Patient Care Policy Agenda 7-28-25

* ***Indicates policy is pending Medical Executive Committee's approval on 7/21/25.***

Title	Area	Revised?	Summary of Changes
Policy for Chaperones for Sensitive Physical Exams	Ambulatory Care	Revised	Minor reformatting
Policy for Radiation Exposure Monitoring	Diagnostic Imaging	Revised	Added DI Leadership approval date of 4/2025
Policy for Radiation Safety/Alara Program	Diagnostic Imaging	Revised	Added DI Leadership approval date of 4/2025
Policy for Occupational Exposure Limits to Radiation	Diagnostic Imaging	Revised	Minor formatting.
Policy for CT Exam Event/Incident Action Level Reporting	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for CT Patient Exposure Recording and Reporting	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Department Radiation Safety Guidelines	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Mobile Fluoroscopic Equipment C-Arm Spacer Exemption	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Exposure to Pregnant Patients	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Safety Committee	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Safety Program	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Anatomical Donations for Tissue and Organ Transplantation *	Hospital & Health Centers	Revised	Removed fetus > 28 weeks verbiage
Policy for Patients' Rights	Hospital & Health Centers	Revised	Updated Section A to match our Patient Rights posters - this is up to date per CHA patient rights and regulatory requirements. Had to add #'s 24 and 25 to match Pt Right attachments. All other changes are for formatting. Updated the Patient Rights attachments in English and Spanish to current versions, including the new CCH logo and branding. No substantive changes from 2022 poster updates.
Serving Arrest Warrants on Hospitalized Patients	Hospital & Health Centers	Revised	Sentence structure
Policy for Assistance Animals at Contra Costa Regional Medical Center and Health Centers *	Infection Control	Revised	Policy updated to reflect changes made to state laws regarding Assistance Animals.
Management of Reusable Instruments Prior to Return to the Sterile Processing Department	Infection Control	Revised	Formatting changes for PolicyStat guidelines (changing step L from saying step 1-8 to say step A-H) Minor verbiage changes for flow/clarity. Updated approval dates for IC Committee and PCP&E.

Title	Area	Revised?	Summary of Changes
Policy for Wound Dressing Changes/Packing *	Nursing	Revised	Reviewed and updated by wound educator. Updated best practices related to infection control procedures and assessment. References updated.
Policy for Critical Congenital Heart Disease Screening	Perinatal	Revised	Updated guidelines: only one retest, threshold, per AAP. Updated reference.
Contact List for Disaster Fan-Out Procedures *	Pharmacy	Revised	Contact names and phone numbers were updated- Approvals section deleted.
Policy for Emergency Procurement of Drugs - Borrowing and Loaning *	Pharmacy	Revised	Removed old approvals. Approval workflow changed.
Policy for Emergency Resources *	Pharmacy	Revised	Cardinal health- pharmacy distribution contact list updated- 2025. In addition, removed approval section and deleted previous outdated Cardinal Contact List
Policy for Pharmacy ccLink Downtime Plan *	Pharmacy	Revised	Removed process for Fentanyl patch as it is no longer stored in Omnicells on the units. Approvals section deleted. BCA Downtime Procedures no longer available. Omnicell content is not printed but provided electronically to the MCS.
Policy for Pharmacy Disaster Fan-Out Procedures *	Pharmacy	Revised	Removed verbiage about pager as pagers are no longer used. Thank you
Policy for 340B Drug Discount Program	Pharmacy	Revised	language to prevent duplicate discounts for Out of State Medicaid claims by excluding them from billing
Policy for Infusion Pump System	Pharmacy	Revised	Removed "Alaris" pump brand name. Removed procedure section and created a new "Procedure" document.
Policy for Reporting Diversion of Controlled Substances	Pharmacy	Revised	Added link to new Board of Pharmacy Online reporting tool
Policy for Titrating Medications	Pharmacy	Revised	Added: If medication is titrated off but order is still active, the nurse may restart to meet the titration goal parameter with reference to the last infusion dose/rate or per provider order. Revised: The provider will be notified as soon as reasonably possible. All titration adjustments should be recorded in the medical record including supporting documentation.
Policy for Pharmacy Security *	Pharmacy	Unchanged	No Comment Provided
Policy for Anticoagulation Program in Ambulatory Care	Pharmacy	Unchanged	No Comment Provided
Policy for Bioterrorism Preparedness	Pharmacy	Unchanged	No Comment Provided
Policy For Neonatal High Flow Nasal Cannula *	Respiratory	New	Created a policy to reflect ezisting standard procedures, replaced NICU with level II nursery.
Policy for Continuous Nebulizer Therapy *	Respiratory	Revised	Minor formatting changes.

Status Pending PolicyStat ID 18105229

Origination	12/2011	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval		
Last Revised	04/2020		
Next Review	3 years after approval		

Policy for Chaperones for Sensitive Physical Exams

POLICY STATEMENT:

To specify how chaperones for sensitive (genital, breast or rectal) exams should be offered, provided, declined, and documented. To provide policy that is patient centered, supported by the established ethical and legal principals, and consistent with the recommendations of the American Academy of Pediatrics, The American College of Obstetrics and Gynecology, and the American Academy of Family Practice.

GUIDELINES:

A. All patients aged 12 and over undergoing a genital, rectal or breast exam should be offered a chaperone for the exam, and their response should be documented by staff.

B. Either a staff member or a family member/guardian is an acceptable chaperone, depending upon the patient's request. The name of the chaperone in the exam room should be documented in ccLink.

C. Patients declining a chaperone are not required to have one unless the examining provider determines it is indicated. This should be documented in ccLink.

D. Provider preference is one indication for a chaperone.

E. If a chaperone is indicated and declined, the provider is not obligated to do the exam, and should discuss with the patient their options, including seeking care elsewhere. This should be documented by the provider in ccLink.

F. This policy applies uniformly to all staff and patients. It does not differ with patient, provider, or chaperone gender.

~~NURSE RESPONSIBILITY:~~

~~A. At the point that it is apparent that a sensitive exam is intended (either on arrival, or when the provider expresses this intention):~~

~~1. The staff member rooming or preparing the patient will ask the patient (or parent/guardian if the patient is under 12 years old) in a private setting whether they would like a chaperone present for the exam and document the response. If a patient under the age of 12 years declines a chaperone, the provider is notified, and documentation is made.~~

~~B. It is recommended that staff members serve as chaperones for sensitive exams.~~

~~PROVIDER RESPONSIBILITY:~~

NURSE RESPONSIBILITY:

A. At the point that it is apparent that a sensitive exam is intended (either on arrival, or when the provider expresses this intention):

1. The staff member rooming or preparing the patient will ask the patient (or parent/guardian if the patient is under 12 years old) in a private setting whether they would like a chaperone present for the exam and document the response. If a patient under the age of 12 years declines a chaperone, the provider is notified, and documentation is made.

A. It is recommended that staff members serve as chaperones for sensitive exams.

PROVIDER RESPONSIBILITY:

A. Providers performing sensitive exams should ensure a chaperone is present if requested.

B. Providers should make clear to the staff they work with, their preferences regarding chaperones.

C. The examining provider should document the presence and name, or absence of, a chaperone in ccLink.

D. Alternatives to undergoing the exam, including seeking care elsewhere, should be given and documented by providers to patients who refuse a chaperone that the provider has determined is indicated.

~~DOCUMENTATION IN CCLINK SHOULD INCLUDE:~~

DOCUMENTATION IN CCLINK SHOULD INCLUDE:

A. The name, title, or relationship of the chaperone is present in the room during the exam.

B. If the patient declines a chaperone and the exam is done without a chaperone.

C. If the patient declines a chaperone, the provider requires a chaperone and the exam is not done.

D. Options for care discussed with the patient.

REFERENCES:

Committee on Practice and Ambulatory Medicine

Pediatrics May 2011, 127 (5) 991-993; DOI: https://doi.org/10.1542/peds.2011-0322

APPROVALS:

Ambulatory Care Policy Committee: 12/2011, 5/2013, 4/2017, 4/2020

Ambulatory Care Committee: 12/2011, 5/2013, 4/2017, 4/2020

Medical Executive Committee: 1/2012, 5/2013, 5/4017/ 4/2020

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Ambulatory Policy Committee	Laura R. Colebourn [LC]	05/2025
Ambulatory Clinical Practice Committee	Helena Martey	05/2025
	Kelley Taylor	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17982690**

Origination	04/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2025
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Exposure Monitoring

POLICY STATEMENT:

To describe the radiation monitoring program implemented to track individuals who are occupationally exposed to ionizing radiation.

GUIDELINE:

A. According to the Code of Federal Regulations (10 CFR 20.1502), monitoring is required for:
    1. Any individual who is likely to receive an annual dose from radiation producing equipment in excess of 10% of the annual occupational limit (500mRem).
    2. Any minor who is likely to receive an annual dose from radiation producing equipment:
        a. A deep dose equivalent in excess of 100 mRem.
        b. A lens dose equivalent in excess of 150 mRem.
        c. A shallow dose to the skin or extremities equivalent to in excess of 500 mRem.
    3. Any individual entering a high or very high radiation area.
    4. Declared pregnant workers who are likely to receive radiation exposure during their entire pregnancy and receive a deep dose equivalent in excess of 100 mRem. (See "Declared Pregnant Worker Policy.")

B. Dosimeters are used to measure the radiation dose that individuals receive while attending patients undergoing therapeutic or diagnostic procedures while working with radiation generation devices (e.g., X-ray, CT, Fluoroscope cases) and radioactive materials.

1. CCRMC uses dosimeter badges to measure the amount of radiation exposure that employees receive while working.
2. If the dosimeter badge is exposed to radiation it will record the exposure on the filter inside of the dosimeter.
    a. When the dosimeter badge is analyzed (monthly), the results will show if the exposure received was static or dynamic.
        i. Static readings indicate that the dosimeter was not being worn when exposed. This can occur when leaving the dosimeter in a car or exam room when not worn.
        ii. Dynamic readings indicate that the dosimeter was worn at the time of exposure and the dose is valid.
3. The radiation dose will be calculated by the contracted vendor (LANDAUER).

C. All individuals who are occupationally exposed to ionizing radiation or radioactive materials on a regular basis will be issued a dosimeter badge.
    1. The following groups have been established along with the frequency of exposure reporting:
        a. Group 1: Radiology technologists (Monthly)
        b. Group 2: Surgery (Monthly)
        c. Group 3: Radiologists (Monthly)

D. Personnel who are exposed to radiation on an occasional basis will only be issued a dosimeter if requested. Examples include: physicians, OR nurses, secretarial staff who work in the clinic but do not work with patients, and nurses working in Interventional Radiology (IR).

E. Dosimeters are assigned to and worn by only one individual. While engaged in hospital work, all individuals who are assigned dosimeters shall always wear the dosimeter while in the presence of ionizing radiation.

F. All dosimeters are to be stored in a radiation-free area when not being worn.

G. Personnel monitors must be processed by a laboratory accredited by the National Voluntary Laboratory Accreditation Program for Personnel Dosimetry Processors (10CFR 20.1501 (c))

H. Individuals are responsible for returning the dosimeter for processing within 7 days of the end of the monitoring period to the assigned representative under the supervision of the Radiation Safety Officer (RSO).
    1. All lost, damaged or inadvertently exposed radiation monitors shall be promptly reported to the RSO.
    2. Late dosimeters may not be read as accurately as dosimeters returned on time. A control badge accompanies the badges while in transit to and from the dosimetry vendor. When a badge is returned late it cannot be processed with the control badge, and a correct exposure may not be reported.
    3. Individuals who habitually lose or return a late dosimeter will be subject to disciplinary action.

I. A monthly report will be generated providing radiation exposure data on all individuals where monitoring is required.
    1. The report will contain, in pursuant of CCR Title 17 section 30255:
        a. Individual information such as: the name of the individual, Social Security number or date of birth, exposure information.
        b. The statement, "This report is furnished to you under the provisions of the California State Department of Public Health Regulations: Standards for Protection Against Radiation. You should preserve this report for future reference."

J. Results of radiation dose monitoring will be reviewed by the RSO and recorded on NRC Form 5 or equivalent. Individuals will receive a written annual report of their occupational radiation dose if:
    1. The individual's occupational dose exceeds 100 mRem total effective dose equivalent or 100 mRem to any individual organ or tissue; or
    2. The individual requests his/her annual dose report.

K. CCR Title 17, section 30255 requires CCRMC to provide a radiation exposure report in the following situations:
    1. At the request of an individual who is terminating employment that involved exposure to radiation or radioactive materials, the Radiation Safety Officer, or their designee shall provide at termination to each worker, or to the worker's designee, a written report regarding the radiation dose received by that worker from operations of the user during the current year or fraction thereof.
        a. If the most recent individual monitoring results are not available at that time, a written estimate of the dose must be provided together with a clear indication that this is an estimate.
    2. At the request of an individual formerly employed at CCRMC who had their radiation exposure monitored:
        a. The report shall be provided within 30 days from the time the request is made, or within 30 days after the exposure to the individual has been determined, whichever is later.
        b. The report shall cover the period that the individual's activities involved exposure to radiation and include the dates and locations of where the individual worked.

L. Wearing of dosimeters (all applicable individuals):
    1. Dosimeters are to be worn at the collar. If lead aprons are used, wear the dosimeter outside of the apron at the collar.
    2. Ring dosimeters are to be worn on the finger where the most radiation exposure is expected.
    3. Protect dosimeters from impact, puncture or compression.

M. Storage of Dosimeters:

1. Store dosimeters in the designated location that contains the control dosimeter.
2. Do not take dosimeters home.
3. All lost dosimeters should be reported to your manager immediately.

N. Dosimetry Reporting:
    1. At the end of the wear period, return the dosimeter to assigned representative under the supervision of the RSO.
        a. Medical Imaging individuals will return their dosimeters at the beginning of each month.
        b. All other hospital personnel will return their dosimeters at the beginning of the newest quarter (e.g., January 1st, April 1st, July 1st, October 1st).
    2. The Radiation Safety Officer will review all exposure records and notify you if you are over the exposure limit. (Refer to "Occupational Exposure Limit to Radiation.")
    3. Exposure records will be posted in your department, so you may review your individual exposure results.
    4. You will receive a written annual report of your occupational radiation dose from the RSO when required or requested as stated in "II – K" above.

O. Radiation exposure requests (RSO or designee):
    1. At the time of termination:
        a. Provide a written report to the requesting individual with the radiation dose received by that individual during the current year or fraction thereof.
        b. If the most recent individual monitoring results are not available at that time, a written estimate of the dose must be provided together with a clear indication that this is an estimate.
    2. At the request of a former employee:
        a. Provide a radiation exposure report to the former employee within 30 days from the time the request is made, or within 30 days after the exposure to the individual has been determined, whichever is later.

REFERENCES:

A. CA Code of Regulations, Title 17, Division 1, Chapter 5, Subchapter 4 "Radiation", Group 3 Article 2, section 30255. (Accessed 2.27.24 PC)

B. Code of Federal Regulations (CFR) Title 10, Part 20, sections: 20.1201 "Occupational dose limits for adults", 20.1502 "Conditions requiring individual monitoring of external and internal occupational dose", and 20.2106 "Records of individual monitoring results". Edition 1.1.2021. (Accessed 1.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025

Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 12/2022, 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17982848**

Origination	06/2006	Owner	Angela Womble: Chief Radiologic Technologist
Last Approved	N/A	Area	Diagnostic Imaging
Effective	Upon Approval		
Last Revised	04/2025		
Next Review	1 year after approval		

Policy for Radiation Safety/Alara Program

POLICY STATEMENT:

To keep the potential for radiation exposure of patients, staff, and visitors to a minimum by using established safeguards and educating the health care workers about the dangers of radiation exposure. Radiation exposure of patients, staff and visitors will be as minimal as possible.

GUIDELINES:

A. Regulating Agency: California Department of Health Services, Cal/OSHA – title 17, Nuclear Regulatory Commission.

B. Responsibilities:

1. Radiation Safety Officer: Administers the Radiation Safety Program to safeguard the interests of its employees, patients, and public.
2. Managers and Supervisors: Responsible to ensure that their employees are trained on an annual basis on radiation safety procedures and put safeguards in place to reduce exposures.
3. All Employees: To know, understand and practice safety techniques when working around radiation sources, and to use personal protective equipment when appropriate.

C. Radiation Safety "ALARA" – Health care workers are required to keep the radiation exposure "As Low As Reasonably Achievable" (ALARA).

D. Radiation Symbol: Whenever this symbol (red symbol on a yellow background) Is displayed, permission must be granted to enter that area.

E. Reducing Exposure Time – by keeping the exposure time to a minimum, the potential for risk is decreased.
    1. Distance – Increasing the distance between the source of radiation, and staff will reduce the potential for exposure.
    2. Shielding: By using personal protective equipment (PPE) (shields, lead aprons, glasses, etc.), the risk to exposure is reduced. However, shielding is not needed for most Nuclear Medicine studies.

F. Exposure Limits and Records: Exposure limits are set by the state safety standards.
    1. A staff member's individual exposure records will be available to them, and any overexposures will be investigated and reported.
    2. The exposure records are part of the employee's permanent record and will be available to them upon termination of their employment.
    3. Only certain health care workers need to be monitored.

G. Questions and Concerns regarding radiation safety issues should be referred to the supervisor or Manager. The Radiation Safety Officer (RSO) may also be contacted for further inquiry.

RELATED LINKS:

Radiation Studies - CDC: ALARA
Ionizing Radiation - Control and Prevention | Occupational Safety and Health Administration (osha.gov)

REFERENCES:

California Code of Regulations, Title 17, Subchapter 4.7 "Nuclear Medicine Technology" (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
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
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17981673**

Origination	06/2008	Owner	Angela Womble: Chief Radiologic Technologist
Last Approved	N/A	Area	Diagnostic Imaging
Effective	Upon Approval		
Last Revised	04/2025		
Next Review	1 year after approval		

Policy for CT Exam Event/Incident Action Level Reporting

POLICY STATEMENT:

To provide a guideline for reporting CT action level events in which the administration of radiation results exceeds the threshold criteria defined in Senate Bill 1237 and CDPH Information Notice California Health and Safety Code, Section 115113.

GUIDELINES:

Diagnostic Imaging Staff should follow the policy and procedure below for reporting to the department an event in which the administration of radiation results in any of the following:

A. Repeating of a CT examination more than once, unless otherwise ordered by a physician or radiologist, if one of the following dose values is exceeded:
    1. 0.05 Sv (5 rem) effective dose
    2. 0.5 Sv (50 rem) to an organ or tissue
    3. 0.5 Sv (50 rem) shallow dose to the skin.

B. A CT X-ray Examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:
    1. 0.05 Sv (5 rem) effective dose
    2. 0.5 Sv (50 rem) to an organ or tissue
    3. 0.5 Sv (50 rem) shallow dose to the skin.

C. A CT X-ray for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is

exceeded:

1. 0.05 Sv (5 rem) effective dose
2. 0.5 Sv (50 rem) to an organ or tissue
3. 0.5 Sv (50 rem) shallow dose to the skin.

D. CT or therapeutic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

E. A CT or therapeutic dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose, that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

RELATED LINKS:

DI 1212 Procedure for CT Exam Event/Incident Action Level Reporting

REFERENCES:

A. Assembly Bill 510, Senate Bill 1237 and Senate Bill 38 (Accesses 2.27.24 PC)

B. California Health and Safety Code, Division 104, Part 9 "Radiation", Section 115113 (Accessed 2.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025.
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17983274

Origination	12/2011
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

Policy for CT Patient Exposure Recording and Reporting

POLICY STATEMENT:

To ensure proper reporting procedures are met in an event in which the administration of radiation results in patient exposure.

GUIDELINES:

Diagnostic Imaging staff will follow the procedure below on reporting radiation exposure, based on Senate Bill 1247.

A. The dose of radiation shall be recorded on every CT study produced during a CT examination.
B. The CT Technologist will send each CT study and dose report page to PACS, which lists the total dose of radiation to the patient.
C. As part of the Physicist's annual survey of the CT scanner, the displayed dose shall be verified to ensure that the displayed dose is within 20% of the true measured dose.

REFERENCES:

Information Notice Regarding Senate Bill (SB) 1237, California Health and Safety (H&S) Code Section 115113 CDPH Letterhead (ca.gov) (Accessed 2.25.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
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
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17983249**

Origination	05/2001	Owner	Angela Womble: Chief Radiologic Technologist
Last Approved	N/A	Area	Diagnostic Imaging
Effective	Upon Approval		
Last Revised	04/2024		
Next Review	1 year after approval		

Policy for Department Radiation Safety Guidelines

POLICY STATEMENT:

To provide radiation safety guidelines for staff. CCRMC Diagnostic Imaging staff will follow the safety guidelines outlined below as required by the Department of Health Services, Radiologic Health Branch.

GUIDELINES:

A. Only authorized persons should be allowed in rooms with radiation sources.

B. Doors to X-ray should be kept closed whenever machines are energized.

C. Always knock before entering a closed X-ray room. Observe warning lights which indicate that a machine is in operation.

D. A distance of at least 6 feet should be maintained between the source of radiation and the portable lead screen if the latter is used instead of a fixed screen.

E. The operator of radiographic equipment should always be in a shields position.

F. Only the required persons should be in X-ray or fluoroscopic rooms during the procedures. A chaperone, as one is necessary, should be placed in a low-dose rate area.

G. Never leave a patient unattended in an X-ray or fluoroscopic room.

H. If necessary to hold a patient during an exposure, the employee or relative should be required to wear a protective apron or gloves, and to keep out of the primary beam.

I. The radiographic field should never be larger than clinically necessary.

J. Appropriate shielding should be used on all patients to protect them from unnecessary radiation. It is particularly important to provide proper shielding for children, pregnant women, and other patients under 45 years of age.

K. Protective apparel should be worn when indicated by the radiographic work being done.

L. Protective apparel must be worn during all fluoroscopic procedures.

M. Protective apparel should be tested for leakage at regular intervals.

N. When using a mobile X-ray unit, the operator should wear a protective apron and should be at least 6 feet from the patient.

O. Personal monitoring devices such as film badges must be properly worn if they are to be of any value.

P. Mobile X-ray units for use in hazardous areas, e.g. operating and delivery rooms, should be Underwriters' Laboratories approved for such areas and should be properly connected and grounded.

Q. Extraneous equipment such as desks, chairs, etc. should be kept at a minimum in radiographic rooms.

R. Keep equipment and furniture out of the line of traffic, especially in darkened rooms.

S. Equipment with mechanical or electrical defects should not be used, and such defects should be reported to your supervisor.

T. Carts should be used to transfer cassettes to and from the darkroom.

U. Carts or stands for film cassettes should be kept in good condition and should never be overloaded.

V. Authority to release information about patients is restricted to certain hospital personnel. Report any query about a patient's condition from an outsider to your supervisor.

W. Always use the correct waste receptacle for discarding disposable syringes and needles.

X. Care should be used in the handling of darkroom chemicals. Any spills should be washed with clear water immediately.

Y. Before doing maintenance work on an automatic film processor, the power should be turned off.

REFERENCES:

A. California Code of Regulations, Title 17, Subchapter 4. "Radiation" and Subchapter 4.5 "Radiation Technology" (Accessed 2.24.24 PC)

B. CCRMC Hospital Policy #365, "Radiation Safety Program"

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025

Patient Care Policy & Evaluation Committee: 9/2022, 6/2024

Medical Executive Committee: 9/2022, 6/17/2024

Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17983281**

Origination	03/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2024
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Mobile Fluoroscopic Equipment C-Arm Spacer Exemption

POLICY STATEMENT:

To provide guidelines for Diagnostic Imaging personnel for general radiation safety with reference to the specific policies in the radiation safety manual. The operator of radiation-producing equipment must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology Regulations (Title 17).

GUIDELINES:

A. The operator must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology regulations (Title 17).

B. Definitions:

1. Fluoroscopy: Medical procedure that makes a real-time video of the movements inside a part of the body by passing x-rays through the body over a period of time. Search Results | CDC
2. C-ARM: When using the C-ARM, use the spacer (cone) on exams/anatomy that will not interfere with the OR table. Anatomy that will exclude the use of spacer (cone) are: Cervical spine, Thoracic spine, Lumbar spine, Thoracic region, Abdominal region, Pelvis region, and Femora. The spacer (cone) shall be reinstalled upon completion of the examination(s) for which removal is authorized.

REFERENCES:

A. California Code of Regulations, Title 17, Division, Chapter 5, Subchapter 4 "Radiation", Group 3, Article 4, 30307. "Fluoroscopic Installations" (Accessed 2.25.24 PC)

B. Search Results | CDC "Radiation in Healthcare: Fluoroscopy" (Accessed 2.25.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 12/2022, 12/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 6/2024
Medical Executive Committee: 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17982359**

Origination	04/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Occupational Exposure Limits to Radiation

POLICY STATEMENT:

To describe the occupational exposure limits to radiation set by regulatory guidelines, the ALARA ("As Low As Reasonably Achievable") principle, and CCRMC Radiation Safety Committee.

GUIDELINES:

A. International Commission on Radiological Protection (ICRP) Occupational dose limits:

1. Occupational dose limits have been established based on the recommendations of the ICRP. The dose limits recommended by the ICRP are used worldwide to ensure safety and radiation protection of radiation workers and the general public. Federal and State regulations follow the dose limits recommended by the ICRP.
2. The following table shows the annual maximum permissible occupational doses allowed by 10 Code of Federal Regulations (CFR) Part 20 and adopted by Title 17, California Code of Regulations (CCR):

Organ, Tissue	Occupational Dose mRem/year
Whole body	5000
Lens of the eye	15000
Shallow dose (skin and extremities)	50000

B. ALARA Program:

1. The ALARA program, monitored and maintained by the Radiation Safety Committee, strives to ensure that occupational radiation exposures are kept "As Low As Reasonably Achievable." This program has established investigation/notification

levels for exposures below those of limits set by State and Federal regulatory agencies in order to minimize risk.

2. The following table shows the annual occupational dose limits set by Medical Imaging in accordance with the ALARA principle.

Organ, Tissue	Occupational Dose mRem/year
Whole Body	125
Lens of the eye	375
Shallow dose (skin and extremities)	1250

3. The Radiation Committee has established two investigation/notification levels for quarterly exposures that exceed the limits set by the ALARA program.
4. In the event an employee or physician exceeds any of the dose limits set by the Radiation Safety Committee, the individual will receive a letter from the RSO providing details of the exposure, and further action will take place depending on the level of exposure.
5. The investigational levels that have been adopted are listed in Table 1 below:
Table 1: Investigational Levels [(millirem (mR) per quarter)]

Organs	Level I (mR)	Level II (mR)
Whole Body Deep (total effective dose equivalent)	125	375
Lens of Eye	375	1125
Whole Body Shallow	1250	3750
Extremity	1250	3750

Note: Investigational level 1 and II are $1/10^{th}$ and $3/10^{th}$ of applicable regulatory limits.

6. Quarterly doses that are less than Investigational Level 1 as described in Table I require no further action., except when deemed appropriate by the Radiation Safety Officer
7. Quarterly doses equal to or greater than Level 1, but less than Level II as described in Table I:
    a. The Radiation Safety Officer will send a notification letter to each individual whose quarterly dose equals or exceeds Investigational Level I but is less than Level II.
    b. For employees, a notification letter will also be sent to the department manager/director for further follow-up.
        i. The department manager/director will investigate in a timely manner the causes of all personnel doses equaling or exceeding Level I but less than Level II and, if warranted, will initiate corrective action.
        ii. The department manager will report back to the Radiation Safety Officer with the results of their investigation.

c. The RSO will keep documentation of the report sent by the department manager/director.

d. The Radiation Safety Officer will report, at the next Radiation Safety Committee meeting, the individuals who exceeded the quarterly doses equal to or greater than Level I but less than Level II.

i. The Radiation Safety Committee minutes will contain the names and quarterly doses of the individuals mentioned at the meeting.

8. Quarterly doses equal to or greater than Level II:

a. The Radiation Safety Officer or designee will send a notification letter to each individual whose quarterly dose equals or exceeds Investigational Level II.

b. The Radiation Safety Officer, and, if applicable, the department manager/ director will investigate in a timely manner the causes of all personnel doses equaling or exceeding Level II and, if warranted, will take action.

c. A report of the investigation and any action taken will be presented to the Radiation Safety Committee at its first meeting following completion of the investigation.

i. The committee minutes will contain the names and quarterly doses of the individuals discussed as well as any details regarding the investigation or any actions that were taken.

~~RELATED LINKS:~~

RELATED LINKS:

The RSO will send a "Radiation Exposure Notification" (Attachment A) to all individuals who exceed the quarterly dose limits set by the Radiation Safety Committee.

~~Attachment A~~Attachment A: Radiation Exposure Notification

REFERENCES:

A. CA Code of Regulations, Title 17, Division 1, Chapter 5, Subchapter 4 "Radiation", Group 3 Article 1, section 30253. (Accessed 2.27.24 PC)

B. Code of Federal Regulations (CFR) Title 10, Part 20, sections: 20.1101 "Radiation protection programs", 20.1202 "Compliance with requirements for summation of external and internal doses", and 20.1502 "Conditions requiring individual monitoring of external and internal occupational dose". Edition 1.1.2021. (Accessed 1.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 6/2024
Medical Executive Committee: 6/17/2024
Joint Conference Committee: 11/14/2024

Attachments

A: Radiation Exposure Notification

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Exposure to Pregnant Patients

POLICY STATEMENT:

To ensure optimal environment for fetal growth and protection. No fetus will be exposed to unnecessary radiation.

GUIDELINES:

A. Pregnancy signs are posted throughout the department to notify personnel if a patient is pregnant.

B. All female patients in childbearing years will be asked regarding the possibility of pregnancy prior to beginning the examination.

C. Patients who indicate they are pregnant may not have a radiologic examination until a Radiologist or attending physician has been consulted.

D. If the Radiologist or attending physician deems the exam to be necessary, the patient must have the following:

1. Consent on the DI request for the "exam during pregnancy" signed.
2. Abdomen double shielded.
3. Only a limited view taken unless otherwise instructed by Radiologist.

REFERENCES:

https://www.cdc.gov/nceh/radiation/emergencies/prenatalphysician.htm (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/17/2024
Joint Conference Committee: 11/14/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Origination	05/2001
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Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Safety Committee

POLICY STATEMENT:

Policy ensures that all individuals who work with or in the vicinity of radioactive material or radiation-producing machines have sufficient training and experience to enable them to perform their duties in accordance with California State regulations and the conditions of the Radioactive Materials license.

GUIDELINES:

To ensure that all radioactive materials and radiation-producing machines are used in accordance with State regulations.

A. A Radiation Safety Committee will be established.

B. The committee will meet on a quarterly basis and minutes of these meetings shall be maintained.

C. Radiation Safety Committee should be composed of representatives of all departments in which personnel directly or indirectly work with radiation.

D. The regulations require that a licensee authorized for two or more different types of use of radioactive material (i.e., material for Imaging Studies and Therapeutic Procedures) shall establish a Radiation Safety Committee to oversee all uses of permitted radioactive material (10CFR35.24{f}).

E. The committee will include an authorized user of each type of use permitted by the license, the Radiation Safety Officer, a representative of the technical staff, and a representative of management who is neither an authorized user nor a Radiation Safety Officer.

F. The committee may include other members whom the licensee considers appropriate.

G. The Radiation Safety Committee responsibilities will include:

1. Reviewing annually procedures for uses, storage, disposal and transport of radioisotopes; and address all other relevant areas.
2. Ensuring that all individuals who work with or in the vicinity of radioactive material or radiation machines have sufficient training and experience to enable them to perform their duties safely and in accordance with California State regulations and the conditions of the radioactive materials license.
3. Ensuring that all uses of radioactive material and of radiation machines are conducted in a safe manner and in accordance with California State regulations and the conditions of the radioactive materials license.
4. The Radiation Safety Committee shall assist the Radiation Safety Officer in implementing the radiation protection program and any remedial action to correct deficiencies identified in the program.
5. Maintaining written records of all committee meetings, action and recommendations, and decisions.
6. Ensure that the radioactive material license is amended when necessary, prior to any changes in facilities, equipment, policies, procedures and personnel.

REFERENCES:

A. California Code of Regulations, Title 17, Subchapter 4. "Radiation" (Accessed 2.24.24 PC)

B. Code of Federal Regulations, Title 10, Chapter 1, Part 35, Subpart B, 35.24. "Authority and responsibilities for the radiation protection program." eCFR :: 10 CFR 35.24 -- Authority and responsibilities for the radiation protection program. (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/2024
Joint Conference Committee: 11/14/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Last Revised	04/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Safety Program

POLICY STATEMENT:

To provide guidelines for Diagnostic Imaging personnel and Public Health Dental Personnel using the Airbex Nomad devices for general radiation safety with reference to the specific policies in the radiation safety manual. The operator of radiation-producing equipment must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology Regulations (Title 17).

GUIDELINES:

A. Licentiate of the Healing Arts is defined as Physicians and Surgeons licensed by the Medical Board of California, Osteopathic Physicians and Surgeons licensed by the Osteopathic Medical Board of California, Podiatrists licensed by the Board of Podiatric Medicine, or Chiropractors licensed by the California Board of Chiropractic Examiners.

B. Per regulations (CCR, Title 17, Section 30400) define fluoroscopy as "a radiological examination utilizing fluorescence for the observation of the transient image."

C. No occupationally exposed employee shall be used to hold X-ray patients or Image Cassettes except in an emergency; and no person shall be regularly used to hold patients (section 30308c1).

D. Careful collimation shall be used to restrict the X-ray beam to the size of the Image Cassette, or smaller (section 30308c3).

E. The operator must make use of the appropriate operator protection devices provided: lead apron, lead shield, etc. (section 30307 & 30308).

F. Personnel monitoring devices must be worn when they are required. The monitoring device

must be worn on the collar outside of the apron when a lead apron is worn (section 30276 & 30309).

G. The operator is responsible for clearing the X-ray room of non-essential persons prior to generating X-rays (section 30308c2).

H. X-ray Procedures: (Sections 30307, 30308, 30309)

1. Protective aprons shall be worn in the fluoroscopic room by the operating staff.
2. The operator of a mobile X-ray unit shall stand at least six feet from the patient and well away from the useful beam. The operator should wear a protective apron.
3. No radiologic technologist may operate a fluoroscope unless they have a fluoroscopy certificate and are in the presence of a certified Supervisor (physician).
4. Dental technicians using the handheld Airbex Nomad device have a protective shield that protects the operator from radiation.

I. Gonadal shielding of not less than 0.5 mm lead equivalent shall be used for patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the direct beam, except for cases in which this would interfere with the diagnostic procedures.

REFERENCES:

California Code of Regulations, Title 17, Subchapter 4. "Radiation" and Subchapter 4.5 "Radiation Technology" (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, ***4/2024, 4/2025***
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022
Joint Conference Committee: 11/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Origination	05/1999
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Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval
Owner	Grace Ma: Nursing Program Manager
Area	Hospital & Health Centers

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 ~~or~~and fetus ~~28 weeks or older~~) 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:

Death Procedure (MR 211)
Checklist for Determination and Declaration of Brain Death (MR 209)
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 Policy #503, 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 [SP]	07/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025
	Grace Ma: Nursing Program Manager	06/2025

Standards

No standards are associated with this document

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Next Review	3 years after approval
Owner	Leah Carlon: Health Care Risk Manager
Area	Hospital & Health Centers

Policy for Patients' Rights

POLICY STATEMENT:

Contra Costa Regional Medical Center and Health Centers is committed to service excellence in providing high quality, service and respect and responsiveness to all. Patients are entitled to considerate and respectful care regardless of race, religion, education, sex, sexual orientation, gender identity, cultural background or financial status in accordance to State and Federal Regulations. The same rights equally apply to the person who has legal responsibility to make medical care decisions on behalf of the patient. Patients or their legal representative have the responsibility to comply with set expectations that are outlined for both inpatient and outpatient services.

GUIDELINES:

A. The rights of patients and their legal representatives include but are not limited to the right to (See Attachment A):

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your personal values and beliefs.
2. Has a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the licensed health care practitioner who has primary responsibility for coordinating your care and the names and professional relationship of other physicians and non-physicians who will see you.
4. Receive information about your health status, course of treatment, prospect for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to participate in the development and implementation

of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedures as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure of treatment. (Policy No. 619 "Patient Self-Determination Act")
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extended permitted by law.
7. Be advised if the hospital/licensed health care practitioner proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decision. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from sever chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Practitioners who provide care, whether in the hospital setting or in our clinics, shall comply with these directives. All patient's rights apply to the person who has legal responsibility to made decisions regarding medical care on your behalf.
11. 1Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care in the hospital or health centers. You will receive a separate ~~(Notice of Privacy Practices)~~Notice of Privacy Practices that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital or health center rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    a. No visitors allowed.
    b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    c. You have told the health facility staff that you no longer want a particular person to visit.
    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform your (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. (Policy No. 603 "Partners in Care Welcoming Policy")
19. Have your wishes considered, if you lack decision-making capacity, for the purpose of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's or health center's bill regardless of the sources of payment.
21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status ore the source of payment for care.
22. File a grievance. If you want to file a grievance with the hospital or health center, you may do so by writing or calling:
    a. Patient Relations Department, 2500 Alhambra Ave., Martinez, CA. 94553 (925) 370-5144. (Policy No. 616)
    b. Contra Costa Health Plan members should contact the Contra Costa Health Plan at 1-877-661-6230.
    c. If the response to your complaint is unsatisfactory, you have the right to

file a grievance with the Grievance Committee. Each grievance will be reviewed and responded to within 30 days. The written response will contain the name of the person to contact at the facility, the steps taken to investigate the grievance, the results of the grievance process and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the Utilization Review Department.

23. File a complaint with the California Department of Public Health (CDPH) regardless of whether you use the hospital and health center's greivance process:
    a. California Department of Public Heealth (CDPH), 850 Marina Bay Parkway, Bldg P, 1st Floor, Richmond, CA 94804-6403 (510) 620-3900.
24. File a complaint with the Department of Fair Employment and Housing at www.dfeh.ca.gov, (800) 884-1684 or (800) 700-2320 (TTY) or 2218 Kausen Dr., #100, Elk Grove, CA 95758.
25. File a complaint with the Medical Board of California at www.mbs.ca.gov/consumers/complaints, (800) 633-2322 or 2005 Evergreen ST., #1200, Sacramento, CA 95815.

B. ~~Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:~~
    1. ~~No visitors allowed.~~
    2. ~~The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.~~
    3. ~~You have told the health facility staff that you no longer want a particular person to visit.~~
    4. ~~However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform your (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. (Policy No. 603 "Partners in Care Welcoming Policy")~~
    5. ~~Have your wishes considered, if you lack decision-making capacity, for the purpose of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.~~
    6. ~~Examine and receive an explanation of the hospital's or health center's bill regardless of the sources of payment.~~
    7. ~~Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status ore the source of payment for care.~~

C. ~~File a complaint:~~

1. ~~If you want to file a complaint with the hospital or health center, you may do so by writing or calling. Patient Relations Department, 2500 Alhambra Ave., Martinez, CA. 94553 (925) 370-5144. (Policy No. 616)~~
2. ~~Contra Costa Health Plan members should contact the Contra Costa Health Plan at 1-877-661-6230.~~
3. ~~If the response to your complaint is unsatisfactory, you have the right to file a grievance with the Grievance Committee. Each grievance will be reviewed and responded to within 30 days. The written response will contain the name of the person to contact at the facility, the steps taken to investigate the grievance, the results of the grievance process and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the Utilization Review Department.~~
4. ~~File a complaint with the Department of Public Health Center for Healthcare Quality Licensing and Certification Program – Santa Rosa / Redwood Coast District Office, 2170 Northpoint Parkway, Santa Rosa, CA 95407. Phone 707-576-6775 and Fax 707-576-2418~~

D. Service Provided Are Not Free:

1. If you do not have health insurance or program coverage for you or your family, you may be eligible for Medi-Cal, Healthy Families, California Children's Services, Basic Health Care, the Health Coverage Initiative, or other health coverage programs.
2. If you are not eligible for any health coverage program, or if you are liable for high medical costs after your insurance pays, you may be eligible for a discount on your medical bill by the CCHS Policy 707-C Discount Payment Program or the CCHS Policy 708-C Charity Care Program.
3. Contact the Financial Counseling Department at 1-800-771-4270 for further information and application assistance. Financial Counselors are available Monday-Friday from 7 A.M. to 6 P.M. California Health and Safety Code 127410.

E. Our mission is to provide safe and effective health care to those in need. To better serve you, we ask that you:

1. Be considerate of other patients, staff and visitors.
2. Provide an accurate and complete description of past medical history, illnesses, medications, hospitalizations, and present condition.
3. Cooperate with physicians and ~~other~~others caring for you.

F. Notification of Patients' Rights

1. The Registration Department will offer the Patients' Rights and Notice of Privacy Practices to the patient or patient's designee when a Consent to Services and Conditions of Services and of Admission form is required during the registration process or upon request. The response will be documented on the Consent to Services and Conditions of Services and on Admission form, and scanned in the patient's Electronic Health Record.

2. A summary of the Patients' Rights is available in the Patient Handbook which is included with admission information.
3. Patients' Rights posters are prominently displayed on hospital units, health centers, Admissions Office and Emergency Department waiting ~~arears~~areas.

RELATED LINKS:

Consent to Services and Conditions (English)
Consent to Service and Conditions (Spanish)
Notice of Privacy Practices/HIPAA (English)
Notice of Privacy Practices/HIPAA (Spanish)

REFERENCES:

A. California Health and Safety Code, Title 22, Section 70707
B. CMS Quality Standards: Hospital Conditions of Participation for Patient Rights, Code A0038
C. CCRMC & HCs Policies and Procedures: "Patient Grievance/Complaint"

APPROVALS:

Clinical Practice Committee: 10/2019
Patient Care Policy & Evaluation Committee: 8/2017, 11/2019
Medical Executive Committee: 9/2017, 6/2018, 12/2019

Attachments

Patients' Rights English

Patients' Rights Spanish

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17531433**

Origination	07/1997	Owner	Adalberto Garibay: Deputy Sheriff-40 Hour
Last Approved	N/A	Area	Hospital & Health Centers
Effective	Upon Approval		
Last Revised	03/2025		
Next Review	3 years after approval		

Serving Arrest Warrants on Hospitalized Patients

POLICY STATEMENT:

To provide guidance ~~to~~ regarding arrest warrants for hospitalized patients. The responsibility of providers and staff is to protect patient privacy and security. No arrest warrant will be served on a patient during the hospitalization. Staff may coordinate with the Hospital Security Office – who will coordinate with the outside Law Enforcement agency – to serve an arrest warrant after discharge. This means the discharged patient would be taken into physical custody.

GUIDELINES:

A. The Hospital may disclose limited information about the presence of an individual on a particular unit in the hospital to a law enforcement agency when the purpose is to identify or locate a suspect, fugitive, material witness, or missing person.

B. Staff will not disclose any information to outside law enforcement agencies, and instead will refer any requests to verify if a particular individual is on a particular unit of the Hospital to our Hospital Security Office (HSO).

C. If the HSO determines the agent/agency is authentic and the reason is a valid arrest warrant, then the HSO will request verification (if the patient is on a particular unit on a particular day) from the Unit Charge Nurse/Lead, then disclose limited information for the purposes of identification and location of a person with a valid arrest warrant to the outside law enforcement agent/agency. The HSO will communicate back to the Charge Nurse/Lead if a disclosure was made and to which agent/agency.

D. The Charge Nurse/Team Lead will share the information about a verified/confirmed arrest warrant with the Social Worker/Mental Health Clinical Specialist, Nurse Program Manager (NPM) or Medical Center Supervisor (MCS), and with the attending physician. Information will

be communicated forward from shift to shift.

E. A patient may only be discharged by physician's order or if a patient signs out Against Medical Advice (AMA). When an estimated discharge date and time is known, the Charge Nurse/Team Lead will notify the Hospital Security Office so that the arrest warrant can be served at the time of the patient's discharge. The Hospital Security Office will coordinate so that a Hospital Security Officer can be standing by at the time of the arrest.

F. The Hospital Security Office will communicate the following guidelines for the arrest to Law Enforcement officials: They will be asked to handcuff (if necessary) and receive custody of the patient in an area outside the unit if at all possible. This will be done to minimize the embarrassment and stress of the arrest, and in an attempt to maintain the dignity of the individual.

REFERENCES:

A. California Code of Regulations, Title 22, Section 70707.

B. California Regulatory Code CFR 164.512, (f)(1) and (f)(2): "Permitted Disclosures: Limited information for identification and location purposes: A covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person."

C. The Joint Commission (TJC) 2024 Standard RI.01.01.01

APPROVALS:

Reviewed: 7/97, 1/02, 7/07, 2/15, 04/22

Revised: 02/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio	05/2025
	Adalberto Garibay	02/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18444758

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Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2025
Next Review	3 years after approval
Owner	Kathy Ferris: Infection Prevention & Control Manager
Area	Infection Control

Policy for Assistance Animals at Contra Costa Regional Medical Center and Health Centers

POLICY STATEMENT:

Contra Costa Regional Medical Center and Health Centers comply with the requirements of the Americans With Disabilities Act (ADA) and all applicable California State laws.

~~Service~~Assistance animals (as defined by California law) will be permitted into any area of the hospital or health center that is unrestricted to patients or visitors provided that the ~~service~~ animal does not pose a threat~~,~~ and the presence of the animal does not require a fundamental alteration in the policies, practices or procedures in that area. Certain animals will be prohibited if they are not allowed to be owned in California or they carry pathogens that may cause harm to others.

GUIDELINES:

A. ~~The Americans with Disabilities Act defines a service animal as dogs that are individually trained to do work or perform tasks for people with disabilities. The work or task must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.~~

B. While the Americans with Disabilities Act defines a service animal as dogs or miniature horses that are individually trained to do work or perform tasks for people with disabilities. California has adopted laws that refer to “Assistance Animals”. An assistance animal is divided into two categories: Service Animals and Support Animals.

1. Service Animals are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified but may be trained by the individual

with a disability or another individual.

2. Support Animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified. Support animals may also be known as comfort or emotional support animals. No breed, size, or weight limitations may be applied to an Assistance Animal. An individual may have more than one Assistance Animal

C. The work or task must be directly related to the person's disability.

D. ~~A service~~An assistance animal will be permitted into any area of the hospital or health center that is open to inpatients, outpatients, or visitors provided that the service animal does not pose a threat or that the presence of the animal would not require a fundamental alteration in the policies, practices, or procedures of that area. ~~Service~~Assistance animals are not allowed in the following locations~~.~~:

1. Areas where equipment/supplies are cleaned or stored.
2. Areas where medications are prepared or stored
3. Areas where food is prepared or stored
4. Areas where invasive procedures are performed. (e.g. OR, GI, L&D, Health Center Procedure Rooms, Post Anesthesia Care Unit, Psychiatric Emergency Services, Inpatient Psychiatric Unit, Diagnostic Imaging -certain procedures, Nursery and Infusion Clinic)

~~Any animal entering CCRMC or Health Centers must be always on a leash and under control of the owner. Service animals are expected to be clean, healthy, and controlled by their owner. The animal is expected to have evidence of a rabies immunization and/or license as required by county law.~~

E. Any assistance animal entering CCRMC or Health Centers must be always on a leash or in an enclosure. Certain assistance animals may need to be off leash in order to perform their task. However, they must be under the control of the handler at all times. For a list of animals not allowed in county facilities please see attachment IC 239C.

F. If a patient with ~~a service~~an assistance animal is to be admitted, notify the Medical Center Supervisor at the time of bed request so that appropriate bed assignment can be made~~.~~

G. The patient is responsible for feeding and toileting of their ~~service~~assistance animal. If the patient is not able to provide this care, ~~they~~he/she may bring a family member or friend who will be responsible for these activities while the patient is hospitalized or receiving care at CCRMC or Health Centers. CCRMC employees will not be assigned responsibility for caring for ~~service~~assistance animals.

H. If there is no family member or friend who can assist the patient and the patient consents; Animal Control may be contacted, they have agreed to board the animal until patient is able to pick up the animal or a friend/family member can pick up the animal. The phone number for animal control is 925 646-2441 (an officer is available 24/7 to respond and pick up the animal.

I. Patients will be provided with a handout outlining the policy at CCRMC and Health Centers

RELATED LINKS:

Procedure for the Management of Service Animals at Contra Costa Regional Medical Center and Health Centers

~~IC 238A Guidelines for Patients with Service Animals~~Guidelines for Patients with Service Animals

Animals Not Permitted in County Facilities

REFERENCES:

A. Americans with Disabilities Act, Service Animals, Last updated 2/28/2020

B. ~~Price Esq, Sarah "Legal Briefings Service Animals under the ADA" November 2010 California Health and Safety Code Section 30850~~California Code of Regulations, Title 2 Div 4.1 Chapter 5 Civil Rights Council Subchapter 9 Nondiscrimination in State-supported Programs and Activities.

C. Murthy et al, ~~"~~"Animals in Healthcare Facilities: Recommendations to Minimize Potential Risks~~"~~ ~~**Infection Control and Hospital Epidemiology**~~" Infection Control and Hospital Epidemiology, May 2015 Vol. 36 No. 5

APPROVALS:

Infection Prevention & Control Committee: 7/22, 5/25
Patient Care Policy & Evaluation Committee: 8/22
Medical Executive Committee: 9/22

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
Infection Prevention & Control Committee	Kathy Ferris: Infection Prevention & Control Manager	06/2025
	Kathy Ferris: Infection Prevention & Control Manager	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17788266**

Origination	10/2016	Owner	Kathy Ferris: Infection Prevention & Control Manager
Last Approved	N/A	Area	Infection Control
Effective	Upon Approval		
Last Revised	03/2025		
Next Review	3 years after approval		

Management of Reusable Instruments Prior to Return to the Sterile Processing Department

POLICY STATEMENT:

At Contra Costa Regional Medical Center and Health Centers, re-usable instruments will be wiped down or rinsed to remove all visible soil, placed in a covered rigid container with a bio-hazard symbol and transported to the Soiled Utility Room. Once in the Soiled Utility Room, the instruments will be kept moist by using a sterile transport gel while awaiting pick-up by Sterile Processing Technician.

In the Operating Room, during the operation, instruments will be managed according to accepted operating room practice. At the end of the procedure, instruments will be kept moist for return to the Sterile Processing Department for cleaning, disinfection and sterilization.

Appropriate Personal Protective Equipment (PPE) will be worn by personnel when using transport gel, cleansers and disinfectants.

GUIDELINES:

Ambulatory Care

A. After procedure, gel hands and don gloves
B. Discard any disposable supplies into appropriate ~~trash~~ container.
    1. Gauze or gloves into appropriate ~~Sharps should be discarded into sharps disposal box~~container.
    2. Sharps should be discarded into sharps disposal box.
    3. Any vials or ampules containing medication should be discarded in appropriate

container.

C. Place the instruments in the transport rigid container marked with the Biohazard symbol ~~and~~for transport ~~them~~ to the soiled utility room. ~~Remove and discard gloves and perform hand hygiene.~~

D. Remove and discard gloves and perform hand hygiene.

E. ~~Perform~~After hand hygiene has been performed, don gloves and wipe down the countertop/ mayo stand and transport container with Super Sani-wipe (Purple Top), or if unavailable, the AF3 wipe (Gray top) is also acceptable~~)~~.

F. Doff gloves, perform hand hygiene, and transport container to soiled utility room.

G. Once in the soiled utility room, ~~Don~~don PPE (gown, mask, eye protection and gloves) prior to cleaning and spraying instruments with Pre Klenz.

H. Rinse and wipe the instruments to remove any obvious debris.

I. Open hinged instruments and place the opened instrument(s) into the large bio-hazard container.

J. Be sure to cover the instrument completely. The spray will initially appear foam-like and will then become a clear gel.

K. Replace cover on the biohazard tray. Remove PPE and perform hand hygiene .

L. If there are additional instruments ~~being placed into~~that require transport, wipe down the transport container ~~at a later~~before leaving the Soiled Utility room, and repeat steps A through H each time~~; repeat step #1 through #6 each time~~ instruments ~~are placed in the container~~need to be added.

M. The soiled utility room container will be picked up on a regular basis by Sterile Processing Department technician.

N. The transport container may be rinsed, wiped dry and ~~the wipe~~then wiped with either the Super Sani Wipe (Purple top) or the AF3 wipe (gray top). Observe recommended ~~contact~~dwell time before it is re-used.

Special Procedures Room

A. After the procedure, gel hands and don gloves and discard disposable supplies into appropriate trash container.

1. Sharps should be discarded into sharps disposal box
2. Any vials or ampules containing medication into appropriate container
3. Discard disposable instruments in appropriate container
4. Dispose of any residual liquids in cups.

B. At the end of the procedure, re-usable instruments will be placed in a covered rigid container with Biohazard label on the lid and kept moist using either of the two methods listed below.

1. Open hinged instruments and a blue towel moistened with sterile water may be placed over the instruments before they are transported to the decontamination room in the Sterile Processing Department (SPD).

2. Open hinged instruments and spray with Pre-Klenz.
3. Contact SPD to pick-up the instruments.

C. If instrument pick-up may be delayed, it may be useful to use the Pre-Klenz spray to keep instruments moist for an extended period of time.

Hospital Nursing Units and ED

A. After procedure, gel hands and don gloves, and wipe down the countertop/mayo stand with Super Sani-wipe (Purple Top) -if unavailable, the AF3 wipe (Gray top) is also acceptable).
B. Place the instruments in the transport rigid container marked with the Biohazard symbol and transport them to the soiled utility room.
C. Once in the soiled utility room Don PPE (gown,mask,eye protection and gloves)
    1. Remove gross soil by wiping with paper towel or gauze moistened with water.
    2. Vaginal Speculums should be rinsed and disassembled.
    3. Open all hinged instruments
D. If the instrument(s) is sharp or pointed, or heavily soiled, place container in sink and rinse thoroughly with water, making sure all instruments are open.
E. Place the opened instrument into the bio-hazard container.
F. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.
G. Replace cover on the rigid biohazard container. Remove PPE and gloves, gel hands.
H. If additional instruments are being placed into container at a later time, repeat step #1 through #7 each time instruments are placed in the container
I. Container will be picked up on a regular basis by Sterile Processing Department technician.
J. The transport container may be rinsed, wiped dry and the wipe with either the Super Sani Wipe (Purple top) or the AF3 wipe (gray top). Observe recommended contact time before it is re-used.

Perinatal Labor and Delivery

A. At the end of the delivery,. place the instruments in the transport rigid container marked with the Biohazard symbol and transport them to the soiled utility room.
B. Place the container in the sink and don appropriate PPE (gown, gloves and mask with eye protection).
C. Remove the instruments, ensure that the instrument is open and rinse under running water. After rinsing, place the instrument into the rigid biohazard container.
D. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.
E. Repeat steps above each time instruments are added to the Biohazard container.

F. Should the container become full prior to regular rounds by the SPD staff, call x5360 to arrange to have the instruments picked up.

Operating Room/Procedure Room

A. During the operation/procedure, instruments will be managed according to accepted OR practice.

B. At the end of the case, instruments will be placed in the appropriate tray with lid for transport to sterile processing. A blue towel moistened with sterile water will be placed over the instruments before they are transported to the decontamination room in the Sterile Processing Department (SPD).

C. If instrument pick-up may be delayed, it may be useful to use the Pre-Klenz spray to keep instruments moist for an extended period of time.

RELATED LINKS:

IC 246A Steris Label
IC 246B Pre-Klenz Safety Data Sheet
IC 249 Procedure for the Management of Dental Instruments Prior to Return to Sterile Processing

REFERENCES:

A. Association for the Advancement of Medical Instrumentation (AAMI) ST79 A1, A2, A3 and A4, 2013

B. CalOSHA Bloodborne Pathogen Standard (8CCR 5193)

C. Steris, "Pre-Klenz" Instructions for Use

APPROVALS:

Infection Prevention & Control Committee: 11/16, 9/22, 12/24
Patient Care Policy & Evaluation Committee: 10/22, 1/25
Medical Ethics Committee: 10/22

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [TT]	05/2025

Infection Prevention & Control Committee	Kathy Ferris	04/2025
	Kathy Ferris	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18277899**

Origination	06/2004
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval

Owner	Ira-Beda Sabio: Director, Inpatient Nursing OP
Area	Nursing

Policy for Wound Dressing Changes/Packing

POLICY STATEMENT:

To provide guidelines for dressing or packing wound appropriately and to prevent contamination and cross-infection during dressing changes.

Dressing changes will be performed using standard precautions and as ordered by the practitioner in ccLink.

Do not remove surgical dressings without provider's orders.

GUIDELINES:

A. Identify patient using at least two patient identifiers.
B. Determine need for pain medication before beginning procedure.
C. Perform hand hygiene; prepare supplies; don clean gloves.
D. Remove soiled dressings and dispose of dressing and packing.
    1. Moisten dressing if adherent to wound.
E. Examine dressings for wound drainage: amount, color consistency, and presence of odor
F. Dispose of dressing and packing in biohazard bin.
G. Remove and discard gloves.
H. Perform hand hygiene and don clean gloves.
I. Assess wound site.
    1. Identify location of wound.

2. ~~Observe wound bed appearance.~~Assess wound bed, margins and periwound skin condition.
3. Check wound size, shape, depth~~, margins~~.
4. Observe exudates or drainage.
5. Evaluate presence of pain.

J. Remove soiled gloves, and discard.

K. ~~Don~~Perform hand hygiene and don clean gloves.

L. Clean wound with saline solution (use if wound culture ordered), sterile water or wound cleanser, per order. Pat wound with 4x4 gauze.

M. Obtain wound culture (if ordered) after cleansing wound with sterile saline. Do not take specimen from exudate or eschar.

N. If tunneling present, loosely pack tunneling area of wound if present before filling the base of the wound.
    1. Place packing material in wound: using a sterile gloved hand or a clean gloved hand with either sterile forceps or sterile cotton tipped applicator, gently guide enough packing material into the wound cavity, undermining, sinus or tunnel to fill the dead tissue without causing the wound tissue to stretch or bulge.

O. Use only one piece or length of packing wherever possible. Leave "tail" end visible.

P. Fill rest of wound with dressing as ordered. Then cover with a dry dressing.

Q. Remove and dispose gloves; dispose soiled instruments. Perform hand hygiene.

RELATED LINKS:

Patient Care Record in ccLink
Wound documentation tab in ccLink

REFERENCES:

TJC Standard PC.01.02.05, "Qualified staff or licensed independent practitioners assess and reassess the patient."

~~Iwamoto, P., Post, M., & Oregon Patient Safety Commission (2014, October 2). Aseptic Technique. In *Basic Principles of Infection Prevention Practice*. Retrieved 9 20 2022, from http://text.apic.org/toc/basic-principles-of-infection-prevention-practice/asepticteчnique#book_section_584~~

Perry,A., Potter, P. & Ostendorf,W., and Laplante, N. (~~2018~~2022). Clinical nursing skills & techniques ~~pp.1016-1017~~ (10th ed). Elsevier.

Wound Ostomy and Continence Nurses Wound Committee and the Association for Professionals in Infection Control and Epidemiology, Inc. 2000 Guidelines Committee. (2011). *Clean vs. Sterile Dressing Techniques for Management of Chronic Wounds: A Fact Sheet.* Wound, Ostomy and Continence Nurses

Society.

APPROVALS:

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

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	07/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025
	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025

Standards

No standards are associated with this document

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Origination	09/2012	Owner	Cita Richeson: Nursing Program Manager
Last Approved	N/A	Area	Perinatal
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Policy for Critical Congenital Heart Disease Screening

POLICY STATEMENT:

~~Pulse ox~~Critical Congenital Heart Disease (CCHD) screening will be performed ~~before discharge from the Nursery~~on infants after they turn 24 hours of age, ~~after~~and are not supported by oxygen. If the infant ~~turns 24 hours of age. If the infant~~ was born prematurely, the screening will be performed when medically appropriate. ~~Pulse~~The use of pulse oximetry, or "pulse ox," for screening is a simple, non-invasive, and painless test that is used to measure CHD and the percent oxygen saturation of hemoglobin in the arterial blood and the pulse rate.

The pulse ox test will be performed on the right hand (pre-ductal) and one foot (post-ductal). The majority of lesions are "duct" dependent and are best diagnosed prior to when the duct closes with the goal of preventing a life-threatening emergency situation.

GUIDELINES:

A. Pulse oximetry screening is done after 24 hours of age, or when medically indicated, on the right hand and on one foot. ~~The measurements should be taken in parallel or one after the other.~~
    1. ~~If the infant was born prematurely, perform screening when medically appropriate.~~
    2. If early discharge is planned, screening should ~~occur~~be done as late as possible.

B. ~~Conduct screening in quiet area with parent present to soothe and comfort the infant.~~

C. ~~If possible, conduct screening while the infant is awake, quiet, and calm.~~

D. ~~Do not attempt to perform pulse oximetry on an infant while he or she is sleeping, crying or cold as oxygen saturations may be affected.~~

E. The measurements should be taken concurrently or one after the other.

F. If the oxygen saturation is ~~>~~≥ 95% in ~~either extremity~~BOTH sites, AND with a ~~<~~≤ 3% saturation difference ~~between the two,~~ the infant will "pass" the screening test.
No additional evaluation will be required unless signs or symptoms of ~~CHD~~CCHD are present.

G. If the pulse oximetry reading is < 90% in either the hand or foot, the infant should be immediately referred to the physician for additional evaluation.

H. If the oxygen saturations are <95% in ~~both the hand and foot~~either extremity, or there is a > 3% saturation difference between the two ~~on three different measurements each separated by~~, the infant will be retested after one hour~~, the newborn will be referred for additional evaluation~~.

1. If retest does not meet threshold, the infant may be referred for additional evaluation.
2. The infant's physician or nurse practitioner will be notified.
3. If cause of hypoxemia is not clear the pediatrician may consider ordering an echocardiogram and cardiology consultation.

I. Recommendations for ~~Follow~~follow-~~Up~~up are made by our pediatricians following guidelines from our consultants ~~and~~, communication of results, and plan of care with infant's parents.

RELATED LINKS:

Procedure for Critical Congenital Heart Disease Screening
~~Critical Congenital Heart Disease Screening Form~~Addendum A: CCHD Screening Algorithm
Addendum B: Referral Letter to Parents
Addendum C: Refusal Letter

REFERENCES:

~~A. Newborn screening for critical congenital heart defect (CCHD). American Academy of Pediatrics. (2023, July 3). https://www.aap.org/en/patient-care/congenital-heart-defects/newborn-screening-for-critical-congenital-heart-defect-cchd/~~

~~B. The Joint Commission Standard (2024) PC.01.02.01, "The hospital assesses and reassesses its patients.~~

~~APPROVALS:~~

Newborn Screening for Critical Congenital Heart Disease: A New Algorithm and Other Updated Recommendations: Clinical Report | Pediatrics | American Academy of Pediatrics (2025)

A. APPROVALS:

Pediatric Department: 11/12, 04/2025
Clinical Practice Committee: 1/2013
Patient Care Policy and Evaluation Committee: 2/2013, 6/2024
Medical Executive Committee

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2025
	Cita Richeson: Nursing Program Manager	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18381473**

Origination	09/2003	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Contact List for Disaster Fan-Out Procedures

PURPOSE STATEMENT:

To provide a mechanism to recall off-duty staff in the event an emergency incident is declared.

PROCEDURE:

A. The Director or designee will continue the fan-out in order of proximity and availability.

B. The number of staff members called in will be at the discretion of the Director of Pharmacy Services and dependent upon the scope of the disaster.

C. Once contacted, staff is expected to report to CCRMC immediately, unless directed otherwise.

~~Inpatient~~Pharmacy Staff:

NAME	Home Phone	Cell Phone	Location
ABELLA, ROSARIO (RN)		510-410-8231	Vallejo
ALAVI, SHIRIN		760-828-2150	Walnut Creek
AL-RAWI, SHAMS		925-567-4570	Walnut Creek
ASCENCION, LISETTE		925-852-4868	Oakley
ATAII, SHIDEH		925-482-4733	Danville
BRODERICK, ETHEL (MDF)		510-375-5356	Martinez
~~CARONE, LORI~~		~~510-575-8637~~	~~Pinole~~
CHAMBERLIN, HOLLY (MDF)		925-207-0156	Martinez
CHOI, SUN		949-293-8497	Pleasant Hill

ELIA, HALA		707-631-4252	Fairfield
EMINUE, GLORY		404-604-0705	~~Vallejo~~Fairfield
EVANS, RONNICA (MDF)		925-577-3418	Pittsburg
FAKURNEJAD, ADEEBEH		925-285-4322	Berkeley
FENG, TRACY		408-368-2027	Martinez
FUNG, SHARON		415-650-8293	Hercules
LAM, ERIC		925-212-4667	Concord
LAI, SHELLY		301-979-1947	Fairfield
LIANG, KENNY		510-520-2699	Concord
LIU, JOE ~~(MDF)~~		415-963-2366	Pacifica
LOLHAM, IVET		925-360-3982	Martinez
LOPEZ, ERICA		415-640-5534	Vallejo
LUO, ANDY		925-698-5698	Pittsburg
MA, ALEX (MDF)		415-937-4718	Antioch
~~MAKEEV, FRANCHESKA~~		~~925-766-6560~~	~~Walnut Creek~~
MALANA, VANESSA		925-642-7883	Pittsburg
MANULAT, NECO (MDF)		650-660-6531	Emeryville
MIRADOR, ROMIE (MDF)		707-319-2784	Vallejo
NG, NHU (BONNIE) (MDF)		408-234-0385	~~Hayward~~Walnut Creek
NGO, PHONG		408-982-7476	Pleasant Hill
OMER, MARYAM		408-708-8585	San Jose
ORELLANA, MARJAN		510-410-6088	Kensington
OUABO, BRIGITTE		661-609-1409	Antioch
PATINO, CHRISTINE		510-677-4527	San Leandro
PAULE, JERICO		707-656-1069	Fairfield
PEREZ, BERNICE		707-315-9748	Benicia
PHAM, KHAI		714-318-8691	Walnut Creek
REYNOSO, JUAN		925-305-0992	Pittsburg
RHEE, GA (MONICA)		707-342-0968	Benicia
RHEE, JOSEPH	707-751-1570		Benicia
~~RIVERA, TROY~~		~~925-768-5868~~	~~Martinez~~
SAHAGUN, CRYSTAL		707-853-7403	Vallejo
SHAH, SONAM		562-980-6535	Concord
SINGH, AMANDEEP (MDF)		925-329-5633	Baypoint

SOTSKOVA, MARINA		925-285-9799	Concord
SPARKS, ANDREA (RN)		510-860-6426	Crockett
TRAN, KRISTIE		408-464-5805	Pleasant Hill
VORA, USHMA		925-788-4343	Clayton
WANG, AMANDA		510-225-8105	Pleasant Hill
WONG, MEILIN		408-219-9236	San Leandro
WONG, CHI HOU (ANTONIO)		650-963-6388	Walnut Creek
WOOD, DENISE		510-807-5578	Walnut Creek

Per Diem Staff:

NAME	Home Phone	Cell Phone	
DO, WILLIAM		714-325-8177	Oakland
KNAUS, ELIZABETH		503-312-2382	San Francisco
MAKEEV, FRANCHESKA		925-766-6560	Walnut Creek
NGUYEN, VICKIE		714-244-2710	~~Walnut Creek~~Lafayette
PARVATANENI, RAO (Ret.)	925-372-9737	925-293-6308	Martinez
PAUL, SUDA (Ret.)	925-376-5165	925-788-1149	Orinda
PECK, RAPHAEL (Ret.)		510-684-8023	Albany
SANCHEZ, LESLIE (NICHOLE)		707-393-1847	Antioch
TUNGOL, ANGELO		415-900-6443	Antioch
VU, HEATHER		510-501-3877	Alameda

Clerical Staff:

NAME	Home Phone	Cell Phone	
MACHA, TATIANA		925-351-5589	Brentwood
~~SEOVIA~~SEGOVIA, IRENE		408-800-8661	Oakley

RELATED LINKS:

Policy for Pharmacy Disaster Fan-Out Procedures

REFERENCES:

A. TJC Standard EM.02.01.01, EM.02.02.01, EM.02.02.07

B. CMS CoP § 482.11(a)(c), 482.12(f), 482.23(c), 482.25(a)(b), 482.41(a)(b), 482.42(a), 482.43(a)(c)(d), 482.55

C. CCRMC Disaster Plan

~~**APPROVALS:**~~

~~Patient Care Policy and Evaluation Committee: 3/2024~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18378463

Origination	04/2005
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval

Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Emergency Procurement of Drugs - Borrowing and Loaning

POLICY STATEMENT:

The Pharmacy Department will have an alternate source of drugs in the event of a shortage, or outage of a prescribed medication, or in a disaster/emergency. During pharmacy hours of operation, new drug requests, shortages, outages, or other emergency needs are to be referred to a pharmacist on duty. He/she will discuss with the provider to assess whether or not an available therapeutic/formulary alternative is appropriate. If it is determined that there are no substitutions, the pharmacist will make all attempts to obtain the item from the wholesaler, the manufacturer; or another hospital, retail pharmacy, or distributor depending upon the urgency. After hours, the Medical Center Supervisor (MCS) may make arrangements to borrow the needed medication from a local hospital or contact the pharmacist on call for assistance in obtaining the necessary items.

RELATED LINKS:

Procedure for Emergency Procurement of Drugs – Borrowing & Loaning

REFERENCES:

A. TJC MM.02.01.01
B. CMS CoP § 482.12(f), 482.23(c), 482.25(a)(c), 482.55
C. California Board of Pharmacy Law Business and Professions Code 4128.5

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18381265

Origination	09/2003
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval
Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Emergency Resources

POLICY STATEMENT:

A list of resources will be available in the event a disaster occurs and normal operational procedures/ channels are not available.

GUIDELINES:

A. IV and Chemo Compounding Aseptic Isolator(s) – CAI – and Compounding Aseptic Containment Isolator(s) – CACI:

1. Nuaire	(800) 328-3352
2. Discovery Scientific Solutions (Nuaire local support)	(844) 742-3818
3. Certification and Inspection:	
a. Biomedical Repair	ext 5472
b. AABC Testing & Certification 1430 Koll Circle Suite. 105, San Jose, CA 95112	Office: (844) 296-7198

B. Computer Systems:

1. Omnicell	
590 East Middlefield Road	(800) 474-2355

Mountain View, CA 94043	(415) 846-5698
Customer Support	(800) 910-2220
2. ccLink	
Hospital Information Systems' Help Desk	(925) 957-7272
595 Center St, Ste 210, Martinez, CA 94553	

C. Drug Wholesaler

1. Cardinal Health 3238 Dwight Road, Elk Grove, CA 95758	(916) 394-3000

D. Alarm Systems

1. Denalect 1309 Pine St, Walnut Creek, CA 94596	(925) 935-2680
2. CCC Building Maintenance	(925) 313-7052

E. Order Entry Services

1. RxeSource	(877) 244-5774
184 Technology Dr, Ste 100	(949) 635-9890
Irvine, CA 92618	(949) 433-5903
Fax: (877)-531-9081	

~~RELATED LINKS:~~

~~A. Cardinal Health Emergency Contact List~~

REFERENCES:

A. TJC Standard EC 4.10, MM 2.10

B. CCRMC Disaster Plan

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Attachments

Cardinal Health- Pharmacy Distribution Contact List.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18385825**

Origination	03/2012	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	07/2025		
Next Review	3 years after approval		

Policy for Pharmacy ccLink Downtime Plan

POLICY STATEMENT:

To provide staff with a plan of what needs to be done when the Electronic Health Record system (ccLink) is not available. Patient care services will not be impacted when the Electronic Health Record system (ccLink) is not available.

GUIDELINES:

A. The following procedures are to be followed for any of the following instances:
   1. Scheduled and unscheduled system unavailability less than 3 hours
      a. **Routine Scheduled (planned) Downtime** is defined as normal scheduled downtime to perform system processing, maintenance and backups.
      b. **Unscheduled (unplanned) Downtime** is defined as system access interrupted due to system or network problems in excess of 5-10 minutes.
   2. Individual module downtime procedures will be followed if isolated modules are not available.

B. **Downtime Notification**
   1. The IS Department will coordinate communication to all departments during downtimes.
   2. Staff will be notified by overhead page that the ccLink system is down.
   3. E-mail will be utilized for notification of any scheduled downtimes and to update areas during extended downtimes.

4. Scheduled downtimes will be communicated at least 24 hours in advance of the actual downtime.
5. All departments will be notified when the system is unavailable and also when the system is again available.
6. During business hours the IS staff will notify all departments
7. After hours the Admissions staff will assist in notification to all departments.
8. Administration will be notified of all unscheduled downtimes.
9. No one should use the system until IS or Admissions staff has contacted the department that the system is available.

C. **Department Responsibility During Computer Downtime**
All departments will do the following to prepare for scheduled downtime:

1. Prepare necessary forms/documents if there is a scheduled downtime
2. Make necessary staffing adjustments during the downtime and after the downtime to allow for time for the re-entry of data.
3. Confirm all staff working are knowledgeable about downtime procedures
4. Communicate appropriately to patients that are seen during the downtime.

D. **Pharmacy Downtime Processes:**

1. A Shadow Read Only (SRO) function will be available on all clinical computers. This will allow access to all screens and content but does not allow data entry. It will display all data up until the point of the downtime.
2. Accessing the BCA-PC will allow printing of the downtime MAR report (automatically and routinely updated in the background). This document will contain a condensed version of the patient's information (which includes allergies and BSI/BMA) and the due times of medications that the patient was on before downtime. On this paper MAR, Pharmacy will be able to view yesterday, today and tomorrow's scheduled due times. Previous administration actions as well as recording users will also appear. If medications were unverified at the time of printing, an alert will appear.
3. Also available on the BCA-PC is a patient-specific downtime medication profile. Like the downtime MAR, it is routinely and automatically updated in the background and can be used as a documentation of orders entered (within 15 minutes) up to the point of the system going down.
4. If the network is available, providers will use the order forms on iSite. If the network is not available, all orders will be hand-written on blank downtime order sheets. The following information must be included:
    a. Patient's name, age, sex, medical record number, location, and admitting diagnosis.
    b. All medication orders must include all legally required information.
5. Orders will be faxed to Pharmacy at 925-370-5345. If the fax is not functional, runners will be utilized to pick up orders.

6. Pharmacy will keep medication orders filled during the downtime. The date and time of the orders will be indicated to allow for proper sequence for entry when ccLink is once again operational.
7. The patient's allergy information, written on the downtime reports, will be entered into ccLink as soon as the computer system is available.
8. The PM shift pharmacist (on weekdays) & DC pharmacist on weekends and holidays to verify orders that were "auto-verified" (when patient is discharged i.e. from the ED etc.) using the "Rx unverified orders" report.
9. Once the order arrives in Pharmacy, labels will be generated from the downtime PC or manually typed and the dispense quantity and time of dispensing will be noted on the paper copy of the prescription/order.
10. All orders will be filed in an alphabetical file for later entry.
11. The ADC will continue to function as a stand-alone system. New patients will need to be manually added and medications will be accessed via override. (See Policy for Pharmacy Department Disaster Plan and Policy for Automated Drug Delivery Systems – Malfunction & Failure)
12. For a planned downtime, run the cart-fill lists from ccLink READ-ONLY icon on the computer desktop to manually print the list and reprint labels. (ccLink READ-ONLY icon > Pharmacy > Cart fill). Saved hard copies of the last cart-fill list will be referenced in an unplanned downtime. The cart-fill list must be reconciled against all new orders.
13. ~~All fentanyl patches will be removed from **all** Omnicells during downtime by the pharmacy department. The patches will be placed back in to Omnicells when the systems are back up by the pharmacy department.~~
14. The clinical pharmacist to check if all baseline INRs were drawn appropriately during downtime.
15. The hospitalist attending in the hospital is to double check the residents/medical staff's orders after hours (i.e. after 7:30 pm M-F and after 6:00 pm on Sat/Sun/ holidays)
16. The pharmacist will email a list of the current Omnicell content to the Medical Center Supervisor (MCS) ~~and put a hard copy in the Night Locker in the pharmacy department~~.

E. **Downtime Recovery:**

1. All orders are to be sorted by patient name and time and entered into ccLink in chronological order.
2. Pharmacy and/or providers will enter all medication orders into ccLink; backdating the time to the time the medication order was written.
3. Orders are to be entered by unit, starting with the ED, then CCU, IMCU, Med-Surg, and OB in that order. Orders are to be entered in chronological order, by patient, starting with STAT and now orders.
4. Pharmacy will run a billing summary for all patients that had medication orders

entered to ensure all doses were billed or credited appropriately.

5. All orders must be entered into ccLink retrospectively. RxeSource may be called upon to help with order entry.

~~RELATED LINKS:~~

~~A. Blank paper order sheets~~

~~B. Procedure for BCA Downtime~~

~~REFERENCES:~~REFERENCES:

A. TJC Standards EM.01.01.01, EM.02.01.01, EM.02.02.01, EM.02.02.09, IM.01.01.01, IM.01.01.03, MM.01.01.01, PC.01.03.01

B. CMS CoP § 482.12(f), 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(b)(c), 482.42(a), 482.55

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee:3/2022~~

~~Medical Executive Committee:~~

~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18381307

Origination	09/2003	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Policy for Pharmacy Disaster Fan-Out Procedures

POLICY STATEMENT:

In the event an emergency incident occurs during pharmacy off hours, the pharmacist on-call will be notified. He/she will begin the fan-out by notifying the Director of Pharmacy and the Inpatient Pharmacist II before immediately reporting to the hospital.

GUIDELINES:

In the event an emergency incident or disaster is declared during off hours, the Pharmacist on-call will be notified via telephone ~~or on-call pager~~ by the appropriate authority.

~~If the pager is used, '911' will be added to the end of the call-back number to alert the pharmacist that the Disaster Plan has been activated.~~

If there is reason to suspect that a disaster situation may exist, the pharmacist on-call should contact the hospital for confirmation and instructions.

The Pharmacist on-call will attempt to contact the Director of Pharmacy and/or Inpatient Pharmacy Supervisor before leaving home to report to the hospital. He/she will report immediately.

Shideh Ataii, Director of Pharmacy (925) ~~648-7728, or (925)~~ 482-4733~~, (Pager: 346-4401)~~

Tracy Feng, Inpatient Pharmacist II (408) 368-2027 or (925) 500-3662

The Director or designee will continue the fan-out in order of proximity and availability (see Contact List for Disaster Fan-Out Procedures).

The number of staff members called in will be at the discretion of the Director of Pharmacy Services and

dependent upon the scope of the disaster.

Once contacted, staff is expected to report to CCRMC immediately, unless directed otherwise.

RELATED LINKS:

Contact List for Disaster Fan-Out Procedures

REFERENCES:

A. TJC Standard EM.02.01.01, EM.02.02.01, EM.02.02.07
B. CMS CoP § 482.11(a)(c), 482.12(f), 482.23(c), 482.25(a)(b), 482.41(a)(b), 482.42(a), 482.43(a)(c)(d), 482.55
C. CCRMC Disaster Plan

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18113617**

Origination	02/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2025
Next Review	1 year after approval

Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for 340B Drug Discount Program

POLICY STATEMENT:

This policy provides the background, definitions, and general compliance obligations relating to the 340B drug discount program. The policy helps govern decisions regarding all 340B transactions and to ensure they are highly auditable. It is the intent of the 340B Program to permit covered entities "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." 340B is part of an overall comprehensive pharmacy services strategy to: Provide patients affordable access to medications, strategically manage financial aspects of pharmacy services, and ultimately, improve patient health.

GUIDELINES:

The 340B Program is a federal drug discount program authorized under section 340B of the Public Health Service Act and established by Congress under the Veterans Health Care Act of 1992 as part of Public Law 102-585. Section 340B requires drug manufacturers to enter into pharmaceutical pricing agreements (PPAs) with the Secretary of Health and Human Services (HHS) as a condition of Medicaid and/or the Medicare Part B program covering and paying for the manufacturer's covered outpatient drugs. The PPAs specify, among other things, that manufacturers may not sell covered outpatient drugs above 340B ceiling prices to covered entities. The program is administered by the Office of Pharmacy Affairs (OPA), a part of the federal Health Resources and Services Administration (HRSA)/Department of Health and Human Services (DHHS).

The covered entity must register with the Office of Pharmacy Affairs (OPA) in order to participate in the program. Upon registration on the OPA Information System (OPAIS) database as a participant in the 340B program, covered entities agree to abide by specific statutory requirement and prohibitions. A Covered Entity (CE) is the statutory name for a facility or program eligible to purchase discounted drugs through the 340B program. Covered entities include 6 categories of hospitals and 13 categories of non-hospitals. See Glossary of Terms for definitions and acronyms of different qualifying covered entities.

Contra Costa Regional Medical Center and Health Centers is registered in OPAIS as a Disproportionate Share

Hospital (DSH). This category of hospitals is defined under the Social Security Act (42 CFR § 412.106) and eligible to participate in the 340B drug discount program if they meet certain 340B eligibility criteria. A DSH hospital serves a disproportionately large share of low-income patients. The Medicare and Medicaid programs provide additional payments to DSH hospitals to compensate them for the higher costs attributable to treating low-income patients. The Medicare DSH adjustment is a percentage add-on to a hospital's prospective payment and is based on the share of Medicaid patients and supplemental security income (SSI) recipients that the hospital serves on an inpatient basis. For a DSH hospital to qualify for the 340B program, it must have a Medicare DSH adjustment percentage of greater than 11.75%.

Other pertinent definitions in this policy are below:

A. **Parent Site:** The main facility of the covered entity that becomes eligible to use 340B drugs by virtue of the entity's enrollment in the 340B program.

B. **Child Site:** Outpatient clinic that has a different street address than the entity's main facility. It must have a separate OPA registration.

C. **Eligible Patient:** To be eligible to receive 340B-purchased drugs, patients must receive health care services (more than just drugs) from the 340B covered entity such that:

    1. the covered entity has established a relationship with the patient and maintains records of the patient's health care: **and**
    2. the patient receives health care services from a provider who is either employed by the covered entity or provides services under a contractual or other arrangement (e.g. referral for consultation) such that the responsibility for the care remains with the covered entity: **and**
    3. the patient is an outpatient

D. **Mixed-Use Setting:** A location that serves both inpatients and outpatients (e.g., radiology, recovery room, endoscopy, etc.). Provided the location and patient qualify for 340B, the outpatient medications would be purchased at 340B pricing. The medications used on inpatients would not qualify.

E. **Covered outpatient drug**: Defined in Section 1927(k) of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title19/1927.htm), and summarized as:

    1. An FDA approved prescription drug, an over-the-counter (OTC) drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine), or FDA-approved insulin
    2. See Attachment A for exclusions and not-covered outpatient drugs (NCODs) from this definition

I. *GENERAL RESPONSIBILITIES*

A. As a participant in the 340B Program, Contra Costa Regional Medical Center and Health Centers:

    A. Meets all 340B Program eligibility requirements.

    B. Maintains electronic records (i.e., through SunRx®), that are available to demonstrate compliance.

    C. Has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

D. Elects to receive information about the 340B Program from trusted sources, including, but not limited to:
    1. The Office of Pharmacy Affairs
    2. The 340B Prime Vendor Program, managed by Apexus
    3. 340B Health

B. Covered entities are prohibited from selling, giving, or otherwise transferring covered outpatient drugs purchased under the program to anyone other than a "patient" of the covered entity as defined under HRSA guidance.

C. Covered entities are prohibited from requesting payment under Medicaid for a covered outpatient drug purchased under the 340B program if the state claims a Medicaid rebate for the same covered outpatient drug from the manufacturer. If the covered entity plans to bill Medicaid for such drugs, then the entity must provide OPA with a relevant Medicaid billing number(s) and/or National Provider Identifier(s) (NPI).

D. Covered Entities must monitor their continuing eligibility to participate in the 340B program, must inform HRSA if it is determined that the hospital or any of its child sites are no longer eligible (e.g., hospital was sold, services were discontinued), and must cease purchasing 340B drugs for the hospital or its registered outpatient sites once the hospital has concluded such locations are no longer eligible.

E. The main hospital, all off-site hospital outpatient locations that dispense or otherwise use 340B drugs, and all contract pharmacies must be registered with OPA.

F. The 340B information on the OPA website database (https://340bopais.hrsa.gov/home) is reviewed and updated as needed, but no less frequently than annually. CCRMC completes this annual review at the time of the annual recertification and notifies OPA of any changes.

G. DSH hospital enrolled in the 340B program are not allowed to purchase covered outpatient drugs through a GPO or other group purchasing arrangement.
    1. Maintains a non-GPO/wholesaler acquisition cost (WAC) account(s).
    2. Has tracking systems and safeguards in place (via split-billing software) to prevent GPO violations

H. 340B covered entities that use one or more contract pharmacies must comply with HRSA's contract pharmacy guidelines. Refer to Contra Costa Health Plan Policies on Contract Pharmacies.

I. 340B covered entities must maintain auditable records that demonstrate compliance with 340B program requirements and are accessible to government auditors, manufacturers or any other party authorized to audit the 340B program.

J. The covered entity must retain ownership of the 340B drugs purchased through the approved wholesaler. Although the 340B inventory is property of the covered entity, it must be kept separate from drugs purchased for inpatient use. Virtual separation of 340B drugs requires tracking and replenishment at the NDC 11-digit level. CCRMC is to maintain separate virtual inventory through a split billing software.
    1. In exceptional circumstances when an 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.

II. *ROLES AND RESPONSIBILITIES*

The following individuals have specific obligations to the 340B program:

A. **Chief Financial Officer:** Responsible as the Authorizing Official and principal officer in charge for the compliance and administration of the program

B. **Fiscal Manager/Director of Compliance**: Responsible as the Primary Contact and for communicating any changes in site eligibility information/status immediately to the Director of Compliance and to the Director of Pharmacy Services

   a. Site registration and accuracy and completeness of information provided to the OPA

   b. Annual site recertification with OPA for all CCRMC 340B-enrolled locations

   c. Submitting change request to the OPA in the event any site registration data is incorrect or if any changes occur

C. **Director of Pharmacy Services**: Accountable agent for 340B compliance at CCRMC and Health Centers

D. **Contra Costa Health Plan Pharmacy Manager**: Accountable agent for 340B compliance at Contract Pharmacies

E. **340B Committee**: CCRMC has established a 340B Committee that is responsible for oversight of the 340B program that meets on a regular basis

III. *ENROLLMENT RECERTIFICATION AND CHANGE REQUESTS*

A. Enrollment

   1. Authorizing Official or Primary Contact identifies upcoming registration dates and deadlines.
   2. Authorizing Official or Primary Contact has available the required documents:
      a. Medicare Cost Report:
         1. Worksheet S, S-2, S-3
         2. Worksheet E, part A
         3. For outpatient facilities:
            a. Worksheet C
            b. Worksheet A
            c. Working trial balance
      b. Certification of ownership status
   3. Authorizing Official or Primary Contact completes registration on 340B OPAIS (https://340bopais.hrsa.gov/).

B. Recertification procedure

   1. Authorizing Official or Primary Contact annually recertifies information on 340B OPAIS.
   2. Authorizing Official or Primary Contact completes the annual recertification by following

the directions in the recertification email sent from HRSA prior to the stated deadline.

3. Authorizing Official or Primary Contact submits specific recertification questions to 340b.recertification@hrsa.gov.

C. Enrollment procedure: New Outpatient Facilities

1. Authorizing Official or Primary Contact determines that a new outpatient service or facility is eligible to participate in the 340B Program.
    a. The criteria used include that the outpatient service is fully integrated into the hospital, appears as a reimbursable service or clinic on the most recently filed Cost Report, has outpatient drug charges and has patients who meet the 340B patient definition.
2. Authorizing Official or Primary Contact completes the online registration process during the registration window.
3. Authorizing Official or Primary Contact will submit any updated Medicare Cost Report information, as required by HRSA.

D. Procedure for Changes to Information in 340B OPAIS

1. Authorizing Official or Primary Contact notifies HRSA immediately of any changes to the Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage ≤ 11.75%.
    a. Covered Entity will stop the purchase of 340B drugs as soon as it files its cost report with a disproportionate share percentage ≤ 11.75%.
    b. Authorizing Official or Primary Contact will complete the online change request as soon as a change in eligibility is identified.
2. Authorizing Official or Primary Contact will notify HRSA immediately of any changes to Covered Entity information on 340B OPAIS.
3. Authorizing official will complete the online change request as soon as a change in eligibility is identified.

IV. *PATIENT ELIGIBILITY/DEFINITION*

CCRMC ensures that 340B drugs are dispensed/administered/prescribed only to eligible patients by:

A. Validating site eligibility:

1. The hospital and clinic sites listed on the Medicare Cost Report and registered on the OPAIS database are eligible to receive 340B drugs

B. Determining patient status (outpatient vs. inpatient)

1. Only patients with an outpatient status at the time of medication charge (on administration or dispensation) is eligible to receive 340B drugs
2. Retrospective changes in patient status are not taken into consideration in either direction (e.g. status changing from inpatient to outpatient or outpatient to inpatient).

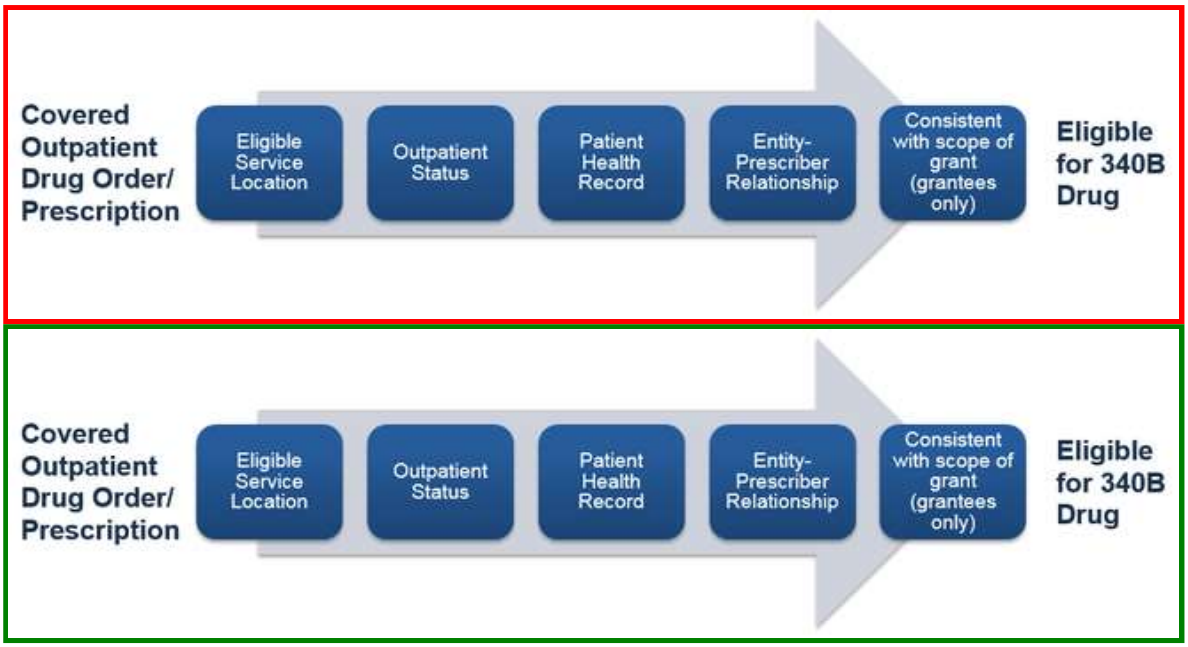
C. Maintaining records of individual's health care

D. Determining provider's eligibility

1. Prescriber is on the hospital's eligible prescriber list as employed by the entity, or under contractual or other arrangements with the entity, and the individual receives a health care service from a health care professional such that the responsibility for care remains with the entity

E. Determining patient's Medicaid status

1. Medicaid claims are flagged with appropriate modifiers to prevent duplicate discounts



V. *PREVENTION OF DUPLICATE DISCOUNTS*

CCRMC Hospital and Health Centers is registered with OPA as a "**carved-in**" entity, meaning our entity bills Medicaid for drugs purchased at 340B prices that may be subject to a payment of a Medicaid rebate to the state. Our entity is listed on the Medicaid Exclusion File so that Medicaid knows not to request reimbursement from drug manufacturers for 340B drugs, thus preventing duplicate discounts.

A. To meet the Federal requirements, Medicaid Provider Numbers and/or NPIs are listed on the OPAIS for the parent and each registered child site location.

1. In addition, out of state Medicaid Programs will not be billed.

B. To meet the State requirements,

1. the required claim identifier ("UD modifier") is used on claims to indicate 340B drugs were administered to Medicaid beneficiaries.
2. drug cost submission on the claim reflects the 340B AAC (Welf. & Inst. Code § 14105.46(d)).
3. Fee-for-Service and Managed Care Medicaid are carved-out for contract pharmacy claims.

C. The Health Centers do not use Medicaid Fee-for-Service billing.

1. If patient seen by a licensed practitioner, the billing claim form will list medication claims

with applicable state requirements (as above) as 'information only.' The information only line does NOT have units/quantity or a dollar amount.

2. If patient not seen by a licensed practitioner, the billing claim form will list medication claims with applicable state requirements (as above), a unit/quantity, and a dollar amount. However, the third-party claims scrubber will not send the bill to Medicaid and the medication charges are written off.
3. There are some program-specific exceptions (e.g. Family Pact) that are billed based on the California Medicaid requirements. Charges that do not meet the program-specific requirements may appear on the claim form as required, but are not billed, not sent to the payor, and written off.

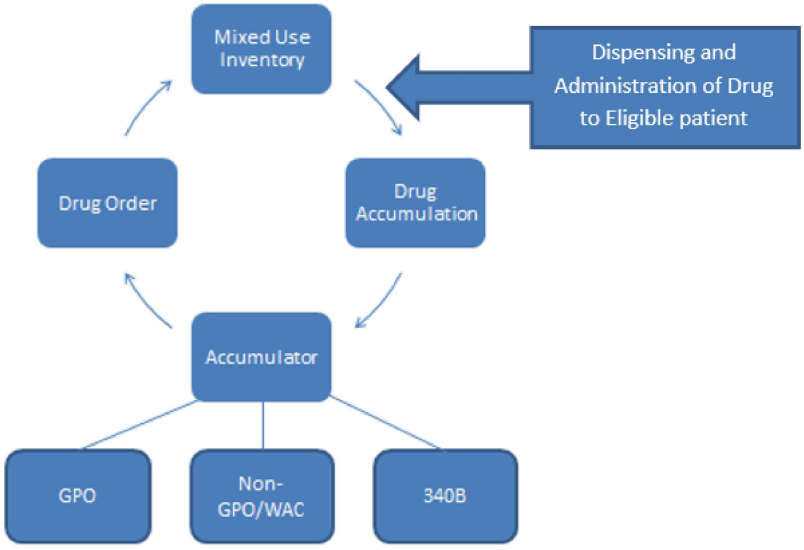
VI. *PROCUREMENT, INVENTORY MANAGEMENT, AND DISPENSING PROCESS*

A. 340B inventory is procured and managed in the following settings:
    1. Hospital pharmacy servicing mixed-use areas of the hospital and providing discharge medications to certain patient populations (at no charge/not billed)
    2. Outpatient pharmacy servicing health center child sites
    3. Contract Pharmacy

B. CCRMC Hospital and Health Centers uses a hybrid (physical and virtual) approach to inventory management.
    1. The parent entity (hospital pharmacy and mixed-use areas of the hospital): uses a ***virtual mixed-used replenishment inventory*** (i.e., neutral) using a split billing software
    2. The parent entity also dispenses discharge medications to patients that are not billed to payers or charged to the patient and therefore are not included on a billing claim form; however, are a part of the virtual inventory.
    3. The outpatient pharmacy and health center child sites use ***physically separated 340B and non-340B inventory.***

C. ***Virtual Mixed-use Inventory Replenishment System*** is maintained at the PARENT ENTITY (hospital pharmacy and mixed-use areas of the hospital)
    1. Split-billing software is used to perform split-billing on medication procurement orders.
    2. Medications administered to specific patient(s) within the hospital are tracked by 11-digit NDC. This information is transmitted to split-billing software with coding indicating patient eligibility for 340B medications.
    3. Medications are charge on administration in the hospital setting, with some exceptions for bulk dispense medications (i.e. topicals, inhalers, etc.) which are charge on dispense. Only medication charges are sent to the split-billing software for accumulation.
    4. Split-billing software accumulates eligible and non-eligible medication administrations and allows for appropriate replenishment. Accumulation occurs at the 11-digit NDC level, and a full package size must be accumulated before replenishment.
        a. In exceptional circumstances when an 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.

5. Purchasing agent exports daily orders from wholesaler ordering system to split-billing software, which then splits the order based on accumulations of 11-digit NDC into corresponding purchasing accounts (i.e., 340B, GPO, or WAC).
6. Procurement order is then placed with wholesaler and accumulations are automatically reduced accordingly from split-billing software.
7. Upon receipt of the drug shipment, pharmacy personnel verify quantity received with the quantity ordered and identifies/resolves inaccuracies in split-billing software.
8. If/when consignment inventory is acquired, and dispensed to a 340B eligible patient, it will be replenished like all other inventory based on accumulations.
9. If medications are unable to be acquired from usual wholesaler channels, medications may be purchased outside of the accumulation process and obtained directly from secondary or tertiary resources on non-340B/non-GPO accounts when needed to fulfill patient medication orders. If 340B or WAC accounts are unavailable direct from the manufacturer, communication will be retained.



D. ***Physical Inventory*** is maintained at the OUTPATIENT PHARMACY and HEALTH CENTER CHILD SITES
    1. Medication procurement is performed through wholesaler on the **340B account** for facility-administered medication requests from child site locations registered on OPAIS as 340B eligible.
    2. Medication procurement is performed through wholesaler on the **GPO account,** which is separate from the Parent hospital/mixed-use account, for medication requests from off-site non-340B eligible locations.
    3. Drugs procured for off-site non-340B eligible locations are stored in a physically separate location from drugs procured for 340B eligible locations.
    4. Medications are charge on administration in the child sites.
E. Inventory of 340B medications wasted do not go back into the accumulator.
F. Patient-specific waste is defined as waste associated with the unused portion of a dosage form of a drug provided (e.g., dispensed, administered) to a patient. The patient-specific waste may be documented and allocated for accumulation and/or purchased based on the patient's eligibility

status.

G. In a state of emergency CCRMC will continue to ensure it has policies and procedures in place to address the purchasing and dispensing of 340B drugs, and it will continue to keep auditable records.

H. As a hospital subject to the GPO prohibition, if unable to purchase a covered outpatient drug at the 340B price, CCRMC will first try and obtain the drug at WAC. If it is unable to purchase the product at WAC due to shortages, the hospital may use a GPO or GPO private label product (e.g. Novaplus) according to the following circumstances described below.

    1. A suitable alternative is not available for purchase.
    2. The drug is required for a medically necessary treatment.
    3. The manufacturer will not or cannot supply the equivalent drug at 340B or WAC pricing, after hospital has attempted to work with the manufacturer to do so.

I. Documentation maintained includes, but is not limited to, screenshots of the WAC, GPO, and 340B accounts for the product being purchased, showing that no stock is available from CCRMC's Primary Drug Wholesaler, and documentation of communications with manufacturer and/or wholesaler regarding non-availability.

VII. *340B COMPLIANCE MONITORING/REPORTING*

A. Routine and/or random self-audit monitoring will be done by the pharmacy department to assure continued compliance with 340B requirements.

B. CCRMC develops an annual internal audit plan approved by the 340B Oversight Committee.

C. CCRMC has established processes in place to ensure 340B Program compliance and oversight at the contract pharmacy location(s).

D. CCRMC reviews 340B policies and procedures annually.

E. CCRMC reviews the HRSA 340B OPAIS to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies annually and as needed.

F. CCRMC reviews the Medicaid Exclusion File (MEF) to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies annually and as needed.

G. CCRMC updates the prescriber eligibility files regularly.

H. CCRMC reconciles purchasing records and dispensing records to ensure that covered outpatient drugs purchased through the 340B Program are dispensed or administered only to patients eligible to receive 340B drugs and that any variances are not the result of diversion quarterly.

I. CCRMC reconciles dispensing records and Medicaid billing practices to demonstrate that CCRMC practice is following the Medicaid billing question on the HRSA 340B Database.

J. CCRMC 340B Oversight Committee reviews the internal audit results:

    1. Assess if audit results are indicative of a material breach.
    2. CCRMC maintains records of 340B-related transactions for a period of 3 years in a readily retrievable and auditable format.

VIII. *REPORTING 340B NON-COMPLIANCE/ MATERIAL BREACH*

A. A material breach is defined as a discrepancy that results in a negative impact of more than 10% of total 340B purchases in a fiscal year and does not self-correct within six (6) months.

B. The Self-Disclosure for Material Breach will be used to take proper action.

RELATED LINKS:

Non Covered 340B Outpatient Drugs (NCODs) (i.e. exclusions)

Self-Disclosure for Material Breach

REFERENCES:

A. HRSA (Health Resources and Services Administration) Health Resources and Services Administration | HRSA

B. OPA (Office of Pharmacy Affairs) 340B Drug Pricing Program | HRSA

C. 340B Health https://www.340bhealth.org/

D. 340B Prime Vendor Program Managed by Apexus 340B Tools (340bpvp.com)

APPROVALS:

Patient Care Policy and Evaluation Committee: 8/2024
Medical Executive Committee: 8/2024
Joint Conference Committee: 11/2024

Attachments

C. Glossary of Terms

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025

Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17972052**

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Last Revised	04/2025
Next Review	3 years after approval

Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Infusion Pump System

POLICY STATEMENT:

To safely administer prescribed IV fluids, medications, and blood products via the ~~Alaris®~~ Smart Infusion Pump at a precise infusion rate. While smart pump technology helps reduce medication errors and prevent patient injury, it is not intended to replace clinical practices, institutional policies, and vigilant patient monitoring.

- The ~~Alaris®~~ Smart pump will be used to deliver prescribed IV fluids, medications, and blood products at a constant and precise infusion rate, utilizing the appropriate profile ~~and Guardrail® features~~ to enhance safe delivery. All intravenous medications will be ordered by a physician and administered by a registered nurse or qualified licensed vocational nurse. The safety software should be used in every situation except for emergent needs when a delay in initiating therapy could have a deleterious effect on patient care.
- When using this technology, clinicians must continue to practice the "five rights" of medication administration: the right patient, the right drug, the right dose, the right route, and the right time. Clinicians should also have another nurse perform an independent double check with high-risk infusions.
- Pharmacy Department is the system administrator for ~~Alaris®~~Smart infusion pump system at CCRMC and the ~~Guardrails®~~ Drug Libraries are managed by this department.
- The Continuous Quality Improvement (CQI) reports are closely monitored by the Pharmacy Department and reported to MSC, PIC and MEC. Nursing leadership will be notified as deemed appropriate.
- Use of the "~~No Guardrails -~~ Basic Infusion" feature requires permission of the nurse program manager or the nurse supervisor except in emergency situations.

Note: If basic infusion is used in an emergency situation, Guardrails® must be enabled for that infusion as soon as the immediate critical status stabilizes.

- Note: Anesthesia dept. is exempt.

This document was prepared on a multidisciplinary fashion by Pharmacy and Nursing

GUIDELINES:

For detailed procedure/instructions – refer to user manual on each types of pump (i.e., PCA, IV, and syringe pumps)

A. Equipment

- PC Unit
- Infusion Module (Pump, PCA, and/or Syringe)
- Intravenous tubing
- Intravenous medication, solution, or blood product, as ordered by provider

1. Assemble all needed equipment and prime tubing.
2. Turn on the PC unit and infusion module to begin programming infusion.
3. Enter patient's medical record number (MRN)
4. Select the appropriate profile.
5. Select one of the following:
    - Guardrails® Drugs
    - Guardrails® IV Fluids
    - No Guardrails - Basic Infusion
6. **Guardrails®** *must* be utilized for any medication of IV fluid found within the Drug Library. "No Guardrails **- Basic Infusion**" mode is *only* available for medications or solutions not listed in the library of the clinical profile. No safety software exists in this mode.
7. Select the appropriate medication using the pharmacy label as a guide.
8. Acknowledge any clinical advisory by selecting "Confirm."
9. If you get a Soft Limit alert, STOP, check the settings, check the order, and reprogram the pump. If you still get the Soft Limit alert, you may perform an override, if indicated, and proceed to give the medication.
10. If you get a **Hard Limit** alert, **STOP,** check the settings, check the order, and reprogram the pump. If the Hard Limit comes up again, STOP and have a 2nd RN perform an independent double check: verify the order and reprogram the pump. If the hard limit comes up again, STOP and notify the prescriber of the Hard Limit and reprogramming attempt.
11. For those IV medications requiring a bolus followed by maintenance infusion, the

bolus will be administered from the bag on indicated medications. Please see attachment 2 for a complete list of medications that can be bolused out of the bag".

12. For infusion of secondary medications, the maintenance infusion must be hung with the hanger fully extended for accurate delivery of medications.
13. Refer to the Quick Reference Guide attached to each device, or the User Guide found on each nursing unit and bio-medical for further instructions.

Note: the Alaris pump drug library is approved on an annual basis at the PCP&E Committee meeting

B. Pediatric Considerations

1. Profiles for all pediatric patients will be based on weight, rather than physical area.
    - Peds 15 Kg or less
    - Peds 15.1 Kg to 40 Kg
2. If the patient's weight is >40 kg, utilize the appropriate adult profile (i.e., Critical Care or Med/Surg).
3. The amount programmed into the Volume to be Infused (VTBI) for the Peds ≤ 3 kg patient cannot exceed 100 mL.

C. Special Considerations

1. When a patient transfers from one unit to another, the receiving unit is responsible for checking and/or changing the profile to meet the level of care provided on that unit.
    - To change profile, the PC unit must be powered down and re-booted.
2. Do not use the Alaris® Infusion System near magnetic resonance imaging (MRI).
3. Nursing Managers may utilize compliance rounds for staff re-education, as deemed necessary.

D. Device Management

1. Equipment will be stored in Central Supply and dispensed when called for.

RELATED LINKS:

Policy for Drug Shortages

REFERENCES:

- TJC Standard MM.06.01.01, NPSG.03.05.01
- CMS CoP § 482.13(c), 482.21(c), 482.23(c), 482.25(a)(b), 482.41(c)
- Institute for Safe Medication Practices - Revised and Expanded Guidelines for the Safe Use of Smart Infusion Pumps. 2020.

- ~~CareFusion®, Directions for use, Alaris® System (with Alaris® PC Unit, Model 8015), (manufacturer's guidelines).~~ Manufacturer's guidelines.

APPROVALS:

Clinical Practice Committee:
Patient Care Policy and Evaluation Committee: 3/2022
Medical Executive Committee:
Joint Conference Committee:

Attachments

1: Infusion Pump Data Set Change Request Form

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18083404

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Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	05/2025		
Next Review	3 years after approval		

Policy for Reporting Diversion of Controlled Substances

POLICY STATEMENT:

All known or suspected diversion of controlled substances will be reported to the appropriate authorities, in accordance with County policies and state and federal regulations.

This policy provides guidelines for reporting drug diversion of controlled substances to the appropriate authorities.

GUIDELINES:

A. Known or suspected diversion must be reported immediately to the department head. The department head is responsible for investigating the incident and notifying the Director of Pharmacy.

B. The Director of Pharmacy Services can and will report all thefts by all disciplines to the DEA and the California Board of Pharmacy.
    1. Affected Department Heads will be notified
    2. Information will be provided to affected Department Heads to report to other regulatory agencies as appropriate (e.g. Board of Registered Nursing, Medical Board, etc.)

C. Reporting a Loss
    1. Definition of Significant Loss
        a. Any loss of a controlled substance, regardless of amount, attributed to employee theft
        b. A trend or pattern of losses repeated over a period of time using software

and technology

c. Losses where the aggregate amount discovered in that category, on or after the same day of the previous year, that equals or exceeds the following, as defined by the Board of Pharmacy Title 16 CCR 1715.6:

i. 99 dosage units – for tablets, capsules, or other oral medications

ii. 10 dosage units – for single-dose injectable medications, lozenges, film (such as oral, buccal, and sublingual), suppositories, or patches

iii. 2 dosage units – for multiple-dose injectable medications/vials, medications administered by continuous infusion, or any other multi-dose unit/container not previously described above.

2. Reporting to the Board of Pharmacy (BOP)

a. The report must be made no later than thirty (30) days after the date of the discovery of the significant loss defined in section (1) above.

b. The report shall specify the identity, amounts, and strengths of each controlled substance lost, and date of discovery of the loss, for all loses that have made the report necessary.

c. Any loss due to theft, diversion, or self-use of a licensed individual employed by or with the pharmacy shall be made within 14 days of discovery as per B&PC section 4104.

3. Reporting to the Drug Enforcement Agency (DEA)

a. Notice of the theft or significant loss must be provided in writing directly to the local DEA Diversion Field Office within one (1) business day upon discovery.

b. The DEA registrant must keep a copy of the notice for its records.

c. The DEA registrant must complete a DEA form 106 (Report of Theft or Loss of Controlled Substances).

RELATED LINKS:

DEA Form 106: https://apps.deadiversion.usdoj.gov/webforms/dtlLogin.jsp

Board of Pharmacy Online Portal for Reporting Theft or Loss of Controlled Substances: Report Drug Loss - California State Board of Pharmacy

REFERENCES:

A. TJC Standards MM.01.01.03, MM.05.01.11, EC.02.01.01, LD.04.01.11

B. CMS CoP § 482.11(a), 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(c)

C. California Board of Pharmacy Law Health and Safety Code 4104, CC&R Title 16 §1715.6

D. DEA Pharmacist's Manual https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-046)(EO-DEA154)_Pharmacist_Manual.pdf

E. Diversion Control Division | Reporting

F. DEA Notification: CFR, Title 21, Sec 1301.76(b)

~~**APPROVALS:**~~

~~Patient Care Policy and Evaluation Committee: 7/2023~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Attachments

Tally of Cumulative CII to CV Losses

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	05/2025

Standards

No standards are associated with this document

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Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	05/2025		
Next Review	3 years after approval		

Policy for Titrating Medications

POLICY STATEMENT:

It is the policy of this institution to allow orders for medication titration, which is the progressive increase or decrease of the medication dose in response to the patient's clinical status. This policy establishes safety guidelines for medications ordered as titrations.

GUIDELINES:

Every titrated medication order must include:

~~A. The starting dose/rate~~

~~B. The increments the dose/rate must be adjusted~~

~~C. The frequency the dose/rate must be adjusted~~

~~D. The titration goal parameter (i.e. SBP, MAP, RASS, etc.)~~

~~E. A dose/rate limit~~

A. Medication name

B. Medication route

C. Initial or starting dose/rate of infusion

D. Incremental units the dose/rate can be increased or decreased

E. Frequency for incremental doses (how often the dose/rate can be increased or decreased)

F. Maximum dose/rate of infusion

G. Objective clinical endpoint (i.e. SBP, MAP, RASS, etc.). This particular element does not have to

reside in the titration order itself but instead may be a separate order in the medical record

Any orders received missing any of the above elements will not be verified or dispensed by the Pharmacy department.

A. Nursing guidelines are in place for titrated medications.

B. Nursing staff must assess the patient frequently when titrating medications to detect potential problems as early as possible.

C. If medication is titrated off but order is still active, the nurse may restart to meet the titration goal parameter with reference to the last infusion dose/rate or per provider order.

When the patient is rapidly deteriorating and is not responding to standard titration orders, the RN is authorized to increase or decrease a titratable drip more rapidly than prescribed, up to the maximum prescribed dose, or "off", as needed to support the patient's immediate stability. The provider will be notified as soon as reasonably possible~~, and additional orders will~~. All titration adjustments should be ~~instituted as communicated by the provider~~recorded in the medical record including supporting documentation. ~~All titration adjustments should be recorded in the medical record including supporting documentation for deviations in dosing outside the ordered parameters.~~

RELATED LINKS:

Guidelines for Administration of Titratable Medications

REFERENCES:

A. TJC Standard MM.04.01.01

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

APPROVALS:

Clinical Practice Committee: 2/18, 5/18, 9/19, 7/20, 7/22
Patient Care Policy and Evaluation Committee: 3/18, 5/18, 11/18, 3/19, 10/19, 7/20, 11/20, 6/21, 3/22, 6/22
Medical Executive Committee: 3/18, 6/18, 4/19, 11/19, 7/20, 11/2020, 6/21, 4/22, 6/22, 8/22
Joint Conference Committee: 9/2022

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending

Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Effective	Upon Approval
Last Revised	12/2022
Next Review	3 years after approval
Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Pharmacy Security

POLICY STATEMENT:

Security of the Pharmacy shall be maintained in accordance with federal, State and local laws. All personnel on duty shall protect Pharmacy assets and records and guard against the theft or diversion of drugs it contains. In addition to ensure that all medications are stored in a secure manner, consistent with all applicable federal and state laws.

GUIDELINES:

Pharmacist is responsible for maintaining the security of the pharmacy.

Locking of Pharmacy Areas:

A. All areas occupied by the Pharmacy shall be capable of being locked by key or combination, to prevent access by unauthorized personnel by force.

B. Keys may only be in the possession of:

    1. Licensed pharmacists employed by CCRMC & HC

C. Locks in the Pharmacy must be rekeyed:

    1. When keys are lost
    2. In case of theft
    3. With changes in personnel, if determined to be necessary

Restricted Access to the Pharmacy (Traffic Control):

A. No person other than a pharmacist, pharmacy technician, intern pharmacist, an authorized officer of the law, or a person authorized to prescribe shall be permitted in the pharmacy wherein controlled substances or dangerous drugs or dangerous devices are stored, possessed, prepared, manufactured, derived, compounded, dispensed, or repackaged.

B. Medical staff, Nursing Services, administrative, Environmental Services and other facility personnel are authorized admission to the pharmacy in relation to their duties and only while **under the supervision of a Pharmacist.**

C. The Pharmacy shall limit nonessential traffic (by medical service representatives, visitors, and others).

D. The Nursing Supervisor may enter the Pharmacy Night Locker **ONLY**, during the hours when no Pharmacist is present only if patient need exists and the medication cannot be obtained elsewhere in the hospital. If the needed medication is only stocked in the Pharmacy and administration to the patient cannot wait until Pharmacy opens, the on-call Pharmacist must be contacted to come in to dispense the medication.

Pharmacy Lock-Up Procedures:

A. Pharmacy lock-up procedures shall ensure that drugs are secure, and that the Pharmacy is free of hazardous conditions. Lock-up procedures shall include, but shall not be limited to, ensuring that:

    1. Controlled drugs are secure
    2. Non-essential lights and electrical equipment are turned off
    3. All doors are locked
    4. The alarm is set

B. The Pharmacy door shall be locked at all times.

C. The Pharmacist will be the only person with a key to the working controlled substance drawers.

D. Pharmacy Administration is in sole possession of the key to circumvent the security of the narcotic vault in the event of a disaster or major system failure in order to provide adequate patient care.

Alarm System:

A. The alarm system for all Pharmacy locations is monitored by Denalact Alarm Company. A list of contact personnel will be provided to them by the Director of Pharmacy and updated as necessary.

B. In the event of an alarm, they will contact the Pharmacist-in-Charge, or Pharmacist designee, from the list. This individual will rectify the situation as appropriate and as necessary.

C. If that person cannot be reached, they will then contact the Director or the Assistant Director of the Pharmacy for resolution of the problem.

Theft or Break-Ins:

A. Any theft, break-in or unexplained loss shall be reported to the Pharmacy Director immediately.

B. The Pharmacy Director shall ascertain the loss and file all necessary reports, in accordance with hospital policy and applicable federal and state laws.

Reports:

A. The Pharmacy Director shall report controlled substance losses, as appropriate, according to Pharmacy Policy for Reporting Diversion of Controlled Substances.

RELATED LINKS:

Pharmacy Policy for Reporting Diversion of Controlled Substances

REFERENCES:

A. TJC Standard EC.02.01.01

B. CMS CoP § 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(b)(c)

C. California Pharmacy Law Business and Professions Code Sections 4116, 4117, 4135

APPROVALS:

Patient Care Policy and Evaluation Committee: 12/2022
Medical Executive Committee:
Joint Conference Committee:

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17987466

Origination	01/2008	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
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Policy for Anticoagulation Program in Ambulatory Care

POLICY STATEMENT:

To assess, evaluate and manage patients on Vitamin K antagonist (VKA) therapy or on enoxaparin for bridging as clinically indicated.

All patients on Vitamin K antagonist (VKA) therapy will be referred by a clinician to the Anticoagulation Clinic. The Primary Care Provider (PCP) will be consulted for approval.

The referring provider or a member of the Internal Medical Department will continue management of the patient's anticoagulation needs until:

A. A PCP has been assigned and/or patient is seen by his/her PCP.
B. The trained staff manages care of the patient's needs and will notify the PCP of enrollment into the program.

GUIDELINES:

A. Training: All staff working in anticoagulation clinics will receive training. Prior to assuming independent care of any patients enrolled in this clinic, staff will complete competency training and assessment.
B. Referral: Provider will send an Anti-coagulation referral for both inpatients and outpatients:
    1. For hospitalized patients' referral to anti-coagulation via ccLink should be placed prior to discharge.
    2. PCP will maintain responsibility for the patient's anticoagulation coordination until patient is enrolled in the program.

C. Compliance: Anticoagulation Clinic staff will review new referrals and check for compliance:

1. Anticoagulation Clinic staff contacts Provider to verify the plan of care as clinically indicated.
2. Patient must have assigned PCP.
3. Patients who have not been seen for 2 months or greater must-see PCP and have a new referral written.
4. When a patient is out of compliance, the Anticoagulation Clinic staff will document justification for the rejection or closing of the active referral.
5. Presence of a signed consent form by the patient.

D. Exclusion Criteria for Anticoagulation Clinic Enrollment:

1. Medications not covered or mentioned in this protocol.
2. Patients who are unknown to our system.
3. Patients who are transferred to OR are currently in-patients in Skilled Nursing Facility (SNF) and all Contra Costa County detention facilities.
4. Patients who are in residential and/or alternative care settings unless the patient has a CCRMC provider.
5. Patients with multiple co-morbidities and highly technical or complex medical care needs (i.e., dialysis patients, anticoagulation therapy is being managed by Cardiology Group, certain blood dyscrasias, etc...)
6. Patients without an assigned PCP with CCRMC privileges.
7. Previously enrolled patients who have been discontinued in collaboration with the provider due to non-compliance will not be readmitted without proof of ability to comply. The Anticoagulation Clinic staff will communicate with PCP regarding readmission.
8. Patients who qualify for therapy with a direct oral anticoagulant (DOAC).

E. Functions of the Anticoagulation Clinic staff:

1. Receives referrals and enrolls patients into the Anticoagulation Clinic program accordingly.
2. Monitors lab results and adjusts the VKA dose to keep patient within therapeutic range.
3. Bridging with enoxaparin if/when indicated.
4. Provides Patient education (e.g., medication regimen, diet, possible drug complications, lab results, medication dose changes, birth control and pregnancy complications, Coumadin video, and handouts).
5. Reviews drug interactions (if present), modifies warfarin dose as necessary and notifies PCP.
6. Gives patient contact information for further questions and education.
7. Reviews with patient each section of Anticoagulation Patient Agreement and patient

education checklist.

8. Orders next lab test and confirms medication dosage.
9. Reorders medications.
10. Documents medication changes.

F. Medication Management
Warfarin (Coumadin®) [VKAs stands for Vitamin K Antagonists]

1. Therapeutic or target INR range is determined and prescribed by the provider.
2. Recommended therapeutic range for oral Warfarin therapy per CHEST guidelines is as follows (References: CHEST Antithrombotic Guidelines, 2019 AHA/ACC/HRS Update of the 2014 AHA/ACC/HRS Guidelines for the Management of Patients With Atrial Fibrillation)
    a. Optimal Therapeutic INR Range: For patients treated with VKAs, the CHEST consultants recommend a therapeutic INR range of 2.0 to 3.0 (target INR of 2.5) rather than a lower (INR<2.0) or higher (INR 3.0-5.0) range (Grade 1B)
    b. Therapeutic Range for High-Risk Groups: For patients with antiphospholipid syndrome with previous arterial or venous thromboembolism, the CHEST guidelines suggest VKA therapy titrated to a moderate intensity INR range (INR 2.0-3.0) rather than higher intensity (INR 3.0-4.5) (Grade 2B).
3. Adjustment in the dosage:
    a. The percentage change is per visit and the following table should be used as "monitoring guidelines."

Current INR	Goal INR	Percent Change1	Visit2
1.0 - 1.8	2.0 - 3.0	10% weekly increase1	See "f" to follow. Check INR sooner if patient unstable (e.g., anywhere from 3 days to a week)
1.0 - 1.8	3.0 - 4.5	20% weekly increase1	See "e" to follow. Check INR sooner if patient unstable (e.g., in 2 to 3 days)2
1.8 - 2.7	3.0 - 4.5	10% weekly increase1	See "F2a." above
4.0 – 5.7	2.0 – 3.0	20% weekly decrease1	See "F2b." above
4.0 – 5.7	3.0 – 4.5	10% weekly decrease1	See "F2a." above
>5.7	2.0	Hold Coumadin	Follow up in 2 days, then in a

	– 3.5	one day, then 20% weekly decrease1	week. Check for signs and symptoms of bleeding

*Note: In extreme and difficult to treat subtherapeutic patients who have had a recent PE (or DVT) it may be necessary to place them on enoxaparin temporarily to maintain adequate anticoagulated state while optimizing the warfarin dose. Consult with the provider before placing the enoxaparin order in.

Loading Dose for Initiation of Vitamin K Antagonist (VKA) Therapy
For patients sufficiently healthy to be treated as outpatients, CHEST guidelines suggest initiating VKA therapy with warfarin 10 mg daily for the first 2 days followed by dosing based on international normalized ratio (INR) measurements rather than starting with the estimated maintenance dose (Grade 2C) . Since this is Grade 2C, do NOT use this approach for elderly population.
1The percent change is per visit and the table above should be followed as "monitoring guidelines".
2For sub-therapeutic pro-time post-thrombotic episodes recheck the INR in 2-3 days.

b. Patients at either extreme, but still within the accepted therapeutic range, may receive a 5% to 10% dosage adjustment to approach the middle of the therapeutic range when deemed appropriate by the Anticoagulation Clinic staff.

c. A one-time Coumadin booster dose of 5-10 mg depending upon weight and INR is to be given when INR <2.0 for low intensity (INR2-3) or when INR <3.0 for high intensity (INR 3.0 -4.5).

d. Patients with risk factors for bleeding (i.e., varying alcohol intake, drug interactions, Hx of GI bleed, etc.) will be maintained to keep the INR ratio at the low end of the therapeutic range.

e. If adjustments of 20% are made in the weekly dosage, frequent INRs will be done until the INR is stable in the therapeutic range. The risk will be assessed and once the dosage is adjusted the INR will be checked as appropriate. Special attention is required for patient with recent deep vein thrombosis or pulmonary emboli.

f. If minor dosage adjustments (10% or less) are made, the patient will be rescheduled in 2 weeks for INR depending on the stability of the patient's previous INRs and risk factors for bleeding.

g. If the provider makes changes in Coumadin dosage, s/he will notify the Anticoagulation Clinic staff.

4. Methods of titration:

a. Dosage adjustments are based on WEEKLY DOSAGE, NOT DAILY DOSAGE. Example: T.W.'s INR range is 2.0 - 3.0. He is taking Coumadin 7.5mg every day. He is a very compliant patient and has had a stable diet for a long time. Lately, he has added spinach to his lunch. On 7/3 (Thursday) the INR

came out to be 1.6 how would you adjust for the dosing regimen, so this patient falls back within the therapeutic range?
Answer:

i. Calculate the weekly intake: 7.5 x 7= 52.5mg (total amount taken per week).
ii. Increase the total weekly dose by 10% per protocol: 52.5mg x 10% = 5.25mg.
iii. Patient should be taking: 52.5mg + 5.25mg = 57.75mg per week.
iv. Correct the daily dose to suit the total weekly changes, that is:
    A. Give 10mg tonight, then if stable diet (including spinach or other green, leafy vegetables) is anticipated, have patient: Take 10mg on Wednesday and Sunday (2 days of 10mg) And 7.5mg for the rest of the week (5 days of 7.5mg) Total weekly dosage =57.5mg
        1. Schedule for an INR check one week later (i.e., the following Thursdays).
        2. Days designated for odd dosages will be defined by the anticoagulation clinic staff
        3. Weekly dosage increases or decreases of 5%, 10% and 20% will be approximated as close as possible to the actual value based on tablet strengths available.
        Example: A.B. is on 5mg every day. On 7/21 the INR came out to be 4.3 while his level should remain between the range of 2.0 – 3.0. After asking appropriate questions, you realize that A.B. has recently changed his diet. How do you correct his dosing regimen?
        Answer:
        Calculate the weekly dose: 5mg x7 = 35mg.
        Decrease the weekly dose by 20% per protocol:35mg x 20% =7.0mg
        35mg – 7.0 = 28mg per week
        Change the dosing regimen to 4mg every day.
        Schedule for an INR check next week.

5. INR monitoring:
    a. The next INR follow –up will be scheduled as follows:

GOALS FOR THE NEXT INR	TIME FROM LAST INR
Post discharge to establish therapeutic window	Twice weekly x 1 week (e.g., Monday and Thursday)

Confirm maintenance dose (weekly)	7 -10 days x 2
Routine follow-up	3 – 4 weeks x 2
Very stable with no risks for complications	weeks

b. Frequency of monitoring may change (e.g., may get shortened or extended) based upon clinical judgment of the Anticoagulation Clinic staff.

c. Based on Anticoagulation Clinic staff's judgment and in very stable patients with no risks for complications who understand dietary restrictions and are aware of notifying the anticoagulation clinic of any changes in their diet, drug regimen or use of over the counter (OTC) medicines, the monitoring frequency may even be extended more.

6. See appendix for dosing instructions for the following:
    a. Enoxaparin (Low Molecular Weight Heparin (LMWH)
    b. Unfractionated Heparin (UFH)
    c. Fondaparinux
    d. Vitamin K:
        i. Management of dental procedures.
        ii. Management of general surgery.
7. At CCRMC it is highly recommended NOT to use Enoxaparin in patients with a creatinine clearance <30mL/min. Instead use Unfractionated Heparin.
8. In addition, the use of Fondaparinux is contraindicated if creatinine clearance is <30ml/min.

G. Handling of Patients with complications:
    1. VITAMIN K POLICY FOR ANTICOAGULATION CLINIC STAFF (see attached for a copy of the protocol).
    2. INRs greater than or equal to 9 or less than or equal to 1.5 with symptoms (and/or within 6 weeks post discharge after a thromboembolic episode) should be referred for a medical assessment in the following order:
        a. Primary Care Provider.
        b. Internal Medicine on call Physician.
        c. Emergency Department.
    3. Refer patients with any of the following signs or symptoms of bleeding immediately to their PCP if available or to the Emergency Department:
    Bleeding disorders
        a. Melena
        b. Gross hematuria

c. Presence of blood in stools
d. Pulse in excess of 120 beats/min
e. Any findings suggestive of serious hemorrhage
f. Any findings suggestive of thromboembolic episode
g. Dizziness, light-headedness
h. Non-stop bleeding
i. Unusual bruising

Thromboembolic events

a. Chest or leg pain
b. Shortness of breath

H. Handling Anticoagulation prescriptions:

1. Renewal:
    a. The Anticoagulation Clinic staff will authorize refills of anticoagulation medication for patients requesting medications during follow-up calls.
    b. Patients will be given a month supply of medication at a time with 1 refill (optional)
    c. A 60-day supply of medication or less as governed by limitations of the patient's insurance coverage may be given if patient is out of the area for an extended period.
2. New prescriptions:
    a. The Anticoagulation Clinic staff will e-prescribe new prescriptions to the pharmacy identified by the patient.
    b. The initiation of a new prescription must carry appropriate sig as per anticoagulation protocol (i.e., warfarin 0.5 mg PO at bedtime).
    c. Situations for which new prescriptions will be generated include patients enrolled in the Anticoagulation Program who require different Warfarin dosage strengths than previous prescribed for titration of Warfarin.
    d. This authorization is limited to Warfarin prescription for Anticoagulation Clinic patients.
3. Discontinuing patient from program or program completion:
    a. Within one month before planned completion, the Anticoagulation Clinic staff will inform PCP that the patient will be completing the program.
    b. PCP will provide a written response by the planned completion date.
    c. For patients not compliant with treatment, the Anticoagulation Clinic staff will contact the patient, document the conversation, and notify the PCP of the situation.
        i. The Anticoagulation Clinic staff, in collaboration with the

provider, will discuss the noncompliant patient. Then the Anticoagulation Clinic staff and/or the PCP will send the patient a letter disenrolling them from the Anticoagulation program (A-585 during Epic downtime). Upon sending this letter, the patient will be simultaneously discontinued from the anti-coagulation program. The letter will instruct patient to contact their PCP to come up with alternative anti-coagulation therapies.

ii. A copy of letter will be retained in ccLink.

iii. The Anticoagulation Clinic staff will not renew or refill the patient's anticoagulant prescription during the period of non-compliance. The continued management of the patient will be returned to the Provider.

RELATED LINKS:

A. Anticoagulation Consent Form

B. Letter A-585 during Epic downtime

REFERENCES:

A. University of Washington Medical Center

B. CHEST Journal. Antithrombotic Therapy and Prevention of Thrombosis. Evidence- Based Clinical Practice Guidelines

C. TJC 2016 Standard PC.04.01.05, "Before the hospital discharges a patient, it informs and educates the patient about his or her follow-up care, treatment, and services."

D. 2021 NPSG.03.05.01, "Use medicines safely: take extra care with patients who take medicines to thin their blood."

E. E-Learning Module for Anticoagulation Clinic Staff

F. 2019 AHA/ACC/HRS Update of the 2014 AHA/ACC/HRS Guidelines for the Management of Patients with Atrial Fibrillation

APPROVALS:

Patient Care Policy and Evaluation Committee: 12/2013, 8/2017, 9/2021, 10/2021
Ambulatory Policy Committee: 10/2021, 7/2022
Medical Executive Committee: 11/2021, 8/2022
Joint Conference Committee: 9/2022

VITAMIN K POLICY FOR ANTICOAGULATION CLINIC	
INR range	**Management**
• INR above the therapeutic range but <4.5	• Hold or reduce warfarin maintenance dose until the INR returns to the therapeutic range • Monitor more frequently

◦ No bleeding	• Resume Warfarin therapy at a lower dose • If only minimally above the therapeutic range, no dose reduction may be required
INR ≥4.5 but < 9 • No bleeding	Hold warfarin AND if the patient is at increased risk for bleeding: • Administer Vitamin K **2.5 mg PO** under direct observation (Oral is the preferred route of administration SEE footnotes) • When a condition exists that would prevent the patient from taking oral medication, such as vomiting, administer Vitamin K **2.5 mg subcutaneously.** • Recheck INR in 24 hours after Vitamin K administration. • If it is Friday, consult with the patient's primary care physician. • If unavailable, refer the patient to the CCRMC Emergency Department on Saturday for follow-up. If INR is unchanged, repeat Vitamin K administration. • If the INR is higher (SEE BELOW, INR ≥9.0), consult with the patient's primary care physician if you need to. • If unavailable, refer the patient to CCRMC Emergency Department. Continue holding warfarin until the INR returns to the therapeutic range • **RAPID REVERSAL:** **If more rapid reversal is required because the patient requires **urgent surgery**, vitamin K (≤5 mg orally) can be given with the expectation that a reduction of the INR will occur in 24 hours. If the INR is still high, additional vitamin K (2.5 mg orally) can be given **MANAGEMENT OF DOSING WHEN AN INVASIVE PROCEDURE IS REQUIRED:** Refer MD to guidelines
• INR 9	• **INR 9.0 with no bleeding**: Hold warfarin and administer a higher dose of vitamin K **(5 mg orally)** with the expectation that the INR will be reduced substantially in 24 to 48 hours. Check the INR in 24 hours. Monitor the patient more frequently and use additional vitamin K if necessary. Resume therapy at lower dose when INR is in the therapeutic range. Leave a courtesy message for the Primary Care Provider.
• INR >9	• **INR >9: REFER TO ED**

	Note: Notify PCP if patient is referred to ED.
• **ANY** elevated INR with bleeding • **ANY therapeutic** INR with concerning bleed • **ANY** INR < 1.5 with s/sx of clot • **ANY** INR with s/sx of clot.	• **REFER PATIENT TO ED** ***Note: Notify PCP if patient is referred to ED.***

*ORAL Vitamin K comes in 5 mg Tablets. Cutting tablets in half provides 2.5 mg of Vitamin K.

TREATMENT of DVT/PE with LMWH, Enoxaparin (Lovenox®)

A. The ***exclusion*** criteria for selection of pts for the treatment of DVT with enoxaparin are:
   - Pregnancy
   - Acute clinical symptoms of PE (supported by VQ scan)
   - Hx of 2 or more DVT or PE
   - Acute GI bleeding
   - Acute hemorrhagic stroke
   - Active coagulopathy

   Enoxaparin therapy in morbidly obese patients as well as Renal failure cases are explained in Special circumstances section (E)

B. ***The expected outcome for usage of LMWH is as follows:***
   1. Therapeutic equivalent outcomes with no increase in bleeding complications
   2. To decrease length of hospital stay with LMWH treatment plan

C. ***LMWH treatment plan for Uncomplicated DVT documented by U/S or Venography and dosing regimen:***

   If you have an otherwise healthy individual, no significant co-morbid conditions, no suspicion of PE
   1. Place the patient on 1 mg/kg SQ enoxaparin Q12h as outpatient
   2. Start patient on coumadin on the same day
   3. Follow the heparin to coumadin protocol (i.e., ***inpatient*** **WARFARIN DOSING GUIDELINES**)

4. Patient can self-administer ***SQ enoxaparin (LMWH) Q12h for 4 to 7 days*** (the average duration of administration in different clinical trials is between 7 to 10 days)
5. Overlap LMWH and coumadin at least 5 days
6. Continue ***therapy with Coumadin (target INR 2-3) for 3 months (based upon your clinical judgment)***
7. ***Daily*** monitoring while on LMWH is required. In general, caution must be exercised through appropriate monitoring of the patient's clinical status and coagulation profile during the time when both Antithrombotic agents are used concomitantly
8. Once placed on Coumadin, monitor INR accordingly (When **enoxaparin** is **D/C**'ed, patients can be referred to the anticoagulation clinic for Coumadin monitoring)

TREATMENT of DVT with LMWH, Enoxaparin (Lovenox[?])
Significant co-morbid condition which may affect ability to care for self or complicated therapy

1. Admit, treat with continuous infusion standard heparin **OR *place the patient on 1 mg/kg SQ enoxaparin Q12 h.***
2. Start patient on coumadin on the same day. Follow the heparin to coumadin protocol (i.e., ***inpatient*** **WARFARIN DOSING GUIDELINES**)
3. When stable, discharge with outpatient regimen as above (Number 4-8)

D. ***Possible Adverse effects with enoxaparin:***

- Either ***minor bleeding*** (e.g., increased bruising***)*** or ***major bleeding*** (e.g., internally)
- Allergic reactions
- Pain and irritation at injection site

E. ***Special circumstances:***
Obesity: Low molecular weight heparin requires anti-factor Xa monitoring for patients with body weight >120 kg.
Use the *Actual Body Weight (ABW)* in dosing enoxaparin for weight as high as 120 kg (i.e., 120 kg is the cut off). Consider IV heparin as an alternative agent when needed.
NOTE: If you intend to use enoxaparin in patients who do not fit in the above categories, e.g., weight >120 kg, the **anti-Xa** will be used to guide proper dosing. The anti-Xa test will be obtained using **outside** lab facilities. The expected therapeutic range for anti-Xa is 0.5-1.2 anti-Xa units. Check for anti-Xa activity 4 hours (when the peak occurs) after administration of the dose. In morbidly obese individuals once the right dose is determined, the anti-Xa activity test is no longer necessary. The turnaround time for obtaining anti-Xa test results is about 48 hours. Use traditional (standard) heparin dosing when appropriate. Always remember that in case of enoxaparin-induced bleeding, you can only neutralize the anti-factor Xa activity up to **60%** by protamine sulfate. There is **no** antidote for 100% reversal!

Pregnancy*:* FDA category: B
Definition of Category B: Either animal-reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women or animal-reproduction studies have shown adverse effect (other than a decrease in fertility) that was not confirmed in controlled

studies in women in the first trimester (and there is no evidence of a risk in later trimesters). As anti-Xa testing is not an in-house test, CCRMC anticoagulation team recommends against administration of this drugs in patients with CLcr of less than 30 ml/min.

Renal Impairment:
Although package insert states that no dose adjustment is recommended in patients with moderate (creatinine clearance 30–50 mL/min) and mild (creatinine clearance 50–80 mL/min) renal impairment, the CHEST supplement recommends against the use of enoxaparin when CLcr<30 ml/min (i.e., using Cockroft and Gault). At CCRMC we follow CHEST supplement recommendations (http://journal.publications.chestnet.org/). The content could be retrieved via iSite →Library. All renally impaired patients should be observed carefully for signs and symptoms of bleeding.
Per Package Insert, in patients with renal impairment, there is an increase in exposure of enoxaparin sodium. All such patients should be observed carefully for signs and symptoms of bleeding. Because exposure of enoxaparin sodium is significantly increased in patients with severe renal impairment (creatinine clearance <30 mL/min), a dosage adjustment is recommended for therapeutic and prophylactic dosage ranges. No dosage adjustment is recommended in patients with moderate (creatinine clearance 30–50 mL/min) and mild (creatinine clearance 50–80 mL/min) renal impairment. The recommended prophylaxis and treatment dosage regimens for patients with severe renal impairment (creatinine clearance <30 mL/min) are described in Table 1below (see next page).

Table 1

Dosage Regimens for Patients with Severe Renal Impairment (creatinine clearance <30mL/ minute)

Indication	Dosage Regimen
Prophylaxis in abdominal surgery	30 mg administered SC once daily
Prophylaxis in hip or knee replacement surgery	30 mg administered SC once daily
Prophylaxis in medical patients during acute illness	30 mg administered SC once daily
Inpatient treatment of acute deep vein thrombosis with or without pulmonary embolism, when administered in conjunction with warfarin sodium	1 mg/kg administered SC once daily
Outpatient treatment of acute deep vein thrombosis without pulmonary embolism, when administered in conjunction with warfarin sodium	1 mg/kg administered SC once daily
Prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction, when concurrently administered with aspirin	1 mg/kg administered SC once daily
Treatment of acute ST-segment elevation myocardial infarction in patients <75 years of age, when administered in conjunction with aspirin	30 mg single IV bolus plus a 1 mg/kg SC dose followed by 1 mg/kg administered SC once daily.
Treatment of acute ST-segment elevation myocardial infarction in geriatric patients ≥75 years of age, when administered in conjunction with	1 mg/kg administered SC once daily (**no** initial bolus)

aspirin	

Geriatric Patients and Geriatrics with Acute ST-Segment Elevation Myocardial Infarction

Dosage in Geriatric Patients: At dosages used for prophylaxis the incidence of bleeding complications is similar between elderly and younger patients. When used for treatment of venous thromboembolism, elderly experience a greater incidence of bleeding complications. Elderly patients weighing less than 45 kg or those predisposed to renal dysfunction should be closely monitored.

For treatment of acute ST-segment elevation myocardial infarction in geriatric patients ≥75 years of age, **do not use an initial IV bolus**. Initiate dosing with **0.75 mg/kg SC every 12 hours (maximum 75 mg for the first two doses only, followed by 0.75 mg/kg dosing for the remaining doses)**. No dose adjustment is necessary for other indications in geriatric patients unless kidney function is impaired.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

Standards

No standards are associated with this document

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Next Review	3 years after approval
Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Bioterrorism Preparedness

POLICY STATEMENT:

In the event of a bioterrorist attack, the HEICS plan would be activated, and those plans and procedures would become operational. CCRMC would work very closely with the Public Health Department in managing and treating the victims. All hospitals in the county play an important part in being prepared. Each facility has been asked to keep a specified amount of medications in stock, and in date, at all times. We have been charged with having enough medication to treat or prophylaxis 50 people for 10 days for any chemical or biological agent that could be used. CCHS has prepared a flip chart as a quick reference guide in the management and treatment for exposure to the most likely agents.

GUIDELINES:

Pharmacy will post a CCHS Bioterrorism Quick Guide posted for reference in the event a bioterrorism event is announced.

The Pharmacy will cooperate fully with the coordinating agency. In the event of a bioterrorist attack, the Public Health Department would be in charge and would have the authority to commandeer medication or personnel. In addition, Public Health has authority over the federal 'PushPack' and 'Chempack' supplies. (See the attachment for the 'Chempack' Activation Flowchart.)

The Pharmacy will keep a stock supply, as requested, of medications that would be used to treatment or prophylaxis of 50 people for 10 days. This stock can include inpatient stock, stock from the outpatient pharmacy.

The CCHS Bioterrorism Quick Guide and the attached chart may be used as a resource for treatment options in the event of an exposure or outbreak of disease.

On a routine basis, inventory will be taken, and expiration dates will be checked. All medications necessary to bring stock up to the required level will be ordered. Soon-to-expire medications should be rotated through working stock to minimize wastage.

REFERENCES:

A. CCRMC Policies and Procedures (Disaster Manual)
B. TJC Standards EM.02.01.01, EM.02.02.03, EM.02.02.07, MM.03.01.03
C. CMS CoP § 482.12(f), 482.23(c), 482.25(a)(b), 482.41(c), 482.55
D. CCHS Bioterrorism Quick Guide
E. The Center for Disease Control: www.bt.cdc.gov/Agent/Agentlist.asp

APPROVALS:

Patient Care Policy and Evaluation Committee: 10/2022
Medical Executive Committee:
Joint Conference Committee:

Attachments

A: Disaster Preparedness Medication Stock

B: Chempack Activation Flowchart

C: Bioterrorist Attack: Treatment & Prophylaxis

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

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Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	N/A		
Next Review	2 years after approval		

Policy For Neonatal High Flow Nasal Cannula

POLICY STATEMENT:

The Respiratory Care Practitioner will deliver high flow nasal cannula as ordered using hospital-approved equipment. High-flow nasal cannula oxygen therapy delivers a heated and humidified blend of air and oxygen at flow rates surpassing a patient's inspiratory demand. High-flow nasal cannula oxygen therapy is administered to critically ill neonates with respiratory failure due to its comfort, simplicity in setup, and low incidence of nasal trauma. High flow nasal cannula may be initiated in the delivery room, ~~NICU~~level II nursery, or emergency room.

RELATED LINKS:

Procedure for Neonatal High Flow Nasal Cannula

REFERENCES:

A. *GUIDELINE FOR THE USE OF HIGH FLOW NASAL CANNULA OXYGEN THERAPY (OPTIFLOW OR AIRVO) IN CHILDREN WITH BRONCHIOLITIS OR AN ACUTE RESPIRATORY ILLNESS*. (n.d.). https://apps.worcsacute.nhs.uk/KeyDocumentPortal/Home/DownloadFile/1726

B. Huang, Y., Zhao, J., Hua, X., Luo, K., Shi, Y., Lin, Z., Tang, J., Feng, Z., Mu, D., & Evidence-Based Medicine Group, Neonatologist Society, Chinese Medical Doctor Association (2023). Guidelines for high-flow nasal cannula oxygen therapy in neonates (2022). *Journal of evidence-based medicine*, *16*(3), 394–413. https://doi.org/10.1111/jebm.12546

C. Contra Costa County Health Services Nursing Department Policy for Nursing Care of the Infant Receiving Oxygen Therapy.

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Michael De Peralta: Respiratory Care Services Mgr	06/2025

Standards

No standards are associated with this document

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Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Continuous Nebulizer Therapy

POLICY STATEMENTT:

The Respiratory Care Practitioner will initiate continuous nebulizer therapy as ordered and monitor the patient until the therapy ends. To provide standardization guidelines for the administration of continuous nebulization therapy (CNT).

~~PURPOSE STATEMENT:~~

~~To provide standardization guidelines for the administration of continuous nebulization therapy (CNT).~~

RELATED LINKS:

Procedure for Continuous Nebulizer Therapy

REFERENCES:

A. Fleisher, G., & Ludwig, S. (2010). Textbook of Pediatric Emergency Medicine (6th ed.). Philadelphia, Pennsylvania: Lippincott, Williams, & Wilkins.

B. Peters, S. (2007, January). Continuous bronchodilator therapy. Chest, 131(1), 286-9. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17218588

APPROVALS:

Approved By PCP&E
Approved by Med Executive Committee

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Michael De Peralta: Respiratory Care Services Mgr	06/2025

Standards

No standards are associated with this document