepared for the following medications and dated/signed by the Pharmacist in Charge
 - ~~1. C-II controlled substances~~
 - ~~2. C-IV controlled substances: alprazolam 1 mg/unit, alprazolam 2 mg/unit, and tramadol 50 mg/unit.~~~~

- ~~3. C-V controlled substance: promethazine with codeine 6.25 mg/10 mg per 5 mL of product~~
- ~~G. The inventory, quarterly reconciliation report, and records used to compile the reports shall be kept in the Pharmacy for three (3) years.~~

Procurement of Controlled Substances

- A. All orders for Schedule CII controlled substances shall be authorized by the Director of Pharmacy Services or designee (through the "Power of Attorney"). Such orders shall be completed on the Drug Enforcement Agency (DEA) form 222.
- B. All orders for Schedule CIII, CIV, and CV controlled substances may be ordered directly from drug wholesaler or direct from the manufacturer.

Receiving Controlled Substances

- A. All Schedule CII controlled substances received by the pharmacy shall be checked in immediately and placed in the narcotic vault.
- B. All Schedule CII controlled substances shall be received and checked in by a pharmacist.
- a. The pharmacist shall document the receipt of all CII medications on DEA Form 222, under the column titled "to be filled by purchaser".
- b. The pharmacist shall record the number of packages received, the date of shipment and the pharmacist's initials.
- C. Schedule CII, CIII, CIV, and CV medications shall be placed in the narcotic vault after receiving the medications.
- D. All controlled substances in the hospital shall be stored in locked conditions at all times. The Pharmacy Department shall assume overall responsibility for the storage of all controlled substances throughout the Hospital.

Dispensing Controlled Substances in Automated Dispensing Cabinets (ADCs)

- A. See policy [PH.92 Automated Drug Cabinet Usage and Documentation](#).

Dispensing Controlled Substances in Adult Infusion Center

- A. Dispensing of controlled substance for patients receiving treatment at the Infusion Center requires a valid prescription.
1. Controlled substance class II: Prescriber must submit a valid prescription using tamper evident security prescription pad. The prescription is valid for 30 days from the written date and for one dispense. Refills are not allowed.
2. Controlled substance class III-V: Prescriber may submit a valid prescription using tamper evident security prescription pad or called-in to the Infusion Center Pharmacy. All orally transmitted prescriptions shall be produced in hard copy form by the pharmacist receiving the order including initials of the pharmacist. This prescription is valid up to 180 days from date written or up to 6 dispenses which ever comes first.
3. Infusion Center pharmacist will transcribe the prescription order details into the electronic health record (EHR) system and label individual medication dispensed to nursing staff for patient administration during the visit. See [Policy PH.55 Medication Order Management](#) for details on labeling requirements.

4. All controlled substances (class II-V) will be kept and dispensed by the infusion center pharmacy and perpetual inventory shall be maintained.
5. All dispense must be reported to Controlled Substance Utilization Review and Evaluation System (CURES) within 24 hours of dispense.

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

Nursing Administration and Documentation

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

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

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

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

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

1. All controlled substance infusions in the ICU shall be placed in a lock box and portless IV tubing used.
2. All end-of-life controlled substance infusions (e.g. morphine 100 mg/100 mL or hydromorphone 50 mg/50 mL).
3. Patient controlled analgesia (PCA) locked in the Alaris Pump PCA module
4. Epidural infusions locked into the appropriate pump
5. Other controlled substance infusions (e.g. fentanyl drip) may be placed in lockboxes with portless IV tubing at the discretion of the care team.

E. Nursing: Discontinuation of Controlled Substance Infusion

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

- a. Remove the controlled substance infusion bag from the patient room and waste the controlled substance. OR
- b. Disconnect the tubing from the patient's intravenous line and secure the bag and tubing in the medication room if the nurse anticipates the controlled substance infusion may be restarted.
 - i. Controlled substances in a bag and tubing secured in the medication room under this circumstance shall be wasted if order is not restarted within 2 hours or at shift change, which ever is shorter.

F. Disposal of Controlled Substances

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

B. Disposal of controlled substances shall be performed by a licensed individual, with disposal activity witnessed by another licensed individual. Both individuals shall record all disposal/waste events in

the automated dispensing cabinets in patient care areas.

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

- a. All fentanyl patches removed from patients shall be disposed of in such a manner to prevent the diversion of the fentanyl patches.
- b. After being removed from the patient, the patches shall be folded in half so that the adhesive parts are attached together.
- c. Steps A & B of this section shall be completed thereafter.

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

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

A. Documenting Controlled Substance wasted from ADC's:

- a. All damaged or wasted controlled medications shall be documented in the ADC, with two licensed health care professionals witnessing the waste.
- b. Witness must observe the wasting and cosign in the ADC. The witness must have an existing user account.
- c. Controlled Substance waste shall be rendered unusable by dumping into a locked pharmaceutical waste container and removed from the medication area in a timely manner.

H. Returned Controlled Substances

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

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

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

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

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

I. Nursing Inventory of controlled substances

1. Two charge nurses shall complete at least weekly inventory count on ADCs of all controlled substance class II to V that were accessed since the prior inventory activity.
2. If charge nurses are unavailable, any licensed nurse (RN) may perform this function.

J. Controlled Substances for Transport

1. Controlled substances (class II to V) will not be dispensed to the emergency medical transport service, i.e. ambulance, outside hospital transport team including air transport.
2. Critically ill patients who are on a continuous infusion of any controlled substances may be transported out of the facility with the oncoming transport team to be used until they reach the final

destination.

- a. Additional medication infusion bags will not be made as a spare.
- b. Additional push doses of controlled substances will not be dispensed.
- c. RN sending out the patient will reconcile the medication with oncoming transport team. The amount of medication left in the bag will be documented on the electronic health record with the name of the person who is receiving the medication.

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

- A. Physical Count Inventories of controlled substances shall be performed by Pharmacist(s).
 1. C-II controlled substances shall be inventoried quarterly.
 2. C-III to C-V controlled substances shall be inventoried yearly.
 3. The inventory report shall be signed by the involved Pharmacist(s) and the Pharmacist in Charge.
- B. Quarterly reconciliation report shall be prepared for the following medications and dated/signed by the Pharmacist in Charge
 1. C-II controlled substances
 2. C-IV controlled substances: alprazolam 1 mg/unit, alprazolam 2 mg/unit, and tramadol 50 mg/unit.
 3. C-V controlled substance: promethazine with codeine 6.25 mg/10 mg per 5 mL of product
- C. The inventory, quarterly reconciliation report, and records used to compile the reports shall be kept in the Pharmacy for three (3) years.

All revision dates:

4/29/2026, 9/15/2025, 1/21/2025, 12/20/2023, 8/8/2023, 6/7/2023, 3/8/2022, 11/10/2021, 11/26/2018, 10/5/2018, 5/1/2016, 5/1/2013

Attachments

 [Attachment A - Lockbox and Portless Tubing Workflow](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/10/2026
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	4/10/2026



VENTURA COUNTY HEALTH CARE AGENCY

Origination: 11/1/2006
 Effective: Upon Approval
 Last Approved: N/A
 Last Revised: 2/27/2026
 Next Review: 3 years after approval
 Owner: Sara Pendleton: Medication Safety Officer
 Policy Area: Administrative - Patient Care
 References:

PH.096 Medication Override from Automated Dispensing Cabinets

PURPOSE

To define the use of the override function on automatic dispensing cabinet (ADC) system, Pyxis ES, and identify the best practices associated with its use.

POLICY:

~~To define the use of the override function on automatic dispensing cabinet (ADC) system, Pyxis ES, and identify the best practices associated with its use.~~

~~PROCEDURE:~~

~~Override medications are medications that can be accessed by nursing staff before review of an order by the pharmacist. The purpose of the override function is to allow for quick administration of medications in emergency and immediate (STAT) situations. The Joint Commission (TJC) standard MM.05.01.01 requires all medication orders be reviewed by a pharmacist prior to dispensing of the drug. There are two allowable exceptions:~~

- ~~1. A licensed practitioner controls the ordering, preparation, and administration of the drug, such as in the Operating Room, Gastroenterology Lab (GI Lab), Emergency Department and the Radiology Department.~~
- ~~2. Emergencies, when time does not permit the pharmacist to review the medication order, such as in a STAT situation when patient harm could result from delay in administration of a medication.~~

~~Accessing, "first dose" medications prior to pharmacist review in "routine situations" violates the TJC Medication Use Standards, therefore the following guidelines have been established.~~

~~Guidelines:~~

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), and Ambulatory Care Clinics (AMB) specifically Adult Infusion Center and Pediatric Hematology/Oncology clinic develops, implements, and monitors the appropriate use of medication overrides from automated dispensing cabinets (ADC).

Background

Definitions¹⁻²

1. **Override:** a process of bypassing the pharmacist's review of a medication order to obtain a medication from the ADC when assessment of the patient indicates that a delay in therapy could harm the patient
2. **Profiled ADC:** a pharmacy-profiled ADC is one in which a health care practitioner (HCP) can select a drug from a patient-specific list on the ADC screen and obtain a medication only after the order has been verified by a pharmacist.
3. **Rescue agent(s) (antidote or reversal agent):** A medication (usually provided urgently) used to reverse an adverse drug effect (e.g., to correct adverse physiologic consequences of a deeper-than-intended level of sedation), or to reverse a pathophysiological condition (e.g., use of a hypertonic saline resuscitate to treat severe hypovolemia).

Per Joint Commission National Patient Goals (NPG) 14.01.01 Element of Performance ID 2

When automatic dispensing cabinets are used, the hospital develops and implements a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.

Procedure:

1. ~~The~~ **Profiled** automated dispensing cabinets (ADC), are interfaced with the electronic health record (EHR) such that all new orders must be reviewed and verified by a pharmacist before a nurse is able to access the medication in the dispensing machine.

~~The Pharmacy & Therapeutics Committee shall review the list of approved override medications periodically (see Attachment A). The override list shall be developed by nursing leadership and the Pharmacy Department. Override medications in general shall only be utilized to access medications in emergency situations. Other non-emergency medications may be approved by the Pharmacy & Therapeutics Committee to be added to the override list if they have strong safety profiles.~~

- ~~1. Institute of Safe Medication Practices (ISMP) recommends the override function for the following circumstances:~~
 - ~~a. Antidotes, rescue agents, and reversal agents~~
 - ~~b. Life-sustaining medications~~
 - ~~c. Urgent comfort measure medications (e.g., to manage acute pain or intractable nausea and vomiting)~~
2. A medication order (e.g., electronic, written, telephone, or verbal) is required prior to removing any medication from an ADC, including those on override.
3. ADC overrides are limited to the following situations
 1. When a licensed independent practitioner controls ordering, preparation, and administration of the medication (e.g., anesthesia)
 2. When medications are required in emergent circumstances and waiting for a pharmacist to review the order could adversely impact the patient's conditions, such as the need for
 - a. Antidotes, rescue agents, and reversal agents

- b. Life-sustaining medications
 - c. Urgent comfort measure medications (e.g., to manage acute pain or intractable nausea and vomiting)
- 4. The Pharmacy & Therapeutics Committee defines the list of override medications (see Attachment A) taking into account the following
 - 1. Formulations, concentrations, and indications needed for emergent need
 - 2. Clinical locations where medications can be removed
 - 3. Health Care Practitioner types and specialties who can remove medications on override
 - 4. Risk versus benefit (i.e., potentially delayed patient care against the reduced risk achieved by pharmacist review of the medication order).
 - 5. Other non-emergency medications may be approved to the override list if they have strong safety profiles.
- 5. Set up and control of the ADC override function is restricted to the System Administrators designated by the Pharmacy Director. See policy [PH.92 Automated Dispensing Cabinet \(ADC\) Usage and Documentation](#)
- 6. Prior to administration of a medication that has been removed by the override function, the following should be reviewed for appropriateness prior to administration.
 - a. Drug, dose, frequency, and route of administration
 - b. Therapeutic duplication
 - c. Real or potential allergic reactions
 - d. Real or potential drug - drug interactions or drug - food interactions, and laboratory values
 - e. Other contraindications
 - f. Variations from the organizational criteria for use
 - g. Other relevant medication related issues or concerns
- 7. Patient safety should be considered in all decisions involving override medications.
- 8. ~~Medications removed using the override function shall be reviewed by the Pharmacy Department on a weekly basis.~~ Medication Override Oversight
 - 1. Medications removed using the override function shall be reviewed by the Pharmacy Department on a weekly basis.
 - 2. Medication override reports are trended by medication, user, and area and presented to Pharmacy and Therapeutics committee on a periodic basis. The reports shall also be used to address barriers to the pharmacist's review of the medication order prior to drug removal.

References

- 1. ASHP Guidelines on the Safe Use of Automated Dispensing Cabinets. Am J Health-Syst Pharm. Volume 79:1; January 1, 2022.
- 2. ISMP Guidelines for the Safe Use of Automated Dispensing Cabinets. 2019
- 3. The Joint Commission National Performance Goals (NPG) 14.01.01 Element of Performance 2. NOTE: Standards effective 1/1/2026. Last accessed 11/21/2025.

All revision dates:

2/27/2026, 3/14/2023, 3/4/2020, 3/21/2019, 2/1/
2016, 10/1/2014, 8/1/2012, 4/1/2012, 8/1/2011, 3/1/
2011, 9/1/2008

Attachments

 [Attachment A - Medication Override List.pdf](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/20/2026
Pharmacy Services	Sara Pendleton: Medication Safety Officer	4/7/2026
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	12/12/2025



VENTURA COUNTY HEALTH CARE AGENCY

Origination: 9/1/2000
Effective: Upon Approval
Last Approved: N/A
Last Revised: 2/20/2026
Next Review: 3 years after approval
Owner: Jessica Rodriguez: Manager, Cardiopulmonary Services
Policy Area: Respiratory Care
References:

R.51 Non-Invasive Ventilation

POLICY:

To provide guidelines for Non-Invasive Ventilation (NIV) at Ventura County Medical Center/Santa Paula Hospital. Patients who are physically unable to remove non-invasive ventilator mask are not to be placed on therapy.

PURPOSE

To establish clear guidelines for initiating, monitoring, documenting, and discontinuing Non-Invasive Ventilation in adult and pediatric patients to ensure patient safety, optimize clinical outcomes, and comply with National Patient Safety Guidelines.

Definitions

NIV- Non Invasive Ventilation

NIPPV- Non invasive Positive Ventilation

CPAP- Continuous Positive Airway Pressure

ICU- Intensive Care Unit

PICU- Pediatric Intensive Care Unit

NICU- Neonatal Intensive Care Unit

LIP- Licensed Independent Practitioner

NPO-Nothing by mouth

: Types of NIPPV:

- BiPAP (Bilevel Positive Airway Pressure): Provides two levels of pressure—a higher inspiratory pressure (IPAP) and a lower expiratory pressure (EPAP).
- CPAP (Continuous Positive Airway Pressure): Delivers a single, constant pressure throughout the breath cycle, primarily used for oxygenation issues rather than ventilation failure.

: Context:

In modern medicine, "NIV" and "NIPPV" are often used interchangeably

CLINICAL INDICATIONS

Acute Respiratory Failure

NIV may be used in acute respiratory distress where the condition is **potentially reversible within hours to days**, including:

- Acute hypercapnic respiratory failure
- Acute hypoxic respiratory failure
- Increased work of breathing
- Hypercapnic respiratory acidosis
- Dyspnea and tachypnea

NIV may also be used to:

- Facilitate **early extubation** in spontaneously breathing patients who would otherwise require prolonged invasive ventilation
- Provide **rescue NIV** for patients who have chosen to forego intubation

Additional Considerations

- Rescue NIV patients will remain **NPO** until respiratory status improves
- **Hand or wrist restraints should be avoided**
- During Rapid Response or pre-ICU transfer, the **Respiratory Care Practitioner must remain with the patient** until stabilized

Obstructive Sleep Apnea (OSA)

- NIV/CPAP may be used for patients with known or suspected OSA.

PATIENT SELECTION CRITERIA

Appropriate Candidates

Patients must meet **all** of the following:

- Spontaneously breathing
- Mentally competent, cooperative, and able to remove the mask independently
- Minimal pulmonary secretions
- Adequate bulbar muscle function and swallowing ability
- Not receiving heavy sedation or narcotics
- Patients who have chosen to forego intubation (DNR/DNI)

Contraindications

NIV **shall not** be used in patients with:

- : Cardiac or respiratory arrest
- : Hemodynamic instability
- : Life-threatening hypoxemia
- : Inability to protect airway or cooperate
- : Active vomiting or high aspiration risk
- : Impaired cough or swallowing
- : Poor secretion clearance
- : Untreated moderate to large pneumothorax
- : Facial trauma, burns, or recent facial/airway surgery
- : Upper GI bleeding or bowel obstruction
- : Angioedema or anaphylaxis with airway compromise

Relative Contraindications

May be considered **only with close monitoring and a mandatory sitter**:

- : Confusion
- : Decreased level of consciousness
- : Small untreated pneumothorax (must be closely monitored)

PROCEDURE:

To establish safe and effective guidelines for performing, documenting, and reporting issues for patients using non-invasive ventilation.

1. Non-Invasive Ventilator for Acute Respiratory Failure

1. Acute respiratory distress situations in which patients are suffering from acute hypercarbic or hypoxic respiratory failure, and where the underlying cause is generally reversible within a relatively short period of time (generally hours to days).
2. Facilitate early extubation of spontaneously breathing patients who would normally require extended periods of invasive ventilation as a supplement therapy for respiratory support.
 - a. The rescue NIV patient will remain NPO until there is an improvement in the patient's respiratory status.
 - b. Avoid use of hand/wrist restraints.
 - c. When used before transfer to the Intensive Care Unit (e.g. Rapid Response Team call), a

Respiratory Care Practitioner should remain in the unit where the patient is located until the patient is stabilized.

2. **Non-Invasive Ventilator for Obstructive Sleep Apnea (OSA)**

1. NIV/CPAP may be used for patients with known or suspected OSA.
 - a. Providers requesting NIV for suspected OSA **without a sleep study** may order NIV with **Auto-Titration** per manufacturer guidelines
2. Home units may be used **only after approval** by Respiratory Therapy and Biomedical Engineering (see Policy R.99)

3. **Skin Integrity with the Use of NIV**

1. The Respiratory Care Practitioner, in collaboration with the Registered Nurse, is to assess the patient risk for skin breakdown with the use of NIV. Based on the assessment, skin protective material (e.g. gel dressing) may be placed over the bridge of the nose or any other pressure points prior to placing the machine interface device mask onto the patient.
2. Skin integrity at the mask interface will be assessed and documented by the Respiratory Care Practitioner and Registered Nurse every four hours and PRN, OSA patients may be excepted.
3. If an area of skin breakdown is noted, the issue will be immediately escalated to the Registered Nurse assigned to the patient for that shift who is to consult with the wound nurse
 - a. If tolerated, an order for short breaks using other oxygen delivery systems (e.g. Heated High Flow Nasal Cannula, non-rebreather) should be obtained in an effort to minimize any patient discomfort or pressure sores that may appear after extended periods of time from facial masks

~~Patient criteria for use of NiPPV~~

- ~~1. Patients who choose to forego intubation~~
- ~~2. Patients who are spontaneously breathing~~
- ~~3. Patients who are mentally competent and cooperative and not using heavy sedation or narcotics~~
- ~~4. Patients who are free of excessive pulmonary secretions~~
- ~~5. Patients with bulbar muscle function adequate for swallowing without risk of aspiration~~

~~Contraindications for use of NiPPV may include, but are not limited to patients who:~~

- ~~1. Are unable to self-manage pulmonary secretions and/or require frequent suctioning~~
- ~~2. Have equipment and/or physical characteristics that will contribute to excessive air leaks with NiPPV (e.g. a nasogastric tube, facial hair)~~
 - ~~a. Although not a contraindication, large amounts of facial hair and gastric tubes will interfere with the mask seal and increase the leak volume.~~
- ~~3. Are not cognitively aware enough to remove facemask in the event of vomiting~~
- ~~4. Do not have adequate cough and gag reflex.~~
- ~~5. Are hemodynamically unstable.~~
- ~~6. Are not breathing spontaneously~~

4. **Special Consideration**

1. Dentures

- a. Remove dentures when on Rescue NiPPV or utilizing High Inspiratory Pressure
- b. May leave dentures in per patient request for OSA NiPPV when using Nasal Pillows or Nasal Prong interface

GUIDELINES

1. Indications include, but are not limited to (1)

- 1. Dyspnea
- 2. Tachypnea
- 3. Increased work of breathing
- 4. Hypercapnic respiratory acidosis
- 5. Hypoxemia

2. Contraindications (1)

- 1. Cardiac arrest
- 2. Respiratory arrest
- 3. Cardiac instability
- ~~Hypotension~~
- 4. Upper GI bleeding
- 5. Impaired cough or swallowing
- ~~Decreased level of consciousness~~
- 6. Status epilepticus
- 7. Poor secretion clearance
- 8. Extensive head or neck tumors
- 9. Tumor that causes extrinsic airway compression
- 10. Angioedema or anaphylaxis that causes airway compromise
- 11. Vomiting
- 12. High risk of aspiration
- ~~Confusion~~
- 13. Inability to cooperate
- 14. Agitation
- 15. Bowel obstruction
- 16. Upper GI surgery
- 17. Upper airway surgery
- 18. Life-threatening hypoxemia
- 19. Facial trauma or surgery
- 20. Airway or facial burns
- 21. Untreated pneumothorax (Moderate to Large)

3. Relative Contraindications

1. Untreated pneumothorax

- a. Small Pneumothorax must be closely monitored

2. Confusion

- a. May be considered with a mandatory sitter available

3. Decreased level of consciousness

- a. May be considered with a mandatory sitter available

4. **Equipment**

A. Non Invasive Ventilator

- a. Rescue NIV device
- b. NIV device for consideration of Obstructed Sleep Apnea
 - i. Physicians requesting NIV for suspected OSA with no sleep study for setting suggestions may order NIV with "Auto Titration" per manufacture ~~guidelines~~guidelines.
- c. Home units will be used as approved by the Respiratory therapy and Biomed.(refer to policy R. 99)
 - i. If a patient used a home NiPPV unit and requires rescue NiPPV ventilation, a hospital NiPPV system will be used until the home unit is approved for use in the hospital

B. Circuit

- a. Heated
 - 1. Heater
 - 2. Sterile water
 - 3. Place on heated circuit if on longer than 24 hours continuously.
- b. Nonheated
 - i. OSA patients

C. Bacteria filter

D. Mask

- a. Use sizing guide to choose appropriate size
- b. Headgear to fasten the mask to the patient's face
- c. Gel barrier (if needed)

E. Suction Equipment as needed

F. Pule oximeter~~-and-probe~~

G. Vital signs monitoring equipment

H. Stethoscope

- I. Gas source that can supply 50 psi (unless ventilator has internal compressor)

J. Manual resuscitation bag with reservoir

K. 22 mm adapter

- a. Only when connecting to trach patients

5. Initiating

- A. Verify active order in Electronic Medical Record
- B. Verify patient with 2 patient identifiers
- C. Perform proper hand ~~hygiene~~ hygiene and adhere to contact ~~precautions~~ precautions
- D. Explain the device and its purpose, how the mask is applied, the duration of use, and any restrictions or accommodations to eating/drinking during therapy.
- E. Initial set up of NIV equipment in accordance with the NIV machine manufactured guidelines.
- F. Determine appropriate size and style of interface mask
 - a. Instruct patient how to quickly release the mask in an emergency
- G. ~~Place patient~~ Place patient on device with interface connected
- H. Observe the patient for any leaks or discomfort and readjust as needed
- I. Ensuring that all NIV machine alarms are set appropriately and audible.
- J. Review special circumstances for pediatric patients vs adults
 - a. Age is not a limitation for NIV in hypercapnic respiratory failure

6. Monitoring

- A. Vital Signs
 - 1. Pulse Oximetry
 - 2. Heart Rate
 - 3. Monitor level of consciousness
 - 4. Breath Sounds
 - 5. Respiratory Rate
- B. Trach patients
 - 1. Heated circuit will be immediately used
 - 2. Patient will be on continuous monitoring
 - 3. Passy Muir may not be used in line with non-invasive ventilation
- C. When a patient has altered mental status, due to elevated PCO₂
 - 1. Will be checked Q1H (every hour) by Nursing or Respiratory
 - a. Changes in sensorium should be noted by nursing
 - b. If status changes and patient is no longer altered, and able to remove mask checks should resume as Q2H (every 2 hours) by Nursing and Respiratory
 - 2. After 4 hours patient should be re-evaluated to ensure effectiveness of therapy
- D. After 48 hours of continuous use patient should be reevaluated
 - 1. Consult with the physician on plan of care
 - 2. Notify wound care if any signs of skin breakdown is present
 - 3. Ensure patient has been placed on heated circuit

Pediatric Patients

- ~~1. Pediatric patient(s) may be admitted for non-respiratory issues and will continue NIV/Cpap~~
 - ~~i. Patients who have stable respiratory status will continue NIV/Cpap care~~
 - ~~ii. Patients using NIV/Cpap at home will have home orders verified~~
 - ~~iii. Home settings should be used for initial setting, unless otherwise directed by the physician~~
 - ~~iv. RT will work in conjunction with the physician to wean patient to home settings, if applicable~~
- ~~2. NIV may be used for patients in respiratory failure if patient is DNR/DNI status~~
 - ~~a. Patients with unstable respiratory status who are full code should be transferred to higher level of care and not admitted to Pediatric Floor~~
 - ~~a. ER will hold patient until transfer can be arranged~~
 - ~~b. RT will monitor in Emergency Room and provide support to ER staff~~
 - ~~b. NIV may be used while awaiting transfer~~
- ~~3. Ensure an appropriately sized resuscitation bag with mask is at bedside~~
- ~~4. Home NIV/Cpap units are allowed~~
 - ~~i. Home nasal pillows, mask, or nasal mask may be used~~

7. In-patient Level of Care

1. Intensive Care Unit (ICU) level of care for both pediatric and adult patients is required for the following condition
 - a. FIO₂ (fraction of inspired oxygen) >60%
 - b. IPAP (inspiratory positive airway pressure) > 22cmH₂O
 - c. Patient meeting ICU criteria per LPLIP guidelines
2. Medical Surgical or Telemetry level of care is appropriate for the following condition
 - a. Obstructive Sleep Apnea
 - b. Other conditions where the patient has chosen to forego intubation yet requires rescue NiV for palliative or comfort Care
3. Chronic Home Use specificallly for Pediatric patients
 - a. Pediatric patient(s) may be admitted for non-respiratory issues and will continue NiPPV or CPAP
 - i. Patients who have stable respiratory status will continue NiPPV or CPAP
 - ii. Patients using NiPPV or CPAP at home will have home orders verified
 - iii. Home settings should be used for initial setting, unless otherwise directed by the physician
 - iv. RT will work in conjunction with the physician to wean patient to home settings, if applicable

8. Special Considerations

1. NiPPV may be used for patients in respiratory failure if patient is DNR/DNI status on Medical Floors

9. Documentation

- A. Home NIV units will not be checked by RT (refer to policy R. 99)
- B. Chronic OSA patients using the hospital's NIV machines will be checked Q6 (every 6 hours)
- C. Acute patients in ICU, PICU, NICU and ER, will be checked Q2 (*every 2 hours*)
- D. NIV on medical floors and DOU will be checked Q4 (every 4 hours)
- E. NIV checks will be documented in the EHR with following items
 - a. NIV sytem settings
 - i. Settings must match LP orders
 - b. Skin assessment
 - c. Patient tolerance
 - d. Type and size of interface
 - e. Alarms
 - i. Per manufacturer guidelines
 - ii. To adhere to National Patient Safety Guidelines
 - f. Vital Signs
 - g. Date and time therapy starts, ends and/or changes
 - h. Unexpected outcomes and related interventions

10. **Discontinuation**

- A. An order shall be obtained for discontinuation of non-invasive ventilation
- B. The physician should be contacted after 24 hours of non-use
 - 1. Re-evaluation of necessity
 - 2. Change in therapy is applicable
- C. Discontinued equipment will be removed before end of shift
- D. RT will document in the EHR discontinuation

11. **Cleaning**

- A. Devices shall be wiped down using proper Infection Control guidelines
 - 1. Adhere to manufacturer dwell time
 - 2. Place equipment bag over device and store in clean room

Source: 1. Lippincott Solutions, Lippincott Procedures. "Noninvasive positive-pressure ventilation, respiratory therapy", November 28, 2002. Lippincott® Solutions (lww.com)

All revision dates:

2/20/2026, 10/9/2024, 5/3/2018, 2/1/2014, 2/1/2012,
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7/1/2008, 7/1/2007

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/20/2026



VENTURA COUNTY HEALTH CARE AGENCY

Origination: 5/1/2007
 Effective: Upon Approval
 Last Approved: N/A
 Last Revised: 2/20/2026
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 Owner: Jessica Rodriguez: Manager,
 Cardiopulmonary Services
 Policy Area: Respiratory Care
 References:

R.57 Respiratory Care Invasive Mechanical Ventilation

POLICY:

To establish standardized guidelines for the initiation, management, transport, monitoring, and discontinuation of mechanical ventilation by Respiratory Care staff at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH). ~~The purpose of this policy is to outline implementation, hazards, transporting, and discontinuation of mechanical ventilation.~~

PROCEDURE:

PURPOSE

To ensure safe, effective, and consistent delivery of mechanical ventilation by outlining provider responsibilities, required equipment, monitoring standards, documentation requirements, and communication expectations.

DEFINITIONS

~~Electronic Health Record-EHR~~

~~Electronic Self-Test-EST~~

~~Liters Per Minute-LPM~~

~~Kilogram-Kg~~

- EHR – Electronic Health Record
- EST – Electronic Self-Test
- LPM – Liters Per Minute
- kg – Kilogram
- RT/RCP – Respiratory Therapist / Respiratory Care Practitioner
- SBT – Spontaneous Breathing Trial
- SAT – Spontaneous Awakening Trial

- ETCO₂ – End-Tidal Carbon Dioxide

GUIDELINES

1. ~~Orders~~ Orders

- ~~Physician is~~ Licensed Independent Practitioners (LIP) are responsible for entering mechanical ventilation orders ~~for mechanical ventilation in the EMR~~ in the EHR as soon as clinically feasible.
~~Orders need to be entered as soon as clinically possible.~~
- Verbal orders should be avoided when possible. ~~Physician in Intensive Care Unit~~ LIP and/or resident is available 24/7 for order clarification or emergencies.
 - ~~Changes in orders need to be done via "Modification" of order. Canceling an order and reentering a new one should be avoided if patient is not extubated.~~
 - Ventilator order changes must be entered as a modification to the existing order. Cancellation and re-entry of orders should be avoided unless the patient has been extubated.
- Mechanical ~~Ventilation~~ ventilation orders must ~~have~~ include:
 - Mode of Ventilation
 - Respiratory Rate
 - ~~Tidal Volume or Pressure Control~~ Tidal volume or pressure control settings
 - Oxygen Concentration
 - Positive End Expiratory Pressure
 - Pressure Support, if applicable
 - Spontaneous Breathing Trial Assessment
- ~~Orders~~ During EHR downtime, orders may be written ~~during~~ per hospital downtime policy. ~~Staff to follow downtime ordering policy~~
- The ~~RT (Respiratory Therapist)~~ RCP will independently set ~~the~~ sensitivity, flow rate, inspiratory time, I:E ratio ~~(inspiratory to expiratory ratio)~~, flow cycle, inspiratory rise, and bias flow to ~~meet the needs of the~~ optimize patient, ventilator synchrony and prevent air-trapping ~~and to maximize ventilator-patient synchrony.~~

2. ~~Equipment~~ Equipment

- Mechanical Ventilator
 - ~~Home~~ Only hospital-approved ventilators will ~~not~~ be used for critical ventilation support
 - Home ventilators are permitted per policy R.99
 - ~~Check~~ Prior to patient use, the ventilator ~~for proper operation of all systems according to~~ must be checked per manufacturer recommendations:
 - No circuit leaks ~~in-circuit~~
 - Pre use check has been preformed
 - Alarms functional and audible
 - All ventilators will be plugged into red outlet
- Ventilator circuit

~~Infant Circuit, 10mm~~

- ~~a. Flow is less than 15 LPM~~
- ~~b. Patient weight is less than 10 Kg~~

~~Pediatric Circuit, 15mm~~

- ~~a. Flow is 15-30 LPM~~
- ~~b. Patient weight is 10-20 Kg~~

~~Adult Ventilator Circuit, 22mm~~

- ~~a. Flow is greater than 30 LPM~~
- ~~b. Patient weight is greater than 20 K~~

1. Circuits will be changed ~~per~~ per manufacture recommendation or as needed (as-neededPRN).
2. When disconnecting patient from circuit red cap should be placed on circuit

C. Humidifier

- a. Sterile water
- b. Set at 37 degrees ~~Fahrenheit~~ Celsius

D. Manual resuscitation bag

- a. Resuscitation Bag must be connected to Oxygen source
- b. Proper size mask connected to resuscitation bag
- c. Resuscitation bag must be present with patient on all transports within the hospital

E. Suction Equipment

1. In-line suction catheters will be used
2. In-line suction catheters will be changed ~~per (as-needed)~~ PRN or per manufacturer recommendation

F. Bacterial Filter

1. Will be placed on inspiratory and expiratory limb
2. ~~Inspiratory~~ Expiratory Filter changed once a shift and when visibly soiled

3. ~~Monitoring~~ Monitoring

A. ~~Physiologic Data~~ Physiological Monitoring

1. Oxygenation: Pulse Oximetry (~~Oxygenation~~ SpO₂)
2. Ventilation: Capnography (~~Capnography~~ ETCO₂ when available)
3. Hemodynamics: (~~Blood Pressure and Heart Rate~~) pressure and heart rate
SpO₂
4. Neurologic

B. Airway Assessment

1. ~~Placement at teeth or gums (Oral intubation)~~ Endotracheal tube placement (documented at teeth/gums)
2. Tracheostomy ~~size~~ (when applicable)

- i. Size
 - ii. Drainage
 - iii. Sutures
 - 3. Cuff pressure
 - 4. Security
 - 5. Patency
 - 6. Skin integrity
 - C. Ventilator Assessment
 - 1. Settings/alarms
 - 2. Graphics
 - 3. Mechanics
 - 4. Synchrony
 - D. Humidification
 - 1. Type
 - 2. Adequacy/Temperature
 - 3. Secretions
 - E. Physical Exam
 - 1. Inspection
 - 2. Auscultation
 - 4. ~~Documentation~~ Documentation
 - A. Ventilator checks should be performed Q4(every 4 hours) or Q2 (every 2 hours) when indicated
 - a. Peep $\geq 14\text{cmH}_2\text{O}$
 - b. Fio2 $\geq 65\%$
 - c. PIP ≥ 35
 - d. Set Respiratory Rate ≥ 30 breaths per minute
 - e. APRV
 - f. Pressure Control Ventilation with inversered I:E
 - B. Neonatal Intensive Care (NICU) Q2
 - C. Pediatric Intensive Care (PICU) Q2
 - D. ~~Ventilator checks should be performed Q4(every 4 hours) or Q2 (every 2 hours) when indicated~~
 - ~~1. Complete a patient assessment within 30 minutes of initiation of mechanical ventilation~~
 - ~~2. Following any adjustments,~~
 - ~~3. Following return of the patient from transport~~
 - ~~4. Following transfer of care from another area of the hospital~~
- Complete a patient assessment within 30 minutes of initiation of mechanical ventilation

E. Additional documentation is required following:

- a. Ventilator adjustments
- b. Patient transport
- c. Transfer of care

F. Ventilator checks will be documented in the EHR

1. ~~Date and time of ventilator check~~ Date and Time
2. ~~Drop a "ventilator check~~ Ventilator day" charge ~~on the~~ (first AM check ~~of the am shift only~~)
3. ETT size ~~and~~ placement, ~~plus~~ cuff pressure ~~if applicable~~, and skin integrity
4. Ventilator settings and dynamic patient data
 - i. The RCP will assess and document current ventilator setting as indicated by ventilator mode type
5. Vital Signs
6. Heater temperature and water level on humidification
7. ~~Notation if tubing is drained, if tubing not drained notation should be made if condensation is seen in the tubing~~ Tubing drainage or presence of condensation
8. Breath sounds
9. Alarm settings
10. Patient position and if the head of bed is elevated
11. Sputum consistency and color

~~Alarms should be set within~~

1. ~~Respiratory Rate: set 10-20 breaths per minute above set rate~~
2. ~~High Minute Volume: set 10-15 above calculate minute volume~~
3. ~~Low Minute Volume: set no lower than 5 per min~~
4. ~~Peep: set 3 below and 3 above~~
5. ~~If alarms need to be set outside these ranges documentation should be provided why~~

~~Discontinuation~~

1. ~~An order shall be obtained for discontinuation of mechanical ventilation~~
2. ~~Respiratory Therapist will verify order~~
3. ~~RT's will remove ventilator from the patient room, clean, and EST before the end of their shift. If time does not permit this, the RT must notify their Lead who will assign another RT to complete this task~~
4. ~~RT will document in EHR ventilator discontinuation~~

G. Ventilators cleaned nightly using hospital-approved disinfectant wipes and documented

5. Alarm Parameters

1. Respiratory Rate: set 10-20 breaths per minute above set rate
2. High Minute Volume: set 10-15 above calculate minute volume

3. Low Minute Volume: set no lower than 5 per min
4. Peep: set 3 below and 3 above
5. If alarms need to be set outside these ranges documentation should be provided why

6. **DISCONTINUATION**

1. A written physician order is required to discontinue mechanical ventilation.
 - a. Verbal orders will not be accepted
2. RCP will verify the order prior to discontinuation.
3. RCP will remove the ventilator from the patient room, clean, and perform a complete system check before the end of the shift.
4. If unable to complete, the RCP must notify the Lead RCP before end of shift.
5. When requested to keep a vent on standby, if patient is off greater than 12 hours, new circuit must be paced on vent.
6. Ventilator discontinuation must be documented in the EHR.

7. ~~Areas of Consideration~~ **Areas of Consideration**

A. ETCO2

1. ~~Will be used~~ Used when available in _line
2. ~~Should be charted in~~ Documented with blood gases
3. ~~Will be checked~~ Assessed and charted during ~~routine~~ ventilator checks ~~and charted in the EHR~~

B. ~~X-ray~~ Imaging

1. ~~RT will assist X-ray Technicians~~ RCP will assist radiology as needed
2. Post ~~X-ray~~ imaging, ~~RT~~ RCP will verify ~~tube~~ airway security and placement

C. Oral Care

1. ~~Is a shared~~ Shared responsibility between ~~RT~~ RCP and RN
2. ~~Respiratory will provide~~ RCP provides oral care Q4, ~~aligned~~ hours with ventilator checks .
 - i. ~~RT will document oral care in EMR~~
 - i. RCP documents oral care in the EHR
3. ~~Respiratory will~~ RCP provides oral care only ~~provide oral care to~~ for intubated patients
4. Oral ~~Care~~ care kit ~~to be~~ placed at bedside immediately after intubation
5. Kits ~~will be~~ replaced ~~ever~~ every 24 hours per manufacturer guidance
Follow manufacturer recommendation

D. Weaning

1. SBT (Spontaneous Breathing Trial) will be assessed daily
 - i. If patient does not meet criteria, ~~Respiratory~~ RCP will document
 - ii. RN and RT will coordinate daily SBT and SAT (spontaneous awaking trial) at approximately 730 am. Please refer to CPG.53

E. ~~Notification~~ **COMMUNICATION & NOTIFICATION**

1. Attending physician will be notified of all sudden changes to respiratory status
~~Rounds will be completed daily in the Critical Care Unit (CCU) with an RT in attendance~~
~~Physicians and Residents will meet with Respiratory Therapy~~
2. Daily Critical Care Unit (CCU) rounds will include an RCP
3. Physicians, residents, RN and RCP will collaborate on ventilated patients
4. All Hand-off Reports of ventilator patients will be performed in the unit the patient is in
5. CCU will not be left without an ~~RT~~RCP when there is an unstable ventilated patient
 - i. If ~~RT~~RCP needs to leave, they will communicate with Charge RN
~~Communicate with RN when any ventilator changes are made~~
6. ~~Communicate with the RN when there are any~~must be notified of all ventilator changes in and
 patient condition changes
8. ~~Cleaning~~**CLEANING & STORAGE**
 - A. Ventilators will be cleaned using hospital approved wipes
 - ~~1. Respiratory Therapy will follow manufacture guidelines, allow proper wet to dry time~~
 1. Manufacturer-recommended wet contact times must be followed
 - B. All Ventilators will complete pre-op check before use
 - ~~1. Any time a Servo-i vent is turned off, a pre-op check must be completed before use~~
 - ~~2. A Hamilton T1 ventilator should be turned off after the pre-check is complete~~
 - C. Place clean equipment bag and return to clean room, keep the vent plugged in
9. **Perioperative Ventilation**
 1. **Use of home ventilators**
 - a. Use of home ventilators in the perioperative setting is discouraged.
 - b. Hospital-approved mechanical ventilators are preferred to ensure full monitoring capability, alarm functionality, and patient safety during recovery.
 2. **Preoperative Screening and Communication**
 - a. The Anesthesiologist is responsible for screening patients who are ventilator-dependent or who use a home ventilator preoperatively.
 - b. The Anesthesiologist will notify the Respiratory Care team and the perioperative care team of anticipated postoperative ventilatory needs prior to the procedure whenever possible.
 - c. Anesthesiologist will put in ventilator orders
 3. **Postoperative Ventilator Management**
 - a. Upon arrival to the post-anesthesia care unit (PACU), ICU, or designated recovery area, the Respiratory Care Practitioner (RCP) will place the patient on a hospital-approved mechanical ventilator unless otherwise ordered by the physician.
 - b. Ventilator setup and management will follow this Mechanical Ventilation Policy, including alarm settings, monitoring, and documentation requirements.
 4. **Home Ventilator Use Postoperatively (When Clinically Necessary)**

- a. If use of a home ventilator is deemed clinically necessary postoperatively or when preparing the patient to go home:
 - i. The decision must be communicated by the physician to Respiratory Care Practitioner (RCP).
 - ii. The RCP will verify ventilator function and settings prior to patient connection.
 - iii. The RCP will ensure a clean HEPA filter is in place before placing the patient on the home ventilator
 - iv. .Continuous monitoring standards equivalent to hospital ventilator use must be maintained.
 - v. Refer to Policy R.99

5. Documentation

- a. RCP will document ventilator type (hospital vs. home ventilator), filter placement, settings, and patient tolerance in the EHR.
- b. Any deviations from standard hospital ventilator use must include documented rationale.

10. . Magnetic Resonance Imaging (MRI)

1. MRI for Chronically Ventilated Patients

- a. Chronically ventilated patients requiring MRI must have a physician order to be placed on the hospital-approved MRI-compatible ventilator.
- b. The order must be entered in the EHR prior to the procedure and include ventilator mode and required settings per mechanical ventilation guidelines.
- c. Home ventilators are not permitted within the MRI environment.

2. Respiratory Therapy Responsibilities

- a. The Respiratory Care Practitioner (RCP) will verify the physician order prior to initiating ventilation on the MRI-compatible ventilator.
- b. RCP will place the patient on the MRI-compatible ventilator and manage ventilation for the duration of the procedure.
- c. RCP will ensure appropriate monitoring, alarm settings, and patient safety throughout transport and imaging

3. Post-Procedure Care

- a. Upon completion of the MRI exam, RCP will transition the patient back to the prescribed ventilator (hospital or home, as applicable) per physician order.
- b. Ventilator changes and patient tolerance will be documented in the EHR.

All revision dates:

2/20/2026, 4/16/2025, 2/1/2014, 2/1/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Medicine and Pediatrics	Stephanie Denson: Manager, Medical Staff Office	5/6/2026
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	2/20/2026



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Last Revised: N/A
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Owner: Jessica Rodriguez: Manager, Cardiopulmonary Services
Policy Area: Respiratory Care
References:

R.104 Tranexamic Acid For Nebulization

Purpose

Pulmonary hemorrhage is a life-threatening condition characterized by bleeding into the pulmonary parenchyma or airways, resulting in impaired gas exchange and potentially severe respiratory compromise. The purpose of this policy is to establish standardized guidance for the safe and effective use of nebulized tranexamic acid (TXA) as an adjunctive treatment for pulmonary hemorrhage.

Scope

This policy applies to all licensed healthcare professionals involved in the care of patients with suspected or confirmed pulmonary hemorrhage, including but not limited to physicians, advanced practice providers, pharmacists, respiratory therapists, and nursing staff.

Policy Statement

Nebulized tranexamic acid (TXA) may be used as an adjunctive therapy for the management of pulmonary hemorrhage when clinically indicated. TXA is an antifibrinolytic agent that promotes localized hemostasis by inhibiting plasminogen activation and fibrin degradation. When administered via nebulization, TXA provides targeted airway hemostatic effects while minimizing systemic absorption and associated adverse effects.

Administration of nebulized TXA requires a provider order and must follow this policy and associated procedures. Patient selection, dosing, and duration of therapy shall be guided by clinical judgment, severity of bleeding, and multidisciplinary collaboration.

Definitions

- **Pulmonary Hemorrhage:** Bleeding originating from the pulmonary vasculature or airways, including hemoptysis and diffuse alveolar hemorrhage.
- **Tranexamic Acid (TXA):** A synthetic antifibrinolytic agent that inhibits fibrin degradation.
- **Nebulization:** Administration of medication via aerosolized particles inhaled into the respiratory tract.

Indications

Nebulized TXA may be considered for patients with:

- Active pulmonary hemorrhage or significant hemoptysis

- Diffuse alveolar hemorrhage as determined by the treating provider
- Ongoing airway bleeding causing respiratory compromise
- Failure or delay of definitive procedural interventions

Contraindications and Precautions

Contraindications:

- Known hypersensitivity to tranexamic acid
- Active intravascular clotting or history of thromboembolic disease where risk outweighs benefit, per provider assessment

Precautions:

- History of thromboembolic events
- Renal impairment
- Concomitant prothrombotic conditions
- Use with caution in mechanically ventilated patients with high airway pressures

Ordering and Dosing

- Nebulized TXA must be ordered by a licensed provider.
- Typical dosing may include TXA 250–500 mg diluted in normal saline and administered via nebulizer every 6–8 hours, or per provider discretion.
- Dose adjustments and duration of therapy should be individualized based on patient response and clinical status.

Administration

- Nebulized TXA shall be prepared by Pharmacy in accordance with sterile compounding standards.
 - Pharmacy shall dispense in a blue syringe
 - Pharmacy shall adhere an auxiliary label “Inhalation only”.
- Administration will be performed by a licensed Respiratory Therapist.
- Administer in standard jet nebulizer.
- Appropriate personal protective equipment (PPE) must be utilized due to aerosolized medication delivery.

Monitoring and Documentation

Patients receiving nebulized TXA must be monitored for:

- Reduction or cessation of pulmonary bleeding
- Respiratory status and oxygenation
- Signs of bronchospasm or airway irritation
- Adverse effects or thromboembolic complications

All administrations, patient responses, and adverse events must be documented in the electronic medical record.

Discontinuation Criteria

Nebulized TXA therapy should be discontinued when:

- Pulmonary hemorrhage has resolved
- No clinical improvement is observed after a reasonable trial
- The patient experiences adverse effects
- Definitive treatment has been achieved

Roles and Responsibilities

- **Providers:** Assess appropriateness, order therapy, and oversee clinical management.
- **Pharmacy:** Prepare medication and provide dosing guidance.
- **Respiratory Therapy:** Administer nebulized TXA and monitor respiratory response.
- **Nursing:** Support patient monitoring and documentation.

Safety and Quality Considerations

Use of nebulized TXA shall be reviewed periodically through quality assurance and pharmacy oversight to ensure patient safety and compliance with evidence-based practice.

References

1. Zhang P, Zheng J, Shan X, Zhou B. *Advances in the study of nebulized tranexamic acid for pulmonary hemorrhage*. Eur J Clin Pharmacol. Published online Nov 30, 2024. Summarizes clinical evidence on nebulized TXA's hemostatic effects and safety profile. (PMC11717782)
2. DrOracle Medical Advisory Board & Editors. *Nebulized Tranexamic Acid (TXA) Protocol for Hemoptysis Management*. DrOracle.ai. Last updated Oct 18, 2025. Describes clinical dosing protocols and monitoring considerations for nebulized TXA in hemoptysis.
3. O'Brien J, Dyer K; Expert Commentary by Tyler D. *Inhaled TXA*. NUEM Blog. Dec 21, 2020. Discusses iTXA dosing ranges and observational data on pulmonary hemorrhage cases. (nuemblog.com)

All revision dates:

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	5/6/2026
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/24/2026
Respiratory Care	Jessica Rodriguez: Manager, Cardiopulmonary Services	3/24/2026



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Last Revised: 3/17/2020
Next Review: 3 years after approval
Owner: Marcos Rodriguez: Manager, Rehabilitation Services
Policy Area: Rehab Services
References:

RS.13 Outpatient Rehab Services Use of Dexamethasone

POLICY:

Dexamethasone is a water soluble corticosteroid used by Outpatient Rehab Services clinical staff for topical application under the orders of an attending physician in conjunction with the iontophoresis system or ultrasound for treatment of acute and subacute inflammation of bursae, tendons and joints. It is also used over scar tissue that needs softening.

PROCEDURE:

Contraindications:

- Allergy to medication or excessive susceptibility to Dexamethasone.
- Do not use over skin with any damage.
- Avoid use when infections are present.

Iontophoresis application:

1. Fill a syringe with 1.5 mL to 3.5 mL of dexamethasone depending on electrode size.
2. Hydrate entire electrode pad.
3. Have patient wash area to be treated.
4. Prep electrode sites on patient's skin, with alcohol prep. Allow skin to dry. Do not apply electrode to damaged skin, skin with ingrown hairs, pimples, razor nicks or open wounds as excessive irritation or burns may occur.
5. Apply hydrated drug electrode on the selected treatment site and secure by pressing on the adhesive border only.
6. Attach twin leads, black to the drug electrode, red to the dispersive pad.
7. Begin treatment, setting parameters on unit per protocol (see instructions with electrode packet).
8. If patient experiences discomfort, lower current and lengthen treatment period proportionally.
9. At end of treatment, turn off machine, disconnect leads, remove electrodes.
10. Check skin for excessive redness or blisters.

Storage:

Medication(s) shall be stored in accordance to [PH.24 Clinic Medications](#).

All revision dates:

3/17/2020, 10/1/2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/10/2026
Rehab Services	Marcos Rodriguez: Manager, Rehabilitation Services	3/10/2026



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Owner: Rhondi Shannon: Compliance Officer
Policy Area: Administrative - Compliance
References:

HIPAA Privacy Policy: General Use, Disclosure, and Confidentiality of Protected Health Information (PHI)

PURPOSE

To establish how Ventura County Health Care Agency (HCA) protects, uses, and discloses Protected Health Information (PHI). This policy ensures compliance with federal and state privacy laws and sets clear expectations for all workforce members regarding appropriate access, handling, and confidentiality of PHI, including Mental Health and Substance Use Disorder (SUD) treatment information.

SCOPE

This policy applies to all HCA divisions and programs, including Ventura County Medical Center, Santa Paula Hospital, Ambulatory Care, Behavioral Health (Mental Health and SUD treatment services), Public Health, and Managed Care. It also applies to employees, contractors, students, trainees, residents, volunteers, and business associates performing work on behalf of HCA.

This policy covers PHI in all forms: written, verbal, electronic, and visual.

HOW TO USE THIS POLICY

This policy establishes baseline privacy rules that apply to all workforce members.

Certain sections apply only in specific situations (such as disclosures to family members, facility directory use or Behavioral Health/SUD information) and are clearly labeled.

When multiple laws apply, the stricter standard governs.

DEFINITIONS

Protected Health Information (PHI)

Information that identifies a patient and relates to their physical or mental health, treatment, or payment for care in any form or medium.

Electronic Protected Health Information (ePHI)

PHI that is created, stored, transmitted, or received electronically.

Use

Accessing, sharing, or applying PHI within HCA.

Disclosure

Releasing or providing PHI to a person or entity outside HCA.

Minimum Necessary

The least amount of PHI needed to accomplish an authorized purpose.

Unauthorized Access

Any viewing, use, or disclosure of PHI not required to perform one's job duties (including accessing one's own PHI or PHI of family, coworkers, public figures, or patients not under one's care/role).

Workforce Member

Employees, contractors, students, trainees, residents, volunteers, and others acting on behalf of HCA.

Business Associate

A person or organization performing work for HCA that involves PHI.

Incidental Disclosure

A minor and unavoidable disclosure occurring as a by-product of a permitted use when reasonable safeguards are in place.

Personal Representative

A person legally authorized to act on behalf of a patient (as recognized by law).

Behavioral Health Information

Mental Health and/or SUD treatment information subject to additional confidentiality protections (including 42 CFR Part 2 when applicable).

Need-to-Know Standard

Workforce may access only the PHI required to perform their assigned duties.

POLICY

HCA is committed to safeguarding PHI and ensuring it is accessed, used, and disclosed only as permitted or required by law and only for legitimate business and clinical purposes.

Workforce members must limit access to PHI to the minimum necessary to perform their job duties and must protect PHI from unauthorized access, use, or disclosure at all times.

Unauthorized access, use, or disclosure of PHI is strictly prohibited and may result in disciplinary action.

HCA maintains administrative, technical, and physical safeguards to protect PHI and minimize incidental disclosures.

PROCEDURE

~~General Rules for Use and Disclosure~~

I. CORE RULES THAT ALWAYS APPLY

General Rules for Use and Disclosure

HCA may use or disclose PHI **without patient authorization** for the following purposes, as permitted by law:

- **Treatment**
Coordination or provision of care, consultations, referrals, and care management.
- **Payment**
Billing, claims submission, eligibility verification, authorizations, and utilization review.
- **Health Care Operations**
Quality improvement, training, accreditation and surveys, audits and compliance activities, care coordination, population health, and other operational functions permitted by law.
- **As Required or Permitted by Law**
Including certain reporting obligations, court orders, lawful law enforcement requests, coroner or medical examiner functions, public health reporting, and oversight activities.

Authorization is required when a use or disclosure is not otherwise permitted by law. See the applicable HCA authorization policy for required elements and processes.

The **minimum necessary standard** applies to uses and disclosures unless an exception applies (for example, disclosures for treatment).

~~General Requirements for Special-Context Disclosures~~

II. GENERAL REQUIREMENTS FOR SPECIAL-CONTEXT DISCLOSURES

Before disclosing PHI in non-routine circumstances (~~including disclosures to individuals involved in care, facility directory disclosures, or other permitted disclosures outside routine treatment workflows~~), workforce members must:

- Confirm the legal basis for the disclosure, including any stricter federal or state requirements (e.g., CMIA, Welfare & Institutions Code, 42 CFR Part 2 when applicable).
- Verify the identity and authority of the requesting party when not known, consistent with HCA verification processes.
- Apply minimum necessary and disclose only what is reasonably needed.
- ~~Obtain~~Seek supervisory or management ~~approval~~review when there is uncertainty, a best-interest determination is required-by, or department process ~~or when there is uncertainty~~requires escalation.
- Document the disclosure in the medical record or approved logging process, including the date, recipient, general description of PHI disclosed, and legal basis.

~~When multiple laws apply, the stricter standard governs.~~

Safeguards

References to supervisory or management approval mean the workforce member's designated supervisor, manager, or department-identified designee consistent with local workflow. Approvals must be documented when required.

III. SAFEGUARDS

HCA maintains safeguards to protect PHI, including but not limited to:

- Role-based and least-privilege access controls
- Secure log-on/log-off practices and workstation security
- Secure faxing, printing, transport, storage, and disposal of PHI
- Secure transmission and storage of ePHI
- Monitoring and auditing of access to PHI

Workforce members must comply with all applicable HCA security and access control policies.

~~Incidental Disclosures~~

IV. INCIDENTAL DISCLOSURES

Incidental disclosures are not violations when:

- The underlying use or disclosure is permitted
- Reasonable safeguards are in place
- Only minimal information is exposed

Examples include limited information overheard during care or a patient name visible on a patient assignment tool when safeguards are used.

~~Unauthorized Access and Prohibited Activities~~

V. UNAUTHORIZED ACCESS AND PROHIBITED ACTIVITIES

Prohibited actions include, but are not limited to:

- Accessing one's own medical record outside approved processes
- Accessing records of family members, friends, coworkers, public figures, or patients not tied to job duties
- Viewing charts out of curiosity
- Discussing PHI in public or non-private areas
- Sharing passwords or credentials
- Sending PHI through unsecured channels or to incorrect recipients
- Posting PHI on social media
- Improper handling or re-disclosure of Behavioral Health or SUD information

~~Disclosures to Individuals Involved in a Patient's Care~~

VI. DISCLOSURES TO INDIVIDUALS INVOLVED IN A PATIENT'S

CARE

HCA may disclose PHI to a family member, relative, close friend, or other person identified by the patient when the information is directly relevant to that person's involvement in the patient's care or payment for care.

When the patient is present and has capacity, disclosure may occur if:

- The patient agrees; ~~or~~
- The patient is given an opportunity to object and does not object; or
- Staff reasonably infer, using professional judgment, that the patient does not object.

When the patient is not present, incapacitated, or an emergency prevents asking, supervisory or management staff (or designee ~~per department process~~) may determine whether disclosure is in the patient's best interest and disclose only the PHI directly relevant to the involvement.

Documentation: ~~of the~~ The disclosure must ~~occur~~ be documented in the medical record or approved disclosure logging process.

When capacity, objection, or best-interest determinations are unclear, staff should pause disclosure and consult a supervisor or the Office of Compliance & Privacy.

Behavioral Health / SUD Note:

If stricter confidentiality laws apply, including 42 CFR Part 2 when applicable, staff must follow the stricter rule and any consent or redisclosure limitations.

~~Facility Directory (Inpatient Directory) Disclosures~~

VII. FACILITY DIRECTORY (INPATIENT DIRECTORY) DISCLOSURES

HCA facilities may maintain a patient directory. ~~Directory information may include~~ including:

- Patient name
- Location in the facility
- General condition (in general terms)
- Religious affiliation (for clergy inquiries)

Notice and Choice:

Upon admission, patients must be informed ~~that directory information may be used or disclosed~~ and given the opportunity to restrict or prohibit disclosure.

~~Restrictions:~~

~~Any restriction must be recorded and communicated through the appropriate workflow.~~

Emergency or Incapacity Admissions:

If the patient cannot be informed at admission:

- Previously expressed preferences must be followed when known.
- If no preference is known, disclosure may occur only if a designated administrator (or designee) determines it is in the patient's best interest.
- Follow-up must occur when the patient regains capacity.

Recipients:

- Clergy may receive directory information, including religious affiliation.
- Others may receive directory information only if they ask for the patient by name and no restriction exists.

~~Organized Health Care Arrangement (OHCA) Disclosures and Join NPP~~

~~When HCA participates in an Organized Health Care Arrangement (OHCA), PHI may be disclosed to other participating covered entities for the OHCA's health care operations, as permitted by law.~~

~~HCA must:~~

- ~~• Maintain an identified list of OHCA participants and service sites.~~
- ~~• Assign responsibility for maintaining the list.~~
- ~~• Ensure any joint Notice of Privacy Practices accurately describes participants, sites, and permitted sharing.~~

~~Reporting Privacy Concerns and Suspected Violations~~

VIII. GOOD-FAITH DECISION MAKING AND ENFORCEMENT

HCA recognizes that privacy decisions often require professional judgment. Workforce members acting in good faith, consistent with training and policy, and seeking supervisory guidance when uncertain will be supported.

Coaching, education, corrective action, or discipline may be used as appropriate based on the nature and circumstances of the issue.

IX. REPORTING PRIVACY CONCERNS AND SUSPECTED VIOLATIONS

Suspected unauthorized access, use, or disclosure of PHI must be reported immediately to:

- A supervisor or manager
- **Office of Compliance & Privacy: (805) 677-5241**
- **Compliance & Privacy Helpline: (833) 823-6631**

Privacy complaints are handled under **Policy 109.011 Processing Privacy Complaints**.

~~Non-Retaliation~~

X. NON-RETALIATION

HCA prohibits retaliation against any individual who raises a privacy concern, reports an incident, or files a complaint.

~~Retention~~

XI. RETENTION

Privacy policies, related procedures, investigations, access logs, disclosure documentation, and related

records will be retained for at least six (6) years or longer if required by law, Medi-Cal, County policy, contract, or other applicable requirements.

REFERENCES

HIPAA Privacy, Security, and Breach Notification Rules

California Confidentiality of Medical Information Act (CMIA)

California Health & Safety Code §1280.15

Welfare & Institutions Code §5328

42 CFR Part 2

Policy 109.011 Processing Privacy Complaints

Relevant HCA HIM, IT Security, and Administrative policies

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Public Health	Katie McKinney: Assistant Director, Public Health	4/15/2026
Behavioral Health	Aliona Pavlovskaya	4/10/2026
Ambulatory Care	Lizeth Barretto: Chief Operating Officer, Ambulatory Care	4/1/2026
Health Information Management	Vibha Gune: HIM Manager	3/19/2026
Compliance & Privacy Office	Rhondi Shannon: Compliance Officer	2/25/2026

Delineation Of Privileges

Cardiology

Name:

Privilege	Requested	Granted
Initial Criteria: a. MD or DO b. Completion of at least 36 months of training in an approved fellowship in Cardiovascular Disease c. Current board certification with subspecialty in Cardiovascular Disease and/or Certificate of Added Qualifications in Clinical Cardiac Electrophysiology and/or Interventional Cardiology or active participation in the examination process leading to certification within 2 years of first opportunity to take the exam d. Documentation of a minimum of 200 cases in the previous 24 mos Evaluation Criteria: A minimum of 6 cases (* Requires concurrent evaluation) All other cases may be concurrent or retrospective evaluation Renewal Criteria: A minimum of 200 cases in the previous 24 mos		
CARDIOLOGY CORE PRIVILEGES:		
Admitting Privileges: Includes the management and coordination of care, treatment and services, including medical history and physical examinations.	—	—
Consultation Only	—	—
EKG Interpretations	—	—
Holter Interpretation	—	—
Exercise Treadmill Stress Tests	—	—
Electrical Cardioversion	—	—
Pericardiocentesis*	—	—
Arterial Catheterization*	—	—
Central Venous Line*	—	—
Temporary Transvenous Pacemaker*	—	—
SUPPLEMENTAL PRIVILEGES (must also meet criteria above)		
Transthoracic Echocardiogram (TTE) <u>Initial Criteria:</u> a. Level 2 training b. Interpretation of at least 200 transthoracic studies during the previous 24 mos <u>Evaluation Criteria:</u> 10 case evaluations <u>Renewal Criteria:</u> a. A minimum of 200 transthoracic echocardiograms in the previous 24 mos b. Failure to meet minimum; additional case evaluations required	—	—

Delineation Of Privileges

Cardiology

Name:

Privilege	Requested	Granted
Echocardiographic Stress Testing Including exercise testing and pharmacologic <u>Initial Criteria:</u> a. Level 2 training b. Interpretation at least 100 stress echocardiograms during the previous 24 mos <u>Evaluation Criteria:</u> 3 case evaluations <u>Renewal Criteria:</u> A minimum of 25 stress tests in the previous 24 mos	—	—
Transesophageal Echocardiogram (TEE)* <u>Initial and Renewal Criteria:</u> a. Level 2 training b. Adult Moderate Sedation Privileges c. Documentation of ~~625~~ prior studies as primary operator during previous 24 mos <i>(If volume criteria not met, first 5 cases evaluated)</i> <u>Evaluation Criteria:</u> 1 concurrent case evaluation	—	—
Adult Moderate Sedation <u>Initial Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) <u>Evaluation Criteria:</u> 3 cases <u>Renewal Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 mos <i>(If volume criteria not met, next case proctored)</i>	—	—
Fluoroscopy Requires current State issued Radiology Supervisor and Operator certificate	—	—
Implantable Loop Recorder* <u>Initial Criteria:</u> Core privileges <u>Evaluation Criteria:</u> 3 concurrent cases (by physician or industry representative) <u>Renewal Criteria:</u> A minimum of ~~104~~ procedures in the previous 24 mos	—	—

Delineation Of Privileges

Cardiology

Name:

Privilege	Requested	Granted
Permanent Pacemaker Implantations* <u>Initial Criteria:</u> a. Core Privileges b. Fluoroscopy c. Documentation of at least 20 procedures as primary operator <u>Evaluation Criteria:</u> 5 concurrent cases <u>Renewal Criteria:</u> A minimum of 5 cases during the previous 24 mos	—	—
Permanent Pacemaker Generator Change* <u>Initial Criteria:</u> a. Core Privileges b. Permanent Pacemaker Implantation Privileges c. Documentation of at least 20 procedures as primary operator <u>Evaluation Criteria:</u> 1 concurrent case <u>Renewal Criteria:</u> A minimum of 10 cases during the previous 24 mos	—	—
Implantable Cardiac Defibrillator (AICD)* <u>Initial Criteria:</u> a. Core Privileges b. Fluoroscopy c. Documentation of at least 25 procedures in previous 24 mos <u>Evaluation Criteria:</u> 5 concurrent cases <u>Renewal Criteria:</u> A minimum of 10 cases in the previous 24 mos	—	—
AICD Generator Change* <u>Initial Criteria:</u> a. Core Privileges b. Implantable Cardiac Defibrillator (AICD) Privileges c. Documentation of at least 25 procedures in previous 24 mos <u>Evaluation Criteria:</u> 1 concurrent case <u>Renewal Criteria:</u> A minimum of 10 cases in the previous 24 mos	—	—

Delineation Of Privileges

Cardiology

Name:

Privilege	Requested	Granted
Subcutaneous Implantable Cardioverter Defibrillator (S-ICD)* <u>Initial Criteria:</u> a. Core Privileges b. Fluoroscopy c. Documentation of training either through manufacturer or fellowship d. Documentation of at least 5 procedures in previous 24 mos <u>Evaluation Criteria:</u> 5 concurrent cases <u>Renewal Criteria:</u> A minimum of 5 cases in the previous 24 mos	—	—
S-ICD Generator Change* <u>Initial Criteria:</u> a. Core Privileges b. Documentation of training either through manufacturer or fellowship c. Documentation of at least 25 procedures in previous 24 mos <u>Evaluation Criteria:</u> 1 concurrent case <u>Renewal Criteria:</u> A minimum of 10 cases in the previous 24 mos	—	—
Resynchronization Therapy (BiV)* <u>Initial Criteria:</u> a. Core Privileges b. Fluoroscopy c. Documentation of at least 20 BiV procedures <u>Evaluation Criteria:</u> 5 concurrent cases (satisfactory completion also satisfies evaluation of other devices except S-ICD) <u>Renewal Criteria:</u> A minimum of 10 cases during the previous 24 mos	—	—
(BiV) Generator Change* <u>Initial Criteria:</u> a. Core Privileges b. Resynchronization Therapy (BiV) Privileges c. Documentation of at least 20 BiV procedures <u>Evaluation Criteria:</u> 3 concurrent cases <u>Renewal Criteria:</u> A minimum of 10 cases during the previous 24 mos	—	—

Delineation Of Privileges

Cardiology

Name:

Privilege	Requested	Granted
Nuclear Cardiac Diagnostic Imaging <u>Initial Criteria:</u> a. Board certified in Nuclear Cardiology or; b. Level 2 training and a minimum of 50 cases in the previous 12 months <u>Evaluation Criteria:</u> 3 case evaluations <u>Renewal Criteria:</u> A minimum of 50 cases during the previous 24 mos		
SPECT Myocardial Perfusion Imaging	—	—
Exercise and pharmacologic nuclear stress tests	—	—
ACKNOWLEDGEMENT OF PRACTITIONER: <i>I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.</i> Applicant's electronic signature on file TEMPORARY PRIVILEGE APPROVAL Department Chief's Signature: _____ Date: _____ Evaluator Assignment: _____ [] PROVISIONAL [] RENEWAL APPROVAL _____ Chief, Department of Medicine Date		

Delineation Of Privileges

Family Medicine Privileges.

Name: _____

Privilege	Requested	Granted
INITIAL CRITERIA: a. Successful completion of an ACGME or AOA-accredited residency in Family Medicine AND ; b. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Medicine within 1 year of completing the training AND ; c. Documentation of the management of general medical problems for at least 100 inpatients and/or outpatients as the attending physician (or senior resident) during the past 2 years RENEWAL CRITERIA: A minimum of 100 inpatient and/or outpatient combined encounters during the previous 24 months EVALUATION REQUIREMENTS: A minimum of 3 cases evaluated <i>If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity.</i> <i>If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.</i>		
CORE PRIVILEGES: Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED. Privileges include but are not limited to the following: Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for ADULT patients Admit, evaluate, diagnose, consult, perform a history and physical exam, and provide treatment for PEDIATRIC patients Anoscopy Arthrocentesis & therapeutic injection, large/small joint Aspiration of subcutaneous cysts, furuncles, etc. Assist in surgery Breast mass aspiration, breast cyst aspiration Cryodestruction (liquid nitrogen) of skin lesions Diaphragm fitting Excision of nail from digit I&D abscess, cysts, hematomas I&D of hemorrhoid, thrombosed IUD insertion/removal Management of burns Neonatal resuscitation standby at C-section Reduction of displaced fractures and dislocations Regional nerve blocks of digits Removal of non-penetrating corneal or conjunctival foreign body Removal of foreign body from ear, nose, skin Skin biopsy or excision Suture of uncomplicated lacerations Waived testing: Rapid strep A test, amnio test, dipstick for urine, urine pregnancy test, fecal occult blood by hemoccult	—	—
CORE PRIVILEGES REQUIRING ADDITIONAL CRITERIA, DOCUMENTATION OR COMPETENCIES:		
Frenulotomy - <i>*1st case evaluated</i>	—	—
Implantable sub-dermal contraception - <i>*Documentation of Nexplanon REMS certification required</i>	—	—
Laser Tattoo Removal - <i>*Documentation of 1-hour training with privileged physician</i>	—	—
Neonatal circumcision - <i>*A minimum of 5 within the previous 2 years, 1st case evaluated</i>	—	—
Osteopathic Manipulative Treatment (OMT) - <i>*Criteria: Doctor of Osteopathic Medicine (DO) Initial evaluation requirements: A minimum of 3 OMT case reviews</i>	—	—
Provider-Performed Microscopy (PPM); wet mount for presence/absence of bacteria, fungi, parasites & human cellular elements; KOH preparations, urine sediment examination, fern testing - <i>*Annual competency assessment required</i>	—	—
Limited bedside ultrasound - <i>*A minimum of 1 case evaluated</i>	—	—
Vasectomy - <i>*A minimum of 5 within the previous 2 years, 1st case evaluated</i>	—	—

Delineation Of Privileges

Family Medicine Privileges.

Name: _____

Privilege	Requested	Granted
CORE OBSTETRICS <i>*Excludes high-risk pregnancies as outlined in MS.102.023 Family Medicine Obstetrical Risk Stratification (Must also meet core privileging criteria)</i> INITIAL CRITERIA: a. New graduates - Documentation of a minimum of 40 deliveries during residency training b. Established physicians - Documentation of a minimum of 25 deliveries during the previous 2 years c. Completion of BETA annual obstetrical module requirements RENEWAL CRITERIA: a. Documentation of a minimum of 20 deliveries in the previous 2 years b. Completion of BETA annual obstetrical module requirements EVALUATION REQUIREMENTS: A minimum of the first 3 deliveries evaluated		
Prenatal care	—	—
CORE OBSTETRIC PRIVILEGES: Indicate in the comment section below, ANY PORTION OF THE CORE PRIVILEGES NOT BEING REQUESTED. Management of labor and delivery equal to or greater than 36 weeks gestation Limited obstetrical ultrasound, includes evaluation of presenting part, amniotic fluid index, placental position, viability Pudendal nerve blocks Paracervical nerve blocks Episiotomies & laceration repair of 1st, 2nd-degree lacerations	—	—
WOMEN'S HEALTH PRIVILEGES REQUIRING ADDITIONAL CRITERIA AND/OR EVALUATION: <i>(Must also meet core privileging criteria)</i> Unless otherwise indicated, a minimum of 1 case (1st case) evaluated for each of the following privileges		
Amniocentesis under ultrasound guidance to determine fetal maturity	—	—
Biopsy of cervix, vagina, vulva	—	—
Colposcopy with biopsy and cryotherapy - <i>*A minimum of the first 3 cases evaluated</i>	—	—
Manual vacuum aspiration (MVA)	—	—
Dilation and curettage:		
Diagnostic	—	—
Incomplete abortion	—	—
Suction curettage-therapeutic abortion	—	—
Loop electrosurgical excision procedure (LEEP) - <i>*A minimum of 3 within the previous 2 years, first 3 cases evaluated</i>	—	—
Low forceps delivery	—	—
Marsupialization of glands, Bartholins, etc	—	—
Repair of 3rd-degree lacerations <i>(no additional criteria or evaluation required)</i>	—	—
Vacuum extraction delivery <i>(no additional criteria or evaluation required)</i>	—	—
ADULT PROCEDURES <i>(Must also meet core privileging criteria)</i> INITIAL/RENEWAL CRITERIA: Documentation of a minimum of 1 of each procedure requested in the previous 2 years EVALUATION REQUIREMENTS: 1st case evaluated for each procedure requested		
Arterial line placement	—	—
Central venous catheter placement	—	—
Chest tube placement	—	—
Endotracheal intubation	—	—
Lumbar puncture	—	—
Paracentesis	—	—

Delineation Of Privileges

Family Medicine Privileges.

Name: _____

Privilege	Requested	Granted
Peripherally Inserted Central Catheter (PICC) - require the first placement with experienced physician (i.e. interventional radiology or other physician)	___	___
Pleural catheter placement	___	___
Posterior nasal pack for epistaxis management	___	___
Repair of extensor tendons	___	___
Revision of minor amputations-digits	___	___
Thoracentesis	___	___
SPECIAL PRIVILEGES: (Must also meet core privileging criteria)		
Pediatric Moderate or Deep Sedation and Analgesia <u>Initial Criteria:</u> a. Current PALS b. Completion of Sedation Module (minimum score of 80%) <u>Evaluation Criteria:</u> A minimum of 3 cases evaluated <u>Renewal Criteria:</u> a. Current PALS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months - If volume not met, the next case evaluated		
Light to moderate sedation	___	___
Deep sedation	___	___
Adult Moderate or Deep Sedation and Analgesia <u>Initial Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) <u>Evaluation Criteria:</u> A minimum of 3 cases evaluated <u>Renewal Criteria:</u> a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months - If volume not met, the next case evaluated		
Light to moderate sedation	___	___
Deep sedation	___	___
ACKNOWLEDGEMENT OF PRACTITIONER: <i>I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.</i>		
Applicant's signature : _____ Date: _____		
TEMPORARY PRIVILEGE APPROVAL		
Department Chief's Signature: _____ Date: _____		
Evaluator Assignment: _____		
[] PROVISIONAL [] RENEWAL APPROVAL		
Chief, Department of Family Medicine _____ Date _____		

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested
Basic Criteria: a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology* b. Current board certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology OR: c. Active participation in the examination process leading to certification within 5 years of completion of training d. Completion of BETA annual obstetrical module requirements (for obstetric privileges only) e. Documentation of case volumes as outlined in each requested privilege section Evaluation Criteria: A minimum of 5 cases representative of requested privileges, specific requirements outlined in each privilege section Renewal Criteria: a. Documentation of case volumes as outlined in each requested privilege section for renewal of privileges b. Compliance with BETA annual obstetrical module requirements <i>* Advanced obstetrics may be requested by family medicine physicians with the appropriate obstetrics fellowship training</i> <i>If initial volume criteria are not met in any of the following sections, privileges may be considered with additional monitoring and/or training requirements based on overall experience and activity. The Return to Practice Plan policy may be used to guide monitoring and/or training requirements.</i> <i>If renewal volume criteria are not met in any of the following sections, privileges may be considered for renewal with additional monitoring and/or training requirements, limited to 1 reappointment cycle.</i>	
OBSTETRICS	
Low-Risk Obstetrics Core Privileges Initial Criteria: a. Documentation of a minimum of 40 deliveries in the previous 24 months OR; b. Documentation of a minimum of 20 deliveries in the previous 24 months AND a minimum of 40 during residency training Evaluation Criteria: A minimum of 1 vaginal delivery Renewal Criteria: Documentation of a minimum of 20 deliveries in the previous 24 months	
Low-Risk Obstetrics Core Privileges Indicate in the comment section below, any portion of the core privileges NOT being requested Privileges include but are not limited to the following: Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any low risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Prenatal care Perform history and physical examination Vaginal delivery Fetal monitoring Vacuum extraction Episiotomy and/or other vaginal laceration repairs (up to 3rd-degree laceration repair) Limited obstetric ultrasound Resuscitation of infant	—
Advanced Obstetrics Core Privileges Initial Criteria: a. Completion of an ACGME or AOA approved residency program in obstetrics and gynecology OR; b. Completion of an ACGME or AOA approved family medicine residency program and an obstetrics fellowship c. Documentation of a minimum of 100 cesarean sections during fellowship AND 20 within the previous 24 months Evaluation Criteria: a. A minimum of 2 cesarean sections (1 primary and 1 repeat) b. Management of 1 complicated prenatal patient (desired but not required) Renewal Criteria: A minimum of 20 patients in the previous 24 months, including a minimum of 20 cesarean sections if requesting c-section privileges	

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested
Advanced Obstetrics Core Privileges <i>Indicate in the comment section below, any portion of the core privileges NOT being requested</i>	—
Privileges include but are not limited to the following: Admission, evaluation, consultation, diagnosis, and treatment of female patients of all ages presenting in any high-risk condition of pregnancy or illnesses, injuries, or disorders of the obstetric system and include; Perform history and physical examination ~~Breech delivery~~ ~~Forceps delivery~~ ~~Cerclage placement~~ ~~Amniocentesis and other procedures related to normal and complicated deliveries~~ ~~Multiple pregnancies~~ ~~Postpartum tubal ligation~~ ~~Obstetric ultrasound~~ ~~4th-degree laceration repair~~ ~~Dilation and curettage (for pregnancy)~~	
~~Breech delivery~~	
~~Forceps delivery~~	
~~Cerclage placement~~	
~~Amniocentesis and other procedures related to normal and complicated deliveries~~	
~~Multiple pregnancies~~	
~~Postpartum tubal ligation~~	
~~Obstetric ultrasound~~	
~~4th-degree laceration repair~~	
~~Dilation and curettage (for pregnancy <14 weeks and postpartum bleeding)~~	
Cesarean section (including tubal ligation done at c-section)	—
Special Privileges Initial Criteria: a. Completion of an Obstetrics and Gynecology residency program b. A minimum of 2 cases in the previous 24 months Evaluation Criteria: A minimum of 1 case evaluated Renewal Criteria: A minimum of 1 case in the previous 24 months	
2nd Trimester dilation and evacuation	—
Use of Laser - CO2 Laser Surgery course certification required	—
GYNECOLOGY Initial Criteria: a. Completion of an Obstetrics and Gynecology residency program b. Documentation of a minimum of 100 patients within the previous 24 months, including 20 surgical cases, unless only requesting outpatient privileges Evaluation Criteria: a. A minimum of 1 major gynecology procedure b. A minimum of 1 minor gynecology procedure (may be fulfilled by satisfactory completion of a major procedure) Renewal Criteria: A minimum of 20 patients, including 10 surgical cases, unless only requesting outpatient privileges	

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested
Gynecology Core Privileges <i>Indicate in the comment section below, any portion of the core privileges NOT being requested</i> Privileges include but are not limited to the following: Admission, evaluation, consultation, diagnosis, pre, intra-, and post-operative care and treatment of female patients of all ages presenting with illnesses, injuries, and disorders of the gynecological system and nonsurgical treatment of illnesses, and injuries of the mammary glands and urinary tract, and include: Perform history and physical examination Outpatient management Diagnostic and operative hysteroscopy Operative laparoscopy Cautery of endometriosis Hysterectomy, including cesarean hysterectomy Repair of bladder injury Repairs for pelvic relaxation and evaluation and treatment of stress urinary incontinence (suspension techniques) Endometrial ablation Reconstruction of vagina/vulva Myomectomy Bartholin cystectomy and catheter placement Biopsy (cervix, vulva, vagina, endometrium) Cervical conization Dilation and curettage Hymenotomy, Hysteroscopy I&D of abscess Oophorectomy Ovarian cystectomy Perineorrhaphy Removal of cervical polyps Repair of recto-vaginal fistula Pelvic ultrasound Presacral neurectomy Salpingectomy Suction curettage Trachelectomy Incidental cystoscopy IUD placement/removal and other contraceptive procedures - <i>*Documentation of Nexplanon REMS certification required</i> Tubal ligation Uterine suspension Vaginal exam under anesthesia Simple vulvectomy	—
GYNECOLOGIC ONCOLOGY Initial Criteria: a. Completion of a gynecologic oncology fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months Evaluation Criteria: a. A minimum of 1 major procedure b. A minimum of 1 laparoscopy procedure Renewal Criteria: A minimum of 20 patients within the previous 24 months	

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested
Gynecologic Oncology Core Privileges Indicate in the comment section below, any portion of the core privileges NOT being requested Privileges include but are not limited to the following: Admission, evaluation, consultation, work-up, diagnosis, and provision of surgical and therapeutic treatment to patients of all ages with malignant diseases, including carcinomas of the cervix, fallopian tubes, ovaries, uterus, vulva, and vagina, and include: Perform history and physical examination Outpatient management Radical hysterectomy with or without lymph node dissection Sentinel node biopsy Operative laparoscopy Retroperitoneal surgery for cancer Microsurgery Chemotherapy Pelvic exenteration Vulvectomy Procedures on the bowel, urethra, and bladder as indicated	—
MATERNAL AND FETAL MEDICINE Initial Criteria: a. Completion of a maternal and fetal medicine fellowship program b. Documentation of a minimum of 100 patients within the previous 24 months Evaluation Criteria: A minimum of 1 complicated patient, procedure, or ultrasound Renewal Criteria: A minimum of 20 patients in the previous 24 months	
Maternal and Fetal Medicine Core Privileges Indicate in the comment section below, any portion of the core privileges NOT being requested Privileges include but are not limited to the following: Admit, evaluate, diagnose, treat and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications, connective tissue disorders, and fetal malformations, conditions, or disease, and include: Perform history and physician examination Chorionic villus sampling Intrauterine transfusion Transuterine fetal procedures Ex Utero Intrapartum Treatment (EXIT) procedures Fetal umbilical cord blood sampling Level II ultrasound	—
ADDITIONAL PRIVILEGES	
Provider Performed Microscopy (PPM) - Annual competency modules required for each exam Indicate in the comment section below, any portion of PPM privileges NOT being requested Fecal WBC Fern Test Pinworm Preparations Qualitative Semen Skin KOH Urine Sediment Vaginal KOH Prep Vaginal Wet Prep	—

Delineation Of Privileges

Obstetrics & Gynecology Privileges

Name:

Privilege	Requested
Adult Moderate or Deep Sedation and Analgesia	
Initial Criteria: a. Current ACLS b. Completion of Sedation Module (minimum score of 80%)	
Evaluation Criteria: A minimum of 3 cases evaluated	
Renewal Criteria: a. Current ACLS b. Completion of Sedation Module (minimum score of 80%) c. A minimum of 6 cases within the previous 24 months <i>- If volume not met, the next case evaluated</i>	
Light to moderate sedation	_____
Deep sedation	_____
ACKNOWLEDGEMENT OF PRACTITIONER: <i>I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Ventura County Medical Center, Santa Paula Campus Hospital, and/or with the VCMC Ambulatory Care System. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation. I am willing to provide documentation of my current competence for the requested privileges.</i>	
Applicant's electronic signature on file	
TEMPORARY PRIVILEGE APPROVAL	
Department Chief's Signature: _____ Date: _____	
Evaluator Assignment: _____	
[] PROVISIONAL [] RENEWAL APPROVAL	
_____ Chief, Department of Obstetrics & Gynecology	
_____ Date	

Delineation Of Privileges

Podiatry (draft)

Name:

Privilege	Requested	Granted
Basic Criteria: a. Completion of a Council of Podiatric Medicine Education (CPME) approved residency in podiatric medicine and surgery b. Current board certification by the American Board of Podiatric Medicine (ABPM) OR American Board of Foot and Ankle Surgery (ABFAS) OR: c. Active participation in the examination process leading to certification within 5 years of completion of training d. Documentation of case volumes as outlined in each requested privilege section Evaluation Requirements: A minimum of 5 cases representative of requested privileges, specific requirements outlined in each privilege section Renewal Criteria: Documentation of case volumes as outlined in each requested privilege section for renewal of privileges <i>*Physicians with complex medical problems outside the range of education/training/experience of the Podiatrist that are present or that arise during hospitalization, the Podiatrist must arrange for a physician (MD/DO) Member of the Medical Staff to assume responsibility for the history and physical in addition to the responsibility for the care of the patient.</i>		
Core Privileges - Category I Basic Criteria: a. Completion of a Council of Podiatric Medicine Education (CPME) approved residency in podiatric medicine and surgery b. A minimum of 30 cases in sufficient variety, reflective of the scope of privileges requested during the past 24 months Evaluation Criteria: A minimum of 4 cases evaluated Renewal Criteria: A minimum of 30 cases in the previous 24 months		
Core Privileges - Category I <i>Indicate in the comment section below, any portion of the core privileges NOT being requested</i> Privileges include but are not limited to the following: Admission, evaluation, consultation, perform history & physical, order diagnostic studies for and treatment of patients of all ages with podiatric problems/conditions of the forefoot, midfoot, and non-reconstructive hind foot by mechanical, medical, or superficial surgical means in the hospital or outpatient clinic Capsulotomy/tenotomy foot Digital surgery including arthroplasty, arthrodesis Osteotomy and osteotomy foot Soft tissue repair and excisions to ankle Fractures - open, closed from digits to midtarsal joint Bunionectomy Joint implant from digits to midtarsal joints Incision and drainage from digits to distal to ankle joint Plantar fasciotomy and fasciectomy Arthrodesis (metatarsophalangeal, metatarsotarsal, tarsal joints, midtarsal joints) Tarsal tunnel release Amputation from digits to distal to choparts joint Pan metatarsal head resection Wound and bone debridement for osteomyelitis to bone graft harvest from foot Tendon repair and transfer distal to ankle joint Extracorporeal shock wave therapy	—	—

Delineation Of Privileges

Podiatry (draft)

Name:

Privilege	Requested	Granted
Core Privileges - Category II Basic Criteria: a. Hold current (Category I) privileges at this hospital with demonstrated competence and an adequate volume of experience b. A minimum of 10 cases in sufficient variety, reflective of the scope of privileges requested during the past 12 months or successful completion of a CPME accredited podiatric surgery residency in the past 12 months Evaluation Criteria: A minimum of 4 cases evaluated Renewal Criteria: A minimum of 12 cases in the previous 24 months		
Core Privileges Category II Indicate in the comment section below, any portion of the core privileges NOT being requested Privileges include but are not limited to the following: Calcaneal osteotomies Gastrocnemius recession (open or endoscopic) Flatfoot and cavus foot reconstruction Subtalar joint implant Tendon transfers, lengthening, repair from the lower calf to the talonavicular and calcaneocuboid joints Repair bone and cartilage defects subtalar and ankle joints Amputations at chopart joint clubfoot and vertical talus surgical reduction Arthrodesis subtalar joint, triple arthrodesis treatment of fractures of the talus, calcaneus, ankle Ankle arthrodesis Ankle arthroplasty without prosthesis Osteomyelitis management ankle Incision and drainage ankle Ankle osteotomy/ostectomy Ankle arthroscopy Bone graft harvesting tibia	—	—
ADDITIONAL PRIVILEGES		
Fluoroscopy - Must maintain a current fluoroscopy license	—	—
I hereby request the chief for the Department of Surgery to consider my application for the procedures requested above. I am willing to provide documentation of my current clinical competence for the requested privileges. _____ Applicant's signature _____ Date TEMPORARY PRIVILEGE APPROVAL _____ Chief, Department of Surgery _____ Date Evaluator Assignment: _____ [] PROVISIONAL [] RENEWAL APPROVAL _____ Chief, Department of Surgery _____ Date		