Patient Care Policies Agenda 5/26/2026

Title	Area	Revised?	Summary of Changes
Policy for Nursing Standard Orders for Prenatal Patients in Healthy Start Program	Ambulatory Care	Revised	No Comment Provided
Policy for Patient Treatment Management Plan	Ambulatory Care	Revised	Made changes adding Medical Director
Policy for Quick Response Cart	Ambulatory Care	Revised	JUST CHANGED DATES AND DID NOT MATCH FOR NEXT REVIEW
Policy for Receipt of Packages Containing Radioactive Materials	Diagnostic Imaging	Unchanged	No Comment Provided
Cardiology Privileges	Hospital & Health Centers	New	No Comment Provided
Emergency Medicine Privilege	Hospital & Health Centers	New	No Comment Provided
Policy for Anatomical Donations for Tissue and Organ Transplantation	Hospital & Health Centers	Revised	Updated to align policy for CDPH morgue program flexibility application during seismic compliance construction project.
Policy for Management of Patients' Personal Property After Discharge or Death	Hospital & Health Centers	Revised	Updated to align policy for CDPH morgue program flexibility application during seismic compliance construction project.
Psychiatry Privileges	Hospital & Health Centers	New	No Comment Provided
Resident Moonlighting-DFAM	Hospital & Health Centers	New	No Comment Provided
Anesthesiology Privilege	Hospital & Health Centers	Revised	Format change with criteria alignment
Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations	Hospital & Health Centers	Revised	Added inpatient progress notes to our delinquency tracking protocol. It also added Results and Cosign Orders to the tracking, which were previously listed as "proposed changes." Lastly, it removed a section that was labeled "other inpatient documentation, as required by law" as this was felt to be unclear and duplicated by the other requirements.
Ambulatory Physician Privileges	Hospital & Health Centers	Unchanged	No Comment Provided
Policy for Cleaning and Disinfection of Ophthalmic Laser Lens	Infection Control	Revised	Updated related links
Policy for Diet Manual	Nutrition	Revised	Updated to match the Nutrition Care Manual
Policy for Umbilical Catheters	Perinatal	Unchanged	No Comment Provided
Policy for Quality Assurance in Pharmaceutical Compounding	Pharmacy	New	No Comment Provided
Medication Error Reduction Plan-Annual MERP Review	Pharmacy	Revised	Updated signature page date (page 1 of attachment) from 3/2025 to 3/2026.
MERP Plan for the Year 2026	Pharmacy	Revised	Replaced MERP Plan for the year 2025 with new MERP plan for the year 2026. New processes are noted under each MERP element in the document.
Policy for Medication Error Reduction Plan (MERP)	Pharmacy	Revised	References were updated
Policy for Mifepristone-RU486 (Mifeprex®)	Pharmacy	Revised	Approval section was removed
Policy for Record Retention and Management	Pharmacy	Revised	Removed approvals section
Policy for Close Observation in Psychiatric Units	Psychiatry	Revised	Changed 4 minor instead of 5 to care in the minor room in policy & attachment, updated references, removed arm length practices in the attachment

Status **Pending** PolicyStat ID **20022639**

Origination	05/2012	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval	Applicability	CCRMC, Health Centers & Detention
Last Revised	03/2026		
Next Review	3 years after approval		

Policy for Nursing Standard Orders for Prenatal Patients in Healthy Start Program

POLICY STATEMENT:

To facilitate the ordering of prenatal laboratory tests and prenatal vitamins for pregnant patients entering care. Documented lab results from another medical facility may be used if they can be obtained expeditiously. If only a handwritten report of lab results is available, attempt to get a lab printout of results. Positive pregnancy test should be documented on all patients.

GUIDELINES:

A. Initial tests to order on all prenatal patients:

1. AMB Healthy Start EUSD PANEL. Order under the name of the EUSD Provider performing the initial care risk stratification.
2. Type & Screen.
3. HBsAG.
4. RPR.
5. HbA1C.
6. Hepatitis B surface antigen
7. Hepatitis C RNA.
8. RPR
9. CBC.

10. HIV
11. HbA1c
12. Hemoglobinopathy Screen- for all patients not of Northern European descent. No need to repeat if previous screen or HB electrophoresis.
13. Pregnancy Test, unless valid proof of pregnancy, from another health care facility is provided.

B. Order AMB HEALTHY START INITIAL PN Lab Panel. Order under the name ~~ofd~~of the Initial Prenatal Care Visit Provider. .
    1. Rubella IgG.
    2. Varicella.
    3. Cystic Fibrosis.
    4. UCRE.
    5. UA.
    6. GC/GT.
    7. POCT Dipstick 4.
    8. SMA.
    9. cFDNA.
    10. MSAFP.
    11. ~~Quantiferon~~QuantiFERON. Do not repeat testing unless there are new risk factors since the last test. Do not repeat if prior positive ~~Quantiferon~~QuantiFERON**.**
        a. Birth, traveled to, lived in or often crossed the border to a country where TB is common, Includes any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.
        b. Have lived with or spent time with someone who has had TB.
        c. A person living with HIV/AIDS or have received and organ transplant.
        d. Takes medication that weakens their immune system
        e. ~~Llve~~Live, ~~ir~~or have lived in a group setting such as homeless shelter or a jail or a prison.

C. Additional laboratory test to order on risk factors- may be ordered by Healthy Start Staff or deferred to provider assessment.
    1. TSH-Thyroid Stimulating Hormone. History of past or current thyroid disease, on or off medication, no test ~~int he~~in the last 6 weeks.
    2. ~~Pre~~History of Diabetes (pre-gestational DM)

D. Comprehensive Prenatal Services Program, State of California
    1. Counseling and tests per the current State of California program.

E. Data gathering that includes Combined Assessment on nutrition, psychosocial, and prenatal

education.

F. ~~.~~Genetic Screening. Screening should be offered to patients meeting the guidelines and scheduled by Healthy Start staff at the correct time if desired by patient as part of the State screening program and if presenting gestational age is early enough and appointment is available.

1. cfDNA screen – Client desires, recommended screening from 10 weeks 0 days through 21 weeks 0 days. It can also be done throughout the pregnancy.
2. MSAFP client desires and gestational age from 15 weeks 0 days through 21 weeks 0 days.
3. NT ultrasound Guidelines**.**
    a. History of neural tube defect in the mother or a previous fetus.
    b. History of congenital heart disease in the mother, father of pregnancy, or prior fetus/child.
    c. Known teratogen exposure.
    d. Known pre-gestational DM1 or DM2.
    e. Screening Hemoglobin A1c >=6.5 at entry to care.
    f. AMA AGE >/+35 Years old at EDD.
    g. Patients scheduled for genetic counseling prior to 14 weeks 2 days.
4. Follow-up on all abnormal NT and PNS screening for any recommended testing by the State Coordinator.
5. Additional Tests**:** Additional test orders may be obtained by calling one of the OB attending physicians.

G. Advanced Maternal Age (AMA) - for women who will be 35 years at the time of EDD, ~~off~~offer a NT or Level ~~11~~2 ultrasound and genetic counseling with the option of amniocentesis ~~ore cell~~orcell- free fetal DNA test or CVS depending on the insurance coverage (CCHP) and provider discretion.

H. EARLY SCREENING GESTATIONAL AGE <24 WEEKS

1. ~~For patients with a diagnosis of diabetes preceding pregnancy:~~
    ~~a. Draw HbA1C with Initial Prenatal Labs~~
    ~~b. Do POCT Glucose~~
    ~~c. Providing patients with a glucometer if she does not have one. Instruct patients to begin monitoring glucoses by the usual protocol of fasting and hour postprandial.~~
    ~~d. Continue pre-existing glyburide of glipizide or metformin and insulin. Consult MD by phone if on other medications.~~
    ~~e. Schedule MD visit within one week. If patient is less than 10 EGA and reports glucose >110 fasting or >180 postprandial or has random glucose >180 consult physician in call for consideration and management.~~

~~2. For all other prenatal patients:~~

~~a. Draw HbA1C on initial prenatal lab test.~~

~~b. If the initial HbA1c IS 6.5 OR ABOVE, order glucometer supplies and schedule diabetic teaching with close follow-up within one week to assess for the need of medication. Check blood sugar during teaching, if glucose >180, call MD on call for consideration of more immediate management.~~

~~c. If the HbA1c is 5.7 to 6.4, order 2 hours 75 GTT. If one value is abnormal, order glucometer supplies and schedule diabetic teaching and follow-up in 1-2 weeks to assess the need for medication.~~

~~3. 24-28 week GDM Screen:~~

~~a. All prenatal patients not already diagnosed with diabetes or gestational diabetes should have a 50 gram one hour GTT ordered between 24-28 weeks' gestation, or at the time of presentation if later than 28 weeks EGA. This includes all patients who had a normal screen prior to 24 weeks EGA.~~

~~4. Screening Test:~~

For patients with a diagnosis of diabetes preceding pregnancy:

a. Draw HbA1C with Initial Prenatal Labs
b. Do POCT Glucose
c. Providing patients with a glucometer if she does not have one. Instruct patients to begin monitoring glucoses by the usual protocol of fasting and hour postprandial.
d. Continue pre-existing glyburide/glipizide or metformin and insulin. Consult MD by phone if on other medications.
e. Schedule MD visit within one week. If patient is less than 10 EGA and reports glucose >110 fasting or >180 postprandial or has random glucose >180 consult physician in call for consideration and management.
2. For all other prenatal patients:
f. Draw HbA1C on initial prenatal lab test.
g. If the initial HbA1c IS 6.5 OR ABOVE, order glucometer supplies and schedule diabetic teaching with close follow-up within one week to assess for the need of medication. Check blood sugar during teaching, if glucose >180, call MD on call for consideration of more immediate management.
h. If the HbA1c is 5.7 to 6.4, order 2 hours 75 GTT. If one value is abnormal, order glucometer supplies and schedule diabetic teaching and follow-up in 1-2 weeks to assess the need for medication.
3. 24-28 week GDM Screen:
i. All prenatal patients not already diagnosed with diabetes or gestational diabetes should have a 50 gram one hour GTT ordered between 24-28 weeks' gestation, or at the time of presentation if later than 28 weeks EGA. This includes all patients who had a normal screen prior to 24 weeks EGA.

4. Screening Test:

j. ~~50 grams one hour GTT~~

   i. ~~The one hour 50-gram GTT is not fasting. Patients should be instructed not to drink or eat a large carbohydrate load immediately preceding the 50 GTT.~~

   ii. ~~They should not eat, smoke, or walk a significant amount during the test hour.~~

   iii. ~~If the one hour GTT is >130 and <200, Healthy Start nurses should contact the patient within one week to have them do the indicated follow-up of a 3 hour 100 gram GTT.~~

   iv. ~~If the one hour GTT is >200 make a presumptive diagnosis of GDM, order glucometer and supplies. schedule patient for GDM teaching. Follow-up in one or two weeks to check blood sugar numbers.~~

~~b. 100 grams 3 hour pregnancy GTT~~

   i. ~~Order if 50 grams one hour GTT is >130 and <200.~~

   ii. ~~The patient should be instructed to fast at least 8 hours and not more than 14 hours prior to the test.~~

   iii. ~~They should not eat, smoke or walk a significant amount during the test.~~

   iv. ~~Some providers may choose to go directly to a 3 hour 100 grams GTT skipping the 50 grams screen. This is most appropriate for patients at higher risk for GDM and acceptable for any patients. This is recommended by the American Diabetic Association.~~

   v. ~~A diagnosis of GDM is made if any two values are abnormal.~~

~~c. After Diagnosis of GDM~~

50 grams one hour GTT

   i. The one hour 50-gram GTT is not fasting. Patients should be instructed not to drink or eat a large carbohydrate load immediately preceding the 50 GTT.

   ii. They should not eat, smoke, or walk a significant amount during the test hour.

   iii. If the one hour GTT is >130 and <200, Healthy Start nurses should contact the patient within one week to have them do the indicated follow-up of a 3 hour 100 gram GTT.

   iv. If the one hour GTT is >200 make a presumptive diagnosis of GDM, order glucometer and supplies. schedule patient for GDM teaching. Follow-up in one or two weeks to check blood sugar numbers.

b. 100 grams 3 hour pregnancy GTT

v. Order if 50 grams one hour GTT is >130 and <200.

vi. The patient should be instructed to fast at least 8 hours and not more than 14 hours prior to the test.

vii. They should not eat, smoke or walk a significant amount during the test.

viii. Some providers may choose to go directly to a 3 hour 100 grams GTT skipping the 50 grams screen. This is most appropriate for patients at higher risk for GDM and acceptable for any patients. This is recommended by the American DIabetic Association.

ix. A diagnosis of GDM is made if any two values are abnormal.
c. After Diagnosis of GDM

x. Patients will be scheduled for glucometer teaching. Healthy Start RN will order supplies for monitoring of glucoses according to the standard regimen of fasting and one hour after each meal for total of 4 times per day.

xi. The Healthy start RN may order the patient's diabetic supplies through the patients preferred designated pharmacy.

xii. An appointment with a dietician will be scheduled as soon as possible.

xiii. Glucose targets are 60-95 fasting and 1 hour postprandial <140. If 20% or more of the blood glucose are above the recommended rage 60-95 fasting and more than 140 postprandial despite diet and exercise, the Healthy Start nurse will consult with the primary prenatal provider for possible initiation of medication.
d. Additional Screening for Congenital Anomalies

xiv. Patients with poorly controlled Diabetes Mellitus at the time of conception have an increase incidence of congenital fetal abnormalities. These patients should be scheduled for the following examinations:

a. HbA1c > 6.5 of FBS >100s:

i. Order a Level 11 anatomy ultrasound, ideally performed at 20 weeks gestation.

ii. Order a fetal echocardiogram in addition to the Level 2 anatomy scan, ideally performed at 20-24 weeks gestation.

~~d. Additional Screening for Congenital Anomalies~~

~~i. Patients with poorly controlled Diabetes Mellitus at the time of conception have an increase incidence of congenital fetal abnormalities. These patients should be scheduled for the~~

following examinations:

a. HbA1c > 6.5 of FBS >100s:

i. Order a Level 11 anatomy ultrasound, ideally performed at 20 weeks gestation.

ii. Order a fetal echocardiogram in addition to the LEvel 11 anatomy scan, ideally performed at 20-24 weeks gestation.

I. Postpartum Screenings:

Patients with a diagnosis of DM in pregnancy should be encouraged to continue diet, glucose monitoring and medication per instructions of their primary provider after pregnancy. They should be encouraged to continue diet, glucose monitoring and medication according to the instructions of their provider after pregnancy. They should be encouraged to breastfeed, use contraception when not intending pregnancy, and to seek assistance with attaining excellent glucose control prior to conception of their next pregnancy.

Patients with a diagnosis of GDM should be encouraged to maintain a healthy diet, like the GDM diet. They should be encouraged to monitor their weight and to maintain regular exercise to prevent Type 11 Diabetes in later life. They should be screened for diabetes or glucose intolerance with HbA1c at 2 – 3 months postpartum. Those with a diagnosis of impaired glucose tolerance should be encouraged to continue diet and exercise, and to be re-screened for diabetes in one year. Medication: Standing Orders.

J. Medications:

Postpartum Screenings:
Patients with a diagnosis of DM in pregnancy should be encouraged to continue diet, glucose monitoring and medication per instructions of their primary provider after pregnancy. They should be encouraged to continue diet, glucose monitoring and medication according to the instructions of their provider after pregnancy. They should be encouraged to breastfeed, use contraception when not intending pregnancy, and to seek assistance with attaining excellent glucose control prior to conception of their next pregnancy.
Patients with a diagnosis of GDM should be encouraged to maintain a healthy diet, like the GDM diet. They should be encouraged to monitor their weight and to maintain regular exercise to prevent Type 11 Diabetes in later life. They should be screened for diabetes or glucose intolerance with HbA1c at 2 – 3 months postpartum. Those with a diagnosis of impaired glucose tolerance should be encouraged to continue diet and exercise, and to be re-screened for diabetes in one year.
J. Medications:

1. for Prenatal Vitamins
2. Dispense: 1 bottle containing 100 tablets- 3 month supply
3. Direction: Take one tablet daily during your pregnancy.
4. The registered nurse will document the provision of the prenatal vitamins in ccLink and complete the Bulk Charging to generate a chargePrenatal Vitamins

a. Dispense: 1 bottle containing 100 tablets- 3 month supply
b. Direction: Take one tablet daily during your pregnancy.
c. The registered nurse will document the provision of the prenatal vitamins in ccLink and complete the Bulk Charging to generate a charge

5. ~~Doxylamine-pyridoxine vit B6 (Diclegis) 10-10 mg delayed release tablet.~~

   ~~Dispense: 60 tablets, refills x 1.~~

   ~~Direction: Take 2 tablets by mouth at bedtime, if nausea still occurring~~

   ~~after 3 days, increase 1 tab in the AM and 2 tabs at bedtime.~~

   ~~The HS RN will order medication, update medication lists, and complete documentation in Epic.~~

   If indicated, Doxylamine-pyridoxine vit B6 (Diclegis) 10-10 mg delayed release tablet.
   a. Dispense: 60 tablets, refills x 1.
   b. Direction: Take 2 tablets by mouth at bedtime, if nausea still occurring after 3 days, increase 1 tab in the AM and 2 tabs at bedtime.
   c. The HS RN will order medication, update medication lists, and complete documentation in Epic.

REFERENCES:

Comprehensive Prenatal Services Program, State of California, "Steps to Take", State Of California Training Binder

~~APPROVALS:~~

~~Perinatal Providers: 10/2022, 7/2025~~
~~Ambulatory Care Policy Committee: 5/2012, 7/2014, 4/2017, 2/2018, 6/2018, 10/2022, 12/2025~~
~~Ambulatory Policy Committee: 9/2012, 12/2014, 4/2018, 7/2018, 11/2022~~
~~Medical Executive Committee: 9/2012, 1/2015, 5/2018, 8/2018, 01/23~~
~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Ambulatory Policy Committee	Laura R. Colebourn [LC]	03/2026

Ambulatory Clinical Practice Committee	Helena Martey: Director of Ambulatory Nursing	02/2026
	Kelley Taylor: Ambulatory Care Clin Supv	02/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **20307105**

Origination	07/2018	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval	Applicability	CCRMC, Health Centers & Detention
Last Revised	04/2026		
Next Review	3 years after approval		

Policy for Patient Treatment Management Plan

POLICY STATEMENT:

Any patient, who exhibits behavior problems which contribute to an "incident" in any Health Center, will receive a face-to-face communication or phone call by the Ambulatory Care Clinical Services Manager (ACCS) or Clinic Coordinator/Center Manager (CC/CM) or designee, to review the incident and to reinforce expected behavior management plan.

GUIDELINES:

A. Whenever a health center employee is aware of or is the recipient of inappropriate behavior by a patient/family member(s)/significant other which contributes to an "incident," that employee should document the incident in the Safety Event Reporting System (SERS) and notify their Ambulatory Care Clinical Services Manager or Clinic Coordinator/Center Manager (CC/CM) as well as the Safety Office/Deputy, if appropriate.
    1. Documentation should be specific as to the contributing factors to the "incident."

B. Ambulatory Care Clinical Supervisor or designee will reach out to the patient for an interview, preferably in person, or via phone to obtain their point of view and provide service recovery if warranted.
    1. If appropriate, acknowledge not being able to meet their expectations.
    2. Take action to address the concerns addressed by the patient.
    3. Explain to the patient what they did that was inappropriate.
    4. Follow up with a summary of the in-person interview or phone conversation, action taken, targeted treatment plan and expectations for future visits to the health center.

5. For cases involving a provider, refer to medical director to contact the staff member involved in the incident. If the provider no longer feels safe or comfortable caring for this patient, this patient will be assigned another provider. For other staff members –for example Nursing, Registration, Laboratory, if their future assignment puts them in contact with this patient, another colleague will care for this patient.
6. If the incident involves a primary care provider and the provider no longer feels safe or comfortable caring for this patient, refer to the Medical Director to then follow the process to have the patient reassigned to a new provider. This includes the provider filing the CCHP Provider Complaint Form for all CCHP patients. Follow the regulations as specified by the Medical Board of California for discharging a patient from a provider's practice. This includes notifying in writing:
    a. The last day the physician will be available to render medical care, assuring the patient has been provided at least 15 days of emergency treatment and prescriptions before discontinuing the physician's availability.
    b. The process for obtaining a different primary care provider in our system including contacting CCHP Member Services or the Appointment Line
    c. The information necessary to obtain the medical records compiled during the patient's care (whom to contact, how and where).
7. The ACCS will send the letter to the patient and be distributed as follows:
    a. Scanned into patient's medical record.
    b. Patient's Primary Care Provider/Electronic notification of Primary Care Provider and Treatment Provider.
    c. Patient Relations Department
    d. CCHP (if patient is a CCHP member).
8. The ACCS will direct the provider to document the inappropriate behavior under the problem list as History of Behavior Incident at Health Center on ---- (date). (ICD-10 Code Z86.59). The provider will include Patient Treatment Management Provider will include Patient Treatment Management Plan letter was sent to patient. letter was sent to a patient.

C. If, after receiving this initial letter, the patient contributes to another incident at the health center, the care team will collaborate with the Patient Relations Department for possible consideration for a care contract. ~~(See also Policy #1006).~~

In the rare event of an egregious incident, the patient may proceed directly to care contract and/or clinic reassignment. This decision shall be made in consultation with the Ambulatory Nursing Director and/or the Ambulatory Medical Director. ~~AC Policy # 6004 regarding Changing.~~

REFERENCES:

A. HSD Workplace Violence Prevention Plan
B. Joint Commission Standard 2024, PC.01.03.05, "The hospital's use of behavior management

procedures adhere to the patient's plan for care, treatment, and services and organization policy." EP 2: "Behavior management procedures, when used, are part of the patient's plan of care."

~~APPROVALS:~~

~~Ambulatory Clinical Practice Committee: 7/2018, 11/2024~~
~~Ambulatory Policy Committee: 7/2018, 6/2019, 10/2019, 11/2024~~
~~Medical Executive Committee: 10/2019, 11/2024~~

Attachments

Sample Letter 1

Sample Letter 2

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Ambulatory Policy Committee	Laura R. Colebourn [LC]	04/2026
Ambulatory Clinical Practice Committee	Kelley Taylor: Ambulatory Care Clin Supv	04/2026
	Kelley Taylor: Ambulatory Care Clin Supv	04/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **20338688**

Origination	04/2008	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval	Applicability	CCRMC, Health Centers & Detention
Last Revised	04/2026		
Next Review	3 years after approval		

Policy for Quick Response Cart

POLICY STATEMENT:

Trained and qualified health center staff will respond to potentially life-threatening medical emergencies at the Basic Life Support level and call 9-1-1 to activate the county's EMS system. These carts will remain locked at all times except when in use.

To specify the medications and supplies to be kept on hand at each Health Center except the Infusion Clinic* located on the CCRMC Campus in Martinez.

The Infusion Clinic located on the CCRMC campus will maintain a crash cart as described in CCRMC Nursing Policy for Crash Cart Readiness.

GUIDELINES:

A. Check Quick Response Cart **DAILY** to make sure locking mechanism is intact and ensure:
   1. All supplies stored on top and outside of the Quick Response Cart are present per **Quick Response Medication and Supply Contents and Expiration List** (See attachment A).
   2. Oxygen cylinder is > 1000 psi and replace if necessary.
   3. Battery operated portable suction is functional.
   4. Battery operated portable suction is plugged into a power source when not in use.
   5. Readiness of AED and resuscitation kit plus extra electrodes with current date. The QUIK-PAK electrode packet should remain connected to the defibrillator and unopened until required for an SCA (sudden cardiac arrest) Quick Response.

6. Expiration date sticker on all drawers is current.
7. One (1) pair of scissors
8. Sign and date the List of Expiration Dates Form.

B. If security seal is broken:
    1. Check the contents immediately.
    2. Replace missing items.
    3. Reseal the Quick Response Cart with appropriate locking mechanism.
    4. Document name, date and seal number on the Quick Response Cart check form.

C. Check the expiration dates of the Quick Response Cart **ONCE A MONTH**.
    1. It will be the monthly responsibility of sterile processing and pharmacy to do monthly checks.
    2. Replace any outdated supplies.
    3. Place date of first drug to outdate on front of drawer.
    4. Check and replenish/exchange all necessary items to the Quick Response Cart immediately after using the cart.
    5. Seal the Quick Response Cart with the appropriate locking device if needed.
    6. Nursing will document with name, seal number and date on the Quick Response Cart check form daily.

REFERENCES:

A. 2020 American Heart Association Advanced Cardiac Life Support (ACLS).

B. American Academy of Pediatrics and the American Heart Association Pediatric Advanced Life Advanced Life Support (PALS) 2016 Guidelines.

C. Nursing Policy for Crash Cart Readiness

D. Pharmacy Policy for Ambulatory Care Quick Response Carts

APPROVALS:

Ambulatory Clinical Practice Committee: 4/2016, 9/2019, 10/2022, 3/2026

Ambulatory Policy Committee: 3/2013, 7/2016, 9/2019, 11/2022, 3/2026

Medical Executive Committee: 8/2016, 10/2017, 12/2022, 3/2026

Joint Conference Committee: 3/2023, 3/2026

Attachments

A_ Quick Response Cart Contents updated old 4064 A.docx

B: Ambulatory Care Quick Response Cart Log

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Ambulatory Policy Committee	Laura R. Colebourn [LC]	04/2026
Ambulatory Clinical Practice Committee	Kelley Taylor: Ambulatory Care Clin Supv	04/2026
	Kelley Taylor: Ambulatory Care Clin Supv	04/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **20219298**

Origination	01/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging
Applicability	CCRMC, Health Centers & Detention

Policy for Receipt of Packages Containing Radioactive Materials

POLICY STATEMENT:

To assure the safety of all personnel, patients, and visitors by avoiding unintended radiation exposure, and to assure the security of radioactive materials and prevent unauthorized use.

GUIDELINES:

Procedures are in place to assure the safety and security of radioactive materials as required by CCRMC's Radioactive Materials License. Under NO circumstances are couriers to have unsupervised access to the Nuclear Medicine Department.

A. During business hours, the radiopharmaceutical couriers have been instructed to deliver radioactive packages directly to the Nuclear Medicine department.

B. Deliveries outside of business hours must be made by prior arrangements by the radiopharmacy with the Nuclear Medicine staff.

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
DI Policy & Procedure Committee	Angela Womble: Chief Radiologic Technologist	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Cardiology
Privileges

Name:
(Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Documentation of successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited postgraduate training program in the relevant medical specialty and successful completion of an accredited fellowship in Cardiology.
Certification	Documentation of current subspecialty certification or Board eligibility (with achievement of certification within the required time frame set forth by the respective Boards) leading to subspecialty certification in Cardiology by the relevant American Board of Medical Specialties or the American Osteopathic Board. **AND** Inpatient/outpatient care to at least 200 patients with cardiovascular diseases, reflective of the scope of privileges requested, during the past 24 months, or successful completion of an ACGME- or AOA-accredited residency, or clinical fellowship within the past 24 months. Please provide a clinical activity/procedure log.
Continuing Education	Continuing education accordance with requirements to maintain certification and licensure in this specialty.
Certificates	Advanced Cardiac Life Support

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Initial Applicants	Maintenance of Certification or Osteopathic Ongoing Certification is required.
Renewal	Current documented competence and an adequate volume of experience (200 patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Cardiovascular Disease Core Privileges

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures and privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques, as determined by the department chair.

To the Applicant: Initial and date next to the privileges you are requesting.

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to recommend
☐	*Initial request:* **Cardiology Clinic and Hospital Based Care** • Performance of history and physical exam • Adult transthoracic echocardiography (TTE), including Doppler and color flow • Adult transesophageal echocardiography (TEE), including Doppler and color flow • Ambulatory electrocardiography monitor interpretation (eg, Holter monitor, etc). • Cardioversion, electrical • ECG (EKG) interpretation • Insertion and management of central venous catheters, pulmonary artery catheters, and arterial lines • Noninvasive hemodynamic monitoring • Exercise Treadmill testing • Stress echocardiography (exercise and pharmacologic stress) • Transcutaneous and transcutaneous External Pacemaker Placement • Pericardiocentesis • Cardioversion • Insertion and management of central venous catheters, pulmonary artery catheters and arterial line for hemodynamic monitoring	☐

Non-Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	Non-core privileges are requested individually, in addition to requesting core privileges.	Division/ Dept Chair: initial to recommend
☐	Documented current competence and evidence of the performance of at least two cases within the past five years for each requested privilege. Supervision of myocardial Perfusion testing: administration and monitoring of vasodilator agents (Regadenoson, Persantine, Adenosine), including interpretation of ECG (EKG) portion (does not include interpretation of imaging portion-see below) Interpretation of myocardial perfusion studies, imaging portion ❑ ***Criteria for Initial Request of each/any of the above-listed non-core privileges:*** 1. Successful completion of an ACGME– or AOA–accredited post graduate training program in the relevant medical specialty and successful completion of an accredited fellowship in Cardiology, including minimum of 50 interpretations of myocardial perfusion studies and/or coronary CT angiograms during training or career. **AND** 2. Documented current competence and evidence of the performance of at least 5 cases of each requested privilege within the past 24 months, or completion of training within the past 24 months. Please provide clinical activity/procedure log. ***Criteria for Renewal of Privileges:*** Documented current competence and evidence of the performance of at least five (5) cases within the past 24 months. **Administration of Sedation and Analgesia:** ❑**Conscious Sedation** (e.g. versed, morphine, fentanyl) – DOES NOT INCLUDE USE OF KETAMINE OR PROPOFOL ***Criteria for Initial Request:*** 3. Successful completion of an ACGME– or AOA–accredited post graduate training program which included training in administration of sedation and	☐

	analgesia, including the necessary airway management skills, or department-approved extra training and experience. **AND** 4. Documented current competence and evidence of the performance of at least five (5) cases (can be any combination) within the past 24 months, or completion of training within the past 24 months. Please provide clinical activity/procedure log. ***Criteria for Renewal of Privileges:*** 1. Documented current competence and evidence of the performance of at least 5 cases (can be any combination) within the past 24 months.	
☐	Privilege to operate and/or supervise operation of fluoroscopy equipment. ***Requirement***: Current Fluoroscopy or Radiology X-Ray Supervisor and Operator Permit from CDPH.	☐

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

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_____

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Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related

documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

- ☐ **Recommend All Requested Privileges**
- ☐ **Recommend Privileges with the Following Conditions/Modifications:**
- ☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Emergency Medicine
Privileges

Name:
(Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings. Medical Staff Office can help you pull relevant reports from EPIC.**

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)—or American Osteopathic Association (AOA)—accredited residency in Emergency Medicine
Certification	Current certification or Board eligibility in the examination process leading to certification in Emergency Medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM)

OR

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)—or American Osteopathic Association (AOA)—accredited residency in Family Medicine. AND EM fellowship or Department-approved experience equivalent to fellowship or Department-approved training planning to get to fellowship-equivalent experience AND Training in the administration of sedation and analgesia, including necessary airway management skills.
Certification	Board Certification or Board Eligibility by the American Board of Family Medicine (ABFM), or American Osteopathic Board of Family Physicians (AOBFP)

AND

Continuing Education	As per state licensure
Clinical Experience (Initial)	At least 200 patient encounters with acceptable results, reflective of the scope and complexity of the privileges requested during the past 24 months. OR Completion of residency training during the past 24 months
Clinical Experience (Reappointment)	At least 200 patient encounters with acceptable results, reflective of the scope and complexity of the privileges requested during the previous 24 months based on results of ongoing professional practice evaluation and outcomes.
Other Requirements	**For providers who are Family Medicine-trained with less than five years of FTE employment at CCRMC, or Emergency Medicine-trained, but not yet board certified,**

please include documentation of current:
-ATLS certification
-ACLS certification
-NRP certification
-PALS certification

Emergency Medicine – Children & Adult Patients Core Privileges

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to recommend
(initials)	Assess, evaluate, diagnose, and initially treat patients of all ages who present in the ED with any symptom, illness, injury, or condition. Provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine. Privileges include, but are not limited to anoscopy, arterial catheter insertion; assessment and examination of physical and sexual abuse; biohazard decontamination; bladder catheterization (foley catheter, suprapubic), capnometry; cardiac pacing (cutaneous, transvenous); cardiopulmonary resuscitation (CPR), including pediatric resuscitation; central venous access, measurement of compartment pressures, control of epistaxis, cricothyrotomy; cystourethrogram; delivery of newborn; drainage of peritonsillar abscess; escharotomy/burn management; evaluation/initial management of testicular torsion; excision of thrombosed hemorrhoid; foreign body removal; fracture/dislocation management, reduction, immobilization; gastric lavage; gastronomy tube placement; history and physical; incision and drainage; intracardiac injection; intubation; laryngoscopy; lateral canthotomy; local anesthesia; lumbar puncture; mechanical ventilation; nasogastric tube placement; non-invasive ventilatory management; ocular pH determination; ocular tonometry; paracentesis; percutaneous transtracheal ventilation; pericardiocentesis; perichondral hematoma incision and draining; peripheral venous cutdown; peritoneal lavage; placement of intraosseous line; POCUS (point of care ultrasound); procedural sedation(including conscious); regional nerve block; removal of rust ring; slit lamp examination; spine immobilization; thoracentesis/thoracotomy/thoracostomy tube insertion; tonometry; tooth stabilization/emergency dental management; tracheostomy management; trephination of nails; trephination of skull; violent patient management/restrain; wound closure and management.	(initials)

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

_____

_____

_____

_____

Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Practitioner's Signature: _____ **Date: _____**

DEPARTMENT / DIVISION CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**

☐ **Recommend Privileges with the Following Conditions/Modifications:**

☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:

_____

_____

_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Status Pending PolicyStat ID 20620258

Origination	05/1999
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2026
Next Review	3 years after approval

Owner	Akiko Tennison: Nursing Program Manager
Area	Hospital & Health Centers
Applicability	CCRMC, Health Centers & Detention

Policy for Anatomical Donations for Tissue and Organ Transplantation

POLICY STATEMENT:

To insure that hospital deaths are considered for possible anatomical donations in conformance with Assembly Bill (AB) 1689, the California Uniform Anatomical Gift Act. To provide a mechanism for the procurement and donation of organs and tissues. This policy applies to donation and procurement after brain death. For policy and procedures relating to organ donation after circulatory/cardiac death (DCD), see Policy #612C.

A. Except in the case where the useful life of the part does not permit, a reasonable search (for at least 12 hours) will be made for possible consenting authority for organ and tissue donation. This search to locate other persons should be documented in the medical record.

B. The Donor Network West (DNW) will be notified of any patient who has died in the hospital (including a stillborn infant and fetus) or whose death is imminent for possible anatomical donations.

GUIDELINES:

A. Procedure:

1. At or near the time of death, the deceased individual's next-of-kin (or other individual) will be asked, by Donor Network West staff, whether the deceased was an

organ donor or if the family is a donor family. Donor Network West staff will work collaboratively with CCRMC staff regarding the suitability of a potential donor.

2. Medical Social Services will assist in conducting a reasonable search for possible consenting authority for organ and tissue donation.
3. Nursing Unit
    a. Charge Nurse or designee will notify the Medical Center Supervisor of the impending death and the need to call Donor Network West.
    b. If organs are to be retrieved, the Operating Room is to be notified by the charge nurse or medical center supervisors after consent for donation is obtained.
    c. The potential donor information worksheet will be initiated to gather information such as the patient's name, medical record number, name of next-of-kin, status of donor authorization, and disposition of the body.
    d. In case of Operating Room (OR) deaths, the potential donor information worksheet will be initiated by the OR Nurse and given to the Medical Center Supervisor to complete the process.
4. Consent for Donation
    a. At the time of death or near the time of death, the family of the deceased shall be asked about the possibility of organ donations by DONOR NETWORK WEST in collaboration with CCRMC staff. Approaching the donor family will be done with sensitivity so as not to impose on their grieving process.
    b. Approval for donation must be obtained by the most reasonably available next-of-kin: (a) the spouse or domestic partner, (b) an adult son or daughter, (c) either parent, (d) an adult brother or sister, (e) adult grandchildren, (f) grandparents, (g) any adult who exhibited special care and concern for the decedent during the decedent's lifetime, (h) a guardian or conservator of the decedent at the time of death, (i) any other person authorized or under obligation to dispose of the body. Immediate acceptance of a family's decision to decline the option to donate organs or tissues will be acknowledged; for un-emancipated minor donors between 15- 18 years of age, only upon written consent of parent or guardian
    c. Donor Network West, or Tissue Bank, staff will obtain the consent from the next-of-kin in person, or on the telephone. A copy of the consent form or transcription of the telephone conversation will be sent to Medical Records for documentation.
5. Notification to Donor Network West
    a. Donor Network West will be notified of a potential organ donors/ at the first indication of irrecoverable illness/ injury, imminent death, prior to family discussion regarding withdrawal life sustaining measure, prior to formal brain death evaluation. For potential tissue donors, DNW will be notified within 1 hour of asystole. Its services are available twenty-four hours of the day, seven days a week, to handle any type of donation and

can assist the hospital staff with any questions that arise.

b. The patient's physician, registered nurse, or designee will (1) notify Donor Network West at 1-800-55-DONOR who will arrange for organ removal and, (2) inform the Executive Director of CCRMC and CCHCs of the anatomical donation. The Unit/Department shall arrange for all fees to be billed to the Donor Network West.

c. The process for ensuring that charges are billed to the Donor Network West at the time of declaration of brain death is as follows:

    i. Notify Admissions Registration at 925-370-5160 to add Specialty Billing Value: Donor Network West to the patient's inpatient encounter which flags the Hospital Account Record (HAR) with a Do Not Bill (DNB) for Patient Accounting to review.

6. Organ Donation: Definitions of Terms

    a. Organ donation can take place when death has been established, and the potential donor is maintained on organ support systems. Contraindications for donation will vary with each organ system; therefore, each potential donor is evaluated on an individual basis. See DONOR NETWORK WEST Referral Guide for additional criteria information

    b. Brain Death: Two physicians must independently confirm brain death, and both physicians must document in the progress records of the chart that the patient is neurologically dead. The Checklist for Determination and Declaration of Brain Death (MR 209) may be completed in lieu of progress notes. Neither physician may be a member of the transplant team.

    c. A brain death is evidenced by an individual who has sustained irreversible cessation of all functions of the entire brain, including the brainstem, as determined by accepted medical standards. The California Brain Death Statute of 1974 (California Health and Safety Code 7180) states, "A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function." The Donor Network West Organ/Tissue Donation Referral Guide may be used to obtain additional details.

7. Donor Maintenance: The donor must be maintained on organ support systems until the transplant team can arrive to remove the organs in surgery.

8. Donation after - Circulatory /cardiac Death: See Policy #612C "Organ Donation after Cardiac Death" for policy and procedures relating to organ donation from a patient who has not been diagnosed as brain dead but will be pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions.

9. Imminent Death: A severely brain injured, ventilator patient, with either clinical findings consistent with a Glasgow Coma Score (GCS) of </=5, or a plan to discontinue mechanical/pharmacological support.

    a. Early Referral for Timely Notification: Referral by a hospital to the Organ Procurement Organization (OPO) at the first indication of irrecoverable illness/ injury, prior to family discussion regarding withdrawal life sustaining measure, prior to formal brain death evaluation.

b. Early Referral for Timely Notification of Potential Tissue Donors: Referral from hospital to the Donor Network within 1 hour of asystole for evaluation of potential tissue donor eligibility.

10. Hospital Reimbursement
    a. All charges that are incurred from the time the patient is declared neurologically dead, including operating room fees, shall be billed to the: DONOR NETWORK WEST -
    b. Notify admissions of the time of brain death declaration (for financial accounting).
11. Tissue Donation
    a. The following are general criteria for tissue donors:
        i. All death: Every hospital death will be evaluated as a potential tissue/eye donor.
        ii. Eye Donations: If used for transplant purposes, the eyes must be recovered within 12 hours after cardiac death. The eye enucleation procedure is performed by a staff member of the Tissue Bank who is trained and authorized by law.
12. Other Tissue Donations: These tissues can be recovered within 24 hours after cardiac death. Potential tissue donors must be placed in refrigeration -immediately after cardiac death. Tissue recovery is performed by the staff of the tissue bank. The tissue bank staff prefers a sterile environment; however, a non-sterile environment, i.e., pathology department, ~~morgue~~ or coroner's office, may be used if necessary.
13. Coroner Authorization:
    If the deceased falls under the jurisdiction of the coroner, the coroner must be advised that a request for anatomical donation has been made; his/her authorization must be obtained before proceeding with the organ and/or tissue donation. Donor Network West will obtain this authorizations.
14. For whole body donation, please refer to The Donor Network West Organ/Tissue Donation Referral Guide (available on nursing units).
15. All dead-on arrival (DOA) cases will be assessed using the same procedures above.
16. Medical Records: On a quarterly basis, copies of the death log will be sent to the Donor Network West for bi-annual audits.
17. Donor Network West/-will provide information regarding referral rates to Administration on a quarterly basis. This information will be shared with appropriate committees within CCRMC.

RELATED LINKS:

MR 211 Death Procedure
MR 209 Checklist for Determination & Declaration of Brain Death
DONOR NETWORK WEST – Consent for Organ and Tissue Donation (brought by Donor Network West)

REFERENCES:

A. California Health and Safety Code "Uniform Anatomical Gift Act" Sections 7150 – 7151.40
B. The Routine Death Notification Legislation (42 CFR Part 482)
C. Designated Organ Procurement Organization (OPO): DONOR NETWORK WEST Resource Manual
D. Contra Costa Regional Medical Center Hospital Procedure for Patient Expiration
E. TJC TS.01.01.01 "The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues."

APPROVALS:

Clinical Practice Committee: 2/2018, 10/2022
Patient Care Policy & Evaluation Committee: 7/2012, 3/2018, 11/2022
Medical Executive Committee: 5/2018, 11/2022
Joint Conference Committee: 3/2023

Attachments

Potential Donor Information Worksheet

Tissue Donor Referral

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2026
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2026
	Akiko Tennison: Nursing Program Manager	05/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status Pending PolicyStat ID 20607552

Origination	06/1997
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2026
Next Review	3 years after approval

Owner	Ira-Beda Sabio: Director, Inpatient Nursing OP
Area	Hospital & Health Centers
Applicability	CCRMC, Health Centers & Detention

Policy for Management of Patients' Personal Property After Discharge or Death

POLICY STATEMENT:

It is the duty of all hospital employees to return personal belongings inadvertently left at the facility to the patient or their representative whenever possible. The hospital will be liable for the damage to or loss of personal property of a patient only if negligence or willful wrongdoing by the hospital/health centers or its employees can be shown.

The hospital is not responsible for:

Patient's personal articles not deposited for safekeeping

Personal articles that cannot be deposited for safekeeping

~~The hospital is not responsible for:~~
~~Patient's~~Unclaimed personal articles ~~not deposited for safekeeping~~
~~Personal articles that cannot be deposited for safekeeping~~
~~Unclaimed personal articles~~ held in Lost and Found located in Environmental Services (EVS) office which will be discarded after 7 calendar days

GUIDELINES:

A. Unclaimed Personal Property:

1. Property of No Substantial Value

a. When personal effects having no apparent substantial value (i.e. clothes) are forgotten or abandoned by a patient, the Charge Nurse or designee will

call the patient and inform them of items forgotten and confirm their address. Disposition of the articles will be discussed at that time. Options include:

i. Disposing of the item in the trash.

ii. Having the patient or a designee come within 24 to 48 hours to retrieve the items from the nursing unit.

iii. ~~If longer than 24 hours, picking items up from the Lost & Found located in the Environmental Services (EVS) office which is located on the southwest corner of CCRMC campus.~~

iv. ~~Items left in Lost & Found longer than 7 calendar days will be discarded.~~

b. After disposition is confirmed, the Charge Nurse or designee will bag the articles and place an **Unclaimed Patient Property** sticker (see attached form MR13) on the outside of the bag. If patient is coming back within 24 hours, hold the bag at the nurses' desk. ~~If the bag is~~Can be discarded from the unit if not ~~retrieved at the end of 24~~picked up after 48 hours~~, take directly to Environmental Services Senior Clerk who must accept items.~~ ~~**Do not leave bags outside the door.**~~

c. ~~Items will be held in Lost and Found up to 7 calendar days, after which time they will be discarded.~~

d. In case of expiration, all valuables (jewelry, etc.) should be safeguarded as soon as possible and released to a family member after signature is obtained. If no family available, all valuables will be listed on the Personal Valuables form and sent to the safe. All clothing, dentures, etc., will be placed in a sealed and labeled bag (as directed above) ~~and sent with the body to the morgue by the~~ Charge Nurse or designee~~. The~~ will contact next of kin and seek direction on disposition of items. If items will be ~~left~~picked up, they will be held on the ~~gurney with the body and released to the mortician at the same time~~unit for up to 48 hours. ~~If the personal~~Items not picked up after 48 hours will be discarded. Alternatively, the items ~~are not picked up by the mortician, Pathology will call~~can be disposed of if so requested by the next-of-kin ~~and seek direction on disposition of the items~~. ~~If the items will be picked up, they will be held 24 hours at the Lab reception desk. If not retrieved in 24 hours, the items will be delivered to Lost and Found located in the Environmental Services (EVS) office and held for up to 7 days. Items not picked up after 7 days will be discarded. Alternatively, the items can be disposed of if so requested by the next-of-kin.~~

e. Weapons**:** Contact Sheriff Deputy in HSD Security office.

2. Property of Substantial Value

a. When personal effects with apparent substantial value are left after a patient's death or discharge, the Charge Nurse or designee will deposit the valuables in the hospital safe located in the Admissions Office. The

envelope will be marked "*expired*" in the case of a patient's death. The Valuable Receipt form will be attached to the Patient's Personal Property Inventory (MR598-0) form and sent to Health Information Management.

b. Admissions clerk will contact the appropriate party via registered mail four weeks after discharge or death and document that on the Unclaimed Valuables Log after Discharge or Death form.

c. The Admissions clerk will track the registered mail. If the return receipt, or letter is returned within 30 days, the Admissions clerk will document that on the Unclaimed Valuables Log after Discharge or Death form and send a second letter via registered mail.

d. If personal property is not claimed within 180 days of deposit in safe or patient's discharge, it will be disposed of according to county procedure. A notice will be mailed to the owner's last known address by certified mail. The letter will contain:

i. Patient's name

ii. Hospital's name

iii. Envelope #

iv. Instructions to obtain valuables

3. Time and place of disposal or auction

a. The Admissions clerks will open the unclaimed valuable envelope(s) and dispose of at Administration's discretion.

b. Unclaimed funds will be deposited into fund 813700. .

c. If item(s) is sold, the facility may deduct from the proceeds of the sale reasonable charges for storage, expenses of sale, and money owed to facility by last known owner. If there is any balance remaining from the sale after the deductions, the owner must claim the funds within one year. If the funds are not claimed, they must be deposited to the county's general fund. In the interim, the funds are to be transferred to the Auditor's Office.

B. Missing Property

1. The patient/visitor must complete the "Board of Supervisors of Contra Costa County Instructions to Claimant Form" and forward to the Clerk of the Board of Supervisors, County Administration Building, Room 106, 651 Pine Street, Martinez, CA, 94553. This form can be obtained from the Patient Relations staff or online from the Contra Costa County website.

2. If an employee receives a report of lost or damaged patient/visitor property, the event must be entered into the Safety Event Reporting System (SERS) which alerts the appropriate supervisor and/or manager for initial investigation and follow-up.

3. Upon receipt of the completed Claim Form by Contra Costa County Risk Management, a written notification will be emailed to Contra Costa Regional Medical Center, Healthcare Risk Manager, who will forward this form to the Patient Relations

Service Coordinator.

4. The Patient Relations Coordinator will contact the Nurse Program Manager (NPM) who will have the patient's health record reviewed to investigate the circumstances of the loss. The NPM will complete the Patient/Visitor Request for Personal Property Reimbursement Form Investigation Form (A408) specifically noting information obtained during the investigation.
5. The Patient/Visitor Request for Personal Property Reimbursement Investigation Form (A408) should be returned to Patient Relations Service Coordinator within 5 calendar days of written notification.
6. The Patient Relations Service Coordinator will return the completed Patient/Visitor Request for Personal Property Reimbursement Investigation Form (A408) and claimant document to Contra Costa County Risk Management for final approval. A copy of this form will be emailed to the Healthcare Risk Manager.
7. After Contra Costa County Risk Management receives the completed A-408 form from Patient Relations Service Coordinator and the filed County Claim Form by the patient/visitor, County Risk Management will review all documents and evaluate for claim payment consideration.
8. Contra Costa County Risk Management will notify patient/visitor of claim reimbursement determination.

RELATED LINKS:

Patient/Visitor Request for Personal Property Reimbursement, form A-408

MR 598-0 Patient's Personal Property Inventory

Admission - Unclaimed Valuable Log after Discharge or Death

Admission - Unclaimed Inventory form

Admission - Letter #1

Admission - Letter #2

Admission - Valuables Release form

Admission - Disposal of Valuables

Board of Supervisors of Contra Costa County Instructions to Claimant Form

Demand on the Treasury of the County of Contra Costa

MR 13 Unclaimed Patient Property form

Property Damage Release

REFERENCES:

A. California Hospital Association Consent Manual 2008, 35thth edition, "Hospital Liability for

Patients' Belongings " Chapter 22

B. CCRMC/HCs Policy & Procedure Manual: Procedure for Compensation for Loss or Damage to Hospital and Health Centers Patient/Visitor Property

C. CCRMC/HCs Policy & Procedure Manual: Procedure for Securing & Releasing Patient's Valuables

APPROVALS:

Clinical Practice Committee: 11/19

Patient Care Policy & Evaluation Committee: 12/19

Medical Executive Committee: 1/20

Attachments

Valuables Receipt Slip

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2026
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2026
	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Psychiatry
Privileges

Name: (Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in psychiatry. If requesting pediatric core privileges only, must have completed Pediatric Psychiatry Fellowship
Certification	Current board certification or board eligible leading to certification in psychiatry (with achievement of certification within the required time frame set forth by the respective Boards) by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
Continuing Education	As per California license and section-specific requirements below.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Initial or Reappointment	Maintenance of board certification or Osteopathic Ongoing Certification is required.
Initial or Reappointment	Current documented competence and an adequate volume of experience 100 patient encounters with acceptable results, reflective of the scope of privileges requested (of the age range of patients they will see at CCRMC), within the past 24 months, based on results of ongoing professional practice evaluation and outcomes.

Inpatient-Outpatient Psychiatry Core Privileges

Applicant:	**For Core Privileges:** you do not have to do all these procedures, but	Division/

initial to request	having the privilege allows you to.	Dept Chair: initial to recommend
(initials)	Adult Core Privileges Admit, evaluate, diagnose, treat (including the outpatient treatment of drug overdoses and outpatient detoxification when either is appropriate to an outpatient setting and medication assisted treatment – MAT) and provide consultation to patients presenting with mental, behavioral, addictive, or emotional disorders (e.g., psychoses, depression, anxiety disorders, substance use disorders, developmental disabilities, sexual dysfunctions, and adjustment disorders). Privileges include providing consultation with physicians in other fields regarding mental, substance use, behavioral, or emotional disorders, pharmacotherapy, psychotherapy, family therapy, behavior modification, consultation to the courts, and emergency psychiatry as well as the ordering of diagnostic laboratory tests and prescribing medications. Includes the performance of a history and physical exam. May provide psychiatric care to patients in the intensive care setting. Assess, stabilize, and determine the disposition of patients with emergent conditions regarding emergency and consultative call services.	(initials)
(initials)	Pediatric Core Privileges (18 years of age and younger) ***(If requesting pediatric core privileges only, must have completed Pediatric Psychiatry Fellowship)*** Admit, evaluate, diagnose, treat (including the outpatient treatment of drug overdoses and outpatient detoxification when either is appropriate to an outpatient setting and medication assisted treatment – MAT) and provide consultation to patients presenting with mental, behavioral, addictive, or emotional disorders (e.g., psychoses, depression, anxiety disorders, substance use disorders, developmental disabilities, sexual dysfunctions, and adjustment disorders). Privileges include providing consultation with physicians in other fields regarding mental, substance use, behavioral, or emotional disorders, pharmacotherapy, psychotherapy, family therapy, behavior modification, consultation to the courts, and emergency psychiatry as well as the ordering of diagnostic laboratory tests and prescribing medications. Includes the performance of a history and physical exam. May provide psychiatric care to patients in the intensive care setting. Assess, stabilize, and determine the disposition of patients with emergent conditions regarding emergency and consultative call services.	(initials)

Addiction Psychiatry

Privileges

Required Qualifications	
Education/Training	The same as for general psychiatry, plus successful completion of an accredited ACGME or AOA residency/fellowship in addiction medicine.
Certification	Current subspecialty board certification or board eligibility leading to subspecialty certification (with achievement of certification within the required time frame set forth by the respective Boards) in addiction medicine by the American Board of Psychiatry and Neurology, or completion of a certificate of added qualifications in addiction medicine by the American Osteopathic Board of Neurology and Psychiatry.
Continuing Education	As per California license and section-specific requirements below.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Initial or Reappointment	Maintenance of board certification or Osteopathic Ongoing Certification is required. Provision of inpatient, outpatient, or consultative services, reflective of the scope of privileges requested, for at least 100 patient encounters within the past 24 months, or successful completion of an ACGME– or AOA–accredited residency or clinical fellowship, within the past 24 months. Please provide a clinical activity log
Initial or Reappointment	Current documented competence and an adequate volume of experience: 50cases with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Addiction Psychiatry Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to	Division/ Dept Chair: initial to recommend
(initials)	Admit, evaluate, diagnose, treat, and provide consultation to patients with alcohol or other substance use disorders and to individuals with the dual diagnosis of substance use disorders and other psychiatric disorders. Treatment modalities, beyond core privileges, include inpatient detoxification, inpatient management of overdoses. and maintenance pharmacotherapy. Includes performance of history and physical exam. May provide care to patients in the intensive care setting. Assess, stabilize, and determine the disposition of patients with emergent conditions regarding emergency and consultative call services.	(initials)

Hypnotherapy Non-Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	Non-core privileges are requested individually, in addition to requesting core privileges.	Division/ Dept Chair: initial to recommend
(initials)	*Initial request:* Successful completion of an ACGME– or AOA–accredited residency in psychiatry **AND** Evidence of at least 40 hours of post-degree training that included at least 20 hours of individualized training by a practitioner experienced in the procedure. **AND** Documented current competence and evidence of the performance of at least 10 hypnotherapy procedures within the past 24 months, or completion of training within the past 24 months. Please provide clinical activity log. *Renewal/Reappointment:* Documented current competence and evidence of the performance of at least 10 hypnotherapy procedures within the past 24 months based on results of ongoing professional practice evaluation and outcomes.	(initials)

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

_____

_____

Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

- ☐ **Recommend All Requested Privileges**
- ☐ **Recommend Privileges with the Following Conditions/Modifications:**
- ☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Resident Moonlighting
Ambulatory Medicine
Privileges

Name: (Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)— or American Osteopathic Association (AOA) and active Residency **in Contra Costa Health Family Residency program**
Certification	Documentation of current certification or board eligibility (with achievement of certification within 3 years) leading to certification in Family Medicine by the American Board of Family Medicine or Family Practice and Osteopathic Manipulative Treatment by the American Osteopathic Board of Family Physicians.
Continuing Education	As per California license and section-specific requirements below.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Initial Applicants	Provision of care, reflective of the scope of privileges requested, for at least 200 adult medicine patient visits during the past 24 months. If requesting pediatric privileges, at least 100 pediatric patients. Please provide clinical activity/procedure log. Experience must correlate to requested privileges As well ass Successful completion of 24 months of residency training and confirmation of good standing by the Residency Program Director or Designee.
Renewal	No renewal provisions, must apply for privileges in the desired department upon graduation from residency

Diagnostic Imaging Core Privileges

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to

		recommend
(initials)	**E**valuate, diagnose, treat, and provide consultation to all patients 18 years old and above, with a wide variety of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive and family planning, genitourinary systems, and including mild to moderate psychiatric disorders, dependence or addiction to alcohol or other drugs, and medical management of chronic pain. Assess, stabilize, consult, and determine disposition of patients with emergent conditions. Procedures include, but are not limited to: performance of history and physical; arthrocentesis and joint injections; cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, tumors, and nodules and superficial foreign body; facilitate medical groups; fluorescein exam; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; pap smears; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration.	(initials)
(initials)	**Pediatric Core Privileges** Evaluate, diagnose, and treat pediatric patients who have common illnesses, injuries, or disorders from birth through 21 years old. This includes routine uncomplicated newborn care in the hospital (i.e. L&D, nursery, postpartum, etc.), assessment of physical, emotional, and social health, treating acute and chronic disease, and determining the disposition of patients with emergent conditions. Procedures include but are not limited to: performance of history and physical; bladder catheterization, cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, nodules, and superficial foreign body; facilitate medical groups; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration.	(initials)

Non-Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	Non-core privileges are requested individually, in addition to requesting core privileges.	Division/ Dept Chair: initial to recommend
(initials)	**Nexplanon Insertion & Removal** *Initial Request:* Completion of the Nexplanon training program. Please submit Training Certification. *Reappointment/Renewal:* none - MSO has on file.	(initials)
(initials)	**Low-risk obstetrics (prenatal and postpartum)**	(initials)

	Evaluate, diagnose, and treat low-risk patients who are pregnant, intend to become pregnant, or are recently post-pregnancy. Management of patients with obesity with BMI </=60; chronic Hypertension with BP < 150/100 **WITHOUT** medication; GDM on diet or orals with A1c < 6.5; AMA; history of pre-eclampsia in one previous pregnancy at >/= 37 weeks; history of cesarean section; substance abuse with or without buprenorphine therapy; cholestasis of pregnancy; size vs. date discrepancies with EFW > 10%; UTI; anemia with hemoglobin > 8; vaginitis. Procedures include but are not limited to: third-trimester POCUS (please request below) *Initial Request:* training during family medicine residency of at least 2 months of obstetrics, including prenatal/postpartum care and POCUS.	
(initials)	**Basic First and Second Trimester POCUS** for dating, location, and viability of pregnancy. *Initial request*: 30 ultrasounds in the past 24 months.	(initials)
(initials)	**Third trimester OB ultrasound** for placental location, viability, presentation, amniotic fluid assessment ☐ **Requested** Initial Criteria: Training in Residency or an Ultrasound course and 20 cases.	(initials)

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

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Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center

Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**
☐ **Recommend Privileges with the Following Conditions/Modifications:**
☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Anesthesiology
Delineation of Privileges

Name:
Effective From: _____/_____/_____ to _____/_____/_____

Instructions:

1. Check the Request checkbox to each privilege in the Core Privileges or Special Non-Core Privileges section.
2. Sign form and submit with the required documentation.
3. This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Note that privileges granted may only be exercised at the site(s) designated by CCRMC and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.

Required Qualifications

Education/Training	Successful completion of an ACGME or AOA-accredited residency in Anesthesiology.
Certification	Current certification or Board eligibility in the examination process leading to certification in Anesthesiology by the American Board of Anesthesiology (ABA) or American Osteopathic Board of Anesthesiology (AOBA)
Continuing Education	Applicant must provide 50 Category I CMEs from the past 24 months. (Waived for applicants who completed training during the past 24 months)
Clinical Experience (Initial)	Applicant must provide a clinical activity/procedure log documentation of 200 cases of anesthesia performed in the hospital, reflective of the scope and complexity of the privileges requested during the past 24 months. (Waived for applicants who completed residency or fellowship training during the past 24 months)
Clinical Experience (Reappointment)	Applicant must provide a clinical activity/procedure log documentation of 200 cases of anesthesia performed in the hospital with acceptable results, reflective of the scope and complexity of the privileges requested during the previous 24 months based on results of ongoing professional practice evaluation and outcomes.
Other Requirements	Current ACLS certification required.

Anesthesiology – Adolescent (≥ 14 yrs of age) & Adult Patients Core Privileges

Check the appropriate box of each privilege/procedure requested.

Request		**Chair**

Name:
Effective From: _____/_____/_____ to _____/_____/_____

		Recommends
	General Anesthesia Privileges for Adolescent and Adult Patients The practitioner is authorized to provide comprehensive anesthesia care for adolescent and adult patients across all appropriate hospital areas, including the intensive care unit, emergency department, and radiology departments. This scope includes the administration of general, regional, and local anesthesia, as well as all levels of sedation. Care focuses on maintaining or restoring stable physiologic function during and immediately following surgical, gynecologic, and diagnostic procedures. As part of these privileges, the practitioner may conduct all essential pre-anesthetic assessments and clinical evaluations, and is responsible for perioperative physiological management and pain control. This includes care of critically ill patients and the use of image-guided techniques as needed. Key capabilities include: • Administering general, regional, and local anesthesia, and all levels of sedation • Providing anesthesia services in all hospital locations (ICU, ED, radiology, and others) • Performing history and physical examinations • Assessing, consulting, and preparing patients for anesthesia • Managing and teaching cardiac and pulmonary resuscitation • Diagnosing and treating acute pain • Evaluating respiratory function and applying respiratory therapy • Performing image-guided procedures such as ultrasound localization • Managing critically ill patients requiring anesthesiologic expertise • Monitoring and maintaining normal physiology during the perioperative period • Preventing and treating pain during and after procedures through sedation/analgesia, general anesthesia, or regional anesthesia	

Obstetrics Anesthesia Core Privileges

Request		Chair Recommends
	Obstetric Anesthesia Privileges The practitioner is authorized to provide comprehensive anesthetic care for women during pregnancy and throughout the puerperium. This includes the administration of general, regional, and local anesthesia, as well as all levels of sedation for adult and adolescent female patients. Privileges apply across all appropriate hospital	

	areas, including the ICU, emergency department, and radiology. Within obstetric anesthesia, the practitioner is eligible to perform all forms of neuraxial analgesia, support labor and delivery (both spontaneous and operative), and provide anesthesia for obstetric procedures as well as non-obstetric surgical care for pregnant patients. Competence in image-guided techniques, including ultrasound assistance, is also included. Key capabilities include: • Administering anesthesia and sedation for pregnant and postpartum patients across all hospital areas • Performing history and physical examinations • Providing epidural, spinal, and combined spinal-epidural analgesia • Managing maintenance of neuraxial analgesia via bolus, continuous infusion, or patient-controlled epidural analgesia • Providing anesthesia for spontaneous and operative vaginal delivery • Managing anesthesia for retained placenta, cervical dilation, uterine curettage, postpartum tubal ligation, and cervical cerclage • Consulting on and managing pregnant patients undergoing non-obstetric surgery • Administering general anesthesia for cesarean delivery • Performing ultrasound-guided localization of relevant anatomical structures	

Focused Professional Practice Evaluation (FPPE) Requirements

For detailed information regarding FPPE/proctoring, see attached guidelines.

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Practitioner's Signature: _____ **Date: _____**

Name:
Effective From: _____/_____/_____ to _____/_____/_____

DEPARTMENT / DIVISION CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

- ☐ **Recommend All Requested Privileges**
- ☐ **Recommend Privileges with the Following Conditions/Modifications:**
- ☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Status **Pending** PolicyStat ID **20225003**

Origination	05/2025
Last Approved	N/A
Effective	Upon Approval
Last Revised	03/2026
Next Review	1 year after approval

Owner	Lauren Wondolowski: Primary Care Prov Lmtd Ex
Area	Hospital & Health Centers
Applicability	CCRMC, Health Centers & Detention
References	TJC 2025

Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations

Table of Contents

ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee and approved by the County Board of Supervisors of Contra Costa Medical Center & Health Centers (collectively referred to as Contra Costa Health or "CCH") to further define the general policies contained in the Contra Costa Medical Center & Health Centers Medical Staff Bylaws ("Bylaws"), and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges (collectively referred to as "Practitioners" as defined within the Bylaws). Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Bylaws. This article supersedes and replaces all other Medical Staff rules and regulations, or policies and procedures, pertaining to the subject matter thereof.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state of California to admit patients to a hospital.

a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.
b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, the admitting diagnosis will be recorded as soon as possible.
c. **Admission Priority and Procedure:** The Hospital "Policy for Admission, Unit Transfer, and Discharge" shall be followed.

2.1.2 Inpatient Psychiatric Services

a. The hospital policies for admission shall be followed for admission to the inpatient psychiatric unit, including specific psychiatry "Policy for Admission Criteria to Inpatient Psychiatry," "Inpatient Psychiatry – Medical/Physical Care of Patients," and "Procedure for Admission Process to Inpatient Psychiatric Service from Psychiatric Emergency Services (PES)."

2.2 EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Practitioners should follow the hospital Policy for EMTALA.

2.2.1 Emergency Department Call Coverage

a. **Call Schedule:** The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an

emergency medical condition. The Department/Division Chairs shall provide the hospital with a list of physicians who are scheduled to provide call coverage to respond to medical emergencies.

b. **Response Time:**
    i. It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame.
    ii. The on-call physician, or designee, should respond to calls from the Emergency Department no longer than twenty (20) minutes by telephone, unless a shorter time is required by contract or accrediting body. The on-call physician or designee must arrive at the Hospital, if requested to see the patient, in a timeframe based on the communication between the ED practitioner and the on-call physician. Specialties that provide telemedicine coverage shall see the patient based on the timeframes defined by contract and/or agreed upon between the ED practitioner and the on-call telemedicine physician.
    iii. In areas of dispute, the ED physician decision rules. If there is disagreement on the timeframe, the ED practitioner shall define the timeframe.
    iv. If the on-call physician does not respond to being called or paged, the physician's documented designee shall be contacted. If the physician's designee does not respond to being called or paged, the Administrative Director should be contacted. Any violations of EMTALA will be reported in compliance with the policy.
    v. Teaching services are expected to respond in the same timeframes or sooner in lieu of the on-call physician when appropriate.

c. **Substitute Coverage:** It is the on-call physician's responsibility to change the online call schedule through communication with the Department or Division leadership when there is enough time to do so as determined by the hospital. Short timeframes require the on-call physician to arrange for coverage and notify the Emergency Department if they are unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.2 Patients Not Requiring Admission

In cases where the Emergency Department consults with the on-call physician and no admission is deemed medically necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. If the Emergency Department physician and the consultant agree that the outpatient visit can serve in lieu of the consultant coming into the Emergency Department, an appropriate outpatient follow-up care plan shall be developed.

If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant, at the request of the emergency physician, is required to assess the patient and make appropriate arrangements and document their decision.

2.2.3 Patient Follow-up After Discharge from the ED

The ED will coordinate or provide information about follow-up care with an appropriate practitioner at CCHS or an external provider as appropriate.

2.2.4 Guidelines for Call Coverage

The following rules should be used in developing service policies regarding call coverage obligations:

a. The hospital shall have physician coverage to comply with basic emergency medical service capability requirements.[1]
b. Call duties, to supply basic stabilization and disposition of the patient, should be based on the practitioner's core privileges and training.

[1] Title 22, § 70413. Basic Emergency Medical Service, Physician on Duty, General Requirements.

c. The Medical Executive Committee in consultation with Administration shall determine which specialties are required to have call schedules (in addition to the basic medical service capability requirements),
d. Emergency duties may be divided by specialty or subspecialty.
e. Call is assigned by the Department or Division Leadership.
f. Call coverage is documented in an electronic call roster (e.g., Amion).
g. If a physician is on-call at more than one hospital simultaneously, they must have an agreed upon back-up physician named to provide coverage in case of emergencies.
h. Physicians must be listed by name on the call roster (they cannot be listed by group).
i. Departments or specialties that do not provide 24/7/365 call coverage shall work with Administration to communicate the coverage schedule to the Emergency Department and develop a back-up plan when coverage is not available.[2]

2.2.5 Failure to Meet Call Obligations

All failures to meet call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.2.6 Qualified Medical Personnel for Screening Examinations

Only physicians are deemed to be Qualified Medical Personnel (QMP) for purposes of (1) performing an appropriate medical screening examination of an individual presenting to CCH to determine whether the individual suffers from an emergency medical condition, and (2) completing the required physician certification for transfer of a patient with an emergency medical condition including active labor who has not been stabilized to another facility for treatment at the direction of the Responsible Physician.

2.3 TRANSFERS

2.3.1 Transfers To and From Other Acute Care Facilities

Patients who are transferred to or from another hospital must follow the Hospital policies including "Policy for Patient Transfers to Other Facilities" and "Policy for Accepting Patient Transfers from Outside Facilities and Referrals from Contra Costa Health Centers," and ensure EMTALA compliance.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers. Hospital policies must be followed including "Policy for Admission, Unit Transfer, and Discharge."

[2] §489.24(j) - Availability of On-call Physicians In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place: (1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending physician, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners caring for patients who are a danger to themselves and/or others should follow "Procedure for Assault Precautions" policy and "Suicide Risk Screening, Evaluation, and Precautions in Psychiatric Units" policy.

2.5 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician, or designee, who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. See Section 3 for the elements of the Discharge Summary. The discharge instructions should include, if appropriate based on age and condition:

a. A list of all medications the patient is to take post-discharge
b. Dietary instructions and modifications
c. Medical equipment and supplies
d. Instructions for pain management
e. Any restrictions or modification of activity
f. Follow up appointments and continuing care instructions
g. Referrals to rehabilitation, physical therapy, and home health services, and
h. Recommended lifestyle changes, such as smoking cessation.

2.6 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient or a patient and their legally authorized representative leave the hospital against the advice of the attending physician, or without a discharge order, hospital policies "Procedure for Patient Leaving Against Medical Advice (AMA)," "Absent Without Leave (AWOL)" and "Access to Outdoors" shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.7 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.8 DISCHARGING FROM THE PSYCHIATRIC UNIT

The patient, patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services shall participate in planning the patient's discharge or transfer. Psychiatry policies "Policy for Discharge Planning / After-Care Plan for Inpatient Psychiatry" and "PES

Discharge Process and After Visit Summary" should be followed.

ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The attending physician is responsible for the preparation of the physician components of the medical record to ensure a complete and legible medical record for each patient.

All practitioners with privileges are required to utilize the electronic health record (EHR), unless a "rare user" exception has been granted, to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All practitioners will complete EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

The medical record must be complete within thirty (30) days after the patient's discharge unless a shorter timeframe is defined by policy.[3] Hospital policies on medical record documentation shall be followed, including "Authority to Make Medical Record Entries", and "Procedure for Medical Record Content."

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.[4]

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the paper medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

3.4.1 Prohibited Abbreviations, Acronyms, and Symbols

The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders; these are noted in the policy on prohibited abbreviations, Pharmacy Policy Unacceptable Abbreviations and Symbols List.[5]

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[3] TJC RC.01.03.01-01: The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient’s discharge.
[4] TJC RC.01.02.01: Entries in the medical record are authenticated.
[5] TJC IM.02.02.01-03: The hospital follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes those listed in this document.

At a minimum, the following abbreviations, acronyms, symbols, and dose designations are prohibited:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

3.4.2 Situations Where Abbreviations Are Not Allowed

Abbreviations, acronyms, and symbols may not be used on informed consents.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the medical history and physical examination are noted in Part I, Section 2 of the medical staff bylaws. For the inpatient psychiatric unit, a psychiatric evaluation must be completed within sixty (60) hours of admission or registration.[6]

3.5.2 Who May Perform and Document the Admission History and Physical Examination

All medical staff with H&P privileges are allowed to perform admitting and outpatient history and physical examinations regardless of specialty.

b. Advanced Practice Providers (e.g., CRNA, NP, PA) may also complete the required history and physical examination if they possess the necessary privileges.[7]

c. For residents and practitioners requiring supervision or collaboration, a physician with privileges shall review and countersign the history and physical examination record within twenty-four (24) hours.[8]

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[6] TJC PC.01.02.13-07: Each patient receives a psychiatric evaluation completed within sixty (60) hours of admission.
[7] TJC MS.03.01.01-08: The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so perform a patient's medical history and physical examination and required updates.
[8] TJC MS.03.01.01-10: The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges.

d. **Examinations by Practitioners without Privileges:** The hospital may accept a history and physical examination performed within thirty (30) days prior to admission by a practitioner without current hospital membership or privileges as long as a practitioner with current hospital membership or privileges endorses

the findings and enters an interval note within twenty-four (24) hours after admission and prior to any operative or other invasive procedure involving general or major regional anesthesia.

3.5.3 Compliance with Documentation Guidelines

a. The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

b. **Complete History and Physical Exam:** A complete history and physical examination is required for all admissions, all operative or invasive procedures requiring anesthesia (general, regional, MAC, or deep/ moderate sedation), and all observation patients. A complete history and physical examination report must include the following information, as age appropriate and based on the patient's condition:

i. Chief complaint or reason for the admission or procedure
ii. A description of the present illness
iii. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
iv. An age-appropriate social history;
v. A pertinent family history;
vi. A review of systems;
vii. Physical examination and relevant physical findings; and
viii. Diagnosis or problem list with a plan of care.

c. Behavioral and Emotional Assessment[9]
Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

i. A psychiatric evaluation
ii. Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
iii. Complete neurological examination at the time of the admission physical examination, when indicated

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[9] TJC PC.01.02.13-06

d. Focused History and Physical Examination/Outpatient Assessment: A focused history and physical examination or outpatient assessment, is used for those outpatients who are undergoing invasive procedures under local anesthesia or conscious sedation should include, as age appropriate and based on the patient's condition:[10]

i. Elements that are immediately pertinent to the chief complaint or presenting problem, including a physical examination of the area of interest for the planned procedure and surrounding structures, if applicable,
ii. Medications and known allergies,

iii. An examination of the heart, lungs, and neurological status, and

iv. Additional assessment as deemed necessary for the safe and effective treatment of the patient.

A brief history and physical may be appropriate in lieu of a comprehensive history and physical, in the following types of care environments: radiology, endoscopy, emergency medicine, and oncology services. The decision must be documented and based on the patient's age, diagnosis, type and number of procedures to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.[11]

e. **Exceptions:**

i. A clinically pertinent note may be substituted for a history and physical for the purpose of emergency surgery or prior to other urgent interventions involving general or major regional anesthesia.

ii. A patient's prenatal records may serve as the history and physical examination for vaginal deliveries as long as there is a documented visit within the thirty (30) days prior to admission. However, an update note should be added to the prenatal record after admission and prior to any procedure requiring general or major regional anesthesia.

iii. An assessment may be substituted for a pre-surgical history and physical examination to the extent allowed for low-risk patients and procedures.

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[10] TJC MS.03.01.01-11: The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.
[11] TJC MS.03.01.01-19: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: patient age, diagnosis, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure. Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures. Applicable state and local health laws.

f. **Interval Note:**

i. An update or interval note should be entered in the medical record whenever the history and physical examination was performed prior to admission or registration for surgery.

ii. Such update or interval note shall document any significant changes reported by or observed in the patient since the pre-admission / pre-registration history and physical examination.

iii. The note should be documented in the medical record within twenty-four (24) hours following admission, and prior to any operative or invasive procedure requiring general or major regional anesthesia.

iv. The interval note may be entered by any practitioner otherwise privileged to complete a history and physical examination as described above.

3.5.4 Responsibility for the Admission History and Physical Examination

The admitting practitioner entering the admission order, or designee with privileges to complete the exam, is responsible for completing the admission history and physical examination.

3.5.5 Admissions for Emotional and Behavioral Disorders[12]

The admitting practitioner is responsible for documenting the 1) reason for admission as stated by the patient and/or others involved in the patient's care, 2) onset of the patient's illness and circumstances leading to admission, and 3) inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan.

The admitting practitioner shall also assess and document the following:

a. Current mental, emotional, and behavioral functioning

b. Maladaptive or other behaviors that create risk to the patient or others

c. Mental status examination

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

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[12] TJC PC.01.02.13: The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Interventional Radiology Department, and

c. certain procedures performed in other treatment areas (such as bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed.[13]

In cases of procedures performed by dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

The attending physician or designee shall see the patient and record a daily progress note, unless a more frequent requirement is documented in a unit policy. Progress notes documented by residents/fellows in training require co-signature by a supervising physician, or designee.

There should also be a progress note for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued hospitalization.

In the Inpatient Psychiatric Unit, progress notes shall be documented at least weekly for the first two (2) months and at least once a month thereafter, and must contain recommendations for revisions in the

treatment plan as indicated as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.[14]

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery,[15] and prior to transferring the patient to the next level of care. Operative/procedure reports will include:[16]

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[13] TJC RC.02.01.03-03: The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. See also PC.01.02.03-04 and 05.
[14] TJC RC.02.01.01-07
[15] TJC RC.02.01.03-05: An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
[16] TJC RC.02.01.03-06 includes the list of required information in the operative report.

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)

b. The name of the procedure performed

c. A description of the procedure

d. Any estimated blood loss

e. Any specimen(s) removed

f. The postoperative diagnosis

3.9 IMMEDIATE POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record due to an unforeseen emergency, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:[17]

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)
b. The name of the procedure performed
c. A description of each procedure finding
d. Any estimated blood loss
e. Any specimen(s) removed
f. The post-operative diagnoses

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS[18]

3.10.1 Pre-anesthesia notes

a. Anesthesia consists of general anesthesia and spinal or major regional anesthesia, does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not

arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuro-muscular function. Cardiovascular function may be impaired.

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[17] TJC RC.02.01.03-07 addresses the requirements of the post-operative progress note.
[18] TJC PC.03.01.03-01: Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered the hospital conducts a pre-sedation or pre-anesthesia patient assessment.

b. Moderate sedation is a drug-induced depression of consciousness during which patients respond to purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a pain stimulus is not considered a purposeful response. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

c. Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance and maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

d. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia, or moderate/deep sedation services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the forty-eight (48) hour time frame. [19]

In accordance with current standards of anesthesia care, some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the forty-eight (48) hour timeframe. However, under no circumstances may these elements[20] be performed more than thirty (30) days prior to surgery or a procedure requiring anesthesia services. A review of these elements must be conducted, and any appropriate updates documented, within the forty-eight (48) hour timeframe.

3.10.2 Pre-sedation assessments

Pre-sedation assessments should comply with the Hospital policy, including "Procedure for Moderate Sedation Administration by Non-Anesthesiologists."

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES[21]

Post-anesthesia and post-sedation notes shall be placed in the record within twenty-four (24) hours after the completion of a procedure involving anesthesia or sedation. The note shall contain the requirements in the appropriate hospital policy.

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[19] TJC PC.03.01.03-18: A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
[20] 482.52(b)(1): Interpretive Guidelines - Elements that must be performed within 48-hours are medical history, drug and allergy history, medical interview, and exam.

3.13 CONSULTATION REPORTS

a. Consultation orders shall be entered into the EHR.

b. The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report will be made part of the patient's record.

c. The consultation report should be completed and entered in the patient's chart no later than twenty-four (24) hours after receipt of notification of the consult request, unless a later timeframe is agreed upon and documented in the medical record.

d. If a consultation is performed by an APP who cannot practice independently in the state of California or a resident/fellow in training, the supervising physician should review and add an addendum with their assessment and recommendations in a timely manner and not more than twenty-four (24) hours after the consult is completed.

e. If a full consultation report is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. When operative procedures are involved, the consultation report, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 INPATIENT PSYCHIATRIC UNIT CARE PLANS

The written plan of care shall be based on the patient's short and long-term goals and the time frames, settings, and services required to meet the goals. The written care plan includes the responsibilities of each team member[22] and the following:

a. A substantiated diagnosis
b. Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
c. Documentation that demonstrates all active therapeutic efforts
d. The specific treatment modalities used to treat the patient

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[21] TJC PC.03.01.07-07: A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. TJC PC.03.01.07-08: The post-anesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff.

[22] TJC PC.01.03.01-05/06/43

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, dated and signed by the discharging practitioner in the discharge summary, transfer note, or death summary of the patient. If pertinent diagnostic information has not been received at the time the patient is discharged, the discharging practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

At the time of the patient's discharge or transfer, the patient or their representative shall be informed about the care, treatment, and services provided to the patient.[23] The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries, including the Death Summary, are the responsibility of the discharging physician, or designee. Documentation should be completed within twenty-four (24) hours of discharge All discharge summaries completed by APPs who are not permitted to practice independently in California and residents/fellows in training must be cosigned.

a. Content: Information for service providers shall include:[24]

i. The reason for the patient's discharge or transfer
ii. The patient's physical and psychosocial status
iii. A summary of care, treatment, and services provided
iv. The patient's progress toward goals
v. A list of community resources or referrals made or provided
vi. The patient's treatment preferences

b. Content: The discharge summary shall contain[25]

i. The reason for hospitalization
ii. The procedures performed
iii. The care, treatment, and services provided
iv. The patient's condition and disposition at discharge
v. Information provided to the patient and family
vi. Provisions for follow-up care

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[23] TJC PC.04.02.01
[24] TJC PC.04.02.01-01: At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the elements noted.
[25] TJC RC.02.04.01-03: In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the elements noted.

c. Death Summary: A discharge summary is required on all inpatients who have expired and will include:

i. Reason for admission,

ii. Summary of hospital course,

iii. Cause of death, and

iv. Final diagnoses.

3.17 CLINIC DOCUMENTATION AND IN-BASKET MANAGEMENT

3.17.1 See Appendix A.

3.18 STUDENTS, RESIDENTS, AND FELLOWS IN TRAINING

3.18.1 Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Graduate Medical Education Committee (GMEC) and the Medical Executive Committee (MEC).

3.18.2 The post-graduate education program director or committee must communicate periodically with the MEC.[26]

3.19 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, protected health information (PHI) contained in the record will be made available to any privileged practitioner attending the patient, to practitioners at other hospitals, and to others in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and state information privacy and security laws. See hospital policies on confidentiality and protected health information.

3.20 INCOMPLETE/DELINQUENT MEDICAL RECORDS

Penalties for noncompliance with medical record completion requirements are outlined in "CCHS Provider Notification and Suspension of Privileges Process" (see Appendix A).

3.21 COPY AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter.

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[26] TJC MS.04.01.01-05: There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

ARTICLE IV. STANDARDS OF PRACTICE

4.1 ORDERS

4.1.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in the EHR. Verbal orders are given directly from the ordering practitioner to the recipient hospital staff; telephone orders are given directly from the ordering practitioner to the recipient hospital staff via telephonic communication means. Verbal/telephone orders must be given to an authorized individual[27] and comply with Hospital Pharmacy "Policy for Telephone, Verbal, and Written Orders for Medication," "Policy for Verbal and Written Orders," and "Policy for Medication

Preparation."

4.1.2 Orders from sources other than the Electronic Health Record

Orders should be entered in the EHR except in cases when the EHR is not available including during downtime. In this case, the Hospital downtime policies should be followed. Orders transmitted by facsimile, written/printed on paper, or other forms of transmittal other than the electronic health record shall be considered properly authenticated and executable provided that:

a. The order is legible, clear, and complete

b. The identity of the patient is clearly documented

c. The order contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law, and

d. The order contains the practitioner's signature.

e. The order may be executed by hospital policy or by a privileged practitioner.

4.1.3 Medication Reconciliation

Medication reconciliation is performed when the patient:

a. is admitted,

b. following surgery (OR/PACU to the unit),

c. is transferred to or from a unit,

d. is transferred to, and readmitted from, another hospital or health care facility, or

e. is discharged.

New orders shall be specifically written following surgery or the transfers noted above.

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[27] RC.02.03.07-01: The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. RC.02.03.07-02: Only authorized staff receive and record verbal orders.

4.1.4 Drugs and Medications

Orders for drugs and medications must follow "Hospital Pharmacy Policy for Prescribing & Ordering", "Policy for Verbal and Written Orders", and "Policy for Telephone, Verbal, and Written Orders for Medications".

4.2 CONSULTATIONS

4.2.1 The following circumstances may prompt consultation or management by a physician or other licensed practitioner:[28]

a. Treatments needs are outside of the scope of privileges of the attending physician,

b. Doubt exists as to the diagnosis or choice of therapeutic measures to be utilized,

c. In unusually complicated situations where specific skills of other practitioners may be needed, and

d. When requested by a patient or their representative and deemed appropriate by the attending physician.

4.2.2 Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending physician, or designee, will provide written authorization in the EMR requesting the consultation, permitting the consulting practitioner to attend or examine their patient. The referring practitioner can determine if the consulting physician, or their designee, is necessary to perform the consultation.

a. Every consultation request should contain the reason for the consultation and the urgency of the consultation; the following timeframes should be followed:

i. Routine consultation – within twenty-four (24) hours,

ii. Urgent/STAT consultation – based on the conversation between the referring and consulting practitioners

b. Practitioner-to-practitioner communication is required for all non-routine consultations (i.e. Urgent or STAT priority).

c. Consultations may be done in timeframes longer than twenty-four (24) hours if appropriate for the patient and their medical condition.

d. Consultants are not required to perform daily visits, unless the patient's condition warrants it.

e. APPs may perform the consultation, including ordering diagnostics or therapeutics.

f. Residents may perform the consultation, including ordering diagnostics or therapeutics. The supervising physician will cosign the resident consultation note.

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[28] TJC MS.03.01.03-04: The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a Doctor of Medicine or Osteopathy, or other licensed practitioner, is required.

4.3 DEATH IN HOSPITAL

4.3.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a physician within a reasonable time. For inpatients, the attending physician is responsible for certifying the cause of death and completing the Death Certificate within fifteen (15) hours and prior to release of the body from the Hospital, in accordance with law.[29] The "Hospital Procedure for Patient Expiration" must be followed. In cases of fetal demise or neonatal death, the "Hospital Policy for Fetal Demise/Neonatal Death" must be followed.

4.3.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable. "Hospital Policy for Anatomical Donations for Tissue and Organ Transplantation" should be followed.

4.4 AUTOPSY

Unless the Medical Examiner exercises jurisdiction, it is the responsibility of the attending physician to consider and order autopsies. It is the responsibility of the attending physician to consider an autopsy in all cases of unusual deaths, in cases of medico-legal, or of special educational interest. A provisional diagnosis and the complete autopsy report will be completed as soon as possible. See "Policy for Patient Expiration" and "Policy for Autopsy Protocol".

4.5 ADVANCED PRACTICE PROVIDERS

4.5.1 Overview

Advanced Practice Providers (APPs) are defined in the Medical Staff Bylaws.

4.5.2 Guidelines for Advanced Practice Providers (APP)

a. Health care services delivered by APPs to patients under their care must be within the scope of each practitioner's authorized practice, as defined by state law.

b. The APP is responsible for coordinating and managing the care of their patients, in collaboration with specialists and other qualified medical professionals, and ensuring the quality of health care provided to patients.

c. The role of the APP in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the Interdisciplinary Practice Committee and approved by the Medical Executive Committee.

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[29] Cal. Health & Saf. Code § 102800: Attending to complete the death certificate within fifteen (15) hours.

d. Consultation, either in person or through telecommunication systems or other means, shall be available at all times.

e. Patients should be made aware whether they are being cared for by a physician or APP.

f. Ongoing Professional Performance Evaluations will be completed on schedule for the APP with the supervising physician or department/division chair as established by MEC policy. The supervising or specialty physician is responsible for clarifying and familiarizing the APP with supervision methods and style of delegating patient care.

g. A record of all supervising or delegating physicians is kept on file by the Medical Staff office, as applicable, and reviewed regularly through the credentialing process.

4.5.3 Supervising/Delegating Practice Agreements

Advanced Practice Providers that require supervision or collaboration must have a written Supervision/ Collaboration Agreement on file in the Medical Staff Office that describes health care-related tasks which may be performed by the APP. This document must be signed by the APP and the supervising/collaborating physician. Changes to the APP's supervising/collaborating physician will be updated through the credentials process.

4.5.4 Supervising/Delegating Physician

a. A physician may not supervise more APPs than is allowed by state law.

b. A physician who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of, or collaboration with, an APP shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.5.5 Medical Record Documentation

Advanced Practice Provider medical record documentation is addressed in Section 3, and in policies "Authority to Make Medical Record Entries" and "Procedure for Medical Record Content".

4.6 INFECTION PREVENTION AND CONTROL

All practitioners are responsible for complying with "Infection Prevention" policies and procedures in the performance of their duties, including hand hygiene.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in "Hospital Policy for Patients' Rights."

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow the "Hospital Policy for Consent to Medical Treatment."

5.3 ADVANCE DIRECTIVES AND DO NOT ATTEMPT RESUSCITATION

Hospital policies delineate the responsibilities, procedure, and documentation that must occur regarding Advance Directives, when withdrawing or withholding life-sustaining treatment, and when initiating or cancelling a Do Not Resuscitate order. See "Policy for Do Not Resuscitate (DNR)," "Policy for Advance Health Care Directive (Patient Self-Determination Act)," and "Policy for Pre-Hospital Do Not Resuscitate Orders."

5.4 DISCLOSURE AND REPORTING OF UNANTICIPATED OUTCOMES

Hospital policies delineate the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur. See policy "Adverse Event Reporting."

5.5 RESTRAINTS AND SECLUSION

The Hospital policy "Procedure for Denial of Patient Rights" delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.6 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the

Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI. SURGICAL CARE

6.1 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens are exempt from pathology examination, as defined in "Policy for Specimen Exempted from Submission for Pathology Examination and Specimens not Routinely Examined Histologically." The pathologist's report will be made a part of the patient's medical record.[30]

6.2 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE[31]

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. Hospital policy "Universal Protocol Procedure", shall be followed.

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[30] TJC PC.03.01.08: The medical staff approves a policy in coordination with Pathology and the Laboratory regarding specimens removed during surgical procedures.
[31] UP.01.01.01-02: Conduct a pre-procedure verification process. The expectation of this element of performance is that the standardized list is available and is used consistently during the pre-procedure verification.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Practitioners are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. "Policy for Appropriate Workplace Behavior" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall be referred to the Medical Staff Assistance Committee.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include spouses, domestic partners, parents, parents-in-law, children, stepchildren, and siblings.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family

members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the "Confidentiality of Patient/Client Information" policy and "Confidentiality/ Security of Electronic Patient Information" policy, regarding access, use, and disclosure to protected health information of themselves or family members to maintain compliance with HIPAA and state privacy laws. Practitioners must utilize the Patient Portal or the traditional release of records process to access their own, or their family member's, medical records. See Procedure for "Removal, Retention, and Destruction of Protected Health Information" policy.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on testing, vaccinations, and all other infection control measures.

7.6 COMMUNICATION METHODS

All practitioners must maintain a currently accessible county e-mail address on file in the Medical Staff Office, as well as a current cell phone number.

All practitioners must use the accepted method of communication regarding clinical care as determined by the MEC and department leadership (eg: Epic Chat, cell phone, etc).

ARTICLE VIII. FUNCTIONS OF THE MEDICAL STAFF

8.1 Description of Medical Staff Functions

The Medical Staff is responsible for the oversight of the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.[32] In addition, the medical staff is responsible for the leadership and oversight of activities related to patient safety.[33] To ensure appropriate oversight, the Medical Staff, acting as a whole or through committees, participates in hospital committees or medical staff committees that address the following:

1) governance, 2) medical care evaluation/performance improvement/patient safety activities, 3) hospital performance improvement and patient safety programs, 4) credentials review, 5) information management, 6) emergency and disaster preparedness, 7) strategic planning, 8) bylaws review, 9) nominating process, 10) infection prevention and control, 11) pharmacy and therapeutics, 12) practitioner health, 13) utilization management 14) continuing education, and 15) collaboration with administration and nursing.

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[32] TJC MS.03.01.01
[33] TJC MS.03.01.01-04/05

ARTICLE IX. MEDICAL STAFF COMMITTEES

9.1 General

Committees, designation, substitution, meetings, special meetings, quorum, and attendance are all outlined

in the Bylaws. The committees listed below report to the MEC, and address the medical staff's responsibility to oversee and participate in hospital and medical staff functions.[34]

9.2 Credentials Committee

The Credentials Committee details are documented in Part III, Section 1 of the Medical Staff Bylaws.

9.3 Peer Review Oversight Committee (PROC)

The details of this committee are documented in the Peer Review Oversight Committee Charter. (see attachments)

9.4 Administrative Affairs (Bylaws) Committee

9.4.1 Composition: Chair and at least one (1) other member of the Medical Staff.

9.4.2 Meetings: The committee shall meet at least biennially, or more often to address required or requested amendments.

9.4.3 Responsibilities: The committee shall be responsible for making recommendations relating to revisions and updating the Bylaws and Rules & Regulations; receiving all correspondence regarding any suggestions of changes or additions to the Bylaws or Rules & Regulations and acting on these suggestions; and being responsible for a comprehensive review of the Bylaws and Rules & Regulations biennially.

9.5 Ambulatory Policy Committee

9.5.1 Composition: Chair, DFAM Chair or designee, at least one Allied Health Professional, ideally one representative from Ob/Gyn, Surgery, Pediatrics, and Specialty Medicine, anyone with special expertise needed on an ad-hoc basis. Non-voting members: Ambulatory Care Medical Director, Chief Nursing Officer or designee. Regional representation (Martinez, Concord, East County, Far East County, West County, North Richmond) is strongly recommended.

9.5.2 Meetings: The committee shall ideally meet monthly, but at minimum ten (10) times per year.

9.5.3 Responsibilities: Sets Medical Staff policy in the health centers and acts as a liaison with Nursing and Administration for coordination of policies and procedures under joint Medical Staff-Administration or Medical Staff-Nursing purview. APC develops policies to resolve issues that affect more than one Medical Staff Department and focuses on policies and projects that relate to quality of care, the efficiency of the health centers and patients that relate to quality care, the regulatory compliance. APC coordinates its activities with PSPIC and receives quality assurance reports suggestive of or requiring changes in policies and procedures from individual Medical Staff Departments and from the Ambulatory Subcommittee of PSPIC.

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[34] Title XXII 70703(d): the medical staff bylaws and rules shall include the following functions: executive review, credential, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting medical staff members impaired by chemical dependency and/or mental illness.

9.6 Ethics Committee

9.6.1 Composition: Chair and at least 4 members from a multidisciplinary representation of clinical services, lay members, hospital administration. The Committee is encouraged to invite other professional or

community members to be utilized when discussing issues involving their particular clinical, ethnic, religious or other background.

9.6.2 Meetings: The committee will meet regularly (at least six (6) times yearly) and will also provide a mechanism for other meetings as necessary to perform case consultation functions.

9.6.3 Responsibilities: The Bioethics Committee provides a multi-disciplinary forum for the development of guidelines for consideration of cases and issues having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment in cases or issues having bioethical implications; consultation with concerned parties to facilitate and education of the hospital staff regarding bioethical matters. The committee chair will report to the Medical Executive Committee.

See "Ethics Committee Policy" for additional committee guidelines.

9.7 Continuing Medical Education Committee

9.7.1 Composition: A Chairperson appointed by the Medical Staff President, subject to MEC approval; at least two additional Medical Staff Members; and, if available, the Medical Librarian, without vote.

9.7.2 Meetings: at least twice a year, and more frequently as needed

9.7.3 Purpose: The Continuing Medical Education Committee (CMEC) directs the development of CME programs in response to quality assurance findings and needs of Medical Staff, in collaboration with nursing staff. The committee apprises the Medical Staff of outside education opportunities. The CMEC also analyzes the status and needs of, and makes recommendations regarding, the medical library services via provider journal subscriptions. The CMEC supports the provider simulation lab to help Medical Staff learn and keep up procedural skills. Simulated procedures can help providers get/maintain privileging. The CMEC Chair will coordinate with departments who will utilize the lab, and with Professional Development on upkeep and expansion.

9.8 Cancer Committee

See Committee Charter (see attachments)

9.9 Medical Staff Assistance Committee

See Committee Charter (see attachments)

9.10 Inter-Disciplinary Practice Committee

See Committee Charter (see attachments)

9.11 Patient Care Policy and Evaluation Committee (PCP&E)

See Committee Charter (see attachments)

9.12 Patient Safety and Performance Improvement Committee

9.12.1 Composition: Chair appointed by the Medical Staff President, subject to MEC Approval; Medical Staff President; CCRMC CEO; Director of Pharmacy; CMO; CNO; Ambulatory Care Medical Director; COO; CQO; past Medical Staff President; Chair of PCP&E; Patient Safety Officer; Director of Safety and Performance Improvement; Medical Director of Quality and Safety; Hospital Medical Director, Specialty Medical Director;

Hospital Regulatory Compliance Officer; Quality Manager Program Coordinator; two medical staff representatives, appointed by the Medical Staff President, subject to MEC approval; one medical staff member representative from the Behavioral Health Division, appointed by the Medical Staff President, subject to MEC approval

9.12.2 Meetings: The committee shall ideally meet monthly, but at minimum 10 times per year.

9.12.3 Responsibilities: The Patient Safety and Performance Improvement Committee (PSPIC) has the authority and responsibility for implementing and directing the Quality Management Program for the Hospital. It is responsible for setting the quality management standards, determining criteria by which care will be measured, setting priorities for which aspects of care will be monitored, and analyzing the quality-of-care studies, indicators, utilization reports, grievances, survey data, and risk management information. A systematic, multi-disciplinary improvement process is followed. It develops an annual plan for performance improvement activities (Quality Management Plan).

Appendix A (screen shot and attachment link provided)

CCRMC Provider Notification and Suspension of Clinical Privileges Process

Current support of In Basket management for providers:

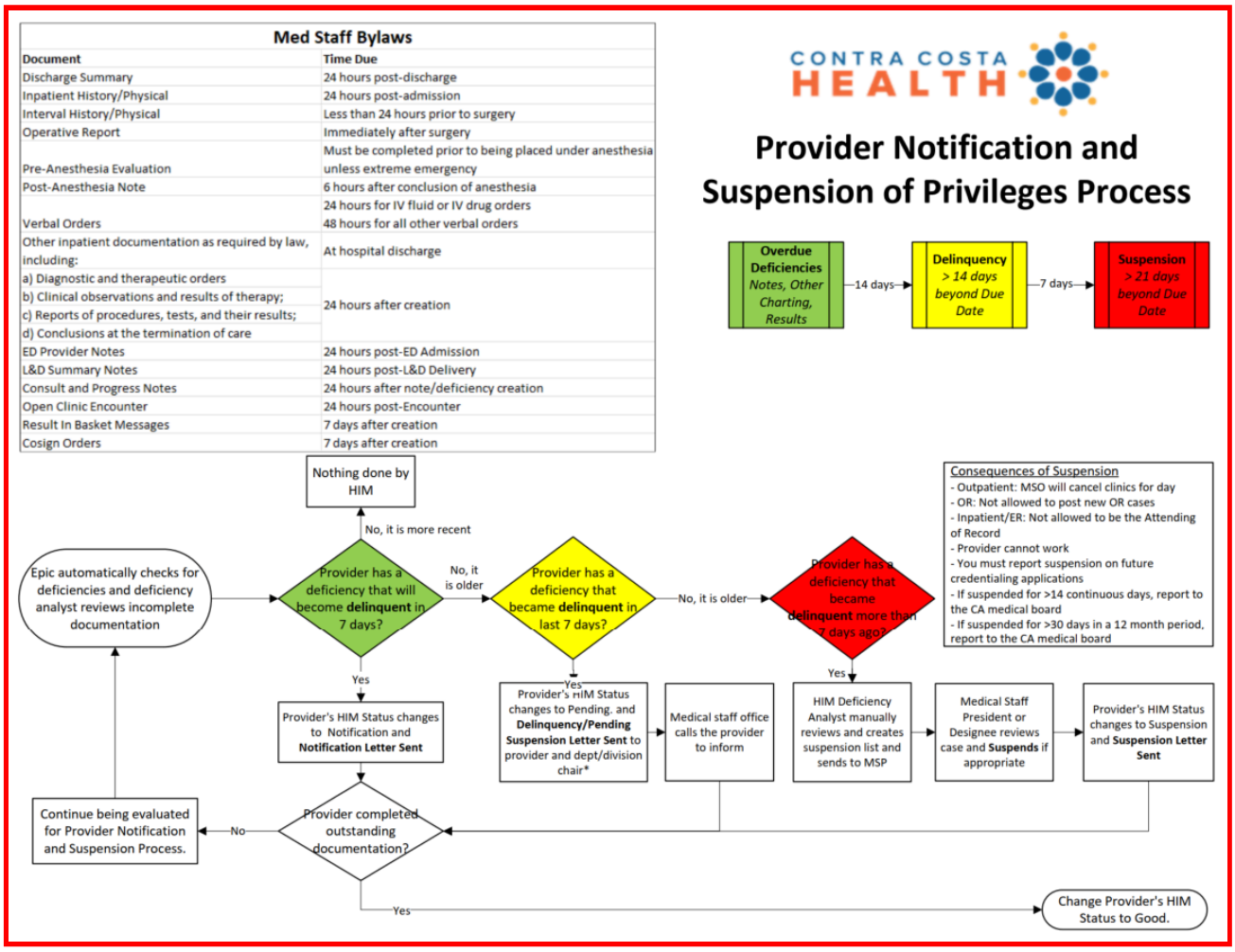
- Medical Staff Office (MSO) can schedule Dragon voice recognition software training upon request
- MSO can help you schedule Super User sessions and cancel clinic for this
- Once you reach delinquency, Health Information Management (HIM) will automatically notify you and your dept/division chair per the attached algorithm
- A human in the MSO will call you once you are one week away from suspension
- Your department/division chair can help you navigate work-life balance, assist adjusting your schedule if possible, and make a referral to the Medical Staff Assistance Committee
- Primary care health home team will help PCPs address messages, prior authorizations, etc.
- As a reminder to PDOCC (Physicians' and Dentists' Organization of Contra Costa) members: MOU (Memorandum of Understanding) changes have helped to increase clinical admin time, and add telephone clinics, and bill for extra telephone encounters
- Future state: Superusers can set you up with AI note writing upon request

* Please remember: If you feel you are falling behind, and might be in danger of a suspension, be PROACTIVE. Call HIM and come up with a plan to get the support you need!

Resources

Your Deficiency Team

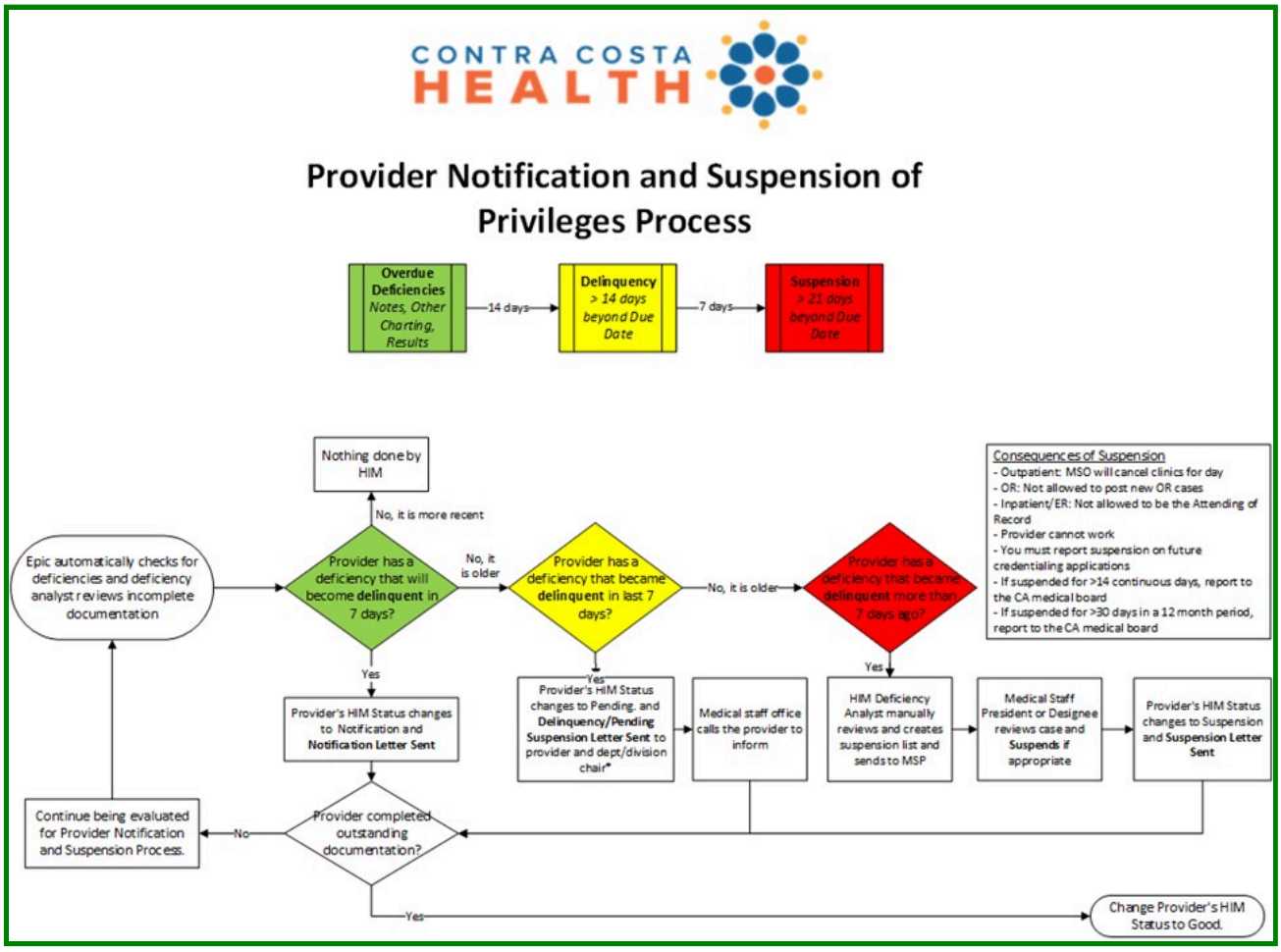
- Your Department Chair
- Medical Staff President/Designee
- HIM Deficiency Analyst
- HIM Director



Med Staff Bylaws

Document	Time Due
Discharge Summary	24 hours post-discharge
Inpatient History/ Physical	24 hours post-admission
Interval History/Physical	Less than 24 hours prior to surgery
Operative Report	Immediately after surgery
Inpatient Progress Notes	24 hours after creation
Pre-Anesthesia Evaluation	Must be completed prior to being placed under anesthesia unless extreme emergency
Post-Anesthesia Note	6 hours after conclusion of anesthesia
Verbal Orders	24 hours for IV fluid or IV drug orders 48 hours for all other verbal orders

ED Provider Notes	24 hours post-ED Admission
L&D Summary Notes	24 hours post-L&D Delivery
Consult and Progress Notes	24 hours after note/deficiency creation
Open Clinic Encounter	24 hours post-encounter
Result In Basket Messages	7 days after creation
Cosign Orders	7 days after creation



Attachments

- Cancer Committee Charter
- CCRMC Provider Notification and Suspension of Clinical Privileges Process.pdf
- Inter-Discpilinary Practice Committee Charter

- Medical Staff Assistance Committee Charter
- Patient Care Policy and Evaluation Committee
- Peer Review Oversight Charter

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	03/2026
	Lauren Wondolowski: Primary Care Prov Lmtd Ex	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Ambulatory Physician
Privileges

Name:
(Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)—or American Osteopathic Association (AOA)—accredited residency in Family Medicine or Internal Medicine. Family Medicine training is required for Pediatric Privileges.
Certification	Documentation of current certification or board eligibility (with achievement of certification within 3 years) leading to certification in Family Medicine by the American Board of Family Medicine or Family Practice and Osteopathic Manipulative Treatment by the American Osteopathic Board of Family Physicians. OR Internal Medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.
Continuing Education	As per California license and section-specific requirements below.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Adult Medicine (Initial or Reappointment)	Provision of care, reflective of the scope of privileges requested, for at least 200 adult medicine patient visits during the past 24 months. If requesting pediatric privileges, at least 100 pediatric patients. Please provide clinical activity/procedure log. Experience must correlate to requested privileges OR Successful completion of an ACGME—or AOA—accredited residency or clinical fellowship within the past 24 months.
Pediatric Medicine (Initial or Reappointment)	Provision of care, reflective of the scope of privileges requested, for at least 100 pediatric patient visits during the past 24 months. Please provide clinical activity/procedure log. Experience must correlate to requested privileges. OR Successful completion of an ACGME—or AOA—accredited residency or clinical fellowship within the past 24 months.

Ambulatory Physician Core Privileges

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to recommend
(initials)	**Adult Medicine Core Privileges** **E**valuate, diagnose, treat, and provide consultation to all patients 18 years old and above, with a wide variety of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive and family planning, genitourinary systems, and including mild to moderate psychiatric disorders, dependence or addiction to alcohol or other drugs, and medical management of chronic pain. Assess, stabilize, consult, and determine disposition of patients with emergent conditions. Procedures include, but are not limited to: performance of history and physical; arthrocentesis and joint injections; cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, tumors, and nodules and superficial foreign body; facilitate medical groups; fluorescein exam; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; pap smears; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration; toenail trephination and removal; venipuncture.	(initials)
(initials)	**Pediatric Core Privileges** Evaluate, diagnose, and treat pediatric patients who have common illnesses, injuries, or disorders from birth through 21 years old. This includes routine uncomplicated newborn care in the hospital (i.e. L&D, nursery, postpartum, etc.), assessment of physical, emotional, and social health, treating acute and chronic disease, and determining the disposition of patients with emergent conditions. Procedures include but are not limited to: performance of history and physical; bladder catheterization, cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, nodules, and superficial foreign body; facilitate medical groups; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration; toenail trephination and removal; venipuncture.	(initials)

Ambulatory Physician Special/Non-Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	Non-core privileges are requested individually, in addition to requesting core privileges.	Division/ Dept Chair: initial to recommend
(initials)	**Nexplanon Insertion & Removal**	(initials)

	Initial Request: Completion of the Nexplanon training program. Please submit Training Certification. *Reappointment/Renewal:* none - MSO has on file.	
(initials)	**EMB and/or Insertion of IUD** *Initial Request:* Residency training in EMB and IUD Insertion OR completion of a hands-on training under the supervision of a qualified preceptor. AND 4 successful EMB/IUD insertions within the past 24 months. *Renewal/Reappointment:* 2 successful EMB/IUD insertions in the past 24 months.	(initials)
(initials)	**Paracentesis** *Initial Request:* Residency training in paracentesis OR completion of a hands-on training in paracentesis under the supervision of a qualified preceptor. AND 2 paracentesis procedures in the past 24 months. *Renewal/Reappointment*: 1 paracentesis procedure in the past 24 months	(initials)
(initials)	**Early pregnancy management: manual uterine aspiration (MUA) and treatment with methotrexate** *Initial Request*: Training during or following residency with 50 MUAs. AND 6 MUAs in the past 24 months. *Renewal/Reappointment:* 6 MUAs in the past 24 months.	(initials)
(initials)	**Acupuncture** *Initial Request:* 200 Hours CME or 10 years of experience. AND 10 cases in the last 24 months *Renewal/Reappointment:* 10 cases in the past 24 months.	(initials)
	Tattoo Removal *Criteria for Initial Request*: Completion of a hands on training in tattoo removal including minimum of 10 tattoo removal procedures (Documented Evidence of Training and clinical log required). *Criteria for Renewal of Privileges*: Demonstrated current competence and evidence of the performance of at least 5 tattoo removal procedures in the past 24 months (Clinical log required) OR Department approved in-service course in tattoo removal in the past 24 months	
(initials)	**HIV/AIDS care** *Initial Request and Renewal/Reappointment: R*equirements of AB 2168 (see attached) must be met.	(initials)
(initials)	**Care of Newborn with Complications in the Level 2 Nursery** *Routine care of well newborns does not require this privilege.* Including but not limited to the admission and care of the late preterm infant 34 – 36 weeks gestation without significant complications, low birth weight, transient hypoglycemia, sepsis risk factors, mild respiratory issues with need for no or minimal respiratory support, in utero drug exposure not requiring medical management, mild to moderate hyperbilirubinemia, and congenital issues without significant clinical impact. This includes attendance at deliveries with mild to moderate risk factors if NRP certification is current. *Initial Request:* Completion of residency training in the past 24 months that included at least 1 month in the Nursery. OR 10 encounters with this level of care in the past 24 months.	(initials)

	Renewal/Reappointment: 10 inpatient encounters in the past 24 months. **Specialty Department Chair/Head reviewed (name): _____**	
(initials)	**Inpatient obstetrics with consultation** Admit, evaluate, and manage patients with uncomplicated term pregnancy, with an expectation of uncomplicated vaginal delivery. Procedures include but are not limited to: amniotomy, assisting with delivery of twins, assisting with fetal versions, augmentation of labor, episiotomy, fetal heart rate monitoring (external and internal), induction of labor, initial management of postpartum hemorrhage, normal spontaneous vaginal delivery; POCUS (please see request below); postpartum care, post-delivery removal of placenta with consultation; repair of 1st and 2nd-degree lacerations; repair of cervical, 3rd, and 4th-degree lacerations with consultation; surgical assisting; vacuum-assisted delivery with consultation. *Initial Request:* Completion of residency in the last 24 months with documentation of at least 4 months of obstetrical rotation during family medicine residency, 80 patients delivered, and ultrasound training OR 8 deliveries in the past 24 months. *Renewal/Reappointment:* 8 deliveries in the last 24 months. **Specialty Department Chair/Head reviewed (name): _____**	(initials)
(initials)	**Low-risk obstetrics (prenatal and postpartum)** Evaluate, diagnose, and treat low-risk patients who are pregnant, intend to become pregnant, or are recently post-pregnancy. Management of patients with obesity with BMI </=60; chronic Hypertension with BP < 150/100 **WITHOUT** medication; GDM on diet or orals with A1c < 6.5; AMA; history of pre-eclampsia in one previous pregnancy at >/= 37 weeks; history of cesarean section; substance abuse with or without buprenorphine therapy; cholestasis of pregnancy; size vs. date discrepancies with EFW > 10%; UTI; anemia with hemoglobin > 8; vaginitis. Procedures include but are not limited to: third-trimester POCUS (please request below) *Initial Request:* training during family medicine residency of at least 2 months of obstetrics, including prenatal/postpartum care and POCUS. OR 50 prenatal/postpartum visits in the past 24 months. *Renewal/Reappointment:* 50 patients plus attestation of 8 Units AAFP/ACOG CME in prenatal care in the past 24 months as well as complete CClearn OB/GYN Q 2 years	(initials)
(initials)	**Forensic Examination Initial:** CCFMTC (California Clinical Forensic Medical Training Center) Training Verification or approved equivalent. Clinical log and verification of experience in this service line with combination of 20 pediatric and adult forensic examinations within last 24 months (train up plan must be included with initial requesting privilege without documentation required) **Forensic Evaluation Reappointment:** Maintain certifications required for initial privilege Combination of 20 pediatric and adult forensic examinations within last 24 months Recommend Sexual Assault Nurse Examiner (SANE) certification when eligible	
(initials)	**All focused and limited POCUS (Point of Care Ultrasound)** *Initial Request:* Successful completion of an accredited POCUS training OR 15	

	hours of Point of Care Ultrasound CME. AND 6 hours of hands-on POCUS relevant to privileges being requested. *Renewal/Reappointment*: 20 ultrasounds in the past 24 months.	
(initials)	Basic First and Second Trimester POCUS for dating, location, and viability of pregnancy. *Initial Request*: 30 ultrasounds in the past 24 months. *Renewal/Reappointment*: 20 ultrasounds in the past 24 months.	(initials)
(initials)	Third trimester OB POCUS for placental location, viability, presentation, amniotic fluid assessment *Initial Request:* 20 ultrasounds in the past 24 months. *Renewal/Reappointment*: 8 ultrasounds in the past 24 months.	(initials)

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

_____

_____

_____

Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related

documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

- ☐ **Recommend All Requested Privileges**
- ☐ **Recommend Privileges with the Following Conditions/Modifications:**
- ☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Status **Pending** PolicyStat ID **19831550**

Origination	03/2021
Last Approved	N/A
Effective	Upon Approval
Last Revised	03/2026
Next Review	3 years after approval

Owner	Erwin Sison: Infection Control Coord
Area	Infection Control
Applicability	CCRMC, Health Centers & Detention

Policy for Cleaning and Disinfection of Ophthalmic Laser Lens

POLICY STATEMENT:

Laser lens that touches the surface of the eye will be cleaned and disinfected between each patient use according to the procedure outlined below.

GUIDELINES:

~~A logbook will be kept at each site where laser lens are used. Place patient label on log The Laser Lens log page attached to this policy will be the log form used. Place patient label on log along with lens # that was used on patient, include the date and clinic staff name who cleaned lens below patient label.~~

~~Employees who assist with laser lens examinations will receive initial training/competency and will annually be required to show competence by successful completion of e-learning module.~~

Laser Lens used at the Martinez Health Center and West County Health Center will be cleaned and disinfected by the Sterile Processing Departments located in the Health Centers named above.

A logbook will be kept that will include information regarding the patient, the date when the lens was cleaned and disinfected and the name of the person who performed the cleaning and disinfection.

RELATED LINKS:

Procedure for Cleaning and Disinfection of Ophthalmic Lens

Reusable Ophthalmic Laser Lens Logbook

Sterilization Cycle Log for Reusable Ocular Laser Lens with Grey Paint

Procedure for Point of Use of Reusable Ophthalmic Laser Lens

REFERENCES:

A. Centers for Disease Control, "Guidelines for Disinfection and Sterilization in Healthcare Facilities", 2008

B. Ocular Inc., Product Care Instructions: Cleaning Method 1

APPROVALS:

Infection Prevention & Control Committee: 3/21, 5/21,1/23
Ambulatory Care Policy and Procedure Committee: 5/21, 3/23
Medical Executive Committee: 5/21, 3/23

Attachments

Ocular Laser Lens IFU 7.27.23

Volk Laser Lens IFU 9.22.22

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	05/2026
Infection Prevention & Control Committee	Kathy Ferris: Infection Control Coord	04/2026
	Erwin Sison: Infection Control Coord	02/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19021721**

Origination	05/2003	Owner	Stephanie Dockham: Dietitian
Last Approved	N/A	Area	Nutrition
Effective	01/2026	Applicability	CCRMC, Health Centers & Detention
Last Revised	04/2026		
Next Review	1 year after approval		

Policy for Diet Manual

POLICY STATEMENT:

~~The Diet Manual is based on evidenced based recommendations of the Academy of Nutrition and Dietetics Nutrition Care Manual. The Diet Manual describes various aspects of the diets such as the indication and purpose of each diet. A general description of the diet with information on nutritional adequacy, appropriate foods, and a sample meal pattern as available is also included.~~

~~To provide facility-specific guidelines for the ordering and preparing of patient diets and to function as a reference for diet and nutrition-related information.~~

The *CCRMC Diet Manual* is the designated therapeutic diet manual at Contra Costa Regional Medical Center (CCRMC); provides guidelines for the ordering and preparing of patient diets and to function as a reference for diet related information.. The manual reflects current scientific practices and nutrient analyses based upon recognized national dietary standards. The publication or revision date of the approved therapeutic diet manual must not be more than 5 years old. The manual is reviewed annually, revised as needed to meet the needs of the patient population and approved by a qualified dietitian and medical staff.

GUIDELINES:

~~A. The Diet Manual is accessible to all patient units via the iSite online Intranet by doing the following:~~

~~1. Click on "iSite" on the desktop~~

~~2. In iSite click on "Clinical Resources"~~

~~3. In Clinical Resources click "Recommended" tab~~

~~B. Hard copies are available in the Food and Nutrition Services Department and the Nursing Administration Office in the event of Computer Downtime.~~

~~C. Revisions to the Diet Manual are approved in writing, prior to implementation by the Physician designee of the Medical Staff (Patient Care Policy and Evaluation Committee).~~

A. The Dietitian will identify an appropriate diet manual, make recommendations to the Chief Medical Officer and seek approval of the manual for use within the facility.

B. The diet manual will be approved by the Dietitian and Chief Medical Officer.

C. The approved diet manual will be available throughout the facility to all medical, nursing and food service personnel via hard copy or PolicyStat. Hard copies are available in the Food and Nutrition Services Department and the Nursing Administration Office in the event of Computer Downtime.

D. The Dietitian will review the diet manual annually noting any updates needed to address current scientific practices or changes in the patient population served by the facility and initiate these procedures on an ongoing basis as needed.

REFERENCES:

~~A. The Joint Commission Standard PC.02.02.03 EP 22~~

~~B. Center for Medicare and Medicaid Services § 482.28, 482.28 (b)(3)~~

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 5/2003, 10/2022~~
~~Medical Executive Committee: 6/2018, 10/2022~~
~~Joint Conference Committee:~~

- Centers for Medicare & Medicaid Services: State Operations Manual for Hospitals (2018)
- The Joint Commission: Comprehensive Accreditation Manual for Hospitals (2019)
- Nutrition Care Manual® (NCM®) (2025)

Attachments

CCRMC Diet Manual.pdf

Diet Manual Crosswalk.pdf

Diet Manual Fiber Position Statement.pdf

Diet Manual Sources of Under Reported Nutrients.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	03/2026
	Sergio Urcuyo: Chief Medical Officer	01/2026
	Stephanie Dockham: Dietitian	01/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19861395**

Origination	06/2007	Owner	Cita Richeson: Nursing Program Manager
Last Approved	N/A	Area	Perinatal
Effective	Upon Approval	Applicability	CCRMC, Health Centers & Detention
Last Revised	05/2022		
Next Review	3 years after approval		

Policy for Umbilical Catheters

POLICY STATEMENT:

This policy outlines how to safely care for neonates with umbilical catheters.

GUIDELINES:

Umbilical artery (UAC) or venous catheters (UVC) will be safely inserted by a physician and maintained by the Nursery RN.

A. Umbilical artery catheters provide access for:
    1. Arterial blood sampling
    2. Continuous arterial blood pressure monitoring
    3. Vascular access for IV fluids when other sites are not available or suitable

B. Umbilical venous catheters provide access for:
    1. Administration of drugs
    2. Fluid administration (hypertonic solutions or inadequate peripheral IV access)
    3. Exchange Transfusion
    4. Central venous pressure monitoring
    5. Measurement of PCO2 and pH
    6. Blood sampling (UAC is preferred)

RELATED LINKS:

Procedure for Umbilical Catheters

REFERENCES:

A. Karlsen, K. (2013). The S.T.A.B.L.E. program: Pre-transport / post-resuscitation stabilization care of sick infants: Guidelines for neonatal healthcare providers: Learner *Provider Manual*. S.T.A.B.L.E. Program. 6th Edition

B. The Joint Commission Standard (2024).IC.02.02.01 "The hospital reduces the risk of infections associated with medical equipment, devices, and supplies".

C. Verklan, M. T., Walden, M., & Forest, S. (2021). *Core curriculum for Neonatal Intensive Care Nursing* (6th ed.). Elsevier.

APPROVALS:

Pediatric Department: 06/2018, 05/2022
Clinical Practice Committee: 01/2013, 05/2022
Patient Care Policy and Evaluation Committee: 02/2013, 08/2018, 05/2022
Medical Executive Committee: 08/2018, 09/2022
Joint Conference Committee: 09/2022

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	05/2026
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2026
	Cita Richeson: Nursing Program Manager	02/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **20001394**

Origination	N/A
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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy
Applicability	CCRMC, Health Centers & Detention

Policy for Quality Assurance in Pharmaceutical Compounding

POLICY STATEMENT:

To establish a Quality Assurance (QA) program for compounded preparations under USP General Chapter <797> Pharmaceutical Compounding – Sterile Preparations and USP General Chapter <795> Pharmaceutical Compounding – Non-Sterile Preparations.

Pharmacy Administration, the Pharmacist-In-Charge, and the Designated Person (Pharmacist II) have the authority and responsibility for the Quality Assurance Program.

The Designated Person (DP) may separately train designee(s) to be an Assigned Trainer. The DP assigns trainers didactic and practical education every 12 months. Assigned Trainers may also be responsible for parts of administering the Quality Assurance program as it relates to compounded preparations.

GUIDELINES:

A. Training

1. There is documentation of training and skill competency for personnel involved in sterile and non-sterile compounding (see Policy for Compounding Competency Assessment).

B. Standard Operating Procedures include but not limited to:

1. Chemical and physical stability and Beyond-Use Dating Procedure E. Assigning Beyond-Use Dates (BUDs)
2. Cleaning and Disinfecting Procedure F. Cleaning the Primary Engineering Controls by

Pharmacy and Procedure G. Cleaning of Secondary Engineering Controls (Compounding Suites) by Environmental Services

3. Component quality evaluation and compounding methods Procedure B. Aseptic Technique
4. Dispensing Policy for Dispensing
5. Documentation Policy for Compounding of Medications and Procedure A. Sterile Compounding of Medications
6. Environmental quality and maintenance Policy for Maintenance of Sterile Compounding Facilities and Equipments, Procedure H. Environmental Surface Sampling, Procedure I. Viable and Non-Viable Environmental Air Sampling
7. Equipment maintenance, calibration, and operation Policy for Maintenance of Sterile Compounding Facilities and Equipments
8. Labeling Policy for Labeling Standards
9. Materials and final compounded preparation handling and storage Procedure A. Sterile Compounding of Medications
10. Measuring and weighing Policy for Maintenance and Calibration of Weighing Balance
11. Packaging and repackaging Policy for Re-Packaging Drugs
12. Patient monitoring, complaints, and adverse event reporting Policy for Adverse Event Reporting and Policy for Medication Recall
13. Personnel cleanliness and garb Procedure C. Hand Hygiene for Sterile and Non-Sterile Compounding
14. Purchasing Policy for Procurement of Medications and Policy for Drug Procurement, Storage & Inventory Control
15. Quality assurance and continuous quality monitoring
16. Training and retraining Policy for Compounding Competency Assessment
17. SOPs are reviewed regularly and updated as necessary

C. Documentation

1. All aspects of compounding operations and procedures are recorded as described in USP Chapter <797> and <795>. See Policy for Maintenance of Sterile Compounding Facilities and Equipments
2. The pharmacist with oversight on compounding personnel is the QA personnel responsibility for reviewing accuracy and completeness of compounding records, prior to dispensing.

D. Verification - to ensure a process, procedure or piece of equipment is functioning properly and producing the expected results.

1. The pharmacist with oversight on compounding personnel provides verification of the compounding procedure, which involves checking to ensure the calculations, weighting and measuring, order of mixing, and compounding techniques and

equipment (e.g. closed-system transfer devices [CSTDs], CADD cassettes, IV tubing, etc.), if necessary, were appropriate and accurately performed.

2. Quality of ingredients are verified upon receipt by purchasing commercially manufactured products as per Policy for Procurement of Medications
3. Equipment verification following equipment manufacturer manual(s) and internally developed documentation logs is performed at regular intervals by the compounding personnel on a daily basis on days when compounding occurs as per Policy for Maintenance of Sterile Compounding Facilities and Equipments.

E. Testing - to determine accurately the adequacy of the compounding process and the quality of the preparation

1. Based on the scope of compounding performed at CCRMC Pharmacy Department, there are minimal to zero number of tests required *during* the compounding process and of the *finished* compounded preparation.
2. The microbiological testing that is performed on *finished* compounded preparations is part of the quality assurance of compounded products and includes sterility testing (for sterile compounded products), potency testing, and endotoxin testing to assess the qualitative and quantitative properties of the compounded preparations. See Procedure J. End Product Testing of IV Admixtures
3. Testing is outsourced to a contract laboratory that shall follow standards set forth in USP general chapters, as appropriate, and preferably be registered with the U.S. Food and Drug Administration (FDA) or accredited through ANSI National Accreditation Board.
    a. To be assured of the contract laboratory activities, the credentials, training and continuing competency activities of the personnel at the contract laboratory may be requested initially and annually thereafter.

F. Cleaning, disinfecting and safety

1. Cleaning and disinfecting of EQUIPMENT used in sterile compounding is performed by the pharmacy personnel as per Policy for Maintenance of Sterile Compounding Facilities and Equipments and Procedure F. Cleaning of Primary Engineering Controls by Pharmacy
2. Cleaning and disinfecting of FACILITIES used in sterile compounding is performed by environmental services (EVS) as per Procedure G. Cleaning of Secondary Engineering Controls (Compounding Suites) by Environmental Services (EVS)
3. The effectiveness of the cleaning and disinfecting of the equipment and facilities is monitored following Procedure H. Environmental Surface Sampling and Procedure I. Viable and Non-Viable Environmental Air Sampling
4. The safety of the sterile compounding equipment and facilities is monitored following Policy for Maintenance of Sterile Compounding Facilities and Equipments

G. Containers, packaging, repackaging, labeling and storage

1. See Policy for Compounding of Medications, Procedure E. Assigning Beyond-Use Dates, Policy for Drug Storage Temperatures – Pharmacy Department Only, Policy

for Room Temperature Monitoring for Drug Storage Areas

2. Policy for Labeling Standards
3. Policy for Re-Packaging Drugs

H. Outsourcing of compounded preparations from pharmacy to pharmacy

1. See Policy for Outsourced Compounding Pharmacy- Quality Assurance
2. Documentation of beyond-use dating for compounded preparations sold to or received from another pharmacy is required and shall be provided upon request.

RELATED LINKS:

Policy for Procurement of Medications

Policy for Drug Procurement, Storage & Inventory Control

Policy for Compounding of Medications

Policy for Compounding Competency Assessment

Policy for Medication Recall

Policy for Adverse Event Reporting

Policy for Maintenance of Sterile Compounding Facilities and Equipments

Policy for Labeling Standards

Policy for Re-Packaging Drugs

Policy for Drug Storage Temperatures – Pharmacy Department Only

Policy for Room Temperature Monitoring for Drug Storage Areas

Policy for Outsourced Compounding Pharmacy- Quality Assurance

Procedure A. Sterile Compounding of Medications

Procedure B. Aseptic Technique

Procedure C. Hand Hygiene for Sterile and Non-Sterile Compounding

Procedure E. Assigning Beyond-Use Dates (BUDs)

Procedure F. Cleaning the Primary Engineering Controls by Pharmacy

Procedure G. Cleaning of Secondary Engineering Controls (Compounding Suites) by Environmental Services

Procedure H. Environmental Surface Sampling

Procedure I. Viable and Non-Viable Environmental Air Sampling

Procedure J. End Product Testing of IV Admixtures

REFERENCES:

A. USP General Chapter <1163>. Quality Assurance in Pharmaceutical Compounding
B. USP General Chapter <795>. Pharmaceutical Compounding – Non-Sterile Preparations
C. USP General Chapter <797>. Pharmaceutical Compounding – Sterile Preparations

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
	Shideh Ataii: Director Of Pharmacy Svcs	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

MEDICATION ERROR REDUCTION PLAN-ANNUAL MERP REVIEW

CONTRA COSTA REGIONAL MEDICAL CENTER (3/2024-3/2027 cycle)

Approval	Signatures	Date
Chief Executive Officer		**3/2025**
Chief Medical Officer		**3/2025**
Chief Nursing Officer		**3/2025**
Director of Safety and Performance Improvement		**3/2025**
Medical Executive Committee		**3/2025**
Patient Safety and Performance Improvement Committee		**3/2025**
Patient Care Policy and Evaluation		**3/2025**
Governing Body		**3/2025**
Director of Pharmacy Services, Medication Safety Committee		**3/2025**

The Medication Error Reduction Plan submitted to CDPH in 2001 as a facility plan to eliminate or substantially reduce medication-related errors (by authority of SB1875/801) and Health & Safety code 1339) has been incorporated in this policy.

Annual review of the effectiveness of the plan will be performed. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions and achieve goals.

Background

CDPH shall monitor the implementation of the plan upon licensure visit every three years.

CCRMC cycles per CDPH audits: started in 2009 and repeats every three years.

MEDICATION ERROR REDUCTION PLAN-ANNUAL MERP REVIEW

CONTRA COSTA REGIONAL MEDICAL CENTER (3/2024-3/2027 cycle)

Table of content

MEDICATION ERROR REDUCTION PLAN-ANNUAL MERP REVIEW
CONTRA COSTA REGIONAL MEDICAL CENTER (3/2024-3/2027 cycle)

I. INTRODUCTION

The following is Contra Costa Regional Medical Center (CCRMC) and Healthcenters' plan (HC) to eliminate or substantially reduce medication-related errors as part of Senate Bill 1875/ 801 and Health & Safety Code 1339 (MERP).

A. CONTRA COSTA REGIONAL MEDICAL CENTER AND HEALTHCENTERS MERP

Contra Costa Regional Medical Center is a 167 bed county hospital located in Martinez California. We are directed and guided by established policies and procedures, protocols and guidelines to minimize medication errors and adverse drug events. Events are reported through an electronic event reporting system (SERS), a voluntary, non-punitive reporting system for all problems/risks identified. Preventive action plans are designed for implementation to reduce errors or potential risks. Medication safety initiatives were developed in 2001. Over the years we have incorporated into our medication safety and quality system risk reduction requirements from Federal and State Laws, including but not limited to CMS, CDPH, FDA, other governmental agencies, TJC standards; National Patient Safety Goals & applicable clinical practice guidelines and recommendations from nationally recognized organizations (e.g., ISMP, The Medical Letter, IDSA, SIDP etc…), professional societies and associations (e.g., ASHP, CSHP, APhA, ADA, etc…) as well as shared learnings from any external resources with successful medication practices demonstrated in reducing medication errors and adverse drug events.

B. VISION

To be the health care system of choice in Contra Costa County where partnerships with patients and employees exist to promote individuals and community wellness.

C. MISSION

The mission of Contra Costa Health Services is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems.

- We provide high quality services with respect and responsiveness to all.
- We are an integrated system of health care services, community health improvement and environmental protection.
- We anticipate community health needs and change to meet those needs.
- We work in partnership with our patients, cities and diverse communities, as well as other health, education and human service agents.
- We encourage creative, ethical and tenacious leadership to implement effective health policies and programs.
- We have a department-wide goal to reduce health care disparities and health disparities by addressing issues of diversity and linguistic and cultural competence

D. VALUES

Respect, Safety, Learning, Honesty, Excellence, Functional, Communication, Stewardship, Creativity, and Compassion.

E. STRATEGIC DIRECTIVES

CCRMC and Clinics use a system-wide approach to identify high risk and problem prone patient care processes, redesign unsafe care processes, implement best practices, and adopt successful practices from other organizations that will improve and ensure patient safety. Our goal is to increase the safety of patients receiving medications at CCRMC and Clinics.

II. OVERVIEW OF CCRMC's MERP

A. SCOPE OF THE MEDICATION ERROR REDUCTION PLAN

1. Ensuring provision of pharmaceutical services meet the patient's therapeutic goal by improving safe medication use processes that optimize therapeutic outcomes
2. Ensuring the safe administration of medications according to physician's orders
3. Ensuring compliance with regulatory requirements related to medication safety and security throughout the hospital

4. Reviewing, analyzing, and trending medication errors and adverse drug events (i.e., Adverse Drug Reactions as well as medication errors), and identifying processes and practices which require improvement
5. Implementing evidence-based practices in medication administration, medication safety and security, and improved technologies and pharmaceuticals

B. GOAL AND OBJECTIVE

Our objective is to increase effectiveness in the implementation of evidence-based medication practices shown to reduce preventable adverse medication events. Medication safety will be improved through compliance with medication error reduction standards and safety practice implementation required by CMS, CDPH, FDA, Board of Pharmacy, TJC and its National Patient Safety Goals.

- Development and revision of policies and procedures and protocols to minimize Adverse Drug Events (ADE) will be based on review of facility reported adverse drug events, medication use evaluation, chart reviews, observed medication passes, accepted professional principles, incorporation of Federal & State laws and regulations, TJC medication management standards and National Patient Safety Goals, as well as its Sentinel Event Reports, other external alerts and/or recommendations from national associations including but not limited to the Institute For Safe Medication Practices (ISMP), National Coordination Council for Medication Error Reporting and Prevention (NCCMERP), Institute of Healthcare Improvement (IHI), other governmental agencies such as FDA Medwatch program, as well as clinical practice guidelines and standards of practice from nationally recognized professional organizations (e.g., American Pharmaceutical Association (APhA), American Society of Healthcare Systems Pharmacists (ASHP), California Society of Healthcare Pharmacists (CSHP), etc.

Our processes include but are not limited to the following:

1. Identify the causes of preventable Adverse Drug Events (ADE)
2. Identify the causes of preventable Rescue medications
3. Implement selected short-term changes, as well as
4. Identify, evaluate and implement long-term strategies that require operational and capital expenditures that will ensure safe medication processes and systems with or without technology.

C. ACTION PLANS AND INITIATIVES

See Medication Safety documents for updated medication safety QA/PI projects, demonstrating numerous medication safety goals, initiatives, and medication related best practices. Our priority is to achieve continual implementation of safe medication practices to substantially reduce medication errors and/or proactively prevent adverse events by addressing issues, actual or potential risk points or deficiencies associated with CDPH MERP elements.

III. ORGANIZATIONAL RESPONSIBILITY AND ACCOUNTABILITIES

(DHS-CDPH guiding principle #1-Establish an organized quality system that addresses the issue of a facility wide reduction of medication errors)

1. CCRMC has an ongoing approved and leadership-supported Medication Error Reporting Program with policies and procedures which clearly establish organizational structure in providing the leadership and quality system in advancing patient safety, risk management, and error reduction. Approved policies and procedures establishing our medication management and quality system are continually addressing issues in improving and refining processes, based on what went wrong, to design corrective actions for implementation and prevent re-occurrence.
2. Under the oversight of the PCP&E, a multidisciplinary Medication Safety Committee was formed in 2001. The Medication Safety Committee (MSC), run by the Department of Pharmacy (SEE

Addendum I), has oversight on all medication management processes, system wide. MSC is a subcommittee of the Patient Care Policy and Evaluation Committee (PCP&E) and reports to several medical staff committees i.e., PCP&E (i.e, P&T), PS&PIC, and MEC on a monthly basis. MSC oversees/addresses ALL medication errors and meets on a multidisciplinary note, every month, to discuss in detail all medication errors that occurred during that month. Medication errors are trended using NCCMERP ratings and through ongoing data aggregation analysis and preventative action design. In addition, at CCRMC, Pharmacy Dept trends near misses as well as harm index (see SBARs in MERP binder or electronic MERP document).

3. The MERP plan for the upcoming year is drafted annually submitted to executive members of this organization as well as medical staff committees (PCP&E, PS&PIC, and MEC) once MSC endorses it.
4. This committee is Chaired by the Director of Pharmacy Dept. The quality of different services in ensuring compliance with all MERP elements and established hospital policies is assessed and monitored via data collection. (See Annual Medication Error Reports in the MERP binder).
5. MSC has oversight on all medication related processes and generates many reports, including but not limited to Medication Errors, Rescue Meds, CSPs (Compounding Sterile Products), Clinical Monitors, Overrides, ADRs, ISMP reports, etc.
6. Medication error reports and adverse drug reaction reports with executive summary and pertinent data feedback relative to the user/user department are sent/referred to relevant medical staff, nursing unit/departments. Action response is requested from unit management/department head before SERS is closed.
7. Feedbacks on medication safety initiatives are reported to the Medical staff as well as Nursing staff through leadership of these departments.

8. A summary of all MSC agenda items are reported to PCP&E, PS&PIC as well as MEC. The Director of Pharmacy Department is a member of all these committees and presents the report on all pertinent information on a monthly basis to the aforementioned committees.
9. Implementation of our MERP is integrated into the facility-wide quality assurance/performance program.
10. Ongoing educational efforts are in place to heighten the awareness of medication safety to our patients.

IV. REPORTING SYSTEMS AND MONITORING

(DHS-CDPH guiding principles #2-Develop effective reporting mechanisms to ensure medication related errors are reviewed)

Reduction of medication errors and adverse reactions can be achieved by effective reporting systems that proactively identify causative factors and are used to implement corrective actions to reduce or prevent reoccurrences. To facilitate reporting, CCRMC adopted a medication error definition that is broad enough in scope to capture actual, potential, or "near miss" events and an adverse drug reaction (ADR) definition to capture suspected as well as actual ADRs.

CCRMC conducts proactive identification of adverse drug events or unsafe care processes including concurrent and retrospective review of patient's clinical records, monitoring of targeted high-risk drugs with pertinent lab results, observing medication passes, conducting drug use evaluation and drug regimen review for high-risk patients for drug and or dosage adjustment to prevent potential adverse drug events, as well as performing other QA/PI initiatives.

At CCRMC the Pharmacy Department believes in transparency and uses our event reporting system (SERS) to place in all near misses as well as discrepancies. Pharmacy Department

believes that SERS is a means of trending and alerting healthcare members of the ongoing challenges in the system. In addition, Pharmacy Department uses analyzed data as a means of identifying QA and PI projects. See Medication Safety documents for examples of system enhancement projects using this methodology by the Pharmacy Department.

Pharmacy Department is the biggest contributor to SERS entry in the organization. All relevant data from our monitors and reports are entered into this system on a concurrent and retrospective basis. Through subsequent follow up with Nursing, Medical Staff, and Quality departments, we have been able to overcome many medication safety challenges in the past few years.

A. CCRMC has a voluntary, non-punitive reporting system to monitor and report Adverse Drug Events (ADE) via a long-standing effective medication error reporting as well as an Adverse Drug Reaction program (ADR) with data collection, aggregation, analysis, and special emphasis on designing and implementation of preventative actions on an ongoing basis.

B. Medication events, actual, potential, or near misses are reviewed and trended to evaluate changes in our systems that could improve patient safety. Evaluation and implementation of medication safety initiatives follow our continuous quality improvement process using the PDSA (Plan-Do-Study-Act) model, the Rapid Cycle Improvement techniques, the Failure Mode and Effect Analysis (FMEA), and the Root Cause Analysis (RCA) model for sentinel event or “near misses” in conjunction with our Quality department / Risk management & Patient Safety Officer.

V. PROCESS-MERP IMPLEMENTATION ASSESSMENT

A. ASSESSMENT

(DHS-CDPH guiding principle #3- Establish a baseline assessment and then, at a minimum annually review the effectiveness of the plan to reduce medication-related errors)

Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

B. CDPH REQUIREMENT IN ASSESSING EFFECTIVENESS OF MERP IMPLEMENTATION:

Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications. CDPH categorized and focused on evaluating twelve elements on MERP implementation for ongoing improvement.

At CCRMC we use our medication error reports to trend challenging elements. Medication errors are reviewed periodically (i.e., monthly and annually).

The following year's plan is drafted after meticulous review of all Medication Errors, analyzing the cumulative data using monthly, quarterly, and annual Med Error patterns. Subsequently thereafter, plans are implemented to reduce the likelihood of the errors in those certain areas.

Pharmacy Dept uses the Run Chart methodology to graph each MERP element to assess the effectiveness of the instituted plans and whether those plans were adequate in reducing medication errors over time.

Run Charts are cumulative; using Median Line, we can detect any trends, shifts, or astronomical data points. We also insert annotations on the aforementioned run charts to be able to describe the cause and effects concerning any peaks or trough vs any observed isolated incidents.

Pharmacy Dept works very well with ALL departments (Nursing, medical staff, or ancillary departments) in conjunction with Quality Managers and the Professional Development Department (PDD) to apply corrective actions. Success is measured by following SERS in the affected areas to see if the action plan was proven effective or not and reflected on the run charts as cited above.

Education and Information dissemination

1. CCRMC disseminates information to hospital leadership, physicians, nurses, pharmacists, and quality managers. The following activities are currently underway to increase awareness of patient safety:
   a. Data feedback to physicians by Pharmacy Department's leadership on medication errors, adverse drug reaction reporting and medication use quality assurance and use audits.
   b. Data feedback to nursing by Pharmacy Department's leadership on medication errors, rescue meds, adverse reactions, and quality audits.

   At CCRMC we have actively received and used new information and notices related to:

   - Medication errors
   - Processes for avoiding errors
   - Recalls
   - Problem prone medications and
   - Resources related to adverse events associated to medications.

A monthly memo is generated by the Pharmacy Department with all the PCP&E updates. In addition, a memo is generated and sent to the Medical Staff president regarding "Preventable ADRs as well as Preventable Rescue Meds as a learning and educational opportunity.

Technology Strategies

(DHS-CDPH guiding principle #4-Technology implementation shall be part of the plan)

Technology will be used whenever possible to improve effectiveness and efficiency in the medication use processes to make errors difficult to commit and to promote a culture of safety and quality in the workplace. Listed below are technological applications completed at CCRMC.

Technology action plan:

1. Automated Dispensing Cabinets (i.e, Omnicell)
    - Continue using the alerts, reports, and paging system available by the Omnicell software
2. Provide ongoing support to maintain quick access and availability to medical information or current IV administration guidelines, online:
    - Micromedex-available to all staff
    - Lexicomp- available to all staff
3. Expanding reporting capabilities of EPIC (our EHR) to generate more and more meaningful reports in form of system lists, workbench reports, or crystal reports.
4. Usage EHR, i.e, ordersets, Best Practice Alerts (BPA's), First Data Bank (FDB) warnings (i.e., concerning allergy, Drug-Drug Interaction, high dose, etc…) enables us to ensure safe medication practices at CCRMC.
5. Utilizing different software and technologies to extract data and trend values

6. VigiLanz (A data mining system)
    - VigiLanz is programmed to include many monitors. It filters the data and reports all monitors that need to be addressed by the pharmacists on a daily basis
    - Bayesian software for vancomycin dosing
7. SERS (Safety Event Reporting System)
    - Electronic event reporting system with the built in reporting mechanism
8. Smart pumps
    - Smart pumps have been programmed to match our EHR rates of administration for all formulary drugs. The use of basic infusion is monitored and use of guardrail is encouraged. Data is trended using its report functionality. Rounds are made by Pharmacy and Nursing to assure compliance with set safety parameters.
9. Kitcheck®
    - Kit check® uses the RFID technology. Pharmacy Dept uses this technology to improve the efficiency of monitoring the expired medications in variety of kits and carts.
    - Kit Check® technology was instituted in Anesthesia Workstations to better manage the inventory of the trays.
10. EHR (ccLink)
    - Barcoding technology
        - Introduced globally as BCMA
        - Introduced departmentally in most areas of the Pharmacy dept

- Antimicrobial Stewardship (ASP) module

11. Central Temperature monitoring software
12. Controlled substance surveillance system

C. Literature review for ongoing review of the plan

(DHS-CDPH guiding principle #5- Review pertinent literature related to the reduction of medication related errors in the development and ongoing review of the plan.)

Pertinent literature related to the reduction of adverse drug events has been and will continue to be reviewed in the development and review of the plan. The ultimate goal is to deliver safe medication practices at CCRMC and Clinics.

Literature for ongoing learning and sharing are readily obtained from any of our resources at CCRMC. We have a very generous library of resources made available to staff, electronically. A few examples would be Micromedex, Up-To-Date, and many journals through our library. In addition to that, we benefit from nationally recognized entities and their publications such as ASHP, FDA Medwatch alerts, etc… (SEE Goal and Objective section above)

D. CCRMC participates in the following medication safety collaborative for learning from errors and sharing of best practices:

- East Bay Society of CSHP (California Society of Healthcare Pharmacists): Collaboration of all East Bay Pharmacy Leadership
- South Bay Society of CSHP (California society of Healthcare Pharmacists): Collaboration of all South Bay Pharmacy Leadership
- ARC-Gordon and Betty Moore foundation: Avoid Readmission Coalition. Pharmacy Director has done a number of presentations for this organization and currently is the expert speaker/presenter for Avoid Readmission Campaign in the East Bay

- ISMP Canada: Pharmacy Director has been invited to ISMP in Canada to share the Medication Reconciliation Process at CCRMC as IHI model hospital

VI. MERP ELEMENTS OF THE PLAN TO MONITOR AND EVALUATE SAFE MEDICATION PRACTICES IN ERROR REDUCTION:

The main section of this report will be categorized by the twelve elements of medication practices: Prescribing, Dispensing, Distribution, Administration, Competency related to medication use, Product-labeling, Packaging and Nomenclature, Compounding, Prescription Order Communication, Monitoring, Use, and Transition of Care.

The annual MERP program assessment review and effectiveness evaluation in support of identifying plan weaknesses and deficiencies for change implementation and MERP program modification are highlighted in our Medication Safety documents.

Processes to Reduce Medication Errors:

Methodologies to reduce medication errors include on-going proactive surveillance and retrospective tools to identify the root causes of variation or deviation in medication management process and system performance. Examples of on-going proactive surveillance tools include the use of trigger tool to identify areas for improvement in clinical care and patient safety, the reviews of medication usage evaluations, and daily monitoring of Automated Dispensing Cabinets medication overrides.

Data from comprehensive review of reported medication events and on-going proactive and retrospective reviews of system performance will be utilized to determine and evaluate medication safety systems related to, but not limited to: prescribing, prescription order

communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, medication use and storage of medications.

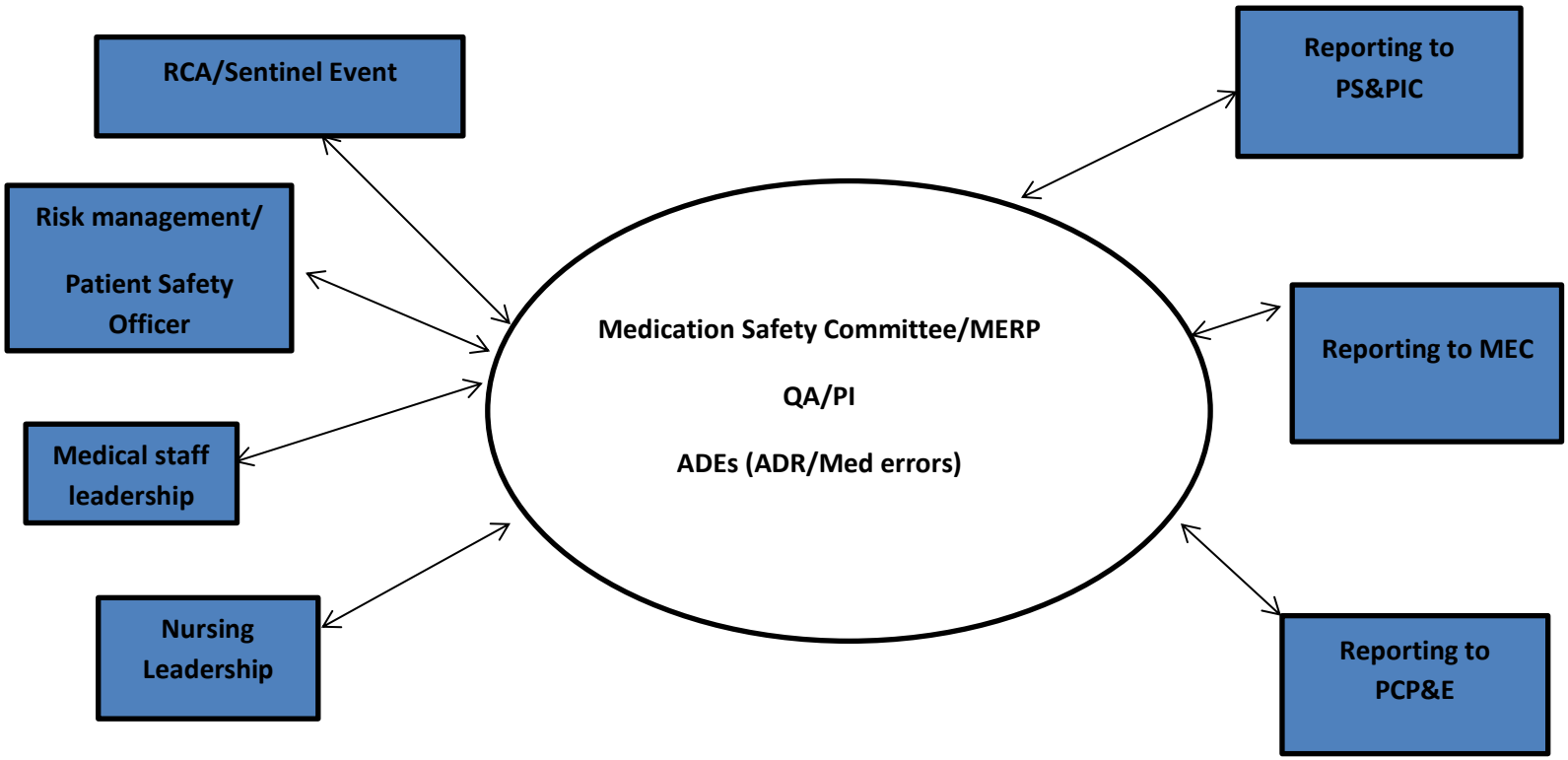
Corrective actions are promptly initiated to address each of the eleven processes and systems once a significant trend or pattern has been identified through the on-going monitoring methodologies as described above. Corrective actions may include changes in systems, procedures, staff and management in-services, and revision in policies and procedures. Should the corrective actions as implemented prove to demonstrate a decrease or reduction in medication errors overtime, then the specific hospital policy and corresponding procedures will be revised and forwarded to the Medication Safety Committee (MSC) as well as the oversight committees (i.e, PCP&E, etc…) for review and approval.

Annually, all the revised and changed procedures and systems will be reviewed and evaluated by the MSC as well as PCP&E to determine if the changes undertaken have been effective, or not; and whether the ongoing indicator should continue to be monitored for the forthcoming year. Frequency of monitoring for the specific indicator that has demonstrated a reduction in medication errors will also be revisited and determined by the Medication Safety Committee and approved by the PCP&E Committee.

VII. Effectiveness of the Plan:

The program has been effective in detecting medication errors and in developing corrective actions for the past year (see Medication Safety documents).

Addendum I- Pharmacy Department's QA/PI collaborative structure



MERP PLAN FOR THE YEAR 2026

PRESCRIBING

- **New Processes:**
  - Pharmacy to work with ccLink IT, inpatient providers and nurses to optimize order sets using the new roundtable tool available in ccLink. Round table facilitates communication and collaboration between different disciplines.

- **Continue the following:**
  - Continue all Pharmacy Monitors in ccLink and Vigilanz®: DDI checks, clinical conditions, lab monitors and reviewing therapeutic appropriateness, etc. Monitors will be optimized as needed.
  - Continue all processes under the Antimicrobial Stewardship Program (ASP). Continue to promote and assess the use of the Empiric Antibiotic Order Set.
  - Continue reviewing all order sets on a multidisciplinary note in ccLink as opportunities for improvement are identified, and work on new order sets as needed with the multidisciplinary trio team.
  - Continue reviewing external resources (ex: ISMP newsletters and self-assessments, FDA alerts, etc.), to analyze current practice at CCRMC and improve processes according to the most recent guidelines and literature.
  - Continue to optimize insulin prescribing. Continue the physician oversight process and provide physician education when needed. Continue to optimize order sets and panels involving insulin to further prevent hypoglycemic events.
  - ADC access:
    - Continue to monitor and trend medication overrides and provide feedback to the end users.
    - Continue to monitor ADC access to ensure that unauthorized personnel (i.e. upon departure or termination of employment of nursing/anesthesiology/pharmacy staff, etc.) are removed from the system upon leaving to prevent unauthorized access to medications.
  - Continue to utilize the rescue medication report and ADR report as an educational tool for medical staff.
  - Pharmacy to continue monitoring and reporting any verbal orders not cosigned within 48 hours via SERS. Continue working with medical staff to ensure compliance.

PRESCRIPTION ORDER COMMUNICATION

- **New Processes:**
  - Continue to update order sets to ensure clear communication of prescription orders. In 2026, order sets to be worked on include (but not limited to) the ED laceration, IP alcohol withdrawal, Plasma exchange, ED MAT protocol.
  - Continue Pharmacy Transitions of Care Discharge Medication Reconciliation for patients with a primary diagnosis of Heart Failure which was initiated in Q4 2025; CCRMC pharmacy staff ensure that prescriptions are communicated appropriately to the retail pharmacy and are filled for the patient.

- **Continue the following:**
  - Continue reviewing all order sets on a multidisciplinary note in ccLink as opportunities for improvement are identified, and work on new order sets as needed with the multidisciplinary trio team.
  - Continue the Transitions of Care (TC) Program to 1) Minimize medication transcribing errors with effective communication with "High Risk" patients (as defined by CCRMC) and 2) Ensure medication understanding and adherence by educating patients.
  - Continue monitoring for duplications in therapy and optimize order sets/order panels as needed to ensure effective prescription order communication of PRN medications.
  - All chemotherapy treatment plans for infusion clinic to go through pharmacy for approval prior to build in ccLink.

PRODUCT LABELING, PACKAGING AND NOMENCLATURE

- **New Processes:**
  - Transition from the current unit dose labeler in pharmacy to a different labeling software (HCL go labels).
  - Zebra label printers installation project will be expanded to include replacement of current label printers in the inpatient pharmacy.
  - Upgrade medication barcode scanners throughout the hospital to read the barcodes printed on the Zebra printer labels.

- **Continue the following:**
  - In the face of drug shortages, appropriate assessment of products available in the market to be conducted and information relayed to the appropriate disciplines (pharmacy staff, nursing staff, medical staff, etc.). Appropriate changes to be made in the electronic health record to avoid transcribing errors, order set errors and medication order errors.
  - Pharmacy and nursing to continue assessing compliance with accurate labeling per nursing of IV solutions retrieved from Medline carts, along with MDVs expiration labeling.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes according to the most recent guidelines and literature.
  - Continue Kit Check labeling and barcoding to optimize PAR levels of medications in anesthesia workstations in the OR and crash carts.
  - Continue barcoding upon dispensation and administration.
  - Continue monitoring MDV expiration labeling.
  - Continue purchasing smaller packaging of fentanyl and hydromorphone IV (fentanyl 50 mcg/1 ml, hydromorphone 0.2 mg/1 ml).

COMPOUNDING

- **New Processes:**
  - Continue to update the master formulas for medications at CCRMC with updated beyond-use dating based on USP 797 effective 11/1/23.
  - Explore switching from external lab ARL to Alta labs 797 for better reporting and a more streamlined process for sampling in the sterile compounding environment.
  - Continue to ensure compliance with all the recent revisions in the CA State Board of Pharmacy regulations surrounding compounding (CCR, Title 16, section 1735-1738) and make necessary changes in practice.
  - Continue to review the 2024 NIOSH list of hazardous drugs in healthcare settings and optimize pharmacy practices.

- **Continue the following:**
  - Continue to review and assess USP 797, 795 and 800 for adequate compliance per CCRMC policy in accordance with the CA State Board of Pharmacy.
  - Continue end-product testing using an external lab for the following: samples of purchased goods from compounding pharmacies, CCRMC compounded products, staff glove fingertip and media-fill test.
  - Continue monthly surface sampling in all sterile compounding environments as required by new/revised USP 797 effective 11/1/2023
  - Continue monitoring relative humidity in sterile compounding environments as required by new/revised USP 797 effective 11/1/23
  - Continued usage of barcoding technology in the inpatient and outpatient IV sterile compounding environments.
  - CCRMC master formula is reviewed and updated on a routine basis.
  - Continue auditing IV room medication compounding within the monthly Pharmacy Dispensing Audit by pharmacy.
  - Continue IV admixture training for nursing staff, and extensive IV competency training for pharmacists and technicians on an annual basis.
  - Continue practical evaluation of pharmacy staff competency for non-sterile compounding (USP 795)
  - Continue using non-sterile and sterile compounding e-learning modules for pharmacy staff to complete.
  - Continue extensive monitoring of compounding environments under the CA State Board of Pharmacy requirements for annual licensure including but not limited to utilizing internal and external resources.

DISPENSING

- **New Processes:**
  - Transition from the current unit dose labeler in pharmacy to a different labeling software (HCL go labels).
  - Barcode scan medications upon return to stock in pharmacy to reduce the risk of dispensing errors.
  - Explore creating a system to barcode scan medications before they are loaded into the Omnicell to reduce the risk of Omnicell fill errors by pharmacy (ex: wrong medication in bin)
  - Zebra label printers installation project will be expanded to include replacement of current label printers in the inpatient pharmacy.
  - Upgrade medication barcode scanners throughout the hospital to read the barcodes printed on the Zebra printer labels.

- **Continue the following:**
  - Continue monitoring all dispensing areas of Pharmacy Dept and utilization of barcode scanning through the department.
  - Continue monitoring the KPI report for pharmacy turn-around-time for order verification.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes according to the most recent guidelines and literature.
  - Continue barcode scanning of medications dispensed (IV medications since inception of EPIC, PO cart fill and first dose medications initiated in 2018).
  - Continue all processes under the Antimicrobial Stewardship Program (ASP) to validate for appropriateness.
  - Continue “Dispense tracking” to better facilitate medication delivery to the unit for nurses.
  - Continue to purchase smaller packaging of fentanyl and hydromorphone IV (fentanyl 50 mcg/1 ml, hydromorphone 0.2 mg/1 ml)
  - As an enhancement to the safety and security of injectable controlled substance medications, pharmacy will continue to purchase medications packaged in the Pfizer Nexxjet syringe (more tamper evident, ready to administer), as available on the market.

DISTRIBUTION

- **New Processes:**
  - Pharmacy worked with IT to develop power BI reports to monitor anesthesia airway kit use, controlled substance diversion with other replacement drugs and opioid prescribing practices. These reports were built in 2025. Going forward in 2026, the pharmacy department will review the newly available reports and create a monitoring plan.
  - Barcode scan medications upon return to stock in pharmacy to reduce the risk of dispensing errors.
  - Explore creating a system to barcode scan medications before they are loaded into the Omnicell to reduce the risk of Omnicell fill errors by pharmacy (ex: wrong medication in bin)

- **Continue the following:**
  - Controlled Substances: continued monitoring of controlled substance transactions and documentation processes in the Nursing and Anesthesiology departments by Pharmacy department for quality assurance. Continue to use Bluesight's ControlCheck surveillance system. Continue to investigate Omnicell controlled substance null transactions on a regular basis.
  - Continue to monitor and trend medication overrides and provide feedback to the end users.
  - Continue detailed daily review of D50 usage via in-basket message to clinical pharmacy dept. (assess for appropriateness of events).
  - Continue Kit Check labeling and barcoding to ensure adequate PAR levels of medications in anesthesia workstations in the OR and crash carts.
  - Continue to monitor ADC access to ensure that unauthorized personnel (i.e. upon departure or termination of employment of nursing/anesthesiology/pharmacy staff, etc.) are removed from the system to prevent unauthorized access to medications.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes according to the most recent guidelines and literature.
  - Pharmacy to continue assessing compliance with accurate expiration labeling of MDVs by nursing.
  - Ongoing pharmacy staff education to ensure accurate filling of Omnicell.
  - Continue "Dispense tracking" to better facilitate medication delivery to the unit for nurses.
  - Ongoing efforts for optimization of Omnicell medication stocking to minimize unit dose cart fill volume.
  - As an enhancement to the safety and security of injectable controlled substance medications, pharmacy will purchase medications packaged in the Pfizer Nexxjet syringe (more tamper evident, ready to administer), as available on the market.

ADMINISTRATION

- **New Processes:**
  - In 2025, CCRMC transitioned from using Alaris infusion pump to ICU Medical's infusion pumps. In 2026, CCRMC will implement interoperability for ICU Medical's Plum Duo pump with EPIC.
  - Monitor ICU Medical Pump compliance rates and QA metrics.
  - Explore possibility of transitioning to NRFit connectors to meet the ISO 80369-6 standard for neuraxial administration.
  - Explore implementing Anesthesia Medication Barcode Scanning
  - Upgrade medication barcode scanners throughout the hospital to read the barcodes printed on the Zebra printer labels.

- **Continue the following:**
  - Controlled Substances: continued monitoring of controlled substance transactions and documentation processes in the Nursing and Anesthesiology departments by Pharmacy department for quality assurance. Continue to use Bluesight's ControlCheck surveillance system.
  - Continue to monitor and trend medication overrides and provide feedback to the end users.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes accordingly.
  - Continue to optimize nursing workflow in ccLink in relation to medication management based on routine review of medication errors and MSC feedback.
  - Continue to monitor barcoding compliance (both patient and medication) in the nursing environment to maintain the Leapfrog goal of greater than 95% compliance.
  - Continue "Dispense tracking" to better facilitate medication delivery to the unit for nurses.

MONITORING

- **New Processes:**
  - Monitor ICU Medical Pump compliance rates and QA metrics, including near miss medication errors.
  - Explore if Insulin infusion calculator in ccLink will be compatible with the titration protocols at CCRMC.

- **Continue the following:**
  - Continue all Pharmacy Monitors, including but not limited to DDI checks, clinical conditions, lab monitors and checking for therapeutic appropriateness via data mining software and various EPIC reports [i.e. crystal, dashboard, system lists]). Monitors will be optimized as needed.
    - Monitors in the inpatient setting: vancomycin, heparin infusion, insulin, psychiatric medications, etc.
    - Monitors in the ambulatory setting: Diabetes Care Management Clinic, ESA Clinic, Transitions in care services, Anticoagulation Clinic etc.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes according to the most recent guidelines and literature.
  - Continue all processes under the Antimicrobial Stewardship Program (ASP).
  - Continue monitoring of ADEs (ADRs and medication errors) retrospectively to assess for appropriateness of medication use and monitoring.
  - Continue retrospective review of different systems, reports, and processes (ex: rescue medication report, medication error report, etc.) for appropriateness of medication use and monitoring from different disciplines (medical staff, nursing, pharmacy, etc.) and implement educational plans for medication monitoring as needed.
  - Continue the physician oversight process for all hypoglycemic events (BG < 50 mg/dl) for patients on insulin at CCRMC to ensure that appropriate actions are taken, and education provided when needed.
  - Continue collaborating with medical staff for different medication safety monitors.
  - Controlled Substances: continued monitoring controlled substance utilization. Continue to review and share data from Bluesight's ControlCheck program on a multidisciplinary note with leadership as deemed appropriate.
  - Continue to monitor and trend medication overrides and provide feedback to the end users.
  - Continue extensive monitoring of compounding environments under the CA State Board of Pharmacy requirements for annual licensure including but not limited to utilizing internal and external resources.

EDUCATION

- **New Processes:**
  - In 2025, CCRMC transitioned from using Alaris infusion pump to ICU Medical's infusion pumps. In 2026, CCRMC will implement interoperability for ICU Medical's Plum Duo pump with EPIC. Education to be incorporated during this transition for end users.
  - Education plan for nurses and pharmacists using the infusion center Omnicell (licensed ADDS).
  - Education to be provided to the Anesthesiologists upon launch of anesthesiology medication barcode scanning,
  - Education to be provided to the Anesthesiologists upon launch of conversion to NRFit connectors.

- **Continue the following:**
  - Continue all pharmacy monitors and educate appropriate staff as errors are identified.
  - Continue formal new pharmacist training and competency assessment for participation in the ASP program, DCM, and ESA Clinics, and all clinical processes upon hire.
  - Continue competency assessments for new pharmacists and pharmacy technicians during orientation.
  - Sterile and nonsterile competency training is completed by pharmacists and technicians
  - Continue ongoing continuing education for clinical pharmacists pertinent to practice.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes accordingly by optimizing operations and educating staff.
  - Continue to in-service nursing staff as needed.
  - Malignant Hyperthermia: Conduct mock MH drills on a unit specific note and use results for staff education, in collaboration with the Professional Development Department.
  - IV competency training for nursing staff annually.
  - Continue the Transitions of Care (TC) Program and provide education to patients to promote safe medication use.
  - Continue retrospective review of different systems, reports and processes and educate staff as necessary (rescue medications, ADRs, etc.).
  - Continue pharmaceutical waste management compliance monitoring in the ambulatory and inpatient settings which includes a full report of any deficiencies found along with a plan of correction.
  - The Antimicrobial Stewardship committee to continue sharing education with the ED Chair and the Hospital Medicine Chair to distribute to medical staff based on stewardship trends.

USE

- **New Processes:**
  - Optimize processes upon data collection and use of ICU Medical's smart pumps.
  - Update all P&Ps based on the Board of Pharmacy's regulations governing nonsterile compounding, sterile compounding, hazardous drugs and radiopharmaceuticals (California Code of Regulations, Title 16, section 1735-1738.

- **Continue the following:**
  - Controlled Substances: continued monitoring of controlled substance transactions and documentation processes in the Nursing and Anesthesiology departments by Pharmacy department for quality assurance. Continue to use Bluesight's ControlCheck surveillance system.
  - Continue reviewing external resources to analyze current practice at CCRMC and improve processes accordingly by optimizing operations and educating staff.
  - Continue to analyze data extracted from numbers of monitors/clinical programs by pharmacy department and apply quality improvement strategies.

MERP PLAN FOR THE YEAR 2026

TECHNOLOGY

- **New Processes:**
  - Continue to develop tracing and tracking medication movement through upgraded DSCSA software.
  - Transition from the current unit dose labeler in pharmacy to a different labeling software (HCL go labels).
  - Pharmacy to work with ccLink IT, inpatient providers and nurses to optimize order sets using the new roundtable tool available in ccLink. Round table facilitates communication and collaboration between different disciplines.
  - Explore creating a system to barcode scan medications before they are loaded into the Omnicell to reduce the risk of Omnicell fill errors by pharmacy (ex: wrong medication in bin)
  - Barcode scan medications upon return to stock in pharmacy to reduce the risk of dispensing errors.
  - In 2025, CCRMC transitioned from using Alaris infusion pump to ICU Medical's infusion pumps. In 2026, CCRMC will implement interoperability for ICU Medical's Plum Duo pump with EPIC.
  - Explore possibility of transitioning to NRFit connectors to meet the ISO 80369-6 standard for neuraxial administration.
  - Explore implementing Anesthesia Medication Barcode Scanning
  - Zebra label printers installation project will be expanded to include replacement of current label printers in the inpatient pharmacy.
  - Upgrade medication barcode scanners throughout the hospital to read the barcodes printed on the Zebra printer labels.

- **Continue the following:**
  - Continue on reviewing all order sets on a multidisciplinary note in ccLink as opportunities for improvement are identified, and work on new order sets as needed.
  - Continue to improve and enhance technological tools (e.g., ccLink, smart pumps, etc.) as a result of medication error trending and analysis.
  - Continue pharmacy monitors/programs with the utilization of technological tools such as system lists and dashboard reports via EPIC as well as data mining software (i.e. Vigilanz®).
  - Continue monitoring of ADEs (ADRs and medication errors) retrospectively with utilization of technological tools.
  - Continue "Dispense tracking" to better facilitate medication delivery to the unit for nurses.
  - Continue AUC/MIC dosing/monitoring of vancomycin using a Bayesian software.
  - Continue to utilize cameras in pharmacy and nursing medication areas to optimize visibility during investigation and consider software upgrades.
  - Continue using ControlCheck for controlled substance monitoring.
  - Continue using and optimizing pharmacy Power BI reports.

TRANSITIONS IN CARE

- **New Processes:**
  - Continue Pharmacy Transitions of Care Discharge Medication Reconciliation for patients with a primary diagnosis of Heart Failure which was initiated in Q4 2025; CCRMC pharmacy staff ensure that prescriptions are communicated appropriately to the retail pharmacy and are filled for the patient. Pharmacy department to collect feedback to optimize CHF management in an effort to reduce readmission rates.

- **Continue the following:**
  - Continue the Pharmacy Transitions of Care (TC) Program and monitor success rate and readmit rates.
  - Continue using "Dispense tracking," to reduce missed doses due to patients transferring from one unit to the next. And continue to educate nurses during nursing orientation that medications must be transferred with patient from one unit to the next.

Status **Pending** PolicyStat ID **20123540**

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Next Review	1 year after approval

Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy
Applicability	CCRMC, Health Centers & Detention

Policy for Medication Error Reduction Plan (MERP)

POLICY STATEMENT:

SB1875 requires an annual review of all Medication Error Reduction Plan (MERP) elements for efficacy. There are twelve different 'elements' to the medication management process that require monitoring: Prescribing, Prescription Order Communication, Product Labeling, Packaging, and Nomenclature, Compounding, Dispensing, Distribution, Administration of Medications, Monitoring, Education, Use, Technology, and Transitions in Care.

GUIDELINES:

Below is a breakdown, by element, of the monitors in place at CCRMC. This is a multidisciplinary process, with many departments involved/responsible for the monitor/audit/report.

A. **Prescribing:**
    1. **Medication errors:** review and analysis of all medication errors involving prescribing
    2. **Adverse Drug Events:** review and analysis of all reported adverse drug events
    3. **Pharmacy interventions**: review and analysis of all reported pharmacist interventions with providers
    4. **Antibiotic stewardship**: report on appropriate prescribing and monitoring of antibiotic therapy
    5. **Fentanyl patch:** review of all fentanyl patch orders for appropriateness of therapy and monitor of provider prescribing process
    6. **Rescue medications:** review of 100% of all doses of rescue medications administered to patients

7. **LASA review:** review of latest literature on LASA and report on all CCRMC medication errors involving look-alike-sound-alike errors

B. **Prescription Order Communication:**

1. **Medication errors:** review and analysis of all medication errors involving order communication

C. **Product Labeling, Packaging, and Nomenclature:**

1. **Medication errors:** review and analysis of all medication errors involving labeling, packaging, and nomenclature
2. **Internal pharmacy audit:** monthly audit of pharmacy-dispensed doses, looking for proper labeling, ingredients, cart fill check, etc
3. **LASA review:** review of latest literature on LASA and report on all CCRMC medication errors involving look-alike-sound-alike errors

D. **Compounding:**

1. **Medication errors:** review and analysis of all medication errors involving compounding
    a. **Internal pharmacy audit:** monthly audit of pharmacy-dispensed doses, looking for proper labeling, ingredients, cart fill check, etc.
    End-Product-Testing

E. **Dispensing:**

1. **Medication errors:** review and analysis of all medication errors involving dispensing
2. **Internal pharmacy audit:** monthly audit of pharmacy-dispensed doses, looking for proper labeling, ingredients, cart fill check, etc
3. **Turn-Around Time:** monitor of pharmacy TAT
4. **LASA review:** review of latest literature on LASA and report on all CCRMC medication errors involving look-alike-sound-alike errors
5. **Dispense tracking:** track medications dispensed from pharmacy to the nursing units

F. **Distribution:**

1. **Medication errors:** review and analysis of all medication errors involving distribution.
2. **Internal pharmacy audit:** monthly audit of pharmacy-dispensed doses, looking for proper labeling, ingredients, cart fill check, etc
3. **High risk/high alert:** review of latest literature on high-risk medications and report of all medication errors involving high risk medications
    LASA review: review of latest literature on LASA and report on all CCRMC medication errors involving look-alike-sound-alike errors

G. **Administration of medications:**

1. **Medication errors:** review and analysis of all medication errors involving administration of medications
2. **Bar code report:** report on medications being administered without proper

barcoding.

3. **Override report:** monitor of medications removed from the automated dispensing machine using the override function
4. **LASA review:** review of latest literature on LASA and report on all CCRMC medication errors involving look-alike-sound-alike errors
5. **Smart pump reports:** report on use of smart pumps

H. **Monitoring:**

1. **Medication errors:** review and analysis of all medication errors involving monitoring of medications
2. **Antibiotic stewardship**: report on appropriate prescribing and monitoring of antibiotic therapy
    a. **Pharmacist-managed Diabetes Care Management Clinic:** review and analysis of patient outcomes for pharmacist-managed diabetes patients vs provider-managed diabetes patients.
    b. **Anticoagulation clinic**
    c. **Erythropoietin stimulating agent clinic**
    d. **Pharmacy interventions** (including but not limited to daily drug information, clinical monitors set via Datamining software as well as EHR)
    e. **D50 Use Review**
    f. **Medication overrides**
    g. **Medication barcoding**
    h. **Controlled substance discrepancies**
    i. **Medication pass audit of the hospital units**
    j. **Pharmacy practices internal audit**
    k. **Review of Rescue medications**
    l. **Adverse Drug Events:** review and analysis of all reported adverse drug events

I. **Education:**

1. **Medication errors:** review and analysis of all medication errors with regards to competency of staff
2. **Patient education on fentanyl patch:** review and monitor for documentation of patient education for all patients being discharged on fentanyl patch
3. Professional Development Department provides ongoing education for nursing staff
4. **Transitions of Care program by pharmacy department:** Conducted in compliance with Senate Bill no.1254.
5. **Anticoagulation clinic program run by Pharmacy Dept (Ambulatory care, Health centers)**

J. **Use:**

1. **Medication errors:** review and analysis of all medication errors related to medication use
2. **Antibiotic stewardship**: report on appropriate prescribing and monitoring of antibiotic therapy
3. **Fentanyl patch:** review of all fentanyl patch orders for appropriateness of therapy and monitor of provider prescribing process

K. **Technology:**

1. **Medication errors:** review and analysis of all medication errors related to technology
2. **ccLink:** reports on system changes made in response to system issues
3. **Smart pump reports:** report on use of smart pumps

L. **Transitions in Care:**

1. **Medication errors:** review and analysis of all medication errors related to transitions in care
2. **Transitions of Care program by pharmacy department:** Conducted in compliance with ~~Senate Bill~~SB no. 1254 and AB no.1503.

An annual report on the effectiveness of the plan, illustrated by the annual medication errors and metrics associated with each element is prepared and presented to the Medication Safety Committee, Patient Care Policy & Evaluations Committee and the Performance Improvement Committee, and the Medical Executive at the end of the MERP year. The plan is then modified, based on the findings, for the following year and adopted by the organization.

RELATED LINKS:

A. Annual MERP Review

B. MERP Plan 2025

REFERENCES:

A. ~~TJC Standards LD.01.03.01, LD.03.01.01, LD.03.02.01, LD.03.05.01, LD.04.04.01, MM.06.01.01, MM.07.01.03, MM.08.01.01, PI.01.01.01, PI. 02.01.01, PI.03.01.01~~TJC Standards MM17.01.01, NPG 14.02.01, NPG 14.03.01, 14.05.01

B. CMS CoP § 482.11(a), 482.12(b)(d)(f), 482.21(a)(b)(c)(d)(e), 482.23(c), 482.25(a)(b), 482.41(c), 482.42(b)

C. California SB 1875

D. California SB 1254, California AB 1503

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
	Shideh Ataii: Director Of Pharmacy Svcs	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy
Applicability	CCRMC, Health Centers & Detention

Policy for Mifepristone-RU486 (Mifeprex®)

POLICY STATEMENT:

Mifepristone (Mifeprex®) is indicated in pregnant females as part of a regimen containing misoprostol for medical termination of intrauterine pregnancy.

Mifepristone should be prescribed only by licensed providers who have read and understood the prescribing information. Mifepristone may be administered only in health center or hospital by the provider, able to assess the gestational age of an embryo and to assess risk of ectopic pregnancies and initiate ectopic diagnostics. Providers must also be able to provide surgical intervention, or to be able to make plans to provider care through others, in cases of incomplete abortion or severe bleeding and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.

GUIDELINES:

Mifepristone, in combination with misoprostol, is indicated for the medical termination of intrauterine pregnancy.

Refer to Prescribing Information and Medication Guide for complete safety information.

Prior to a provider using mifepristone in his/her practice, at least **ONE** provider at CCRMC must sign and return to Danco Laboratories the Prescriber's Agreement, indicating that they meet the qualifications and will observe the guidelines outlined below. However, the content of the FDA approved Prescriber's Agreement must be reviewed and acknowledged by ALL/ANY providers prescribing and administering this medication at CCRMC and health centers. This would replace the requirements for individual providers signing and returning the document to Danco Laboratories.

Danco Laboratories will not ship Mifepristone to CCRMC Pharmacy until a provider on the record has the "signed Prescriber Agreement" on file. The Pharmacy Department assumes the role of ordering and securely storing Mifepristone at CCRMC.

Mifepristone must be provided by a healthcare provider who prescribes and meets the following qualifications:

1. Ability to assess the duration of pregnancy accurately
2. Ability to assess for risk of ectopic pregnancies and initiate ectopic
3. Ability to provide surgical intervention, or to have made plans to provide such care through others, in cases of incomplete abortion or severe bleeding, and ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
4. Has read and understood the prescribing information of Mifepristone (Mifeprex®). The prescribing information is attached to this policy as a hyperlink and is also available by calling 1-877-4 Early Option (1-877-432-7596) or website: www.earlyoptionpill.com.

In addition to these qualifications, the provider must provide Mifepristone in a manner consistent with the following guidelines:

1. Review the patient agreement form with the patient and fully explain the risks of mifepristone treatment regimen. Answer any questions the patient may have prior to receiving mifepristone
2. Sign and obtain the patients signature on the patient agreement form
3. Provide the patient with a copy of the Patient Agreement Form and the medication guide
4. Place the signed Patient Agreement Form in the patients' medical record
5. Record the serial number from each package of mifepristone in each patient record
6. Report deaths to Danco laboratories identifying the patient by a non-identifiable patient reference and the serial number from each package of mifepristone

RELATED LINKS:

Mifepristone REMS Summary Document

Mifepristone REMS full document

Mifepristone Patient Agreement Form

Mifeprex(R) Prescribing Information (Danco)

Mifepristone 200mg tablet Prescribing Information (Generic)

Mifeprex(R) Medication Guide (Danco)

Mifepristone 200mg tablet Medication Guide (Generic)

REFERENCES:

A. https://www.accessdata.fda.gov/scripts/cder/rems/

index.cfm?event=RemsDetails.page&REMS=390

B. Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation | FDA

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 5/2023~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Attachments

Contra Costa Health Services Mifepristone MIFEPREX Provider Agreement

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
	Shideh Ataii: Director Of Pharmacy Svcs	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy
Applicability	CCRMC, Health Centers & Detention

Policy for Record Retention and Management

POLICY STATEMENT:

To protect and safeguard "inactive" official Pharmacy Department records, and to ensure: (1) that records are retained for as long as necessary for retrieval and official use, (2) that as soon as the retention of particular records is no longer necessary, that such records are destroyed in an appropriate manner, and (3) that this process is carefully documented to account for and keep track of all records. Records (that no longer need to be retained) must be routinely destroyed or discarded in order to avoid the unnecessary cost of storing records longer than necessary. All pharmacy records shall be maintained for no less than the required retention period. Storage may be on-site in Pharmacy or off-site with the County-approved storage company/vendor. A Record Storage Log is maintained, listing the tracking number, box contents, department identification, and date for destruction. No less frequently than every 6 months, boxes beyond their storage date will be ordered to be destroyed. Destruction records will be obtained. The department will ensure that all inactive records are accounted for, that no records are lost or missing, and an investigation will be conducted to locate any temporarily missing records.

GUIDELINES:

A. The Director of Pharmacy or his/her designee:

1. Shall determine and document the length of time that pharmacy records must be retained, pursuant to all applicable Federal, State, governing agency, professional and/or Department requirements or guidelines.
2. Shall set a 'reasonable and practical' destruction date when there is no statutory authority.

3. Shall determine the actual retention period (beginning and ending dates) for each collection of actual records as they are transferred from active status to inactive status and are moved to a storage site.

B. All storage boxes are to be marked and labeled with:
    1. The department name (CCRMC Inpatient Pharmacy)
    2. The automatic retrieval/review/destruction date
    3. A bar-coded strip with box number (provided by storage vendor)
    4. A transmittal form is to be created for each pick-up by the storage company. The form will include:
        a. Account name: **CCRMC**
        b. Acct No: **719-6345**
        c. Date form prepared
        d. Department Name: **Inpatient Pharmacy**
        e. Contact person**: Pharmacy Administrative Support (or designee)**
        f. Phone number: **926-370-5250 x Ext 6**
        g. Form prepared by preparer's name
        h. Barcode number of each box
        i. Description of contents of each box
        j. Destroy date (MO/YR) for each box

C. Pharmacy law requires prescriptions to be stored in the pharmacy for one year from dispensing unless a waiver for storage has been obtained. The CCRMC Inpatient Pharmacy has obtained a waiver. The waiver is on file with the self-assessment and inspections documents.

D. See attached 'Record Retention Schedule' for destruction dates for all pharmacy document types.

RELATED LINKS:

Access Transmittal Form

REFERENCES:

A. TJC Standards RC.01.05.01, RC.01.01.01

B. CMS CoP § 482.11(a),482.23(c), 482.24(c), 482.25(a)(b)

C. 21 C.F.R. 291.505(d) (13) (ii), 803.18©, 1304.04(a, h), 1304.22

D. 22 C.C.R. 70263(f), 71233(f), 66265.16, 70733, 70837, 70839(b), 71531, 71641, 71643(b), 72639(b), 73515, 73637(b), 77127, 79337

E. 27 C.F.R. 22.164

F. 29 C.F.R. 516.6

G. B&PC Article 5. 4081 (a); 4083 (e); 4105 (c), (d), (e), (f); 4169(a)(5); 4333(a), 4427.65(c)(1), 1261.6(b)

H. CCR Division 17, Title 16. Article 2. 1707(a)-(g);1715(d); 1715.1(d); 1715.65(e)(2); 1718

I. CCR Division 17, Title 16. Article 4.5. 1735.3

J. CCR Division 17, Title 16. Article 7. 1751.1; 1751.4(f); 1751.6(c), 1751.6(e)(2)

K. H&SC Division 10. Chapter 4. Article 1. Section 11159; 11162.1(c)(4)(A); 11179

L. H&SC Division 10. Chapter 4. Article 5. 11205; 11209

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 5/2023~~

~~Medical Executive Committee:~~

~~Joint Conference Committee:~~

Record Retention Schedule

Record	Years
Acquisition records of dangerous drugs & devices [1]	3
Alcohol reports	6
Automated Unit Dose System (AUDS)[3]	
Transaction information records	3
Cash receipts	6
Compounded Drug Preparations Records[7] • Master formula document • Compounding log • Acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding	3
Correspondence	6
Corrective action plan to Board of Pharmacy[2]	3
Continuing Education records	4
Controlled Substances	
• Chart order for patient in County of Licensed Hospital[11]	7
• delivery/receipt records and any discrepancy records[14]	3

Record	Years
• dispensed/distribution[1]	3
• invoices[1]	3
• inventory[6]	3
• inventory reconciliation records[5]	3
• inventory reconciliation report[5]	3
• prescription forms issued to prescribers record log[12]	3
• prescriptions[1]	3
• purchases/sales records[13]	3
Equipment, maintenance logs	3
operating manuals	life + 6
records	life + 6
Hazardous waste training records	Termination + 6
IRB/IRC records	7
Inspection records, monthly	3
Invoices[1]	3
Licenses, certificates	Exp date + 6
MedWatch reports, drugs or devices	6
Methadone maintenance, dispensing records	3
MSDS, printed copies	5
Order of correction from Board of Pharmacy[2]	3
Packing slips	3 mos
Patient medication profiles	1
Personnel records	10
Prescriptions[1]	3
Purchase orders, receipts	3
Quality control reports	6
Recall, drug records	2

Record	Years
Receiving records of dangerous drugs & devices[1]	3
Returned goods credits	2
Self-Assessments for Board of Pharmacy[4]	3
Shipment records of dangerous drugs & devices[1]	3
Sterility testing records	3
Thermometer charts	3
Timesheet copies	2
Transaction information for Drug Supply Chain Security Act (DSCSA)	6
Sterile Compounding Records[8]	3
• Training and Competency Evaluations in policies & procedures[10]	Termination + 3 years
• Results of employee hand hygiene and garbing assessments [10]	Termination + 3 years
• Results of employee assessments of aseptic techniques, including media-fill tests and gloved fingertip testing[10]	Termination + 3 years
• Results of viable air and surface sampling	3
• Video smoke studies in all ISO 5 certified species	3
• Documents indicating daily documentation of room, refrigerator, freezer, and incubator temperatures	3
• Certification(s) of the sterile compounding environment(s)[9]	3
• Documents indicating daily documentation of air pressure differentials between all adjoining ISO rooms or areas, including those associated with compounding aseptic (containment) isolators, and air pressure differentials between all rooms or spaces with an immediate entry to ISO rooms or areas	3
• Other facility quality control records specific to pharmacy's policies and procedures (e.g., cleaning logs for facilities and equipment)	3
• Logs or other documentation of inspections for expired or recalled drug products	3

Record	Years
• Preparation records, including the master formula document, the preparation compounding log, and records of end-product evaluation testing and results.	3

1. B&PC Article 5. 4081 (a); 4105 (c), (d), (e), (f); 4169(a)(5); 4333(a), CCR 1707(a)-(g), 11179
2. B&PC Article 5. 4083 (e)
3. B&PC 4427.65(c)(1), 1261.6(b)
4. CCR Division 17, Title 16. Article 2. 1715(d), 1715.1(d)
5. CCR Division 17, Title 16. Article 2. 1715.65(e)(2)
6. CCR Division 17, Title 16. Article 2. 1718
7. CCR Division 17, Title 16. Article 4.5. 1735.3
8. CCR Division 17, Title 16. Article 7. 1751.1
9. CCR Division 17, Title 16. Article 7. 1751.4(f)
10. CCR Division 17, Title 16. Article 7. 1751.6(c), 1751.6(e)(2)
11. H&SC Division 10. Chapter 4. Article 1. Section 11159
12. H&SC Division 10. Chapter 4. Article 1. Section 11162.1(c)(4)(A)
13. H&SC Division 10. Chapter 4. Article 5. 11205
14. H&SC Division 10. Chapter 4. Article 5. Article 5. 11209

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
	Shideh Ataii: Director Of Pharmacy Svcs	03/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **20012374**

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Effective	Upon Approval	Applicability	CCRMC, Health Centers & Detention
Last Revised	02/2026		
Next Review	3 years after approval		

Policy for Close Observation in Psychiatric Units

POLICY STATEMENT:

This policy covers close observation of patients in the psychiatric units: Psychiatric Emergency Services (PES) and Inpatient Psychiatry (4C and 4D). The psychiatric units are locked ligature resistant units. Close observation is close proximity continuous line of sight observation of patients who require this for safety. Close observation in the psychiatric units is ordered by the attending psychiatrist. The Charge Nurse/Lead is responsible for assigning close observation. Staff assigned to carry out close observation will follow the guidelines in this policy and the attachment. See ~~Guidelines for Close Observation Assignment in Psychiatric Units.~~Guidelines for Close Observation Assignment in Psychiatric Units.

GUIDELINES:

A. Close observation in psychiatric units can be (#staff: #patients): 1:1 or 2:1 or 1:2 (for two patients in the same room on inpatient psychiatry units only).

B. Guidelines for ordering close observation in psychiatric units:

1. Patients with special precautions such as risk for fall, mobility, or inappropriate sexual behavior may be assigned close observation
2. Patients with Precaution Risk Level 4 (Extremely High Risk) for Suicide, and/or Assault risk require close observation with 1:1 staffing or 2:1 staffing.
3. Patients with Suicide or Assault Precaution Risk Level 3 (High Risk) may be assigned close observation if indicated based on assessment, but it is not required.
4. All minors (ages 17 and younger) in the PES are continuously monitored by nursing staff (up to ~~5~~4 minors in the same room). ~~Minors in different age groups (12 and under, 13-17) are separately monitored in different rooms.~~ This type of close

observation does not require a physician order.

5. Inpatient psychiatry units may implement 1:2 close observation in some situations such as when one patient has an ace bandage, and the other patient has a fall risk and both patients are sleeping in the same room.

C. Nursing staff who carry out close observation may include RN, LVN, LPT, or C.N.A.

D. To ensure adequate staffing: The Charge Nurse or Lead will notify the Nurse Program Manager and is advised to notify the Medical Center Supervisor when close observation is ordered or anticipated.

E. Nursing staff assigned to carry out close observation will report to the Charge Nurse for assignment and carry out break and shift change hand-off reports according to standard nursing practice, with additional guidelines in the attachments to this policy. The staff member will remain with the patient at all times and frequently document the patient's behavior (approximately every 15 minutes).

F. The need for close observation staffing will be reevaluated daily by members of the treatment team.

G. Every effort will be made to discontinue the close observation order as soon as it is safely possible. The attending psychiatrist orders close observation and discontinues the order. This does not apply to minor patients in PES, who are always continuously monitored and do not require a physician's order for monitoring.

RELATED LINKS:

Related Policies (Search):
Suicide Risk Screening, Evaluation, & Precautions in Psychiatric Units
CCRMC Psychiatric Nursing Policy 600, 603 and 615 Attachment: Guidelines for Suicide, Elopement, and Assault Precautions

REFERENCES:

A. California Code of Regulations, Title 22: Sections 70707, 70577, 71213, 71507.

B. The Joint Commission ~~2023~~2026 Standards: EC 02.06.01, LD 04.03.01, PC 02.01.01, PC 02.01.19, PC 02.02.01.

C. ~~The Joint Commission NPSG 2023: 15.01.01: Identify patient safety risks: Reduce the risk for suicide.~~The Joint Commission (TJC) 2026 National Performance Goal (NPG) #8: The hospital reduces the risk for suicide

APPROVALS:

Psychiatry Department: 10/2023
, 02/2026
Clinical Practice Committee: ~~7/2019, 10/2023~~

Patient Care Policy and Evaluation Committee: ~~8/2019, 11/2023~~

Medical Executive Committee:~~11/2023~~

Joint Conference Committee: ~~11/2023~~

Attachments

Guidelines for Close Observation Assignment in Psychiatric Units rev 02.26.26.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	04/2026
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	03/2026
	Mariamay Torres: Nursing Program Manager	02/2026

Applicability

CCRMC, Health Centers & Detention

Standards

No standards are associated with this document