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

ITEM: 18.1
(ID # 29880)
MEETING DATE:
Tuesday, March 03, 2026

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 2/3/2026

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Medina, 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:	March 3, 2026
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: 25/26	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

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

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

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

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

Impact on Residents and Businesses

The RUHS Medical Center offers a 439-bed facility 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.

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

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 revised October 21, 2025, Item 18.2, ID 29056. During the first quarter of Fiscal Year 2025/2026 there were a total of four existing policies that were revised, as well as the addition of four new policies. The details of both the revised policies and new policies are summarized within Attachment A.

ATTACHMENTS:
Attachment A: RUHS Policy Summary 07.01.25 to 09.30.25
Attachment B: RUHS Policies 07.01.25 to 09.30.25

Jacqueline Ruiz, Principal Analyst 2/25/2026

Gregg Gu, Chief Deputy County Counsel 2/4/2026

RUHS-Medical Center Housewide Policies Quarter 1, FY25/26

#	Name	Version Effective Date	Additions, Revision or Correction
1	HW 200 Financial Assistance Programs	7/10/2025	**Revision Summary:** Minor changes helping to clarify qualification for the RUHS Financial Assistance Program. _____ **Revision Details:** 4.12 Added i. If patient failed to provide information that is necessary to determine eligibility, it may may be considered failure to comply and ineligible for Financial Assistance/Charity Care 4.14 Removed 4.14 C. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program Added b. Determination of Eligibility requirements Application for Financial Assistance/Charity Care I. copy of picture identification II. Proof of Family income (recent paystubs or income tax returns), III. Statement of support if there is no income IV. Patient may apply for Financial Assistance/Charity Care at any time. f. Added: Phone # 877-501-5085 Added: Assistant Director contact
2	HW 501 Waste Disposal at Point of Origin	7/10/2025	**Addition Summary:** New policy written to assist in keeping RUHS-MC compliant with medical waste management regulations.

3	HW 614 Visitation Rights and Safety of Patients	7/10/2025	**Revision Summary:** Non substantive changes addressing supervision, restrictions and hygiene guidelines specific to visitation. _____ **Revision Details:** Add section 1.1 policy statement for welcoming family as care partners. Update visitor restrictions to CHA manual (2023) Add section 1.9 (h-k) visitor guidelines. Add supervision of children requirement. Request to add PPE instructions for visitors to patients on isolation, and instructions to follow hand hygiene guidelines. Request confirmation of sick visitor policy and visitor badge policy. Delete reference to expired regulatory COVID guidance. Grammatical suggestions. Add section saying all visitors to all incarcerated patients (not just in DCU) must be approved by RUHS Admin. Separated out Cal State and Riv Co Sheriff procedures. Generalized CIW patients with 'pregnant patients' and 'law enforcement partners".
4	HW 627 Abuse Trafficking Victim Request for Assistance	9/24/2025	**Addition Summary:** New policy to identify patients who are trafficking victims.
5	HW 628 Moderate Procedural and Deep Sedation	7/16/2025	**Revision Summary:** Major formatting and policy revisions specific to sedation, as it relates to post procedure transport and discharging of patients. _____ **Revision Details:** Major revisions to format and section details. Updated dosing table. Add post procedure transport. Specify post procedure assessments and discharge criteria. Update references, redefine minimal anxiolysis Update dosing table with ISMP text recommendations Minor wording change, specify nursing competency Provider Credentialling & Nursing competency requirements for independent administration and monitoring of moderate sedation. Define ketamine as deep sedation Add NICU/PICU intensivists to 6.1 7.2a add known or suspected difficult airway (safe patient selection)

6	HW 678 Blood Transfusions	8/18/2025	**Revision Summary:** Non substantive changes regarding the blood refrigerators. _____ **Revision Details:** The main reason for this change in HW 678 is due to go-live of the blood refrigerators. This is found on section 3.4 of the policy – Dispensing of Blood/Blood Components with a blood refrigerator attachment 5.3 Nurse requirements change and clarification of the workflow is found in 3.3b – there is not a regulatory requirement for verification by 2 staff members
7	HW 681 Guidelines for Blood Culture Collection	9/2/2025	**Addition Summary:** New policy to improve blood culture collection.
8	HW 1094 Electronic Communications Usage and Retention Policy	8/15/2025	**Addition Summary:** New policy for retention of communication.

RUHS-Medical Center Policies Approved 07/01/25 through 09/30/25

#	Name	Version Effective Date
1	HW 1094 Electronic Communications Usage and Retention Policy	8/15/2025
2	HW 200 Financial Assistance Programs	7/10/2025
3	HW 501 Waste Disposal at Point of Origin	7/10/2025
4	HW 614 Visitation Rights and Safety of Patients	7/10/2025
5	HW 627 Abuse Trafficking Victim Request for Assistance	9/24/2025
6	HW 628 Moderate Procedural and Deep Sedation	7/16/2025
7	HW 678 Blood Transfusions	8/18/2025
8	HW 681 Guidelines for Blood Culture Collection	9/2/2025

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 200	Page 1 of 10
Title: Financial Assistance for Low Income, Uninsured/Underinsured Patients	**Effective Date:** 7/10/2025	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☒ **Procedure** ☒ **Guideline**

1. PURPOSE

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

1.2 This policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, January 1, 2015 and January 01, 2025 (SB 1276), and United States Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance/Charity Care. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance program.

1.3 The financial screening criteria in this policy are based primarily on the Federal Poverty Level (“FPL”) guidelines updated periodically by HHS in the Federal Register.

2. SCOPE

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

3. DEFINITIONS

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

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

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

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

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

    i. Serious impairment to bodily functions; or

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

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

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

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

3.5 **High medical cost patient**; that exceed 10% of their family income in the prior 12 months. Out-of-pocket costs include expenses for medical care not reimbursed by insurance or health coverage programs, such as Medicare copays or Medi-Cal cost-sharing. Annual out-of-pocket expenses that exceed 10% of their family income, if they provide documentation of medical expenses paid by the patient or their family in the prior 12 months. This also refers to expenses not covered by insurance or other health coverage

a. Have a family income at or below 400% of the Federal Poverty Level (FPL).

b. Not be already receiving a discounted rate as a result of their insurance coverage. This means that even if a patient has insurance, if that insurance doesn't provide a significant discount, they may still qualify based on their income and medical expenses

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

3.6 **Medically necessary service**: A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted,

3.7 **Patient's family:** For all patients, regardless of age: Includes all dependent children, irrespective of their age. For non-minor patients who are dependent children: Includes the parents of the patient.
For dependent children under 21 years of age: Includes dependent children under the age of 21 years, whether living at home or not.
For patients under 18 years of age: Includes the patient's parent, caretaker relatives (as defined below), and other children under 21 years of age of the parent or caretaker relative.

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

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

a. No third-party coverage.

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

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

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

A. POLICY

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

4.2 Patients with demonstrated financial need may be eligible if they satisfy the definition of a financial assistance patient or high medical cost patient as defined in section 3.9 of this document.

4.3 This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases.

4.4 Throughout RUHS – Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with RUHS – Medical Center legal counsel.

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

4.6 This policy will not apply if the patient/responsible party provides false information regarding financial eligibility.

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

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

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

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

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

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

4.13 Departmental Responsibilities

a. The RUHS - MEDICAL CENTER Financial Assistance shall be reviewed and updated to reflect the current Federal Poverty Level Guidelines (Attachment 6.3).

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

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

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

    i. If patient failed to provide information that is necessary to determine eligibility, it may may be considered failure to comply and ineligible for Financial Assistance/Charity Care program.

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

iii. Individuals with household incomes exceeding 400% of the Federal Poverty Level (FPL) are ineligible for Financial Assistance.

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

i. Notice (Attachment 6.2) that provides information about the patient may be eligible for a government-sponsored program or for the RUHS – MEDICAL CENTER Financial Assistance Program. This notice will be posted in areas throughout the hospital.

4.14 Customer Service

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

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

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

4.15 Eligibility

a. Patients with income at or below 100% of the federal poverty level are eligible for RUHS – MEDICAL CENTER Free Charity Care Program. Patients with combined income at or below 400% of federal poverty level and are uninsured or underinsured will be eligible to apply for the RUHS – MEDICAL CENTER (discount payment) Financial Assistance Program

b. Determination of Eligibility requirements

i. Application for Financial Assistance/Charity Care

ii. Copy of picture identification

iii. Proof of Family income (recent paystubs or income tax returns)

iv. Statement of support if there is no income

v. Patient may apply for Financial Assistance/Charity Care at any time.

c. Commercial Insurance deductible, Hospital may waive or reduce Medi-Cal and Medicare cost sharing amounts as part of its Charity Care Program or discount payment program.

d. Co-Insurance does not constitute being underinsured.

e. Patients applying for the RUHS - MEDICAL CENTER Financial Assistance Program, who are denied eligibility have the right to file an appeal within 10 days. A patient has 10 days from the date that the county mailed or provided written Notice of Action (NOA). An appeal may be made by the patient contacting the RUHS - MEDICAL CENTER - MISP office 877-501-5085 to make an appointment with the appeals supervisor or Assistant Director.

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

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

4.16 Documentation Includes:

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

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

c. Copy of the application form

d. Copy of the approval or denial letter

4.17 Coverage Restrictions

a. Outpatient prescriptions are not covered under the RUHS- MEDICAL CENTER Financial Assistance Program. Elective or cosmetic Surgery must be deemed medically necessary to be covered under this policy.

4.18 Billing

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

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

c. For patients qualifying for discounted payments (household income at or below 400% FPL), the expected payment will not exceed the greater of the expected Medicare or Medi-Cal reimbursement. If no such rate exists for a service, an appropriate discounted payment will be applied. Eligible patients are not required to participate in independent dispute resolution.

d. The hospital will provide an extended payment plan to patients who qualify for discounted payments or charity care, allowing for the payment of the discounted price over time. The terms of the payment plan will be negotiated between the hospital and the patient or their legal representative, considering the patient's family income and essential living expenses. If the hospital and the patient cannot agree on the payment plan terms, the hospital will apply a reasonable payment plan based on the formula defined in California Health and Safety Code Section 127400(i). California Code, Health and Safety Code

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

f. If a patient or guarantor fails to make all consecutive payments as required by their established extended payment plan for a period exceeding 90 days, the extended payment plan may be declared inoperable. Before declaring the plan inoperable, the hospital or its representative must try to contact the patient by phone to discuss missed payments and offer to renegotiate the plan. A written notice must also be sent at least 60 days after the first missed payment, informing the patient the plan may become inoperative and offering renegotiation. This notice must give the patient at least 30 days to make a payment. If these attempts are unsuccessful and the plan is declared inoperative, the patient's responsibility is limited to the previously determined discounted amount, and they receive credit for payments made. Adverse credit reporting or civil action cannot begin until after the plan is declared inoperative.

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

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

REFERENCES

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

5.2 MISP policy number MISP 10

5.3 MISP policy number MISP 14

5.4 MISP policy number MISP 20

5.5 MISP policy number MISP 21

5.6 RUHS - CHC 112 Sliding Fee Discount Policy

ATTACHMENTS

6.1 RUHS – Medical Center Financial Assistance Statement

6.2 RUHS – Medical Center Financial Assistance Notice

6.3 Federal Poverty Guidelines

Document History:

Prior Release Dates: 11/13/2017, 5/22/2019, 4/1/2022, 1/17/2023, 9/11/2024, 01/01/2025	**Retire Date:** N/A
Document Owner: MISP	**Replaces Policy:** MISP Policies No. 204.2 and 204.3

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
1/1/2025	Policy Approval Committee	N	4.12 Added i. f patient failed to provide information that is necessary to determine eligibility, it may may be considered failure to comply and ineligible for Financial Assistance/Charity Care 4.14 Removed 4.14 C. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program Added b. Determination of Eligibility requirements Application for Financial Assistance/Charity Care I. copy of picture identification II. Proof of Family income (recent paystubs or income tax returns), III. Statement of support if there is no income IV. Patient may apply for Financial Assistance/Charity Care at any time. f. Added: Phone # 877-501-5085 Added: Assistant Director contact
8/1/2025	Minor typo/corrections		

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

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

These programs include, but are not limited to:

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

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

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

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

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
26600 Cactus Ave 1st M1047
Moreno Valley CA, 92555
877-501-5085

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

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

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

These programs include, but are not limited to:

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

877-501-5085

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

ATTACHMENT 6.3

Annual 25/26 Poverty Guidelines

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

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 501	Page 1 of 5
Title: Waste Disposal at Point of Origin	**Effective Date:** 7/10/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center**
Approved By:  Jennifer Cruikshank CEO/Hospital CEO		☒ **Housewide** ☐ **Departmental** ☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. **PURPOSE:** To communicate medical waste disposal requirements to all workforce members.

2. **DEFINITIONS:**

2.1 **Biohazardous Waste:** Waste that may contain bloody (liquid, semi-liquid) or infectious substances or other materials that are dangerous to public health or the environment.

2.2 **Commingled sharps and pharmaceutical waste:** Sharps and non-hazardous pharmaceutical waste in a single container.

2.3 **Empty:** A container is considered empty when no material can be poured or scraped.

2.4 **Medical Waste:** Includes biohazardous, pathology, pharmaceutical, sharps, and chemotherapy waste generated in healthcare settings.

2.5 **Medical Waste Management Plan:** The plan, required by the California Medical Waste Management Act, that details how medical waste is handled, stored, treated, and disposed of.

2.6 **Pathology Waste:** Human body parts removed during surgery or autopsy, excluding teeth.

2.7 **Pharmaceutical Waste:** Remainder, partially used, or medications that cannot otherwise be returned to pharmacy.

2.8 **RCRA:** The Resource Conservation and Recovery Act

2.9 **RCRA Waste:** Waste that is toxic, flammable, reactive, or corrosive, usually

2.10 **Sharps Waste:** Needles, syringes with needles, blades, and similar items capable of cutting or piercing.

2.11 **Sharps Container:** Rigid, puncture-resistant container for sharps disposal.

2.12 **Soiled Linen:** Any fabric that has been in contact with a patient's body, body fluids and/or excreta.

2.13 **Trace chemotherapeutic waste:** waste that is contaminated through contact with, or having previously contained, chemotherapeutic agents.

**RUHS - Medical Center includes Arlington Campus, unless Arlington Campus is specifically excluded in the scope section.*

2.14 **Universal Waste:** hazardous waste that was determined to pose a lower immediate risk to people and the environment compared to other hazardous wastes.

2.15 **Waste Management Stream Guide:** The attached reference guide showing designated waste for each waste container.

2.16 **Workforce Members:** any regular employee, temporary assistant 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 – Medical Center, is under the direct control of, whether or not they are paid by RUHS – Medical Center.

3. POLICY

3.1 RUHS-Medical Center shall comply with all medical waste disposal regulations.

3.2 Workforce members shall properly dispose of waste in designated containers as detailed in Attachment: Waste Management Stream Guide.

3.3 Environmental Services must maintain a Medical Waste Management Plan, as required in the Medical Waste Management Act.

4. WASTE SEGREGATION PROCEDURES

4.1 General considerations:

a. Workforce Members shall always follow standard precautions when disposing of waste as per RUHS Policy HW 1100 Standard Precautions.

b. Double bagging should be performed if contamination occurs or if bag integrity is compromised.

c. All patient information should be deidentified before disposal in unsecure or open disposal containers.

d. Liquid waste (body fluids), including contents of suction canister, may be disposed of in a toilet or hopper, including liquid blood. If the fluid vessel contained blood, dispose of it in biohazardous waste. Containers without blood may be placed in regular waste.

e. Unused units of blood or blood products must be returned to the clinical laboratory.

f. RCRA and Universal Waste containers must be dated by the department using them. The date noted on the container must be the day that the first item is disposed of in the container.

g. When containers are ¾ full, departments must contact EVS for disposal and replacement.

4.2 Biohazardous Waste:

a. Discard biohazardous waste in a red biohazard bag at the site of origin.

b. Place in puncture-resistant, covered containers labeled "BIOHAZARDOUS WASTE" with two exceptions, as per the Medical Waste Management Act:

i. Medical waste may be placed into a biohazard bag not to exceed three pounds weight or one gallon volume and tied in a patient room and shall be immediately transported upon completion of the procedure directly from the point of generation and placed into a biohazard container stored in a soiled utility room or other biohazardous waste storage area without having first been placed into a secondary container in the patient room.

ii. Medical waste may be placed into a biohazard bag hung on a hamper stand in a surgery suite and the bag removed from the hamper stand after completion of the procedure, taken out of the surgery suite, and placed into a biohazard container stored in a soiled utility room or other biohazard waste storage area.

- Reference ‘biohazardous waste’ section of the attached Waste Management Stream Guide for more details.

4.3 Commingled sharps and pharmaceutical waste:

a. RUHS – Medical Center utilizes containers that can comingle sharps and non-hazardous (Not-RCRA and not-Chemo categorized) pharmaceuticals.

b. Withdraw remaining contents of partially used medication vials or ampules with a syringe prior to disposal in bin. Expel liquid contents from the syringe into the waste bin.

- Reference ‘commingled sharps and pharm only’ section of the attached Waste Management Stream Guide for more details.

4.4 Trace chemotherapeutic waste

a. Place all chemotherapeutic waste in the yellow Trace Chemotherapy Waste container.

- Reference ‘chemo waste’ and ‘RCRA’ sections of the attached Waste Management Stream Guide.

4.5 Regular Waste. Reference ‘regular waste’ section of attached Waste Management Stream Guide for more details.

4.6 The Resource Conservation and Recovery Act (RCRA) Waste:

a. Place RCRA in black RCRA bins.

- Reference RCRA Waste section in the attached Waste Management Stream Guide for more details.

4.7 Recycling

a. Place all paper items that can identify a patient into the designated locked recycling bin as per RUHS policy HW 700 Patient Privacy HIPAA.

- Reference the 'recycling' section in the attached Waste Management Stream Guide for more details.

4.8 Universal Waste

a. Place in green universal waste container as per the attached Waste Management Stream Guide.

4.9 Soiled Linen

a. Place soiled linen in soiled linen hamper as per the attached Waste Management Stream Guide.

b. Remove disposable items, and trash from linen before placing in soiled linen hamper.

4.10 Pathology Waste: Please refer to the Medical Waste Management Plan and the RUHS Departmental Policy LAB 9.4 Disposal of Laboratory Waste.

5. ATTACHMENT

5.1 Waste Management Stream Guide

6. REFERENCES

6.1 RUHS HW 865 Hazardous Drug Spill Deactivation and Waste Management
6.2 RUHS Policy HW 1100 Standard Precautions
6.3 RUHS Policy HW 1105 Bloodborne Pathogen Exposure Prevention Plan
6.4 RUHS Departmental Policy EVS 011 Infectious Waste Handling
6.5 RUHS Departmental Policy OR Sharps Safety
6.6 RUHS Departmental Policy LAB 9.4 Disposal of Laboratory Waste
6.7 RUHS Departmental Policy LAB 9.5 Disposal Policy for Formalin, Xylene, and Clear-Rite 3 in Histology, Surgical Pathology, and the Morgue.
6.8 RUHS Nursing Department Policy 703.01 Chemotherapy (Tier 1 – Antineoplastic HDs) and Immunotherapy Administration.
6.9 Medical Waste Management Act (MWMA). California Health and Safety Code SECTIONS 117600-118360
6.10 Code of Federal Regulations 40 CFR 265.173 (a), 29 CFR 1910.1030 (d)(4)(iii), 29 CFR 1910.1030 (d)(4)(iii)(A)(3) and (i), 29 CFR 1910.1030 (d)(4)(iii)(A)(2)(i) 29 CFR 1910.145(e)(4), 49 CFR 173.24 (f)
6.11 California Health and Safety Code Title 22, Div 5, Chapter 1, Article 8

Document History:

Prior Release Dates: New		**Retire Date:** N/A	
Document Owner: EVS Manager		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Suggested Revisions Y/N**	**Summary of Owner Accepted Revisions**
2/2025	Chief Clinical Integration Officer	Y	
2/2025	Chief Nursing Officer	Y	
3/3/2025	Infection Prevention and Control Manager	Y	
3/3/2025	Executive Director, Perioperative Services	Y	
3/3/2025	Code Team & Sepsis Program Coordinator	Y	
3/3/2025	Clinical Director of Nursing Unit 3500/General Surgery Acute Unit (3C)	Y	
3/3/2025	Director of Pharmacy	Y	
3/3/2025	Clinical Director of Nursing Unit 4500	Y	
3/4/2025	PAC	Y	Modify def'n 2.1 biohaz. – to focus on blood/blood stream infection risk. Name attachment as "Guide". Clarify 4.1c – deidentification for unsecure containers. Requested additions to the attachment guide: add breastmilk, suction canisters with contents, non-blood body fluids

WASTE STREAM GUIDE

Red Biohazard Bin

Remove or Identi-hide PHI

- Blood tubing/bags
- Blood-soaked dressing/Chux/PPE
- Vials of blood
- Syringes of blood without needles
- Suction canisters with any blood
- Drains with fluid
- Biohazard specimen bags

Any question, please call:

Safety office: 64689

Infection Control: 64690

EVS: 65480

Pharmacy: 64502

Commingled Sharps and Pharmaceutical Bin

- Needles
- Scalpels
- Forceps
- Medical pins
- Trocars/guidewires
- Staple removers
- Razor blades
- Glass ampules
- Lancets
- Broken rigid plastic
- Glass Slides
- Syringe flush/ medication
- IV bags and tubing
- Medication vials
- Medications
- Narcotic patches
- Medication cups with syrup/residue
- Any vacutainer device
- Syringe with needle containing blood.
- Med Neb medication cup

Regular Waste Bin

Remove or Identi-hide PHI

- Paper, wrappers
- Bath basins, cups, toothbrushes
- Non bloody dressings
- Infant and adult diapers
- Sanitary napkins
- Empty irrigation bottles (water, saline)
- PPE
- Disposable respiratory circuits & equipment
- Suction canisters without blood (e.g., urine, gastric contents, sputum)
- Breast milk, pumping supplies and tubing
- Pill cups (no residue)

Trace Chemo

Antineoplastics

All supplies used to make and administer chemo medication:

- Tubing, empty bags/bottles/vials, syringes, gloves, masks, gowns, wipes, etc.
- Chemo Sharps are Only to be placed in 2-gallon Yellow Chemo sharps container.
- Contact the pharmacy to pick up all unused/unopened chemotherapy.

Soiled Linen

- All linens regardless of amount or type of soil
- Remove all tape and disposable items.

Accumulation Date Required

RCRA Waste

Toxic, Corrosive, Ignitable, Reactive Waste

- Epinephrine
- Nitroglycerin
- Warfarin
- Inhalers
- Barium
- Nicotine patches/gum
- Birth control pills
- Zinc oxide, silver nitrate
- Medications in a container under pressure
- Chemo (*only when chemo left in infusion bag, NOT TRACE in tubing*)
- Insulin
- Topical Gel with alcohol > 24%
- Med Neb Inhalant

Accumulation Date Required

Universal Waste

- Batteries

Updated 3-2025

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 614	Page 1 of 6
Title: Visitation Rights and Safety of Patients	**Effective Date:** 7/10/2025	☐ **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. POLICY

1.1 Riverside University Health System (RUHS) welcomes the presence and participation of family and other "partners in care" according to the patient preference and conduct expectations which support front line staff in providing care safely and efficiently with families present.

1.2 Patients have the right to designate a representative and have visitors, as per RUHS Policy HW 601 Patient Rights and Responsibilities and Title-22, Patient Rights.

a. Patients have the right to designate, withdraw or deny his/her consent to receive specific visitors, either orally or in writing.

b. In the event the patient is a minor, the parent or legal guardian of the minor shall designate the individuals permitted to visit the minor patient.

c. A patient may designate a support person (this person does not have to be the same person as the patient's legal representative). The support person, when the patient is incapacitated, may exercise the patient's visitation rights on their behalf.

d. If a legal representative and support person who are not the same individual disagree on who should be allowed to visit the patients, the legal representative will retain decision making authority.

1.3 Patients, legal representatives or support persons will be provided with the required notice of patient's visitation rights.

1.4 Visitation is not restricted, limited or otherwise denied on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

1.5 For patients who are incapacitated or otherwise unable to communicate who should be present, there is no advanced directive designating a representative on file, or when there is no obvious significant other, such as a spouse or life partner, or parent or adult child, hospital staff make the most appropriate decisions possible under the circumstances.

a. In the absence of an advanced directive, power of attorney or similar document, or oral designation by the patient; there is no relational hierarchy to whom should be chosen as a surrogate/representative. The surrogate should demonstrate special care and concern for the patient, is familiar with the patient's personal values and beliefs to the extent known and is reasonably

available and willing to serve. The hospital will accept assertions as a patients representative without supporting documentation.

b. In situations where more than one individual claims to be the patients representative it is appropriate for the hospital to ask each individual for documentation including but not limited to proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates familiarity with the patient's preferences concerning medical treatment.

   i. A refusal by the hospital of an individual's request to be treated as the patient's support person with respect to visitation rights must be documented in the patient's medical record, along with the specific basis for the refusal.

1.6 Visitor Restrictions (RUHS may restrict visitation in the following circumstances):

a. No visitors are allowed.

b. Infection control issues.

c. RUHS reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility.

d. The facility reasonably determines that the presence of a particular visitor would significantly disrupt the operations of the facility.

e. The patient has indicated to RUHS staff that the patient no longer wants this person to visit.

f. Visitation may interfere with the care of other patients.

g. The hospital is aware that there is an existing court order restricting contact.

h. Visitors engage in disruptive, threatening or violent behavior of any kind.

i. The patient or patient's roommate(s) need rest or privacy.

j. In the case of inpatient substance abuse treatment program, there are protocols limiting visitation.

1.7 Visiting hours:

a. General visiting hours will be from 10:00 AM - 8:00 PM.

b. Nursing departments with respect to support persons/partners in care may authorize overnight visitation and/or 24 hours a day presence according to patient preference.

c. Due to the critical nature of intensive care units, the number of visitors at the bedside may be limited.

1.8 General visitor guidelines:

a. All partners in care, and any guests of a patient, should be free of communicable diseases and must respect the hospital's infection control policies.

b. Visitors will be issued a visitor badge at the designated points of entry. Visitors will only be allowed in the patient care area/area specified on their

badge. Badges must be renewed at entry points every 24 hours (or when visibly VOID). Badges must be worn at all times.

c. Children aged 12 and above may visit and must always be accompanied by a responsible adult while in the facility. Children under 12 generally may not visit, exceptions are made with the approval of the Healthcare Team, Nursing Director or designee, or Nursing House Supervisor.

- Children must be developmentally capable to adhere to infection control practices such as wearing personal protective equipment.
- In cases where a patient is in critical condition or undergoing specific treatments, visitation by children may be restricted or require special arrangements (examples include, new life alerting illness/injuries, patients who are immunocompromised, patients at end of life).
- Child Life Specialists may be requested to meet with children as necessary to ensure the safety and well-being of the child prior to the visitation.
    - An appointment, preferably 24 hours in advance, is recommended.

d. Clergy registered with the hospital may visit at any time at the request of the patient and/or at the discretion of the Health Care Team.

e. Visitors are always required to wear clothes and shoes.

f. Smoking is NOT allowed anywhere inside the building and is permitted in designated areas only outside the building.

g. Furniture will be used only as intended.

h. The healthcare team will provide guidance about:

i. How to partner to ensure safe quality care

ii. How to be involved in care and how to support the patient during the hospital stay and during transition to community or home care

iii. How to honor privacy and be respectful of other patients and families in close proximity.

i. The number of people welcomed at the bedside at any one time will be determined in collaboration with the patient and family. In situations where there are shared rooms, this negotiation will include the other patient, his or her family, and other partners in care.

j. Families are encouraged to designate a spokesperson to facilitate effective communication among extended family members and hospital staff.

k. Hospital Staff will monitor visitor compliance with infection control standards and address any non-compliance promptly.

l. Disruptive behavior and unsafe practices are not acceptable; these situations, while usually rare, will be addressed directly and promptly.

1.9 Visitors to Incarcerated Patients

a. On Duty Nursing House Supervisor will be responsible for approving all visitors for incarcerated patients. Incarcerated patients who are admitted to patient care areas outside the DCU will not be allowed visitation without prior approval. (Special circumstances may be taken into consideration, such as end of life). No visitation will occur without the prior knowledge of the law enforcement agency responsible for the custody of the patient.

b. Visitors to incarcerated California Department of Corrections patients may only be granted by the Warden's office based on the patient's acuity/emergent nature of the hospitalization.

    i. Written approval must be provided to RUHS administration for review and approval prior to the anticipated visitation date.

c. Riverside County Sheriff's Department (RSD) incarcerated patient visitation may only be granted by RSD administration and/or the DCU supervisor.

    i. Written approval must be provided to RUHS administration prior to the anticipated visitation date.

d. Any other law enforcement agency with an incarcerated patient will be required to follow the same processes as listed above.

e. Officers charged with guarding an incarcerated patient should have information about whether visitation is allowed and by whom.

f. Visiting will be conducted in as accommodating a manner as possible in keeping with the need to maintain order, safety of persons, the security of the medical facility, and required custodial and medical activities. Failure to comply with the established regulations and policies may result in a warning, termination, suspension, or revocation of visiting privileges at RUHS – Medical Center.

1.10 Inmates in Labor

a. Incarcerated women in labor may choose to have a support person present during labor, childbirth, and postpartum recovery while hospitalized as approved by the warden.

b. RUHS - Medical Center, in cooperation with its law enforcement partners, offers pregnant inmates the opportunity of a Birth Coach to assist in the labor and delivery process.

c. All Birth Coach arrangements must follow the same guidelines set forth in section 2.10.

d. Any visitor acting as the Birth Coach for an incarcerated patient must follow the established process and guidelines for the responsible law enforcement agency.

e. After the delivery of the newborn, no other visiting privileges will be extended to visitors unless prior written approval is received as described in section 2.10.

f. Visiting will be conducted in as accommodating a manner as possible in keeping with the need to maintain order, safety of persons, the security of the medical facility, and required custodial and medical activities. Failure to comply with the established regulations and policies may result in a warning, termination, suspension, or revocation of visiting privileges at RUHS – Medical Center.

g. Upon Warden's approval and review of the inmate's Central File, the reviewing authority will note on the "Request for Authorization of Temporary Removal for Medical Treatment" (CDCR 7252) the Birth Coach's name and identification, which the custody officer at RUHS – Medical Center will use to identify the approved Birth Coach. Upon the Birth Coach's arrival to RUHS – Medical Center, the custody officer will provide this information to RUHS – Medical Center staff.

h. If the inmate/patient does not have an approved Birth Coach, there is NO visitation.

1.11 Patient Complaints. If any patient of RUHS – Medical Center believes that his or her patient visitation rights have been violated, they may file a complaint using RUHS – Medical Center internal grievance system as described in RUHS policy HW 649 Complaints and Grievances.

1.12 Injuries Involving Visitors. If an incident occurs involving a visitor, with or without injuries, it will be handled in accordance with RUHS policy HW 122 Incident Reporting.

2. REFERENCES

2.1 Institute for Patient- and Family-Centered Care. (2017). Advancing the practice of patient and family centered care in hospitals. Institute for Patient- and Family-Centered Care.

2.2 Visitor Limitation Guidance at General Acute Care Hospitals. (GACHs), AFL 21-31.1 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-31.aspx

2.3 Department of Health & Human Services (DHHS), CMS Manual; Hospital Interpretive Guidelines for Hospitals

2.4 2011 State of California, California Code of Regulations Title 15.

2.5 HW 145 Animals in the Hospital

2.6 RUHS Policy HW 601 Patient Rights and Responsibilities

2.7 RUHS Policy HW 649 Complaints and Grievances

2.8 RUHS Policy HW 556 Patient Visitor Conduct

2.9 Crime Prevention and Corrections; January 2015

2.10 Penal Code Sections 3408 and 4203.8

Document History:

Prior Release Dates: 12/19/91, 2/22/03, 8/3/11, 9/21/2016; 9/3/19; 8/17/2021		**Retire Date:** N/A	
Document Owner: Nursing Administration		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
07/11/2024	Nursing Admin	Y	Add section 1.1 policy statement for welcoming family as care partners. Update visitor restrictions to CHA manual (2023) Add section 1.9 (h-k) visitor guidelines. Add supervision of children requirement.
7/9/2024	Infection Prevention and Control Manager	Y	Request to add PPE instructions for visitors to patients on isolation, and instructions to follow hand hygiene guidelines. Request confirmation of sick visitor policy and visitor badge policy.
7/9/2024	Nurse Coordinator, Regulatory Compliance and Accreditation	Y	Delete reference to expired regulatory COVID guidance. Grammatical suggestions.
7/9/2024	Sgt, Riverside County Sheriff	Y	Add section saying all visitors to all incarcerated patients (not just in DCU) must be approved by RUHS Admin. Separated out Cal State and Riv Co Sheriff procedures. Generalized CIW patients with 'pregnant patients' and 'law enforcement partners".
7/9/2024	Quality Outcome Coordinator, Patient Safety Officer	Y	Suggest to define: Patient Support Person, and Minor. Suggest removing language referring to 'legal' relationship with patient. Raised concern about 'clinical reasons for visitation denial'. Addition of public health language.
7/10/2024	Patient Advocate	N	
7/18/2024	County Counsel	N	
6/19/2025	Nursing P&P	Y	Change to guideline
7/1/2025	PAC	Y	Add reference to Animals in the Hospital

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 627	Page 1 of 3
Title: Abuse/ Trafficking Victim Request for Assistance	**Effective Date:** 9/24/2025	☐ **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 Red flag indicators. Objective and subjective signs of abuse, neglect, and/ or exploitation such as (but not limited to):

a. Someone else is holding identification documents.

b. Inability to speak to the patient alone.

c. Someone else answers questions for the patient.

d. Answers appear scripted or rehearsed.

e. Signs of physical abuse.

f. Inconsistent story.

g. Submissive, fearful, anxious, tense, nervous behaviors.

h. Multiple hotel room keys.

i. Under 18 years of age and in prostitution.

1.2 Designated hand signal. The hand signal chosen by RUHS-Medical Center to allow a victim of abuse to silently indicate that they need assistance getting away from the person they are with.

1.3 Mandated reporting. “Any health practitioner employed in a health facility, clinic, physician’s office, local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a [victim of abuse, neglect, or exploitation], shall immediately make a report” to the appropriate agency.[4.1]

1.4 Mandated reporter. Includes, but are not limited to: “A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code. An emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code. A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code. A marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code. An unlicensed marriage and therapist intern registered under Section 4980.44 of the Business and Professions Code. A state or county public health employee who treats a minor for venereal disease or any other condition.”[4.2]

1.5 Abuse. "The willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish."[4.3]

1.6 Neglect. The willful omission, without lawful excuse, to furnish necessary clothing, food, shelter, or medical attendance, or other remedial care.[4.4]

1.7 Exploitation. The use or utilization for profit.

2. GUIDELINES

2.1 Staff recognizes *red flag indicators* for abuse or exploitation, or the patient uses the *designated hand signal,* or the patient self-identifies as a victim of human trafficking or domestic violence, staff shall:

a. Document the red flag indicators in EPIC. For downtime, documentation may be done as a multi-disciplinary note.

b. Commence a small huddle including the patient's primary nurse, the charge nurse, and the patient's provider.

- During this huddle the staff member will report their suspicions/ use the designated hand signal with the huddle members

c. The patient's provider will then order a radiological study that best suits the patient's chief complaint.

d. The patient's primary nurse will escort the patient to radiology without the suspected abuser.

e. The patient will be taken to a secure location within radiology and given options regarding care, separation, reporting, and forensic services.

f. A larger huddle will commence once the patient has decided what they wish to do, this huddle should include the primary nurse, charge nurse, practitioner, law enforcement, social worker, and SAFE Clinic RN, where appropriate

2.2 *Mandated reporting* shall be done by any of the *mandated reporters* involved pursuant to Housewide Abuse, Neglect, and/or Intimate Partner Assessment and Reporting Policy 626.

3. REFERENCES

3.1 California Penal Code §11160(a)

3.2 California Penal Code §11165.7(a)

3.3 Centers for Medicare and Medicaid Services (CMS). State Operations Manual §483.5

3.4 California Penal Code §270

3.5 California Health and Safety Code §1281.5

4. ATTACHMENTS

4.1 Abuse/ Trafficking Victim Request for Assistance Algorithm

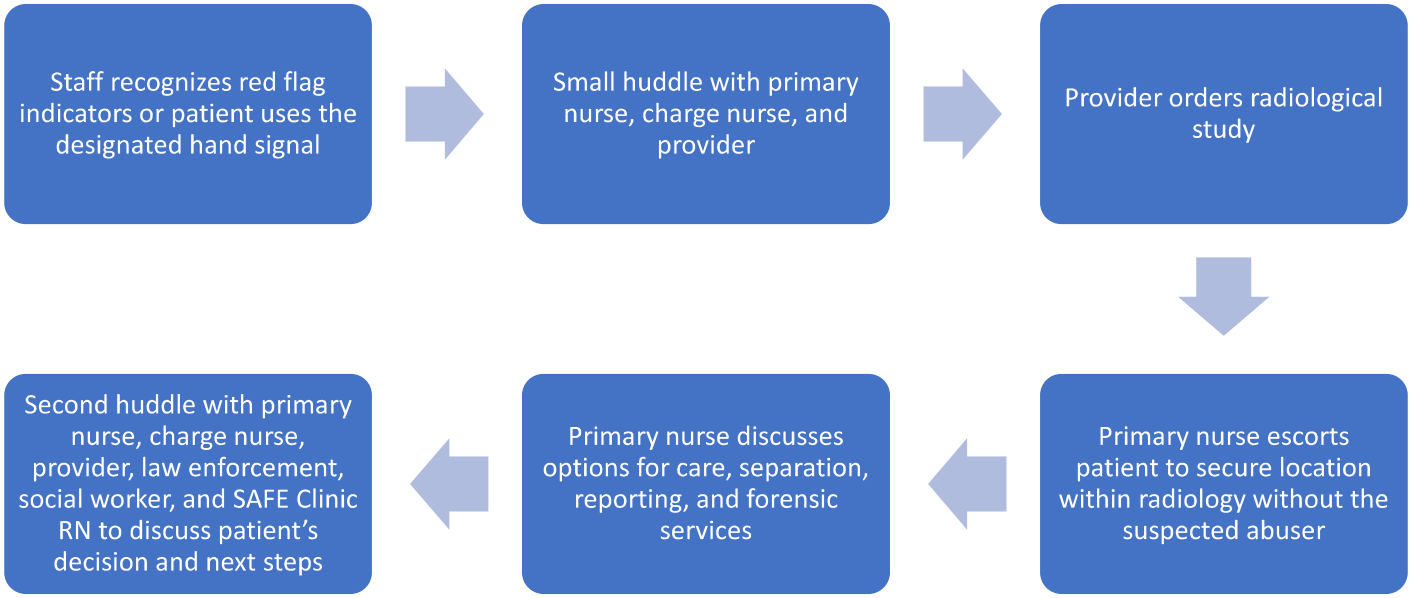
4.2 Depiction of Designated Hand Signal

Document History:

Prior Release Dates: New	**Retire Date:** N/A
Document Owner: **Sexual Assault and Forensic Evaluation (SAFE) Clinic**	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
2/20/2025	NPP	No	
3/4/2025	PAC	No	Suggestions for education before roll out. Owner agrees to let us know when ready to roll out with education.

Abuse/ Trafficking Victim Request for Assistance Algorithm



1. Palm outward and upward and tuck thumb

2. Trap the thumb

RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER
Housewide

	Document No: 628	Page 1 of 13
Title: Moderate/Procedural and Deep Sedation	Effective Date: 7/16/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☒ **Housewide** ☐ **Departmental** ☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. PURPOSE

1.1 The goal of Riverside University Health System – Medical Center (RUHS-Medical Center) is to provide quality and safe care to our patients in compliance with regulatory requirements (The Joint Commission, Centers for Medicaid and Medicare Services' Conditions of Participation) and evidenced based practice (American Society of Anesthesiologists and American College of Emergency Physicians). This guideline describes the minimum requirements for the delivery of moderate or deep sedation to ensure safe and appropriate care.

2. SCOPE

2.1 This guideline applies to the delivery of moderate or deep sedation.

2.2 This guideline does not apply to the following:

a. Administration of medications for anxiolysis or pain management. If the patient's level of sedation becomes deeper than minimal, there must be an appropriate escalation of care

b. Sedation performed by practitioners of the Department of Anesthesiology

c. Routine care of patients during procedures (dressing changes, etc.) for which analgesics or sedatives may be used with the intent of providing analgesia or to alleviate anxiety (minimal sedation)

d. Use of sedation to manage ventilated patients in critical care areas.

e. Guidelines for Inpatient Management of Alcohol Withdrawal

3. DEFINITIONS.

3.1 Analgesia: The use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not

lose consciousness but does not
perceive pain to the same extent that he or she may without the medication.

3.2 Levels of Sedation: The distinctions among levels of sedation are made for the purpose of describing appropriate levels of training for personnel, the level of physiologic monitoring, and anticipated risk.

3.3 Minimal Sedation (Anxiolysis): A single oral, intranasal, intramuscular or intravenous sedative or analgesic medication administered in doses appropriate for the unsupervised treatment of anxiety or pain. A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

3.4 Moderate (Conscious) Sedation/Analgesia: A drug-induced depression of consciousness during which patients respond purposefully to verbal command, either alone or accomplished by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3.5 Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate; cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner who has been determined to be qualified to manage such progression. Deep sedation requires specific privileging.

3.6 Dissociative Sedation: a trance-like cataleptic state characterized by profound analgesia and amnesia, with retention of protective airway reflexes, spontaneous respirations, and cardiopulmonary stability. In the ED, ketamine is commonly administered to evoke dissociative levels of sedation. A dissociative state can minimize pain for moderate to severely painful procedures, as well as procedures requiring immobilization in uncooperative patients.

3.7 General Anesthesia: A drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

3.8 Rescue Capacity: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Procedures must be in place to rescue patients whose level of sedation becomes deeper than initially intended, for example, patients who inadvertently enter a state of Deep Sedation/Analgesia when moderate sedation was intended. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects the adverse physiologic consequences of the deeper-than-intended level of sedation.

4. PROGRAM OVERSIGHT

4.1 Oversight for moderate and deep sedation will be provided by the RUHS – MC Chair of Anesthesiology.

5. STATEMENT OF POLICY

5.1 Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, medical staff members who are privileged to administer sedation intending to produce a given level of sedation should be able to rescue patients whose level of moderate or deep sedation becomes deeper than that initially intended.

a. Providers administering moderate sedation should be able to rescue patients who enter a state of deep sedation, while those administering deep sedation should be able to rescue patients who enter a state of general anesthesia.

5.2 Deep sedation privileges are limited to credentialed providers in the Departments of Anesthesia, Emergency Medicine and Division of Pulmonary/Critical Care Medicine.

	Minimal Sedation (Anxiolysis)	Moderate Sedation	Deep Sedation	General Anesthesia
Responsiveness	Normal Response to verbal stimulation	Purposeful response to verbal or tactile stimulation	Purposeful response following repeated/painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No Intervention Required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be adequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

6. PROVIDER COMPETENCY FOR MODERATE SEDATION

6.1 Attendings in the specialties of Anesthesia, Emergency Medicine, Pulmonary Critical Care, Neonatal Critical Care, Pediatric Critical Care shall be considered to have training in their professional preparation and shall not require additional training to perform moderate sedation/anesthesia as described below.

6.2 Attending Physicians must be privileged to administer or supervise moderate sedation.

a. Training for providers privileged to perform moderate sedation shall be defined by the Medical Staff Departments, subject to approval by the Chair of Anesthesiology and the Medical Executive Committee.

b. Initial Privileging requirements:

i. Completion of online Moderate Sedation Course with successful passing of examination.

ii. Knowledge of airway management as demonstrated by ACLS/PALS or as defined in specialty core training (Emergency Medicine and Pulmonary Critical Care are examples of specialties that have airway skills in their core training).

iii. Successful completion of proctoring as defined by privileging forms

iv. Moderate sedation for Pediatric patients requires training in the care of children age 14 and younger by residency/fellowship.

c. Reappointment is required every two years (Biennial) (performed by Chief of Service or designee)

i. Review of two (2) cases performed or

ii. Successful passing of written sedation exam

6.3 Resident Physicians/Fellows may administer moderate sedation under supervision of a privileged attending and only if they have:

a. Completed approved online moderate sedation course with successful passing of examination

b. Current BLS and ACLS/PALS certification

c. Program directors and the GME office are responsible for ensuring resident compliance and updating online competency programs.

7. REGISTERED NURSE ROLES

7.1 Registered Nurses assisting in moderate and deep sedation:

a. BLS and Advanced life support defined by patient population.

b. RNs assisting in moderate/deep sedation must have proof of training and competency.

c. Registered nurses who provide and monitor patients receiving moderate sedation will have knowledge of the pharmacology (recommended dose, onset, peak effect, duration) of those medications to be used as well as for their antagonists.

d. Assisting RNs may administer sedative agents only at the direction of and in the presence of the LIP. RNs may not titrate or adjust sedation medications unless specifically directed by the LIP, who must be present at the bedside. Nurses have the right to refuse medications that would deepen sedation beyond safe levels.

e. The RN must remain with the patient unit they meet discharge criteria

f. RNs shall not be delegated the responsibility to monitor patients receiving deep sedation or anesthesia levels deeper than moderate sedation, as these require continuous monitoring by a Licensed Independent Practitioner specifically credentialed and trained for such care.

7.2 RN Independent Administration of Moderate Sedation

a. RNs may administer moderate sedation only under the following conditions:

i. Limited to Moderate Sedation

ii. Only for patients classified as ASA I-III

iii. Order must be written by a sedation-privileged Physician using approved order sets

iv. NPO Status may not be waived

v. Physician Assessment of Sedation H&P must be completed prior to sedation

vi. Patients may not have the following conditions: Sleep Apnea, Mallampati IV, known or suspected difficult intubation.

b. RNs may be authorized to administer moderate sedation independently only if they meet all the following:

i. BLS and Advanced life support defined by patient population.

ii. Proof of training and competency which will include the following:

- Pharmacology of sedative and analgesic agent as well as their antagonists
- Patient selection and risk stratification.
- Sedation assessment tools and documentation standards.
- Airway management and emergency response.

c. The RN may administer sedation and analgesic medications within ordered parameters

d. The RN will adhere to practice guidelines detailed in this guideline

e. The RN must remain with the patient unit they meet discharge criteria

8. EQUIPMENT/SAFETY

8.1 Appropriate monitoring and emergency equipment that is age and size specific and readily available for use in the clinical setting:

8.2 Equipment to monitor the patient's physiologic status, including blood pressure, heart rate, respiratory rate, oxygen saturation and respiratory effectiveness via end tidal CO2 (ETCO2)

a. Supplemental Oxygen and delivery equipment

b. Airway Equipment, including an appropriately sized bag-valve-mask

c. Crash Cart with appropriate ACLS and/or PALS medication and equipment

d. Cardiac Monitor, including defibrillator

e. Suction Equipment

f. Adequate lighting to observe patient.

g. Adequate power outlets connected to the hospital emergency power supply.

h. Methods for immediate access to the designated Emergency Response Team.

9. REVERSAL AGENTS

9.1 Appropriate antagonists shall be readily available.

10. PERSONNEL

10.1 Licensed personnel who are competent in age-appropriate Basic life support and/or emergency airway management should be in attendance or immediately available until the patient's level of sedation is no longer moderate or deeper.

10.2 A designated individual other than the practitioner performing the procedures must be present to monitor the patient throughout the procedure.

a. The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction.

b. The designated person may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital sign have stabilized, provide that adequate monitoring for the patient's level of sedation is maintained.

11. CONSENT

11.1 Informed consent for moderate or deep sedation must be obtained and documented by the provider.

12. NOTHING BY MOUTH (NPO) STATUS.

a. The following are the minimum NPO guidelines, which apply to otherwise healthy patients. (It is recognized that when emergent or urgent sedation is required, following NPO guidelines may not be feasible. Whenever drugs for sedation are administered, the benefits of sedation against the risk of possible aspiration must be assessed):

b. For infants, children and adults NPO before sedation:

i. Solids for a minimum of eight 8 hours

ii. Breast milk for a minimum of four (4) hours

iii. Clear liquids for a minimum of two (2) hours

iv. Formula or nonhuman milk for a minimum of six (6) hours

13. PRE-SEDATION EVALUATION AND PLAN

13.1 An appropriate pre-sedation evaluation must be performed within 30 days prior to the sedation and be documented in the medical record by the provider. An interval history and physical is required within 24 hours. Medical record documentation must include:

a. A judgment as to the safety of sedation for the patient, which includes consideration of the patient's age and medical condition.

b. ASA (American Society of Anesthesiologists) physical status classification

c. NPO status

d. Medical, anesthetic, allergy, and drug history

e. Physical Exam

i. Weight/BMI

ii. Cardiac/Pulmonary Exam

iii. Vital Signs

iv. Airway evaluation (Mallampati)

f. Diagnostic Data, as appropriate

g. Plan for sedation.

13.2 Pre-Sedation assessment and plan for moderate sedation may only be performed by a resident physician if their supervising attending is privileged.

13.3 Pre-Sedation assessment and plan for Deep Sedation may NOT be delegated. It must be performed by the Attending physician who is privileged.

14. PRE-PROCEDURE

14.1 Reassessment by both the registered nurse and provider must be performed and documented immediately prior to the administration of sedation.

14.2 Assessment and documentation by the Registered Nurse should include:

a. Vital Signs

b. Confirmation of ASA physical status (pre-sedation H&P)

c. Confirmation of NPO Status

d. Time Out

e. Modified Aldrete Score

15. INTRAPROCEDURE MONITORING

15.1 Oxygenation, ventilation (ETCO2), circulation (e.g. blood pressure, heart rate), level of consciousness (Richmond Agitation-Sedation Scale) and Pain are monitored continuously. These items shall be recorded every 5 minutes.

15.2 Record all medication administered during the procedure in the medical record.

15.3 Record complications, reversal agents and the management of those events in the medical record

16. POST-PROCEDURE

16.1 Post-procedure monitoring is required for at least 30 minutes after the last dose of IV opioid/sedative or 60 minutes after the last dose of IM/PO drug administration. The patient must also have returned to pre procedural baseline in accordance with assessment tools (e.g. Aldrete Score)

16.2 Any patient receiving a reversal agent must be monitored for at least (2) two hours after administration of the agent to detect potential re-sedation.

16.3 Oxygenation, ventilation (ETCO2), circulation (e.g. blood pressure, heart rate), level of consciousness (Richmond Agitation-Sedation Scale) and Pain are monitored continuously. These items shall be recorded every 15 minutes until:

a. The patient scores a minimum of 8 on the Modified Aldrete Score. (Exceptions: critical care patients, paraplegics, quadriplegics, or other hospital patients with conditions which preclude use of such a scoring system.)

16.4 If transported to another location for post-procedure observation/recovery the patient will be monitored with the following equipment/supplies by a qualified RN:

a. Continuous pulse oximetry

b. Continuous capnography

c. Continuous cardiac monitoring

d. Oxygen and appropriate airway management equipment/supplies

e. Handoff items should include (but not limited to):

i. Reason for sedation

ii. Condition of the patient, including pain score

iii. Sedation agents administered, total dose and last dose given

iv. Any significant clinical events

v. Any additional provider orders related to the moderate sedation

16.5 Unusual events or post-procedure complications and their management also shall be documented

17. THE OUTPATIENT

17.1 The outpatient is discharged to “home” by a specific discharge order from the physician and must meet the following additional criteria:

a. Able to dress and ambulate consistent with developmental age.

b. Received and indicated understanding of discharge instructions.

c. Has a responsible person to transport them home and care for them at home.

d. Infants and patients whose mental status was initially abnormal should have returned to their baseline status

18. OUTPATIENT DISCHARGE INSTRUCTION

18.1 Discharge instructions to the patient and responsible adult who will be caring for the patient at home will include:

a. Diet

b. Medications

c. Activity level

d. Signs and symptoms of complications

e. Parents/caregivers must be aware that pediatric patients are at risk for airway obstruction should the head fall forward while the child is secured in a car seat. Parents/caregivers will be educated that children in car seats should not ride alone in the backseat.

f. Patients will be discharged into the care of a responsible adult.

19. DEEP SEDATION ADDITIONAL REQUIREMENTS

19.1 In addition to those requirements set forth in this policy for moderation sedation, the following are required for the administration of deep sedation:

19.2 PROVIDER COMPETENCY: deep sedation shall only be administered by qualified Anesthesiologists, CRNAs (under direct supervision of an Anesthesiologist), Emergency Medicine Attendings and Pulmonary/Critical Care Attendings.

19.3 PERSONNEL:

a. A provider who has current privileges for deep sedation (ability to rescue)

b. A licensed personnel member must be assigned to only monitor the patient without any other responsibilities.

i. Any procedure performed under deep sedation with RN monitoring must be one that can be immediately interrupted to allow the provider to be available to provide rescue maneuvers if needed.

19.4 POST PROCEDURE CARE

a. A provider who is privileged to provide deep sedation must be available immediately throughout the recovery period.

b. When deep sedation is administered by the privileged provider, a post Anesthesia evaluation must be completed and documented by this provider within 48 hours.

20. PERFORMANCE IMPROVEMENT

20.1 Adverse events related to using moderate or deep sedation will be tracked, trended and analyzed.

20.2 An event report should be completed for any incident when the below indicators are triggered:

a. All cases in which naloxone or flumazenil is administered

b. All cases in which new assisted ventilation is required or the need for endotracheal intubation

c. All cases in which unanticipated hospital admissions or increased level of care is required

d. All cases in which there is hemodynamic instability that requires intervention

e. SpO2 < 90% (< 86% for neonates) for more than five (5) minutes including recovery time or less than 80% for any period

f. Cardiac or respiratory arrest

g. Unplanned progression to deeper levels of sedation

21. REFERENCES

21.1 Statement on granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals, Ad Hoc Committee on Credentialing; reaffirmed by the American Society of Anesthesiologists House of Delegates, October 2021.

21.2 The Joint Commission Standards, Provision of Care, PC.03.01.01 through PC.03.01.07, Effective date November 17, 2022

21.3 Moderate Sedation/Analgesia, Perioperative Standards and Recommended Practices, 2012. Guideline Summary: Moderate Sedation/Analgesia, AORN 2016

21.4 Centers for Medicare & Medicaid Services §482.52 Conditions of Participation: Anesthesia Services. Rev. 176, 12-29-17.

21.5 Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018. Anesthesiology 2018; 128:437-479.

21.6 Model Sedation Protocol for Moderate Sedation and Analgesia Performed by Non-Anesthesia Practitioners during Procedures on Adults and Children Older than 12 years of Age. California Society of Anesthesiologists. 2010.

21.7 Moderate Sedation Packet: Moderate Sedation Provider Packet. An Educational Packet for review by Non-anesthesiologists Providing Moderate Sedation During Elective, Diagnostic, and Therapeutic Procedures. Upstate University. 2018.

21.8 American Society of Anesthesiologists Safe Sedation Training – Moderate. Society for Pediatric Sedation - Sedation Provider Course for pediatric moderate sedation https://learnpedsedation.org/; 2021.

22. ATTACHMENTS

22.1 Dosing Guide for Moderate Sedation/Analgesia for Adult Patients ≥40kg

a. Dosing Guides for Sedation/Analgesia Moderate Sedation for Patients ≤40kg

22.2 RASS SCALE

22.3 ALDRETE SCALE

22.4 MALLAMPTI SCORE

22.5 ASA STATUS

Document History:

Prior Release Dates: 01/17/03, 11/15/08, 12/15//11, 1/15/12, 1/29/2015, 5/7/18	**Retire Date:** N/A
Document Owner: Anesthesia	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Y/N	Revision Description
04/01/2024	Anesthesia and Nursing	**Y**	Major revisions to format and section details. Updated dosing table. Add post procedure transport. Specify post procedure assessments and discharge criteria. Update references, Redefine minimal anxiolysis
5/13/2024	Pharmacy Review Committee	**Y**	Update dosing table with ISMP text recommendations
9/5/2024	Pre-Nursing P&P Committee	**Y**	Minor wording change, specify nursing competency
10/17/2024	Nursing P&P	**N**	approved
11/5/2024	PAC	**N**	
12/2/2024	Pharmacy & Therapeutics Committee	**N**	Approved
01/09/2025	Medical Executive Committee	**N**	Provider Credentialling & Nursing competency requirements for independent administration and monitoring of moderate sedation. Define ketamine as deep sedation
07/10/2025	Medical Executive Committee	**Y**	Add NICU/PICU intensivists to 6.1 7.2a add known or suspected difficult airway (safe patient selection)

ATTACHMENT A FOR CHILDREN GREATER THAN OR EQUAL TO 40 kg AND ALL ADULT PATIENTS

The following are guidelines for administering medications. The provider in attendance is responsible for the safe administration of all medications. For all agents during moderate sedation, start low, go slow.

Onset: Delay between administration and effect**. Duration:** Length of time effect persists.

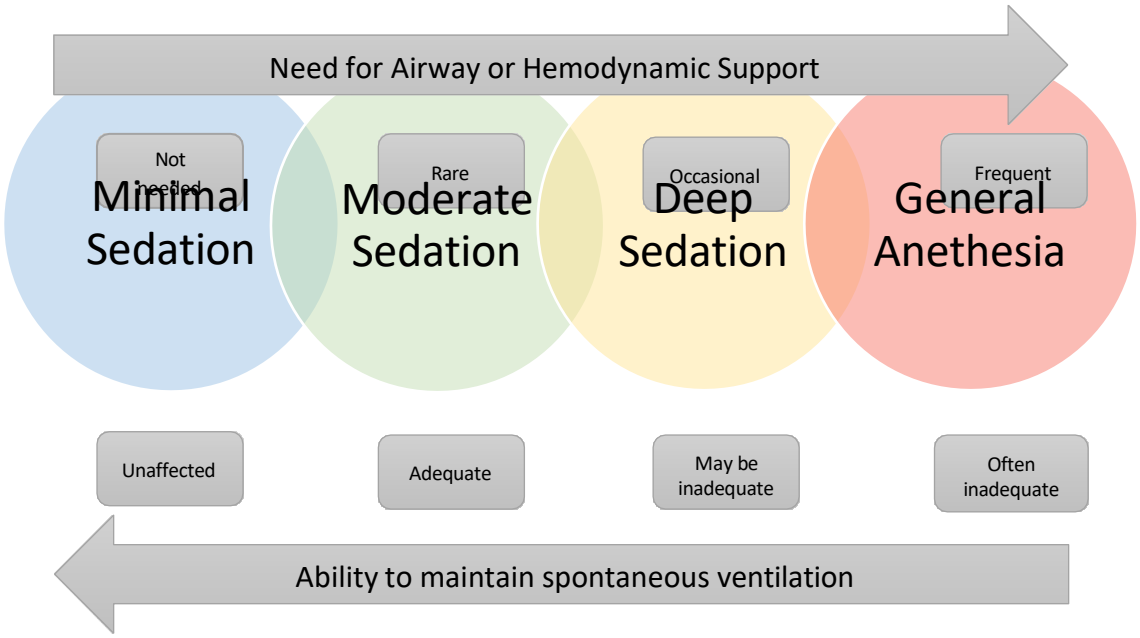
- *fenta**NYL** is the preferred opioid because of faster onset, shorter recovery time, and does not induce histamine release.*
- *midazolam is the preferred benzodiazepines because of faster onset, shorter duration of action, and multiple routes for administration*
- *For all agents:* Half dosage and rate of administration in patients who are elderly, debilitated or have renal or hepatic disease.

MODERATE SEDATION					
Medication	**Increment and Max Dosing**	**Onset**	**Duration**	**Special Considerations**	**Reversal Agent**
fenta**NYL**	25-50 mcg IV over 1-2 minutes every 5 minutes PRN to a max of or 250 mcg. Alternate with IV sedation agent.	IV 3-5 minutes	0.5-1 hours	Rapid administration may cause muscular rigidity of the thorax to the point that ventilation (spontaneous or controlled) is impossible	naloxone
midazolam (Versed)	0.5-1 mg IV over 2 min every 5 minutes PRN to a max of 5 mg. Alternate with IV analgesia.	IV 1-5 minutes	1-2 hours	May cause pain at the injection site	flumazenil
hydromorphone (Dilaudid)	0.2-0.4 mg IV over 1-2 minutes every 5 minutes PRN to a max of 1 mg. Alternate with IV sedation agent.	IV 1-5 minutes	2-4 hours		naloxone
morphine	1 mg IV over 1-2 minutes every 5 minutes PRN to a max dose of 10 mg Alternate with IV sedation agent.	IV 5-10 minutes	2-4 hours		naloxone
DISSOCIATIVE AGENTS (only permitted for Deep Sedation Privileged Practioners)					
ketamine (Ketalar)	Dissociative dose: 0.5 to 1.0 mg/kg IV, may repeat every 5-15 minutes Or 4-5 mg/kg IM *Subdissociative dosing for pain: 0.1-0.3 mg/kg, may repeat every 15-30 minutes*	<1 minute	5-15 minutes IV 12-25 minutes IM	May cause emergence delirium, hypertension, tachycardia, laryngospasm (manage with high flow O2, BVM, be	NONE

				prepared for Rapid Sequence intubation	
DEEP SEDATION AGENTS					
propofol (Diprivan)	0.5-1 mg/kg IV every 5-15 minutes PRN If using in conjunction with ketamine, administer and alternate 0.25-0.5 mg/kg IV of **each** component, may repeat every 5-15 minutes	<1 minute	5-10 minutes	May cause hypotension, bradycardia, respiratory depression and apnea. Avoid in patients with allergy to eggs, soy	NONE
etomidate	0.1 mg/kg IV	<1 minute	3-5 minutes	May cause myoclonus, nausea and vomiting	NONE

REVERSAL(ANTAGONIST) AGENTS

GREATER THAN OR EQUAL TO 40 kg		
Agents	**Typical Dose**	**Typical Frequency**
flumazenil	0.2 mg	Q 1 minute up to 1 mg
naloxone	0.04 – 0.4 mg	Q 1minute up to 2 mg



ATTACHMENT B FOR PEDIATRIC PATIENTS LESS THAN 40 kg

The following are guidelines for administering medications in pediatric patients only (age > 28 days). The provider in attendance is responsible for the safe administration of all medications. For all agents during moderate sedation, start low, go slow.

Onset: Delay between administration and effect**. Duration:** Length of time effect persists.

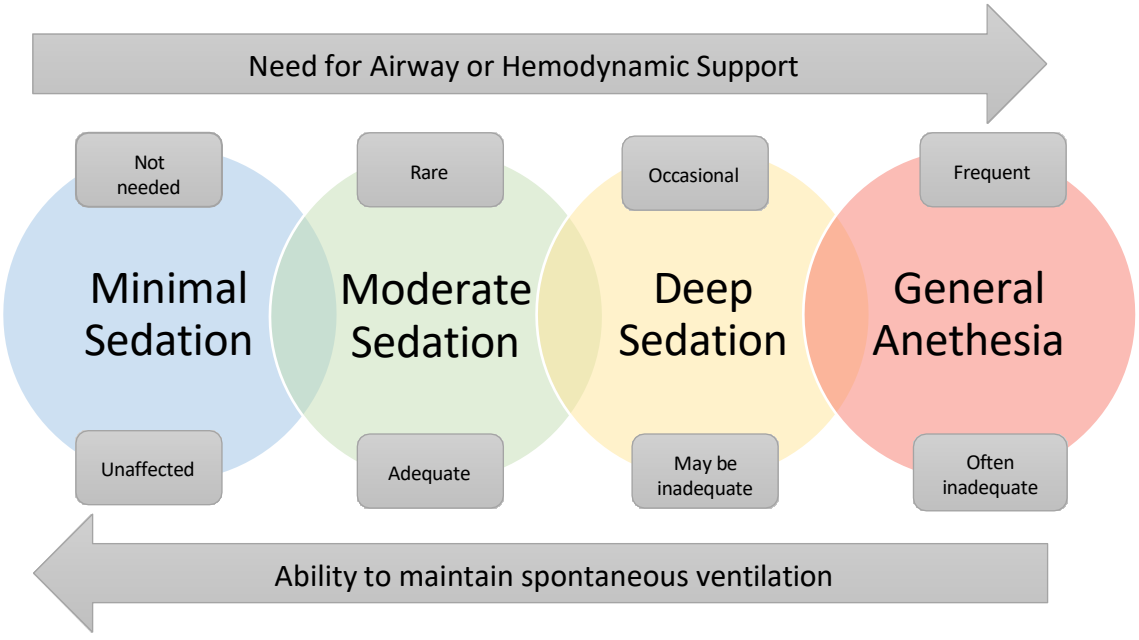
- *fenta**NYL** is the preferred opioid because of faster onset, shorter recovery time, and does not induce histamine release.*
- *midazolam is the preferred benzodiazepines because of faster onset, shorter duration of action, and multiple routes for administration*

MODERATE SEDATION					
Medication	**Increment and Max Dosing**	**Onset**	**Duration**	**Special Considerations**	**Reversal Agent**
fenta**NYL** *Preferred in <6 months*	**IV** 0.5-1 mcg/kg over 2-3 minutes, may repeat every 5 minutes PRN to a max of 2 mcg/kg *<12 yo max 50 mcg/dose* *>12 yo max 100 mcg/dose* **Intranasal (NAS)** 1.5-2 mcg/kg (max 100 mcg)	IV 1-2 minutes NAS 5-10 minutes	0.5-1 hours	may cause muscular rigidity of the thorax to the point that ventilation (spontaneous or controlled) is impossible	naloxone
hydromorphone (Dilaudid)	**Age > 6 months:** **IV** 0.01 mg/kg over 2-3 minutes every 5 minutes PRN to a max of 0.03 mg/kg	IV 1-5 minutes	2-4 hours		naloxone
midazolam (Versed)	**Age > 6 months:** **IV** 0.025-0.05 mg/kg over 2-3 minutes every 5 minutes PRN to a max dose of 0.1 mg/kg **PO** 0.25-0.5 mg/kg x 1 dose (max 20 mg) **Intranasal (NAS)** 0.5 mg/kg (max 10 mg)	IV 2-5 minutes PO 10-20 minutes NAS 5-10 minutes	1-2 hours Up to 2 hours 20-30 minutes		flumazenil
morphine *Preferred in <6 months*	**IV** 0.05 mg/kg over 2-3 minutes every 5 minutes PRN to a max dose of 0.1 mg/kg	IV 5-10 minutes	2-6 hours		naloxone
DISSOCIATIVE AGENTS (only permitted for Deep Sedation Privileged Practioners)					
ketamine *Consider lower dose for brief procedures	**Age > 3 months:** **IV** 0.2-1 mg/kg/dose, may repeat 0.2-1 mg/kg x 1 in 5-15 minutes PRN **IM** 2-5 mg/kg/dose x 1 **Intranasal** 2-6 mg/kg/dose may	<1 minute 5-15 minutes	5-20 minutes 10-30 minutes	May cause emergence delirium, hypertension, tachycardia, laryngospasm (manage with high flow O2, BVM, be prepared for	

	repeat ½ the initial dose x 1 to max cumulative dose 100 mg	5-10 minutes	30-60 minutes	Rapid Sequence intubation	
DEEP SEDATION					
propofol (Diprivan)	**IV** 0.5-1 mg/kg/dose, may repeat 0.25-0.5 mg/kg/dose every 5-15 minutes PRN	<1 minute	5-10 minutes	May cause hypotension, bradycardia, respiratory depression and apnea. Avoid in patients with allergy to eggs, soy	
etomidate	**Age > 6 months:** **IV** 0.1 mg/kg, may repeat every 3-5 minutes up to max total 0.3 mg/kg	<1 minute	3-5 minutes	May cause myoclonus, nausea and vomiting	

REVERSAL AGENTS

LESS THAN 40 kg		
Agents	**Typical Dose**	**Typical Frequency**
flumazenil	0.01 mg/kg max of 0.2 mg/dose	Q 1 minute up to 1 mg
naloxone	0.01-0.1 mg/kg	Q 1 minute up to 2 mg



ATTACHMENT C: RASS SCALE

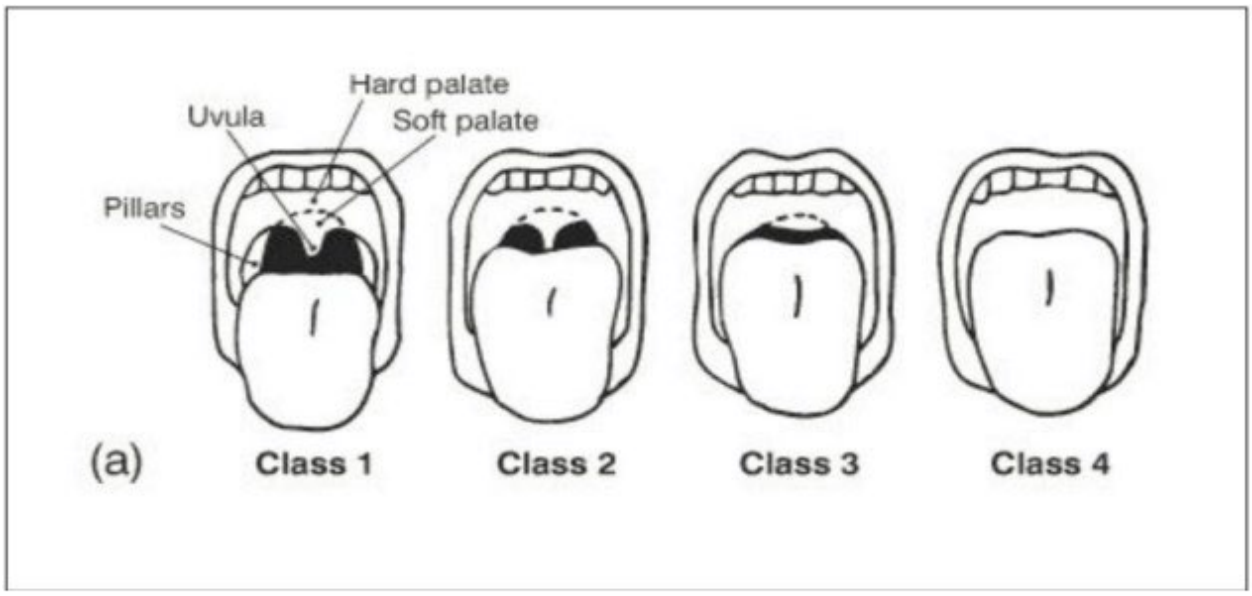
Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s), aggressive	
+2	Agitated	Frequent nonpurposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressively vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert but has sustained awakening (eye opening/eye contact) to *voice* (≥10 seconds)	Verbal Stimulation
-2	Light sedation	Briefly awakens to *voice* with eye contact (<10 seconds)	
-3	Moderate sedation	Movement or eye opening to *voice* (but no eye contact)	
-4	Deep sedation	No response to voice but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice* or *physical* stimulation	

ATTACHMENT D: MODIFIED ALDRETE SCORING

Aldrete Scoring System	
ACTIVITY	
Able to move four extremities voluntarily on command	2
Able to move two extremities voluntarily on command	1
Able to move one extremity voluntarily on command	0
RESPIRATION	
Able to breathe and cough freely	2
Dyspnea or limited breathing	1
Apnea	0
CIRCULATION	
Blood pressure within 20% of pre anesthesia level	2
Blood pressure +20 to 50% of pre anesthesia level	1
Blood pressure 50% of pre anesthesia level	0
CONCIOUSNESS	
Fully awake	2
Arousable on calling	1
Not responding	0
COLOR	
Pink and orange assay O2 rather than 95% pale	2
Blotchy and our SO 290 to 95%	1
Cyanotic dusky and our SO2 less than 90%	0

ATTACHMENT E: MALLAMPATI SCORE



Class 1: Complete visualization of the uvula
Class 2: Visualization of only the base of the uvula
Class 3: Only soft and hard palates are visible Class
4: Only hard palate is visible

Reference: Ginapp, T. (2012). Ask the Instructor. Retrieved from http://www.cathlabdigest.com/files.

ATTACHMENT F: AMERICAN SOCIETY OF ANESTHESIOLOGISTS PHYSICAL STATUS

ASA Physical Status	Description
1	No Systemic Disease
2	Mild, or Well Controlled Systemic Disease, No Functional Limitations
3	Severe Systemic Disease, Definite Functional Limitations
4	Severe Systemic Disease, Constant Threat to Life
5	Moribund, Not Expected to Survive for 24 Hours, Irrespective of Operation.
E	Emergency – a modifier to ASA status

The patient with a physical status rating of ASA 3 or higher should alert the practitioner that a higher level of vigilance is required. In patients of ASA physical status 3, 4 or 5 (e.g., severe cardiac, pulmonary, hepatic, renal, CNS disease, morbid obesity, sleep apnea, others), or in certain selected classes of patients such as uncooperative patients, extremes of age (under 1 year or over 70 years of age), the pregnant patient, those with sleep apnea or drug/alcohol abusers there is an increased risk of developing complications related to sedation and analgesia unless special precautions are taken.

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
Housewide

	Document No: 678	Page 1 of 15
Title: Blood Transfusions	**Effective Date:** 8/18/2025	☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 The scope of this guideline is to outline within Riverside University Health System (RUHS) practice standards for processing and safe administration of blood transfusions in accordance with current practice guidelines for all clinical staff who perform blood transfusions and/or blood component transfusions.

1.2 For Pediatrics and Neonates, where the term patient or authorized surrogate is used, it is understood that a parent or legal guardian applies.

2. DEFINITIONS

2.1 **Blood Volume** - Is defined as approximately 60ml/kg to 80ml/kg in adult patients, 70ml/kg to 90ml/kg in pediatric patients, and 90ml/kg to 100ml/kg in neonatal patients.

2.2 **Emergency Release** – is a process of dispensing un-crossmatched blood at the physician's request due to a life-threatening emergency or major traumatic injury.

2.3 **Informed consent** – Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving this information, the patient/authorized surrogate then either consents to or refuses such a procedure or treatment.

2.4 **Licensed Practitioner (LP)** – An individual as permitted by law and regulation and also by the organization, to provide care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization.

2.5 **Massive Blood Transfusion Protocol (MTP)** – Is defined as the replacement of a patient's (Adult, Pediatric) total blood volume within the first 12 hours of transfusion (Referenced per RUHS – MC policy HW 604.2 Massive Transfusion).

2.6 **Patient Identifiers –** Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended. Acceptable identifiers may be the individual's name, an assigned identification number (Medical Record Number), date of birth, or other person-specific identifier.

2.7 **Obstetrics/Post-Partum (OB/PP) Blood Response –** Is defined as a blood transfusion for any obstetric patient with continued bleeding after initial measures have failed to stop the bleeding.

3. PROCEDURE

3.1 All blood and blood component requests must be legible, accurate and complete with two independent identifiers for correct recipient identification.

3.2 **Pre-Procedure:**

a. Compliance with the Gann Act (California Health and Safety Code 1645) mandates that every LP who determines that there is reasonable possibility that his/her patient may require a blood transfusion must provide the patient with the legal document "A Patient's Guide To Blood Transfusion" Found here: https://www.mbc.ca.gov/Resources/brochures/blood- transfusions.aspx Transfusionists shall ask about previous transfusions and reactions and notify the Physician and Blood Bank if previous transfusions or reactions have occurred.

b. Provide education to the patient or authorized surrogate decision maker. If the patient will not be monitored in a clinical setting post transfusion, provide written instructions for transfusion reaction monitoring.

c. Baseline Assessment: includes measurement of vital signs (blood pressure, heart rate, temperature, respiratory rate, oxygen saturation). Assessment should include symptoms of transfusion reaction such as urticaria, pruritus, edema, chest pain, dyspnea, wheezing and chills.

3.3 **Compatibility Testing:**

a. RN to obtain Specimen for compatibility testing and place in the appropriate specimen collection tube. Specimens must be collected three days prior to initiating the transfusion.

b. Patient Verification is acceptable by either;

i. Blood Bank approved electronic identification system (bar code scanning) of patient and specimen label in the presence of the patient.

ii. Downtime Procedure: Independent verification by staff member of patient identification and specimen labeling. This should be performed in the presence of the patient.

c. Cross Match Band: Place Blood Bank armband with the corresponding crossmatch numbers. If the wrist is not available, may be attached to the patient's ankle. Date and time can serve as an indicator of expiration for subsequent care teams

d. Second determination of compatibility testing (second collection)

i. Blood Bank will notify nursing units when a second draw is required. A retype order will be entered. (AABB Standard 5.14.5).

ii. During Blood Bank system down time all patients will require second determination of compatibility

3.4 Dispensing of Blood/Blood Components

a. For routine/crossmatched products: The RN/transfusionist will release the order from the blood administration module in EPIC, print the release form and write the crossmatch number (obtained from the patient's crossmatch armband.)

b. For emergent/non crossmatched products: see attached workflow, bring patient labels to blood bank and affix to Form #665

   i. Alternate workflow in ED, OR, and L&D may utilize "emergency stock" in blood refrigerators. See blood refrigerator attachment.

c. Only 1 blood product unit may be retrieved at a time (Exception: Operating Room (OR), Post Anesthesia Care Unit (PACU), Emergency Department (ED), Labor and Delivery (L&D), and Adult Critical Care Unit (ACCU).

   i. Blood products (excluding Platelets and Cryoprecipitate) may be released in Blood Bank issued cooler. The cooler is a holding and transportation unit designed to maintain and monitor blood products within a 1 to 6°C temperature range for 24+ hours.

d. Transfusion service staff (lab) and RN/designee will verify:

   i. Forms, tags, and label identification must have identical information.
   - Patients Full Name
   - Medical Record Number
   - Date of Birth
   - Patients Blood Type or confirmation type is unknown
   - Donor Blood Type
   - Donor Unit Number
   - Expiration date of donor unit

Recipient ABO type	ABO Compatible RBC Units	ABO Compatible Plasma or Platelet Units
O	O	A, B, O, AB
A	A, O	A, AB
B	B, O	B, AB
AB	A, B, O, AB	AB

e. If the blood or blood product is NOT going to be transfused, it must be returned to the Blood Bank within the first thirty (30) minutes from the time that it was released from Blood Bank for the purpose of maintaining an appropriate temperature to allow re-issue.

   i. Exception: if the blood products are released in a blood cooler.

3.5 **Administration of Blood**

a. Refer to our point of care and learning online resource for clinical skill detail.

b. Administer prophylactic medication if applicable.

i. Oral premedication should be administered 30 minutes before transfusion start

ii. IV premedication should be administered within 10 minutes of transfusion start

c. Prepare equipment: blood warmer (if applicable), infusion system, syringe infusion pump, IV access, infusion set with compatible IV solution (0.9% Normal Saline).

d. Verification at the time of Administration: Two licensed staff (e.g.: two RNs; one RN and an LVN; one RN and a physician; or two physicians) shall verify <u>in the presence of the patient, the following:</u>

i. Physician order for transfusion and consent to transfuse.

ii. Intended recipient/Patient's name, DOB, MRN, Cross match number, ABO group and Rh type.

iii. Donation identification number, Donor ABO group and if required donor, Rh type.

iv. Special transfusion or blood component processing requirements.

v. Components expiration date and if applicable, time.

vi. The date and time of issue. (infusion must begin within 30 minutes of issue time)

vii. Final visual inspection of the product.

e. Upon verification the transfusionist and independent verifier shall complete the Transfusion Record Form #625 or #665 Emergency Release Form.

f. Starting the Transfusion: Transfusion should be started slowly for first 15 minutes (1-2mL/min; not faster than 120 mL/hr) and then rate can be increased to as fast as tolerated and routine transfusion should not exceed 300mL/h. Slower rates recommended for patients at risk for circulatory overload. Faster rates of infusion, applicable to hemorrhagic shock are at the discretion of the treatment team and not within the scope of this guideline.

g. Observe for a transfusion reaction and measure vital signs within 15 minutes

h. After the first 15 minutes if no adverse events are suspected the rate of transfusion should be increased and must be completed within 4 hours of the start of the transfusion. However, the patients size, blood volume and hemodynamic condition should be taken into consideration in determining flow rate.

i. Monitoring during the transfusion: periodically monitor the patient throughout the infusion including IV site

j. Vitals signs should be taken before, 15 minutes after initiation and after transfusion. Vital signs should be taken immediately if there is a suspected transfusion reaction or change in the clinical condition of the patient

k. Suspected Transfusion Reactions:

i. Transfusion reactions symptoms may include;

- Fever ≥1 C rise in temperature to ≥38 C,
- Chills with or without rigors
- Respiratory distress, including wheezing, coughing, hypoxia, dyspnea
- Hyper or hypotension
- Abdominal, chest, flank, or back pain
- Pain at the infusion site
- Skin manifestations: rash, flushing, urticaria, pruritus, and localized edema
- Nausea/Vomiting

ii. Patient Focused Steps;

- Stop transfusion immediately, keep line open
- Perform clerical recheck between patient and the components.
- Consult with clinical team for a plan of care
- Identify and complete additional diagnostic steps to investigate in collaboration with blood bank.

iii. Component focused Steps;

- Contract blood bank for directions on investigating potential causes of the reaction
- Obtain instructions for returning any remaining component, associated intravenous fluid bags and tubing
- If transfusion reaction is confirmed, order a Transfusion Reaction Investigation (LAB4734), draw one pink top tube of blood and send to the Blood Bank.

3.6 **Special Considerations when administering blood products via syringe (neonates, infants, and small pediatrics. Patients receiving less than a full unit):**

a. Connect Y tubing to the appropriate syringe on "Y" and to extension tubing on bottom end.

b. Spike blood component: ensure extension tubing remains closed

c. Aspirate full volume of bag into syringe

d. Clamp tubing to bag and open clamp for extension tubing

e. Prime tubing with blood product

f. Turn off and disconnect IV fluids if infusing in IV line to be used for blood component administration.

g. Flush line with 0.9% sodium chloride solution

h. Connect syringe to IV pump designated for blood transfusion

i. Connect IV tubing to child's IV line

j. Open clamp to blood component

k. Start pump. Unless otherwise specifically indicated by the child's clinical condition.

l. Observe patients closely for the first 15 minutes and take vital signs

3.7 **Completing the Transfusion**

a. Assess vital signs in addition to the stop date/time and volume received.

b. Discard the empty blood container and tubing in a biohazard container

3.8 **Document all required information on:**

a. EPIC activity for blood administration

b. Forms issued with product Transfusion Record Form #625,#665 Emergency Release Form, or Massive Transfusion Blood Resuscitation Log Form #825.

c. Documenting "See EHR" is acceptable when elements of the transfusion are imbedded in the electronic health record workflow.

d. In case of Electronic Health Record downtime, the downtime process is as follows:

i. LP to write transfusion order on downtime order form

ii. Nurse to complete downtime form #630 and send with blood sample to blood bank for compatibility testing.

iii. When blood is ready to transfuse, Nurse to complete form #8 and send to blood bank. The specific unit is released with a copy of form #630 to be completed during transfusion process.

4. REFERENCES

4.1 AABB Standards for Blood Banks and Transfusion Services, 33rd Edition, 2022.

4.2 California Hospital Association Consent Manual 2016 Page 4.2 Section III. Blood Transfusions.

4.3 Dynamic Health, CDS + Skills, Blood Product Administration

4.4 Dynamic Health, CDS + Skills, Blood Product Administration (Pediatrics)

4.5 The Joint Commission, clabsi_toolkit_tool_3-22_cvc_maintenance_bundles.pdf (jointcommission.org), February 2023.

4.6 Paul Gann Act, Health and Safety Code Section 1645

4.7 RUHS Housewide Policy 604.2, Massive Transfusion

4.8 RUHS Housewide Policy 606.1 Consent for Blood Transfusion Paul Gann Act

4.9 RUHS Nursing Policy 610, Specimen Labeling Policy

5. ATTACHMENTS

5.1 Transfusion Record Form 625

5.2 Emergency Release Blood Product Workflow

5.3 Blood Refrigerator Workflow

5.4 Authorization to Release Blood Products, Form 8, (Downtime Form)

5.5 Crossmatch Administration Request, Form 630 (Downtime form)

5.6 Emergency Release of Blood, Form 665

5.7 Emergency Release of Blood, Form 665 (Downtime Form)

Document History:

Prior Release Dates: 8/17/16, 5/10/2018, 8/26/2019, 7/20/2023	**Retire Date:** N/A
Document Owner: Nursing Director Trauma Services	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
5/5/2025	Nursing, Stephen Kernop, TPD	Y	Minor updates to 3.2. 3.3.b. Removed 2 license independent verification. Added 3.4.b.i. Alternate workflow. Added 5.3 Blood refrigerator workflow
5/12/2025	Blood and Tissue Committee	N	
6/19/2025	Nursing P&P	Y	3.3 update for downtime procedure, Modify 5.3 notification to blood bank, Refer to P&T
7/7/2025	P&T	N	Consent agenda, no changes.
8/18/2025	Policy Approval Committee (PAC)	N	E-Vote, update Elsevier to Dynamic Health.
8/19/2025	MEC	N	E-Vote, no changes.

Transfusion Record Form # 625

TEST, RUHOTX
MR No: **20023931** Acct #: 108834
LOC: RANA-A1301 ABO/Rh: **O Pos** DOB: 04/10/1985
Specimen Draw Date/Time: 07/21/2022, 13:09
Special Needs: KNEG
Patient Antibodies: C, WRM

Unit No: **W126622027985** O
Product ABO/Rh: **O Pos**
Product: E2720V00 - FFP CP2D
570

Expiration Date/Time: 07/26/2022, 23:59
Blood Unit Antigens: CMV -

Crossmatch #: E264499
Crossmatch Interpretation: Not Required
Tech Id: E264499 Product Selection: 07/21/2022 14:44
Product Issued Date/Time:
Comments:
PTAG180

TRANSFUSION RECORD

State Law requires that the women tested be informed as to the rhesus (Rh) typing test results.

BLOOD/COMPONENTS MUST BE RETURNED TO BLOOD BANK WITHIN 30 MINUTES IF NOT TRANSFUSED OR STORED IN A COOLER.

VERIFICATION OF:

- ☐ Patient's Name, DOB, and M.R. No. against Patient's wristband
- ☐ Patient and Donor ABO/Rh
- ☐ Donor No. and Expiration Date on all Forms and Labels
- ☐ Paul Gann consent on file (Form 163)
- ☐ Crossmatch Number: _____ PT. UNIT_____

BLOOK

_____
Signature of person starting transfusion (Print name, date, and time)

_____
Signature of person verifying transfusion (Print name, date, and time)

_____
Signature of person completing/stopping transfusion (Print name, date, and time)

Date/Time Started:			Date/Time Stopped:
AMT Given: ALL	3/4	1/2	1/4

VITAL SIGNS	Temp.	Pulse	B/P
Pre-Txn			
15 min. vitals			
Post-Txn within 1 hour			

Transfusion Reaction: ☐ Yes ☐ No (If YES, check all symptoms that are present)

- ☐ Chills
- ☐ Nausea/Vomiting
- ☐ Pain (chest/back/arm)
- ☐ Dyspnea
- ☐ Elevated Temperature
- ☐ Other: _____
- ☐ Hypotension/Shock
- ☐ Hypertension
- ☐ Hematuria
- ☐ Jaundice
- ☐ Facial Flushing
- ☐ Hemoglobinuria
- ☐ Abnormal Bleeding
- ☐ Oliguria/Anuria
- ☐ Heat at Infusion Site
- ☐ Edema-Pulmonary/Peripheral

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SEE REVERSE FOR INSTRUCTIONS IF PATIENT REACTS ADVERSELY TO TRANSFUSION

Form # 625 Rev. 06/19 Original – Medical Record • 2nd – Blood Bank

AT THE FIRST SIGN OF AN ADVERSE REACTION:

1. **STOP TRANSFUSION IMMEDIATELY!**
2. Keep IV open with slow saline drip, but use a new administration set to avoid infusing the blood remaining in the original set.
3. Check for agreement of all identifying names and numbers on donor unit, transfusion record and patient wristband.
4. Notify the attending physician and the Blood Bank at once and describe symptoms.
5. Send the following to the Blood Bank STAT:
   - Pink top tube drawn atraumatically to avoid hemolysis
   - An order for a Transfusion Reaction Workup.
   - Remainder of the unit with attached IV set tied off and needles removed. (Avoid contaminating the unit as it may need to be cultured).
   - "Blood Bank" copy of the completed Transfusion Record.
   - At Blood Bank's request, first voided urine marked "Post Transfusion".

NOTE: "Signs and symptoms suggestive of mild allergic reactions (eg. urticaria) need NOT be reported to the blood bank or transfusion service." (Section 7.4.1.2 25th ed. AABB Standards, 2006)

Emergency Release Blood Product Workflow

Emergency Release Process

Step	Action
1.	Call Blood Bank x65266
2.	Time required for blood
3.	Provide the patient's name and MRN *Exception: Inbound Trauma Activation*
4.	Indicate the blood component and amount required or indicate Trauma Cooler
5.	Provide patient's age and sex
6.	Provide the number and name of the ordering physician
7.	Indicate the location of the patient
8.	Verify or correct when orders are read back to assure accuracy
9.	Send staff to collect blood with sheet of patient labels
10.	Collect pre-transfusion specimen (if not already in blood bank)

Blood Availability:

Immediate	**10-30 minutes from receipt of sample in Lab**	**>30 minutes from receipt of sample in Lab**
O Type (+ or -) blood	**Group Specific uncross matched Blood**	**Crossmatched Blood**

Emergency Release Documentation

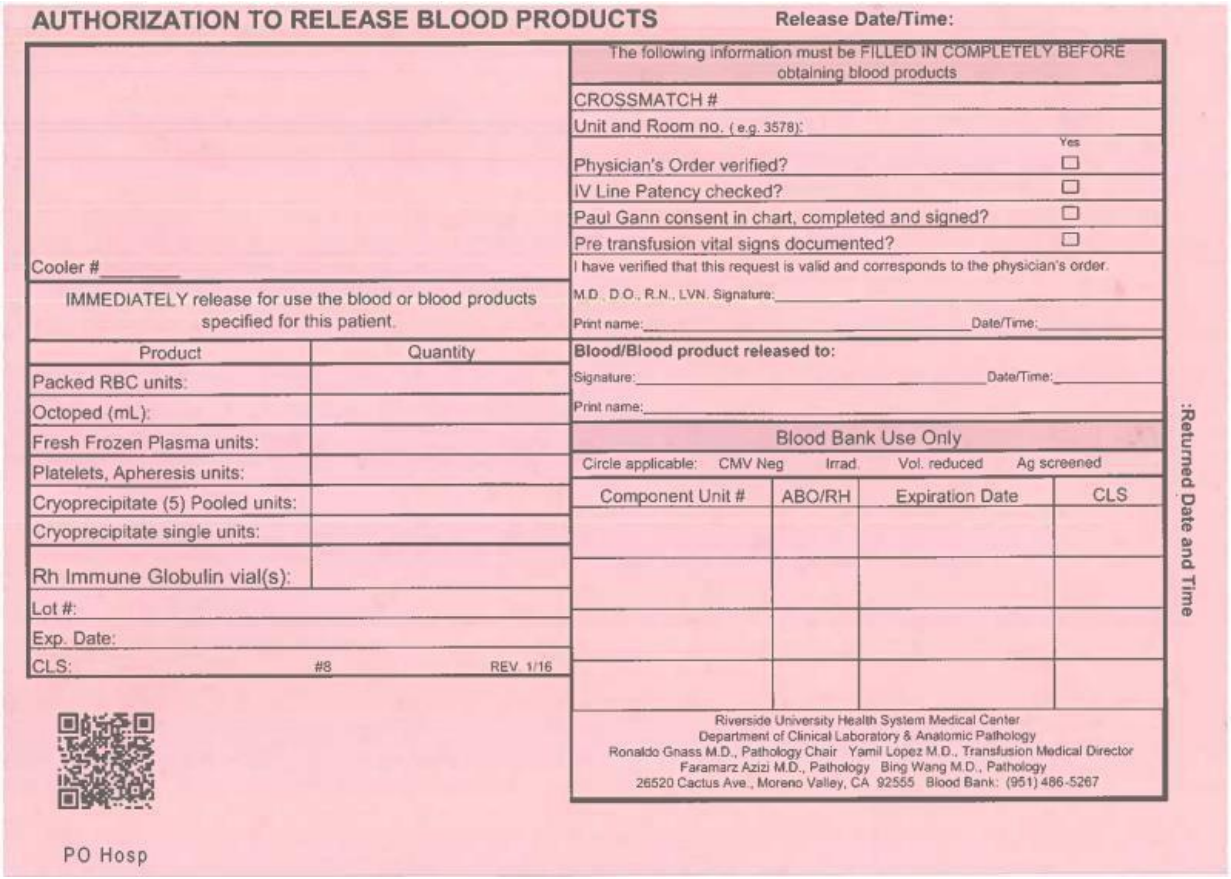
- The Transfusion Record Form #655, emergency released units will contain the caution that the blood is being released on an emergency basis.
- The physician authorizing the emergency release must sign the Emergency Request section of the Blood Bank Requisition Form and return it to the Blood Bank.
- Blood specimens and requisitions must be appropriately labeled. Many hemolytic transfusion reactions have occurred under emergency conditions when routine patient identification procedures are ignored or circumvented.
- The Blood Bank will complete testing and notify the physician of the results of testing.

Blood Refrigerator Emergency Release Blood Product Workflow

For use in ED, OR, or L&D

1. **HaemoBanks: The requirement for immediately available blood for unstable patients has been satisfied by HaemoBank blood refrigerators located in the emergency department, operating room, and labor and delivery containing type O positive and O negative PRBC and type A fresh frozen plasma or liquid plasma, as available.**
2. **Upon the verbal order of the ED, Trauma, Anesthesia, or Obstetrics Attending physician, products are removed from this blood refrigerator and transfused to the patient. After removing products from the blood refrigerator, they must be transfused within 30 minutes or returned to the Haemobank blood refrigerator.**
3. **Clinical departments should notify the blood bank of product use to facilitate timely restocking.**

Authorization to Release Blood Form # 8 (Downtime form)



AUTHORIZATION TO RELEASE BLOOD PRODUCTS **Release Date/Time:**

Cooler #_____

IMMEDIATELY release for use the blood or blood products specified for this patient.

Product	Quantity
Packed RBC units:	
Octoped (mL):	
Fresh Frozen Plasma units:	
Platelets, Apheresis units:	
Cryoprecipitate (5) Pooled units:	
Cryoprecipitate single units:	
Rh Immune Globulin vial(s):	

Lot #:

Exp. Date:

CLS: #8 REV 1/16

PO Hosp

The following information must be FILLED IN COMPLETELY BEFORE obtaining blood products

CROSSMATCH #

Unit and Room no. (e.g. 3578):

	Yes
Physician's Order verified?	☐
IV Line Patency checked?	☐
Paul Gann consent in chart, completed and signed?	☐
Pre transfusion vital signs documented?	☐

I have verified that this request is valid and corresponds to the physician's order.

M.D., D.O., R.N., LVN. Signature:_____

Print name:_____ Date/Time:_____

Blood/Blood product released to:

Signature:_____ Date/Time:_____

Print name:_____

Blood Bank Use Only

Circle applicable: CMV Neg Irrad. Vol. reduced Ag screened

Component Unit #	ABO/RH	Expiration Date	CLS

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Department of Clinical Laboratory & Anatomic Pathology
Ronaldo Gnass M.D., Pathology Chair Yamil Lopez M.D., Transfusion Medical Director
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26520 Cactus Ave., Moreno Valley, CA 92555 Blood Bank: (951) 486-5267

:Returned Date and Time

Crossmatch Administration Request Form # 630 (Downtime Form)

TEST GROUPS	INDIVIDUAL TESTS	COMPONENT REQUESTED
Type & Screen ABO, RhD, Antibody Screen	ABO	Red Blood cells ☐ Irradiated
Type & Crossmatch ABO, RhD, Ab. Sc., Crossmatch	RhD	Fresh Frozen Plasma/Frozen Plasma 200 mL / 400 mL / 500 mL / 600 mL
Cord Blood Study ABO, RhD, Direct Coombs	Antibody Screen	Platelet Pheresis ☐ Irradiated
Rhogam Screen ABO, RhD, Antibody Screen	Antibody I.D.	Neonate Octoped
Prenatal Screen ABO, RhD, AB. Sc, ID	Antibody Titer:	Cryoprecipitate - small unit, 20 mL
☐ Suspected Transfusion Reaction Workup	Antibody Score:	Cryoprecipitate - Pooled 5 units, 100 mL
Rhogam Lot Number & Expiration Date	Direct Coombs (DAT)	PREVIOUS RECORD AVAILABLE: Yes ☐ No ☐
State Law requires that the woman being tested be informed as to the Rhesus (RhoD) Blood Typing results.	Fetal - Maternal Bleed	PATIL GAIN CONSENT ON FILE: Yes ☐ No ☐

DATE & TIME RECEIVED

DATE & TIME COMPLETED

Patient Identification and Sample Collection:
Well have collected a blood sample on the below named patient, verified the name, DOB, verified the MR number, and have verified the Crossmatch number placed on the tubes to be correct.

Date verified: _____ Time verified: _____ Nursing Unit _____ Crossmatch # _____

Signature of individual(s) collecting blood samples: _____ ☐ Specimens in Lab

CLINICAL DIAGNOSIS:

ORDERING AND ATTENDING DOCTORS ☐ STAT ☐ ROUTINE

BLOOD/COMPONENTS MUST BE RETURNED TO BLOOD BANK WITHIN 30 MIN. IF NOT TRANSFUSED

TRANSFUSION RECORD

	ABO GROUP	Rh TYPE	ANTIBODY SCREEN/ I.D.
PATIENT			
DONOR NO. _____ Expires:			

CROSSMATCH RESULTS: ___ COMPATIBLE ___ COMPATIBLE, PREWARMED
___ LEAST INCOMPATIBLE

CLS Signature _____

VERIFICATION OF:
- ☐ Patient's Name, DOB and M.R. No. against Patient's Armband
- ☐ Patient and Donor ABO, RH
- ☐ Donor No. and Expiration Date on all Forms and Labels
- ☐ Crossmatch Number: _____

Signature of person starting transfusion

Signature of person verifying identification

PT. UNIT

Signature of person completing/stopping transfusion

Date/Time Started:	Date/Time Stopped:
AMT. Given: ALL ¼ ½ ¼	

TRANSFUSION REACTION REPORT

SIGNS/SYMPTOMS NOTED ☐ Yes ☐ No
Name of Physician notified Date: Time

If YES, ID CHECK:		
Does armband name, DOB & M.R. No. = Name, DOB & M.R. No. on unit tag?	☐ Yes	☐ No
Does armband name, DOB & M.R. No. = Name, DOB & M.R. No. on Crossmatch Form?	☐ Yes	☐ No

If a transfusion reaction is suspended, stop the transfusion, drip saline, and consult a physician IMMEDIATELY. Call the Blood Bank at Ext. 65266. Return the unused portion of unit with tubing as well as a post transfusion blood sample (pink top tube) to the Blood Bank along with the yellow copy.

Symptoms (3)
- ☐ Flushing of the Skin
- ☐ Hypotension
- ☐ Excessive Pain in Vein
- ☐ Nausea, Vomiting
- ☐ Hemoglobinuria
- ☐ Bleeding at Surgical Site
- ☐ Increased Temperature
- ☐ Itching
- ☐ Chills
- ☐ Shortness of Breath
- ☐ Sweating
- ☐ Chest/Back Pain
- ☐ Confusion
- ☐ Diffuse Bleeding
- ☐ Other _____

VITAL SIGNS	Temp.	Pulse	B/P
Pre-Txn			
15 min. vitals			
Post-Txn within 1 hour			

DATE & TIME DISPENSED

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FORM 630 (10/15) CROSSMATCH ADMINISTRATION REQUEST

White - Chart Yellow - Lab Pink - Component (attached to blood product)

RLDRK

Crossmatch Administration Request Form # 630 (Downtime Form) (Cont.)

FOR SUSPECTED TRANSFUSION REACTIONS SUGGESTED CLINICAL MANAGEMENT (This is not an order)

FINDINGS	PROCEDURE
I. Circulatory Overload	1. Notify Licensed Provider
II. Urticaria only	1. Notify Licensed Provider 2. Slow transfusion, give IM antihistaminics, resume transfusion at a normal rate in 15 minutes if therapy is effective.
III. Fever, chills, lumbar pain dyspnea, chest pain or oozing	1. **STOP** transfusion, but keep IV open 2. Notify Licensed Provider 3. **CALL** the Blood Bank - Phone Number 951-486-5267 4. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank. 5. Obtain urine sample for free hemoglobin
IV. Shock, Hemoglobinuria, oliguria, bleeding	1. **STOP** transfusion, but keep IV open 2. Notify Licensed Provider 3. **CALL** the Blood Bank - Phone Number 951-486-5267 4. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank. 5. **INSTITUTE PROPHYLACTIC TREATMENT IMMEDIATELY** a. Maintain blood pressure b. Maintain urine flow over 100 ml/hr for adult over 1-2 ml/kg/hr for child 1) Furosemide, 40-80 mg. I.V. for adult 0.5 - 1 mg/kg/dose (max dose 40 mg) for child (This dose may be repeated once) 2) Fluids - keep strict I & O c. Consider possible indications for: 1) Heparin 2) Platelet concentrates 3) Fresh frozen plasma or Factor VIII concentrates d. Therapy for sepsis 6. Obtain urine sample (catheterize if necessary) for free hemoglobin. 7. Get baseline studies: a. Platelet count b. Prothrombin Time c. PTT d. Bilirubin e. Hemoglobin and/or Hematocrit f. WBC g. BUN, Creatinine and Electrolytes
V. Anaphylaxis or anaphylactoid reaction	1. **STOP** transfusion, but keep IV open 2. Epinephrine 0.4 ml of 1:1000 solution I.M., for **adult** 3. Epinephrine 0.01 mg/kg/dose (max dose 0.3 mg per injection) of 1:1000 solution I.M. Q15 min for **child** 4. Notify Licensed Provider 5. **CALL** the Blood Bank - Phone Number 951-486-5267 6. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank, 7. Consider bacterial contamination or antibodies to IgA in further evaluation and treatment 8. Obtain urine sample (catheterize if necessary) for free hemoglobin.

RLDBK

Emergency Release of Blood Form # 665

EMERGENCY BLOOD RELEASE FORM
CROSSMATCH NOT PERFORMED

Riverside University HEALTH SYSTEM

NAME:
DOE112, DOE112

Pt. Blood Type

STX Order ID: 154

MR:
DOB: 01/01/2000

Male
19 years old

Product	Unit Number	Prod. code	Unit Blood Type	Exp Date	Loc	Issued D/T	Issued to:	Transfused	Returned
RBC	W125619000100	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000101	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000102	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000103	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000109	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000110	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000105	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000106	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000107	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000108	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000112	E5548V00	A Pos	5/12/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000113	E5548V00	A Pos	5/12/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
PLT	W125619000116	E3077V00	A Pos	5/10/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐ Room temp
PCRY	W125619000118	E3591V00	AB Pos	5/8/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐ Room temp

Cooler # _____

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Riverside University Health System
26520 Cactus Ave., Moreno Valley, CA 92555

CLINICAL DIAGNOSIS

I, _____
SIGNATURE/PRINT NAME OF PHYSICIAN DATE/TIME

accept the responsibility for the transfusion of the blood listed above without waiting for completion of the compatibility tests.

BLOOD RELEASED TO (SIGNATURE/PRINT REQUIRED) DATE/TIME

SIGNATURE/PRINT NAME OF CLINICAL LAB SCIENTIST RELEASING BLOOD DATE/TIME

Riverside University Health System
Medical Center & Community Health Centers

EMERGENCY BLOOD RELEASE FORM

Form #665 5/2019

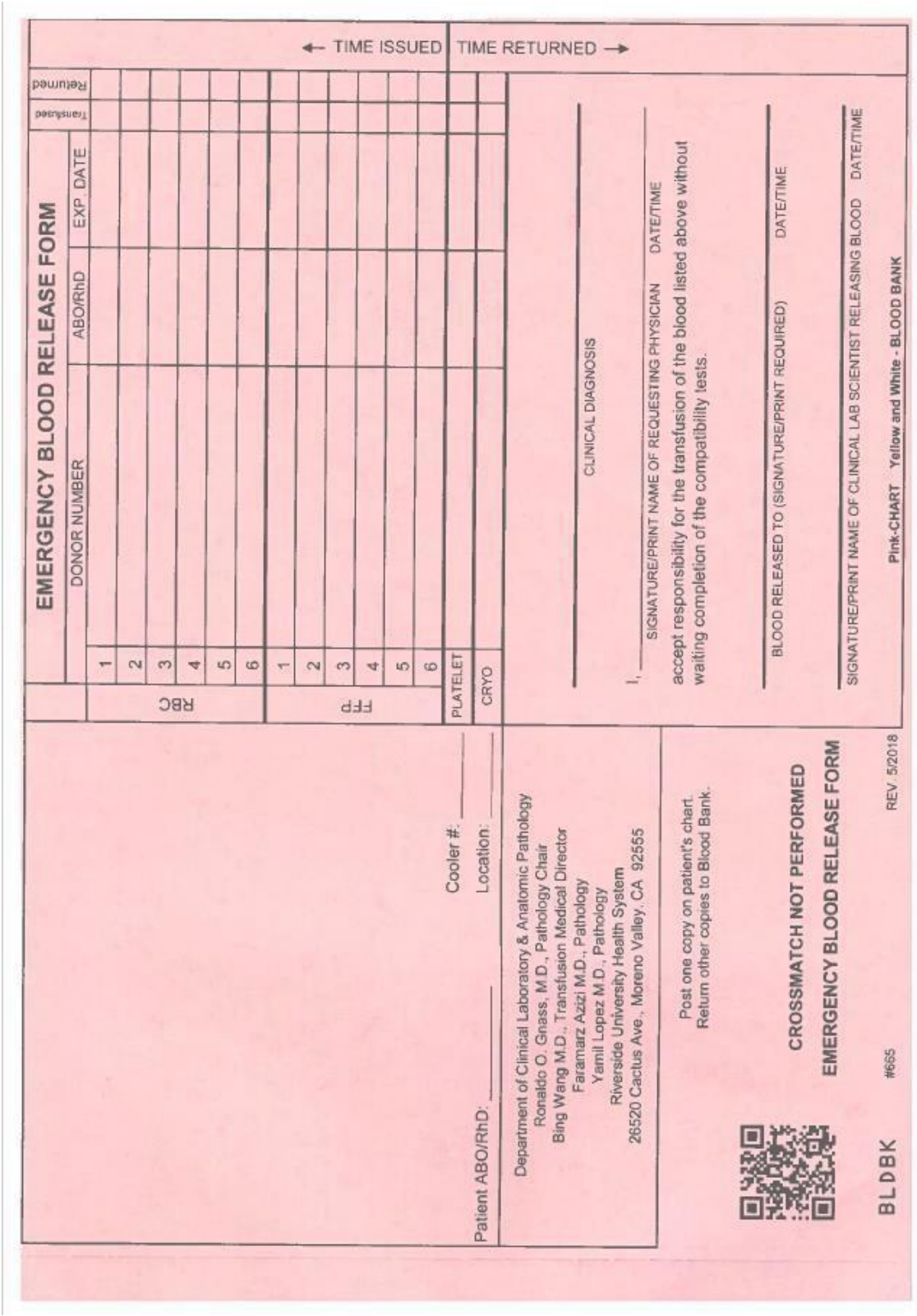
BLDBK

Distribution: White – Chart / Yellow & Pink – Blood Bank

Place pt. label here

DATE/TIME RETURNED:
CLS Initials:

A Patient's Guide to Blood Transfusion
(Downtime Form)



EMERGENCY BLOOD RELEASE FORM

	DONOR NUMBER	ABO/RhD	EXP DATE	Transfused	Returned
RBC 1					
RBC 2					
RBC 3					
RBC 4					
RBC 5					
RBC 6					
FFP 1					
FFP 2					
FFP 3					
FFP 4					
FFP 5					
FFP 6					
PLATELET					
CRYO					

← TIME ISSUED | TIME RETURNED →

Patient ABO/RhD: _____ Cooler #: _____

Location: _____

Department of Clinical Laboratory & Anatomic Pathology
Ronaldo O. Gnass, M.D., Pathology Chair
Bing Wang M.D., Transfusion Medical Director
Faramarz Azizi M.D., Pathology
Yamil Lopez M.D., Pathology
Riverside University Health System
26520 Cactus Ave., Moreno Valley, CA 92555

Post one copy on patient's chart.
Return other copies to Blood Bank.

CLINICAL DIAGNOSIS _____

I, _____ SIGNATURE/PRINT NAME OF REQUESTING PHYSICIAN DATE/TIME
accept responsibility for the transfusion of the blood listed above without waiting completion of the compatibility tests.

_____ BLOOD RELEASED TO (SIGNATURE/PRINT REQUIRED) DATE/TIME

_____ SIGNATURE/PRINT NAME OF CLINICAL LAB SCIENTIST RELEASING BLOOD DATE/TIME

Pink-CHART Yellow and White - BLOOD BANK

CROSSMATCH NOT PERFORMED
EMERGENCY BLOOD RELEASE FORM

BLDBK #665 REV 5/2018

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER

Housewide

	Document No: 681	Page 1 of 7
Title: **Guidelines for Blood Culture Collection**	**Effective Date:** 9/2/2025	☐ **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 ensure accurate and contamination-free blood culture collection, supporting timely diagnosis, appropriate treatment, and improved patient outcomes.

2. DEFINITIONS

2.1 Inoculation: the process of intentionally introducing microorganisms into a culture medium to enable their growth and study

2.2 Standard Aseptic Non-Touch Technique (Standard-ANTT) is a method used to prevent infection during simple medical procedures by maintaining cleanliness and avoiding direct contact with sterile parts (Key-Parts) or body sites (Key-Sites). It involves cleaning the work area, keeping items in sterile packaging until use, performing hand hygiene, and avoiding direct contact with Key-Parts (e.g. blood culture bottle tops) and Key-Sites (e.g. venipuncture sites).

3. STANDARDS

3.1 SPECIMEN COLLECTION

a. See Attachment A-C for procedural steps and supplies required.

b. Multi-Sampling Venipuncture is the preferred technique (sampling from two venipuncture sites).

3.2 Standard: blood cultures should be collected from two different venipuncture sites

- Exception: For patients with difficult intravenous access or pediatric patients, single sampling strategies are acceptable (whereby the whole blood sample is collected from one venipuncture site).
  - The reason for the inability to collect from a second site should be clearly documented.
- For sub-acute infective endocarditis draw blood at intervals 30-60 minutes apart (provider to specify).

b. Collect samples prior to antibiotic administration whenever possible.

c. Use standard precautions and maintain strict ANTT during blood culture collection.

d. No more than three (3) sets of blood cultures should be drawn in a twenty-four (24) hour period.

e. Blood cultures should not be repeated for two to five days as the blood does not become sterile immediately following the start of therapy.

3.3 **BLOOD DRAW LIMITATIONS**

a. In instances of a difficult blood draw, the aerobic bottle should be prioritized.

3.4 **FILL VOLUME**

a. Proper fill volumes are essential to maximize recovery of microorganisms and reduce false-negative results.

b. Adults and children ≥10 years: Fill with 8-10 mL of blood per bottle.

3.5 Pediatric bottles: A general rule is to collect up to 4% of the total blood volume of the child to maximize pathogen detection while ensuring patient safety. Blood volume ≈ 80 mL per kg of body weight (for a 10kg child: 10kg x 80mL/kg = 800mL blood volume)

Patient weight (kg)	Sample volume (mL)
<2.0	1.0
>2.0 – 10	1.0-2.0
>10	Up to 4

a. Do not underfill or overfill bottles**,** as improper volume can affect microbial growth detection and test sensitivity.

b. Ensure bottles are gently mixed immediately after collection to distribute blood evenly in the culture medium.

3.6 **SPECIMEN REJECTION & STORAGE CRITERIA**

a. Blood culture bottles received >24 hours after collection.

b. Unlabeled bottles.

3.7 If there is an unavoidable delay in processing, inoculated blood culture bottles may be stored at room temperature for up to 24 hours before being loaded onto the instrument.

a. Blood culture bottles are incubated on the instrument for a standard period of 5 days. Bottles must have an expiration date at least 5 days beyond the date of collection to ensure full incubation time.

4. REFERENCE:

4.1 Clinical Laboratory Standards Institute CLSI M47

4.2 Centers for Disease Control and Prevention CS 331454-B: : Blood Culture Contamination: An Overview for Infection Control and Antibiotic Stewardship Programs Working with the Clinical Laboratory

4.3 BIOMÉRIEUX instructions for use BACT/ALERT FA Plus, BACT/ALERT FN Plus. BACT/ALERT PF Plus. 043784- 03 - en - 2020-02, 2020-08, 2023-03.

4.4 ASM. Practical Guidance for Clinical Microbiology Laboratories: A Comprehensive Update on the Problem of Blood Culture Contamination and a Discussion of Methods for Addressing the Problem. Practical Guidance for Clinical Microbiology. January 2020 Volume 33 Issue 1 10.1128/cmr.00009-19

5. ATTACHMENTS

5.1 ATTACHEMENT A: WINGED TIP COLLECTION

5.2 ATTACHEMENT B: SYRINGE COLLECTION

5.3 ATTACHMENT C: SUPPLIES NEEDED

5.4 ATTACHMENT D: SPECIMENT LABELING

Document History:

Prior Release Dates: New Housewide		**Retire Date:** N/A	
Document Owner: Clinical Laboratory: Pre-Analytical Department		**Replaces Policy:** 681 release dates 11/2015, 03/2020, 01/2023, 05/21/2023	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
04/15/2025	Stacie Kahyai, CLS	No	Updated to new template
04/15/2025	Cedric Bol, CLS Laboratory Director	No	
04/15/2025	Ronaldo Gnass, MD Medical Laboratory Director	No	
04/15/2025	Bruce Campbell, CLS	Yes	Major Changes: Standardization of blood culture collection protocol to current practices. Reestablish hospital wide collection practices. Update to new blood culture system.
8/21/2025	Nursing Policy and Procedure	No	Approved
9/2/2025	PAC	Y	Update References

ATTACHEMENT A: WINGED TIP COLLECTION (VENIPUNCTURE, preferred method)

1. PREPARE BLOOD COLLECTION KIT
    1. Confirm the patient's identity and gather all required materials before collection.
    2. Do not use bottles beyond their expiration date or bottles which show signs of damage or deterioration.
2. PREPARE BOTTLES FOR INOCULATION
    1. Perform hand hygiene using soap and water or use alcohol-based hand sanitizer.
    2. Remove plastic flip cap and disinfect the septum with 70% isopropyl alcohol (use a fresh alcohol wipe for each bottle). Allow bottle tops to air dry completely to ensure full disinfection. Disinfect the red waste tube septum with alcohol, allow to dry.
3. PREPARE VENIPUNCTURE SITE
    1. Apply tourniquet and palpate for a vein
    2. Cleanse the skin using an appropriate disinfectant (scrub for 30 seconds) and allow to dry. The site is not clean until the disinfectant has fully dried.
        - Chlorhexidine in 70% isopropyl alcohol for children and adults
        - Povidone-iodine in neonates.
4. VENIPUNCTURE
    1. Do not re-palpate the vein after site preparation.
    2. Insert the winged tip needle into the prepared vein.
5. CULTURE BOTTLE INOCULATION
    1. Use transfer device to fill a red-top tube with 1mL of waste
    2. Place the adapter cap over the **aerobic** (green) bottle to pierce the septum
    3. Hold the bottle upright, below the level of the draw site and add up to 10mL per adult bottle and up to 4mL per pediatric bottle.
    4. Repeat the procedure for the **anaerobic** (orange) bottle.
    5. Gently invert each bottle 2-3 times to mix specimen with reagent. Do not shake vigorously
6. OTHER BLOOD TESTS
    1. If other blood tests are requested, always collect the blood cultures first
7. FINISH THE PROCEDURE
    1. Discard collection set into sharps.
    2. Cover the venipuncture site
    3. Remove gloves, perform hand hygiene
    4. Label specimen bottles and record procedure
        - Ensure labels are placed only in the designated space on the bottle and do not cover any barcodes.
    5. Place bottles in a biohazard transport bag.
    6. Transport to the lab promptly.

ATTACHEMENT B: SYRINGE COLLECTION AND TRANSFER (LINE DRAW)

Do not collect blood cultures from existing lines — use a fresh venipuncture site unless specified by order (e.g., blood cultures from a central line may be collected *if* specifically ordered)

1. PREPARE BLOOD COLLECTION KIT
    1. Confirm the patient's identity and gather all required materials before collection.
    2. Do not use bottles beyond their expiration date or bottles which show signs of damage or deterioration
2. PREPARE BOTTLES FOR INOCULATION
    1. Perform hand hygiene using soap and water or use alcohol-based hand sanitizer
    2. Remove plastic flip cap and disinfect the septum with 70% isopropyl alcohol (use a fresh alcohol wipe for each bottle). Allow bottle tops to air dry completely to ensure full disinfection
3. PREPARE COLLECTION SITE (CVAD or PIV Placement)
    1. Central Vascular Access Device (CVAD)
        - Stop any infusing fluids through the device for at least 2 minutes prior to collection.
        - Remove the existing needleless connector and replace with a new sterile needleless connector
        - Scrub the hub with an alcohol pad for at least 15 seconds; allow to air dry.
    2. Venipuncture Site
        - Apply tourniquet and palpate for a vein
        - Cleanse the skin using an appropriate disinfectant (scrub for 30 seconds) and allow to dry. The site is not clean until the disinfectant has fully dried.
            - Chlorhexidine in 70% isopropyl alcohol for children and adults
            - Povidone-iodine in neonates.
        - Do not re-palpate the vein after disinfecting the site
        - Insert the catheter needle into the prepared vein
4. CULTURE BOTTLE INOCULATION
    1. Using a sterile 10mL syringe, connect to the needleless connector, draw 1mL and discard blood appropriately (waste volume)
    2. Using a sterile 10 mL syringe, connect to the needleless connector
    3. Do not flush prior to drawing
    4. Gently pull back the plunger to aspirate the required volume of blood into syringe
    5. Detach the syringe from the access site and immediately attach a sterile blood transfer device
    6. Inoculate the **aerobic** (green):
        - Add up to 10mL per adult bottle and up to 4mL per pediatric bottle
    7. Repeat the procedure for the **anaerobic** (orange) bottle
    8. Gently invert each bottle 2-3 times to mix specimen with reagent. Do not shake vigorously.
5. FINISH THE PROCEDURE
    1. Flush the vascular access device with 10–20 mL of normal saline
    2. Resume infusions as ordered or apply antiseptic barrier cap to the needleless connector
    3. Discard collection set into sharps
    4. Remove gloves and perform hand hygiene
    5. Label the specimen bottles and record procedure
        - Ensure labels are placed only in the designated space on the bottle and do not cover any barcodes
    6. Place bottles into a biohazard transport bag and transport to the lab promptly

ATTACHMENT C: SUPPLIES NEEDED

WINGED TIP COLLECTION (VENIPUNCTURE)

- Identification labels with confirmed patient identifiers
- Blood Culture bottles (Aerobic & Anaerobic)
- Alcohol prep pads (70%)
- Chloraprep (2%chlorhexidine gluconate/ 70% Isopropyl alcohol)
- Clean gloves
- Butterfly blood collection set preferred
- Blood culture Male Luer Adapter
- Sterile 2 × 2-inch gauze pads
- Tourniquet
- Red-top tube (used as waste draw)

NEEDLE AND SYRINGE COLLECTION (LINE DRAW)

- Identification labels with confirmed patient identifiers
- Blood Culture bottles (Aerobic & Anaerobic)
- Alcohol pads (70% isopropyl alcohol)
- Clean gloves
- (2) sterile syringes (10 mL)
- Blood transfer device (e.g., female vacutainer adapter)
- (2) 10mL normal saline prefilled flush syringes
- New sterile needleless connector
- Red-top tube or sterile syringe (used as waste draw)

ATTACHMENT D: SPECIMENT LABELING

Always place the user label VERTICAL and ONLY in the correct BACT/ALERT bottle label area identified above. Make sure the top of the specimen label DOES NOT go above the bottle label.

Avoid these placements

Fill the bottle to the white line on the label NOT the black arrow. If you fill it to the black arrow you will overfill the bottle.

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICAL CENTER, COMMUNITY HEALTH CENTERS, AND HOSPITAL BASED CLINICS

	Document No: 1094	Page 1 of 3
Title: Electronic Communications Usage and Retention Policy	**Effective Date:** 8/15/2025	☒ **RUHS – Community Health Centers** ☒ **RUHS – Medical Center** ☒ **RUHS – Hospital Based Clinics** ☒ **Departmental.**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. PURPOSE

This policy establishes the standards and responsibilities for the usage, retention, and protection of Riverside University Health System (RUHS) electronic communications, including emails, instant messages, and other approved digital collaboration tools and platforms. This ensures compliance with Health Insurance Portability and Accountability Act (HIPAA), the California Public Records Act (CPRA), and other regulatory mandates.

The policy also defines required practices for transmitting sensitive information, such as Protected Health Information (PHI) and Personally Identifiable Information (PII), and outlines procedures for legal hold, auto-deletion, and managing email accounts of terminating employees (voluntary/involuntary).

2. SCOPE

2.1 The policy applies to:

a. All RUHS workforce members, including regular and temporary employees, volunteers, students, interns, consultants, and contractors who create, receive, transmit, or store electronic communications while performing official duties.
b. All RUHS-owned or managed email systems, instant messaging, and collaboration platforms.
c. Communications generated while providing services, including but not limited to healthcare operations, administrative coordination, patient care, and internal governance.

3. DEFINITIONS

a. **Electronic Communications:** All email messages, Microsoft Teams messages (chats and channels), and other defined and approved internal messaging tools.
b. **Retention Period:** The length of time an electronic communication record must be preserved before auto-deletion rule applies.
c. **Auto-Deletion:** Data exceeding retention period will be automatically and permanently deleted.
d. **Exclusion Request:** A formal request to retain emails or messages beyond the defined retention periods, subject to RUHS Executive approval.

4. POLICY

4.1 General Email Usage

a. RUHS owns any communication sent via email or other authorized electronic communications method. RUHS maintains the right to monitor electronic communications and therefore workforce members must not have the expectation of privacy related to any electronic communications.
b. RUHS provided email systems must be used for official business only. Personal email is prohibited to use for RUHS official business or any County business pursuant to Riverside County Policy A-50.
c. All staff must use encryption tools (e.g. by inserting **[Secure]** in the email subject line) when transmitting messages containing sensitive information (PHI/PII in the email body content or attachments. Information in the subject line of the email message is not encrypted and must not include any confidential or sensitive information.

4.2 Retention of Electronic Communications

a. Default Retentions:
    1. Email will be automatically deleted if older than 90 days.
    2. MS Teams Chat (individual/group) will be automatically deleted if older than 30 days.

b. Exclusions and Exceptions:
    1. Users may request exemption from the 90-day retention policy by submitting a *Retention Exemption Request* to RUHS Administration or a designated Senior Executive for approval.
    2. Mailboxes under legal hold or related to ongoing investigations, audits, or litigation must be preserved indefinitely or until the hold is lifted.
c. Email accounts that are terminated (voluntary/involuntary) will be disabled according to IT Policy 1058: Identity and Access Management for Terminated or Modified Access. Mailboxes will be purged in accordance with the email retention policy processes after being disabled, which can be completed within 90 days from the disabled date unless the mailbox is subject to retention requirements such as litigation, investigations, audits or have administrative approval.
d. Employees must be aware that email communications may be subject to public record requirements under HIPAA, CPRA, or other applicable legal or regulatory frameworks as referenced in Riverside County Policy A-50 – Electronic Media and Use Policy.

4.3 Litigation holds

1. A “litigation hold” is the process used by the Office of County Counsel, or the Human Resources Department to notify RUHS departments about pending or reasonably anticipated litigation.

2. The Office of County Counsel, or the Human Resources Department are authorized to direct any RUHS department to place a litigation hold whenever information transmitted by email is or may be relevant to pending or reasonably anticipated litigation involving RUHS.

3. When any RUHS department is directed by the Office of County Counsel, or the Human Resources Department to institute a litigation hold, the department must promptly contact and coordinate with the RUHS ISO to implement the litigation hold.

4.4 Auditing

The RUHS ISO will conduct annual audits to ensure compliance with this Electronic Communications Usage and Retention Policy.

5. REFERENCES

Internal

County of Riverside, Board of Supervisors

- Policy A-50 – Electronic Media and Use Policy

County of Riverside RMAP Retention Schedule

County of Riverside, RCIT Information Security Office

- Information Security Standard and Specifications 2.0

RUHS Information Services

- Policy IS 1045 - Encryption and Decryption

RUHS Information Services

- IS 1049 Transmission Security

External

US Department of HHS

- HIPAA Security Final Rule – Administrative and Technical Safeguards

Document History

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Date Reviewed	Reviewed By:	Revisions Made	Revision Description
06/17/2025	Joshua Alexander, RUHS Chief Information Officer Matthew Mason, RUHS Chief Technology Officer Jimmy Tran, RUHS Chief Information Security Officer Eddie Garcia, RUHS IT Manager III Michael Morales, RUHS IT Manager III Daniel De La Torre, RUHS IT Manager I Louis Tillis, Information Security Analyst III	N/A	- Initial Publication
07/02/2025	Davalyn Tidwell Pharmacy Director Matthew Mason RUHS Chief Technology Officer Jimmy Tran RUHS Chief Information Security Officer Louis Tillis Information Security Analyst III	Yes	- Revised Section 4.2.d per PAC Discussion on Public Record Awareness
7/1/2025	PAC meeting	Yes	Request to clarify requirements for the user.Add reference to county retention plan
7/22/2025	PAC Evote	Yes	Compliance suggested language clarification