Northern Inyo Healthcare District

# Board Packets

## February 15, 2023 Regular Board of Directors Meeting

Regular Board of Directors Meeting

NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

# *AGENDA*
# NORTHERN INYO HEALTHCARE DISTRICT
# BOARD OF DIRECTORS REGULAR MEETING

## February 15, 2023 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

**PHONE** CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom:

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. Chief Executive Officer Report
      a. Pioneer Home Health Update *(Board will receive this report)*
      b. Symons Ambulance Closure *(Board will receive this report)*
      c. Position Consolidations *(Board will receive this report)*
   B. Chief Financial Officer Report
      a. Financial & Statistical Reports (*Board will consider the approval of these reports*)

b. RSM Update *(Board will receive this report)*

c. TAG Update *(Board will receive this report)*

C. Contract Labor Utilization – Allison Partridge *(Board will receive this information)*

D. MAT Presentation – Jannalyn Lawrence *(Board will receive this information)*

E. Ad Hoc HR Committee Vacancy – Chad Chadwick *(Board will consider the approval of appointing another member to the AD Hoc HR Committee)*

F. Ad Hoc Committee Reporting – Chad Chadwick *(Board will consider the approval of staff's recommendation)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Policies (*Board will consider the approval of these Policies and Procedures*)

a. *Admission Procedure of a Pediatric Patient*
b. *Clinic Emergency Response Kit*
c. *Critical Value Reporting of Lab Results*
d. *DI – CT Contrast Administration*
e. *DI – CT Premedication for Contrast Sensitivity*
f. *Floating Nursing Workforce*
g. *Infant Feeding Policy*
h. *Lippincott Procedure Manual Adoption Policy*
i. *Misoprostol for Cervical Ripening*
j. *Nursing Quality Assurance Performance Improvement Plan*
k. *Orthopedic Hardware*
l. *Oxytocin (Pitocin) Administration*
m. *Patient Identification for Clinical Care and Treatment/Armband Usage*
n. *Sentinel Event/Serious Harm Reporting and Prevention*

B. Medical Executive Committee Report *(Board will receive this report)*

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***Consent Agenda***

***All matters listed under the consent agenda are considered routine***

***and will be enacted by one motion unless any member of the***

***Board wishes to remove an item for discussion.***

5. Approval of minutes of the January 18, 2023 Regular Board Meeting (Board will consider the approval of these minutes)

6. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*

a. *Sending Protected Health Information by Fax*

b. *Nursing Certification*

c. *Used Equipment Sales*

d. *Cross-Training of RN Staff*

e. *Check Signing*

f. *Capitalization of Assets*
g. *Smoking Tobacco Policy*
h. *Prompt Pay Discounts*

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7. Reports from Board Members (*Board will provide this information*)
8. Public comments on closed session items.
9. Adjournment to Closed Session to/for:
    a. Conference with Labor Negotiators, District Designated Representatives: Interim CEO and HR Director; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)
10. Return to open session and report on any actions taken in closed session.
11. Adjournment

*In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.*

# Northern Inyo Healthcare District
# December 2022 – Financial Summary

| | MONTH | PY Month | YTD | PY Month |
|---|---|---|---|---|
| **IP Gross Revenue** | 3,417,547 | 2,404,683 | 19,026,153 | 18,255,748 |
| **OP Gross Revenue** | 11,309,707 | 11,882,529 | 71,967,668 | 65,356,152 |
| **Clinic Gross Revenue** | 1,602,344 | 1,136,568 | 8,223,277 | 6,836,821 |
| **Net Patient Revenue** | 5,680,166 | 10,429,510 | 40,181,005 | 52,120,126 |
| | | | | |
| **IP Days:** | 231 | 169 | 1,257 | 1,286 |
| **IP Days w/o Newborns** | 202 | 147 | 1,119 | 1,147 |
| **OP Visits** | 3,641 | 3,510 | 21,773 | 22,057 |
| **RHC Visits** | 2,869 | 2,722 | 15,776 | 16,274 |
| **NIA Clinics** | 1,711 | 1,557 | 10,059 | 10,091 |
| | | | | |
| **Surgeries IP** | 21 | 17 | 116 | 115 |
| **Surgeries OP** | 88 | 126 | 595 | 591 |
| **Diagnostic Imaging** | 1,970 | 1,976 | 12,161 | 11,777 |
| **Emergency** | 765 | 665 | 5,026 | 4,082 |
| **Rehab** | 870 | 833 | 4,406 | 5,080 |
| **Nursing Visits** | 234 | 237 | 1,534 | 1,693 |
| **Observation Hours** | 1,800 | | 10,954 | |

**REVENUE**

**Payor mix**

| | | | | |
|---|---|---|---|---|
| Blue Cross | 23.4% | 17.7% | 25.7% | 18.3% |
| Commercial | 3.9% | 2.7% | 6.4% | 5.1% |
| Medicaid | 25.7% | 19.7% | 33.0% | 29.9% |
| Medicare | 46.3% | 55.1% | 56.4% | 44.1% |
| Self-pay | 4.3% | 4.8% | 4.0% | 2.1% |
| Workers' Comp | 0.9% | 0.0% | 0.2% | 0.5% |

**Deductions**

| | | | | |
|---|---|---|---|---|
| Contract Adjust | 8,204,159 | 7,224,448 | 49,275,414 | 40,395,437 |
| Bad Debt | 2,354,124 | 266,596 | 7,294,099 | 2,885,256 |
| Write-off | 344,283 | 286,045 | 2,843,024 | 755,878 |
| Other | -249,590 | -2,780,184 | -340,648 | -5,598,681 |

Other deductions is favorable due to a gain in the Hospital Quality Assure Revenue Fund receipts. This category is moving from deductions to other revenue.

**CENSUS**

| | | | | |
|---|---|---|---|---|
| Patient Days | 231 | 169 | 1,530 | 1,286 |
| Adjusted Days | 871 | 873 | 6,365 | 5,253 |
| Employed FTE | 328.6 | 340.2 | 361.0 | 354.0 |
| Contract FTE | 26.36 | 42.41 | 51.92 | 37.66 |
| Total FTE | 355 | 383 | 413 | 392 |
| EPOB | 1.76 | 2.60 | 3.56 | 2.03 |

**DENIALS** under review

**CHARITY** under review

**BAD DEBT** under review

**CASH**

Cash collections were $6,732,042 for December and $13,287,985 for January.
Disbursements were $9,589,5549 for December and $9,858,312.
Total cash increased for December and January was $6,555,943 partly due to funds received from Inyo County for $1,785,906

**Payor Issues**

Blue Cross owes $1.3 million of non-routine collections. We have reported to the insurance commissioner's office.
MCR Cost Settlement (January) $2,429,480 – secondary audit on-going

**SALARIES**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $2,907 | $3,596 | $2,430 | $2,979 |
| Total Salaries | $2,531,942 | $3,139,196 | $15,464,413 | $15,648,408 |

Outpatient revenue saw a 6% decline from YTD average, thus a lower per adjusted bed day driving current expense higher per metric.

**BENEFITS**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $317 | $2,827 | $1,841 | $2,444 |
| Total Benefits | $275,891 | $2,467,909 | $11,716,940 | $12,840,391 |

One-time accounting correction for $1.1 million in released accruals

**PROFESSIONAL FEES**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $1,976 | $2,619 | $2,751 | $2,620 |
| Total Professional Fee | $1,335,588 | | $7,813,379 | |
| Total Contract Labor | $359,098 | | $6,910,689 | |

Contract labor saw a one-time correction in Other Contract Labor for $330k, RN Contract Labor saw a one-time correction of approximately $500k.

**PHARMACY**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $309 | $436 | $305 | $410 |
| Total Rx Expense | $268,920 | $380,870 | $1,939,229 | $2,152,851 |

Consistent with YTD average. Decrease from PY through a reduction in chemotherapy.

**MEDICAL SUPPLIES**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $515 | $570 | $389 | $421 |
| Total Medical Supplies | $448,838 | $497,972 | $2,474,048 | $2,210,633 |

One-time charge for oxygen as accruals were not completed ($32k); increase in orthopedic implants.

**EHR SYSTEM**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $62 | $133 | $147 | $133 |
| Total EHR Expense | $54,304 | $115,958 | $933,398 | $696,318 |

One-time accounting correction due to over-accrued expense.

**OTHER EXPENSE**

| | | | | |
|---|---|---|---|---|
| Per Adjust Bed Day | $391 | $423 | $320 | $410 |
| Total Other | $340,523 | $369,148 | $2,033,927 | $2,151,503 |

**Northern Inyo Healthcare District**
**Income Statement**
**Fiscal Year 2023**

| | 11/30/2022 | 11/30/2021 | 12/31/2022 | 12/31/2021 | 2023 YTD | 2022 YTD |
|---|---|---|---|---|---|---|
| **Gross Patient Service Revenue** | | | | | | |
| Inpatient Patient Revenue | 3,474,955 | 3,958,181 | 3,417,547 | 2,404,683 | 19,026,153 | 18,255,748 |
| Outpatient Revenue | 12,582,796 | 10,120,970 | 11,309,707 | 11,882,529 | 71,967,668 | 65,356,152 |
| Clinic Revenue | 1,616,268 | 1,137,285 | 1,602,344 | 1,136,568 | 8,223,277 | 6,836,821 |
| **Gross Patient Service Revenue** | **17,674,019** | **15,216,437** | **16,329,598** | **15,423,780** | **99,217,097** | **90,448,720** |
| **Deductions from Revenue** | | | | | | |
| Contractual Adjustments | (8,553,896) | (7,207,126) | (8,204,159) | (7,224,448) | (49,275,414) | (40,395,437) |
| Bad Debt | (134,138) | (132,762) | (2,354,124) | (266,596) | (7,294,099) | (2,885,256) |
| A/R Writeoffs | (338,106) | (181,117) | (344,283) | (286,045) | (2,843,024) | (755,878) |
| Other Deductions from Revenue | 17,166 | 394,000 | 249,590 | 2,780,184 | 340,648 | 5,598,681 |
| **Deductions from Revenue** | **(9,008,974)** | **(7,127,005)** | **(10,652,976)** | **(4,996,905)** | **(59,071,888)** | **(38,437,890)** |
| **Other Patient Revenue** | | | | | | |
| Incentive Income | - | 1,619 | - | 10 | - | 26,017 |
| Other Oper Rev - Rehab Thera Serv | 7,875 | 15,908 | 3,545 | 2,625 | 35,796 | 83,279 |
| Medical Office Net Revenue | - | - | - | - | - | - |
| Other Revenue | 7,875 | 17,528 | 3,545 | 2,635 | 35,796 | 109,296 |
| **Net Patient Service Revenue** | **8,672,921** | **8,106,959** | **5,680,166** | **10,429,510** | **40,181,005** | **52,120,126** |
| **Cost of Services - Direct** | | | | | | |
| Salaries and Wages | 2,262,511 | 2,303,918 | 2,158,750 | 2,726,796 | 13,239,890 | 13,612,408 |
| Benefits | 1,754,398 | 2,059,894 | 1,064,181 | 2,085,215 | 10,057,077 | 10,996,448 |
| Professional Fees | 3,457,119 | 1,790,435 | 1,631,927 | 1,823,508 | 15,448,675 | 11,653,589 |
| Pharmacy | 596,330 | 392,006 | 268,920 | 380,870 | 1,939,229 | 2,152,851 |
| Medical Supplies | 474,848 | 451,788 | 448,838 | 497,972 | 2,474,048 | 2,210,633 |
| Hospice Operations | - | - | - | - | - | - |
| EHR System Expense | 146,908 | 108,392 | 54,304 | 115,958 | 933,398 | 696,318 |
| Other Direct Expenses | 793,341 | 618,316 | 471,021 | 679,861 | 3,859,664 | 3,707,556 |
| Total Cost of Services - Direct | 9,485,455 | 7,724,749 | 6,097,940 | 8,310,179 | 47,951,982 | 45,029,802 |
| | | | | | | |
| **General and Administrative Overhead** | | | | | | |
| Salaries and Wages | 373,439 | 355,039 | 373,193 | 412,400 | 2,224,523 | 2,036,001 |
| Benefits | 302,169 | 322,152 | (788,291) | 382,695 | 1,659,863 | 1,843,944 |
| Professional Fees | 430,772 | 300,113 | 89,029 | 462,506 | 2,060,739 | 2,109,571 |
| Depreciation and Amortization | 346,018 | 347,192 | 340,523 | 369,148 | 2,033,927 | 2,151,503 |
| Other Administative Expenses | 314,165 | 154,566 | 152,489 | 190,884 | 1,029,188 | 972,490 |
| Total General and Administrative Overhead | 1,766,564 | 1,479,063 | 166,944 | 1,817,634 | 9,008,240 | 9,113,509 |
| **Total Expenses** | **11,252,019** | **9,203,811** | **6,264,884** | **10,127,813** | **56,960,222** | **54,143,311** |
| | | | | | | |
| Financing Expense | 178,894 | 136,649 | 183,171 | 101,007 | 1,090,597 | 911,587 |
| Financing Income | 247,716 | 173,785 | 247,716 | 173,785 | 1,486,295 | 1,042,708 |
| Investment Income | 16,704 | 16,045 | 50,390 | 27,865 | 246,027 | 125,528 |
| Miscellaneous Income | 68,632 | 80,081 | 2,021,935 | (460) | 2,294,189 | 9,421,199 |
| **Net Income** | **(2,424,941)** | **(963,590)** | **1,552,152** | **401,879** | **(13,843,304)** | **7,654,663** |
| **Operating Income** | **(2,579,099)** | **(1,096,852)** | **(584,717)** | **301,697** | **(16,779,217)** | **(2,023,184)** |

**Northern Inyo Healthcare District**
**Balance Sheet**
**Fiscal Year 2023**

| | Oct 2022 | Oct 2021 | Nov 2022 | Nov 2021 | Dec 2022 | Dec 2021 |
|---|---|---|---|---|---|---|
| Assets | | | | | | |
| Current Assets | | | | | | |
| Cash and Liquid Capital | 8,362,653 | 10,520,186 | 7,944,312 | 14,241,387 | 7,573,136 | 14,713,417 |
| Short Term Investments | 21,873,055 | 34,353,251 | 19,367,377 | 34,281,644 | 16,815,916 | 34,196,777 |
| PMA Partnership | - | - | - | - | - | - |
| Accounts Receivable, Net of Allowance | 17,315,384 | 19,413,168 | 18,278,787 | 20,940,657 | 14,674,565 | 21,359,592 |
| Other Receivables | 3,433,651 | 13,216,871 | 3,673,398 | 10,901,419 | 8,350,857 | 9,978,572 |
| Inventory | 3,071,145 | 3,371,955 | 3,077,236 | 3,379,016 | 3,037,613 | 3,341,506 |
| Prepaid Expenses | 1,404,076 | 1,476,186 | 1,765,502 | 1,554,182 | 1,717,688 | 1,612,547 |
| **Total Current Assets** | **55,459,964** | **82,351,618** | **54,106,613** | **85,298,304** | **52,169,776** | **85,202,410** |
| Assets Limited as to Use | | | | | | |
| Internally Designated for Capital Acquisitions | - | - | - | - | - | - |
| Short Term - Restricted | 1,327,387 | 61,230 | 182,493 | 61,232 | 182,501 | 61,232 |
| Limited Use Assets | | | | | | |
| LAIF - DC Pension Board Restricted | 714,585 | 1,046,467 | 720,262 | 1,118,074 | 771,724 | 1,202,941 |
| DB Pension | 14,044,924 | 18,395,253 | 14,044,924 | 18,395,253 | 14,044,924 | 18,395,253 |
| PEPRA - Deferred Outflows | - | - | - | - | - | - |
| PEPRA Pension | - | - | - | - | - | - |
| **Total Limited Use Assets** | **14,759,509** | **19,441,720** | **14,765,186** | **19,513,327** | **14,816,648** | **19,598,194** |
| Revenue Bonds Held by a Trustee | 1,085,089 | 3,694,911 | 1,079,366 | 4,004,827 | 1,092,945 | 14,392,668 |
| Total Assets Limited as to Use | 17,171,984 | 23,197,861 | 16,027,045 | 23,579,386 | 16,092,094 | 34,052,094 |
| Long Term Assets | | | | | | |
| Long Term Investment | 2,731,432 | 997,171 | 2,729,926 | 996,539 | 2,745,703 | 1,002,414 |
| Fixed Assets, Net of Depreciation | 76,801,887 | 76,203,344 | 76,795,344 | 75,900,447 | 76,891,894 | 75,809,403 |
| **Total Long Term Assets** | **79,533,319** | **77,200,515** | **79,525,271** | **76,896,986** | **79,637,597** | **76,811,816** |
| **Total Assets** | **152,165,267** | **182,749,993** | **149,658,928** | **185,774,676** | **147,899,466** | **196,066,320** |
| Liabilities | | | | | | |
| Current Liabilities | | | | | | |
| Current Maturities of Long-Term Debt | 2,053,565 | 2,901,929 | 1,405,934 | 2,866,983 | 1,381,851 | 1,601,919 |
| Accounts Payable | 5,447,118 | 3,578,083 | 6,960,778 | 4,124,296 | 5,056,395 | 2,899,914 |
| Accrued Payroll and Related | 6,726,652 | 7,392,086 | 6,895,391 | 8,762,183 | 6,678,615 | 9,981,694 |
| Accrued Interest and Sales Tax | 126,986 | 303,558 | 17,172 | 405,047 | 94,617 | 149,454 |
| Notes Payable | 2,133,708 | 458,744 | 2,133,708 | 458,744 | 2,133,708 | 458,744 |
| Unearned Revenue | 607,290 | 12,867,638 | 607,290 | 14,815,460 | 268,418 | 14,410,638 |
| Due to 3rd Party Payors | - | - | - | - | - | - |
| Due to Specific Purpose Funds | - | (25,098) | - | (25,098) | - | (25,098) |
| Other Deferred Credits - Pension | 2,146,080 | 2,124,655 | 2,146,080 | 2,124,655 | 2,146,080 | 2,124,655 |
| **Total Current Liabilities** | **19,241,398** | **29,601,595** | **20,166,352** | **33,532,270** | **17,759,683** | **31,601,920** |
| Long Term Liabilities | | | | | | |
| Long Term Debt | 33,455,947 | 35,257,947 | 32,310,948 | 35,257,947 | 33,053,530 | 47,102,947 |
| Bond Premium | 228,359 | 363,059 | 225,222 | 358,931 | 222,085 | 354,804 |
| Accreted Interest | 17,105,668 | 15,772,325 | 17,200,803 | 15,806,051 | 16,553,354 | 15,806,051 |
| Other Non-Current Liability - Pension | 48,813,068 | 45,570,613 | 48,813,068 | 45,570,613 | 47,821,876 | 45,570,613 |
| **Total Long Term Liabilities** | **99,603,043** | **96,963,944** | **98,550,041** | **96,993,542** | **97,650,846** | **108,834,415** |
| Suspense Liabilities | - | (70,699) | - | (70,699) | - | (70,699) |
| Uncategorized Liabilities | 790,738 | 705,749 | 837,281 | 733,749 | 831,523 | 712,992 |
| **Total Liabilities** | **119,635,178** | **127,200,589** | **119,553,674** | **131,188,862** | **116,242,052** | **141,078,627** |
| Fund Balance | | | | | | |
| Fund Balance | 42,910,729 | 44,833,874 | 42,910,729 | 44,833,874 | 42,910,729 | 44,833,874 |
| Temporarily Restricted | 2,589,875 | 2,499,156 | 2,589,981 | 2,499,156 | 2,589,989 | 2,499,156 |
| Net Income | (12,970,515) | 8,216,374 | (15,395,456) | 7,252,784 | (13,843,304) | 7,654,663 |
| Total Fund Balance | 32,530,088 | 55,549,404 | 30,105,254 | 54,585,814 | 31,657,414 | 54,987,693 |
| Liabilities + Fund Balance | 152,165,267 | 182,749,993 | 149,658,928 | 185,774,676 | 147,899,466 | 196,066,320 |
| **(decline)/Gain** | **(3,510,761)** | **(626,972)** | **(2,506,339)** | **3,024,683** | **(1,759,462)** | **10,291,644** |
| | - | - | - | - | - | - |

| NIHD Statistics | Oct Totals | | | Nov Totals | | | Dec Totals | | | YTD FY 2023 Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 2023 | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix |
| **Inpatient Days** | | | | | | | | | | | | |
| Total Patient Days | **170** | **148** | | **264** | **241** | | **231** | **202** | | **1,530** | **1,366** | |
| Total Admits | **75** | **60** | | **93** | **79** | | **98** | **79** | | **590** | **487** | |
| Total Discharges | **73** | **57** | | **90** | **77** | | **105** | **86** | | **591** | **489** | |
| ADC (average daily census) | 5.48 | 4.77 | | 8.80 | 8.03 | | 7.45 | 6.52 | | | 3.74 | |
| ALOS (average length of stay) | 2.27 | 2.47 | | 2.84 | 3.05 | | 2.36 | 2.56 | | | | |
| Inpatient Revenue | | 2,817,763 | | | 3,477,901 | | | 3,416,759 | | | 22,931,045 | |
| Outpatient Revenue | | 12,337,627 | | | 12,582,796 | | | 11,309,707 | | | 83,911,479 | |
| Total Hospital Revenue | | **15,155,390** | | | **16,060,697** | | | **14,726,466** | | | **106,842,524** | |
| Clinic (RHC) Revenue | | 1,312,937 | | | 1,616,268 | | | 1,602,344 | | | 9,775,470 | |
| Total Gross Revenue | | **16,468,327** | | | **17,676,965** | | | **16,328,811** | | | **116,617,994** | |
| Hospital Only OP Factor | | 5.38 | | | 4.62 | | | 4.31 | | | 4.66 | |
| Total OP Factor | | 5.84 | | | 5.08 | | | 4.78 | | | 5.09 | |
| Adjusted Admissions | | 323 | | | 365 | | | 340 | | | 2,269 | |
| Adjusted Patient Days (Hospital) | | 796 | | | 1,113 | | | 871 | | | 6,365 | |
| Adjusted Patient Days (Total) | | 865 | | | 1,225 | | | 965 | | | 6,947 | |
| Adjusted ADC | | 27.90 | | | 40.83 | | | 31.14 | | | 19.03 | |
| **Patient Days by Financial Class** | | | | | | | | | | | | |
| Blue Cross | 40 | 26 | 17.6% | 26 | 21 | 8.7% | 54 | 41 | | 281 | 215 | 15.7% |
| Commercial | 1 | 1 | 0.7% | 20 | 20 | 8.3% | 9 | 9 | | 91 | 87 | 6.4% |
| Medicaid | 9 | 9 | 6.1% | - | - | 0.0% | 5 | 2 | | 27 | 24 | 1.8% |
| Medi-Cal | 12 | 10 | 6.8% | 32 | 22 | 9.1% | 7 | 5 | | 122 | 97 | 7.1% |
| Medi-Cal Managed Care | 24 | 20 | 13.5% | 47 | 40 | 16.6% | 37 | 27 | | 247 | 189 | 13.8% |
| Medicare | 72 | 72 | 48.6% | 129 | 129 | 53.5% | 107 | 107 | | 697 | 697 | 51.0% |
| Medicare Advantage | 3 | 3 | 2.0% | 1 | 1 | 0.4% | - | - | | 17 | 17 | 1.2% |
| Other | | | | | | | | | | | | |
| Self Pay | 9 | 7 | 4.7% | 9 | 8 | 3.3% | 10 | 10 | | 41 | 34 | 2.5% |
| Veterans Administration | - | - | 0.0% | - | - | 0.0% | - | - | | - | - | 0.0% |
| Worker's Compensation | - | - | 0.0% | - | - | 0.0% | 2 | 1 | | 2 | 1 | 0.1% |
| **Admissions by Financial Class** | | | | | | | | | | | | |
| Blue Cross | 22 | 13 | 21.7% | 17 | 13 | 16.5% | 30 | 21 | | 139 | 97 | 19.9% |
| Commercial | 1 | 1 | 1.7% | 7 | 7 | 8.9% | 4 | 4 | | 36 | 33 | 6.8% |
| Medicaid | 2 | 2 | 3.3% | - | - | 0.0% | 2 | 1 | | 10 | 9 | 1.8% |
| Medi-Cal | 7 | 5 | 8.3% | 14 | 9 | 11.4% | 7 | 5 | | 55 | 40 | 8.2% |
| Medi-Cal Managed Care | 14 | 11 | 18.3% | 20 | 16 | 20.3% | 20 | 14 | | 134 | 97 | 19.9% |
| Medicare | 24 | 24 | 40.0% | 31 | 31 | 39.2% | 30 | 30 | | 192 | 192 | 39.4% |
| Medicare Advantage | 1 | 1 | 1.7% | - | - | 0.0% | - | - | | 5 | 5 | 1.0% |
| Other | | | | | | | | | | | | |
| Self Pay | 4 | 3 | 5.0% | 4 | 3 | 3.8% | 3 | 3 | | 16 | 12 | 2.5% |
| Veterans Administration | - | - | 0.0% | - | - | 0.0% | 2 | 1 | | 2 | 1 | 0.2% |
| Worker's Compensation | - | - | 0.0% | - | - | 0.0% | - | - | | - | - | 0.0% |
| **Discharges by Financial Class** | | | | | | | | | | | | |
| Blue Cross | 19 | 10 | 17.5% | 15 | 12 | 15.6% | 33 | 24 | | 139 | 97 | 19.8% |
| Commercial | - | - | 0.0% | 5 | 5 | 6.5% | 6 | 6 | | 35 | 32 | 6.5% |
| Medicaid | 3 | 3 | 5.3% | - | - | 0.0% | 2 | 1 | | 10 | 9 | 1.8% |

| NIHD Statistics | Oct Totals | | | Nov Totals | | | Dec Totals | | | YTD FY 2023 Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 2023 | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix |
| Medi-Cal | 8 | 6 | 10.5% | 14 | 9 | 11.7% | 7 | 5 | | 55 | 40 | 8.2% |
| Medi-Cal Managed Care | 14 | 10 | 17.5% | 20 | 16 | 20.8% | 19 | 13 | | 130 | 94 | 19.2% |
| Medicare | 24 | 24 | 42.1% | 31 | 31 | 40.3% | 33 | 33 | | 199 | 199 | 40.7% |
| Medicare Advantage | 1 | 1 | 1.8% | 1 | 1 | 1.3% | - | - | | 5 | 5 | 1.0% |
| Other | | | | | | | | | | | | |
| Self Pay | 4 | 3 | 5.3% | 4 | 3 | 3.9% | 3 | 3 | | 15 | 11 | 2.2% |
| Veterans Administration | - | - | 0.0% | - | - | 0.0% | 2 | 1 | | 2 | 1 | 0.2% |
| Worker's Compensation | - | - | 0.0% | - | - | 0.0% | - | - | | - | - | 0.0% |
| **Surgery** | | | | | | | | | | | | |
| Surgeries - IP | **13** | | | **17** | | | **21** | | | **116** | | |
| Surgeries - OP | **119** | | | **112** | | | **88** | | | **595** | | |
| **Total Surgeries** | **132** | | | **129** | | | **109** | | | **711** | | |
| Surgery Minutes - IP | **829** | | | **1,049** | | | **1,144** | | | **6,652** | | |
| Surgery Minutes - OP | **5,096** | | | **4,379** | | | **3,447** | | | **23,770** | | |
| C-Section Deliveries | **4** | | | **4** | | | **6** | | | **30** | | |
| Anesthesia Minutes - IP | **1,235** | | | **1,641** | | | **1,903** | | | **10,740** | | |
| Anesthesia Minutes - OP | **7,920** | | | **6,754** | | | **5,433** | | | **37,389** | | |
| **Outpatient Visits **OP Visits Exclude Clinic & ED** | | | | | | | | | | | | |
| **Total Outpatient Visits** | **3,737** | | | **3,455** | | | **3,641** | | | **21,773** | | |
| Blue Cross | 1,152 | | 30.8% | 1,146 | | 33.2% | 1,264 | | 34.7% | 6,962 | | 32.0% |
| Charity | - | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Client | 115 | | 3.1% | 45 | | 1.3% | 64 | | 1.8% | 536 | | 2.5% |
| Commercial | 195 | | 5.2% | 173 | | 5.0% | 186 | | 5.1% | 1,154 | | 5.3% |
| Indian Beneficiary | | | 0.0% | | | 0.0% | | | 0.0% | 11 | | 0.1% |
| Medicaid | 11 | | 0.3% | 6 | | 0.2% | 7 | | 0.2% | 187 | | 0.9% |
| Medi-Cal | 127 | | 3.4% | 117 | | 3.4% | 112 | | 3.1% | 931 | | 4.3% |
| Medi-Cal Managed Care | 457 | | 12.2% | 412 | | 11.9% | 435 | | 11.9% | 3,560 | | 16.4% |
| Medicare | 1,455 | | 38.9% | 1,371 | | 39.7% | 1,381 | | 37.9% | 7,297 | | 33.5% |
| Medicare Advantage | 90 | | 2.4% | 54 | | 1.6% | 61 | | 1.7% | 339 | | 1.6% |
| Other | 7 | | 0.2% | 2 | | 0.1% | 12 | | 0.3% | 42 | | 0.2% |
| Self Pay | 66 | | 1.8% | 58 | | 1.7% | 41 | | 1.1% | 293 | | 1.3% |
| Veterans Administration | 5 | | 0.1% | 6 | | 0.2% | 5 | | 0.1% | 83 | | 0.4% |
| Worker's Compensation | 57 | | 1.5% | 65 | | 1.9% | 73 | | 2.0% | 312 | | 1.4% |
| **Clinic Visits** | | | | | | | | | | | | |
| **Rural Health Clinic Visits** | **2,708** | | | **2,957** | | | **2,869** | | | **15,776** | | |
| Blue Cross | 1,046 | | 38.6% | 1,184 | | 40.0% | 1,090 | | 38.0% | 5,949 | | 37.7% |
| Charity | - | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Commercial | 165 | | 6.1% | 146 | | 4.9% | 180 | | 6.3% | 1,015 | | 6.4% |
| Medicaid | 10 | | 0.4% | 4 | | 0.1% | 6 | | 0.2% | 51 | | 0.3% |
| Medi-Cal | 117 | | 4.3% | 123 | | 4.2% | 101 | | 3.5% | 656 | | 4.2% |
| Medi-Cal Managed Care | 491 | | 18.1% | 600 | | 20.3% | 528 | | 18.4% | 2,891 | | 18.3% |
| Medicare | 741 | | 27.4% | 737 | | 24.9% | 821 | | 28.6% | 4,376 | | 27.7% |
| Medicare Advantage | 16 | | 0.6% | 27 | | 0.9% | 27 | | 0.9% | 156 | | 1.0% |
| Other | - | | 0.0% | | | 0.0% | | | 0.0% | 1 | | 0.0% |
| Self Pay | 97 | | 3.6% | 105 | | 3.6% | 87 | | 3.0% | 524 | | 3.3% |

| NIHD Statistics | Oct Totals | | | Nov Totals | | | Dec Totals | | | YTD FY 2023 Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 2023 | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix |
| Veterans Administration | 3 | | 0.1% | 9 | | 0.3% | 7 | | 0.2% | 32 | | 0.2% |
| Worker's Compensation | 22 | | 0.8% | 22 | | 0.7% | 22 | | 0.8% | 125 | | 0.8% |
| **Total NIA Clinic Visits** | **1,689** | | | **1,850** | | | **1,711** | | | **10,059** | | |
| Bronco Clinic Visits | 39 | | | 35 | | | 23 | | | 141 | | |
| Internal Medicine Clinic Visits | 357 | | | 425 | | | 338 | | | 2,303 | | |
| Orthopedic Clinic Visits | 306 | | | 320 | | | 310 | | | 1,905 | | |
| Pediatric & Allergy Clinic Visits | 613 | | | 641 | | | 655 | | | 3,421 | | |
| Specialty Clinic Visits | 229 | | | 302 | | | 233 | | | 1,507 | | |
| Surgery Clinic Visits | 105 | | | 86 | | | 100 | | | 539 | | |
| Virtual Care Clinic Visits | 40 | | | 41 | | | 52 | | | 243 | | |
| **Total Clinics** | **4,397** | | | **4,807** | | | **4,580** | | | **25,835** | | |
| **DI Exams** | | | | | | | | | | | | |
| Bone Density | 32 | | | 39 | | | 35 | | | 243 | | |
| Computed Tomography | 348 | | | 330 | | | 366 | | | 2,173 | | |
| General Diagnostic | 893 | | | 926 | | | 856 | | | 5,385 | | |
| Magnetic Resonance Imaging | 122 | | | 128 | | | 136 | | | 787 | | |
| Mammography | 229 | | | 171 | | | 171 | | | 1,054 | | |
| Nuclear Cardiac | 15 | | | 25 | | | 15 | | | 101 | | |
| Nuclear Medicine | 8 | | | 4 | | | 9 | | | 52 | | |
| Ultrasound | 340 | | | 326 | | | 335 | | | 2,054 | | |
| Vascular Ultrasound | 48 | | | 43 | | | 47 | | | 312 | | |
| **Total Exams** | **2,035** | | | **1,992** | | | **1,970** | | | **12,161** | | |
| **ED Visits** | | | | | | | | | | | | |
| ED Visits per day | 26.77 | | | 32.87 | | | 24.68 | | | | | |
| ED Visits - OP | 784 | | | 922 | | | 703 | | | 4,704 | | |
| ED Visits - Admitted to IP | 46 | | | 59 | | | 62 | | | 317 | | |
| ED Admits % of ED Visits | 5.5% | | | 6.0% | | | 8.1% | | | | | |
| ED Left W/O Being Seen (No Charges) | 4 | | | 3 | | | 2 | | | 24 | | |
| **Total ED Visits** | **830** | | | **986** | | | **765** | | | **5,026** | | |
| Blue Cross | 200 | | 24.1% | 251 | | | 158 | | 20.7% | 1,161 | | 23.1% |
| Charity | - | | 0.0% | | | | | | 0.0% | - | | 0.0% |
| Commercial | 58 | | 7.0% | 51 | | | 59 | | 7.7% | 389 | | 7.7% |
| Medicaid | 10 | | 1.2% | 9 | | | 12 | | 1.6% | 82 | | 1.6% |
| Medi-Cal | 64 | | 7.7% | 76 | | | 51 | | 6.7% | 402 | | 8.0% |
| Medi-Cal Managed Care | 190 | | 22.9% | 301 | | | 196 | | 25.6% | 1,237 | | 24.6% |
| Medicare | 230 | | 27.7% | 214 | | | 204 | | 26.7% | 1,217 | | 24.2% |
| Medicare Advantage | 8 | | 1.0% | 16 | | | 17 | | 2.2% | 92 | | 1.8% |
| Other | 2 | | 0.2% | 2 | | | 4 | | 0.5% | 9 | | 0.2% |
| Self Pay | 45 | | 5.4% | 45 | | | 39 | | 5.1% | 293 | | 5.8% |
| Veterans Administration | 4 | | 0.5% | 3 | | | 2 | | 0.3% | 19 | | 0.4% |
| Worker's Compensation | 19 | | 2.3% | 18 | | | 23 | | 3.0% | 125 | | 2.5% |
| **Outpatient Nursing Visits** | | | | | | | | | | | | |
| Infusion | 133 | | | 140 | | | 121 | | | 854 | | |
| Injection | 52 | | | 56 | | | 57 | | | 329 | | |
| Multiple Services | | | | | | | | | | 1 | | |
| Wound Care | 60 | | | 55 | | | 56 | | | 350 | | |

| NIHD Statistics | Oct Totals | | | Nov Totals | | | Dec Totals | | | YTD FY 2023 Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 2023 | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix | Total | Total w/o NB | Payor Mix |
| **Total OP Nursing Visits** | **245** | | | **251** | | | **234** | | | **1,534** | | |
| Blue Cross | | | 0.0% | 44 | | 17.5% | 82.00 | | 35.0% | 126 | | 8.2% |
| Charity | | | 0.0% | - | | 0.0% | | | 0.0% | - | | 0.0% |
| Commercial | | | 0.0% | 10 | | 4.0% | 14.00 | | 6.0% | 24 | | 1.6% |
| Medicaid | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Medi-Cal | | | 0.0% | 16 | | 6.4% | 8.00 | | 3.4% | 24 | | 1.6% |
| Medi-Cal Managed Care | | | 0.0% | 47 | | 18.7% | 13.00 | | 5.6% | 60 | | 3.9% |
| Medicare | | | 0.0% | 124 | | 49.4% | 112.00 | | 47.9% | 236 | | 15.4% |
| Medicare Advantage | | | 0.0% | 9 | | 3.6% | 5.00 | | 2.1% | 14 | | 0.9% |
| Other | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Self Pay | | | 0.0% | 1 | | 0.4% | | | 0.0% | 1 | | 0.1% |
| Veterans Administration | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Worker's Compensation | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| **Rehab Visits** | | | | | | | | | | | | |
| Occupational Therapy | 79 | | | 84 | | | 91 | | | 502 | | |
| Physical Therapy | 526 | | | 533 | | | 719 | | | 3,485 | | |
| Speech Therapy | 64 | | | 62 | | | 60 | | | 419 | | |
| **Total Rehab Visits** | **669** | | | **679** | | | **870** | | | **4,406** | | |
| Blue Cross | | | 0.0% | 258 | | 38.0% | 344.00 | | 19.1% | 602 | | 13.7% |
| Charity | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Commercial | | | 0.0% | 39 | | 5.7% | 47.00 | | 2.6% | 86 | | 2.0% |
| Medicaid | | | 0.0% | | | 0.0% | 2.00 | | 0.1% | 2 | | 0.0% |
| Medi-Cal | | | 0.0% | 7 | | 1.0% | 16.00 | | 0.9% | 23 | | 0.5% |
| Medi-Cal Managed Care | | | 0.0% | 88 | | 13.0% | 107.00 | | 5.9% | 195 | | 4.4% |
| Medicare | | | 0.0% | 219 | | 32.3% | 278.00 | | 15.4% | 497 | | 11.3% |
| Medicare Advantage | | | 0.0% | 13 | | 1.9% | 10.00 | | 0.6% | 23 | | 0.5% |
| Other | | | 0.0% | | | 0.0% | 6.00 | | 0.3% | 6 | | 0.1% |
| Self Pay | | | 0.0% | | | 0.0% | 2.00 | | 0.1% | 2 | | 0.0% |
| Veterans Administration | | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Worker's Compensation | | | 0.0% | 55 | | 8.1% | 58.00 | | 3.2% | 113 | | 2.6% |
| **Other Hospital Statistics** | | | | | | | | | | | | |
| **Observation Days** | **75** | | | **83** | | | **75** | | | **456** | | |
| **Observation Visits** | **79** | | | **69** | | | **70** | | | **438** | | |
| **Observation Hours** | **1,793.18** | | | **2,000.74** | | | **1,800.28** | | | **12,692.23** | | |
| Blue Cross | 622.89 | | 34.7% | 294.90 | | 14.7% | 407.64 | | 22.6% | 2,586.13 | | 20.4% |
| Charity | - | | 0.0% | | | 0.0% | | | 0.0% | - | | 0.0% |
| Commercial | 37.50 | | 2.1% | 301.16 | | 15.1% | 25.01 | | 1.4% | 1,174.00 | | 9.2% |
| Medicaid | - | | 0.0% | 8.01 | | 0.4% | 2.47 | | 0.1% | 229.26 | | 1.8% |
| Medi-Cal | 77.87 | | 4.3% | 182.96 | | 9.1% | 141.05 | | 7.8% | 687.48 | | 5.4% |
| Medi-Cal Managed Care | 191.47 | | 10.7% | 215.27 | | 10.8% | 126.11 | | 7.0% | 1,564.49 | | 12.3% |
| Medicare | 711.28 | | 39.7% | 973.65 | | 48.7% | 822.14 | | 45.7% | 5,390.40 | | 42.5% |
| Medicare Advantage | 16.83 | | 0.9% | | | 0.0% | 152.06 | | 8.4% | 708.15 | | 5.6% |
| Other | | | 0.0% | | | 0.0% | 51.68 | | 2.9% | 51.68 | | 0.4% |
| Self Pay | 109.92 | | 6.1% | 24.79 | | 1.2% | 50.48 | | 2.8% | 253.58 | | 2.0% |
| Veterans Administration | | | 0.0% | | | 0.0% | 21.65 | | 1.2% | 21.65 | | 0.2% |
| Worker's Compensation | 25.41 | | 1.4% | | | 0.0% | | | 0.0% | 25.41 | | 0.2% |

| NIHD Statistics | Oct Totals | | | Nov Totals | | | Dec Totals | | | YTD FY 2023 Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 2023 | **Total** | **Total w/o NB** | **Payor Mix** | **Total** | **Total w/o NB** | **Payor Mix** | **Total** | **Total w/o NB** | **Payor Mix** | **Total** | **Total w/o NB** | **Payor Mix** |
| **Meals Served - Cafeteria** | **6,609** | | | **6,633** | | | **5,773** | | | **38,675** | | |
| **Meals Served - Dietary** | **784** | | | **1,116** | | | **1,302** | | | **5,983** | | |
| **Meals Served - Total** | **7,393** | | | **7,749** | | | **7,075** | | | **44,658** | | |
| **Care Coordination Trips** | | | | | | | | | | **704** | | |
| **Clean Lbs - Laundry** | - | | | - | | | - | | | **12,970** | | |
| **Employee Statistics** | | | | | | | | | | | | |
| FTE factor | 177.14 | | | 171.43 | | | 177.14 | | | | | |
| PP 1 Hours | 27,616.02 | PPE 10/08/22 | | 27,297.26 | PPE 11/05/22 | | 25,226.16 | PPE 12/03/22 | | | | |
| PP 2 Hours | 27,253.19 | PPE 10/22/22 | | 27,869.08 | PPE 11/19/22 | | 28,269.33 | PPE 12/17/22 | | | | |
| PP 3 Hours (if applicable) | | | | | | | 26,603.97 | PPE 12/31/22 | | | | |
| **Employee FTEs** | **342.25** | | | **334.17** | | | **328.56** | | | | | |
| Contract Labor Hours | 6,662 | | | 5,666 | | | 4,670 | | | | | |
| **Contract FTEs** | **37.61** | | | **33.05** | | | **26.36** | | | | | |
| **Total FTEs** | **380** | | | **367** | | | **355** | | | | | |
| **EPOB (employee per occupied bed)** | **2.57** | | | **1.47** | | | **1.76** | | | | | |

# Northern Inyo Healthcare District
# Revenue Cycle / Margin Improvement

## Weekly Leadership Meeting

**February 7, 2023**

# Table of Contents

# ACTIVITIES COMPLETED

# NIH Department Workflow Discovery Sessions

## Sessions Completed

| Interview Group | Date & Time (PST) |
|---|---|
| Informatics | Tuesday 1/31 @ 1:30-2:00pm |
| HIM | Wednesday 2/1 @ 8:00-9:00am |
| Patient Access | Wednesday 2/1 @ 10:00-11:00am |
| Revenue Integrity | Wednesday 2/1 @ 11:30-12:30pm |
| Project Management Team | Wednesday 2/1 @ 1:00-2:00pm |
| Controller | Thursday 2/2 @ 9:00-10:00am |
| IT | Thursday 2/2 @ 1:00-1:30pm |
| Business Office | Friday 2/3 @ 9:00-10:00am |
| OS Health | Friday 2/3 @ 11:00-12:00pm |



NIHD RSM

# OUTSTANDING ITEMS

# Outstanding Items – RFI – Data Request Status

| | Assigned To | Status | Estimated Completion |
|---|---|---|---|
| **General Organization Information** | | | |
| Service Organization Structure | Stephen | Pending | 2/7 |
| Revenue Cycle Org Chart | Stephen | Pending | 2/7 |
| Revenue Cycle Staff Allocation | Stephen | Pending | 2/7 |
| Payer Contract Matrix / Payer Contracts | Stephen | Pending | 2/10 |
| System Integration List | Lynda | Complete | |
| Policies and Procedures | Stephen | Pending | 2/7 |
| Cerner Contract | Stephen | Pending | 2/7 |
| **System Access** | | | |
| Network Access (Storefront) | Aaron Pause | Pending | 2/9 |
| Cerner Community Works | Aaron Pause | Pending | 2/9 |
| Experian ClaimSource | Aaron Pause | Pending | 2/9 |
| Experian OneSource | Aaron Pause | Pending | 2/9 |
| EfficientC | Sue and Fabi | Pending | TBD |
| Lights On | Kim Pham | Pending | TBD |
| nThrive | Jalaine Beams | Pending | TBD |
| **Data Requests** | | | |
| 835 Remittance Files (12 months) | Alex Duke | Pending | TBD |

# EXECUTIVE SUMMARY

# Executive Summary – as of 2/7/2023

## Activities Completed

- Meeting Minutes
- Discovery Workflow Sessions
- System Integration List

## Activities In Process

- Establish 835 file data connection
- Begin financial data analysis
    - Pending system access activation

## Items for Escalation

- N/a

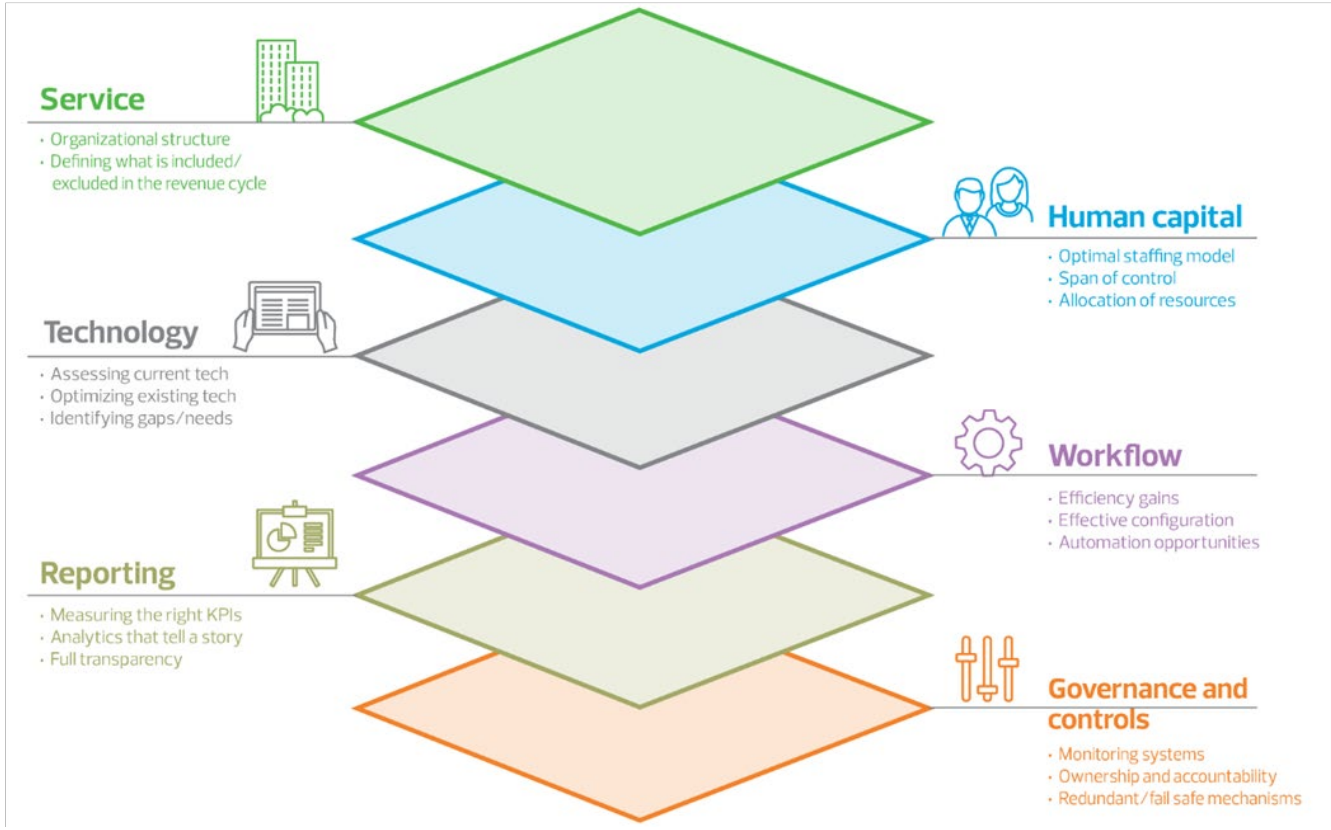
# WEEKLY FINDINGS

# Our Approach

Our approach is designed to cover every aspect of an organization and is designed to answer:

1. How your organization is structured
2. The workflow efficiency of your people
3. The processes that they use and the extent to which they can be automated
4. The technologies that are utilized and whether or not new ones are needed
5. The reporting needs to help drive operational performance
6. The governance and controls needed to prevent issues and “see around the corner”

## Our holistic approach utilizes our Target Operating Model



# Initial Findings

| TOM | Finding | Initial Observation of Impact |
|---|---|---|
| Workflow | **Work Queue Functionality**<br>• Not all of the NIH Patient Access staff and OS Health are using Cerner Work Queues<br>• There are departments that use Dummy WQs to address/resolve claim errors | • Instead of working out of individually assigned work queues, some of the Patient Access staff are working out of Cerner pools. As a result, there is a lack of accountability to ensure claims are corrected on a timely basis |
| Governance and Controls | **In/Out of Network Payors**<br>• There are questions within NIH as to which payors are in-network vs out-of-network<br>• They do not have a payor matrix that has been validated as to the in-network vs out-of-network payors, as well as the contract reimbursement terms and conditions | • Staff do not have a payor matrix tool that validates that NIH is receiving accurate reimbursement from payors<br>• This tool is needed to validate that the payor contracts have been entered correctly into CommunityWorks |
| | **Daily Charge Reconciliation**<br>• Not all of the NIH departments inputting charges complete a daily charge reconciliation | • Best practice for charge entry is to complete a daily reconciliation of all charges to confirm that they have captured all charges, as well as to identify any revenue leakage |
| Technology | **Cerner Client Billing Functionality**<br>• Client billing functionality has not been rolled out to all of the clinics | • NIH employees are manually creating invoices and submitting them for payment |
| | **Cerner SR's**<br>• Cerner is not responding to Service Requests in a timely manner. There are 200 number of open tickets with an average age of 197 days. The oldest tickets is 622 days old | • Delays in Cerner handling NIH tickets negatively impacts the staff's ability to accurately perform revenue cycle functions, causes delays in billing, and increases administrative work for the staff |

# NEXT STEPS

# Next Steps

**Immediate Needs**

- Complete RFI items & System Access

**This week**

- Begin data analysis
    - Dependent on system access activation
- Define roles and responsibilities of 3rd party vendors

# QUESTIONS AND ANSWERS?

# THANK YOU FOR YOUR TIME AND ATTENTION

# Turnaround Action Group

We are using a three-pronged approach: Financial (revenue improvements), expenses (salaries, wages, benefits, supplies, services), and tax support.

Finance Subcommittee

- RSM started fieldwork
- Billing (OS) transitioned "claim scrubber" – enhanced data collection
- UASI Clinical Documentation Specialist started – review and training
- Billing Office will be fully staffed by mid-month
    - Started working all claims less than $250
    - Started AR clean-up in Athena
- Patient Access is increasing up-front collections
- New policies implemented (Prompt Pay, Charity, Collections)

Labor Subcommittee

- Developed path forward for analyzing departments
- Set dates to interview department leaders
    - 2/13, 2/14, 2/21, 2/27, 2/28
- HR working to reduce contract labor
- FTE management
- 

| NIHD Statistics | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| FY 2023 | **Total** | **Total** | **Total** | **Total** | **Total** | **Total** |
| **Employee FTEs** | **331.39** | **345.37** | **336.29** | **342.25** | **334.17** | **328.56** |
| Contract Labor Hours | 7,788 | 7,317 | 7,794 | 6,662 | 5,666 | 4,670 |
| **Contract FTEs** | **43.97** | **41.31** | **30.29** | **37.61** | **33.05** | **26.36** |
| **Total FTEs** | **375** | **387** | **367** | **380** | **367** | **355** |
| **EPOB (employee per occupied bed)** | **1.71** | **2.17** | **2.73** | **2.57** | **1.47** | **1.76** |

Service/Operations Subcommittee

- Requested information from cost report to understand departmental costing
- Team members named
- Start date 2/9

Purchasing Subcommittee

- Start date 1/30
- Team members assigned
- Identified 5 areas to review
    - Contracts
    - Microbiology through GPO
    - Surgery Clinic purchase
    - Physical therapy purchase
    - Supply chain

**NORTHERN INYO HEALTHCARE DISTRICT**
**REPORT TO THE BOARD OF DIRECTORS**
**FOR INFORMATION**

Date: 02/03/23

Title: **CONTRACT LABOR UTILIZATION**

Synopsis: Information will be presented on the utilization of contract labor in nursing services.

Prepared by: Allison Partridge CNO
Name
Title

Reviewed by: _____
Name
Title of Chief who reviewed

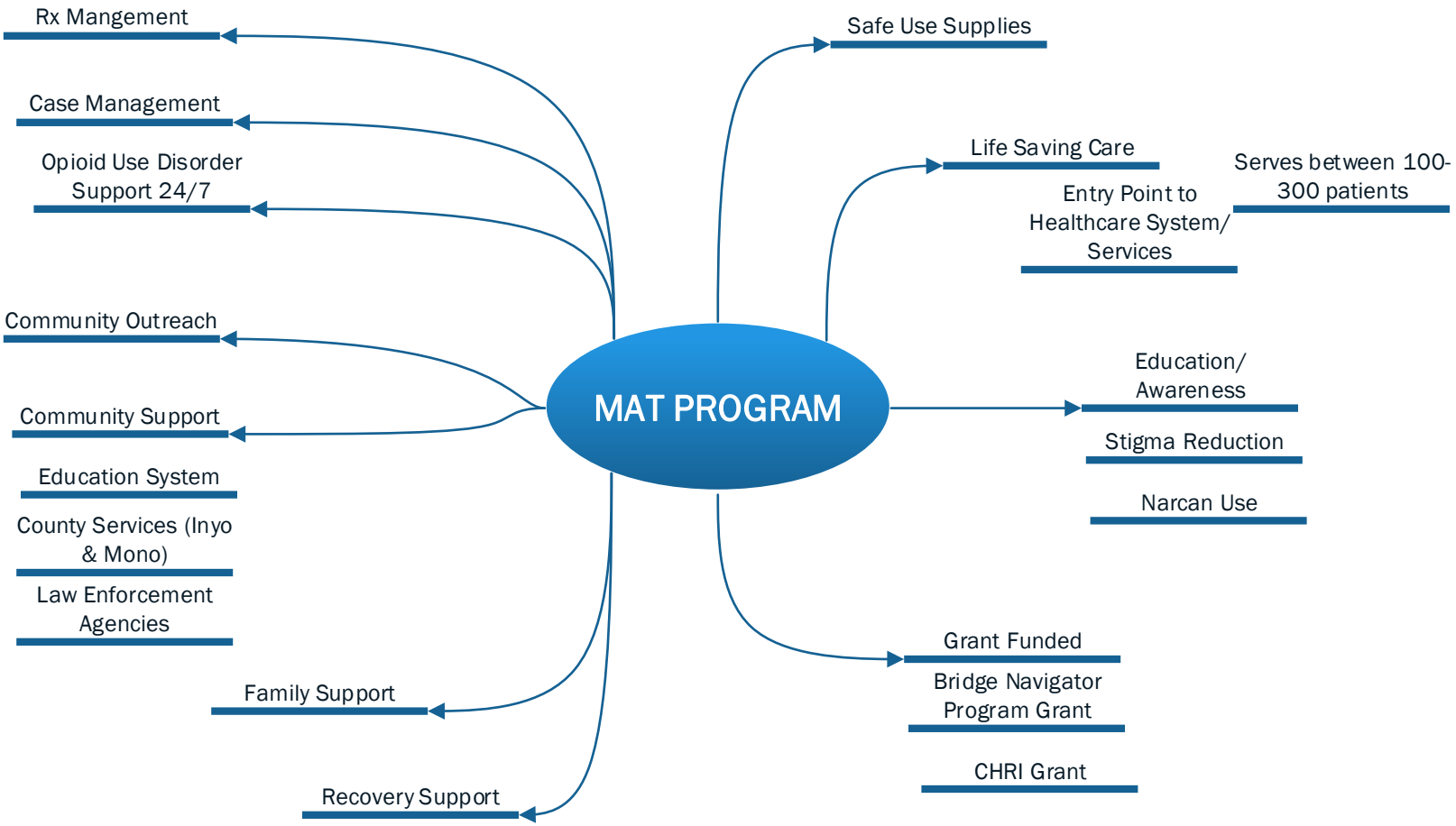
Approved by: _____
Name
Title of Chief who approved

**FOR EXECUTIVE TEAM USE ONLY:**

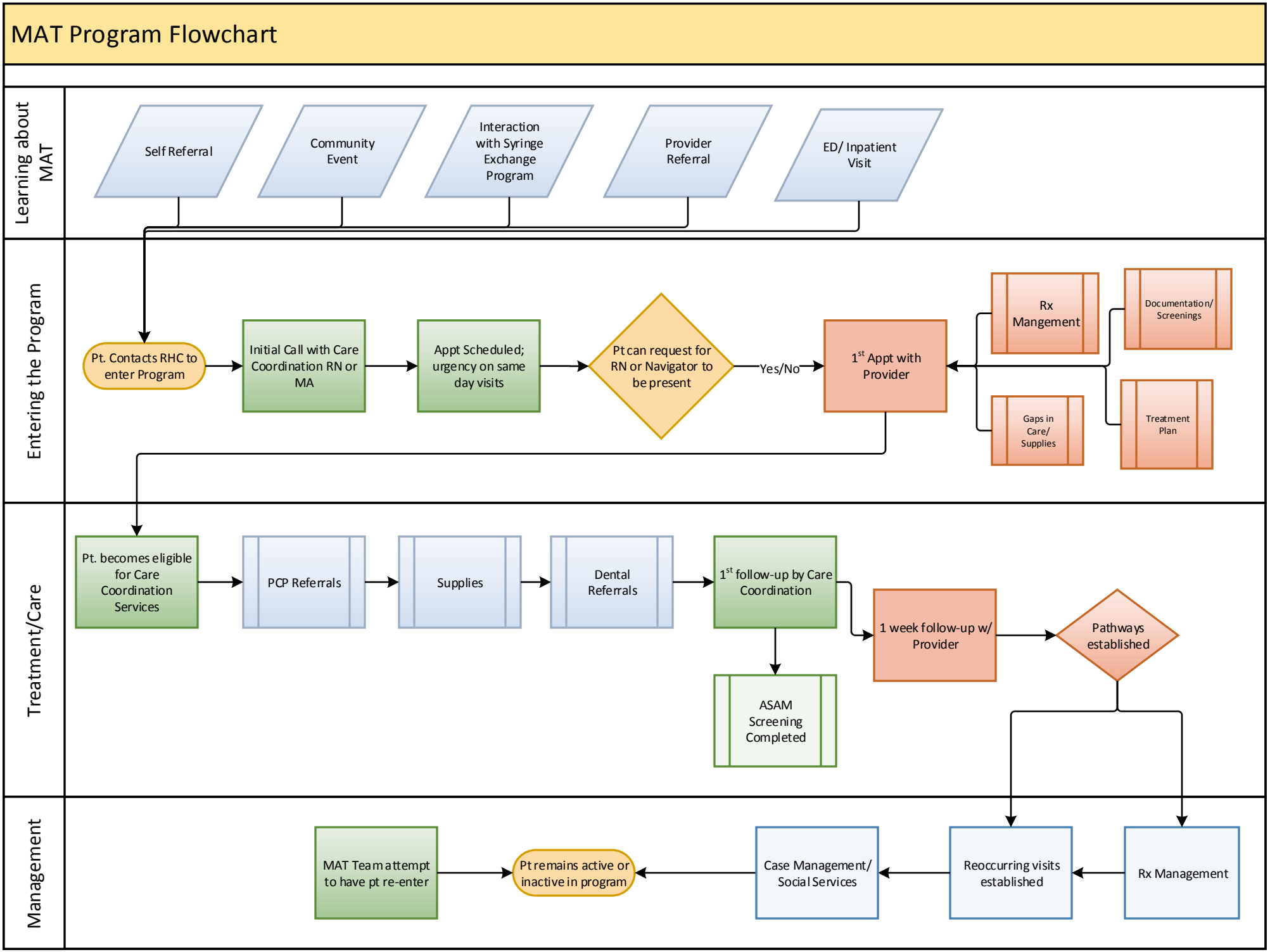
Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

**NORTHERN INYO HEALTHCARE DISTRICT**
**RECOMMENDATION TO THE BOARD OF DIRECTORS**
**FOR ACTION**

Date: The date of submittal of the form


MAT PROGRAM
Rx Mangement
Case Management
Opioid Use Disorder Support 24/7
Community Outreach
Community Support
Education System
County Services (Inyo & Mono)
Law Enforcement Agencies
Family Support
Recovery Support
Safe Use Supplies
Life Saving Care
Serves between 100-300 patients
Entry Point to Healthcare System/ Services
Education/ Awareness
Stigma Reduction
Narcan Use
Grant Funded
Bridge Navigator Program Grant
CHRI Grant

# MAT Program Flowchart



**NORTHERN INYO HOSPITAL**
*Northern Inyo Healthcare District*
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: February 7, 2023
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Policies (*action item*)
    1. *Admission Procedure of a Pediatric Patient*
    2. *Clinic Emergency Response Kit*
    3. *Critical Value Reporting of Lab Results*
    4. *DI – CT Contrast Administration*
    5. *DI – CT Premedication for Contrast Sensitivity*
    6. *Floating Nursing Workforce*
    7. *Infant Feeding Policy*
    8. *Lippincott Procedure Manual Adoption Policy*
    9. *Misoprostol for Cervical Ripening*
    10. *Nursing Quality Assurance Performance Improvement Plan*
    11. *Orthopedic Hardware*
    12. *Oxytocin (Pitocin) Administration*
    13. *Patient Identification for Clinical Care and Treatment/Armband Usage*
    14. *Sentinel Event/Serious Harm Reporting and Prevention*

B. Medical Executive Committee Meeting Report (*information item*)

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Admission Procedure of Pediatric Patient | | |
| Owner: MANAGER MED SURG ICU | Department: Acute/Subacute Unit | |
| Scope: Acute/Subacute Unit | | |
| Date Last Modified: 12/14/2022 | Last Review Date: No Review Date | Version: 9 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/1995 | |

**PURPOSE:**
To prepare the pediatric patient and their legal guardian for the hospital stay; establish a friendly, therapeutic relationship between the patient, parents, and hospital staff by thoroughly orienting them to the department, explaining procedures and equipment involved, obtaining necessary information about the patient, as well as obtaining consents for special treatments or surgery.

**POLICY:**
All patients will be assigned an appropriate room utilizing diagnosis and age specific considerations. A "Quick Check" of each patient will be completed within 30 minutes of arrival. The time of admission is the time that the patient arrives on the department.

**DEFINITIONS:**
Pediatric – The patient age-specific population defined as pediatric is age 28 days to 13th birthday.

**PROCEDURE:**
1. Prior to admission:
   A. Get "Room Ready" by obtaining:
      a. Age appropriate crib or bed
      b. Age appropriate scale for admission weight
      c. Measuring tape for head circumference measurement (As Needed)
      d. Pediatric blood pressure cuff
      e. Patient labeled pediatric stethoscope
      f. Age and size appropriate apparel
2. Upon Admission:
   A. Greet parents and patient in a friendly manner using AIDET.
   B. Complete a quick check.
   C. Obtain a complete set of vital signs including a blood pressure.
   D. Obtain height and weight
      a. Obtain the correct colored square paper that corresponds to the Broselow Pediatric Emergency Tape and write the weight on this colored square.
         i. Attach the colored square to the head of the bed or the foot of the crib
         ii. Place a colored square on door
         iii. Inform parents the importance of the colored paper
         iv. Make a copy of the appropriate color Broselow Emergency Tape (front and back) and hang it on the bed or crib as well as on the door
   E. Complete the pediatric admission assessment form with the parents' and patient's assistance.

F. Attach the patient security tag to the child's leg or arm and activate it per policy. Inform the parents what this is for, where on the unit they are able to go with the child and answer any questions related to child security and safety.
G. After confirming correct name and date of birth, apply the armband to the pediatric patient.
H. Apply a duplicate armband to the legal guardian of the pediatric patient. (Parent/Legal guardian)
I. Complete a **CODE AMBER INFORMATION SHEET. Place it in the first section of the chart.**
J. Ensure that photo of the child is uploaded onto the EHR.
K. Make the patient as comfortable as possible.
L. Discuss NIHD fall prevention and precautions taken while patient is in the hospital.
    a. Show the older pediatric patient and all parents how to use the call bell.
    b. Explain intake and output (I&O) as well as the need to measure <u>all</u> I&O of fluids.
    c. Explain the use of the urinal, bedpan, commode, and emesis bag.
    d. If the pediatric patient is able to ambulate, give them a full room orientation.
    e. Place a pitcher of water at the bedside if patient is able to drink fluids.
    f. Explain the use of the pediatric pain scale.
    g. Give parents WIFI password.
M. Review Physicians orders:
    a. If medication is ordered, print out medication information from Up-to-Date on each medication the RN will be administering
    b. Calculate dosage based on the pediatric patient's weight
    c. Verify dose with second RN or qualified Healthcare Professional. (**New Dose calculation needed with weight change.)**
    d. Respiratory Therapist will be responsible for double checking respiratory medications they will be administering.
N. Place vital signs chart taped to vitals machine. Normal ranges highlighted.
O. Include parents in the care of the child, being considerate and kind in your approach.
    a. Provide parents with the Pediatric Unit Welcome Letter. Allow the parent time to read the letter and stand by to answer any questions they may have.
    b. Parents are to be encouraged to become involved in the child's care.
    c. Explain to parents that no smoking is allowed at Northern Inyo Hospital including the outside grounds. The Parent Letter discusses the smoking policy.
P. Explain all treatments and procedures the parent and patient should anticipate.
Q. Initiate Patient Care Plan and share with parent and patient as appropriate.
R. At time of discharge, **Child Safety Seat** form will be signed.

**REFERENCES:**


1. General Acute Care Hospitals, 22 CCR Div.5, 2014.
2. ANA. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org


**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Pediatric Standards of Care and Routines
2. Newborn & pediatric Abduction Prevention Safety and Security
3. Weights for Infant and Pediatric Patients

| |
|---|
| Supersedes: v.8 Admission Procedure of Pediatric Patient |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Clinic Emergency Response Kit | | |
| Owner: Director of Outpatient Clinics | Department: Rural Health Clinic | |
| Scope: Outpatient Clinics | | |
| Date Last Modified: 12/15/2022 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 05/07/2014 | |

**PURPOSE:**
To assure emergency equipment and medications are readily available, allowing for emergency response when needed at the Northern Inyo Healthcare District (NIHD) Clinics.

**POLICY:**
1. In the event of a patient care emergency, Basic Life Support (BLS) protocol will be followed including initiation of 911.
2. Emergency medications pertinent to the care of clinic patients are stocked in the kit.
3. Emergency supplies pertinent to the care of clinic patients are stocked.
4. An Automated External Defibrillator (AED) is accessible to all clinics.
5. Clinical staff will maintain BLS certification.

**PROCEDURE:**
1. Contents of the emergency response kit are determined by:
    A. Pharmacy will review the requested medications at Pharmacy &Therapeutics committee annually.
    B. Pharmacy will stock the emergency response cart drugs and monitor for outdates.
2. The emergency medication kits shall be further sealed with a breakaway lock. Locks will be stored in the pharmacy and shall be available only to a pharmacist.
3. A member of each clinic staff will check the emergency response kit monthly.
    A. If emergency supply kit lock is broken or the number does not match the checklist, clinic staff will contact pharmacy to verify kit contents and provide new breakaway lock.
    B. An emergency response kit checklist will be completed by the staff monthly (see attached) and reviewed by the clinic manager monthly.
    C. Clinic staff will monitor the equipment and replace outdated equipment.
4. The AED functionality will be checked by Clinical Engineering (biomed). For procedure on use of the AED, see Lippincott Procedure.

**REFERENCES:**

1. CMS (6/30/2004) rural health clinic and federally qualified health center manual. 42 cfa ch. IV; 491.9 provision of services area 3

**RECORD RETENTION AND DESTRUCTION:**
Documentation of emergency care is maintained within the patient's medical record, which is managed by the Northern Inyo Healthcare District Health Information Management Services.

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. InQuiseek – Emergency Care and Treatment
2. Emergency Medication and Code Blue Crash Cart Policy

| Supersedes: v.1 Emergency Response Cart |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Critical Value Reporting of Lab Results | | |
| Owner: Medical Laboratory Services Manager | Department: Laboratory | |
| Scope: Lab, Nursing, Respiratory Care Practitioners, NIHD Clinics | | |
| Date Last Modified: 01/31/2023 | Last Review Date: No Review Date | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/01/2005 | |

**PURPOSE:**

To define critical values and establish a communication/documentation process

**POLICY:**

1. A current listing of Critical Values will be maintained in this policy. Critical values are also defined in the LIS to allow automated flagging and also appear in bold red type in the Electronic Medical Record
2. Critical results generated by automated analyzers are **not** required to be verified by repeat analysis
3. All critical values will be called and documented, except for **decreasing** critical Troponin results within the same visit
4. When a patient is transferred to another healthcare facility: Critical results will be called to the primary nurse. If unable to deliver critical results to the appropriate personnel, the results may be given to a Clinical Laboratory Scientist (CLS) at that facility.

**DEFINITION:**

1. Critical results are those findings whose value reflects a potential life threatening situation that requires rapid communication of results.
2. Critical results can be relayed to licensed providers (such as Registered Nurses, Licensed Vocational Nurses) or clerical office staff as determined by the outpatient clinic or call facility.

HEMATOLOGY:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **Fibrinogen** | 100 | -- | mg/dL |
| **Hematocrit** | 15 | 66 | % |
| **Hemoglobin (<21 days)** | 7 | 22 | g/dL |
| **Hemoglobin (>21 days)** | 7 | 20 | g/dL |
| **INR** | -- | 4.5 | ratio |
| **WBC (<21 days)** | 2.5 | 30 | x10^3/mcl |
| **WBC (>21 days)** | 2.5 | 20 | x10^3/mcl |
| **Platelet** | 30 | 800 | x10^3/mcl |
| **PTT** | -- | 90 | Seconds |

CHEMISTRY:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **Acetaminophen** | -- | 50 | ug/mL |
| **Neonatal bilirubin** | -- | 15.0 | mg/dL |
| **Total bilirubin (adult)** | | 15.0 | mg/dL |
| **Calcium** | 6.0 | 14.0 | mg/dL |
| **Carbamazepine** | -- | 12 | ug/mL |
| **Creatinine** | -- | 5.0 | mg/dL |
| **CO2** | 10 | 40 | mmol/L |
| **Digoxin** | -- | 2.5 | ng/mL |
| **Ethanol** | -- | 300 | mg/dL |
| **Gentamicin (Random)** | -- | 8.0 | ug/mL |
| **Gentamicin (Peak)** | -- | 10.0 | ug/mL |
| **Gentamicin (Trough)** | -- | 2.1 | ug/mL |
| **Glucose (>1 year)** | 50 | 400 | mg/dL |
| **Glucose (0 - 28 days)** | 30 | 300 | mg/dL |
| **Glucose (28 days - 1 year)** | 40 | 400 | mg/dL |
| **Lactic acid** | -- | 5.0 | mmol/L |
| **Lithium** | -- | 2.0 | mmol/L |
| **Phenobarbital** | -- | 40 | ug/mL |
| **Phenytoin** | -- | 30 | ug/mL |
| **Potassium (<9 days)** | 3.0 | 8.0 | mmol/L |
| **Potassium (>9 days)** | 3.0 | 6.0 | mmol/L |
| **Salicylate** | -- | 30 | mg/dL |
| **Sodium** | 120 | 160 | mmol/L |
| **Tobramycin (Random)** | -- | 8 | ug/mL |
| **Tobramycin (Peak)** | -- | 10 | ug/mL |
| **Tobramycin (Trough)** | -- | 2.1 | ug/mL |
| **Troponin-I** | -- | 0.3 | ng/mL |
| **Valproic Acid** | -- | 200 | ug/mL |
| **Vancomycin (Random)** | -- | 30 | ug/mL |
| **Vancomycin (Peak)** | -- | 40 | ug/mL |
| **Vancomycin (Trough)** | -- | 25 | ug/mL |

BLOOD GAS:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **pH (arterial, venous, cord)** | 7.2 | 7.6 | -- |
| **pO2 (arterial)** | 40 | -- | mmHg |
| **pCO2 (arterial)** | 20 | 70 | mmHg |
| **pCO2 (venous)** | 15 | 70 | mmHg |
| **HCO3 (arterial, cord arterial)** | 15 | 40 | mmol/L |
| **Hemoglobin (arterial)** | 7 | 20 | g/dL |

TRANSFUSION SERVICE:

1. All units crossmatched are incompatible
2. Blood products are unavailable

MICROBIOLOGY:

1. Positive gram stains (organisms seen) from these sites:
   A. Blood cultures
      i. **Inpatients**: only call first positive bottle if the organism morphology is consistent across bottles
      ii. **Outpatients and discharged patients**: call all positive bottles
   B. CSF
   C. Body fluids (from normally sterile sites)
      i. Pleural
      ii. Pericardial
      iii. Thoracentesis
      iv. Joint fluid
      v. Peritoneal fluid
2. EHEC organism (O:157) and Shiga toxin positive stool specimen
3. Suspicion of *Salmonella typhi*
4. Suspicion of bioterrorism organism
   - *B. anthracis*
   - *C. botulinum*
   - *Brucella* species
   - *F. tularensis*
   - *Y. pestis*
   - *B. mallei*
   - *B. pseudomallei*
5. Positive Acid Fast Bacilli (AFB) stains and organism identification (result will originate from reference laboratory)

*Note: See Microbiology SOP "Direct Notification of Abnormal Findings" for reporting instructions of non-critical microbiology culture results*

**PROCEDURE:**

LABORATORY AND RESPIRATORY THERAPY

1. The critical test result reporting time frame is from the time the result is available to the time the result is documented as received.
   A. Inpatients and Emergency Department: Report within 30 minutes of the availability of result
   B. Outpatient clinics: Report within 60 minutes of the availability of the result.
2. Clinical Laboratory Scientists (CLS) are responsible for notifying a nurse, on-call Provider, or other qualified recipient such as a call center representative or CLS at an outside facility. The notification (and any attempts) must be documented.
3. Respiratory Therapists are responsible for analyzing, reporting, and notifying the provider of critical blood gas results. The notification (and any attempts) must be documented.
4. If unable to reach a nurse, attempt to contact an on-call provider respective to the ordering provider's clinic/location.

5. If unable to contact a nurse or provider within 60 minutes after initial contact attempt, notify an Emergency Department Physician to help assess situation and contact patient if appropriate. The notification (and any attempts) must be documented.
6. Once a contact has been found:
   A. Report the patient's name and date of birth
      i. A room number is not a proper identifier, per The Joint Commission
   B. Report the ordering provider's name if speaking with an on-call contact or a clinic
   C. Report the name of the test and the critical value
   D. Ask the contact to repeat the above information back to you
7. **Required information to be documented in the LIS by the CLS or RT:**
   **A. First name and last initial/last name of contact person**
   **B. Location of contact person (i.e. ED, RHC, Med/Surg, City of Hope, etc)**
   **C. Date and time contact notified**
   **D. Reporting CLS or RT initials**
   **E. Documentation of any delays or problems in notification**
8. To ensure all necessary documentation is included, use the Cerner comments:
   A. **29crit** (for Result Entry) or **29mbcrit** (for Microbiology Result Entry):
      *Critical Result called to _ on _ by _. Read back and verified*.
9. CLS and RTs are required to verbally report all critical values, regardless of whether they are returning to "normal".

NURSING

1. The nurse is responsible for notifying the ordering provider of critical values that are reported from the CLS or RT within 30 minutes of being notified.
2. **The nurse is responsible for documenting the conversation with the provider. Documentation will include:**
   **A. Date and time nurse was notified by lab**
   **B. Date, time and name of provider notified**
   **C. Name and value of critical result reported**
   **D. Documentation of any delays or problems in notification**
3. If consecutive critical values from the same test are improving (trending closer to the normal range) or staying at the same level, the nurse is not required to contact the provider.

**REFERENCES:**

1. The Joint Commission E-dition Critical Access Hospital, current edition.

**RECORD RETENTION AND DESTRUCTION:**

Documentation of critical values is kept in the patient's medical record, which is maintained by the NIHD Medical Records Department.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Direct Notification of Abnormal Findings Microbiology SOP

| Supersedes: v.5 Critical Value Reporting of Lab Results* |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: DI - CT Contrast administration | | |
| Owner: DIRECTOR OF DIAGNOSTIC SERVICES | Department: Diagnostic Imaging | |
| Scope: Diagnostic Technologists | | |
| Date Last Modified: 11/16/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 07/01/2018 | |

**PURPOSE:** To maintain safety in regards to performing contrast enhanced CT (Computerized Tomography) examinations and address issues relating to the administration of intravenous contrast material

**POLICY:**

1. Intravenous iodinated contrast may be administered by authorized personnel who are in compliance with all applicable state laws and have been educated patient screening for potential contrast sensitivity, renal insufficiency, recognition of minor and major contrast reactions, and emergency procedures of minor and major contrast reactions.
2. Personnel starting intravenous access must have education and training in venipuncture.
3. Intravenous (IV) iodinated contrast may only be administered only when the appropriate supervising physician has been informed.
4. All patients having IV contrast enhanced imaging studies must read, complete, and sign the CT Contrast consent form. The technologist shall review and complete the consent form with the patient. This form will be entered as a part of the patient's medical record.
5. Any patients noting multiple reactions to medications, iodinated contrast, or foods containing iodine will have their information reviewed by the technologist and supervising physician. Information will be evaluated for increased risk of an IV contrast reaction.
   a. If premedication is needed refer to CT Premedication for Contrast Allergy Policy.
6. If the patient is age 60 or older, a creatinine blood test must be performed. For outpatients within the last 30 days and within 7 days for inpatients. The Supervising Radiologist or Other Physician shall review results.
   a. If **EGFR is greater than 30**, no adjustments needed to contrast dose.
   b. If **EGFR is below 30** (see steps below):
      - Patient has an Acute Renal Failure:
        Consult Radiologist.
      - Patient scheduled for Dialysis:
        Consult Radiologist for volume on contrast for exam.
      - Patient **not** receiving Dialysis:
        Schedule patient for outpatient hydration protocol 1 hour prior to scan time.
   c. **Hydration Protocol:**
      - **Inpatients:** 0.9% NS at 100ml/hr. IV bolus beginning 6-12 hours prior to IV contrast administration and continuing for 4-12 hours post exam.

- **Outpatients:** 0.9% NS 500ml IV bolus prior to IV contrast administration. Additionally, post exam oral hydration (1 Cup of water per hour for 8 hours)

7. If ordering provider requires contrast to be given, technologist will document the EFGR value on CT Contrast Consent form as well as obtain the signature of the ordering provider to proceed.
6. Unless otherwise directed by the ordering or supervising physician, contrast will be delivered per the CT contrast Protocol section of this policy.

**ACUTE MEDICAL EMERGENCIES:**

1. All staff involved directly with patient care will be Basic Life Support (BLS) certified.
2. Emergency phone numbers are posted by each phone in the Imaging suite (2400).
3. Emergency equipment (crash cart) is available.
4. In the event of an emergency, staff will call a "Code Blue" or "Rapid Response" in the CT suite.
5. The supervising physician will be notified immediately.

**CONTRAST SHORTAGES:**

In the event that the Isovue 300 or 370 unable to be provided by the manufacturer. The Isovue volumes may be substituted with an alternative contrast brand and/or amount approved by the Radiologist and if needed by the Pharmacist.

**REFERENCES:**


1. ACR Contrast Manual 2022
2. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.913.8515&rep=rep1&type=pdf


**RECORD RETENTION AND DESTRUCTION:**

Consent forms are part of medical record and retained per Medical Record policy

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. DI - CT Premedication for Contrast Allergy
2. Contrast use with patients on Metformin

Supersedes: v.2 DI - CT Contrast administration

**CT Contrast Protocols:**

| CT PROCEDURE | IV CONTRAST TYPE | VOLUME (ml) | RATE (ml/sec) | RECOMMENDED NEEDLE SIZE (ga) | MAX INJECTION PRESSURE (psi) |
|---|---|---|---|---|---|
| ABDOMEN | ISOVUE 300 | 100 | 2.5 | 20/22 | 300 |
| ABDOMEN/PELVIS | ISOVUE 300 | 100 | 2.5 | 20/22 | 300 |
| PELVIS | ISOVUE 300 | 100 | 2.5 | 20/22 | 300 |
| BRAIN | ISOVUE 300 | 75 | 2.5 | 20/22 | 300 |
| FACIAL, TEMPORAL, IAC | ISOVUE 300 | 75 | 2.0 | 20/22 | 300 |
| CHEST | ISOVUE 300 | 100 | 2.5 | 20/22 | 300 |
| CHEST/ABDOMEN/PELVIS | ISOVUE 300 | 100 | 2.5 | 20/22 | 300 |
| TRAUMA CHEST/ABDOMEN/PELVIS | ISOVUE 300 | 100 | 1.8 | 20/22 | 300 |
| ENTEROGRAPHY | ISOVUE 370 | 100 | 4.0 | 20 | 300 |
| UROGRAM | ISOVUE 300 | 125 | 2.5 | 20/22 | 300 |
| SOFT TISSUE NECK | ISOVUE 300 | 75 | 2.0 | 20/22 | 300 |
| SOFT TISSUE NECK CHEST/ABDOMEN/PELVIS | ISOVUE 300 | 75/75 | 2.5 | 20/22 | 300 |
| CERVICAL SPINE | ISOVUE 300 | 100 | 2.0 | 20/22 | 300 |
| THORACIC SPINE | ISOVUE 300 | 100 | 2.0 | 20/22 | 300 |
| LUMBAR SPINE | ISOVUE 300 | 100 | 2.0 | 20/22 | 300 |
| VENOGRAM | ISOVUE 370 | 150 | 3.0 | 20 | 300 |
| CTA CHEST | ISOVUE 370 | 100 | 4.0 | 20 | 300 |
| CTA CAROTID | ISOVUE 370 | 75 | 4.0 | 20 | 300 |
| CTA BRAIN (COW) | ISOVUE 370 | 75 | 4.0 | 20 | 300 |
| CTA BRAIN/CAROTID | ISOVUE 370 | 75 | 4.0 | 20 | 300 |
| CTA ABDOMEN | ISOVUE 370 | 100 | 4.0 | 20 | 300 |
| CTA ABDOMEN W RUNOFF | ISOVUE 370 | 125 | 4.0 | 20 | 300 |

| | | | | | |
|---|---|---|---|---|---|
| CTA CARDIAC | ISOVUE 370 | 75 | 5.0 | 20 | 300 |
| CTA EXTREMITY | ISOVUE 370 | 100 | 4.0 | 20 | 300 |
| PEDS BRAIN | ISOVUE 300 | 2ml per kg | 2.0 | 22 | 300 |
| PEDS CHEST | ISOVUE 300 | 2ml per kg MAX 100ml | 2.0 | 22 | 300 |
| PEDS ABDOMEN | ISOVUE 300 | 2ml per kg MAX 100ml | 2.0 | 22 | 300 |

Reference Table for Maximum injection rates for Pediatric CT Studies

**TABLE 4: Maximum Suggested Injection Rates for Pediatric CT Studies**

| Maximum Injection Rate | Catheter Size |
|---|---|
| 5.0 mL/s | 16–18 gauge |
| 4.0 mL/s | 20 gauge |
| 2.5 mL/s | 22 gauge |
| 1.0 mL/s | 24 gauge |

**TABLE 5: Suggested IV Contrast Media Injection Rates for Routine (Non–CT Angiography) Contrast-Enhanced CT Studies in Pediatric Patients**

| Injection Rate | Study |
|---|---|
| 1.0–2.0 mL/s | Head CT |
| 1.0–2.0 mL/s | Neck, chest, extremity, or abdomen/pelvis CT |

Note—Injection rates of less than 1.0 mL/s may be acceptable for certain indications, and some implanted ports, peripherally inserted central catheters, or small-gauge (24-gauge) angiocatheters may necessitate a rate of 1.0 mL/s or less.

**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: DI - Premedication for Contrast Sensitivity | | |
| Owner: DIRECTOR OF DIAGNOSTIC SERVICES | Department: Diagnostic Imaging | |
| Scope: Medical Provider, Imaging Admission Clerks | | |
| Date Last Modified: 11/16/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 7/25/2014 | |

**PURPOSE:** Provides guidance for premedication of patients with known sensitivity to radiographic contrast.

**POLICY:**

1. At the time of scheduling, Imaging Admissions Clerks verify if the patient has known sensitivity to radiographic contrast or has had a significant allergic reaction to iodine or contrast.
2. NIHD may pre-medicate patients with known sensitivity to (iodinated or non-iodinated) radiographic contrast upon receipt of orders from the referring physician or radiologist.
3. These reactions necessitate notification of the radiologist or referring physician for pre-medication orders.
    a. Diffuse erythema / hives
    b. Respiratory compromise / shortness of breath
    c. Facial / laryngeal edema
4. Technologist will verify allergy is documented in patients' medical record, if not present technologist will add allergy.
5. **Pre-medication protocol:**
    a. **Oral (preferred)**:
        1. Methylprednisolone 32 mg (or equivalent) orally 12 hr and 2 hours before exam time.
        2. Antihistamine Cetirizine (Zyrtec) 10 mg OR Diphenhydramine 50mg 1 hour before exam time.
    **b. Accelerated Steroid Prophylaxis (Intravenously):**
        1. 200mg hydrocortisone IV at 5 hours before scan and 1 hour before scan
        2. Diphenhydramine– 50 mg IV push 1 hour before exam,

**REFERENCES:**

1. ACR Manual on Contrast Media – 2022 edition

**RECORD RETENTION AND DESTRUCTION:**

Documentation of allergies and medications administered per provider's orders a part of the patient's medical record. NIHD Health Information Management Department maintains all medical records.

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. DI - Premedication for Contrast Sensitivity
2. Diagnostic Imaging Method of Practice
3. DI – CT Contrast Administration

| Supersedes: v.2 Diagnostic Imaging - Premedication for Radiographic Contrast Sensitivity* |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Floating Nursing Workforce | | |
| Owner: Chief Nursing Officer | Department: Nursing Administration | |
| Scope: Nursing Department | | |
| Date Last Modified: 12/29/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: various dates by units | |

## PURPOSE:

1. To identify the process for floating nursing workforce who do not have a patient case load in their routinely assigned (home) department.
2. To decrease the need to low-census workforce from departments where census has decreased; to utilize available workforce to provide care in other nursing units where need exists.
3. To maintain each unit's standard of care at all times.
4. To make expectations clear to both the employee being floated and to the experienced unit workforce who will function as the resource nurse.

## POLICY:

1. Workforce members that are required to be on site who do not have a patient load may be floated to assist with care (within the workforce person's competency) in another department.
   a. The floated workforce member may be assigned a caseload of patients under the direction of the home department's RNs
   b. The floated workforce member may be assigned tasks
2. Departments with workforce who are required to be on site with and without patients include: Emergency Department (ED) and Labor & Delivery (L&D)/Triage. This is referred to as "fixed staffing".
3. The ED and L&D departments must have 1 RN in the department at all times. Additional nurses may be floated.
4. A float RN will never be placed into the triage role.
5. All nursing workforce at Northern Inyo Healthcare District (NIHD) will be floated to nursing units other than the one to which they are assigned only when necessary. However, there are more limited floating expectations of the surgery, Post Anesthesia Care Unit (PACU), and sterile processing workforce. This policy refers only to floating; refer to "Cross Training of RN Staff" policy for information on that topic.

## PROCEDURE:

1. The House Supervisor (HS) may float workforce members that are required to be on site to another department to assist with care activities.
2. The floated workforce member would be assigned to a resource nurse, home-based to that unit.
   a. The resource nurse will be the charge nurse on units where this position is routinely filled.
   b. A resource nurse would assign care activities to the floated workforce member.
   c. The floated workforce member works under the direction of the resource nurse and only performs care activities within their competency skill sets.

d. In the event the floated workforce member needs to return to their home department, the floated workforce member completes documentation of care activities and reports off to the replacement workforce member.

3. The fixed workforce member floated without an assignment does not clock out of the Home Department while floating.
4. The ED and L&D RN who must remain in the department at all times will be expected to use their time to complete work related projects or training.

**Floating Orientation:**

1. An employee who is routinely floated to another unit will be one who has completed a basic orientation to the unit.
2. This basic orientation will consist of completing the "Floating Orientation Checklist/Summary" and "Equipment Competency Validation Checklist" under the guidance of an assigned preceptor. The amount of time required to complete this basic orientation will be individualized to each employee's needs and experience.
   (Unit specific float orientation checklists are located on NIHD Intranet>Resources>Forms and Templates>Nursing Administration.)
3. After completion of the basic orientation, the employee will be able to "float" to oriented department to assist with care activities in times of need.
4. If the employee has not floated for a year after orientation, they may be required to reorient.

**General Guidelines to Consider:**

1. Employee should not routinely be floated during the introductory period. If possible, the Unit Manager should be consulted prior to floating the orientee during their introductory period.
2. While it is preferable for workforce to be float-oriented to other units prior to floating, this will not always be possible. Instead, at the time they are floated, the float will be given copies of both the floating guidelines, unit specific "Floating Orientation Checklist/Summary" and "Equipment Competency Validation Checklist" for that unit. Low census times should be used to float orient workforce to other units.
3. An RN floated into a unit will not be the only RN in the unit.
4. Float workforce should not be left alone on the unit when other workforce goes to lunch or on a break.
5. Float workforce are usually not assigned to the more critical or complicated patients. If the condition of the patient changes, assignments may be changed**,** or team nursing can be utilized.
6. Whenever possible, patients will not be assigned to float workforce for two consecutive shifts.
7. Careful consideration shall be given in determining the patient load that a float is expected to take. In most cases, they will not be expected to take the same patient load as an experienced unit workforce member or cross trained nurse.
6. Patients requiring initial teaching specific to the unit should not be assigned to a float. How to provide other patient teaching needs and reinforcement of previous teaching will be discussed between the float and the resource person.
7. Each unit will develop a specific checklist for floating. Copies of these will be available in each unit. The float workforce will be expected to review it as needed and to discuss any questions with their resource person.
8. The float person should be in the unit and available for report on a timely basis.
9. The Floated Workforce Member may complete the Float Staff Shift Evaluation of Department Worked and return to the manager of the unit where the floated workforce member worked. See attachments or

use the following path.
file://root.nih.org/home/Public/Intranet%20Redesign/Intranet%20Links/Forms/Nursing%20Administration/P&P%20Float%20Staff%20Shift%20Evaluation%20of%20Department%20Worked%20form.pdf

**REFERENCES:**


1. The Joint Commission (CAMCAH Manual) (Jan. 1, 2022) NR.02.01.01 EP 4.
2. The Joint Commission (CAMCAH Manual) (Jan. 1, 2022) NR.02.02.01 EP 1.
3. The Joint Commission (CAMCAH Manual) (Jan. 1, 2022) NR.02.03.01 EP 5.


**RECORD RETENTION AND DESTRUCTION:**

Staffing records are maintained for fifteen (15) years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Emergency Staffing
2. Competency Plan
3. Nursing Services Competency Plan
4. Orientation Competency Committee Charter
5. Staffing Management Plan
6. Staffing Management Plan Operating Room
7. Staffing Management Plan OP/PACU

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| Supersedes: v.2 Floating Nursing Staff* |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Infant Feeding Policy | | |
| Owner: PERINATAL NURSE MANAGER | Department: Perinatal | |
| Scope: Perinatal Staff | | |
| Date Last Modified: 12/13/2022 | Last Review Date: No Review Date | Version: 7 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 12/1998 | |

## PURPOSE:

To create a philosophy that supports and views breastfeeding as the normal way to feed an infant, and to provide guidelines for safe and effective methods to assist the new mother in establishing a successful and satisfying breastfeeding experience.

## POLICY:

All mothers will be given education and support to initiate and promote exclusive breastfeeding for the first 6 months of life and to continue breastfeeding after complementary foods are introduced for 2 years or longer, or as long as mutually desirable by the mother and infant. Northern Inyo Healthcare District believes that breastfeeding is the optimal feeding choice for most babies and will promote exclusive breast milk feeding. Those mothers, after education and documentation, that choose to formula feed will be supported in their decision and be given individual education on the preparation, storage, and administration of infant formula.

Exclusive breastmilk feeding will be defined according to the WHO's definition of "the infant only receives breast milk without any additional food or drink, not even water."

This policy is based on the latest evidence-based practice and recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health (US Department of Health and Human Services), The Joint Commission's Perinatal Core Measures for Exclusive Breastfeeding, the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, the World Health Organization (WHO), the American Dietetic Association, the Academy of Breastfeeding Medicine, UNICEF/WHO evidence-based "Ten Steps to Successful Breastfeeding," and Baby Friendly USA. F

## PRECAUTIONS:

1. The mother's wishes regarding infant feedings will be respected and supported by the nursing staff.
2. Supply literature on infant feeding as requested by the patient or as necessary according to the judgment of the nursing staff.
3. Assess patient's willingness and need for technological interventions/supplies. These supplies are meant for short-term problem solving and can lead to poor feeding practices if not used correctly. These patients should be referred to a Lactation Specialist and or International Board Certified Lactation Consultant (IBCLC).
4. Assess the woman's desire to breastfeed as well as what information or support she will need. Frequently new mothers are overwhelmed by too many different suggestions/techniques offered by friends, relatives and health care providers. It is essential that assistance to these mothers be given in a **consistent and**

**repetitive** way that takes into account the transient problems with memory functions frequently encountered during the initial postpartum period. If problems arise that cannot be solved with basic interventions, or if further assistance will be needed after discharge, referral to the patient's health care provider, a home visit (i.e. Home Health nurse), and/or a lactation consult may be indicated.

**PROCEDURE:**

1. **Policy management, orientation, and training**
    a. The Perinatal Nurse Manager, clinical staff educator (CSE), Peri-Peds Committee will be responsible for the development, updating, evaluation, and revision of this policy.
    b. All staff that comes into direct contact with pregnant, laboring or postpartum women or newborn infants are responsible for implementing the policy.
    c. New hires will be oriented to the policy by their preceptor or supervisor within two weeks of their start date.
    d. All maternity staff will receive 20 hours of education in breastfeeding and lactation management. The curriculum for this education will cover the 15 sessions identified by Baby-Friendly USA and include 5 hours of supervised clinical training.
    e. All new hires will be required to complete the breastfeeding training course as outlined by Baby Friendly USA within 6 months of hire.
    f. Certificate of completion of course and clinical training competency will be documented in employee's file.
    g. If training occurred prior to employment, employee must provide certificate of completion and verify that the other facility was certified as Baby Friendly at the time of taking the course. The employee will complete the same clinical competency as all maternity staff at NIHD.
    h. The Perinatal Nurse Manager is responsible for ensuring all staff are trained in accordance with this policy and the maintenance of competency documentation.
    i. The policy will be reviewed every two years per NIHD protocol, and revisions will take place at that time as needed. Revisions will take place more frequently than every two years if evidence steers current practice to a different procedure/technique.
2. **Inform all pregnant women about the benefits and management of breastfeeding**
    a. The Perinatal department at NIHD has developed an education plan aimed at reaching pregnant women through the OB/GYN office, First 5, Toiyabe Indian Health Project and WIC. NIHD fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages. Staff in the Perinatal department at NIHD have provided to other organizations that offer prenatal services a sample curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding. In addition, members of the staff participate in the local breastfeeding coalition. Physicians, Nurse Practitioners, Certified Nurse Midwives, nursing staff, and clinic staff will all be responsible to provide prenatal breastfeeding education, guidance, and educational materials.
        i. Education given during prenatal clinic visits
        ii. Prenatal classes offered periodically (collaboration with NIHD, First 5, WIC, and Toiyabe)
        iii. Preadmission visits performed in the patient's third trimester

b. Education will include but not be limited to:
    1. The benefits of breastfeeding/risks of formula feeding
    2. The importance of exclusive breastfeeding for a minimum of 6 months and continued breastfeeding after complementary foods are introduced for 2 years or longer, or as long as mutually desirable by the mother and infant
    3. Labor management techniques aimed at reducing the need for pharmacologic intervention
    4. Early initiation of breastfeeding (within 1 hour preferably)
    5. Immediate, uninterrupted skin-to-skin contact after birth
    6. 24-hour rooming-in practices
    7. Basic breastfeeding management - baby-led feeding in response to feeding cues, proper positioning and latch, frequency of feeds to establish and maintain milk supply, and signs of infant satiety
    8. Hand expression of breastmilk and use of a pump if indicated
    9. Medical indications for supplementation will be addressed on an individual basis when applicable
    10. Contraindications to breastfeeding will be addressed on an individual basis when applicable
    11. Formula feeding will only be addressed on an individual basis if, after education, the patient has chosen to formula feed
c. All educational handouts will be compliant with the International Code of Marketing Breastmilk Substitutes.
d. Document all prenatal breastfeeding education performed in the patient's medical record.

**3. Help mothers initiate breastfeeding within 1 hour of birth**

a. Offer skin-to-skin care to all mothers and infants: The infant will be dressed in no more than a diaper and hat and placed on the mother's bare chest covered by a warm blanket.
b. The safety and stability of both mother and infant will be addressed prior to initiation of skin-to-skin. If there is a medical contraindication, skin-to-skin will be delayed.
c. Regardless of planned feeding modality, all eligible infant-mother pairs will be offered direct skin-to-skin contact. If mother and infant are both medically stable, the infant will be placed skin-to-skin immediately after a vaginal birth or a cesarean section birth (after initial stabilization of infant under radiant warmer).
d. The nursing staff present at delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding: A stable infant will be immediately placed prone on the mother's chest and/or abdomen. The infant should be able to access the mother's breast with no interference. Support for breastfeeding will be provided, including help in identifying feeding cues and allowing the infant to self-attach to the breast. A warm blanket will be laid over the mother and infant. If both patients remain stable, there will be no interruption of contact for at least one hour. If the mother chooses to formula feed, she will still be encouraged to engage in skin-to-skin time.
e. Routine procedures should be done with the baby skin-to-skin with the mother including medication administration. Procedures requiring the cessation of skin-to-skin should be delayed

until after this initial skin-to-skin contact period is completed. Procedures such as weight, measurements, and the infant bath should be delayed and conducted at the mother's bedside whenever possible.

f. If the infant is transferred to another facility for NICU care, the mother will be educated regarding the importance of skin-to-skin care.
g. In the event that mother and baby are separated for medical reasons, skin-to-skin contact will be initiated as soon as possible.
h. After cesarean birth, stable babies will be placed in continuous, uninterrupted skin-to-skin contact with the mother as soon as she is responsive, alert, and medically stable. Babies may be placed skin-to-skin with the support person if unable to be with the mother.
i. Documentation of the time skin-to-skin is initiated and the duration of at least 1 hour will occur in the infant's medical record.

**4. Breastfeeding Support**

a. Perinatal Unit nurses and cross-trained nurses will assess and document the mother's breastfeeding techniques and, if needed, demonstrate and assist mothers with appropriate breastfeeding positions and latching at least twice per shift and more frequently according to infant/mother need. The documentation will occur in the infant's medical record.
b. All patients should be seen by a Certified Lactation Educator Counselor (CLEC) prior to discharge.
c. The following patients should be referred to see an IBCLC as soon as possible:
    i. Maternal:
        1. Mother/infant separation
        2. Cracks, abrasions, or bleeding nipples
        3. History of breast surgery
        4. Unsuccessful breastfeeding with prior child/children
        5. Questionable medication usage
        6. Severe engorgement, plugged ducts, or mastitis
    ii. Infant:
        1. Multiples
        2. Weight loss greater than 7% during the hospital stay in a breastfeeding newborn
        3. Late Preterm Infants (born between 34 0/7 and 36 6/7 weeks gestation)
        4. Small For Gestational Age (SGA) infants
        5. Ineffective latch after 24 hours of age
        6. Supplementation protocol initiated
        7. Infants with anomalies
        8. Signs of dehydration
        9. Persistent symptomatic hypoglycemia
        10. Ankyloglossia (tongue-tie) with difficulty feeding
        11. Infant being treated for hyperbilirubinemia
d. Breastfeeding mothers should be educated on basic breastfeeding practices, including:
    i. The importance of exclusive breastfeeding for the first 6 months of life and continued breastfeeding after complementary foods have been introduced

ii. How to recognize and feed their infants on cue (increased alertness, rooting, licking or smacking of lips, hands to mouth, increased activity)
iii. Normal newborn feeding behavior such as cluster feeding, feeding throughout the night and feeding at least 10 times in a 24-hour period to maintain lactation
iv. No limitations will be taught to mothers regarding feeding lengths or number of feedings
v. Proper positioning, latch, and detachment
vi. Newborn stomach capacity and milk supply in relation to day of life
vii. Elimination patterns
viii. Signs of a good feeding (bursts of sucking, pause and self start, audible swallows)
ix. Manual hand expression of breastmilk
x. How to deal with situations such as sore nipples, engorgement and proper pumping techniques
xi. Normal infant weight loss patterns (average of 7%, not to exceed 10%) with expected birth weight regained by day of life 10-14
xii. Reasons to contact the clinician or IBCLC for breastfeeding support

e. In cases of mother/baby separation:
i. The mother will be educated on hand expression and breast massage
ii. The mother will be given a double-electric hospital-grade breast pump and initiate pumping as soon as possible, or within 6 hours of delivery if the mother is stable
iii. She will be instructed to pump a minimum of every 3 hours for a 15-minute duration
iv. Expressed breastmilk will be given to the infant as soon as the infant is stable and able to tolerate feeds (see supplementation)
v. Mothers will receive education related to pumping, handling, and storage of breastmilk
vi. Expressed breastmilk may remain at room temperature for up to 4 hours. After 4 hours the Perinatal Unit staff will take the mother's milk, label it with the mother or infant label, date, and time, and place in the breastmilk refrigerator until it is needed

5. **No food or drink (i.e., supplemental water, glucose water, or formula) other than breastmilk will be given to infants unless medically indicated or by the mother's documented and informed request (formula only):**
a. When a mother requests that her breastfed infant be given infant formula, the staff will address the mother’s reason for the request. Staff will provide education regarding the risks of formula feeding and benefits of breastfeeding. If the mother still requests formula, the process of counseling, education and informed decision will be documented in the medical record.
i. These mothers will receive individual written and verbal instruction about baby-led feeding, safe formula preparation, handling, and feeding based on the World Health Organization’s guidelines
ii. This education will be documented in infant's medical record.
b. Possible indications for supplementation:
i. Infant Indications
1. Weight loss guidelines
a. Weight loss between 75$^{th}$ and 90$^{th}$ percentile for age (Based on nomogram: www.newbornweight.org).

i. Initiate pumping/hand expression and provide infant with pumped milk if any
ii. Initiate BID weights
iii. Consider supplemental feeding plan (see below) after breastfeeding evaluation completed by Perinatal RN/Certified Lactation Educator Counselor (CLEC) and/or IBCLC and in discussion with infant's provider

b. Weight loss greater than 90$^{th}$ percentile for age (based on nomogram: www.newbornweight.org).
i. Initiate supplemental feeding plan (see below)
ii. Initiate BID weights

2. Hypoglycemia per Newborn Blood Glucose Monitoring policy.
3. Clinical and laboratory evidence of significant dehydration (e.g., high sodium, poor feeding, lethargy, etc.) that has not improved after skilled assessment and proper management of breastfeeding.
4. Delayed bowel movements or continued meconium stools on day 5 (120 hours).
5. Insufficient intake despite an adequate milk supply (poor milk transfer) after infant is 24 hours old.
6. Hyperbilirubinemia
a. Suboptimal intake jaundice of the newborn associated with poor breastmilk intake despite appropriate intervention.
b. Breastmilk jaundice when levels reach 20–25 mg/dL in an otherwise thriving infant and where a diagnostic and/or therapeutic interruption of breastfeeding may be helpful.
7. Macronutrient supplementation is indicated (e.g., inborn errors of metabolism).

ii. Maternal Indications:
1. Delayed lactogenesis II (day 3–5 or later [72–120 hours]) and inadequate intake by the infant.
2. Primary glandular insufficiency, as evidenced by poor breast growth during pregnancy and minimal indications of lactogenesis.
3. Breast pathology or prior breast surgery resulting in poor milk production.
4. Intolerable pain during feedings unrelieved by interventions.
5. Temporary cessation of breastfeeding due to certain medications or temporary separation of mother and baby without expressed breast milk available.

c. Supplemental Feeding Plan- for above listed indications
i. Breastfeed infant on cue, at least every 2-3 hours. In addition to breastfeeding, give supplements per day of life.
ii. Once supplementing is indicated, initiate pumping using a hospital grade, double-electric breast pump and pump each breast for 15 min after each feed, or every 2-3 hours
iii. All efforts will be made to supplement the infant with the mother's own milk. If mother's milk supply is inadequate, a combination of breastmilk and formula will be used until mother's milk volume increases.
iv. The supplementation guidelines are in addition to breastfeeding and should occur at the breast. The amount should reflect the physiologic stomach capacity of a newborn.
1. Day 1: 5-10 ml's at each feed

2. Day 2: 10-20 ml's at each feed
3. Day 3:20-30 ml's at each feed
4. Day 4: 30-45 ml's at each feed
5. Day 5: 45-60 ml's at each feed

v. Methods for supplementation
    1. When supplementation is medically indicated, all efforts will be made to avoid artificial nipples and an alternate feeding method will be utilized. These alternate feeding methods decrease the risk of flow preference and preserve the mother/infant breastfeeding skills. The mother will be educated and instructed on how to administer the supplementation by the RN or lactation specialist.
        a. The ideal supplementation is at the breast. Use a 5 French feeding tube connected to a 12 ml syringe, or a supplemental nursing system (SNS)
        b. Finger feeding- with a gloved finger, use 5 French feeding tube and 12 ml syringe. Feed infant with pad side up.
        c. Cup feeding- using a Foley cup or spoon feeding
        d. Paced bottle feeding- used as a last resort

vi. When Supplemental feeding plan is indicated, refer to IBCLC if possible

vii. Place order after discussion with physician or per protocol for above listed indications for supplementation as infant formula is not a part of the standing newborn order set

viii. Document the type of supplementation, method, and reason for supplementation in the infant's medical record.

ix. Formula will not be placed in or around the breastfeeding infant's room or bassinette

d. Contraindications to breastfeeding
    i. Infant indications
        1. Inborn errors of metabolism (e.g., Galactosemia, maple syrup urine disease)
    ii. Maternal indications
        1. Infected with HIV (in developed countries)
        2. Untreated, active tuberculosis. Tuberculosis is not transmitted through breastmilk and therefore, the mother can pump her breasts and expressed breastmilk can be given to the infant. If mother starts antituberculin therapy, she should be able to resume direct breastfeeding after treatment for 2 weeks when the mother is no longer contagious.
        3. Untreated varicella infection
        4. Infected with human T-cell lymphotropic virus type I or type II
        5. Undergoing radiation therapy
        6. Active herpes lesions on the breast. May breastfeed if the sores can be covered so that the baby does not come into contact with them. If the sores are anywhere the baby may touch, the mother should express milk from that breast until the sores heal, while continuing to breastfeed on the unaffected breast. May resume breastfeeding when lesions are fully healed. Mother's should use careful hand hygiene and cover any lesions that infant may come into contact with.
        7. Substance abuse, illicit drug use, or excessive alcohol intake

a. If maternal urine drug screen is negative, may continue to breastfeed
b. If maternal urine drug screen is positive, may pump and dump until a negative screen is achieved
c. Mothers in a supervised methadone maintenance program may still breastfeed if testing comes back negative for illicit drugs
d. THC is considered a relative contraindication to breastfeeding. If mother tests positive for THC, then she will be encouraged to discontinue THC use. Risks will be discussed regarding breastfeeding and TCH usage referencing Medications and Mother's Milk book. Mother may still choose to breastfeed after education is provided. Nursing or physicians may provide the education with proper referencing.

8. Taking medications contraindicated with breastfeeding (e.g., chemotherapy agents, antiretroviral medications)
    a. Acceptable reference to check medications: Medications and Mothers' Milk book by Dr. Thomas Hale, LACTMED website- http://toxnet.nlm.nih.gov

**6. The avoidance of artificial nipples and pacifiers for breastfeeding infants**

a. Perinatal staff will educate all breastfeeding mothers about how the use of bottles and/or pacifiers interferes with the development of optimal breastfeeding. Pacifiers will not be given to well, full-term breastfeeding infants.
b. When a mother requests that her breastfed infant be given a bottle and/or pacifier, the staff will address the mother's reason for the request. Alternate methods for soothing and feeding her baby will be discussed. If the mother still requests a bottle or pacifier, the process of counseling, education and informed decision will be documented in the medical record. The mother will be supported in her decisions.
c. Pacifiers will only be used to comfort infants needing pain relief from painful procedures (e.g., circumcision). Once the procedure is completed, the pacifier will be disposed of; the infant will not return to the mother with a pacifier.
d. In the case that a mother and infant must be separated due to medical necessity for an extended period of time, a pacifier may be used to comfort the infant. Once the mother and infant are reunited, the pacifier will be disposed of; the infant will not return to the mother with a pacifier.
e. All artificial nipples, infant feeding bottles and breastmilk substitutes are purchased at a fair market value by this facility

**7. Rooming-in practices**

a. NIHD promotes the practice of rooming-in to encourage family-centered care, good attachment between the mother and her infant, emotional stability, protection from infection, and increased breastfeeding rates. Rooming-in will be encouraged to all mothers regardless of feeding type.
b. Staff will not routinely offer to take the infant to the well baby nursery.
c. Rooming-in is defined as keeping the infant in the mother's room 24 hours per day. For procedures that require mother-baby separation, 1 hour in a 24-hour period is acceptable. All procedures that can be done in the mother's room will be done in the mother's room (e.g., bath, hearing screen, newborn screen, weights, lab draws).

d. Mothers who give birth vaginally will begin rooming-in immediately. Mothers who give birth by cesarean will begin rooming-in once the mother is back on the Perinatal Unit.
e. Location of the infant and the reason for interruption of rooming-in must be documented each time the infant leaves the mother's room, as well as the time the infant returns to the mother's room as quality assurance measurements.
f. If maternal or infant condition warrants separation, all efforts will be made to return the infant to the mother's room once the mother or infant is stabilized.
g. If a mother requests her infant be taken to the nursery, the healthcare staff will:
    i. Explore the reason for the request
    ii. Educate and encourage the mother about the advantages of rooming-in 24 hours per day
    iii. Support the mothers decision
    iv. If the mother still requests that the baby be cared for in the nursery, the infant will be brought back to the mother PRN feeding cues or every 3 hours (whichever comes first) to feed to encourage exclusive breastfeeding
    v. All education and interruption of rooming-in will be documented in the infant's medical record including the length of time that the couplet was separated

**8. Continuity of care and breastfeeding support upon discharge and beyond**

a. Prior to discharge, the breastfeeding mother should be able to:
    i. Position the infant correctly at the breast
    ii. Latch the baby to the breast properly
    iii. State when the baby is swallowing milk
    iv. State that the baby should be nursed at least 10 times in 24 hours
    v. State the appropriate elimination patterns (at least 6 or more wet diapers and 3 or more stools per day by day of life 6)
    vi. List indications for contacting the physician or lactation support
    vii. Demonstrate manual expression of breastmilk
    viii. This education will be documented in the medical record prior to discharge
b. Instruct all mother/infant dyads to return to the Pediatric Clinic 24-48 hours after discharge for assessment and breastfeeding support.
c. Provide all patients, with their discharge instructions, a copy of a community resource list.
d. Collaboration between First 5 Inyo County, WIC, and Toiyabe Indian Health Project is in place to support breastfeeding women throughout the county.

**9. International Code of Marketing of Breastmilk Substitutes**

a. Employees of manufacturers or distributers of breastmilk substitutes, bottles, nipples and pacifiers have no direct communication with pregnant women and mothers.
b. The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breastmilk substitutes, bottles, nipples, and pacifiers.
c. No pregnant women, mothers, or families are given marketing materials or samples or gift packs by the facility that consist of breastmilk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

d. Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breastmilk.

**10. The Ten Steps to Successful Breastfeeding**

a. Have a written breastfeeding policy that is routinely communicated to all health care staff.
b. Train all health care staff in the skills necessary to implement this policy.
c. Inform all pregnant women about the benefits and management of breastfeeding.
d. Help mothers initiate breastfeeding within one hour of birth.
e. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
f. Give infants no food or drink other than breastmilk, unless medically indicated.
g. Practice rooming-in - allow mothers and infants to remain together 24 hours a day.
h. Encourage breastfeeding on demand.
i. Give no pacifiers or artificial nipples to breastfeeding infants.
j. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

**REFERENCES:**


http://pediatrics.aappublications.org/content/129/3/e827.full.pdf
http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
http://www.uptodate.com/contents/late-preterm-infants
http://www.centertrt.org/content/docs/Intervention_Documents/Intervention_Materials/BFHI/LactationconsultantReferralGuidelines.pdf
https://www2.aap.org/breastfeeding/curriculum/documents/pdf/Hospital%20Breastfeeding%20Policy_FINAL.pdf
http://www.bfmed.org/Media/Files/Protocols/protocol_2GoingHome_revised2014.pdf
http://www.womenshealth.gov/breastfeeding/pumping-and-milk-storage/
http://www.who.int/foodsafety/publications/micro/PIF_Bottle_en.pdf
http://www.bfmed.org/Resources/Download.aspx?filename=ABMProtocol_3%20Revised.pdf
http://www.tensteps.org/step-6-successful-breastfeeding.shtml
http://www.cdc.gov/breastfeeding/disease/index.htm
http://pediatrics.aappublications.org/content/100/6/1035.full
http://www.uptodate.com/contents/breastfeeding-parental-education-and-support?source=search_result&search=breastfeeding+and+tuberculosis&selectedTitle=5%7E150
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994120/


**CROSS REFERENCE POLICY AND PROCEDURES:**

1. Newborn Blood Glucose Monitoring

**RECORD RETENTION AND DESTRUCTION:**

Maintain documentation within the patient medical record, which is managed by the NIHD Health Information Management Services (HIMS) Department.

| Supersedes: v.6 Breastfeeding the Term Infant* |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Lippincott Procedure Manual Adoption Policy | | |
| Owner: Chief Medical Officer | Department: Medical Staff | |
| Scope: District Wide Clinical Workforce | | |
| Date Last Modified: 01/05/2023 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**PURPOSE:**
To have current, best practice procedure manual available to the clinical departments at Northern Inyo Healthcare District (NIHD).

**POLICY:**
NIHD will utilize Lippincott Procedures, published by Wolters Kluwer, as a resource for clinical procedures not maintained within the Policy Procedure Manager system.

**REFERENCES:** N/A

**RECORD RETENTION AND DESTRUCTION:**
Lippincott Procedures maintains the archives of past procedures.

**CROSS REFERENCE POLICIES AND PROCEDURES:** N/A

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|---|
| Supersedes: Not Set |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Misoprostol for Cervical Ripening | | |
| Owner: PERINATAL NURSE MANAGER | Department: Perinatal | |
| Scope: Perinatal Workforce | | |
| Date Last Modified: 10/11/2022 | Last Review Date: 03/18/2020 | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 07/2009 | |

**PURPOSE:**
To provide guidelines for the management and care using Misoprostol for the elective initiation and or continuation of cervical ripening in patients with an unfavorable cervix, in whom there is a medical and/or obstetrical indication for delivery.

**POLICY:**
1. A physician and or Certified Nurse Midwife (CNM) order is required prior to Misoprostol administration.
2. The patient will be located in the Perinatal Unit.
3. A Non-Stress Test (NST) and uterine activity assessment are required prior to the administration of Misoprostol.
    a. In the case of fetal demise, uterine activity assessment only is required prior to Misoprostol administration.
4. Verify that the patient has received informed consent by physician and/or CNM for induction, and that the Consent for Induction or Augmentation of Labor has been signed.
5. IV access must be established prior to insertion of Misoprostol.

**CONTRAINDICATIONS:**

1. Non-vertex presentation or unknown presentation
2. Known hypersensitivity to prostaglandins or known patient allergy to Misoprostol
3. Placenta previa, abruptio placenta or unexplained vaginal bleeding
4. Previous Cesarean Section or major uterine surgery

5. Patients currently receiving Pitocin:
    a. If the patient has been on Pitocin, wait until Pitocin has been discontinued for a minimum of 30 minutes prior to using Misoprostol.
    b. Pitocin should not be started until at minimum of 4 hours after the last dose of Misoprostol.

6. Re-dosing to be withheld for the presence of any of the following:
    a. 3 or more painful uterine contractions (UCs) in 10 minutes, averaged over 30-minute window.
    b. Prolonged contraction within 30 minutes prior to administration of dose.
    c. Tachysystole.
    d. Category II or III fetal heart tracing
    e. Favorable vaginal exam (greater than or equal to 3 cm, 100% effaced, Bishop score greater than 8) and/or adequate cervical ripening.
    f. Active labor.

7. **Use with Caution:** (Obstetric conditions that are not contraindications to induction but may require special attention):
    a. Prior uterine tachysystole and/or prolonged contractions
    b. Unstable vertex presentation
    c. Multiple gestation
    d. Maternal cardiac, renal or hepatic disease
    e. Severe hypertension
    f. Polyhydramnios
    g. Fever
    h. Chorioamnionitis
    i. IUGR

**PROCEDURE:**

1. **Teaching:** Patients physician and or CNM will have discussed the plan of care regarding the cervical ripening/induction process, either vaginal or sublingual administration.
    a. Verify that the patient has received informed consent by physician and or CNM for induction, and that the Consent for Induction or Augmentation of Labor has been signed.
    b. Review administration with the patient, including intended effects of prostaglandin and possible adverse effects. Advise the patient to inform the RN of any of the following:
        i. Patient reports more than 3 painful UCs in 10 minutes
        ii. Prolonged UC (1 UC greater than 120 seconds)
        iii. SROM
        iv. Change in color of vaginal fluid (Presence of Meconium)

2. **Administration: (Vaginal/Sublingual)**
    a. Perinatal RN will confirm OB Induction/Augmentation Subphase is activated within the patient record. Verify that correct order is placed within the Electronic health record medication administration record.
    b. Baseline fetal heart tracing interpretation and uterine activity assessment for 30 minutes are required prior to the administration of Misoprostol for live fetuses.
        i. In the case of fetal demise, only uterine activity assessment prior to Misoprostol administration.
    d. Insert 18g or 20g IV saline lock prior to giving the first dose of Misoprostol.
    e. Instruct patient to empty their bladder prior to each dose of Misoprostol.
    f. Subsequent doses may be repeated according to physician or CNM order.
    g. A sterile vaginal exam (SVE) is performed and documented.
        i. Do not complete SVE if rupture of membranes (ROM) is suspected or present, unless requested by physician.
    h. Continuous EFM for 2 hours after initial administration. Following initial 2 hours, frequency of fetal monitoring surveillance and uterine activity monitoring are as follows, unless otherwise specified by the provider:
        i. **If Category I interpretation**: Resume EFM every 4 hours for 30 minutes to assess FHR and uterine activity patterns.
        ii. **If Category II interpretation:** Continuous EFM and notify managing provider to obtain additional orders for fetal surveillance. Begin intrauterine resuscitation if indicated.

i. At NIHD, continuous fetal monitoring is required for the presence of any of the following:
    a. Prolonged contraction(s)
    b. Presence of tachysystole
    c. Any FHR tracing that evolves into Category II
    d. SROM:
        i. Continuous EFM x 2 hours from identification of SROM
        ii. Wait for up to 2 hours after SROM before subsequent administrations, as patient may enter active labor
        iii. Notify provider
    iii. **Category III interpretation:** Continuous EFM, notify managing provider and begin intrauterine resuscitation efforts.

j. Fetal Intrauterine Resuscitation will involve:
    i. Notify physician or CNM immediately
    ii. Assist patient to lateral position
    iii. Give 500mL fluid bolus of LR as ordered by provider
    iv. Terbutaline 0.25mg SQ readily available for administration as ordered by provider
    v. For mothers with normal Sp02 readings ≥95%, maternal oxygen is not recommended. If maternal SpO2 <95%, supplement with 10L SpO2 via non-rebreather mask as ordered by provider
    vi. Document all measures implemented

k. NPO x1 hour after first dose administration. Subsequent doses, diet per MD order.

l. Vital signs (BP, HR, RR, Temp, Pain score)
    i. Prior to placement
    ii. Every 2 hours in early labor and or if ROM present
    iii. Every 4 hours while asleep
    iv. Every hour in active labor and or if febrile, regardless of labor stage

**Vaginal Administration:**

1. Position patient for vaginal exam, assist patient into the lithotomy position.
2. Do not remove tablet from capsule. Do not use lubricant jelly.
3. The physician, CNM or Perinatal RN will insert misoprostol into the posterior vaginal fornix with sterile glove and sterile saline.
4. Maintain patient in bed for 30 minutes in low semi-fowlers or lateral position, and monitor fetal heart rate and uterine activity continuously for 2 hours.

**Sublingual Administration:**

1. RN can offer fluid prior to administration.
2. Instruct patient not to swallow tablet.
3. Remove tablet from capsule and place under the patient's tongue. Administer Misoprostol sublingually.
4. Keep under tongue x15 minutes or until dissolves.
5. NPO x1 hour after first dose administration. Subsequent doses, patient to remain NPO x15minutes following administration, diet per MD order.

6. Continuous EFM for 2 hours after initial administration.

3. **Documentation in the Medical Record.**
    a. Initiation of, use of, and any changes to the parameters set forth in this policy
    b. Administration and effectiveness of medication, including cervical change
    c. Response to medication, including FHR and UC pattern, documented using NIHD Nomenclature including presence of complications, interventions and response to interventions.

**REFERENCES:**


1. American College of Obstetricians and Gynecologists (ACOG). (2009, reaffirmed 2020). ACOG practice bulletin no. 107: Induction of labor. Obstetrics and Gynecology, 114, 386–397. Retrieved January 2022 from https://doi.org/10.1097/AOG.0b013e3181b48ef5 (Level VII)
2. Pfizer Labs. (2021). Cytotec® misoprostol tablets. Retrieved January 2022 from http://labeling.pfizer.com/ShowLabeling.aspx?id=559


**RECORD RETENTION AND DESTRUCTION:**

Documentation is maintained within the patient medical record, which is managed by the NIHD Medical Records Department.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

Lippincott Procedure: Cervical Ripening using Misoprostol

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|---|
| Supersedes: v.5 Misoprostol for Cervical Ripening* |

10. Applicator sticks

## VIII. QUALITY CONTROL:

Expected Values:

| FETALtrol Controls | | | |
|---|---|---|---|
| | **Level 1** | **Level 2** | **Level 3** |
| **% Fetal Cells** | 0.00 – 0.06% | 0.05 – 0.35% | 0.85%-2.65% |

It is recommended that positive and negative control slides be included in each series of tests. The appearance of negative and positive lab prepared controls should be recorded but need not be counted.

## IX. REFERENCES:


1. SureTech Kleihauer Betke Fetal Hemoglobin Procedure

2. Technical Manual, Association for the Advancement of Blood and Biotherapies (AABB), 20th edition, Method 5-2

3. https://www.ncbi.nlm.nih.gov/books/NBK430876/


## X. DISTRIBUTION:

1. Transfusion Service

| Supersedes: Not Set |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Nursing Quality Assurance/Performance Improvement (QA/PI) | | |
| Owner: Chief Nursing Officer | Department: Nursing Administration | |
| Scope: Nursing Department | | |
| Date Last Modified: 01/09/2023 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 04/15/2017 | |

**PURPOSE:** The nursing department of Northern Inyo Healthcare District (NIHD) supports the organization wide commitment to continuously improve the quality of care provided for its patients. Nursing involvement in quality assurance and performance improvement effort is based on the nursing philosophy, the quality framework of NIHD and yearly plans established by Nursing and NIHD.

This program is to promote a comprehensive method to measure, examine and evaluate problems in patient care and to provide opportunities to improve patient care.

**POLICY:**

1. Identified within the nursing philosophy is the belief that all patients should receive safe, patient centered, cost effective, quality health care services, directed toward optimizing achievable health status.
2. Nursing will follow the quality measurement framework established by the District -Wide Performance Improvement Plan.
3. Departmental goals will help to determine key measurements within the Pillars of Excellence QA/PI scorecard.
4. Nursing will support and participate in, as requested, identified NIHD Performance Improvement and risk reduction projects.
5. Nursing will support and participate with the oversight of assigned Functional Chapters for measurement and improvement from The Joint Commission as assigned by the Manager of Quality and Survey Readiness, Chief Medical Officer CMO or designee.
6. The Chief Nursing Officer (CNO) has the responsibility to ensure that the nursing QA/PI is done in a way that monitors the appropriateness of nursing care and develops a resolution to identified problems; this includes the redesign of systems, operations and patient care delivery processes when needed.
7. The CMO and Manager of Quality and Survey Readiness (or designee) facilitates performance management activities and provides education and consultative services related to standards development and performance improvement processes. This position also facilitates the meeting of regulatory agency requirements, sentinel event investigation as it applies to nursing and supports information management for select areas of measurement.
8. Nursing Role Responsibilities:
    a. Chief Nursing Officer:
        i. Leadership for Nursing Quality Assurance/Performance Improvement.
        ii. Continually improves the quality and cost efficiency of patient care.
        iii. Ensures that Nursing QA/PI is coordinated within the NIHD QA/PI Plan.
        iv. Reviews and participates in decisions regarding changes required.
        v. Uses the Performance Management Process FOCUS-PDSA as a guide.
    b. Manager of Quality and Survey Readiness:

i. In conjunction with the CNO, provides leadership for Nursing QA/PI.
ii. Reports to CMO, per chain of command matrix, for Quality role.
iii. Works with nursing to create documentation processes to collect quality data.

c. Nurse Managers:
i. Continually improves the quality and cost efficiency of patient care for an identified continuum of service and/or assigned programs /departments.
ii. Develops and assists with development of performance improvement indicators for an identified continuum of services, and/or assigned programs/departments.
iii. Oversees data collection, analysis, and communication of data analysis results for an identified continuum of service and/or assigned programs/departments.
iv. Assists with staff education to increase the awareness and understanding of the quality assurance/performance improvement process.
v. Serves as a role model for performance improvement.

d. Clinical Staff Educator (unit specific)/Staff Nurse/Other Nursing Department Members:
i. Continually improves the quality and cost efficiency of patient care.
ii. Assist with development of program/department indicators.
iii. Participates in data collection.
iv. Participates in program/department staff meetings to discuss performance improvement issues and activities (identifies areas of opportunities and what is working).
v. Implements required changes in daily practice to provide excellence in care.
vi. Participates and demonstrates knowledge of educational opportunities related to performance improvement.
vii. Participates on task forces, committees, and PI teams.

9. Scope:
a. Nursing participates in quality/performance improvement efforts at many levels. Activities may revolve around standards or processes applicable to all of nursing, be conducted at the program/department level, or span the continuum of care for select populations. Likewise, efforts may be of an interdisciplinary nature, or focus on the independent domain of nursing. Activities may involve active problem identification/resolution via ongoing data sources; processes consistent with identified priority goals, and compliance monitoring to structure, process, and outcome standards.
b. Activities
The overall Nursing QA/PI Plan is based on the following interdependent activities:
i. Assessment of priority functions;
ii. Standards development;
iii. Continuing education;
iv. Ongoing performance appraisal;
v. Selective/appropriate use of auditing;
vi. Active problem identification via ongoing data sources (including, but not limited to data from: event reports, infection control, utilization review, patient and staff satisfaction surveys, and stakeholder feedback.
c. Time Frames for the frequency of evaluation are determined by the specific indicators, data availability and stage of process improvement. Evaluation of PI projects should be conducted at predetermined intervals defined by the process improvement team. Evaluation includes progress towards goal and process stabilization.

**PROCEDURE:**

1. Goals will be established by the teams in each nursing department on a fiscal year basis.
2. The Pillars of Excellence format will be utilized to track performance improvement areas.
    a. The Pillars of Excellence data will use color coding data for ease of interpretation.

| LEGEND | |
|---|---|
| | Best-in-Class Performance, Exceeds Goal |
| | Above Average, Meets Goal |
| | About Average, Does Not Meet Goal |
| | Below Average, Does Not Meet Goal |

    b. Findings that are below average, does not meet goal (red) will be assessed utilizing the failure point's checklist to determine cause and help to determine focus for improvement opportunities. Intranet>References>forms and templates>nursing administration>PI-Assessment of Failure Points Checklist.

**REFERENCES:**

1. CAMCAH 2022 of TJC, Standard NR.02.02.01-EP 5.
2. CAMCAH 2022 of TJC, Standard NR.02.01.01-EP 3, 5 & 6.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Nursing Services Philosophy
2. Pathways for Development, Review and Revision of Nursing Standards
3. NIHD Quality Assurance & Performance Improvement (QAPI) Plan

**RECORD RETENTION AND DESTRUCTION:**
Pillars of Excellence records will be stored for a minimum of 39 months.

| Supersedes: v.1 Nursing Quality Assurance/Performance Improvement (QA/PI)* |
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**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Orthopedic Hardware AP-005-2022 | | |
| Owner: ANATOMIC PATHOLOGY LEAD | Department: Lab- Pathology | |
| Scope: Surgery, Pathology, Orthopedic offices | | |
| Date Last Modified: 01/25/2023 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 2/2018 | |

**PURPOSE:**

To assure proper handling and distribution of hardware

**POLICY:**

**Orthopedic Hardware** will be measured and counted. After the Pathology report is finalized the Hardware will be released to patient/physician/staff. Otherwise it is disposed of according to regulations, with a minimum of two-week retention.

**REFERENCES: N/A**

**RECORD RETENTION AND DESTRUCTION: N/A**

**CROSS REFERENCED POLICIES AND PROCEDURES: NONE**

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|---|
| Supersedes: v.1 ORTHOPEDIC HARDWARE |

## X. DISTRIBUTION:

1. Microbiology

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|---|
| Supersedes: v.1 Oxacillin Disk Procedure |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Oxytocin (Pitocin) Administration | | |
| Owner: PERINATAL NURSE MANAGER | Department: Perinatal | |
| Scope: Perinatal Unit | | |
| Date Last Modified: 12/15/2022 | Last Review Date: 01/20/2020 | Version: 7 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 01/18/2017 | |

**PURPOSE:**
To provide guidelines for the administration of Oxytocin (Pitocin) to induce or augment labor in a pregnant woman when delivery is indicated and a vaginal delivery is desired.

**POLICY:**
Intravenous oxytocin as ordered by the physician and/or Certified Nurse Midwife (CNM) and clinically indicated may be used to induce or augment uterine contractions providing the following criteria are met:

A. A qualified Perinatal RN who is familiar with the effects of oxytocin and able to identify both maternal and fetal complications will be responsible for the delivery of care during the administration of oxytocin.
B. The patient's medical record will be accessible in the electronic health record (EHR) before the oxytocin is started to confirm gestational age for non-medically indicated inductions.
    a. Elective induction may be performed at 39 weeks
C. If the required patient documentation from the physician's office is not present with the prenatal record upon admission, the nurse will verify that the patient has received informed consent by physician and/or CNM for induction or augmentation. The Consent for Induction or Augmentation of Labor must be signed prior to proceeding with induction/augmentation.
D. Confirm fetal presentation by SVE or ultrasound prior to proceeding with induction/augmentation.
E. Prior to initiation of Oxytocin for Induction or Augmentation, the RN must complete the Pre-Induction or Pre- Augmentation checklist.
    i. If the Pre Induction or Pre Augmentation Checklist Criteria cannot be met, Oxytocin should not be initiated. Notify the physician/ CNM immediately.
F. Once the infusion is started, the physician must be readily available per District policy to manage any complications, including an emergency cesarean delivery.
G. Oxytocin for induction/augmentation may be initiated 4 hours after the last dose of Misoprostol (Cytotec) administration.

**INDICATIONS:**

A. Induction of labor to achieve a vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor.
B. Augmentation of early labor to enhance inadequate uterine contractions.
C. Augmentation of a patient in active labor with dystocia, either protraction or arrest of labor.

**CONTRAINDICATIONS:**

A. Placenta previa

B. Unfavorable fetal positions or presentations which are undeliverable without conversion prior to delivery i.e. transverse lie, breech.
C. Umbilical cord prolapse
D. Previous uterine surgery (per provider order).

**EQUIPMENT:**

A. Electronic Fetal Monitor
B. Primary IV solution per physician/CNM order
C. IV solution with oxytocin as ordered by physician/CNM in the electronic medical record for induction/augmentation.
D. Automatic infusion pumps for each solution
E. Sterile exam gloves

**PROCEDURE:**

A. **Oxytocin infusion for induction or augmentation:**

1. Verify informed consent for induction or augmentation of labor.
2. Review the patient's chart for induction indications, medical and nursing assessment of fetal/maternal status and clarity of physician/CNM orders.
3. Confirm gestational age
4. Confirm cephalic presentation
    a. For ROM at term, confirm vertex via ultrasound
5. Complete assessment to obtain baseline values of mother and fetus as follows:
    a. Determine baseline blood pressure, pulse, respirations and temperature for mother.
    b. Determine baseline fetal heart rate via electronic continuous fetal monitoring; documenting baseline FHR, and variability, the presence of periodic or episodic accelerations and decelerations and uterine contraction pattern.
    c. Monitor for a minimum of 30 minutes to assess fetal well-being prior to beginning infusion.
6. Complete the Pre-Oxytocin checklist with initiation and every 30 minutes thereafter.
7. For SVE completed >30 minutes ago with no uterine activity, repeat SVE is not required prior to initiation of oxytocin infusion.
8. Insert 18g intravenous catheter and begin infusion of main-line IV solution as ordered by physician/CNM.
9. Obtain double electronic infusion pump.
10. Use premixed infusion of 30 units Oxytocin in 500 mL 0.9% Normal Saline Solution.
11. Load the IV tubing into the automatic infusion pump.
12. Label tubing with Oxytocin label at point of insertion site and at pump. Connect Oxytocin infusion at port closest to insertion site.
13. Oxytocin is a high risk medication and requires a double check prior to administration. Before administering the Oxytocin infusion, a 2nd Qualified Perinatal RN is required to perform independent double-check to verify administration is safe and proper for the patient, the pump settings are correct, and the infusion line is attached to the correct port.
    a. If no discrepancies exist from the 2nd RN medication validation, start Oxytocin at 2 milliunits/minute (mU/min) via infusion pump per OB Induction/Augmentation Subphase Order Set.
14. Vital Sign Documentation, or per physician/CNM order:
    a. Blood pressure, HR, and RR every 1 hour or and/or prior to increase of oxytocin dosages.

b. Temperature every 2 hours if membranes intact
c. Temperature hourly if membranes are ruptured.
d. Pain, comfort and position every hour
e. Intake and output every 8 hours

15. Titrate per Oxytocin Order Set: Titration increases may occur every 30 minutes by 1mU/min or 2 mU/min based on provider order, not to exceed maximum dose of 32 mU/min; until adequate labor as uterine activity indicates.
    a. An adequate contraction pattern is evidenced by:
        i. Contractions every 2-3 minutes or no more than 5 contractions in 10 minutes, with;
        ii. Duration of contractions of 40-90 seconds; and
        iii. Contraction strength of moderate to strong by palpation, or;
        iv. Adequate resting tone by palpation that is soft and relaxed, or IUPC reading of less than or equal to 25mmHg.
        v. Montevideo units greater than or equal to 200 in a 10 minute window.
16. Once an effective contraction pattern is established as defined above, hold the oxytocin at that rate and determine progression of cervical dilation and effacement are being made. If progress is not being made after 2 hours, notify managing physician/CNM.
17. When 20 mU/min has been reached, and the patient is not in labor as evidenced by cervical change, notify physician/CNM. Oxytocin infusion may be increased beyond 20 mU/ min, to a maximum dose of 32 mU/min, with a physician/CNM order.
18. The fetal heart rate and contraction pattern will be assessed and documented as follows:
    a. When starting Oxytocin infusion
    b. Assessed and documented every 15 minutes after initiating infusion
    c. Document every 15 minutes during maintenance
    d. Second Stage (Active pushing): Every 5 minutes

**B. <u>Oxytocin will be maintained as follows:</u>**

1. In any situation when the Registered Nurse is concerned about fetal status, the Oxytocin infusion should be immediately discontinued or decreased with prompt notification to managing physician/CNM.

2. <u>*Category III tracing*</u>:
    a. Notify physician/CNM immediately to evaluate the patient.
    b. Discontinue Oxytocin
    c. Initiate intrauterine resuscitation measures
    d. Anticipate rapid delivery

3. <u>*For Tachysystole*</u> (a uterine contraction pattern of more than 5 UCs in a 10 minute window) perform the following interventions:
    a. *Category I Tracing*:
        i. Reposition to lateral recumbent
        ii. Administer 500 mL IV bolus of mainline fluid
        iii. Observe for 15 minutes.
        iv. If Tachysystole unresolved 15 minutes after intervention, decrease Oxytocin rate by ½ and observe for additional 15 minutes. If Tachysystole unresolved after 30 minutes, discontinue Oxytocin and notify primary physician/CNM.

4. <u>*When Tachysystole resolves:*</u>
    a. If Oxytocin has been off less than 30 minutes, restart at ½ the rate of administration when discontinued.

b. If Oxytocin has been off longer than 30 minutes, restart at 2 milliunits/minute and increase per induction/augmentation physician/CNM orders.

5. *Category II tracing:* *Recurrent variable or late decelerations with* ***moderate variability***:
   a. Reduce Oxytocin infusion rate by ½
   b. Reposition patient to lateral recumbent
   c. Consider IV bolus of mainline fluid, per physician order.
   d. Observe for 15 minutes. If no improvement, discontinue Oxytocin infusion and notify primary physician/CNM.

6. *Category II tracing:* *Recurrent variable or late decelerations with* ***minimal variability****:*
   a. Discontinue Oxytocin
   b. Reposition to lateral recumbent
   c. Administer 500 mL IV bolus of mainline fluid and observe for 15 minutes.
   d. Consider administration of a tocolytic medication (Terbutaline 0.25 mG SQ X 1), administration of such medication would require physician/CNM order.

7. After stopping oxytocin, it may be resumed *when the criteria for oxytocin initiation have been met.* The nurse will review the fetal monitor tracing and complete the Pre-oxytocin checklist.
   a. The physician/CNM will be informed if the tracing does not meet the criteria for oxytocin to be restarted.
   b. If after reviewing the tracing and the entire clinical picture, the physician/CNM chooses to restart or continue the oxytocin infusion, he/she will document the rationale for deviating from the oxytocin guidelines in the medical record.
   c. The nurse will document her communication with the physician/CNM and any interventions as indicated. The oxytocin infusion may then be restarted.

**DOCUMENTATION:**

During induction or augmentation of labor with oxytocin, the FHR should be evaluated and documented before and following dosing changes. Document the following in the electronic medical record:

a. Dosage of oxytocin in mU/min in the MAR.
b. A systematic admission assessment of the woman and fetus;
c. Ongoing assessments of the woman and fetus, including FHR and uterine activity data;
d. Interventions provided and evaluation to responses;
e. Communication with the woman and her family or primary support person;
f. Communication with providers; and
g. Communication related to escalation of concerns.
h. With every increase in Oxytocin rate, or every 30 minutes complete the "Oxytocin In Use Checklist."

**REFERENCES:**

Grobman, W. (2022). Induction of labor with oxytocin. In: *UpToDate*, Lockwood, C. J. (Ed.). UpToDate Full text.

American College of Obstetrics and Gynecologists. Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Number 107. (2009, reaffirmed 2019). *Induction of Labor.*

ACOG (2019) *Practice Bulletin Number 205. Vaginal birth after cesarean delivery. The American College of Obstetricians and Gynecologists. Washington DC.*

ACOG/SMFM. (2014, reaffirmed 2019). Safe prevention of the primary cesarean section delivery. American Journal of Obstetrics and Gynecology. (123) 693-711.

Clark, S., Belfort, M., Saade, G., Hankins, G., Miller, D & Frye, D. (2007) *Implementation of a conservative checklist-based protocol for oxytocin administration: maternal and newborn outcomes.* AM J Obstet Gynecol 2007; 197:480.e1-480.e5.

Macones A, Hankins G, Spong C, Hauth J, Moore T. *The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring. Update on Definitions, Interpretation, and Research Guidelines*. American College of Obstetricians and Gynecologists September 2008, Vol. 112, No.3.

Simpson, K. and Creehan, P. (2021). *Perinatal Nursing*. *AWHONN*. (5th Edition). Lippincott: Philadelphia.

Simpson, K. R. *(2020). Cervical ripening and induction and augmentation of labor*. (5th edition). Association of Women's Health and Neonatal Nurses: Washington DC.

**RECORD RETENTION AND DESTRUCTION:**

Documentation is maintained within the patient and medical record, which is managed by the NIHD Medical Records Department.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Lippincott Procedures: Oxytocin administration during labor and delivery
2. Postpartum Pitocin Administration

| Supersedes: v.6 Oxytocin (Pitocin) Administration |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Patient Identification for Clinical Care and Treatment/Armband Usage | | |
| Owner: Director of Patient Access | Department: Patient Access | |
| Scope: Acute/Subacute, ED, Outpatient Infusion, PACU, Perinatal, ICU, Surgery, DI for Invasive Procedures and Admission Services | | |
| Date Last Modified: 01/11/2023 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/2003 | |

**PURPOSE:**

In an effort to improve the safety and quality of healthcare delivery at Northern Inyo Healthcare (NIHD), development of a standardized process to issue armbands to patient's types listed in this policy, will ensure the following:

1. Provides positive identification of patients from the time of admittance or acceptance for treatment.
2. Allows for barcode usage as best practice to improve medication administration safety.
3. Provides a positive method of linking patients to their medical records and treatment.
4. Minimizes the possibility that identifying data can be lost or transferred from one patient to another.
5. Improves the accuracy of patient identification, decreases error occurrence and promotes patient safety.

**POLICY:**

It is the policy of NIHD to ensure that all patients are properly identified by our workforce prior to any services, care, or treatments being rendered. Where possible, identification shall be performed with the two-identifier process (name and date-of-birth). District armbands will be applied in the following areas/specific patient types as soon as possible:

1. Inpatient settings (ICU/Acute-Subacute and Perinatal Units).
2. Hospital armbands will be used in the following Outpatient settings:
    a. Emergency Department
    b. Same Day Surgery (PACU)
    c. Diagnostic Imaging
        i. Invasive Procedures that require nursing support for anxiolysis/sedation
        ii. Nuclear Medicine
    d. Infusion Center
    e. Patients whose care requires transportation that crosses multiple hospital departments
    f. Patients receiving medications (excluding in Clinics)
    g. Observation patients
    h. Perinatal Outpatients
    i. Pulmonary Function Testing (PFT)

A District armband is a tamperproof, nontransferable identification band. It will include the patient's full name, District identification number, medical record number, patient's date of birth, age, sex and the attending physician's name. It also contains a unique barcode for each patient. If the District armband is cut off or

becomes unreadable, staff will contact Admission Services and request a new District armband or print if armband printer is available in their department for the patient.

**PROCEDURE:**

**A. Patient Identification**

1. Upon arrival at NIHD, the use of at least two identifiers (patient name and date of birth) will be used to properly match the correct patient with the correct care to be administered. The patient will be asked to state their name and date of birth; and that information will be compared to the patient's armband.
2. A NIHD armband shall be placed on the patient as soon as possible after the identification has been made for patients receiving care in the departments or for services requiring use of armband identification.
3. Application of the District armband will be done by District Workforce after confirmation of the two-patient identifier process.
4. Patients unable to provide identifying information or who experience conditions requiring emergency care will not have emergency care delayed. If the patient or family/caregiver is unable to actively participate in the patient identification process, the patient will receive a District armband with a temporary or fictitious name and identification number assigned by Admission Services until identification is confirmed, at which time the armband will be replaced.
5. Before any elective procedure is carried out, the District armband shall be placed on the patient and will be checked by the receiving and each subsequent care provider.
6. Whenever possible staff should also verbally assess the patient to assure proper identification by asking the patient's name and date of birth and matching the verbal confirmation to the written information on the District armband. If the patient's date of birth is not available, other acceptable identifiers defined by the National Patient Safety Goals 01.01.01, include another specific assigned identification number, telephone number, or other person-specific identifier.
7. Procedures and/or activities include, but are not limited to:
    a. Placement/replacement of patient District armband
    b. When a patient is introduced to a caregiver
    c. Transfer/discharge
    d. Medication administration (Barcode usage)
    e. Transportation from one District area/department to another area/department
    f. Diagnostic/therapeutic treatments
    g. Meal/snack trays
    h. Transfusions of blood or blood components
    i. Obtaining informed consent
    j. Vital sign checks per shift/per provider orders
    k. Surgical procedures
    l. When performing a treatment
8. No procedure shall be conducted when the patient's identity cannot be verified because the imprinted band is illegible or missing except in an emergent situation.
9. Defective or missing District armbands shall be replaced immediately with a new District armband.
10. Each healthcare provider conducting assessments on the patient shall include a check of the patient's District armband to assure the band is present and legible, as a routine component of the patient assessment process.

**B. Temporary/Downtime District Armband Procedure:**

In the event of a delay in the creation or placement of a District armband, or a system downtime occurs where use of a computer and printer is available, Admission Services will print labels that affix onto the armband for patient identification. If there is loss of computer and/or printer functions, a legible handwritten label with the patient's name, date of birth, date and time of admission, and attending physician will be affixed to the armband and placed on the patient. Once the system is operational again, an armband with the appropriate information will be printed and placed on the patient. The handwritten armband will be removed and discarded.

**C. Children:**

A parent or guardian should verify the identification of minor patients, when present at the time of the patient encounter.

**D. Unconscious/Confused/Incompetent Patients:**

In order to complete the verification process, any unconscious/confused/incompetent patients should, whenever possible, have their identification confirmed by a person (relative, transferring facility, etc.) before the District armband is placed on the patient. For the unconscious/confused/incompetent patient who arrives at NIHD without someone accompanying them, or identifying paperwork from a transferring facility, a temporary name (e.g. Jane or John Doe) and identifying number (e.g. medical record number) are assigned to the patient. These identifiers can be used to identify the patient and match against specimen labels, medications ordered for the patient or blood product labels. Formal identification of the patient should occur as soon as possible and once confirmed, the confirmed identifying information should be used instead of the temporary identification. Under no circumstance, except for lifesaving or emergency measures, should any patient encounter occur if a District armband is not present as required in the policy statement above.

**E. Patient Refusal:**

If the patient is capable and refuses to wear the District armband, an explanation of the risks will be provided to the patient and/or family. The designated staff member will reinforce that is the patient's and/or family's opportunity to participate in efforts to prevent medical errors, and it is their responsibility as part of the healthcare team. The designated staff member will document in the medical record patient's refusal, and the explanation provided by the patient or their family member.

**REFERENCES:**


1. Floyd Memorial Hospital. *Patient Safety-Patients*. Floyd Memorial Hospital, n.d. Web. 29 Sept. 2015. <http://floydmemorial.com/patients/patient-safety/>.
2. Applied Ergonomics Vol 52, Jan 2016 pg 1-7. *Human factors engineering approaches to patient identification armband design.*
3. The Joint Commission. "National Patient Safety Goals (NPSG)." *Comprehensive Accreditation Manual for Critical Access Hospitals*. Oak Brook: Joint Commission Resource, 2022. NPSG-3.
4. Main Line Health, Inc. *Administrative Policy and Procedure Manual, Patient Identification*. Main Line Health, n.d. Web. 31 Aug. 2016. <http://www.mainlinehealth.org/doc/Page.asp?PageID=DOC001368>.


**RECORD RETENTION AND DESTRUCTION:** N/A

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Color-Coded Wristband Use
2. Patient Identification and Preparation, specimen collection, labeling and transport

3. Barcode Medication Administration
4. Universal Protocol

| Supersedes: v.3 Patient Identification for Clinical Care and Treatment/Armband Usage* |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Sentinel Event/Serious Harm Reporting and Prevention | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 06/21/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/05/2012 | |

**PURPOSE:**

1. To have a positive impact in improving patient care, treatment and services and in preventing unintended harm.
2. When a sentinel event/serious adverse event occurs, to focus attention on efforts to understand the factors that contributed to the event and to change the hospital's culture, systems and processes in order to reduce the probability of such an event in the future.
3. To increase the general knowledge about patient safety events, their contributing factors and strategies for prevention of errors.
4. To maintain the confidence of the public (community) and Northern Inyo Healthcare District (NIHD) workforce that patient safety is a priority.
5. To outline the reporting requirements and process as required by California Department of Public Health (CDPH) and The Joint Commission (TJC).

**DEFINITIONS:**

**Action Plan**

The product of the root cause analysis, which identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future. An appropriate action plan should demonstrate the following:

a. Identification of changes that can be implemented to reduce risks, or formulates a rationale for not undertaking such changes.
b. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time-lines, and strategies for measuring the effectiveness of the actions.

**Adverse event:**

An unplanned or unusual deviation in the patient care process.

**Close call:** (or "Good Catch", "Near Miss")

A patient safety event that did not reach the patient. Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

**Hazardous condition:**

A circumstance, other than the patient's own disease process, or condition, that increased the probability of an adverse event.

**No-harm event:**

A patient safety event that reaches the patient but does not cause harm.

**Patient safety event:**

An incident or condition that could have resulted or did result in harm to a patient. It can be the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, close calls and hazardous conditions.

**Sentinel Event:**

An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. This may include "risk thereof" situations.

The Joint Commission suggests notification of Sentinel Events on a voluntary basis, which include those resulting in unanticipated death or major permanent loss of function, or severe harm.

TJC defines this as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm or permanent harm. The following list includes items that are sentinel events. This list does not include all possible sentinel events:

a. Unanticipated death of a full-term infant;
b. Maternal intrapartum death or severe maternal morbidity (leading to permanent harm or severe harm);
c. Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the Emergency Department;
d. Discharge of an infant to the wrong family;
e. Severe neonatal hyperbilirubinemia (bilirubin>30 milligrams/deciliter);
f. Abduction of any patient receiving care, treatment or service;
g. Elopement of any patient from a staffed around-the-clock care setting that leads to death, permanent harm or severe temporary harm to a patient;
h. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;
i. Sexual abuse or physical assault (leading to permanent harm, severe harm or death) of patient while receiving care by the District workforce;
j. Sexual abuse or physical assault (leading to permanent harm, severe harm or death) of workforce, visitor or vendor while on site at the District or while providing care or supervision to patients;
k. Surgical or Invasive procedure on the wrong patient, site or that is the wrong procedure;
l. Unintended retention of foreign object in a patient after an invasive procedure or surgery;
m. Fluoroscopy resulting in permanent tissue injury when clinical practice parameters were not followed;
n. Fire, flame, unanticipated smoke, heat or flashes during direct patient care caused by equipment utilized by the District;
o. Falls in staffed around the clock units or in settings not staffed around the clock, but where staff is present at the time of the fall and result in any of the following:
    1. which lead to fracture or result in need for surgery, casting or traction;
    2. result in neurological or internal injury;
    3. happen to a patient with coagulopathy who received blood products as a result of the fall;
    4. Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall).

**Unusual Occurrences:**

An incident is any unanticipated occurrence that deviates from regular District operations; injury may or may not result from the incident. At NIHD an Unusual Occurrence Report (UOR) is completed by staff aware of the unusual occurrence to allow for investigation, tracking/trending and performance improvement needs identification.

CDPH requires notification of events which could seriously compromise quality or patient safety. Title 22 requires NIHD to report any occurrence, as soon as reasonably practicable, to the local health officer and to CDPH Licensing and Certification office (San Bernardino), which includes, but is not limited to, the following:

a. An epidemic outbreak;
a. Poisoning;
b. Fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors.

**Serious Injury:**

A serious injury is further defined as one that results in a transfer to a higher level of care, extended hospital stays or additional medical treatment.

**Risk Thereof:**

For the purposes of this policy, the phrase "or risk thereof" is defined as an event that did not result in death or serious injury, but carries a significant chance of recurring; the recurrence of which may indeed have a more untoward outcome. In determining the risk of an event recurring, the following guidelines are used:

a. Processes involved in the event that are not well codified or standardized across the organization are more likely to result in the recurrence of the event.
b. Processes that cross multiple disciplines and department lines and involve multiple steps in the process are more likely to result in the recurrence of the event.
c. Processes that demonstrate significant variation (i.e. lack of stability) are more likely to result in the recurrence of the event.

**Root Cause Analysis (RCA):**

An RCA is defined as a process for identifying the basic and casual factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause is the most fundamental reason a problem (a situation where performance does not meet expectation) has occurred.

**POLICY:**

1. All Adverse Events of a serious nature that result in harm, or risk thereof, to a patient, workforce member, visitor or vendor (per the CDPH and TJC definitions) will require immediate notification via District's chain of command to the Administrator-On-Call. Timely investigation and reporting, when necessary, will be completed via the Administrator-On-Call or the Compliance Officer.
2. Reportable Sentinel Events/Severe Adverse Events will necessitate a Root Cause Analysis within 45 days of knowledge of the event.
3. Action Plans will be implemented and monitored for completion by the Quality/Informatics/Survey Readiness team, under the direction of the Director of Quality & Infection Prevention and the Chief Medical Officer. These findings will be reported to the Compliance Officer and the Executive Committee.

**PROCEDURE:**

I. Identification of a Sentinel Event/ Unusual Occurrence
   A. Any potential sentinel event/significant adverse event is to be reported immediately to the Compliance Officer or the Administrator-On-Call via the NIHD chain of command. Upon notification, this individual will undertake or direct an initial investigation to determine if the occurrence is indeed a sentinel event/significant adverse event as defined by this policy.

B. If the event is determined not to be sentinel/significant in nature, it will be addressed in accordance with established unusual occurrence management policy and procedure. If the event is determined to be sentinel/significant adverse event in nature, then NIHD shall respond as noted in this document.

II. Mandated Reporting of Sentinel Event/Adverse Event

A. Reporting the Event to Beta Healthcare (NIHD Insurance)
    1. Adverse Events of significance require prompt notification of NIHD's Risk Management Company.
    2. Prior to notification to other agencies, appropriate risk/benefit discussion with Beta Health should occur and should involve the District CEO or designee.

B. Reporting of Sentinel Events to the Joint Commission (TJC)
    1. TJC experts will help to clarify whether an event meets the sentinel event definition.
    2. TJC can provide support and expertise during the review of a sentinel event by providing collaboration with their patient safety specialist resource.
    3. Reporting, although not required, raises the level of transparency and helps to promote transparency.
    4. Reporting proactively provides messaging that the District is working to prevent similar patient safety events in the future.

C. Reporting of Sentinel Event to CDPH
    1. Report adverse events upon detection, within 24 hours of an ongoing urgent or emergent threat, or five (5) days for all other significant adverse events.
        a. Detection is defined as occurring on the first business day on which such adverse event is known to the hospital, or by exercising reasonable diligence that would have been known to the hospital. (e.g. error is discovered at 8pm on Tuesday; first business day begins on Wednesday at 8am.)
        b. Report the detection or allegation of sexual assault within 24 hours.
        c. Reportable events associated with restraints DO NOT include chemical restraints.
        d. Reportable medication errors DO NOT include when the medication is in control of the patient or consumer.
    2. Healthcare Event Reporting tool – CalHEART portal will be utilized to report.
        a. Email or telephone reporting may be utilized if CalHEART site is down/secure internet website is nonoperational.
        b. Administrator-On-Call to complete report via CalHEART or Compliance Officer if needed.

III. Investigation of Event/Conducting a Root Cause Analysis (RCA)

A. Remediation of any immediate threat or likelihood of recurrent sentinel event/adverse event will be put into place to prevent further occurrences.

B. RCA should take place timely – within 45-day window of discovery.

C. RCA team is to be formed to respond to a sentinel event/unusual occurrence.
    1. Various District departments will participate in the investigation as necessary to obtain complete information related to the circumstances involved.
    2. An experience District Leader will lead the RCA team.
    3. Individuals directly involved in the event should participate.

D. Root Cause Analysis (six steps)
    1. Define the problem
        a. Develop an accurate, impartial description of the event.
        b. Define the scope of the issue(s).

2. Find causes
    a. List potential causes of the event in question
    b. Develop a deeper understanding of the issue(s)
3. Finding the root cause (most common tools utilized)
    a. Five Whys
    b. Histogram
    c. Fault Tree
    d. Scatter Chart
    e. Cause & Event Tree
    f. Pareto Analysis
4. Find solutions (design corrective action plan using tools)
    a. Common tools
    b. Interviewing
    c. Brainstorming
    d. Benchmarking
    e. Flow Charts
    f. Why Not Process
5. Take action
    a. Take steps to implement the corrective action plan created by RCA team
    b. Include steps to ensure sustainability of the change(s)
    c. Update any necessary policy or procedural documents that are impacted to sustain the action plan.
    d. Educate workforce on policy or procedural changes.
6. Verify solution effectiveness
    a. Analyze results using data and/or observations

E. Protection from Discovery – All activities of investigation and RCA shall be done under the auspices of the medical staff quality/peer review process.

IV. Assess Culture of Safety Every Two Years using a nationally recognized survey tool

**REFERENCES:**


1. Title 22, California Code of Regulations, Sections 70737 (general acute care hospital).
2. Health and Safety Code, Division 2. Health Facilities; Article 3 – 1279.1, 1279.2, and 1279.6 (Jan 1, 2022).
3. CDPH All Facilities Letter (AFL 21-40, Nov. 12, 2021).
4. The Joint Commission (CAMCAH Manual) Sentinel Events Chapter (Jan. 1, 2022).
5. The Joint Commission (CAMCAH Manual) Standard LD.03.03.01 (Jan. 1, 2022).


**RECORD RETENTION AND DESTRUCTION:**

A record of the investigation into the sentinel event/unusual occurrence, the subsequent RCA, and any performance improvement activities undertaken is to be maintained by the Director of Nursing Quality & Infection Prevention and should be constructed in such a way as to be afforded statutory protection from discovery.

1. Records related to Adverse Event reports to California Department of Public Health (CDPH) will be maintained for 6 years after any appeal is concluded.

2. Records related to Adverse Events associated with Medical Devices will be maintained for the life of the device, plus 6 years.
3. Records related to adverse reaction to blood and blood component will be maintained for 15 years after the expiration date on the blood product.
4. RCA documents will be maintained for 6 years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Unusual Occurrence Report Instructions
2. Communication with the patient/family after a harm event
3. DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine

| Supersedes: v.2 Sentinel Event/Serious Harm Reporting and Prevention |
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| | |
|---|---|
| CALL TO ORDER | The meeting was called to order at 5:30 p.m. by Mary Mae Kilpatrick, Northern Inyo Healthcare District (NIHD) Board Chair. |
| PRESENT | Mary Mae Kilpatrick, Chair<br>Melissa Best-Baker, Vice Chair<br>Jean Turner, Secretary<br>Ted Gardner, Treasurer<br>Jody Veenker, Member-at-Large (arrived at 5:55 p.m.)<br>Lionel Chadwick PhD, Interim Chief Executive Officer<br>Allison Partridge RN, MSN, Chief Nursing Officer<br>Stephen Del Rossi, MSA, Chief Financial Officer<br>Joy Engblade, MD, Chief Medical Officer |
| ABSENT | NONE |
| OPPORTUNITY FOR PUBLIC COMMENT | Chair Kilpatrick reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. Public comments were heard from the following:<br>• MC Hubbard<br>• Patty Dickson |
| SWEARING IN OF NEWLY APPOINTED BOARD MEMBER | Chair Kilpatrick announced that newly appointed Board member, Ted Gardner, would be sworn in. Interim Chief Executive Officer, Lionel Chadwick swore in Ted Gadner, Treasurer of the NIHD Board of Directors. Ted Gardner repeated his Oath of Office. |
| RECOGNITION OF JOHN HALFEN'S CONTRIBUTIONS TO NIHD | Chair Kilpatrick introduced the recognition of John of John Halfen's contributions to NIHD. Several community members and former NIHD employees expressed gratitude for John Halfen's contributions and honorable service. The group proposed that a plaque honoring John Halfen's contributions and dedicated service be placed in the hospital. After making a proposal, a discussion ensued.<br><br>It was motioned by Secretary, Jean Turner to coordinate with NIHD staff to create and determine a location of the memorial that will be proposed to the Board of Directors. Vice Chair, Melissa Best-Baker seconded and the motion passed 4-0.<br><br>AYES: Jean Turner, Melissa Best-Baker, Mary Mae Kilpatrick and Ted |

Gardner.

NOES: None

ABSENT: Jody Veenker

CHIEF EXECUTIVE OFFICER REPORT

Chair Kilpatrick introduced the Chief Executive Officer Report. Interim CEO Chadwick announced NIHD was working on a new piece of labor legislation, which will align with private organizations.

Additionally, CEO Chadwick commended staff for work during recent rainstorms and mentioned the need to do permanent repairs on roofing.

CEO Chadwick announced Joy Engblade's resignation. He expressed thanks for all of Joy's contributions and will have additional updates regarding her position in the future. CEO Chadwick opened for additional questions and comments.

Secretary Turner asked a question regarding the MAT program and a discussion ensued.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

CFO Del Rossi provided an overview of the financial and statistical reports.

It was motioned by Melissa Best-Baker to approve the financial and statistical reports, seconded by Jean Turner and the motion passed 5-0.

CFO Del Rossi provided a financial analysis on the Joseph House as well as an update on the need for roofing.

CFO Del Rossi introduced the Turn Around Action Group (TAG) and opened for questions. A discussion ensued.

Chief Financial Officer DelRossi introduced RSM who would be presenting an audit, tax and consulting services. It was proposed that NIHD contract with RSM in order to improve financials. Chair Kilpatrick asked for clarification and a discussion ensued.

Melissa Best-Baker motioned to approve the contract for the Revenue Cycle Transformation Jody Veenker seconded and the motion passed 5-0.

CHIEF MEDICAL OFFICER REPORT

Dr. Engblade introduced her Chief Medical Officer report and provided an overview of the Annual Physician Compensation report. MMK

appreciated the overview of the report and a discussion ensued.

It was motioned by Jean Turner to approve the Annual Physician Compensation report, seconded by Melissa Best-Baker and passed 5-0.

Dr. Engblade provided an overview of the CMO bi-monthly report.

It was motioned by Melissa Best-Baker to approve the bi-monthly report, seconded by Jean Turner and passed 5-0.

Dr. Engblade introduced Ali Finberg who presented the QAPI plan. The only significant change in the plan is the annual review process.

Jody Veenker motioned to approve the QAPI plan, Melissa Best-Baker seconded and the motion passed 5-0.

ATTENDANCE OF LEGAL COUNSEL AT BOARD MEETINGS

Chair Kilpatrick introduced the discussion of the need for legal counsel to attend meetings. It was addressed that different organizations address this in different ways.

A discussion ensued.

It was motioned by Melissa Best-Baker to continue the attendance of legal counsel at meetings at this time, seconded by Ted Gardner and passed 4-1.

AYES: Jean Turner, Melissa Best-Baker, Jody Veenker and Ted Gardner

NOES: Mary May Kilpatrick

CHIEF OF STAFF REPORT

Chair Kilpatrick introduced Dr. Engblade who provided the Chief of Staff report.

MEDICAL STAFF REAPPOINTMENTS

Dr. Engblade introduced the medical staff reappointments and provided clarification regarding credentialing.

1. Lisa K. Manzanares, MD (*family medicine*

POLICIES

It was motioned to approve the medical staff reappointment by Melissa Best-Baker, seconded by Jody Veenker and passed 5-0.

Dr. Engblade provided an overview of policies for approval.

1. *Advance Directives*

2. *Airborne Infection Isolation Rooms (AIIR)*
3. *Code of Ethics for Nurses*
4. *Healthcare Worker Health Screening and Maintenance Requirements*
5. *Opioid Administration*
6. *Opioid Sedation Scale*
7. *Organ/Tissue/Eye Donation*
8. *Pain Management and Documentation*
9. *Patient Valuables*
10. *Standardized Procedure – Adult Health Maintenance Policy for the NP or CNM*

It was motioned to approve the policies by Melissa Best-Baker, seconded by Jean Turner and the motion passed 5-0.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Engblade provided an update on the Medical Executive Committee.

CONSENT AGENDA

Chair Kilpatrick called attention to the consent agenda. A discussion ensued.

It was motioned to approve the consent agenda with noted changes by Jean Turner, seconded by Melissa Best-Baker and passed 5-0.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick opened up reports to Board Members.

Member-at-Large, Jody Veenker commented on extreme weather and hardship and continued battle against illness. She thanked the staff for their hard work.

Chair Kilpatrick mentioned she attended City Council meeting and appreciated what CEO Chadwick had to share. Chair Kilpatrick also thanked the Human Resource department and mentioned we will be seeing two candidates on campus soon.

ADJOURNMENT

Chair Kilpatrick announced that there is no need for closed session

Meeting adjourned at 7:19 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

Attest: _____
Jean Turner, Northern Inyo Healthcare District, Secretary

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Sending Protected Health Information by Fax | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 11/21/2022 | Last Review Date: No Review Date | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 04/09/2010 | |

## PURPOSE:

To provide guidance for sending protected health information (PHI) by fax to prevent the occurrence of a breach of patient information.

## POLICY:

1. PHI may only be faxed by Northern Inyo Healthcare District (NIHD) personnel who have been trained in this policy.

2. Preprogrammed fax machines shall undergo a fax number verification prior to being released for use by staff. Requests for a programmed fax number shall be submitted through the IT Helpdesk ticket system.

    a. The Department requesting a programmed fax number will call or send a fax to verify the fax number requested is correct.
    b. The verification request fax will contain at least the following statement or words of similar import: "This fax verification is intended for _____. If the intended party has received this fax, check here and fax back to _____. If someone other than the intended party has received this fax, check here and fax back to _____."
    c. The requesting department will submit the fax request on the "Fax Verification Request" Sharepoint located on the NIHD intranet.
    d. IT will program and attach the visual verification to the Sharepoint.
    e. Compliance will perform a "double verification" to ensure the numbers that were verified are the numbers that were programmed into the fax machine.
    f. The preprogrammed fax machine will not be released for staff use until all preprogrammed fax numbers have been verified in accordance with this section.
    g. The Sharepoint will send notification to the requesting department once the process has been completed and the programmed fax button is ready for use.

3. The Compliance Department will be responsible for determining that a preprogrammed fax machine can be released to staff in accordance with this policy.

4. Multi-use fax machines are defined as capable of copying as well as receiving and sending faxes. Multi-use fax machines may only be put in service if an alarm is set to notify operators of a fax being received.

5. Prior to faxing PHI, NIHD personnel must either:
    a. Verify the fax number as being accurate and correct for the intended recipient, or
    b. Utilize a preprogrammed fax number by accessing the number memory of the fax machine or faxing program.

6. Verification of a fax number must be done through one of the following means:
    a. Contacting the intended recipient (or the recipient's office personnel) and reading back the number to that individual; or
    b. Sending a test fax asking for the recipient to send a verification fax back.

7. NIHD personnel performing fax verification must document
    a. Who verified the recipient's fax number for the recipient; and
    b. Which NIHD person performed the verification; and
    c. The date and time of verification.

FAXING TO AN UNINTENDED RECIPIENT

8. NIHD personnel who send faxes of PHI in accordance with this policy, but through human error still send a fax to an unintended recipient, must report the mistake to the NIHD Compliance Officer via phone or via email **as soon as the mistake is recognized** and also must complete an Unusual Occurrence Report (UOR). The UOR link is available on the Hospital Intranet. It is vital to include all information in the UOR, including who faxed the document, for Compliance to be able to follow up.

9. NIHD personnel who are notified by an unintended recipient that they received a fax containing PHI must report to the Compliance Officer by phone or email, as soon as possible, but not later than the end of their shift. The notified person should also enter a UOR. The employee who receives this notification from the unintended recipient must report the following (in the UOR):
    a. The name and telephone number of the unintended recipient.
    b. The time and date of the notification by the unintended recipient.
    c. A description of the PHI that was received including the patients name and the general type of PHI (doctors' orders, test results, etc.).
    d. The disposition of the PHI (e.g. the recipient will send the document(s) back to us, the recipient will deliver the document(s) to the hospital, the recipient will shred the document(s)).

10. Only if the unintended recipient is a hospital, medical or dental practice or facility, NIHD employees receiving notification from those offices may instruct the offices to shred the documents or send them to the NIHD Compliance Officer.

11. If the unintended recipient is other than a hospital, medical or dental practice or facility, then the NIHD employee **must** ask the recipient to send the documents to the NIHD Compliance Officer. Shredding is not to be recommended.

**REFERENCES**

1. CA Health and Safety Code 1280.15
2. 42 USC Section 17939
3. California Issues New Regulations on Notification Obligations for Medical Information Breaches; P. Coie Sept. 10, 2021.

**RECORD RETENTION AND DESTRUCTION:**
Maintain Unusual Occurrence Reports for 10 years by NIHD.

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
2. Communicating Protected Health Information Via Electronic Mail (Email)

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|---|
| Supersedes: v.5 Sending Protected Health Information by Fax |

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Nursing Certification | | |
| Owner: Chief Nursing Officer | Department: Nursing Administration | |
| Scope: Registered Nurses | | |
| Date Last Modified: 03/31/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 04/20/2016 | |

**PURPOSE:** To identify eligible nursing certification for wage adjustments that are not required as part of the position qualifications.

**POLICY:**

1. Nursing Staff that complete and maintain specialty certification to approved categories may receive an education pay differential.
2. Up to two certifications will be eligible for education pay differential.
3. Certification's that are required as part of the job description will not be eligible for increase.
4. Registered Nurses who have received certification may have the initial RN-BC (Registered Nurse – Board Certified) placed on their identification badge and may include those initials in their signature.

**PROCEDURE:**

1. The below listed certifications are approved for the following categories of staff:
    a. RN:
        - Ambulatory Care Nursing
        - Cardiac Vascular Nursing
        - Certified Emergency Nurse
        - Certified Nurse Operating Room
        - Certified Vascular Nursing*
        - Critical Care Registered Nurse
        - Diabetes Management – Advanced
        - General Nursing Practice*
        - Gerontological Nursing
        - Hemostasis Nursing
        - Informatics Nursing
        - International Board Certified Lactation Consultant
        - Medical-Surgical Nursing
        - Nurse Executive
        - Nurse Executive Advanced
        - Nursing Case Management
        - Acute/Critical Care Knowledge Professional
        - Pain Management Nursing
        - Pediatric Nursing

- Perinatal Nursing*
- Inpatient Obstetric Nursing – RNC-OB

*Exam retired. The credential can still be renewed

b. CNA:
   - Restorative Certified Aide

c. Department Clerk:
   - Health Unit Clerk Certification

2. Staff that complete certification to approved certification categories (that are not required as part of employment), from the American Nurses Credentialing Center or other designated sources may turn their certificate into their manager for recognition and education pay differential.
   a. The manager completes the Personnel Action Form.
   b. The education pay differential is applied on the first day of the start of new pay period.

3. Once certification has been achieved the RN may have an updated identification badge made within the HR identification badge constraints.
   a. The preferred order of listing credentials is:
      i. Highest earned degree
      ii. Licensure
      iii. State designations or requirements
      iv. National Certifications
      v. Other recognitions
         i.e. John Doe, PhD, MSN.
   b. If you have a second degree in another relevant field you may choose to list it, i.e. John Doe, MBA, MS.
      1. Note that the highest non-nursing degree is listed first followed by the highest nursing degree.
      2. If you have a doctorate and a master's degree, omit the baccalaureate degree. i.e. John Doe PhD, MSN.
   c. Multiple nursing credentials may be listed in the order you prefer, but consider listing them either in order of relevance to your practice or in the order they were obtained with the most recent first. i.e. John Doe, BSN RN, MICN, CEN

4. HR will oversee the record of certifications and the renewal dates.
   a. HR will notify the employee's manager who notifies the employee that the updated certification is due.
   b. If the certification is no longer active, the 2% adjustment will be discontinued.

**REFERENCES:**


1. *How to List the Order of Credentials After a Name*; Indeed, Editorial Team (October 4, 2021).
2. How to display your credentials; ANCC American Nurse Credentialing Center Certification. (June 2013).


**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Licensing of Nursing Personnel

**RECORD RETENTION AND DESTRUCTION:**
Records are maintained in the workforce member's personnel record for the length of employment, plus 6 years.

| Supersedes: v.2 Nursing Certification* |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Used Equipment Sales | | |
| Owner: Chief Financial Officer | Department: Fiscal Services | |
| Scope: District Wide | | |
| Date Last Modified: 11/21/2022 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/7/1995 | |

**PURPOSE:**
Northern Inyo Healthcare District (NIHD) occasionally has equipment and furniture that no longer serves the District, but may be of value. Resale of these items allows for recycling and continued use, while generating funds for the District.

**POLICY:**
NIHD does not purchase equipment or furnishings for resale to the public. Periodically NIHD sells used equipment or furnishings that are no longer useful for the provision of services at the District. Pricing of used items is at the direction of the Chief Financial Officer or designee. Chief Executive Officer must approve sale of items prior to disposition (sale, donation, or destruction). Notification of the Accounting Office on all items sold is required to maintain records of assets.
Payment method will be cash, check, debit or credit card at time of purchase unless the Administrator has previously approved credit terms.

**REFERENCE:** N/A

**RECORD RETENTION AND DESTRUCTION:**
Maintain records related to equipment sales for ten (10) years.

**CROSS REFERENCE POLICIES AND PROCEDURES:**
1. Asset Management
2. Disposal of Equipment

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|---|
| Supersedes: v.1 Used Equipment Sales |

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Cross-Training of RN Staff | | |
| Owner: Chief Nursing Officer | Department: Nursing Administration | |
| Scope: District RNs | | |
| Date Last Modified: 07/08/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/16/2016 | |

## PURPOSE:

To describe the method for cross-training Registered Nurses (RN's) to alternate clinical roles.

## POLICY:

1. RN's in a cross-trained position shall receive orientation to that department. This does not apply to RN's who may occasionally be assigned to a different department working within their competency or workforce working under the direct supervision of an RN oriented to that department.
2. Cross trained positions will be posted based on the Staffing Management Plan Position Control.
3. Any cross-trained RN will:
   a. Receive an orientation to the cross-trained position
   b. Receive an annual feedback to the cross-trained department job skill performance standards or position.
   c. Complete the annual competency plan to the department job skill or position.
   d. Take a full assignment in the cross-trained department when the need arises during a scheduled shift.
4. An RN may be hired into a position that requires competency to another department or role as part of the position. This is not considered a cross-trained position.
5. Orientation will be completed to the primary role prior to orientation to a cross-trained position. The RN shall work in the primary role in home department until deemed appropriate by their manager before cross-training to another department or role. Should a manager determine the RN is not ready for cross-training, they will develop an action plan to support the RN's growth and readiness for cross-training.
6. The department Position Control will indicate staff currently cross-trained to another department or role.
   a. Staff who are cross-trained to another position or role within the department will also be listed on the position control of the department to which they are cross-trained.
7. An RN may cross train to a maximum of two departments and/or positions.
8. A cross-trained RN must work sixty (60) hours in the cross trained department per calendar year, with a minimum of 24 hours in the first six months of the calendar year.
   a. Managers shall assist in scheduling cross-trained RNs to meet their requirements.
   b. Cross-trained RNs will be assigned to the cross-trained department prior to using a float RN when available.
9. Annual feedback and on-going Competency Plan is maintained on the cross-trained employee by the home department manager with input from the manager of the department where the RN is cross-trained.
10. If the RN does not continue to meet the cross training requirements, the RN will lose the cross-training differential.

11. An RN who transfers from a department to another department may retain her/his cross-training from the transferred department if:
    a. The RN wishes to be cross-trained to the department they are transferring from;
    b. And the District has an open position in the department master staffing plan for a cross-trained RN;
    c. If there are no open cross-training positions, the District will confer with the Union prior to making a decision. The decision will be presented to the Board of Directors.

**DEFINITIONS:**

1. **Cross-trained Staff**: RN has completed skills checklist and annual competencies to the cross-trained department. The RN must meet the minimum worked requirement to maintain skills in the cross-trained department.
2. **Floating**: RNs who is assigned to work in an alternate department without having completed the cross-training competency validation and being assigned in the cross-trained role on the master staffing plan for the assigned department. The person functions within the performance standards in which they are competent. In some situations, the floated RN works under the care coordination of another RN in the department to which they have been floated. i.e., Med-Surg RN floated to ICU.
3. **Cross-trained for a Skill**: Employees are provided orientation to a particular skill to be performed in another department on a per diem basis, i.e., a Scrub Tech has been trained to wrap instrument pans and can be floated to CSP. A Skills Checklist for wrapping instruments is present in the employee file.

**PROCEDURE:**

1. The department Position Control will indicate the number of cross trained positions within each unit. Open cross trained positions will be posted via the Human Resources Department. Posting for internal applicants only will include the job description.
2. Staff who are cross-trained to another department or role will be the first person selected to work in the cross-trained department or role if a need exists.
3. The Manager of the cross-trained department will complete an annual review of the job skills performance standards (use Annual Alternate RN review).
    a. The RN's core position department Manager will complete the annual feedback and include the cross trained department Alternate RN Review.
    b. Formal evaluation will be provided by alternate department Manager, should cross trained employee fail to meet performance standards. The primary Manager of the home department shall be present for this evaluation process.

**REFERENCES:**

1. The Joint Commission (CAMCAH Manual) (2021) Nursing Functional Chapter Standard NR 02.03.01

**RECORD RETENTION AND DESTRUCTION:**

NIHD utilizes scheduling software which contains information on scheduled shifts and departments in which the RN works. This information is maintained for fifteen (15) years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Staffing Management Plan
2. Deployment of Nursing Staff at Department Level and Patient Care Assignments
3. District Low Census Days
4. Floating Nursing Workforce
5. Scheduling of Nursing Personnel
6. Orientation/Cross Training Time Frames

| Supersedes: v.2 Cross-Training of RN Staff |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Check Signing | | |
| Owner: Chief Financial Officer | Department: Fiscal Services | |
| Scope: CEO, CFO, CMO, CNO | | |
| Date Last Modified: 01/05/2023 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 04/16/2003 | |

**PURPOSE:** To identify who has approval to sign checks and to set limits as to the amount needed for signatures.

**POLICY:** The Board of Directors assigns and approves signatory authority for all contracts, legal documents, and related papers to the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Administrator on Call (AOC). No other person regardless of their position is authorized to sign such documents on behalf of Northern Inyo Healthcare District. This authority is to be used in connection and compliance with the current approved Board policy and all contracts, actions, and borrowings approved by the Board of Trustees.

**PROCEDURE:**

**Disbursement Account**

1. A facsimile signature bearing the name of either the CEO, CFO, CMO, or CNO may be used for signing disbursement account checks not exceeding $9,999.99.
2. Checks exceeding $9,999.99 must be hand signed by at least one of the following – the second signature can be presented via facsimile:
   a. CEO
   b. CFO
   c. CMO
   d. CNO
   e. AOC

**Payroll Accounts**

1. A facsimile signature bearing the name of the CEO, CFO, CMO, or CNO may be used for signing payroll checks issued in lieu of direct deposit.

**Wire Transfer, ACH, EFT**

1. A wire transfer, ACH, and EFT can only be released by the following: CEO, CFO, CMO, and CNO.

**REFERENCES:** N/A

**RECORD RETENTION AND DESTRUCTION:**
Maintenance of Fiscal records, including documents associated with procurement contracts and purchase orders is for fifteen (15) years.

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Purchasing and Signature Authority

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| Supersedes: v.1 Check Signing Policy |

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Capitalization of Assets | | |
| Owner: Chief Financial Officer | Department: Fiscal Services | |
| Scope: Fiscal Services, Purchasing, Department Heads | | |
| Date Last Modified: 01/05/2023 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 08/18/2004 | |

**PURPOSE:**
To update minimum criteria dollar amount for capitalizing assets.

**POLICY:**
This policy outlines in general terms the distinction between capitalized and non-capitalized plant and equipment acquisitions. Property and plant is divided into three categories (land, buildings and improvements other than buildings). Equipment is categorized as either movable or fixed. Each category will be defined below along with the respective capitalization method.

**Capitalized Expenditures**

A. Land

1. Capitalize new acquisitions of land at cost.
2. Establish land donated value by an appraisal. The value is the fair market value as of the date of the gift.
3. Land does not depreciate.

B. Buildings

1. Treat buildings as a single asset without separating the "shell" from other building components.
2. Building additions that add square footage to a building are capitalized and componentized.
3. Certain major replacements or renovations of a building, which extend the original life of the building or enhance the value, may be capitalized.

C. Improvements other than Buildings

1. This category consists of land improvements outside the periphery of the building. Examples include parking lots, sidewalks, electric lines, telephone lines, etc.
2. Improvements have the same capitalization criteria as buildings.
3. Costs incurred must meet threshold of $25,000 and be in the same building section.

D. Movable Equipment

1. Capitalize items of equipment or furnishings that have an acquisition cost of $3,000 or more and a life expectancy of greater than one year. This includes the cost of any modifications and attachments or accessories necessary for the equipment's intended purpose upon initial purchase. Delivery, installation, taxes, and initial equipment calibration are also included in the total equipment cost.

2. Expenditures for the restoration or betterment of equipment may be capitalized if the expenditure restores the item to like new condition and extends the useful life or increases the item's book value. The item will be capitalized at the restoration cost, provided the item meets the capital threshold requirements. This capitalized cost should not exceed the present fair market value of the item.
3. Accessories purchased after the first year of an item's acquisition must meet the movable equipment capitalization threshold and will be capitalized separately. Accessories are non-disposable items.
4. Group or mass purchases of furnishings, computers, or similar items, which individually are less than the capitalization threshold, are capitalized and depreciated over the average useful life of the items.
5. Software purchases processed on a separate purchase order will be capitalized and issued a property tag as long as the unit cost is $3,000 or more.
6. Equipment gifted are recorded at the lower of fair market value or purchase price, if new.

E. Fixed Equipment

1. Fixed equipment has the same capitalization threshold as movable equipment. These assets are stationary and are attached to another structure, such as a wall or floor. Examples of fixed equipment include biosafety cabinets, audiovisual systems, cubicle walls, time clock machines, and fume hoods.

**Expenditures of costs considered capital expenditures include**:

1. Demolition costs and preparing the site for construction
2. Cost of building materials
3. Contractor and construction costs
4. Architect and consultant fees
5. Building permit fees
6. Subcontract fees
7. Payment for rented equipment to complete the construction
8. Operating and maintenance costs for work performed in building the asset
9. Cost of supplies consumed in the construction

Fixed assets will be transferred from construction in progress and depreciation will begin to be recognized once the construction project cost is completed and the asset has been put into service for the intended use.

**Expenditures that should not be capitalized as plant and equipment**

1. Expenditures for repairs, maintenance, or replacement of component parts which do not extend the unit's original life or increase the net book value. Examples of these include carpet installations, paint and patching of walls, and pothole repairs.
2. Expenditures for moving partitions in an existing building or renovations that do not add value to the buildings that are not part of an overall renovation.
3. Expenditures incurred in connection with the rearrangement, transfer, or moving of capitalized items from one location to another.
4. Expenditures made to maintain fixed assets in normal operating condition or to restore fixed assets to normal operating condition.

**Depreciation**
Depreciation is calculated using the straight-line method over the useful life of the asset ranging up to forty years. Land is not subject to depreciation. Assets are depreciated over their useful lives as presented in the American Hospital Association's *Estimated Useful Lives of Depreciable Hospital Assets*.

**Disposition**
Movable equipment should be disposed of through trade-in, retirement, sale, or disposal. Finance will review and approve the disposal once the disposal is requested. (See attachment – Asset Disposition Form)

**REFERENCE:**
AHA: Estimated Useful Lives of Depreciable Hospital Assets

**RECORD RETENTION AND DESTRUCTION:**
1. Indefinitely

**CROSS REFERENCE POLICIES AND PROCEDURES:**
1. Asset Management
2. Asset Control

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| Supersedes: v.3 Capitalization of Assets |

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Smoking/Tobacco Policy | | |
| Owner: Interim CEO | Department: Administration | |
| Scope: District Wide | | |
| Date Last Modified: 01/24/2023 | Last Review Date: No Review Date | Version: 5 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/08/2001 | |

**PURPOSE:**

To provide a tobacco/nicotine free environment for all persons seeking care or providing services at Northern Inyo Healthcare District. This is consistent with the Northern Inyo Healthcare District (NIHD) mission of "One Goal, Your Health".

**POLICY:**

All patients, visitors, and workforce (physicians, contracts and employees) of NIHD shall adhere to the following policies:

1. Patients, visitors, workforce (physicians, contracts and employees of the District) are not allowed to smoke within any buildings on District property or outdoors on District property. This includes use of nicotine delivery devices or tobacco products in cars while on Northern Inyo Healthcare District (NIHD) property.
2. It is the responsibility of workforce who smoke off campus to mitigate any of their own personal smoke odors, which may be irritating to others.
3. Cigarettes and other tobacco products will not be sold at NIHD.
4. Signage will be posted at entrances as notification to persons entering the District campus of the "No Tobacco" environment.
5. Workforce members who within the District Campus may be subject to disciplinary action up to and including termination.

**REFERENCE:**

1. California Assembly Bill 1807 (Jan 26, 2006).
2. California Assembly Bill 846, Chapter 342 Section 7596 to 7598, Section 19994.30 to19994.33 (Prohibits smoking within 20 feet of main entrances/exits and operable windows of all state, county and city buildings).
3. California Assembly Bill 2037, Chapter 989 California Labor Code, Section 6404.5. (Prohibits smoking in indoor workplaces.)
4. Health & Safety Code 1234 – Division 2 and Chapter 2 Clinics.

**RECORD RETENTION AND DESTRUCTION:** N/A

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Smoking Cessation
2. InQuiseek – Smoke-Free Workplace

| Supersedes: v.4 Smoking/Tobacco Policy |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Prompt Pay Discounts | | |
| Owner: Chief Financial Officer | Department: Fiscal Services | |
| Scope: Billing & Collections, Patient Access | | |
| Date Last Modified: 01/27/2023 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 05/12/2015 | |

**PURPOSE:**
The purpose of the Policy is to offer a discount to patients for their portion of their bill. Offering a discount for early payment decreases the amount of time to final adjudication of the bill, and it decreases the amount of work by shortening the collection cycle.

**POLICY:**
It is the policy of NIHD to offer prompt pay, district residents, and non-district resident's payment discounts for paying the accounts either at the time of service or within 30 days of first bill. It is not the policy of the district to reduce co-pay amounts.

**PROCEDURE:**
**30% Prompt Pay Discount:**
Private patients (self-pay) who pay their estimated charges at the time of service are eligible for a Discount of 30%. The 30% discount is in lieu of the hospital submitting the bill to any insurance or third party payer. Should patient's total bill differ upon final computation of charges, resulting in additional balance owed, patient will have opportunity to submit additional payment less 30%.

**25% District Resident Discount:**
District Private patients (self-pay) who reside within Northern Inyo Healthcare District within the following zip codes qualify for the discount: 93513, 93514, 93515 who pay their out of pocket portion of their bill within 30 days of the date of the hospital's first statement showing the balance due by the patient are eligible for a Discount of 25%.

**20% Discount:**
Non-District Private patients (self-pay) who pay their out of pocket portion of their bill within 30 days of the date of the hospital's first statement showing the balance due by the patient are eligible for a Discount of 20%. Credit & Billing Information Office (760) 873-2190 / Monday through Friday, 8:30 a.m. - 4:00 p.m.

**REFERENCE:** N/A

**RECORD RETENTION AND DESTRUCTION:**
Retain patient account records for no less than fifteen (15) years or until a minor reaches the age of 28.

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Charity Care
2. Bad Debt
3. Billing and Collections
4. Price Transparency Policy

| Supersedes: v.2 Prompt Pay Discounts |
|---|