SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 18.5
(ID # 28054)
MEETING DATE:
Tuesday, June 10, 2025

FROM : RUHS-MEDICAL CENTER

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER: Approve Policies, All Districts. [Total Cost $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Review and approve the attached Medical Center and Clinics Policies.

ACTION:Consent

Jennifer Cruikshank
Jennifer Cruikshank, Chief Executive Officer – Health System 5/28/2025

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Gutierrez, seconded by Supervisor Washington and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Medina, Spiegel, Washington, Perez and Gutierrez
Nays:	None
Absent:	None
Date:	June 10, 2025
xc:	RUHS-MC

Kimberly A. Rector
Clerk of the Board
By: _____
Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			Budget Adjustment: No	
			For Fiscal Year: 24/25	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

The Riverside University Health System Medical Center (RUHS MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. RUHS MC currently has two campuses – one in Moreno Valley and one on County Farm Road in the City of Riverside.

As an acute care hospital RUHS MC is required by the State of California to have a "governing body" separate from its administrative leaders and medical staff leadership. The "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital." 22 CCR §70035. (See also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01) The Board of Supervisors serves as the "governing body" for the hospital.

Various regulatory requirements mandate that the Governing Board participate in the leadership and decision-making of the Medical Center by reviewing and approving its policies relating to certain topics.

RUHS-MC is committed to furnishing a safe, accessible, effective and efficient environment consistent with its mission, services and applicable governmental mandates. This includes fostering the protection, safety and well-being of patients, employees, staff and visitors during natural or man-made disasters and ensuring to the greatest extent possible, adherence to our social responsibility and commitment to the community.

Impact on Residents and Businesses

The RUHS Medical Center offers a 439-bed providing adult, Pediatric and Neonatal Services, including a Level 1 Trauma Center, the county's only Pediatric Intensive Care Unit, a Stroke Center, with over 40 specialty care clinics, as well as a Medical and Surgical Center featuring state-of-the-art Outpatient Surgical, Diagnostic and Imaging Equipment, Rehabilitation Services, and an Outpatient Pharmacy. The RUHS Emergency Treatment Services/Inpatient Treatment Facility at the Arlington Campus located in Riverside is a 77-bed inpatient Psychiatric Treatment Facility. The integrated healthcare continuum is fortified with 14 RUHS-CHCs conveniently located throughout the county which work in close partnership with RUHS-BH and RUHS-PH to

offer access to comprehensive high-quality and integrated primary, Behavioral Health, Specialty Care, Dental Care and Health Promotion services.

Training future healthcare leaders is fundamental to our commitment to serving our community as well as our mission as a safety net institution. An efficient, well-functioning medical center providing care of high quality creates many positive benefits for Riverside County citizens and its businesses.

ATTACHMENTS:
Attachment A: RUHS Policy List 01.01.25 to 03.30.25
Attachment B: RUHS Policies 01.01.25 to 03.30.25

Jacqueline Ruiz, Principal Analyst 6/5/2025

Gregg Gu, Chief Deputy County Counsel 5/28/2025

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

MEDICAL CENTER and Hospital Based Clinics

<table>
<tr><td></td><td colspan="2">Document No: 899</td><td>Page 1 of 16</td></tr>
<tr><td>Title:

Controlled Substances Handling & Medication Diversion Management</td><td>Effective Date:

3/14/2025</td><td colspan="2">☐ RUHS – Behavioral Health
☐ RUHS – Community Health Centers
☒ RUHS – Hospital Based Clinics
☒ RUHS – Medical Center
☐ RUHS – Public Health
☐ Departmental</td></tr>
<tr><td colspan="2">Approved By:
 
Jennifer Cruikshank
CEO/ Hospital Director</td><td colspan="2">☒ Policy
☐ Procedure
☐ Guideline</td></tr>
</table>

1. SCOPE

1.1 This policy applies to the RUHS Medical Center, Arlington Campus, Hospital Pharmacy departments and care delivery locations such as nursing units, operating rooms, and procedural areas. The locations also include the RUHS owned and/or operated outpatient retail pharmacies.

1.2 This policy applies to all RUHS staff that handle medications in the medication use and management processes: procurement, storage, distribution, administration, disposal, and monitoring of the use of the controlled and non-controlled substances.

2. PURPOSE

2.1 To establish guidance and shared understanding for all included participants in the responsibility to maintain compliance with all federal and state regulatory requirements of the medication management and use processes (DEA, FDA, CMS, CDPH, respective state boards for professional consumer affairs).

2.2 To establish guidelines for the procurement, receiving, storage, dispensing, administering, reconciling, security and record keeping of all controlled substances and reduce the potential for drug diversion.

3. DEFINITIONS

3.1 Automated Dispensing Cabinet (ADC) – Medication cabinet that dispenses medications in patient care areas.

3.2 CNO - Chief Nursing Officer

3.3 CSAR - Controlled Substance Administration Record

3.4 Discrepancy - A mismatch between the expected quantity and actual quantity of medications; for example, as documented in the medical record, or from the ADC

3.5 Discrepancy Variance

a. A discrepancy that is unresolved

b. A resolved discrepancy with an unacceptable or unclear resolution

3.6 Override – A process to allow medication removal from ADC prior to pharmacist review and may be before a documented physician order

3.7 Override Variance – An override that does not have a corresponding physician order

3.8 Discrepancy Reconciliation - Document to notify the Supervisor of an employee, or a unit designee, regarding medication activity in question that has resulted in a discrepancy. The document serves to notify, request for information, resolution, and appropriate education of the involved parties.

3.9 Appropriate medication documentation – Patient medical record accurately reflects the medications administered and contains all necessary fields of a medication order

3.10 Appropriate medication return - Any unused medications that are untampered in its original packaging must be returned to the appropriate location (Pyxis or Pharmacy)

3.11 Appropriate medication waste – Any unused portions of medications that have been opened must be discarded in the appropriate waste container. Any controlled substance or otherwise specified medication must be wasted with a witness in Pyxis.

3.12 Pyxis – product name of automated dispensing cabinets (ADC) utilized throughout RUHS

3.13 RUHS Staff – all employees, contractors, and trainees who are granted access to use of medications within the medical center or clinics.

4. RESPONSIBILITY

4.1 HOSPITAL

a. Director of Pharmacy or designee: is responsible for, accountability, and proper dispensing of all controlled substances and uncontrolled substances in accordance with all applicable local, state, and federal laws.

b. The Director of Nursing, or designee in each patient care area is responsible for the proper storage, use, and accountability for controlled substances or otherwise specified medications in the patient care area.

c. The Anesthesia Department Chair or designee is responsible for the proper storage, use, and accountability for controlled substances or otherwise specified medication by anesthesiologists, trainees, and SRNAs/CRNAs.

4.2 Inpatient and Outpatient Pharmacies will purchase, receive, store, and ensure accountability and proper dispensing of all controlled substances in accordance with all applicable local, state, and federal laws.

4.3 All employees and licensed healthcare practitioners must strictly adhere to all laws, regulations, and hospital policies & procedures with regards to procurement, distribution, storage, administration, documentation, proper return, and destruction of prescription drugs and controlled substances.

4.4 Violations of this policy have significant implications for RUHS, employees and the communities we serve. As such, failure to comply with this policy, any applicable state and/or federal law or hospital policy or procedure related to the purchase, storage, access, accountability, dispensing, administering, documentation, return, or wastage of controlled substances are considered offenses requiring severe disciplinary action, up to and including, immediate termination.

5. PROCEDURES

5.1 **PHARMACY** ORDERING OF CONTROLLED SUBSTANCES

a. Either a DEA (Drug Enforcement Administration) Form 222 or its electronic equivalent is required to order Schedule II controlled substances (CII). Each DEA Form 222 must be signed and dated, or completed electronically, by the person authorized to sign a registration application or a person granted power of attorney to sign a DEA Form 222. DEA Form 222s are to be stored in a secure location.

b. The registrant of the DEA renewal is the person of record for the Power of Attorney for the site. The Pharmacist-in-Charge will determine the maximum number of pharmacists who will be granted the Power of Attorney authority to execute orders for CII drugs.

c. If a Pharmacist-in-Charge changes and/or the DEA renewal registrant changes, all new Power of Attorney paperwork for pharmacists must be completed prior to execution of CII order forms.

d. All existing power of attorney documents must be revoked within seven (7) days after a person with Power of Attorney separates from the organization.

e. Power of Attorney authority and paperwork are maintained on site at the pharmacy. Revoked power of attorney documents are maintained on site at the pharmacy for a minimum of three (3) years.

f. For CSOS (Controlled Substance Ordering System), a Power of Attorney may be granted to additional staff pharmacists as allowed by law.

5.2 **PHARMACY** RECEIPT OF CONTROLLED SUBSTANCES

a. The department of pharmacy will maintain documentation of the receipt of all controlled substances. All invoices received will be dated and signed by at least one pharmacist receiving the medications.

b. Invoices for schedule II-controlled substances will be maintained separately from all other records.

c. Invoices for schedules III, IV and V controlled substances will be maintained in a single file separately from all other records

d. Upon receipt of controlled substances, the package is opened, and the count, condition, and identification of the drugs are verified by a pharmacist. The receiving pharmacist will complete the electronic 222 through the Controlled Substance Ordering System (CSOS).

e. During downtime, the pharmacist will fill out and retain a copy of the DEA Form 222 for all Schedule II controlled substances, indicating the actual number of packages received and date received, and will sign the form or complete the electronic 222 through the Controlled Substance Ordering System (CSOS). The date received and signature is required for each line item.

- The executed DEA Form 222 will be maintained separately from all other records.

- A copy of the supplier's invoice may be attached to the DEA Form 222.
- A reconciled invoice with CSOS system will be used to match the quantity received with quantity ordered.

f. All CII controlled substances will be immediately stored in the respective locked controlled substance area and the perpetual inventory updated accordingly. CIII-V controlled substances will be stored in a locked controlled substance area or may be interspersed with general stock.

g. Any discrepancies in shipment must be identified immediately and reported (same day) to the Director of Pharmacy and/or Pharmacist-in-Charge.

h. Maximum orderable bottle size for controlled substance oral tablets/capsules will be 100, except in extenuating circumstances (i.e. drug shortage). No purchases of greater than 100 count products are allowed without prior approval from the Pharmacist-in-Charge.

6. STORAGE AND ACCESS OF CONTROLLED SUBSTANCES

6.1 HOSPITAL PHARMACY(IES). All controlled substances will be stored in a securely locked area. Access to this area/vault is authorized by the Pharmacy Director or designee, and only to hospital-employed, registered pharmacists. A pharmacy technician, resident or intern assisting in the preparation and dispensing of controlled substances may be granted access to this area, but never without a pharmacist being present. All environmental services or other non-pharmacy staff will only be permitted in this area with a pharmacist present.

6.2 PATIENT CARE AREAS / PYXIS. Controlled substances that are kept at the nursing unit or other patient care area will be securely stored in PYXIS or other securely locked cabinet. The Pharmacy Director or designee will restrict access to authorized personnel.

a. Pyxis access is authorized for staff that administer medication after completion of orientation, review of Pyxis training, and completion of authorization forms. Access is authorized for designated locations of care.

b. Pyxis access for Anesthesia providers (A-carts) is authorized for anesthesia care providers (Anesthesiologists, anesthesia residents, CRNA, SRNA) after completion of orientation, review of Pyxis training, and completion of authorization forms. Access is authorized for designation locations of care.

6.3 PATIENT CARE AREAS – IV MEDICATION BEING ADMINISTERED. Controlled substances being administered must be under sufficient monitoring, security, or surveillance to provide for safe patient care and prevent diversion. Tactics include:

a. Direct observation of IV medication being administered, where the RN is able to provide oversight and control of the medications.

b. Hardware, lockbox to secure IV medication on a pole while being administered to prevent diversion and interfere with the ability to tamper or adulterate the medication preparation.

6.4 OUTPATIENT/RETAIL PHARMACY(IES). CII controlled substances will be stored in a securely locked area. Access to this area/vault is authorized by the Pharmacy

Director or designee, and only to RUHS-employed, registered pharmacists. Only a pharmacist may have keys (or combination) to the locked area. CIII-CV controlled substances may be stored within the securely locked area or may be interspersed among the general stock non-controlled medications.

7. INVENTORY OF CONTROLLED SUBSTANCES

7.1 The Department of Pharmacy (Hospital) and Pharmacist-in-Charge (Inpatient and Outpatient Pharmacies) will maintain a perpetual inventory system for all scheduled drugs and will maintain all controlled substances in accordance with all applicable local, state, and federal laws. These records will be available for inspection by all state and federal regulators

7.2 PERPETUAL INVENTORY systems are used throughout the institution, and may be electronic, digital, or paper. The inventory systems are applied to monitor and manage the inventory of all storage locations.

7.3 Each time that controlled substances are received, dispensed, returned to the pharmacy, or otherwise removed from or added to the inventory, the transaction will be recorded in the perpetual inventory through the PYXIS, or manual log, including:

a. Name and strength of drug

b. Date

c. Amount

d. Area dispensed to or received from

e. Staff member generating the transaction

f. The new inventory balance on hand

7.4 PHYSICAL INVENTORY of controlled substances and designated non-controlled substances is performed regularly throughout the institution.

7.5 HOSPITAL / OUTPATIENT/ RETAIL pharmacies will perform physical inventory of the pharmacy stock monthly by two pharmacy staff members. The physical inventory will be compared to the computed balance in the perpetual inventory system and any discrepancies will be reconciled.

7.6 PATIENT CARE AREAS designated staff will perform physical inventory of all controlled substances in the ADCs no less frequently than once weekly.

a. In addition, a physical inventory is performed on all accessed controlled substances at the end of each shift.

b. The Pharmacy Director, or designee, may require specific areas to perform controlled substance inventories more often as a risk management strategy.

7.7 DEA requires that physical inventory of all stocks of controlled substances will be taken at least every two years at either the opening or closing of business. It will be dated, signed and timed. The biennial inventory will include controlled substances:

a. Stocked in the pharmacy

b. Stocked in the ADCs

c. Expired controlled substances removed from stock but still in control of the registrant

7.8 STATE BOARD OF PHARMACY requires that physical inventory of all stocks of controlled substances will be completed at least quarterly. The quarterly inventory will include controlled substances:

a. Stocked in the pharmacy

b. Stocked in the ADCs

c. Expired controlled substances removed from stock but still in control of the registrant

7.9 When a drug not previously listed as a controlled substance becomes scheduled by the DEA, or drug is rescheduled, the drug will be inventoried as of the effective date of scheduling or change in scheduling as noticed by the DEA.

8. DISPENSING OF CONTROLLED SUBSTANCES:

HOSPITAL:

8.1 Controlled substances will be dispensed from the pharmacy to the nursing units and other patient care areas through the ADC whenever possible. The quantity replenished will be verified by a witness. Personnel authorized to witness include: pharmacy technicians, pharmacists, anesthesiologists, CRNAs and licensed nurses.

8.2 Individual doses of controlled substances (i.e. patient specific) dispensed by the pharmacy will be delivered by authorized pharmacy personnel to the patient care unit. The licensed nurse receiving each controlled substance will sign the delivery form.

8.3 Each controlled substance dispensing will be reconciled after each Pyxis refill or delivery to nurse and is completed by the dispensing pharmacist by reviewing Pyxis receipt or nurse's signature on delivery log. The Pharmacy Director or designee will also review the CII Safe vs Pyxis delivery report routinely as an additional quality assurance process.

8.4 ADC Exception reports will be maintained in the pharmacy for a minimum of three (3) years.

OUTPATIENT PHARMACIES:

8.5 Every time a prescription for a controlled substance is filled, the perpetual inventory log for that drug will be updated accordingly. Documentation will include date, prescription number, drug, strength, quantity and the initials of the pharmacist filling the prescription. The process of completing the inventory log includes the requirement that the initial and final inventory counts are verified

8.6 Filled prescriptions for CII controlled substances that are waiting for pick-up will be stored in a secured designated location.

8.7 Electronic prescriptions may be transmitted and received as allowed by state and federal regulations for CII-V when all criteria are met for electronic prescribing of controlled substances (EPCS).

8.8 In the absence of an approved EPCS system, during downtime procedures, or in the case of an exception to utilizing EPCS, all prescriptions for CII controlled substance will require a written prescription on a valid state approved security form. Exemptions to this requirement may be noted in state codes for hospice or terminally ill patients.

(e.g. California Health and Safety code 11175.2 for hospice patients) and in declarations of emergency by the government.

8.9 All controlled substance prescriptions not submitted through EPCS for CIII, IV, and V must be on a valid state approved security form, phoned in to the pharmacy by a designated representative of the prescriber, or faxed to the pharmacy from the prescriber's office with a valid signature.

8.10 All verbal orders for CIII-V medications shall be transcribed by the receiving pharmacist and initialed/signed and dated.

8.11 Prior to dispensing a CII medication, the quantity of medication in patient's prescription bottle requires a double count. The medication returned to the stock bottle will be counted back. An equivalent process that ensures a valid count documented on the perpetual inventory is also acceptable.

8.12 A licensed staff member is to circle the quantity of medication supplied on the prescription label and initial to signify the double count has been completed.

9. CONTROLLED SUBSTANCE DISCREPANCIES:

9.1 Discrepancy variances will be reported in the hospital event reporting system

9.2 Any discrepancies in controlled substance count will be investigated and documented.

9.3 Discrepancy investigation, documentation, and reconciliation forms are to be returned to Pharmacy auditing program within **7 days**. Early identification, review, and intervention is essential to program integrity.

a. If the reconciliation cannot be feasibly completed within 7 days (e.g., prolonged vacation, FMLA, leave of absence), the status must be submitted for extension consideration.

b. For separated employees, documented attempts will be made to contact the employee before closure of the event.

HOSPITAL:

9.4 Staff Responsibilities (nurses, and Anesthesia care providers):

a. When notified by the ADC system of a controlled substance discrepancy, the user will initiate an investigation as soon as possible. The user should review the ADC printout. The user should review the discrepancy with the previous operator indicated on the ADC printout.

b. The user and the previous operator should document/resolve the discrepancy by entering the findings/reasons for the discrepancy in the ADC and give the ADC printed receipt to the Charge Nurse or Anesthesia Attending for review (if the previous operator is not available, documentation/resolution may be completed with another nurse or anesthesia care provider).

9.5 To reduce the potential for unresolved and inappropriate resolutions, all discrepancies should be resolved by the end of the work shift. All licensed staff must remain in the unit until released by Department Manager and/or House Supervisor.

9.6 Any unresolved discrepancies must be reported by the Department Manager and/or House Supervisor by the next business day to:

a. Director of Pharmacy who will notify Chief Executive Officer or designee as necessary

b. Nursing Administration if applicable

c. Anesthesia Administration if applicable

9.7 Attending Anesthesiologist (or designee) Responsibilities:

a. Orient and train the anesthesia care providers to review Pyxis anesthesia cart activity and the anesthesia record for complete documentation and wastage after each case.

b. The attending physician should review Pyxis activity and Anesthesia record for appropriate use, documentation and wastage after each case to reduce the potential for unresolved and inappropriate resolutions. All ADC discrepancies should be resolved by the end of the work shift. If a discrepancy is identified, the attending physician shall discuss and re-educate anesthesia staff.

c. Anesthesia records with discrepancies will be forwarded to Chair of Anesthesia or designee for investigation.

d. Chair of Anesthesia or designee will investigate all controlled substance discrepancies. Findings will be documented on the Anesthesia/Pyxis Activity Reconciliation Form and returned to Pharmacy within 7 days.

9.8 Nurse Director (or designee) Responsibilities:

a. The Nurse Director will be notified of discrepancies for their unit.

b. The Nurse Director may assign a designee, such as the Charge Nurse, to review all unresolved discrepancies at the ADC prior to the end of his or her shift.

c. The Charge Nurse should immediately follow-up with the user and previous operator on those undocumented discrepancies or where the resolution is unclear or inconsistent and report to the manager.

d. Any undocumented discrepancies or discrepancies with questionable documentation will be reported (same day) to pharmacy management immediately.

e. It is the responsibility of the Nurse Director to monitor ALL discrepancies for appropriate resolutions.

f. Nurse Director or designee will research all unresolved override and discrepancy variances described in the controlled substance reconciliation and submit a response to pharmacy with resolution within seven (7) days of notification.

9.9 Pharmacy's Responsibilities:

a. For any count discrepancy identified within the Pharmacy, the user will investigate the discrepancy and document/resolve the discrepancy with another user. If the discrepancy cannot be resolved, the user will immediately report the discrepancy and the result of their investigation to the Director of Pharmacy or designee.

b. Pharmacy auditing program will send a weekly report of outstanding discrepancy variances to Nursing directors, Anesthesia Attendings, CNO, and Assistant CNOs.

9.10 The Director of Pharmacy or designee will:

a. Monitor and review all discrepancies to ensure appropriate resolution.

b. Follow up with the Nurse Director or Chief of Anesthesia on all discrepancy variances

c. Conduct an immediate investigation of discrepancy variances logged in the ADC system or from the CSARs.

d. Report discrepancies resulting in a loss of a controlled substance to the DEA within one business day, and Board of Pharmacy in accordance with State and Federal regulations. Reporting to local law enforcement may be completed as well. Prior to reporting to the DEA, the Board of Pharmacy and the local police department, the Director of Pharmacy will notify the Chief Executive Officer and Chief Nursing Officer of the hospital.

e. Take appropriate actions that includes options such as:

- Generate additional Pyxis Reports
- Complete Incident Report
- Accept corrections from department manager
- Update controlled substance reconciliation database
- Escalation to appropriate parties if unable to resolve
- Removal of staff access to Pyxis until education and remediation have been satisfactorily completed. Remediation may include direct observation and retraining
- All incidents may be referred to Human Resources and the Controlled Substance Diversion Prevention Team

9.11 OUTPATIENT PHARMACIES:

a. The user that identifies the discrepancy will investigate the discrepancy and document/resolve the discrepancy with another user. If the discrepancy cannot be resolved, the user will immediately report the discrepancy and the result of their investigation to the Pharmacist-in-Charge. In addition, the user will fill out a controlled substances discrepancy report

b. The Pharmacist-in-Charge or designee will conduct an immediate investigation of the discrepancy and attempt to resolve it.

c. Discrepancies resulting in a loss of a controlled substance will be reported to the DEA within one business day of identification on form 106 and Board of Pharmacy by the Pharmacist-in-Charge or designee in accordance with State and Federal regulations. Reporting to the local police department will be completed in a timely fashion if necessary. Prior to reporting to the DEA, the Board of Pharmacy and the local police department, the Director of Pharmacy will notify the Hospital Director of Pharmacy and the Chief Executive Officer of the hospital.

10. ADMINISTRATION OF CONTROLLED SUBSTANCE:

10.1 At the time the dose is needed for administration, the administering licensed staff member will remove the medication from the ADC.

10.2 The administering licensed staff member must document each dose of controlled substances administered on the Medication Administration Record or as otherwise appropriate in the medical record.

11. RETURNING AND WASTING OF CONTROLLED SUBSTANCES:

In Hospitals:

11.1 Unused and unopened controlled substances must be returned to the ADC or pharmacy as soon as possible, within 30 minutes of medication removal or end of procedure as permissible by patient safety and medication administration policy. All medications are returned and reconciled no later than the end of the shift.

11.2 Inside the OR, all opened controlled substances, including waste, will be returned with the printed receipt and will be placed in the ADC's secure, external return bin.

11.3 Individually dispensed doses of controlled substances not stocked in an ADC, may be returned to pharmacy according to the following procedure:

a. Upon receipt of the product, the pharmacist will verify the item and quantity returned, sign and record on the return log, and return the item back to CII safe or waste as appropriate.

11.4 Whenever a portion of a dose or full dose in unused, it must be wasted by licensed personnel in the presence of a second licensed personnel who serves as a witness. The wastage will be recorded through the ADC.

11.5 A controlled substance is not considered wasted until the waste is documented and the medication has been destroyed. The contents of partially used syringes, ampules, vials, etc. should be expelled into the pharmaceutical waste container before the product is discarded to prevent possible abuse in the waste stream.

11.6 A report of unreconciled waste will be sent, as necessary, to the unit manager for investigation. The unit manager will provide follow-up on each unreconciled waste to the Director of Pharmacy or designee.

11.7 Anesthesia must be complete the post-case reconciliation of all transactions from the anesthesia workstation or manual administration card. Unused and unopened medications may be returned to the ADC and partially administered doses must be wasted as described above or returned to the pharmacy in the locked anesthesia box for recording and witnessing by two pharmacy personnel (at least one of which must be a pharmacist).

11.8 Procedural areas that waste controlled substances outside of the ADC must have a daily reconciliation process that validates documentation of a witness to the waste.

11.9 Outpatient Pharmacy: if a controlled substance needs to be wasted, like a broken or crushed tablet, the event shall be witnessed and documented by two pharmacists.

12. ONBOARDING PROCESS AND CONTINUED EDUCATION:

12.1 Chair of Department/Director or designee shall orient staff under the guidance of the Pharmacy Department to include:

a. Pyxis tutorial
b. Bio ID enrollment
c. Anesthesia documentation (if required)
d. Returns & waste process
e. Inventory process
f. Reconciliation process

12.2 An educational module on controlled substance diversion prevention will be developed and all staff with access to CS will complete this training on an annual

basis. Human Resources is responsible for assuring compliance with this requirement. Content of this module to include training on signs and symptoms of substance abuse and addiction, drug diversion monitoring and prevention, and the duty to report when CS discrepancies or suspected CS diversion are encountered.

13. CONTROLLED SUBSTANCE KEYS:

13.1 Keys for refrigerator lock boxes or manual controlled substance drawers/cabinets will be stored in and accessed through the ADC whenever possible.

13.2 Any lost keys will be reviewed as a discrepancy variance and will be investigated and documented accordingly. All incidents will be documented in the event reporting system by the licensed staff who lost the key or their supervisor.

14. EXPIRED CONTROLLED SUBSTANCES:

HOSPITAL

14.1 A pharmacist (or other pharmacy personnel as allowed by state regulations) will routinely check all ADCs and the CII safe for the presence of expired medications

14.2 Controlled substances require a witness, for those not a licensed pharmacist, to remove the expired medication or validation through the ADC

14.3 Expired medication will be removed from the ADC using the “expired/recall” function.

14.4 Expired medication supply in the CII safe in the pharmacy will be removed and processed as an expired medication.

14.5 Expired controlled substances will be returned to the CII safe designated expired area and will be recorded through the ADC system.

14.6 Expired CII controlled substances will be stored separately from C III - V items.

OUTPATIENT PHARMACIES:

14.7 Expired controlled substances must be debited from “active inventory” and tracked in an “expired inventory”.

14.8 Expired CII controlled substances will be stored separately from CIII – V items.

14.9 Reverse Distribution for Hospital and Outpatient Pharmacies:

a. Expired controlled substances will be transferred to a DEA registered reverse distributor who handles the disposal of controlled substances (CS). A member of the pharmacy staff will count the CS to be returned in the presence of the reverse distributor staff and validate the count matches the pharmacy record prior to releasing the CS to the reverse distributor.
b. The reverse distributor will issue an official DEA Form 222 or the electronic equivalent for the transfer of the controlled substances.
c. The pharmacy will maintain a record of distribution that lists:
- Drug name
- Dosage form
- Strength
- Quantity

d. The pharmacy will compare the controlled substances listed on the DEA Form 222 to the expected list of controlled substances to be transferred. Any discrepancies will be reconciled.

e. The pharmacy will compare the report of schedule III - V controlled substances on the vendor return report to the expected list of controlled substances to be transferred. Any discrepancies will be reconciled.

15. COMPREHENSIVE MONITORING OF CONTROLLED SUBSTANCES:

15.1 The Pharmacy Director, Pharmacist-in-Charge or designee is responsible for oversight of the Controlled Substance Diversion Prevention Auditing Program.

15.2 Pharmacy Director or designee will review Pyxis Activity Report for patients with Anesthesia records and/or MARs for:

a. Medication dispensed from Pyxis

b. Documentation of medications administered

c. Controlled substance returns and waste

15.3 Proactive diversion monitoring will be performed by a pharmacy reviewer to track controlled substance activity trends that are outliers in comparison to their peers. These warrant further investigation to determine if there is a valid explanation behind the increased activity.

15.4 Each ADC, and anesthesia cart will have its controlled substance activity reviewed

15.5 All controlled substances that are removed on override are reviewed for the following components:

a. Corresponding physician order is documented and signed

b. Order had not been discontinued prior to administration

15.6 Additional causes for investigation and suspected diversion:

a. Incorrect procedure – e.g. removal of controlled substance not on patient profile using inventory function, removal of a controlled substance and return back to ADC after longer than a reasonable amount of time

b. Dose/Order mismatch

c. Remove too soon – removal of controlled substances with PRN indications but removed more frequently than order specifications

d. Unreasonable duration of time between medication removal and documentation of medication disposition: administration, waste, or return.

- Nursing users: Medication documentation disposition is expected to occur within 30 (thirty) minutes of removal from ADC
- Anesthesia care providers: Medication documentation disposition is expected to occur as close to immediately after the end of each case

e. Incorrect patient ID – controlled substance removed under temporary patient and not reconciled

f. Waste – expected waste amount based on the ordered amount compared to the formulation size is not matching or wasting entire dose without an acceptable documentation of reason

g. Multiple pain medications removed – When a mild, moderate, and/or severe pain order are pulled within short duration

15.7 All override and discrepancy variances will be documented in a pharmacy database

15.8 New variances will be communicated to department managers via a controlled substance reconciliation to request for more information, resolution and appropriate education of the involved parties

16. DIVERSION OF CONTROLLED SUBSTANCES:

16.1 No prescription drug or controlled substance may be sold, transferred or otherwise distributed, except as allowed by law and as authorized by written policy or by the appropriate individual charged with such responsibility. All employees must strictly adhere to all laws, regulations, and hospital policies and procedures regarding procurement, distribution, storage, administration, documentation, and destruction of prescription drugs and controlled substances.

16.2 The hospital and outpatient pharmacy have a responsibility to investigate and intervene when there is a report and/or suspicion of drug diversion. There is a multidisciplinary process to respond to reported or suspected diversions.

16.3 The multidisciplinary process may include designated representatives from the following areas (Controlled Substance Diversion Prevention Team (CSDPT)):

a. Pharmacy Administration

b. Hospital Administration

c. Nursing Administration

d. Human Resources Administration

e. Quality and Compliance Management

f. Security

g. Medical Staff Administration

h. Anesthesia Administration

16.4 Roles and responsibilities:

a. Pharmacy Administration: The Pharmacy Director, Pharmacist-in-Charge or designee will monitor, review and evaluate controlled substance usage patterns, individual activity reports, statistical usage reports and discrepancies. The Director/designee will participate in all investigative interviews involving suspected diversion. In addition, the Director of Pharmacy or Pharmacist-in-Charge is responsible for reporting all theft/loss or suspicion of drug diversion to the State Board of Pharmacy, the DEA and local law enforcement as appropriate

b. Nursing Administration: The CNO or designee will assist with diversion investigation and chart review as needed. The CNO/designee will act as liaison with nursing personnel, including registry. In addition, the CNO is responsible for ensuring regulatory reporting to the appropriate licensing board for all known or suspected drug diversions.

c. Human Resources Administration: The Director of Human Resources or designee will facilitate investigative interviews with employees, and act as liaison with the appropriate unions for represented employees. In addition, they will be responsible for all employment issues and maintaining all pertinent documentation in the employee's file.

d. Quality and Compliance Management: The Quality Manager will assist with diversion investigation and chart review as needed in collaboration with the CNO and CEO. The Quality Manager is responsible for required regulatory reporting of any adverse events related to a known or suspected drug diversion.

e. Hospital Administration: Hospital administration will assist in the review and resolution of all known or suspected incidents of drug diversion.

f. Security Staff: Security will provide assistance when a request is made by a member of the Drug Diversion Team. The Director of Security or their designee may be requested to assist with and conduct interviews or investigations of drug diversions. At no time will security officers force an employee to submit to a search or touch the employee without their consent. If there is reasonable suspicion to believe that a particular individual may be in possession of materials in violation of this policy, security officers may conduct a search of the employee (with their consent), their work area, lockers, personal items, and vehicle if the vehicle is parked on property owned and/or operated by RUHS, and with the employee or owner's consent. All searches shall be witnessed by a second party.

g. Medical Staff Administration: Information for any suspected incidence of drug diversion involving a member of the medical staff will promptly be reported to Medical Staff Administration for appropriate follow up/resolution by the CMO in accordance with the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policy.

h. Anesthesiology Administration: In the event a suspected incidence of drug diversion involves a member of the anesthesia department (Anesthesiologist, CRNA, or SNRA), a member of anesthesiology administration will be invited to the meeting.

16.5 Entire team: In addition to ad hoc meetings called in response to a reported or suspected diversion, the CSDPT will:

a. Meet on a regular basis to review diversion prevention monitoring reports, as well as analyze findings and modify the monitoring process as needed.

b. Review the educational module on CS diversion prevention prior to implementation and annually, as well as modify as needed.

16.6 Suspected Drug Diversion Investigation:

a. All employees are expected to report knowledge/suspicion of drug diversion. Employees should report any known or suspected drug diversion incidents to their manager/director. Department Managers/ Directors will notify the Director of Pharmacy or designee for further follow up.

b. The Director of Pharmacy, Pharmacist-in-Charge or designee will initiate a preliminary investigation. The Director of Pharmacy, Pharmacist-in-Charge or designee may also initiate an investigation based on the ongoing monitoring and auditing of controlled substance usage.

c. If, after review of the preliminary investigation, drug diversion is suspected or cannot be excluded as a possibility, the Director of Pharmacy, Department Manager of suspected employee or designee will initiate the multidisciplinary drug diversion investigation process.

d. An employee suspected of drug diversion will have access to controlled substances immediately revoked by the Director of Pharmacy or designee.

e. An employee suspected of drug diversion may be placed on administrative suspension while the investigation is in process. No decision regarding employment is made until the investigation has been completed and management and Human Resources have been consulted. The manager will make the decision regarding employment in consultation with Human Resources.

f. Suspected diversion involving a member of the medical staff will be reported to Medical Staff Administration.

g. An intensive investigation of the suspected diversion incident will be conducted and will include, but not limited to, review of controlled substance dispensing records, MARs, physician orders, nursing notes, records of waste, pain assessments, and staff interviews.

h. The Hospital Controlled Substance Diversion Prevention Team will review the results of the investigation and determine whether further investigation, including an investigative interview with the employee and/or any potential witnesses is warranted.

i. Once the investigation is completed, Human Resources will consult with the appropriate director/manager regarding any disciplinary action, up to and including termination of employment.

- The CMO will follow up with members of the medical staff in accordance with the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policy.

j. The hospital will report all known or suspected cases of drug diversion to the appropriate licensing board. Incidents of known or suspected drug diversion may also be reported to local law enforcement as appropriate.

17. REPORTING OF LOSS OR THEFT OF CONTROLLED SUBSTANCES:

17.1 Discovery of theft or loss must be reported immediately (same day and prior to reporting outside of the organization) to the Chief Nursing Officer and Chief Executive Officer.

17.2 The Director of Pharmacy, Pharmacist-in-Charge or designee will notify the local Field Division office of the DEA of any theft or significant loss of any controlled substances within 24 hours of the discovery of such theft or loss.

17.3 When determining whether a loss is significant, the following factors should be considered:

a. The actual quantity of controlled substances lost;
b. The specific controlled substance lost;
c. Whether the loss of the controlled substances can be associated with access to those controlled substances by specific individuals, or whether the loss can be attributed to unique activities that may take place involving the controlled substance.
d. A pattern of losses over a specific time period, whether the losses appear to be random, and the results of efforts taken to resolve the losses; and if known.
e. Whether the specific controlled substance are likely candidates for diversion.
f. Local trends and other indicators of the diversion potential of the missing controlled substance.

17.4 A DEA Form 106 will be completed regarding such theft or loss.
   a. If, after the initial notification to the DEA, the investigation of the theft or loss determines no such theft or loss of controlled substance occurred, a DEA Form 106 does not need to be filed. However, the DEA must be notified in writing of this fact in order to resolve the initial report and explain the decision to not file a DEA form 106.

17.5 Thefts will be reported whether the controlled substances are subsequently recovered and/or the responsible partied are identified and action taken against them.

17.6 Loss or theft of controlled substance will also be reported to:

   a. State Board of Pharmacy as required
   b. Local law enforcement / police.
   c. RUHS event reporting system.

18. REFERENCES

18.1 21 CFR. Theft/Loss Reporting. https://www.deadiversion.usdoj.gov/21cfr_reports/theft/index.html

18.2 California State Board of Pharmacy. Business & Professions Code, §4104

18.3 California Code of Regulations, Division 17, Title 16, §1715.6

18.4 CMS State Operations Manual. Appendix A.

Document History:

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Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
5/14/2024	Pharmacy Review Committee		Updated 5.2 d/e due to change in DEA 222 forms; updated 8.8 for downtime; updated 9.3 for extensions and separated employees
6/3/2024	Pharmacy & Therapeutics Committee		Update 7.6 for inventory count of accessed medications
7/3/2024	Pre Nursing P&P	N	No recommended changes, move to NPP for consent agenda item.
7/18/2024	Nursing P&P	N	Consent agenda item
11/5/2024	PAC	N	Consent calendar
1/8/2025	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

MEDICAL CENTER and COMMUNITY HEALTH CENTERS

	Document No: 885	Page 1 of 5
Title: Patient-Delivered Partner Therapy (PDPT) for Sexually Transmitted Infections- Chlamydia & Gonorrhea	**Effective Date:** 3/14/2025	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 This policy applies to RUHS- Medical Center, Emergency Department, and RUHS - Community Health Centers.

1.2 This procedure applies to patients 12 years of age or older with a sexual partner diagnosed with Chlamydia (CT) /Gonorrhea (GC) infections, including pregnant women.

1.3 Patient-Delivered Partner Therapy is not appropriate for suspected child abuse, sexual assault/rape, intimate partner violence or any situation where patient-partner communication or safety is in doubt.

2. DEFINITIONS

2.1 PDPT. Patient-Delivered Partner Therapy is a free alternative partner management strategy for patient's sexual partners. PDPT is funded by Title X for healthcare providers/facilities meeting funding criteria.

2.2 STI: Sexually transmitted infection

3. POLICY

3.1 A combination of partner strategies may be used. For example, a patient may choose to refer one partner to the clinic but take PDPT for other partner(s).

3.2 The first-choice strategy for managing partners of patients CT/GC is to attempt to have all sex partners evaluated, tested, and treated for STIs by a provider.

3.3 The partner(s) should still be encouraged to seek follow-up medical care as soon as possible even if PDPT is provided.

3.4 Appropriate persons for PDPT are those with a sexual partner diagnosis with CT/GC infection.

3.5 The diagnosis of these infections in the index patient should be either by:

a. Laboratory confirmed results consistent with infection OR

b. High clinical suspicion - Provider observes and documents that he/she has a high clinical suspicious for CT/GC infection.

3.6 All Partners in the 60 days prior to diagnosis should be considered at risk for infection and should be treated. If patient reports no partners in previous 60 days, the most recent partner(s) should be treated.

3.7 Gender of Partner or the index patient is not a consideration in selecting PDPT. Sexual orientation of the Partner or the index patient is not a consideration in selecting PDPT.

4. PROCEDURES:

4.1 Patient eligibility for PDPT

a. **Indication of CT/GC infection:**

- Uncomplicated: No Pelvic Inflammatory Disease (PID), epididymitis, disseminated gonococcal infection (DGI) or lymphogranuloma venereum (LGV)
- Confirmed by laboratory testing (e.g., gram stain, culture, NAAT test) OR confirmed infection by outside provider OR provider documents high clinical suspicion of CT/GC infection.
  Exception: Patients known to be co-infected with syphilis are not good candidates for PDPT as more aggressive partner management strategies should be pursued.

4.2 Prescribing PDPT:

After determining the patient's interest, the provider prescribes appropriate PDPT packs:

a. CT Only Pack (Chlamydia):
- **Doxycycline 100 mg PO every 12 hours x 7 days**
- Chlamydia index patient brochure (see Attachment 7.1-7.2)
- The information of nearby clinics for STI evaluation and treatment
- Gonorrhea and chlamydia PDPT Partner information brochures

b. GC/CT Combination Pack (both gonorrhea and chlamydia):
- **Doxycycline 100 mg PO every 12 hours x 7 days PLUS**
- **Cefixime 800mg orally one time (400mg x 2 tabs)**
- Gonorrhea and chlamydia index patient brochures (See Attachment 7.1-7.4)
- The information of nearby clinics for STI evaluation and treatment
- Gonorrhea and chlamydia PDPT Partner information brochures

c. Pregnant Patient Pack (both gonorrhea and chlamydia):
- **Azithromycin 1 gram orally one time (500mg x 2 tabs) PLUS**
- **Cefixime 800mg orally one time (400mg x 2 tabs)**
- Gonorrhea and chlamydia index patient brochures (See Attachment 7.1-7.4)
- The information of nearby clinics for STI evaluation and treatment
- Gonorrhea and chlamydia PDPT Partner information brochures

4.3 Providing PDPT to the patient or Partners:

a. Authorized clinic staff who can provide PDPT packages to the eligible Partners:
- Registered nurses (RN)
- Licensed vocational nurses (LVN)

b. Responsibilities:

- Place contents as indicated above into a bag or envelope.
- Provide PDPT education materials and pack(s) to patient's partner(s)
- Review the appropriate PDPT informational brochures including emphasis of the following:

i. Partners to read all the informational material carefully before taking the medication.

ii. Circumstances when an individual should not take the medication include a known history of severe allergic reactions to penicillin or cephalosporins, a serious long-term illness such as kidney, heart or liver disease, and use of other prescription medication, including medicine for diabetes

iii. Potential adverse drug events and what to do in case of severe reaction**.**

iv. The importance of seeing a doctor for complete STI evaluation and the nearby clinic information

v. Patients and partners should abstain from sex for at least seven days after treatment and until seven days after all partners have been treated in order to reduce the risk of recurrent infection

vi. Number(s) to call for problems or questions

4.4 Documentation:

a. All PDPT medications activities shall be documented in the PDPT medication tracking log

b. PDPT medication tracking log will include the following tracking information (See attachment 7.5):

- The number of Partners to receive PDPT pack(s)
- The type of PDPT packs prescribed
- PDPT education material reviewed with patient

c. The PDPT tracking log is primarily for the medication management and inventory purpose.

4.5 Reporting adverse drug reactions to PDPT:

a. In addition to the standard RUHS process of reporting adverse drug reactions, providers should also email EPT@cdph.ca.gov or contact 510-620-3400 to alert the State Control Branch

b. The Area Medical Director should report any notable adverse drug reactions to PDPT to the Division of HIV and STI Programs at 213-368-7441

5. PDPT Medication Management

5.1 Procurement/Ordering Process

a. PDPT medications will only be ordered from the state program by the assigned point-person

b. The assigned point-person will order PDPT medications by submitting the ordering form to CT/GC PDPT Distribution Program

c. PDPT medications may be ordered no more frequently than once per month. Essential Access Health recommends placing two bulk orders per year per site

d. There is currently no cap on the amount of medication that can be requested per order. Essential Access Health advises ordering a six-month supply for each practice site

5.2 Storage

a. PDPT medications will be stored separately from the regular clinic or departmental stock medications

b. PDPT medications shall follow all applicable RUHS medication storage policies and procedures

c. PDPT medications shall be stored in the **designated locked storage areas and locked carts**

d. Only authorized, licensed individuals can access the PDPT medications. Non-licensed staff members shall be accompanied and supervised when maintaining the medication rooms by authorized, licensed staff.

e. The designated ED Providers conduct review of the PDPT medication supply for outdated/expired medication.

f. In the ambulatory clinics, the qualified RUHS pharmacist will conduct inspections of medication storage areas.

5.3 Expired PDPT medications

a. When the PDPT medications are expired, the following steps shall be followed:

- Waste the expired PDPT medications to the appropriate medication waste bins following the RUHS waste management process.
- Record the amount of PDPT medications wasted in the PDPT medication tracking log

6. REFERENCES

6.1 California Code, Family Code - FAM § 6926

6.2 *Patient-Delivered Partner Therapy (PDPT) for Chlamydia, Gonorrhea, and Trichomoniasis: Guidance for Medical Providers in California*. California Department of Public Health Sexually Transmitted Diseases (STD) Control Branch in collaboration with the California STD Controllers Association, and the California Prevention Training Center (CAPTC)

7. ATTACHMENTS

7.1 PDPT Chlamydia Patient Education – English

7.2 PDPT Chlamydia Patient Education – Spanish

7.3 PDPT Gonorrhea Patient Education – English

7.4 PDPT Gonorrhea Patient Education -- Spanish

7.5 PDPT Medication tracking log

Document History:

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08/30/24	Infection Prevention, ED Dr. Sy, Pharmacy	Y	Reviewed all roles, procedures. Updated 5.2(e) – ED storage is inspected by ED providers
09/10/2024	Pharmacy Review Committee	Y	Added 5.2 (f) med inspection by RPh in ambulatory clinics.
10/7/2024	Pharmacy & Therapeutics Committee	N	
12/3/2024	PAC	N	
1/8/2025	MEC	N	

What is Chlamydia (cla-MI-dee-a)?

- Chlamydia is an infection you can get in your vagina, penis, anus or throat.
- Most people with Chlamydia do not have any signs or symptoms.
- When people do have symptoms, they can be mild at first.

You may have some of these symptoms:

- Pain or burning when you urinate (pee)
- Fluid from the vagina, penis, or anus that smells or looks strange
- Bleeding from the vagina during or after sex
- Pain or tingling in the penis
- Pain in the lower belly or back, especially when having sex (women)
- A fever

Is Chlamydia serious?

Yes! If you don't get treated:

- It may be impossible to get pregnant or have babies later on.
- You may pass Chlamydia to people you have sex with.
- You can pass it to your baby during birth.
- You may feel pain in your lower belly during sex for months or even years. (women)
- You may have pain and swelling in your testicles.
- It can cause you to have a pregnancy that grows outside of your uterus, which can cause death.
- You may get other diseases more easily, like HIV.

How did I get Chlamydia?

- You got it by having vaginal, anal, or oral sex with someone who has it.
- Most people don't know they have it and you can't tell if someone has it by looking at them.
- Getting tested is the only way to find out if you have it.

What should I do now?

Chlamydia can be cured if you follow these 3 important steps:

1. Take all of the medicine your doctor or nurse gives you.
2. Make sure ALL of your sex partners from the past 2 months get medicine for Chlamydia as soon as possible.
3. Don't have sex until 7 DAYS AFTER both you and your sex partner(s) finish the medicine.
   → If you do have sex before 7 days, use a condom.

If you don't follow all of these steps, you can get Chlamydia AGAIN and it can be worse!

Many people who get Chlamydia GET IT AGAIN:

Get tested again in 3 months!

- Having Chlamydia once will NOT protect you from getting it again.
- Getting another infection with Chlamydia is really common.
- Getting infected with Chlamydia again can cause a lot more harm inside your body.
- Most of the time there are no symptoms when you get Chlamydia again.

→ It is really important to come back to **get tested again in 3 months**.

Remember! It is also very important to:

- Return to the clinic if your symptoms don't go away within a few days.
- Use a condom every time you have sex so you don't get Chlamydia again.

Chlamydia

What should I know about my treatment?

DO NOT HAVE SEX UNTIL 7 DAYS AFTER YOU AND YOUR PARTNER(S) FINISH THE MEDICINE

You have been given the medicine checked below:

❑ **Azithromycin**

Take all of this medicine at once, as soon as you get it.

❑ **Doxycycline**

- Take 1 pill in the morning and 1 pill at night for 7 days.
- DO NOT take this medication if you think you may be pregnant or if you are nursing.
- Take this medicine with food or milk if it upsets your stomach.
- You can be easily sunburned while on this medication.

What are the possible side-effects of treatment?

If you have either of these problems, **call 911 right away:**

- Wheezing
- Trouble breathing

If you have any of these problems, **please call the clinic:**

- A skin rash or bumps
- Itching
- Vomiting (throwing up)

WHAT IF I'M PREGNANT?

- If you think you are pregnant, tell the doctor or nurse before you take any medicine.
- Tell the doctor you are seeing for your pregnancy that you have tested positive for Chlamydia.
- If you are keeping the pregnancy, you will need to get tested again for Chlamydia in **3 to 4 weeks**. This is to make sure that you are cured.
- If you do not get treated, you can pass Chlamydia to your baby while giving birth. This can cause serious eye or lung infections in your baby.

What about my sex partner(s)?

There are many ways to make sure your sex partners get medicine for Chlamydia. Here are some of them:

- Bring your partner into clinic with you when you come in for treatment.
- Ask your doctor or nurse for extra medicine to take to your partner(s).
- Ask your partner(s) to go to their own doctor to get medicine.
- Go to the website www.inspot.org to send an email telling your partner(s) they may have Chlamydia – you can do this without giving your name.

What else do I need to know?

- Chlamydia is a very common sexually transmitted infection (STI):
  - 1 in 10 girls and young women have it. Lots of guys get it, too.
- Most people with Chlamydia *do not* have any symptoms:
  - If you do have symptoms, they can show up right away or as long as 30 days after having sex with someone who has Chlamydia.
- Once you've had Chlamydia, there is a very high chance of getting it again. You might get it again:
  - If you have sex with someone who did not get treated, or
  - If you have sex too soon after you and your sex partner(s) finish the medicine, or
  - If you have sex with a new partner who has it.
- You can have Chlamydia and other STIs at the same time.

Portions of this form were adopted from the California Department of Public Health, Office of Family Planning: *Chlamydia-What You Need To Know* (OF2701), retrieved from http://www.familypact.org

If you have a medical problem or concern after clinic hours, call: 1-XXX-XXX-XXXX
Your Organization Address and Phone Number Here

¿Qué es la clamidia?

- La clamidia es una infección que puede afectar a la vagina, el pene, el ano o la garganta.
- La mayoría de las personas con clamidia no muestra señales o síntomas de la infección.
- Cuando los síntomas están presentes, estos pueden ser leves al principio.

Usted podría presentar algunos de los siguientes síntomas:

- Dolor o ardor al orinar
- Flujo de olor o apariencia extraños en la vagina, el pene o el ano
- Sangrado en la vagina durante o después de las relaciones sexuales
- Dolor o cosquilleo en el pene
- Dolor abdominal o en la espalda, particularmente durante las relaciones sexuales (las mujeres)
- Fiebre

¿Es grave la clamidia?

Sí lo es, y de no recibir tratamiento, usted:

- Enfrentaría la posibilidad de no poder quedar embarazada o tener bebés en el futuro.
- Podría transmitir la clamidia a otras personas con las que tenga relaciones sexuales.
- Podría transmitirla a su bebé durante el parto.
- Podría experimentar dolores abdominales durante las relaciones sexuales durante meses o incluso años (las mujeres).
- Podría experimentar dolor e inflamación de sus testículos.
- Podría causarle embarazos extra uterinos, con riesgo de muerte.
- Tendría más susceptibilidad a infectarse con otras enfermedades, como el VIH.

¿Cómo me infecté con clamidia?

- Usted la contrajo al tener relaciones sexuales vaginales, anales u orales con alguien que ya la tenía.
- La mayoría de las personas no saben que están infectadas y es imposible saberlo con solo mirar a la persona.
- La única manera de saber si usted se ha infectado es hacerse las pruebas.

¿Qué debo hacer ahora?

La clamidia se cura fácilmente si usted sigue los siguientes tres pasos:

1. Tómese toda la medicina que su doctor o la enfermera le receten.
2. Asegúrese de que TODAS sus parejas con las que ha tenido relaciones sexuales en los últimos dos meses obtengan tratamiento para la clamidia lo antes posible.
3. No tenga relaciones sexuales hasta que hayan transcurrido SIETE DÍAS desde que usted y su(s) pareja(s) sexual(es) terminaron el tratamiento.

→ Si tuviera relaciones sexuales antes de los siete días, utilice un condón.

Si no siguiera todos los pasos anteriores, usted podría REINFECTARSE de clamidia con efectos aún más graves.

Muchas personas que se infectan con clamidia VUELVEN A REINFECTARSE

Hágase la prueba nuevamente en TRES meses.

- El haber contraído clamidia NO confiere inmunidad contra la reinfección posterior.
- La reinfección con clamidia es bastante común.
- La reinfección con clamidia puede causarle daños aún mayores en su cuerpo.
- En la mayoría de los casos, no se presentan síntomas debido a la reinfección con clamidia.

→ Es fundamental que regrese y **se haga la prueba de nuevo a los tres meses**.

Recuerde: Es muy importante que:

- Regrese a la clínica si sus síntomas no desaparecen en pocos días.
- Utilice un condón cada vez que tenga relaciones sexuales para que no se reinfecte con clamidia.

Clamidia

¿Qué debo saber sobre mi tratamiento?

NO TENGA RELACIONES SEXUALES HASTA SIETE DÍAS DESPUÉS DE QUE USTED Y SU(S) PAREJA(S) HAYAN TERMINADO EL TRATAMIENTO.

Se le ha entregado la medicina marcada a continuación:

❑ **Azitromicina** (Azithromycin)

Tómese toda esta medicina de una sola vez tan pronto se la den.

❑ **Doxiciclina** (Doxycycline)

- Tómese UNA píldora en la mañana y otra por la noche durante SIETE días.
- NO tome esta medicina si cree que pueda estar embarazada o si está amamantando.
- Si esta medicina le molestara el estómago, tómela con los alimentos o con leche.
- Esta medicina puede causarle susceptibilidad a las quemaduras de sol.

¿Cuáles son los posibles efectos secundarios de este tratamiento?

Llame inmediatamente al 911 si presentara alguno de los siguientes problemas:

- Resuellos (jadeos)
- Dificultad para respirar

Llame a la clínica si presentara alguno de los siguientes síntomas:

- Sarpullido o protuberancias en la piel
- Picazón
- Vómito

¿QUÉ SUCEDE SI ESTOY EMBARAZADA?

- Si cree que está embarazada, dígaselo a su doctor o enfermera antes de tomar cualquier medicina.
- Dígale al médico que le da atención prenatal, que el resultado de la prueba indica que es positiva para clamidia.
- Si va a continuar con su embarazo, será preciso que se haga nuevamente las pruebas para clamidia en **tres o cuatro semanas más.** Esto se hace para garantizar que ya esté curada.
- Si usted no recibiera tratamiento para la clamidia, puede contagiar a su bebé durante el parto. Esto puede causarle serias infecciones en los ojos o los pulmones a su bebé.

¿Qué hay de mi(s) pareja(s) sexual(es)?

Hay muchas maneras de lograr que su(s) pareja(s) sexual(es) reciban tratamiento para la clamidia. A continuación se mencionan algunas de ellas:

- Hágase acompañar de su pareja cuando venga a la clínica a recibir tratamiento.
- Pídale a su doctor o enfermera que le den una dosis adicional para llevársela a su(s) pareja(s).
- Pídale a su(s) pareja(a) que visite a su propio médico para recibir tratamiento.
- Visite el sitio web www.inspot.org, desde donde podrá enviar un correo electrónico anónimo a su(s) pareja(s) para informarle(s) que podría(n) tener clamidia.

¿Qué más necesito saber?

- La clamidia es una infección de transmisión sexual (ITS) muy común.
  - Una de cada diez adolescentes y mujeres jóvenes la tiene. Muchos varones también la tienen.
- La mayoría de las personas con clamidia no muestran ningún síntoma.
  - De presentarse, los síntomas pueden aparecer inmediatamente o incluso hasta 30 días después de haber tenido relaciones sexuales con una persona infectada.
- Si usted ya tuvo clamidia, la probabilidad de reinfectarse es muy alta. La reinfección podría ocurrir si:
  - Tiene relaciones sexuales con alguien que no recibió tratamiento, o…
  - Tiene relaciones sexuales muy pronto después de que usted y su(s) pareja(s) sexual(es) ha(n) completado el tratamiento, o…
  - Tiene relaciones sexuales con una nueva pareja ya infectada.
- Es posible que usted tenga clamidia y otras ITS simultáneamente.

Partes de este formulario son adaptaciones del documento California Department of Public Health, Office of Family Planning: Chlamydia-What You Need To Know (OF2701), obtenido en http://www.familypact.org

Si tuviera algún problema médico u otra inquietud cuando la clínica se encuentre cerrada, llame al 1-XXX-XXX-XXXX
Your Organization Address and Phone Number Here

What is Gonorrhea (gon-o-RHEE-a)?

- Gonorrhea is an infection you can get in your vagina, penis, anus or throat.
- Many people with Gonorrhea do not have any signs or symptoms.
- When people do have symptoms, they can be mild at first.

You may have some of these symptoms:

- Pain or burning when you urinate (pee)
- Fluid from the vagina, penis, or anus that smells or looks strange
- Bleeding from the vagina during or after sex
- Pain or tingling in the penis
- Pain in the lower belly or back, especially when having sex (women)
- A fever

Is Gonorrhea serious?

Yes! If you don't get treated:

- It may be impossible to get pregnant or have babies later on.
- You may pass Gonorrhea to people you have sex with.
- You can pass it to your baby during birth.
- You may feel pain in your lower belly during sex for months or even years. (women)
- You may have pain and swelling in your testicles.
- It can cause you to have a pregnancy that grows outside of your uterus, which can cause death.
- It can spread to your blood and joints.
- You may get other diseases more easily, like HIV.

How did I get Gonorrhea?

- You got it by having vaginal, anal, or oral sex with someone who has it.
- Most people don't know they have it and you can't tell if someone has it by looking at them.
- Getting tested is the only way to find out if you have it.

What should I do now?

Gonorrhea can be cured if you follow these 3 important steps:

1. Take all of the medicine your doctor or nurse gives you.
2. Make sure ALL of your sex partners from the past 2 months get medicine for Gonorrhea as soon as possible.
3. Don't have sex until 7 DAYS AFTER both you and your sex partner(s) finish the medicine.
   → If you do have sex before 7 days, use a condom.

If you don't follow all of these steps, you can get Gonorrhea AGAIN and it can be worse!

Many people who get Gonorrhea GET IT AGAIN:

Get tested again in 3 months!

- Having Gonorrhea once will NOT protect you from getting it again.
- Getting another infection with Gonorrhea is really common.
- Getting infected with Gonorrhea again can cause a lot more harm inside your body.
- Most of the time there are no symptoms when you get Gonorrhea again.

→ It is really important to come back to **get tested again in 3 months.**

Remember! It is also very important to:

- Return to the clinic if your symptoms don't go away within a few days.
- Use a condom every time you have sex so you don't get Gonorrhea again.

Gonorrhea

What should I know about my treatment?

DO NOT HAVE SEX UNTIL 7 DAYS AFTER YOU AND YOUR PARTNER(S) FINISH THE MEDICINE

You have been given the medicine checked below:

❑ **Ceftriaxone** (by shot given in the clinic)

❑ **Cefixime** ❑ **Cefpodoxime**

Take all of this medicine at once, as soon as you get it.

AND, you may also have been given:

❑ **Azithromycin**

Take all of this medicine at once, as soon as you get it.

❑ **Doxycycline**

- Take 1 pill in the morning and 1 pill at night for 7 days.
- DO NOT take this medication if you think you may be pregnant or if you are nursing.
- Take this medicine with food or milk if it upsets your stomach.
- You can be easily sunburned while on this medication.

What are the possible side-effects of treatment?

If you have either of these problems, **call 911 right away:**

- Wheezing
- Trouble breathing

If you have any of these problems, **please call the clinic:**

- A skin rash or bumps
- Itching
- Vomiting (throwing up)

WHAT IF I'M PREGNANT?

- If you think you are pregnant, tell the doctor or nurse before you take any medicine.
- Tell the doctor you are seeing for your pregnancy that you have tested positive for Gonorrhea.
- If you are keeping the pregnancy, you will need to get tested again for Gonorrhea in **3 to 4 weeks**. This is to make sure that you are cured.
- If you do not get treated, you can pass Gonorrhea to your baby while giving birth. This can cause serious eye, joint, or blood infections in your baby.

What about my sex partner(s)?

There are many ways to make sure your sex partners get medicine for Gonorrhea. Here are some of them:

- Bring your partner into clinic with you when you come in for treatment.
- Ask your doctor or nurse for extra medicine to take to your partner(s).
- Ask your partner(s) to go to their own doctor to get medicine.
- Go to the website www.inspot.org to send an email telling your partner(s) they may have Gonorrhea – you can do this without giving your name.

What else do I need to know?

- Gonorrhea is a very common sexually transmitted infection (STI).
- Many people infected with Gonorrhea are *also* infected with Chlamydia.
- Many people with Gonorrhea *do not* have any symptoms:
  - If you do have symptoms, they can show up right away or as long as 30 days after having sex with someone who has Gonorrhea.
- Once you've had Gonorrhea, there is a very high chance of getting it again. You might get it again:
  - If you have sex with someone who did not get treated, or
  - If you have sex too soon after you and your sex partner(s) finish the medicine, or
  - If you have sex with a new partner who has it.
- You can have Gonorrhea and other STIs at the same time.

Portions of this form were adopted from the California Department of Public Health, Office of Family Planning: *Gonorrhea-What You Need To Know* (OF4074), retrieved from http://www.familypact.org

If you have a medical problem or concern after clinic hours, call: 1-XXX-XXX-XXXX
Your Organization Address and Phone Number Here

¿Qué es la gonorrea?

- La gonorrea es una infección que puede afectar a la vagina, el pene, el ano o la garganta.
- Muchas personas con gonorrea no muestran señales o síntomas de la infección.
- Cuando los síntomas están presentes, estos pueden ser leves al principio.

Usted podría presentar algunos de los siguientes síntomas:

- Dolor o ardor al orinar
- Flujo de olor o apariencia extraños en la vagina, el pene o el ano
- Sangrado en la vagina durante o después de las relaciones sexuales
- Dolor o cosquilleo en el pene
- Dolor abdominal o en la espalda, particularmente durante las relaciones sexuales (las mujeres)
- Fiebre

¿Es grave la gonorrea?

Sí lo es, y de no recibir tratamiento, usted:

- Enfrentaría la posibilidad de no poder quedar embarazada o tener bebés en el futuro.
- Podría transmitir la gonorrea a otras personas con las que tenga relaciones sexuales.
- Podría transmitirla a su bebé durante el parto.
- Podría experimentar dolores abdominales durante las relaciones sexuales durante meses o incluso años (las mujeres).
- Podría experimentar dolor e inflamación de sus testículos.
- Podría causarle embarazos extra uterinos, con riesgo de muerte.
- Puede propagarse a la sangre y a las articulaciones.
- Tendría más susceptibilidad a infectarse con otras enfermedades, como el VIH.

¿Cómo me infecté con gonorrea?

- Usted la contrajo al tener relaciones sexuales vaginales, anales u orales con alguien que ya la tenía.
- La mayoría de las personas no saben que están infectada y es imposible saberlo con solo mirar a la persona.
- La única manera de saber si usted se ha infectado es hacerse las pruebas.

¿Qué debo hacer ahora?

La gonorrea se cura fácilmente si usted sigue los siguientes tres pasos:

1. Tómese toda la medicina que su doctor o la enfermera le receten.
2. Asegúrese de que TODAS sus parejas sexuales de los últimos dos meses obtengan tratamiento para la gonorrea lo antes posible.
3. No tenga relaciones sexuales hasta que hayan transcurrido SIETE DÍAS desde que usted y su(s) pareja(s) sexual(es) terminaron el tratamiento.
   → Si tuviera relaciones sexuales antes de los siete días, utilice un condón.

Si no siguiera todos los pasos anteriores, usted podría REINFECTARSE de gonorrea, con efectos aún más graves.

Muchas personas que se infectan con gonorrea VUELVEN A REINFECTARSE:
Hágase la prueba nuevamente en TRES meses.

- El haber contraído gonorrea NO confiere inmunidad contra la reinfección posterior.
- La reinfección con gonorrea es bastante común.
- La reinfección con gonorrea puede causarle daños aún mayores en su cuerpo.
- En la mayoría de los casos, no se presentan síntomas debido a la reinfección con gonorrea.

→ Es fundamental que regrese y **se haga la prueba de nuevo a los tres meses**.

Recuerde: Es muy importante que:

- Regrese a la clínica si sus síntomas no desaparecen en pocos días.
- Utilice un condón cada vez que tenga relaciones sexuales para que no se reinfecte con gonorrea.

Gonorrea

¿Qué debo saber sobre mi tratamiento?

NO TENGA RELACIONES SEXUALES HASTA SIETE DÍAS DESPUÉS DE QUE USTED Y SU(S) PAREJA(S) SEXUAL(ES) HAYAN TERMINADO EL TRATAMIENTO.

Se le ha entregado la medicina marcada a continuación:

❑ **Cefixima (**Cefixime) ❑ **Cefpodoxima** (Cefpodoxime)

Tómese toda esta medicina de una sola vez tan pronto se la den.

❑ **Ceftriaxona** (Ceftriaxone) (administrada por inyección en la clínica)

Y, también le pueden haber dado:

❑ **Azitromicina** (Azithromycin)

Tómese toda esta medicina de una sola vez tan pronto se la den.

❑ **Doxiciclina** (Doxycycline)

- Tómese UNA píldora en la mañana y otra por la noche durante SIETE días.
- NO tome esta medicina si cree que pueda estar embarazada o si está amamantando.
- Si esta medicina le molestara el estómago, tómela con los alimentos o con leche.
- Esta medicina puede causarle susceptibilidad a las quemaduras de sol.

¿Cuáles son los posibles efectos secundarios de este tratamiento?

Llame inmediatamente al 911 si presentara alguno de los siguientes problemas:

- Resuellos (jadeos)
- Dificultad para respirar

Llame a la clínica si presentara alguno de los siguientes síntomas:

- Sarpullido o protuberancias en la piel
- Picazón

¿QUÉ SUCEDE SI ESTOY EMBARAZADA?

- Si cree que está embarazada, dígaselo a su doctor o enfermera antes de tomar cualquier medicina.
- Dígale al médico que le da atención prenatal que el resultado de la prueba indica que es positiva para gonorrea.
- Si va a continuar con su embarazo, será preciso que se haga nuevamente las pruebas para gonorrea en **tres o cuatro semanas más.** Esto se hace para garantizar que ya esté curada.
- Si usted no recibiera tratamiento para la gonorrea, puede contagiar a su bebé durante el parto. Esto puede causarle serias infecciones en los ojos, las articulaciones o en la sangre a su bebé.

¿Qué hay de mi(s) pareja(s) sexual(es)?

Hay muchas maneras de lograr que su(s) pareja(s) sexual(es) reciban tratamiento para la gonorrea: A continuación se mencionan algunas de ellas:

- Hágase acompañar de su pareja cuando venga a la clínica a recibir tratamiento.
- Pídale a su doctor o enfermera que le den una dosis adicional para llevársela a su(s) pareja(s).
- Pídale a su(s) pareja(a) que visite a su propio médico para recibir tratamiento.
- Visite el sitio web www.inspot.org, desde donde podrá enviar un correo electrónico anónimo a su(s) pareja(s) para informarle(s) que podría(n) tener gonorrea.

¿Qué más necesito saber?

- La gonorrea es una infección de transmisión sexual (ITS) muy común.
- Muchas personas con gonorrea también están infectadas con clamidia.
- Muchas personas con gonorrea no muestran ningún síntoma de la infección.
  - De presentarse, los síntomas pueden aparecer inmediatamente o incluso hasta 30 días después de haber tenido relaciones sexuales con una persona infectada con gonorrea.
- Si usted ya tuvo gonorrea, la probabilidad de reinfectarse es muy alta. La reinfección podría ocurrir si:
  - Tiene relaciones sexuales con alguien que no recibió tratamiento, o…
  - Tiene relaciones sexuales muy pronto después de que usted y su(s) pareja(s) sexual(es) ha(n) completado el tratamiento, o…
  - Tiene relaciones sexuales con una nueva pareja ya infectada.
- Es posible que usted tenga gonorrea y otras ITS simultáneamente.

Partes de este formulario son adaptaciones del documento California Department of Public Health, Office of Family Planning: Gonorrhea-What You Need To Know (OF4074), obtenido en http://www.familypact.org

Si tuviera algún problema médico u otra inquietud cuando la clínica se encuentre cerrada, llame al 1-XXX-XXX-XXXX
Your Organization Address and Phone Number Here

2019 PDPT Monthly Totals

	Order Date	Amt GC Ordered	Amt CH Ordered	When received	How many Distributed	How many Expired
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
Totals						

PDPT Medication Tracking Log

Updated 10.08.2019

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RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 844	Page 1 of 4
Title: Antimicrobial Stewardship Program	**Effective Date:** 3/14/2025	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 IDSA. Infectious Disease Society of America. An information source, and standard practice guide for current, evidence-based practices.

2. PURPOSE

2.1 The Antimicrobial Stewardship Program (ASP) at Riverside University Health System (RUHS) Medical Center will provide ongoing monitoring of antimicrobial utilization, healthcare associated infections and resistance trends. The primary goal of this program is to reduce antimicrobial resistance, reduce antimicrobial-related adverse events, improve antibiotic susceptibilities, promote appropriate antimicrobial regimen selection (dosing, duration, route of administration), and improve patient care in both inpatient and ambulatory care settings.

2.2 Infection Prevention and Antimicrobial Stewardship Programs are both integral parts of comprehensive antimicrobial utilization programs. ASP will foster collaboration between Infection Control, Pharmacy, Microbiology and Quality Improvement.

3. SPECIFICATIONS

3.1 Authority of ASP:

a. The ASP is a subcommittee of the Pharmacy and Therapeutics (P&T) Committee. It communicates with Infection Control Committee and reports to Quality Improvement Committee (Performance Improvement and Patients Safety Committee at RUHS).

b. The ASP subcommittee will be responsible for the development, implementation, evaluation, and follow-up of all ASP activities at RUHS Medical Center and ambulatory clinics.

c. Policies and procedures recommended by ASP subcommittee shall be approved by P&T Committee and Medical Executive Committee prior to implementation.

3.2 Membership / Participation - Core

a. Infectious Diseases Physician: serves as the director of the program and chair of committee

b. Infectious Diseases Clinical Pharmacist: serves as lead and co-chair of committee

c. Director of Infection Prevention

d. Clinical Microbiologist

3.3 Membership / Participation – Ad Hoc

a. Internal Medicine Physicians / Teaching Services

b. Hospitalists

c. Surgeons

d. Family Medicine Physicians

e. Critical Care / Emergency Medicine

f. Pharmacy leadership

g. Quality Improvement

h. Informatics specialist

i. Nursing

3.4 The subcommittee will meet once every quarter with its Core members. Ad hoc members will be invited to all meetings, but their participation is not mandatory. The subcommittee membership may vary based on work assigned by the committee.

3.5 Members will serve as leaders to champion implementation of evidence-based ASP practices at the process or department level.

4. PROCEDURES / SERVICES PROVIDED

4.1 Adopt IDSA antimicrobial stewardship guidelines, the Joint Commission antimicrobial stewardship measures, CDC's core elements for ASP, and other best practices and tailor them to meet institutional needs.

4.2 Develop evidence- based policies and intervention strategies to impact antimicrobial utilization across the healthcare system.

4.3 Develop annual ambulatory ASP goals and implement ASP interventions including evidenced-based guidelines and education to optimize antimicrobial utilization.

4.4 Establish ongoing self-assessment and quality improvement programs to assess the efficacy of antimicrobial stewardship measures.

4.5 Provide oversight of initiatives.

a. Antimicrobial Preauthorization

b. Prospective audit with intervention feedback

c. Formulary management of anti-infectives

d. Streamlining or de-escalation of therapy

e. Antimicrobial time-out

f. Dose optimization

g. Parenteral to oral conversion

h. Microbiology reporting

i. Guidelines and clinical pathways

j. Antimicrobial order sets

k. Peri-operative antimicrobial prophylaxis

l. Education for healthcare professionals and patients

4.6 Publish an antibiogram annually.

4.7 Address any CMS measures, Joint Commission standards, CDC core elements, or other regulatory standards related to antimicrobial stewardship and infectious diseases management.

5. PERFORMANCE IMPROVEMENT

5.1 Design and implement audits and intervention strategies to prevent inappropriate prescribing of antimicrobials.

5.2 Communicate recommendations to prescribing physicians. Suggestions may include de-escalation or escalation of antimicrobial agents, discontinuation of antimicrobial therapy, change route of administration, dose, schedule, or obtain a formal Infectious Diseases consult. Any recommendations made are considered part of quality improvement initiatives. The prescribing physician shall retain autonomy for care of the patient.

5.3 Develop a plan for addressing prescribers that may be outliers for deviation from stewardship best practices.

5.4 Perform periodic reviews of antimicrobial utilization, including clinical indications, duration of therapy, results of microbiology cultures and sensitivities, and antimicrobial related parameters via medication use evaluations (MUE) and disease-state evaluations.

5.5 Collect and report data related to inpatient and ambulatory stewardship initiatives.

5.6 Pertinent data on ASP activities will be presented at P&T, Performance Improvement and Patient Safety Committee, and the ASP subcommittee on a quarterly basis.

a. RUHS antimicrobial utilization (AU) data will be presented as Days of Therapy per 1000 patient-days.

5.7 Submit AU and antimicrobial resistance (AR) data to National Healthcare Safety Network (NHSN) and report Standardized Antimicrobial Administration Ratio (SAAR) and Standardized Resistant Infection Ratio (SRIR) to P&T, Performance Improvement and Patient Safety Committee.

6. EDUCATION

6.1 Develop a plan for ongoing antimicrobial stewardship awareness and education.

a. Orientation programming, online education, required trainings, presentations, and informational resources

b. Medical residents, ambulatory care providers, pharmacists, and trainees on infectious diseases-related topics

c. Nursing education as needed

d. Patient education as needed

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
7/9/2024	Infectious Diseases Pharmacist	Y	Added antibiotic time-out and peri-operative antimicrobials Updated AR reporting
9/10/24	Pharmacy Review Committee	Y	Added antimicrobial resistance for AR abbreviation
10/7/24	P&T	N	
12/3/2024	PAC	N	
1/8/2025	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 689	Page 1 of 10
Title: Code Stroke	**Effective Date:** 3/14/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 This policy applies to the Moreno Valley campus of the Riverside University Health System – Medical Center (RUHS – Medical Center). Arlington campus staff shall call 9-1-1 in case of stroke related emergency.

1.2 To provide multidisciplinary guidelines for the recognition and activation of a Code Stroke.

1.3 To identify the roles and responsibilities of the Code Stroke Team.

2. DEFINITIONS

2.1 **IV Thrombolytic:** defined as “clot buster” medication used to dissolve blood clots.

2.2 **Clinical Practice Guidelines:** defined as statements that include recommendations**,** intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. For the purposes of this guideline, clinical practice guidelines are pulled from the American Heart/American Stroke Association to guide the care, treatment and services of stroke patients that present to RUHS – Medical Center

2.3 **Code Stroke:** defined as an emergent process for the recognition and treatment of acute stroke within less than 24 hours of ‘last known well time’.

2.4 **Last Known Well Time:** defined as the time in which a patient was last known to be without the signs or symptoms of the current stroke or at his or her prior baseline. Note: Time of *discovery* does not equal last known well time. For example, if a patient was last seen normal at 10 pm, goes to bed, and is found to have new deficits at 6 am the following morning, the last known well time is 10 pm the night before.

2.5 **National Institute of Health Stroke Scale (NIHSS):** defined as a standardized method used by healthcare professionals to measure the level of impairment caused by stroke.

2.6 **NPO**: Abbreviation for Latin *non per os* or *nil per os*, nothing by mouth.

2.7 **Originating site:** defined as the site where a patient is located at the time health care services are provided via a telecommunications system.

2.8 **Primary Medical Team:** defined as the primary admitting team that oversees the provision of care during a patient’s hospitalization.

2.9 **Remote site:** defined as a site where the physician specialist (Neurologist) who provides health care services is located while providing these services via a telecommunications system.

2.10 **Synchronous interaction:** defined as a real-time interaction between a patient and a healthcare provider located at a remote site.

2.11 **Telehealth:** defined as a mode of delivering health care services via information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patient at the originating site by a health care provider at a remote site.

2.12 **Tele-Neurologist:** defined as those specialists identified by the originating site that provide specialty services (Neurology for the purposes of this policy and procedure) via Telehealth. Physicians providing care via telehealth to patients at RUHS Medical Center must have appropriate staff privileges to do so.

2.13 **Workforce Member:** for the purpose of this policy is defined as employees, physicians, volunteers, students, residents, and other persons whose performance of work is conducted at an RUHS facility, whether or not they are paid by RUHS.

2.14 Signs and Symptoms of a stroke which may include but are not limited to:

a. Sudden numbness or weakness of face, arm, or leg, especially on one side of the body.

b. Sudden confusion or trouble speaking or understanding.

c. Sudden dimness or loss of vision from one or both eyes.

d. Sudden loss of balance, coordination, and/or difficulty with ambulation.

e. Sudden severe headache with no known cause.

3. GUIDELINES

3.1 A Code Stroke will be activated on any patient exhibiting any acute neurological changes indicative of stroke with a last known well time of less than 24 hours.

3.2 Patient presenting meeting both code stroke activation criteria and trauma activation criteria should have **both** teams activated to ensure a collaborative discussion regarding potential patient management.

3.3 A neurology consultation shall be activated on any patient exhibiting acute neurological changes indicative of stroke with a last known well time of less than 4.5 hours and NO intracranial hemorrhage/mass/lesion as determined via computerized tomography (CT) Scan or magnetic resonance imaging (MRI) . A consult need not be requested if obvious contraindications for IV thrombolytics are identified by the treating provider.

3.4 IV thrombolytics are to be considered for any eligible patient that presents with signs and symptoms of stroke within 4.5 hour of last known well time. If the patient meets inclusion criteria for IV thrombolytic therapy, follow the RUHS-Medical Center policy Patient Informed Consent.

3.5 A Telehealth neurologist will be used for consultations between the hours of 1700-0800 and weekends.

3.6 For suspected stroke patients that arrive to the emergency department (ED) via ambulance, the following process is recommended:

a. A pre-hospital Stroke Scale will be completed in the field prior to paramedic base station contact and Emergency Department (ED) arrival whenever

possible.

b. Emergency Medical Services personnel will contact RUHS – Medical Center base station Mobile Intensive Care Nurse (MICN) whenever possible.

c. The MICN will attempt to gather the following information:.

   i. Associated signs or symptoms of stroke. Last known well time.

   ii. Blood glucose result or request one if not previously done.

d. If the patient exhibits any acute neurological change indicative of a stroke and the last known well time is less than 24 hours, a workforce member is to activate a Code Stroke prior to arrival.

e. Dial 9-1-1 from a hospital phone or handset, inform the operator you want to activate a Code Stroke and provide the operator with the following information as available:

   i. Patient location

   ii. Estimated time of arrival (ETA) if applicable.

   iii. Patient's age,

   iv. Patient's gender

   v. Current Glasgow Coma Scale (GCS) if available

f. The operator will notify the following Code Stroke ED team:

   i. Registered Nurse (RN) Code Team

   ii. Clinical Pharmacist

   iii. Computerized tomography (CT) scan technologist

   iv. Designated certified nursing assistant

   v. House Supervisor

   vi. Stroke Coordinator

g. The MICN will:

   h. Notify the ED attending physician.

   ii. Notify the ED charge nurse.

   iii. Notify the ED Bed Control RN.

3.7 For *suspected* stroke patients who arrive to ED via walk-in triage, ED staff will:

a. Ensure the patient is triaged by the ED RN and assessed for signs or symptoms of stroke.

b. Confirm last known well time.

c. Perform a point of care
blood glucose on the patient to rule out hypoglycemia.

d. If the patient is displaying acute signs or symptoms of stroke and the last known well time is less than 24 hours a workforce member is to activate a Code Stroke in the manner identified in 3.5-F.

3.8 If the patient is displaying acute signs or symptoms of stroke and the last known well time is more than 24 hours notify ED provider.

3.9 For In-Patient suspected stroke patients, the following will occur:

a. The primary nurse will assess the patient for acute signs and symptoms of stroke.

b. Confirm last known well time.

c. Ensure patient blood glucose > 60 mg/dl.

d. If there is any doubt as to whether the patient is displaying signs or symptoms of an acute stroke within the In-patient setting, the nurse shall immediately activate the Rapid Response Team (RRT) by calling 9-1-1 and the responding team will further evaluate the patient.

e. When last known well time is less than 24 hours: If an in-patient exhibits acute neurological symptoms indicative of stroke, the last known well time is less than 24 hours and a current blood glucose level is greater than 60 mg/dl, any nurse or a member of the Rapid Response Team shall activate a Code Stroke and immediately notify the primary physician.

f. When last known well time greater than 24 hours: For any patient exhibiting acute neurological changes indicative of stroke and the last known well time is greater than 24 hours, notify the appropriate physician immediately.

3.10 To activate an Inpatient Code Stroke a workforce member is to activate a Code Stroke in the manner identified in 3.5-F.

4. Roles and responsibilities

4.1 Members of the Code Stroke ED Response Team:

a. RN Code Team

b. Primary Care ED RN

c. ED physician

d. Clinical Pharmacist (to remain on standby)
e. Designated certified nursing assistant (as available)
f. Stroke Coordinator (as available)
g. Neurologist (will be consulted for potential thrombolytic candidates)

B. Contributing members of the Code Stroke ED response Team not reporting to bedside:

i. Radiology
ii. Neurosurgeon (if indicated)
iii. Clinical Laboratory Scientist (CLS)
iv. House supervisor (as available)
v. Neurointerventional Radiology team (as available)

4.2 Members of the Code Stroke In-Patient Response Team:

a. RN Code Team
b. Primary care RN
c. Primary Medical Team
d. Clinical pharmacist (to remain on standby)
e. Designated certified nursing assistant (as available)
f. Stroke Program Coordinator (as available)
g. Neurologist (will be consulted for potential thrombolytic candidates)
h. Contributing members of the Code Stroke In-patient Response Team not reporting to the bedside:

i. Radiology
ii. Neurosurgeon (if indicated)
iii. Clinical Laboratory Scientist (CLS)
iv. House supervisor (if available)

4.3 Neurointerventional Radiology team (as available) Responsibilities of the RN Code Team:

a. Assist with confirmation of last known well time.
b. Perform a comprehensive assessment, including NIHSS.
c. Ensure attempts are made to follow the recommended guidelines for turnaround times as outlined in Attachment 1.

i. Note: The physician will evaluate the patient. If upon exam, the physician determines that a Code Stroke is not appropriate, the physician may request a Code Stroke cancellation.

d. Notify the provider immediately after completion of CT scan and patient return to the appropriate unit.
   i. ED physician (Code Stroke ED)
   ii. Primary Medical Team (Code Stroke In-Patient)

e. If Telehealth is to be utilized, the following will occur:
   i. Set-up conference equipment at the patient's bedside.
   ii. Assist with synchronous interaction between the patient and the Tele- Neurologist as needed.
   iii. Ensure completed labs and radiology reports are available for physician review, however, do not delay encounter if labs or radiology reports are not available.

f. If the patient is a candidate for IV thrombolytic therapy, the following is recommended:
   i. Ensure a physician has reviewed any potential risks, consequences, benefits, side effects and alternatives with patient and/or legal representative regarding the use of thrombolytics prior to administration.
   ii. Administer IV thrombolytics as ordered. Refer to Nursing Policy Medication: IV Thrombolytic Therapy for use in Acute Ischemic Stroke.
   iii. Anticipate admission to ICU for at least 24 hours for patients treated with thrombolytics if not transferred.
   iv. Provide patient and family education.

g. **Assist with the emergent tertiary transfer process if available and applicable.**

4.4 Responsibilities of the Responding Physician:

a. Respond for medical screening exam from Code Stroke activation.

b. For Code Stroke activation that is initiated prior to patient arrival by the MICN, respond for medically screening on arrival. ***Note***: Upon evaluation, if a Code Stroke is determined NOT appropriate, notify the primary RN and request a Code Stroke cancellation. Provide the appropriate orders for the continuation of care.

c. Ensure initiation of Stroke Orders.
   i. Computed tomography perfusion (CTP) and angiogram (CTA) of the head and neck should be considered for patients that present with NIHSS scores greater than 6 and/or cortical signs: isolated aphasia, gaze deviation and hemi-neglect.

d. Communicate with RUHS neurologist/telehealth neurologist if appropriate for 18 years and older. Consult Loma Linda University Medical Center neurologist/telehealth neurologist for pediatric code stroke patients.

e. When neurological consultation/ Telehealth is utilized, the following is recommended:
    i. Confer with the Tele-Neurologist regarding patient's eligibility for a Telehealth consultation. Note: If it is determined not to be a suitable case the interaction will be complete.
    ii. Upon completion of neurology consultation, the treating provider and neurologists shall review inclusion and exclusion criteria and discuss patient eligibility for IV thrombolytic therapy.

f. If a patient meets inclusion criteria for IV thrombolytic therapy, ensure the potential risks, consequences, benefits and alternatives of thrombolytic therapy are reviewed with the patient and/or legal representative prior to administration as able. (Written informed consent is not a prerequisite for IV thrombolytic therapy).

g. Implement IV thrombolytic Adult Use Acute Ischemic Stroke Physician Orders as appropriate.
    i. Orders may be written by an attending physician, or a residentworking under the direction of an attending physician.

i. Document reason if an IV thrombolytic is not ordered in the medical record.

j. Document reason if an IV thrombolytic administration or emergent tertiary transfer is delayed.

k. With limited improvement s/p IV thrombolytic infusion or NIHSS > 6 and/or cortical signs: isolated aphasia, gaze deviation or hemi-neglect with confirmed/suspected large vessel occlusions, patients should be considered for neurological intervention.
    i. Ensure stat consult with Neurointerventional Radiology (NIR) or tertiary center for patients exhibiting stroke symptoms with potential large vessel occlusions or critical stenosis.
    ii. Ensure stat consult with NIR or tertiary center for patients exhibiting stroke symptoms with cerebral aneurysms or arteriovenous malformations.

4.5 Responsibilities of the Neurologist/Tele-Neurologist for ischemic stroke patients:

a. Respond to stat consult request and speak directly to the treating provider.

b. If Telehealth is to be utilized, the following will occur:
    i. Obtain pertinent patient information from the treating provider to determine eligibility for a Telehealth consultation.

c. If it is determined not to be a suitable case, verbalize exclusion criteria and the interaction will be complete.

d. Review diagnostic studies.

e. Conduct synchronous interaction with the assistance of a NIHSS certified RN.

f. Review any potential risks, consequences, benefits, and alternatives with patient and/or legal representative regarding the use of IV thrombolytics prior to administration. Document this discussion in the medical record.

g. Speak with the treating provider post patient evaluation and discuss case including review of Inclusion & Exclusion Criteria and patient eligibility for IV thrombolytic.

h. Communicate and document recommendations to the treating provider including but not limited to:

i. Recommendation to treat with IV thrombolytics if appropriate.

ii. Reason if IV thrombolytic are not ordered in the medical record.

iii. Reason if IV thrombolytic administration is delayed.

iv. Acute care recommendations in the event IV thrombolytics are utilized.

v. Recommendation for neurological interventional care when appropriate.

i. Provide a completed consultation note to become a part of the patient's permanent medical record. Consult notes are to be entered in the medical record as soon as possible but no later than 24 hours post patient encounter. In the event of remote access/equipment failure, contact the originating site and obtain verbal confirmation of patient presentation and diagnostic studies from treating provider and provide verbal consultation recommendations.

4.6 Responsibilities of the clinical pharmacist:

a. To remain on alert until confirmation of diagnostic studies.

b. Ensure IV thrombolytic medication availability.

c. Assist with reconstitution of IV thrombolytic as needed.

d. Assist with expediting arrival of medications as required to manage patient.

4.7 Responsibilities of the designated nursing assistant or designee:

a. Respond immediately to Code Stroke activation.

b. Assist with monitor implementation and transportation as needed.

c. Assist with Telehealth when indicated.

4.8 Responsibilities of the ED RN or Code Team RN:

a. Respond immediately to the Code Stroke.

b. Obtain blood specimens.

c. Transport blood products directly to the Clinical Laboratory Scientist (CLS).

d. Confirm with CLS to expedite stroke labs.

4.9 Responsibilities of the Stroke Program Coordinator:

a. Function as a strong resource nurse (as available).

b. Notified via e-mail/page of Code Stroke activations for tracking and quality assurance.

c. Review effectiveness of code stroke process and provide feedback to the IDT as needed.

4.10 Responsibilities of Radiology department:

a. Radiology Technician
prepares for emergent non-contrast CT scan of the head. (Clears the table of non-emergent patients)

b. Radiologist to read CT scan or other radiological study deemed necessary and report the findings to the ordering physician immediately after the reading is completed.

c. Goal is as early as possible or ≤ 30 minutes from patient arrival to non-contrast CT scan report to be provided to the treating physician and documented

d. Goal is as early as possible or ≤ 45 minutes from patient arrival to CTA head and neck report to be provided to the treating physician and documented if ordered.

i. The use of artificial intelligence (AI) software may be employed to facilitate prioritization and communication.

4.11 Responsibilities of Neurosurgeon for hemorrhagic stroke patients:

a. Consult if requested for intracranial hemorrhage, suspected aneurysm, AVM, tumor bleed, or posterior fossa bleed.

4.12 Responsibilities of the House Supervisor:

a. Acts as a facilitator and resource person as needed.

5. ATTACHMENTS

5.1 Recommended Code Stroke Turnaround Times

6. RELATED POLICIES

6.1 HW 677 Medication: IV Thrombolytics for use in Acute Ischemic Stroke

6.2 HW 602 Patient Informed Consent

6.3 NURS SP 400 Rapid Response Team RRT Standardized Procedures

6.4 HW 695 Stroke Program Scope and Services

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7/25/24	Stroke Committee	Yes	Addition of CT perfusion software. Added information regarding AI software and simplified some process instructions.
9/4/24	Pre-Nursing Policy and Procedure	No	Consent Agenda for Nursing P&P.
5/6/2024	P&T	No	
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1/07/25	MEC	Yes	Recommended a rewording of CTP statement. Re-approved at Stroke Committee on 1/16/25.

PHASE III
TARGET: STROKE℠
SUGGESTED TIME INTERVAL GOALS

American Heart Association®
Target: Stroke℠

THE 30 MINUTES DTN GOAL TIME INTERVAL GOALS ARE:

ACTION	TIME
Door to physician	≤2.5 minutes
Door to stroke team	≤5 minutes
Door to CT/MRI initiation	≤15 minutes
Door to CT/MRI interpretation	≤25 minutes
Door to needle time	**≤30 minutes**

THE 45 MINUTES DTN GOAL TIME INTERVAL GOALS ARE:

ACTION	TIME
Door to physician	≤5 minutes
Door to stroke team	≤10 minutes
Door to CT/MRI initiation	≤20 minutes
Door to CT/MRI interpretation	≤35 minutes
Door to needle time	**≤45 minutes**

THE 60 MINUTES DTN GOAL TIME INTERVAL GOALS ARE:

ACTION	TIME
Door to physician	≤10 minutes
Door to stroke team	≤15 minutes
Door to CT/MRI initiation	≤25 minutes
Door to CT/MRI interpretation	≤45 minutes
Door to needle time	**≤60 minutes**

THE 90 MINUTES DTD GOAL TIME INTERVAL GOALS ARE:

ACTION	TIME
Door to physician	≤5 minutes
Door to stroke team	≤10 minutes
Door to CT/MRI initiation	≤20 minutes
Door to CT/MRI interpretation	≤35 minutes
Door to neurointerventional team activation	≤40 minutes
Door to needle time	≤45 minutes
Door to patient arrival in NI suite	≤60 minutes
Door to puncture	≤75 minutes
Door to device	**≤90 minutes**

The suggested time intervals are intended to facilitate time interval benchmarking and quality improvement efforts towards achieving the Target: Stroke DTN and DTD goals. The interval benchmarks may be modified as needed. Individual institutions may wish to modify these to achieve ultimate intervention within recommended time frame.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 651	Page 1 of 17
Title: Death by Neurologic Criteria	**Effective Date:** 3/14/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Death by Neurologic Criteria (DNC) (formerly Brain Death) (BD): irreversible cessation of all functions of the entire brain, including the brain stem, as defined by the Uniform Determination of Death Act.

1.2 Reasonably Brief Period: An amount of time afforded to gather family or next of kin at the patient's bedside while being considerate to the needs of other patients and prospective patients in urgent need of care.

2. POLICY

2.1 Diagnose brain death by demonstrating an irreversible cessation of all brain and brain stem functions;

2.2 Accept a brain death diagnosis only from licensed physicians and with appropriate confirmation as described in this guideline;

2.3 Notify the Organ Procurement Organization of patients whose death is imminent or of patients who have died, regardless of the decedent's medical suitability for organ donation;

2.4 Provide the patient's family, or next of kin, with a reasonable brief period of time at the patient's bedside after brain death is diagnosed;

2.5 Make reasonable efforts to accommodate religious and cultural practices and concerns surrounding the issue of brain death;

2.6 Make available, upon request, a written statement of the policy regarding family accommodation after diagnosis of brain death.

3. PROCEDURES

3.1 Pre-requisites for Death by Neurologic Criteria

a. Age: ≥37 weeks corrected gestational age

b. Etiology of brain injury: Establish the presence of a catastrophic, permanent brain injury caused by an identified mechanism known to lead to BD/DNC.

c. Observation period after brain injury and before initiating the BD/DNC evaluation:

i. Observe for at least 48 h after acute brain injury before initiating BD/DNC evaluation in patients younger than 24 months

ii. Observe for at least 24 h after hypoxic ischemic brain injury before initiating BD/DNC evaluation in patients 24 months or older

iii. Observe for a sufficient amount of time (based on the pathophysiology of the brain injury) after brain injury before initiating BD/DNC evaluation to ensure that there is no potential for recovery

iv. Observe for a sufficient amount of time (based on the pathophysiology of the brain injury and the findings on neuroimaging) after medical or surgical interventions to treat elevated intracranial pressure before initiating BD/DNC evaluation to ensure that there is no potential for recovery

d. Severity of brain injury: establish that brain injury is permanent

e. Neuroimaging results: ensure the neuroimaging is consistent with the mechanism and severity of brain injury

f. Temperature: Core temp >36℃. Wait at least 24 h after rewarming to 36˚C before BD/DNC evaluation if core body temperature has been ≤35.5˚C

g. Blood Pressure:

i. Ensure that systolic blood pressure is ≥100 mmHg and mean arterial pressure is ≥ 75 mm Hg in adults

ii. Ensure that SBP and MAP are ≥5th percentile for age in children

iii. Target a SBP and MAP that approximates the known chronic baseline of patients who have a baseline blood pressure that varies significantly from their age-based normal

h. Exclude Intoxication:

i. Ensure blood and urine drug screen are negative (if clinically indicated) (blood alcohol should be <80mg/dL)

ii. Wait at least 5 half-lives, taking hepatic or renal dysfunction, body mass index, body temperature into consideration n

iii. Ensure phenobarbital level is <5µg/mL or below the lower limit of detection for the laboratory (if administered)

i. Exclude Pharmacologic Paralysis: exclude pharmacologic paralysis if administrated or suspected through the use of train-of-four stimulator or demonstration of deep tendon reflexes

j. Laboratory Parameters: exclude severe metabolic, acid-base, or endocrine disturbance

k. Other Considerations: pregnancy is not a contraindication for BD/DNC evaluation

3.2 Examination

a. Brain death examinations must be performed by:

i. For Adults 18 years of age and greater

- Two Attending physicians;
    - NOTE: it is permissible for neurosurgical residents who are licensed to perform the clinical exam

ii. For patients 37 weeks gestational age to 18 years of age

- Two attending physicians
- A minimum of 12 hours should separate the 2 examinations.

iii. The brain death examinations will be in accordance with accepted medical standards and documented on approved hospital forms.

3.3 Components of Examination

a. Assess for unresponsiveness to visual/auditory/tactile stimulation

b. Assess for the absence of motor response of face/extremities

c. Assess for the absence of pupillary reflexes

d. Assess for the absence of oculocephalic reflexes unless there is a concern for cervical spine/skull base integrity

e. Assess for the absence of oculovestibular reflexes if the oculocephalic reflexes are absent or not assessed because of concern for cervical spine/skull base integrity).

i. If the OCR cannot be performed, but the OVR is performed bilaterally and there are no extraocular movements, ancillary testing is not required.

f. Allow for a 5 minute interval between to allow the endolymph temperature to equilibrate Assess for the absence of corneal reflexes

g. Assess for the absence of gag and cough reflexes

i. Assess for the absence of sucking and rooting reflexes (<6 mo old)

3.4 Apnea testing

a. Adults require 1 test after the final neurologic examination

b. Pediatrics requires 2 tests (after each neurologic examination)

c. Ensure the patient is not hypoxemic/hypotensive/hypovolemic

d. Apnea testing is contraindicated in high risk of cardiopulmonary decompensation

e. Ensure pH is normal (7.35-7.45) and PaCO2 is normal (35-45 mmHg) or if the patient is known to have chronic hypercarbia, PaCO2 is at baseline or at estimated baseline

i. Ancillary testing is required if a patient is known/suspected to have chronic hypercarbia but baseline PaO2 is not known

f. PaO2 >200 mmHg after hyperoxygenation

g. Disconnect the patient from intermittent mandatory ventilation and provide apneic oxygenation

h. ABGs shall be performed after 8 minutes and every 2-3 minutes thereafter. The duration of testing is typically 10-15 minutes but can be carried out for longer if the patient is stable.The apnea test is consistent with BD/DNC if these conditions are met :

i. No respirations are observed

ii. Arterial pH is <7.30

iii. One of the following:

- In patients who are known NOT TO HAVE chronic CO2 retention, the Paco2 level is ≥60 mm Hg AND ≥20 mm Hg above the patient's pre-apnea test baseline level.
- In patients who are KNOWN TO HAVE chronic CO2 retention, and the baseline Paco2 is KNOWN, the Paco2 level is ≥60 mm Hg AND ≥20 mm Hg above the patient's known chronic elevated premorbid baseline level.
- In patients who are SUSPECTED TO HAVE chronic CO2 retention, but the baseline Paco2 is UNKNOWN, the Paco2 level is ≥60 mm Hg AND ≥20 mm Hg above the patient's pre-apnea test level, and an ancillary test is required.

3.5 Ancillary Testing

a. Indications:

i. Inability to correct metabolic derangements adequately, but the neurologic examinations(s)/apnea test(s) are consistent with BD/DNC

ii. Inability to perform components of the examination because of an underlying medical condition (e.g. Examples:

- A fracture of the base of the skull or petrous temporal bone may obliterate the response on the side of the fracture, and ancillary testing is recommended in this instance.
- Severe orbital or scleral edema or chemosis may affect the free motion of the globes, and ancillary testing is recommended in this instance.
- In the setting of anophthalmia, ancillary testing is recommended.

iii. Inability to interpret whether examination findings are such as limb movements are spinally mediated

iv. Inability to perform apnea test due to risk of cardiopulmonary decompensation

v. Knowledge/suspicion of chronic hypercarbia without knowledge of the chronic baseline PaCO2.

vi. In pediatric patients: an ancillary test can be used to shorten the duration of the interexamination observation period

b. Timing: Shall be performed after two clinical exams

i. Neurologic examination (s) and apeana (test(s) need to be performed to the fullest extent possible and findings must be consistent with BD/DNC before ancillary testing is performed.

c. Acceptable Tests:

i. 4-vessel catheter angiography

ii. Radionuclide cerebral blood flow scan

iii. Transcranial doppler (in adults only)

3.6 Time of Death

a. If apnea testing is performed: time of death is the time the arterial blood gas results from the final apnea test

b. If apnea cannot be performed: Time of death is the time an attending clinician (e.g. nuclear medicine physician or angiographer) documents in the medical result that the ancillary test results are consistent with BD/DNC (if ancillary testing is required and performed)

3.7 Family Accommodation

a. Provide families with a reasonable but limited amount of time with the deceased patient before discontinuation of organ support

b. Ensure communication is clear, concise and supportive

c. Use Simple terminology

d. Permit family presence during neurologic examination and apnea testing

e. Inform families about the potential for spinal reflexes and the fact that these movements do not preclude BD/DNC determination

f. During this time:
   i. Only previously ordered cardiopulmonary support will be continued;
   ii. No other medical intervention is required.

g. If the patient's legally recognized health care decision maker, family or next of kin:
   i. Requests a written statement of the policy regarding a *reasonably brief period of accommodation,* the policy will be provided no later than shortly after the treating physician has determined that the potential for brain death is imminent (Attachment 3: Riverside University Health System – Medical Center Statement of Family Accommodation Policy).
   ii. Voices any special religious or cultural practices or concerns surrounding the issue of brain death, reasonable efforts will be made to accommodate the practices and concerns.

h. The physician will arrange a time with Nursing and the family for organ support to be discontinued. The physician, or resident, is to be present for removal of organ support.

4. REFERENCES

4.1 California Health & Safety Code § 7180

4.2 California Health & Safety Code § 7181

4.3 California Health & Safety Code § 1254.4

4.4 Greer DM, Kirschen MP, Lewis A, et al. Pediatric and adult brain death/death by neurologic criteria consensus guideline. Neurol Clin Pract. 2023; 13:e200189. doi:10.1212/CPJ.0000000000200189

4.5 Lewis A, Kirschen MP, Greer D. The 2023 AAN/AAP/CNS/ SCCM pediatric and adult brain death/death by neurologic criteria consensus practice guideline: a comparison with the 2010 and 2011 guidelines. Neurol Clin Pract. 2023;13(6): e200189. doi: 10.1212/CPJ.000000000020018

5. ATTACHMENTS

5.1 Attachment 1: Death by Neurologic Criteria Checklist in Patients ≥ 18 years of age

5.2 Attachment 2: Death by Neurologic Criteria Checklist in Patients 37 Month to 18 years of age

5.3 **Attachment 3**: RUHS-Medical Center Statement of Family Accommodation Policy

5.4 Attachment 4: METABOLIC DERANGEMENTS THAT MAY CONFOUND BD/DNC EVALUATION

Document History:

Prior Release Dates: 8/31/01, 3/11/09, 1/12/11, 8/8/12, 9/7/2016, 9/16/2019	**Retire Date:** N/A
Document Owner: Trauma Services	**Replaces Policy:** Brain Death and Family Accomodations

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
02/2023	Bioethics Committee & Critical Care Committee	Y	Major Changes related to 2023 AAN Guidelines Remove EEG as acceptable ancillary testing, specify residents who may perform exam, specify core temp requirements, specify observation period, specify systolic blood pressure, specify drug clearance, add blood alcohol level, add toxicology scree, specify oculocephalic reflex not required for clinical exam, add time of death determination, align language of brain death to death by neurologic criteria, specify consent for exam, eliminate electrolyte specific range
5/2/2024	Pre-Nursing P&P	Y	Minor formatting
5/16/2024	Nursing P&P	N	Consent Agenda Items
7/2/2024	PAC	Y	
1/9/2025	MEC	N	

Determination of Death by Neurologic Criteria in Adults

Must have 2 licensed physicians available to perform brain death exams.

Pre-Exam Checklist

- ☐ Clinical or neuroimaging evidence of acute CNS catastrophe compatible with irreversible loss of brain function
- ☐ Absence of severe electrolyte*, acid/base, endocrine disturbances or severe hyperammonemia
- ☐ Absence of drug intoxication, poisoning, sedatives or neuromuscular blocking agents
- ☐ Core temperature ≥ 96.8°F (36°C) and SBP ≥ 100 mmHg (with or without pressors)
- ☐ Next of Kin/Family and One Legacy have been contacted and are aware of patient's condition and suspicion of death by neurologic criteria.

*Acceptable Sodium Level: ≤ 160 meq/L

Notes: _____

_____

Brain Death Exam #1: Examiner Name: _____ Date & Time of Exam: _____

- ☐ No cerebrally-mediated response to auditory and tactile noxious stimulation, peripherally and in the cranium
- ☐ Both pupils fixed and dilated (4-9mm); unresponsive to direct light in low ambient lighting
- ☐ No oculovestibular reflexes bilaterally with 50mL of ice water instilled in each ear (1 minute observation).
- ☐ No oculocephalic response (contraindicated when C-spine integrity questioned).
- ☐ No corneal reflexes
- ☐ No posterior pharyngeal reflex (gag reflex)
- ☐ No response to bronchial suction (cough reflex)
- ☐ No spontaneous breaths noted

License #: _____

Signature: _____

Notes: _____

_____

Brain Death Exam #2▲: Examiner Name: _____ Date & Time of Exam: _____

- ☐ No cerebrally-mediated response to auditory and tactile noxious stimulation, peripherally and in the cranium
- ☐ Both pupils fixed and dilated (4-9mm); unresponsive to direct light in low ambient lighting
- ☐ No oculovestibular reflexes bilaterally with 50mL of ice water instilled in each ear (1 minute observation).
- ☐ No oculocephalic response (contraindicated when C-spine integrity questioned).
- ☐ No corneal reflexes
- ☐ No posterior pharyngeal reflex (gag reflex)
- ☐ No response to bronchial suction (cough reflex)
- ☐ No spontaneous breaths noted

License #: _____

Signature: _____

▲ No time interval required for second brain death exam in adults.

Notes: _____

_____

If both exams are consistent with brain death, proceed to Apnea Test (page 2)

Must be pe1formed by a licensed physician

Pre-Apnea Test Checklist

- D Brain death exam completed by two licensed physicians (see page I)
- D Respiratory therapist present with ready access to ventilator and to obtain arterial blood gas
- ☐ Core temperature c". 96.8°F (36°C)
- D Systolic Blood Pressure c". 100 mmHg (may use pressors to reach goal)
- D Uncover the chest to observe for spontaneous breaths (note that a sensitive ventilator can trigger a breath)
- D Pre-Test arterial blood gas and ventilator requirements:
  - D paO_2 2'.: 90 mmHg and CO_2 40 ± 5 mmHg (obtain baseline for known CO_2 retainer).
  - D Tidal Volumes 6-8 cc/kg, PEEP= 5 cm H_2O

Apnea Test

- D Pre-Oxygenate to goal paO_2 c". 200 mmHg, set FiO_2 to 100% for at least IO minutes
- D Disconnect ventilator from endotracheal tube and deliver oxygen through insufflation tubing connected to supplemental oxygen at 6 LPM
- D Draw arterial blood gas after 8-10 minutes and reconnect the ventilator, increase rate to accommodate for increased pCO_2 from apnea test.
- D Abort apnea test and draw ABG immediately if:
  - ☐ Systolic blood pressure drops below 90 mmHg or there is cardiovascular collapse
  - ☐ SpO_2 drops below 85% for > 30 seconds
  - D Significant cardiac arrhythmia develops
  - D Spontaneous respiratory movement is noted

Notes: _____

Apnea test was successfully completed?

Yes ! No !

Interpretation

- D pCO_2 is 2'.: 60 mmHg

OR

- D pCO_2 > 20 mmHg above patient's baseline (if CO_2 retainer)

Time of Death= Time ABG was drawn

Ancillary Testing to Demonstrate Brain Death

- D Nuclear medicine cerebral blood flow (Tech 99M)

OR

- D Conventional catheter-based cerebral angiography

OR

- D Transcranial doppler ultrasound

OR

- D Electroencephalography

Time of Death = Time of A/lending Radiologist/Neurologist Read

Date and Time of Death by Neurologic Criteria:

Physician Signature: _____ Date and Time: _____

Riverside University Health System
Moreno Valley, CA 92555

ADULT BRAIN DEATH NOTE

Comatose Child

(37 weeks gestational age to 18 years of age)

Does Neurologic Examination Satisfy Clinical Criteria for Brain Death?

A. Physiologic parameters have been normalized:
   a. Normothermic: Core Temperature greater than 35° C (95° F)
   b. Normotensive for age without volume depletion
B. Coma: No purposeful responsive to external stimuli (exclude spinal reflexes)
C. Examination reveals absent brainstem reflexes: Pupillary, corneal, vestibuloocular (Caloric), gag.
D. Apnea: No spontaneous respirations with a measured $pCO_2 \geq 60$ mmHg or ≥ 20 mmHg above the baseline $PaCO_2$

NO

A. Continue observation and management
B. Consider diagnostic studies: baseline EEG and imaging studies

YES

Toxic, drug or metabolic disorders have been excluded?

NO

A. Await results of metabolic studies and drug screen
B. Continued observation and reexamination

YES

Patient Can Be Declared Brain Dead

(by age-related observation periods*)

A. **Newborn 37 weeks gestation to 30 days**: Examinations 24 hours apart remain unchanged with persistent coma, absent brainstem reflexes and apnea. Ancillary testing with EEG or CBF studies should be considered if there is any concern about the validity of the examination.
B. **30 days to 18 years**: Examinations 12 hours apart remain unchanged. Ancillary testing with EEG or CBF should be considered if there is any concern about testing the validity of the examination.

*Ancillary studies (EEG & CBF) are not required but can be used when (i) components of the examination or apnea testing cannot be safely completed; (ii) there is uncertainty about the examination; (iii) if a medication effect may interfere with the evaluation or (iv) to reduce the observation period.

ATTACHMENT 1

Brain Death/Death by Neurologic Criteria Checklist for Patients ≥18 Years of Age

Last name	*First name*	*DOB*	*MRN*

PREREQUISITES FOR CLINICAL EXAMINATION	
1. Ascertainment that the patient has sustained a catastrophic, permanent brain injury caused by an identified mechanism that is known to lead to brain death/death by neurologic criteria (BD/DNC)	☐ Yes ☐ No Etiology:
2. Neuroimaging consistent with mechanism and severity of brain injury (in patients with primary posterior fossa injury, neuroimaging should demonstrate catastrophic supratentorial injury)	☐ Yes ☐ No
3. Observation for permanency a) ≥48 hours after acute brain injury (particularly hypoxic ischemic brain injury) for patients ≤2-years-old b) ≥24 hours after hypoxic ischemic brain injury for patients ≥2-years-old c) A sufficient amount of time after brain injury to ensure there is no potential for recovery of brain function as determined by the evaluator based on the pathophysiology of the brain injury	☐ Yes ☐ No
4. Core body temperature ≥ 36oC (for ≥24 hours for patients whose core body temperature has been ≤35.5°C	☐ Yes ☐ No
5. Systolic blood pressure (SBP) ≥ 100 mm Hg and mean arterial pressure (MAP) ≥ 75 mm Hg for adults/SBP and MAP ≥ 5th percentile for age in children	☐ Yes ☐ No
6. Exclusion of pharmacologic paralysis (if administered or suspected) through use of train-of-four stimulator or demonstration of deep tendon reflexes	☐ Yes ☐ No
7. Drug levels for medications that may suppress central nervous system function are therapeutic/subtherapeutic (if available), pentobarbital level is <5 mcg/mL (if the patient received pentobarbital) and at least five half-lives for all other such drugs have passed (longer if there is renal/hepatic dysfunction or if the patient is obese or was hypothermic	☐ Yes ☐ No
8. Alcohol blood level ≤80 mg/dL (if clinically indicated)	☐ Yes ☐ No
9. Toxicology screen (urine and blood) is negative (if clinically indicated)	☐ Yes ☐ No
10. Exclusion of severe metabolic, acid-base, and endocrine derangements	☐ Yes ☐ No
11. A reasonable attempt has been made to inform the patient's family of the plan to perform a BD/DNC examination	☐ Yes ☐ No
Prerequisite Summary (check one):	
☐ All prerequires were met ☐ Unable to adequately correct metabolic derangements, but all other prerequisites were met, so will complete the neurologic examination apnea test(s) and if they are consistent the BD/DNC, will perform ancillary testing ☐ One or more prerequisite were note met, so the evaluation was not completed.	
Attending name, signature, date	

CLINICAL EXAM	YES	NO	Not Tested
12. Coma with unresponsiveness to visual, auditory, and tactile stimulation			
13. Absent motor responses, other than spinally mediated reflexes, of the head/face, neck, and extremities after application of noxious stimuli to the head/face, trunk, and limbs			
14. Absent pupillary responses to bright light bilaterally			
15. Absent oculocephalic reflex (unless there is concern for cervical spine or skull base integrity)			
16. Absent oculovestibular reflexes bilaterally (50mL ice water instilled in each ear with 1 minute observation)			
17. Absent corneal reflexes bilaterally			
18. Absent gag reflex			
19. Absent cough reflex			

Clinical Examination Results (check one);

☐ All elements of the ☐ First ☐ Second clinical exam were completed and findings were consistent with BD/DNC or all elements of the clinical exam except the oculocephalic reflex were completed and findings were consistent with BD/DNC

☐ A portion of the clinical exam other than the oculocephalic reflex could not be assessed safely or it was unclear whether observed limb movements were spinally mediated (note that even if a person does not have all limbs, painful stimulation can still be provided to the torso as close to the termination of the limb as possible, so this does not necessitate ancillary testing); however, the remainder of the test was performed to the fullest extent possible and responses were consistent with BD/DNC. (Ancillary testing is required.)

Reason(s) for incomplete testing (check all that apply):

☐ Anophthalmia; ☐ Corneal trauma or transplantation; ☐ Fracture of the base of the skull or petrous temporal bone; ☐ High cervical cord injury ☐ Ophthalmic surgery that influences pupillary reactivity; ☐ Severe facial trauma; ☐ Severe pre-existing neuromuscular disorder ☐ Severe orbital or scleral edema or chemosis; ☐ Limb movements that may be spinally mediated; ☐ Other (specify):

☐ One or more elements of the clinical exam were inconsistent with BD/DNC, so the patient does NOT meet criteria for BD/DNC

Attending name, signature, date

APNEA TEST	Yes	No
APNEA TESTING PREREQUISITES		
No hypoxemia, hypotension, hypovolemia	☐	☐
pH is normal (7.35-7.45) and PaCO2 is normal (35-45 mm Hg) or if the patient is known to have chronic hypercarbia, PaCO2 is at baseline if baseline is known or at estimated baseline if baseline is not known	☐	☐
	Value:	
PaO2 > 200 mm Hg	☐	☐
	Value:	
APNEA TESTING PERFORMED	☐	☐
Techniques for providing apneic oxygenation		
Tracheal insufflation for patients ≥18 years old a) Place a catheter inside the endotracheal or tracheostomy tube such that it approximately		

terminates just above the level of the carina.

b) The catheter diameter should be <70% of the diameter of the endotracheal or tracheostomy tube

c) Delivery 100% FiO2 at a flow rate of 4-6L/min

Monitor During the Apnea Test for respiratory effort and cardiopulmonary status

Performance of serial arterial blood gases
If point of care blood gas testing is available, perform serial ABG's (approximately every 2 minutes) beginning at approximately 8 minutes of apnea, if the patient does not have hemodynamic instability or hypoxemia, until the ABG results are consistent with the criteria below.

Apnea duration (minutes)	
Post PaCO2 Value (mm Hg)	
Post pH Value	

Final Apnea Testing Results (check one):

☐ Apnea confirmed – no respirations and targets reached (pH < 7.30 and final PaCO2 ≥ 60 mm Hg and ≥ 20 mm Hg above pre-apnea test baseline
(≥ 20 mm Hg) above chronic baseline for patients known to have chronic hypercarbia whose baseline is known) (Ancillary testing is required if patient is known/suspected to have chronic hypercarbia but baseline PaCO2 is not known.)

☐ Apnea testing is inconclusive (could not be completed and no respirations and targets not reached) due to:

- ☐ SBP < 100 mm Hg or MAP < 75 mm Hg or SBP/MAP < 5th percentile for age in children
- ☐ Progressive oxygen desaturation < 85%
- ☐ Cardiac arrhythmia with hemodynamic instability

☐ Apnea testing is negative – one or more spontaneous respirations were seen; findings are not consistent with BD/DNC

Attending name, signature, date

ATTACHMENT 2

Death by Neurologic Criteria Checklist in Patients 37 Month to 18 years of age

Last name	*First name*	*DOB*	*MRN*

PREREQUISITES FOR CLINICAL EXAMINATION	
20. Ascertainment that the patient has sustained a catastrophic, permanent brain injury caused by an identified mechanism that is known to lead to brain death/death by neurologic criteria (BD/DNC)	☐ Yes ☐ No Etiology:
21. Neuroimaging consistent with mechanism and severity of brain injury (in patients with primary posterior fossa injury, neuroimaging should demonstrate catastrophic supratentorial injury)	☐ Yes ☐ No
22. Observation for permanency d) ≥48 hours after acute brain injury (particularly hypoxic ischemic brain injury) for patients ≤2-years-old e) ≥24 hours after hypoxic ischemic brain injury for patients ≥2-years-old f) A sufficient amount of time after brain injury to ensure there is no potential for recovery of brain function as determined by the evaluator based on the pathophysiology of the brain injury	☐ Yes ☐ No
23. Core body temperature ≥ 36oC (for ≥24 hours for patients whose core body temperature has been ≤35.5°C	☐ Yes ☐ No
24. Systolic blood pressure (SBP) ≥ 100 mm Hg and mean arterial pressure (MAP) ≥ 75 mm Hg for adults/SBP and MAP ≥ 5th percentile for age in children	☐ Yes ☐ No
25. Exclusion of pharmacologic paralysis (if administered or suspected) through use of train-of-four stimulator or demonstration of deep tendon reflexes	☐ Yes ☐ No
26. Drug levels for medications that may suppress central nervous system function are therapeutic/subtherapeutic (if available), pentobarbital level is <5 mcg/mL (if the patient received pentobarbital) and at least five half-lives for all other such drugs have passed (longer if there is renal/hepatic dysfunction or if the patient is obese or was hypothermic	☐ Yes ☐ No
27. Alcohol blood level ≤80 mg/dL (if clinically indicated)	☐ Yes ☐ No
28. Toxicology screen (urine and blood) is negative (if clinically indicated)	☐ Yes ☐ No
29. Exclusion of severe metabolic, acid-base, and endocrine derangements	☐ Yes ☐ No
30. A reasonable attempt has been made to inform the patient's family of the plan to perform a BD/DNC examination	☐ Yes ☐ No

Prerequisite Summary (check one):

☐ All prerequires were met

☐ Unable to adequately correct metabolic derangements, but all other prerequisites were met, so will complete the neurologic examination apnea test(s) and if they are consistent the BD/DNC, will perform ancillary testing

☐ One or more prerequisite were note met, so the evaluation was not completed.

Attending name, signature, date

CLINICAL EXAM	YES	NO	Not Tested
31. Coma with unresponsiveness to visual, auditory, and tactile stimulation			
32. Absent motor responses, other than spinally mediated reflexes, of the head/face, neck, and extremities after application of noxious stimuli to the head/face, trunk, and limbs			
33. Absent pupillary responses to bright light bilaterally			
34. Absent oculocephalic reflex (unless there is concern for cervical spine or skull base integrity)			
35. Absent oculovestibular reflexes bilaterally (50mL ice water instilled in each ear with 1 minute observation)			
36. Absent corneal reflexes bilaterally			
37. Absent gag reflex			
38. Absent cough reflex			
39. Absence of sucking and rooting reflexes (patients <6 months only)			

Clinical Examination Results (check one);

☐ All elements of the ☐ First ☐ Second clinical exam were completed and findings were consistent with BD/DNC or all elements of the clinical exam except the oculocephalic reflex were completed and findings were consistent with BD/DNC

☐ A portion of the clinical exam other than the oculocephalic reflex could not be assessed safely or it was unclear whether observed limb movements were spinally mediated (note that even if a person does not have all limbs, painful stimulation can still be provided to the torso as close to the termination of the limb as possible, so this does not necessitate ancillary testing); however, the remainder of the test was performed to the fullest extent possible and responses were consistent with BD/DNC. (Ancillary testing is required.)

Reason(s) for incomplete testing (check all that apply):

☐ Anophthalmia; ☐ Corneal trauma or transplantation; ☐ Fracture of the base of the skull or petrous temporal bone; ☐ High cervical cord injury ☐ Ophthalmic surgery that influences pupillary reactivity; ☐ Severe facial trauma; ☐ Severe pre-existing neuromuscular disorder ☐ Severe orbital or scleral edema or chemosis; ☐ Limb movements that may be spinally mediated; ☐ Other (specify):

☐ One or more elements of the clinical exam were inconsistent with BD/DNC, so the patient does NOT meet criteria for BD/DNC

Attending name, signature, date

APNEA TEST	Yes	No
APNEA TESTING PREREQUISITES		
No hypoxemia, hypotension, hypovolemia	☐	☐
pH is normal (7.35-7.45) and PaCO2 is normal (35-45 mm Hg) or if the patient is known to have chronic hypercarbia, PaCO2 is at baseline if baseline is known or at estimated baseline if baseline is not known	☐	☐
	Value:	
PaO2 > 200 mm Hg	☐	☐
	Value:	
APNEA TESTING PERFORMED	☐	☐
Techniques for providing apneic oxygenation in children		
The patient can be changed to a T-piece attached to the endotracheal tube or a self inflating bag valve		

system such as a Mapleson circuit connected to the endotracheal tube. Giving oxygen at 4-12 L/min via endotracheal tube, or changing ventilator to CPAP mode with amount of PEEP needed prior to apnea test can also be used during the apnea test (ENSURE APNEA DEFAULT SETTINGS ARE DISABLED ON VENTILATOR).

Monitor During the Apnea Test for respiratory effort and cardiopulmonary status

Performance of serial arterial blood gases
If point of care blood gas testing is available, perform serial ABG's (approximately every 2 minutes) beginning at approximately 8 minutes of apnea, if the patient does not have hemodynamic instability or hypoxemia, until the ABG results are consistent with the criteria below.

Apnea duration (minutes)	
Post $PaCO_2$ Value (mm Hg)	
Post pH Value	

Final Apnea Testing Results (check one):

☐ Apnea confirmed – no respirations and targets reached (pH < 7.30 and final $PaCO_2$ ≥ 60 mm Hg and ≥ 20 mm Hg above pre-apnea test baseline
(≥ 20 mm Hg) above chronic baseline for patients known to have chronic hypercarbia whose baseline is known) (Ancillary testing is required if patient is known/suspected to have chronic hypercarbia but baseline $PaCO_2$ is not known.)

☐ Apnea testing is inconclusive (could not be completed and no respirations and targets not reached) due to:

- ☐ SBP < 100 mm Hg or MAP < 75 mm Hg or SBP/MAP < 5th percentile for age in children
- ☐ Progressive oxygen desaturation < 85%
- ☐ Cardiac arrhythmia with hemodynamic instability

☐ Apnea testing is negative – one or more spontaneous respirations were seen; findings are not consistent with BD/DNC

Attending name, signature, date

ATTACHMENT 3

Riverside University Health System – Medical Center
Statement of Family Accommodation Policy

The healthcare team at Riverside University Health System – Medical Center extends our sympathy to you and your family as you grieve your family member's declining health. The physicians have diagnosed your loved one as being brain dead.

The State of California defines brain death as:

- The absence of breathing
- The absence of all brain activity, including the brain stem.

It is the policy of Riverside University Health System – Medical Center, when a patient is declared brain dead, to provide a reasonably brief period of accommodation to gather the family at bedside prior to discontinuation of ventilator support for the patient.

The State of California defines "reasonably brief period" as an amount of time needed to gather family or next of kin at the patient's bedside while being considerate to the needs of other patients and prospective patients in urgent need of care.

ATTACHMENT 4: METABOLIC DERANGEMENTS THAT MAY CONFOUND BD/DNC EVALUATION

METABOLIC DERANGEMENTS THAT MAY CONFOUND BD/DNC EVALUATION	
Laboratory Result	Value
Metabolic	
Ammonia	>75 µmol/L
Blood urea nitrogen	>75 mg/dL
Calcium (or ionized calcium	11 mg/dL (or 1.3 mmol/L)
Glucose	<70 mg/dL or >300 mg/dL
Magnesium	<1.5 mg/dL or >4 mg/dL
Potassium	<3mmol/L or >6 mmol/L
Sodium	<130 mmol/L or >160 mmol/L
Acid-Base	
pH	<7.3 or >7.5
Endocrine	
Total T4	<3 mg/dL or >30 mg/dL
Free T4	≤0.4 ng/dL or >5 ng/dL

The exact values at which the laboratory abnormality could affect the clinical evaluation are uncertain, and the values listed in this table are practical thresholds based on consensus only.

RIVERSIDE UNIVERSITY HEALTH SYSTEM- MEDICAL CENTER
Housewide

	Document No: 630	Page 1 of 9
Title: Restraints and Seclusion	**Effective Date:** 3/14/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **Restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely

1.2 **Seclusion** is the involuntary confinement of a person alone in a room or an area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. Time out is not considered seclusion.

1.3 **Violent Behavior** is violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others.

1.4 **Non-Violent Behavior** is the behavior that interferences with medical treatments, lifesaving interventions or ambulating before medically appropriate.

1.5 **Chemical Restraint** is the use of a medication used to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition

2. GENERAL GUIDELINES FOR ALL RESTRAINT/SECLUSION USE

2.1 Indications

a. Restraint or seclusion may be used when least restrictive measure is not sufficient to protect the physical safety of patients, staff members or others.

b. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others.

2.2 Initiation: Each episode of restraint or seclusion shall be initiated:

a. Upon the order of a physician or licensed practitioner who is responsible for the patient or

b. In an emergency situation where the need for restraint or seclusion may occur so quickly that an order cannot be obtained prior to initiation, a registered nurse may initiate if he/she determines it is necessary to protect the patient. An order from a physician or licensed practitioner who is responsible for the patient shall be obtained as soon as clinically appropriate to pause in the process of providing care.

2.3 Use of Antipsychotic Medications to Manage Violent Behavior

a. Antipsychotic medications shall be used in doses consistent with the community standard, to protect the patient or others and to allow the patient to more effectively interact with their environment. Such use is not considered Chemical Restraint.

2.4 Notification

a. Notification to the Attending Physician: If the restraint was not ordered by a physician with attending responsibility for the patient, an attending physician shall be notified that restraint was applied within 24 hours following initiation. When the attending of record is unavailable responsibility for the patient must be delegated to another physician, who would then be considered the attending physician.

b. Documentation anywhere within the medical record by an attending physician, whether or not it addresses restraint, is considered evidence that the physician was notified of the restraint episode.

2.5 Orders for the use of restraint or seclusion shall never be written as a standing order or on an as needed basis (PRN).

2.6 Duration of the Order

a. **Non-Violent Restraint**

i. Orders for restraint for the management of Non-Violent Behavior shall remain in effect until the patient's behavior or situation no longer requires restraint. *Restraint orders expire at the end of the next calendar day.*

b. **Violent or Self-Destructive Restraint or Seclusion**

i. Orders for restraint or seclusion applied to manage Violent Behavior or Self- Destructive Behavior shall remain in effect until the patient's behavior or situation no longer requires restraint or seclusion, in accordance with the following limits up to a total of 24 hours.

- 4 hours for adults 18 years of age or older;
- 2 hours for children and adolescents 9 to 17 years of age;
- 1 hour for children under 9 years of age.

ii. Continuation / renewal of restraint or seclusion order for the management of Violent Behavior for longer than 24 hours shall be based on an in-person evaluation “face to face assessment” by a responsible physician or licensed practitioner. Exception: repetitive self-mutilating behavior; chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome

2.7 Assessment and Monitoring

a. Non-Violent Restraint/ Restraint used for the management of Non-Violent Behavior shall be subject to ongoing monitoring and assessment as specified in the patient's plan of care.

i. Monitoring and assessments shall occur at least every two hours, however, concurrent documentation of the monitoring/assessment with unchanged findings is not required.

b. Violent or Self-Destructive Restraint or Seclusion. One-hour Face-to-face Assessment

i. A responsible physician, licensed practitioner or Registered Nurse who has been trained in accordance with Attachment 4.4 shall perform a face-to-face assessment of the patient's physical and psychological status within one hour of the *initiation* of restraint or seclusion. Person conducting assessment shall evaluate:

1. The patient's immediate situation
2. The patient's reaction of the intervention
3. The patients' medical and behavioral conditions; and
4. The need to continue or terminate the restraint or seclusion.

ii. When a trained RN or Physician Assistant performs the face-to-face evaluation, they must consult with the Attending Physician or other LP as soon as possible to discuss:

1. Findings of Face to face
2. Need for other interventions or treatment
3. The need to continue or discontinue the use of restraint or seclusion

2.8 Monitoring of patients requiring Violent or Self-Destructive Restraints

a. Restrained or secluded patients shall be carefully monitored and observed at least every 15 minutes through face-to-face observation by staff members trained to do so.

i. In the acute care hospital, compliance with this requirement can be performed by attestation.

ii. In the acute psychiatric unit, compliance with this requirement must be specifically noted in the patient's record.

iii. Trained, unlicensed staff with demonstrated competency may perform components of monitoring (e.g. checking the patient's vital signs, hydration and circulation, the patient's level of distress and agitation, and skin integrity), and may also provide for general care needs (e.g. eating, hydration, toileting and range of motion exercises).

b. Assessment of patients requiring Violent or Self-Destructive Restraints

i. Assessments by a registered nurse, physician assistant or physician shall occur as often as indicated by the patient's condition, behavior, and environmental considerations or at least every two hours.

c. Debriefing Restraint and or Seclusion Use in the Psychiatric Unit

i. For patients admitted to the psychiatric unit who require restraint or seclusion for violent / self-destructive behavior a debriefing must occur as soon as possible, but no later than 24 hours after the use of seclusion or restraint. Patients may participate in the debriefing if applicable.

ii. The debriefing will be recorded to the patient's Medical Record

2.9 Documentation

a. Episodes of restraint shall be documented as indicated on currently approved assessments, monitoring and ordering forms and computerized flowsheets.

2.10 Care Plan or Treatment Plan

a. The restrained or secluded patient's written plan of care shall be modified to address appropriate interventions implemented and encourage the least restrictive means of protecting the patient. The entire medical record is considered evidence of the plan of care.

b. The plan of care will include an assessment, intervention and evaluation.

2.11 Restraint and Seclusion Training (Please refer to Attachment 4.3 & 4.4)

2.12 Discontinuation of Restraint or Seclusion

a. Restraint or Seclusion must be discontinued at the earliest possible time regardless of the length of the order. The discontinuation should be based on the determination that the need for restraint or seclusion is no longer present, or that the patient needs may be addressed using less restrictive methods.

b. Temporary, directly supervised release, that occurs for the purpose of caring for patient's needs (toileting, range of motion, feeding, etc) is not considered discontinuation as long as the patient remains under direct supervision.

2.13 Reporting Restraint Related Deaths

a. Hospital personnel shall promptly contact hospital administration whenever a patient expires:
   i. While in a restraint and/or seclusion
   ii. Within 24 hours after being released from restraint; or
   iii. As the result of a restraint-related condition within 7 days after restraint removal.

b. Designated hospital representatives shall notify the Centers for Medicare and Medicaid Services (CMS) Regional Office of such deaths within one business day of their discovery. Such notification shall be documented in the patient's medical record.

   i. EXCEPTION: Such deaths may be recorded in a log rather than being reported to CMS if a) the death was not a result of or related to the restraint and b) only soft wrist ties were used to restraint the patient most proximate to death.

   ii. Log is maintained with Regulatory Compliance

3. REFERENCES

3.1 42 CFR § 482.13 Condition of participation: Patient's Rights. (e)(f)(g)

3.2 Interpretive Guidelines (Tags A0154-A-0214)

3.3 Health & Safety Code §§ 1180.1 to 1180.5

3.4 HW 654: Adverse Events

3.5 Rules and Regulations (2019). *Federal Register* Vol. 84, No. 189.

4. ATTACHMENTS

4.1 Examples of Restraints

4.2 Antipsychotic Medications Used to Manage Violent Behavior

4.3 Restraint and Seclusion Training Plan

Document History:

Prior Release Dates: 3/1994, 8/2007, 12/2013, 10/2/2016, 5/6/2019, 1/25/2021, 12/6/2021			**Retire Date:** N/A
Document Owner: Restraints Committee			**Replaces Policy:** 630.1, 630.2, 630.3
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
07/12/2024	Nursing Administration	Y	Attachment 4.1; specify side rails on stretchers are not considered a restraint. Update references. Add section 2.10 Discontinuation, specify restraint documentation for Arlington (every 15 minutes) Attachment 4.4 RN training for face to face. NonViolent restrains discontinue with absence of behavior. Define temporary release of restraints under observation, add debrief requirement for psych unit, specify monitoring of violent restraints in psych vs non psych hospital, clarify responsible attending physician under provider notification, update attachment 4.2 Chemical restraint definition, Add trainer requirements in training plan
10/17/2024	Nursing P&P	N	
12/2025	PAC	Y	Minor wording clarifications for Arlington
1/9/2025	MEC	N	

ATTACHMENT 4.1
Examples of Physical Restraint

Device	Not Restraint	Restraint
Devices to protect the patient during a procedure or anesthesia	During a procedure or anesthesia and recovery	Once the patient has recovered from anesthesia and devices are not removed or patient transfers to another unit
Side Rails	Used to keep the patient from **falling out of bed or with a specialty mattress. Not a restraint if the patient can physically get out of bed regardless of rails raise or not. Side rails on a stretcher are not a restraint.**	Used to keep the patient from **getting out of bed.**
Mittens	N/A	Patient cannot flex fingers or does not have access to his / her body.
Arm Boards	To protect site of intravenous access.	If used to prevent the patient from having access to his or her body. If attached to the bed.
Adaptive Devices: Seat belts, waist belts, Geri chairs, etc.	The patient can remove the device (or remove themselves from the device) in the same manner in which it was applied (e.g. unlatching a seat belt, untying a knot, letting the side rail down)	The patient cannot easily remove the device.
Covered bed	Covered bassinet for age or developmentally appropriate patients.	For adults to keep them from getting out of bed.
Protective interventions for infants, toddlers and pre- school children	Stroller safety belts; seat belts for high chairs; etc.	N/A
Holding the patient	Light touching during escort	"Therapeutic" hold, patient cannot remove or escape grasp
Forensic Devices (handcuffs, shackles)	Used for patients in the direct custody of a law enforcement officer.	shall not be used as a device for restraint
Walking Restraints	NA	Device used to prevent the elopement of a patient on an involuntary legal hold during transport to an offsite facility. (Arlington Campus only)

Examples of Seclusion

Not Seclusion	Seclusion
Confinement on a locked unit or ward where the patient is with others.	Confinement in a locked room apart from other patients
Having the patient agree to confine their movements to a room with an open door.	Physically preventing a patient from leaving an unlocked room
A "time out" in a quiet (unlocked) location.	Preventing a patient from leaving an unlocked room through intimidation.

ATTACHMENT 4.2

Antipsychotic and Psychoactive Medications Used to Manage Violent Behavior

Not Chemical Restraint	**Chemical Restraint**
Common use and dose of medications within the standards of care and practice and well-documented by literature; used for the safety of patient or others and to help the patient more effectively interact with their environment; documentation describes the behavior supporting the use of the medication.	Use of a medication to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition; uncommon or outmoded use of medications for the management of behavior; lack of documentation of the behaviors indicating the need for the medication; used for staff convenience.
Order may be PRN	Orders may **not** be PRN
Order renewed as required in medication management policy.	Order renewed at least every 4 hours for adults, every 2 hours for adolescents, every 1 hours for children. (**One- time orders preferred**.)
Medication and dose are consistent with professional standards of practice.	
Used for the safety of patients or others and to help the patient more effectively interact with their environment.	
May NOT be used for staff convenience.	
Documentation describes the behavior supporting the use of the medication.	
Monitoring of vital signs appropriate for the potential sedating effects of the medication and dose.	

ATTACHMENT 4.3

Restraint and Seclusion Training Plan

The patient has the right to safe implementation of restraint or seclusion by a trained staff. Minimum training shall include:

1. Policy review and education for physicians and other licensed practitioners who order restraint or seclusion.
2. The instruction and competency requirements of hospital staff who assess and plan care for patients that require restraints or seclusion include:
    a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
    b. The use of nonphysical intervention skills.
    c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
    d. The safe application and use of all types of restraint or seclusion used by the staff member, including training on how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
    e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
    f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs.
    g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.
    h. Documentation requirements, including but not limited to the plan of care, patient and family education, currently prescribed forms and computerized flowsheets.
3. The instructions and competency requirements for hospital staff that monitor patients in restraints or seclusion include:
    a. Recognition of signs of physical and psychological distress.
4. Training shall be completed as part of orientation and on a periodic basis based on policy changes, new equipment and based on QAPI data..
5. The hospital shall document in the staff personnel records that training and demonstration of competency has been completed.
6. Trainer Requirements: Individuals providing staff training must be qualified as evidenced by education, training, and experienced in techniques use to address patients behaviors.

ATTACHMEN 4.4

Additional RN/PA Training to Perform Face to Face Assessment

Training for an RN to conduct the one-hour face-to-face evaluation would also include content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medications, most recent lab results, etc. The purpose of the one-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 200	Page 1 of 11
Title: Financial Assistance for Low Income, Uninsured/Underinsured Patients	**Effective Date:** 01/01/2025	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. PURPOSE

1.1 The RUHS – Medical Center mission is to improve the health and well-being of our patients and communities through dedication to exceptional and compassionate care, education, and research. Our vision is to lead the transformation of healthcare and inspire wellness, in collaboration with our communities, through an integrated delivery network to bring hope and healing to those we serve. This policy demonstrates the RUHS – Medical Center commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between RUHS – Medical Center and a third-party payer, nor is it intended to provide discounts to a non- contracted third-party payer or any other entity that is legally responsible for making payment on behalf of a beneficiary, covered person or insured.

1.2 This policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance program. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.

2. SCOPE

2.1 This policy covers hospital inpatient and outpatient departments. An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or High Medical Cost patients who are at or below 400% of the FPL. Emergency Room physician fees are covered under a separate policy. All other physician fees are excluded.

3. DEFINITIONS

3.1 Bad debt: A bad debt results from services rendered to a patient who is determined by RUHS – Medical Center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

3.2 Financial assistance patient: Discount payment any charge for care that is reduced but not free. A financially eligible Self-Pay patient or a High Medical Cost patient.

3.3 Charity Care: Free health services provided to eligible patients as outlined in hospital's Charity Care program. Charity care does to include bad debt defined as uncollectable charges that the hospital recorded as revenue but wrote off due to a patient's failure to pay.

3.4 Emergent medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

i. Serious impairment to bodily functions; or

ii. Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions:

i. When there is inadequate time to effect a safe transfer to another hospital before delivery; or

ii. The transfer may pose a threat to the health or safety of the woman or the unborn child.

3.5 High medical cost patient: It is clarified that "out of pocket" costs such and expenses "means any expenses for medical care that are not reimbursed by insurance or health coverage program, such as Medicare copays or Medi-Cal cost sharing."

a. Not self-pay (has third party coverage)

b. Patient's family income at or below 400% of the Federal Poverty Level (FPL)

c. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of Patient's Family income

3.6 Medically necessary service: A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

3.7 Patient's family: Is expanded to include dependent children of any age, and to account for the inclusion of parents when the patient is a dependent child who is not a minor and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, patient's family means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

3.8 Reasonable payment plan: Monthly payments that are not more than 10 percent of a Patient's Family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

3.9 Self-pay patient: A financially eligible self-pay patient is defined as follows:

a. No third-party coverage;

b. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay;

c. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third-party liability as determined and documented by the hospital;

d. Patient's Family income is at or below 400% of the Federal Poverty Level (FPL)

4. POLICY

4.1 This policy is designed to provide assistance to financially qualified patients who require medically necessary services, are uninsured, ineligible for third party assistance, or have high medical costs. Patients are granted assistance from unfunded financial assistance, State-funded California Healthcare for Indigent Program (CHIP), county programs, or grant programs for some or all their financial responsibility depending upon their specific circumstances.

4.2 Patients with demonstrated financial need may be eligible if they satisfy the definition of a financial assistance patient or high medical cost patient as defined in section 3.8 of this document.

4.3 This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout RUHS – Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with RUHS – Medical Center legal counsel.

4.4 Services that are not medically necessary services or services that are separately- billed physician services are not eligible for Financial Assistance program. Emergency department physician services are covered under a separate policy.

4.5 This policy will not apply if the patient/responsible party provides false information regarding financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

4.6 Regardless of ability to pay, RUHS Medical Center shall accept, manage and track medically necessary referrals received from RUHS Community Health Centers for all patients. Discounted medical care made available under the RUHS-CHC Sliding Fee Discount Schedule Program will be provided to patients referred from RUHS-CHC to the Medical Center.

4.7 RUHS – Medical Center, will ensure that patients are made aware of the importance of financial screening and completion of necessary paperwork to gain appropriate healthcare coverage for costs incurred for healthcare services provided at RUHS - MEDICAL CENTER.

4.8 All patients will be provided emergency services in accordance with Emergency Medical Treatment & Active Labor Act (EMTALA) regulations. RUHS - MEDICAL CENTER staff will comply with federal and state laws regarding the conduct of county hospital financial business practices.

4.9 The Financial Assistance Program available through RUHS - MEDICAL CENTER will not substitute for personal responsibility of the patient. All patients are expected to contribute to the cost of their care based on their individual ability to pay.

4.10 Emergency Physicians, as defined in AB 1503, Stats. 2010, Ch. 445.) Section127450, who provides emergency medical services in a hospital that provides emergency care, are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the Federal Poverty Level. This statement shall not be construed to impose any responsibilities upon the hospital.

4.11 Eligibility for the Financial Assistance Program will be considered for those individuals who are uninsured, under-insured, ineligible for any government health care benefits program and unable to pay for their care based upon a determination of financial need.

4.12 Departmental Responsibilities

a. The RUHS - MEDICAL CENTER Financial Assistance shall be reviewed and updated to reflect the current Federal Poverty Level Guidelines (Attachment III).

b. MISP and Patient Accounts managers and staff will ensure that the policies and procedures established for the Financial Assistance Program are applied consistently. Likewise, registration shall provide to all patients the same information concerning services and charges for RUHS – Medical Center.

c. MISP eligibility staff will determine if the patient is required to apply for Federal or State sponsored programs. Patients not linked to SSI/SSDI, Medi- Cal, Medicare, or MISP will be screened for the RUHS – Medical Center Financial Assistance Program.

d. MISP eligibility staff will apply the following when determining eligibility for Financial Assistance:

    i. Monetary assets will no longer be considered in determining eligibility for Charity care or discount payments.

    ii. Individuals who exceed 400% FPL this limit will not qualify for assistance.

    iii. Retirement accounts, deferred compensation plans qualified under Internal Revenue code, or nonqualified deferred compensation plans are not included in the determination of monetary assets.

e. RUHS - MEDICAL CENTER will post and make available income requirements, the patient may be eligible for a government- sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program.

    i. Notice (Attachment II) that provides information about the patient may be eligible for a government-sponsored program or for the RUHS – MEDICAL CENTER Financial Assistance Program. This notice will be posted in areas throughout the hospital.

4.13 Customer Service

a. Patients (or their legal representatives) seeking financial assistance will be asked to provide information quarterly concerning their health benefits coverage, financial status, and any other information that is necessary for RUHS – Medical Center to make a determination regarding the patient's need for financial assistance.

b. Financial screening provided by MISP Eligibility staff, using eligibility criteria (income, family size), will determine the amount a patient is responsible to pay.

c. All RUHS – Medical Center staff shall be informed of availability of Financial Assistance Programs.

4.14 Eligibility

a. Patients with income at or below 100% of the federal poverty level are eligible for RUHS - MEDICAL CENTER Free Care Financial Assistance Program. Patients with combined income at or be 400% of federal poverty level and are uninsured or underinsured will be eligible to apply for the RUHS - MEDICAL CENTER Partial Financial Assistance Program after all other types of assistance have been exhausted.

b. Patient with high medical costs" means an insured patient with high medical costs (co-payment, coinsurance and/or reached a lifetime limit, non-covered relating to services not medically necessary), with income at or below 400% of the Federal poverty level and not already receiving a discounted rate as a result of insurance coverage, then the patient may qualify for a discount from usual charges in accordance to the following guidelines herein, including but not limited to the California Fair Pricing Law. High medical costs" means (1) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

c. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program.

d. Commercial Insurance deductible, Hospital may waive or reduce Medi-Cal and Medicare cost sharing amounts as part of its charity care program or discount payment program.

e. Co- insurance do not constitute being underinsured.

f. Patients applying for the RUHS - MEDICAL CENTER Financial Assistance Program, who are denied eligibility have the right to file an appeal within 10 days. A patient has 10 days from the date that the county mailed or provided written Notice of Action (NOA). An appeal may be made by the patient contacting the RUHS - MEDICAL CENTER - MISP office to make an appointment with the appeals supervisor.

g. If determined to be eligible for the RUHS - MEDICAL CENTER Partial Financial Assistance Program by MISP eligibility staff, the patient will be referred to Patient Accounts to arrange payment of the hospital bill(s).

h. Documentation of the financial screening process will be retained by MISP according to MISP policy

4.15 Documentation Includes:

a. Date of determination of eligibility or denial for this program

b. Level of eligibility per the RUHS - MEDICAL CENTER Financial Assistance program

c. Copy of the application form

d. Copy of the approval or denial letter

4.16 Coverage Restrictions

a. Outpatient prescriptions and cosmetic surgeries are not covered under the RUHS- MEDICAL CENTER Financial Assistance Program.

4.17 Billing

a. Amounts payable to medical service providers other than RUHS - MEDICAL CENTER are excluded from this policy.

b. A Patient qualifying for assistance under the RUHS - MEDICAL CENTER Financial Assistance Policy and cooperating with Patient Accounts will not be referred to a collection agency.

c. A patient that fails to comply with requested financial updates will be responsible for payment of the original balance owned for their Hospital bill(s) in full.

d. In the event that the cost of medical care received at RUHS – MEDICAL CENTER is less than the amount the patient is responsible for, the patient will only be billed for the cost of those services. The cost of services provided will be determined using the most recently filed Medicare cost report.

e. Payment arrangements will be made for any amount owed that exceeds 10% of the monthly income of the patient. Payment plans will not exceed 12 months.

f. If a patient is cooperating and complying with the payments required according to the established responsibility for that patient, RUHS – Medical Center will not place wage garnishments or liens on primary residencies or other properties as a means of collecting the unpaid hospital UMDAP (Uniform Method of Determining Ability to Pay) bills.

g. If a patient fails to comply with their established payment plan for more than 90 days, the payment plan may be declared inoperable and the patient will be responsible for payment of the original balance owed for their Hospital bill(s) in full. Patient Accounts will attempt to contact the patient at the last known address and at the last known phone number of the patient to re-negotiate the payment plan prior to declaring any payment plan inoperable.

h. If it is determined an overpayment by the patient has occurred, RUHS – Medical

i. Center will refund any amount owed within 30 days of the determination. Interest owed on this overpayment by the hospital to the patient will be paid to the patient at the statutory rate (10% per annum) according to Civil Procedure Code 685.010 and Health and Safety Code section 127440. Interest will be accrued beginning on the date payment was received by the hospital. If the amount of interest due to the patient is less than five dollars ($5.00), the hospital is not required to pay the interest.

j. RUHS – Medical Center contracted collection agencies; billing services are required to conform to the billing/collection practices outlined in this policy.

5. REFERENCES

5.1 2004 CHA Voluntary Principles and Guidelines for Assisting Low Income, Uninsured Patients.

5.2 MISP policy number MISP 10

5.3 MISP policy number MISP 14

5.4 MISP policy number MISP 20

5.5 MISP policy number MISP 21

5.6 RUHS - CHC 112 Sliding Fee Discount Policy

6. ATTACHMENTS

6.1 RUHS – Medical Center Financial Assistance Statement

6.2 RUHS – Medical Center Financial Assistance Notice

6.3 Federal Poverty Guidelines

Document History:

Prior Release Dates: 11/13/2017, 5/22/2019, 4/1/2022, 1/17/2023, 9/11/2024	**Retire Date:** N/A		
Document Owner: MISP	**Replaces Policy:** MISP Policies No. 204.2 and 204.3		
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
12/3/2024	Policy Approval Committee	N	Discount payment any charge for care that is reduced but not free. A financially eligible Self-Pay patient or a High Medical Cost patient. It is clarified that “out of pocket” costs such and expenses “means any expenses for medical care that are not reimbursed by insurance or health coverage program, such as Medicare copays or Medi-Cal cost sharing.” Is expanded to include dependent children of any age, and to account for the inclusion of parents when the patient is a dependent child who is not a minor. Monetary assets will no longer be considered in determining eligibility for Charity care or discount payments. Hospital may waive or reduce Medi-Cal and Medicare cost sharing amounts as part of its charity care program or discount payment program.

ATTACHMENT 6.1
RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS – MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medi-Cal Medicare MISP
RUHS - MEDICAL CENTER
Financial Assistance –
UMDAP

Inpatient Services – Patients expressing concern with payment for Hospital services should be referred to the Inpatient MISP Eligibility staff for assistance.

Outpatient/Emergency Room Services – Patients expressing concern with payment for outpatient or emergency room services can be referred to the MISP office to pick up an MISP/RUHS - MEDICAL CENTER Financial Assistance Program application and schedule an appointment to meet with an MISP eligibility staff.

As part of the interview/screening appointment with the MISP eligibility staff, the patient requesting assistance will be screened for eligibility for all programs named above.

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
26600 Cactus Ave Ast Floor #14
Moreno Valley CA, 92555
877-501-5085

Medi-Cal	MISP	Medicare
877-410-8827	**1-877-501-5085**	**1-800-633-4227**

ATTACHMENT 6.2
RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS - MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medically Indigent Services Program
(MISP) RUHS - MEDICAL CENTER Financial Assistance Program

877-501-5085

Medi-Cal	MISP	Medicare
877-410-8827	**1-877-501-5085**	**1-800-633-4227**

ATTACHMENT
6.3

Annual 25/26 Poverty Guidelines

Household/Family Size	100%	138%	200%	322%	400%
1	$15,650	$21,597	$31,300	$50,393	$62,600
2	$21,150	$29,187	$42,300	$68,103	$84,600
3	$26,650	$36,777	$53,300	$85,813	$106,600
4	$32,150	$44,367	$64,300	$103,523	$128,600
5	$37,650	$51,957	$75,300	$121,233	$150,600
6	$43,150	$59,547	$86,300	$138,943	$172,600
7	$48,650	$67,137	$97,300	$156,653	$194,600
8	$54,150	$74,727	$108,300	$174,363	$216,600
Each Additional Person Add	$5,500	$7,590	$11,000	$17,710	$22,000

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
HOUSEWIDE

	Document No: 139	Page 1 of 4
Title: QIP Data Integrity and Internal Data Validation	**Effective Date:** 1/14/2025	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☒ **Procedure** ☐ **Guideline**

1. PURPOSE

Riverside University Health System (RUHS) is committed to safeguarding electronic Protected Health Information (ePHI. As such, RUHS will continually assess potential risks and vulnerabilities to ePHI in its possession, and develop, implement, and maintain appropriate technical security measures in accordance with 45 C.F.R. §164.312(c)(1).

2. DEFINITIONS

2.1 Data Integrity. The property that data has not been altered or destroyed in an unauthorized manner.

2.2 Electronic Protected Health Information (ePHI). PHI that is transmitted by electronic media or is maintained in electronic media is ePHI. For example, ePHI includes all data that may be transmitted over the Internet or stored on a computer, a CD, a disk, magnetic tape or other media

2.3 Protected Health Information (PHI). Verbal, written, or electronic information created or maintained by RUHS that identifies an individual patient. Patient PHI includes, but is not limited to:

a. The patient's presence or location at RUHS.

b. Demographic information, such as name, age, date of birth, address, telephone and/or fax number, email income, social security number, account number, driver's license number, health plan, and/or medical record number.

c. Information about the patient's medical condition, diagnostics/testing, treatment, and prognosis.

2.4 Quality Incentive Pool (QIP) Program. A California Department of Health Care Services program in which payments are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

2.5 System Administrator. Individuals with ultimate responsibility for the creation of the data used or stored in organizational information (computer) systems.

2.6 Workforce Members. Workforce Member is defined as any regular employee, temporary assistance employee (TAP), per diem employee, contract employee, volunteer, trainee, residents, medical students, and/or any other persons whose conduct, in the performance of work for RUHS, is under the direct control of, whether or not they are paid by RUHS. Medical Staff members may also be part of the "workforce"

3. POLICY

3.1 RUHS System Administrators will take reasonable and appropriate steps to implement electronic mechanisms to prove that ePHI has not been altered or destroyed in an unauthorized manner, including:

a. Which ePHI will be authenticated

b. Which electronic mechanisms would be reasonable and appropriate

3.2 RUHS must perform regular risk analysis to determine the appropriate electronic mechanisms to protect the integrity of all ePHI contained on its information systems.

3.3 RUHS workforce members must receive regular training and awareness about such electronic mechanisms. All such mechanisms must be approved by RUHS' HIPAA Security Officer.

3.4 RUHS' HIPAA Security Officer will approve the electronic mechanisms that have been implemented to protect ePHI from unauthorized alteration or destruction and to authenticate the integrity of ePHI, and will take reasonable and appropriate steps to ensure that the electronic mechanisms are reviewed and that integrity incident reports are generated from the electronic mechanisms.

3.5 RUHS Department Managers will take reasonable and appropriate steps to train workforce members regarding the electronic mechanism(s) the covered component has implemented to confirm the integrity of ePHI.

3.6 RUHS is a QIP entity for the Quality Incentive Pool and, as such, has additional data integrity requirements which consists of the following:

a. The QIP entity's leadership, management and staff must make a good faith effort to manage the risks that might undermine data integrity of the QIP Program;

b. QIP entity must facilitate data integrity through a process of self-governance, meaning that QIP entities have the lead responsibility for preventing, deterring, identifying, and rectifying any data integrity issues within their respective programs;

c. QIP entities must ensure that QIP data meet the following standards:

- Attributable--establishing who performed an action and when;
- Legible--recorded permanently in a durable medium, readable by others, with traceable changes;
- Contemporaneous--with activities recorded at the time they occur (when an activity is performed, or information is obtained); and
- Accurate--reflecting the true information

d. QIP entities must retain applicable supporting documentation for a period of five years after submission of Demonstration Year reports, and make such documentation available in case of an audit conducted by external parties;

e. QIP entities must document and retain records of all incentive payment amounts earned under QIP, as well as clinical and quality improvement data for QIP reports;

f. QIP entities must report to DHCS within 3 business days of discovery, any breach of these requirements that results in discrepancies from submitted QIP quantitative or qualitative reports

4. REFERENCES

4.1 RUHS departmental policy IS 1005 Information Systems Review Activity

4.2 RUHS departmental policy IS 1046 Audit Controls

4.3 45 C.F.R. §164.312(c)(1)(2) Technical Safeguards.

4.4 National Institute of Standards and Technology (NIST) Special Publication 800-14, "Generally Accepted Principles and Practices for Securing Information Technology Systems" (http://csrc.nist.gov/publications/nistpubs/800-14/800-14.pdf)

4.5 National Institute of Standards and Technology (NIST) Special Publication 800-50, "Building an Information Technology Security Awareness and Training Program" (http://csrc.nist.gov/publications/nistpubs/800-50/NIST-SP800-50.pdf)

4.6 National Institute of Standards and Technology (NIST) Special Publication 800-16, "IT Security Training Requirements: Role and Performance Based Model" (http://csrc.nist.gov/publications/nistpubs/800-16/800-16.pdf)

4.7 National Institute of Standards and Technology (NIST) Special Publication 800-63-1, "Electric Authentication Guideline" (http://csrc.nist.gov/publications/nistpubs/800-63-1/SP-800-63-1.pdf)

4.8 National Institute of Standards and Technology (NIST) Special Publication 800-12, Chapter 17 "An Introduction to Computer Security: The NIST Handbook" (http://csrc.nist.gov/publications/nistpubs/800-12/handbook.pdf)

4.9 National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1, "A Resource Guide for Implementing The HIPAA Security Rule" (http:/csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf).

4.10 National Institute of Standards and Technology (NIST) Special Publication 800-30 Revision 1, "Guide for Conducting Risk Assessments" (http://csrc.nist.gov/publications/nistpubs/800-30-rev1/sp800_30_r1.pdf)

4.11 Health and Human Services – Office of Civil Rights, "Final Guidance on Risk Analysis", (http://www.datamountain.com/wp-content/uploads/OCR_Risk-Analysis_Final_guidance.pdf)

4.12 HIPAA Security Final Rule (https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/securityrule/securityrulepdf.pdf))

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1/7/2024	Policy Approval Committee	Y	Update title “HIPAA Security Officer” to “Chief Information Security Officer”

RUHS Medical Center Policies Approved 01/01/2025 through 03/30/2025

#	Name	Version Effective Date
1	HW 139 QIP Data Integrity and Internal Data Validation	1/14/2025
2	HW 200 Financial Assistance Programs	1/1/2025
3	HW 630 Restraints and Seclusion	3/14/2025
4	HW 351 Death by Neurologic Criteria	3/14/2025
5	HW689 Code Stroke	3/14/2025
6	HW 844 Antimicrobial Stewardship	3/14/2025
7	HW 885 Patient Delivered Partner Therapy PDPT for Sexually Transmitted Infections STI	3/14/2025
8	HW 899 Controlled Substances Handling Medication Diversion Management	3/14/2025