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

ITEM: 18.2
(ID # 28672)
MEETING DATE:
Tuesday, September 09, 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 8/17/2025

MINUTES OF THE GOVERNING BOARD

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

Ayes:	Medina, Spiegel, Perez and Gutierrez
Nays:	None
Absent:	Washington
Date:	September 09, 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:

Impact on Citizens and Businesses

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.

This item requires Board approval in accordance with the requirements of the State of California which state that an acute care hospital shall have a "governing body" separate from its administrative leaders and medical staff leadership. The Board of Supervisors has declared itself to be the "governing body" for the RUHS Medical Center (Motion, February 23, 1988, 3-35). Furthermore, on April 12, 1998 the Board determined that it would hold regularly scheduled meetings, acting as the Medical Center governing board, to "review hospital policy, quality of

care, medical staff credentialing, institutional planning and continuing education matters" pursuant to Resolution No. 88-166.

As such, RUHS-MC is required to report quarterly for each fiscal year in accordance with RUHS Hospital Bylaws Adopted November 14, 2017, Item 3.22 ID 5496 Article VI.

ATTACHMENTS:
Attachment A: RUHS Policy List 04.01.25 to 06.30.25
Attachment B: RUHS Policies 04.01.25 to 06.30.25

Jacqueline Ruiz, Principal Analyst 9/3/2025

Gregg Gu, Chief Deputy County Counsel 8/18/2025

RUHS-Medical Center Policies Approved 04/01/25 through 06/30/25

#	Name	Version Effective Date
1	HW 131 Patient Belongings.pdf	6/18/2025
2	HW 145 Animals in the Hospital.pdf	5/6/2025
3	HW 601.1 Mental Health Patient Rights.pdf	5/6/2025
4	HW 603 Organization and Provision of Patient and Family Care.pdf	5/6/2025
5	HW 633 Elopement and AMA.pdf	6/18/2025
6	HW 695 Stroke Program Scope of Service.pdf	6/18/2025
7	HW 712 Computer Hardware and Software Access Use and Security.pdf	5/6/2025
8	HW 739 Treating Oneself or Family Member.pdf	4/14/2025
9	HW 804 High Alert Medication.pdf	6/18/2025
10	HW 808 Snakebite Management.pdf	5/6/2025
11	HW 842 Drug Formulary Non Formulary Process.pdf	5/6/2025
12	HW 870 Management of Extravasation and Infiltration of Intravenous Drugs.pdf	5/6/2025
13	HW 903 Food from Outside.pdf	5/6/2025

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Housewide

	Document No: 131	Page 1 of 5
Title: Patient Belongings	**Effective Date:** 5/15/2024	☐ **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 guideline shall govern how patient belongings are processed at Riverside University Health System – Medical Center Moreno Valley campus (RUHS). The Arlington Campus shall maintain their own policy for patient belongings.

2. DEFINITIONS

2.1 **Activities of Daily Living (ADL):** are the things normally done in daily living including any daily activity performed for self-care such as feeding, bathing, dressing, grooming, work, homemaking, and leisure.

2.2 **Contraband:** is defined, for the purposes of this document only, as items that staff perceive that a patient/visitor could use to cause harm to self or others, violate another person's rights, and/or interfere in any way with the provision of care to other patients and the environment.

2.3 **Entrusted Property:** Patient Monies and/or Valuables that the patient entrusts to the licensee for safekeeping.

2.4 **Medical Equipment:** is equipment prescribed by a physician that is medically necessary for the diagnosis or treatment of an illness or injury, or to prevent the patient's further deterioration.

2.5 **Patient Belongings:** are a patient's personal possessions.

2.6 **Patient Supplied Medical Equipment:** is defined as any medical equipment that is not owned, leased, or contracted by RUHS – Medical Center, which is brought into the facility by the patient/family or representative for the patient's personal use during their hospitalization.

2.7 **Personal Care Device:** is a patient belonging that assists the patient in the activities of daily living. Examples include: dentures, eyeglasses, hearing aids, contact lenses, etc.

3. GUIDELINE

3.1 **Admitting shall:**

a. Inform the patient that:

i. Personal belongings should be sent home with a family member.

ii. The hospital is not financially responsible for any belongings retained by the patient.

iii. The patient may request to store valuables in the locked, fireproof, RUHS – medical center safe.

iv. According to California state law, RUHS – MEDICAL CENTER is only liable for belongings accepted for storage in that safe and only up to a maximum liability of $500.00.

v. NOTE: If the patient states or staff observes that the patient has currency that exceeds $500.00 in value, and the patient refuses to place that currency in the locked safe, staff shall notify the receiving care area and document the refusal.

vi. The above information is included in the Conditions of Treatment that is signed by the patient or legal representative.

3.2 **If the patient indicates they DO have valuables for storage:**

a. The valuables shall be placed in a property bag and the bag shall be sealed in the presence of the patient. The patient shall sign the form and staff shall inform the patient how they can claim the bag at a later time.

i. Inventory of valuables:

- Only list the type and quantity of any credit/debit card.(ie;debit/visa card x2)
- List the check numbers of checks.
- Itemize currency by denomination of bills and total them. The count shall be witnessed and co-signed by that witness.
- Use objective, basic descriptors (i.e., what appears to be a diamond in a gold ring should be described as a “yellow metal ring with a clear stone”; a cell phone of any type should be described simply as a “cell phone”).
- Sign the inventory.
- Transport to Nurse Staffing Office

ii. EXCEPTION: If the patient states that they have valuables in the form of personal medication from home, personal care device, or personal medical equipment, staff will advise the patient to take those items home via a trusted family member or friend. If they cannot be returned home, the patient record will reflect that the items followed the patient to the receiving care area. Home medication should be processed per HW 857 Patient’s Personal Home Medication.

iii. NOTE: If the belongings include currency that exceeds $500.00 in value, staff must obtain a witness during the securement process.

iv. NOTE: If any hospital staff writes a receipt for any patient belonging that specifically states that the value of the belonging exceeds $500 then the hospital is liable for that amount even though it exceeds $500.

v. NOTE: If the patient is wearing valuables i.e. rings, bracelets. etc. and refuses to place items in the safe, this shall be documented in the health record.

b. The valuables bag shall then be transported to the Nurse Staffing Office.

3.3 **Entrusted Property to the Hospital**

a. When the Nurse Staffing Office receives patient valuables bags for storage in the locked safe, they shall note it in a log, inventory contents in the presence of a Riverside County Sheriff Deputy, seal and place the bag in the safe.

b. When a patient directly requests the return of patient valuables from the locked safe, the Nursing Staffing Office shall ask for identification AND a signature.

c. When a patient family member, caregiver, or representative asks for the patient valuables, Nurse Staffing Office staff shall call the patient care area to verify with the patient. If the patient lacks capacity in decision making, the social worker will be called to verify who is listed as the patient's representative to confirm that the individual is authorized to do so. If the belongings are released to that individual, an identification and signature shall be required.

d. Upon a patient's death, monies and valuable(s) will be given to the legal responsible party within 30 days. The Nurse Staffing Office can utilize the Patient Advocate Office in search for family of a decedent as needed.

e. If Monies and/or Valuables are left behind by a patient, items will be sent to the Patient Advocate Office. The Patient Advocate Office will attempt to make contact with the patient for pick up. If they are not successful, the cash will be sent to the Cashier Office. Remaining non-cash valuables will be kept for a period of 180-days.

f. The Cashiers Office will receive the cash and hold it to be claimed for a period of 4-7 years. At which time, it will be sent to the State as unclaimed monies.

3.4 Entrusted Property Loss

a. All reports of lost monies and/or valuables shall be investigated by the appropriate Department Manager, or designee.

b. The patient shall be reminded that RUHS - MEDICAL CENTER cannot assume liability for lost, missing, or damaged belongings retained at the bedside. A search for lost belongs can be conducted for service recovery but is not required.

c. If the property is not found after a search of the safe, and the patient would like to make a complaint or claim, the Department Manager, or designee shall:

   i. Fill out form ND#81 (ATTACHMENT 5.1) with the patient information and forward it to the Patient Advocate.

   ii. Provide the patient with contact information for the Patient Advocate.

   iii. Forward any written communication from the patient or patient representatives regarding their lost or damaged property to the Hospital Patient Advocate.

   iv. Complete an online Incident Report

   v. Notify the Security Department if a crime is suspected.

3.5 Patient Care Unit

a. Unconscious Patients

   i. If the patient is unconscious , the receiving patient care unit shall offer the patient belongings to the patient's family or representative.

   ii. If there is no family representative present, or the family refuses the belongings, nursing staff shall inventory patient personal belongings via the electronic health record, place items in a property bag and seal the bag. During downtime use form #111 *Patient Property and Transfer Record*

iii. EXCEPTION: Some belongings may require a different bagging procedure due to safety and/or infection prevention and control precautions.

b. Follow Inventory of valuables process, refer to section 3.2 a. i. Inventory of valuables:
   i. Ensure use of an approved device for photographing.
   ii. Ensure all items are visible in the photograph.
   iii. Ensure the patient's identification sticker is present in all photographs.
   iv. Upload photographs to the health record.
   v. Nursing or other healthcare staff should enter a comment in the EPIC Patient Belongings flowsheet indicating that the patient's belongings have been inventoried/photographed.

c. Personal Home Medications
   i. The receiving nursing unit shall process personal medication from home in compliance with *HW 857 Patient's Personal Home Medication*.
   ii. If the patient submits plant materials as personal home medication, staff shall process it in compliance with *HW 857 Patient's Personal Home Medication*.

d. Personal Care Device from Home
   i. Patient Care unit staff shall assist patients with personal care devices from home according to individual unit practices.

e. Personal Medical Equipment from Home
   i. Nursing units shall process medical equipment according to policy *HW 673 Use of Patient Supplied Medical Equipment.*

f. Suicidal Patient's Belongings
   i. Refer to Policy HW 668 *Suicide Prevention*

g. Unit Transfers
   i. Patients transferred to other patient care unit shall have all belongings that are retained at the bedside transferred with them by the sending unit.
   ii. If the patient is unconscious, nursing staff of the sending unit shall ensure the integrity of the sealed belongings bag. If integrity is compromised, the contents will be reviewed to ensure all items photographed are present. If all items are present, the items will be sealed in a new belongings bag. The belongings bag will be transported with the patient to the receiving care unit.

h. Return of patient monies and/or valuables
   i. The patient may request the return of their monies and/or valuables at any time, not solely upon discharge. Receipt of valuables will be obtained from the patient at the time monies and/or valuables are returned.

i. Belongings left behind
   i. When patient belongings are found in a patient care unit after a patient's discharge and staff can identify the owner, staff shall attempt to contact the patient and ask him/her or their designee to pick up his/her belongings.

ii. If no owner could be identified, or if belongings were not picked up within 3 days after contact, the patient care unit staff will tag the belongings and send to the Patient Advocate Office.

iii. After 60 days, if the patient does not return contact/retrieve belongings, the hospital will no longer be liable for their storage.

iv. EXCEPTION: Soiled belongings will not be stored for any period of time for sanitary purposes.

3.6 **Safety and Contraband**

a. Any staff that identifies contraband shall secure the item(s) using appropriate PPE, if safe to do so, and immediately call the Security Operations Center (SOC) for assistance. If the staff is unable to safely secure the item(s), they shall remain in direct observation of the patient or visitor until someone from the SOC responds or call and activate the appropriate hospital code (ie. Code silver or Code green), if necessary. If staff requests contraband from a patient and a patient is unwilling to surrender contraband, immediately call SOC for assistance and activate appropriate code, if necessary.

b. If staff is uncertain of what to do in any situation involving contraband, they shall call the SOC, so they can triage the situation appropriately.

4. REFERENCES:

4.1 California Civil Code Sections 1859, 1860, and 1862.5

4.2 California Probate Code Section 330 and 13104(d)

4.3 California Code of Regulations 22 CCR 70755 Patients' Monies and Valuables

4.4 California Government Code Section 50050-50057

4.5 RUHS Medical Center Conditions of Treatment

4.6 HW 673 *Use of Patient Supplied Medical Equipment*

4.7 *HW 857 Patient's Personal Home Medication*

4.8 HW 668 *Suicide Prevention*

5. ATTACHMENTS

5.1 Form ND #81 Patient Property Complaint

5.2 Patient Property and Transfer Record #111

5.3 Form 249 Patient's Valuables Record

5.4 Belongings Left Behind Tag

Document History:

Release Dates: 2/1/13, 9/5/2017, 3/18/2021	**Retire Date:** N/A
Sponsored by: Director of Nursing - 4100	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
2/29/2024	Pre-Nursing P&P	Yes	Recommendations 3.4, 3.5. Decide the ED to OR patient belonging pathway. Heather to review the photo process
3/27/2024	Nursing P&P	Yes	3.2a – review the process with house sups to confirm or change methods.
5/7/2024	Policy Approval Committee	Yes	Minor wording changes to contraband definitions, adding 'that staff perceives'

DATE:_____ File#: _____

PATIENT PROPERTY COMPLAINT

PATIENT NAME: _____ MRN: _____

PATIENT ADDRESS: _____

PHONE#:_____ DATE DISCHARGED:_____FROM UNIT: _____

DESCRIPTION OF MISSING PROPERTY: _____

_____

_____

_____

Name of person filing complaint (if other than patient):_____

Relationship:_____ Phone#_____

****

FOLLOW-UP ON MISSING PROPERTY:

[ ] Admitting contacted for property By:_____

[ ] Unit contacted/searched for property By:_____

[ ] Chart reviewed – property sheet copied: By:_____

[ ] Staff involved asked about property By:_____

[ ] Patient/family notified of results of search By:_____

Summary regarding property:_____

_____

_____

_____

PLEASE RETURN THIS COMPLETED FORM TO: PATIENT ADVOCATE OFFICE

NOTE

Property retained at bedside (at owner's risk) *Objetos de valor permaneciendo con el paciente (por cuenta y riesgo del dueño)*	**Property taken to Nursing Staffing Office SAFE:** (*Objetos de valor llevados a la oficina de negocios*)	**Property given to person accompanying patient at Admission** (*Objetos de valor llevados a casa al ingreso*) Rec'd By (*Recibidos por*):
☐ **Drivers License** *(Licencia)* ☐ **Keys** *(Llaves)* ☐ **Cell Phone** (*cellula*) ☐ **Charger** *(cargado)* ☐ **Money/Credit Card** (*dinero/tarjeta de credito)* Describe (*Describa*): _____ ☐ **Jewelery**/ Describe (*Describa*): _____ _____ ☐ **Dentures**: (*Dentadura Postiza*) ☐ Upper (*Superior*) ☐ Lower (*Inferior*) ☐ **Removable Bridge**: (*Removible Puente*) ☐ **Glasses**: (*Anteojos*) Describe (*Describa*)_____ ☐ **Contact Lens** (*Lentes de Contacto*) ☐ **Medical Appliance** (*Dispositivo Médico*) Describe (*Describa*)_____ ☐ **Clothing** ☐ Hat or Cap (*Sombrero o Gorra*) ☐ Jacket/Sweater (*Chaqueta/Suéter*) ☐ Shirt or Blouse (*Camisa o Blusa*) ☐ Dress (*Vestido*) ☐ Pants (*pantalones*) ☐ Underwear (*Ropa Interior)* ☐ Undershirt *(Camiseta*) ☐ Bra (*Sostén*) ☐ Pajamas/nightgown (*Pijama/Camisón)* ☐ Robe (*Bata*) ☐ Socks or Hose (*Calcetines o Medias*) ☐ Shoes/Slippers (*Zapatos o chanclas*) ☐**Other**_____ _____ _____	☐ **Drivers License** *(Licencia)* ☐ **Keys** *(Llaves)* ☐ **Cell Phone** (*cellula*) ☐ **Charger** *(cargado)* ☐ **Money/Credit Card** (*dinero/tarjeta de credito)* Describe (*Describa*): _____ ☐ **Dentures**: (*Dentadura Postiza*) ☐ Upper (*Superior*) ☐ Lower (*Inferior*) ☐ **Removable Bridge**: (*Removible Puente*) ☐ **Glasses**: (*Anteojos*) Describe (*Describa*)_____ ☐ **Contact Lens** (*Lentes de Contacto*) ☐ **Medical Appliance** (*Dispositivo Médico*) Describe (*Describa*)_____ ☐**Other**_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	☐ **Drivers License** *(Licencia)* ☐ **Keys** *(Llaves)* ☐ **Cell Phone** (*cellula*) ☐ **Charger** *(cargado)* ☐ **Money/Credit Card** (*dinero/tarjeta de credito)* Describe (*Describa*): _____ ☐ **Jewelery**/ Describe (*Describa*): _____ _____ ☐ **Dentures**: (*Dentadura Postiza*) ☐ Upper (*Superior*) ☐ Lower (*Inferior*) ☐ **Removable Bridge**: (*Removible Puente*) ☐ **Glasses**: (*Anteojos*) Describe (*Describa*)_____ ☐ **Contact Lens** (*Lentes de Contacto*) ☐ **Medical Appliance** (*Dispositivo Médico*) Describe (*Describa*)_____ ☐ **Clothing** ☐ Hat or Cap (*Sombrero o Gorra*) ☐ Jacket/Sweater (*Chaqueta/Suéter* ☐ Shirt or Blouse (*Camisa o Blusa*) ☐ Dress (*Vestido*) ☐ Pants (*pantalones*) ☐ Underwear (*Ropa Interior)* ☐ Undershirt *(Camiseta*) ☐ Bra (*Sostén*) ☐ Pajamas/nightgown (*Pijama/Camisón)* ☐ Robe (*Bata*) ☐ Socks or Hose (*Calcetines o Medias*) ☐ Shoes/Slippers (*Zapatos o chanclas*) ☐**Other**_____ _____ _____

The above list of property is complete and accurate (*La lista de bienes arriba mencionada es correcta y completa*):

Patient/Representative: (*Paciente*)_____ Witness: (*Testigo*) _____
Date/Time:_____

TRANSFER RECORD

Date	Time	From	To	Sent By	Received By	Property remain same as above	If different, complete new form

DISCHARGE RETURN OF VALUABLES *(Devolucion De Objectos De Valor)*
Received All Property Listed Above (*Se recibieron todos los bienes arriba mencionados*)

Returned By (*Devueltos por*) _____ To (Recibidos por) _____ Date/Time_____
Patient/Responsible Party
(*Paciente/Pariente Responsable*)

Riverside University Health System Medical Center
Moreno Valley, California 92555

PATIENT'S PROPERTY AND TRANSFER RECORD
111 Rev. 10/16
Chart-Green; White-ED, Yellow- Patient, Blue-Safe (Attach to Property Bag)

VALUABLES TO FLOOR: MONEY — **NONE** ☐

OTHER —

DATE:

NONE ☐

UNIT:

VALUABLES TO BUSINESS OFFICE

OTHER PROPERTY	DATE	REFERENCE	PATIENT'S CASH		
			IN	OUT	BALANCE

The above is a correct statement of valuables deposited with this Hospital on the above date and the patient, consideration of his (her) admission to and treatment by the Hospital release the Hospital from liability for loss and all property and valuables retained by him (her).

IMPORTANT NOTICE: Valuables in safekeeping may be released only during business hours, 8:00 a.m. - 4:30 p.m. weekdays. Arrangements must be made in advance for other hours.

(Signature of Patient or Guardian) Date (Employee receiving property from patient) Date

Valuables turned in by:

Date CASHIER: Date

Received valuables noted above in full:

(Signature of person receiving valuables) Date

Riverside University Health System
Medical Center & Community Health Centers

PATIENT'S VALUABLES RECORD

249 Rev. 1/98

NOTE White-Chart, Yellow-Cashier, Pink-Patient

BELONGINGS LEFT BEHIND

**Attach Completed Tag to Bag Exterior*

INSERT PATIENT'S STICKER HERE	ROOM: _____ DATE: _____ TIME: _____ SENDING STAFF NAME: _____ RECEIVING STAFF NAME: _____
BRIEF LIST OF ITEMS SENT:	

Do Not Send Soiled Items. Send All Valuables or Items with Sentimental Value

MAKE A COPY OF COMPLETED FORM AND PLACE IN UNIT LOG
THANK YOU!

BELONGINGS LEFT BEHIND

**Attach Completed Tag to Bag Exterior*

INSERT PATIENT'S STICKER HERE	ROOM: _____ DATE: _____ TIME: _____ SENDING STAFF NAME: _____ RECEIVING STAFF NAME: _____
BRIEF LIST OF ITEMS SENT:	

Do Not Send Soiled Items. Send All Valuables or Items with Sentimental Value

MAKE A COPY OF COMPLETED FORM AND PLACE IN UNIT LOG
THANK YOU!

RIVERSIDE UNIVERSITY HEALTH SYSTEM -
Medical Center, Hospital Based Clinics, and Community Health Centers

	Document No: 145	Page 1 of 4
Title: Animals in the Hospital	**Effective Date:** 5/6/2025	☒ **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 **The Americans with Disabilities Act (ADA)** prohibits discrimination and guarantees that people with disabilities have the same opportunities to participate in the mainstream of American life. The ADA was signed into law on July 26, 1990.

1.2 **Service Animal:** The U.S. Department of Justice (DOJ) defines a service animal as a dog or a miniature horse that is individually trained to do work or perform tasks for people with disabilities, whether or not they have been licensed or certified by a state or local government.

a. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties.

b. Service animals are working animals, not pets.

c. The work or task a dog has been trained to provide must be directly related to the person's disability.

d. Dogs or miniature horses whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

1.3 **Therapy Animal:** A therapy animal is an animal affiliated with Inland Empire Pet Partners. Inland Empire Pet Partners conducts the official RUHS – Medical Center therapy animal program.

1.4 **Pets:** A pet is a domesticated animal kept for companionship, and is NOT a service animal.

2. SERVICE ANIMALS

2.1 Any establishment that refuses to admit any type of service animal on the basis of local health department regulations or other state or local laws is in violation of the ADA. The ADA takes priority over the local or state laws or regulations.

2.2 Service animal verification: A public entity shall not ask about the nature or extent of a person's disability, but may make two inquiries to determine whether an animal qualifies as a service animal.

a. A public entity may ask if:

i. The animal is required because of a disability and

ii. What work or task the animal has been trained to perform.

b. Generally, a public entity may not make these inquiries about a service animal when it is readily apparent that an animal is trained to do work or perform tasks for an individual with a disability (e.g., the dog is observed guiding an individual who is blind or has low vision, or is pulling a person's wheelchair).

2.3 A public entity shall not require documentation, such as proof that the animal has been certified, trained, or licensed as a service animal.

2.4 A service animal shall have a harness, leash, or other tether, unless the handler is unable to hold one, in which case the service animal must be otherwise under the handler's control at all times. (e.g., voice control, signals, or other effective means).

2.5 Individuals with disabilities shall be permitted to be accompanied by their service animals into all areas of a public entity's facilities where members of the public are allowed to go.

2.6 If the service animal needs to be taken into restricted areas, Infection Prevention and Control must be contacted first. These areas include: Perioperative Services, Surgical Nursing Units, and all Critical Care areas. The unit manager and the Infection Prevention and Control Nurse shall evaluate the situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk. (ADA 28 CFR 36.208)

2.7 A person with a disability cannot be asked to remove his/her service animal from the premises unless:

a. The animal is out of control and the animal's handler does not take effective action to control it.

b. The presence of the animal creates a fundamental alteration in the nature of services.

c. The animal is not housebroken. RUHS staff are not responsible for feeding or excretion activities.

2.8 If a public entity properly excludes an animal for the above reasons, it shall give the individual with a disability the opportunity to participate in the service, program or activity without having the service animal on the premises.

2.9 Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals.

2.10 People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals.

2.11 People with disabilities may have a designee supervise the service animal, but are not entitled to designate hospital staff as their designee.

2.12 **ARLINGTON CAMPUS CRITERIA**. When a patient presents with a service animal in triage, a decision must be made regarding a service animal’s access to Arlington Campus facility. The psychiatry provider will evaluate the service animal, patient, and

health-care situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk. (ADA 28 CFR 36.208). The following considerations will be assessed:

a. The facility is a locked ligature free psychiatric environment.

b. Harnesses, leashes, and tethers are prohibited as they pose a direct threat to the health and safety of other patients who may be a danger to themselves and could lead to fatality by suicide.

c. The presence of the service dog requires fundamental alteration in services due to the presence of patients that are a danger to others, danger to selves, gravely disabled, or actively psychotic who may have poor insight or poor judgement and place the service animal at risk for harm.

d. Movement of the service animal may be restricted because of the use of a common area by all patients and the unavailability of private patient rooms.

e. The ability of the owner to supervise the service animal and be in direct control of their service animal, as they will be in a locked facility without a designee.

3. THERAPY ANIMALS

3.1 All therapy animals that enter RUHS – Medical Center must be registered participants with Inland Empire Pet Partners and follow the rules and regulations of that program. Contact Volunteer Services to request a therapy dog visit.

4. PERSONAL PETS

4.1 Only service animals are permitted entry to RUHS clinics. All other animals are prohibited.

4.2 A dog or cat shall be permitted to visit individual patients admitted as an inpatient, by previous arrangement with Infection Control and the Unit Director prior to the animal entering any of the RUHS – Medical Center buildings.

a. Documentation of the health of the pet by a veterinarian, dated within the previous 6 months, must be provided to the Unit Manager prior to the animal's visit. A copy of the veterinarian report must be placed in the patient's medical record.

b. Personal pets must be supervised at all times by an individual who accepts full responsibility for the animal. RUHS – Medical Center shall not be responsible for the care or supervision of a pet.

c. Pets shall not be permitted to have contact with any patients other than their owner, and they may not visit any other area or unit of the hospital.

d. Visits shall be kept brief enough so that the animal's feeding and excretion activities need not be addressed. Use of water bowls is not allowed due to safety and fall risks.

5. INCIDENT REPORTING AND DOCUMENTATION

5.1 Staff shall take prompt action in the event of biting or scratching that breaks the skin, and shall:

a. Remove the animal from the facility.

b. Promptly treat any scratches, bites, or other breaks in the skin.

c. Report incident to an immediate supervisor.

   i. In the case of staff injury, the supervisor will ensure proper reporting as appropriate to Workers Compensation and Occupational Health.

d. Create an incident report, as per RUHS policy HW 122 Incident Reporting.

e. The treating licensed practitioner will report the incident to the public health department and/or animal services as required by regulation.

6. REFERENCES

6.1 CDC Guidelines for Environmental Infection Prevention in Healthcare Facilities: Recommendations of CDC and the Healthcare Infection Prevention Practice Advisory Committee (HICPAC). MMWR 2003; 52 (No. RR-10).

6.2 APIC. Guidelines for Animal-Assisted Intervention in Health Care Facilities. Am J Infect Control 2008: 36: 504

6.3 Americans with Disabilities Act, 1990

6.4 U.S. Department of Justice, Civil Rights Division, Disability Rights Section publication on Service Animals, July 12, 2011

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
2023	Policy Program Administrator	Y	Correct formatting to improve comprehension and flow. Distribute for review and comment.
09/28/23	Arlington	Y	2.12 Arlington Campus Criteria added (RRL: revised for flow and comprehension)
11/28/2023	Director of Infection Prevention and Control	Y	4.2 (1) says documentation of health of the pet must be provided to IPC or unit manager. I would change this to just the unit manager/director. We do not need to see this documentation and would have no where to keep it. 4.2 (5), 3rd bullet point states: Report the incident to RUHS – Medical Center Infection Prevention and Control and RUHS – Medical Center Compliance Office. I would think this would be a worker's comp claim that would need to be reported to their supervisor and then occ health as well? (RRL: I created a new section for reporting and documentation to expand and correct the reporting requirements)
6/2024	Legal review	Y	Specify that a patient with disabilities may have a designee supervise the animal, but that they are not entitled to designate hospital staff as designee. Suggestion to add header for therapy animal.(RRL: accepted both suggestions and revised)
6/2024	Volunteer Services	N	Confirmed therapy information correct.
3/20/2025	Nursing Policies and Procedures	N	
4/1/2025	PAC	Y	Correction by Infection Control to reporting section, and deletion of some of Arlington procedures regarding Animal Services.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 601.1	Page 1 of 4

Title:	**Effective Date:**	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Mental Health Patient Rights	5/6/2025	
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Conservator: Court appointed to arrange for care and protection, decides where conservatee shall live, and is generally in charge of health care, food, clothes, personal care, housekeeping, and transportation of another person.

2. POLICY

2.1 Rights of Mental Health Patients: Mental Health patients have the right to:

a. Wear their own clothes.

b. Keep and use their own personal possessions, including toilet articles.

c. Keep and be allowed to spend a reasonable sum of their own money for minor expenses and small purchases.

d. Have access to individual storage for their own private use.

e. See visitors each day.

f. Have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them.

g. Have reasonable access to letter writing materials, including stamps.

h. Mail and receive unopened correspondence.

i. Refuse convulsive treatment. (NOTE: RUHS – Medical Center does not provide electroconvulsive treatment (ECT) on site at any of its facilities but may make a referral for the patient to another hospital for this purpose).

j. Refuse psychosurgery.

k. See and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

l. Other rights, as specified by regulations.

2.2 Notification of Rights. Upon admission:

a. Each mental health patient shall be notified personally of their rights in writing, in a language understandable by the patient or shall have the rights conveyed by other means as necessary.

b. Giving each mental health patient a copy of the State Department of Health Care Services prepared patients' rights handbook fulfills this requirement in most cases.

c. A notation to the effect that notification, or an attempt to provide notification has occurred shall be entered into the patient's medical record within 24 hours of admission by the nurse.

d. Incomplete advisement may occur by necessity under certain circumstances. The nurse shall document the good cause for incomplete advisement, ensuring that subsequent attempts to advise are made and documented as well.

2.3 Posted Rights Listing. A listing of mental health patient rights as well as the complaint procedure, shall be posted in English and Spanish at each Unit where mental health patients have beds in the unit. The listing shall include:

a. Name, telephone number, availability of the RUHS – Medical Center Hospital Patient advocate.

b. Riverside County Department of Mental Health Patient Rights' Advocate to whom a complaint may be directed.

c. Name and phone number of the State Patient's Rights Office.

2.4 Denial of Rights. The Chief of Psychiatry or designee may, for good cause, deny a person any of the rights stated under Section 2.1, except:

a. Except the right to refuse psychosurgery and

b. The right to see and receive the services of a patient advocate.

c. The rights to refuse convulsive treatment may be denied only under the conditions specified in WIC Section 5326.7. (RUHS does not provide convulsive treatment at any of its facilities).

2.5 Good Cause for Denial of Rights. The good cause for denial shall meet the definition stated in Title 9. Division 1. Chapter 4. Article 6. Section 865.2.

a. Good cause exists when there is good reason to believe that:

i. The exercise of a specific right would be injurious to the patient; or

ii. The exercise of a specific right would seriously infringe on the rights of others; or

iii. The hospital suffer serious damage if the specific right is not denied;and

iv. There is no less restrictive way of protecting the interests specified in above.

b. The reason used to justify the denial of a right must be related to the specific right denied.

c. A right shall not be withheld or denied as a punitive measure, nor shall a right be considered a privilege to be earned.

d. Treatment modalities shall not include denial of any right.

e. Waivers signed by a patient or responsible relative/guardian/conservator shall not be used as a basis for denial of a right.

f. Parents, conservators, or other legally responsible persons (other than the licensed psychiatrist) shall not be allowed to deny patient rights of a minor.

2.6 Documentation of Denial of Rights:

a. Each denial of a patient's right shall be documented in the medical record immediately upon denial of the right and shall include:

- The date and time the right was denied.
- The specific right denied.
- Good cause for denial of the right.
- Date of review if denial is extended beyond 30 days.
- Signature of the Chief of Psychiatry or designee authorizing the denial of right.
- Date and time the right was restored.

b. The patient shall be told of the content of the notation

c. The assigned nurse shall complete DHCS 1803 (MH 306): Patient Rights Denial - Monthly Talley information each day the patient is denied their right(s).

2.7 Seclusion and Restraints:

Each instance of the use of restraints and/or seclusion constitutes denial of rights and must be documented in the patient's records in compliance with RUHS policy HW 630 Restraints and Seclusion.

2.8 Restoration of Rights:

a. A right shall not continue to be denied to a patient when good cause for its denial no longer exists.

b. Staff shall employ the least restrictive method of managing the behavior that led to the denial.

c. The date and time a specific right is restored shall be documented in the patient's record.

2.9 Rights Which Cannot be Denied. The following rights shall not be denied:

a. A right to treatment services which promote the potential of the person to function independently. Treatment shall be provided in ways that are least restrictive of personal liberty of the individual.

b. A right of dignity, privacy and humane care.

c. A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the treatment program.

d. A right to prompt medical care and treatment.

e. A right to religious freedom and practice.

f. A right to participate in appropriate programs of publicly supported education.

g. A right to social interaction and participation in community activities.

h. A right to physical exercise and recreational opportunities.

i. A right to be free from hazardous procedures.

2.10 Complaint Procedure. The list of rights that shall be posted, provided, or explained to the patient shall contain**:**

a. Notification that any patient who believes their right(s) has been abused, punitively withheld, or unreasonably denied may file a complaint with the Patients' Advocate.

b. The name of the Patients' Advocate who has been assigned to handle such complaints, their telephone number, and the times during which they may be contacted.

2.11 Monthly Report:

a. Nursing Administration shall prepare a monthly report using form *DHCS 1804 (MH 307): Denial of Rights/Seclusion & Restraint – Monthly*, of the number of mental health persons whose rights were denied and the specific right or rights denied for submission to the Department of Mental Health.

3. REFERENCES

3.1 RUHS Medical center Policy HW 601 Patient Rights and Responsibilities
3.2 RUHS Medical Center Policy HW 630 Restraints and Seclusion
3.3 RUHS Medical Center Policy HW 649 Complaints Grievances
3.4 California Code of Regulations CCR Title 9. Division 1. Chapter 4. Article 6 - Patient Rights: Denial for Good Cause https://regulations.justia.com/states/california/title-9/division-1/chapter-4/article-6/
3.5 California Code of Regulations CCR Title 22. Division 5. Chapter 2. Article 6 Section 71507 – Patients' Rights
3.6 DHCS.gov 2014. Rights For Individuals In Mental Health Facilities. https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf
3.7 Welfare and Institutions Code – WIC. DIVISION 5. PART 1. CHAPTER 2. ARTICLE 7. Legal and Civil Rights of Persons Involuntarily Detained [5325 - 5337] https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=2.&article=7

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2/18/2025	Rachael Obi	Y	Word changes and re-arrangements. Added Complaint Procedure, updated references
2/20/2025	Nursing Policy & Procedure	N	None
4/1/2025	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 603	Page 1 of 10
Title: Organization and Provision of Patient and Family Care	**Effective Date:** 5/6/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☒ **Housewide** ☐ **Departmental** ☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. MISSION, VISION, AND VALUES

1.1 RUHS-Medical Center Mission: Improve the health and well-being of our patients and communities through our dedication to exceptional and compassionate care, education, and research.

1.2 RUHS-Medical Center Vision: 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.

1.3 RUHS-Medical Center Values: TRIED and TRUE to our values. **T**eamwork, **R**espect**,** **I**ntegrity, **E**xcellence, **D**iscovery.

2. GOVERNANCE

2.1 The Medical Center is operated by the County of Riverside under the legal authority and stewardship of the Riverside County Board of Supervisors (BOS) for the benefit of the residents of Riverside County.

2.2 RUHS-Medical Center includes a Moreno Valley campus providing both medical and psychiatric care, and a Riverside Campus focusing on psychiatric care.

2.3 Responsibility for the provision of patient care is a shared responsibility among the Board of Supervisors, Administration and the Medical Staff.

3. DEFINITIONS

3.1 Nursing Practice: Nursing practice is defined in accordance with the California State Board of Nursing as follows: "…the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill…"

3.2 Nursing Process: The Nursing Process is the organized framework used by the professional nurse to address specific nursing needs of individual patients. Components are assessment, nursing diagnosis, planning, intervention and evaluation. The Nursing Process is dynamic and enables the professional nurse to analyze and synthesize information received from the patient/family and other available data, to identify patient needs, set mutual goals and interventions, and allows for evaluation of patient outcomes.

4. POLICY

4.1 The provision of patient care at Riverside University Healthcare System (RUHS) – Medical Center is guided by the mission, vision and values of our organization and adopted by our staff.

4.2 Anti-Discrimination and Patient Access or patient population:

a. RUHS – Medical Center provides age specific culturally sensitive whole person care. All patients are treated with respect regardless of age, gender or gender identity, race or nationality.

b. Age Specific: The patient populations served ranges from neonates (0-28 days) through geriatric (65+ years). Age specific equipment is used when indicated and staff utilize an age specific treatment and communication style with the patients.

c. The Medical Center provides care, without discrimination, to the needy and indigent county residents and other patients/insured who elect to receive our services.

d. The patient population includes a high percentage of patients and their families with Spanish as a primary language. There is a language interpretation service available as per policy HW 142 Access to Language Services.

e. RUHS-Medical Center periodically evaluates the needs of the community and patients and defines strategic and operational plans, develops budgets and allocates resources to meet the current and changing needs of its patient population and community.

4.3 RUHS- Medical Center Nursing Standards and Process

a. Standards

i. Nursing care is guided by nationally recognized nursing standards including, but not limited to, American Nurses Association (Scope & Standards of Practice and Scope and Standards for Nursing Administrators), and other national nursing organizations.

ii. Nursing care conforms to all federal and state laws and regulations.

b. Process

i. The Registered Nurse utilizes the Nursing Process and critical thinking skills in the care of their patient.

4.4 RUHS-Medical Center special designations and populations

a. The Medical Center is approved by the California Children's Services (CCS) as a Pediatric Community Hospital, Community Level Neonatal Intensive Care Unit, and Pediatric Intensive Care Unit.

b. The Medical Center is a 5150 designated facility and incorporates the use of a Psychiatrist and nurse team (Psychiatric Consultation Liaison Services - PCLS), to assist in the care of patients with psychiatric/behavioral health issues.

c. The Medical Center is a designated Baby Friendly facility.

d. The Medical Center Emergency Department is a Base Station hospital, and an American College of Surgeons (ACS) verified Level I Trauma Center for adults and county designated Level II Trauma Center for Pediatrics.

e. The Medical Center is contracted for the care and treatment of patients in custody with Riverside County or the State of California.

f. The Medical Center offers services of the Sexual Assault and Forensic Evaluation

Team for adults and adolescent patients and The Riverside County Child Assessment Team for children.

5. Principles of Care Core Components

5.1 **Assessments.** Assessments assist in determining the care, treatment and services that meet the patient's initial and continuing needs.

a. Assessment should begin at the patient's entry into the Medical Center system and reassessments are completed at regular intervals dependent upon the patient's needs, goals, changes in level of care, the services provided and the defined minimum assessments per each level of care.

b. An assessment each twelve-hour shift is the hospital baseline for assessment intervals. Higher acuity areas may include more frequent reassessments.

c. Assessments include physical, psychological, social, nutritional, hydration, and functional elements.

d. The initial assessment should also include assessing for fall risk and for possible abuse, neglect, suicide and sexual orientation and gender identify (SOGI)

e. Assessment should also consider the patient's spiritual and cultural values that may influence the patient/families' preferences and perceptions of care.

f. Assessment should include the patient's perception of the effectiveness of treatments.

g. Referrals to other clinical disciplines are requested, following assessment, by physicians and, and in some instances, by a Registered Nurse (RN).

h. Refer to 100.10 Assessing and Meeting Patient Care Needs Nursing Process and NURS 103: Acuity, Patient Classification System

5.2 **Plan of Care.** Each patient has a plan of care that is utilized in a multidisciplinary approach that promotes continuity of care and optimal outcomes.

a. Care is provided based on an individualized Plan of Care. The plan of care is created that utilizes identified issues, goals, and interventions. Goals may be immediate and long term.
b. Plan of Care is developed through analysis of patient/family information and preferences, clinical data, nursing observations, physician diagnosis/orders, safety needs, and the patient's physical, spiritual or cultural factors.

c. Refer to policy HW 692 Interdisciplinary Plan of Care

5.3 **Family centered.** Every patient is treated with courtesy and respect, with staff awareness that the family is an important part of the care of the patient.

5.4 **Quality and safety** are primary drivers of decisions made in the Nursing Department. Ongoing Quality of Care and Performance Improvement.

a. The clinical departments have regularly scheduled meetings and activities to continuously facilitate communication about trends and issues and to plan the provision of care for the patient. Regular meetings include Nurse Executive Team Meetings, Clinical Leadership Meetings, daily staffing/safety meetings, staff meetings, staff huddles and interdisciplinary meetings among departments

b. Departments evaluate a variety of indicators to determine ongoing performance improvement and to select quality indicators. Selections of projects and indicators to monitor may be determined by, but not limited to, staff input, trends noted by

committees such as Medication Safety or Fall Prevention, patient outcomes, input from patients, regulatory mandates, throughput issues, core measures, changes in delivery of care, safety concerns, program initiatives or requirements, research/evidence-based practice and literature review.

c. With the approval of Clinical Leadership, individual clinical services may select quality or performance improvement monitors specific to their specialty or unit trends. The projects and data shall be reported through Clinical Leadership and designated committees, both those specific to the specialty and also Performance Improvement Patient Safety Committee (PIPSC). PIPSC reports data to Medical Staff and through the hospital senior leadership structure. Data is posted in the nursing units and discussed at both staff meetings and staff huddles.

d. Clinical Leadership discusses and selects other performance improvement projects that may cross several service lines. Data from all areas is compiled and discussed within the Clinical Leadership meeting and presented to PIPSC. Analysis of data, actions taken and re-analysis of data after actions implemented is discussed. Data is posted in the clinical areas and discussed at both staff meetings and staff huddles.

e. Many of the specialty nursing departments have quality data that is first reported in a department specific meeting and then results are reported to PIPSC.

f. Numerous departments participate in a variety of Quality Assurance Performance Improvement (QAPI) activities with other disciplines, including Medical Staff, Pharmacy, Physical Therapy, Laboratory, etc., to monitor and comply with safety and regulatory standards.

g. The Quality Department consults and assists departments with identifying projects and indicators of value to promote the quality process. Methods such as use of Root Cause Analysis (RCA), Failure Mode Evaluation Analysis (FMEA) and analysis of trends and incidents are also utilized. Evidence based practice, current literature and emerging technologies, trends and studies are also utilized to promote quality.

h. A multidisciplinary Risk Management Team at the Riverside Campus reviews all behavioral events occurring at the facility.

5.5 **Patient privacy and confidentiality** is maintained at all times as per RUHS policy HW 700 Patient Privacy and HIPAA.

6. Providing Care

6.1 RUHS care providers utilize orders from a licensed independent practitioner and the most recent patient order is utilized.

7. Staffing

7.1 Care is provided by the appropriate classification of staff members, based on hospital policy, regulations, licensure and scope of practice. Advanced Practice Nurses, including Nurse Practitioners and Nurse Midwives, may be utilized in approved, credentialed roles.

7.2 The planning of human resources allocated to meet identified needs is a priority and is evaluated frequently. The Staffing Effectiveness Council meets a minimum of twice a year to discuss and review staffing effectiveness and other staffing related issues.

7.3 Whenever staffing allocation is dictated by minimum Registered Nurse staffing ratios, national standards or other regulations, RUHS-Medical Center plans for, and makes every effort, to meet and exceed these goals.

7.4 Refer to NURS 131 Staffing policy, and HW 157 Capacity Alert Plan

8. Coordination of Care

8.1 Communication, collaboration and mutual respect are key to optimal outcomes in patient care. Department Managers and Directors are responsible for the integration and facilitation of care within their departments.

8.2 The Multidisciplinary Team works in collaboration within a variety of disciplines and departments to provide safe and quality care for our patients.

8.3 Communication between disciplines can occur by informal discussion, written communication, Interdisciplinary Care Plans, progress notes, SBAR reports and meetings. Communications regarding patients should include two patient identifiers. The two identifiers are name and date of birth or medical record number. For infants, the identifiers are date of birth and medical record #, in addition to name. We share necessary patient information with internal and external providers of care, as needed throughout the continuum of care.

8.4 When patient hand offs occur, communication regarding the patient occurs in the Situation, Background, Assessment, and Recommendation (SBAR) format to promote completeness and uniformity. SBAR can occur in a variety of situations but should include the opportunity for discussion or questions, as needed, in person or via phone. Refer to policy HW 601.1 Hand-off Communication.

8.5 The hand off between Operating Room (OR) teams and to the Post Anesthesia Care Unit (PACU) utilizes the SWITCH acronym, which stands for Surgical procedure, Wet (fluids/drains), Isolation/Instruments/ Implants, Tissue, Complications/Counts/Concerns, and Have you any more questions.

9. NURSING DEPARTMENTS

9.1 Arlington Campus, located 9990 County Farm Road, Riverside, CA Behavioral Health Services Scope of Services: The Behavioral Health Services consists of four inpatient units and Emergency Treatment Services. Vital signs are evaluated once per shift.

a. Units

i. Unit A - This nine bed unit provides inpatient care for high acuity, intensive care Behavioral Health patients, and ages 18 and over.

ii. Unit B - This 28 bed unit provides inpatient care for acute psychiatric patients. Ages 18 and over.

iii. Unit C - This 28 bed unit provides inpatient care for acute psychiatric patients. Ages 18 and over.

iv. Unit D - This 10 bed unit provides acute inpatient care for adolescent patients ages 13-17.

v. Emergency Treatment Services provides psychiatric emergency services for patients of all ages and has a capacity for 24 adult patients and 4 child and adolescent patients.

b. Staffing

i. Minimum staffing ratios for acute adult psychiatry is 1 nurse to 6 patients are maintained. In addition, patient acuity is and assignments adjusted as necessary.

9.2 Medical/Surgical Services

a. Units

i. Unit 3100 – This 34-bed unit provides acute inpatient care for Intermediate Care patients with telemetry and basic to moderate acuity medical/surgical patients with and without telemetry, the majority consisting of general medical with some post-op general surgery patients, ages 18 and over as well as observation level patients.

ii. Unit 3500 – This 34-bed unit provides acute inpatient care for basic to moderate acuity medical/surgical patients with and without telemetry, ages 18 and over. The unit also provides care for inpatients receiving chemotherapy, recovery of post-operative total knee, hip and shoulder replacements, and hip fracture surgeries.

iii. Unit 4100 – This 34-bed unit provides acute inpatient care for basic to moderate acuity medical/surgical patients with and without telemetry, ages 18 and over. The unit also provides care for patients suffering from stroke, post-operative spinal surgery, and post Cath lab/TR Band patients.

iv. Unit 4200 – This 34-bed unit, serves as a general medical-surgical unit for patients with and without telemetry, State and County inpatient overflow from Unit 4400, as well as observation level patients.

v. Unit 4400 – This 22-bed jail unit provides acute inpatient care for basic to moderate acuity medical/surgical county and state inmates with and without telemetry, ages 18 and over. The unit also provides inpatient care for inmates with acute psychiatric conditions. State Corrections and Riverside County Sheriffs work in collaboration with Nursing to provide a safe environment.

vi. Unit 4500 – This 34-bed unit provides acute inpatient care for basic to moderate acuity medical/surgical patient with and without telemetry, ages 18 and over. The unit also provides care for inpatients receiving chemotherapy and observation level patients.

b. Staffing Plan

i. Minimum staffing ratios for intermediate care patients is 1 nurse to 3 patients; acute adult medical/surgical services is 1 nurse to 4 patients (1:4) with telemetry; 1 nurse to 5 patients (1:5) without telemetry. The unit nursing team may also include a designated Charge Nurse and a procedure nurse for Unit 3100. Nursing leadership is provided by Nursing Directors and ANMs (Assistant Nurse Managers).

9.3 Emergency Department (ED)

a. Units

i. The Emergency Department is comprised of 44 treatment beds. There are (5) acute trauma beds, (9) acute cardiac beds, (4) security holding cells, 26 general exam rooms which include external and internal decontamination capabilities, cast room and one helipad.

b. Staffing Plan

i. The ED provides basic emergency medical service with a physician on duty

24/7 to provide prompt care for any patient presenting with urgent medical problems.

ii. All patients are triaged using the five level Emergency Severity Index (ESI) system. Nursing is staffed 1:4 acuity for most patients, 1:2 for ACCU admits. Critical Medical and Trauma patients are staffed 1:1 during initial resuscitation.

9.4 Adult Critical Care Unit (ACCU). The Adult Critical Care Units (ACCU) provide care to critically ill patients, and those requiring special therapeutic diagnostic and pharmacological interventions who are fourteen years of age and older.

a. Units

i. The Adult Critical Care Units consist of 36 beds, separated into 2 units of 24 bed Medical Intensive Care and 12 bed Surgical/Trauma Intensive Care beds.

b. Staffing Plan

i. Staffing is determined by the acuity of the patients as determined by Riverside University Health System – Medical Center's Patient Classification Staffing System (PCSS). State and Title 22 regulations are followed. The nurse patient ratio is either 2:1 or 1:1.

9.5 Intermediate Care Unit. Intermediate care patients are moderately stable with less complexity than the ICU; they require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care.

a. Units

i. The Intermediate Care Unit is comprised of 33 private rooms, three of which are negative pressure isolation rooms. The Intermediate Care Unit is located on the second floor of the Medical Center.

b. Staffing Plan. Staffing is determined by the acuity of the patients as determined by Riverside University Health System – Medical Center's Patient Classification Staffing System (PCSS). State and Title 22 regulations are followed. The nurse patient ratio is either 3:1 or 4:1.

i. LOW / 4:1 RATIO - Includes patients who may move/ambulate with assistance, requires assistance with Activities of Daily Living and is in no acute distress with relatively stable vital signs. Monitoring and documenting vital signs every 4 hours as routine. Intake and Output, blood glucose and neuro status may also be evaluated every four hours.

ii. HIGH / 3:1 RATIO - Monitoring and documenting of vital signs every 2 hours as routine and may include blood glucose, neuro status and intake and output. Examples would include patients on non-titratable drips with every 2-4 hours assessments and interventions, (i.e., renal dose Dopamine, Dobutamine, Cardizem and Amiodarone).

9.6 Operating Room (Perioperative Services) provides care for inpatients and outpatients. Specialties include: General, Gynecology, Orthopedics, Podiatry, Urology, Vascular, Plastics, Ophthalmology, Neurology, Spine, Ear/Nose/Throat, Oral, Thoracic, Cardiology, Neuro Intervention, Pain, Gastroenterology, Pulmonary and Respiratory. Pediatric surgeries may include general abdominal laparotomies, laparoscopies, endoscopies, orthopedics and genitoplasties. Cardiac procedures include insertion of implantable cardioverter – defibrillators/pacemakers, and heart catheterizations. Robotic assisted

procedures in Urology, Gynecology, Vascular, Thoracic and General are also performed.

a. Units.

i. There are 11 Operating Room (OR) suites, 1 Cath Lab suite, and 1 Endoscopy suite in the Medical Center.

ii. There are 8 Operating Room suites and 3 Procedure Rooms at the Medical/Surgical Center (MSC).

iii. Upon completion of the surgical procedure, the patient is transferred to SDS, PACU or the ICU based on patient condition.

b. The staffing plan is based on the following:

i. Staff scheduled to provide care for the anticipated daily surgical schedule volume based on AORN Position Statement.

ii. Each OR suite is staffed by a RN and a scrub person (either an RN or a Surgical Technologist)

1) There is always an RN in the circulating role.

2) Assigned staff may be increased to provide additional help as needed to cover specialty procedure requirements.

iii. PACU staffing is determined by ASPAN recommendations depending upon the age of the patient, type of anesthesia, and acuity of the patient. The nurse patient ratio is either 1:1 or 1:2.

iv. Same Day Surgery/Pre-Op and Pre-Op Holding Area staffing is determined by ASPAN and AORN recommendations which adjust with the changes in patient's status, including the frequency with which the needs for specific nursing care activities change.

v. Charge nurses and the management team communicate with other units and the nursing House Supervisor during scheduled patient flow/bed meetings and on an as-needed basis.

9.7 Perinatal. The multi-disciplinary staff of the Perinatal Unit provides obstetrical and newborn infant care to patients of all ethnic origins and financial abilities. This care includes physical, psychosocial, cultural, age specific and spiritual needs. Complexity of care ranges from the uncomplicated labor and delivery process culminating in a well infant to the care of the high-risk prenatal patient with an infant at risk.

a. Units

i. There are 12 Labor-Delivery-Recovery (LDR) rooms, 2 L&D triage beds and two surgical suites; 3 bed Post Anesthesia Recovery Unit (PACU, 40 Postpartum beds for MotherBaby couplets, Low acuity /Antepartum and Post Op GYN patient rooms.

b. Staffing Plan

i. Staffing is provided by RNs functioning in a total care nursing system in accordance with Title 22 mandated ratios. Patient care is provided by RNs in a mixed skill nursing system.

ii. RNs are assisted by medical unit clerks, certified nurse assistants, and surgical technicians.

iii. A Charge Nurse is designated for each unit and shift. The Charge Nurse is responsible for supervision and the quality of care delivered by personnel on their shift.

9.8 Pediatric Acute Care. The Pediatric Unit provides care to patients from 30 days old through 17 years of age, as ordered by a physician. Admitted patient are hemodynamically stable and require nursing care for a medical or surgical diagnosis. The Pediatric Unit is a referral center for acutely ill children in the Riverside County region.

a. Units

i. Unit 3400 includes an inpatient 21-bed Pediatric Acute Care Unit

b. Staffing Plan

i. Staffing is provided by RNs and Certified Nursing Assistants, when present, in accordance with Title 22 mandated ratios. There is an RN Charge nurse assigned for each shift who is responsible for unit supervision and the quality of care delivered by nursing personnel during the shift.

9.9 Pediatric Intensive Care Unit (PICU) provides 24-hour intensive nursing care for patients from 30 days of age through 17 years with serious illness, trauma, or post-operative needs. The PICU is a referral center for critically ill children in the Riverside County region and provides trauma care. The most common conditions and diagnoses treated are respiratory diseases, compromise and failure.

a. Units.

i. Unit 3400 includes an inpatient, 8-bed Pediatric Intensive Care Unit

b. Staffing

i. Staffing is provided by RNs functioning in a total care nursing system in accordance with Title 22 mandated ratios. There is a charge nurse assigned for each shift who is responsible for unit supervision and the quality of care delivered by nursing personnel during the shift.

ii. Staffing is determined by the acuity of the patients as determined by Riverside University Health System – Medical Center's. Unit Rationale Guidelines, State and Title 22 regulations are followed. The nurse patient ratio is either 2:1 or 1:1.

9.10 Neonatal Intensive Care Unit provides 24-hour, intensive and continuing medical and nursing care to at risk and critically ill infants and their families in the Riverside County region.

a. Unit

i. Unit 3300-N is a 32-bed, Community-Level Neonatal Intensive Care Unit (NICU), California Children's Services Certified (CCS) NICU.

b. Staffing

i. Staffing is provided by RNs functioning in a total care nursing system in accordance with Title 22 mandated ratios and approved program flexibility granted by the California Department of Public Health on 8/9/2012. There is a charge nurse assigned for each shift who is responsible for unit supervision and the quality of care delivered by nursing personnel during the shift.

10. REFERENCES

10.1 California Title XXII AB394

10.2 The Joint Commission (TJC) Accreditation Standards for Hospitals, Provision of Care, Treatment and Services

10.3 RUHS – Medical Center policy HW 142 Access to Language Services

10.4 RUHS – Medical Center policy HW 157 Capacity Alert Plan

10.5 RUHS – Medical Center policy HW 601.1 Hand-Off Communication

10.6 RUHS – Medical Center policy HW 692 Interdisciplinary Plan of Care

10.7 RUHS - Medical Center policy HW 700 Patient Privacy HIPAA

10.8 RUHS – Medical Center policy NURS 100.10 Assessing and Meeting Patient Care Needs Nursing Process

10.9 RUHS-Medical Center policy NURS 103: Acuity, Patient Classification System

10.10 RUHS-Medical Center policy NURS 131 Staffing

10.11 Quality Assurance Performance Improvement QAPI Plan

Document History:

Prior Release Dates: 04/2017, 07/2014, 08/2020, 3/31/2023	**Retire Date:** N/A
Document Owner: Nursing Administration	**Replaces Policy:** NURS 100.11

Date Reviewed	**Reviewed By:**	**Revisions Made? Yes/No**	**Revision Description**
09/26/2024	Arlington Campus Nursing Policy Committee	Yes	Added ETS Capacity Alert Escalation and Treatment Plan requirements.
03/20/2025	Nursing Policy and Procedure Committee	Yes	Edited Sec. 3.2 a. and deleted Sections 3.2 b.- d.
3/27/2025	Policy Program Administrator	Yes	Correcting formatting, correct template, grouped information in subheadings, organizing for theme, and deleted repetitive information. Added relevant policies in references section. Deleted retired policy references.
3/30/2025	Chair NPP, CNO	N	
4/1/2025	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 633	Page 1 of 6
Title: AMA, Missing, and Eloped Patients	**Effective Date:** 6/18/2025	☐ **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 Riverside University Health Systems-Medical Center is dedicated to ensuring that all patients presenting to Riverside University Health Systems-Medical Center have the right to maintain autonomy and self-determination throughout their visit. This policy is to provide guidance to staff when a patient or patient representative requests to leave Against Medical Advice (AMA); has eloped; or is missing from the inpatient unit, outpatient surgery, or Emergency Department (ED).

2. DEFINITIONS:

2.1 **Elopement** is defined as an unauthorized departure of a patient from the facility. Such as when the patient walks away, runs away, escapes, or otherwise leaves the hospital unsupervised, unnoticed, and/or prior to their scheduled discharge. Also to include patients that are reported missing at any time during their visit.

2.2 **Decisional capacity** is defined as an individual's ability to (1) understand the nature and consequences of a decision (2) to make and (3) communicate a decision. Decisional capacity can vary over time and patients that cannot decide one aspect of their care may still retain that capacity concerning other decisions. This determination will be made by the provider and will be documented in the patient's medical record.

2.3 **Leaving against medical advice (AMA)** is defined as the patient's decision to leave Riverside University Health Systems – Medical Center after having been informed of and having the ability to appreciate the risk of leaving without completing treatment. Fully competent patients are legally able to leave Riverside University Health Systems-Medical Center premises without completing treatment.

2.4 **Medical Incapacity Hold (MIH)** is an order that allows for involuntary detainment of a patient in Riverside University Health Systems-Medical Center who meets all the following criteria:

a. The patient lacks decisional capacity but is expressing an intention to leave the Medical Center.

b. The patient's intention to leave poses a serious threat to their own safety or the safety of others.

c. The patient does not meet the criteria for a psychiatric hold based on California State mental health care law.

d. A substitute decision-maker is not immediately available, or a substitute decision-maker has consented to the MIH.

e. Please refer to HW Policy 694 *Guidelines for addressing non-psychiatric patients who lack decisional making capacity and who are a threat to themselves or others.*

3. POLICY:

3.1 **Missing Patient/unsafe wandering**. When a patient is missing, the Nursing Director, Nurse Manager or designee will:

a. Attempt to contact the patient or patient representative by phone, if applicable.

b. Assign personnel to initiate a search for the patient. The search will be within the unit the patient was assigned and expanded hospital-wide including common areas outside of the facility.

c. Notification: If the patient is not found within 30 minutes, notify:

i. Provider

ii. Next of kin, emergency contact, and/or family

iii. House Supervisor (inpatient only)

iv. Social worker (inpatient only)

v. If applicable, law enforcement *(See HW Guideline 631*) or if patient known to have left with an intravenous catheter.

3.2 **Patients Located after Search (inpatient only).** A two (2) hour timeline will be used to make determinations regarding a patient's status. If the patient is located:

a. Within two (2) hours:

i. The patient shall be escorted back to their hospital room and given instructions about remaining there.

ii. The patient shall be reassessed.

iii. The treatment plan shall be updated, as needed.

iv. The entire episode shall be documented in the medical record.

b. After two (2) hours:

i. The patient shall be sent to the ED for assessment and re-admittance, as appropriate.

3.3 **Eloped Patient (inpatient only)** If the patient is not located within two (2) hours, or the patient has left the medical center's grounds (at any time), the patient's absence is considered an elopement. The following steps should occur.

a. Attempt to contact the patient on their phone, if applicable. If the patient is contacted and is deemed to have decision-making capacity, they may request that their protected healthcare information (including the decision to elope) not be disclosed to family or others.

b. The assigned unit will
contact the patient's family, emergency contact, or next of kin to inform them of the patient's status (unless the patient has decisional capacity and has requested the family, emergency contact, or next of kin not be contacted as stated in section 3.3 a.).

c. Conservators and legal guardians such as CPS, shall be notified when a patient is under conservatorship/guardianship. The patient's status will be documented by the provider and/or primary nurse in the medical record.

d. Notify:

i. Attending Physician and if indicated, the Psychiatrist, House Supervisor, Administrator-on-Call, Executive Director, and the Nursing Director / Nurse Manager of the unit involved.

ii. Law enforcement, if applicable, or if patient known to have left with an intravenous catheter.

3.4 **Eloped Patients (ED/outpatients):** If at any time the patient has been called for treatment and is not able to be found, ED personnel will follow these steps:

a. Search the immediate location for the patient.

b. Attempt to call the patient on the number the patient provided or the patient's representative.

c. Notify the provider.

d. The patient's status will be documented by the provider and primary nurse in the medical record.

e. Conservators and legal guardians such as CPS/APS, shall be notified when a patient is under conservatorship/guardianship.

i. Notify, law enforcement, if applicable**,** or if patient known to have left with an intravenous catheter.

3.5 **Documentation**

a. Complete appropriate reports

b. Document all pertinent information about the patient's absence/elopement in the patient's medical record e.g. phone calls to patient/family, areas searched, number of search attempts, etc.

3.6 **Patient with Intent to Leave Against Medical Advice (AMA).** When a patient or a patient representative tells any staff member of their intent to leave AMA, the staff member will immediately notify the primary nurse and the charge nurse.

The primary nurse will:

a. Immediately notify the primary provider.

b. Assess reasons for leaving and attempt to resolve concerns.

c. Notify the social worker (if inpatient or applicable to ED)

d. Involve the family/patient's representative if appropriate and available

e. Notify the Nursing House Supervisor (if inpatient or applicable to the Emergency Department).

f. Assess for intravenous access and remove prior to patient leaving the hospital.

3.7 **Minors / Patients lacking capacity**

a. Special urgency should be given to locating minors and patients with impaired decision-making capacity unless it is known that they have been removed from the facility by a custodial parent or a guardian with the authority to make medical decisions after discussion with the primary provider.

b. Parents with custody over a minor also have the authority to remove the minor against medical advice. If the primary nurse or primary provider believes that such removal poses an immediate danger to the health or safety of the minor, or others law enforcement should be called to take temporary custody of the minor on behalf of the Juvenile Court.

3.8 **Provider Responsibility to AMA Patients.** The provider should determine whether the patient or the patient's representative has the legal authority to decide to leave AMA or if the patient has decision-making capacity. The provider's responsibility is to provide the patient or patient representative with the rationale for ordering the treatment and the possible ill effects if the treatment is refused. The provider should explain why continuing treatment is recommended, and any alternatives to continued treatment. The provider should ensure that all information is relevant for the patient/representative to make an informed decision, understanding potential consequences and risks, including death or disability, if deciding to leave AMA.

a. Providers who deem that the patient lacks capacity to make medical decisions and a patient representative is not available, should place the patient on the appropriate hold (medical incapacity hold versus involuntary psychiatric hold). The provider will then obtain the appropriate consults needed for the patient.

b. Providers and medical staff should take proper precautions to ensure that the patient leaves the facility in a safe manner, which could include:

i. Warning patients if their medical condition or medications the patient has taken could impair their ability to drive safely.

ii. Providing an escort to the patient's vehicle

iii. Assisting with a wheelchair if necessary

iv. Encouraging the patient to call family or friends

v. Utilizing the social worker to secure transportation

vi. Providing DME if available, applicable, and appropriate (ACE wraps, orthopedic boot/shoe, crutches, etc.)

vii. Hospital staff will not be permitted to accompany patients off Riverside University Health Systems-Medical Center property.

c. Patient and/or patient's representative deemed to have decisional capacity; request that the patient or patient representative sign the *Release for Patient Leaving Hospital Against Medical Advice of Provider* form. The original is placed in the medical record, and a copy is provided to the patient/representative. If the

patient/representative refuses
to sign, the notation "patient/representative refuses to sign" should be made at the place for the signature, and the witness should sign the form in the designated space, noting the time and date of the refusal.

d. Complete discharge summary (inpatient only), including list of referrals for follow-up appointments, list of medically necessary medications, and discharge note documenting decisional capacity determination, all recommendations, and patient's refusal(s).

e. ED discharge: Providers should attempt to provide all pertinent information regarding the patient's ED visit, which can include a medication list; prescriptions; diagnostic results, outpatient appointments, ED visit summary.

3.9 **Patients Leaving without Speaking to Provider**. If the provider is unable to speak to the patient despite the nurse's notification attempts, and the patient insists on leaving AMA**,** The nurse will:

a. Educate the patient/representative of the risks of leaving AMA versus the benefits of waiting for the provider, including significant clinical signs or symptoms requiring immediate medical attention, any follow-up instructions, and advisement that they can return to the ED at any time or if they would like to discuss pertinent information.

b. Have the patient/representative sign the *Release for Patient Leaving Hospital Against Medical Advice of Provider* form. The nurse will sign the designated signature and a witness will co-sign. If the patient and/or representative refuses to sign, the notation "patient/representative refuses to sign" should be made at the place for the signature, and the witness should sign the form in the designated space, noting the time and date of the refusal.

i. The original will be placed in the medical record and a copy given to the patient/representative.

c. Attempt to provide a copy of the discharge summary (inpatient only) or after-visit summary (ED) and medication list to the patient if the patient leaves AMA.

d. Documentation of the event in the medical record.

4. Patients on Involuntary Legal Holds (5150/5585// 5250 /5260/5270/etc.)

4.1 **Missing Patients Who Are on Involuntary Legal Holds.** If a patient who is on an involuntary hold is noted to be missing from their room, the patient is immediately considered to be an eloped patient. The following steps shall be immediately put into place:

a. Activate a Code Green.

b. Notify:

i. Law enforcement

ii. Attending Provider and Psychiatrist (if in-patient)

iii. House Supervisor, Administrator-on-Call, Executive Director, and the Nursing Director / Nurse Manager of the unit involved.

iv. If patient is missing greater than 2 hours, please follow section 3.3 & 3.4

4.2 The assigned unit will contact the patient's family, emergency contact, or next of kin to inform them of the patient's status.

a. Conservators and legal guardians, shall be notified when a patient is under conservatorship/guardianship.

b. The patient's status will be documented by the provider in the medical record.

5. Patients on a Medical Incapacity Hold (MIH)

5.1 When a patient is placed on an MIH or lacks decisional capacity and is missing, The following steps shall be immediately put into place:

5.2 Activate a Code Green

5.3 Notify:

i. Law enforcement

ii. Attending Provider

iii. House Supervisor, Administrator-on-Call, Executive Director, and the Nursing Director / Nurse Manager of the unit involved.

6. REFERENCES

6.1 California Health and Safety Code §1279.1

6.2 Welfare and Institutions Code §305

6.3 California Hospital Consent Manual Section 6.6

6.4 HW Guideline 631 *"Code BERT/Code Green", 2024"*

6.5 HW Policy 694 "*Guidelines for addressing non-psychiatric patients who lack decisional making capacity and who are a threat to themselves or others."*

Document History:

Release Dates: 10/03/86, 3/16/00, 3/25/03, 5/22/2016, 10/1/2018, 8/26/2019, 7/20/2023	**Retire Date:** N/A
Document Owner: Nursing	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
01/08/2025	Lisa Mackie, Clinical Director of Nursing, ED Fairuz Despujos Harfouche, ED Attending Rodger Garrison, Medical Program Director	Y	Replaced "physician" with "provider"; differentiated outpatient vs inpatient process, added MIH/decisional capacity; updated recommendations from CH Consent Manual, 2024 including transportation, AMA form, Scope added
3/2025	Nursing P&P	N	
6/2025	Policy Approval Committee (PAC)	N	
5/2025	Medical Executive Committee (MEC)	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 695	Page 1 of 4
Title: Stroke Program Scope of Service	**Effective Date:** 6/18/2025	☐ **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 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.

1.2 Telehealth: defined as a mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

1.3 The Core Stroke Team is defined as the Stroke Program Medical Director and the Stroke Coordinator.

2. PURPOSE

2.1 Riverside University Health System-Medical Center's (RUHS) Stroke Program is established to ensure excellent stroke care for patients with neurological deficits secondary to cerebrovascular disease, including but not limited to thrombosis, embolism, or hemorrhage through early recognition, following evidence-based interventions while maintaining a safe, patient centered environment.

3. GUIDELINES

3.1 Location, hours of service: 24 hours per day, 7 days per week.

a. Stroke Program services will respond to the Emergency Department (ED) and all in-patient units.

b. Stroke Program services will be provided by the Stroke Team.

3.2 Scope of services provided:

a. The Stroke Team serves three critical functions:

i. Facilitate effective interaction and collaboration among agencies, services, and people involved in providing prevention and the timely identification, transport, treatment, and rehabilitation of individual stroke patients.

ii. Utilization of a standardized approach to stroke care.

iii. Use of established performance measures to evaluate effectiveness and to revise, as needed, for improvement.

3.3 The Stroke Team provides patients and providers with best practice recommendations to promote effective stroke prevention, treatment, and rehabilitation.

a. Ensures that decisions about protocols and patient care are individualized and are in the patients' best interest.

b. Identifies and addresses potential obstacles to successful implementation.

c. Provides the appropriate resources and delivers primary stroke care, in accordance with best practice guidelines.

d. Works under the guidance of a Stroke Medical Director, Stroke Coordinator, Stroke Committee, written care protocols, pre-printed stroke physician orders and in collaboration with Emergency Medical System (EMS), neuroimaging, telehealth, radiology and laboratory services.

3.4 The stroke team consists of the following individuals or their designee:

a. Emergency Department:

i. ED physician

ii. NIHSS certified RN

iii. Clinical pharmacist (stand by)

iv. Designated certified nursing assistant (as needed)

v. Neurologist or telehealth (when indicated)

vi. Stroke coordinator (as available)

b. Inpatient

i. Primary medical team provider

ii. NIHSS certified RN

iii. Clinical pharmacist (stand by)

iv. Certified nursing assistant (as needed)

v. Neurologist or telehealth (when indicated)

vi. Stroke coordinator (as available)

3.5 The Stroke Committee is responsible for:

a. Defining criteria for the evaluation of process and outcome measures, quality management, performance monitoring, problem identification, analysis, and reporting. Criteria are defined by consensus, institutional guidelines, and are based on evidence-based practice parameters.

3.6 The Stroke Committee is a multidisciplinary team and includes the following:

a. Neurology Chair or representative.

b. Stroke Medical Director or representative.

c. Chief Nursing Officer or representative.

d. Department of Emergency Medicine or representative.

e. Department of Neurosurgery or representative.

f. Department of Radiology Chair or representative.

g. Stroke Program Coordinator (Stroke Committee Co-Chair).

h. Department of Rehabilitation Services Manager or representative.

i. Director of Pharmacy or representative.

j. Department of Patient and Family Services Manager or representative when indicated.

k. Laboratory Manager or representative when indicated.

l. Quality Management representative.

m. Patient Safety Officer or representative when indicated.

n. Pre-hospital Liaison Nurse or representative

o. Food & Nutrition Services Manager or representative when indicated.

3.7 Meetings are conducted a minimum of quarterly per year or as needed.

3.8 Education Requirements:

a. The following health care providers are required to maintain NIHSS certification: (Note: NIHSS certifications remain valid through the end of the calendar month, two years from the date the certification course was completed

i. Cath Lab RNs, Code Team RNs, Emergency department RNs, Adult critical care RNs, Intermediate Care Unit RNs, Medical/Surgical/Telemetry RNs, Post anesthesia care unit, Same day surgery RNs, Throughput RNs, Trauma services RNs.

4. EDUCATION

4.1 The Core Stroke Team and the Stroke Committee will approve the written stroke education plan on an annual basis.

4.2 Community:

a. Collaboration with local agencies and/or communities to increase knowledge of stroke risks factors and symptoms with activities related to stroke for a minimum of twice per year.

5. QUALITY IMPROVEMENT:

5.1 The effectiveness of the Stroke Program is evaluated through data collection, data monitoring, and performance improvement as follows:

5.2 Performance improvement goal is to streamline and improve stroke procedures, coordinate stroke care, meet and exceed stroke performance standards and continually monitor and measure standards for improvement.

a. Monitor performance of the Stroke Program through case review, concurrent and retrospective chart review, and stroke achievement measures.

b. Identify and analyze problems and or issues.

c. Plan and implement resolutions to identified problems and or issues as they arise including corrective action as indicated.

d. Evaluate effectiveness of corrective actions.

5.3 Data collection

a. A stroke registry (AHA Get With the Guidelines) will be used for data collection, analysis, and benchmarking.

b. Charts will be audited in compliance with The Joint Commission recommendations.

5.4 Reporting data

a. Stroke data will be reported to the Stroke Committee, the Performance Improvement and Patient Safety Committee (PIPSC) and the Medical Executive Committee.

b. The Stroke Program will follow requirements from Riverside Emergency Medical Services Agency (REMSA) Stroke Center policies.

Document History:

Release Dates: 12/2013, 12/2015, 10/20/18, 3/9/2021	**Retire Date:**		
Sponsored by: **Stroke Committee**	**Replaces Policy:** **# 100.02**		
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
5/15/25	Stroke Committee	Yes	Change to verbiage on NIHSS expiration to clarify that, while NIHSS certifications previously expire on the date listed on the certificate, staff will now be allowed a grace period until the end of that month for compliance. This aligns with the process already in place for the majority of our other certifications and will help ensure consistency across the board.
6/2025	Nursing P&P	No	
610/2025	PAC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 712	Page 1 of 5
Title: Computer Hardware and Software – Access, Use and Security	**Effective Date:** 5/6/2025	☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☒ **Procedure** ☐ **Guideline**

1. **POLICY.** The policy of RUHS is to:

   1.1 Ensure the security and privacy of the information stored and/or transmitted through the RUHS computer hardware, software, networks, internet, and email system.

   1.2 Establish and enforce workstation standards and safeguards for user access to the RUHS computer systems and applications.

   a. RUHS reserves the right to amend policies and guidelines without notice in accordance with applicable federal, state, and local laws and regulations.

2. **DEFINITIONS**

   2.1 Information Technology (IT). A computer system comprising hardware and software used to store, process, and maintain data electronically. This includes software link to multiple users via RUHS networked servers.

   2.2 Information Services Department (IS). The department responsible for managing electronic systems and data stored, processed, and maintained in the RUHS environment.

   2.3 Security Standards. Reasonable safeguards required by federal, state, and local laws/regulations to protect the confidentiality, integrity, and availability of RUHS systems and data.

   2.4 System Access Request (SAR) form. A required form to obtain access to RUHS computer systems and applications. The form specifies requested access and can be found under the RUHS Intranet, Information Services (IS), Help Desk, Services Desk Forms.

   2.5 Workforce Members. Employees regular or temporary, physicians, volunteers, students, residents, interns, and other persons whose performance of work is conducted at a RUHS facility.

3. GUIDELINES

3.1 Authorized Use and Access

Only authorized workforce members approved through the SAR process will be granted access to computer hardware, software, and networks for the delivery of services. RUHS retains the right to monitor all RUHS systems to ensure proper use.

a. Use of the RUHS systems implies agreement to the terms of this RUHS policy.
   - RUHS users have no expectation of privacy when using RUHS-owned hardware, software, and network, including email.

b. Authorized workforce members must be acting within the scope of their employment or contractual relationship with RUHS.

c. Users will receive specific usernames and passwords, and agree to:
   - Not to share their credentials with anyone, including coworkers, supervisors, and/or managers.
   - To take appropriate steps to prevent the loss or theft of their credentials.

d. Users must implement reasonable safeguards to protect the integrity, confidentiality, and availability of systems and applications.

3.2 Use prohibitions include but are not limited to:

a. Sending or sharing any sensitive or confidential information with unauthorized individuals.

b. Making copies of any sensitive or confidential data without authorization.

c. Installing non-standard software or hardware that has not been approved by RUHS IS Department.

d. Attaching non-authorized personal mobile devices to RUHS private/internal network

e. Attaching non-authorized personal computers to RUHS private/internal network without written permission from RUHS IS Department.

f. Using network resources to play or download games, music, or videos that are not in support or under the scope of employment at RUHS for business or educational functions.

g. Leaving workstations unattended without locking or logging out of the workstation.

h. Leaving workstations unattended without locking or logging out of the workstation.

i. Using RUHS network resources for, or in, support of unlawful activities as defined by federal, state, and local law.

j. Utilizing network resources for activities that violate conduct policies as established by RUHS and the County of Riverside.

k. Users agree that Protected Health Information (PHI) will not be stored or maintained on electronic remote access devices to be taken off site from any RUHS location including, but not limited to, laptop computers or other portable electronic devices, flash drives, USB, etc.

l. Users agree any such person with access, authorized or not, to RUHS computer system(s) who damages RUHS hardware or software due to having installed, downloaded, or upgraded unauthorized software will be responsible for the cost of the repair. Any computer related purchases of goods or services will be coordinated through the RUHS IS Department.

3.3 Access to RUHS Networked Computer Systems. Workforce members requesting access to the RUHS computer system must complete and submit a SAR form to the IS Department for processing.

3.4 Workstation Security. Workforce members will take reasonable steps to protect the integrity and confidentiality of information stored and maintained on the RUHS computer system.

a. Users shall log-off or lock their workstations prior to walking away and leaving their workstation unattended.

b. Screen savers shall not be de-activated, where installed.

c. Workstations shall be placed in the most secure area possible, preferably behind locked doors or other secured areas of RUHS.

d. Monitors shall be positioned in such a way that they are not easily viewed by any passerby.

e. Screen protectors shall be utilized in areas where there is a probability of unauthorized individual(s) viewing electronic Protected Health Information (ePHI).

3.5 Email Use. Email shall be used for communication which will assist in the efficient performance of job-related tasks. Email shall not be used for personal reasons.

a. Any information communicated via email shall be limited to only the minimum necessary information and, unless encrypted, shall not include protected or sensitive information (i.e. PHI/PII/Confidential).

b. A system generated confidentiality statement is automatically added to emails sent outside the RUHS domain.

c. Users are encouraged to “Archive” or create separate file folders to store email needed for future reference. All items in the email “Deleted Items” folder and “Conversation History” folder will be purged in 24 hrs.

3.6 Email Prohibitions. Emails should be used only to send courteous, professional, and businesslike communications. The following list provides examples of information that may **not** be transmitted via email:

a. Patient information (unless encrypted).

- Including names in any format, medical record numbers, date of birth, account numbers, social security numbers, etc.

b. Confidential material to an unauthorized recipient.

c. Unsolicited junk email, advertising, items-for-sale postings, or chain letters (e.g. "spam").

d. Any communications that violate County and/or RUHS conduct policies.

3.7 Network Drives. The RUHS Network is the safest storage choice for business-related documents and/or confidential information.

a. Business related documents and confidential information shall be saved to a local network drive Microsoft OneDrive/SharePoint. Such documents shall not be saved to any storage media outside of the network (i.e., "C" or "D" drive, USB devices, or any other portable devices).

b. Storing or sharing files through the Internet (i.e. Yahoo Briefcase, Google Documents, Drop Box, or any similar service) is strictly prohibited, with the exceptions of Microsoft OneDrive and Box.

3.8 Purchases of Computer Hardware, Software, Applications, or Other Computer Tools. Purchases of any computer hardware, software, applications, or other computer tools must be approved by IS Department prior to submittal for purchase. A Request for Supplies or Services Form must be completed.

3.9 IT Equipment Relocation

a. IT equipment relocation requests must be submitted to IS for processing and must include Department manager or Administrator approval.

b. The request will be sent to IS for review and approval.

- IS teams that may be expected to review are Desktop Support, Networking, and/or Communications.

- IS will sign off on the Move Request form and notify the requestor.

c. Once approval is received from the appropriate IS teams, requestor will be authorized to facilitate the move according to the relocation requirements indicated in the Move request form.

3.10 Reports of Policy Violations or Computer Concerns. Any suspicion of violations to this policy or suspicions of computer virus, worm, or other malicious malware that has infiltrated the computer workstation shall be reported immediately to the IS Help Desk at (951) 486-HELP (486-4357).

4. REFERENCES

4.1 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

4.2 Board of Supervisors Policy A-50, Electronic Media and Use Policy

Document History:

Prior Release Dates: 3/2000, 4/2005, 1/2015, 10/1/2018, 10/10/2019	**Retire Date:** N/A
Document Owner: Information Services	**Replaces Policy:** N/A

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
3/24/2025	RUHS ISO	Y	• Standardized term for IS to include all Information Services departments. • Corrected network storage location guidance. • Modified section 3.9 to updating review/approval requirements. • Removed non-relevant policy H-11 • Removed A-38 – rescinded • Remove A-58 – non-relevant policy
4/1/2025	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Housewide

	Document No: 739	Page 1 of 4
Title: Treating Oneself or Family Members	**Effective Date:** 4/14/2025	☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. PURPOSE

1.1 To establish clear guidelines for when health care providers or workforce members may treat or provide care for themselves or their family members within the RUHS – Medical Center, Community Health Centers, and Hospital Based Clinics Medical Record System.

2. DEFINITIONS

2.1 **Family member:** An individual with whom the workforce member has a familial connection or with whom the workforce member has a personal or close relationship, where the relationship is of such a nature that it may reasonably affect the work force member's professional judgment. This includes but is not limited to the work force member's spouse or partner, parent, child, sibling, members of the workforce member's extended family, or those of the work force member's spouse or partner (for example: in-laws)**.**

2.2 **Treatment:** Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose. This includes: the performance of any controlled act; ordering and performing tests (including blood tests and diagnostic imaging); providing a course of treatment, plan of treatment, or community treatment plan**.**

a. **Community Treatment Plan**: refers to a civil court procedure wherein a legal process orders an individual diagnosed with a severe mental disorder to adhere to an outpatient treatment plan designed to prevent further deterioration or recurrence that is harmful to themselves or others.

2.3 **Emergency or Medical Emergency:** A medical emergency exists when:

a. Immediate Services are required for the alleviation of severe pain

OR

b. The procedure is required for immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

2.4 **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 RUHS, whether or not they are paid by RUHS. Medical Staff members may also be part of the "workforce".

2.5 **Scheduled Controlled Substances:** Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA). These substances are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the U.S., their relative abuse potential, and likelihood of causing dependence when abused.

3. GUIDELINES

3.1 Treatment

a. In general, a workforce member should not provide professional care or treatment on an inpatient or outpatient basis for themselves or family members unless an emergency exists. This restriction is based on ethical norms and the increased potential to violate Federal and State Laws, as well as RUHS and County policies and procedures.

   i. Workforce Members will decline to treat or provide care to family members unless an emergency exists.

   ii. Workforce Members should not serve as a primary care provider for themselves. In general, Workforce members should not give verbal orders for themselves, or access or document in the Medical Record regarding themselves unless a RUHS business purpose exists for the access or documentation.

   iii. Workforce Members will not give verbal orders for or access the medical records of a family member unless a RUHS business purpose exists for the access.

b. In an emergency, when treating or providing care for a family member, Workforce Members will:

   i. Conduct and document a sufficient examination similar in extent and detail to that which would be provided to a patient who is not a family member.

   ii. Document any treatment, care or advice provided in the patient's medical record and convey relevant information to the patient's primary care physician.

   iii. If the patient does not possess the ability to inform their primary health care physician (e.g., children), the Workforce Member should advise the patient's primary health care professional of the treatment they provided.

   iv. Avoid providing sensitive or intimate care especially for a minor patient who may be uncomfortable being treated by a family member and/or has the right to seek such care independently under state law.

   v. Notify their direct supervisor or manager of the treatment or care provided.

3.2 **Referrals**

a. Workforce Members should not make referrals for themselves or family members. Referrals are to be made by the patient's primary physician or attending physician.

3.3 **Prescribing Schedule II, III, IV, & V Controlled Substances**

a. Schedule II Controlled Substances

i. Self-prescribing of Schedule II controlled substances is prohibited by law, thus prohibited by RUHS.

ii. Workforce Members will not prescribe Schedule II controlled substances to family members.

b. Emergency Situations

i. Workforce Members will not prescribe Schedule II, III, IV, or V controlled substances for themselves or family members unless it is an emergency situation exists.

1. Under no circumstance may prescriptions for Schedule II, III, IV, or V controlled substances be written for themselves or family members on a long-term or refillable basis.

2. Workforce members prescribing Schedule II, III, IV, or V controlled substances under emergency circumstances for themselves or family members shall adequately document the emergency and the reason the substance was necessary in the patient's chart and inform the patient's primary care provider of such.

c. Workforce members will report to their direct manager or supervisor or the compliance hotline/department immediately if they become aware that any practice described in paragraphs 3.3(a)(i), 3.3(a)(ii), or 3.3(b)(i) is occurring.

3.4 **Electronic Health Record (EHR)**

a. RUHS policy prohibits accessing medical records without a RUHS business need to do so

i. Workforce Members will not access the electronic Health Record of themselves or a family member unless a RUHS Business need exists.

b. Workforce Members will follow the proper RUHS channels to access or request the medical records of themselves or a family member when there is no RUHS business to access the EHR. Such channels can include contacting the HIM department and/or accessing records via Mychart.

4. REFERENCES

4.1 AMA Code of Medical Ethics Opinion 1.1.1, Patient-Physician Relationships

4.2 AMA Code of Medical Ethics Opinion 1.2.1, Treating Self or Family

4.3 Federal Stark Law

4.4 RUHS Nursing Policy, Chain of Command

4.5 RUHS House wide Policy 602; Patient Informed Consent

Document History:

Prior Release Dates: 1/31/2022	**Retire Date:** N/A
Document Owner: Compliance Department	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
12/2024	Compliance	Y	Added 3.3 c. ii ii. "Workforce members prescribing Schedule II, III, IV, or V controlled substances under emergency circumstances for family members shall adequately document the emergency and the reason the substance was necessary in the patient's chart and inform the patient's primary care provider of such."
3/20/2025	Nursing Policies and Procedures	Y	Added schedule V (previously only II, III, and IV
4/1/2025	PAC	N	
4/10/2025	MEC	Y	Streamline repetitive language

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 804	Page 1 of 3
Title: High-Alert Medications	**Effective Date:** 6/18/2025	☐ **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 all medications stored and utilized for adult and pediatric patients: RUHS – Medical Center Moreno Valley and Arlington campuses, and hospital-based clinics.

1.2 Risk-mitigation strategies and interventions need to be varied and suited to reduce the risk of errors or patient harm. See Appendix.

2. DEFINITIONS

2.1 Automated Dispensing Cabinets. Automated dispensing cabinets are computerized drug storage devices or cabinets that allow medications to be stored and dispensed near the point of care, while controlling and tracking drug distribution.[3,4]

2.2 Bar Code Medication Administration (BCMA). Bar Code Medication Administration is a technology designed to prevent medication errors in the healthcare setting and improve the quality and safety of medication administration. The overall goals of BCMA are to improve accuracy, prevent errors, and generate electronic records of medication administration.

2.3 Clinical Decision Support. Clinical decision support is technology that provides clinicians with knowledge and patient-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care. Examples of this include allergy and therapeutic duplication alerts.

2.4 Computerized physician order entry (CPOE). CPOE is the process of a medical professional entering medication orders or other physician instructions electronically instead of on paper charts. A primary benefit of CPOE is that it can help reduce errors related to poor handwriting or transcription of medication orders.

2.5 High-Alert Medications. The Joint Commission defines High-Alert Medications as Medications that bear a heightened risk of causing significant harm to individuals when they are used in error.

2.6 Independent Double Check (IDC). The Institute for Safe Medication Practices defines an Independent Double Check as a procedure in which two clinicians separately check (alone and apart from each other) each component of prescribing, dispensing, and verifying the high-alert medication before administering it to the patient.

2.7 Medication Use Process. Encompasses the following categories: Procuring, Storing, Prescribing, Transcribing, Preparing, Dispensing, Administering, Monitoring.

2.8 Smart Infusion Pump. Medication infusion pumps deliver parenteral medications at precise rates or in specific amounts. "Smart" infusion pumps have built in software that can alert users to potential errors. This software (sometimes referred to as Drug Error Reducing or "DER" software) maintains a drug library that provides medication dosing guidelines by establishing concentrations, dose limits, and clinical advisories.

3. POLICY

3.1 High-Alert Medications require heightened attention by those involved in the medication use process because of the risk of causing significant harm when used in error. In addition to standard safety measures detailed above, other safety measures utilized to mitigate the risk of High-Alert Medications include, but are not limited to, the following: medication procurement, special storage, use of specified auxiliary labels, and specific monitoring. Appendix A details these measures based on medication category.

3.2 Standard medication safety measures at RUHS include the following:

a. PRESCRIBING AND TRANSCRIBING:

- Use of CPOE including standardized electronic order sets with clinical decision support technology

b. PREPARING AND DISPENSING:

- Use of bar code medication technology both within the pharmacy and at the automated dispensing cabinets.
- Use of standardized formulas for compounding both extemporaneous and sterile preparations
- Independent double checks for target patient populations and/or medication classes, i.e. pediatric and neonatal orders/doses

c. ADMINISTERING:

- Use of BCMA technology
- Use of smart infusion pumps
- Use of clinical alerts including IDC

In the event of an electronic downtime, either planned or unplanned, downtime procedures will be followed.

3.3 If there is a risk to patient safety at any point along the medication use process, the organization supports staff in STOPPING the activity being performed and elevating the concern through the appropriate chain of command.

3.4 Drug information resources are readily available electronically for all staff in addition to Pharmacy Services.

4. REFERENCES

4.1 The Joint Commission standards MM.01.01.03 and NPSG.03.05.01

4.2 CMS Conditions of Participation § 482.23(c)(1), § 482.23(c)(2), § 482.23(c)(4), § 482.25(a), and § 482.25(b)(6)

4.3 Adapted from the Institute for Safe Medication Practices “Proceedings From the ISMP Summit on the Use of Smart Infusion Pumps” 2009.

4.4 Adapted from the Institute for Safe Medication Practices “Guidance on the Interdisciplinary Safe Use of Automated Dispensing Cabinets” 2008.

5. ATTACHMENTS

5.1 Appendix A: High-Alert Medications Grid

Document History:

Prior Release Dates: 5/22/17, 1/7/21, 7/26/2022, 11/22/2024	**Retire Date:** N/A
Sponsored by: Pharmacy Department	**Replaces Policies:** Nursing PnP 700: Continuous Infusion of High Risk Nursing PnP 708: High Risk and High Alert Administration Pharmacy PnP F624: Handling of High-Risk (High Alert) Medications in Pharmacy Department

Date Reviewed	**Reviewed By:**	**Revisions Made?**	**Revision Description**
01/23/2025	Perinatal – Pharmacy workgroup (TJC)	Y	Added 1.2, and 3.4 regarding drug information resources. Create new category in high alert med appendix for Perinatal – include pumps, Oxytocin, Magnesium.
02/11/2025	Pharmacy Review Committee – informational	N	
02/03/2025	Pharmacy & Therapeutics Committee	N	
6/2025	PAC	N	

APPENDIX A: HIGH-ALERT MEDICATION GRID

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
ANTICOAGULANTS AND THROMBOLYTICS	**PARENTERAL ANTICOAGULANTS and THROMBOLYTICS** Examples include alteplase (ACTIVASE®), argatroban, bivalirudin (Angiomax), enoxaparin (LOVENOX®), fondaparinux (ARIXTRA®), heparin, tenecteplase (TNKASE®)	- Prefilled syringes of enoxaparin and fondaparinux procured - The number of heparin concentrations is minimized. - Premixed heparin infusion bags with standard 100 unit/mL concentration are procured. -Alteplase and tenecteplase are located in the ED and ICU Pyxis only.	- CPOE - Standardized order sets are used for alteplase, tenecteplase, bivalirudin, argatroban, and heparin infusions.	- Concentrations for intravenous infusions of alteplase, argatroban, bivalirudin, and heparin standardized. - Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for vials, syringes, and premixed bags. - HIGH ALERT auxiliary label adhered to product for alteplase, argatroban, bivalirudin, and heparin infusions.	- For intravenous anticoagulant and thrombolytic infusions (**excludes** heparin flushes and alteplase for catheter occlusion), IDC done upon initial administration, each bag or rate change, and at handoff. - Smart infusion pumps utilized to administer intravenous anticoagulant or thrombolytic infusions. - Dedicated line required for alteplase administration. - Med administration guidelines in place for IV thrombolytics in stroke and pulmonary embolism - BCMA	-1:1 nursing ratio for the first 8 hours after administration of thrombolytic, when applicable. - Standardized labs for argatroban, LMWH and heparin monitoring. - Standardized neurological checks when thrombolytics are administered.
	ORAL ANTICOAGULANTS Examples include apixaban, rivaroxaban, warfarin	- Unit-dosed products procured if available.	- CPOE, BPA to be triggered if patient has received DOAC or LMWH within the past 24 hours. - Pharmacist protocols utilized for warfarin initiation and maintenance which includes documentation and assessment of the patient's baseline INR. 6- Order sets for DOAC to maintain dosing per indication. - Allow for continuation of home medication dosing	- Barcode technology used during distribution and dispensing.	- BCMA	- Pharmacist protocols utilized to monitor labs and adjust dosing for patients on warfarin therapy. - Warfarin education to patient/caregiver completed by a pharmacist to all patients initiated on warfarin therapy. - DOAC education to patient/caregiver completed by a pharmacist or nurse to all patients initiated on DOAC therapy.

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
CHEMOTHERAPY / HAZARDOUS	**PARENTERAL CHEMOTHERAPY**	- Storage of tier 1 injectable hazardous drugs (chemotherapy) limited to the Infusion Center Pharmacy - Prepared parenteral chemotherapy is hand-delivered and stored in segregated bins located in the medication rooms of patient care units.	- CPOE, separate oncology prescribing module from EHR. - Chemotherapy must be ordered by attending physician. - No verbal orders for chemotherapy are allowed.	- Vinca alkaloids are standardly prepared in 50 mL of normal saline to prevent inadvertent intrathecal administration. - Barcode technology used in the pharmacy during preparation of compounded items. - Tier 1-3 hazardous drug warning level applied to final product per NIOSH. - CHEMOTHERAPY final prep is placed in a separate identifying bag. - Chemotherapy and HD parenteral therapy dispensed with tubing and lines primed. - Reminder for PPE pop-up at Pyxis upon removal of medication	- IDC - Chemotherapy Nurse administers parenteral chemotherapy. - Smart infusion pumps utilized to administer intravenous chemotherapy infusions (exception: peripherally administered small volume vesicant chemotherapy). - BCMA - Nursing chemotherapy and biotherapy med administration guidelines in place for best practices	- Oncology Pharmacist reviews labs, IV lines attached to prepared medication, vitals prior to initiation, and for all subsequent dose dispenses. - Hardstop reviews in separate oncology module.
VASOPRESSORS AND INOTROPES	**VASOPRESSORS and INOTROPES** Examples include norepinephrine, EPINEPHrine, phenylephrine, vasopressin, DOBUTamine, DOPamine	- Stored in the pharmacy in designated bins. - Norepinephrine, DOBUTamine, and DOPamine infusion bags with standard concentrations stored separately from other infusion bags in the ICU and ED Pyxis. - Norepinephrine, EPINEPHrine, phenylephrine, vasopressin prefilled syringes and/or vials and DOBUTamine premixed bags are also located in areas where emergency care may be needed (e.g., crash carts, code boxes, Pyxis in critical cares areas).	- CPOE	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing. - Pharmacist pre-post check when compounding. - CENTRAL LINE ONLY auxiliary label adhered to central line concentrations. - Placement of pre-filled syringes in OR pyxis when possible and cost-effective	- Infusions for this category of medications are restricted to critical care units. - Smart infusion pumps utilized to administer intravenous infusions. - BCMA -RUHS has Peripheral IV Vasopressor Medication Administration policy.	- Nurse to assess peripheral IV function every 2 hours if vasopressor is given peripherally. - Immediate notification to the medical team if peripheral IV extravasation is noted.

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
ELECTROLYTES	**CONCENTRATED ELECTROLYTES** Examples include *concentrated* calcium chloride, calcium gluconate, magnesium sulfate, potassium chloride, potassium phosphate, sodium phosphate Hypertonic Saline (concentrations >0.9% aka) 3% and 23.4%, **Cardioplegic solution**	- Concentrated electrolytes are stored only in the pharmacy in designated HIGH ALERT bins Exceptions: calcium chloride, calcium gluconate, magnesium sulfate, and 3% NaCl, which are also located in areas where emergency care may be needed (e.g., crash carts, Pyxis in critical care areas). - Procure 3% hypertonic saline from different manufacturer when possible and store separately from 23.4% HTS, or normal saline. - ~~**Cardioplegia**~~ ~~is segregated~~ in the pharmacy separate from IV solutions, and in the locked (tamper evident) Cardiopulmonary Bypass (CPB) Medication kit	- CPOE - Guidelines for prescribing - **Cardioplegic** solutions are restricted to authorized prescribers trained in the use and administration of cardioplegic solution	- Concentrated electrolytes are diluted to concentration safe for administration prior to dispensing. - Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for premixed items. - CENTRAL LINE ONLY auxiliary label adhered when applicable to certain concentrations of electrolytes; - HIGH ALERT auxiliary label adhered to hypertonic saline, magnesium doses 20 gm or greater, and potassium 20meq and greater. - Pharmacist pre-check when compounding with concentrated electrolytes. - Hypertonic solutions distributed by Pharmacy, 3% HTS stored in ED Resus Pyxis - The **CPB Kit** is stored in pharmacy and is checked in and out when needed, by the perfusionist who is trained in the area of use only the amount necessary to meet patient care needs for each case is dispensed	- IDC for hypertonic saline - IDC for intravenous magnesium doses 20 gm or higher – see Perinatal - Smart infusion pumps utilized to administer intravenous electrolytes. - BCMA - Guidelines for administration and use exist for electrolyte replacement, HTS, and parenteral nutrition **Cardioplegic** solution is for cardiac instillation only (NOT for intravenous injection) Cardioplegic solutions are only administered after aseptic addition of sodium bicarbonate 8.4% and only by trained perfusionists for cardiac instillation	**Cardioplegic** solution - The perfusionist is responsible for tracking flow rate, volume, temperature, components and timing of each dose. The perfusionist also monitors intraluminal pressure and adjusts accordingly Safe use is ensured by the entire team working concertedly utilizing closed-loop feedback communication to diminish potential errors
PARENTERAL NUTRITION	**PARENTERAL NUTRITION** Includes both total and peripheral parenteral nutrition	- Standard bulk preparations of amino acids, dextrose, and lipids are procured.	- CPOE - Pharmacist protocols utilized for dosing parenteral nutrition in adults and pediatrics and neonates. - Method of ordering of parenteral nutrition standardized.	- Special compounder with barcode and gravimetric technology used to prepare individualized bags for patients. - IDC done by two pharmacists comparing TPN order to compounder label. - Pharmacist pre-check prior to manual addition of additives. - HIGH ALERT auxiliary label adhered to prepared product.	- Smart infusion pumps utilized to administer parenteral nutrition. IDC – performed by nurses for NICU and Pediatric PN-BCMA	- Pharmacist protocols utilized to monitor labs and make adjustments to parenteral nutrition as needed.

Commented [SE1]: @Davalyn Tidwell please review revision

Commented [DT2R1]: I agree with the revision

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
STERILE WATER	**STERILE WATER**	- Sterile water for enteral use is stocked in nursing wards - Sterile water for irrigation BOTTLES is in limited stock on patient care units - When utilized for large volume irrigation, only sterile water 2 LITER bags are distributed by the materials management department to the patient care unit upon request only. - Sterile water bags used for compounding are sequestered in the pharmacy. -Sterile water vials stored in pyxis for medication reconstitution.		- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for sterile water VIALS.	- Med administration guidelines define the indicated use of Sterile water for enteral use, and indicate when sterile water for irrigation may be used	
EPIDURALS / REGIONAL ANALGESIA	**EPIDURALS** Examples include bupivacaine and ropivacaine epidurals	- Premixed ropivacaine epidural with standard concentration procured. - Premixed ropivacaine epidurals segregated in the pharmacy from other similar sized bags.	- CPOE - Order set for PCEA, by anesthesia only - Order set for PCRA by both anesthesia providers and surgeons	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for premixed items.	- New starts/1st bags initiated by the Anesthesia practitioner, or Surgeon based on protocol - Epidurals administered using smart infusion pumps specifically configured for epidural use only. - Regional analgesia administered via dedicated pumps and library - Pumps for epidural/regional use are programmed by Provider only - Dedicated smart infusion pump library for epidurals. - BCMA - IDC	- Monitoring and guideline per protocol by anesthesia/surgeon, and nursing
LIPOSOMAL FORMULATIONS	**LIPOSOMAL FORMULATIONS** Examples include liposomal amphotericin B (AmBisome®)	- Stored in the pharmacy in designated bins.	- CPOE - Infectious diseases consultation and approval required for AmBisome®.	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing. - Pharmacist pre-post check when compounding.	- Smart infusion pumps utilized to administer intravenous infusions. - BCMA	

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
INSULINS	**INSULINS** Examples include insulin lispro, regular insulin, isophane insulin, and insulin glargine	- Small (3 mL) vial size procured when commercially available for use and stored in Pyxis - Stored in designated HIGH ALERT bins in pharmacy areas. - Commercially available IV insulin bags procured for use only in the OR core	- CPOE - Standardized order sets used for continuous insulin infusions.	- Concentration for insulin infusion standardized. - Regular insulin compounded for use in the emergency department, ICU and operating room. - Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for premixed items. - Pharmacist direct observation when compounding with insulin. - HIGH ALERT auxiliary label adhered to product. - IDC when preparing patient specific long-acting insulin. - Pharmacy prepares patient specific doses of long-acting insulin glargine.	- Smart infusion pumps utilized to administer intravenous insulin infusions. - Intravenous insulin infusions restricted to critical care units. - For insulin infusions, IDC done upon initial administration, each bag change, with each rate change, and at handoff. - IDC performed when IV insulin syringe is administered for hyperkalemia - For subcutaneous insulin, IDC prior to each dose administered. - BCMA	- Standardized frequencies of blood glucose checks. - Guidelines for response and management of hypoglycemia
NEUROMUSCULAR BLOCKERS	**NEUROMUSCULAR BLOCKERS** Examples include succinylcholine, rocuronium, and cisatracurium	- Stored in the pharmacy in designated lidded bins. -Stored in rapid sequence intubation kits in pyxis.	- CPOE - Standardized order sets utilized for neuromuscular blocker infusions.	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for premixed items. - Pharmacist pre-post check when compounding. - PARALYZING AGENT auxiliary label adhered to compounded preparations as well as to vials and prefilled syringes.	- Neuromuscular blocker infusions restricted to critical care units. - Smart infusion pumps utilized to administer intravenous neuromuscular blocker infusions. - BCMA	- Train of four monitoring utilized during neuromuscular blocker infusions, when applicable. - Reversal agents readily available.

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

HIGH-ALERT MEDICATION CATEGORY		PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
OPIOIDS AND BENZODIAZEPINES	**CONTINUOUS INTRAVENOUS OPIOID and BENZODIAZEPINE INFUSIONS AND PATIENT-CONTROLLED ANALGESIA (PCA)** Examples include intravenous infusions of fentaNYL, morphine, HYDROmorphone (DILAUDID®), and midazolam (VERSED®) as well as morphine PCA and HYDROmorphone PCA	- All controlled substances are maintained under locked storage both in the pharmacy and at patient care units. - fentaNYL, midazolam, and morphine infusion bags with standard concentrations. - Premixed morphine PCA and HYDROmorphone PCA syringes with standard concentrations procured.	- CPOE - Standardized order sets utilized. - Automatic stops for opioids and benzodiazepines to promote review of therapy by providers. - Standard concentrations and volumes defined in med administration guidelines	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing for premixed items. - Pharmacist pre-post check when compounding.	- For continuous infusions, IDC done upon initial administration, each bag change, and at handoff. - For PCAs, IDC done upon initial administration, each syringe change, each dose/rate change, and at handoff. - Opioid and benzodiazepine infusions restricted per prescribing guidelines. - Smart infusion pumps utilized to administer infusions and PCA. - BCMA - Use of IV med lockboxes on IV poles during administration outside of ICU	- Patients on PCA have continuous end tidal CO2 monitoring as well as standardized frequencies of vital signs checked and documented. - For patients on continuous infusion of opioids and benzodiazepine, mechanical ventilation is required and have continuous pulse oximetry monitoring. - Monitoring tools for sedatives and opioids include RASS, CPOT scales.
	FENTANYL PATCH	- All controlled substances are maintained under locked storage both in the pharmacy and at patient care units.	- CPOE - Required prescriber documentation attesting to patient opioid-tolerant status for all fentanyl patch orders. - Pharmacist review completed on all fentanyl patch orders to ensure patient is opioid-tolerant prior to dispensing.	- Barcode technology used during distribution and dispensing.	- Patch removal is documented on medication administration record. - BCMA	- Adherence to fentanyl patch safe prescribing shared at PIPSC
SEDATIVE INFUSIONS (NON-NARCOTIC)	**SEDATIVE INFUSIONS (NON-NARCOTIC)** Examples include dexmedetomidine and propofol	- Propofol for the OR stored inside the OR room in designated location. - Propofol and dexmedetomidine are stored in ED and ICU pyxis.	- CPOE - Standardized order sets utilized.	- Barcode technology used during distribution and dispensing. - Standard concentration for infusions. - Pharmacist pre-post check when compounding.	- Infusions for this category of medications are restricted to critical care units. - Smart infusion pumps utilized to administer intravenous infusions. - BCMA	- Monitoring of propofol use in the ORs

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

	HIGH-ALERT MEDICATION CATEGORY	PROCUREMENT & STORAGE	PRESCRIBING & TRANSCRIBING	PREPARING & DISPENSING	ADMINISTERING	MONITORING
NEONATAL & PEDIATRICS – TARGETED POPULATIONS	**PATIENT POPULATIONS WHERE MEDICATION ERRORS ARE HIGHLY LIKELY TO RESULT IN HARM** Examples include neonatal and pediatric populations	- Medications used specifically in neonates are stored in a segregated area of the pharmacy in designated bins.	- CPOE - Standardized weight-based dosing utilized. - Dual Pharmacist verification of all neonatal orders. - Dual Pharmacist verification of targeted pediatric medications: aminoglycosides (gentamicin, tobramycin, and amikacin), vancomycin, and TPN orders	- Patient-specific, dose for medication prepared by pharmacy for scheduled (routine) pediatric and neonatal medications. - Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing. - For medications prepared on patient care units, IDC is done on medications where a partial amount of a vial, ampule, or cup is drawn up. This excludes medications used in an emergency situation.	- Smart infusion pumps utilized to administer intravenous infusions. - Separate infusion pumps used to administer continuous albuterol therapy. - BCMA	- Pharmacist specialists trained in neonatal and pediatric populations present
PERINATAL– TARGETED POPULATIONS	Pregnant patients / women of childbearing age		Pregnancy test review for medication orders with potential or risk of harm in pregnancy for women of childbearing age		Dedicated smart infusion pump for administration of epidurals in the laboring patient (see EPIDURALS)	
	OXYTOCIN	- Procure premixed bags - Stored separately from other infusion bags in L&D/OB area	- CPOE - Order sets for induction and post-partum - Standard concentrations used	- Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing. - OXYTOCIN label affixed to both sides of the bag	- Smart infusion pumps utilized to administer intravenous infusions. - Medication use guideline for the use of Oxytocin	- Response and use monitoring per protocol
	MAGNESIUM SULFATE	- Procure premixed bags	- CPOE - Standard concentrations used	HIGH ALERT auxiliary label adhered to magnesium doses 20 gm/500mL bag - Barcode technology used in the pharmacy during preparation of compounded items. - Barcode technology used during distribution and dispensing.	- Smart infusion pumps utilized to administer intravenous infusions. - Medication use guideline for the use of Magnesium Sulfate - IDC for initial L&D magnesium bolus - IDC for maintenance Magnesium Sulfate (20gm/500mL)	- Response and use monitoring per protocol

LEGEND: CPOE = Computerized Physician Order Entry BCMA = Bar Code Medication Administration IDC = Independent Double Check

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 808	Page 1 of 3
Title: Snakebite Management	**Effective Date:** 5/6/2025	☐ **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 guideline is to describe safe, effective, and appropriate administration of antivenom for the management of adult and pediatric patients with North American crotalid envenomation.

2. DEFINITIONS

2.1 North American crotalid: A subfamily of Viperidae (pit vipers) with poisonous venom. North American crotalids include rattlesnakes, copperheads and cottonmouth snakes.

2.2 Antivenom: Purified antibodies against snake venom use to treat venomous snakebites. There are currently two formulations of antivenoms for crotalids available in the United Sates: crotalidae immune F(ab')2 equine (ANAVIP) and Crotlidae polyvalent immune Fab ovine (Crofab). Riverside University Health Systems has ANAVIP on formulary.

2.3 Dry bite: 20% of crotalid bites will be a dry bite in which there is no envenomation.

3. GUIDELINES

3.1 Initial patient assessment

a. Asses for envenomation vs dry bite:

i. Local tissue damage: swelling, pain, redness, ecchymosis, hemorrhagic bullae

ii. Hemotoxicity: coagulopathy, thrombocytopenia

iii. Rare: compartment syndrome, rhabdomyolysis, shock, angioedema, vomiting and diarrhea, neurotoxicity

b. Mark leading edge of pain and induration every hour

i. Obtain a circumferential measurement at 3 points along the affected limb every hour to assess progressive swelling/induration

c. Immobilize and elevate limb

d. Obtain baseline labs (PT/INR, platelets, fibrinogen)

e. Consider Poison Center consult: 1-800-222-1222

3.2 Treatment – ANAVIP

a. Dry bite: no antivenom indicated. Monitor for 8-12 hours, repeat labs and exam before discharge

b. Indications

i. Significant or progressive induration (>2 cm), swelling beyond bite site

ii. Hematologic toxicities: elevated PT/INR, decreased fibrinogen or platelets

iii. Systemic signs (i.e., shock, neurotoxicity, bleeding)

iv. Face/airway involvement

c. Relative contraindications

i. Allergy to horse serum, pepsin and cresol

d. Dosing (Adult and Pediatric)

i. Initial dose: 10 vials IVPB

3.3 Re-dose 10 vials IVPB every 1 hour as needed **AFTER** infusion completion of initial dose until initial symptom control obtained (local signs not progressing, systemic symptoms resolved and coagulation parameters trend toward normal)

i. Re-emerging symptoms after initial symptom control: 4 vials IVPB as needed

3.4 Administration

i. Vials shall be diluted to a total volume of 250 mL NS

ii. Fluid volumes may need to be adjusted for very small children or infants

iii. Infuse first dose at a rate of 25 mL/hr for the first 10 minutes, if no reaction observed, increase rate to 250 mL/hr. All subsequent doses to be infused at 250 mL/hr

iv. Initiate infusion slowly to monitor for allergic reaction

a. Monitoring

i. Check for signs of hypersensitivity or allergic reactions

ii. Check labs (PT/INR, platelets, fibrinogen) 1 hour after antivenom infusion and every 6 hours thereafter

iii. Observe for 18- 24 hours after initial control. If antivenom re-dose is required, restart observation period

iv. Signs of progressing envenomation (signs, symptoms, labs)

g. Allergic or hypersensitivity reactions

i. Stop ANAVIP infusion

ii. Give epinephrine, steroids, and antihistamines as appropriate

iii. Monitor airway and vitals

iv. Reassess risk versus benefit of antivenom

3.5 Adverse reactions: anaphylaxis, urticaria, pruritus, rash, erythema, headache, nausea, vomiting, arthralgia, pain in extremity, myalgia

3.6 Additional Treatment

a. Treat pain with IV opioids

i. Avoid NSAIDS

b. Update tetanus vaccine if required

3.7 Discharge instructions

a. Prior to discharge coagulation labs should be normalized or improving with no signs of active bleeding

b. Consider delaying discharge in those with critical lab values (i.e., INR >3.0, platelets <50,000 cells/mm3, fibrinogen <75 mg/dL) and/or active bleeding

c. Instruct patient to watch for signs or symptoms of allergic reaction, abnormal bleeding, or serum sickness (i.e., rash, fever, myalgia, arthralgia)

d. Patient with rattlesnake envenomation or abnormal coagulation labs should take bleeding precautions for 2 weeks (i.e., no contact sports, elective surgeries, or dental work)

4. REFERENCES

4.1 Anavip [package insert]. Laboratorios Silanes S.A. de C.V.; 2021

4.2 Bernstein JN. Critical Care Toxicology. Springer 2016; 2493-2501

4.3 Lavonas EJ, Ruha AM, Banner W, et al. Unified treatment algorithm for the management of crotaline snakebite in the United States: results of an evidence-informed consensus workshop. BMC Emerg Med. 2011;11:2

4.4 Pizon AF, Ruha AM. Goldfrank's Toxicologic Emergencies. 2015; 10e

Document History:

Prior Release Dates: New	**Retire Date:** N/A
Document Owner: Pharmacy	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
11/12/24	Pharmacy Review Committee	Y	Formatting, specify labs
12/20/24	Nursing PNP	Y	Including wording of "initial dose" for redosing
1/6/2025	P&T approved	N	
1/7/2025	PAC	N	
5/10/2025	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
Housewide

Title:	**Effective Date:**	☐ **RUHS – Community Health Centers** ☒ **RUHS – Medical Center** ☐ **RUHS – Hospital Based Clinics** ☐ **Departmental**
Drug Formulary and Non-Formulary Process	5/6/2025	
Approved By and Date Approved:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1. This policy applies to the Riverside University Health System – Medical Center. Moreno Valley and Arlington Campuses, inpatient pharmacy services.

2. DEFINITIONS

2.1. Abbreviated Formulary Addition Package. An abbreviated package of documents consisting of Formulary Addition Request form and prescribing information.

2.2. Active Ingredient. A chemical compound that provides pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body.

2.3. Biological Products. Therapies used to treat diseases and health conditions, including vaccines, blood and blood components, gene therapies, tissues, and proteins. Unlike most prescription drugs made through chemical processes, biological products generally are made from human and/or animal materials. May also be called a “reference product;”. example: infliximab, filgrastim

2.4. Biosimilar. A biosimilar biological product that is deemed by the FDA to be highly similar to an already FDA-approved biological product, for which there are no clinically meaningful differences in terms of safety, purity, and potency. There may be minor differences in clinically inactive components; example: infliximab-dyyb, filgrastrim-sndz.

2.5. Closed Formulary. A limited list of medications. A closed formulary limits drugs to specific physicians, patient care areas, or disease states via formulary restrictions.

2.6. Dosage Form. The physical form of a dose of a chemical compound used as a medication intended for administration. Examples of dosage forms include tablet, capsule, and injectable.

2.7. Drug. A drug is defined as:

a. A substance recognized by an official pharmacopoeia or formulary.

b. A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.

c. A substance (other than food) intended to affect the structure or any function of the body.

d. A substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device.

e. Biological products are included within this definition.

2.8. Drug Monograph. Drug Monograph is a document supporting the use of a medication with the goal of optimal patient outcomes. The Department of Pharmacy will maintain a template of the Drug Monograph, which will be provided upon request. At the minimum, the Drug Monograph will contain the following elements:

a. Indications for Use

b. Effectiveness

c. Drug Interactions

d. Potential for Errors and Abuse

e. Adverse Drug Events

f. Sentinel Event Advisories

g. Other Risks

h. Costs

i. Population(s) served (for example, pediatrics, geriatrics, etc.)

2.9. Fact Sheet or equivalent (i.e. P&T Review). A summary of the drug monograph that serves as an informational and educational aid.

2.10. Formulary. An approved list of active ingredient medications, including medication strength and dosage form, available for use by RUHS - Medical Center. Active ingredients, specific dosage forms, and strengths on this list are procurable by Department of Pharmacy.

2.11. Formulary Addition Package. A three document package consisting of a Formulary Addition Request form, a Drug Monograph, and a Fact Sheet (or equivalent).

2.12. Interchangeable biosimilars. Biosimilars that meet additional standards and expected to produce the same clinical result as the reference product. The FDA states the pharmacist may substitute an interchangeable biological product for the reference product without the intervention of the clinician who prescribed the reference product.

2.13. Non-Formulary. Medication is not on the approved list of formulary medications.

2.14. Non-Formulary Request. A request to use a medication not on the approved list of formulary medications. The request is required for active ingredients not on formulary and/or routes of administration not approved by Pharmacy & Therapeutics Committee (P&T).

2.15. Reference Product. The biological product already approved by the FDA, with which biosimilars strive to be highly similar.

3. POLICY

3.1. A closed formulary will be maintained with active ingredient names, strengths, and dosage forms, in electronic format.

3.2. The number of drug concentrations are standardized and limited, while meeting

patient care needs.

3.3. Only medications from the RUHS - Medical Center Drug Formulary and pharmacy approved non-formulary medications will be dispensed.

3.4. Additions, deletions, and/or changes to formulary medications will be reviewed periodically and as needed through the Pharmacy Review Committee to address the needs of the institution. These will be submitted to P&T and Medical Executive Committee (MEC) for approval.

3.5. P&T and MEC reviews and approves changes to formulary active ingredients, biosimilars of reference products, and routes of administration of formulary active ingredients. Review of the formulary will occur no less frequently than every 1 year.

3.6. The Department of Pharmacy reviews and approves changes to medication strength and/or dosage forms of formulary active ingredients and approved routes of administration.

3.7. Emerging safety, efficacy information, drug shortage disruptions, utilization or sustainability concerns will be discussed by Pharmacy Review Committee for consideration of specific formulary medication revision or formulary class revision.

3.8. Biosimilars of formulary reference products must be added to formulary prior to use. Reference products cannot be substituted to biosimilars unless:

a. The biosimilar is defined as an interchangeable by the FDA, or

b. The reference product and/or biosimilar is included in an automatic substitution policy and approved by P&T.

3.9. Extrapolation of indications approved for the reference biological product to completely different diseases and/or age groups will not be allowed without adequate preclinical, safety or efficacy data, and approval by P&T.

3.10. P&T may require a hospital-wide surveillance of a medication if there is a potential for an increased risk for a medication error for new active ingredients and/or new usage to an existing ingredient that are added to formulary. The hospital-wide surveillance must be in place to monitor for compliance and success with established safeguards for at least 6 months from the time of the addition. This evaluation will be initiated by the Department of Pharmacy and will be reviewed by P&T.

4. PROCEDURES

4.1. Adding or Deleting: Active Ingredients to Formulary or Routes of Administration of Active Ingredients on Formulary

a. Adding Active Ingredient: The requestor must be a Chief of Service, Director of the Department of Pharmacy, or designee. The requestor must complete and submit the formulary addition package to the Department of Pharmacy.

b. In the event of an emergency, such as critically low supply of medication or pandemic, an abbreviated formulary addition package will be accepted in lieu of the formulary addition package.

c. Adding Route of Administration of Active Ingredient on Formulary: The Department of Pharmacy will review route of administration addition requests

and may request for additional supportive documentation, such as a formulary addition package from the requestor.

d. The requestor, or designee, must appear at P&T meeting to present the request.

e. The Department of Pharmacy will provide a recommendation at the P&T meeting.

f. Deleting: The requestor must communicate to the Department of Pharmacy regarding recommendation to delete an active ingredient from formulary or delete a route of administration of an active ingredient from formulary. The recommendation must be accompanied with an explanation.

g. The recommendations of P&T will be submitted to the MEC for final approval.

h. Pharmacy systems will be updated to reflect additions/deletions approved by MEC.

i. If a request is denied, the requestor may ask to appear before the P&T to appeal the decision. Appealing a decision does not guarantee formulary addition or deletion.

4.2. Adding or Deleting Dosage Forms and/or Strengths of Active Ingredients on Formulary

a. The Department of Pharmacy will review and approve 1) Additions or deletions of dosage forms and strengths of active ingredients on formulary, and 2) Changes to restrictions or comments of formulary active ingredients.

b. The additions, deletions, and/or changes to the formulary will be submitted to P&T and MEC for retrospective review.

4.3. Non-Formulary Process

a. Active Ingredients Not On Formulary

i. Attending Physician, Senior Resident Physician, Director of Pharmacy or designee must complete and submit the non-formulary request. Non-formulary request may be submitted in electronic format.

ii. Approval is dependent upon medical necessity with the following criteria:

- Use of the medication for the specified indication is supported by medical literature (clinical guidelines, FDA approval, clinical trials, etc.), AND
- Use of formulary alternative(s) are inappropriate for the specific patient (hypersensitivity reactions, treatment failure at maximum tolerated doses, etc.), AND
- No significant interactions between the requested medication and other medications are present, AND
- The patient has the means to obtain and continue the medication on an outpatient basis if chronic, ongoing use is indicated.

iii. Submissions are reviewed by the Department of Pharmacy. For those at an excessive cost to the institution, approval must be received by the Chief Medical Officer or designee.

iv. Approvals: The medication will be procured (ordered or borrowed, if possible) by the pharmacy staff upon receipt of approved non-formulary request. Because the Department of Pharmacy does not stock non-formulary medications, an extended turnaround time might be expected.

v. Denials: The prescriber will be communicated the denial.

b. Active Ingredient on Formulary, but Dosage Form and/or Strength Not on Formulary

i. The Department of Pharmacy will approve or deny a request to procure and dispense dosage forms and/or strengths not listed on the formulary of approved active ingredients and approved routes of administration.

ii. The approved usage of these dosage forms and/or strengths will be considered for addition to formulary.

5. REFERENCES

5.1. TJC, Revision to: Elements of Performance for Medication Management, MM.02.01.01

5.2. Routes of Administration. US Food & Drug Administration. November 14th, 2017. https://www.fda.gov/drugs/data-standards-manual-monographs/route-administration

6. ATTACHMENTS

6.1. Formulary Addition Request Form

6.2. Non-Formulary Medication Request Form

Document History:

Release Dates: 12/28/15, 5/6/19, 2/12/2023		**Retire Date:**	
Sponsored by: Pharmacy Department		**Replaces Policy:** **HW 872 Biosimilars**	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
2/11/25	Pharmacy Review Committee		Narrow scope to inpatient Change 'is invited' to 'must appear' to P&T to request change to formulary 4.3 a. iii. Add For those at an excessive cost to the institution, approval must be received by the Chief Medical Officer or designee.
3/3/25	P&T	No	
4/1/2025	PAC	N	
4/10/2025	MEC	N	

Riverside University Health System—Medical Center, Pharmacy

Formulary Addition or Deletion Request

Return To: Pharmacy and Therapeutics Committee
Phone (951) 486-4523; email: d.garcia@RUHealth.org

Date: _____

Drug (generic): _____ Formulation: _____

Trade Name: _____ Route: _____

Strength: _____

☐ **ADDITION**	
Comparable Formulary Medication(s):	
Indications or situations in which request is superior to existing formulary medications:	
Therapeutic effectiveness compared to existing formulary medications:	
Risks (including propensity for medication errors, abuse potential, and sentinel events):	
Current formulary medications which may be deleted upon addition of the medication requested:	
Requested for use in the following settings:	
Restrictions (if applicable):	☐ Inpatient ☐ Outpatient ☐ Attending ☐ Sr. Resident ☐ Specialty (specify):
☐ **DELETION**	
Reason for deletion request:	☐ Unavailable (FDA removal; market or manufacturer removal) ☐ Ineffective or lack of evidence of therapeutic efficacy ☐ Replaced by alternative (improved efficacy or decreased ADRs) ☐ Replaced by alternative (equal efficacy but less expensive) ☐ No usage within last 18 months (does not include antidotes etc.)

Please list relevant references or studies that support the addition/deletion of this agent to the current formulary:

_____

_____

Potential conflict of interest disclosure:

I received financial or research support from the manufacturer: ☐Yes ☐No
I have a consulting agreement with the manufacturer: ☐Yes ☐No
I, my spouse, or dependent(s) have a financial interest in the manufacturer of this agent: ☐Yes ☐No

Request must be made by one of the following: Chief of Service, Attending Physician, or Pharmacy Directors

_____ _____
Print Name Department or Title

_____ _____
Signature Phone

PLEASE NOTE:
Requestor or designee will be invited to attend the Pharmacy & Therapeutics Committee meeting to discuss the addition of this medication to the formulary. If there is a potential for an increased risk for a medication error, a hospital-wide surveillance process must be in place to monitor for compliance and success with established safeguards for at least 6 months from time the medication is added to the formulary.

RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER
DEPARTMENT OF PHARMACY SERVICES

NON-FORMULARY MEDICATION REQUEST FORM

*Required Fields

Notes:

- Electronic version of form is available within EPIC
- Form is required for the following: medication/biosimilar not on formulary, routes of administration and indications not RUHS approved, non-formulary for inpatient setting, non-formulary for outpatient setting where medication is provided by inpatient pharmacy
- This is a non-formulary request only. It is not a medication order.

*Date _____

*Patient Name_____*MRN_____

*Medication, Dose, Route, Frequency: _____

*Indication for use: _____ *Estimated Duration of Therapy: _____

*Formulary alternatives and why inappropriate: _____

_____

Evidence to support use of requested medication in lieu of formulary alternatives for this indication (treatment guidelines, clinical trial(s), FDA approval, etc.): _____

_____

Attending Staff Physician, or Senior Resident Physician:

_____	_____	_____
*Printed Name	*Signature	*Date

RETURN TO THE PHARMACY AS SOON AS POSSIBLE TO REDUCE ANY DELAY IN MEDICATION ORDER PROCESSING.
Please note that if request is approved, it may take more than 24 hours for pharmacy to acquire the medication.

FOR PHARMACY USE ONLY:

Approval is dependent upon medical necessity with the following criteria:

1. Use of the medication for the specified indication is supported by medical literature (clinical guidelines, FDA approval, clinical trials, etc.), AND
2. Use of formulary alternative(s) are inappropriate for the specific patient (hypersensitivity reactions, treatment failure at maximum tolerated doses, etc.), AND
3. Use outweighs any interactions between the requested medication and current medications, AND
4. The patient has the means to obtain and continue the medication on an outpatient basis if chronic, ongoing use is indicated.

Reviewing Pharmacist (Antimicrobials, pediatric/neonatal medications, and chemotherapy shall be communicated to the corresponding clinical pharmacist.):

_____	_____	_____
*Printed Name	*Signature	*Date

Corresponding Clinical Pharmacist:

_____	_____	_____
Printed Name	Date	Method of Communication

Approving Senior Pharmacist:

_____	_____	_____
*Printed Name	*Signature	*Date

Last Updated: 11/7/22

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 870	Page 1 of 5
Title: Prevention and Management of Extravasation and Infiltration of Intravenous Drugs	**Effective Date:** 5/6/2025	☐ **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 Applies to all patients, including pediatrics, admitted in the inpatient areas, patients receiving treatment in the Emergency Department and Hospital-based clinics specifically the Infusion Center

1.2 Provide guidelines and standards in conjunction with current online Clinical Skills systems.

2. DEFINITIONS

2.1 Extravasation: Unintentional or inadvertent leakage (infiltration) of vesicant solution or medication out of a blood vessel into surrounding tissue.

2.2 Irritant: An agent that causes aching, stinging, tightness, and phlebitis with or without immediate external signs of vein inflammation but does not typically cause tissue necrosis. Irritants can cause necrosis if the infiltration/extravasation is severe or left untreated.

2.3 Vesicant: An agent that has the potential to cause blistering, severe tissue injury, or tissue necrosis when extravasated.

2.4 Non-vesicant: Solutions and medications that do not normally produce tissue damage when inadvertently delivered into surrounding tissue. May produce tissue damage in neonates and infants.

2.5 Infiltration: Inadvertent administration of a non-vesicant solution or medication out of a blood vessel into surrounding tissue.

2.6 Flare reaction: Local, nonpainful, possibly allergic reaction often accompanied by reddening of the skin along the vein

2.7 Phlebitis: Inflammation of a vein; may be accompanied by pain, erythema, edema, streak formation, and/or palpable cord.

2.8 Vessel Irritation: The tightness or pain felt along a vein during or after a chemotherapy drug was administered by I.V.

2.9 Central Vascular access Device (CVAD): A device that permits access to the central vascular system which includes central venous catheter (CVC), implanted port, peripherally inserted central catheter (PICC), and short- and long-term hemodialysis (HD) catheter with the tip residing in the superior vena cava (SVC) or inferior vena cava (IVC).

2.10 Vascular access device (VAD): Catheter, tube, or device inserted into the vascular system.

3. GUIDELINES

3.1 Nurses should be familiar with, and review evidence-based practice related to preventing extravasations/infiltrations by accessing current online clinical skills system.

3.2 Only those Registered Nurses (RN) who are chemotherapy competent may administer a vesicant-type cytotoxic agent.

3.3 **Identify the vesicant nature of a medication before administration.** Refer to available drug references and online drug references (e.g. LexiDrugs).

3.4 Use of a CVAD is a recommended precaution against drug extravasation. Use of a CVAD has several advantages, including high patient satisfaction, reliable venous access, high flow rates, and rapid dilution of the drug.

3.5 Collaborate with the Provider regarding placement of a CVAD, if indicated.

3.6 Give vesicant drugs via CVAD if possible, or into a confirmed patent I.V. site

3.7 When choosing a site, avoid areas of flexion because excessive movement increases the risk of extravasation.

3.8 Visually inspect IV site: assess the catheter access site for redness, tenderness, swelling, drainage, numbness, tingling, paresthesia, and pain

3.9 Ensure the securement of VAD to prevent displacement

3.10 Confirm patency of the VAD by aspirating for blood return and flushing the VAD

3.11 Do not rely on pump alarms to detect I.V. infiltration or extravasation, as these alarms are not intended to detect disruption of the fluid flow pathway.

3.12 Signs and symptoms of infiltration or extravasation may include:

a. pain, burning or blistering at the Intravenous (I.V.) site. Swelling, no blood return and decrease in I.V. flow or resistance felt during I.V. push may also be noted.

b. The full extent of the tissue damage from a vesicant may not be fully apparent for 1-4 weeks after extravasation.

4. INFILTRATION MANAGEMENT

4.1 At the first suspicion of infiltration, the infusion and I.V. fluids should be stopped.

4.2 A nurse may refer to RUHS online clinical skills system, e.g. Elsevier, for initial infiltration management.

5. EXTRAVASATION MANAGEMENT

5.1 Refer to clinical resources, e.g. LexiDrugs Online for extravasation antidote guidelines.

5.2 Notify the provider of extravasation and treat site promptly to reduce tissue damage, per provider's order.

5.3 See appendix for available RUHS formulary antidotes. Consult the pharmacist for guidance, as needed.

5.4 Immediate nursing interventions:

a. Stop the infusion immediately

b. Assess the extremity distal to the Vascular Access Device (VAD) for capillary refill, sensation, and motor function.

c. Do NOT flush the line.

5.5 Disconnect the IV tubing from the catheter, and needleless connector, if on CVAD.

a. Do NOT remove the non-coring needle.

b. Aspirate extravasated fluid to the extent possible.

- Do not aspirate extravasated contrast media

c. If administering an antidote to the extravasation site, do not remove or move the catheter to ensure delivery of the antidote to the extravasation site. When this has been accomplished, the catheter should then be removed.

5.6 Remove catheter/needle if an antidote is <u>not</u> going to be administered into the extravasation site.

a. Remove the catheter/needle after completing aspiration

b. The affected extremity should be elevated to encourage lymphatic reabsorption of the solution/medication.

c. Apply compresses, if ordered.

d. Mark the extravasation site (using a surgical felt pen, gently draw an outline on the skin of the extravasation area), and photograph the site

6. EXTRAVASATION DOCUMENTATION

6.1 Document the date and time, type of medication, size, and location of the VAD involved, and other elements under the IV Assessment flowsheet.

6.2 Upload photographs of affected site into the medical record per hospital policy.

6.3 Document a follow-up assessment in regular intervals for any pain, redness, swelling, ulceration or necrosis on the site, or any changes in appearance.

6.4 Follow institutional guidelines with reporting extravasation events.

6.5 Document all solutions and medications involved (name, dose, concentration) and method of administration (I.V. push, rate of infusion, type of pump)

6.6 Document the estimated amount of solution in the tissue.

6.7 Document patient/parent/legal guardian education/notification.

7. PATIENT EDUCATION

7.1 Educate the patient to immediately report any signs of infiltration and extravasation.

7.2 If Outpatient, teach the patient when to go to emergency department to seek additional medical care: the signs of ulceration and necrosis, worsening of pain,

swelling, development of paresthesia, and diminished range of motion of the fingers. Also instruct the patient on continuation of heat or cold applications at home, as per provider orders.

8. REFERENCES

8.1 Management of Drug Extravasations. *Lexi-Drugs.* UpToDate Lexidrug. UpToDate Inc. https://online.lexi.com. Accessed August 21, 2024.

8.1 HW 707 Patient and Workforce Photography

8.2 ACR Manual on Contrast Media 2020. ACR Committee on Drugs and Contrast Media.

8.3 Intravenous Therapy: Management of Extravasations. Elsevier. https://point-of-care.elsevierperformancemanager.com/skills/19633/extended-text?skillId=GNMS_60&virtualname=riversidecountyregionalmc-camorenovalley#scrollToTop. Accessed December 5, 2024.

9. ATTACHMENTS

9.1 RUHS Preferred Antidotes

Document History:

Prior Release Dates: 12/1987, 08/96, 04/97, 09/97, 03/00, 03/03, 10/06, 11/10, 9/5/17, 4/13/2021	**Retire Date:** N/A
Document Owner: Pharmacy Department, Chemo Quality of Care	**Replaces Policy:** Pharmacy A154, Nursing 703.02

Date Reviewed	Reviewed By:	Revisions Made	Revision Description
12/4/2024	Chemotherapy & Hazardous Drug Committee Radiology & Diagnostic Imaging Review	Yes	Changes made throughout the document
12/5/2024	Erin Lee, RN, MSN, CNS Peds/PICU	Yes	Minor w/ comments & questions. Added Elsevier reference
01/16/2025	Nursing P&P	Yes	Remove section for house-wide staff education as is done per dept. Update to consistent use of provider vs physician throughout.
02/11/2025	Pharmacy Review Committee	Yes	Minor grammar edits; add more examples to Table of antidotes: non-cytotoxic vesicants, epinephrine; clarify max dosing of dexarazoxane 2000mg/day
03/03/2025	P&T	No	
4/1/2025	PAC	No	
4/10/2025	MEC	No	

9.1 Available Preferred RUHS Formulary Antidotes

Preferred Antidote	Drug Examples	Preparation	Administration
Hyaluronidase	Vesicant, non-cytotoxic Potassium chloride, Nafcillin, parenteral nutrition (TPN), sodium bicarbonate, calcium solutions Vesicant, cytotoxic: VinBLAStine, VinCRIStine	Mix 0.1ml of 150unit/mL with 0.9mL of NS to have 15 units/mL. Use 150 unit/mL solution	Non-cytotoxic: Intradermal or SUBQ: Inject a total of 1 mL (15 units/mL) as five separate 0.2 mL injections (using a tuberculin syringe) around the site of extravasation; if IV catheter remains in place, administer through the infiltrated IV catheter; may repeat in 30 to 60 minutes if no resolution Cytotoxic: If needle/cannula still in place: Administer 1 to 6 mL (150 units/mL) into existing IV line; usual dose is 1 mL for each 1 mL of extravasated drug If needle/cannula was removed: Inject 1 to 6 mL (150 units/mL) subcutaneously in a clockwise manner using 1 mL for each 1 mL of drug extravasated or administer 1 mL (150 units/mL) as five separate 0.2 mL injections (using a 25-gauge needle) into the extravasation site.
Phentolamine	Norepinephrine, EPINEPHrine	Dilute phentolamine 5mg in 10 mL NS.	Dilute phentolamine 5 mg in 10 mL NS intradermal inject into the extravasation area as soon as possible after extravasation but within 12 hours.
Sodium Thiosulfate	Mechlorethamine, Cisplatin	Dilute 4mL of a sodium thiosulfate 10% solution into a syringe with 6ml of Sterile water for injection, resulting in 10 mL of $^1/_6$ molar solution.	Inject the $^1/_6$ molar sodium thiosulfate solution either into the existing needle/cannula or subcutaneously around the edge of the extravasation site using a tuberculin syringe, using a new syringe for each injection site.
Dexrazoxane	Doxorubicin	Dexrazoxane 500mg vial, reconstituted with sterile water and further dilute with Lactated Ringer's solution.	3 IV infusions over 1 to 2 hours through a different venous access location: 1,000 mg/m^2 within 6 hours, 1,000 mg/m^2 after 24 hours, and 500 mg/m^2 after 48 hours of the actual extravasation; maximum total dose of 2,000 mg/day on days 1 and 2 and 1,000 mg on day 3.
Nitroglycerin topical 2% ointment	EPINEPHrine	n/a	Apply a 1-inch strip to the site of ischemia to cover the affected area; may repeat every 8 hours as necessary. Alternative to phentolamine.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 903	Page 1 of 2
Title: Food from Outside	**Effective Date:** 5/6/2025	☐ **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 Food from Outside: Food not provided to patients as part of normal meal service by Food and Nutrition Services.

1.2 Therapeutic Diet: All diets except: Regular, transitional diets, (i.e. GI Soft diet, Full Liquid and Clear Liquid diets) and diets modified for patients' preferences or lifestyle choice (Vegan or Vegetarian).

2. GUIDELINES

2.1 Due to the potential for foodborne illness, Riverside University Health System - Medical Center discourages visitors from bringing patients food from outside.

2.2 When made aware of a request to consume food from outside, the responsible provider writes an order in the medical record that grants permission for the patient to consume food from the outside, taking into consideration the patient's diet and medical condition.

2.3 Nursing staff or dietitian will educate the patient and family/visitors regarding hospital guidelines for safe food handling practices.

a. Food from outside must be ready to eat. No cooking of food items is allowed at RUHS – Medical Center.
b. Perishable food items should not remain at the bedside for longer than two hours.
c. RUHS – Medical Center does not provide refrigeration/reheating services for food from the outside.

2.4 Nursing staff may request a consult from Nutrition Services for the purposes of family and/or patient education.

2.5 Nursing staff will document oral intake in the patient's medical record.

3. REFERENCES

3.1 RUHS – Medical Center policy FNS 2003 Nutritional Screening and Assessment

3.2 Title 22, 70273 Dietetic Services General Requirements

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
7/10//2024	Director & Assistant Dir of Nutrition Services	No	No changes
9/9/2024	Assistant Dir of Nutrition Services and Nurse Education Instructor	Yes	Minor changes
11/21/2024	Nursing Policy & Procedure Committee	Yes	Specify that provider will document IF made aware
1/2025	PAC	Yes	Add prohibition on staff using microwaves to reheat outside food for patients