Northern Inyo Hospital

December 13 2017 Regular Meeting

December 13 2017 Regular Meeting - December 13 2017 Reg

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

December 13, 2017 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Appointment of Board member to District Zone 2 (*action item*).
   B. Election of Board Officers for 2018 calendar year (*action item*).
   C. Financial Strategy Workshop #3 (*information item*).

Consent Agenda (action items)

4. Approval of minutes of the November 13 2017 special meeting
5. Approval of minutes of the November 15 2017 regular meeting
6. Financial and Statistical Reports as of October 31 2017
7. 2013 CMS Validation Survey Monitoring, December 2017
8. Compliance Department Quarterly report

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9. Chief of Staff Report; Richard Meredick, MD:
   A. Policies/Procedures/Protocols/Order Sets approvals (*action items*):
      - *Advanced Directives*
      - *Assisted Living Facilities*
      - *California Children Services Referral*
      - *Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge*
      - *Designated Areas for Food and Drink in Patient Care Areas*
      - *DI – Handling of Radioactive Packages, non-nuclear Medicine Personnel*
      - *DI –Radioactive Material Hot Lab Security*

- *DI – Radioactive Materials Delivery After-hours Policy/Procedure*
- *DI – Radioactive Waste Storage and Disposal*
- *ED Triage Protocol Policy*
- *Environmental Disinfectant-Cleaning Solution*
- *Handling of Soiled Linen*
- *Home Health Care*
- *Hospice Care*
- *Hospi-Gard Portable Filtration Unit (H.G.U.)*
- *Infection Control: Handwashing for Safe Food Handling*
- *Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu*
- *Long Term Acute Care Hospital*
- *Meals on Wheels*
- *Nursing Services Standing Committee Structure and Hospital Committee Participation*
- *Ombudsman*
- *Sharps Injury Protection Plan (supersedes: Handling and Disposal of Contaminated Needles/Syringes*
- *Working with Other Agencies in the Community*

B. Medical Staff Appointment/Privileges (*action items*):

1. Brian Mikolasko, MD (hospitalist) – Provisional Active Staff
2. Trong Quach, MD (hospitalist) – Provisional Active Staff
3. Amikjit Reen, MD (hospitalist) – Provisional Active Staff
4. Wilbur Peralta, MD (hospitalist) – Provisional Active Staff

C. Temporary Locum Tenens Privileges (*action items*):

1. H. Charlie Wolf, MD (emergency medicine) – for 60 days in the 2018 calendar year effective January 1, 2018. Dr. Wolf will be providing coverage for the Eastern Sierra Emergency Physicians on a locum tenens basis.
2. Tien H. Cheng, MD (radiology) – for 60 days effective December 11, 2017. Dr. Cheng will be providing coverage for the Bishop Radiology Group on a locum tenens basis.

D. Medical Staff Advancements (*action items*):

1. Sarah Zuger, MD (family medicine) – advancement from Provisional Active Staff to Active Staff
2. Cecilia Rhodus, MD (pediatrics) – advancement from Provisional Active Staff to Active Staff

E. Medical Staff/Allied Health Professional Re-appointments, 2018-2019 (*action items*):

Forty applicants submitted for renewal of privileges for the 2018 and 2019 calendar years. All applicants underwent a recredentialing process consisting of the following:

- *Verification of current unrestricted licensure, certifications, and registrations*
- *Queries to the AMA, the NPDB, and the OIG exclusion database*
- *Investigation of any professional liability cases*
- *Verification of compliance with CME requirements*
- *Evaluation of evidence indicating current competence and training related to the privileges requested*
- *Review of the applicant's performance and standing at NIHD and outside affiliations*
- *Review of available Ongoing and Focused Professional Practice Evaluation data (OPPE and FPPE), which includes peer review data and evaluation of the six ACGME core competencies*

1. After careful review and consideration of the applicant reappointment profiles, the Medical Executive Committee recommends the following applicants for reappointment to the Medical Staff/Allied Professional Staff in the category listed effective January 1, 2018, for a period not to exceed two years:
    - Anderson, Ivan MD, *Cardiology* (Telemedicine)
    - Black, Helena L. MD, *Emergency Medicine* (Active Medical Staff)
    - Brown, Stacey L. MD, *Family Medicine* (Active Medical Staff)
    - Bryce, Thomas MD, *Radiology* (Telemedicine)
    - Chan, Brandon MD, *Radiology* (Telemedicine)
    - Dillon, Michael L. MD, *Emergency Medicine* (Active Medical Staff)
    - Farooki, Aamer MD, *Radiology* (Telemedicine)
    - Ganchan, Richard MD, *Cardiology* (Telemedicine)
    - Harness, Jay K. MD, *Surgery* (Active Medical Staff)
    - Hathaway, Nickoline M. MD, *Internal Medicine* (Active Medical Staff)
    - Hewchuck, Andrew D. DPM, *Podiatry* (Active Medical Staff – LLP)

- Kamei, Asao MD, *Internal Medicine* (Active Medical Staff)
- Kim, Martha MD, *Obstetrics & Gynecology* (Active Medical Staff)
- Klabacha, Rita PA-C, *Family Medicine* (AHP)
- Lin, Doris MD, *Emergency Medicine* (Active Medical Staff)
- McNamara, Thomas O. MD, *Radiology* (Active Medical Staff)
- Meredick, Richard MD, *Orthopedics* (Active Medical Staff)
- Norris, Jennifer CNM, *Nurse-Midwife* (AHP)
- Nylk, Thomas MD, *Cardiology* (Telemedicine)
- O'Neill, Tammy PA-C, *Orthopedics* (AHP)
- Phillips, Michael W. MD, *Emergency Medicine* (Active Medical Staff)
- Pisculli, Leo M. MD, *Psychiatry* (Consulting Medical Staff)
- Pomeranz, David MD, *Emergency Medicine* (Active Medical Staff)
- Reid, Thomas K. MD, *Ophthalmology* (Active Medical Staff)
- Rhodus, Cecilia MD, *Pediatrics* (Active Medical Staff)
- Richardson, James A. MD, *Internal Medicine* (Honorary Medical Staff)
- Rowan, Christopher MD, *Cardiology* (Telemedicine)
- Saft, Amy CRNA, *Nurse Anesthesia* (AHP)
- Schweizer, Curtis MD, *Anesthesiology* (Active Medical Staff)
- Seher, Richard MD, *Cardiology* (Telemedicine)
- Swackhamer, Robert MD, *Cardiology* (Telemedicine)
- Taylor, Gregory MD, *Emergency Medicine* (Active Medical Staff)
- Tiernan, Carolyn J. MD, *Emergency Medicine* (Active Medical Staff)
- Vaid, Rajesh MD, *Radiology* (Telemedicine)
- Wasef, Eva S. MD, *Pathology* (Active Medical Staff)
- Wei, Stephen MD, *Radiology* (Telemedicine)
- Weiss, Taema F. MD, *Family Medicine* (Active Medical Staff)
- Wilson, Christopher MD, *Cardiology* (Telemedicine)
- Zuger, Sarah MD, *Family Medicine* (Active Medical Staff)

2. The following applicant did not meet the necessary qualifications and criteria for reappointment to the NIHD Active Staff as outlined in the Medical Staff bylaws. The applicant's privileges will expire after December 31, 2017:

- Ramadan, Amr MD, *Family Medicine* (Active Medical Staff)

10. Reports from Board members (*information items*).
11. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).
    D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
12. Return to open session and report of any action taken in closed session.
13. 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

Health Care Finances Discussions

Session #3

December 13, 2017

Agenda

- Review of Long Term Strategies/Goals
- Strategies Being Deployed to Avoid Economic Issues
- Update of WIPFLI Strategic Comparison Graphs
- Planning for Unexpected Negatives Changes in the volumes, services and provision of care
- Analysis of the Negative Change
- District Philosophy in Responding to Negative Changes in Environment/Volumes

VISION

- Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with trusted regional partners

Long Term Strategies

- Provide Care Equal to/or Better Than Others
- Be the Dominant Provider of Care in the District
- Maintain Economically Viable Health Care Entities
- Provide as Many Services Locally as Viable
- Support Local Employment in Health Care
- Replace the Clinics with Modern Facilities
- Replace Equipment within Modern Standards
- Expand the Provision of Care Locally
- Be the District's Employer of Choice
- Grow Volumes to be 80% Outpatient
- Provide Services at a Value Price

Deployed Growth Strategies

- Da Vinci
- Expansion of Physicians & Specialties
  - Urology
  - Orthopedics
  - Cardiology
  - Telehealth
  - Neonatal Medicine & Genetic Counseling
- Transportation – Care Shuttle
- Expanded Swing Bed Program
- RHC Care Follow-up
- Expanded Interpreter Services

Benchmarking: NIH Volumes

Northern Inyo Healthcare District **Fiscal Year** **6/30/15**

WIPFLi CPAs and Consultants

Bottom performance group
Below average performance group
Above average performance group
Best performance group

Indicator	6/30/17	Hospital Values	Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Total Surgeries	1,513	1,313	742	84	285	541	994	3,032
ER Visits	9,750	8,831	5,874	1,215	3,246	4,552	7,975	21,405
Births	199	198	142	1	47	155	215	359
Lab Tests	107,484	115,335	77,838	18,258	41,145	61,219	87,884	373,409
Radiology Tests	12,346	12,224	8,096	1,272	4,007	6,544	11,873	26,986
CT Tests	2,643	1,405	2,796	488	1,058	1,489	2,743	33,175
Ultrasound Tests	2,350	2,137	1,894	343	773	1,082	1,585	17,693
MRI Tests	1,325	7,193	763	65	276	367	850	7,193
Respiratory Therapies		50,686	11,787	828	3,728	9,018	14,745	66,902
Physical Therapies	21,640	20,362	15,036	353	6,013	12,922	19,888	56,448
Pharmacy Units		255,434	115,668	0	63,773	89,328	179,251	355,880

Benchmarking: NIH Costs

Northern Inyo Healthcare District **Fiscal Year** **6/30/15**

WIPFLi
CPAs and Consultants

Bottom performance group
Below average performance group
Above average performance group
Best performance group

Indicator	6/30/17 Hospital Values		Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Labor Hours	775,154	700,960	416,110	140,816	247,718	333,476	535,933	1,108,744
Hours per APD	60.20	58.44	28.00	7.23	20.16	26.45	33.54	62.99
Outpatient Revenue %	69.8%	66.7%	78.1%	48.2%	73.8%	78.2%	84.7%	92.5%
ER $ per Visit	$704.23	$545.12	$379.48	$115.77	$261.12	$373.60	$475.64	$945.73
Nursing Expense per APD		$254.16	$156.74	$50.43	$92.31	$133.66	$190.86	$633.64
ICU Expense per Day	$5,670	$4,894.88	$1,958.08	$448.59	$985.94	$1,731.41	$2,136.14	$5,256.00
Surgery Expense per Surgery	$6,187	$3,199.73	$1,783.59	$249.36	$937.54	$1,417.22	$2,142.25	$5,431.27
$ per Lab Test	$62.10	$41.57	$20.57	$1.38	$15.63	$18.94	$22.39	$58.48
$ per Radiology Test	$274.44	$423.74	$153.46	$41.77	$98.78	$138.95	$167.34	$464.32
$ per Physical Therapies		$58.56	$46.93	$6.78	$27.88	$39.46	$46.12	$207.39

Benchmarking: Overhead/General Costs

Northern Inyo Healthcare District **Fiscal Year** **6/30/15**

WIPFLi
CPAs and Consultants

Bottom performance group
Below average performance group
Above average performance group
Best performance group

Indicator	6/30/17 Hospital Values		Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Cost (Salaries/Benefits) per Hour	$53.15	$54.80	$37.18	$21.28	$31.17	$36.99	$41.69	$54.80
Hours per APD	60.20	58.44	28.00	7.23	20.16	26.45	33.54	62.99
Maintenance $ per Square Foot		$14.46	$9.96	$2.48	$6.77	$9.40	$11.94	$36.77
Housekeeping $ per Square Foot		$10.04	$4.49	$1.09	$2.66	$3.39	$5.41	$18.23
Medical Records $ per Acute APD		$81.96	$28.77	$3.97	$17.00	$23.93	$37.93	$109.17
Human Resources $ per All APD		$39.90	$23.13	$2.17	$7.39	$15.37	$26.41	$189.18
Finance $ per All APD		$62.93	$24.87	$0.00	$9.84	$20.07	$33.09	$98.22

Providers: Rural Health Clinic Benchmarking

NORTHERN INYO RURAL HEALTH CLINIC
150 PIONEER LANE
BISHOP, CA 93514

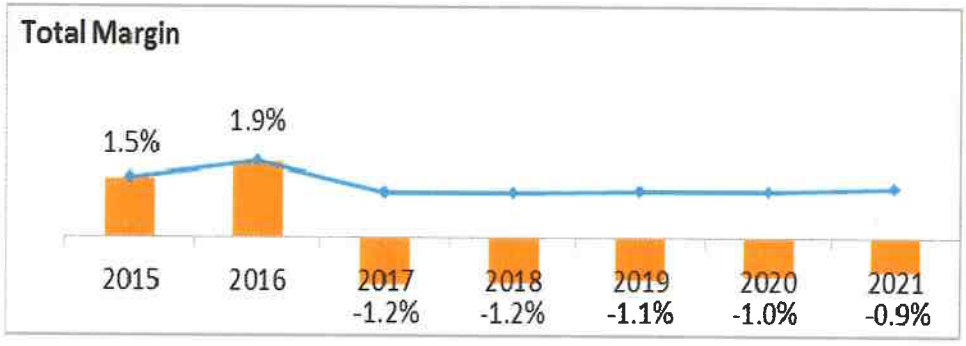
Category/Indicator	6/30/2013 RHC NIH		6/30/2013 Mean CA	6/30/2013 Mean Western	6/30/2013 Mean Nation	6/30/2014 RHC NIH		6/30/2014 Mean CA	6/30/2014 Mean Western	6/30/2014 Mean Nation
Number of Facilities	1		139	381	1,881	1		147	383	1,917
Clinic Cost per Encounter:										
Total Direct Costs of Medical Services	144.23	↓	95.39	104.86	95.22	138.45	↓	101.41	108.45	97.74
Total Allowable Cost per Actual Encounter	247.08	↓	180.14	193.85	174.69	232.05	→	188.69	199.51	180.25
Total Allowable Cost per Adjusted Encounter	247.08	↑	177.13	187.13	166.09	232.05	↑	184.03	192.30	172.09
Average Medicare Encounters	5,362		2,034	2,335	2,489	5,933		1,741	2,399	2,540
Medicare Percent of Visits	30.51%		14.00%	20.56%	25.47%	29.07%		13.04%	20.22%	25.22%

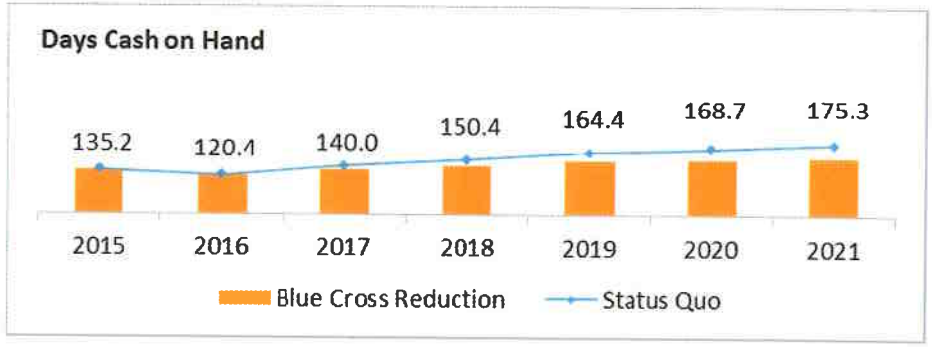
- NIH is able to capture all of the costs per encounter for the RHC
- There has been a significant increase in Medicare encounters since 2013 and NIH sees almost 2.5x the number of Medicare patients than the average California RHC

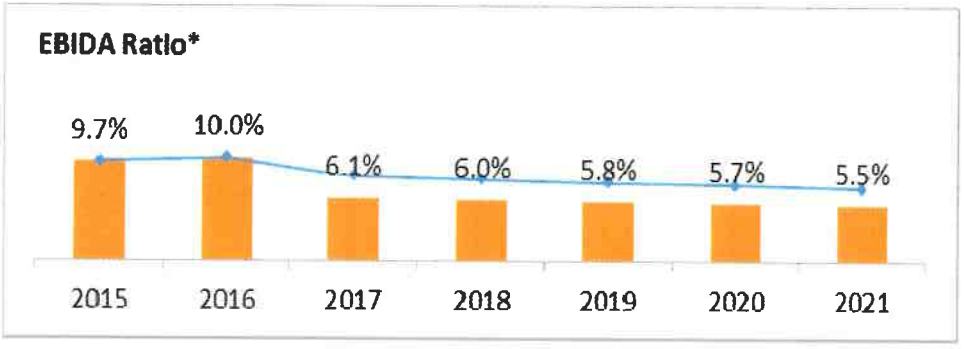
Sources of Negative Changes

- Reduction in Available Providers or Specialties
- Changes in Federal (Medicare) Payments
- Reduction in the ability to provide a service(s)
- Changes in HMO/Managed Care Payments
- Implementation of Prior Authorizations by Federal, State or Payor organizations (reduction in demand)
- Changes in the provision of medical care (progress)
- Shortages of key professional staff
- Increased Competition (Local & Internet)
- General Economic Decline/loss of major employer
- Is General Trend (Aging Boomers) catching up to us?

Blue Cross Contract Reduction Scenario

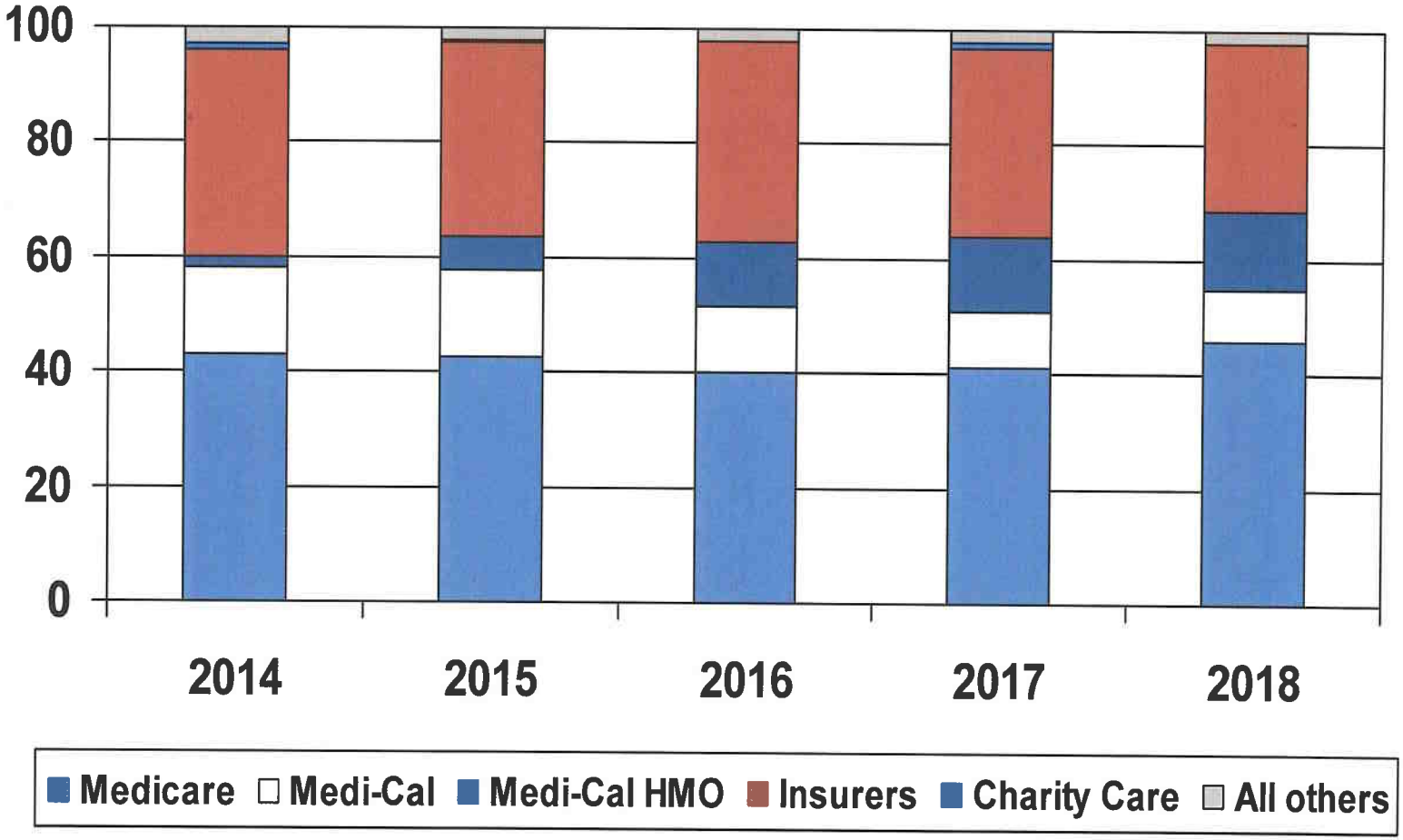






- NIH receives about 28% of their gross revenues from Blue Cross
- If Blue Cross reduced reimbursement by 5% in 2017 then the finanical impact is about $2MM less in net revenues on average per year
- Illustrates the importance of commercial contracts to the overall financials

General Payor Trends



Analysis of the Negative Change

- Is the Change specific? Loss of a provider(s)
- Are the impacted departments (Sales/Volumes)specific and identifiable?
- Is the Negativity temporary (6 months or less)
- Do expenses leave as the service is lost?
- Are we left with a white elephant (or a herd?)
- Is the area(s) of Negativity Medicare dependent?
- What is the five year trend for the negatively impacted departments….revenues, expenses, etc.
- Is the negativity related to quality concerns?
- Are we hearing anything from the Community?

Worksheet C Cost to Charges

KPMG LLP Compu-Max 2552-10

NORTHERN INYO HOSPITAL Provider CCN: 05-1324	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 09:36 Version: 2017.01 (09/14/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,380,018		7,380,018				30
31	Intensive Care Unit	1,354,991		1,354,991				31
43	Nursery	420,048		420,048				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,739,912	9,740,167	14,480,079	0.646454			50
52	Delivery Room & Labor Room	514,059	279,861	793,920	1.678043			52
53	Anesthesiology	1,490,150	2,629,387	4,119,537	0.075461			53
54	Radiology-Diagnostic	2,324,287	20,194,774	22,519,061	0.248725			54
56	Radioisotope	29,885	1,123,081	1,152,966	0.511679			56
60	Laboratory	3,625,575	12,584,781	16,210,356	0.411764			60
62	Whole Blood & Packed Red Blood Cells	37,949	33,241	71,190	1.502809			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,765,185	687,440	3,452,625	0.540363			65
66	Physical Therapy	548,150	2,139,243	2,687,393	0.799357			66
69	Electrocardiology	428,115	2,341,195	2,769,310	0.305554			69
71	Medical Supplies Charged to Patients	583,948	754,827	1,338,775	0.377771			71
72	Impl. Dev. Charged to Patients	2,495,790	997,058	3,492,848	0.642591			72
73	Drugs Charged to Patients	7,618,818	11,605,364	19,224,182	0.246916			73
76	PATHOLOGY	66,831	391,730	458,561	1.080018			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		6,575,467	6,575,467				88
90	Clinic	4,293	1,281,883	1,286,176	0.485370			90
91	Emergency	422,186	7,434,531	7,856,717	0.873933			91
92	Observation Beds (Non-Distinct Part)	314,398	1,478,728	1,793,126	0.872991			92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	37,164,588	82,272,758	119,437,346				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	37,164,588	82,272,758	119,437,346				202

District Philosophy

- Where do we define Mission critical? ER, OB, ICU, Inpatient, Surgery, Imaging, Clinics?
- How do we address current availability versus new paradigm availability?
- What is our position on build (local employment) versus buy (outsource with potential less local employment)
- How much subsidy is too much subsidy (profit/loss)
  - Limited volumes and ability to continue an effective service
  - Human resource intensive operations/services
  - Capital intensive operations/services
  - Services with local competitors

District Philosophy

- Reductions in Revenues = Reduction in Expenses
- Not all Cost Centers are the Same for Allowable Expenses (Medicare impact of Expense Reductions)
- Functions whose Revenues do not meet Expenses
  - Non – Critical Services
  - Use of Space….reduced occupancy….space retirement
- Hours of Operations Reductions
  - Part time FTEs versus fewer FTEs
- Functionality versus Modern Appearance
- Provide versus Partner in the Community

Potential Responses

- Elimination of Nice to Provide Services/Roles
- General Voluntary Reduction of Worked Time
- Department Specific Voluntary Reduction of Worked Time (Goals Based)
- Reduction/delay in Capital purchases
- Freeze in pay/increases
- Reduction in Hours of Operations
- General Staff FTE Reduction
- Outsource to cheaper option
- Reduction in Employee Benefits
- Reduction in pay (Temporary of Permanent)

Today's District Plan

- Grow Volumes to avoid financial issues and meet our Vision
- Strive to increase efficiency and reduce per unit costs (per adjusted patient day)
- Use every contract renewal as an opportunity to reduce costs or raise net revenues
- Ask ourselves why we do things and should we be a) doing them or b) doing them in a different manner
- Regularly question processes and practices which have as part of the answer; "we've always done it that way"
- Communicate volumes throughout the organization
- Identify Margin Opportunities and Implement
- Improve the use of Today's available technology/resources to improve our customer's experiences

District Plan – Short Term Negative Event

District Plan – Long Term Negative Event

CALL TO ORDER	The meeting was called to order at 10:00 am by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
ABSENT	Richard Meredick MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced at this time persons in 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. No comments were heard.
BUDGET AND FINANCIAL STRATEGY WORKSHOP	Chief Financial Officer John Tremble presented a budget and financial strategy workshop for the Board of Directors and the Northern Inyo Healthcare District (NIHD) Executive Team, with the intent of strategizing for the future in order to help strengthen the District's financial performance going forward. Mr. Tremble's presentation included information on the following: - Review of information provided in the first (October 13, 2017) financial strategy workshop - Overview of District Payor Trends and Payment Methods - District Expenditures and Trends - Debt and Capital Review - Overview of operations and other challenges Chief Executive Officer Kevin S. Flanigan MD, MBA stated that a 3rd financial strategy workshop will be scheduled in the month of December, and the focus of that workshop will be to develop "what if" plans to implement in the event that the District's financial performance is poor. The "what ifs" will address either cutting District costs and reducing expenses; or developing additional revenue-generating services.
ADJOURNMENT	The meeting was adjourned at 11:34 pm.

_____ _____

Peter Watercott, President Attest: M.C. Hubbard, Secretary

CALL TO ORDER

The meeting was called to order at 5:30 pm by Peter Watercott, President.

PRESENT

Peter Watercott, President
John Ungersma MD, Vice President
M.C. Hubbard, Secretary
Mary Mae Kilpatrick, Treasurer
Richard Meredick MD, Chief of Staff
Kevin S. Flanigan, MD, MBA, Chief Executive Officer
Kelli Huntsinger, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Evelyn Campos Diaz, Chief Human Resources Officer
Sandy Blumberg, Executive Assistant

OPPORTUNITY FOR PUBLIC COMMENT

Mr. Watercott announced at this time persons in the audience may speak on any items not on the agenda for this meeting on any matters within the jurisdiction of the District Board (members of the audience will have an opportunity to address the Board on every item on the agenda), and speakers will be limited to a maximum of three minutes each. Comments were heard from Ms. Jane Thompson, Northern Inyo Healthcare District (NIHD) Board candidate for District Zone 2.

NEW BUSINESS

WIPFLI LLP ANNUAL AUDIT REPORT FOR FISCAL YEAR 2016/2017

Chief Executive Officer (CEO) Kevin S. Flanigan, MD, MBA introduced Jeff Johnson with Wipfli LLP to present NIHD's annual audit for the 2016/2017 fiscal year. Mr. Johnson's report included the following:

- Review of schedule of sources and uses of District revenues
- Review of Audited Financial Statements
- Review of net Pension Liability Changes of Assumptions (plan currently funded at 46 percent)
- Financial analysis of annual performance
- Healthcare Industry update including trends, issues, and legislation
- Review of Key Financial Indicators
- Report of a bottom line loss for the year of $536,404

Following review of the information provided it was moved by M.C. Hubbard, seconded by John Ungersma MD, and unanimously passed to approve Wipfli LLP's annual audit for the fiscal year ending June 30 2017 as presented.

POLICY AND PROCEDURE APPROVALS

Doctor Flanigan called attention to approval of the following District wide Policies and Procedures:

- *Sanctions for Breach of Patient Privacy*
- *Sending Protected Health Information by Fax*
- *Disclosures of PHI over the Telephone*
- *Patient's rights*
- *Employee Recognition*
- *Inyo Mono Advocates for Community Action*

- *Nursing Services Jobs and Titles*

It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve all seven District wide policies and procedures as presented.

NURSING COMMITTEE CHARTER APPROVALS

Chief Nursing Officer Tracy Aspel, RN called attention to proposed Nursing Committee Charters for the following:

- *Clinical Consistency Oversight Committee*
- *Professional Practice Council*
- *Safe Patient Handling Subcommittee*
- *Staffing Issues Advisory Committee*

It was moved by Mary Mae Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve all four Nursing Committee Charters as presented.

HOSPITAL WIDE PILLARS OF EXCELLENCE

Chief Operating Officer Kelli Huntsinger called attention to Hospital-Wide Pillars of Excellence for the year-to-date, which included data on District patient satisfaction scores; quality measures; employee turnover; OSHA recordable incident rates; and financial quality pillars. Ms. Huntsinger noted the District has set high performance excellence goals and is making progress in many key areas.

BOARD CANDIDATE INTERVIEW COMMITTEE

Mr. Watercott announced that the District has received three letters of interest in the Board vacancy for District Zone 2, and an Ad Hoc Committee of two existing Board members will be formed to conduct interviews then make a selection recommendation to the full Board. It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to establish an Ad Hoc Committee of directors Kilpatrick and Ungersma to interview potential Board candidates for District Zone 2.

SCHOOL CLINIC UPDATE

Doctor Flanigan reported it is hoped that the Bishop Union High School (BUHS) Student Health Clinic will open soon, and at this time NIHD and BUHS administration is working together to determine the most favorable way to establish the Clinic as a legal entity.

COMPOUNDING PHARMACY UPDATE

Dr. Flanigan additionally reported that NIHD has received a waiver from the California Board of Pharmacy to continue compounding pharmacy operations until such time as improvements can be made to the compounding room to bring it into compliance with new regulations.

CONSENT AGENDA

Mr. Watercott called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the October 2, 2017 special meeting
- Approval of minutes of the October 18 2017 regular meeting
- Financial and statistical reports as of September 30, 2017
- 2013 CMS Validation Survey Monitoring, November 2017

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve all 4 Consent Agenda items as presented.

PATIENT EXPERIENCE COMMITTEE REPORT

Chief Nursing Officer Tracy Aspel, RN provided a bi-monthly report on work accomplished by the District's Patient Experience Committee, including a review of improvements made to District phone tree systems, and notification of upcoming customer service trainings for District staff.

WORKFORCE EXPERIENCE COMMITTEE REPORT

Chief Human Relations Officer Evelyn Campos Diaz provided a bi-monthly report on progress made by the Workforce Experience Committee in the following areas:

- Employee engagement survey results and monitoring
- Introduction of District employee empowerment tools (including employee recognition efforts)
- Leadership development trainings and mentoring programs for emerging NIHD leaders
- Development of additional HR tools for District employees
- Efforts to encourage employee work-life balance

CHIEF OF STAFF REPORT

POLICIES, PROCEDURES, PROTOCOLS, ORDER SETS

Chief of Staff Richard Meredick MD reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following policies, procedures, protocols, and order sets:

- *Universal Protocol*
- *Airway Management*
- *Child Abuse and Neglect*
- *Admission, Discharge, Transfer of Patients: Continuum of Care*
- *Nursing Care of Outpatient Interventional Radiology Patient*
- *Contrast Use with Patients on Metformin*
- *Order Set Approval and Archiving*
- *Cosyntropin Stimulation Test*
- *Nursing Services Standing Committee Structure and Hospital Committee Participation*
- *EMTALA*
- *Medical Screening Examination of the Obstetrical Patient*
- *Blood Bank – Emergency Requests for Blood Components*
- *Medication Dosing in Renal Failure*

It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve all 13 policies, procedures, protocols, and order sets as presented.

CORE PRIVILEGE FORM

Doctor Meredick also called attention to a proposed Core Privileging Form for Obstetrics and Gynecology. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the Obstetrics and Gynecology Core Privileging Form as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGES

Doctor Meredick additionally reported following careful review and consideration by the appropriate Committees, the Medical Executive Committee recommends approval of the following Medical Staff Appointments and Privileges:

- William I. Feske, MD (*Radiology – Provisional Active Staff*) – Dr.

Feske was approved for a 90-day introductory period under temporary privileges in August 2017. The Bishop Radiology Group will continue to work with Dr. Feske. Dr. Feske is being recommended for provisional active staff membership.

- Irin Pansawira, OD (*UC Berkeley Optometry – telemedicine staff*)(credentialing by proxy per bylaws section 3.6.1).

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve both Medical Staff appointments and privileges as requested.

TEMPORARY LOCUMS TENENS PRIVILEGES

Doctor Meredick also informed the Board that Temporary Locum Tenens Privileges have been granted to Zunaira Islam MD (*Hospitalist*), and that Doctor Islam underwent the expedited approval and credentialing process as designated in the Medical Staff Bylaws to meet an urgent patient care need for a maximum of 60 days in the 2017-2018 calendar year (start date: 11/3/17).

BOARD MEMBER REPORTS

Mr. Watercott asked if any members of the Board of Directors wished to comment on any items of interest. Director Kilpatrick reported that the 2nd Annual NIHD Foundation Employee and Physician recognition event was a tremendous success, and Mr. Watercott also noted that the NIHD Foundation is still seeking additional persons interested in serving as Board members. Director Hubbard reported that the Association of California Healthcare Districts (ACHD) has valuable educational webinars available (free of charge), which can be accessed via the ACHD website.

ADJOURNMENT TO CLOSED SESSION

At 7:16 pm Mr. Watercott announced the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
C. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:20 pm the meeting returned to open session. Mr. Watercott reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 8:21 pm.

Peter Watercott, President Attest: M.C. Hubbard, Secretary

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Compliance Report
December 2017

1. Breaches
    a. Calendar Year (CY) 2017 (through 11/27/2017)
        i. 58 alleged breaches of PHI (Personal Health Information) potentially affecting at least 99 patients have been investigated by the Compliance Office
        ii. 26 alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. 3 cases were unsubstantiated;
            2. 6 cases were substantiated, but no deficiency was assigned;
            3. 6 have had deficiencies assigned. When a deficiency is assigned, civil monetary penalties may be assessed.
            4. 11 case is still pending CDPH investigation.
2. Issues and Inquiries – (through 11/27/2017)
    a. CY 2017 – More than 300 requests for research and input on a wide variety of topics have been made to the Compliance Department
3. Conflicts of Interest questionnaires
        i. 100% of Conflict of Interest questionnaires provided to employees have been completed and returned to the Compliance Department.
        ii. 100% of questionnaires have been reviewed by the Compliance Department and, as necessary, by the Business Compliance Team.
4. The Compliance and Business Ethics Committee will have its first meeting on 11/30/2017.
5. 2017 HIPAA risk assessment is underway. This mandatory annual risk assessment is a collaborative effort between the Compliance and Information Technology Departments.
6. A comprehensive report will be completed for calendar year 2017 by the February Board meeting.

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending October 31, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	951,880	804,423	147,457	3,653,184	3,191,740	461,444
Ancillary	2,944,515	2,790,390	154,125	11,441,344	11,071,551	369,793
Total Inpatient Service Revenue	3,896,395	3,594,813	301,582	15,094,528	14,263,291	831,237
Outpatient Service	9,248,991	8,119,362	1,129,629	34,326,915	32,215,524	2,111,391
Gross Patient Service Revenue	**13,145,386**	**11,714,175**	**1,431,211**	**49,421,443**	**46,478,815**	**2,942,628**
Less Deductions from Revenue						
Patient Service Revenue Deductions	90,858	234,723	(143,865)	569,914	931,322	(361,408)
Contractual Adjustments	5,505,300	4,493,004	1,012,296	20,415,458	17,827,080	2,588,378
Prior Period Adjustments	(10,460)	(13,400)	2,940	(701,068)	(53,167)	(647,901)
Total Deductions from Patient Service Revenue	**5,585,698**	**4,714,327**	**871,371**	**20,284,303**	**18,705,235**	**1,579,068**
Net Patient Service Revenue	**7,559,688**	**6,999,848**	**559,840**	**29,137,140**	**27,773,580**	**1,363,560**
Other revenue	60,184	76,819	(16,635)	205,164	304,799	(99,635)
Total Other Revenue	**60,184**	**76,819**	**(16,635)**	**205,164**	**304,799**	**(99,635)**
Expenses:						
Salaries and Wages	2,104,311	2,328,739	(224,428)	8,605,308	9,239,835	(634,527)
Employee Benefits	1,645,956	1,589,908	56,048	6,084,340	6,308,343	(224,003)
Professional Fees	1,116,305	724,509	391,796	4,124,176	2,874,669	1,249,507
Supplies	758,472	648,488	109,984	2,910,184	2,573,031	337,153
Purchased Services	351,460	360,086	(8,626)	1,133,724	1,428,728	(295,004)
Depreciation	409,460	443,023	(33,563)	1,632,311	1,757,800	(125,489)
Bad Debts	279,897	242,784	37,113	989,869	963,304	26,565
Other Expense	397,987	352,700	45,287	1,608,485	1,399,427	209,058
Total Expenses	**7,063,849**	**6,690,237**	**373,612**	**27,088,397**	**26,545,137**	**543,260**
Operating Income (Loss)	**556,024**	**386,430**	**169,594**	**2,253,907**	**1,533,242**	**720,665**
Other Income:						
District Tax Receipts	43,955	49,096	(5,141)	175,820	194,801	(18,981)
Tax Revenue for Debt	128,647	165,487	(36,840)	514,587	656,609	(142,022)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	-	42,466	(42,466)	36,035	168,494	(132,459)
Interest Income	43,698	16,845	26,853	125,837	66,837	59,000
Interest Expense	(243,845)	(260,547)	16,702	(976,084)	(1,033,783)	57,699
Other Non-Operating Income	5,904	2,422	3,482	19,921	9,610	10,311
Net Medical Office	(355,079)	(396,696)	41,617	(1,389,527)	(1,573,989)	184,462
340B Net Activity	-	16,987	(16,987)	932	67,400	(66,468)
Non-Operating Income/Loss	**(376,720)**	**(363,940)**	**(12,780)**	**(1,492,479)**	**(1,444,021)**	**(48,458)**
Net Income/Loss	**179,304**	**22,490**	**156,814**	**761,428**	**89,221**	**672,207**

Northern Inyo Healthcare District

Preliminary Financial Indicators as of October 31, 2017

	Target	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16
Current Ratio	>1.5-2.0	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45	3.53	3.69	2.85	2.95
Quick Ratio	>1.33-1.5	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90	2.93	2.92	2.46	2.41
Days Cash on Hand prior method	>75	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10	151.40	140.37	160.86	145.43
Days Cash on Hand Short Term	>75	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99	71.85	62.90	85.97	67.02
Debt Service Coverage	>1.5-2.0	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23	2.17	2.13	2.46	2.30
Operating Margin		7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83	6.30	5.59	7.48	6.43
Outpatient Revenue % of Total		69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11	69.10	69.28	68.11	67.48
Cash flow (CF) margin (EBIDA to revenue)		4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27	3.94	3.71	5.43	4.53
Days in Patient Accounts Receivable	<60 Days	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10	76.70	80.80	77.70	75.60	75.00

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivlable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income /(Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Oct-17 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending October 31, 2017

	-40	or	-3%	less IP days than in the prior fiscal year
$	831,237	or	5.83%	over budget in Total IP Revenue and
$	2,111,391	or	6.6%	over budget in OP Revenue resulting in
$	2,942,628	or	6.3%	over budget in gross patient revenue &
$	1,363,560	or	4.9%	over budget in net patient revenue

Year-to-date Net Revenue was			$	29,137,140
Total Operating Expenses were:			$	27,088,397
				for the fiscal Year To Date
$	543,260	or	2.0%	over budget. Salaries and Wages were
$	(634,527)	or	-6.9%	under budget and Employee Benefits
$	(224,003)	or	-3.6%	under budget
			71%	Employee Benefits Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$	1,249,507	or	43.5%	Professional Fees are over budget due to contract labor budgeted as employees
$	209,058	or	14.9%	Other Expenses are over budget due to timing difference on Annual Directors & Officers Liability

Other Information:

$	2,253,907			Operating Income, less
$	(1,492,479)			loss in non-operating activities resulted in a Net
$	761,428	$	672,207	over budget.
			41.04%	Contractual Percentages for Year and
			40.24%	Budgeted Contractual Percentages including

$	701,068	in prior year cost report favorable settlement activity for Medicare & Medi-Cal

Non-Operating activities included:

$	(1,389,527)	loss	$	184,462	favorable to budget in Medical Office Activities
$	36,035		$	(132,459)	unfavorable to budget in Grants and Other

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending October 31, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	8,608,982	2,415,236	6,193,746
Short-Term Investments	9,291,018	9,350,190	(59,172)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	62,414,744	61,287,972	1,126,772
Less: Allowances	(46,595,223)	(44,860,333)	(1,734,890)
Other Receivables	2,306,911	4,269,253	(1,962,342)
Inventories	4,030,899	4,001,771	29,128
Prepaid Expenses	1,593,840	1,739,941	(146,101)
Total Current Assets	**42,745,199**	**39,298,058**	**3,447,141**
Internally Designated for Capital Acquisitions	1,125,180	1,125,132	49
Special Purpose Assets	453,491	1,049,858	(596,367)
Limited Use Asset; Defined Contribution Pension	819,815	729,521	90,294
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	7,119	3,820	3,299
Revenue Bonds Held by a Trustee	3,363,754	3,202,755	161,000
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,134,744**	**19,476,470**	**(341,726)**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	78,576,296	78,839,213	(262,918)
Unamortized Bond Costs	-	-	-
Total Assets	**142,206,239**	**139,363,742**	**2,842,497**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending October 31, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	1,946,222	1,951,402	(5,180)
Accounts Payable	2,417,128	2,013,078	404,050
Accrued Salaries, Wages & Benefits	5,459,493	5,259,714	199,779
Accrued Interest and Sales Tax	681,605	549,965	131,640
Deferred Income	2,712,404	473,024	2,239,380
Due to 3rd Party Payors	1,203,233	1,020,233	183,000
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	4,513,935	4,510,636	3,299
Total Current Liabilities	**18,934,018**	**15,778,051**	**3,155,967**
Long Term Debt, Net of Current Maturities	43,931,947	43,931,947	-
Bond Premium	592,467	599,714	(7,247)
Accreted Interest	11,309,289	11,198,740	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**86,321,235**	**86,217,933**	**103,302**
Net Assets			
Unrestricted Net Assets less Income	36,497,496	36,317,900	179,596
Temporarily Restricted	453,491	1,049,858	(596,367)
Net Income (Income Clearing)	(761,432)	(582,123)	(179,309)
Total Net Assets	**36,950,986**	**37,367,758**	**(416,771)**
Total Liabilities and Net Assets	**142,206,239**	**139,363,742**	**2,842,497**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending October 31, 2017

		FYE 2018	FYE 2017		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	331	1,236	1,276	(40)	-3%
Total Patient Days without NB	295	1,113	1,150	(37)	-3%
Swing Bed Days	49	120	200	(80)	-40%
Discharges without NB	84	358	375	(17)	-5%
Swing Discharges	7	15	28	(13)	-46%
Days in Month	31	31	31		
Occupancy without NB	9.52	35.90	37.10	(1.2)	-3%
Average Stay (days) without NB	3.51	3.11	3.07	0.0	1%
Average LOS without NB/Swing	3.19	2.90	2.74	0.2	6%
Hours of Observation	574	4,218	2,892	1,326	46%
Observation Adj Days	24	176	121	55	46%
ER Visits All Visits	775	3,598	3,392	206	6%
RHC Visits	2,342	11,600	8,018	3,582	45%
Outpatient Visits	4,274	15,791	13,794	1,997	14%
IP Surgeries	20	94	101	(7)	-7%
OP Surgery	106	417	373	44	12%
Worked FTE's	341.97	343.58	322.79	21	6%
Paid FTE's	381.47	391.04	358.99	32	9%
Hours Worked to Hours Paid%	89.6%	87.9%	89.9%	-2.1%	-2%
Payor %					
Medicare		42%	41%	1%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		36%	33%	3%	
Indigent (Charity Care)		0.6%	1.2%	-0.5%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of October 31, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	31-Oct-17	01-Nov-17	Local Agency Investment Fund	Northern Inyo Hospital	1.14%		9,041,017.88
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			9,291,017.88
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				Long Term Investments		$	1,750,000.00
				Total Investments		$	11,041,017.88
1	10/31/2017	11/1/2017	LAIF Defined Cont Plan	Northern Inyo Hospital	1.14%	$	819,815.11
				LAIF PENSION INVESTMENTS		$	819,815.11

NORTHERN INYO HEALTHCARE DISTRICT

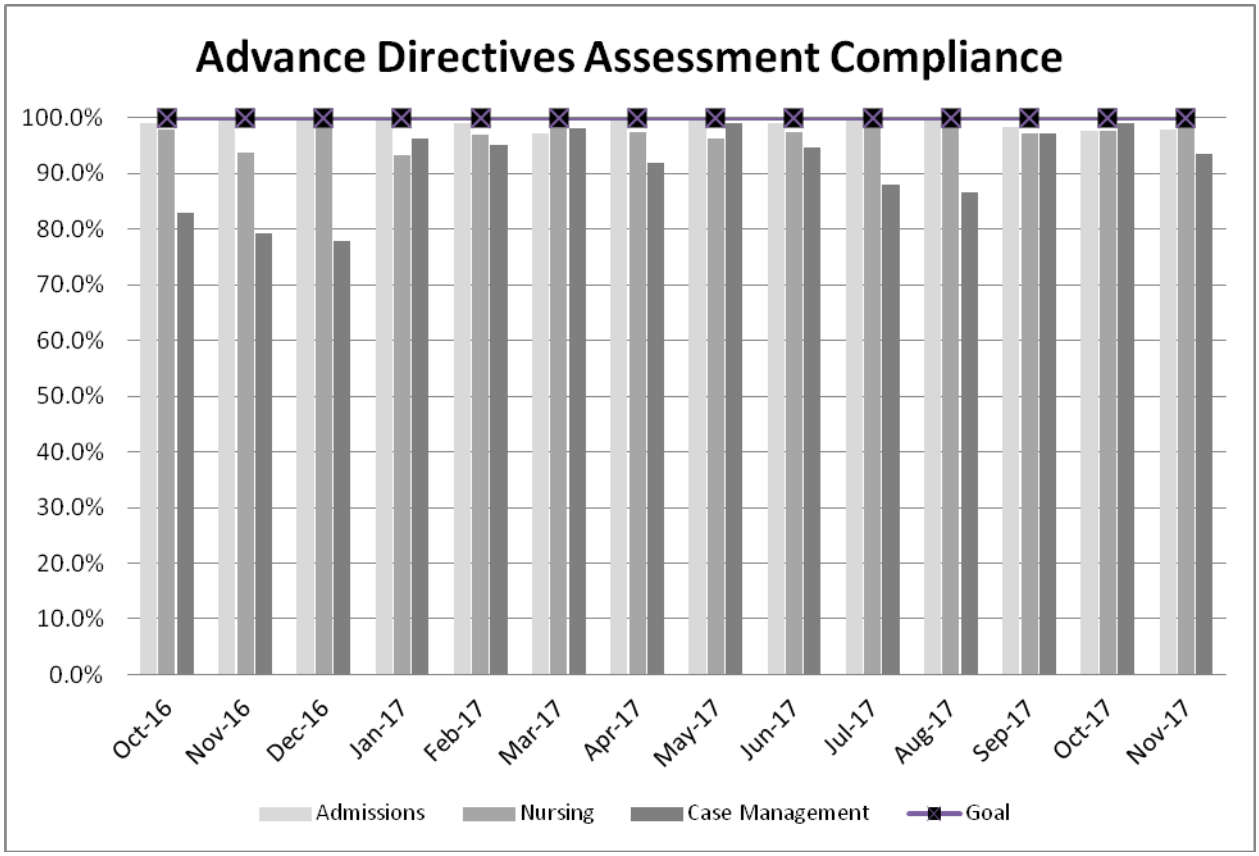
Restricted and Specific Purpose Fund Balances
for period ending October 31, 2017

	Current Month	Prior Month	Change
Board Designated Funds:	October		
Tobacco Fund Savings Account	$ 1,098,455	$ 1,098,406	49
Equipment Fund Savings Account	$ 26,725	$ 26,725	-
Total Board Designated Funds:	**$ 1,125,180**	**$ 1,125,131**	**$ 49**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 320,336	$ 916,704	$ (596,368)
Nursing Scholarship Savings Account	$ 33,038	$ 33,038	$ -
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,041	$ 100,041	$ -
Total Specific Purpose Funds:	**$ 453,491**	**$ 1,049,859**	**$ (596,368)**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,578,671**	**$ 2,174,989**	**$ (596,319)**

2013 CMS Validation Survey Monitoring-December 2017

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

    a. Advance Directives Monitoring.

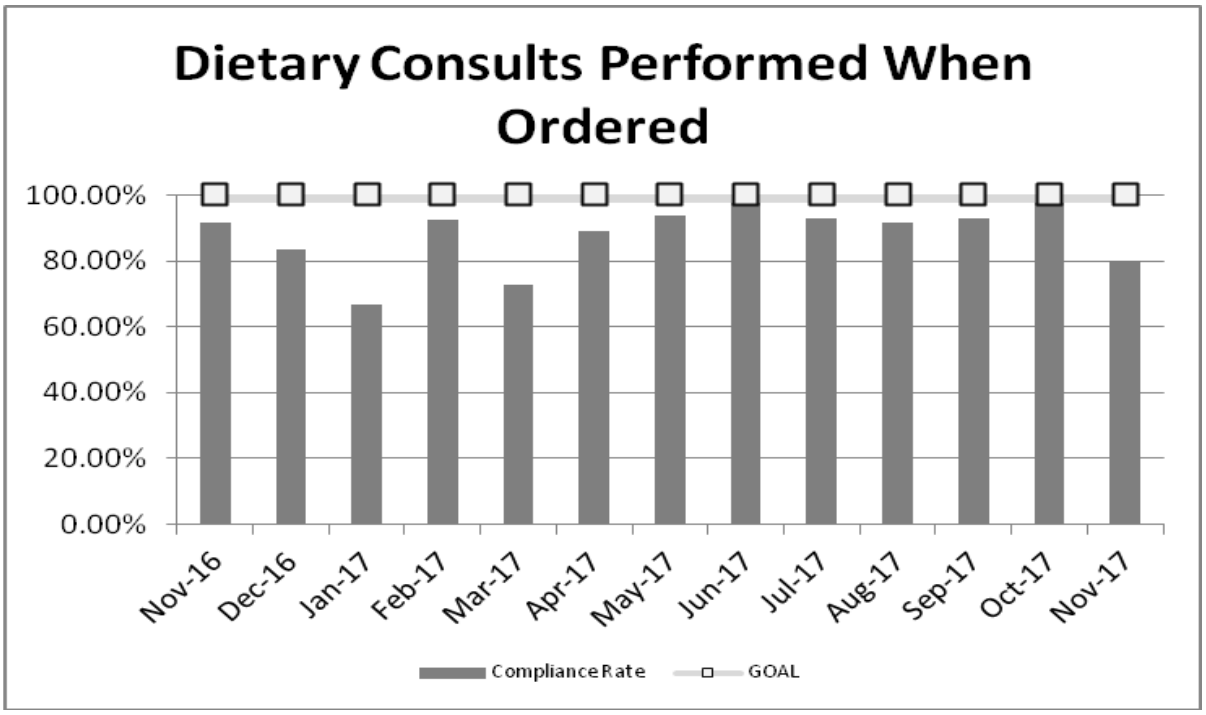


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

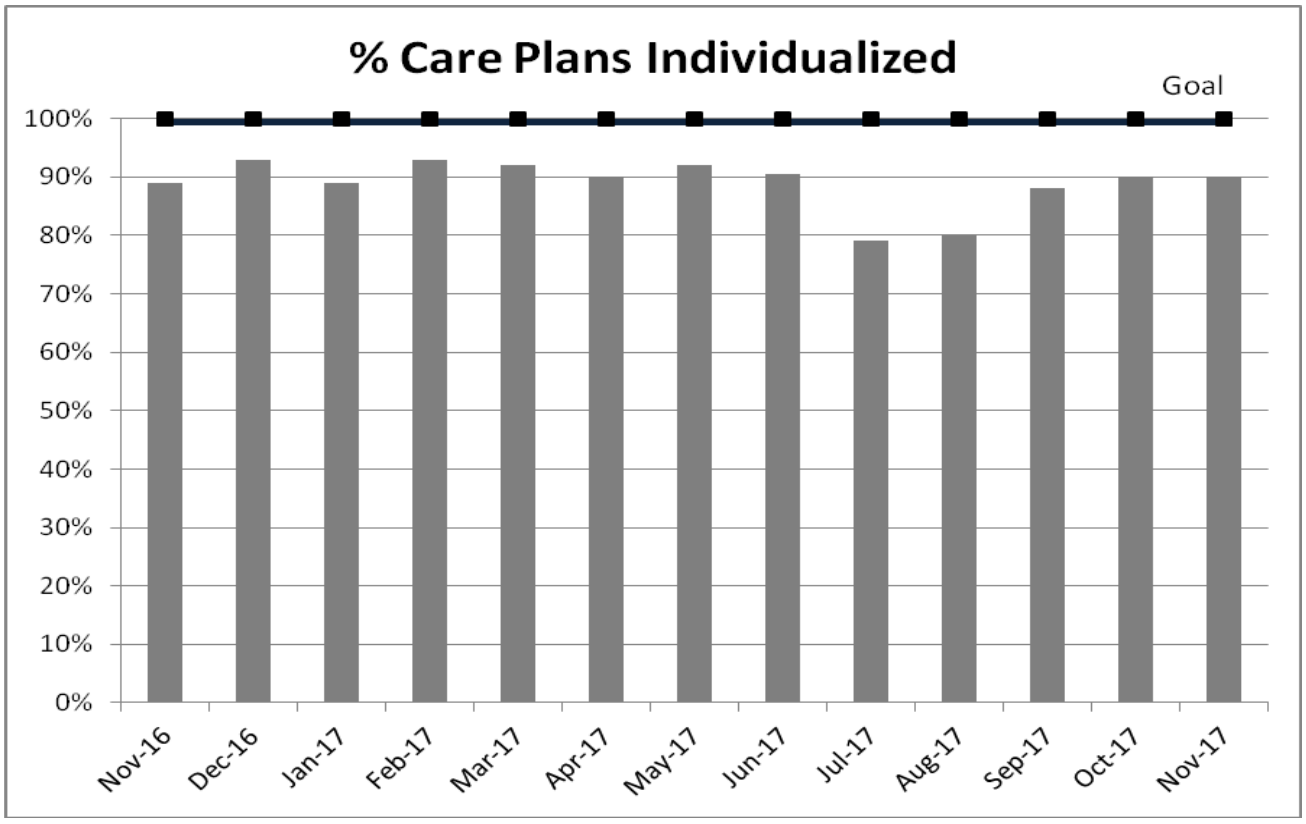
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.



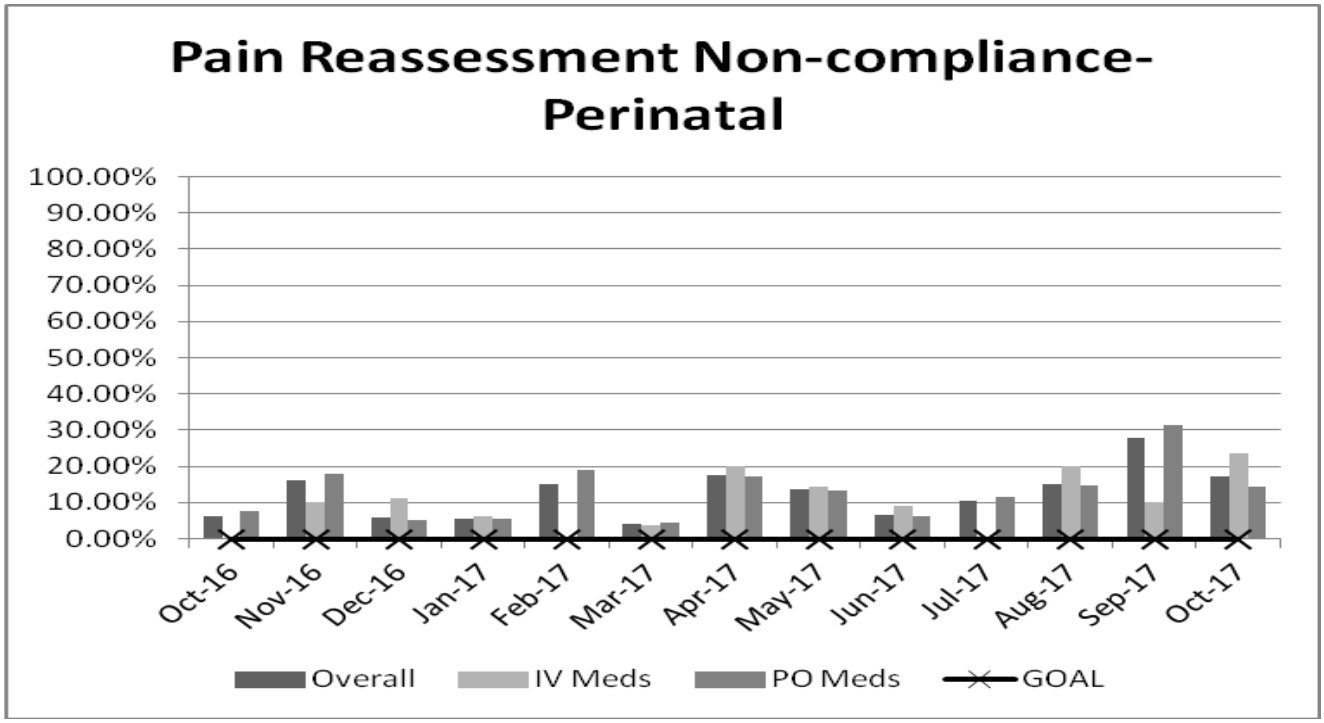
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

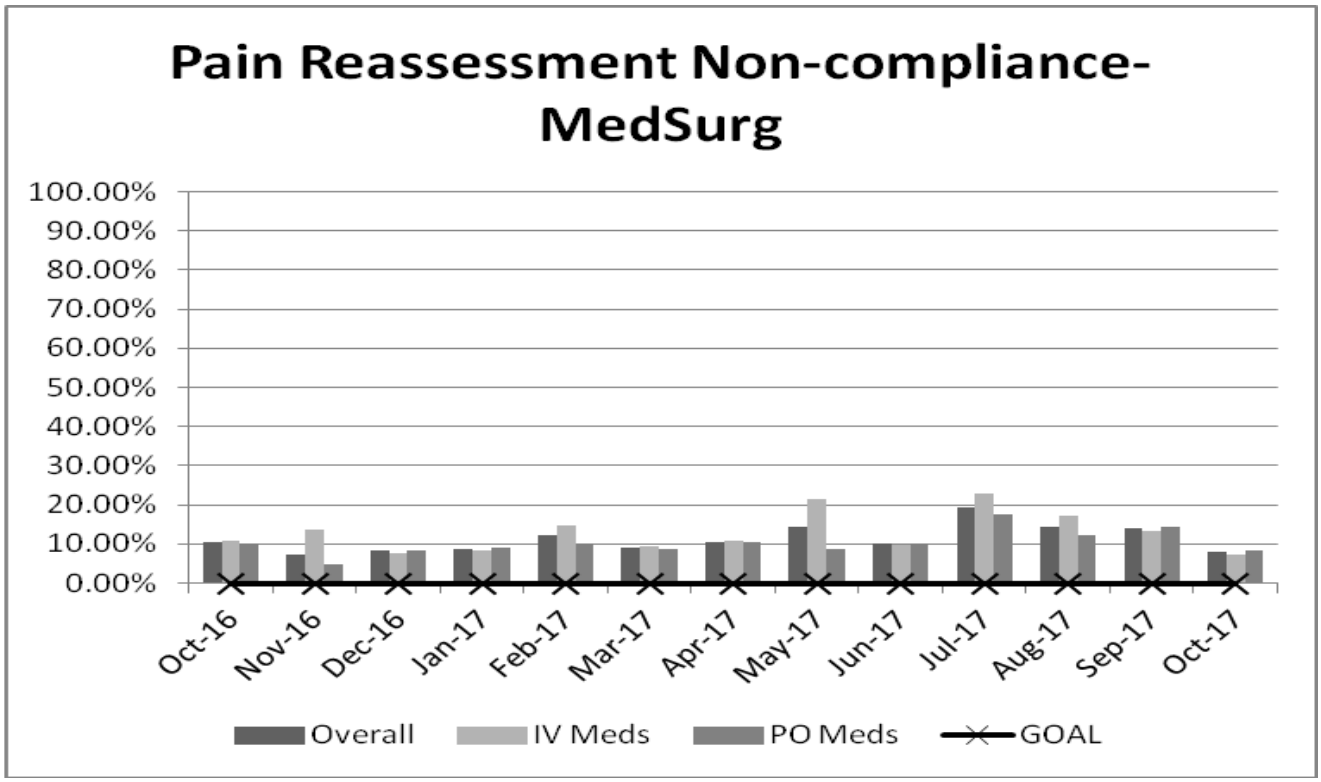


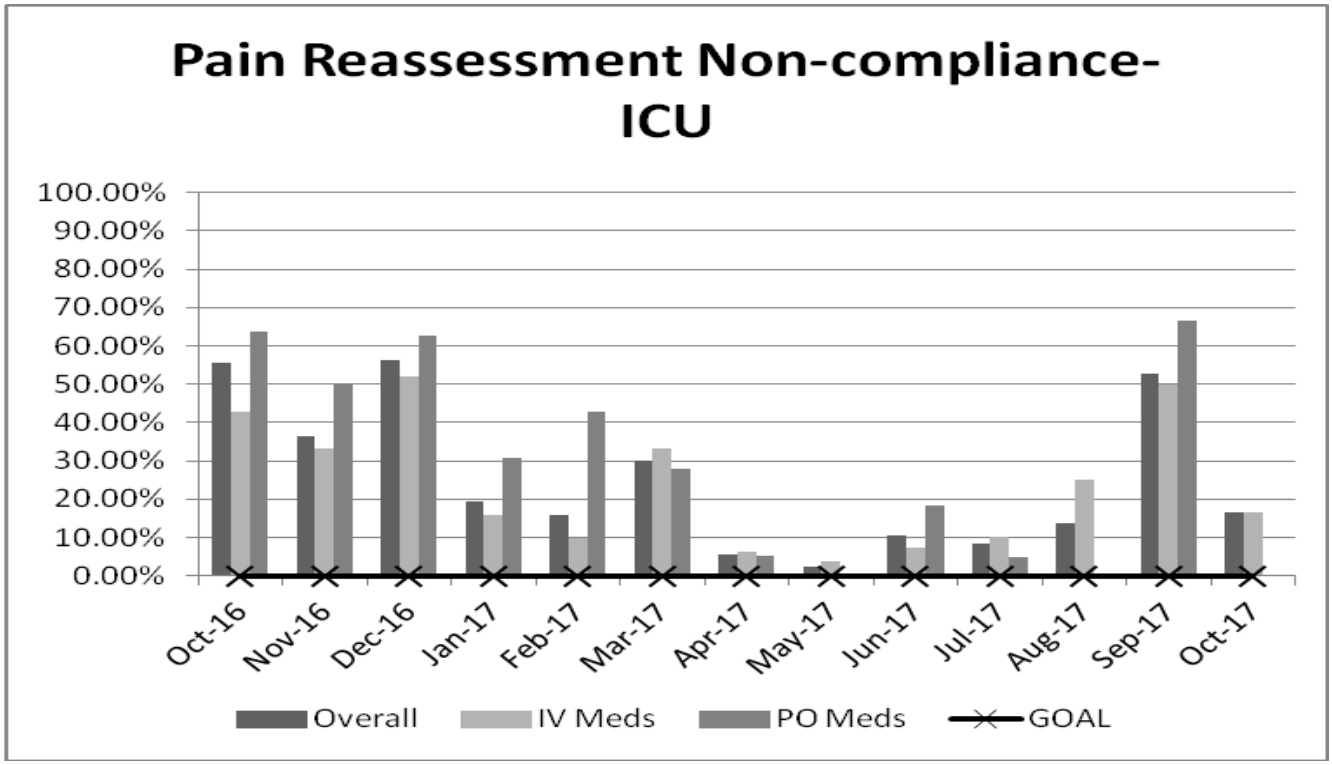
2

g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.

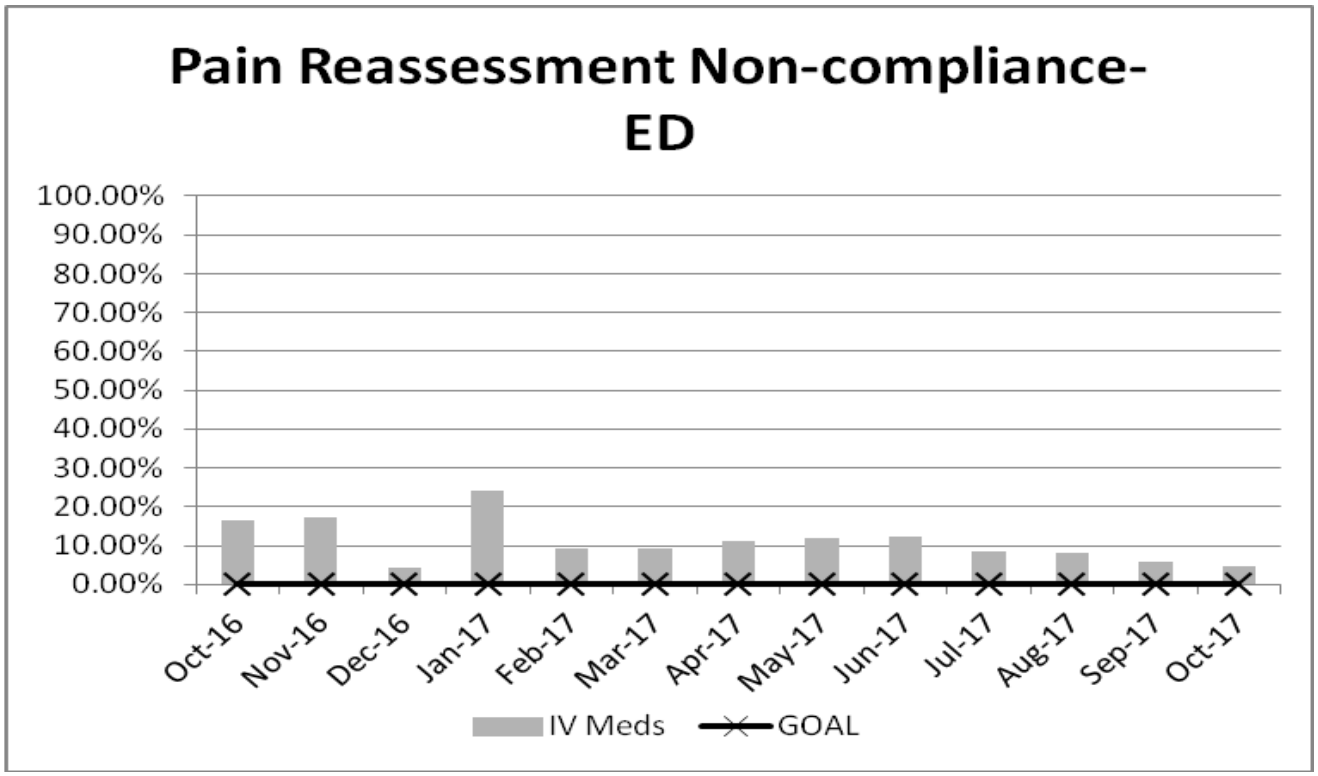


Table 6. Restraint chart monitoring for legal orders.

	April 2017*	***May 2017***	***June 2017***	***July 2017***	***Aug 2017***	***Sept 2017***	***Oct 2017***	***Nov 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints		2/2 (100%)	2/2 (100%)	3/3 (100%)	3/3 (100%)	2/2 (100%)	3/3 (100%)	1/1 (100%)	100%
Physician signed order within 24 hours		2/2 (100%)	2/2 (100%)	3/3 (100%)	2/3 (66%)	1/2 (50%)	2/3 (66%)	1/1 (100%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)		2/2 (100%)	1/2 (50%)	3/3 (100%)	1/3 (33%)	0/2 (0%)	2/3 (66%)	1/1 (100%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)		0/1 (0%)	3/3 (100%)	2/5 (40%)	2/8 (25%)	0/2 (0%)	1/2 (50%)	N/A	100%
Orders are for 24 hours		3/3 (100%)	5/5 (100%)	8/8 (100%)	11/11 (100%)	4/4 (100%)	5/5 (100%)	1/1 (100%)	100%
Is this a PRN (as needed) Order		0/3 (0%)	0/5 (0%)	0/8 (0%)	0/11 (0%)	0/4 (0%)	0/5 (0%)	0/1 (0%)	0%

*No restraint orders for this time interval

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

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: December 5, 2017
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. Policy/Procedure/Protocols/Order Sets (*action items*)

1. *Advanced Directives*
2. *Assisted Living Facilities*
3. *California Children Services Referral*
4. *Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge*
5. *Designated Areas for Food and Drink in Patient Care Areas*
6. *DI – Handling of Radioactive Packages, Non-nuclear Medicine Personnel*
7. *DI – Radioactive Material Hot Lab Security*
8. *DI – Radioactive Materials Delivery After-hours Policy/Procedure*
9. *DI – Radioactive Waste Storage and Disposal*
10. *ED Triage Protocol Policy*
11. *Environmental Disinfectant-Cleaning Solution*
12. *Handling of Soiled Linen*
13. *Home Health Care*
14. *Hospice Care*
15. *Hospi-Gard Portable Filtration Unit (H.G.U.)*
16. *Infection Control: Handwashing for Safe Food Handling*
17. *Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu*
18. *Long Term Acute Care Hospital*
19. *Meals on Wheels*
20. *Nursing Services Standing Committee Structure and Hospital Committee Participation*
21. *Ombudsman*

22. *Sharps Injury Protection Plan (supersedes: Handling and Disposal of Contaminated Needles/Syringes)*
23. *Working with Other Agencies in the Community*

B. Medical Staff Appointment/Privileges (*action items*)

1. Brian Mikolasko, MD (hospitalist) – provisional active staff
2. Truong Quach, MD (hospitalist) – provisional active staff
3. Amikjit Reen, MD (hospitalist) – provisional active staff
4. Wilbur Peralta, MD (hospitalist) – provisional active staff

C. Temporary Locum Tenens Privileges (*action items*)

1. H. Charlie Wolf, MD (emergency medicine) – for 60 days in the 2018 calendar year effective January 1, 2018. Dr. Wolf will be providing coverage for the Eastern Sierra Emergency Physicians on a locum tenens basis.
2. Tien H. Cheng, MD (radiology) – for 60 days effective December 11, 2017. Dr. Cheng will be providing coverage for the Bishop Radiology Group on a locum tenens basis.

D. Advancements (*action items*)

1. Sarah Zuger, MD (family medicine) – advancement from provisional active staff to active staff
2. Cecilia Rhodus, MD (pediatrics) – advancement from provisional active staff to active staff

E. Medical Staff/Allied Health Professional Reappointments 2018-2019 (*action items*)

Forty applicants submitted for renewal of privileges for the 2018-2019 calendar years. All applicants underwent a recredentialing process consisting of the following:

- *Verification of current unrestricted licensure, certifications, and registrations;*
- *Queries to the AMA, the NPDB, and the OIG exclusion database;*
- *Investigation of any professional liability cases;*
- *Verification of compliance with CME requirements;*
- *Evaluation of evidence indicating current competence and training related to the privileges requested;*
- *Review of the applicant's performance and standing at NIHD and outside affiliations;*
- *Review of available Ongoing and Focused Professional Practice Evaluation data (OPPE and FPPE), which includes peer review data and evaluation of the six ACGME core competencies.*

1. After careful review and consideration of the applicant reappointment profiles, the Medical Executive Committee recommends the following applicants for reappointment to the Medical Staff/Allied Health Professional Staff in the category listed effective January 1, 2018, for a period not to exceed two years:

	Name	Title	Category	Specialty
1.	Anderson, Ivan	MD	Telemedicine	Cardiology
2.	Black, Helena L	MD	Active	Emergency Medicine
3.	Brown, Stacey L	MD	Active	Family Medicine
4.	Bryce, Thomas	MD	Telemedicine	Radiology
5.	Chan, Brandon	MD	Telemedicine	Radiology
6.	Dillon, Michael L	MD	Active	Emergency Medicine
7.	Farooki, Aamer	MD	Telemedicine	Radiology
8.	Ganchan, Richard	MD	Telemedicine	Cardiology
9.	Harness, Jay K	MD	Active	Surgery
10.	Hathaway, Nickoline M	MD	Active	Internal Medicine
11.	Hewchuck, Andrew D	DPM	Active – LLP	Podiatry
12.	Kamei, Asao	MD	Active	Internal Medicine
13.	Kim, Martha	MD	Active	Obstetrics & Gynecology
14.	Klabacha, Rita	PA-C	AHP	Family Medicine
15.	Lin, Doris	MD	Active	Emergency Medicine
16.	McNamara, Thomas O	MD	Active	Radiology
17.	Meredick, Richard	MD	Active	Orthopedics
18.	Norris, Jennifer	CNM	AHP	Nurse-Midwife
19.	Nylk, Thomas	MD	Telemedicine	Cardiology
20.	O'Neill, Tammy	PA-C	AHP	Orthopedics
21.	Phillips, Michael W	MD	Active	Emergency Medicine
22.	Pisculli, Leo M	MD	Consulting	Psychiatry
23.	Pomeranz, David	MD	Active	Emergency Medicine
24.	Reid, Thomas K	MD	Active	Ophthalmology
25.	Rhodus, Cecilia	MD	Active	Pediatrics
26.	Richardson, James A	MD	Honorary	Internal Medicine
27.	Rowan, Christopher	MD	Telemedicine	Cardiology
28.	Saft, Amy	CRNA	AHP	Nurse Anesthesia
29.	Schweizer, Curtis	MD	Active	Anesthesiology
30.	Seher, Richard	MD	Telemedicine	Cardiology
31.	Swackhamer, Robert	MD	Telemedicine	Cardiology
32.	Taylor, Gregory M	MD	Active	Emergency Medicine
33.	Tiernan, Carolyn J	MD	Active	Emergency Medicine
34.	Vaid, Rajesh	MD	Telemedicine	Radiology
35.	Wasef, Eva S	MD	Active	Pathology
36.	Wei, Stephen	MD	Telemedicine	Radiology
37.	Weiss, Taema F	MD	Active	Family Medicine
38.	Wilson, Christopher	MD	Telemedicine	Cardiology
39.	Zuger, Sarah	MD	Active	Family Medicine

2. The following applicant did not meet the necessary qualifications and criteria for reappointment to the NIHD Active Staff as outlined in the Medical Staff bylaws. The applicant's privileges will expire after December 31, 2017.

	Name	Title	Category	Specialty
1.	Ramadan, Amr	MD	Active	Family Medicine

_____

Richard B. Meredick, MD, Chief of Staff

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Advanced Directives	
Scope: NIHD	Manual: CPM - End of Life (EOL)
Source: Chief Nursing Officer	Effective Date:

PURPOSE:
NIHD is committed to honoring the directives as expressed and written by our patients or their designee, known as the durable power of attorney for health care (DPOA), related to medical treatment. In order to meet this goal patient must be offered education about and the option of completing advanced directive paperwork.

DEFINITIONS:
Advanced Directive: Is a written instruction, such as a living will or durable power of attorney for health care, which is recognized under state law. It is not a signed physician order and cannot take the place of such. Generally the AD helps to define the wishes relative to end of life care for the patient and identifies the DPOA who can speak for the patient in the event that they are incapacitated.
Physician Order for Life Sustaining Treatment (POLST): This is a physician signed order that is co-signed by the patient or their DPOA, which is utilized in non-hospital settings. This provides orders for care related to resuscitation which are honored by pre-hospital care providers. This form does not contain a DPOA and for this reason is not considered an advanced directive.

POLICY:
All inpatients and applicable outpatients, or their representatives will be advised of the patient's right to formulate an advanced directive. They will also be advised of their right to update or change the advanced directive at any time. For those in patients with an advanced directive will have a copy placed in the medical record.

PROCEDURE:
Admission Services Responsibilities-
1. At the time of registration, NIHD registration clerk will have the patient or family/caregiver complete the top portion of the Adult Advanced Directive Acknowledgement form. Form may be found on intranet>forms>departments>Admissions>Adult Advanced Directive Acknowledgement.
2. The registration clerk will complete the bottom portion of the Adult Advanced Directive Acknowledgement form. They will provide the patient with handouts as described in the form.
3. If any type of advanced directive is obtained from the patient, the admission clerk will scan it into the patient's electronic medical record to assure it is available to staff providing care to the patient.
    a. Prior to scanning the patient's name, date of birth and medical records number will be written onto the top right hand corner by the admission clerk.
    b. When possible the clerk will request that a case manager review the advanced directive for completeness prior to having it scanned.

Nursing Services Responsibilities -
1. The RN will assess for and document the existence of the patient's advanced directive as a part of the admission assessment process for all adult patients in an inpatient status.
2. Should an advanced directive for the patient be found within the medical records repository, the nurse will assure that it is printed and placed into the patient chart. The RN will be responsible to clarify with the patient if the document represents their current

wishes. Patients have the right to review or revise their advanced directives should they wish to do so.

3. If the patient has advanced directives which are not within the NIHD medical records repository, the family should be encouraged by the RN to bring them to the hospital as soon as feasible. This shall be documented within the patient's electronic medical record.
4. The RN should communicate pertinent information related to the advanced directive to the patient's physician or advanced practice provider (APP).

Case Management (CM) Responsibilities -

1. A member of the case management team will review each adult patient who is in an admitted or observation status on a daily basis to determine need for education or support related to advanced directives.
2. When requested by a patient or family/caregiver, Case Management will provide copies and explain the advance directives process. Support will be provided to assist with completion of forms in a timely manner and support physician/APP discussions.
3. Documentation of process will be completed by the CM team member who provided the service within the patient electronic medical record.
4. Case Management will be available to train staff on the advance directive process as needed.

Physician/APP Responsibilities -

1. The attending physician/APP shall review an Advance Directive contained in the patient's chart and discuss its content with the patient and/or patient's healthcare representative.
2. The physician shall document a summary of all discussions with the patient or significant others concerning the patient's Advance Directive within the electronic medical record.
3. If an Advance Directive exists, but a copy is not available for the record, important care decisions shall be made by the attending physician in consultation with the decision maker using substituted judgment or best interest criteria as appropriate.
4. The physician will incorporate the executed Advance Directive in the patient's treatment plan.
5. Computerized Physician Order Entry shall be completed by the physician/APP to give directions on code status during the hospitalization as appropriate.

Completion of Advanced Directive Forms-

1. In order for the advanced directive to be legally binding it must be notarized **or** signed by two witnesses meeting the following criteria.
   a. The witness must know the patient who is signing the advanced directive or the patient must provide convincing evidence of their identity to the witness
   b. The witness must not be appointed as an agent in the advanced directive
   c. The witness must not be the patient's health care provider or an employee of the patient's health care provider or an operator or employee of a community care facility or residential care facility where the patient is receiving care
   d. At least one of the witnesses must not be a family member or a person that would benefit from the advanced directive or benefit from the patient's estate after their death
2. In order to complete and sign the advanced directive the following rules apply:

   a. The patient must not be under any duress to sign the document and the patient must be of sound mind
   b. The patient must sign the document in front of the notary or in front of the witness
   c. If the patient is a resident of a skilled nursing facility, the document must also be signed by a patient advocate or an ombudsman of the facility.
3. Once the advanced directive is completed, a copy of the advanced directive will be placed into the patient's electronic medical record and onto the chart located on the unit where the patient is located.
4. The advanced directive may be changed at anytime by the patient. A newer advanced directive supersedes any previous advanced directive.

REFERENCES:

1. California State Operations Manual 12/2016, 42 CFR 489.100 & 489.102
2. CMS 485.608(a)
3. California Probate Code, Division 4.7, 4701
4. CAMCAH January 2016 RI.01.02.01

CROSS REFERENCE P&P:

1. Admission Procedure of Hospice Inpatient
2. Admission, Documentation, Assessment, Discharge and Transfer of Swing-Bed Patients
3. Code Blue Procedure – Code Blue Team
4. Color-Coded wristband use
5. Consent for Medical Treatment
6. Discharge Planning for the Hospitalized Patient
7. Documentation of Case Management Services
8. End of Life Option Act
9. Forms Development and Control Policy
10. Legal Health Record
11. Long Term Acute Care Hospital
12. Nursing Assessment & Reassessment
13. Organ, Tissue, Eye Donation
14. Patient Transfer/Discharge to another facility
15. Patient's Rights
16. Pediatric Standards of Care and Routines
17. Requests Regarding Resuscitative Measures and Physician Orders for Life Sustaining Treatment (POLST)
18. Rights of Swing Bed Patients
19. Standards of Care for Adult patients and the Rural Health Clinic
20. Standards of Care: End of Life
21. Standards of Care – Swing Bed Resident
22. Standards of Care – Acute-Subacute services – adult patient

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Advanced Directives	
Scope: NIHD	Manual: CPM - End of Life (EOL)
Source: Chief Nursing Officer	Effective Date:

Approval	**Date**
CCOC	10/4/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 5/4/11
Reviewed:
Revised: 10/2017
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Assisted Living Facilities	
Scope: District	Manual: Social Services
Source: Licensed Clinical Social Worker	Effective Date:

PURPOSE:
Assisted living facilities (ALF) become home to individuals who can no longer live independently but do not require skilled or supportive nursing care. This policy clarifies the Districts role in transitioning patients into Assisted Living Facilities and supporting patients who reside in these facilities.
In the Northern Inyo Hospital District we have one such facility:

Sterling Heights
369 E. Pine St.
Bishop, CA 93514
760-873-3100

POLICY:
Patients have the right to determine their living situation unless under court appointed guardianship. District staff (medical staff, social worker or case manager) will work with the patient/family-caregiver regarding the recommended need for change in living arrangements and the need for residential care, otherwise known as assisted living.

PROCEDURE:

1. Any patient over 60 years of age who can no longer live independently but does not require skilled or supportive nursing care will be considered a candidate for assisted living facility.
2. Patients under 60 years of age may be considered as potential residents but the facility must receive a waiver from State licensing to accept the patient as a resident. If the State considers that the needs of this patient and the needs of the home's residents are compatible it will grant the waiver.
3. Assisted living communities are designed to provide residents with assistance with basic activities of daily living (ADLs) such as bathing, grooming, dressing, and more. Some also offer medication assistance.
4. Assisted living communities differ from nursing homes in that they don't' offer complex medical services. The patient cannot have open wounds or new colostomies, etc. Patients can require oxygen but must be able to understand the use of and care for the oxygen or respiratory therapy equipment. If any question about this type of care, call the facility.
5. The facility will evaluate the patient, contact state licensing and obtain a waiver to care for a patient if appropriate. It is appropriate for the Assisted Living Facility staff to assess patients prior to acceptance and they may do so at NIHD during hospitalization as needed.
6. The physician, family, and /or the social worker will counsel the patient regarding the recommendation of any need for change in living arrangements and the recommendation of a residential care facility if needed.
7. The physician must complete the Physicians Report for Residential Facilities for the Elderly before the patient can be admitted to the facility (see attached 602 Form). This includes TB screening.
8. All medications utilized by the patient at the ALF must be ordered by a licensed medical provider.
   a. Prescriptions must clearly indicate if the patient may self administer the medication or not.
   b. Medications to be kept at the patient's bedside must have this specified on the prescription
9. If needed patients can receive home health services at the assisted living facility.
10. The patient and family will be encouraged to make all such arrangements for placement as they are able. They will be encouraged to visit the prospective facility and have the proprietor of each facility visit with the patient while in the hospital.

Title: Assisted Living Facilities	
Scope: District	Manual: Social Services
Source: Licensed Clinical Social Worker	Effective Date:

11. The social worker/case manager will assist the patient and family to understand the financial obligation of each of the residential care facilities available in Bishop. Sterling Heights does not accept SSI. They are a private pay facility. The Veteran's Association can help financially with certain cases, Medicare, MediCal, or private insurance.

12. The social worker/case manager will adequately document in the patient's chart on the progress notes and place a note on the Multidisciplinary patient Care Plan.

13. The patient's right to choose is to be respected in this matter. If the patient refuses to accept placement or is unable to make appropriate decisions and the physician feels that the patient is not competent, the physician may choose to recommend the patient for a probate of L.P.S. conservatorship. The social worker will provide assistance as required.

REFERENCES:

1. California Hospital Association Consent Manual 2017-Chapter 1-Patients' Rights and the basic principles of consent.

CROSS REFERENCE P&P:

1. Discharge Planning for the Hospitalized Patient

Approval	**Date**
CCOC	11/6/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 10/2017
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: California Children Services Referral	
Scope: District	Manual: Social Services, Utilization Review, Case Management
Source: CNO	Effective Date:

PURPOSE:

Inyo County Residents	Mono County Residents
Inyo County Health Department	Mono County Health Department
207 W. South St	437 Old Mammoth Road #Q
Bishop, CA 93514	Mammoth Lakes, CA 93546
Phone 760-873-7878	Phone 760-924-1841
Fax 760-873-7800	Fax 760-924-1831

POLICY:
NIHD staff will support the process of identification and referral of children that may benefit from California Children's Services (CCS). This program offers further diagnosis or medical treatment for children with specific medical conditions, usually of a more serious or chronic nature. It provides expert medical care from a wide array of pediatric specialists who are in the California CCS system, including large children's medical centers. NIHD will collaborate with the child's home county public health department to determine if the child qualifies for CCS services.

PROCEDURE:
1. All patients under the age of 21 transferred to a tertiary care center should be referred for CCS coverage to the appropriate CCS agency, depending upon the residency of the child.
2. Identifying CCS eligible conditions is a joint responsibility of the admission department, social worker, nursing staff and the physician. When identified, the social worker or Case Manager will refer any patient, who may have a CCS eligible condition, to the appropriate agency. A list of CCS eligible conditions is attached. If there are questions about a potential CCS referral, the social worker or Case Manager will call the appropriate county CCS to further assess eligibility.
3. All pediatric inpatients will be assessed for eligibility. Additionally, any child transferred to an acute facility providing higher level of care will be referred for CCS eligibility.
4. Pediatric inpatients will be screened for CCS eligibility. The social worker or Case Manager will screen the patients by looking at daily ER logs. If a patient is found to have a potential eligible CCS condition based on the attached criteria, a CCS referral will be made. Additionally, patients who are receiving CCS services, according to a MediCal Point of Service (POS) document, will be further screened to assess CCS eligibility for that visit. If appropriate, a Service Authorization Request (SAR) form will be completed and sent to the appropriate CCS office.
5. Patients who are not currently enrolled in MediCal and that have been identified as possible CCS must be referred within 2 business days of the date of treatment.
6. Referrals can be made to the county health department in the county of the patient's residence (see contact information above). A SAR and appropriate medical records should be faxed to the appropriate public health department.
7. Northern Inyo Hospital is an approved short stay (5 day) CCS facility. In order to be eligible for coverage, not only does the child need to have a CCS eligible condition, he or she must be financially eligible and be attended by a CCS paneled physician. Exception will be made by CCS for a non-paneled physician to care for the child at NIHD when the child is being referred to and followed by a special care center (i.e.: diabetic, cleft palate complications, snake bite, etc.). The CCS agency can

determine if the physician is paneled. The social worker/case manager will phone the appropriate CCS agency for initial referral and either the social worker or Case Manager will phone for more covered days as required or send in another SAR form to the CCS agency.

8. Personal case management helping families access these medical specialists and some financial assistance is provided through the local CCS office if eligible. The child must be a California resident, have a specific medical conditions or concern, and may be required to meet other financial requirements. Please see attached document for more information regarding eligible CCS conditions.
9. Therapy services and evaluations such as physical and occupational therapy, durable medical equipment, and bracing are available when the child is eligible.
10. Approval by the patient's family will be secured, when possible, before the referral is made.

REFERENCES:

1. California Hospital Association Consent Manual: Children Multidisciplinary Services Teams-Welfare and Institutions Code Sections 18986.40 and 18986.46.

CROSS REFERENCE P&P:

1. Sending protected health information by fax

Approval	**Date**
CCOC	11/6/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	3/15/17

Developed:
Reviewed:
Revised: 10/2017
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge	
Scope:	Manual: Environmental Services
Source: Environmental Services	Effective Date:

PURPOSE:

-To distinguish between routine cleaning and contact or enteric precaution room cleaning at discharge or after patient is transferred to another room in any unit in the hospital.
To thoroughly clean rooms after discharge to reduce possibility of transmission of C-Diff or Multi-Drug Resistant Organisms (MDRO's).

POLICY:

1. All contact and enteric precaution rooms shall be cleaned when a patient is transferred to another room, unit or discharged
2. Nursing personnel shall notify Environmental Services (EVS) when the patient has left the premises. EVS shall clean the room as soon as possible
3. EVS must perform hand hygiene and put on appropriate Personal Protective Equipment (PPE) prior to entering room and remove PPE and perform hand hygiene prior to leaving the room ~~To thoroughly clean rooms after discharge to reduce possibility of transmission of C-Diff or Multi-Drug Resistant Organisms (MDRO's).~~

PROCEDURE:

1. Prepare cleaning cart with hospital approved disinfectant or sporicidal disinfectant cleaner ii~~i~~f enteric precaution. All items are to be cleaned with the recommended contact time per disinfectant.
2. Don appropriate PPE.
3. All open items are thrown away such as gloves, respiratory parts (opened and unopened).
4. All trash is placed into red bag trash.
5. All linens are placed in soiled linen bags. All linen bags from enteric precautions are placed into red bags.
6. Remove all curtains in the room and place in clear bag or red bag if enteric.
7. Check patient personal closets for items.
8. Communicate to the Department Clerk or Nurse to remove leftover medications, personal belongings, etc. for which~~that~~ Environmental Services is not responsible ~~for~~.
9. Thoroughly clean all non-critical patient care equipment following manufactures guidelines.
~~9.~~10. Clean all high touch surface areas including tabletops, bedside tables and inner drawer, phone, call light, armchairs, light switches etc.
10. Wash all surfaces, sinks, patient cupboards, blinds, and windows.
11. Wash the bed and mattress.
12. Wash the walls with T-pole or microfiber mop.
13. Mop floor.
14. Remove Personal Protective Equipment prior to leaving room and perform hand hygiene
~~14~~15. After entire room has had sufficient contact time and is dry, replenish disposed supplies such as gloves, TP, etc. Make bed, hang curtains and replace trash and linen bags.
~~15~~16. Curtain change is to be logged as changed due to precaution.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge	
Scope:	Manual: Environmental Services
Source: Environmental Services	Effective Date:

REFERENCES:

1. Centers for Disease Control and Prevention. (2017). Guidelines for Environmental Infection Control in Health-Care Facilities. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf

2. Infection Control Today. (2009) Patient Room Cleaning Protocol. Retrieved from http://www.infectioncontroltoday.com/articles/2009/11/patient-room-cleaning-protocol.aspx#

~~1.~~

CROSS REFERENCE P&P:

1. **Lippincott Contact Precautions**
2. **C-difficile Spore Cleaning agent**
~~1.~~3. **Environmental Disinfectant-Cleaning Solution**

Approval	Date
CCOC	11/6/17
Infection Control Committee	11/28/17
MEC	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 10/2017 A.S./Rc
Reviewed:
Revised:
Supersedes: **MRSA Cleaning Procedures: Checklist for Cleaning Med/Surg Unit;**
MRSA Cleaning Procedures: Checklist For Cleaning ICU;
MRSA Cleaning Procedures: Checklist For Emergency Department;
MRSA Cleaning Procedures: Checklist For Cleaning Perinatal Birthing Room;
Cleaning Procedures: Nursing Units: Isolation Rooms

Index Listings:

NORTHERN INYO ~~HOSPITAL~~HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Designated Areas for Food and Drink in Patient Care Areas*	
Scope: NIHD Clinical Care Areas	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 12/1/2017~~7/1/17~~

PURPOSE:
To provide instructions on where food and drink may be consumed ~~in~~ near a patient care area.

POLICY:
It is the policy of Northern Inyo ~~Hospital~~ Healthcare District to maintain a safe and clean environment for patients, physicians, employees, and visitors by limiting the ~~patient care~~ areas where food and drink may be consumed or stored.

PROCEDURE:
1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses is prohibited in areas where there is a reasonable likelihood of contamination with laboratory specimens, chemicals, or other potentially infectious materials as determined by the Infection Control Preventionist.
2. Food and drink for employees will not be stored in areas where blood, chemicals, or ~~and other~~ potentially infectious materials are stored. Food items for employees will be stored in covered containers in offices, lockers, and refrigerators designated for employees.
3. Beverages may be consumed by employees in **covered** containers ~~in~~ near patient care areas, as designated in the chart below. ~~e.g. nurses' stations, other than locations within the patient care area where laboratory specimens and other potentially infectious materials are stored.~~ Department ~~Directors~~ Managers are accountable for designating those locations.
4. Food and beverages for employees may be consumed in the cafeteria, staff lounges, and ~~other~~ designated areas on patient care units, as specified by the Department ~~Director/~~Manager, in collaboration with the Infection Preventionist.
5. Food and beverage containers and utensils used by employees must be discarded in designated waste containers as soon as possible after the food or beverage has been consumed.
6. Food and drink ~~will~~ shall not be stored in refrigerators, freezers, shelves, and cabinets or on countertops or bench-tops where chemicals, blood, or other potentially infectious materials are present.
~~6.~~7. Food and drink may not be stored or transported on environmental services carts.

DESIGNATED BEVERAGE AREAS:

Department	Designated area	Department	Designated area
ICU	Nurses Station	Rehab Services	Staff Break Room
Acute/Sub-acute	Nurses Station	Cardiopulmonary	Respiratory Office EKG Break Room PFT when no patient in room.
Perinatal	Behind Nurses Station by Sink	Diagnostic Imaging	Office Space, Break Room, Non-Clinical Tech work area
PACU:	Counter area near patient Refrigerator	RHC	Front Office: Designated countertop Back Office: Designated counter top
Outpatient Infusion:	Break Room	~~Bishop~~ NIA Pediatric	Break Area

NORTHERN INYO ~~HOSPITAL~~HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Designated Areas for Food and Drink in Patient Care Areas*	
Scope: NIHD Clinical Care Areas	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 12/1/2017~~7/1/17~~

Department	Designated area	Department	Designated area
Operating Room:	OR Lounge	RHC Women's Clinic	Front Office: Staff Lounge Back Office: Provider/Nurse Desk
Emergency Department	Nurses Front Desk and Lounge	NIA Surgery Clinic	Kitchen/Office Area Admission staff: At Desk
Laboratory	Non-Clinical area, Break Room	NIA Ortho Clinic	Break Room
Phlebotomy	Not designated at this time	Admission Services	Work Stations
EVS	In the designated food/beverage area for the unit the EVS personnel is assigned to.	Internal Medicine	Break Room
Pharmacy	Drinks must be covered. NO FOOD ALLOWED		

REFERENCES:

1. APIC Text of Infection Control and Epidemiology, 3rd Edition, 2009
2. The Joint Commission (2017). Environment of Care Risk Assessment- Staff Food and Drink. Retrieved from https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1229&StandardsFAQChapterId=64&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=&print=y
3. Occupational Safety and Health Administration (OSHA) Blood-borne Pathogen Standard: CFR 1910.1030. Retrieved from https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS

CROSS REFERECNES:

1. Bloodborne Pathogen Exposure Control Plan

Committee Approval	**Date**
CCOC	4/24/17
Infection Control	11/28/17
MEC	12/5/17
Board of Directors	
Last Board of Director Review	6/21/17

Developed: 10/2014
Reviewed:
Revised: 4/17 rc, 10/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: provide guidelines and documentation of training of non-nuclear medicine personnel for the safe handling and delivery (to nuclear medicine department) of radioactive packages

POLICY:
All non-nuclear medicine personnel, i.e., security officer on duty or purchasing/materials management personnel, who may receive and/or deliver (to nuclear medicine) packages containing radioactive materials will be trained regarding proper handling and delivery of these packages.

PROCEDURE:
Appropriate personnel are instructed to follow the guidelines listed below upon receiving radioactive packages. A signed copy of this procedure will be kept in the Radiology Manager's office to document training.

- Visually inspect the package, prior to handling. Notify Nuclear Medicine personnel immediately if package appears to be damaged or leaking. Do not handle a damaged or leaking package.
- Wear gloves when handling any radioactive package.
- Use cart or "dolly" to deliver radioactive packages. This maximizes distance between personnel and the package, minimizing radiation exposure rates.
- Promptly deliver all radioactive packages received to the Nuclear Medicine Department. If a nuclear medicine technologist is present, deliver package to them. If no nuclear medicine technologist is present, leave package at the hot lab door.
- Remove gloves immediately after delivery of package, dispose of the gloves in the Nuclear Medicine Imaging room trash.

If there are any questions regarding handling of radioactive packages, contact the Nuclear Medicine Department, ext. 2636; or the Director of Diagnostic Imaging, ext. 2634.

This document may be printed and used for documentation of annual training.

Trainee signature:_____

Nuclear Medicine Technologist – Trainer: _____

REFERENCES:

1. 10 CFR 20
2. 10 CFR 35
3. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,

Committee Approval	Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Radiology Services Committee	**~~8/19/2014~~11/21/2017**
Medical Executive Committee	**~~9/2/2014~~12/5/2017**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed:
Reviewed:
Revised: 7/23/2014
Supercedes: Handling of Radioactive Packages, Non-nuclear medicine personnel, 2006
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Material Hot Lab Security	
Scope: Hospital Wide	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:
To define authorized entrance to the radioactive materials (RAM) hot lab.

POLICY:
1. The hot lab door shall remain locked at all times, unless authorized personnel are inside or supervising entrance to the hot lab.
2. Only authorized nuclear medicine personnel, Radiation Safety Officer and Medical Physicists may enter the hot lab unsupervised.
3. For after hours deliveries, contact the Nuclear Medicine Technologist, the Imaging Manager, or Director of Diagnostic Services for access to the hot lab for deliveries of RAM packages after –hours in accordance with the "Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure"

REFERENCES:
1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2. 10 CFR 35

Cross Reference Policy
1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

Committee Approval	Date
Radiology Services Committee	~~**8/19/2014**~~**11/21/2017**
Medical Executive Committee	~~**9/2/2014**~~**12/5/2017**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed:
Reviewed: 7/23/2014, PD
Revised:
Supercedes: Hot Lab Security, 2006
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: provides procedure for the safe receipt and handling of radioactive materials when nuclear medicine and trained purchasing/materials management personnel are not present to receive packages

POLICY:

1. If a courier arrives at the hospital after operating hours with radioactive packages, the courier will be directed to the Emergency entrance.

2. The Emergency Department clerk or any other emergency department personnel will call the Nursing Supervisor to sign for the package.

3. The Nursing Supervisor will contact:

    1. The Nuclear Medicine Technologist
    2. Manager of Diagnostic Imaging, or
    3. The Director of Diagnostic Services

4. The Nursing Supervisor will escort the courier to the Nuclear Medicine department to secure the radioactive packages in the Hot Lab (R132 in Nuclear Medicine).

5. The Nursing Supervisor will not handle the radioactive package at any time.

6. Should any problems or questions arise regarding this policy and procedure the Nuclear Medicine Technologist and/or the Radiation Safety Officer (RSO) will be called by the Nursing Supervisor. The numbers for the NMT and the RSO are posted on the hot lab door.

PROCEDURE:

1. Call the Nursing Supervisor to the Emergency entrance upon arrival of a courier making delivery of radioactive isotopes.
2. The Nursing Supervisor will sign for the package and escort the courier to the Nuclear Medicine Hot Lab and unlock the door with the punch key provided.
3. The courier will place the package in the Hot Lab on the floor to the left of the door and the Nursing Supervisor will make sure that the Hot Lab door is securely locked when he or she leaves.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2. 10 CFR 35

Cross Reference Policy

1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Committee Approval	**Date**
Radiology Services Committee	**~~8/19/2014~~11/21/17**
Medical Executive Committee	**~~9/2/2014~~12/5/2017**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed:
Reviewed:
Revised:
Supercedes: Nuclear Medicine after hours delivery - 2006
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Waste Storage and Disposal	
Scope: Diagnostic Imaging, Nuclear Medicine	Manual: Diagnostic Imaging, Nuclear Medicine
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:
To ensure that radioactive waste is properly stored and handled until such time that it can be discarded following the general hospital waste procedures.

POLICY:
Radioactive waste shall be stored in the hot lab, or designated radioactive materials storage room, shielded, for a minimum of 10 half-lives and until it is indistinguishable from background radiation exposure levels, whichever is longer.

Human excreta is not considered radioactive waste. Human waste from patients undergoing diagnostic nuclear medicine procedures shall be handled according to hospital body fluid policy.

Radioactive materials are not disposed of into the sewage system, except wash water, which does NOT exceed allowable limits as stated in 10 CFR 20.

PROCEDURE:
1) Document all radioactive waste stored for decay on the "Waste Storage Log." If multiple isotopes are involved, always document the isotope with the longest half-life.
2) Store radioactive waste for 10 half-lives and until the radiation exposure levels, at the surface, are indistinguishable from background, whichever is longer.
3) Deface or destroy all radioactive labels.
4) Discard waste that is indistinguishable from background, and has been stored greater than 10 half-lives, following regular hospital waste guidelines.
5) Log discarded trash out on the "Waste Storage Log."

REFERENCES:
10 CFR 20.2

Approval	**Date**
Radiology Services Committee	11/21/2017
Medical Executive Committee	12/5/2017
Board of Directors	
Last Board of Director Review	

Developed: 7/20/2014
Reviewed:
Revised: 9/17 rc
Supersedes: Radioactive waste storage and disposal, 11/2009

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: ED Triage Protocols	
Scope: Emergency Department	Manual:
Source: Medical Director of Emergency Services Committee	Effective Date:

PURPOSE: To provide a set of protocols that the Emergency Department (ED) Registered Nurse (RN) can initiate to address urgent/emergent medical conditions of patients presenting to the ED prior to evaluation by the ED physician.

Definitions:

- Protocol – an order approved by the Emergency Services Committee that may be executed prior to initial physician evaluation. Protocols are limited to a subset of orders addressing specific medical conditions or patient circumstances that are necessary for timely and efficient care.

POLICY:

A. Prior to implementation, the Emergency Services Committee must approve all ED Triage Protocols. These triage protocols are not intended to replace more detailed order sets, guidelines or protocols.
B. The ED RN may initiate triage protocols if the physician is occupied.
C. The ED RN will initiate orders off the triage protocols if the assessment findings warrant the triage protocol intervention within their scope of competency and within the resources of the ED.
    1. The Triage Protocols are complaint-specific.
    2. The RN may not alter the content of any triage protocol.
    3. A triage protocol does not need to be implemented in its entirety. The RN should implement applicable sections of each set based on the patient assessment.
    4. More than one triage protocol may be used for a patient as appropriate per patient need and the RN assessment.
D. The RN may consult with the ED physician at any time if clarification is needed in initiating a triage protocol.
E. The RN is accountable and responsible for the delegation of any intervention in the triage protocol. The triage RN is accountable and responsible for any intervention performed on patients are in the waiting room.
F. The RN must document all assessment findings, interventions and outcomes as required by hospital policies and procedures.
G. ED triage protocols must be entered into the patient's medical record and authenticated by the ED physician.

PROCEDURE:

A. Patient presents to the ED triage with a chief complaint.
B. RN assessment confirms the symptoms or condition that warrants initiation of one or more Triage Protocols.
C. RN initiates corresponding triage protocol(s) and consults with the ED physician if additional clarification is needed.
D. The ED physician authenticates the orders in the medical record during the patient's ED treatment course.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: ED Triage Protocols	
Scope: Emergency Department	Manual:
Source: Medical Director of Emergency Services Committee	Effective Date:

REFERENCES:

CROSS REFERENCE P&P:
1. Triage

Approval	**Date**
Emergency Room Service Committee	11/8/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Environmental Disinfectant - Cleaning Solution	
Scope: All Unit	**Manual:** HOSPITAL WIDE, Infection Control Orange Manual
Source: Infection Control Practitioner	**Effective Date: August 2007**

PURPOSE:

To use disinfectants/cleaners that will reduce the risk of transmission of infectious organisms, and to use the cleaning/disinfectant products according manufactures instructions. ~~:~~

~~1. Are EPA approved and meet OSHA requirements.~~

~~2. Clean and disinfect environmental surfaces and non-critical items effectively.~~

POLICY:

1. Northern Inyo Healthcare District shall ensure that all cleaning supplies and chemicals are properly selected, used and maintained.

~~1.~~2. The Environmental Services Manager and the Infection Preventionist Manger will review all products and Safety Data Sheets (SDS) intended for any level of disinfection. Several factors will be taken into consideration when selecting new disinfecting and cleaning products, they include

- Ease of use
- Efficacy
- Acceptability
- Safety
- Cost

3. All cleaning and disinfection products shall be reviewed annually by the Infection Prevention Committee.
4. Prior to the product becoming available to staff for use, the Environmental Services Manger shall ensure the proper use and dilution procedure for the chemical is included in the Environmental Services Department training upon hire, annually, and with any new product.
5. All cleaning supplies and chemicals shall be properly measured and diluted according to manufacturer's instructions.

~~2.~~6. Disinfectants should be dispensed into clean, dry, appropriately-sized bottles that are clearly labeled and dated; not topped up; and discarded after the expiration date.

7. A broad-spectrum, EPA approved disinfectant is used for cleaning of environmental surfaces, non-critical patient-care items, as well as wiping up blood spills.

~~3.~~8. Staff will use appropriate personal protective equipment (e.g. gloves, eye protection, gowns, and masks) when using cleaning and disinfecting solutions.

9. Cleaning agents will not be used after the expiration date noted on the original container, except when placed in a secondary container. See below for products placed in separate containers.

- HB Quat after mixing discard after seven days and write expiration date on bottle
- Perisept discard after 24 hours after mixing and write expiration date on bottle.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Environmental Disinfectant - Cleaning Solution	
Scope: All Unit	**Manual:** HOSPITAL WIDE, Infection Control Orange Manual
Source: Infection Control Practitioner	**Effective Date: August 2007**

10. Labels provided by the manufacturers will be placed on all secondary containers in which cleaning agents are stored indicating the following:
    - The product name
    - Appropriate caution sign
    - Expiration date

~~1. uA 1/10 bleach/water solution is an acceptable disinfectant solution.~~

~~Phenolic solutions are **not** used on any items that may touch a newborn's skin, such as crib, scale, et~~**DEFINITIONS:**

1. **Broad Spectrum:** Effective against several antimicrobials
2. **Cleaning:** Cleaning is the manual removal of foreign material (e.g., soil, and organic material) from objects and is normally accomplished using water with detergents or enzymatic products.
3. **Decontamination:** Decontamination renders an item or material safe to handle. The level of microbial contamination is reduced enough that it can be reasonably assumed free of risk of infection transmission
4. **Disinfection:** Eliminates most pathogens but not necessarily all types of microbes. Disinfection reduces the level of microbial contamination. Chemical disinfection does not kill spores
5. **Environmental Protection Agency (EPA):** An independent federal agency, created in 1970, that sets and enforces rules and standards that protect the environment and control pollution
6. **Hospital-approved detergent disinfectant:** EPA-registered disinfectants approved by the institution's Infection Control Committee to meet the overall needs of the healthcare facility for routine cleaning and disinfection; used according to the manufacturer's recommendations for amount, dilution, and contact time sufficient to remove pathogens from surfaces of rooms where colonized or infected individuals are housed.
7. **Non-Critical Items:** Objects that may come in contact with intact skin but not mucous membranes and should undergo cleaning and low- or immediate level disinfection depending on the nature and degree of contamination. (e.g. vital sing machines, thermometers, stethoscopes)
8. **Safety data sheet (SDS):** formerly known as material safety data sheet or MSDS): information document on substance to ensure that individuals handle and/or use it safely. Information on the sheet includes physical data, toxicity, health effects, first aid reactivity, storage, disposal, PPE, and procedures for handling spills. Every EPA-registered cleaning agent has an SDS.

PROCEDURE:

1. ~~1.~~ Follow manufacturer's instructions if any mixing is necessary. ~~(Currently using premixed)~~
2. Use an Environmental Protection Agency (EPA)-registered disinfectant following the manufacturer's instructions because required contact time varies among products

~~1.~~3. Use appropriate PPE

~~2.~~4. Cleaning and disinfection of noncritical equipment should be performed by staff that are properly trained and competent to do so.

~~3.~~5. ~~2.~~ Clean surfaces and items with clean solutions. ~~-~~Discard when solution becomes dirty.

~~4.~~6. ~~3.~~ Rinse only if deemed necessary or recommended by manufacturer.

~~5.~~7. ~~4.~~ Spray or squeeze bottles are acceptable.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Environmental Disinfectant - Cleaning Solution	
Scope: All Unit	**Manual:** HOSPITAL WIDE, Infection Control Orange Manual
Source: Infection Control Practitioner	**Effective Date: August 2007**

Environmental Services personnel who use cleaning agents are responsible for disposing of them properly.

~~6. Phenolic Solutions are not used at Northern Inyo Hospital.~~

8.

REFERENCES:

1. Centers for Disease Control and Prevention (CDC), (2016). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf
2. Chou, T. (2014). Environmental Services. Washington, DC: Association for Professionals in Infection Control and Epidemiology (APIC) 2016 Copyright. Retrieved from http://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/environmental-services
3. Ling, M. L., Apisarnthanarak, A., Thu, L. T. A., Villanueva, V., Pandjaitan, C., & Yusof, M. Y. (2015). APSIC Guidelines for environmental cleaning and decontamination. Antimicrobial Resistance and Infection Control, 4, 58. http://doi.org/10.1186/s13756-015-0099-7. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696151/
4. Occupational Safety & Health Administration (OSHA). (Site accessed August 25, 2017). Hospital eTool: Housekeeping. Retrieved from https://www.osha.gov/SLTC/etools/hospital/housekeeping/housekeeping.html

CROSS REFERENCE P&P:

1. Disinfection, noncritical patient care equipment, ambulatory care: Lippincott Procedures

Approval	**Date**
CCOC	11/6/17
Infection Control Committee	11/28/17
MEC	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 1/94
Reviewed: 5/97; 11/99; 4/2003; 09/2005; 8/2007; 5/11 mc, 9/12 BS,
Revised: 11/15NH, 9/17 RC/RM
Supersedes: Cleaning agents: Cleaning Solutions, Cleaning Agents: Disposal of Cleaning Agents, Cleaning Agents: Identifying and Labeling Cleaning Agents, and Cleaning Agents: Selection, Measurement, and Use of Cleaning Agents
Index Listings: environmental disinfectant, cleaning solution, cleaning

~~**Reference:** OSHA Bloodborne Pathogen Standard, CDC Guideline on Environmental Monitoring~~
~~**Committee Approval Needed:** X Yes, No. Infection Control Committee~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Environmental Disinfectant - Cleaning Solution	
Scope: All Unit	**Manual:** HOSPITAL WIDE, Infection Control Orange Manual
Source: Infection Control Practitioner	**Effective Date: August 2007**

~~**Responsibility for review and maintenance:** Infection Control Officer~~
~~**Index Listing:** Environmental Disinfectant - Cleaning Solution~~
~~**Revised:** 1/94; 5/97; 11/99; 4/2003; 09/2005; 8/2007; 5/11 mc, 9/12 BS,~~
~~**Reviewed:** 11/15 NH~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Handling of Soiled Linen	
Scope: NIHD	Manual: CPM: Infection Control-Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date:

PURPOSE:
The aim of this policy is intended to inform staff of the correct management and disposal of used linen, in order to protect patients, healthcare workers and laundry staff from contamination or injury.

POLICY:
1. All soiled linen is considered contaminated
2. Soiled linen shall be handled as little as possible and with minimum agitation to prevent contamination of the air and persons handling the linen
3. Bag contaminated laundry at the location of use. Do not sort or rinse laundry at the location where it is used.
4. Contaminated linen or linen bags should not be held close to the body when handling to avoid exposure
5. Hand Hygiene must be completed after each contact with soiled linen and before contact with clean linen
6. Appropriate PPE will be worn when handling contaminated linen
7. Linen heavily contaminated with blood or other bodily fluids shall be bagged and transported in a manner that prevents leakage.

PROCEDURE:

1. Linen bags should not be more than ¾ full and be tied securely. There will be a linen hamper in every patient room. Environmental services personnel will remove and replace line bags as required.
2. Personal protective equipment (PPEs) must be worn for sorting soiled linen.
3. Gloves, impervious gown, face shield, or mask and goggles must be worn to protect the sorter from body fluids.
4. Hand Hygiene must be completed after each contact with soiled linen, and before contact with clean linen.
5. Soap and Water must be used if gloves are soiled, and if linen is contaminated from a patient in C-diff precaution.
6. Contaminated linen bag from an enteric precaution room (e.g. C-diff or Norovirus) shall be place in a red biohazard bag before leaving the patient room.
7. Linen contaminated with Hazardous Drugs will be placed in the Chemo Spill Kit Bucket. If a large amount of spill occurs the linen will be double bagged using the labeled bags found in the Spill Kit and subsequently placed in a rigid, labeled bucket for disposal. Refer to Chemotherapy Spill Protocol

REFERENCES:

1. Centers for Disease Control and Prevention. (2017). Infection Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html
2. Centers for Disease Control and Prevention. (2014). CDC's Infection Prevention and Control Recommendations for Hospitalized patients with Known or Suspected Ebola. https://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf
3. Infection Control Today. (June 18, 2015). Best Practices to Prevent Infections during Laundering of Healthcare Textiles. Retrieved from http://www.infectioncontroltoday.com/news/2015/06/best-practices-to-prevent-infections-during-laundering-of-healthcare-textiles.aspx
4. Occupational Safety & Health Administration. Laundry. Retrieved from https://www.osha.gov/SLTC/etools/hospital/laundry/laundry.html
5. Occupational Safety and Health Administration. Controlling Occupational Exposure to Hazardous Drugs. Retrieved from https://www.osha.gov/dts/osta/otm/otm_vi/otm_vi_2.html

CROSS REFERENCE P&P:
1. Bloodborne Pathogen Exposure Control Plan
2. Severe Acute Respiratory Syndrome Coronavirus (SAS-CoV) Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations for Hospitalized Patients
3. Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Ebola Virus*

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Handling of Soiled Linen	
Scope: NIHD	Manual: CPM: Infection Control-Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date:

4. Chemotherapy Spill Protocol
5. Aerosolized Transmissible Disease Plan

Approval	**Date**
CCOC	8/28/17
Infection Control Committee	11/28/17
MEC	12/5/17
Board of Directors	

Developed: 8/2007
Reviewed: 6/11 bss, 9/12bss
Revised: 8/17rc/ls/as/ad
Supersedes:
Index Listings: Soiled linen, contaminated linen, laundry

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Home Health Care	
Scope: District	Manual: Case Management
Source: Case Manager	Effective Date:

PURPOSE:
To assure a smooth transition of care after hospitalization in those patients who require additional support services, skilled nursing or physical therapy, in the home.

Home Health Care
(Skilled Nursing Services at Home)

Pioneer Home Health Care
162 E. Line Street
Bishop, CA
Phone 760-872-4663
Fax 760-872-4663

POLICY:

1. Those patients requiring skilled nursing services at home, including physical therapy, Occupational therapy, speech therapy, medical social work and home health aides will be referred to an appropriate home health agency upon the order of the attending physician.
2. Patients requiring such care at home will be referred to Pioneer Home Health Care.
3. Pioneer Home Health accepts Medicare and some private insurance plans with the appropriate program restrictions as well as private insurance. If the patient will be a "cash" patient or the service requested will not be covered by the patient's insurance program, this should be discussed with the agency and the patient. Pioneer Home Health is not a free service nor is there any service provided by the county. Pioneer home health does not accept MediCal, CMSP or CCS.
4. Pioneer Home Health Care is available to service the majority of Inyo and Southern Mono County. This agency has 24 hour answering service available for referrals.
5. Pioneer Home Health Care team provides a wide range of services including:

- **Skilled Nursing Care**
  - Instruction, treatment and coordination of health care
  - Prenatal, post partum, pediatric, and geriatric care
  - Wound and ostomy care
  - Intravenous and enteral therapy administration
  - Pain management
  - Hospice

- **Rehabilitation Therapy**
  - Development and restoration of functional mobility and strength
  - Re-education of self-care abilities and cognitive skills

- **Social Services**
  - Social and emotional counseling related to issues of loss, illness, and need for care
  - Assistance to implement community and financial resources

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Home Health Care	
Scope: District	Manual: Case Management
Source: Case Manager	Effective Date:

- **Certified Home Health Aide Care**
  - Assistance with bathing and personal care – shopping
  - Patient assistance with established therapy exercise program
  - Meal preparation, laundry, companionship

- **Payment**
  - Home health care is a covered benefit under Medicare and most private insurance plans. We will verify coverage and bill the appropriate insurer on the patient's behalf. Pioneer Home Health does not accept MediCal or CMSP.

PROCEDURE:

1. When a physician order is written to for Pioneer Home Health Services the social worker will assure that appropriate medical records are sent to Pioneer Home Health. The physician must also complete in their discharge summary the following criteria (please see attached). This must be completed before the patient can be seen by Pioneer Home Health.
2. The Social Worker/Case Manager will provide information regarding Pioneer Home Health to patients and/or families as appropriate.
3. The patient's nurse will call Pioneer Home Health with a nursing report upon discharge from Northern Inyo Hospital.

REFERENCES:

1. CAMCAH Manual 2016: PC.02.02.01

CROSS REFERENCE P&P:

1. Discharge Planning

Approval	**Date**
CCOC	11/20/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	3/15/17

Developed: 11/2017ta
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HOSPICE CARE**	
Scope: District	Department: **Social Services**
Source: Social Worker	Effective Date:

PURPOSE:
To establish end of life care and support of the patient and family in need of Hospice Care

Hospice of the Owens Valley
153 Pioneer Lane
Bishop, CA 93514
760-873-3742

Hospice of Southern Inyo
760876-5501

POLICY:

1. The Social Worker/Case Manger, when requested, will make referral to Hospice home care for the care of the terminally ill patient in his home or a skilled nursing facility.
2. Hospice care is defined as that care given to support the patient who has a predicted 6 months or less to live, this being the definition of terminal care.
3. The physician will approve the referral to hospice care by the social worker/case manager for those patients hospitalized at Northern Inyo Hospital. The social worker/case manager will give information to patients and families who request information on this program.
4. The social worker/case manager will assist with reminding the nursing staff of the appropriate paper work requirements when a Hospice care patient is hospitalized.

*Please also refer to Nursing – The Hospitalized Hospice Patient.

PROCEDURE:

Pioneer Home Health Care, Inc.
Hospice Admission Criteria

1) The patient must be under the care of a physician who will order and approve the provision of Hospice care, be willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.
2) The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed.
3) The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and Hospice Medical Director, utilizing standard clinical prognosis criteria.
4) The patient and family/caregiver must desire Hospice services, and be award of the diagnosis and prognosis.
5) The focus of care desired must be palliative versus curative.
6) The patient and family/caregiver agree to participate in the plan of care, and sign the consent form for Hospice care.
7) The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which would be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HOSPICE CARE**	
Scope: District	Department: **Social Services**
Source: Social Worker	Effective Date:

8) The physical facilities and equipment in the patient's home must be adequate for safe and effective care.
9) The patient must reside within the geographical are that the Hospice Program services.
10) If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance Hospice benefit reimbursement.
11) Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of Hospice care.

REFERENCES:

1. CAMCAH Manual 2016: PC.04.02.01

CROSS REFERENCE P&P:

1. Admission of Hospice Inpatient
2. Standards of Care Hospice Inpatient

Approval	**Date**
CCOC	11/20/17
UR Committee	
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 11/2017ta
Reviewed:
Revised:
Supersedes:
Index Listings:

~~**POLICY:**~~

~~Hospice of the Owens Valley~~
~~153 Pioneer Lane~~
~~Bishop, CA 93514~~
~~873-3742~~

~~Hospice of Southern Inyo~~
~~876-5501~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HOSPICE CARE**	
Scope: District	Department: **Social Services**
Source: Social Worker	Effective Date:

~~The social worker, when requested, will make referral to Hospice home care for the care of the terminally ill patient in his home, a board and care facility, or a skilled nursing facility.~~

~~Hospice care is defined as that care given to support the patient who has a predicted 6 months or less to live, this being the definition of terminal care.~~

~~The physician will approve the referral to hospice care by the social worker for those patients hospitalized at Northern Inyo Hospital. The social worker will give information to patients and families who request information on this program.~~

~~The social worker will assist with reminding the nursing staff of the appropriate paper work requirements when a Hospice care patient is hospitalized.~~

~~Please also refer to Nursing Policy - The Hospitalized Hospice Patient,~~

~~**Committee Approval**~~	~~**Date**~~

~~**Revised:**~~
~~Reviewed:~~
~~Supercedes:~~

~~**Responsibility for review and maintenance:**~~
~~**Index Listings:**~~
~~**Initiated:**~~
~~**Revised/Reviewed:**~~

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Hospi-Gard Portable Filtration Unit (H.G.U.)	
Scope: NIHN	Manual: CPM- ICP
Source: Quality Informatics Nurse/ Infection Preventionist Manager	Effective Date:

PURPOSE:
To provide a positive pressure clean air re-circulating system that can be used as a partial exhausting system for patients with known or suspected airborne disease.

Note: Hospi-Gard Filtration Unit does not create a negative pressure isolation room unless vented to outside.

POLICY:
1. Use the Hospi-Gard Filtration Unit in patient treatment areas when Airborne Infection Isolation room is not available in department
2. Place Airborne Isolation signs outside room visible to staff and visitors
3. If patient requires Airborne Isolation with use of Hospi-Gard Filtration Unit for more than five hours the patient should be considered for transfer to another facility. Transfer should occur within 5 hours of identification, unless the-physician documents, at the end of the 5 hour period, and at least every 24 hours thereafter, one of the following:

    - The Physician, Infection Preventionist or House Supervisor has contacted the local health officer.
    - There is no Airborne Infection Isolation Room (AIIR) room or area available within that department
    - Reasonable efforts have been made to contact establishments outside of that department.
    - Applicable measures recommended by the local health officer and the Physician or other licensed health care professional

4. If Hospi-Gard Filtration Unit is being use for suspected or known airborne precaution patient and the patient requires an aerosolizing procedure, the procedure needs to occur in a Airborne Infection Isolation Room (AIIR) if room available.
5. Staff to wear appropriate PPE

Note: Refer to Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program

PROCEDURE:
1. Notify Environmental Services to set up Hospi-Gard Filtration Unit.
2. Keep door closed
3. Place Airborne Isolation sign outside door
4. Staff and visitors to wear N95 mask when entering room
5. Activate the Hospi-Gard Filtration Unit., (a) plug in, (b) turn "on" switch, (c) check plastic gauge on right side of unit - Small black ball should be bouncing approximately in middle of green zone; check each shift. Call Maintenance if not accurate.
6. Do not obstruct air grills on top and bottom of Hospi-Gard Filtration Unit
7. After patient discharged, leave door closed with unit running for 30 minutes.

CLEANING:
1. Cleaning of Hospi-Gard Filtration Unit will be done by Environmental Services

Title: Hospi-Gard Portable Filtration Unit (H.G.U.)	
Scope: NIHN	Manual: CPM- ICP
Source: Quality Informatics Nurse/ Infection Preventionist Manager	Effective Date:

2. Exterior cabinet must be cleaned with the Hospi-Gard Filtration Unit running using hospital approved disinfectant. Paying particular attention to the prefilter intake grille

MAINTENACE:

1. Notify Clinical Engineering if any malfunction is suspected
2. Prefilter replacement is required every 18months to two years depending on use of the device. Apply appropriate PPE
3. When Clinical Engineering replaces pre-filter, spray Lysol into the air intake grille.

REFERENCES:

1. California Department of Public Health (CDPH). (2012). Respirator Use in Health Care Workplaces: Cal/OSHA Aerosol Transmissible Disease Standard. Retrieved from 12.California Department of Public Health (CDPH). (2012). Respirator Use in Health Care Workplaces: Cal/OSHA Aerosol Transmissible Disease Standard.
2. Envirco Innovators in clean air technology (accessed October 16, 2017). Hospi-Gard IsoClean and IsoClean with Ultraviolet Light. Retrieved from https://www.envirco-hvac.com/products/index.aspx?prod=HospiGard_IsoClean

CROSS REFERENCE P&P:

1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
2. Lippincott Airborne Precautions
3. Tuberculosis Exposure Control Plan
4. Sever Acute Respiratory Syndrome Coronavirus (SARS-CoV) or Middle East respiratory Syndrome Coronavirus (MERS-CoV) Control Recommendations for Hospitalized Patients

Approval	**Date**
CCOC	10/23/17
Infection Control Committee	11/28/17
MEC	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 11/1994
Reviewed: 5/1997, 9/2000, 5/2003, 5/2005, 7/2010bss, 8/2011RC, 9/2012bs
Revised: 10/16/2017
Supersedes:
Index Listings: HEPA filter, Airborne Precautions, Air Filtration Unit

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Infection Control: Handwashing For Safe Food Handling**	
Scope: Infection Control	Department: **Nutritional Services**
Source: Dietary Director	Effective Date:

PURPOSE:

To establish infection control standards to minimize risk of food borne illness and outline proper procedure for hand washing.

GENERAL INFORMATION:

1. The underlying principle of hand washing is to mechanically remove dirt and bacteria by sudsing and flushing the hands with running water and soap.

2. Personal hand creams and lotions are not sterile and, therefore, can be a source of contamination. They should be used at home, not at work.

POLICY:

1. Personnel shall wash their hands in accordance with the procedure described below:
    a. When coming on duty, or re-entering the kitchen
    b. When hands are obviously soiled
    c. After personal use of toilets
    d. After blowing and wiping the nose, or coughing
    e. When handling ready-to-eat foods
    f. After removing gloves
    g. After completing a task or when switching tasks
    h. After eating or drinking
    i. After touching human body parts (face, neck etc)

PROCEDURE:

1. Wet hands with water
2. Apply enough soap to cover all hand surfaces
3. Rub Hands palm to palm
4. Right palm over left dorsum with interlaced fingers and vice versa
5. Palm to palm with fingers interlaced
6. Backs of fingers to opposing palms with fingers interlocked
7. Rotated rubbing of left thumb clasped in right palm and vice versa
8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
9. Rinse hands with water
10. Dry hands with a single use towel
11. Use towel to turn off faucet

REFERENCES:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Infection Control: Handwashing For Safe Food Handling**	
Scope: Infection Control	Department: **Nutritional Services**
Source: Dietary Director	Effective Date:

1. U.S. Public Health Service Food Code. 2013. United Stated Department of Health and Human Service, Food and Drug Administration. Personal Cleanliness 2-301 Hands and Arms.
2. World Health Organization. May 2009. *How to HandWash?*. Retrieved from http://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf?ua=1

CROSS REFERENCE P&P:

1.

Approval	**Date**
Infection Control Committee	11/28/17
Medical Executive Committee	12/5/17
Board of Directors	

Developed: 11/14/2017
Reviewed:
Revised:
Supercedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu	
Scope: NIHD	Manual: CPM: ICE
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date:

PURPOSE:
To minimize exposure to patients, healthcare workers, and visitors by way of patients presenting with Avian, Novel and seasonal flu like symptoms or a confirmed diagnosis.

DEFINITIONS:

1. **Avian Influenza:** Influenza viruses that are different from currently circulating human influenza A virus subtypes and include viruses from predominantly avian and swine origin Novel and variant Influenza A viruses can infect and cause severe respiratory illness in humans e.g. H1N1, H5N1, and H7N9. Highly contagious. Avian flu viruses do not normally infect humans. However, sporadic human infections with avian flu viruses have occurred.
2. **Case Classification**
    - **Suspected:** A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza viruses is classified as a suspected case until the confirmation process is complete
    - **Probable:** A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza viruses is classified as a suspected case until the confirmation process is complete.
    - **Confirmed:** A case of human infection with a novel influenza A virus confirmed by CDC's influenza laboratory or using methods agreed upon by CDC and CSTE as noted in Laboratory Criteria.
3. **Endemic:** Refers to the constant presence and/or usual prevalence of a disease or infectious agent in a population within a geographic area
4. **Epidemic:** Refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.
5. **Outbreak:** Carries the same definition of epidemic, but is often used for a more limited geographic area
6. **Novel Influenza A Virus:** Refers to a virus not seen before. A virus that has caused human infection and is different from current seasonal influenza A viruses spreading among people. Novel influenza A viruses can be viruses that originate in animals that gain the ability to infect and spread among humans or human viruses that change significantly so as to be different from current human seasonal influenza A viruses
7. **Pandemic:** Refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.
8. **Seasonal Influenza Virus:** Seasonal influenza viruses are influenza A and B viruses that spread and cause illness in people during the time of year known as the "flu season." Seasonal influenza viruses cause annual U.S. influenza epidemics during fall, winter, and spring, and circulate among people worldwide. Seasonal influenza A and B viruses are continually undergoing evolution in unpredictable ways.
9. **Sporadic:** Refers to a disease that occurs infrequently and irregularly.

POLICY:

1. Prompt screen and triage of symptomatic patients by a Physician or Registered Nurse
2. Implement transmission based procedures on symptomatic and confirmed patients.

3. Notify Infection Preventionist, House Supervisor, or designee immediately of all patients admitted with suspected Avian or Novel Influenza.
4. Report all cases of suspected Avian and Novel Flu that meet the current case definition will be reported within one working day to the local health department.
5. Visitors will be limited to immediate family or caregiver for short period of time. Visitors to follow appropriate standard and transmission based precautions.
6. If able dedicate healthcare workers to care for confirmed or suspected patients, to minimize risk and exposure to other patients and healthcare workers.
7. Keep a list of all healthcare workers who care for or enter the room of the suspected or confirmed case of Avian Flu or Novel Influenza A Virus.
8. Infection Prevention Manager will complete a Pandemic and Seasonal Influenza Readiness Assessment Checklist annually. The template is located on NIHD Intranet>forms>Infection Control.

PROCEDURE:

1. Screen all patients with influenza like illnesses
2. Institute Isolation Precautions as indicated: Droplet, Airborne, Contact, and Standard Precautions
    - Place surgical mask on every outpatient or during transport who has a cough or signs and symptoms of influenza.
    - Implement Respiratory Hygiene and Cough Etiquette
    - Institute droplet precautions for suspected or confirmed cases of seasonal flu
    - Place patient in Airborne Isolation if suspected or confirmed Avian or Novel A Influenza virus or performing aerosolizing producing procedures with any influenza type patient.
        - Option 1: Room 5, Medical surgical Unit
        - Option 2: Room 1, ICU Unit
        - Option 3: Infusion Room 6
        - Option 4: Place patient in surgical mask, staff, family and visitors are to don N 95 mask, shut door and place Airborne Isolation signage on door. Place HEPA filtration unit in room to allow air recirculation. Any aerosolizing producing treatments will be completed in an Airborne Infection Isolation Room if room available.
3. Don Personal Protective Equipment upon entering patient room
    - Hand Hygiene
    - Gown
    - Gloves
    - Eye protection
    - N95 mask or PAPR
4. Avoid touching the eyes, mouth, and nose after touching any contaminated material while wearing PPE.
5. Provide education to patient, family, and visitors.

HEALTHCARE WORKER EXPOSURE: AVIAN AND NOVEL INFLUENZA

1. Healthcare workers (HCW) who have unprotected direct contact with an Avian or Novel A Influenza Flu patient must report the exposure to Infection Control. The HCW must complete the "HCW Contact with Case of an Aerosolized Transmissible Disease" screening form and be instructed to monitor their temperature in the morning and in the evening for at least 10 days.

2. All staff will be vigilant for the development of fever, respiratory symptoms and/or conjunctivitis for one (1) week after the last exposure to avian influenza-infected patients.
3. If a fever or cough develops, the HCW will be instructed to seek medical evaluation immediately.
4. Refer to Novel Avian Influenza-H5N1 Flu Hospitalized Patients Infection Control policy and procedure

HEALTHCARE WORKER EXPOSURE: SEASONAL FLU

1. Refer to Novel Avian Influenza-H5N1 Flu Hospitalized Patients Infection Control policy and procedure

HANDWASHING:

- Hands are to be washed prior to after patient contact. Follow the World Health Organization guidelines: Your 5 Moments for Hand Hygiene
- If hands are not visibly soiled or the patient does not have C-diff or norovirus, alcohol-based rub can be used.

TRANSPORTING PATIENTS:

- Patients should not be transported to other areas of the hospital unless absolutely necessary.
- If patients must be transported, place a surgical mask over patient's nose and mouth.

PATIENT CARE EQUIPMENT:

- Patient care equipment (e.g., thermometers, blood pressure cuffs, stethoscopes and commodes) should be kept in the patient's room if able. Use disposable equipment whenever possible.
- Reusable equipment will be cleaned per protocol before re-use.

LINENS, WASTE AND ROOM CLEANING:

- All linen will be considered contaminated
- High touch surface areas will be cleaned more frequently
- Terminal clean will be completed at discharge

REFERENCES:

1. Centers for Disease Control and Prevention. (2014). Novel Influenza A Virus Infections 2014 Case Definition. Retrieved from https://wwwn.cdc.gov/nndss/conditions/novel-influenza-a-virus-infections/case-definition/2014/
2. Centers for Disease Control and Prevention. (2016). Interim Guidance for Infection Control within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease. Retrieved from https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm
3. Centers for Disease Control and Prevention. (2016). Prevention strategies for Seasonal Influenza in Healthcare Settings. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm
4. Centers for Disease Control and Prevention. (2017). Pandemic Influenza Plan 2017 Update. Retrieved from https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf
5. Centers for Disease Control and Prevention. (2017). Glossary of Influenza (flu) Terms. Retrieved from https://www.cdc.gov/flu/glossary/index.htm#case-under-investigation

Title: Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu	
Scope: NIHD	Manual: CPM: ICE
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date:

6. Occupational Safety and Health Administration. (Retrieved August, 24th, 2017). Seasonal Flu: Employer Guidance Reducing Healthcare Worker's Exposures to Seasonal Flu Virus. Retrieved from https://www.osha.gov/dts/guidance/flu/healthcare.html

CROSS REFERENCES:

1. Aerosolized Transmissible Disease Plan
2. Airborne Precautions, Contact Precautions, Droplet Precautions, and Standard Precautions: Lippincott Procedures
3. Airborne Infection Isolation Rooms (AIIR)
4. Health Care Workers with Influenza like illness
5. Reportable Diseases: Lippincott Procedures
6. Personal Protective Equipment (PPE) Putting on, Personal Protective Equipment, Removal: Lippincott Procedures
7. Disinfection, noncritical patient care equipment, ambulatory care: Lippincott Procedures
8. Handling of Soiled Linen
9. Hospi-Gard Portable Filtration Unit (H.G.U.)
10. Infection Prevention Plan

Approval	**Date**
CCOC	9/25/17
Infection Control Committee	11/28/17
MEC	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 3/2006
Reviewed
Revised 5/16/07, 8/2008; 8/11RC; 9/12bs, 8/17 rc
Supersedes:
Index Listing: Avian Flu, H5N1 Influenza

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Long Term Acute Care Hospital (LTACH)	
Scope: Case Management Team	Manual: Social Services, Utilization Review, Case Management
Source: Case Manager	Effective Date:

PURPOSE:
To provide care to patients with medically complex problems that may require a long hospitalization that cannot be managed at a lower level of care.

POLICY:
1. LTACHs are licensed as acute care or specialty hospitals and they are certified by Medicare as long-term care hospitals. LTACHs must maintain a 25-day average length of stay and be accredited by Healthcare Facilities Accreditation Program (HFAP) or The Joint Commission (TJC). Patients must meet acute care admission and continued stay criteria.
2. LTACHs provide acute services for patients that are medically complex and require a long hospitalization. LTACHs offer specialized care for a variety of conditions including, but not limited to:
    - Ventilator dependent and weaning difficulty
    - Pressure wounds/Wound Care complications
    - Cardiac diseases
    - Neuromuscular/neurovascular diseases
    - Multi-system organ failure
    - Gastrointestinal diseases
    - Post-op complications
    - Pulmonary disease
    - Acute renal failure including dialysis
    - Infectious diseases requiring long term IV therapy

Patients who are admitted to long-term acute care (LTAC) hospital typically
- Require acute care services as determined by a physician
- Are not candidates for treatment at a lower level of care
- Require physician management of multiple acute complexities

Patients that meet LTAC admission criteria usually have one or more of the following needs:
- Mechanical ventilation for respiratory failure
- Stabilization of underlying disease and ventilator weaning
- Pulmonary hygiene
- Tracheostomy with respiratory insufficiency
- Exacerbation of COPD
- Infectious disease with two or more co-morbidities
- Primary cardiac and/or peripheral vascular disease with co-morbidities
- Wound management requiring interdisciplinary team care
- High level orthopedic conditions
- Low-tolerance rehabilitation, 1-3 hours daily
- Other primary medically complex condition or illness

Title: Long Term Acute Care Hospital (LTACH)	
Scope: Case Management Team	Manual: Social Services, Utilization Review, Case Management
Source: Case Manager	Effective Date:

- Malnutrition requiring feeding tube or TPN, and speech therapy intervention with swallowing techniques

Long Term Acute Care Services Include:

- Multi-specialty medical and surgical consultations available
- Diagnostic services available
- Respiratory therapy services on-site 24/7
- Continuous cardiac monitoring and critical care available
- Weekly interdisciplinary team review
- Medical Surgical services with nurse staffing the same as short term acute care
- Intensive Care services with nurse staffing the same as short term acute care
- Interdisciplinary wound management
- Daily physician rounds

PROCEDURE:

1. If a patient meets criteria for an LTAC admission, social services or Case Management may do a referral to an appropriate facility. Admission referrals should include the following:
    - Current History and Physical
    - Progress Notes
    - Current MAR
    - Laboratory Reports including cultures
    - Radiology Reports
    - Advance Directives/Power of Attorney or POLST forms
    - Face Sheet
    - PT, OT Progress Notes
    - Respiratory Notes or Ventilator Flow Sheets
    - PASSAR if out of state
2. The patient will be educated on the need for LTAC transfer and options related to follow-up care, treatment and services.
3. A referral should be made to at least two facilities.
4. Referral to the LTAC should be documented in the social service progress notes including: Date and time of referral and who the referral is made to. If contact is made with any person, this should be documented.
5. If patient is accepted, social services may do the following:
    - Assist with the arrangement of transportation
    - Assist the family with appropriate housing referrals if needed
    - Acceptance of the patient must also be documented in the social service progress notes. This should include date and time of acceptance, contact person at accepting facility, name of receiving physician and time that patient will be expected at accepting facility. Additionally, a contact number should be documented so that a nurse report can be called to the facility upon the patient's discharge.

Title: Long Term Acute Care Hospital (LTACH)	
Scope: Case Management Team	Manual: Social Services, Utilization Review, Case Management
Source: Case Manager	Effective Date:

5. Upon transfer, the following must be sent with the patient:
    - Transfer paperwork including emergent or non-emergent transfer paperwork
    - Justification for transportation by ambulance
    - Transfer Summary/Discharge Summary
    - Current History and Physical
    - Progress Notes
    - Current MAR
    - Laboratory Reports including cultures
    - Radiology Reports
    - Advance Directives/Power of Attorney or POLST forms
    - Face Sheet
    - PT, OT Progress Notes
    - Respiratory Notes or Ventilator Flow Sheets
    - Pre Admission Screening and Resident Review (PASRR) form if out of state
6. Upon discharge the patient's nurse will call report to the receiving facility

REFERENCES:

1. TJC CAMCAH 2016, PC.04.01.01, PC.04.01.03, PC.04.01.05, PC.04.02.01

CROSS REFERENCE P&P:

1. Utilization Review Plan
2. Patient Transfer/Discharge to another Facility
3. Transfer & Transportation for Patients

Approval	**Date**
CCOC	11/6/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 10/2017
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: MEALS ON WHEELS	
Scope: District	Manual: Social Services
Source: Case Management	Effective Date:

PURPOSE:
Meals on Wheels are provided to support individual's ability to remain living independently by providing nutrition in the home to persons with limited ability to obtain and prepare food. This service may be utilized on a temporary or permanent basis.

POLICY:
1. Meals on Wheels are available to any senior citizen over the age of 60 or any couple when one member is over 60.
2. One hot meal is delivered around noon 4 days per week. Four (4) frozen meals are available upon request and when budget allows. Payment is by donation.
3. Social worker/case manager will discuss the availability of one nutritious meal per day with each referred patient. If the patient agrees, the social worker will arrange for this service by telephone to the appropriate meal site.
4. A daily meal is available at each senior site also. Senior citizen patients should be encouraged whenever possible to participate in this activity because of the stimulation and companionship it provides.
5. There are waiting lists for the free meals
6. Based on income and to start the program sooner, the senior can pay for their meals until a "free" slot is open. This can be either $1.00 per meal up to $9.00 per meal and a six (6) week deposit will be asked for up front. When a slot for free meals is open the senior's money will be reimbursed.
7. At the time of discharge the patient will be notified of the plan to provide the Meals on Wheels service and provided with the phone number to call for any concerns.

- Benton Senior Center 760-933-2272
  Behind the Firehouse
  Benton, CA 93512

- Big Pine Senior Center 760-938-2345
  150 Dewey St
  Big Pine, CA 93513

- Bishop Senior Center 760-873-5240
  506 Park Ave
  Bishop, CA 93514

- Lone Pine Senior Center 760-876-5518
  138 Jackson St
  Lone Pine, CA 93525

- Tonopah Senior Center 775-482-6450
  #1 Senior Center Dr
  P.O. Box 392
  Tonopah, NV 87049

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: MEALS ON WHEELS	
Scope: District	Manual: Social Services
Source: Case Management	Effective Date:

PROCEDURE:

1. District staff may call the patient's local Meals on Wheels center to arrange this service.
2. The patient/family-caregiver will be at the center of the decision to receive this service.

REFERENCES:

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services; CMS Manual, Conditions of Participation 482.43(a) – 482.43 (e)
2. California Department of Public Health, Senate Bill 675: Hospital Discharge Planning and Family Caregivers; Health and Safety Code section 1262.5, Chapter 494
3. The Comprehensive Accreditation Manual for Critical Care Access Hospitals as published by The Joint Commission; Standards PC.04.01.03; PC.04.02.01; PC.04.01.05

CROSS REFERENCE P&P:

1. Discharge Planning

Approval	**Date**
CCOC	11/6/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Directors Review	3/15/17

Developed:
Reviewed:
Revised:10/2017
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Services Standing Committee Structure and Hospital Committee Participation	
Scope: Nursing Services	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: CNO	Effective Date:

PURPOSE:

1. Standing committees are permanently established within Nursing Services to make decisions or handle problems related to a specific function. Concerns addressed by standing committee are those that need continual monitoring over the life time of the hospital.

POLICY:

1. Members of Nursing Service hold positions in a variety of standing committees including Hospital Administration, Medical Staff, ancillary Services, Nursing Services, Support Services and the Community.
2. Nursing Services participates in a variety of non-routine meetings that include Task Force and PI Teams.
3. Monthly meetings are held by Nursing Management in each department with staff (direct reports).
4. Nursing Services committees are evaluated for structure and function via review of the following questions:
    a. Does the committee fill a vital need that is not within the scope of any other committee? Does the committee continue to meet the purpose for existing? Are committee goals set for accomplishment?
    b. Are there adequate (too few or too many) committees to enable Nursing Services to reach its goals? Are there any obvious omissions? Is staff involved in committee decision-making when appropriate?
    c. Are the purpose statements of the committee consistent with the Mission/Vision Philosophy of Nursing Services?
    d. Is the total number of committees and membership logical for the size of Nursing Services and the established objectives of annual goals?

PROCEDURE:

1. Nursing Services members actively participate in the following Nursing Services, Hospital Administration, Medical Staff, Ancillary Services, Support Services, and Community Committees.
    a. Nursing Services Committees (see attached purpose, etc)
        i. Nursing Executive Committee
        ii. Shared Governance Central Council
            1. Orientation Competency Committee
            2. Staffing Issues Advisory Committee
            3. Professional Practice Committee
            4. Clerk/Tech Council
        iii. Safe Patient Handling
        iv. Clinical Consistency Oversight Committee
        v. Staffing Huddle
    b. Hospital Administration
        i. Senior Leadership
        ii. Department Heads Committee
        iii. Resuscitation Committee/Emergency Management/End of Life Committee
        iv. Safety Committee
        v. Data Integrity Meeting
        vi. Workforce Experience Committee
        vii. Patient Experience Committee
    c. Medical Staff Committees
        i. Medical Executive Committee
        ii. Quality Improvement and Library/Medical Education Committee
        iii. Pharmacy & Therapeutics Committee
        iv. Infection Control Committee

Title: Nursing Services Standing Committee Structure and Hospital Committee Participation	
Scope: Nursing Services	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: CNO	Effective Date:

v. Emergency Services Committee
vi. Perinatal/Pediatrics Committee
vii. Medical Services/ICU Committee
viii. Utilization Review and Medical Records Committee
ix. Interdisciplinary Practice Meeting
x. Surgery, Tissue, Transfusion and Anesthesia Committee

d. Ancillary Services
   i. Radiation Safety Committee
   ii. Medication (MAIC)

Nursing Services Staff participation on committees must be approved by the person's manager.

REFERENCES:

1. CAMCAH 2016 of TJC Standard NR.01.01.01- EP #4.

CROSS REFERENCE P&P:

1. Medical Staff Rules & Regulations

Approval	**Date**
NEC	**10/18/17**
MEC	**12/5/17**
Board	

Developed: 6/2013
Reviewed:
Revised: 1/15, 2/2017ta
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Ombudsman	
Scope: District	Manual: Social Services, Swing Bed
Source: Chief Nursing Officer	Effective Date:

PURPOSE:
The Ombudsman program is state mandated to provide advocacy for residents in long term care facilities which include both residential care facilities (board and care facilities) and skilled nursing facilities and to investigate all complaints brought to the program by a resident, family member, or interested party

Ombudsman Advocacy Service of
Inyo and Mono Counties
162 E Line St
Bishop, CA 93514
760 872-4128

POLICY:
1. When patients or families express concern and/or complaints regarding their care or treatment in a residential or long term care facility, including issues related to personal belongings, the social worker will advise them of this program and instruct them on their right to bring all such complaints to the Ombudsman.

2. The social worker, if requested, can arrange for a meeting in the hospital between the Ombudsman and the patient or family.

3. Northern Inyo Hospital employees are mandated reporters for dependent and elder abuse and neglect. When questions of care or adult/elder abuse of a patient is suspected by staff and when the patient is a resident in a residential care facility or nursing home, the report will be made to the Ombudsman program. The report will be made first by telephone and followed by the appropriate written report. The social worker will assist staff as needed.

REFERENCES:

1. CHA Consent Manual 2016 Edition, Chapter 19 Assault and Abuse Reporting Requirements; Abuse of Elders and Dependent Adults (19.19 – 19.28).
2. CA.GOV. California Department Pubic Health CDPH Health Facilities Consumer Information System http://hfcis.cdph.ca.gov/LongTermCare/ConsumerComplaint.aspx
3. North Bay Healthcare Administrative Manual. Elder and Dependent Adult Abuse, Neglect and Exploitation; Policy #309.

CROSS REFERENCE P&P:
1. Elder and Dependent Adult Abuse

Approval	**Date**
CCOC	11/6/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Ombudsman	
Scope: District	Manual: Social Services, Swing Bed
Source: Chief Nursing Officer	Effective Date:

UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board of Director review	3/15/17

Revised: 10/2017ta
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Handling and Disposal of Contaminated Needles/Syringes~~ Sharps Injury Protection Plan	
Scope: ~~**All Unit**~~**NIHD**	**Department:** Infection Control Orange Manual
Source: **Quality Informatics Nurse/**Infection Prevention ~~Practitioner~~Manager	**Effective Date: August 2007**

PURPOSE:

The purpose of engineered sharps safety is to increase protection from sharps injuries, which can transmit HIV, hepatitis B, hepatitis C and other bloodborne pathogens. This is accomplished by stronger requirements for employers to use needles and other sharps which are engineered to reduce the chances of inadvertent needlesticks or other sharps injuries.

Note: NIHD is *required to keep a sharps injury log, which records the date and time of each sharps injury, as well as the type and brand of device involved in the exposure incident, the task being done when the injury occurred and whether the injury occurred before, during or after the task was performed. This log is used to evaluate sharps products and employee practices to prevent further exposures.*

~~1. *To avoid needle stick injuries.*~~

~~*2. To avoid splatter of blood/body fluids.*~~

POLICY:

~~1.~~ Needles/syringes shall not be recapped, broken, clipped, bent or otherwise manipulated by hand.

1.

~~2.~~ Needles/syringes will have safety features, if they are available in the marketplace.

2.

~~3.~~ If a needle/syringe does not have an incorporated safety feature, additional safety equipment will be used.

3.

4. IV catheters with safety features are used.

5. The employee or physician performing the procedure **MUST** dispose of their own sharps

~~4.~~ 6. Contaminated sharps will be placed in appropriate sharps container

DEFINITIONS:

1. Passive safety: A feature that requires no action by the user.
2. Safety Engineered Devices: A device that has a built in sharps injury protection mechanism such as an attached sheath covering the needle or scalpel after use or needles that retract.
3. Sharps: Devices or objects capable of cutting or piercing. Examples include scalpels, razor blades, broken glass, microscope slides, and needles.
4. Sharps container: Rigid puncture resistant container with a secure lid that can safely store sharps waste.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Handling and Disposal of Contaminated Needles/Syringes~~ Sharps Injury Protection Plan	
Scope: ~~**All Unit**~~**NIHD**	**Department:** Infection Control Orange Manual
Source: **Quality Informatics Nurse/**Infection Prevention ~~Practitioner~~Manager	**Effective Date: August 2007**

PROCEDURE:

~~1.~~1. Needles/syringes shall be disposed of immediately after activation of the safety feature, and placed into the closest sharps container provided on each medication cart, patient room, and other designated work areas in the nursing and patient treatment units. This may require placing a portable sharps container in the area of point of use.

~~2.~~2. Do not place sharps on bedding, drapes, tables or into trash.

3. ~~3.~~ Do not transport uncovered needles.

~~5.~~4. Be responsible to discard needles yourself- avoid handing to another person unless safety feature is activated.

~~6.~~5. During any surgical or diagnostic procedure, as well as suturing of intravenous or intra-arterial catheters, place suture needles on designated towel, collection unit, or on disposable tray.

~~7.~~6. Avoid placing hands, yours or someone else's, in close proximity of suturing, cutting or injecting.

~~8.~~7. Needles found on floor, trays, linen, tables, etc. must **NOT** be picked up by hand; use needle holder, tongs, or dustpan and broom to retrieve.

~~9.~~ 8. For needles without attached engineered safety protection, use point lock needle protection device ~~red tip~~ protector to protect used needles before discarding or removing needle from syringe.

~~10.~~ 9. When safety syringe/needle is used, safety feature must be activated immediately after use. Use a hard surface to activate the safety feature

~~11.~~ 10. Always dispose of needles into sharps box with one-handed technique; do not open lid with second hand.

~~12.~~ 11.. During blood draws, it is preferable to use:

* Safety vacutainer
* Safety butterfly system

If using a needle:

a. Utilize a needle with engineered safety protection
b. Draw blood
c. Activate the safety feature of the needle immediately; or stab into tip protector immediately
d. discard in sharps container
e. Use transfer dome to fill tubes/bottles.

Title: ~~Handling and Disposal of Contaminated Needles/Syringes~~ Sharps Injury Protection Plan	
Scope: ~~**All Unit**~~**NIHD**	**Department:** Infection Control Orange Manual
Source: **Quality Informatics Nurse/**Infection Prevention ~~Practitioner~~Manager	**Effective Date: August 2007**

12. After drawing up medication to inject ~~into tubing:~~
    a. ~~a.~~ activate safety feature and dispose of needle at med cart – do not take into patient room
    b. cover tip with port protector or cap from syringe tip for transport

Recapping of Contaminated Needles:

1. Due to safety features, recapping contaminated needles is never ~~necessary or~~ allowed.

Sharps Disposal Systems:

1. Sharps boxes shall:
   a. Be clearly marked as sharps disposal systems and have clearly visible Biohazard labels.
   b. Be puncture and leak-proof.
   c. Have opening easily accessible and safe to use. Do not place items on top of sharps container
   d. Staff must ensure that no items are sticking out of opening, and sharps are not stuck in the opening of sharps container.
   e. Be designed to prevent used sharps from being easily removed or spilled.
   f. Be stable/or secured to avoid tipping.
   g. Not be overfilled - maximum 3/4 full. Sharps container must be changed if at the fill line.
   h. Be sealed and placed in designated dumpster for sterilization *before* disposal to the landfill.
   i. Be locked to wall brackets to prevent removal when placed in patient rooms.

~~2.2.1~~

2. Environmental Services is responsible for checking sharps containers daily and is responsible for their removal and disposal.

~~3.~~ IV and Phlebotomy trays may have small sharps disposable boxes for needle disposal.

3.

ACCEPTING COMMUNITY NEEDLES:

IT IS IMPERATIVE THAT THIS POLICY IS STRICTLY ADHERED TO!

1. NIHD will accept contaminated needles from the community for disposal.

2. Refer questions from persons with needles to infection control or maintenance.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Handling and Disposal of Contaminated Needles/Syringes~~ Sharps Injury Protection Plan	
Scope: ~~**All Unit**~~**NIHD**	**Department:** Infection Control Orange Manual
Source: **Quality Informatics Nurse/**Infection Prevention ~~Practitioner~~Manager	**Effective Date: August 2007**

3. A sharps disposal unit is at the front of the hospital and all community sharps may be placed in this unit.

4. Sharps containers may not be sold or given to patients or other individuals for home use.

5. Sharps disposal located at ~~nih~~ NIHD front entrance (large **red** receptacle with the wording "**sharps**")

   A. Must be in rigid hard plastic bottles or containers with screw lids or
   B. Must be in sharps boxes designed for this purpose;
   ~~C.~~ Will not be accepted otherwise.

~~6. Infectious waste is in this same category! **If after hours advise persons that they must return the next working day.**~~

C.

~~7~~6. Any ambulance service may dispose of their needles/infectious waste at NIHD, at any time, but must dispose of it themselves in appropriate infectious waste containers.

REFERENCES:

1. Centers for Disease Control and Prevention. (2015). Workbook for Designing, Implementing and Evaluating a Sharps Injury Prevention Program. Retrieved from https://www.cdc.gov/sharpssafety/pdf/sharpsworkbook_2008.pdf
2. International Sharps Injury Prevention Society. (2017) Scalpel Injuries are a major source of bloodborne pathogen exposure in the OR. Retrieved from http://www.isips.org/page/scalpel_injuries

CROSS REFERENCE P&P:

1. Bloodborne Pathogen Exposure Control Plan
2. Work Related Accidents/Exposures

Approval	**Date**
CCOC	8/28/2017
Safety Committee	
Infection Control Committee	11/28/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Handling and Disposal of Contaminated Needles/Syringes~~ Sharps Injury Protection Plan	
Scope: ~~**All Unit**~~**NIHD**	**Department:** Infection Control Orange Manual
Source: **Quality Informatics Nurse/**Infection Prevention ~~Practitioner~~Manager	**Effective Date: August 2007**

MEC	12/5/17
Board of Directors	
Last Board of Directors Review	5/17/17

Developed: 4/92
Reviewed:
Revised: 12/93,12/94, 1/95, 2/97, 8/99, 6/01, 4/03, 9/03, 1/04; 8/04, 11/04, 5/05; 8/07; 8/08, 6/11JB; 9/12 BS; 11/15 NH, 6/17RC
Supersedes:
Index Listings: Sharps, injury

~~Last Board of Director review~~	~~5/17/17~~

~~Revised 4/92, 12/93,12/94, 1/95, 2/97, 8/99, 6/01, 4/03, 9/03, 1/04; 8/04, 11/04, 5/05; 8/07; 8/08, 6/11JB; 9/12 BS; 11/15 NH~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **WORKING WITH OTHER AGENCIES IN THE COMMUNITY**	
Scope: District	Department: **Social Services**
Source: Social Worker	Effective Date:

PURPOSE:
In order to achieve the goal of the Social Service Department to make timely, appropriate referrals for social service assistance, we practice an open, informal manner of cooperation between Northern Inyo Hospital and other community resources.

POLICY:

1. While each patient will not require social services, it is the policy of Northern Inyo Hospital to have services available to every patient, inpatient or outpatient, and his or her family.

2. Social Service Department is an integral part of the total health care of the patient and family. Social services are planned and administered in combination with related medical, educational and public assistance services. This involves referral to the services as discussed in this section of the Social Service Manual.

~~GENERAL~~ PROCEDURE:~~S~~

1. Patient referral for services can come from many sources and can encompass many problems. Patient referral may come from physicians, nursing staff, the patient, his or her family and friends.

2. The social worker should be contacted as soon as possible after a request for social service has been made. The social worker will respond promptly to each referral (within 24 hours, weekends and holidays excluded), and record the results and referrals in the patient's medical record. During emergencies, social services assistance will be available by calling the social worker, the relief social worker or in their absence, the Utilization Review Coordinator, who has also been trained in providing social service support to patients and family.

3. After consultation with the patient, family and/or physician, when referrals are to be made the basic procedure is to contact the agency by telephone. A written referral to that service will follow when required.

4. Whenever circumstances indicate, the social worker shall contact the patient or family after discharge to determine the status of the patient.

5. All information received by the social worker shall be treated with the strictest confidentiality and shared with only the appropriate referral sources as required to ensure proper care for the patient. No breach of the policy will be allowed.

REFERENCES:

1. Title 22- 70711. Social Services

CROSS REFERENCE P&P:

1. Utilization Review Plan
2. Discharge Planning

Committee Approval	Date
CCOC	11/20/17
UR Committee	12/1/17
Medical Executive Committee	12/5/17
Board of Directors	
Last Board Review	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **WORKING WITH OTHER AGENCIES IN THE COMMUNITY**	
Scope: District	Department: **Social Services**
Source: Social Worker	Effective Date:

Revised:
Reviewed:
Supercedes:

Responsibility for review and maintenance:
Index Listings:
Initiated:
Revised/Reviewed: