Northern Inyo Hospital

February 15 2017 Regular Meeting

February 15 2017 Regular Meeting - February 15 2017 Regul

CARE Act Letter of support and Information

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
February 15, 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.)*

Consent Agenda (action items)

3. Approval of minutes of the January 18, 2017 regular meeting
4. 2013 CMS Validation Survey Monitoring, February 2017

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5. Quarterly Financial and Statistical Reports at December 31, 2016 (*action item*)
6. Data and Information Committee Report (*information item*)
7. Chief of Staff Report; Joy Engblade, MD:
   A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
      - *Cesarean Delivery (*supersedes both *Cesarean Deliveries – Nurses Responsibilities in the OR* and *Cesarean Delivery – Emergency)*
      - *Falls Risk Prevention – Perinatal*
      - *Death – Disposition of Body*
      - *Pronouncement of Death*
      - *Scope of Services, Infusion Center*
      - *Scheduling Surgical Procedures*
      - *Patient Safety Attendant or 1:1 Staffing Guidelines*
      - *Credentialing Health Care Practitioners in the Event of a Disaster*
      - *Medical Staff and Allied Health Professional Application Fee Processing*
      - *Transfusion Criteria*
      - *New Transfusion Reaction Document*

B. Annual Approval of Critical Indicators (*action items*):
   - Emergency Room Service
   - Surgery, Tissue, Transfusion and Anesthesia
   - Medicine/Intensive Care

C. Medical Staff Appointments/Privileging (*action items*):
   - Saif Siddiqi, MD (Teleradiology)
   - Robert James, MD (Pathology – Locum tenens)

D. Performance Monitoring Plan - Focused Professional Practice Evaluation (FPPE) – (*action item*):
   - Sarah Zuger, MD (Family Medicine & OB/Gyn)
     - Evaluation methods to include direct observation, medical record review, and discussion with peers (including OB evaluation) for 5 procedures and 5 discharges. Plan set forth by Anne Gasior, MD.
   - Cecilia Rhodus, MD (Pediatrics)
     - Findings: Practitioner has demonstrated competency in performing the clinical privileges granted. Evaluation completed by Charlotte Helvie, MD.
   - Manish Pandya, MD (Internal Medicine/Hospitalist)
     - Findings: Practitioner has demonstrated competency in performing the clinical privileges granted. Evaluation completed by Joy Engblade, MD.

E. Other
   - Addition of "Portacath Insertion" to interventional radiology privileges (*action item*)

8. Chief Executive Officer Report (*information items*)
   - Pharmacy/OSHPD update
   - Director of Diagnostic Imaging and Lab
   - Electronic Health Record update
   - 340B update
9. Chief Operating Officer Report (*information item*)
   - Introduction of Amber Morin, Dietician
10. Chief of Fiscal Services Report (*information item*)
11. Chief Nursing Officer Report (*information items*)
   - Nursing Department restructure
   - Perinatal manager update

- Nitrox and the perinatal unit

12. Chief Human Relations Officer Report (*information item*)
13. Chief Performance Excellence Officer Report (*information items*)
    - Joint Commission Accreditation
    - General Survey Readiness Activities
    - Hospital wide Quality Assurance and Performance Improvement (QAPI) Plan
    - Service Excellence
    - TeamSTEPPS
    - Pillars of Excellence
    - Training & Education-Incident Reporting
14. District Compliance Report (*information item*)
15. Hospital Wide Policy and Procedure annual approvals (*action items*); Attachment A to agenda.
16. Old Business
    A. Bishop Union High School student clinic update (*information item*).
17. New Business
    A. Nursing Department Policy and Procedure approvals (*action items*):
        1. *Admission of a Pediatric Patient*
        2. *Admission to the Acute/Sub Acute Department*
        3. *Care Plan, Inpatient*
        4. *Down Time Procedures for OP, PACU*
        5. *Fixed Floating*
        6. *Staffing Huddle*
        7. *Surgery Charges*
        - *Surgery Charges, Attachment*

    B. Hospital wide Policy and Procedure approval: *Exempt Employees* (*action item*).
    C. Hospital wide Personnel Policy approval: *Paid Absence* (*action item*).
    D. Hospital wide Policy and Procedure approval: *United States Postal Service Mail* (*action item*).
    E. Hospital wide Policy and Procedure approval: *Medicare Outpatient Observation Notice* (*action item*).
    F. Hospital wide Policy and Procedure approval: *Charge Master Procedures for Clinics* (*action item*).

G. Hospital wide Policy and Procedure approval: *Charity Care Program* (*action item*).

H. Radiology RFP Process and proposed contract (*action item*).

I. Compliance Program for NIHD (*revised*)(*action item*).

J. Diet Manual approval, RD's for Healthcare (*action item*).

K. Letter of support for Critical Access and Rural Equity Act (CARE)(*action item*).

18. Reports from Board members (*information items*).
19. 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. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3 matters pending (*pursuant to Government Code Section 54956.9*).
    C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
20. Return to open session and report of any action taken in closed session.
21. 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.

ATTACHMENT A

FEBRUARY 15 2017 DISTRICT BOARD AGENDA

1. **Annual approval, Hospital Wide Policy and Procedure: *Hospital District Credit Card Policy***

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD			
	PHARMACY DEPT.			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Black Box Warnings	2/15/2017		
2	Automated Dispensing Unit	2/15/2017		
3	Automatic Stop of Medication Orders	2/15/2017		
4	Discharge Medications	2/15/2017		
5	Drug Orders	2/15/2017		

POLICIES TO THE BOD
SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD			
	SECURITY AND MAINTENANCE			
	TITLE	TO BOD	APPROVED	COMMENTS
1	Policy on Risk Assessment for Safety	2/15/2017		
2	Policy on Action to Safety & Security Risk	2/15/2017		
3	Policy on Maintaining Grounds & Equipment	2/15/2017		
4	Policy on Identification of Individuals	2/15/2017		
5	Policy on Access to Security Sensitive Areas.doc	2/15/2017		
6	Code Gray Combative Patient	2/15/2017		
7	EOP ERP- Active Shooter EP-EM.02.01.01EP2	2/15/2017		
8	Policy on Product Recalls	2/15/2017		

POLICIES TO THE BOD
CARDIO/RESPIRATORY

	POLICY & PROCEDURES TO THE BOARD OF DIRECTORS			
	CARDIOPULMONARY/RESPIRATORY			
	TITLE	TO BOD	APPROVED	COMMENTS
1	Nebulized Lidocaine	2/15/2017		
2	Continuous Bronchodilator with MiniHeart Hi-Flow Continuous Nebulizer	2/15/2017		

POLICIES TO THE BOD
REHABILITATION

	POLICY & PROCEDURES TO THE BOARD			
	REHABILITATION			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	General Policies for In-Patients/OPO/Swing Patients	2/15/2017		
2	Functional Risk Assessment Criteria for Therapy Referral	2/15/2017		
3	Code of Ethical Behavior	2/15/2017		

POLICIES TO THE BOD
DIAGNOSTIC SERVICES

POLICIES TO THE BOARD				
DIAGNOSTIC SERVICES				
	TITLE	TO BOD	APPROVED	COMMENTS
1	DI-Area Monitoring and Controls	2/15/2017		
2	DI-Communication of Mammography Results to the Patient	2/15/2017		
3	DI-CT Dose documentation	2/15/2017		
4	DI-Diagnostic Paravertebal Nerve Block	2/15/2017		
5	DI-MRI Safety Burn/Thermal Incident Reduction Policy	2/15/2017		
6	DI-NM Cisternogram	2/15/2017		

Gilstrap, Summer (Manager of Perinatal Department)
Area: Published

Ref #	Title	TO BOD	APPROVED	COMMENTS
618	Admission and Care of Newborn			
619	Admission Assessment of Obstetrical Patient			
620	Antepartum / Postpartum Patients Admission			
656	Antepartum/Postpartum Patient Discharge			
719	BiliChek Transcutaneous Bilirubin Testing			
718	Bili-Lite Pad Olympic			
1243	Certified Nurse Midwife-Stardardized Procedures			
640	Cervical Culture Procedure			
636	Cesarean Deliveries Nurses Responsibilities in the			
983	Cesarean Delivery Emergency			
1118	Consent for Induction or Augmentation of Labor			
639	Cord Blood Procedures			
655	Discharge of Newborn			
1109	Drugs of Abuse Maternal and Infant			
659	Education for Perinatal Nurses			
701	Emergency Medication Boxes in Perinatal Unit			
660	Epidural Anesthesia: Management of the Laboring			
661	Epidural PCA for Obstetric Analgesic Services			
681	Ferning			
682	Fetal Fibronectin Testing			
666	Fetal Heart Rate Monitoring in OB			
280	Fetal Heart Rate Monitoring when not in the OB Unit			
668	Fetal Monitoring Internal			
686	Hearing Screening Program Newborn			
165	Hepatitis B Vaccination of Newborns			
1724	High Risk OB Patients			
1122	HIV Prevention Program Perinatal			
674	Infant Formula Preparation and Storage			
693	Infection Control Policy Perinatal*			
690	Intrapartum Care			
695	Intubation of an Infant			
613	Isolette Policy and Procedure			
651	LDRP Delivery			
700	Meconium Delivery			
1125	Medical Screening Exam for the Obstetrical Patient - Standardized Procedure			
704	Microscope Use for Ferning			
1102	Misoprostol for Cervical Ripening			
1103	Misoprostol For Induction of Labor Order Sheet			
657	Neonatal Death, Fetal Demise & Spontaneous			
694	Neonatal Intravenous Therapy: Initiation and			
731	Neonatal Resuscitation/Neonatal Code			
600	Newborn Blood Glucose Monitoring			
1317	Newborn Hearing Policy			

2185	Newborn Pulse Oximetry Screen			
1435	Newborn Screening Test			
766	Newborn Transport to XRay Department			
3984	Nitrous Oxide Use in the Intrapartum/Immediate			
2138	Overflow Placement of Perinatal Patients			
616	Pain Management of the Neonate			
99	Perinatal / Neonatal Unit Performance Improvement			
717	Phototherapy			
688	Pitocin Administration			
727	Placenta Disposal			
2140	Postpartum Hemorrhage Policy			
720	Postpartum Patient after Vaginal Delivery Care of			
728	Postpartum Recovery			
721	Pre-Eclamptic and /or Eclamptic Patient Care of			
722	Premature and/or High Risk Infant Care of			
723	Premature Infant with Order for "No Code" Care of			
663	Prophylactic Eye Treatment for the Newborn			
664	Prophylactic Eye Treatment of Infant Refusal			
251	Rhogam Administration			
733	Rooming In Protocol			
735	Safety Policy for Perinatal Unit Patients			
1152	Shoulder Dystocia			
742	Staffing Guidelines Perinatal Unit Including High Risk			
744	Standards of Patient Care in the Perinatal Unit			
1821	Standing Orders For Newborn Nursery			
745	Sterile Speculum Exam			
761	Sterile Vaginal Examination on Patients with Premature Rupture of Membranes and/or Premature			
743	Support Person for the Obstetrical Patient in the Birthing and Operating Rooms			
603	Surfactant (exogenous) Therapy in Preterm Infants			
3840	Telephone Triage			
1153	Ultrasound in the Perinatal Unit			
757	Unassigned Obstetrical Patients Policy			
649	Urinary Catheterization Neonate			
759	Vaginal Birth After a Cesarean Section (VBAC)			
641	Vaginal Culture Procedure			
652	Vaginal Delivery in the OR			
762	Vaginal Prep			
646	Video taping in Delivery			
764	Visiting Policy Perinatal Unit			
696	Vitamin K (Phytonadione) Administration			

CALL TO ORDER	The meeting was called to order at 5:34 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Phil Hartz, Member at Large Joy Engblade MD, Chief of Staff
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Maria Sirois, Chief Performance Excellence Officer Alison Murray, Interim Chief Human Relations Officer Sandy Blumberg, Executive Assistant
ABSENT	Carrie Petersen, Chief of Fiscal Services Tracy Aspel RN, Interim Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced 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 and speakers will be limited to a maximum of three minutes each. Comments were heard from Bishop Union High School Varsity Football coach Arnie Palu.
CONSENT AGENDA	Mr. Watercott called attention to the Consent Agenda for this meeting which contained the following items: - Approval of minutes of the December 14, 2016 regular meeting - Financial and statistical reports for November 2016 - 2013 CMS Validation Survey Monitoring, January 2017 It was moved by Mary Mae Kilpatrick, seconded by Phil Hartz, and unanimously passed to approve all three Consent Agenda items as presented.
STRATEGIC PLAN OVERVIEW	Chief Executive Officer Kevin S. Flanigan, MD, MBA provided an overview of the District's Strategic Plan, reviewing the purpose of the Workforce Experience Committee; the Data and Information Committee; and the Patient Experience Committee. The format for Board meetings going forward will include bi-monthly reports from each of these three Committees for the purpose of providing updates on progress made toward achieving the goals of the District's Strategic Plan.
WORKFORCE EXPERIENCE COMMITTEE REPORT	Interim Chief Human Relations Officer Alison Murray provided a Workforce Experience Committee (WEC) report which included the following: - An Employee Engagement survey has just been completed and

the results will be tallied in the next month. Employee participation in the survey was excellent with 333 out of 427 employees participating.

- Next steps on Committee projects include: creating an employee empowerment and engagement program; developing manager training tools; holding a Human Relations Open House for all employees; improving communications with employees; improving the job posting process; and improving the on boarding and off boarding processes (already underway).
- Human Relations is also in the process of conducting an employee salary survey

PATIENT EXPERIENCE COMMITTEE REPORT

Chief Performance Excellence Officer Maria Sirois reported the Patient Experience Committee (PEC) continues to focus on improving patient access at the Northern Inyo Healthcare District (NIHD) Rural Health Clinic (RHC) and is in the process of collecting data on patient service demand. A staff retreat for Clinic employees was recently held and customer service trainings for staff continue. The Clinic team is focused on finding ways to improve patient satisfaction, and additional support staff is being hired for RHC providers (now 10 practitioners total). Ms. Sirois also distributed information on AIDET interaction and assessment as it relates to patient encounters, and on medical practice profiles (models).

The Patient Experience Committee also continues to work on the following:

- Improving continuity of care across regional and local health care entities
- Pursuing telemedicine options
- Expanding community education opportunities

CHIEF OF STAFF REPORT

Chief of Staff Joy Engblade, MD reported following careful review, consideration, and approval by the appropriate committees, the Medical Executive Committee recommends approval of the following hospital wide policies and procedures:

POLICY AND PROCEDURE APPROVALS

- *Management of Discharge Disputes from Medicare Patients*
- *Utilization Review Plan (annual approval)*
- *Pitocin Administration (superseding: Pitocin Induction or Augmentation of Labor)*
- *Certified Nurse Midwife Standardized procedures (changes highlighted)*
- *Procedural Sedation (changes highlighted)*
- *Patient Restraints (Behavioral and Non-Behavioral) – Addition of Safety Vests*
- *Swing Bed Patient Restraints – Addition of Safety Vests*

It was moved by Ms. Kilpatrick, seconded by M.C. Hubbard and unanimously passed to approve all 7 hospital wide policies and procedures as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGING

Doctor Engblade also reported following careful review, consideration, and approval by the appropriate committees the Medical Executive Committee recommends approval of the Medical Staff appointment and privileging of Jennifer McKinley PA-C (RHC Family Practice). It was moved by John Ungersma, MD, seconded by Ms. Hubbard, and unanimously passed to approve the Medical Staff credentialing and privileging of Jennifer McKinley PA-C as requested.

FPPE RECOMMENDATION

Doctor Engblade additionally reported the Medical Executive Committee recommends approval of the Focused Professional Practice Evaluation (FPPE) Recommendation Form for Amy Saft CRNA (Certified Registered Nurse Anesthetist), and recommendation for completion of FPPE based on six proctored cases and discussion with peers. It was moved by Mr. Hartz, seconded by Doctor Ungersma, and unanimously passed to approve the FPPE Recommendation Form for Amy Saft, CRNA.

HOSPITAL WIDE POLICY AND PROCEDURE ANNUAL APPROVALS

Doctor Flanigan called attention to the list of Hospital Wide Policies and Procedures being presented for annual approval (Attachment A to the agenda for this meeting). It was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to approve all policies and procedures listed in Attachment A as presented.

AGENDA ITEMS RE-ORDERED

Doctor Flanigan requested that the agenda items for the remainder of the meeting be re-ordered to accommodate the schedules of individuals present to address specific topics. The Board agreed to addressing the agenda items for this meeting in an alternate order.

OCCUPATIONAL HEALTH CLINIC

Doctor Flanigan stated that the District is now at full capacity for primary care providers, however one service need remains unmet and that service is Occupational Health (Occ Med). He additionally stated that Ashvin Pandya, MD is certified for Department of Transportation physical exams, and he is interested in practicing at NIHD and providing both Occ Med and Urgent Care services. After receiving comments from Dr. Pandya (who was present at this meeting) it was moved by Ms. Kilpatrick, seconded by Ms. Hubbard and unanimously passed to approve the District moving forward to establish an Occupational Medicine and Urgent Care practice with Ashvin Pandya, MD.

BISHOP UNION HIGH SCHOOL CLINIC

Doctor Flanigan introduced Barry Simpson, Bishop Union High School (BUHS) Superintendent who was present for discussion of possibly establishing a student health clinic on the Bishop High School campus. The clinic would provide students with access to a variety of State authorized healthcare services, and provide education on sensitive issues such as addiction, reproductive health, general health, and emotional health issues. The concept of a school clinic has already been discussed (but not approved) by the BUHS Board of Directors. NIHD may

potentially provide a practitioner experienced in adolescent medicine for the clinic, who would be one campus one or two days per week. Following in-depth discussion of this issue it was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to allow NIHD Administration to continue discussion with BUHS regarding the possibly of operating an on-campus student health clinic.

REACH AIR MEDICAL SERVICES AGREEMENT

Doctor Flanigan introduced Jim Marchio with Sierra Life Flight, who informed the Board that Reach Air Medical Services has purchased Sierra Life Flight, the hospital's preferred patient air transport service provider for many years. Reach Air seeks to contract with the District to continue the relationship as preferred provider for this community. Following discussion of Reach services and programs (including a discount membership program for area residents) it was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the proposed contract with Reach Air Medical Services as presented.

COLLABORATION WITH RIDGECREST HOSPITAL ON HER REVIEW

Doctor Flanigan requested Board approval to move forward to collaborate with Ridgecrest Hospital to review Electronic Health Record (EHR) options for the District. Following discussion it was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve collaborating with Ridgecrest Hospital to review potential Electronic Health Record systems. The Board further recommended a Committee be formed for the purpose of reviewing potential EHR options for the District, and Director Hartz volunteered to serve as a member of that committee.

OPTIONS FOR EXPANSION OF PHYSICIAN RECRUITING

Doctor Flanigan requested Board approval of a philosophical change to how the District structures its physician recruitment packages, in order to improve its ability to attract new physicians to this area. New options might include a combination of sign on bonuses; student loan repayments; and student loan support for a portion of physician residency; and may also include requirements that incoming physicians provide service to the District for a minimum specified amount of time. Following discussion of the need to obtain providers for certain specialties it was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to approve expanding the variety of physician recruitment incentives currently offered by the District.

HEALTHCARE COST SOLUTIONS AUDIT AND AGREEMENT

Doctor Flanigan reported following receipt of a report regarding unusual distribution of coding for patient services, the District enlisted Healthcare Cost Solutions (HCS) to conduct an audit and review of patient medical records for the purpose of verifying coding accuracy. The audit found serious inconsistencies in coding for services with an error rate of 30 to 70 percent for five physicians audited. Because of the importance of addressing the problem as quickly as possible hospital administration signed an agreement with HCS to address the problem immediately, and

now requests ratification of that agreement. It was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to ratify the agreement with Healthcare Cost Solutions as requested.

NURSING DEPARTMENT POLICIES AND PROCEDURES

On behalf of Interim Chief Nursing Officer Tracy Aspel RN, Doctor Flanigan requested approval of the following Nursing Department Policies and Procedures:

1. *Community Skills Session; Reservation, No Show or Cancellation Policy*
2. *Cross-Training RN Staff*
3. *Orientation-Cross Training Time Frame*
4. *Nursing Assessment and Reassessment*
   a. *Nursing Assessment Reassessment Chart Time Frames*
5. *Nursing Care Plan*

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve Nursing Policies and Procedures 1 through 5 as presented.

BOARD MEMBER REPORTS

Mr. Watercott asked if any members of the Board wished to report on any items of interest. Director Ungersma encouraged his fellow Board members to attend the Association of California Healthcare Districts (ACHD) Leadership Academy in February, suggesting that they network with other District representatives as much as possible on the topic of EHR's. Director Hubbard also reported that she is working on completing the requirements for the District to obtain ACHD certification, and as part of that effort she will be developing (brief) Board member biographies for posting to the Northern Inyo Hospital (NIH) website.

CLOSED SESSION

At 8:27 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. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation (*pursuant to Government Code Section 54956.9*).
C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation (2nd case) (*pursuant to Government Code Section 54956.9*).
D. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation (3rd case) (*pursuant to Government Code Section 54956.9*).
E. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).

F. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 9:29 pm the meeting returned to open session. Mr. Watercott reported that the Board took no reportable action.

ADJOUNRMENT

The meeting was adjourned at 9:30 pm.

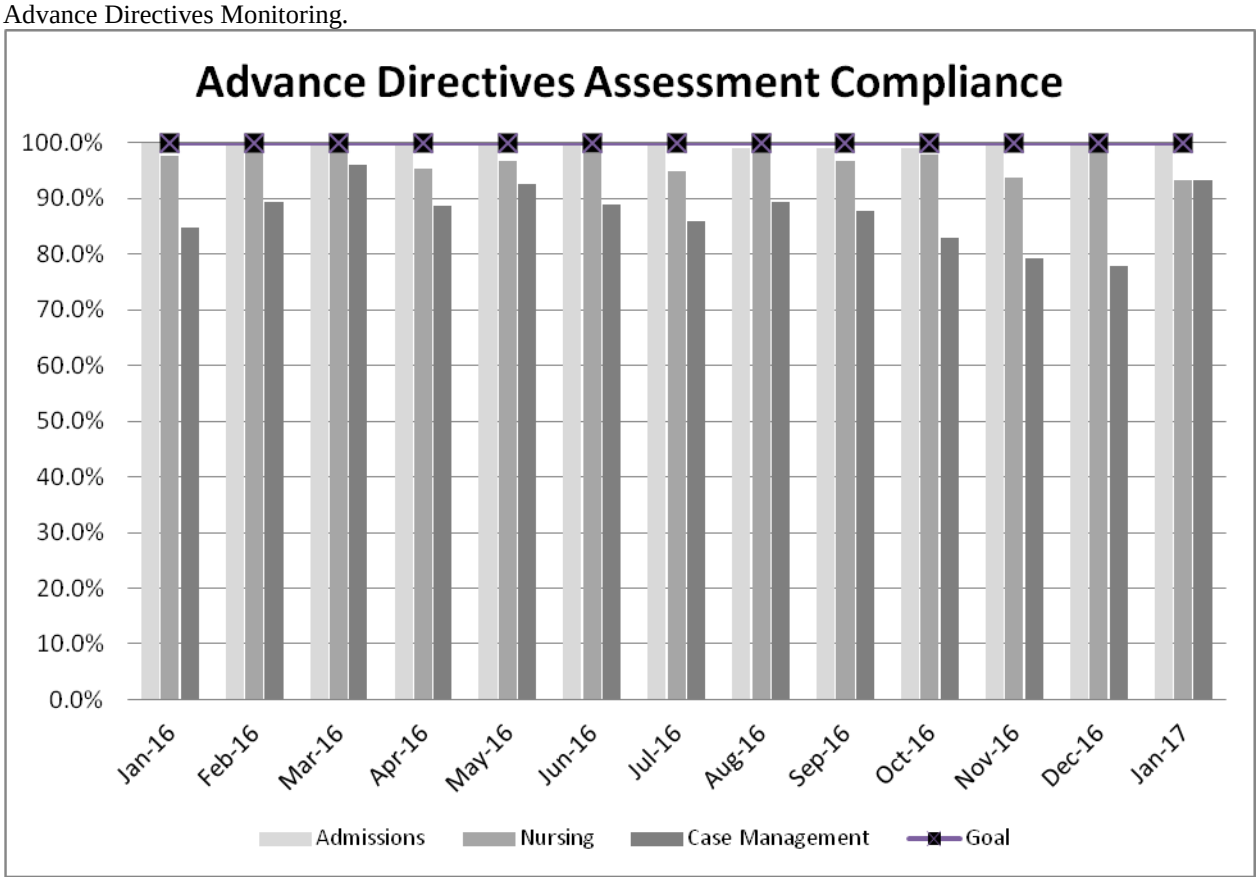
_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

2013 CMS Validation Survey Monitoring-February 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.

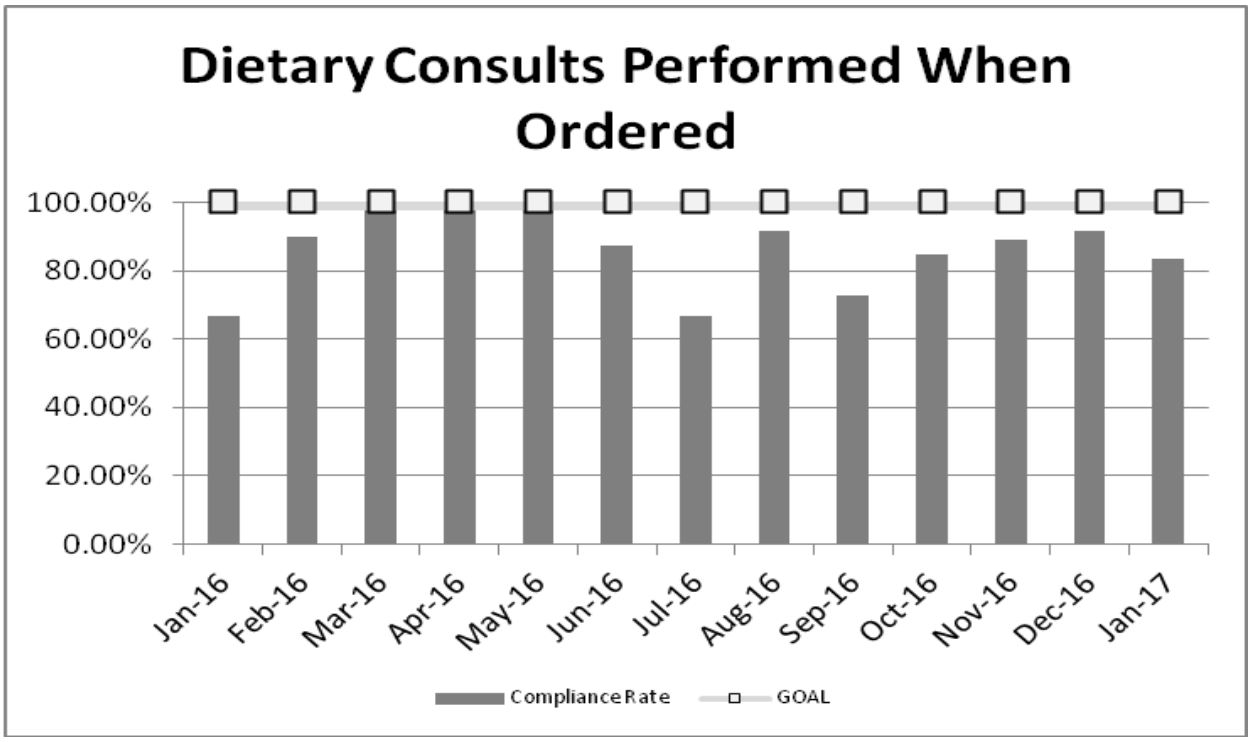


   b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

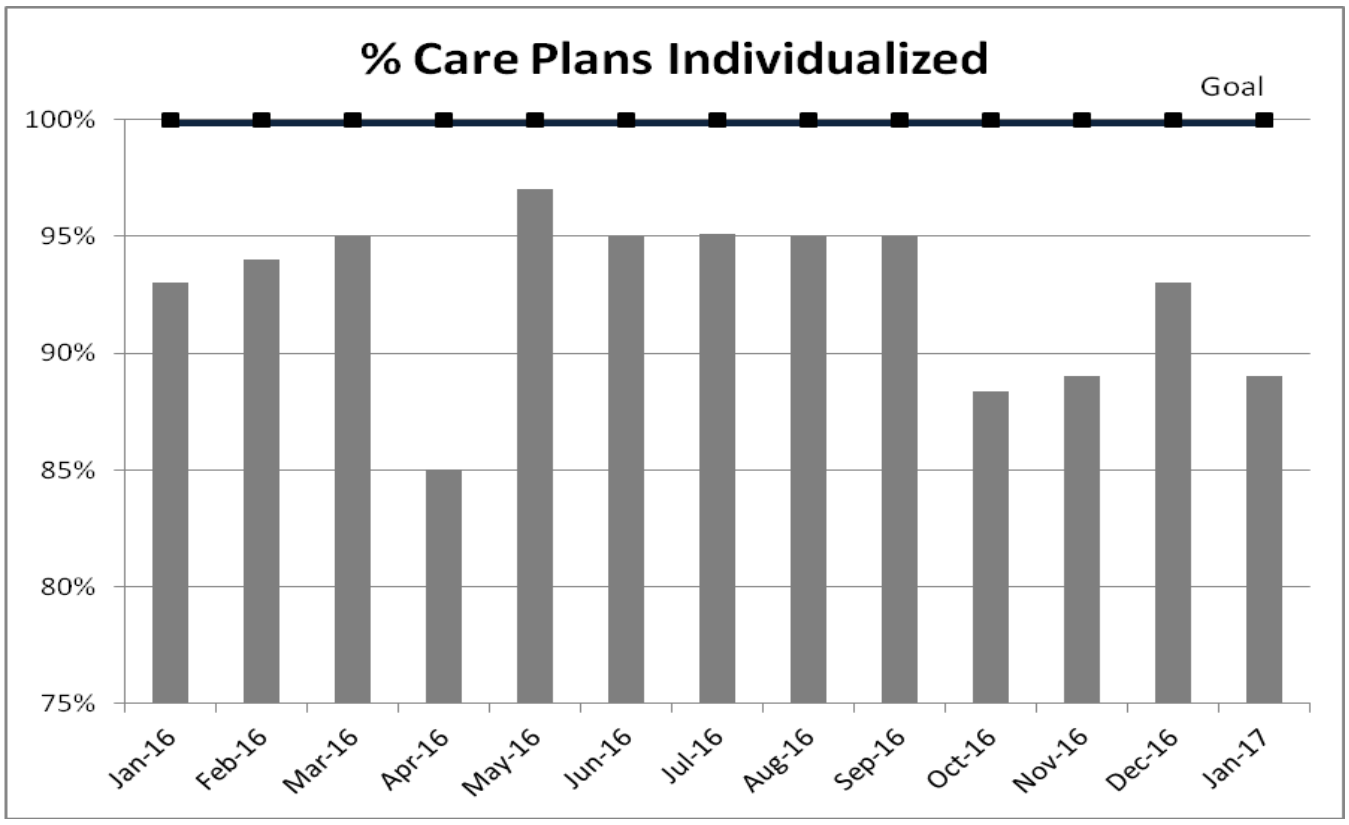
   c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

   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.



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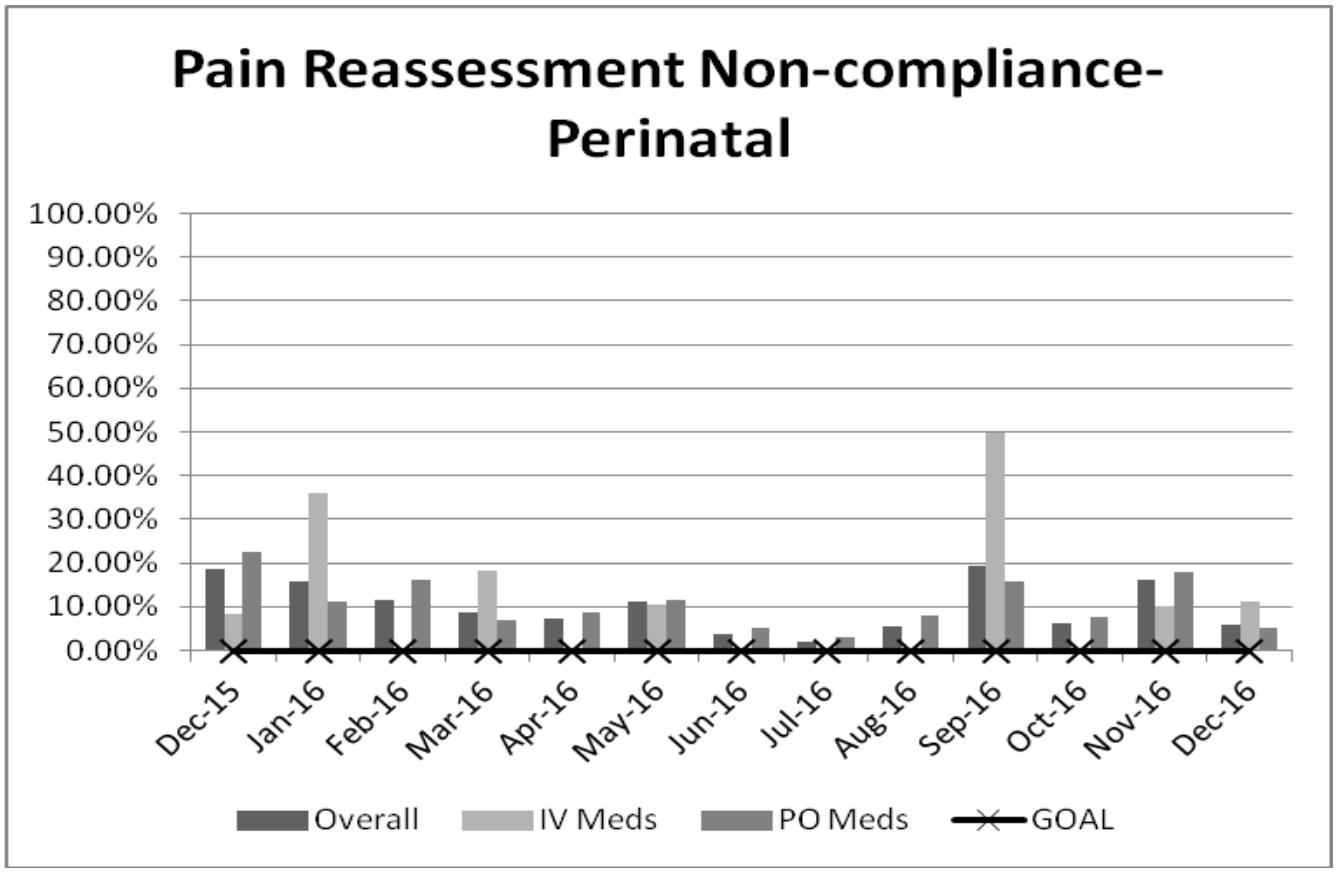
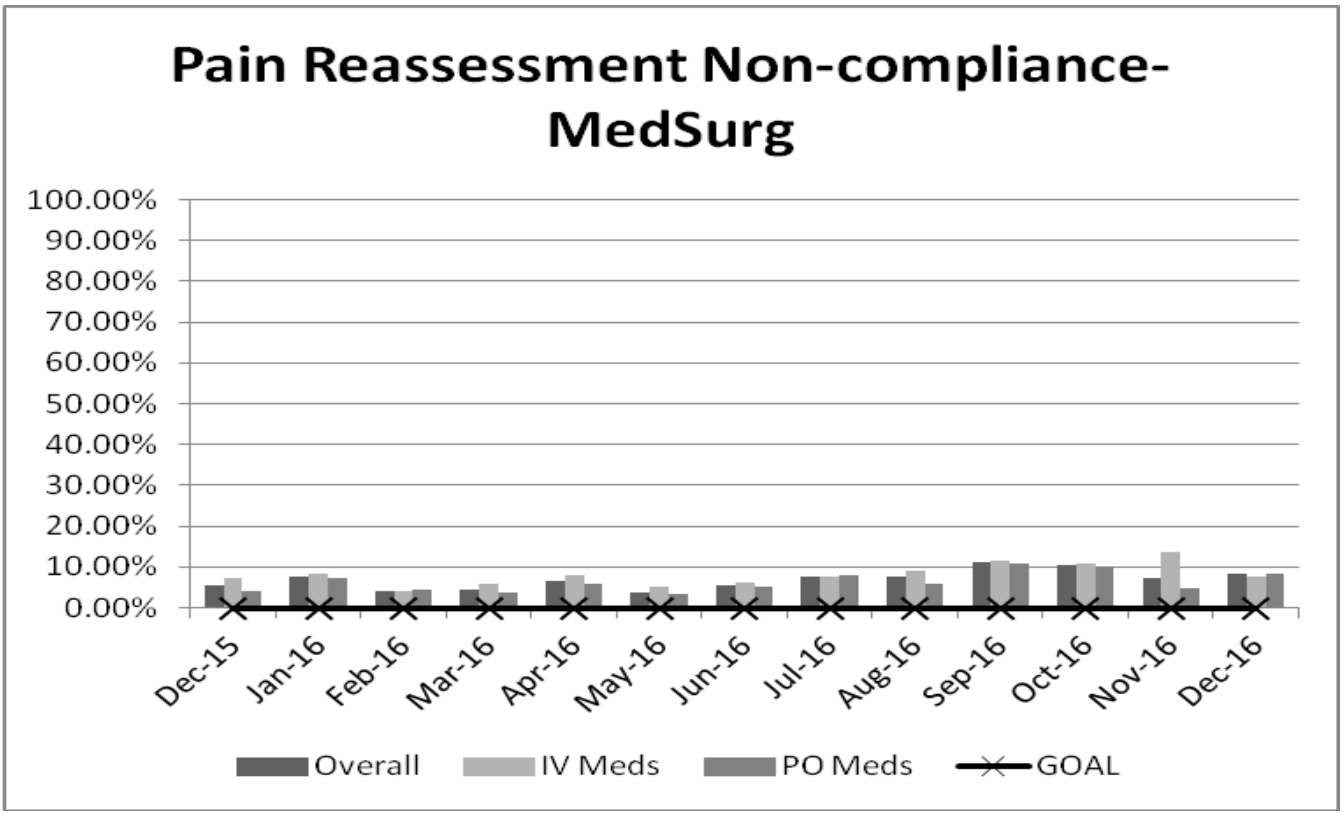
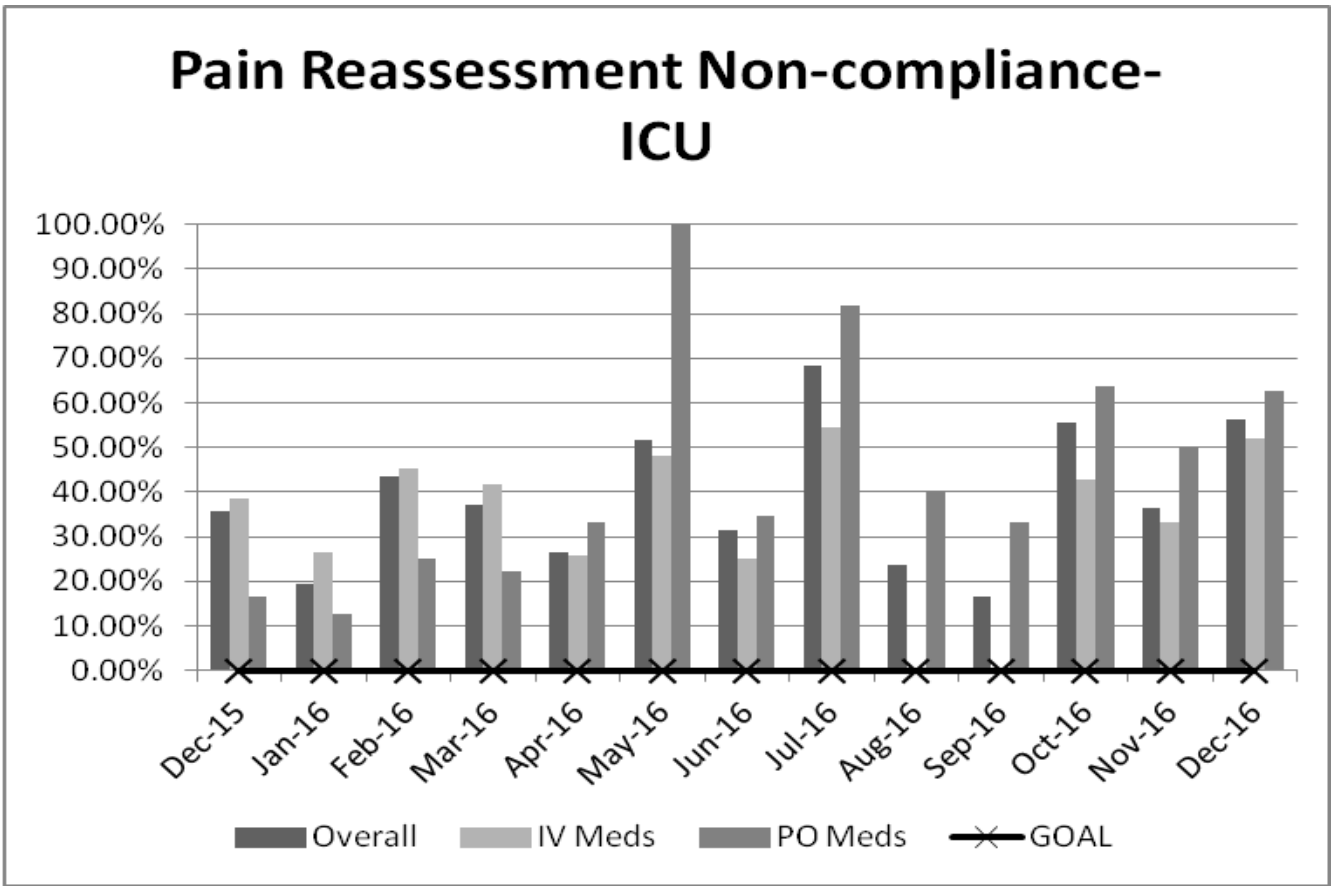
g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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.

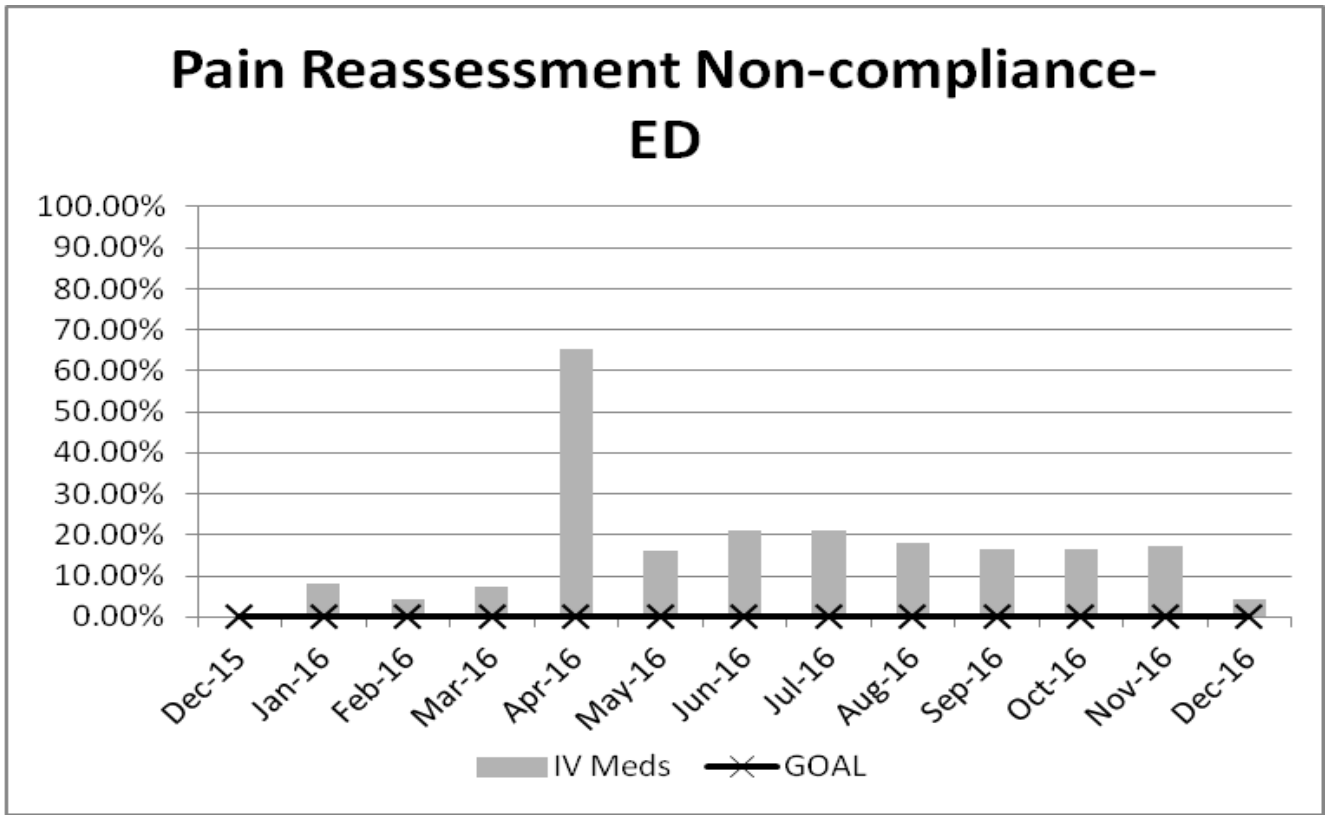


Table 6. Restraint chart monitoring for legal orders.

	May 2016	***June 2016***	***July 2016***	***Aug 2016***	***Sept 2016***	***Oct 2016***	***Nov 2016***	***Dec 2016***	***Jan 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	1/1 (100%)	2/3 (66%)	2/2 (100%)	1/1 (100%)	1/1 (100%)	1/2 (50%)	1/1 (100%)	2/2 (100%)	2/2 (100%	100%
Physician signed order within 24 hours	1/1 (100%)	3/3 (100%)	1/2 (50%)	1/1 (100%)	1/1 (100%)	1/2 (50%)	0/1 (0%)	2/2 (100%)	½ (50%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	1/1 (100%)	1/3 (33%)	1/2 (50%)	0/1 (0%)	0/1 (0%)	0/2 (0%)	0/1 (0%)	2/2 (100%)	0/2 (0%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	1/1 (100%)	2/6 (33%)	N/A	0/1 (0%)	N/A	2/4 (50%)	1/3 (33%)	2/2 (100%)	3/9 (33%)	100%
Orders are for 24 hours	2/2 (100%)	9/9 (100%)	2/2 (100%)	2/2 (100%)	1/1 (100%)	5/6 (83%)	4/4 (100%)	4/4 (100%)	11/11 (100%)	100%
Is this a PRN (as needed) Order	0/2 (0%)	0/9 (0%)	0/2 (0%)	0/2 (0%)	0/1 (0%)	0/6 (0%)	0/4 (0%)	0/4 (0%)	0/11 (0%)	0%

*No restraint orders for this time interval

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NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Dec-16 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending December 31, 2017

	-313	or	-15%	less IP days than in the prior fiscal year
$	(3,205,050)	or	-14.08%	under budget in Total IP Revenue and
$	(358,208)	or	-0.8%	under budget in OP Revenue resulting in
$	(3,563,257)	or	-5.3%	under budget in gross patient revenue &
$	(1,232,660)	or	-3.1%	under budget in net patient revenue

Year-to-date Net Revenue was			$	38,445,732
Total Operating Expenses were:			$	36,526,304
				for the fiscal year to date
$	(238,996)	or	-0.7%	under budget. Salaries and Wages were
$	(1,670,515)	or	-12.9%	under budget and Employee Benefits
$	70,437	or	0.8%	over budget.
			65%	Employee Benefits Percentage of Wages

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

$	1,025,396	or	24.0%	Professional Fees due to Contract Employees and reflected in salaries and wages being under budget
$	95,361	or	3.8%	Depreciation Expense continues to run high based on capital purchases
$	54,638	or	2.8%	Other Expenses are running high due to travel/education that has happened in the first half of fiscal year; should even out over year

Other Information:

$	2,181,048			Operating Income, less
$	(1,718,190)			loss in non-operating activities created a net income of;
$	462,859	$	(200,643)	under budget.
		39.63%		Contractual Percentages for Year and
		41.00%		Budgeted Contractual Percentages including

$ 2,591,343 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals are also reduced for the PRIME IGT of $1,490,000 and Final for Medicare 15

Non-Operating actives included:

$	(1,918,934)	loss	$	(171,152)	under budget in Medical Office Activities
$	(70,377)		$	(143,471)	under budget in 340B Pharmacy Activity

Northern Inyo Healthcare District
Balance Sheet
Period Ending December 31, 2016

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	672,074	4,129,245	(3,457,171)
Short-Term Investments	11,814,167	12,883,290	(1,069,123)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	779,134	845,660	(66,526)
Patient Receivable	56,179,545	55,111,728	1,067,817
Less: Allowances	(43,010,180)	(42,285,512)	(724,668)
Other Receivables	2,138,253	306,691	1,831,562
Inventories	3,364,327	3,381,843	(17,516)
Prepaid Expenses	1,431,321	1,147,107	284,215
Total Current Assets	**33,368,645**	**35,520,055**	**(2,151,410)**
Internally Designated for Capital Acquisitions	1,124,714	1,124,667	46
Special Purpose Assets	243,821	240,545	3,276
Limited Use Asset; Defined Contribution Pension	928,514	868,771	59,743
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	9,380	-	9,380
Revenue Bonds Held by a Trustee	2,215,161	3,526,538	(1,311,377)
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**18,666,115**	**19,905,047**	**(1,238,932)**
Long Term Investments	2,552,143	2,552,143	-
			-
Property & equipment, net Accumulated Depreciation	81,857,402	82,219,872	(362,469)
Unamortized Bond Costs	-	33	(33)
Total Assets	**136,444,305**	**140,197,149**	**(3,752,844)**

Northern Inyo Healthcare District
Balance Sheet
Period Ending December 31, 2016

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	700,019	1,757,878	(1,057,859)
Accounts Payable	1,426,754	2,121,181	(694,427)
Accrued Salaries, Wages & Benefits	4,575,029	5,244,769	(669,740)
Accrued Interest and Sales Tax	(17,817)	328,873	(346,690)
Deferred Income	291,864	340,508	(48,644)
Due to 3rd Party Payors	639,030	1,262,688	(623,658)
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**9,042,399**	**12,483,417**	**(3,441,018)**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	726,356	727,611	(1,254)
Accreted Interest	10,203,802	10,093,253	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,435,382**	**90,326,088**	**109,294**
Net Assets			
Unrestricted Net Assets less Income			
Clearing	36,259,844	36,243,065	16,779
Temporarily Restricted	243,821	140,545	103,276
Net Income (Income Clearing)	462,859	1,004,034	(541,175)
Total Net Assets	**36,966,523**	**37,387,644**	**(421,121)**
Total Liabilities and Net Assets	**136,444,305**	**140,197,149**	**(3,752,844)**

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending December 31, 2016

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	562,748	891,349	(328,601)	4,296,484	5,290,602	(994,118)
Ancillary	2,039,085	2,944,453	(905,368)	15,265,832	17,476,764	(2,210,932)
Total Inpatient Service Revenue	2,601,833	3,835,802	(1,233,969)	19,562,316	22,767,366	(3,205,050)
Outpatient Service Revenue	7,910,203	7,494,616	415,587	44,125,944	44,484,152	(358,208)
Gross Patient Service Revenue	**10,512,036**	**11,330,418**	**(818,382)**	**63,688,261**	**67,251,518**	**(3,563,257)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	371,711	174,933	196,778	1,168,272	1,038,312	129,960
Contractual Adjustments	4,966,104	4,470,539	495,565	26,665,599	26,534,814	130,785
Prior Period Adjustments	(701,137)	-	(701,137)	(2,591,343)	-	(2,591,343)
Total Deductions from Patient Service Revenue	**4,636,677**	**4,645,472**	**(8,795)**	**25,242,529**	**27,573,126**	**(2,330,597)**
Net Patient Service Revenue	**5,875,359**	**6,684,946**	**(809,587)**	**38,445,732**	**39,678,392**	**(1,232,660)**
Other revenue	86,850	53,820	33,030	261,620	319,446	(57,826)
Total Other Revenue	**86,850**	**53,820**	**33,030**	**261,620**	**319,446**	**(57,826)**
Expenses:						
Salaries and Wages	1,975,638	2,188,850	(213,212)	11,321,365	12,991,880	(1,670,515)
Employee Benefits	1,415,033	1,423,901	(8,868)	8,522,013	8,451,576	70,437
Professional Fees	837,829	718,979	118,850	5,292,880	4,267,484	1,025,396
Supplies	659,354	568,638	90,716	3,788,827	3,375,142	413,685
Purchased Services	276,355	342,193	(65,838)	1,631,179	2,031,088	(399,909)
Depreciation	446,436	428,152	18,284	2,636,649	2,541,288	95,361
Bad Debts	276,661	198,503	78,158	1,350,122	1,178,212	171,910
Other Expense	362,391	324,933	37,458	1,983,268	1,928,630	54,638
Total Expenses	**6,249,696**	**6,194,149**	**55,547**	**36,526,304**	**36,765,300**	**(238,996)**
Operating Income (Loss)	**(287,487)**	**544,617**	**(832,104)**	**2,181,048**	**3,232,538**	**(1,051,490)**
Other Income:						
District Tax Receipts	48,644	49,577	(933)	291,864	294,264	(2,400)
Tax Revenue for Debt	150,920	73,076	77,844	905,520	433,742	471,778
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	23,164	8,493	14,671	554,695	50,410	504,285
Interest Income	15,284	18,563	(3,279)	99,100	110,182	(11,082)
Interest Expense	(265,685)	(244,925)	(20,760)	(1,592,542)	(1,453,748)	(138,794)
Other Non-Operating Income	4,076	2,208	1,868	12,484	13,106	(622)
Net Medical Office Activity	(211,092)	(352,134)	141,042	(1,918,934)	(2,090,086)	171,152
340B Net Activity	(18,999)	12,315	(31,314)	(70,377)	73,094	(143,471)
Non-Operating Income/Loss	**(253,688)**	**(432,827)**	**179,139**	**(1,718,190)**	**(2,569,036)**	**850,846**
Net Income/Loss	**(541,175)**	**111,790**	**(652,965)**	**462,859**	**663,502**	**(200,643)**

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period endingDecember 31, 2016

		FYE 2017	FYE 2016		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	214	1,767	2,080	(313)	-15%
Total Patient Days without NB	193	1,589	1,877	(288)	-15%
Swing Bed Days	28	270	327	(57)	-17%
Discharges without NB	75	536	578	(42)	-7%
Swing Discharges	5	39	51	(12)	-24%
Days in Month	31	184	184		
Occupancy without NB	6.23	8.64	10.20	(1.6)	-15%
Average Stay (days) without NB	2.57	2.96	3.25	(0.3)	-9%
Average LOS without NB/Swing	2.36	2.65	2.94	(0.3)	-10%
Hours of Observation (OSHPD)	985	4,303	3,278	1,025	31%
Observation Adj Days	41	179	137	43	31%
ER Visits All Visits	747	4,796	4,521	275	6%
RHC Visits (OSHPD)	2,014	12,230	12,629	(399)	-3%
Outpatient Visits (OSHPD)	3,132	19,132	19,049	83	0%
IP Surgeries (OSHPD)	21	142	161	(19)	-12%
OP Surgery (OSHPD)	126	600	613	(13)	-2%
Worked FTE's	353.00	324.00	336.00	(12)	-4%
Paid FTE's	381.00	365.00	386.00	(21)	-5%
Hours Worked to Hours Paid%	92.7%	88.8%	87.0%	1.7%	2%
Payor %					
Medicare		40%	40%	0%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		34%	35%	-1%	
Indigent (Charity Care)		1.0%	0.3%	0.7%	
All Other		2%	2%	1%	
Total		100%	100%		

Northern Inyo Healthcare District

Financial Indicators as of December 31, 2016

	Target	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16	May-16	Apr-16
Current Ratio	>1.5-2.0	3.69	2.85	2.95	2.60	2.15	2.05	1.98	2.92	2.96
Quick Ratio	>1.33-1.5	2.92	2.46	2.41	2.20	1.83	1.74	1.71	2.57	2.56
Days Cash on Hand prior method	>75	140.37	160.86	145.43	157.98	168.91	162.64	161.90	177.01	167.60
Days Cash on Hand Short Term Sources	>75	62.90	85.97	67.02	77.60	86.56	91.08	96.57	96.43	91.56
Debt Service Coverage	>1.5-2.0	2.13	2.46	2.30	2.80	3.18	2.03	1.95	2.48	2.30
Operating Margin		5.59	7.48	6.43	8.37					
Outpatient Revenue % of Total Revenue		69.28	68.11	67.48	67.03					
Cash flow (CF) margin (EBIDA to revenue)		3.71	5.43	4.53	7.01					
Days in Patient Accounts Receivable	<60 Days	77.70	75.60	75.00	77.80	78.50	73.10	63.20	68.60	65.90

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverate 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

Investments as of December 31, 2016

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
3	31-Dec-16	01-Jan-17	Local Agency Investment Fund	Northern Inyo Hospital	0.72%	$	12,366,309.98
4	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	$	250,000.00
				SHORT TERM INVESTMENTS		$	12,616,309.98
5	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	$	150,000.00
6	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	$	250,000.00
7	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	$	250,000.00
8	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	$	100,000.00
9	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	$	250,000.00
10	02-Sep-16	28-Sep-21	Capital One Bank	Gemini Financial Services, LL	1.70%	$	250,000.00
11	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	$	250,000.00
12	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		$	14,366,309.98
1	31-Dec-16	01-Jan-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.72%	$	928,514.46
2	31-Dec-16	01-Jan-17	LAIF PEPRA DB PLAN	Northern Inyo Hospital	0.72%	$	9,380.00
				DEFINED CONTRIBUTION ACCRUA		$	937,894.46
							15,304,204.44

NORTHERN INYO HEALTHCARE DISTRICT

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

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,097,990	$ 1,097,944	46
Equipment Fund Savings Account	$ 26,723	$ 26,723	1
Total Board Designated Funds:	**$ 1,124,714**	**$ 1,124,667**	**$ 47**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 110,706	$ 110,702	$ 4
Nursing Scholarship Savings Account	$ 33,036	$ 29,767	$ 3,268
Medical Education Savings Account	$ 76	$ 76	$ -
Joint NIHD/Physician Group Savings Account	$ 100,003	$ 100,000	$ 3
Total Specific Purpose Funds:	**$ 243,822**	**$ 240,546**	**$ 3,276**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,368,535**	**$ 1,365,213**	**$ 3,322**

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001738 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

001739 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

001740 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002261 6380	EXAM/PROCEDURE LIGHT, RECESSED LIGHT	10/13/2016 4 -2017	6380 - OBSTETRICS	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$4,329.22	$0.00	$4,329.22	$0.00	$0.00	$0.00	$43.73	$4,285.49

002262 6380	EXAM/PROCEDURE LIGHT, RECESSED LIGHT	10/13/2016 4 -2017	6380 - OBSTETRICS	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$4,329.22	$0.00	$4,329.22	$0.00	$0.00	$0.00	$43.73	$4,285.49

002263 6380	EXAM/PROCEDURE LIGHT, RECESSED LIGHT	10/13/2016 4 -2017	6380 - OBSTETRICS	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$4,329.22	$0.00	$4,329.22	$0.00	$0.00	$0.00	$43.73	$4,285.49

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002264 6380	EXAM/PROCEDURE LIGHT, RECESSED LIGHT	10/13/2016 4 -2017	6380 - OBSTETRICS	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$4,329.22	$0.00	$4,329.22	$0.00	$0.00	$0.00	$43.73	$4,285.49

002393 7010	BOOM, SINGLE WITH SINGLE LIGHT	10/13/2016 4 -2017	7010 - ER	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$15,325.13	$0.00	$15,325.13	$0.00	$0.00	$0.00	$154.80	$15,170.33

002402 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002403 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$14,421.35	$0.00	$14,421.35	$0.00	$0.00	$0.00	$145.67	$14,275.68

002408 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$14,421.35	$0.00	$14,421.35	$0.00	$0.00	$0.00	$145.67	$14,275.68

002409 7420	SURGICAL BOOM LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002421 / 7420	SURGICAL BOOM LIGHT	10/13/2016 / 4 -2017	7420 - SURGERY	1225 - 1201	8813 - 8074	1275 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$14,421.35	$0.00	$14,421.35	$0.00	$0.00	$0.00	$145.67	$14,275.68

002422 / 7420	SURGICAL BOOM LIGHT			10/13/2016 / 4 -2017	7420 - SURGERY		1225 - 1201	8813 - 8074		1275 - 1260	
	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$12,658.01	$0.00	$12,658.01	$0.00	$0.00	$0.00	$127.86	$12,530.15

Sch. 1:	$151,854.12	$0.00	$151,854.12	$0.00	$0.00	$0.00	$1,533.89	$150,320.23

Total For: Asset Account - (1225 - 1201)

001736 / 8462	MOBILE-SHOP PM CART	11/01/2016 / 5 -2017	8462 - PROJECT/PROPERTY MC	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	120	7-2017	$4,100.00	$0.00	$4,100.00	$0.00	$0.00	$0.00	$25.63	$4,074.37

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001741 7427	EXAM/PROCEDURE LIGHT, FLOOR	10/13/2016 4 -2017	7427 - PACU	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$896.85	$0.00	$896.85	$0.00	$0.00	$0.00	$9.06	$887.79

001742 6010	EXAM/PROCEDURE LIGHT, FLOOR	10/13/2016 4 -2017	6010 - ICU	1241 - 1201	8814 - 8074	1291 - 1260	

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$2,414.59	$0.00	$2,414.59	$0.00	$0.00	$0.00	$24.39	$2,390.20

001743 6010	EXAM/PROCEDURE LIGHT, FLOOR	10/13/2016 4 -2017	6010 - ICU	1241 - 1201	8814 - 8074	1291 - 1260	

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	132	7-2017	$2,414.59	$0.00	$2,414.59	$0.00	$0.00	$0.00	$24.39	$2,390.20

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001744 8320	PLANETARY STAND MIXER	11/11/2016 5 -2017	8320 - KITCHEN	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	120	7-2017	$5,193.65	$0.00	$5,193.65	$0.00	$0.00	$0.00	$32.46	$5,161.19

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001745 7420	TRENGUARD PATIENT POSITIONING SYSTEM	11/16/2016 5 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	120	7-2017	$14,094.81	$0.00	$14,094.81	$0.00	$0.00	$0.00	$88.09	$14,006.72

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001746 8480	CORP. L1 VSHERE 6.0 ENTERPRISE LICENSES	11/01/2016 5 -2017	8480 - INFORMATION TECHNOL	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	36	7-2017	$14,266.92	$0.00	$14,266.92	$0.00	$0.00	$0.00	$297.23	$13,969.69

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001747 8390	OMNICELL VIRTUAL TEST SERVER	12/17/2016 6 -2017	8390 - PHARMACY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	36	7-2017	$10,800.00	$0.00	$10,800.00	$0.00	$0.00	$0.00	$0.00	$10,800.00

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001757 9517	EXAM TABLE BASE W/TLT HTR RECPT MIDMRK	12/08/2016 6 -2017	9517 - NIA SURGERY CLINIC	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	180	7-2017	$5,902.14	$0.00	$5,902.14	$0.00	$0.00	$0.00	$0.00	$5,902.14

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001758 7010	CANON IR-ADV 500IF	12/14/2016 6 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	60	7-2017	$4,855.51	$0.00	$4,855.51	$0.00	$0.00	$0.00	$0.00	$4,855.51

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002317 6380	EXAM/PROCEDURE LIGHT, WALL	10/13/2016 4 -2017	6380 - OBSTETRICS	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,352.25	$0.00	$1,352.25	$0.00	$0.00	$0.00	$13.66	$1,338.59

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002386 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002387 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002388 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002389 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002390 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002391 7010	EXAM/PROCEDURE LIGHT, CEILING	10/13/2016 4 -2017	7010 - ER	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	132	7-2017	$1,726.42	$0.00	$1,726.42	$0.00	$0.00	$0.00	$17.44	$1,708.98

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002398 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.27	$0.00	$1,464.27	$0.00	$0.00	$0.00	$27.12	$1,437.15

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002399 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.27	$0.00	$1,464.27	$0.00	$0.00	$0.00	$27.12	$1,437.15

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002405 7420	VIDEO/DATA COMMUNICATION SYSTEM	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	12	7-2017	$62,774.10	$0.00	$62,774.10	$0.00	$0.00	$0.00	$6,974.90	$55,799.20

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002406 7420	NURSE DOCUMENTATION WORKSTATION	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$8,581.54	$0.00	$8,581.54	$0.00	$0.00	$0.00	$158.92	$8,422.62

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002410 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.27	$0.00	$1,464.27	$0.00	$0.00	$0.00	$27.12	$1,437.15

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002411 / 7420	OR SUPPLY CABINET	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002412 / 7420	OR SUPPLY CABINET	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002413 / 7420	OR SUPPLY CABINET	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002415 7420	VIDEO/DATA COMMUNICATION SYSTEM	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	12	7-2017	$62,498.99	$0.00	$62,498.99	$0.00	$0.00	$0.00	$6,944.34	$55,554.65

002416 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

002417 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002418 7420	OR SUPPLY CABINET	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$1,464.28	$0.00	$1,464.28	$0.00	$0.00	$0.00	$27.12	$1,437.16

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002419 7420	OR, CAMERA SYSTEM, IN-LIGHT	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$3,690.87	$0.00	$3,690.87	$0.00	$0.00	$0.00	$68.35	$3,622.52

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002424 7420	NURSE DOCUMENTATION WORKSTATION	10/13/2016 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: Straight Line 1/2 Year	72	7-2017	$8,581.54	$0.00	$8,581.54	$0.00	$0.00	$0.00	$158.92	$8,422.62

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002425 / 7420	VIDEO/DATA COMMUNICATION SYSTEM	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	12	7-2017	$62,498.99	$0.00	$62,498.99	$0.00	$0.00	$0.00	$6,944.34	$55,554.65

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002428 / 7420	NURSE DOCUMENTATION WORKSTATION	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	72	7-2017	$8,581.54	$0.00	$8,581.54	$0.00	$0.00	$0.00	$158.92	$8,422.62

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
002429 / 7420	TABLE, SURGICAL, MAJOR	10/13/2016 / 4 -2017	7420 - SURGERY	1241 - 1201	8814 - 8074	1291 - 1260

	Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1:	Straight Line 1/2 Year	72	7-2017	$16,123.04	$0.00	$16,123.04	$0.00	$0.00	$0.00	$298.58	$15,824.46

Sch. 1:	$323,158.93	$0.00	$323,158.93	$0.00	$0.00	$0.00	$22,570.90	$300,588.03

Total For: Asset Account - (1241 - 1201)

NORTHERN INYO HEALTHCARE DISTRICT

Asset Acquisition Report by Date

10/01/2016 to 12/31/2016

Asset ID: / Permanent Location:	Description:	Acq. Date: / Entry Period:	Department:	GL Asset Account #:	GL Depreciation Expense Account:	GL Accumulated Depreciation Account:
001760 8390	USP-797/800 MODULAR CLEANROOM SYST	12/19/2016		1253 - 1253		

Method	Asset Life	Start Period	Acquisition Cost:	Cost Adjust/Trans:	Total Cost:	Salvage Value	Current Period Depreciation	YTD Depreciation	Accumulated Depreciation	Book Value
Sch. 1: 0	0		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sch. 1:			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Total For: Asset Account - (1253 - 1253)

Grand Totals:	$475,013.05	$0.00	$475,013.05	$0.00	$0.00	$0.00	$24,104.79	$450,908.26

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Cesarean Delivery**	
Scope: Perinatal, Surgery	Manual: **CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)**
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:
To provide guidelines of care for the Perinatal Nurse to take care of the mom going for a scheduled, unscheduled, or emergent cesarean section in the OR.

POLICY:

I. SCHEDULED CESAREAN SECTION DELIVERY:

1. An informed consent will be obtained and signed.
2. Admit assessment will be done and charted while obtaining a 20 min NST strip.
3. Get scrubs or bunny suit for support person, including hat, mask, and booties.
4. After the reactive strip is obtained (if not reactive, call OB physician), call PACU and accompany mom and support person to the PACU with mom's paper chart.
5. Check that the infant warmer is fully stocked, functioning properly, has a Doppler for FHT's in the OR, and take to the OR.
6. A qualified Perinatal RN with current Neonatal Resuscitation (NRP) certification will attend the delivery in the OR.
7. Call RT and give them a "heads-up" that there is a C/S (cesarean section) scheduled and will call when ready for them to attend the delivery.
8. When in OR, use sterile technique for baby hand-off.
9. After infant is placed on warmer, provide care based on NRP guidelines. At any time, the pediatrician can be called to assist with resuscitation if needed (and baby will be transferred to the nursery, steps 10-12 will be skipped).
10. After infant stable, assist mom with skin-to-skin care, standing at OR table for safety, and assist with breastfeeding if cues are present. Put newborn orders in Paragon to be able to retrieve meds.
11. When mom ready to move from OR table to gurney, take support person and infant to the PACU on warmer, get meds, give within 2 hours after delivery, do weight, measurements, etc.
12. Then when mom arrives in PACU, assist with continued skin-to-skin and breastfeeding, as OB staffing allows and mom stable. If mom not stable, or OB staffing does not allow RN to stay in PACU, take infant in warmer back up to mom's room on OB floor, allowing support person to accompany baby if they desire.
13. When mom is recovered, receive report from PACU staff, and assist with pericare and transfer mom from gurney to postpartum bed.

II. UNSCHEDULED CESAREAN SECTION DELIVERY:

1. Doctor's order for a cesarean section will be obtained.
2. Patient will remain NPO except for antacid if ordered.
3. An informed consent for "non-elective" cesarean section and blood transfusion will be obtained and signed, and C/S chart forms placed into chart.
4. OB doctor will call the House supervisor to get the OR ready and OR circulating team. (expectation of decision to incision is 20 minutes, requirement is 30 minutes).
5. Paragon admit assessment will be done (if not already done and in labor) and charted while obtaining a 20 min NST strip. Or continuous monitoring if in labor.

6. Get scrubs or bunny suit for support person, including hat, mask, and booties.
7. Give Bicitra or Reglan if ordered by Anesthesia.
8. Using electric clippers, shave lower abdomen, no hair to be seen with closed legs.
9. Start PIV with a #16 or #18 catheter, preferably in the arm. Give warmed LR of 1000 ml (or doctor's solution choice). If IV already running, add the Discofix IV extension tubing, and change IV pump tubing to gravity tubing.
10. Complete attached pre-op checklist and take with patient to the OR.
11. Communicate with PACU team on transport of patient to the OR.
12. Follow steps 5-13 in **I. Scheduled Cesarean Section Delivery**.

III. EMERGENT CESAREAN SECTION DELIVERY:

1. If C/S is STAT, move the patient to the OR (after hours) in the left lateral position and complete procedures there. Have someone notify House Supervisor if OB doctor has not done so already.
2. Enter Cesarean orders STAT to be able to get access to needed medications.
3. If patient unable to sign the consent form (due to severity of medical condition), OB doctor must document in progress note why patient unable to sign for procedure and why procedure is necessary.
4. If patient able to sign, and time allows, an informed consent will be signed for "emergency" cesarean section and blood transfusion.
5. Infuse warmed LR or other IV fluid as ordered by OB doctor/anesthesiologist.
6. Give Bicitra or Reglan if ordered by Anesthesia.
7. Transport mom to the OR via birthing bed or gurney, give brief report to OR personnel, and fill out pre-op checklist after transport of mom.
8. Take EFM portable monitor or Dopple FHT's per doctor's orders, stocked infant warmer, patient's chart and stickers with mom to the OR.
9. Stay with mom in the OR (follow steps 5-13 in **I. Scheduled Cesarean Section Delivery**).

DOCUMENTATION:

1. OB charts the decision time for the cesarean section.
2. Chart all care given to the patient to prep for the C/S (i.e. shave prep, Bicitra, doppled fetal heart tones etc.)
3. Chart arrival times of all providers when mom is on the OB unit.
4. Chart time of transfer to the OR or PACU for pre-op.
5. Complete all delivery summary information and newborn bands.

IV. RECOVERY OF THE CESAREAN SECTION DELIVERY IN THE PERINATAL UNIT:

1. After mom has been transferred to the Perinatal Unit, and report received on the Postpartum mom, complete a head-to-toe assessment.
2. If Postpartum Pitocin not hanging, hang on IV pump according to Pitocin Administration policy.
3. Confirm with PACU that med orders have been charted in eMAR, or meds given in PACU have been faxed to pharmacy to ensure correct medication administration and times.

Title: **Cesarean Delivery**	
Scope: Perinatal, Surgery	Manual: **CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)**
Source: Manager of Perinatal Department	Effective Date:

4. Obtain post-op vital signs and fundal assessments as outlined below in DOCUMENTATION.

DOCUMENTATION:

1. Obtain maternal vital signs including B/P, pulse, respirations, and pulse oximetry reading:
    a. Every 15 minutes x 4 (for an hour)
    b. Every 30 minutes x 2 (for an hour)
    c. Every 1 hour x 1
    d. Every 4 hours until discharge to home.

2. Perform fundal check and lochia assessment:
    a. Every 15 minutes x 2.
    b. Fundal check and lochia assessment PRN if patient condition indicates more frequent assessment.
    c. Every 8 hours until discharge to home.

Committee Approval	**Date**
Peri-Peds	**11-7-16**
STTA	**1/25/17**
CCOC	**11/14/16**
MEC	**02/07/17**
Board of Directors	

Responsibility for review and maintenance: Perinatal Nurse Manager and Surgery Nurse Manager
Revised: 5/92; 11/97; 12/03, 9/11jk, 8/16SG

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Risk Prevention - Perinatal	
Scope: Perinatal	Manual: Perinatal – Patient Safety (PS)
Source: Perinatal Manager	Effective Date:

PURPOSE:
To provide a guideline for the prevention of inpatient/outpatient and visitor falls in the Perinatal Unit, with population-specific fall prevention strategies for pediatric, obstetric and neonatal patients.

SUPPORTIVE DATA:
Pregnant, laboring and newly delivered women, as well as newborn and pediatric children have unique risk factors that may contribute to falls. While the Morse scale has not been tested on this population, it can identify pre-existing fall risk factors in adult patients (such as crutch use or recent history of a fall). Therefore, for pregnant women, the Morse scale is assessed upon admission. For newborn and pediatric patients, the Morse scale is not utilized at all, nor is it used as an ongoing assessment tool for maternal patients.

POLICY:
Due to the fact that Perinatal patients have unique fall risks, all Perinatal patients will be considered high risk for falls, and assessed for fall risk. **Prevention and Management of Falls** with the following exceptions:

1. Morse scale will only be used for admission on adult patients
2. Falls Protocol will only be implemented for ongoing high risk patients
3. Universal Fall Precautions will include population-specific measures

Visitors experiencing a fall are managed per hospital safety policy "injury to patients and visitors" policy

I. **Perinatal Universal Precautions** (includes both A and B)

A. Universal Fall Precautions: For every patient, the perinatal staff will implement the following Universal Fall Precautions below.

- Orient the patient/family to the environment and the potential for falls.
- Non skid footwear/slippers/socks when ambulating.
- Assure that the bed is in low position when care is not being given.
- Wheels on a bed, gurney, wheelchair, and BSC (if locks present) are locked when appropriate.
- Spills are wiped up immediately.
- Call light/telephone/water/personal items are within reach.
- Siderails up x2 or x3 only.
- Ensure a safe environment (no spills, pick up clutter and remove "trip" items, such as electrical cords and unnecessary equipment).
- Assure that the room is properly lit.
- If a medication is given that can affect balance or sedation - Inform the patient and ask them to "Speak up" if you need help.
- Consider peak effect for prescribed medications that affect LOC, gait, and elimination and plan care accordingly.
- Ambulate patients early and often.

- Defective equipment or hazards are reported immediately
- Use safe patient handling equipment such as Sara Steady and pink sheet for patient transfers.

B. Perinatal Population-Specific Measures:

1. **Labor and Delivery:** All women who are pregnant, laboring or newly delivered are considered and managed as at episodic risk for falls due to the delivery experience, including (but not limited to):
   a. Analgesia/anesthesia or other medications (such as anti-hypertensives or anti-psychotics) that are identified in the administrative protocol as placing patients at high risk for falls.
   b. Specific positions for laboring (standing and squatting) and labor support - Patients and labor support persons will be educated to fall risk prevention and the RN will monitor patient and support person activity as at risk for fall.
   c. Second stage of labor - patient side rails upX2; RN or MD in attendance at all times. Support person and other visitors will be offered a place to be seated during the delivery and educated to the need to inform the hospital staff, member of feelings of dizziness, lightheaded or nauseated. The person will be assisted to a sitting or lying position as need is assessed.
   d. Transfer to PACU - A labor and delivery staff member will assist patients and support persons walking to or from the PACU. If a patient will be going straight to the OR, the patient will be transported via wheelchair, gurney, or bed.
   e. Ambulation assistance - All immediate postpartum patients will be assisted, when up to ambulate/use the restroom including the use of the patient transfer device as needed. Patient and family will be educated to call for help for initial postpartum use of bathroom, and additionally until assessed as stable by RN. Any labor patient on IV's may also need assistance at any stage to navigate to the bathroom.

2. **Recovery:** All newly delivered mothers will be considered high risk for falls due to the following (but not limited to):
   a. Ambulation-All newly admitted mothers will be assisted when ambulating for the first time after admission until the RN has assessed and determined her to be capable of adequate coordination, strength, and weight bearing to ambulate independently.
   b. Analgesia/anesthesia or other medications that are identified in the administrative protocol as placing patients at high risk for falls.
3. **Newborn:** All newborns are considered at high risk for falls due to the following (but not limited to):
   a. Developmental stage and inability to stabilize and maintain body positions.
   b. Potential to roll off the bed if left unattended.
   c. Maternal sleepiness and/or analgesia.

Mother of baby/parent will be educated to monitor self for sleepiness while in bed or chair and holding infant, and encouraged to place baby in bassinet at bedside when she needs to rest.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Risk Prevention - Perinatal	
Scope: Perinatal	Manual: Perinatal – Patient Safety (PS)
Source: Perinatal Manager	Effective Date:

Safety interventions are noted in the Standard of Care/Standard of Practice Policy for Mother-Baby Unit and NICU specific nursing care.

II. Fall Protocol

A. Since all Perinatal patients are considered at risk for falls, the Fall Protocol will only be implemented for ongoing high risk patients due to special circumstances. These are patients identified by the RN as meeting criteria beyond the expected high risk factors, for example:
   1. Impaired gait after an epidural procedure, or after delivery
   2. Postpartum hemorrhage with blood loss affecting balance or strength
   3. Substance abuse affecting judgment, level of consciousness, balance, strength or gait
   4. Dizziness with ambulation-If RN assists patient to bathroom twice, but dizziness persists greater than two trips
   5. Persistent orthostatic blood pressure changes
   6. Ambulatory aid required
   7. Current fall during hospitalization

B. The RN is responsible for initiating and ensuring the ongoing implementation of the Fall Protocol

III. Management of the In-Patient Fall

1. All falls require Post Fall management to be implemented on a witnessed fall, patient found on floor, or report of a fall. The RN will complete an immediate post fall assessment (includes physical assessment and assessment of injuries), notify the physician, document in the medical record and notify the house supervisor.

REFERENCES:

1. Simpson, K. & Creehan, P. AWHONN: Perinatal nursing. Lippincott, Williams & Wilkins:Philadelphia.

CROSS REFERENCES:

1. Functional Risk assessment for criteria for therapy referral

Approval	**Date**
CCOC	1/25/17
Peri-peds	2/2/2017
MEC	2/7/2017
BOD	

Developed: 12/16 SG
Reviewed:
Revised:
Index:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Death-Disposition of Body	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

To instruct the Nursing Staff on the procedure following a patient's death related to disposition of the body and personal belongings, and to ensure that the remains of deceased patients (hereinafter "the body") are handled in accordance with patient/family wishes and the needs of the hospital while complying with industry standards for disposition

POLICY:

1. In the event of a patient's death, the nursing staff will follow the following procedure related to Pronouncement of Death, Organ/Tissue/Eye Donation and Coroner's Case policies.

2. California Health and Safety Code requires health care facilities to notify the mortuary attendant, prior to removal of the body, if the patient is afflicted with a reportable disease listed in Title 17, California Code of Regulation, Section 2500 (c), i.e., HIV disease, Hepatitis, etc. (See attached), without written authorization of the patient's representative, but the release must be tracked.

3. Any instructions given to the hospital in writing by the patient for the disposition (type of disposition, or place of interment) of the body will be carried out as required by law.

4. If the coroner is called, the coroner will receive the body regardless of the deceased patient's written instructions, or any instructions of the patient's survivors.

5. If there are no written instructions in the chart for the disposition of the deceased patient's body, the hospital will follow the instructions as provided by the person with the most authority. The following persons in the order listed below will determine the plan for the remains of the deceased.
    a. Person appointed as agent for the patient through a power of attorney.
    b. Spouse or domestic partner
    c. Adult (over 18) child, or the majority of the surviving adult children, or if the majority of surviving adult children are not available, the instructions of the children available
    d. Parent(s) of the deceased. If both parents are alive, but one is not available, then, the instructions of the one that is available will be followed.
    e. Sibling(s)
    f. Next of kin in order of degrees of kinship
    g. Public Administrator

6. If after contacting an out of town funeral director as instructed, that funeral director is unable or unwilling to remove the body from the hospital within 3 hours of death, or if the bed is needed immediately, the hospital shall call the local funeral director in Bishop California to remove the body.

7. If the local funeral director is called to remove the body of a patient whose instructions required using an out of town funeral home, or if the instructions of the deceased patient's agent requires using an out of town funeral home, then, the nursing supervisor will inform the agent or next of kin that the body had to be removed by the local funeral director and there will be a charge from them for this service.

8. The patient's belongings are either given to the family or placed in a bag and given to the mortuary attendant. A list of belongings sent either home or to the mortuary should be noted on the "Release of Body to Mortuary Form." The original form will be maintained by NIHD in the medical record. A copy of the form will be sent with the body.

9. Notification of the Organ Procurement Organization will be completed per policy and documented on the "Release of Body to Mortuary Form." See "Organ/Tissue/Eye Donation" policy for procedure.

10. Should an Autopsy be required, the physician shall discuss the rationale with the next of kin and obtain a signature on the California Hospital Association form 11-1 found in the consent manual (on the DVD).

PROCEDURE:

1. The nurse shall notify the attending physician or ED physician to pronounce the patient's death. The physician may request RN staff trained in the process to pronounce the patient as noted in the "Pronouncement of Death" policy.

2. The physician shall notify the family of the patient's death or will request that the nurse do this.

3. If the family wishes to view the body, the nurse will make arrangements for this.

4. The nurse shall prepare the body for transfer to the mortuary. All tubes, dressings, (unless containing drainage), etc. shall be removed prior to transfer. Follow established policy if a coroner's case.

5. The Shift Supervisor or their designee will report all deaths to the Organ Procurement Organization following the Organ Procurement policy, prior to releasing the body to the mortuary. All releases of patient information to tissue/organ procurement/donor organizations must be documented on the Release of Body to Mortuary form, for HIPAA tracking purposes.

Title: Death-Disposition of Body	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

6. Nursing Supervisor or designee will
    a. Check the chart for instructions for disposition of the decedent's remains.
    b. Call the funeral director listed or the County Coroner if the case warrants.
    c. Call the funeral director chosen by the person in authority in accordance with this policy if there are no written instructions
    d. Call the local funeral director if the body cannot be picked up within 3 hours, OR, if the supervisor determines that the bed is needed sooner than 3 hours.
    e. Fill out all necessary paperwork and file the copy of the Release of Body in the chart
7. The mortuary attendant will sign the RELEASE OF BODY TO MORTUARY (form HIPAA-43). This completed form remains in the medical record of the patient. The hospital may release to the mortuary:
    a. the patient's name
    b. date and time of death
    c. the patient's face sheet.
8. The House Supervisor will provide a copy of the Release of Body form to the NIHD Social Worker, who will follow-up with the family of the deceased by telephone within the following month.

REFERENCES:

1. California Hospital Association. Consent Manual (2016) Chapter 11, Section II.
2. The BRN Report; volume 14, NO. 1. http://www.rn.ca.gov/pdfs/forms/brnspring2001.pdf, page 6.

CROSS REFERENCE P&P:

1. **Coroner's Case**
2. **Organ/Tissue/Eye Donation**
3. **Pronouncement of Death**
4. **Release of Body to Mortuary** form found on intranet under Forms>HIPAA>HIPPA43

Approval	**Date**
CCOC	12/12/16
Medical Services/ICU	01/26/17
MEC	02/07/17
Board of Directors	

Developed: 5/2009
Reviewed: 9/2010, 9/2012
Revised: 5/2011, 10/2013, 12/2016 ta
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pronouncement of Death	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

To permit select Registered Nurses (RN) to pronounce death on patients meeting specific criteria.

POLICY:

1. Death may be pronounced by Registered Nurses in the following positions:
    - Directors of Nursing
    - House Supervisors
    - House Supervisor Assistants

PROCEDURE:

1. The Following patient conditions must be met before the above identified RN's can pronounce death:
    a. The following documentation must both be present in the patient's health record:
        i. Physician progress note stating that the patient is terminal or moribund; and
        ii. Physician order for do not attempt cardiopulmonary resuscitation.
    b. The patient must not be sustained by external mechanical life support equipment.
    c. The patients must not be reportable to the coroner under Government Code, Sate of California, Section 102850 (see Nursing Policy "Coroner's Case").
    d. The coroner did not accept the case.
    e. The patient must not be a potential solid organ donor (see "Organ/Tissue/Eye Donation" policy).
2. The physician may request that a registered nurse pronounce death if the above criteria is met. The physician's order to pronounce death shall be written in the Health Record by the physician or a telephone order must be given by the physician to the RN. (See "Verbal and/or Phone Medical Staff Practitioner Orders" policy).
3. Release of Body to the Mortuary requires an order from the physician, which may be placed by the physician in advance of the death as contained in the orderset.
4. If the above patient conditions criteria are met, the unit staff nurse will contact one of the above-designated RN's to pronounce death of the patient.
5. The RN pronouncing death will also review that the conditions listed are met.
6. The RN will pronounce death post-examination of the patient if cessation of cardio pulmonary function is present as determined by all of the following:
    a. No respirations
    b. No apical pulse
    c. Non-reactive pupils
    d. Lack of response to physical stimuli
7. The RN pronouncing death is to document in the EHR.
8. The RN caring for the patient will assure completion of "Release of Body to Mortuary" prior to the removal of the body from the facility.
9. The attending/covering physician shall be notified at the time of death and retains responsibility for:
    a. Notifying family
    b. Completing health record documentation.
    c. Seeking permission for autopsy.
    d. Signing death certificate.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pronouncement of Death	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

REFERENCES:

1. California Board of Registered Nursing. (2014). Scope of Regulation, Division 2, Chapter 6, Article 2, Section 2725. Legislative intent: Practice of Nursing Define. Retrieved from http://www.rn.ca.gov/pdfs/regulations/npr-i-15.pdf
   Retrieved from http://www.rn.ca.gov/pdfs/forms/brnspring2001.pdf
2. State of California. (2014). California Government Code, Section 27491. Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=27491.&lawCode=GOV
3. California Hospital Association. Consent Manual. (2016) Chapter 11, Section II.

CROSS REFERENCE P&P:

1. Death-Disposition of Body
2. Coroner's Case
3. Organ/Tissue/Eye Donation
4. Verbal and/or Phone Medical Staff Practitioner Orders

Approval	**Date**
CCOC	12/12/17
Medical Services/ICU	01/26/17
MEC	02/07/17
Board of Directors	

Developed: 12/2/2016
Reviewed:
Revised:
Supercedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scope of Services, Infusion Center**	
Scope: Infusion Center	Manual: **Infusion Center**
Source: DON Perioperative Services	Effective Date:

I. Department Description:

The Outpatient Infusion Unit is located in the old hospital building off the main corridor. The unit can be accessed two ways: from the corridor that links the old hospital to the new hospital, and from the old hospital corridor leading from the cafeteria to the outside of the old hospital.

The Outpatient Infusion Center department has 6 treatment rooms, one for Argon Laser eye treatments, and 5 for infusions or procedures. One of these rooms can be set up as an isolation room if needed for contact precautions. Each room has space for an infusion chair or a gurney, an over-bed table, a TV, and infusion pumps. There is space for a visitor or two to be with the patient and there are curtains for privacy.

II. Mission:

To provide care to patients in our community in need of outpatient infusions (including chemotherapy), injections, phlebotomies, transfusions dressing changes, and observation / monitoring after interventional radiology procedures. Additionally, the ophthalmologist can utilize the Argon laser for eye treatments in the first room which is a designated laser room.

III. Vision:

- To maintain competency in administration of medications to treat a variety of diagnoses.
- To provide treatment locally so patients in the community are not forced to drive long distances to receive treatment that can be administered through the outpatient unit here at NIH.

IV. Scope:

The purpose of the Infusion Center is to provide competent staff and a pleasant, safe facility in which outpatient infusions and treatments can be performed. Routine service is provided to the public 5 days a week Monday through Friday from 0800-1700, after hour care may be arranged on an individual basis if needed. Patients are scheduled by the Infusion Center Clerk once orders have been received, authorization for treatment obtained, and Pharmacy has ensured medication availability (if applicable). The patients' primary care practitioner is apprised of any complications or need for further evaluation. Patients whose acuity exceeds the scope of services of the Infusion Center will be transferred to the emergency department at NIH either by wheelchair or gurney based on acuity.

V. Staffing:

The Infusion Center is staffed daily by one or more RNs and an Infusion Center Clerk. The number of RNs is based on the number of patients scheduled. The nursing staff administering chemotherapy has completed the Oncology Nursing Society "Chemotherapy and Biotherapy Administration" training.

VI. Customers

Internal customers include nursing staff, other hospital department staff, medical staff practitioners, and administration. External customers include patients, families, visitors, and suppliers.
The Infusion Center works in partnership with all services provided by NIH for lab, diagnostic imaging, physical therapy, surgery, or inpatient needs.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scope of Services, Infusion Center**	
Scope: Infusion Center	Manual: **Infusion Center**
Source: DON Perioperative Services	Effective Date:

The Infusion Center works in partnership with community resources provided by Pioneer Home Health, Hospice, Toiyabe Indian Health Clinic and Dialysis Unit, Inyo county department of public health, Bishop Care Center, and Sterling Heights.

VII. Ages Serviced:

The Infusion Center provides care across the life span
Pediatrics: 28 days to 13th birthday
Adult: 13 to 65 years
Geriatric: > 65 years

VIII. QA/PI:

The department establishes Pillars of Excellence and department goals annually. Performance Improvement projects and teams are identified and prioritized based on feedback from patients, staff, medical staff, regulatory survey, audits, changes in technology, etc.
The Infusion Center is State licensed and Joint Commission accredited.

XI. Budgeted Staff :

Refer to Master staffing plan

Approval	**Date**
CCOC	**1/25/17**
Med/ICU	**1/26/17**
MEC	
Board of Directors	

Developed: 1/86
Reviewed:
Revised: 2/98, 3/06 AW,8/10 AW, 09/12, 3/16 AW, 1/17AW
Supercedes:

Responsibility for review and maintenance:
Index Listings: Scope of Service Infusion; Infusion Scope of Service

Dev. 7/14

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

PURPOSE:
To facilitate the process of scheduling elective, after-hours, and emergency surgical procedures.

POLICY:
When scheduling surgical procedures, the following procedure will be utilized.

PROCEDURE
SCHEDULING ELECTIVE SURGERIES / PROCEDURES:
Surgical procedures will be scheduled by the perioperative clerk, or a perioperative nurse during regular working hours which start at 0700 and end at 1700 weekdays. Hospital designated holidays excluded.

Information taken upon scheduling will be:

- Patient name
- Patient date of birth
- In-patient / same-day / am admit status
- Date of procedure
- Time of procedure
- Proposed surgical procedure or procedures
- Length of surgery
- Name of Surgeon and assistant (if one has been arranged)
- Need for RNFA
- Need for special equipment (instruments, trays, implants, etc.)
- Need for imaging (C-arm, needle localization)

1. Procedures are scheduled on the date requested when possible; and surgery time is assigned as available on first come, first served basis.

2. The first procedure of the day is scheduled to start at 0730. All other procedures are scheduled to follow. Each room can accommodate a 0730 procedure unless there is no anesthesia coverage for the second room.

3. Children under seven years of age, cesarean sections, total joint replacements, and diabetic patients are given a first hour (0730) space whenever possible.

4. No elective cases should be scheduled after 1600 without consent of the Surgery Coordinator or Perioperative DON.

5. Procedures may be delayed for a variety of reasons. Depending on the reason for the delay or cancellation, the surgery may need to be rescheduled for the next available or appropriate time. In the event procedures run longer or shorter than anticipated, the perioperative clerk or RN should notify the surgeon and assistant and provide an approximate time when their procedure will begin. The perioperative clerk or RN should also notify the anesthesiologist of any schedule changes.

6. When two separate unrelated procedures are to be done simultaneously (by two different surgeons) on one patient, each surgeon will have a scrub nurse in attendance.

7. Patients who meet the health and procedural requirements for same-day, or AM Admit surgeries should be given the following information by the physician's office staff:
   - Date, time, and place for the preoperative testing (if ordered)
   - Date and time of the surgery
   - Anticipated arrival time at the hospital the day of the surgery (about 90 minutes prior to the procedure)
   - NPO instructions
   - Appropriate clothing
   - Arrangements for a responsible adult provide transportation / care postoperatively
   - An RN from the perioperative unit will be calling the day prior to surgery for a preoperative interview
   - Information hand-outs shall be provided relative to insurance coverage or non-coverage

8. The physician's office personnel will send the following to the preoperative unit:
   - Signed orders: which address surgical consent, preoperative testing, preoperative prep, and medications including an IV, and any other preoperative care the physician would like the patient to receive
   - H&P (completed within 30 days of the scheduled surgery)
   - Consent (witnessed)
   - Preoperative worksheet (if applicable) for equipment, instruments, implants and contact information for vendors that may provide specialized products.

PREOPERATIVE INTERVIEW

An RN from the perioperative unit will call the patient the weekday prior to the scheduled surgery to review medication use, allergies, medical history, history of prior procedures, and provide more detailed preoperative instructions and start postoperative teaching

AFTER – HOURS SCHEDULING:

1. Emergency procedures may preempt elective procedures by mutual consent of the surgeons involved or are scheduled as soon as on-call personnel are available (within 15 minutes) after normal operating room hours.

2. After hours, urgent surgeries, additions, or cancellations to the schedule that will occur in the following 24 hours will be handled by the House Supervisor who will notify the Perioperative DON or Surgery Coordinator. The DON or coordinator will instruct the House Supervisor to notify other team members if needed (Board Runner, anesthesia provider, vendors, etc.)

EMERGENCY SURGERIES/PROCEDURES

The surgeon scheduling an emergency surgery or a surgery to be done during "on call" hours should notify the House Supervisor.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

The House Supervisor should ask the surgeon for the following information:

- **Type of surgery and side (for cases involving laterality –this is important for OR set-up)**
- **Patient's date of birth**
- **Physician**
- **Time of surgery**
- **If the Surgery is STAT**, urgent, or scheduled after -hours
- **Has anesthesia been called** (this should be a surgeon to anesthesiologist call for appropriate information exchange but the supervisor may need to call if the surgeon cannot do so)
- **Need for an assistant**
- **Need for radiology or imaging**
- **Any special equipment**

If this is a STAT case, the OR Team should be called in.
The Perioperative on-call staff is currently listed together on the intranet under "Code Team/Call Sheet"
The House Supervisor should relay the following information to the OR Team:

Type of surgery: _____ Side: Left Right N/A
Name of patient: _____ DOB: _____
Surgeon: _____
STAT / Urgent / "Scheduled" (timing of case)
Other: Assistant, imaging, special equipment

The House supervisor checklist:

1. **Call the circulating RN**
2. **Call the scrub tech or second RN**
3. **Make sure the anesthesiologist has been notified**
4. **Check on an assistant: is one needed? has the surgeon found one? does one need to be called?**
5. **Check with circulator – will the circulator notify PACU will the shift supervisor notify PACU?**

Usually the operating room nurse circulating the procedure will notify the PACU nurse on call when the surgeon begins to finish the procedure, allowing time to prepare the PACU before completion of the surgery.

The OR Team should be notified of any "scheduled" after-hours case (like a Saturday morning hip repair) as soon as it is scheduled by the surgeon – but there is no need to call the OR Team during usual sleeping hours for a case that is not an emergency.

Also inform the OR Team if any case that was going to be done during "On Call" is canceled.

TRANSFERRING THE PATIENT FOR EMERGENCY SURGERY

On off hours, holidays and week-ends, patients are transported directly to the OR. The OR circulator will come to the department, identify the patient and transport the patient by stretcher (or bed if it is an orthopedic total

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

joint case) to the OR. The sending department will assist with the transport to the OR elevator entrance. The sending department transport assistant will escort the patient's family to the front lobby OR waiting area.

The unit RN completes the Preoperative Checklist

The Surgeon completes the informed consent by reviewing the risks benefits and alternatives of the surgical procedure with the patient/family. If the signed consent is not on the chart, the RN may witness the consent. The RN signature on the consent indicates that the Surgeon reviewed the risks, benefits and alternatives of the surgical procedure with the patient/family and or patient representative.

The unit RN follows the Surgeon's preoperative orders. If the unit RN has questions about the surgical preparation, the RN is to call the Surgeon for orders.

If no orders are received to change the IV solution, the patient will be sent to surgery with the current IV on a pump. If the surgery is scheduled for the next day, the Surgeon will usually order NPO at 2400. If the patient does not have an IV ordered, the Surgeon should be called for IV orders.

REFERENCES:

1. AORN 2016 Standards, California Code of Regulations, Title 22 : 70225

CROSS REFERENCE P&Ps:

1. Cesarean Delivery
2. Preoperative Preparation and Teaching

Approval	**Date**
CCOC	12/12/16
Surgery/Tissue Committee	1/25/17
MEC	
Board of Directors	

Developed: 1/01 bs
Revised: 8/2011bs, 11/16 AW
Reviewed:
Index listings: Scheduling Surgical Procedures
Supersedes: Scheduling Emergency Surgeries

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines	
Scope: Nursing Services	Manual:
Source:	Effective Date: 4/1/16

PURPOSE:

The purpose of a Patient Safety Attendant (SA) is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation. ~~to avoid falls of patient self harm.~~

POLICY:

1. A Medical Staff Practitioner ~~must~~ may write an order for a patient safety attendant however a nurse may also initiate the use of a SA through assessment and by collaboration with other team members. ~~.~~ Patient safety attendant criteria include:
   a. Suicide precaution (All patients on suicide precautions will have a safety attendant until a physician has cleared the patient from such precautions.)
   b. ~~Fall protection~~Protecting patients from harm when they are at high risk for falls
   c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient safety attendant may be from different levels of care providers, including LVN, CNA,~~,~~ Clerk, Security, Environmental Services, etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:

1. ~~Patient Safety Attendant assignment require a medical Staff practitioner order.~~ When a patient safety attendant ~~order is received~~is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) ~~S~~ for ~~sitter~~ coverage. The HS will find staffing coverage.
   a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio
   ~~b. Light duty staff may be utilized as sitters~~
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
   a. Call for assistance as needed using the call bell~~, and~~
   b. Not to leave the patient unattended
3. A guest tray may be ordered for the family member who is sitting with the patient~~sitter~~.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
   a. Give direction to the ~~sitter~~ SA based on the ~~sitters~~ SA's job description performance standards
   b. Check on the ~~sitter~~ SA when completing hourly rounding every hour from 0800~~-1000~~ 2200 and every two hours from2200-0800
5. The patient ~~safety attendant~~SA will be located in the room with the patient. The patient ~~safety attendant~~SA will:
   a. Not leave the room (i.e. breaks and meals unless relieved by another person)
   b. Notify the RN~~B~~ of any assistance needed or concerns
6. The patient need for a patient safety attendant should be re-assessed on an ongoing basis but not less that every 24 hours.
   a. Patient Safety Attendant continuation will be reviewed at the daily ~~staffing huddle~~interdisciplinary team meeting

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines	
Scope: Nursing Services	Manual:
Source:	Effective Date: 4/1/16

REFERENCES:

CROSS REFERENCE P&P:

1. Suicide Precautions

Committee Approval	**Date**
CCOC	**1/16**
MEC	**3/3/16**
Board of Directors	**3/16/16**

Developed: 12/92
Reviewed: 10/97, 3/06, 5/09, 5/11, 9/12
Revised: **1/16**

Replaces 1:1 Staffing (Sitter)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

POLICY:

In the event of a disaster or emergency where the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient care needs, the Chief Executive Officer or the Chief of Staff or their designee(s) may grant Disaster Privileges to individuals presenting themselves as health care practitioners seeking to volunteer their services, after the process outlined below has been followed.

PROCEDURE:

1. All Hospital departments and supervisory personnel (including Disaster Team Leaders) shall be instructed to direct all volunteering health care practitioners ("HCPs") to the Disaster Command Center. If there is no Disaster Command Center, the HCP will be directed to area where care is being delivered.

2. ~~Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the~~The volunteer~~ing~~ HCP (who may be a licensed independent practitioner or other individual required by law and regulation to have a license, certification, or registration) shall be required to produce ~~a~~ valid government-issued photo ~~ID card~~ identification with a signature (e.g., driver's license or passport) and at least one of the following:
    a. a current license to practice medicine, or other certification or registration, issued by a state, federal, or regulatory agency; or
    b. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
    c. identification indicating that the individual has been granted authority, by a federal, state or municipal entity,~~-~~ to render patient care, treatment, or services in disaster circumstances; or
    d. a signed statement by a current Hospital or Medical Staff Member with personal knowledge regarding the practitioner's identity and ability to act as a ~~licensed independent~~ qualified practitioner during a disaster.

    If possible, copies of these documents should be made (and/or notation of the current hospital or medical staff member with personal knowledge). If it is not possible to make copies, the identification information (including full name, address, license number, issuing agency, etc.) shall be recorded.

    If documents are not readily accessible, the attending medical staff member will be responsible for making the final decision to allow the volunteer HCP to participate in disaster care.

Comment [d1]: Joint Commission standard EM02.02.15 requires critical access hospitals to set a process for assigning disaster responsibilities to volunteer practitioners who are NOT necessarily licensed independent practitioners. I have defined an HCP as both LIPs and non-LIPs to satisfy both EM02.02.13 and EM.02.02.15 in one policy.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

3. The Request for Disaster Privileges/Responsibilities form shall be completed (as indicated on the attached form).

4. The volunteering HCP shall be requested to indicate his/her malpractice carrier and the name of the hospital(s) where he/she currently holds privileges (if applicable). ~~If possible,~~Primary source verification of licensure, certification or registration, insurance, and hospital affiliations shall be made ~~by telephone or electronic query~~as soon as the disaster is under control, or within 72 hours from the time the volunteer HCP presents him- or herself to the hospital, whichever comes first. A query to the NPDB and OIG shall also be submitted, unless technologically not possible. In the event this information cannot be verified, emergency approval of Disaster Privileges may still be granted pending verification.

   If primary source verification of licensure, certification or registration cannot be completed within 72 hours of the volunteer HCP's arrival due to extraordinary circumstances, it is performed as soon as possible. The following should be documented:

   - Reason(s) the verification could not be performed within the 72 hours.
   - Evidence of the volunteer HCP's demonstrated ability to continue to provide adequate care, treatment, or services.
   - Evidence of the attempt to perform primary source verification as soon as possible.

~~3. The Request for Disaster Privileges form shall be completed (as indicated on the attached form).~~

~~4.~~5. The available information shall be reviewed by the individual(s) authorized to grant emergency approval of Disaster Privileges, listed below. ~~per NIH Policy "Credentialing Health Care Practitioners in the Event of a Disaster".~~ The on-site responsible Medical Staff member (i.e., in accordance with facility disaster plan, e.g., ER physician) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information to the highest ranking individual as follows who are authorized to grant Disaster Privileges:

   A. Chief of Staff
   B. CEO
   C. Any MEC member
   D. Any Service Chief
   E. Any active medical staff member
   F. Designee of any of the above

   In the event of similar ranking individuals, preference would be given to the medical staff member with the practice most appropriate to the volunteer HCP's background/training.

~~5.~~6. The volunteer HCP shall be partnered with a member of the Medical Staff or Allied Health staff of similar specialty, if possible. The medical staff member or Allied Health staff member will oversee the performance of the volunteer HCP through direct observation,

Comment [d2]: No changes were made to this form -dp

Comment [d3]: To satisfy EP 8 (EM.02.02.13 and EM.02.02.15)

Comment [d4]: To satisfy EP 8 and 9 (EM.02.02.13 and EM.02.02.15)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

mentoring, or medical record review. Partnering information shall be recorded with the other information regarding the volunteer HCP. More than one HCP may be partnered with a single medical staff member or AHP.

~~6.~~7. The volunteer HCP shall be issued a temporary identification badge (if available) indicating his/her name, status as an approved volunteer HCP, and notation of his/her partner.

8. A decision whether to continue the volunteer HCP's assigned disaster responsibilities is to be made within 72 hours of the practitioner's arrival.

~~7.~~9. Any such Disaster Privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster Privileges shall be terminated immediately if any information is received that suggests the volunteer HCP is not capable of rendering services as approved. HCP may be terminated by the partner or any of the grantors in 5 above. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then HCP privileges will be terminated.

~~8.~~10. The Hospital will make every effort to recognize and thank the services provided by the HCPs once the Disaster is over.

Comment [d5]: EP4 states the method of overseeing the volunteer practitioner should be described in writing

Comment [d6]: To satisfy EP 7

Approval	**Date**
Bylaws Committee	1/15/2016
Medical Staff Committee	2/8/2016
Medical Executive Committee	2/2/2016
Board of Directors	2/17/16

Revised: 1/14/2016; 2/2/2016; 12/21/2016 dp

REFERENCES:

1. The Joint Commission (2016) CAMCAH EM 02.02.13 and EM 02.02.15
2. California Medicaid Services §485.623 Condition of Participation: Emergency Services

CROSS REFERENCE P&P:

1. Request for Disaster Privileges form (attached)

Responsibility for review and maintenance: Medical Staff Support Manager
Index Listings: emergency credentialing, disaster credentialing, disaster privileges

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Staff and Allied Health Professional Application Fee Processing	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

PURPOSE:

To ensure that Medical Staff and Allied Health Professional application fees are handled and processed according to the procedures outlined in this policy.

POLICY:

1. **Medical Staff Policy**: Application for appointment and reappointment to the Medical Staff and/or for granting of clinical privileges will include an application fee in accordance with the following fee schedule as approved by the Board of Directors:
   - **Physicians:**

     - $300.00 per application for appointment

     - $100.00 per application for reappointment

   - **Allied Health Professionals (AHPs):**

     - $150.00 per application for appointment

     - $75.00 per application for reappointment

2. **Medical Staff Office Policy:** It is the goal of the Medical Staff Office to submit money for application fees to the Credit and Billing Information Office or the Receptionist in the front lobby within 30 days of receipt.

PROCEDURE:

1. Medical Staff Office personnel receives application fees for appointment and reappointment.

2. Medical Staff Office personnel will submit money for fees to the Credit and Billing Information Office or the Receptionist in the front lobby. The Credit and Billing Information Office or the Receptionist in the front lobby will provide a receipt of payment for fees to Medical Staff Office personnel.

   These fees will be recorded by using the Non-Patient Transaction process with the following codes:

   - 90076-Provider Application Fees

   This Charge Code is mapped to the General Ledger Accounts 5780-5935 Other Operating Revenue; Provider Application Fees (Other Oper Rev-Prov Appl Fees).

3. The Accountant with oversight of Other Operating Revenue accounts will monitor this account as part of the review of all Other Operating Revenue.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Staff and Allied Health Professional Application Fee Processing	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

REFERENCES:

1. Northern Inyo Healthcare District Board of Directors (2016, August 17). *Regular Meeting*. Retrieved from http://www.nih.org/docs/DistrictBoardMinutesAugust172016RegularMeeting.pdf

Approval	**Date**
MEC	**02/07/2017**
Board of Directors	

Developed: 8/25/16
Reviewed:
Revised:
Supersedes:

Responsibility for review and maintenance:
Index Listings: Application Fees

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Transfusion Criteria	
Scope: Hospital Wide	Department:
Author: Catherine Baldwin, BS, CLS, MT(ASCP)SBB	Effective Date:
Copy Location:	Revised Date:

I. Purpose

To define transfusion criteria adopted by the Tissue, Surgery and Transfusion Committee at Northern Inyo Hospital.

II. Policy

The transfusion criteria at Northern Inyo Hospital utilize evidence-based medical and surgical concepts designed to maintain hemoglobin concentration, optimize hemostasis, minimize blood loss and reduce transfusion associated risks.

III. Procedure

RED BLOOD CELL transfusion is indicated when:

1. Hgb </= 7g/dL in a stable patient
2. Hgb </=8g/dL in a patient with symptoms of cardiac ischemia, orthostatic hypotension or tachycardia
3. The ordering physician documents a clinical circumstance that would benefit from transfusion
4. Active bleeding is present

FROZEN PLASMA transfusion is indicated if:

1. INR >1.8 in a patient with bleeding, a planned invasive procedure, or a planned surgery with anticipated significant blood loss
2. Active bleeding is present

PLATELET transfusion is indicated if:

1. Platelet count</=10,000/uL in a stable patient
2. Platelet count </=20,000/uL in a patient with a coagulopathy or with an anatomic lesion likely to bleed.
3. Platelet count</=50,000/uL in a patient with a current bleed or surgical procedure
4. Massive transfusion

CRYOPRECIPITATE transfusion is indicated if:

1. Fibrinogen </=100 mg/dL

IV. References

a. Carson JL, Grossman JB, Kleinman S, et al. Red Blood Cell Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2012; 157:49-58 [PMID:22751760]
b. Fung MK, Grossman jB, Hillyer C et al, eds. AABB Technical Manual, 18th ed, Bethesda, MD; AABB Press, 2014
c. Kaufman RM, Djulbegovic B, Gemsheimer T, et al. Platelet Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2015; 162:205-13

Title: Transfusion Criteria	
Scope: Hospital Wide	Department:
Author: Catherine Baldwin, BS, CLS, MT(ASCP)SBB	Effective Date:
Copy Location:	Revised Date:

d. Qaseem A, et al. Treatment of Anemia in Patients with Heart Disease: A Clinical Practice Guideline from the American College of Physicians. *Ann Intern Med*. 2013;159(11):770-779.
e. Shander A, Gross I, Hill S, et al, A New Perspective on Best Transfusion Practices; *Blood Transfus* 2013; 11:193-202 DOI 10.2450/2012.0195-12

Reviewed by	Date
STTA	10/26/16
Med/ICU	1/26/17
MEC	2/7/17
BOD	

NORTHERN INYO HOSPITAL
BISHOP, CA 93514

TRANSFUSION INVESTIGATION—use one form for each unit transfused

Patient Name:_____ (Or Place Sticker Here)
Medical Record Number:_____
Birth date:_____
Physician: _____

NURSING PROCEDURES: IMMEDIATE STEPS:

Check off each step as completed:

- ☐ Stop transfusion. Keep lines open.
- ☐ Attend to patient needs
- ☐ Notify physician
- ☐ Notify laboratory X2113
- ☐ Call phlebotomy to draw post-transfusion specimen; one large purple top tube is needed
- ☐ Collect first urine
- ☐ Complete form below
- ☐ Send form, urine, purple top tube and remainder of unit with IV lines to laboratory

Reaction Date	Time of Reaction	Donor Unit and Code Number W0419_____ Code E_____VOO	Original Vol of Product
Time Unit Started	Time Unit Stopped	Diagnosis/reason for transfusion:	Vol of Unit Transfused %_____

Clerical Check: ID BAND_____ REQUISITION_____ UNIT LABEL_____ UNIT TAG_____

	PRETRANSFUSION	POSTTRANSFUSION	Type of Product:
TEMP			___RBCs
B/P			___PLTs
Pulse			___FFP
Respiration			___CRYO

CHECK SYMPTOMS THAT APPLY:

___Fever	___Chills	___Pain at Infusion Site	___Generalized Bleeding	___Urticaria
___Dyspnea (SOB)	___Nausea	___Chest Pain	___Back Pain	___Hypotension
___Hemoglobinuria	___Flushing	___Other_____		

DATE_____ TIME_____ PRINTED NAME & SIGNATURE_____

LABORATORY INVESTIGATION:

Clerical Check: Record the actual information that you see on the work card, unit tag and unit label
Clerical check OK? _____ Call pathologist if not

	Record patient name:	Record MR#	Record DOB	Record ABO/RH	Record ab screen	Unit number	Code number	exp date
workcard						W0419_____	E_____VOO	
unit tag								
unit	n/a	n/a	n/a		n/a			

Repeat Testing: Fill in following information (shaded areas) Repeat testing OK? _____ Call pathologist if not
Perform Bili, LDH, Haptoglobin and RBC/HPF only if deemed necessary

	ABO/RH	HEMOLYSIS	ICTERUS	DAT	BILI	LDH	Hapto-globin	Post Transfusion Urine
Pre-transfusion sample								dipstick blood _____
Post-transfusion sample								RBC/HPF_____
Unit #			n/a	n/a	n/a	n/a	n/a	

If a clerical error is detected which indicates a patient received an incompatible unit or if hemoglobinuria, positive DAT, hemolysis, or icterus is noted on a post-transfusion sample and was absent on the pre-transfusion sample, do the following:

1. **Immediately notify the patient's physician, the pathologist and the blood bank supervisor**
2. **Repeat antibody screen on pretransfusion sample and perform screen on post transfusion sample**
3. **Repeat crossmatch on pretransfusion sample and crossmatch post transfusion sample—both IS and gel methods**

unit #	IS xmatch	Gel xmatch	interp:	ab screen:	CLS:
Pre-transfusion sample					
Post-transfusion sample					

4. **If screen is positive on either sample, send sample out for antibody id. Do not transfuse units until antibody is identified. Send unit segments with sample.**
5. **If DAT is positive on either sample, send both samples out for positive DAT workups. Do not transfuse units until positive DAT workup is completed. Send unit segments with sample.**
6. **Complete any other testing requested by pathologist**

Examine unit and tubing, if tubing/unit is discolored or if patient's temperature increase is greater than 2°C, culture transfused units. Refer to culture procedure included in "Suspected Transfusion Reaction":

Unit number	exp date:	culture results:

CLS initials:_____ Date/Time:_____ Supervisor Check:_____ Date/Time:_____

Pathologist's evaluation: Reaction is: _____Nonhemolytic _____ Hemolytic (acute/delayed) _____ Allergic _____ Febrile _____Other
Conclusions:

Pathologist:_____Date/Time:_____

Emergency Room Service Critical Indicators Annual Review

- Nursing Concerns
- All non-5150 Transfers
- Formal Patient Complaints
- Pt. Refusal of Treatment, AMA, or Elopements
- Unscheduled Return or Admit Seen Within 48 Hours
- All Codes, Deaths, and Critical Patients
- ED Acquired Infections
- Death Within 24 Hours of Visit
- Laceration Repair With Recheck Concern
- Specific Procedures
  a) Procedural Sedation
- All Incoming Transfers
- Suicide or Attempted Suicide in the ED
- Nosocomial Infections (For Referral)
- Concern Regarding Quality of Pre-Hospital Care
- Unscheduled ED Visit of Pt. Discharged Within 72 Hours

Approved: Emergency Room Service Committee on 1/19/2017

Approved: MEC on 2/7/2017

Approved: BOD on

SURGICAL CRITICAL INDICATORS:

1. ☐ Death within 30 days of a surgical or anesthetic procedure.
2. ☐ Unanticipated admission to the Intensive Care Unit from a lower level of care
3. ☐ Unanticipated return to the Operating Room
4. ☐ Unanticipated readmission to the hospital within 30 days following a surgical procedure
5. ☐ Unanticipated return to the hospital following surgery
6. ☐ Unanticipated removal or repair of tissue not considered to be a common outcome of the procedure.
7. ☐ Unanticipated patient retention of foreign material.
8. ☐ Complication consequent to implantation of prosthetic devices or to their malfunction or failure.
9. ☐ Documented significant postoperative complication within 30 days. These will include ventilatory failure, myocardial infarction, stroke, renal failure, pulmonary embolus or deep vein thromboembolic disease, sepsis, or impairment of body function to a level less than that present prior to a surgical or anesthetic procedure, and less than commonly expected as a result of the operative procedure.
10. ☐ Airway Management for Moderate Sedation (oral airway or bagging patient)
11. ☐ Wrong site surgery

ANESTHESIA CRITICAL INDICATORS FOR INTRA-OP AND POST-OP PATIENTS:

12. ☐ Mortality within the same hospital stay; CNS complications
13. ☐ Cardiac arrest or Respiratory arrest within the same hospital stay
14. ☐ Failure to emerge from general anesthesia within 2 hours or regional anesthesia within 6 hours
15. ☐ Development of injury to the brain, spinal cord or peripheral nervous system within the same hospital stay
16. ☐ Clinically apparent Acute MI within the same hospital stay
17. ☐ New onset of pulmonary edema or CHF within the same hospital stay
18. ☐ Aspiration of gastric contents
19. ☐ Ocular injury during Anesthesia care
20. ☐ Reintubation in the O.R. or PACU or unplanned use of ventilator in the Recovery Room.
21. ☐ Anaphylaxis allergic event
22. ☐ O_2 saturation less than 90 for more than 10 minutes
23. ☐ Complicated or Traumatic Airway Management
    a. Intubation taking longer than 5 minutes (defined as from the time the physical act of intubation begins)
    b. O2 saturation less than 85 for more than 5 minutes (during intubation)
    c. Intubation requiring more than 3 attempts
    d. Dental or mouth injury
    e. Surgical Airway

Reviewed 4/98; Revised 5/00; Reviewed 4/04; Revised 6/06; Reviewed 1/07; 1/08; 1/09;1/2010; 1/2012/; 4/27/16

Approved: STTA on 1/25/17, MEC on 2/7/2017, Board on ___

Medical Services Critical Indicators Annual Review

- Readmit to hospital w/in 30 days-same or related problem
- Medical death
- Hospice inpatient
- Use of restraints
- Staff Concerns

Approved: Medicine/ICU Committee on 1/26/2017

Approved: MEC on 2/7/2017

Approved: BOD on

ICU Critical Indicators Annual Review

- Unexpected Deaths
- Ventilator Associated Complications
- Unexpected Complications After Discharge or Transfer from ICU
- Staff Concerns

Approved: Medicine/ICU Committee on 1/26/2017

Approved: MEC on 2/7/2017

Approved: BOD on

RADIOLOGY SERVICE

_____ Supervise Allied Health Professional

TELERADIOLOGY

Diagnostic Radiology

_____ GI/OR fluoroscopy interpretation, as requested by supervising physician
_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity

CT

_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity
_____ Vascular Exams (Angio)

MRI

_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity
_____ Vascular Exams (Angio)

US

_____ Head, Neck, Chest, Abdomen and Retroperitoneal
_____ Pelvic, Obstetric and Scrotal
_____ Soft tissue, superficial and deep
_____ Extremity
_____ Vascular including color flow doppler

Nuclear Medicine

_____ ALL Nuclear Medicine studies

ON-SITE RADIOLOGY

A physician with On-site privileges may also read via teleradiology.

General Fluoroscopy

_____ General fluoroscopy (current CA Radiography & Fluoroscopy X-Ray Supervisor & Operator Permit required)

Diagnostic Radiology

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Extremity
_____ Gastrointestinal studies with contrast
_____ Cholangiography, IV, O.R, & T-tube
_____ Sialography
_____ Lumbar Puncture
_____ Pediatric Lumbar Puncture
_____ Hysterosalpingography

CT

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Extremity
_____ Vascular Exams (Angio)

MRI

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Prostate
_____ Extremity
_____ Vascular Exams (Angio)

NORTHERN INYO HOSPITAL MEDICAL STAFF
CLINICAL PRIVILEGES REQUEST FORM

Dr. _____

RADIOLOGY SERVICE

ON-SITE RADIOLOGY

NM

Must be an authorized user (on NIH Radioactive materials license or have temporary authorized user status)

_____ GI studies
_____ Lung studies
_____ Musculoskeletal studies
_____ Infection/Tumor Studies
_____ Renal Studies
_____ Endocrine studies
_____ Hepato/biliary studies
_____ Myocardial/Vascular Studies
_____ CSF/LEAK studies

US

_____ Neck, Chest, Abdomen and Retroperitoneal
_____ Pelvic, Obstetric and Scrotal
_____ Soft tissue, superficial and deep
_____ Extremity
_____ Vascular including color flow doppler
_____ Cardiac/pericardial

Interventional Procedures

_____ Fluoroscopic guidance
_____ US guidance
_____ CT guidance
_____ MR guidance
_____ Portacath insertion

DEXA

_____ Bone Densitometry

Vascular

_____ Angiography
_____ Percutaneous Vena Cava Filter Placement / Removal (IVC)
_____ Peripherally Inserted Central Catheter
_____ Central Line insertion
_____ Insertion/management of hemodialysis catheter

Urography

_____ Cystography
_____ Urethrography
_____ Intravenous Urography
_____ Nephrostogram
_____ Nephrostomy Tube Placement
_____ Bladder Drainage Catheter

Biopsy

_____ Soft tissue, superficial/deep
_____ Peritoneal/Retroperitoneal
_____ Musculoskeletal
_____ Percutaneous Organ Biopsy

Drainage/Aspiration/Centesis

_____ Soft tissue, superficial/deep
_____ Peritoneal/Retroperitoneal
_____ Musculoskeletal
_____ Thoracostomy Tube Placement/Thoracentesis
_____ Percutaneous Abscess or Cyst Drainage
_____ Transhepatic Biliary Studies
_____ Paracentesis

RADIOLOGY SERVICE

Pain Management

_____ Radiofrequency Ablation - Nerves
_____ Vertebroplasty/Kyphoplasty
_____ Trigger Point Injections

Epidurals

_____ Translaminal
_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral
_____ Transforaminal
_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral
_____ Caudal
_____ Sacral

Facet/Paravertebral Nerve Injections

_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral

Athrocentesis/Arthography

_____ Large Joint (Knee, Shoulder, etc)
_____ Medium Joint (Wrist, Ankle, etc)
_____ Small Joint (Finger, Toe)
_____ SI Joint

Anesthesia

_____ Topical anesthesia
_____ Local infiltration
_____ Peripheral Nerve Block
_____ Minimal Sedation (Anxiolysis)
_____ Moderate Sedation/analgesia (Conscious Sedation)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Cesarean Delivery**	
Scope: Perinatal, Surgery	Manual: **CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)**
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:
To provide guidelines of care for the Perinatal Nurse to take care of the mom going for a scheduled, unscheduled, or emergent cesarean section in the OR.

POLICY:

I. SCHEDULED CESAREAN SECTION DELIVERY:

1. An informed consent will be obtained and signed.
2. Admit assessment will be done and charted while obtaining a 20 min NST strip.
3. Get scrubs or bunny suit for support person, including hat, mask, and booties.
4. After the reactive strip is obtained (if not reactive, call OB physician), call PACU and accompany mom and support person to the PACU with mom's paper chart.
5. Check that the infant warmer is fully stocked, functioning properly, has a Doppler for FHT's in the OR, and take to the OR.
6. A qualified Perinatal RN with current Neonatal Resuscitation (NRP) certification will attend the delivery in the OR.
7. Call RT and give them a "heads-up" that there is a C/S (cesarean section) scheduled and will call when ready for them to attend the delivery.
8. When in OR, use sterile technique for baby hand-off.
9. After infant is placed on warmer, provide care based on NRP guidelines. At any time, the pediatrician can be called to assist with resuscitation if needed (and baby will be transferred to the nursery, steps 10-12 will be skipped).
10. After infant stable, assist mom with skin-to-skin care, standing at OR table for safety, and assist with breastfeeding if cues are present. Put newborn orders in Paragon to be able to retrieve meds.
11. When mom ready to move from OR table to gurney, take support person and infant to the PACU on warmer, get meds, give within 2 hours after delivery, do weight, measurements, etc.
12. Then when mom arrives in PACU, assist with continued skin-to-skin and breastfeeding, as OB staffing allows and mom stable. If mom not stable, or OB staffing does not allow RN to stay in PACU, take infant in warmer back up to mom's room on OB floor, allowing support person to accompany baby if they desire.
13. When mom is recovered, receive report from PACU staff, and assist with pericare and transfer mom from gurney to postpartum bed.

II. UNSCHEDULED CESAREAN SECTION DELIVERY:

1. Doctor's order for a cesarean section will be obtained.
2. Patient will remain NPO except for antacid if ordered.
3. An informed consent for "non-elective" cesarean section and blood transfusion will be obtained and signed, and C/S chart forms placed into chart.
4. OB doctor will call the House supervisor to get the OR ready and OR circulating team. (expectation of decision to incision is 20 minutes, requirement is 30 minutes).
5. Paragon admit assessment will be done (if not already done and in labor) and charted while obtaining a 20 min NST strip. Or continuous monitoring if in labor.

6. Get scrubs or bunny suit for support person, including hat, mask, and booties.
7. Give Bicitra or Reglan if ordered by Anesthesia.
8. Using electric clippers, shave lower abdomen, no hair to be seen with closed legs.
9. Start PIV with a #16 or #18 catheter, preferably in the arm. Give warmed LR of 1000 ml (or doctor's solution choice). If IV already running, add the Discofix IV extension tubing, and change IV pump tubing to gravity tubing.
10. Complete attached pre-op checklist and take with patient to the OR.
11. Communicate with PACU team on transport of patient to the OR.
12. Follow steps 5-13 in **I. Scheduled Cesarean Section Delivery**.

III. EMERGENT CESAREAN SECTION DELIVERY:

1. If C/S is STAT, move the patient to the OR (after hours) in the left lateral position and complete procedures there. Have someone notify House Supervisor if OB doctor has not done so already.
2. Enter Cesarean orders STAT to be able to get access to needed medications.
3. If patient unable to sign the consent form (due to severity of medical condition), OB doctor must document in progress note why patient unable to sign for procedure and why procedure is necessary.
4. If patient able to sign, and time allows, an informed consent will be signed for "emergency" cesarean section and blood transfusion.
5. Infuse warmed LR or other IV fluid as ordered by OB doctor/anesthesiologist.
6. Give Bicitra or Reglan if ordered by Anesthesia.
7. Transport mom to the OR via birthing bed or gurney, give brief report to OR personnel, and fill out pre-op checklist after transport of mom.
8. Take EFM portable monitor or Dopple FHT's per doctor's orders, stocked infant warmer, patient's chart and stickers with mom to the OR.
9. Stay with mom in the OR (follow steps 5-13 in **I. Scheduled Cesarean Section Delivery**).

DOCUMENTATION:

1. OB charts the decision time for the cesarean section.
2. Chart all care given to the patient to prep for the C/S (i.e. shave prep, Bicitra, doppled fetal heart tones etc.)
3. Chart arrival times of all providers when mom is on the OB unit.
4. Chart time of transfer to the OR or PACU for pre-op.
5. Complete all delivery summary information and newborn bands.

IV. RECOVERY OF THE CESAREAN SECTION DELIVERY IN THE PERINATAL UNIT:

1. After mom has been transferred to the Perinatal Unit, and report received on the Postpartum mom, complete a head-to-toe assessment.
2. If Postpartum Pitocin not hanging, hang on IV pump according to Pitocin Administration policy.
3. Confirm with PACU that med orders have been charted in eMAR, or meds given in PACU have been faxed to pharmacy to ensure correct medication administration and times.

Title: **Cesarean Delivery**	
Scope: Perinatal, Surgery	Manual: **CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)**
Source: Manager of Perinatal Department	Effective Date:

4. Obtain post-op vital signs and fundal assessments as outlined below in DOCUMENTATION.

DOCUMENTATION:

1. Obtain maternal vital signs including B/P, pulse, respirations, and pulse oximetry reading:
    a. Every 15 minutes x 4 (for an hour)
    b. Every 30 minutes x 2 (for an hour)
    c. Every 1 hour x 1
    d. Every 4 hours until discharge to home.

2. Perform fundal check and lochia assessment:
    a. Every 15 minutes x 2.
    b. Fundal check and lochia assessment PRN if patient condition indicates more frequent assessment.
    c. Every 8 hours until discharge to home.

Committee Approval	**Date**
Peri-Peds	**11-7-16**
STTA	**1/25/17**
CCOC	**11/14/16**
MEC	**02/07/17**
Board of Directors	

Responsibility for review and maintenance: Perinatal Nurse Manager and Surgery Nurse Manager
Revised: 5/92; 11/97; 12/03, 9/11jk, 8/16SG

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Risk Prevention - Perinatal	
Scope: Perinatal	Manual: Perinatal – Patient Safety (PS)
Source: Perinatal Manager	Effective Date:

PURPOSE:
To provide a guideline for the prevention of inpatient/outpatient and visitor falls in the Perinatal Unit, with population-specific fall prevention strategies for pediatric, obstetric and neonatal patients.

SUPPORTIVE DATA:
Pregnant, laboring and newly delivered women, as well as newborn and pediatric children have unique risk factors that may contribute to falls. While the Morse scale has not been tested on this population, it can identify pre-existing fall risk factors in adult patients (such as crutch use or recent history of a fall). Therefore, for pregnant women, the Morse scale is assessed upon admission. For newborn and pediatric patients, the Morse scale is not utilized at all, nor is it used as an ongoing assessment tool for maternal patients.

POLICY:
Due to the fact that Perinatal patients have unique fall risks, all Perinatal patients will be considered high risk for falls, and assessed for fall risk. **Prevention and Management of Falls** with the following exceptions:

1. Morse scale will only be used for admission on adult patients
2. Falls Protocol will only be implemented for <u>ongoing high risk</u> patients
3. Universal Fall Precautions will include population-specific measures

Visitors experiencing a fall are managed per hospital safety policy "injury to patients and visitors" policy

I. **Perinatal Universal Precautions** (includes both A and B)

A. Universal Fall Precautions: For every patient, the perinatal staff will implement the following Universal Fall Precautions below.

- Orient the patient/family to the environment and the potential for falls.
- Non skid footwear/slippers/socks when ambulating.
- Assure that the bed is in low position when care is not being given.
- Wheels on a bed, gurney, wheelchair, and BSC (if locks present) are locked when appropriate.
- Spills are wiped up immediately.
- Call light/telephone/water/personal items are within reach.
- Siderails up x2 or x3 only.
- Ensure a safe environment (no spills, pick up clutter and remove "trip" items, such as electrical cords and unnecessary equipment).
- Assure that the room is properly lit.
- If a medication is given that can affect balance or sedation - Inform the patient and ask them to "Speak up" if you need help.
- Consider peak effect for prescribed medications that affect LOC, gait, and elimination and plan care accordingly.
- Ambulate patients early and often.

- Defective equipment or hazards are reported immediately
- Use safe patient handling equipment such as Sara Steady and pink sheet for patient transfers.

B. Perinatal Population-Specific Measures:

1. **Labor and Delivery:** All women who are pregnant, laboring or newly delivered are considered and managed as at episodic risk for falls due to the delivery experience, including (but not limited to):
   a. Analgesia/anesthesia or other medications (such as anti-hypertensives or anti-psychotics) that are identified in the administrative protocol as placing patients at high risk for falls.
   b. Specific positions for laboring (standing and squatting) and labor support - Patients and labor support persons will be educated to fall risk prevention and the RN will monitor patient and support person activity as at risk for fall.
   c. Second stage of labor - patient side rails upX2; RN or MD in attendance at all times. Support person and other visitors will be offered a place to be seated during the delivery and educated to the need to inform the hospital staff, member of feelings of dizziness, lightheaded or nauseated. The person will be assisted to a sitting or lying position as need is assessed.
   d. Transfer to PACU - A labor and delivery staff member will assist patients and support persons walking to or from the PACU. If a patient will be going straight to the OR, the patient will be transported via wheelchair, gurney, or bed.
   e. Ambulation assistance - All immediate postpartum patients will be assisted, when up to ambulate/use the restroom including the use of the patient transfer device as needed. Patient and family will be educated to call for help for initial postpartum use of bathroom, and additionally until assessed as stable by RN. Any labor patient on IV's may also need assistance at any stage to navigate to the bathroom.

2. **Recovery:** All newly delivered mothers will be considered high risk for falls due to the following (but not limited to):
   a. Ambulation-All newly admitted mothers will be assisted when ambulating for the first time after admission until the RN has assessed and determined her to be capable of adequate coordination, strength, and weight bearing to ambulate independently.
   b. Analgesia/anesthesia or other medications that are identified in the administrative protocol as placing patients at high risk for falls.
3. **Newborn:** All newborns are considered at high risk for falls due to the following (but not limited to):
   a. Developmental stage and inability to stabilize and maintain body positions.
   b. Potential to roll off the bed if left unattended.
   c. Maternal sleepiness and/or analgesia.

Mother of baby/parent will be educated to monitor self for sleepiness while in bed or chair and holding infant, and encouraged to place baby in bassinet at bedside when she needs to rest.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Risk Prevention - Perinatal	
Scope: Perinatal	Manual: Perinatal – Patient Safety (PS)
Source: Perinatal Manager	Effective Date:

Safety interventions are noted in the Standard of Care/Standard of Practice Policy for Mother-Baby Unit and NICU specific nursing care.

II. Fall Protocol

A. Since all Perinatal patients are considered at risk for falls, the Fall Protocol will only be implemented for ongoing high risk patients due to special circumstances. These are patients identified by the RN as meeting criteria beyond the expected high risk factors, for example:
   1. Impaired gait after an epidural procedure, or after delivery
   2. Postpartum hemorrhage with blood loss affecting balance or strength
   3. Substance abuse affecting judgment, level of consciousness, balance, strength or gait
   4. Dizziness with ambulation-If RN assists patient to bathroom twice, but dizziness persists greater than two trips
   5. Persistent orthostatic blood pressure changes
   6. Ambulatory aid required
   7. Current fall during hospitalization

B. The RN is responsible for initiating and ensuring the ongoing implementation of the Fall Protocol

III. Management of the In-Patient Fall

1. All falls require Post Fall management to be implemented on a witnessed fall, patient found on floor, or report of a fall. The RN will complete an immediate post fall assessment (includes physical assessment and assessment of injuries), notify the physician, document in the medical record and notify the house supervisor.

REFERENCES:

1. Simpson, K. & Creehan, P. AWHONN: Perinatal nursing. Lippincott, Williams & Wilkins:Philadelphia.

CROSS REFERENCES:

1. Functional Risk assessment for criteria for therapy referral

Approval	**Date**
CCOC	1/25/17
Peri-peds	2/2/2017
MEC	2/7/2017
BOD	

Developed: 12/16 SG
Reviewed:
Revised:
Index:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Death-Disposition of Body	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

To instruct the Nursing Staff on the procedure following a patient's death related to disposition of the body and personal belongings, and to ensure that the remains of deceased patients (hereinafter "the body") are handled in accordance with patient/family wishes and the needs of the hospital while complying with industry standards for disposition

POLICY:

1. In the event of a patient's death, the nursing staff will follow the following procedure related to Pronouncement of Death, Organ/Tissue/Eye Donation and Coroner's Case policies.

2. California Health and Safety Code requires health care facilities to notify the mortuary attendant, prior to removal of the body, if the patient is afflicted with a reportable disease listed in Title 17, California Code of Regulation, Section 2500 (c), i.e., HIV disease, Hepatitis, etc. (See attached), without written authorization of the patient's representative, but the release must be tracked.

3. Any instructions given to the hospital in writing by the patient for the disposition (type of disposition, or place of interment) of the body will be carried out as required by law.

4. If the coroner is called, the coroner will receive the body regardless of the deceased patient's written instructions, or any instructions of the patient's survivors.

5. If there are no written instructions in the chart for the disposition of the deceased patient's body, the hospital will follow the instructions as provided by the person with the most authority. The following persons in the order listed below will determine the plan for the remains of the deceased.
    a. Person appointed as agent for the patient through a power of attorney.
    b. Spouse or domestic partner
    c. Adult (over 18) child, or the majority of the surviving adult children, or if the majority of surviving adult children are not available, the instructions of the children available
    d. Parent(s) of the deceased. If both parents are alive, but one is not available, then, the instructions of the one that is available will be followed.
    e. Sibling(s)
    f. Next of kin in order of degrees of kinship
    g. Public Administrator

6. If after contacting an out of town funeral director as instructed, that funeral director is unable or unwilling to remove the body from the hospital within 3 hours of death, or if the bed is needed immediately, the hospital shall call the local funeral director in Bishop California to remove the body.

7. If the local funeral director is called to remove the body of a patient whose instructions required using an out of town funeral home, or if the instructions of the deceased patient's agent requires using an out of town funeral home, then, the nursing supervisor will inform the agent or next of kin that the body had to be removed by the local funeral director and there will be a charge from them for this service.

8. The patient's belongings are either given to the family or placed in a bag and given to the mortuary attendant. A list of belongings sent either home or to the mortuary should be noted on the "Release of Body to Mortuary Form." The original form will be maintained by NIHD in the medical record. A copy of the form will be sent with the body.

9. Notification of the Organ Procurement Organization will be completed per policy and documented on the "Release of Body to Mortuary Form." See "Organ/Tissue/Eye Donation" policy for procedure.

10. Should an Autopsy be required, the physician shall discuss the rationale with the next of kin and obtain a signature on the California Hospital Association form 11-1 found in the consent manual (on the DVD).

PROCEDURE:

1. The nurse shall notify the attending physician or ED physician to pronounce the patient's death. The physician may request RN staff trained in the process to pronounce the patient as noted in the "Pronouncement of Death" policy.

2. The physician shall notify the family of the patient's death or will request that the nurse do this.

3. If the family wishes to view the body, the nurse will make arrangements for this.

4. The nurse shall prepare the body for transfer to the mortuary. All tubes, dressings, (unless containing drainage), etc. shall be removed prior to transfer. Follow established policy if a coroner's case.

5. The Shift Supervisor or their designee will report all deaths to the Organ Procurement Organization following the Organ Procurement policy, prior to releasing the body to the mortuary. All releases of patient information to tissue/organ procurement/donor organizations must be documented on the Release of Body to Mortuary form, for HIPAA tracking purposes.

Title: Death-Disposition of Body	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

6. Nursing Supervisor or designee will
    a. Check the chart for instructions for disposition of the decedent's remains.
    b. Call the funeral director listed or the County Coroner if the case warrants.
    c. Call the funeral director chosen by the person in authority in accordance with this policy if there are no written instructions
    d. Call the local funeral director if the body cannot be picked up within 3 hours, OR, if the supervisor determines that the bed is needed sooner than 3 hours.
    e. Fill out all necessary paperwork and file the copy of the Release of Body in the chart
7. The mortuary attendant will sign the RELEASE OF BODY TO MORTUARY (form HIPAA-43). This completed form remains in the medical record of the patient. The hospital may release to the mortuary:
    a. the patient's name
    b. date and time of death
    c. the patient's face sheet.
8. The House Supervisor will provide a copy of the Release of Body form to the NIHD Social Worker, who will follow-up with the family of the deceased by telephone within the following month.

REFERENCES:

1. California Hospital Association. Consent Manual (2016) Chapter 11, Section II.
2. The BRN Report; volume 14, NO. 1. http://www.rn.ca.gov/pdfs/forms/brnspring2001.pdf, page 6.

CROSS REFERENCE P&P:

1. **Coroner's Case**
2. **Organ/Tissue/Eye Donation**
3. **Pronouncement of Death**
4. **Release of Body to Mortuary** form found on intranet under Forms>HIPAA>HIPPA43

Approval	**Date**
CCOC	12/12/16
Medical Services/ICU	01/26/17
MEC	02/07/17
Board of Directors	

Developed: 5/2009
Reviewed: 9/2010, 9/2012
Revised: 5/2011, 10/2013, 12/2016 ta
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pronouncement of Death	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

To permit select Registered Nurses (RN) to pronounce death on patients meeting specific criteria.

POLICY:

1. Death may be pronounced by Registered Nurses in the following positions:
    - Directors of Nursing
    - House Supervisors
    - House Supervisor Assistants

PROCEDURE:

1. The Following patient conditions must be met before the above identified RN's can pronounce death:
    a. The following documentation must both be present in the patient's health record:
        i. Physician progress note stating that the patient is terminal or moribund; and
        ii. Physician order for do not attempt cardiopulmonary resuscitation.
    b. The patient must not be sustained by external mechanical life support equipment.
    c. The patients must not be reportable to the coroner under Government Code, Sate of California, Section 102850 (see Nursing Policy "Coroner's Case").
    d. The coroner did not accept the case.
    e. The patient must not be a potential solid organ donor (see "Organ/Tissue/Eye Donation" policy).
2. The physician may request that a registered nurse pronounce death if the above criteria is met. The physician's order to pronounce death shall be written in the Health Record by the physician or a telephone order must be given by the physician to the RN. (See "Verbal and/or Phone Medical Staff Practitioner Orders" policy).
3. Release of Body to the Mortuary requires an order from the physician, which may be placed by the physician in advance of the death as contained in the orderset.
4. If the above patient conditions criteria are met, the unit staff nurse will contact one of the above-designated RN's to pronounce death of the patient.
5. The RN pronouncing death will also review that the conditions listed are met.
6. The RN will pronounce death post-examination of the patient if cessation of cardio pulmonary function is present as determined by all of the following:
    a. No respirations
    b. No apical pulse
    c. Non-reactive pupils
    d. Lack of response to physical stimuli
7. The RN pronouncing death is to document in the EHR.
8. The RN caring for the patient will assure completion of "Release of Body to Mortuary" prior to the removal of the body from the facility.
9. The attending/covering physician shall be notified at the time of death and retains responsibility for:
    a. Notifying family
    b. Completing health record documentation.
    c. Seeking permission for autopsy.
    d. Signing death certificate.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pronouncement of Death	
Scope: Northern Inyo Hospital	Manual: CPM-End of Life
Source: Director of Nursing Practice	Effective Date:

REFERENCES:

1. California Board of Registered Nursing. (2014). Scope of Regulation, Division 2, Chapter 6, Article 2, Section 2725. Legislative intent: Practice of Nursing Define. Retrieved from http://www.rn.ca.gov/pdfs/regulations/npr-i-15.pdf
   Retrieved from http://www.rn.ca.gov/pdfs/forms/brnspring2001.pdf
2. State of California. (2014). California Government Code, Section 27491. Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=27491.&lawCode=GOV
3. California Hospital Association. Consent Manual. (2016) Chapter 11, Section II.

CROSS REFERENCE P&P:

1. Death-Disposition of Body
2. Coroner's Case
3. Organ/Tissue/Eye Donation
4. Verbal and/or Phone Medical Staff Practitioner Orders

Approval	**Date**
CCOC	12/12/17
Medical Services/ICU	01/26/17
MEC	02/07/17
Board of Directors	

Developed: 12/2/2016
Reviewed:
Revised:
Supercedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scope of Services, Infusion Center**	
Scope: Infusion Center	Manual: **Infusion Center**
Source: DON Perioperative Services	Effective Date:

I. Department Description:

The Outpatient Infusion Unit is located in the old hospital building off the main corridor. The unit can be accessed two ways: from the corridor that links the old hospital to the new hospital, and from the old hospital corridor leading from the cafeteria to the outside of the old hospital.

The Outpatient Infusion Center department has 6 treatment rooms, one for Argon Laser eye treatments, and 5 for infusions or procedures. One of these rooms can be set up as an isolation room if needed for contact precautions. Each room has space for an infusion chair or a gurney, an over-bed table, a TV, and infusion pumps. There is space for a visitor or two to be with the patient and there are curtains for privacy.

II. Mission:

To provide care to patients in our community in need of outpatient infusions (including chemotherapy), injections, phlebotomies, transfusions dressing changes, and observation / monitoring after interventional radiology procedures. Additionally, the ophthalmologist can utilize the Argon laser for eye treatments in the first room which is a designated laser room.

III. Vision:

- To maintain competency in administration of medications to treat a variety of diagnoses.
- To provide treatment locally so patients in the community are not forced to drive long distances to receive treatment that can be administered through the outpatient unit here at NIH.

IV. Scope:

The purpose of the Infusion Center is to provide competent staff and a pleasant, safe facility in which outpatient infusions and treatments can be performed. Routine service is provided to the public 5 days a week Monday through Friday from 0800-1700, after hour care may be arranged on an individual basis if needed. Patients are scheduled by the Infusion Center Clerk once orders have been received, authorization for treatment obtained, and Pharmacy has ensured medication availability (if applicable). The patients' primary care practitioner is apprised of any complications or need for further evaluation. Patients whose acuity exceeds the scope of services of the Infusion Center will be transferred to the emergency department at NIH either by wheelchair or gurney based on acuity.

V. Staffing:

The Infusion Center is staffed daily by one or more RNs and an Infusion Center Clerk. The number of RNs is based on the number of patients scheduled. The nursing staff administering chemotherapy has completed the Oncology Nursing Society "Chemotherapy and Biotherapy Administration" training.

VI. Customers

Internal customers include nursing staff, other hospital department staff, medical staff practitioners, and administration. External customers include patients, families, visitors, and suppliers.
The Infusion Center works in partnership with all services provided by NIH for lab, diagnostic imaging, physical therapy, surgery, or inpatient needs.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scope of Services, Infusion Center**	
Scope: Infusion Center	Manual: **Infusion Center**
Source: DON Perioperative Services	Effective Date:

The Infusion Center works in partnership with community resources provided by Pioneer Home Health, Hospice, Toiyabe Indian Health Clinic and Dialysis Unit, Inyo county department of public health, Bishop Care Center, and Sterling Heights.

VII. Ages Serviced:

The Infusion Center provides care across the life span
Pediatrics: 28 days to 13th birthday
Adult: 13 to 65 years
Geriatric: > 65 years

VIII. QA/PI:

The department establishes Pillars of Excellence and department goals annually. Performance Improvement projects and teams are identified and prioritized based on feedback from patients, staff, medical staff, regulatory survey, audits, changes in technology, etc.
The Infusion Center is State licensed and Joint Commission accredited.

XI. Budgeted Staff :

Refer to Master staffing plan

Approval	**Date**
CCOC	**1/25/17**
Med/ICU	**1/26/17**
MEC	
Board of Directors	

Developed: 1/86
Reviewed:
Revised: 2/98, 3/06 AW,8/10 AW, 09/12, 3/16 AW, 1/17AW
Supercedes:

Responsibility for review and maintenance:
Index Listings: Scope of Service Infusion; Infusion Scope of Service

Dev. 7/14

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

PURPOSE:
To facilitate the process of scheduling elective, after-hours, and emergency surgical procedures.

POLICY:
When scheduling surgical procedures, the following procedure will be utilized.

PROCEDURE
SCHEDULING ELECTIVE SURGERIES / PROCEDURES:
Surgical procedures will be scheduled by the perioperative clerk, or a perioperative nurse during regular working hours which start at 0700 and end at 1700 weekdays. Hospital designated holidays excluded.

Information taken upon scheduling will be:

- Patient name
- Patient date of birth
- In-patient / same-day / am admit status
- Date of procedure
- Time of procedure
- Proposed surgical procedure or procedures
- Length of surgery
- Name of Surgeon and assistant (if one has been arranged)
- Need for RNFA
- Need for special equipment (instruments, trays, implants, etc.)
- Need for imaging (C-arm, needle localization)

1. Procedures are scheduled on the date requested when possible; and surgery time is assigned as available on first come, first served basis.

2. The first procedure of the day is scheduled to start at 0730. All other procedures are scheduled to follow. Each room can accommodate a 0730 procedure unless there is no anesthesia coverage for the second room.

3. Children under seven years of age, cesarean sections, total joint replacements, and diabetic patients are given a first hour (0730) space whenever possible.

4. No elective cases should be scheduled after 1600 without consent of the Surgery Coordinator or Perioperative DON.

5. Procedures may be delayed for a variety of reasons. Depending on the reason for the delay or cancellation, the surgery may need to be rescheduled for the next available or appropriate time. In the event procedures run longer or shorter than anticipated, the perioperative clerk or RN should notify the surgeon and assistant and provide an approximate time when their procedure will begin. The perioperative clerk or RN should also notify the anesthesiologist of any schedule changes.

6. When two separate unrelated procedures are to be done simultaneously (by two different surgeons) on one patient, each surgeon will have a scrub nurse in attendance.

7. Patients who meet the health and procedural requirements for same-day, or AM Admit surgeries should be given the following information by the physician's office staff:
   - Date, time, and place for the preoperative testing (if ordered)
   - Date and time of the surgery
   - Anticipated arrival time at the hospital the day of the surgery (about 90 minutes prior to the procedure)
   - NPO instructions
   - Appropriate clothing
   - Arrangements for a responsible adult provide transportation / care postoperatively
   - An RN from the perioperative unit will be calling the day prior to surgery for a preoperative interview
   - Information hand-outs shall be provided relative to insurance coverage or non-coverage

8. The physician's office personnel will send the following to the preoperative unit:
   - Signed orders: which address surgical consent, preoperative testing, preoperative prep, and medications including an IV, and any other preoperative care the physician would like the patient to receive
   - H&P (completed within 30 days of the scheduled surgery)
   - Consent (witnessed)
   - Preoperative worksheet (if applicable) for equipment, instruments, implants and contact information for vendors that may provide specialized products.

PREOPERATIVE INTERVIEW

An RN from the perioperative unit will call the patient the weekday prior to the scheduled surgery to review medication use, allergies, medical history, history of prior procedures, and provide more detailed preoperative instructions and start postoperative teaching

AFTER – HOURS SCHEDULING:

1. Emergency procedures may preempt elective procedures by mutual consent of the surgeons involved or are scheduled as soon as on-call personnel are available (within 15 minutes) after normal operating room hours.

2. After hours, urgent surgeries, additions, or cancellations to the schedule that will occur in the following 24 hours will be handled by the House Supervisor who will notify the Perioperative DON or Surgery Coordinator. The DON or coordinator will instruct the House Supervisor to notify other team members if needed (Board Runner, anesthesia provider, vendors, etc.)

EMERGENCY SURGERIES/PROCEDURES

The surgeon scheduling an emergency surgery or a surgery to be done during "on call" hours should notify the House Supervisor.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

The House Supervisor should ask the surgeon for the following information:

- **Type of surgery and side (for cases involving laterality –this is important for OR set-up)**
- **Patient's date of birth**
- **Physician**
- **Time of surgery**
- **If the Surgery is STAT**, urgent, or scheduled after -hours
- **Has anesthesia been called** (this should be a surgeon to anesthesiologist call for appropriate information exchange but the supervisor may need to call if the surgeon cannot do so)
- **Need for an assistant**
- **Need for radiology or imaging**
- **Any special equipment**

If this is a STAT case, the OR Team should be called in.
The Perioperative on-call staff is currently listed together on the intranet under "Code Team/Call Sheet"
The House Supervisor should relay the following information to the OR Team:

Type of surgery: _____ Side: Left Right N/A
Name of patient: _____ DOB: _____
Surgeon: _____
STAT / Urgent / "Scheduled" (timing of case)
Other: Assistant, imaging, special equipment

The House supervisor checklist:

1. **Call the circulating RN**
2. **Call the scrub tech or second RN**
3. **Make sure the anesthesiologist has been notified**
4. **Check on an assistant: is one needed? has the surgeon found one? does one need to be called?**
5. **Check with circulator – will the circulator notify PACU will the shift supervisor notify PACU?**

Usually the operating room nurse circulating the procedure will notify the PACU nurse on call when the surgeon begins to finish the procedure, allowing time to prepare the PACU before completion of the surgery.

The OR Team should be notified of any "scheduled" after-hours case (like a Saturday morning hip repair) as soon as it is scheduled by the surgeon – but there is no need to call the OR Team during usual sleeping hours for a case that is not an emergency.

Also inform the OR Team if any case that was going to be done during "On Call" is canceled.

TRANSFERRING THE PATIENT FOR EMERGENCY SURGERY

On off hours, holidays and week-ends, patients are transported directly to the OR. The OR circulator will come to the department, identify the patient and transport the patient by stretcher (or bed if it is an orthopedic total

Title: **Scheduling Surgical Procedures**	
Scope: Nursing	Manual: **Anesthesia, Outpatient, Surgery**
Source: Perioperative DON	Effective Date:

joint case) to the OR. The sending department will assist with the transport to the OR elevator entrance. The sending department transport assistant will escort the patient's family to the front lobby OR waiting area.

The unit RN completes the Preoperative Checklist

The Surgeon completes the informed consent by reviewing the risks benefits and alternatives of the surgical procedure with the patient/family. If the signed consent is not on the chart, the RN may witness the consent. The RN signature on the consent indicates that the Surgeon reviewed the risks, benefits and alternatives of the surgical procedure with the patient/family and or patient representative.

The unit RN follows the Surgeon's preoperative orders. If the unit RN has questions about the surgical preparation, the RN is to call the Surgeon for orders.

If no orders are received to change the IV solution, the patient will be sent to surgery with the current IV on a pump. If the surgery is scheduled for the next day, the Surgeon will usually order NPO at 2400. If the patient does not have an IV ordered, the Surgeon should be called for IV orders.

REFERENCES:

1. AORN 2016 Standards, California Code of Regulations, Title 22 : 70225

CROSS REFERENCE P&Ps:

1. Cesarean Delivery
2. Preoperative Preparation and Teaching

Approval	**Date**
CCOC	12/12/16
Surgery/Tissue Committee	1/25/17
MEC	
Board of Directors	

Developed: 1/01 bs
Revised: 8/2011bs, 11/16 AW
Reviewed:
Index listings: Scheduling Surgical Procedures
Supersedes: Scheduling Emergency Surgeries

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines	
Scope: Nursing Services	Manual:
Source:	Effective Date: 4/1/16

PURPOSE:

The purpose of a Patient Safety Attendant (SA) is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation. ~~to avoid falls of patient self harm.~~

POLICY:

1. A Medical Staff Practitioner ~~must~~ may write an order for a patient safety attendant however a nurse may also initiate the use of a SA through assessment and by collaboration with other team members. ~~.~~ Patient safety attendant criteria include:
   a. Suicide precaution (All patients on suicide precautions will have a safety attendant until a physician has cleared the patient from such precautions.)
   b. ~~Fall protection~~Protecting patients from harm when they are at high risk for falls
   c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient safety attendant may be from different levels of care providers, including LVN, CNA,~~,~~ Clerk, Security, Environmental Services, etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:

1. ~~Patient Safety Attendant assignment require a medical Staff practitioner order.~~ When a patient safety attendant ~~order is received~~is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) ~~S~~ for ~~sitter~~ coverage. The HS will find staffing coverage.
   a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio
   ~~b. Light duty staff may be utilized as sitters~~
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
   a. Call for assistance as needed using the call bell~~, and~~
   b. Not to leave the patient unattended
3. A guest tray may be ordered for the family member who is sitting with the patient~~sitter~~.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
   a. Give direction to the ~~sitter~~ SA based on the ~~sitters~~ SA's job description performance standards
   b. Check on the ~~sitter~~ SA when completing hourly rounding every hour from 0800~~-1000~~ 2200 and every two hours from2200-0800
5. The patient ~~safety attendant~~SA will be located in the room with the patient. The patient ~~safety attendant~~SA will:
   a. Not leave the room (i.e. breaks and meals unless relieved by another person)
   b. Notify the RN~~B~~ of any assistance needed or concerns
6. The patient need for a patient safety attendant should be re-assessed on an ongoing basis but not less that every 24 hours.
   a. Patient Safety Attendant continuation will be reviewed at the daily ~~staffing huddle~~interdisciplinary team meeting

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines	
Scope: Nursing Services	Manual:
Source:	Effective Date: 4/1/16

REFERENCES:

CROSS REFERENCE P&P:

1. Suicide Precautions

Committee Approval	**Date**
CCOC	**1/16**
MEC	**3/3/16**
Board of Directors	**3/16/16**

Developed: 12/92
Reviewed: 10/97, 3/06, 5/09, 5/11, 9/12
Revised: **1/16**

Replaces 1:1 Staffing (Sitter)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

POLICY:

In the event of a disaster or emergency where the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient care needs, the Chief Executive Officer or the Chief of Staff or their designee(s) may grant Disaster Privileges to individuals presenting themselves as health care practitioners seeking to volunteer their services, after the process outlined below has been followed.

PROCEDURE:

1. All Hospital departments and supervisory personnel (including Disaster Team Leaders) shall be instructed to direct all volunteering health care practitioners ("HCPs") to the Disaster Command Center. If there is no Disaster Command Center, the HCP will be directed to area where care is being delivered.

2. ~~Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the~~The volunteer~~ing~~ HCP (who may be a licensed independent practitioner or other individual required by law and regulation to have a license, certification, or registration) shall be required to produce ~~a~~ valid government-issued photo ~~ID card~~ identification with a signature (e.g., driver's license or passport) and at least one of the following:
    a. a current license to practice medicine, or other certification or registration, issued by a state, federal, or regulatory agency; or
    b. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
    c. identification indicating that the individual has been granted authority, by a federal, state or municipal entity,~~-~~ to render patient care, treatment, or services in disaster circumstances; or
    d. a signed statement by a current Hospital or Medical Staff Member with personal knowledge regarding the practitioner's identity and ability to act as a ~~licensed independent~~ qualified practitioner during a disaster.

    If possible, copies of these documents should be made (and/or notation of the current hospital or medical staff member with personal knowledge). If it is not possible to make copies, the identification information (including full name, address, license number, issuing agency, etc.) shall be recorded.

    If documents are not readily accessible, the attending medical staff member will be responsible for making the final decision to allow the volunteer HCP to participate in disaster care.

Comment [d1]: Joint Commission standard EM02.02.15 requires critical access hospitals to set a process for assigning disaster responsibilities to volunteer practitioners who are NOT necessarily licensed independent practitioners. I have defined an HCP as both LIPs and non-LIPs to satisfy both EM02.02.13 and EM.02.02.15 in one policy.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

3. The Request for Disaster Privileges/Responsibilities form shall be completed (as indicated on the attached form).

4. The volunteering HCP shall be requested to indicate his/her malpractice carrier and the name of the hospital(s) where he/she currently holds privileges (if applicable). ~~If possible,~~Primary source verification of licensure, certification or registration, insurance, and hospital affiliations shall be made ~~by telephone or electronic query~~as soon as the disaster is under control, or within 72 hours from the time the volunteer HCP presents him- or herself to the hospital, whichever comes first. A query to the NPDB and OIG shall also be submitted, unless technologically not possible. In the event this information cannot be verified, emergency approval of Disaster Privileges may still be granted pending verification.

   If primary source verification of licensure, certification or registration cannot be completed within 72 hours of the volunteer HCP's arrival due to extraordinary circumstances, it is performed as soon as possible. The following should be documented:

   - Reason(s) the verification could not be performed within the 72 hours.
   - Evidence of the volunteer HCP's demonstrated ability to continue to provide adequate care, treatment, or services.
   - Evidence of the attempt to perform primary source verification as soon as possible.

~~3. The Request for Disaster Privileges form shall be completed (as indicated on the attached form).~~

~~4.~~5. The available information shall be reviewed by the individual(s) authorized to grant emergency approval of Disaster Privileges, listed below. ~~per NIH Policy "Credentialing Health Care Practitioners in the Event of a Disaster".~~ The on-site responsible Medical Staff member (i.e., in accordance with facility disaster plan, e.g., ER physician) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information to the highest ranking individual as follows who are authorized to grant Disaster Privileges:

   A. Chief of Staff
   B. CEO
   C. Any MEC member
   D. Any Service Chief
   E. Any active medical staff member
   F. Designee of any of the above

   In the event of similar ranking individuals, preference would be given to the medical staff member with the practice most appropriate to the volunteer HCP's background/training.

~~5.~~6. The volunteer HCP shall be partnered with a member of the Medical Staff or Allied Health staff of similar specialty, if possible. The medical staff member or Allied Health staff member will oversee the performance of the volunteer HCP through direct observation.

Comment [d2]: No changes were made to this form -dp

Comment [d3]: To satisfy EP 8 (EM.02.02.13 and EM.02.02.15)

Comment [d4]: To satisfy EP 8 and 9 (EM.02.02.13 and EM.02.02.15)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: CREDENTIALING HEALTH CARE PRACTITIONERS IN THE EVENT OF A DISASTER	
Scope: NIHD	Department: **Medical Staff**
Source: Medical Staff Support Manager	Effective Date: 2/18/16

mentoring, or medical record review. Partnering information shall be recorded with the other information regarding the volunteer HCP. More than one HCP may be partnered with a single medical staff member or AHP.

~~6.~~7. The volunteer HCP shall be issued a temporary identification badge (if available) indicating his/her name, status as an approved volunteer HCP, and notation of his/her partner.

8. A decision whether to continue the volunteer HCP's assigned disaster responsibilities is to be made within 72 hours of the practitioner's arrival.

~~7.~~9. Any such Disaster Privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster Privileges shall be terminated immediately if any information is received that suggests the volunteer HCP is not capable of rendering services as approved. HCP may be terminated by the partner or any of the grantors in 5 above. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then HCP privileges will be terminated.

~~8.~~10. The Hospital will make every effort to recognize and thank the services provided by the HCPs once the Disaster is over.

Comment [d5]: EP4 states the method of overseeing the volunteer practitioner should be described in writing

Comment [d6]: To satisfy EP 7

Approval	**Date**
Bylaws Committee	1/15/2016
Medical Staff Committee	2/8/2016
Medical Executive Committee	2/2/2016
Board of Directors	2/17/16

Revised: 1/14/2016; 2/2/2016; 12/21/2016 dp

REFERENCES:

1. The Joint Commission (2016) CAMCAH EM 02.02.13 and EM 02.02.15
2. California Medicaid Services §485.623 Condition of Participation: Emergency Services

CROSS REFERENCE P&P:

1. Request for Disaster Privileges form (attached)

Responsibility for review and maintenance: Medical Staff Support Manager
Index Listings: emergency credentialing, disaster credentialing, disaster privileges

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Staff and Allied Health Professional Application Fee Processing	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

PURPOSE:

To ensure that Medical Staff and Allied Health Professional application fees are handled and processed according to the procedures outlined in this policy.

POLICY:

1. **Medical Staff Policy**: Application for appointment and reappointment to the Medical Staff and/or for granting of clinical privileges will include an application fee in accordance with the following fee schedule as approved by the Board of Directors:
   - **Physicians:**

     - $300.00 per application for appointment

     - $100.00 per application for reappointment

   - **Allied Health Professionals (AHPs):**

     - $150.00 per application for appointment

     - $75.00 per application for reappointment

2. **Medical Staff Office Policy:** It is the goal of the Medical Staff Office to submit money for application fees to the Credit and Billing Information Office or the Receptionist in the front lobby within 30 days of receipt.

PROCEDURE:

1. Medical Staff Office personnel receives application fees for appointment and reappointment.

2. Medical Staff Office personnel will submit money for fees to the Credit and Billing Information Office or the Receptionist in the front lobby. The Credit and Billing Information Office or the Receptionist in the front lobby will provide a receipt of payment for fees to Medical Staff Office personnel.

   These fees will be recorded by using the Non-Patient Transaction process with the following codes:

   - 90076-Provider Application Fees

   This Charge Code is mapped to the General Ledger Accounts 5780-5935 Other Operating Revenue; Provider Application Fees (Other Oper Rev-Prov Appl Fees).

3. The Accountant with oversight of Other Operating Revenue accounts will monitor this account as part of the review of all Other Operating Revenue.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Staff and Allied Health Professional Application Fee Processing	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

REFERENCES:

1. Northern Inyo Healthcare District Board of Directors (2016, August 17). *Regular Meeting*. Retrieved from http://www.nih.org/docs/DistrictBoardMinutesAugust172016RegularMeeting.pdf

Approval	**Date**
MEC	**02/07/2017**
Board of Directors	

Developed: 8/25/16
Reviewed:
Revised:
Supersedes:

Responsibility for review and maintenance:
Index Listings: Application Fees

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Transfusion Criteria	
Scope: Hospital Wide	Department:
Author: Catherine Baldwin, BS, CLS, MT(ASCP)SBB	Effective Date:
Copy Location:	Revised Date:

I. Purpose

To define transfusion criteria adopted by the Tissue, Surgery and Transfusion Committee at Northern Inyo Hospital.

II. Policy

The transfusion criteria at Northern Inyo Hospital utilize evidence-based medical and surgical concepts designed to maintain hemoglobin concentration, optimize hemostasis, minimize blood loss and reduce transfusion associated risks.

III. Procedure

RED BLOOD CELL transfusion is indicated when:

1. Hgb </= 7g/dL in a stable patient
2. Hgb </=8g/dL in a patient with symptoms of cardiac ischemia, orthostatic hypotension or tachycardia
3. The ordering physician documents a clinical circumstance that would benefit from transfusion
4. Active bleeding is present

FROZEN PLASMA transfusion is indicated if:

1. INR >1.8 in a patient with bleeding, a planned invasive procedure, or a planned surgery with anticipated significant blood loss
2. Active bleeding is present

PLATELET transfusion is indicated if:

1. Platelet count</=10,000/uL in a stable patient
2. Platelet count </=20,000/uL in a patient with a coagulopathy or with an anatomic lesion likely to bleed.
3. Platelet count</=50,000/uL in a patient with a current bleed or surgical procedure
4. Massive transfusion

CRYOPRECIPITATE transfusion is indicated if:

1. Fibrinogen </=100 mg/dL

IV. References

a. Carson JL, Grossman JB, Kleinman S, et al. Red Blood Cell Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2012; 157:49-58 [PMID:22751760]
b. Fung MK, Grossman jB, Hillyer C et al, eds. AABB Technical Manual, 18th ed, Bethesda, MD; AABB Press, 2014
c. Kaufman RM, Djulbegovic B, Gemsheimer T, et al. Platelet Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2015; 162:205-13

Title: Transfusion Criteria	
Scope: Hospital Wide	Department:
Author: Catherine Baldwin, BS, CLS, MT(ASCP)SBB	Effective Date:
Copy Location:	Revised Date:

d. Qaseem A, et al. Treatment of Anemia in Patients with Heart Disease: A Clinical Practice Guideline from the American College of Physicians. *Ann Intern Med*. 2013;159(11):770-779.
e. Shander A, Gross I, Hill S, et al, A New Perspective on Best Transfusion Practices; *Blood Transfus* 2013; 11:193-202 DOI 10.2450/2012.0195-12

Reviewed by	Date
STTA	10/26/16
Med/ICU	1/26/17
MEC	2/7/17
BOD	

NORTHERN INYO HOSPITAL
BISHOP, CA 93514

TRANSFUSION INVESTIGATION—use one form for each unit transfused

Patient Name:_____ (Or Place Sticker Here)
Medical Record Number:_____
Birth date:_____
Physician: _____

NURSING PROCEDURES: IMMEDIATE STEPS:

Check off each step as completed:

- ☐ Stop transfusion. Keep lines open.
- ☐ Attend to patient needs
- ☐ Notify physician
- ☐ Notify laboratory X2113
- ☐ Call phlebotomy to draw post-transfusion specimen; one large purple top tube is needed
- ☐ Collect first urine
- ☐ Complete form below
- ☐ Send form, urine, purple top tube and remainder of unit with IV lines to laboratory

Reaction Date	Time of Reaction	Donor Unit and Code Number W0419_____ Code E_____VOO	Original Vol of Product
Time Unit Started	Time Unit Stopped	Diagnosis/reason for transfusion:	Vol of Unit Transfused %_____

Clerical Check: ID BAND_____ REQUISITION_____ UNIT LABEL_____ UNIT TAG_____

	PRETRANSFUSION	POSTTRANSFUSION	Type of Product:
TEMP			___RBCs
B/P			___PLTs
Pulse			___FFP
Respiration			___CRYO

CHECK SYMPTOMS THAT APPLY:

___Fever	___Chills	___Pain at Infusion Site	___Generalized Bleeding	___Urticaria
___Dyspnea (SOB)	___Nausea	___Chest Pain	___Back Pain	___Hypotension
___Hemoglobinuria	___Flushing	___Other_____		

DATE_____ TIME_____ PRINTED NAME & SIGNATURE_____

LABORATORY INVESTIGATION:

Clerical Check: Record the actual information that you see on the work card, unit tag and unit label
Clerical check OK? _____ Call pathologist if not

	Record patient name:	Record MR#	Record DOB	Record ABO/RH	Record ab screen	Unit number	Code number	exp date
workcard						W0419_____	E_____VOO	
unit tag								
unit	n/a	n/a	n/a		n/a			

Repeat Testing: Fill in following information (shaded areas) Repeat testing OK? _____ Call pathologist if not
Perform Bili, LDH, Haptoglobin and RBC/HPF only if deemed necessary

	ABO/RH	HEMOLYSIS	ICTERUS	DAT	BILI	LDH	Hapto-globin	Post Transfusion Urine
Pre-transfusion sample								dipstick blood _____
Post-transfusion sample								RBC/HPF_____
Unit #			n/a	n/a	n/a	n/a	n/a	

If a clerical error is detected which indicates a patient received an incompatible unit or if hemoglobinuria, positive DAT, hemolysis, or icterus is noted on a post-transfusion sample and was absent on the pre-transfusion sample, do the following:

1. **Immediately notify the patient's physician, the pathologist and the blood bank supervisor**
2. **Repeat antibody screen on pretransfusion sample and perform screen on post transfusion sample**
3. **Repeat crossmatch on pretransfusion sample and crossmatch post transfusion sample—both IS and gel methods**

unit #	IS xmatch	Gel xmatch	interp:	ab screen:	CLS:
Pre-transfusion sample					
Post-transfusion sample					

4. **If screen is positive on either sample, send sample out for antibody id. Do not transfuse units until antibody is identified. Send unit segments with sample.**
5. **If DAT is positive on either sample, send both samples out for positive DAT workups. Do not transfuse units until positive DAT workup is completed. Send unit segments with sample.**
6. **Complete any other testing requested by pathologist**

Examine unit and tubing, if tubing/unit is discolored or if patient's temperature increase is greater than 2°C, culture transfused units. Refer to culture procedure included in "Suspected Transfusion Reaction":

Unit number	exp date:	culture results:

CLS initials:_____ Date/Time:_____ Supervisor Check:_____ Date/Time:_____

Pathologist's evaluation: Reaction is: _____Nonhemolytic _____ Hemolytic (acute/delayed) _____ Allergic _____ Febrile _____Other
Conclusions:

Pathologist:_____Date/Time:_____

Emergency Room Service Critical Indicators Annual Review

- Nursing Concerns
- All non-5150 Transfers
- Formal Patient Complaints
- Pt. Refusal of Treatment, AMA, or Elopements
- Unscheduled Return or Admit Seen Within 48 Hours
- All Codes, Deaths, and Critical Patients
- ED Acquired Infections
- Death Within 24 Hours of Visit
- Laceration Repair With Recheck Concern
- Specific Procedures
  a) Procedural Sedation
- All Incoming Transfers
- Suicide or Attempted Suicide in the ED
- Nosocomial Infections (For Referral)
- Concern Regarding Quality of Pre-Hospital Care
- Unscheduled ED Visit of Pt. Discharged Within 72 Hours

Approved: Emergency Room Service Committee on 1/19/2017

Approved: MEC on 2/7/2017

Approved: BOD on

SURGICAL CRITICAL INDICATORS:

1. ☐ Death within 30 days of a surgical or anesthetic procedure.
2. ☐ Unanticipated admission to the Intensive Care Unit from a lower level of care
3. ☐ Unanticipated return to the Operating Room
4. ☐ Unanticipated readmission to the hospital within 30 days following a surgical procedure
5. ☐ Unanticipated return to the hospital following surgery
6. ☐ Unanticipated removal or repair of tissue not considered to be a common outcome of the procedure.
7. ☐ Unanticipated patient retention of foreign material.
8. ☐ Complication consequent to implantation of prosthetic devices or to their malfunction or failure.
9. ☐ Documented significant postoperative complication within 30 days. These will include ventilatory failure, myocardial infarction, stroke, renal failure, pulmonary embolus or deep vein thromboembolic disease, sepsis, or impairment of body function to a level less than that present prior to a surgical or anesthetic procedure, and less than commonly expected as a result of the operative procedure.
10. ☐ Airway Management for Moderate Sedation (oral airway or bagging patient)
11. ☐ Wrong site surgery

ANESTHESIA CRITICAL INDICATORS FOR INTRA-OP AND POST-OP PATIENTS:

12. ☐ Mortality within the same hospital stay; CNS complications
13. ☐ Cardiac arrest or Respiratory arrest within the same hospital stay
14. ☐ Failure to emerge from general anesthesia within 2 hours or regional anesthesia within 6 hours
15. ☐ Development of injury to the brain, spinal cord or peripheral nervous system within the same hospital stay
16. ☐ Clinically apparent Acute MI within the same hospital stay
17. ☐ New onset of pulmonary edema or CHF within the same hospital stay
18. ☐ Aspiration of gastric contents
19. ☐ Ocular injury during Anesthesia care
20. ☐ Reintubation in the O.R. or PACU or unplanned use of ventilator in the Recovery Room.
21. ☐ Anaphylaxis allergic event
22. ☐ O_2 saturation less than 90 for more than 10 minutes
23. ☐ Complicated or Traumatic Airway Management
    a. Intubation taking longer than 5 minutes (defined as from the time the physical act of intubation begins)
    b. O_2 saturation less than 85 for more than 5 minutes (during intubation)
    c. Intubation requiring more than 3 attempts
    d. Dental or mouth injury
    e. Surgical Airway

Reviewed 4/98; Revised 5/00; Reviewed 4/04; Revised 6/06; Reviewed 1/07; 1/08; 1/09;1/2010; 1/2012/; 4/27/16

Approved: STTA on 1/25/17, MEC on 2/7/2017, Board on ___

Medical Services Critical Indicators Annual Review

- Readmit to hospital w/in 30 days-same or related problem
- Medical death
- Hospice inpatient
- Use of restraints
- Staff Concerns

Approved: Medicine/ICU Committee on 1/26/2017

Approved: MEC on 2/7/2017

Approved: BOD on

ICU Critical Indicators Annual Review

- Unexpected Deaths
- Ventilator Associated Complications
- Unexpected Complications After Discharge or Transfer from ICU
- Staff Concerns

Approved: Medicine/ICU Committee on 1/26/2017

Approved: MEC on 2/7/2017

Approved: BOD on

RADIOLOGY SERVICE

_____ Supervise Allied Health Professional

TELERADIOLOGY

Diagnostic Radiology

_____ GI/OR fluoroscopy interpretation, as requested by supervising physician
_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity

CT

_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity
_____ Vascular Exams (Angio)

MRI

_____ Head, Neck, Chest, Abdomen and Pelvis
_____ Spine
_____ Extremity
_____ Vascular Exams (Angio)

US

_____ Head, Neck, Chest, Abdomen and Retroperitoneal
_____ Pelvic, Obstetric and Scrotal
_____ Soft tissue, superficial and deep
_____ Extremity
_____ Vascular including color flow doppler

Nuclear Medicine

_____ ALL Nuclear Medicine studies

ON-SITE RADIOLOGY

A physician with On-site privileges may also read via teleradiology.

General Fluoroscopy

_____ General fluoroscopy (current CA Radiography & Fluoroscopy X-Ray Supervisor & Operator Permit required)

Diagnostic Radiology

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Extremity
_____ Gastrointestinal studies with contrast
_____ Cholangiography, IV, O.R, & T-tube
_____ Sialography
_____ Lumbar Puncture
_____ Pediatric Lumbar Puncture
_____ Hysterosalpingography

CT

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Extremity
_____ Vascular Exams (Angio)

MRI

_____ Head, Neck, Chest, Abdomen, Pelvis and Spine
_____ Prostate
_____ Extremity
_____ Vascular Exams (Angio)

NORTHERN INYO HOSPITAL MEDICAL STAFF
CLINICAL PRIVILEGES REQUEST FORM

Dr. _____

RADIOLOGY SERVICE

ON-SITE RADIOLOGY

NM

Must be an authorized user (on NIH Radioactive materials license or have temporary authorized user status)

_____ GI studies
_____ Lung studies
_____ Musculoskeletal studies
_____ Infection/Tumor Studies
_____ Renal Studies
_____ Endocrine studies
_____ Hepato/biliary studies
_____ Myocardial/Vascular Studies
_____ CSF/LEAK studies

US

_____ Neck, Chest, Abdomen and Retroperitoneal
_____ Pelvic, Obstetric and Scrotal
_____ Soft tissue, superficial and deep
_____ Extremity
_____ Vascular including color flow doppler
_____ Cardiac/pericardial

Interventional Procedures

_____ Fluoroscopic guidance
_____ US guidance
_____ CT guidance
_____ MR guidance
_____ Portacath insertion

DEXA

_____ Bone Densitometry

Vascular

_____ Angiography
_____ Percutaneous Vena Cava Filter Placement / Removal (IVC)
_____ Peripherally Inserted Central Catheter
_____ Central Line insertion
_____ Insertion/management of hemodialysis catheter

Urography

_____ Cystography
_____ Urethrography
_____ Intravenous Urography
_____ Nephrostogram
_____ Nephrostomy Tube Placement
_____ Bladder Drainage Catheter

Biopsy

_____ Soft tissue, superficial/deep
_____ Peritoneal/Retroperitoneal
_____ Musculoskeletal
_____ Percutaneous Organ Biopsy

Drainage/Aspiration/Centesis

_____ Soft tissue, superficial/deep
_____ Peritoneal/Retroperitoneal
_____ Musculoskeletal
_____ Thoracostomy Tube Placement/Thoracentesis
_____ Percutaneous Abscess or Cyst Drainage
_____ Transhepatic Biliary Studies
_____ Paracentesis

RADIOLOGY SERVICE

Pain Management

_____ Radiofrequency Ablation - Nerves
_____ Vertebroplasty/Kyphoplasty
_____ Trigger Point Injections

Epidurals

_____ Translaminal
_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral
_____ Transforaminal
_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral
_____ Caudal
_____ Sacral

Facet/Paravertebral Nerve Injections

_____ Cervical
_____ Thoracic
_____ Lumbar
_____ Sacral

Athrocentesis/Arthography

_____ Large Joint (Knee, Shoulder, etc)
_____ Medium Joint (Wrist, Ankle, etc)
_____ Small Joint (Finger, Toe)
_____ SI Joint

Anesthesia

_____ Topical anesthesia
_____ Local infiltration
_____ Peripheral Nerve Block
_____ Minimal Sedation (Anxiolysis)
_____ Moderate Sedation/analgesia (Conscious Sedation)

Patient Experience Committee-CPEO Report *February, 2017*

1. **Joint Commission Accreditation**
   A. 1/20/17-Intracycle Monitoring also known as the Focused Standards Assessment submitted and accepted by The Joint Commission; next steps include Executive Team debriefing.
2. **CDPH Survey Readiness**
   A. Facility is due for a full state California Department of Public Health (CDPH) survey.
3. **General Survey Readiness Activities.**
   A. Tracer Tracking Log has been developed and a facility-wide *tracer* plan is being developed. To learn more about *tracers*, see attached "Facts about the Tracer Methodology". Nursing, Quality Assurance & Performance Improvement (QAPI) and other departments will be increasing the number of tracers to prepare for our survey and increase staff awareness of and knowledge about survey methods. (Plan)
4. **Hospital-Wide QAPI Plan**
   A. Annual Evaluation & updated Annual Work Plan is forthcoming; plan to present at March MEC meeting & Board meeting for approval. (Plan)
5. **Service Excellence**
   A. New & improved QAPI & Risk Management Orientation packet to be included in the Hospital-Wide General Orientation includes a Customer Service Standards pamphlet (handout) and a customer service training module to set service expectations from an employee's first day. The new training is scheduled to start on 2/13/17. (Execute)
   B. Working with Strategic Communications to develop Patient Relations/Patient Safety linked web pages with a feedback form with which patients, their families and visitors may provide feedback. (Execute)
   C. Conducted a Language Access Services satisfaction survey and currently analyzing results to identify opportunities for improvement. (Execute)
6. **Project Updates**
   A. Antibiotic Stewardship Plan-Multiple meetings held with new pharmacist to discuss next steps. (Execute)
   B. Workplace Violence (WV) Assessment and Improvement (Execute)
      1. Handover WV activities to Workforce Experience Committee on 1/19/17.
   C. Incident Reporting System (New)-Current incident reporting system is on paper and an ACCESS database and is at the end of its useful life; the QAPI department will be investigation web-based reporting systems and has submitted an IT Project Request. (Initiate-Plan)

D. Radiology Services RFP-Recommendations sent by Evaluation Team to the CEO for review and Notice of Preliminary Award posted to RFP webpage at nih.org website; annotated process maps, forms & templates created. (Monitor & Control)

E. Language Access Services Call Center-Exploring an innovative idea for a financially sustainable model for provision of Interpretive Services for our Spanish-speaking stakeholders. (Initiate-Plan)

F. **Team S**trategies and **T**ools to **E**nhance **P**erformance and **P**atient **S**afety (TeamSTEPPS) (See attached handout) (Plan)

1. Beta has accepted our request to implement TeamSTEPPS in areas other than the Operating Room initially and will provide training and related materials to us free of charge. The training is planned for June, 2017.

7. **Pillars of Excellence**- *(See Attached)*
8. **2013 CMS Validation Survey Monitoring** *(Moved to Consent Agenda)*
9. **Training & Education**

A. Developed a brief presentation for management and staff to emphasize the importance and value of Incident/Event Reporting and Root Cause Analysis; presented at the Diagnostic Imaging staff meeting; plan to present at Dept. Heads meeting. (Execute)

Project Management Methodology Keys

FOCUS-PDSA CYCLE: F (Find), O (Organize), C (Clarify), U (understand), S (Select), P (Plan), D (DO), S (Study), A (Act)
5S: Sort, Set, Sweep/Shine, Standardize, Sustain
DMAIC: Define –Measure-Analyze-Improve-Control
DMADV: Define-Measure-Analyze-Design-Verify
PMBOK: Initiate-Plan-Execute-Monitor & Control-Close-Out

Topic Details

Saturday 5:03 CST, February 4, 2017

Topic Library Item

Facts about the Tracer Methodology

January 26, 2016

A key part of The Joint Commission's on-site survey process is the tracer methodology. The tracer methodology uses information from the organization to follow the experience of care, treatment or services for a number of patients through the organization's entire health care delivery process. Tracers allow surveyors to identify performance issues in one or more steps of the process, or interfaces between processes. The types of tracers used by The Joint Commission during the on-site survey are:

Individual tracer activity: These tracers are designed to "trace" the care experiences that a patient had while at an organization. It is a way to analyze the organization's system of providing care, treatment or services using actual patients as the framework for assessing standards compliance. Patients selected for these tracers will likely be those in high-risk areas or whose diagnosis, age or type of services received may enable the best in-depth evaluation of the organization's processes and practices.

System tracer activity: Includes an interactive session with a surveyor and relevant staff members in tracing one specific "system" or process within the organization, based on information from individual tracers. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The three topics evaluated by system tracers are data management, infection control and medication management. Whether all system tracers are conducted varies, but the data use system tracer is performed on every survey.

Accreditation program-specific tracers: The goal of these tracers is to identify risk points and safety concerns within different levels and types of care, treatment or services. Program-specific tracers focus on important issues relevant to the organization — such as clinical services offered and high-risk, high-volume patient populations.

Read more about the accreditation process

- Accreditation process overview
- On-site survey process
- Unannounced survey process
- Scoring and accreditation decisions
- Intracycle monitoring process and focused standards assessment

UCSF Medical Center SAMPLE

Patient Relations

Patient Relations is here to help ensure that your experience at UCSF Medical Center is a good one. If you or a family member have a question or concern about your hospital stay, please let us know. We suggest you first discuss your concerns with your nurse, department manager and your doctor. If your concern remains unresolved, the Patient Relations staff or a nursing supervisor are available to help you reach a resolution or provide more information.

Patient Relations

Phone: (415) 353-1936
Fax: (415) 353-8556
Email: patient.relations@ucsfmedctr.org
Hours: Monday to Friday, 8:30 a.m. – 5 p.m.

Nursing Supervisor

Phone: (415) 353-1797
Hours: Weekends and holidays

Feedback

If you would like to submit a complaint, compliment or other feedback, complete our online feedback form, or email or fax the Patient Visitor Report Form to Patient Relations.

Fax: (415) 353-8556
Email: patient.relations@ucsfmedctr.org

The Patient Visitor Report Form is available in the following languages in addition to English:

- Chinese
- Russian
- Spanish

Hospital Administration

Concerns also may be sent to the hospital administration:

Mark Laret
Chief Executive Officer
UCSF Medical Center
500 Parnassus Ave.
San Francisco, CA 94143-0296
Phone: (415) 353-2733

Patient Privacy

UCSF Medical Center is committed to protecting your medical information. For information about your rights and the obligations we have regarding the use and disclosure of your medical information, please see our Notice of Privacy Practices.

Patient Rights

See information about patient rights in Hospital Policies.

Patient Safety

To report a patient safety issue, call the Patient Safety Hotline at any time. Information may be submitted anonymously.

Patient Safety Hotline

Phone: (415) 353-8787

Joint Commission

If you feel your concerns about patient care and safety have not been adequately addressed by UCSF Medical Center, please contact the Joint Commission Office of Quality Monitoring.

Phone: (800) 994-6610
Fax: (630) 792-5636
complaint@jointcommission.org

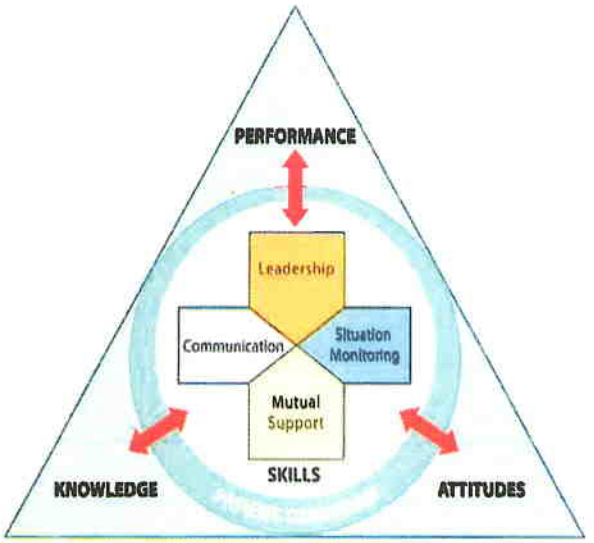
SAMPLE (Continued)

You also can write to:

Joint Commission
Office of Quality Monitoring
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Others to contact include the state Department of Health at (800) 554-0353 or your health insurance company.

Need a doctor? Call us at **(888) 689-UCSF** or browse our directory.



TeamSTEPPS™

TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based framework to optimize team performance across the healthcare delivery system.

The core of the TeamSTEPPS framework is comprised of four skills: **Leadership**, **Situation Monitoring**, **Mutual Support**, and **Communication**. These skills must interplay with the Team Competency Outcomes: **Knowledge**, **Attitudes**, and **Performance**.

LEADERSHIP

There are two types of leaders: 1) Designated and 2) Situational. In effective teams, any member of the team with the skills to best manage the situation can assume the leadership role.

An effective team leader: organizes the team; articulates clear goals; makes decisions through collective input of members; empowers members to speak up and challenge, when appropriate; actively promotes and facilitates good teamwork; and skillfully resolves conflicts.

Team Events
- **Brief:** This is a short session for planning prior to start to discuss team formation; assign essential roles; establish expectations and climate; and anticipate outcomes and likely contingencies
- **Huddle:** When problem solving is needed, this ad hoc planning is used to reestablish situation awareness; reinforce plans already in place; and assess the need to adjust the plan.
- **Debrief:** This informal information exchange session is designed to improve team performance and effectiveness. Feedback from the team drives future process improvement.

SITUATION MONITORING

Situation monitoring is the process of continually scanning and assessing what's going on around you to maintain situation awareness. (STEP = Status of the patient, Team members, Environment, Progress towards goal)

Situation awareness is "knowing what is going on around you" and knowing the conditions that affect your work.

Shared mental models result from each team member maintaining his or her situation awareness and sharing relevant facts with the entire team. Doing so helps ensure that everyone on the team is "on the same page."

Cross Monitoring: an error reduction strategy that involves monitoring actions of other team members; providing a safety net within the team; ensuring mistakes or oversights are caught quickly and easily; and "watching each other's back"

MUTUAL SUPPORT

Task assistance is one form of mutual support in which team members:

- Protect each other from work overload situations
- Place all offers and requests for assistance in the context of patient safety
- Foster a climate where it is expected that assistance will be actively sought and offered

COMMUNICATION

Effective communication is complete, clear, brief, and timely.

SBARQ is a technique for communicating critical information that requires immediate attention and action concerning a patient's condition and is especially important during handoff.

Situation—What is going on with the patient?
Background—What is the clinical background or context?
Assessment—What do I think the problem is?
Recommendation and Request—What would I do to correct it?
Questions—An opportunity to ask or answer any questions.

Using "CUS" words is one way to "stop the line" and alert other team members to your concerns.

I am **C**oncerned
I am **U**ncomfortable
This is a **S**afety issue or I don't feel like this is **S**afe!

Examples: "Dr. Adams, I am *concerned* about Mr. Smith's heart rate. I'm *uncomfortable* with what we're seeing. I don't feel like this is *safe*. I think we should call the Rapid Response Team."

"I am *concerned* about Mrs. Roberts' labor. I'm *uncomfortable* watching these late decelerations. I just don't think it's *safe* to continue labor.

Two Challenge Rule

When an initial assertion is ignored:

- It is your responsibility to assertively voice concern at least *two times* to ensure it has been heard
- The team member being challenged must acknowledge the concern
- If the outcome is still not acceptable:
  - Take a stronger course of action
  - Utilize supervisor or chain of command

The two challenge rule empowers all team members to "stop the line" if they sense or discover an essential safety breach.

There are other tools that everyone is expected to use to improve communication during team events:

- **Call Outs**: used to communicate important information to all team members simultaneously
- **Check Backs**: closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended (i.e. restate what was said)

Northern Inyo Healthcare District

Hospital-Wide Pillars of Excellence: FY July 1, 2016-June 30, 2017

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. Avatar RHC- Overall score % Top Box	75.28 Below Average	85.0 Better Than Most	78.10 Below Average	Not Yet Available			Not Yet Available
b. Avatar Emergency Department- Overall score % Top Box	78.20 Above Average	85.0 Better Than Most	73.28 Below Average	Not Yet Available			Not Yet Available
c. HCAHPS Perinatal- Overall score % Top Box	72.64 Below Average	85.0 Better Than Most	68.65 Below Average	Not Yet Available			Not Yet Available
d. HCAHPS MedSurg- Overall score % Top Box	75.86 About Average	85.0 Better Than Most	74.52 About Average	Not Yet Available			Not Yet Available
Note: In the process of switching from Avatar to Press-Ganey; Q1 data is based on two months, not three months. Data for the Perinatal unit for Q1 should be interpreted with caution due to a small sample size of only 4 patients.							
Quality							
1. Adverse Drug Events-Anticoagulants*	2/44 (4.5%)	0	1/2 (50%)	0/4 0%)			1/6 (16.7%)
2. Surgical Site Infections*,[1]	5/1104 (0.45%)	0	2/312 (0.64%)	3/348 (0.86%)			5/660 (0.76%)
3. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*	0/155 (0)	0	0/79 (0)	0/60 (0)			0/139 (0)
4. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*	0/579 (0)	0	1/180 (5.55)	0/189 (0)			1/369 (2.71)
5. Ventilator Associated Pneumonia*	0/36 (0%)	0	0/3 (0%)	0/5 (0%)			0/8 (0%)
6. Falls With Injuries (Per 1000 Patient Days)*	3/4394 (0.68)	0	0/943 (0)	1/707 (1.41)			1/1650 (0.61)
7. 30 Day Readmission Rate (Inpatient)*	64/1181 (5.4%)	<15%	10/324[2] (3.1%)	7/277 (2.5%)			17/601[2] (2.8%)
*Note: Baseline period for these metrics is FY 15-16. 1. SSI National average is about 2.0%. 2. Correction was made in denominator for this data.							
People							
1. Overall Turnover Rate, 3	89/491 (18.13%)	<15%	21/432 (4.86%)	21/441 (4.76%)			42/437 (9.61%)
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**, 3	37/407 (9.09)	0	14/414 (3.38)	3/416 (0.72%)			17/415 (4.09)
3.Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio	2.87	>2.0	2.27	3.16			2.72
2. Days Cash on Hand-Short Term Sources	82	>75	85	72			78
3. Debt Service Coverage Ratio	2.43	>1.5-2.0	2.67	2.30			2.48
4. A/R Days (Inpatient & Outpatient)	65	<60	76	76			76

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

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the highest number of frequencies determines the overall assignment of Red (Below Average), Yellow (About Average), Green (Above Average), or Blue (Best in Class). It is recommended that specific performance categories be assessed by area leadership to identify opportunities for improvement.

Rev. 2/2/17 mjs

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
February 2017

1. In October 2016, NIHD Board of Directors approved a comprehensive Compliance Program for the District.
    a. In November 2016, we assigned the document to 458 employees to review.
    b. As of January 31, 2017, 64% of those to whom it was assigned have reviewed the Compliance Program. The goal is 100%.
    c. Live training for the Compliance Program is approximately 10% complete.
        i. The Board of Directors - completed in October
        ii. Department Directors and Supervisors – completed in November
        iii. Medical Staff – Completed in January
2. Breaches
    a. Calendar Year 2016
        i. 38 breaches of PHI (Personal Health Information) investigated by the Compliance Office
        ii. 12 had to be reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. 9 were assigned deficiencies. When a deficiency is assigned, civil monetary penalties may be assessed.
            2. 1 case is still pending CDPH investigation.
3. Issues and Inquiries
    a. FY 2017 – More than 85 requests for research and input on a wide variety of topics have been made to the Compliance Department
4. Audits
    a. Employee Access Audits - The Compliance Office manually completes access audits of patient information systems to ensure that employees access records only on a "need to know" and "minimum necessary" basis.
        i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.

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ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
iii. Compliance performs between 400-500 audits monthly.
1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.

b. Evaluation and Management Claims Audits
i. Monthly auditing and monitoring of professional claims
c. Signage Audit
i. Review and assessment of required signs and postings in the District.
ii. There are approximately 600-700 documents that must be posted in different locations around the hospital and District Clinic offices.

5. Policies for review
a. Compliance Program
i. Only change in substance to the Compliance Program is membership of the committee
ii. Housekeeping – typographical error and grammar corrections

6. Next steps for Compliance Office
a. Business Ethics and Compliance Committee implementation
b. Compliance Department Work Plan (CY 2017)
c. Employee Access Auditing Software Project (FY 2018)
d. HIPAA Privacy and Security Audit
e. Dashboard format for Board Report

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Care Plan-In Patient	
Scope: ICU, Acute/Sub Acute, Perinatal	Department: **CPM – Communication (COM)**
Source: Quality/Nurse Infection Prevention	Effective Date: 2/1/2017

POLICY:
A plan of care will be developed for each patient in coordination with the interdisciplinary team. The patient care plan is in the care plan entry/Inquiry section of the electronic chart and is reviewed every shift, revised as needed, and is an integral part of the patient's permanent records. A care plan shall be initiated for each patient admission.

The multidisciplinary plan shall be initiated by each department in their section of the electronic record.

PROCEDURE:

1. Following the admission assessment to the unit, a plan of care will be initiated within twelve (12) hours.
2. The care plan will be individualized to meet the needs of each patient.
3. Based upon assessment findings, appropriate interventions will be identified and documented in the electronic care plan.
4. Additional care plans will be added with changes in the patient's condition.
5. The plan of care will be utilized throughout the patient's stay.
6. Unresolved issues will be addressed with the patient prior to discharge or transfer.
7. The plan of care will be reviewed by the oncoming and off going nurses at shift change.
8. The plan of care will be evaluated by a nurse during each shift.

Approval	Date
NEC	**2/1/2017**
Board of Directors	**5/2/2013**

Initiated: 7/94
Reviewed: 2/95; 4/96; 8/2000 BM; 02/2006 sm; 4/09 MW, 5/11JM; **9/12bs**
Revised: 1/17la
Index Listings: In-Patient Care Plan

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Admission of Pediatric Patient	
Scope: Acute/Sub Acute Services	Manual: Discharge, Pediatric - Admission, Transfer Documentation (ADT)
Source: DON ICU/Acute/Subacute Services	Effective Date:

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

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

PROCEDURE:
1. Prior to admission:
   A. Get "Room Ready" by obtaining:
      a. Age appropriate crib or bed
      b. Age appropriate scale for admission weight
      c. Measuring tape for head circumference measurement (As Needed)
      d. Pediatric blood pressure cuff
      e. Patient labeled pediatric stethoscope
      f. Age and size appropriate apparel
2. Upon Admission:
   A. Greet parents and patient in a friendly manner using AIDET.
   B. Complete a quick check.
   C. Obtain a complete set of vital signs including a blood pressure.
   D. Obtain height and weight
      a. Obtain the correct colored square paper that corresponds to the Broselow Pediatric Emergency Tape and write the weight on this colored square.
         i. Attach the colored square to the head of the bed or the foot of the crib
         ii. Place a colored square on door
         iii. Inform parents the importance of the colored paper
         iv. Make a copy of the appropriate color Broselow Emergency Tape (front and back) and hang it on the bed or crib as well as on the door
   E. Complete the pediatric admission assessment form with the parents and patient's assistance.
   F. Attach the patient security tag to the child's leg or arm and activate it per policy. Inform the parents what this is for, where on the unit they are able to go with the child and answer any questions related to child security and safety.
   G. After confirming correct name and date of birth, apply the armband to the pediatric patient.
   H. Apply a duplicate armband to the legal guardian of the pediatric patient. (Parent/Legal guardian)
   I. Complete a **CODE AMBER INFORMATION SHEET. Place it in the first section of the chart.**
   J. Take a photo of the child and place it in the first section of the chart.
   K. Make the patient as comfortable as possible.
   L. Discuss NIHD fall prevention and precautions taken while patient is in the hospital.
      a. Show the older pediatric patient and all parents how to use the call bell.

Title: Admission of Pediatric Patient	
Scope: Acute/Sub Acute Services	Manual: Discharge, Pediatric - Admission, Transfer Documentation (ADT)
Source: DON ICU/Acute/Subacute Services	Effective Date:

b. Explain intake and output (I&O) as well as the need to measure all I&O of fluids, including jello, popsicles, etc. to parents and the pediatric patient
c. Explain the use of the urinal, bedpan, commode, and emesis bag
d. If the pediatric patient is able to ambulate, give them a full room orientation
e. Place a pitcher of water at the bedside if patient is able to drink fluids
f. Explain the use of the pediatric pain scale
g. Give parents WIFI password.

M. Review Physicians orders:
   a. If medications ordered, print out medication information from Up-to-Date on each medication
   b. Calculate dosage based on the pediatric patient's weight
   c. Verify dose with second RN. **(New Dose calculation needed with weight change.)**

N. Place Vital signs chart taped to vitals machine. Normal ranges highlighted.

O. Include parents in the care of the child, being considerate and kind in your approach.
   a. Provide parents with the Pediatric Unit Welcome Letter (attached to Pediatric Admission Assessment). Allow the parent time to read the letter and stand by to answer any questions they may have.
   b. Parents are to be encouraged to become involved in the child's care.
   c. Explain to parents that no smoking is allowed at Northern Inyo Hospital including the outside grounds. The Parent Letter discusses the smoking policy.

P. Explain all treatments and procedures the parent and patient should anticipate.

Q. Initiate Patient Care Plan and share with parent and patient as appropriate.

R. At time of discharge, **Child Safety Seat** form will be signed.

Approval	**Date**
NEC	2/1/2017
Board of Directors	

Developed: 3/95
Revised: 3/98; 9/2000, 11/03bss:03/06bss 11/07rc; 9/09CH,5/11JM; **BS 9/12, 1/17 la**
Reviewed:
Index listings: Admission Pediatric Patient; Pediatric Admission; Growth Charts, Admission of Pediatric Patient

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Floating Nursing Staff	
Scope: Nursing Services	Manual: 3. NAM – Utilization of Nursing Staff and Staffing Budget
Source: Director of Nursing Practice	Effective Date: 12/1/14

PURPOSE:

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

POLICY:

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

PROCEDURE:

1. The House Supervisor (HS) may float staff members that are required to be on site to another department to assist with care activities.
2. The floated staff member would be assigned to a resource nurse, home-based to that unit.
   a. The resource nurse will be the charge nurse on units where this position is routinely filled.
   b. A resource nurse would assign care activities to the floated staff member.
   c. The floated staff member works under the direction of the resource nurse and only performs care activities within their competency skill sets.
   d. In the event the floated staff member needs to return to their home department, the floated staff member completes documentation of care activities and reports off to the replacement staff member.
3. The fixed staff member floated without an assignment does not clock out of the Home Department while floating.
4. The ED and L&D RN who must remain in the department at all times will be expected to use their time to complete work related projects or training.

Floating Orientation:

1. An employee who is routinely floated to another unit will be one who has completed a basic orientation to the unit.

Title: Floating Nursing Staff	
Scope: Nursing Services	Manual: 3. NAM – Utilization of Nursing Staff and Staffing Budget
Source: Director of Nursing Practice	Effective Date: 12/1/14

2. This basic orientation will consist of completing the "Floating Orientation Checklist/Summary" and "Equipment Competency Validation Checklist" under the guidance of an assigned preceptor. The amount of time required to complete this basic orientation will be individualized to each employee's needs and experience.
3. After completion of the basic orientation, the employee will be able to "float" to oriented department to assist with care activities in times of need.
4. If the employee has not floated for a year after orientation, they may be required to reorient.

General Guidelines to Consider:

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

Committee Approval	**Date**
Orientation Competency Committee	**1/11/2017**
Nurse Executive Committee	**2/1/2017**
Board of Directors	

Developed: 9/16/14
Reviewed:
Revised: 1/17
Supercedes:

1. **Fixed Staff Floating; Floating Guidelines**
2. **Floating Guidelines for ICU**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Floating Nursing Staff	
Scope: Nursing Services	Manual: 3. NAM – Utilization of Nursing Staff and Staffing Budget
Source: Director of Nursing Practice	Effective Date: 12/1/14

3. **Floating Guidelines for OPD/PACU**
4. **Floating Guidelines for the Emergency Department**
5. **Floating/Orientation and Cross Training Programs for Medical Surgical**
6. **Floating and Cross-Training Programs for ICU**
7. **Med Surg unit Floating Guidelines**

NORTHERN INYO HOSPITAL
Emergency Department
FLOAT TRAINING CHECKLIST/SUMMARY

NAME_____
DATE_____

Date and Initial all items on check list

	Demo	Verbal	Comments
Department Tour			
Policy and Procedure Manuals			
Standards of Care and Floating Guidelines			
Department Shift/Room Checklist			
Patient Room Set Up			
Call Light and Telephone System			
Crash Cart Location/ Code Blue Buttons			
Bedside Cardiac Monitor			
Paragon Tracking Board			
ED Nursing Documentation			
Paragon Medication Administration			
Paragon/CPOE Order Process			
Level of Care Worksheet			
Electronic Discharge Instructions			
Inter-facility Transfer Process			
Inpatient Admission Process			
Pre-op Surgical Process			
Specialty Carts and Bedside Carts			
Medication/ Omnicell Room			
Cleaning Rooms and Equipment			
IV Start and Blood Specimen Collection			
Point of Care Testing			
Supplies and Utility Rooms			
Reporting Requirements Process (Suspicious Injury, Confidential Morbidity, Sexual Assault, Suspected Child/ Adult Abuse, Animal Bites)			

Signature	Initials	Signature	Initials

NORTHERN INYO HOSPITAL
Outpatient Department/Post Anesthesia Care Unit

FLOATING ORIENTATION CHECKLIST

Date and Initial

	Demo	Verbal	Comments
• OP/PACU Policy and Procedure Manuals			
• Standards of Care and Guidelines, PACU / OPD			
• PACU Discharge Criteria			
• Admission to the PACU			
• Discharge from the PACU			
• Surgical checklist, PACU Record, Outpatient Procedure Records			
• Scanning of patient supplies			
• Other forms/ teaching materials			
• Log books			
• PACU Omnicell			
• PCA location / set-up			
• Patient Monitors			
• Gurneys			
• Call buttons / Telephones			
• Oxygen / Suction			
• Crash Cart /Code Blue buttons			
• Supplies / Carts (pre-op, wound)			
• IV solutions & tubings			

1/2017

NORTHERN INYO HOSPITAL
Acute/Subacute Unit
Floating Orientation Checklist Summary

Name _____
Date Initiated_____ **Date and Initial all items on check list**
Assigned Preceptor: _____

	Demo	Verbal	Comments
1. Unit Tour			
2. Policy/Procedure Manual			
3. Standards of Care/ Floating Guidelines			
4. Concept of Team Nursing			
5. Physician's Phone #s			
6. Call Light/Emergency Assist/ Fall Prevention			
7. Restraint Protocol			
8. Checking O2/Suction in Rooms			
9. Chart forms/Charting			
10. Teaching Materials			
11. Medication Carts/Omnicell			
12. Department Clerk Responsibilities/ Transcription of Orders			
13. Shift Responsibilities/Routine Care Activities			
14. Admission Procedure			
15. Discharge Procedure			
16. Transfers			
17. Care and Cleaning Equipment			
18. Pediatric Supplies			
19.How to obtain PPE on unit			
20. Review Infant/Pediatric security system.			
21. Competency Validation Equip/ Procedures for Orientation (see attached for list)			

Specific procedures this nurse is not able to perform: _____
_____

This nurse will be able to practice on the Med-Surg/Pediatric Unit in times of need under the supervision of a Med-Surg/Pediatric RN or cross trained RN.

Employee _____ Date _____

Preceptor _____ Date _____

Director of Nursing _____ Date _____

1/2017

NORTHERN INYO HOSPITAL
ACUTE/SUBACUTE UNIT
CROSS TRAINING CHECKLIST/SUMMARY

NAME_____
DATE_____

Date and Initial all items on check list

	Demo	Verbal	Comments
1. Infant/Pediatric security system			
2. Crib			
3. Hoyer Lift/Slipp			
4. Philips HeartStart MRX /Crash Cart			
5. Telemetry /Set up and Standards			
6. CVC Maintenance			
7. NIBP Machine (Peds & Adults)			
8. PCA/Narcotic Infusions/Epidural			
9. Wall Suction			
10. Scales-Stand/Bed/Infant			
11. AccuData GTS Plus, glucose monitor			
12. Chest Tube Maintenance			
13. Dip sticks for specific gravity			
14. Ice Man Cold therapy system			
15. Foot Pumps			
16. CPM-Knee Exerciser			
17.Orthopedic Post op Patients a. Total Knee b. Total Hip			
18. Bladder Scan (video)			
19. Blood Warmer			
20. Hill Rom Bed (video)			
21. Doppler			
22. RN+			
23. Bucks traction			
24. Patient assist mover			

Signature	Initials	Signature	Initials

1/2017

NORTHERN INYO HOSPITAL
MED-SURG/PEDIATRIC UNIT
CROSS TRAINING CHECKLIST/SUMMARY

NAME _____
DATE _____

Competency validation Equip/Procedures for Orientation to Float complete: _____
Date

Competency validation-Annual Unit Requirements complete: _____
Date

Specific procedures this nurse is not able to perform:

_____

_____

This nurse is cross-trained to the Med-Surg Unit and will be able to function as a Med-Surg/Pediatric Staff Nurse with another Med-Surg/Pediatric licensed nurse assigned.

Employee _____ Date _____

Preceptor _____ Date _____

Director of Nursing _____ Date _____

1/2017

NORTHERN INYO HOSPITAL
INTENSIVE CARE UNIT
CROSS TRAINING CHECKLIST/SUMMARY

NAME_____
DATE _____

Date and Initial all items on check list

	Demo	Verbal	Comments
Tour of ICU			
Clean and dirty utility room			
Call light system			
Patient Room lights			
Crash Cart location/code blue buttons			
Use of Cardiac Monitor/recoding strips			
Telemetry /Set up and Standards			
CVC Maintenance			
Policy Manual (electronic)			
Standards of Care for ICU			
Wall Suction/O2 in room - checks			
Scales-Stand/Bed			
AccuData GTS Plus, glucose Monitor/location			
Chest Tube Maintenance			
Documentation in EHR			
Patient Care Plans requirement in EHR			
Patient Education in HER (Truven)			
Admission Process			
Transfer internal/External Process			
PPE location in ICU			
Lifting equipment			
Blood Warmer			
Hill Rom Bed (video)			
Doppler			
Work Station on Wheels (WOW)			
OmniCell/refrigerator medications			
Patient food refrigerator			
Pneumatic Tube System			

Signature	Initials	Signature	Initials

1/2017

NIH Perinatal Department Specific Orientation Checklist for Float Staff

Name (print):_____

Signature:_____ Initials:_____

Preceptor Name (print):_____Signature:_____

Preceptor Name (print):_____Signature:_____

Instructions: Orientee and Preceptor are to date and initial when the following items have been taught/found on the unit. Then **return to Perinatal Nurse Manager** within the the initial orientation period.

Acknowledgement: By initialing below, you acknowledge that you have been trained and educated on the below items by initialed preceptor.

Topic	Orientee's initials	Preceptor's initials	Date
Fire Safety:	----------	----------	----------
Fire Alarms			
Fire extinguishers			
Exit/evacuation routes and equipment (baby apron)			
Medical gas shut-off valve			
Emergency Preparedness	----------	----------	----------
Unit role in a disaster/infant abduction			
Reporting area in a disaster			
Baby carrier			
Exposure Control and Infection Control Plans	----------	----------	----------
Location of PPE			
Location of eye wash station and shower			
Hazardous Materials	----------	----------	----------
Location of equipment safety training sheets and safety manual			
Security	----------	----------	----------
How to protect personal belongings (locker and code)			
Panic Button			
Push-to-talk phone system			
Intranet on-call sheet			
HUGS System			
Mother-baby bands, infant release			
Unit Tour	----------	----------	----------
Break Room			

NIH Perinatal Department Specific Orientation Checklist for Float Staff

Bathrooms (and pt bathroom policy)			
Clean Supply Room • Equipment location • PAR system (scanning) • Fluid warmer and stocking			

NEST
• General overview
• NEST folder and worksheets
• Breastfeeding-promoting practices
  ○ Breastfeeding Policy
  ○ Skin to Skin policy
  ○ Delayed bathing
  ○ Rooming in			

Blanket warmer			
Nursery • Respiratory equipment • Pulse oximetry (CVHD test) • Bili scanner • Hearing screen machines and supplies • IV start supplies • Baby supplies • Feeding supplies • Nursery daily check			
Omnicell and access			
Patient fridge (as well as Med-Surg)			
WOW drawer codes and supplies			
Location of normal saline flushes			
Linen closet			
LDRPs and Room Checks • Equipment cabinets • Bed controls/breakdown • Lights • Bathroom supply setup • O2 and suction • Lights and controls • Thermostat			
Infant warmer • O2 and suction setups ready • Stocked drawers in bassinette • New warmer infant scale • Newborn AMBU bag stocked in all bassinettes			

NIH Perinatal Department Specific Orientation Checklist for Float Staff

Dirty Utility Room • Cleaning of instruments/delivery table			
PPH cart			
Recycling of BP cuffs, AT leg pumps, pulse ox			
Policy Index – location of resource book			
Resource scheduling			
Location of paper forms: • Transfer forms • Consent forms			

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	**Department:** NAM – Nursing Quality
Source: Acute Sub Acute Services DON	**Effective Date:**

PURPOSE: The Nursing Department of the Northern Inyo Hospital supports the organization wide commitment to continuously improve the quality of care provided for its patients. This program is planned to promote a comprehensive method to examine, measure and evaluate problems in patient care and to provide opportunities to improve patient care.

OBJECTIVES:
The Acute Sub Acute Service unit of the Nursing Department will, through this Performance Improvement Plan, provide a program which evaluates the delivery of patient care for all patients and seek to continually improve care through a planned and systematic monitoring program. Quality of patient care is evaluated to identify problem areas and opportunities for improvement, and to resolve identified problems. Data is collected through concurrent and retrospective review of records utilizing effective critical indicators, observation of nursing functions, and monitoring of patient / family satisfaction. Quality Improvement activities will be coordinated with other Nursing units, Medical Staff service committees, other hospital departments and patient care support services throughout the hospital.

AUTHORITY AND RESPONSIBILITY
The Acute Sub/Acute Services DON will function as Coordinator for all unit Performance Improvement activities and serve as chair person for the Acute Sub/Acute Services Performance Improvement program. The DON, with the assistance of the unit representatives to the Nursing Performance Improvement Committee, is responsible for the implementation of the nursing quality improvement program on the Acute Sub/Acute Services and for the resolution of problems and issues relating to the provision quality nursing care.

Acute Sub/Acute Services **SCOPE OF CARE**:
The Acute Sub/Acute Services department provides nursing care for patients of all ages meeting the specialized medical care needs of a predominantly elderly patient population, as well as, Surgical, Telemetry, Orthopedic and Pediatric patients.

Acute Sub/Acute Services management is a joint function of the Medical Staff and Nursing Department working in close cooperation with: PT, RT, Lab, Pharmacy, EKG, Dietary, and Radiology departments. The Acute Sub/Acute Services DON supervises: Staff RNs, LVNs, Certified Nursing Assistants, and Department Clerks. Patient care is delivered in nurse patient ratios that are determined by patient acuity *and the State of California mandated staffing ratios*. Nursing functions include: Patient assessment, accurate and timely provision of medications and treatments, maintenance of infection control and patient safety, coordinating patient care with physicians, other departments and services, patient and family education and documentation of nursing care.

Services offered include but are not limited to: continuous cardiac telemetry monitoring, multiple drug therapies, Physical and Respiratory Therapy services. Equipment available includes: IV, PCA, and syringe pumps, blood warmer, defibrillators, pulse oximeters, continuous passive motion (CPM) knee exercisers, blood glucose monitor, cold therapy, a-thrombic pumps, non-invasive blood pressure monitors, brady/apnea monitor, bed and standing scales, infant scales, patient assist lifter and patient lift.

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	**Department:** NAM – Nursing Quality
Source: Acute Sub Acute Services DON	**Effective Date:**

The 16 bed unit consists of private rooms. All rooms are equipped with wall suction and oxygen outlets, electric beds with emergency head board release and nurse call buttons. Cribs are available for the pediatric population

The Acute Sub/Acute Services DON integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares reports concerning nursing quality improvement programs for the Nurse Performance Improvement Committee. Activities of the Acute Sub/Acute Services Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the Nursing Management/ Performance Improvement Committee quarterly.

The duties and responsibilities shall include:

1. To involve all nursing staff members in problem identification, development of solutions and in promoting quality patient care.
2. To review nursing indicators for the Medical Surgical Nursing unit and assist in their revision,
3. To analyze the information collected through ongoing monitoring of patient care provided by nursing staff. To establish priorities in targeting areas of patient care for review to include: high risk activities, activities involving large numbers of the patients and areas where need for improvement in patient care has been identified.
4. To identify problems or trends through analysis of the collected information. To determine necessary corrective measures, and resolve problems.
5. To provide recommendations for actions to resolve identified problems.
6. To continue to follow up and review the results of action taken to determine if a problem has been resolved or if there is a need for further action.

NURSING DEPARTMENT IMPORTANT ASPECTS OF CARE:

1. Providing patient centered, comprehensive, patient care
2. Providing all aspects of patient safety, in a safe patient care environment
3. Maintaining patient privacy and confidentiality, and ensuring patient advocacy
4. Maintaining Standard Precautions and Infection Control Standards
5. Ensuring accuracy of administration of all medications and IV therapy
6. Providing complete and accurate patient assessments
7. Providing accurate and concise nursing reports
8. Providing thorough and current patient care plans.
9. Providing prompt and efficient response to Code Blue
10. Assessing and appropriately documenting allergy status
11. Coordinating patient care with other services and departments
12. Documenting patient status, care activities and response accurately in nursing records.
13. Ensuring accuracy of patients consents
14. Providing leadership and coordination of patient care activities for unlicensed staff
15. Ensuring availability and proper use and function of equipment

NURSING DEPARTMENT CRITICAL INDICATORS:

Patients developing decubitus ulcers or damage to integument, while in the hospital
Treatment errors
Medication errors
Complaints from patients and physicians

Patient falls and injuries
Infections
Transfusion reactions
Equipment malfunction or not available
All Code Blue patients

IMPORTANT ASPECTS OF CARE ACUTE SUB/ACUTE DEPARTMENT

In addition to all Nursing Department Important Aspects of Care and Critical Indicators, the Acute Sub/Acute Services department will also utilize the following:

1. Prevention of adverse drug reactions.
2. Prevention of infected peripheral and central venous catheter sites.
3. Prevention of upper respiratory complications not present on admission and/or transfer to the Acute Sub/Acute Services department
4. Prevention of patient falls and/or injury.
5. Appropriate use and function of Acute Sub/Acute Services equipment
6. Standards of care accurately followed for Telemetry patients
7. Timely recognition and appropriate physician notification of significant patient status changes
8. Appropriate transfer of patients to a higher level of care.
9. Assurance that all patients shall have appropriate discharge planning.

CRITICAL INDICATORS Primary and Secondary (patients and/or incidences meeting the secondary screens either meet the standard of care or partially meet the standard of care)

1. Adverse drug reactions
    a. Inappropriate dose, route, time, patient
    b. Inappropriate drug combination
    c. Delayed recognition of drug toxicity
    d. Extravasation of drug causing patient injury, e.g. chemo
2. Infected central venous or peripheral IV catheter site
    a. CVC dressing not changed per policy
    b. CVC not discontinued at first sign of infection (erythema, edema, purulent drainage)
    c. Peripheral IV not discontinued at first sign of tenderness, redness, swelling)

3. Development of upper respiratory complication not present on admission or transfer to the unit
    a. No incentive spirometry
    b. No documentation of turn, cough, or deep breathe
    c. Patient not out of bed within 24-48 hours post op (depending on type of surgery)
    d. Fever develops within 48 hours of decreased activity
    e. Development of increase oxygen need
    f. Development of adventitious lung sounds not present on admission
    g. Increasing fluid retention with dyspnea
    h. Aspiration pneumonia from feeding and or enteral feeding
4. Patient fall or injury
    a. Inadequate assessment of patient activity/risk level on admission
    b. Siderails not in used appropriately
    c. Restraints or safety attendants not in use when indicated necessary by assessment
    d. Adverse medication combination
    e. Policy not followed regarding positioning, transferring, etc.

f. Damage to integument (decubiti, abrasion, burns, etc.)
g. Incorrect placement of equipment resulting in injury to patient
h. Incorrect use of equipment resulting in injury to patient
i. Patient failure to follow instructions or hospital rules

5. Equipment malfunction not recognized corrected (see equipment list)
   a. No notification of maintenance, biomedical or CS personnel, as indicated
   b. Broken equipment not removed from service
   c. Identification of equipment malfunction not noted on equipment
   d. Delay in equipment repair or return to service
6. Standard of care not followed for Telemetry patient
   c. No written parameters when indicated (DNR)
   d. Protocol not followed by nurse (daily wgt, I&O, initiate therapy when indicated
7. Changes in patient status not recognized in a timely manner and physician notified appropriately
   e. No trending of changes in VS, I&O, and other measurable statistics such as: frequency of irrigation, increased wound drainage, swelling
   f. No identification of increasing need for supplemental oxygen requirements such as inconsistent sat checks
   g. No identification and interpretation of abnormal lab values
   h. Physician not notified of changes in patient condition
8. Inaccurate recognition and coordination of transfer of critical patients to higher level of care (CU) or another acute care facility
   i. Did not inform physician of deteriorating patient condition
   j. Did not inform supervisor of changes in patient condition and need for transfer
   k. Transfer consents and form incomplete
   l. Social worker not involved in transfer
9. Readmission within 30 days of discharge with same diagnosis.
   m. Inadequate discharge planning
   n. Discharge instructions not understood
   o. Discharge instructions not written, given verbal
   p. Patient discharged to inappropriate environment

IMPORTANT ASPECTS OF CARE: PEDIATRICS UNIT

In addition to the Acute Sub/Acute Services department Important Aspects of Care that apply to the Pediatric population:

1. All patients under age 2 will be placed in a crib unless patient normally sleeps in bed.
2. All patients IVs will delivered through an IV pump
3. Observation for signs of abuse
4. Provision of an apnea monitor or close observations for patients to young to use call bell system
5. Emergency supplies readily available in unit

CRITICAL INDICATORS: PEDIATRICS

In addition Acute Sub/Acute Services Critical Indicators that apply to Peds:

1. Failure to deliver IVs and IV Medication with a Pump
   a. IV infiltration
2. Failure to observe for and notify appropriate authority of signs of parental abuse
3. Failure to provide apnea monitor or close observation for patient too young to use call bell.

4. Failure to place child under age 2 in a crib (unless patient sleeps in bed)
5. Emergency supplies not available
6. Failure to follow Pediatric Standards of Care.

PROBLEM IDENTIFICATION:
Findings from the hospital wide quality improvement program which concern nursing will be distributed to the Nursing Management Committee who will share this information with the nursing unit committees. This includes findings from:

Quality Review (Incident) Reports
Information from nursing reports
Pharmacy and therapeutics review
Surgical case review
Blood utilization (transfusion) review
Medical records review
Infection control committee reports
Safety committee reports (especially patient-related incidents, such as falls)
Performance Improvement reports
Reports from the Performance Improvement activities of other departments and services

IDENTIFICATION OF PROBABLE CAUSES OF INAPPROPRIATE CARE

Lack of knowledge or skill
Knew what to do, but did not do so
Equipment deficiency
Deficiency in chart documentation
Policy or procedure violation
Inappropriate delay in problem management
Infection control violation

CORRECTIVE ACTION

Once problems are identified, corrective actions will be determined
Identify who or what needs to change.
Identify appropriate action for problem cause, scope, and severity.
Identify goal for when change is to occur.
Establish monitoring program for specific problem.
Document all of above in the Nursing Performance Improvement Committee minutes.
Report incident and action to the Performance Improvement Committee.

Any problems which cannot be resolved at the nursing unit level because they are too political, expensive, or too involved will be forwarded to the Nursing Management Committee and if applicable to the hospital wide Performance Improvement Committee for consideration and resolution.

ASSESS ACTIONS AND DOCUMENT IMPROVEMENT
The Acute Sub/Acute Services Nursing Performance Improvement program will be evaluated on an ongoing basis for the effectiveness, importance and relevance of indicators. Which will be included in the formal annual review of the overall program, and this will be documented in the Nursing Management committee minutes.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	**Department:** NAM – Nursing Quality
Source: Acute Sub Acute Services DON	**Effective Date:**

Approval	**Date**
CCOC	1/25/17
Board of Directors	

Initiated: 4/97
Revised: 3/98; 11/2000; 2/2001, 2/06 bss; 1/2010bss; 7/11RC; **BS 9/12 1/17la**
Reviewed: 6/11mc
Index Listing: Med-Surg Performance Improvement

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Admission to Acute Sub/Acute Department	
Scope: Acute/SubAcute Services	Manual: – Admission, Discharge, Transfer (ADT)
Source: DON ICU Acute Sub/Acute	Effective Date:

PURPOSE:
To admit patients to nursing service in such a manner as to alleviate their apprehensions, provide for their comfort, assess their condition, identify their problems, outline their plan of care, and identify their discharge planning needs.

POLICY:
Patients admitted to the Acute Sub/Acute Department require acute care that does not meet ICU admission criteria. All patients will be assigned an appropriate room utilizing diagnosis and age specific considerations. An RN must complete an assessment of the patient within 2 hours of admission.

Valuables will be itemized and placed in a valuables envelope by the admitting nurse and secured in the hospital safe by the admission clerk. When the front office is closed, valuables will be placed in the safe by the ER clerk. Medications brought in by the patient are placed in a bag, labeled and given to the house supervisor, the supervisor then places them in a locked file cabinet and a note is placed on the chart making a notation of patient's own medications.
NOTE: Whenever possible, valuables and patient medications should be sent home.

A. Medical Admissions
   1. The admitting physician is responsible for contacting the shift supervisor before sending a patient to the hospital for admission.
   2. The shift supervisor or nurse accepting the patient may take admission verbal orders from the physician over the phone. It is preferable that the physician send written orders with the patient.

B. AM Surgery Admissions
   1. All AM admits will come to the front office desk the morning of their scheduled surgery.
   2. When the physician's office staff calls to schedule the patient, surgery will assign a patient admission time and will coordinate this with the patient representative.
   3. When the patient representative pre-admits the patient by phone, she will verify the date and time for pre-op tests and the time and place of admission.
   4. At the time of the pre-op interview with surgery, the nurse will re-enforce the time of arrival.
   5. The Ward Clerk will make up patient charts on the PM shift the evening before admission. The front office Clerk will have pertinent records for admission, including the consent, etc.
   6. The OP nurse will check all charts for completion the day before surgery is scheduled.
   7. Room numbers will be logged in Admitting by the Shift Supervisor by 0700 the morning of surgery.
   8. All surgeries will be logged in the appointment book in the Admitting Office.

C. Determination of Admission Times

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Admission to Acute Sub/Acute Department	
Scope: Acute/SubAcute Services	Manual: – Admission, Discharge, Transfer (ADT)
Source: DON ICU Acute Sub/Acute	Effective Date:

1. The time of admission is the time that the patient arrives on the unit. In the case of a patient being admitted from the Emergency Room, the time of admission remains the time the patient arrives on the unit, not the time of admission to the Emergency Room.

PROCEDURE:

1. Escort the patient to be admitted to his/her assigned room which has been prepared by opening the bed and the admit pack. Have the necessary items needed to assess the patient upon arrival to the unit.
2. Orient the patient to the room and surroundings, including introducing to the unit.
3. Secure patient's valuables, be sure there is an accurate list of all valuables brought in by the Patient and that valuables are placed in the safe. If not placed in the safe, document why left with patient. Place clothing in a patient belongings bag and label with patient sticker or write patient name on bag and then place in closet assigned to the patient.
4. The Admission Assessment/Pediatric Admission Assessment is initiated within 4 hours and completed within 12 hours of admission.
5. Assess patient's risk factors and take steps to ensure patient's safety. Review Falls Prevention Guidelines with the patient and his family.

DOCUMENTATION:

1. Complete and document an admission assessment in the EHR or on a down time form as needed.
2. Complete the patient's home medications list in the EHR under the patient profile.
3. Complete the MRSA screening form and complete swab and send to lab if indicated.
4. Document admission physical assessment in the EHR or on the downtime form as needed.
5. Initiate the Patient Care Plan and Discharge plans.
6. Initiate skin assessment and take picture if indicated.

Approval	Date
NEC	2/1/2017
Board of Directors	

Developed: 2/98
Revised: 9/2000, 11/2003 BS. 9/07bs;5/09CH, 8/11JM; **BS 9/12, 1/17 la**
Reviewed:
Index Listings: Admission to Med-Surg Unit

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Charges**	
Scope: Perioperative Nursing	Department: **Surgery, PACU**
Source: Perioperative DON	Effective Date:

POLICY:

1. Surgeries will be charged based on surgery and anesthesia times unless there is an actual procedure charge for the surgery or procedure that was completed.

2. There is a minimal charge of 1 hour for all surgeries that are based on OR time. Procedures however are charged by the procedure and not hourly.

3. Procedures as noted in the attached list are charged a procedure charge (see below for a partial list) instead of an hourly charge. The procedure charge includes PACU time so a separate PACU time will not be added for these cases. The cataract extraction / lens implant procedure includes the MAC anesthesia. The other procedures do not include anesthesia charges so the anesthesia charges (MAC, Local/Spinal, General, or Comprehensive) will be added separately.
   - Blepharoplasties
   - Bronchoscopies
   - Cataract extraction / lens implant and other eye surgeries
   - Colonoscopies (Diagnostic and Screening)
   - EGD procedures (UGI Endoscopy procedures)
   - Frenulectomies
   - LEEP procedures, cold conizations, cervical biopsies
   - Lithotripsies
   - Rectal Exam under anesthesia with fulguration / excision skin tags/ drain placement

4. Surgeries will be grouped into three categories according to their complexity and invasiveness:
   - Low Level
   - Minor
   - Major
   - Comprehensive (for more than one procedure on the same patient)

   Anesthesia time will be grouped into three categories (block charges) according to their complexity:
   - Local/Spinal
   - General
   - Comprehensive

5. Surgery and anesthesia time will be calculated from the time the patient enters the room until the patient is received in the Post Anesthesia Care Unit. Surgery and anesthesia charges will be calculated in two parts:
   - First Hour
   - Each additional 15 minutes (time over 6 minutes is counted as an additional 15min)

   Example: 4 hours of surgery will be 1-First Hour and 12-additional 15-minute increments.

6. Unless the patient is being charged for a procedure, PACU time will also be charged for:
   - First Hour
   - Each additional 15 minutes (time over 6 minutes is counted as an additional 15min)

   Example: 2 hours of PACU will be 1-First Hour and 4-additional 15-minute increments.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Charges**	
Scope: Perioperative Nursing	Department: **Surgery, PACU**
Source: Perioperative DON	Effective Date:

7. The hourly charge covers supplies utilized for the care of the patient including preparing the patient for surgery in the preoperative unit and in surgery until the patient is admitted to the Post Anesthesia Care Unit.

8. Medications, IV Solutions, prostheses, and implants will be charged separately and will not be included in the hourly charge. Except for special screening colonoscopies, patients are charged for medications and IVs used, such as the narcotics. The narcotics are automatically charged in the Omni Cell when they are taken out. Occasionally, there are special implants utilized for surgical procedures that are not in the charge system; the Surgery Material Management Clerk will request a charge code from Med Assets.

9. If a patient has both Colonoscopy and UGI Endoscopy done at the same time, there is a procedure charge to reflect this.

10. If an RN provides procedural sedation /monitors the patient, the patient does not get charged for anesthesia time. If an anesthesiologist is providing the anesthesia or MAC anesthesia, the patient will be charged for the medications and the anesthesia time or a MAC anesthesia charge.

11. Ophthalmologic Procedures will be charged an all-inclusive charge for procedure; all eye medications are included in the procedure charge. The lenses are charged separately for procedures requiring lens replacement. Patients having a Multifocal Lens will have an additional charge attached to them to cover the cost of the specialty lens in addition to the regular lens charge.

12. Lithotripsy procedures will be charged an all-inclusive charge and not an hourly charge. If a stent is implanted, it must be charged separately.

PROCEDURE:
Charges are generated electronically by the circulating RN assigned to the surgery / procedure through OR Manager in Paragon and checked / adjusted if needed by the Surgery Materials Management Inventory Clerk prior to the charges being submitted. The Surgery Materials Management Inventory Clerk ensures all implants and charges are correct before submitting, usually by invoice.

Approval	**Date**
NEC	12/7/16
Billing Coding and Compliance (BCC)	12/13/16
Board of Directors	

Developed: 2/2003 Reviewed: 8/2011
Revised: 2/2009, 11/2016AW
Index Listings: Surgery Charges

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Staffing Huddle	
Scope: House Supervisor on Duty and Nursing Management	Manual: CPM – Communication (COM)
Source: Chief Nursing Officer	Effective Date:

PURPOSE:

- To communicate the staffing plan for the hospital for the current and upcoming next shift
- To allow for input from directors and managers relative to staffing needs
- To identify high acuity or safety attendant needs
- To establish meal relief planning

POLICY: Staffing Huddle will be held at 0800 Monday thru Friday. Attendance of Directors and Managers is encouraged. The meeting will be run by the House Supervisor on duty.

PROCEDURE:

1. Directors and managers will arrive with awareness of upcoming schedule of patients within their department.
2. House supervisor will have daily staffing information for the Emergency, Perinatal, Acute/Subacute and ICU departments.
3. Numbers of patients and status will be presented along with the staffing for each inpatient unit by the House Supervisor.
4. Special situations requiring patient care attendants and the staffing implications will be reviewed to meet safety/fall prevention requirements of the patients as needed.
5. PACU/OR/Infusion/Outpatient schedule will be reviewed by the Perioperative DON.
6. Overall staffing for AM and PM will be discussed.
7. Collaboration relative to floating of staff between nursing management members will occur to best meet the patient needs for the day.
8. In order to assure meal breaks, plan will be discussed to illicit assistance as needed.

REFERENCES:

1. TJC CAMCAH 2016; PC.01.02.08 Element of Performance #2.

CROSS REFERENCE P&P:

1. Staffing Management Plan
2. Patient Safety Attendant or 1:1 Staffing Guidelines
3. ICU Staffing
4. Staffing Guidelines Perinatal Unit Including High Risk Including High Risk
5. Staffing Plan in the Operating Room
6. Staffing Plan OP/PACU

Approval	**Date**
NEC	**2/1/2017**
Board of Directors	

Developed: 1/2017
Reviewed:
Revised:
Supercedes: AM Staffing/Bed Huddle

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Down Time Procedures for OP/PACU**	
Scope: PACU	Manual: **Admission, Discharge, Transfer Documentation (ADT)**
Source: DON Perioperative Services	Effective Date:

PURPOSE: Clarify documentation process if electronic charting is unavailable. Electronic records should be updated when computer systems are functioning.

POLICY: Charting on paper record will be implemented if electronic charting is unavailable.

ORDERS / ORDER ENTRY: Providers will write orders on the Down-time order forms and paper requisitions will be completed and sent by pneumatic tube or hand-carried to the appropriate departments as needed.

PACU RECORD: Identify each page of the PACU record with patient name, DOB, and physician.

Page 1: Information for the Preoperative Data Base including patient allergies may be obtained from the Preoperative Checklist, H&P among other preoperative records. The Admission Data and system review should be completed.

Fill in the PARGAR score at the bottom. The key for the Aldrete PARGAR scoring is on the back of the PACU Record. Also complete the Intake and Output section at the bottom.

Vital signs are documented in sequence in columns on the left and will not necessarily correspond to the Nursing Notes to the right. Because of this a time for each Nursing Note entry should be documented.

Medications and IVs administered or started in the PACU should be documented on the section for PACU medication administration.

Continuing documentation of the patient's condition may include: improved mentation, pain, evaluation of response to pain relieving measures, nausea, response to nausea relieving measures, teaching, and all nursing procedures.

The discharge assessment should be completed on inpatients and outpatients. Items/instructions/teaching material/equipment sent home with the outpatient should be circled and extra items written in as needed. The discharge time as well as temperature on discharge and RN signature should be completed. The patient should be alert and oriented and meet the PACU Discharge Criteria for patients going home from the PACU.

- **Outpatients:** Patients must meet the additional criteria for discharge to home. Document outpatient discharge instruction review including the patient understanding and the responsible adult with the patient at the time of the instruction review.
- **Inpatients:** Complete the discharge assessment and in addition, the name of the nurse on the receiving unit that took report on the patient, and the first set of vital signs taken on the nursing unit.

Page 2: This is additional space for vital signs, nurses' notes, and medication administration if needed. There is also an assessment box for the postpartum patient in the PACU and should be completed on all C-section patients and vaginal delivery patients that are admitted to the PACU.

Title: **Down Time Procedures for OP/PACU**	
Scope: PACU	Manual: **Admission, Discharge, Transfer Documentation (ADT)**
Source: DON Perioperative Services	Effective Date:

Page 3: This is the PACU care plan and reflects the care given in the PACU utilizing the PACU Standards of Care and PACU Care Guidelines.
Fill in the care plan (to the left) appropriately utilizing information from the preoperative records and the report received from the OR RN and anesthesiologist as well as problems noted in the PACU. The bottom care plan box has been left empty for use in documenting unique patient problems identified by the PACU nurse.
The right column is used for PACU nurse follow-up documentation. Inpatient visit information can be documented in the right-hand column. Outpatient follow-up phone call information can be documented in the right-hand column or at the bottom of the page.
Once outpatient phone follow-up documentation has been completed two photocopies of page 3 should be made: one copy given to the surgeon, one copy in the phone follow-up book in the PACU. This information will be kept confidential and at the end of the month utilized in evaluation of PACU care.

Page 4: This is an area that contains the PARGAR scoring information and equipment/supplies documentation section if the equipment/ supplies are not documented in the body of the record (narrative or discharge equipment checklist).

RETRIEVING LAB/RADIOLOGY RESULTS: Critical lab work results should be called to the physician /nurse by the laboratory staff. Results from routine lab work orders that are not critical can be delivered by pneumatic tube.
Radiology reports should be phoned to the appropriate doctor and/or the nurses in OP/PACU so as not to jeopardize patient care.

Approval	**Date**
NEC	2/1/2017
Board of Directors	

Developed:
Reviewed:
Revised: 05/11 AW, 9/12AW, 1/17AW
Supercedes:

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
ORGANHARV	Harvesting Organ	180	zzGeneral Surgery	<None>	<Primary>
ANB	Regional Anesthesia/analgesia	45	zzAnesthesiology	<None>	<Primary>
TISSUEHARV	Harvesting Tissue	180	zzGeneral Surgery	<None>	<Primary>
OPBLEPHAR	Blepharoplasty	75	zzOphthalmology	Blepharoplasty	Care Plan Ophthalmology
OPBLEPHA02	Blepharoplasty Bilateral	75	zzOphthalmology	Blepharoplasty Bilateral	Care Plan Ophthalmology
GEBRONCHC	Bronchoscopy General	45	zzGeneral Surgery	Bronchoscopy	Minor Procedure Care Plan
GEBRONCH0	Bronchoscopy with Moderate Sedation	45	zzGeneral Surgery	Bronchoscopy	Minor Procedure Care Plan
GEBRONCH0	Bronchoscopy for Intubation General	45	zzGeneral Surgery	Bronchoscopy for Intubation	Minor Procedure Care Plan
OPCATWIOL	Cataract Extract with Intraocular Lens	30	zzOphthalmology	Cataract IOL	Care Plan Ophthalmology
OPCATARBIL	Cataract IOL Bilateral	45	zzOphthalmology	Cataract IOL Bilateral	Care Plan Ophthalmology
OPSILICONE	Eye Removal Debris or Silicone Oil	30	zzOphthalmology	Cataract IOL Revision	Care Plan Ophthalmology
OPIRRASPEY	Irrigation and Aspiration of the Eye	30	zzOphthalmology	Cataract IOL Revision	Care Plan Ophthalmology
OPCATARACT	Cataract Revision	30	zzOphthalmology	Cataract IOL Revision	Care Plan Ophthalmology
OPIOLEXCHA	IOL Exchange	45	zzOphthalmology	Cataract IOL Revision	Care Plan Ophthalmology
OPCATWIOL2	Cataract Extract W IOL and Trabulectopla	45	zzOphthalmology	Cataract IOL Trabeculectomy	Care Plan Ophthalmology
ENCOLSCO0	Colonoscopy General with Biopsy	45	zzGeneral Surgery	Colonoscopy Biopsy	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy Moderate Sedat with Biopsy	45	zzGeneral Surgery	Colonoscopy Biopsy	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy General	45	zzGeneral Surgery	Colonoscopy Diagnostic	Minor Procedure Care Plan
GEOSTOMYC	Colostomy Change Moderate Sedation	45	zzGeneral Surgery	Colonoscopy Diagnostic	<Primary>
ENCOLSCO0	Colonoscopy Moderate Sedation	45	zzGeneral Surgery	Colonoscopy Diagnostic	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy General with Polypectomy	45	zzGeneral Surgery	Colonoscopy Polypectomy	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy ModeratSedat with Polypectom	45	zzGeneral Surgery	Colonoscopy Polypectomy	Minor Procedure Care Plan
ENCOLSCOS	Colonoscopy Screening Special All	45	zzGeneral Surgery	Colonoscopy Screening Spec	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy w Hemorr Band	45	zzGeneral Surgery	Colonoscopy with Hemorrhoid	Minor Procedure Care Plan
GEABDAORT	Abdominal Aortic Aneurysm	180	zzVascular	Comprehensive Surgery	Standard Care Plan
GEABDPERR	Abdominal Perineal Colon Resection	180	zzGeneral Surgery	Comprehensive Surgery	Standard Care Plan
URCRYOPRC	Cryotherapy Prostate w suprapub/cysto	90	zzUrology	Cryosurgery Prostate	Standard Care Plan
OBCESESTA	Vaginal Delevery in OR, C-Section	90	zzObstetrics	C-Section Standby	Standard Care Plan
OPECTROPIA	Ectropian Entropian Repair Local	45	zzOphthalmology	Ectropian or Entropian Local	Care Plan Ophthalmology
OPENTROPIA	Ectropian or Entropian Repair	45	zzOphthalmology	Ectropian or Entropian Local	Care Plan Ophthalmology
OPPUNTOEN	Punctoplasty with Entropian Ectrop Repa	45	zzOphthalmology	Ectropian Puctoplasty	Care Plan Ophthalmology
ENESOPOG0	EGD Moderate Sedation	45	zzGeneral Surgery	EGD	Minor Procedure Care Plan
ENESOPOG0	EGD General	45	zzGeneral Surgery	EGD	Minor Procedure Care Plan
ENESOPHAG	Esophagoscopy General	60	zzGeneral Surgery	EGD	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy and EGD Moderate Sedation	45	zzGeneral Surgery	EGD and Colonoscopy	Minor Procedure Care Plan
ENCOLSCO0	Colonoscopy and EGD General	45	zzGeneral Surgery	EGD and Colonoscopy	Minor Procedure Care Plan
ENESOPHD0	EGD with Biop or Fore Body General	60	zzGeneral Surgery	EGD Biopsy or Foreign Body	Minor Procedure Care Plan
ENESOPHD0	EGD with Biopsy/Foreign Body Moderate Se	60	zzGeneral Surgery	EGD Biopsy or Foreign Body	Minor Procedure Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
ENESOPHD0	Esophageal Dilatation Moderate Sedatio	60	zzGeneral Surgery	EGD Dilitation	Minor Procedure Care Plan
ENESOPDILP	Esophageal Balloon Dilatation ModeratSed	60	zzGeneral Surgery	EGD Dilitation	Minor Procedure Care Plan
ENESOPHDIL	Esophageal Balloon Dilatation General	60	zzGeneral Surgery	EGD Dilitation	Minor Procedure Care Plan
ENESOPHA0	EGD with Scleral Band Staples General	60	zzGeneral Surgery	EGD Scleral Bands Staples	Minor Procedure Care Plan
ENESOPHA0	EGD with Scleral Band Staples ModeratSed	60	zzGeneral Surgery	EGD Scleral Bands Staples	Minor Procedure Care Plan
ENGASTTUB	Gastrostomy Tube Placement PEG Proce Se	60	zzGeneral Surgery	EGD with Peg Insertion	Minor Procedure Care Plan
ENGASTTU02	Gastrostomy Tube Placement PEG General	60	zzGeneral Surgery	EGD with Peg Insertion	Minor Procedure Care Plan
GEVEINLA02	Endovenous Laser Bilateral ModeratSedati	180	zzVascular	Endovenous Laser Bilateral	Minor Procedure Care Plan
GEVEINLASE	Endovenous Laser Single Moderate Sedat	120	zzGeneral Surgery	Endovenous Laser Single	Minor Procedure Care Plan
OPENUCLEA	Enucleation	75	zzOphthalmology	Enucleation	Care Plan Ophthalmology
OPEXOSTOS	Exostosis	75	zzOphthalmology	Excision Eye Lesion	Care Plan Ophthalmology
OPIRIDECTO	Iridectomy	45	zzOphthalmology	Excision Eye Lesion	Care Plan Ophthalmology
OPORBMASS	Orbital Mass Excision	75	zzOphthalmology	Excision Eye Lesion	Care Plan Ophthalmology
OPLESIONEY	Eye Excision of Lesion	75	zzOphthalmology	Excision Eye Lesion	Care Plan Ophthalmology
OPREMFISH	Eye Removal of Fish Hook from	45	zzOphthalmology	Foreign Body Removal Anterio	Care Plan Ophthalmology
OPFBREMO0	Foreign Body Removal Corneal	75	zzOphthalmology	Foreign body Removal Cornea	Care Plan Ophthalmology
GEFRENULE	Frenulectomy	30	zzGeneral Surgery	Frenulectomy	Minor Procedure Care Plan
OPICLLEFT	ICL Implant for Refractory Left	30	zzOphthalmology	ICL Insertion for Refractory	Care Plan Ophthalmology
OPICLRIGHT	ICL Implant for Refractory Right	30	zzOphthalmology	ICL Insertion for Refractory	Care Plan Ophthalmology
OPLIMBALRE	Eye Limbal Relaxing Incision of the	30	zzOphthalmology	Lacrimal Probing	Care Plan Ophthalmology
OPLACRIMAL	Lacrimal Probing	30	zzOphthalmology	Lacrimal Probing	Care Plan Ophthalmology
GYCOLDCON	Cold Coneization of Cervix	60	zzGynecology	Leep	Minor Procedure Care Plan
GYCERVBIOP	Cervical Biopsy	60	zzGynecology	Leep	Minor Procedure Care Plan
GYLEEP	Leep Procedure	75	zzGynecology	Leep	Minor Procedure Care Plan
OPIOLFARSI	IOL Implant for Farsighted	30	zzOphthalmology	Lens Implant for Farsighted	Care Plan Ophthalmology
URLITHOT02	Lithotripsy with Cystoscopy and Stent	90	zzUrology	Lithotripsy Unilateral	Standard Care Plan
URLITHOTRI	Lithotripsy	90	zzUrology	Lithotripsy Unilateral	Minor Procedure Care Plan
ORHIPRELOC	Hip Relocation under Anesthesia	90	zzOrthopedics	Low Level Surgery	Minor Procedure Care Plan
ORCARPMET	Carpal Metacarpal Arthroplasty	120	zzOrthopedics	Major Surgery	Standard Care Plan
ORKNEARTH	Knee Arthroscopy Diagnostic Operative	90	zzOrthopedics	Major Surgery	Standard Care Plan
ORKNEAC02	Knee Arthroscopic ACL Auto/Allograft	180	zzOrthopedics	Major Surgery	Standard Care Plan
URCALCULO	Calculotripsy	105	zzUrology	Major Surgery	Minor Procedure Care Plan
URBLADGRA	Bladder Sling Suspension with Autograft	120	zzGynecology	Major Surgery	Standard Care Plan
GELAPHER02	Inguinal Lap Hernia TEPP Repair	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GELAPINHER	Incisional Hernia Repair, Laparoscopic	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
URBLADREP	Bladder Repair	15	zzUrology	Major Surgery	Standard Care Plan
GECOLONR0	Ileostomy Takedown /Reanastamosis	90	<None>	Major Surgery	Standard Care Plan
ORANKFUSI	Ankle Fusion	180	zzOrthopedics	Major Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
POBUNION02	Bunionectomy Chevron (Austin)	90	zzPodiatry	Major Surgery	Standard Care Plan
URURETREP/	Ureteral Repair Reimplantation w Stent	90	zzUrology	Major Surgery	Standard Care Plan
ORKNECAPR	Knee Capsular Release	90	zzOrthopedics	Major Surgery	Standard Care Plan
ORKNEEREV	Knee Total Arthroplasty Revision	270	zzOrthopedics	Major Surgery	Standard Care Plan
URCYSTOBL	Cystoscopy With Removal Bladder Stone	90	zzUrology	Major Surgery	<Primary>
ORKNETOTA	Knee Total Arthroplasty	210	zzOrthopedics	Major Surgery	Standard Care Plan
ORHUMER02	Humeral ORIF	120	zzOrthopedics	Major Surgery	Standard Care Plan
ORHIPUNIPO	Hip Unipolar Arthroplasty	120	zzOrthopedics	Major Surgery	Standard Care Plan
GYLAPCYSTE	Laparoscopic Cystectomy	90	zzGynecology	Major Surgery	Standard Care Plan
ORELBOARTI	Elbow Arthroscopy Diagnostic Operative	90	zzOrthopedics	Major Surgery	<Primary>
URNEPHRE0	Nephrectomy Laparoscopic	180	zzUrology	Major Surgery	Standard Care Plan
URNEPHREC	Nephrectomy Open	180	zzUrology	Major Surgery	Standard Care Plan
GELYMPHNO	Lymph Node Dissection	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
OBCESAREA	Cesarean Section	90	zzObstetrics	Major Surgery	Standard Care Plan
GEPELVICEX	Pelvic/Rectal Exam with Anesthesia	30	zzGeneral Surgery	Major Surgery	Standard Care Plan
GELAPCHOL	Cholecystectomy Laparoscopic	60	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORHIPARTHR	Hip Arthroscopy	120	zzOrthopedics	Major Surgery	<Primary>
GEPAROTIDE	Parotidectomy	180	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORKNEEHAR	Knee Hardware Removal	75	zzOrthopedics	Major Surgery	Standard Care Plan
MASTPARLO	Breast Mastectomy Part Needle Loc	120	zzGeneral Surgery	Major Surgery	<Primary>
GEPARATHYF	Parathyroidectomy	180	zzGeneral Surgery	Major Surgery	Standard Care Plan
GECOLOSTO	Colostomy Takedown	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
URNEPHRE0	Nephrectomy Radical	180	zzUrology	Major Surgery	Standard Care Plan
URNEPHRE0	Nephrectomy Partial	180	zzUrology	Major Surgery	Standard Care Plan
ORHIPDHS	Hip Compression DHS ORIF	120	zzOrthopedics	Major Surgery	Standard Care Plan
GYUTERI02	Uterine Suspension Laparoscopic	90	zzUrology	Major Surgery	Standard Care Plan
ORTIBRODDI	Tibial Rodding	135	zzOrthopedics	Major Surgery	Standard Care Plan
ORHUMERAL	Humeral Nailing	120	zzOrthopedics	Major Surgery	Standard Care Plan
URPROSTA01	Prostatectomy Retropubic	210	zzUrology	Major Surgery	Standard Care Plan
GYLAPOOPH	Laparoscopic Oophorectomy	135	zzGynecology	Major Surgery	Standard Care Plan
GYHYSTER1(	Hysterectomy Abdominal	120	zzGynecology	Major Surgery	<Primary>
GYHYSTER02	Hysterectomy Abdominal with Urethropexy	120	zzGynecology	Major Surgery	Standard Care Plan
ORELBOORIF	Elbow ORIF	90	zzOrthopedics	Major Surgery	Standard Care Plan
ORKNEEREM	Knee Total Removal of Implants	120	zzOrthopedics	Major Surgery	Standard Care Plan
POARTHMTP	Arthroplasty Metatarsal Phalangeal Joint	90	zzPodiatry	Major Surgery	Standard Care Plan
MASTPARND	Breast Mastectomy Part Ndl Loc/Sent Nd	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
POBUNION03	Bunionectomy Lapidus (Screw Fixation)	90	zzPodiatry	Major Surgery	Standard Care Plan
ORILIZAROV	Ilizarov Spacial Frame Application	180	zzOrthopedics	Major Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
GEINGHERNI	Inguinal Hernia Repair	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GELAPHERNI	Inguinal Intra Peritoneal Hernia Laparo	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
URPROSTA02	Prostatectomy Suprapubic	210	zzUrology	Major Surgery	Standard Care Plan
RADMASTEC	Radical Mastectomy	105	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORFEMUROL	Femoral/Tibial Nail (Rod)	90	zzOrthopedics	Major Surgery	Standard Care Plan
GECOLONR0	Bowel Resection Laparoscopic Right Colon	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORSHOLARTI	Shoulder Arthroscopy	60	zzOrthopedics	Major Surgery	<Primary>
GEAMPUBKA	Amputation Below the Knee	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GEINGHER03	Ventral Hernia Repair Laparoscopic	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
GYBLADDSUI	Bladder Suspension	120	zzGynecology	Major Surgery	Standard Care Plan
ORHIPREVIS	Hip Total Arthroplasy Revison	210	zzOrthopedics	Major Surgery	Standard Care Plan
GEAPPENDL	Appendectomy Laparoscopic	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
GEGASTROV	Gastric Oversew Open for Perforated Ulce	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORACHTENR	Achilles Tendon Repair	120	zzOrthopedics	Major Surgery	Standard Care Plan
ORHIPGAMM	HIP ORIF Gamma Nail	90	zzOrthopedics	Major Surgery	<Primary>
ROBOINCHRI	Robotic Hernia Incisional Repair	90	zzGeneral Surgery	Major Surgery	<Primary>
GEAMPUSYM	Amputation Symes or Mid Foot	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ONCORECON	Breast Oncoplastic Reconstruction	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GEAPPENDR	Robotic Appendectomy	90	zzGeneral Surgery	Major Surgery	<Primary>
ROBOCOLON	Robotic Colon Resection Right	120	zzGeneral Surgery	Major Surgery	<Primary>
ROBOLOWAN	Robotic Bowel/Colectomy Low Anterior	120	zzGeneral Surgery	Major Surgery	<Primary>
ROBOHEMO	Robotic Hemicolectomy	120	zzGeneral Surgery	Major Surgery	<Primary>
ORFEMUROC	Hip Fracture (TFN) Synthes	90	zzOrthopedics	Major Surgery	Standard Care Plan
ORHIPTOTAL	Hip Total Arthroplasty	210	zzOrthopedics	Major Surgery	Standard Care Plan
ORCLAVICOF	Clavicle ORIF	75	zzOrthopedics	Major Surgery	Standard Care Plan
ROBOGYHYS	Robotic Hysterectomy	180	zzGynecology	Major Surgery	Standard Care Plan
GYUTERINE	Uterine Suspension	90	zzUrology	Major Surgery	Standard Care Plan
GEHERSCRO	Scrotal Hernia Repair	75	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORQUADRTE	Quadraceps Tendon Repair	90	zzOrthopedics	Major Surgery	Standard Care Plan
GEFEMPOPB	Femoral Popliteal Bypass	180	zzVascular	Major Surgery	Standard Care Plan
GEAPPENDO	Appendectomy Open	60	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORACHILTEN	Achilles Tendon Lengthening	135	zzOrthopedics	Major Surgery	Standard Care Plan
GEAMPUTAM	Amputation Minor	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
GEBREAX	Breast Lumpectomy with Axill Node Disect	120	zzGeneral Surgery	Major Surgery	<Primary>
GEGASTJE02	Gastrojejunostomy Laparoscopic	120	zzUrology	Major Surgery	Standard Care Plan
GEMASTEC0	Breast Mastectomy Modified Radical	105	zzGeneral Surgery	Major Surgery	Standard Care Plan
PERIRESC	Perineal Reconstruction	75	zzGynecology	Major Surgery	Standard Care Plan
URPROSTAR	Prostatectomy Radical	210	zzUrology	Major Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
GEHERFEMO	Femoral Hernia Repair	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORFEMDISTC	Femoral ORIF Distal Condyle	90	zzOrthopedics	Major Surgery	Standard Care Plan
GETHYROIDE	Thyroidectomy	180	zzGeneral Surgery	Major Surgery	Standard Care Plan
GECOLONR0	Bowel Resection Open	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORSHOLORIF	Shoulder ORIF	90	zzOrthopedics	Major Surgery	<Primary>
ORSHOLBAN	Shoulder Arthroscopy, Bankhart Repair	120	zzOrthopedics	Major Surgery	<Primary>
ORANKORIF	Ankle ORIF	120	zzOrthopedics	Major Surgery	Standard Care Plan
GECHOLEYO	Cholecystectomy Open	60	zzGeneral Surgery	Major Surgery	Standard Care Plan
GECOLECLO	Bowel/Colectomy Low Anterior	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ROBOINGHRI	Robotic Hernia Inguinal Repair	90	zzGeneral Surgery	Major Surgery	<Primary>
GELAPLOWA	Bowel Resect Laparoscop Low Anterior	180	zzGeneral Surgery	Major Surgery	Standard Care Plan
ROBOCHOLE	Robotic Cholecystectomy	60	zzGeneral Surgery	Major Surgery	<Primary>
POFOOTMET	Foot Metatarsal Fusion	90	zzPodiatry	Major Surgery	Standard Care Plan
ROBOOVCYS	Robotic Cystectomy Ovarian	90	zzGynecology	Major Surgery	<Primary>
ORKNEEHA0	Hardware Removal Knee with Antibiotic Sp	75	zzOrthopedics	Major Surgery	Standard Care Plan
ROBOHRNVE	Robotic Hernia Ventral Repair	90	zzGeneral Surgery	Major Surgery	<Primary>
ORPATTEND	Patellar Tendon Repair Arthroscopic Assi	120	zzOrthopedics	Major Surgery	Standard Care Plan
GEUMBHERC	Robotic Umbilical Hernia Repair	120	zzGeneral Surgery	Major Surgery	<Primary>
ORTIBOSTEC	Tibial Osteotomy	90	zzOrthopedics	Major Surgery	Standard Care Plan
ORTIBORIF	Tibial ORIF	135	zzOrthopedics	Major Surgery	Standard Care Plan
GEBREAAX	Breast Lump with Axill Node, Needle Loc	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORSHOREVE	Shoulder Total Arthroplasty	180	zzOrthopedics	Major Surgery	<Primary>
GEUMBHERL	Umbilical Hernia Repair Laparoscopic	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GECOLONR0	Bowel Repair Open	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORTIBPLATE	Tibial Plateau ORIF	135	zzOrthopedics	Major Surgery	Standard Care Plan
ORTIBPILON	Tibial Distal ORIF Pilon Fracture	90	zzOrthopedics	Major Surgery	Standard Care Plan
GELAPGASTI	Gastric Ulcer Oversew Laparoscopic	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORFEMUROF	Femur ORIF	90	zzOrthopedics	Major Surgery	Standard Care Plan
GESPLENEC	Splenectomy	150	zzGeneral Surgery	Major Surgery	Standard Care Plan
ROBOSAL	Robotic Salpingectomy	90	zzGynecology	Major Surgery	<Primary>
URORCHIEC	Orchiectomy Inguinal Approach	75	zzUrology	Major Surgery	Standard Care Plan
GELAPDIVCC	Colostomy Laparoscopic Diverting	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORLEGHARD	Hardware Removal Leg	75	zzOrthopedics	Major Surgery	<Primary>
GEDIVERCOL	Colostomy Diverting Open	90	zzGeneral Surgery	Major Surgery	<Primary>
GEINCARHEF	Ventral/Incisional Hernia Repair Open	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GECOLONR0	Bowel Repair Laparoscopic	150	zzGeneral Surgery	Major Surgery	Standard Care Plan
PARTMASTE	Breast Mastectomy Partial	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORTIBROD03	Tibial Spine Fracture ORIF	135	zzOrthopedics	Major Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
GYABDSACSI	Abdominal Sacral Culpopexy W Mesh	180	zzGynecology	Major Surgery	Standard Care Plan
GEAXILLARY	Axillary Node Dissection	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORHIPSCREV	Hip Cannulated Screw ORIF	120	zzOrthopedics	Major Surgery	Standard Care Plan
GYNECOMAS	Mastectomy for Gynecomastia	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORMALLEOL	Malleolar ORIF	90	zzOrthopedics	Major Surgery	Standard Care Plan
URURETREIM	Ureteral Reimplantation with Stent	90	zzUrology	Major Surgery	Standard Care Plan
GEOPELYADH	Lysis of Adhesions Open	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORANKLIGRE	Ankle Ligament Reconstruction	120	zzOrthopedics	Major Surgery	Standard Care Plan
GYLAPTUBAL	Tubal Ligation or Fulgerati Laparoscopic	90	zzGynecology	Major Surgery	Standard Care Plan
URNEPHRE0(	Nephrectomy Radical Laparoscopic	180	zzUrology	Major Surgery	Standard Care Plan
URNEPHRE0-	Nephrectomy Partial Laparoscopic	180	zzUrology	Major Surgery	Standard Care Plan
ORHARDWAC	Hip Hardware Removal	120	zzOrthopedics	Major Surgery	Standard Care Plan
ORHIPBONEC	Hip Bulk Allograft wtih THA	90	zzOrthopedics	Major Surgery	Standard Care Plan
GELIVEROPE	Liver Biopsy Open	15	zzGeneral Surgery	Major Surgery	Standard Care Plan
URRESPROS	Transurethral Resection Prostate	75	zzUrology	Major Surgery	Standard Care Plan
GELAPEXPLO	Laparotomy Exploratory	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
GERECPOLA	Transanal Tumor or Polyp Excision	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GELAPDIDIA	Laparoscopy Diagnostic	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
GELAPLYADH	Laparoscopic Lysis of Adhesions	90	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORHIPEXBON	Hip Excision Bone All	120	zzOrthopedics	Major Surgery	<Primary>
ORELBOTENI	Elbow Tendon Repair or Transposition	90	zzOrthopedics	Major Surgery	Standard Care Plan
URBIOARC	Bladder Suspension with Sling	90	zzUrology	Major Surgery	Standard Care Plan
GEAMPUTAT	Amputation Leg	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
GYTVT	Transvaginal Tension Free Taping TVT	60	zzGynecology	Major Surgery	Minor Procedure Care Plan
SIMPLEMAST	Breast Mastectomy Simple	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORTIBROD02	Tibial Rod Removal	135	zzOrthopedics	Major Surgery	Standard Care Plan
ROBOBSO	Robotic Oophorectomy Salpingectomy	90	zzGynecology	Major Surgery	<Primary>
GYHYSTER09	Hysterectomy Laparoscopic	180	zzGynecology	Major Surgery	Standard Care Plan
GYHYSTER06	Hysterectomy Vaginal	120	zzGynecology	Major Surgery	Standard Care Plan
URPENISIMP	Penis Implant	120	zzUrology	Major Surgery	<Primary>
GYHYSTERO:	Hysteroscopy with Lap Oophorectomy	15	zzGynecology	Major Surgery	Standard Care Plan
GEHERDIAPF	Diaphragmatic Hernia Repair	120	zzGeneral Surgery	Major Surgery	Standard Care Plan
ORELBOHAR	Elbow Hardware Removal	90	zzOrthopedics	Minor Surgery	Standard Care Plan
ORELBOCRE	Elbow Closed Reduction	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORCARPAL	Carpal Tunnel Release	45	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORKNEEINJE	Knee Injection with Fluoroscopy	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORKNEEEVAI	Knee Evaluation and Manipulation Anesthe	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORKNEART02	Knee Arthroscopy I and D	90	zzOrthopedics	Minor Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
GECARDIOVE	Cardioversion	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORHARDWAF	Ankle Hardware Removal	120	zzOrthopedics	Minor Surgery	Standard Care Plan
GEAMPUFINC	Amputation Finger	90	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GEINTUBATI	Intubation by Anesthesia	30	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
BRSTTISEXP	Insertion of Breast Tissue Expanders	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORCALCAOR	Calcaneal ORIF	120	zzOrthopedics	Minor Surgery	Standard Care Plan
GEINGHER02	Inguinal Hernia Repair Child	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORDUPUYTR	Dupuytrens Contracture Repair	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
POBUNION01	Bunionectomy Simple (Keller, Taylor)	90	zzPodiatry	Minor Surgery	Standard Care Plan
IDABSCECYS	Incision and Drainage Abscesses & Cysts	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GEDRESSCH	Dressing Change/Wound Vac w/ Anesthesia	60	zzGeneral Surgery	Minor Surgery	<Primary>
GEBONEBIOP	Iliac Crest Bone Biopsy	45	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEDRESCHG	Dressing Change/Wound Vac Mod Sedation	60	zzGeneral Surgery	Minor Surgery	<Primary>
GYDANDCLO	Dilitation and Curettage Moderate Seda	60	zzGynecology	Minor Surgery	Minor Procedure Care Plan
GEID	I and D Abscess, Clot,	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEINCDRAAE	I and D Abscess Extremity	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GYDANDCGE	Dilitation and Curettage General	60	zzGynecology	Minor Surgery	Minor Procedure Care Plan
ORKNEBURS	Knee Bursectomy	90	zzOrthopedics	Minor Surgery	<Primary>
BIOPLYMPHN	Biopsy Lymph Node, Skin, or SQ Tumor	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GYHYSTERO	Hysterotomy	90	zzGynecology	Minor Surgery	Standard Care Plan
GYHYSOSC01	Hysteroscopy Diagnostic VS Operative	75	zzGynecology	Minor Surgery	Standard Care Plan
URDETORTE	De Torsion of Testicle	60	zzUrology	Minor Surgery	Standard Care Plan
ORKNEEIAD	Knee Irrigation and Debridement	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
URCYSTSTEN	Cystoscopy with Ureteral Stent ALL	90	zzUrology	Minor Surgery	Standard Care Plan
URHYPOSPA	Hypospadius Repair	75	zzUrology	Minor Surgery	Standard Care Plan
ORBICEPTEN	Biceps Tendon Repair	120	zzOrthopedics	Minor Surgery	Standard Care Plan
GYHYMENEC	Hymenectomy	75	zzGynecology	Minor Surgery	Minor Procedure Care Plan
URHYDROCE	Hydrocelectomy	75	zzUrology	Minor Surgery	Standard Care Plan
URCYSPROB	Cystoscopy with Prostate Biopsy	60	zzUrology	Minor Surgery	Standard Care Plan
ORHUMER03	Humeral Percutaneous Pinning	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
URCYSTCOA	Cystoscopy with Coaptite Injection	60	zzUrology	Minor Surgery	Standard Care Plan
URCYSBLADI	Cystoscopy with Bladder Biopsy	60	zzUrology	Minor Surgery	Standard Care Plan
BRSTSENTNI	Breast Sentinel Node/Axil Node Sampling	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORHIPBUSEC	Hip Trochanteric Bursectomy, IT Band Rel	90	zzOrthopedics	Minor Surgery	<Primary>
GEVENACAV	Vena Cava Filter Insertion	120	zzVascular	Minor Surgery	Minor Procedure Care Plan
GEVIENST02	Vein Stripping and Ligation Procedur Sed	150	zzVascular	Minor Surgery	Standard Care Plan
GYBARTHOLI	Bartholin/Labial Cyst Marsupiallization	75	zzGynecology	Minor Surgery	Minor Procedure Care Plan
ORANKEXFIX	Ankle External Fixator	135	zzOrthopedics	Minor Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
URVARICOCE	Varicocelectomy	60	zzUrology	Minor Surgery	Standard Care Plan
URCYSTOSC	Cystoscopy	90	zzUrology	Minor Surgery	Standard Care Plan
URETHROTO	Urethrotomy Visual Internal	60	zzUrology	Minor Surgery	Standard Care Plan
URURETHRO	Urethrotomy Bladder Neck Contrature	45	zzUrology	Minor Surgery	Standard Care Plan
ORHIPIANDD	Hip I and D	90	zzOrthopedics	Minor Surgery	Standard Care Plan
ORCUBITALT	Cubital Tunnel Release	75	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GEUMBHERN	Umbilical Hernia Repair	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ULNARNER02	Ulnar Nerve Transposition Decompression	120	zzOrthopedics	Minor Surgery	Standard Care Plan
GYPPTL	Tubal Ligation Post Partum	60	zzGynecology	Minor Surgery	Minor Procedure Care Plan
ORHIPEVAL	Hip Evaluation and Injection Anesthes	45	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
CRESMASTO	Crescent Mastopexy	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
DONMASTOP	Breast Mastopexy Donut	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORBAKERCY	Bakers Cyst Excision	75	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORDHSHARD	Hip DHS Hardware Removal	90	zzOrthopedics	Minor Surgery	Standard Care Plan
ORHIPDECO	Hip Core Decompression	120	zzOrthopedics	Minor Surgery	<Primary>
CORENEEDL	Core Needle/Vacuum assisted needle Biop	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GYCONDYLO	Condyloma Excision	60	zzGynecology	Minor Surgery	Standard Care Plan
GETONSILLE	Tonsillectomy	75	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORHIPCLREC	Hip Closed Reduction	90	zzOrthopedics	Minor Surgery	Standard Care Plan
GEANALFIST	Anal Fistulotomy	75	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
POTOETENO	Toe Tenotomy/Tendon Repair	90	zzOrthopedics	Minor Surgery	Standard Care Plan
POTOEOSTE	Toe Ostectomy	90	zzPodiatry	Minor Surgery	Standard Care Plan
GECOMDUCE	Common Duct Exploration Laparoscopic	75	zzGeneral Surgery	Minor Surgery	Standard Care Plan
POTOEORIF	Toe ORIF	90	zzPodiatry	Minor Surgery	Standard Care Plan
POTOENAIL	Toe Nail Removal	60	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
ORHIPASPER	Hip Asperation/Injection with Anesthesia	45	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
POTOEIAND	Toe I And D	90	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
POTOEHAMM	Toe Hammer Repair	90	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
GYVAGCOLPI	Colposcopy	90	zzGynecology	Minor Surgery	Minor Procedure Care Plan
GEWOUNCLO	Wound Closure Secondary	120	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEHEMORRH	Hemorrhoidectomy	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
POTOECHEIL	Toe Cheilectomy	90	zzPodiatry	Minor Surgery	Standard Care Plan
ENHEMORBA	Hemorrhoidal Banding	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
POTOEARTHI	Toe Arthroplasty	90	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
POTOEAMPU	Toe Amputation	90	zzOrthopedics	Minor Surgery	Standard Care Plan
POFOOTHAR	Hardware Removal of the Foot	60	zzPodiatry	Minor Surgery	Standard Care Plan
ORTIBIACRE	Tibia Closed Reduction	90	zzOrthopedics	Minor Surgery	Standard Care Plan
ORTHUMB02	Thumb ORIF with Tendon Repair	90	zzOrthopedics	Minor Surgery	Standard Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
ORWRISHAR	Hardware Removal Hand/Wrist/Upper Extren	75	zzOrthopedics	Minor Surgery	Standard Care Plan
ORHANDTEN	Hand Tendon and Nerve Repair	120	zzOrthopedics	Minor Surgery	Standard Care Plan
GETEMPARTI	Temporal Artery Biopsy	60	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORHANDORI	Hand ORIF	120	zzOrthopedics	Minor Surgery	Standard Care Plan
ORHANDNER	Hand Nerve Repair	120	zzOrthopedics	Minor Surgery	Standard Care Plan
URSUPRAPU	Suprapubic Catheter Insertion	60	zzUrology	Minor Surgery	Minor Procedure Care Plan
SQMASTECT	Subcutaneous Mastectomy	120	zzGeneral Surgery	Minor Surgery	Secondary Procedure Care Plai
ORHANDCR	Hand Closed Reduction	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
SPLTTHCKSK	Split Thickness Skin Graft	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GESKINGRAF	Skin Graft	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GEANALFISS	Anal Fissurectomy	15	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GENGASTOP	Gastrostomy Tube Placement Open	60	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GEGASTJEJU	Gastrojejunostomy Open	120	zzUrology	Minor Surgery	Standard Care Plan
GEVIENSTRI	Vein Stripping and Ligation General	150	zzGeneral Surgery	Minor Surgery	Standard Care Plan
SENTNODEBI	Sentinel Node Biopsy	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORGANGLIO	Ganglion Cyst Excision	75	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GEFOREGINE	Foreign Body Removal General	90	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEBREANEE	Breast Biopsy,Lumpectomy w Needle Locali	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORORIFFOO	Foot Open Reduction Internal Fixation	120	zzOrthopedics	Minor Surgery	Standard Care Plan
POMORTNEU	Foot Mortons Neuroma Excision	60	zzPodiatry	Minor Surgery	Standard Care Plan
ORIDFOOT	Foot I and D	60	zzOrthopedics	Minor Surgery	Standard Care Plan
POFOOTCRE	Foot Closed Reduction	60	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
GEBREASTBI	Breast Biopsy, Lumpectomy, Lesion Excisi	75	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GYAPREPAIR	Anterior Posterior Repair (Rectocele)	75	zzGynecology	Minor Surgery	Standard Care Plan
ORFINTRIGG	Finger Trigger Release	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
BRSTEXPRE	Removal of Breast Tissue Expanders	120	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GERECTUMP	Rectal Tumor or Polypectomy Excision	90	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORFINTENNE	Finger Tendon Nerve Repair	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GERECTSPHI	Rectal Sphincterotomy	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GERECTPRO	Rectal Prolapse Repair	90	zzGeneral Surgery	Minor Surgery	Standard Care Plan
ORFINGORIF	Finger ORIF	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORFINGIAD	Finger I and D	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GERECTBIOP	Rectal Biopsy	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GERECTIANC	Rectal Abscess I and D	45	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORRADULCR	Radius Ulna Closed Reduction	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORFINGPERF	Finger Closed Reduction w Percu Pinning	90	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORRADULNP	Radius Ulna Closed Reduc Perc Pinning	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORRADULNE	Radius Ulna Closed Reduc External Fixato	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
ORCLAVICHA	Clavicle Hardware Removal	75	zzOrthopedics	Minor Surgery	Standard Care Plan
ORRADIUSOI	Radius Open Reduction Internal Fixation	75	zzOrthopedics	Minor Surgery	Standard Care Plan
ORCLAVEXCI	Clavicle Distal Excision	60	zzOrthopedics	Minor Surgery	<Primary>
ORCLAVICCR	Clavicle Closed Reduction	75	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
ORANKPPIN	Ankle Percutaneous Pinning or Screw	90	zzOrthopedics	Minor Surgery	Standard Care Plan
GEGROMAC	PortPower Placement MAC	60	zzGeneral Surgery	Minor Surgery	<Primary>
ORFEMROD1	Femoral Rod Removal	90	zzOrthopedics	Minor Surgery	Standard Care Plan
GEGROSHO0	PortPower Placement General	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEGROSHO0	Port Power Placement Proc Sedation	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORFASCIOTC	Fasciotomy	120	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
URCIRCUMCI	Circumcison Non Newborn	60	zzUrology	Minor Surgery	Minor Procedure Care Plan
GEPORTREM	Port Infusion Removal	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GEPILONIDA	Pilonidal Cyst Excision	60	zzGeneral Surgery	Minor Surgery	Standard Care Plan
OPREPAEYEL	Eyelid Repair of Laceration	75	zzOphthalmology	Minor Surgery	Care Plan Ophthalmology
POPERTEND	Peroneus Brevis Tendon Repair	120	zzPodiatry	Minor Surgery	Standard Care Plan
URCHORDEE	Chordee Repair	60	zzUrology	Minor Surgery	Minor Procedure Care Plan
URPENISFRA	Penis Repair of Fracture	90	zzUrology	Minor Surgery	Standard Care Plan
URPENILFRE	Penile Biopsy or Frenular Band Release	60	zzUrology	Minor Surgery	Minor Procedure Care Plan
ORTALAREXC	Talar Exostectomy	120	zzOrthopedics	Minor Surgery	Standard Care Plan
ORTALARORI	Talar ORIF	180	zzOrthopedics	Minor Surgery	Standard Care Plan
ORPATELORI	Patella ORIF	105	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GETHORACE	Thoracentesis	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORTHUMB01	Thumb ORIF	90	zzOrthopedics	Minor Surgery	Standard Care Plan
ORTHUMB03	Thumb ORIF with Tendon Nerve Repair	90	zzOrthopedics	Minor Surgery	Standard Care Plan
OREXFIXINF	External Fixator Infected Pin	60	zzOrthopedics	Minor Surgery	<Primary>
GEPACEMAK	Pacemaker Insertion	75	zzVascular	Minor Surgery	Minor Procedure Care Plan
OREXFIXIAD	External Fixator Generic	60	zzOrthopedics	Minor Surgery	Minor Procedure Care Plan
GEPACGENR	Pacemaker Generator Replacement	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
URORCHIOPI	Orchiopexy	75	zzUrology	Minor Surgery	Minor Procedure Care Plan
URORCHIE02	Orchiectomy Scrotal Approach	75	zzUrology	Minor Surgery	Minor Procedure Care Plan
GEMASSEX0	Excision Mass Moderate Sedation	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
OPORBFRAC	Orbital Fracture	75	zzOphthalmology	Minor Surgery	Care Plan Ophthalmology
GEMASSEXS	Excision Mass General	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
URNEPHPER	Nephrostomy Percutaneous	90	zzUrology	Minor Surgery	Standard Care Plan
GELIPOMA	Excision Lipoma General	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GELESEXC02	Excision Lesion Moderate Sedation	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GYCERCLAG	Cerclage	60	zzObstetrics	Minor Surgery	Minor Procedure Care Plan
POTOEDESY	Toe Desyndactylization	90	zzOrthopedics	Minor Surgery	<Primary>

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
POTOEEXOS	Toe Exostectomy	90	zzPodiatry	Minor Surgery	Minor Procedure Care Plan
POTOEFUSIC	Toe Fusion	90	zzPodiatry	Minor Surgery	Standard Care Plan
GELESEXCIS	Excision Lesion General	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
POMETHEDR	Metatarsal Head Resection	90	zzPodiatry	Minor Surgery	Standard Care Plan
GELESEXC03	Excision Lesion or Lipoma Forehead Gen	60	zzGeneral Surgery	Minor Surgery	Standard Care Plan
GECENTLINE	Central Line or Groshong Moderate Sed	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
URMEATOTO	Meatotomy	60	zzUrology	Minor Surgery	Minor Procedure Care Plan
POTOEOSTE	Toe Osteotomy	90	zzPodiatry	Minor Surgery	Standard Care Plan
GECENTLI02	Central Line or Groshong General	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GETONGUE	Tongue Excision	60	zzGeneral Surgery	Minor Surgery	<Primary>
GELIVERNEE	Liver Biopsy Needle	15	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GETONSIL02	Tonsillectomy and Adenoidectomy	75	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
ORLEGHARD	Leg Hardware Removal	90	zzOrthopedics	Minor Surgery	<Primary>
GYSALPINGL	Laparoscopic Salpingectomy	90	zzGynecology	Minor Surgery	Standard Care Plan
ORELBODEB	Elbow Tenotomy or Debridement	90	zzOrthopedics	Minor Surgery	<Primary>
GETRACHEO	Tracheostomy	75	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
GELACERATI	Laceration Repair	60	zzGeneral Surgery	Minor Surgery	Minor Procedure Care Plan
URRESBLAD	Transurethral Resec Bladder Tumor	75	zzUrology	Minor Surgery	Standard Care Plan
GYLABIARED	Labia Reduction	75	zzGynecology	Minor Surgery	Minor Procedure Care Plan
ORANKLSCR	Ankle Hardware Removal Simple	45	zzOrthopedics	Minor Surgery	<Primary>
GYIUDREMO	IUD Removal OR	30	zzGynecology	Minor Surgery Inital 15 Minute:	Minor Procedure Care Plan
ORSHOUL01	Shoulder Relocation/Manipulatio w/Anesth	60	zzOrthopedics	Minor Surgery Inital 15 Minute:	Minor Procedure Care Plan
GEPELVEXLC	Pelvic/Rectal Exam with Proced Sedation	30	zzGeneral Surgery	Minor Surgery Inital 15 Minute:	Minor Procedure Care Plan
OPPTOSIS	Ptosis Repair of the Eye	75	zzOphthalmology	Ptosis Repair	Care Plan Ophthalmology
OPPTERGIUM	Pterygium Excision	75	zzOphthalmology	Pytergium with Graft	Care Plan Ophthalmology
GERECTALE>	Rectal EUA/Drain/Fulguration/Skin Tag	45	zzGeneral Surgery	Rectal EUA/Drain/Fulguration/	<Primary>
URCYSPERIM	Cystoscopy W Removal of Perimeatal Mass	60	zzUrology	Retinal Cryo-Buckle-Gas	Standard Care Plan
OPRETINA03	Retinal Detachment Cryo Gas Buckling	90	zzOphthalmology	Retinal Cryo-Buckle-Gas	Care Plan Ophthalmology
OPRETIN02	Retinal Cryopexy Cryo and Gas	90	zzOphthalmology	Retinal Detachment Cryo-Gas	Care Plan Ophthalmology
OPRETINA01	Retinal Detachment Cryotherapy	90	zzOphthalmology	Retinal Detachment Cryopexy	Care Plan Ophthalmology
OPRUPTUGL	Ruptured Globe Repair	75	zzOphthalmology	Ruptured Globe	Care Plan Ophthalmology
ENSIGMOI02	Sigmoidoscopy Procedural Sedation	60	zzGeneral Surgery	Sigmoidoscopy	Minor Procedure Care Plan
ENSIGMOIDO	Sigmoidoscopy General	60	zzGeneral Surgery	Sigmoidoscopy	Minor Procedure Care Plan
ENSIGMOI07	Sigmoidoscopy Rigid Flex Procedural Seda	60	zzGeneral Surgery	Sigmoidoscopy Flex and Rigid	Minor Procedure Care Plan
ENSIGMOI05	Sigmoidoscopy Rigid Flex General	60	zzGeneral Surgery	Sigmoidoscopy Flex and Rigid	Minor Procedure Care Plan
ENSIGMOI04	Sigmoidoscopy Biopsy Procedural Sedation	60	zzGeneral Surgery	Sigmoidoscopy with Biopsy	Minor Procedure Care Plan
ENSIGMOI03	Sigmoidoscopy Biopsy General	60	zzGeneral Surgery	Sigmoidoscopy with Biopsy	Minor Procedure Care Plan
OPTRABECU	Trabeculectomy	75	zzOphthalmology	Trabeculectomy	Care Plan Ophthalmology

Code	Procedure	Duration	Service	OR Charge Level	Plan of Care
OPTRABEC02	Trabeculectomy Revision	75	zzOphthalmology	Trabeculectomy Revision	Care Plan Ophthalmology
OPTRABEC03	Trabeculectomy with Visco Canalostomy	75	zzOphthalmology	Trabeculectomy Visco Cannul	Care Plan Ophthalmology
OPVISCOCAN	Visco Canalostomy	75	zzOphthalmology	Visco Cannulostomy	Care Plan Ophthalmology

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Wages – EXEMPT EMPLOYEES (05-04)	
Scope: Hospital Wide	Department: Human resources – Employee Handbook
Source: Human Resources	Effective Date:

PURPOSE:
In accordance with the Fair Labor Standards Act regulations, exempt employees who are required to be paid on a salary basis may not have their pay reduced for variations in the quantity or quality of work performed.

POLICY:

1. Exempt employees normally must receive their full salary for any week in which they perform any work, without regard to the number of days or hours worked. However, exempt employees need not be paid for any workweek in which they perform no work at all for the organization.
2. Deductions from pay cannot be made as a result of absences due to the circumstances listed below. Such improper pay deductions are therefore specifically prohibited by Northern Inyo Healthcare District (NIHD) regardless of the circumstances.
    a. Jury duty.
    b. Attendance as a witness.
    c. Temporary military leave.
    d. Absences caused by the employer.
    e. Absences caused by the operating requirements of the business.
    f. Partial day amounts other than those specifically discussed below.
3. The few exceptions to the requirement to pay exempt employees on a salary basis are listed below. In these cases deductions may be permissible per NIHD policies and practices.
    a. Absences of one or more full days for personal reasons other than illness or accident (partial days must be paid).
    b. Absences of one or more full days due to illness or accident.
    c. Fees received by the employee for jury or witness duty or military leave. These fees may be applied to offset the pay otherwise due to the employee for the week. No deductions can be made for failure to work for these reasons, however.
    d. Penalties imposed by infractions of safety rules of major significance.
    e. Unpaid disciplinary suspensions of one or more full days in accordance with The Progressive Discipline policy.
    f. Deductions for the first and last week of employment, when only part of the week is worked by the employee.
    g. Deductions for unpaid leave taken in accordance with a legitimate absence under the Family and Medical Leave Act.

Committee Approval	**Date**
Human Resources	
Board of Directors	

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: PAID ABSENCE	
Scope: Hospital Wide	Department: Human resources – Employee Handbook
Source: Human Resources	Effective Date:

POLICY:

All requests for paid absences must be made through and approved by your supervisor and/or department head. Requests for various types of paid absences will be considered for full-time and regular part-time employees as follows:

1. Bereavement Leave: Upon completion of the introductory period, up to three days (24 hours) paid absence may be authorized for full-time employees following the death of an immediate family member as outlined below:

a. Parents
b. Siblings
c. Spouse
d. Children
e. Domestic partner
f. Mother/father-in-law
g. Sister/brother in-law
h. Daughter/son-in-law
i. Grandparent
j. Grandchild
k. domestic partner's mother, father, sister, brother, son, or daughter
l. Spouse's or domestic partner's grandparent or grandchild
m. An adult who stood "in loco parentis" during an employee's childhood
n. Step-children
o. Step-parents

Regular part-time employees may be authorized up to three days prorated pay (maximum of 19.2 hours) following a death in the family. Bereavement leave must be taken within 30 calendar days of the date of the death. Time off without pay may be arranged with the supervisor or department head for an employee who wishes to attend a funeral of a relative or close friend.

2. Jury Duty: Upon completion of the introductory period, full-time and regular part-time employees are eligible for jury duty pay from the hospital. If you are called for jury duty, your department head should be notified immediately. If you are not excused from jury duty, and you have completed your introductory period, the hospital will pay the difference between the jury duty fee and your normal base salary, exclusive of differential pay, up to a maximum of 20 working days a year.

Employees are reimbursed by the court system (for mileage and jury duty fee) for each day they are called for jury duty. Although the employee is allowed to retain the mileage

Title: PAID ABSENCE	
Scope: Hospital Wide	Department: Human resources – Employee Handbook
Source: Human Resources	Effective Date:

reimbursement, the jury duty fee must be paid back to the hospital, since the hospital has already paid the employee for jury duty. The Accounting Office will assist employees in determining the amount to be reimbursed to the hospital for jury duty.

3. Other: Paid absences may be authorized on an individual basis for employees selected to participate in meetings relating to their hospital work.

Committee Approval	**Date**
Human Resources	
Administration	
Board of Directors	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Processing United States Postal Service Mail	
Scope: Admission Services	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

PURPOSE:
To provide guidance on processing Northern Inyo Healthcare District (NIHD) outgoing and incoming United States Postal Service (USPS) mail.

POLICY:
The Admission Services Department is responsible for processing all mail received from the USPS or being sent out via the USPS. FedEx and United Parcel Service transactions are handled by the Purchasing Department.

NIHD mail processing is reserved exclusively for **NIHD business mail**
- Postage may NOT be applied to any employees, patients or visitors personal mail
- Employees may not send or receive mail or packages of a personal nature through NIHD mail processing with **one** exception:
    - An employee may place a **sealed, self-stamped, letter sized envelope** in the outgoing USPS letter tray
    - No personal flats or packages *of any kind* may be put in the USPS mail lug, *even if postage has been applied.* These must be deposited in a U.S. Postal Service mailbox offsite, or taken to the Post Office on personal time.
- A patient is required to apply their own postage to disability paperwork that they leave with their doctor to complete. Postage cannot be applied to this personal mail by NIHD.
- Only trained Admission Services staff may process mail using the postal meter machine.

PROCEDURE:
Outgoing mail:
- NIHD business mail being sent via the USPS is processed in the Central Registration work area where the postal meter machine is located.
- Admission Services staff will seal (if unsealed), stamp and sort all outgoing mail into the USPS mail lug or letter tray
    - Postage may be applied **ONLY** to NIHD business related mail
    - The postal meter machine will be used to weigh and apply first class postage to all types of mail (letters, flats and parcels) both domestic and international, and to seal unsealed letter mail. Flats and packages are to be sealed by the sender.
    - *Any* type of mail that is designated by the postal meter machine as a "*package*" (when calculating the postage) requires a USPS barcode sticker to be applied to the side of or below the mailing address. This designation will show in the view window of the postal meter machine.
        Note: This sticker does not need to be applied in the case of items being sent by Certified mail, as there is already a barcode.
- Certified mail will be checked to make sure the appropriate USPS certified mail forms have been applied and the appropriate Certified postage will be applied taking into consideration:

  - Whether or not the sender requires a "Return Receipt"
  - Whether or not the Certified mail is being sent as "Restricted"
  - Whether or not the piece of mail is bendable. If it cannot be bent, postage must be calculated as if it were a "parcel" even if it is a regular envelope or a flat.
- Certified mail will be put into the USPS mail lug or letter tray to be picked up by the USPS carrier.
  - If the sender wishes to receive the *paper* Certified mail receipt which is stamped by the post office, they may take their certified mail directly to the post office
  - The return receipt *card*, if affixed to the back of the envelope, will be returned to NIHD once the certified mail has been delivered.
    - The return receipt card will be returned to the sender if the department or person is included as a part of the return address.
    - If the department or sender is not included in the return address on the return receipt card, it will be kept in the Central Registration work area for a period of 6 months, after which it will be shredded.

Incoming mail:

- Is delivered by the USPS to the Central Registration work area, Monday through Saturday excluding Federal holidays.
- Incoming mail is sorted and delivered to the NIHD mailroom with the following exception:

  No mail containing a payment may be left in the Mailroom, but must be delivered directly to an Accounts Receivable Technician.
- Mail received on Saturday is delivered to the mailroom on the following Monday, or the Tuesday following a Monday holiday.
- Refer to the attached document titled "Important Mail Routing Information" for tips on routing the mail to the appropriate location.

Downloading Postage and ordering supplies/service for the postage machine:

The Admission Services Manager or his/her designee will be responsible for:

- Down loading postage into the postal meter machine per that companies guidelines
- Notifying the Accounts Payable clerk of the amount downloaded, supplying him/her with a tape printed from the postage machine
- Ordering supplies (red ink, tape, USPS barcode stickers, and distilled water) and obtaining Certified mail stickers and cards from the Bishop Post Office for the postal meter machine.
- Arranging for service calls as necessary per the service agreement for the machine

Postage machine downtime:

If the Postage machine breaks down, the Admission Services manager will:

- Immediately arrange for a service call
- Coordinate the processing and delivery of outgoing mail

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Processing United States Postal Service Mail	
Scope: Admission Services	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

- As necessary the outgoing mail will be taken directly to the US Post Office in Bishop by either the Admission Services manager or, in his/her absence, the Admission Services Coordinator.
- Stamps are to be purchased and kept in the safe in Central Registration to be used during postage processing downtimes.
- All receipts from the USPS are to be submitted for reimbursement along with an Accounts Payable Check Request form.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. **N/A**

Approval	**Date**
Fiscal Services Managers	1/25/2017
Board of Directors	

Developed: January 2017
Reviewed: January 2017
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medicare Outpatient Observation Notice	
Scope: Admissions Services	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

PURPOSE:

To assure Northern Inyo Healthcare District's (NIHD) fulfillment of CMS's (Centers for Medicare and Medicaid) requirement for the delivery and discussion of the "Medicare Outpatient Observation Notice" (MOON), mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), August 6, 2015, to all Medicare beneficiaries when they are receiving observation services.

The MOON informs *Medicare beneficiaries* when they are receiving observation services they are an *outpatient*, not an inpatient and the financial implications of being in outpatient observation status vs. inpatient status.

POLICY:

The MOON must be delivered to beneficiaries who have Original Medicare (fee-for-service) and Medicare Advantage plan enrollees who receive outpatient observation services for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after outpatient observation services begin.

NIHD Admission Services (AS) staff will deliver the MOON to a beneficiary receiving observation services as an outpatient *before* the 24 hour mark has been reached.

The MOON is intended to inform beneficiaries who receive observation services that they are outpatients, receiving observation services, not inpatients; and the reasons for being in outpatient observation status.

The AS Staff will provide the required oral explanation of the MOON ideally in conjunction with delivery of the notice, and will obtain a signature from the beneficiary or their representative, to acknowledge receipt.

In cases where the beneficiary or their representative refuses to sign the MOON, the (AS) staff member of NIHD providing the notice will sign the notice to certify that notification was presented.

The MOON may be delivered to a beneficiary's representative if necessary

All (AS) staff will have read and have an understanding of the contents of the MOON so they are able to explain the contents and the implications of coverage/non-coverage to the beneficiary or their representative.

PROCEDURE:

- Medicare beneficiaries who are placed in outpatient observation are to have the MOON included as a part of their signature packet.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medicare Outpatient Observation Notice	
Scope: Admissions Services	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

- If the Medicare beneficiary is placed in observation from the Emergency Department (ED), the ED Admissions clerk will attempt to access the patient, prior to them leaving the ED, discuss the MOON and obtain the signature.
- If the ED Registration clerk is not able to access the Medicare patient prior to them being taken to the floor, the Inpatient/PBX Admission clerk will attempt to obtain signatures and discuss the MOON as soon as possible, either later the same day or the next business day, as applicable.
- If the Medicare patient is a direct admit to observation and they come through Central Registration, the discussion and signature will be completed and obtained during the registration process with one of the Admission staff in Central Registration.
- If the Medicare patient is a direct admit and bypasses Registration (is taken directly to the floor), the Inpatient/PBX Admission clerk will make it their responsibility to discuss the MOON and obtain the signature.

The discussion with the patient or their representative is to be tailored to the patient's current insurance situation, e. g. do they have:

- Federal Medicare - parts A and B coverage or part A only
  - Medicare with a Secondary plan
  - Medicare with a Supplement
  - Medicare with Medi-Cal
- A Medicare Advantage plan

With all of the above scenarios:

- Discussion of the MOON is to be delivered using positive language
- At the conclusion of the discussion, ask the patient and/or their representative if they have any questions about what was discussed
- Give a copy of the MOON to the patient or their representative
- The Admission clerk is to sign, date and time the MOON to indicate that they discussed the content of the MOON with the patient or patient's representative
- The completed MOON is to be scanned into the patient's EMR.

Before leaving the patient, remember to:

- Ask if there is anything else you can do for the patient
- Thank the patient

REFERENCES:

1. CMS's Interpretive Guidance

CROSS REFERENCE P&P:

1.

Approval	**Date**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medicare Outpatient Observation Notice	
Scope: Admissions Services	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

Board of Directors	

Developed:
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Charge Master Procedure for Clinics	
Scope: Outline Charge Master Process	Department: Fiscal Services
Source: Chief of Fiscal Services	Effective Date: 7/1/15

PURPOSE: Outline of Process for Charge Master Entry and Maintenance for Rural Health and Northern Inyo Associates

POLICY: Clinic Directors/Managers will work with the Fiscal Services and Information Technology Departments to establish and maintain an appropriate charge master for the clinics.

PROCEDURE:

1. Adding
    a. To add new charges code for Paragon and Centricity
        i. Chief of Fiscal Services, Billing Office Staff or the Clinic Managers will request a charge code directly from the hospital charge master program, currently Med-Assets.
        ii. The Charge Master Process will be followed according to current guidelines and an email will go to the requestor when it is approved.
        iii. The Requestor will forward the approved charge master request by email with any additional info (as needed) to the IT Helpdesk
        iv. IT Centricity Informatics will build this info into Centricity as requested and will notify requestor when available.
    b. If the Charge code Exists in the hospital information system, currently Paragon
        i. The Requestor will submit an IT Helpdesk request for this addition
            1. Must include the following info: Price/unit, description, RVU, Rev Code
        ii. IT Centricity Informatics will build this info into Centricity as requested and will notify requestor
            1. Adding to the proper Fee Schedule
2. Changing
    a. Chief of Fiscal Services, Billing Office Staff or the Clinic Managers will request a charge code Change directly from the hospital charge master program, currently Med-Assets
    b. The Charge Master Change Process will be followed and an email will go to the requestor when it is approved
    c. The Requestor will forward the approved charge master change request email with any additional info (as needed) to the IT Helpdesk
    d. IT Centricity Informatics will build this info into Centricity as requested and will notify requestor when available.

3. Inactivating Charges

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Charge Master Procedure for Clinics	
Scope: Outline Charge Master Process	Department: Fiscal Services
Source: Chief of Fiscal Services	Effective Date: 7/1/15

a. Chief of Fiscal Services, Billing Office Staff or the Clinic Managers will request a charge code to be inactivated directly from the hospital charge master program, currently Med-Assets
b. The Charge Master Change Process will be followed to change the code from active to inactive and an email will go to the requestor when it is approved
c. The Requestor will forward the approved charge master change request by email with any additional info (as needed) to the IT Helpdesk
d. IT Centricity Informatics will remove this info from Centricity as requested and will notify requestor.

REFERENCES:

1. User Guide to Med Assets
2. User Guide to Centricity

Approval	Date
Compliance Committee	n/a
Policy and Procedure Committee	7/17/15
Medical Executive Committee	
Administration	
Board of Directors	n/a

Developed: RHC & Clinic Charge Master Team
Reviewed: RHC and Clinic Charge Master Team
Revised:
Supercedes:

Responsibility for review and maintenance: Chief of Fiscal Services
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **CHARITY CARE PROGRAM**	
Scope: Hospital Wide	Department: Fiscal Services
Source: Revenue Cycle Director	Effective Date: 01/01/2007

PURPOSE:

To define the parameters of eligibility and the process of access to the charity care program mandated by California Health and Safety Code Section 127400-127446

POLICY:

Northern Inyo Healthcare District (NIHD) will provide healthcare access at no cost to individuals who are uninsured or under insured or to individuals with high medical costs. Federal Poverty Level Guidelines (FPL) for income will be the basis of eligibility for NIHD's Charity Care Program. The Notice of Available Charity/Discount Services included in this policy will be updated annually when FPL is released, using 350 percent of the government poverty income levels as the standard guideline for determination of poverty income. The following criteria will be followed for determination:

1. Eligibility criteria will be the applicant's and family's, or entire household gross income, including alimony, child support-court ordered or not, and financial support of absent parent, plus household size.
2. Income to be considered will be the applicant's or family's gross income of the last 12 months preceding the application, or gross income of the last three months preceding the application multiplied by four.
3. Monetary assets will be considered in the determination of eligibility. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.
4. Verification of the family's household income may consist of the following applicable documents determined to be sufficient based upon the applicant's current circumstances:
    a. Paycheck stubs for current three months
    b. Unemployment payment stubs
    c. Disability payment stubs
    d. Bank statements for current three months
    e. Copy of current or previous year income tax return
    f. Copy of current local social service assistance program (MediCal/CMSP) application determination
5. Should the applicant have no source of income, verification of support means, or family support may be requested.
6. All other resources of coverage will first be sought. This includes, but is not limited to, any available local social service assistance program such as Medi-Cal, CMSP (County Medicaid Service Program) and CCS (California Children's Services); Medicare; Insurance; employer provided or offered health plan; other available third party sources; and/or participating in the Affordable Care Act, making application for health plans.
    a. Individuals without insurance will be assisted in following the Affordable Care Act, participating in "Open Enrollment" to access affordable health insurance with potential government subsidy if they have not yet completed this process.
    b. Written denial is required for applicants not eligible for assistance through their local department of social services.

c. Should an applicant be eligible for MediCal or CMSP with a Share of Cost, the applicant may still be entitled to the Charity Care Program to assist with meeting Share of Cost responsibilities. Once their Share of Cost is satisfied, the applicant's MediCal or CMSP will be accepted as payment for covered services.
d. Failure to comply with timely application for local social service assistance programs, or failure to complete application for available local social service assistance programs may be a basis for denial of the NIHD Charity Care Program.

7. To sustain eligibility, NIHD Charity Care recipients will be required to submit a new Charity Care application every twelve months, including new application to available local social service assistance programs.
8. If any information given proves to be untrue, NIHD may re-evaluate the application and take whatever action becomes appropriate.
9. Effort to identify patient's qualification for NIHD Charity Care Program will be initiated as early as possible but will not be criteria of determination.
10. Conditional qualification may be made in cases where eligibility for other available assistance programs such as MediCal or CMSP has not yet been determined.
11. Individuals who do not respond to notices of Charity or Discount services, and who do not respond to billings and collection efforts and are subsequently assigned to an outside collection agency may not be considered for NIHD's Charity Care program.
12. Patients who are denied Charity Care based upon their income may become subsequently approved should their income change following their original determination based on additional supplied information. Subsequent determinations will not result in a refund of prior payments.
13. Effect of the determination of eligibility will not be open-ended, but may remain in effect to cover future scheduled services.
14. Upon discharge of service, uninsured patients will be offered the local county application for medical assistance program(s) and an application for the Healthy Families Program.
15. Included in the initial billing (patient statement) of the uninsured individuals, will be the NORTHERN INYO HEALTHCARE DISTRICT REQUEST FOR HEALTH COVERAGE INFORMATION / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF OTHER COVERAGE PROGRAMS / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF AVAILABLE CHARITY/DISCOUNT SERVICES (included in this policy).
16. Notices of NIHD's Charity Care & Discount Payment Program will be posted in all patient care areas, waiting rooms and reception areas as well as the Credit (payment) and Billing Information Office. This will include the Rural Health Clinic and all Northern Inyo Associates Offices.
17. Applications for the NIHD Charity Care Services will be available through Northern Inyo Healthcare District Administration, Social Services Department, and the Credit and Billing Information Office.
    a. The application will include the patient's or applicant's complete name; address; telephone number; social security number; employer; family size; income as described above; service rendered/requested; date of service; applicant's signature; and space for eligibility determination.
18. The Credit & Billing Information Staff will process complete applications within ten (10) business days.
19. The applicant will be sent a final determination by the US mail.

REQUEST FOR HEALTH COVERAGE INFORMATION

NOTICE OF OTHER COVERAGE PROGRAMS

NOTICE OF AVAILABLE CHARITY/DISCOUNT SERVICES

When you presented for your recent services, it appeared that you may not have health insurance or other coverage. If this is incorrect, please contact our Credit and Billing Information office at (760) 873-2190 at your earliest convenience to provide us with your coverage information.

If you do not have health insurance coverage, or other coverage, you may be eligible for Medicare, Healthy Families, MediCal, CMSP, or CCS.

You may contact our Credit and Billing Information office at (760) 873-2190 or your local Social Services office for an application for MediCal, CMSP, or the Healthy Families Program.

You may obtain information from the Social Security Office regarding Medicare benefits or your local county Health Department regarding CCS benefits.

It is the policy of the Northern Inyo County Local Healthcare District to provide a reasonable amount of care without, or below charge to people who are uninsured or under insured, or an individual with high medical costs. Individuals within the annual income requirements established below may be eligible to receive free medical care.

Size of Family Unit	Poverty Income Guidelines
1	$ 42,210
2	$ 56,840
3	$ 71,470
4	$ 86,100
5	$ 100,730
6	$115,360
7	$129,990
8	$144,620

For family units with more than eight members, add $14,630 for each additional member.

If you believe you may be eligible, or if you would like more information or an application, contact the Credit and Billing Information Office, Monday – Friday 8:30a.m.- 4:30p.m. Telephone: (760) 873-2190.

Approval	Date
Board of Directors	
Revenue Cycle Director	02/01/2017
Fiscal Services Management Team	02/01/2017

Revised 02/2017
Reviewed 02/2017
Supercedes 12/2007

Radiology Services

EXHIBIT A

SPECIALTIES; WORK LOCATION; WORK SCHEDULE; ETC.

Specialties (if none, so indicate): Radiology

Full-Time Practice Group will provide either directly or through contracted services radiologic coverage 24/7/365

1) Work Location: Northern Inyo Healthcare District

2) Work Schedule: Onsite 7A-430P Mon-Fri; 430P-11P Mon-Fri and all day Sat &Sun onsite procedures as needed

Minimum Performance Standards (if any): Please see RFP

On-Call Coverage Schedule: 430P-7A direct or contracted radiology reading services

Additional Duties (if any): 1) To participate in activities and committees as required by the bylaws of the medical staff of NIH to include Medical Director appointment and Radiation Safety Officer appointment; participate in the Quality Assessment and Performance Improvement activities of NIH as well as meet the requirements of Meaningful Use and code patient visits and procedures for billing purposes in a timely fashion.

2) Radiology Medical Director Services

3) Radiation Safety Officer

EXHIBIT B

COMPENSATION

Base Compensation:

Year 1-	$1,000,000 to be paid in equal monthly alottments per hospital policy
Year 2-	$1,000,012 to be paid in equal monthly alottments per hospital policy
Year 3-	$1,000,024 to be paid in equal monthly alottments per hospital policy

Fringe Benefits: None

COMPLIANCE PROGRAM
FOR
NORTHERN INYO HEALTHCARE DISTRICT

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COMPLIANCE PROGRAM
FOR
NORTHERN INYO HEALTHCARE DISTRICT

INTRODUCTION

It is the fundamental policy of NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "NIHD" or "the District"), that quality patient care and governance is provided by the District, its governing board, medical staff, employees and affiliates, in a manner that fully complies with all applicable state and federal laws, and that all of the District's business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, all other applicable state and local laws and ordinances, and the ethical standards and practices of the medical profession, the health care industry and this organization.

There is significant concern about "waste, fraud and abuse" in healthcare. In light of this, the Office of the Inspector General (OIG) has issued a document entitled "Compliance Program Guidance for Hospitals." The OIG has recommended that an effective compliance program should contain the following seven elements:

> ***1.*** *The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Company's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;*
>
> ***2****. The designation of a compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;*
>
> ***3****. The development and implementation of regular, effective education and training programs for all affected employees;*
>
> ***4.*** *The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;*
>
> ***5.*** *The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;*
>
> ***6.*** *The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and*
>
> ***7.*** *The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.*

This Compliance Program outlines the process NIHD will utilize to assure that it is in compliance with all the various laws and regulations established by both the Federal government as well as the State of California.

COMPLIANCE PROGRAM
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This Compliance Program (the "Program") is intended as a guide to help implement this policy of compliance with all applicable standards. The federal, state, and local laws, regulations, and ethical rules that govern health care are too numerous to list in the Program. Fundamentally, all individuals associated with NIHD by employment, contract or otherwise, are expected to conduct all business activities honestly and fairly. Each employee or contractor is responsible for his or her own conduct in complying with the Program.

The Program provides for the designation of a Compliance Officer who has ultimate responsibility and accountability for directing, monitoring, and reporting on compliance matters. The Compliance Officer shall implement and administer this Program, together with training and education as necessary to affect the full participation of District governing board, medical staff, employees, affiliates, and other agents.

This Program provides a framework for individual or departmental compliance efforts, and applies to all District Personnel and activities. However, each individual employee or agent of the District remains responsible and accountable for his or her own compliance with applicable laws, regulations, standards, policies, and procedures.

The Program identifies those organizational imperatives necessary to prevent accidental and intentional non-compliance with applicable laws. It is further designed to detect non-compliance should it occur. Additionally, it is designed to promote such steps as are necessary to prevent future non-compliance, including education and corrective action.

Northern Inyo Healthcare District is committed to maintaining in the community a positive reputation for conduct in accordance with the highest levels of business ethics. This Program supports that objective. The Program fully supports the NIHD mission: Improving our communities, one life at a time. One team. One goal. Your health!

SECTION 1 — COMPLIANCE PROGRAM SUMMARY

Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Affiliate"** means any person or entity controlled by, or under common control with, Northern Inyo Healthcare District.
- **"District"** means Northern Inyo Healthcare District, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all members of the governing board, medical staff, employees of the District, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of District Compliance Program and a Conflict of Interest Questionnaire Form.
- **"Board"** means the Board of Directors of the District.

COMPLIANCE PROGRAM
FOR
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Purpose of this Compliance Program

Northern Inyo Healthcare District is committed to ensuring compliance with all applicable statutes, regulations, and policies governing our daily business activities. To that end, the District will have a Compliance Program. The document is to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. Additionally this Compliance Program is to serve as a mechanism for preventing violations and for reporting any violation in a manner that protects those that identify and report the lack of compliance with those laws.

While this Compliance Program contains policies regarding the business of Northern Inyo Healthcare District, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. Northern Inyo Healthcare District maintains other policies with which employees are required to comply. If you have questions about which policies apply to you, please ask your supervisor.

It is the policy of the District that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of retribution; and
- Mechanisms exist to investigate and take corrective actions in the event of noncompliance.

Who is Affected

Everyone employed by Northern Inyo Healthcare District is required to comply with our Compliance Program. Because not all sections will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

Please note that compliance requirements are subject to change as a result of new laws and changes to existing laws and regulations. Collectively, we must all keep this Compliance Program current and useful. Therefore, you are encouraged to let the Compliance Officer or your supervisor know when you become aware of changes in law or District policy that might affect this Compliance Program.

How to Use This Compliance Program

The District has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this manual is organized follows.

COMPLIANCE PROGRAM
FOR
NORTHERN INYO HEALTHCARE DISTRICT

1. **Section I – Compliance Program Summary**

2. **Section II – Code of Conduct**

This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism, and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

3. **Section III – Compliance Program Systems and Processes**

This section explains the roles of the Compliance Officer and the Compliance and Business Ethics Committee. It also contains information about Compliance Program education and training, auditing, and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Compliance Confidential Report Line at 1-888-200-9764 or by emailing the Compliance Officer directly. All Personnel will receive training on this section.

4. **Section IV – Compliance Policies**

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Here are some tips on how to use this Compliance Program effectively:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to locate the topic you are looking for quickly.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that you can refer to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The District has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.
- **Keep it Handy.** Keep this Compliance Program information easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are applied uniformly. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

SECTION II – CODE OF CONDUCT

COMPLIANCE PROGRAM
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Our Compliance Mission

The mission of Northern Inyo Healthcare District's Compliance Department is to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

Northern Inyo Healthcare District believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. This Code of Conduct is a critical component of the overall District Compliance Program. It guides and assists the District in carrying out daily activities in accordance with appropriate ethical and legal standards. These obligations apply to the District's relationship with patients, affiliated physicians, third-party payers, regulatory agencies, subcontractors, contractors, vendors, consultants, and one another. They require that all program participants comply with all applicable federal, state and local laws and regulations. Participants must also comply with all Northern Inyo Healthcare District Standards of Conduct. The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

Compliance with Laws

It is the policy of the District, its affiliates, contractors, and employees to comply with all applicable laws. When the application of the law is uncertain, the District will seek guidance from legal counsel.

Open Communication

The District encourages open lines of communication among Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the District's attention. Your supervisor is the best place to start, but you can also contact the District's Compliance Officer or call the Compliance Confidential Report Line (1-888-200-9764) to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The District does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

Your Personal Conduct

The District's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the District. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty, trust, and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say that the District's integrity and reputation are in your hands.

The District's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the District, the District may be required to take corrective action.

The Work Environment

The District strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately address and report to your supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, or other factors that are unrelated to the District's legitimate business interests. The District will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the District, either by informing your supervisor, the District's Compliance Officer, or by calling the Compliance Confidential Report Line (1-888-200-9764). The District considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type on the premises, except for exempt or authorized Personnel;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale, or possession of illegal drugs or any other controlled substances, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the District premises or in the District work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

Employee Privacy

The District collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the District or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the District's Personnel policies or practices.

Use of District Property

District equipment, systems, facilities, corporate charge cards, and supplies must be used only for conducting District business or for purposes authorized by management.

Personal items, messages, or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, workspaces, desks, credenzas, or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on District equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at District work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use District supplies for personal use.

Use of District Computers

The increasing reliance placed on computer systems, internal information, and communications facilities in carrying out District business makes it absolutely essential to ensure their integrity. Like other District assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting District business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of District assets.

While the District conducts audits to help ensure that District systems, networks, and databases are being used properly, it is your responsibility to make sure that each use you make of any District system is authorized and proper.

Personnel are not allowed to load or download software or data onto District computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use District e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on District premises or computer, information, or communication systems.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with District services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; District business and product

plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the District industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The District alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the District considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the District.

Inadvertent Disclosure
The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information that has not been made public by the District. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized District employees if you are in the presence of others who are not authorized — for example, at a meeting, conference or in a public area. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

Direct Requests for Information
If someone outside the District asks you questions about the District or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the District. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information, or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the District's business, you should refer the request to the office of the District's Chief Executive Officer or Compliance Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the District or the industry, direct the person to your supervisor.

Disclosure and Use of District Proprietary Information
Besides your obligation not to disclose any District proprietary information to anyone outside the District, you are also required to use such information only in connection with the District's business. These obligations apply whether or not you developed the information yourself.

Proprietary and Competitive Information about Others
In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other Districts and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from District patients is prohibited.

The District will not tolerate any form of questionable intelligence gathering.

Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the District (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the District is also strictly prohibited and could lead to civil or even criminal liability for you and the District. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the District.

Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

Gifts and Entertainment

The District understands that vendors and others doing business with the District may wish to provide gifts, promotional items, or entertainment to District Personnel as part of such vendors' own marketing activities. The District also understands that there may be occasions where the District may wish to provide reasonable business gifts to promote the District's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

General Policy

It is the general policy of the District that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting District business. It is the intent of the District that this policy be construed broadly such that all business transactions with vendors, contractors, and other third parties are transacted to avoid even the appearance of improper activity. Pharmaceutical samples provided to physicians by manufacturers for patient use are generally allowed. Please discuss any concerns with the Compliance Officer or District legal counsel.

Spending Limits — Gifts, Dining and Entertainment

The District has developed policies that clearly define the spending limits permitted for items such as gifts, dining, and entertainment. Occasional gifts from vendors, of nominal value (less than $10), that do not influence or appear to influence the objective judgment of personnel, such as sales promotional items (an inexpensive pen), or business related meal or snack for a department are permitted with approval. All Personnel are strictly prohibited from making any expenditure of District or personal funds for gifts, dining or entertainment in any way related to

District business, unless such expenditures are made in strict accordance with District policies.

Marketing and Promotions in Health Care

As a provider of health care services, the marketing and promotional activities of the District may be subject to anti-kickback and other laws that specifically apply to the health care industry. The District has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the District that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the District.

Marketing

The District has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Parts of those efforts involve advertising, marketing, and other promotional activities. While such activities are important to the success of the District, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the District closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with District objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the District. In addition to those policies, it is the general policy of the District that no Personnel engage in any advertising, marketing, or other promotional activities on behalf of the District unless such activities are approved in advance by the appropriate District representative. You should ask your supervisor to determine the appropriate District representative to contact. In addition, no advertising, marketing or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the District's Chief Executive Officer, Compliance Officer, or legal counsel.

All content posted on Internet websites maintained by the District must be approved in advance by the District's Compliance Officer or legal counsel.

Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the District's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the District's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the District's current or potential services or products. You may not, without prior consent, work for such an organization as an employee (including working through a registry or "moonlighting" and picking up shifts at other health care facilities), independent contractor, a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the District and that organization. While many of these activities are approved with a management plan or Non-Disclosure agreement, failure to obtain prior consent in advance from the District's Compliance Officer or legal counsel may be grounds for corrective action, up to and including termination.

Outside Employment and Business Interests
You are not permitted to work on any personal business venture on the District premises or while working on District time. In addition, you are not permitted to use District equipment, telephones, computers, materials, resources, or proprietary information for any business unrelated to District business. You must abstain from any decision or discussion affecting the District when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the District's Compliance Officer or legal counsel.

Contracting with the District
You may not contract with the District to be a supplier, to represent a supplier to the District, or to work for a supplier to the District while you are an employee of the District. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the District.

Required Standards
All decisions and transactions undertaken by Personnel in the conduct of the District's business must be made in a manner that promotes the best interests of the District, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed elsewhere in the Compliance Program.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.
2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the District. There are two types of significant financial interests:

a. Receipt of anything of monetary value from a single source. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and

b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.

3. Personnel must disclose any activity, relationship, or interest that may be perceived to be a conflict of interest so that these activities, relationships, and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the District. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community, or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the District.
5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the District. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation, or entertainment from vendors, contractors, or other third parties that have current or prospective business with the District. Questions regarding the gifts should be directed to the District's Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the District work environment and shall be kept separate and distinct from the District's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the District, the use of any of the District's equipment, supplies, or property, or any direct relationship with the District's business or operation. Certain emergency situations may require collaboration with suppliers, vendors, or other healthcare organizations. Disclosure and approval by Chief Executive Officer, Compliance Officer, or legal counsel at an appropriate time would further clarify compliance; however, nothing in this Program should be interpreted as interfering with the provision of high quality, efficient patient care in a legally compliant manner. Questions should be directed to the District's Compliance Officer.
8. Personnel must guard patient and District information against improper access, disclosure, or use by unauthorized individuals.
9. The District's materials, products, designs, plans, ideas, and data are the property of the District and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid even the appearance of impropriety when dealing with clinicians and referral sources.

11. All vendors and contractors who have or desire business relationships with the District must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the District must report these to their supervisor, manager, the District Compliance Officer, or by using the Confidential Compliance Report Line (1-888-200-9764).
12. Personnel shall not sell any merchandise on District premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the District, whether on or off District premises, unless prior approval is obtained from the District's Compliance Officer.
13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the District's Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the District's Compliance Officer.

Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Questionnaire Form within 90 days of being subject to this Compliance Program (that is, being hired by the District, beginning to volunteer at the District, or assuming any responsibilities at the District). At least annually thereafter, you must review this Compliance Program and Conflict of Interest Questionnaire. You are required to file a Conflict of Interest Questionnaire Form annually, and when there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your questionnaire form and contact the District's Compliance Officer. It is your responsibility to report promptly any actual or potential conflicts.

All questionnaire forms must be sent to the District's Compliance Officer. The Compliance Officer will review all disclosures and determine which disclosures require further action. The Compliance Officer will consult with the Business Compliance Team if an actual or perceived conflict of interest may exist. The District's Chief Executive Officer or legal counsel may be consulted as needed to determine if further action is required. The outcome of these consultations will result in a written determination stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest, which may include that:

1. The conflict of interest is not significant and is generally permissible;
2. The activity may represent a potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure with a Management Plan or Non-Disclosure Agreement;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest;
4. The activity represents an actual conflict of interest which may be permitted to go

forward after disclosure with an appropriate Management Plan or Non-Disclosure Agreement to eliminate the conflict, safeguard against prejudice toward Northern Inyo Healthcare District activities, and provide continuing oversight; or

5. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Compliance Officer, or designee, will review any written determination with you and discuss any necessary action you are to take.

Anti-Competitive Activities

If you work in sales or marketing, the District asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other Districts, hospitals, and health facilities.)

Reporting Violations

The District supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies, or this Code of Conduct.

The District has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the District Compliance Program, including this Code of Conduct, must report the improper conduct to the District's Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

District policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the District that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to corrective action, if after an investigation the District reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts either to cause harm to someone else or to protect or benefit himself or herself.

Additional, detailed information may be found in the NIHD Code of Business Ethics and Conduct.

SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the District has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the District has established for the purpose of providing structure and support to the Compliance Program.

COMPLIANCE PROGRAM
FOR
NORTHERN INYO HEALTHCARE DISTRICT

Compliance Officers and Committee

Compliance Officer

The District has a Compliance Officer who serves as the primary supervisor of this Compliance Program. The District's Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the District at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for oversight of the work of the Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the District's compliance efforts and takes any appropriate and necessary actions to ensure that the District conducts its activities in compliance with the law and sound business ethics.

The Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

Responsibilities of the Compliance Officer

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than annually) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the District's risk of fraud, waste, and abuse.
- Periodically revising the Compliance Program in light of changes in the needs of the District and changes in applicable statutes, regulations, and government policies.
- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the Program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the District are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the District have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any

other federal or state heath care program.

- Ensuring that the District does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as quality improvement, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel.

Compliance and Business Ethics Committee
The District has established a Compliance and Business Ethics Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance and Business Ethics Committee (CBEC) provides the perspectives of individuals with diverse knowledge and responsibilities within the District.

Members of the Compliance and Business Ethics Committee
The Compliance and Business Ethics Committee consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Information Security Representative
- Medical Staff Representative
- Chief Human Resources Officer
- Chief Performance Excellence Officer/Risk Manager

- As appropriate, a member of the Board of Directors, Health Information Management Director, Chief Nursing Officer, or department designee from Emergency, Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

The Board of Directors' representative to the CBEC shall be appointed by the full Board of Directors. The Board of Directors' representative shall meet the following qualifications prior to consideration for appointment:

- Completion of ethics and governance training as required by AB1234; and,
- Attended an Association of California Healthcare District (ACHD) Leadership Academy within past two years; and,
- Has completed and filed CA Form 700; and,
- NIHD Conflict of Interest for Members of the Board of Directors has been completed, returned, and reviewed by the Business Compliance Team.

Each member of the CBEC shall sign a Non-Disclosure Agreement (NDA).

Functions of the Compliance and Business Ethics Committee
The Compliance and Business Ethics Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Compliance Officer to develop standards of conduct and policies to promote compliance.
- Development on Annual Compliance Department Work Plan and Audit Plan, including review and re-prioritizing as necessary
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate, and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance and Business Ethics Committee work.
- Consulting with vendors of the District on a periodic basis to promote adherence to

this Compliance Program as it applies to those vendors and to promote their development of formal Compliance Programs.

The tasks listed above are not intended to be exhaustive. The CBEC may also address other compliance-related matters as determined by the Compliance Officer.

The CBEC may, from time to time, create one or more sub-committees which shall have that authority specifically designated thereto. Each sub-committee shall answer directly to the respective Compliance and Business Ethics Committee.

The District has established a Billing, Coding, and Compliance Committee (BCCC), which is a sub-committee of the Compliance and Business Ethics Committee, to advise the Compliance Officer and assist in monitoring of billing, coding, and revenue cycle management. The Billing, Coding, and Compliance Committee shall be renamed the Billing and Coding Compliance Subcommittee (BCCS).

The District has established a Business Compliance Team (BCT) to assist the Compliance Officer in appropriate determinations and plans of action for reported, actual, or perceived conflicts of interest. The Business Compliance Team is a subcommittee of the CBEC.

Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all District employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the District with the opportunity to take corrective action.

Training and Education

The District acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the District requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by

the District for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at a minimum the identification of the Personnel participating in the training, the subject matter of the training, the time and date of the training, the training materials used, and any other relevant information.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the District's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the District's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the District's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is

a factor in the annual evaluation of each District employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs to complement the District's standards of conduct and compliance policies. The Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The District expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

Lines of Communicating and Reporting

Open Door Policy

The District recognizes that clear and open lines of communication between the Compliance Officer and District Personnel are important to the success of this Compliance Program. The District maintains an open door policy in regards to all Compliance Program related matters. District Personnel are encouraged to seek clarification from the Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The District has established a telephone hotline for use by District Personnel to report concerns or possible wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Confidential Report Line."

The Compliance Confidential Report Line contact number is:

Phone: 1-888-200-9764

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

Compliance Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

The Compliance Confidential Report Line number and the Compliance Officer's contact information are posted in conspicuous locations throughout the District's facilities.

All calls to the Compliance Confidential Report Line are treated confidentially and are not traced. The caller need not provide his or her name. The District's Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Confidential Report Line and letters mailed to the Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that

governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Confidential Report Line or in writing that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A log is maintained by the Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the District's Governing Board and Chief Executive Officer.

Non-Retaliation Policy
It is the District's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, District Personnel cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

Enforcing Standards and Policies

Policies
It is the policy of the District to use appropriate corrective action with District Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with applicable laws, will also result in sanctions.
- Corrective action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in corrective action.

Because the District takes compliance seriously, the District will respond to Personnel misconduct.

Corrective Action Procedures
Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the District. Any such discipline is within the sole discretion of the District. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Compliance Officer.

Upon determining that an employee of the District or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to

review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Compliance Officer during the investigation of the violation. Legal counsel may be consulted prior to final actions or disciplinary measures, as appropriate.

Auditing and Monitoring

The District conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Compliance Officer.

The Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the District, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the District's billing system), reimbursement, and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The District shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the District Personnel.
- Reviews of all billing documentation, including medical and financial records and other source documents, that support claims for reimbursement and claims submissions.
- Presentations of a written report on compliance activities to the Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the District shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

Corrective Action

Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the District's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the District's business and reputation, and can lead to serious sanctions against the District. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation with legal counsel.

Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Compliance Officer to assist in an investigation where the Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

Reporting

If the Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state

law enforcement agency having jurisdiction over such matter. Such reports will be made by the Compliance Officer on a timely basis.

All overpayments identified by the District shall be promptly disclosed and/or refunded to the appropriate public or private payer or other entity.

SECTION IV – COMPLIANCE POLICIES

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Approval	**Date**
Compliance Officer	2/3/2017
Board of Directors	

Effective date: 2/20/2017
Developed: 09/2016
Reviewed: 09/2016
Revised: 2/3/2017
Index:

Diet Manual

Northern Inyo Hospital

2015

Prepared by:

RDs for Healthcare, Inc.

1420 W. Kettleman Ln. N-5
Lodi, CA 95242
(209) 333-2115

APPROVAL

This manual has been evaluated and approved by the Patient care Policy Committee of

_____ _____

Facility Date

_____ _____M.D.

Dietitian Signature Medical Director Signature

YEARLY REVIEWS:

Date:_____Dietitian:_____Medical Director:_____

Date:_____Dietitian:_____Medical Director:_____

Date: _____ Dietitian:_____Medical Director:_____

Date:_____Dietitian:_____Medical Director:_____

Date:_____ Dietitian:_____ Medical Director:_____

RDs for Healthcare, Inc. - 2015

2015 Diet Manual
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RDs for Healthcare, Inc.- 5/2015

2015 Diet Manual
Addendum Diets
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RDs for HEALTHCARE, INC. INTRODUCES:

A DIET MANUAL DESIGNED TO MEET THE SPECIFIC NEEDS OF ACUTE CARE AND INTERMEDIARY CARE FACILITIES

OBJECTIVES

1. To provide a realistic approach to diets in order to make them adaptable and flexible to the individual needs and cultural backgrounds of the patients and residents.

2. To meet the most recent Recommended Dietary Allowances. The RDA's were used as a basis for determining the adequacy of the diets. It must be recognized that these allowances were developed for the maintenance of good nutrition in healthy individuals. A patient or resident may require more or less of these nutrients.

3. To have a common language of communication among dietary, nursing, physicians, residents and their families.

REGULAR DIET

DESCRIPTION:

The regular diet is designed to meet the nutritional needs of residents who do not need dietary modification or restrictions. Individual preferences or intolerances may necessitate the exclusion of certain food items.

NUTRITIONAL BREAKDOWN:
Calories- 2100-2400
Protein- 90 - 105 grams
Fat- 95-110 grams
Carbohydrate- 230-250 grams

RDA: This diet is adequate for all age groups and genders except for the following nutrient: Vitamin D. 10µg (mcg) is provided in the regular diet.

Variety in food selection is the key to good nutrition. Menu planning should reflect a wide selection of foods from the basic groups in accordance with resident preferences, cultural and religious practices and social activities. Holiday and special occasion menus should include traditional foods. Include food from each of the four general food groups every day.

1. MEAT 2. MILK 3. FRUITS AND VEGETABLES 4. BREADS AND CEREALS

MEAT GROUP

6 ounces of cooked meat or the equivalent each day.

- It is recommended to serve some food from this group at every meal (1 ounce for breakfast, 3 ounces for lunch and 2 ounces for dinner)
- Meat, fish, poultry is equal to one ounce after cooking, without bone or fat.
- One egg, ½ cup cooked dried beans, peas or lentils, 2 Tablespoons of peanut butter, ¼ cup cottage cheese, or 1 ounce hard cheese equals one ounce of meat.
- If textured vegetable protein is used, it may be added proportionately as follows; One-third hydrated soy to two-thirds of meat.

MILK GROUP

16 ounces of milk each day with meals. Whole milk is used in the above nutritional breakdown.

- All kinds of milk- fluid whole, low-fat, fat free, evaporated, buttermilk or dry milk are included.
- Non-fat dry milk may be used only for cooking purposes or to fortify (add to) a glass of milk, soup, etc.
- Cheese, ice cream and yogurt may be used in place of part of the milk as follows:
  1 ounce cheese= 2/3 cup milk
  ½ cup cottage cheese= 1/3 cup milk
  ½ cup ice cream = ¼ cup milk
  ½ cup yogurt = ½ cup milk

Every patient or resident should be encouraged to drink some milk or milk beverage daily. Persons who cannot tolerate milk as a beverage due to lactose intolerance may find that soy milk, buttermilk, yogurt, and ripened cheeses are excellent alternatives or that fluid milk in smaller quantities is acceptable. Ready to use, lactose reduced dairy products, are available. If fluid milk is not consumed, other sources of vitamin D and calcium should be given. Vitamin D is obtained from egg yolks, liver, fortified dry cereals, tuna and regular exposure to sunlight. Calcium supplements may be indicated if milk products are totally excluded from the diet.

FRUIT AND VEGETABLE GROUP

Five or more servings daily. Encourage raw fruits, raw vegetables and dried beans.

- A serving is ½ cup of fruit or cooked vegetable, or a portion as ordinarily served; such as one medium orange, banana, potato or tomato; or half a medium grapefruit; or ¼ cantaloupe.
- Include on the menus citrus fruit such as an orange, grapefruit, tangerine or other food source of Vitamin C such as strawberries, cantaloupe, broccoli, Brussels sprouts, raw cabbage, green pepper, kiwifruit, spinach or tomato.
- One serving of 50% juice will account for ½ serving of this group.
- A serving is 1 cup raw leafy vegetable or ½ cup chopped raw vegetable.
- A deep green leafy or deep yellow vegetable such as spinach, winter and acorn squash, tomato, leaf lettuce, carrot, sweet potato, greens, broccoli, Brussels sprouts, asparagus, bok choy, or pumpkin will be served 4 times per week to provide Vitamin A (at least every other day)
- A serving, ½ cup cooked of legumes, lentils, split peas, 3 or more times a week.

BREADS AND CEREAL GROUP

Four or more servings daily, primarily using whole grain cereal products.

- A serving is one slice of bread, one ounce or ¾ cup ready to eat cereal, 4 crackers, ½ cup cooked cereal, rice, pasta or noodles, etc.
- All cereal products served should be whole grain, enriched, or fortified.

FLUIDS

At least 1,000cc visible fluids will be served from the dietary department per resident unless the diet contraindicates this. This will include milk, juice, coffee, etc. as the resident desires.

Standard will be:
Breakfast: 8oz milk+ 4oz juice, 6-8 ounce coffee, tea, **or** water, etc.(18-20 oz= 540-600cc)
Lunch: 4oz milk+ 6-8 oz of juice, coffee, tea, **or** water, etc. (10-12 oz=300-360cc)
Dinner: 4oz milk+ 6-8 oz of juice, coffee, tea, **or** water, etc. (10-12 oz=300-360cc)
In addition, the food itself provides approximately 800-1200cc fluid (in solid food, soup, ice cream, puddings, etc)

SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH	DINNER	HS SNACK
4 oz Orange Juice	3 oz Roast Beef	8 oz Navy Bean Soup	4 oz Milk
6 oz Oatmeal	½ c. Mashed Potatoes	Chicken Salad (2oz meat)	2 Graham Crackers
1 Poached Egg	Gravy 1-2 oz	Sandwich	
1 Slice Wheat Toast	½ c. Fresh Broccoli	Pickle Garnish	
1 tsp. Margarine	Wheat Roll	½ cup Cantaloupe	(assure a snack
8oz Milk	1 tsp. Margarine	1 Pkg. Saltine Crackers	of nutritional
8 oz Coffee	1/8 Lemon Pie	8 oz Ice Tea	value is routinely
2 Sugar Pkg.	8 oz Punch or Water	1 Sugar Pkg.	offered)
Salt and Pepper Pkg.	4 oz Milk	4 oz Milk	
	Salt and Pepper Pkg.	Salt and Pepper Pkg.	

IODIZED SALT: Iodized salt will be used (unless contraindicated)

ADDITIONAL FOODS:

An adequate number of additional foods should be offered to meet calorie needs. This group includes sugars, margarine, fats or oils. These foods help to meet caloric needs but are generally poor sources of other nutrients. Salt and pepper packets offered all meals unless contraindicated on the diet.

SMALL PORTIONS:

Observe the four food groups. Serve a minimum of 5 ounces meat/protein, 20 ounces of milk, four servings of fruits and vegetables and four servings of breads and cereals per day. With minimum amounts of the four food groups, the added sugar and added fat will automatically be limited. Calories will equal about 1600-1900 calories per day, 80-90 gms protein and 190-205 gms carbohydrates. If a resident requests smaller portions than are specified on the "small portion" menu, the dietitian should be consulted. A multivitamin with minerals is recommended because small portions do not meet all RDAs of vitamins & minerals.

LARGE PORTIONS:

Follow the regular diet. Increase calories by adding food from the milk, meat, bread and cereal groups. Addition of these foods will increase the sugars and fats in the diet. Calories will equal about 2500-2800 calories per day, 120-130 gms protein, and 295-315 gms carbohydrates. If a resident requests larger portions than are specified on the menu, increase the specific food the resident enjoys.

REGULAR DIET - FINGER FOODS

DESCRIPTION: The Finger Foods Diet is a Regular Diet that provides food in appropriate size, texture and shape to be eaten without utensils but rather with the fingers. Indications for use are Alzheimers Disease, inadequate digital dexterity to operate utensils, and Dementia. This diet may be adapted for the mechanical soft diet by the dietitian.

RDA: This diet is adequate for all age groups and genders except for the following nutrients: Vitamin D - 10 µg(mcg) is provided in the finger food diet.
Magnesium - approx. 395mg is provided in the finger food diet.

Examples of Foods:

Protein Foods	Starches	Vegetables	Fruits	Dessert
Beef Strips	Biscuits	Broccoli Florets	Apple Wedges	Bar Cookies
Cheese	Bread	Carrot Coins	Banana	Cookies
Chicken Nuggets	Chips	Carrot Sticks (Can be slightly blanched	Dried Fruit	Cream Puff
Chicken Strips	Crackers	Cauliflower Florets	Figs	Cupcake or Cake
Egg Rolls	French Fries	Corn on the Cob	Fresh Berries	Éclair
Fish Sticks/ Nuggets	Large Pasta	Cucumber Slices	Fresh Peach Sections	Firm Gelatin Squares
Hamburger	Muffins	Cut Green Beans	Melon Slices	Fruit Turnover
Hard Boiled Egg	Pancake	Lettuce/leafy	Nectarine Sections	Graham Crackers
Lunch Meats	Potato Wedges	Lettuce/ Wedge	Orange Sections	Ice Cream Bar
Pizza	Rolls	Spinach*	Plum	Popsicles
Sandwiches	Tator Tots	Tomato Wedges/slices	Drained Canned Fruit	
Turkey Strips	Tortilla	Zucchini Sticks		

*Important to keep spinach in the diet for the nutritional value

Suggestions:

Adaptive equipment such as plate guards, sippy cups, divided plates, soup bowls, mugs or cups with one or two handles.

Soup and hot cereal should be served in a cup or mug with a handle.

Cut food in bite-size pieces, (approximately 1") in wedges/slices, or serve in a sandwich, which is cut in four triangles or quarters.

Hard-boiled eggs can be sliced, wedges, or served in a sandwich.

Choose thick, large pasta such as tortellini, penne, rotini, or bowties that are easy to pick up.

Serve gravy, syrup, sauces, salad dressings and other condiments in small cups for dipping.

Serve buttered toast, muffins and biscuits, etc.

SAMPLE MEAL PATTERN

Breakfast:
4 oz. Pineapple Juice
3/4 cup Hot Cereal in a mug/cup
1 Slice Toast with Margarine
1 Hard Boiled Egg Sliced
8 oz. Milk and 8 oz. Coffee

Lunch:
6 Chicken Nuggets
½ c Tater Tots
½ c Broccoli Florets
1 Dinner Roll with 1tsp Marg.
1 Cupcake
4 oz Milk and 8 oz Ice Tea

Dinner:
8 oz Cream of Celery Soup in cup/mug
1 Ham Sandwich cut in 4 Triangles
½ c Partially Cooked Carrot Sticks or Coins
1 oz Ranch Dressing in a Small Soufflé Cup
½ c Orange Sections
4 oz Milk and 8 oz Juice

VEGETARIAN DIET

DESCRIPTION:

The Academy of Nutrition & Dietetics recognizes that well planned vegetarian diets are consistent with good nutritional status. A careful diet history is needed to ensure healthy food practices and the correct type of vegetarian diet. Diet orders need to clarify the correct category.

NUTRITIONAL BREAKDOWN:

Calories 2000-2250

Protein 78-85 gms

Fat 100-105gms

Carbohydrates 245-265 gms

RDA: The Lacto ovo vegetarian diet is adequate for all age groups and genders except for the following nutrient: Vitamin D. 10µg (mcg) is provided in the Vegetarian Diet. The other three diets may not meet all RDAs. Recommend a daily vitamin with minerals.

There are four general categories of adequate vegetarian diets:

1. Total vegetarians or vegans use vegetables, salads, legumes, fruits, whole grains, nuts and seed All animal foods are excluded.
2. Lacto-ovo-vegetarians use the above plus dairy products (milk, butter, cheese, yogurt) and eggs.
3. Lacto-vegetarians use dairy items but no eggs.
4. Semi-vegetarians consume some groups of animal foods but not all of them. Red meat is usually excluded.

A total vegetarian diet can be planned nutritionally adequate if attention is given to specific nutrients which may be in a less available form or in lower concentration or absent in plant foods. In applying the food group pattern, the following recommendations are important:

1. Reduce substantially all "empty calorie" foods. In their place, use unrefined foods as far as practical which, on a calorie basis, supply their share of nutrients.
2. Replace meat in the protein-rich (meat) group by increasing intake of plant proteins from legumes, seeds, and nuts.
3. Use a variety of fruits and vegetables. Include a food high in ascorbic acid in each meal to enhance iron absorption.

When planning a total vegetarian diet, the following additional considerations are important:

1. Maintain energy intake. Increase the use of leaven bread, cereals, legumes, nuts and seeds.
2. Use a variety of legumes and whole grains.
3. Increase quantities of food that supply nutrients found in significant amounts in the deleted milk group. The following measures should be considered:
   A. Use a fortified soybean milk drink
   B. Use a modest amount of nutritional yeast
   c. Increase the use of green, leafy vegetables low in oxalic acid
   D. Increase the use of legumes, nuts and dried fruit
4. Purchase soy protein products which provide complete protein.

VEGETARIAN DIETS

Provide at meals:

BREAKFAST=	LUNCH=	DINNER=
1 oz **protein equivalent**	2 to 3 oz **protein equivalent**	2 oz **protein equivalent**

Each food item is listed according to the equivalent of 1 oz. of protein.

Product	Amount
Cheese	1 oz
Cottage Cheese	¼ cup(#16 scoop)
Egg	1
Legumes	½ cup
Peanut Butter	2 Tablespoons
Peanuts	2 Tablespoons
Sunflower or Sesame Seeds	3-4 Tablespoons
Tofu	¼ cup
Walnuts	16 to 20 nuts
Yogurt	8 oz

Sample Menu:

Breakfast	Lunch	Dinner
Blended Juice- 4 oz	Grilled Tofu- ½ cup with 1 oz Rosemary Sauce	Tomato Soup - 8 oz with Saltine Crackers - 1 pkg
Scrambled Egg - 1	Boiled Red Potatoes- ½ cup	Grilled Cheese (2oz) Sandwich
Wheat Toast - 1 slice Margarine - 1 tsp	Broccoli- ½ cup	Green Salad – ½ cup
Raisin Bran - ¾ cup	Wheat Roll-1 Margarine-1 tsp	Salad Dressing - ½ oz
Milk-8 oz	Ice Cream- 3oz	Fruit Cup – ½ cup
	Milk -4 oz	Milk -4 oz
	Ice Tea- 8 oz	Ice Tea- 8 oz

IDEAS:

CHEESE:	**EGGS:**
Cold Cheese Sandwich	Egg Omelet
Grilled Cheese Sandwich	Egg Salad or Egg Salad Sandwich
Macaroni and Cheese	Hard cooked Egg
Strips of Various Cheeses	Scrambled Eggs with Cheese
	Vegetable Omelet
COTTAGE CHEESE:	**PEANUT BUTTER:**
Cottage Cheese and Fruit	Peanut Butter and Jelly Sandwich
Baked Potato with Cottage Cheese or Cheese Sauce	Peanut Butter with Crackers
BEANS:	**SOUPS:**
Baked Beans	Split Pea Soup
Bean Soup	Navy Bean Soup
Lima Beans	**Yogurt:** Plain
Retried Beans	Flavored

HIGH PROTEIN DIET

DESCRIPTION:

The High Protein Diet is a Regular Diet that provides an increased amount of high quality protein foods. These come from the meat/protein and milk/dairy group. Nourishments and/or supplements may be included to meet the increased needs. Indications for use may include pressure ulcers and wound healing, malnutrition, and infections. This diet may be contraindicated for residents with renal impairment.

NUTRITIONAL BREAKDOWN:

The grams of protein will be specified by the physician or the protein level will be calculated by the dietitian to meet the resident's requirements. High Protein diets will assure greater than 1.2 grams/protein/kg weight. Additional foods high in protein may not be needed, as the regular diet is moderately high in protein.

FOODS:

Choose eggs, meat, fish, poultry, cheese, milk, yogurt, peanut butter, beans, cream soups, tofu, puddings or custard. Commercially prepared protein products such as shakes, high protein broths or juices may also be given. Non-fat dry milk or protein powders can be added to fluids, soups, hot cereal, pudding etc. One-third cup dry milk provides protein to equal one cup fluid milk and approximately 8 grams of protein.

HIGH CALORIE DIET

DESCRIPTION:

The High Calorie Diet is a regular diet that provides an increased quantity of foods, primarily from carbohydrate and fat sources, to meet the resident's higher calorie needs. Indications for use include weight loss, increased physical activity or calorie expenditure, stressful injury, pressure ulcer, fever or infection.

NUTRITIONAL BREAKDOWN:

The high calorie diet will be approximately 300-500 calories above the resident's daily needs per day. The dietitian can vary the calorie levels to meet individual requirements.

FOODS:

Choose foods, which the resident enjoys. Because energy is the major consideration, carbohydrate foods are often selected. High caloric density foods such as fortified drinks, breads with margarine and jelly, juices and milk for fluids in place of coffee or tea, pasta with margarine or sauce, sandwiches, or puddings are suggested. The additional foods can be provided as larger portions or nourishments.

FORTIFIED DIET

DESCRIPTION:

The fortified diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status.

NUTRITIONAL BREAKDOWN:

The goal is to increase the calorie density of the foods commonly consumed by the resident. The amount of calorie increase should be approximately 300-500 per day.

FOODS:

Examples of adding calories may include-

- Extra margarine or butter to food items such as vegetables, potatoes, hot cereal, bread, toast, pancakes, waffles, rice, pasta, etc.
- Extra gravy and sauces to meats, casseroles, potatoes, rice and pasta.
- Non-dairy creamer or half and half to drink, or added to hot cereal or soups.
- Extra mayonnaise added to sandwiches and mayonnaise based salads.
- Corn syrup added to fruit or juice beverages.
- Extra jelly on breads.
- Non-fat dry milk powder added to soups, puddings and drinks.
- Commercial calorie and/or protein powders added to beverages, puddings, cereals or soups.
- Top with whipped topping or chocolate sauce.
- Add cheese to soups.

SAMPLE FORTIFIED MEAL PLAN:

Breakfast: High calorie cereal
Extra margarine on toast, pancakes, waffles or french toast and/or jelly with toast or muffin

Lunch: Extra sauce or gravy on meat
Extra margarine on potatoes, rice or pasta
Extra margarine on hot vegetables
Whip topping on gelatin, pie, cobblers and puddings

Dinner: Extra mayonnaise on sandwich
Soup made with non-dairy creamer in place of milk
Extra salad dressing for tossed green salad
Whip topping on gelatin, pie, cobblers and pudding

APPROXIMATE CALORIES OF FOODS USED FOR FORTIFYING DIET:

- Butter, margarine or mayonnaise- 1 tsp = 35 calorie
  1 Tbsp = 100 calories
- Cheese- 1 Tbsp/ ½ oz = 55 calories
- Chocolate Sauce – 1 Tbsp = 55 calories
- Corn syrup- 1 Tbsp = 60 calories
- Gravy or sauce- 1 oz = 25 calories
- Half & Half- 1 oz = 40 calories
- Non-dairy creamer- 1oz =40 calories
- Salad Dressing 1 Tbsp = ranges form 45 - 75 calories
- Sour Cream 1 Tbsp = 25 calories
- Sugar, brown sugar, jellies, maple syrup or honey- 1 Tbsp = 45 calories
- Whipped cream- 1 Tbsp = 50 calories

REGULAR MECHANICAL SOFT DIET

DESCRIPTION: The Mechanical Soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified in texture to a soft, chopped or ground consistency as per foods below. Other textures may be included such as a mechanical soft diet with pureed meats if further texture reduction is required. Strive to individualize a resident's diet before going to a full pureed texture.

RDA: This diet is adequate for all age groups and genders except for the following nutrient: Vitamin D. 10 µg (mcg) is provided in the regular mechanical soft diet.

Definition of Ground: To reduce to small fragments by friction. Recommend using a grinder/food processor to achieve the consistency of ground beef.

Definition of Minced: To cut or chop into very small pieces. Pieces need to be less than 1/2".

FOODS	ALLOWED	AVOID
Milk	All milk, smooth yogurt.	
Meats, Poultry, and Fish	Ground with meat juices, gravy or sauce. Moist meatloaf or meatballs with gravy or sauce. Casseroles with meat sauces using ground meat. Flaked, moist fish (plain or breaded), without bones. Peanut butter, (smooth or with crushed nuts).	Whole or chopped meat. Dry meat. (Chopped meat only allowed when ordered by Speech Therapist. Size of meat should be specified in diet order, such as less than 1/2" or less than 1")
Cheese	Cheese used in cooking; cheeses, cottage cheese.	Chunks of cheese
Eggs	Scrambled, fried or poached eggs, Sliced or grated hard cooked eggs.	
Tofu	May give.	
Raw Vegetables	Minced salads. Minced vegetables in gelatin. Minced tomatoes. Beans served cold need to be minced. (Minced =To cut or chop into very small pieces, less than 1/2")	Whole tomatoes and any raw vegetables unless minced.
Cooked Vegetables (served hot or cold)	Mashed or soft whole vegetables. Mashed or soft whole cooked beans. Creamed corn. Corn may be whole when in mixed vegetables or soups. Soft baked potatoes (skin may be served if soft)- white or red. Chopped soft Brussels sprouts- 1/2" or less. Soft French fries and tater tots.	Canned new potatoes unless chopped in quarters. Potato chips, tortilla chips or corn chips, popcorn.

MECHANICAL SOFT DIET, (cont)

FOODS	ALLOWED	AVOID
Raw/cooked/ canned fruit	Ripe, pitted, soft and chopped 1/2"- no skins. May serve whole ripe banana.	Plums or whole grapes (may use skinless grapes which are cut in half).
Dried Fruit	Chopped stewed prunes- 1/2". May serve raisins. All other dried fruit to be pureed.	
Breads, Cereals	Soft breads, soft tortillas, and hot cereals. Cold cereals when served with milk or fluid to soften cereal. Soft grilled sandwiches. Waffles, pancakes, donuts, sweet rolls,(if added fruit be sure soft- 1/2" –no skins). Soft crackers such as saltines, Ritz, graham crackers, pasta/noodles.	Breads with hard crusts. Breads with whole or chopped nuts. English Muffins. Grainy or hard crackers such as Triscuits or Wheat Thins.
Desserts	Soft cookies, cakes and pies. Miniature marshmallows only. Chocolate chips. Ice cream, pudding, gelatin.	Desserts with whole or chopped nuts.
Other	Minced pickles, crushed nuts, parsley flakes, coconut flakes, seeds, sliced or chopped olives.	Parsley sprigs. Whole or sliced pickles. Whole or chopped nuts. Shredded coconut. Whole olives.

All above avoided foods may be given if pureed.

REGULAR PUREED DIET

DESCRIPTION:

The Pureed Diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified on the Hospital menu. Detailed procedure for pureeing foods is in the recipe binder with each RDs for Healthcare menu cycle.

RDA: This diet is adequate for all age groups and genders except for the following nutrient: Vitamin D. 10µg (mcg) is provided in the regular pureed diet.

All foods are prepared in a food processor or blender, with the exception of foods which are normally in a soft and smooth state such as pudding, ice cream, applesauce, mashed potatoes, etc. Additional liquid is added in the form of broth, gravy, vegetable or fruit juices, or milk to achieve the appropriate consistency. Water is not used since it dilutes flavors and results in a poorly accepted product. Foods such as cake, cookies, pancakes, and breads may be soaked in milk, syrup or slurried until the proper consistency is achieved. A slurry is a combination of fluid with added food thickener of choice.

FOODS	ALLOWED	AVOID
Meats, Poultry, Fish	Puree all meats- add sauces, gravies and broth as needed. Puree casseroles. Puree sandwiches. (May puree sandwich filling and slurry bread). Meat may be pureed and served in a souffle or mold in order to improve the acceptance.	
Cheese	Used in cooking. Creamy Cottage Cheese may be served. May need to puree Cottage Cheese for some residents	Unmelted Cheese. Dry Cottage Cheese
Eggs	Scrambled eggs-pureed or steamed for a smooth product	
Tofu	Pureed	
Raw Vegetables	Pureed	
Cooked Vegetables	Pureed	
Raw/Dried/Cooked/Canned Fruit	Pureed. May serve ripe bananas, avocado or papaya	Seeds. Exception to no seeds- may have seeds if the seeds become smooth in texture when pureed.

Pureed Diet (cont.)

FOODS	ALLOWED	AVOID
Cereals	Cooked smooth cereals, oatmeal or malt o meal. Dry cereal (cornflakes or bran flakes only) may be given if completely soaked in milk before serving. Given on an as tolerated basis only	
Breads	May be given soaked in liquids such as milk, soup, broth or gelatin water or pureed. Plain crackers completely soaked in liquid or pureed in soup. Pancakes may be given whole if completely soaked in syrup. (May also be pureed.) Hot breads and French toast (no crust on French toast) are to be completely soaked in milk or other liquid before serving. (May also be pureed).	
Soups	Pureed or broth. Can serve in a mug or cup.	
Desserts	Pureed. Cream pies can be served without the crust. Plain cookies and cakes completely soaked in milk/slurry or pureed. May serve gelatin.	Nuts, chocolate chips, raisins, etc.
Other	Pureed garnishes. Parsley flakes in place of parsley.	No Peanut butter. (Exception: may be used as a flavoring ingredient in a cake mix, cookies, pudding, frosting, so long as it is completely incorporated in the mix and then pureed.) No seeds. (Exception:- may have seeds if they become smooth in texture when pureed.)

LIQUEFIED PUREED DIET

(OR THIN PUREED IN CUPS)

The Liquefied Pureed diet is designed for residents who have difficulty eating solid food (including puree texture) from a spoon or fork, whether assisted by staff or self-initiated. The diet would be considered for those who have more success consuming foods in liquid form from a mug, cup or glass. The texture of all foods served will be smooth, free of lumps and liquefied adequately to flow freely from a mug. The regular servings for a pureed diet are to be served and then thinned to a drinkable consistency using appropriate fluids. This is done to ensure proper nutrition. Hot foods are to be thinned with hot fluids and cold foods are to be thinned with cold fluids. Hot foods are to be served in a mug. Cold foods are to be served in a mug, cup or glass. This diet should be served only by resident need and per physician order.

Foods	**Fluids to be added**
Meats, Poultry and Fish	Gravy, sauces, broth, or milk
Cheese	Milk
Eggs	Milk
Vegetables	Broth
Salads/Dressing	Thinned down oil-base or mayonnaise-base salad
Fruit	Juice
Starches (Potato, Rice, Noodles)	Milk, broth, gravy or sauces
Cereal	Milk
Breads	Milk
Pancakes, Waffles, French Toast	Milk and syrup
Desserts	Milk or juice

NUTRITION MANAGEMENT OF DYSPHAGIA

DESCRIPTION: Dysphagia, or difficulty swallowing, can occur in those who have experienced stroke, cerebral vascular accident, closed head trauma, Parkinson's disease, amyotrophic lateral sclerosis, myasthenia gravis, Huntington's chorea, tumor or obstruction of the throat. The difficulties can be with chewing or swallowing or both. Aspiration is, often, the result of dysphagia and prevention of aspiration is the goal of the dietary modifications.
Dysphagia is characterized by coughing or choking after swallowing, pocketing of food in the cheek, excessive drooling, runny nose or eyes, gargled voice after eating, or poor tongue control. The Speech Pathologist or Occupational Therapist can screen or evaluate residents that display any of the symptoms of dysphagia and recommend the appropriate texture, as it is highly individualized. Residents will be placed on the following diet textures or combinations of textures:

Puree diet
Liquefied (thin puree in cups)
Dysphagia mechanical (or Dysphagia mechanical soft accepted)
Mechanical soft
Nectar thick liquids
Honey thick liquids
Pudding thick liquids

Nectar Thick Liquids - Syrup consistency, such as thick nectars, tomato juice, V-8 juice, thick eggnog, strained cream soups. Thin liquids will require thickening.

Honey Thick Liquids - Molasses consistency, such as thick milkshake. Most liquids will require thickening to this consistency.

Pudding Thick Liquids - Fluids that hold together on a spoon, such as pudding, mousse, custard, yogurt. Other liquids will require thickening.

Foods and fluids can be thickened with commercial thickeners or food products such as potato flakes, gelatin, cereals, etc. However, commercial thickeners that are starch-based are recommended because they release the fluid for hydration.

NUTRITION MANAGEMENT OF DYSPHAGIA (continued)

Dysphagia Mechanical

This diet consists of foods that are moist, mechanically altered, or easily mashed. This is necessary in order to form a cohesive bolus requiring little chewing. Foods must not be sticky or bulky increasing the risk of airway obstruction.

General Principles:

- Foods served should form a cohesive bolus and not fall apart when swallowed. Beware of foods that crumble like corn bread, cake, etc., or are dry such as rice, meat without gravy, some vegetables and fruits, or long stringy pasta like spaghetti. Dry foods should be softened with fluid or gravy, like ground meat moistened with gravy, corn bread pureed or soaked with milk. Rice and vegetables that have a hull such as peas or corn should be pureed.

- Foods that are sticky or bulky should be avoided as they can cause obstruction of the airway. Examples of this are fresh white bread, meat not mechanically altered, mashed potatoes without gravy, fresh fruits (especially bananas) and vegetables, refried beans, and All Bran cereal. May puree these foods. No peanut butter, (exception- may be used as a flavoring ingredient in a cake mix, cookies, pudding, frosting, so long as it is completely incorporated in the mix and then pureed).

- Avoid foods with a combination of textures. They are more difficult to direct in the mouth to form a bolus. These include vegetable soup and gelatin salads.

- Avoid foods that are difficult to chew. These include nuts, seeds, coconut, dried fruits, vegetables with hulls, and raw fruits and vegetables. Small bite- size pieces will help with the allowed foods.

- Foods that are very cold or very warm may stimulate swallowing.

- Small, frequent meals may aid in the prevention of exhaustion at meals and increase attention during eating, increase intake and optimize food temperatures.

Dysphagia Mechanical

- Observe the ordered thickness of liquids in the foods that have liquid. Foods such as soup, soaked bread or cake, canned fruit, gravy or sauce, and pureed foods may contain fluids that are thinner than prescribed. In such cases, the food would have to be modified to obtain compliance, i.e. thicken soups, gravies, and sauces to appropriate thickness, soak bread in pre-thickened fluid or puree to proper consistency, drain fruit, and thicken pureed food items that are thinner than the prescribed thickness. Foods that melt at room temperature can change consistencies and cause difficulties. Examples of this are ice cream, sherbet, popsicles, and gelatin.

- Provide fluids adequate for hydration. Serving fluids between meals is essential to meeting hydration needs. Fluids thickened with starch-based commercial thickeners are recommended as they release the fluid for hydration vs. the gum-based thickeners that bind the fluid. Other thickeners that can be used are pudding, gelatin or potato flakes.

NUTRITIONAL MANAGEMENT OF DYSPHAGIA (continued)

FOODS	ALLOWED	AVOID
Milk group	Milk thickened to the proper consistency; moist cheese, cottage cheese.	Yogurt or ice cream with chunks of fruit, seeds, or nuts; dry cottage cheese, cheese slices and cubes
Meat and Alternate Group	Ground meat or fish served with gravy or sauce; Meat loaf or meat balls, moistened with sauce or gravy; (meatloaf & meatballs to be mashable). Scrambled egg, Lean Ham, Meat spreads, i.e. moist egg/tuna/poultry/ham spreads made with meat and mayonnaise only; Sandwiches with spread on allowed bread; Macaroni and cheese.	Meat slices, patties, or chunks; Grisly meats, i.e. sausage, ham, hot dogs, bratwurst, bacon, corned beef; Casseroles or quiches with chunks of meat or vegetables. Peanut butter, (exception- may be used as flavoring ingredient in a cake mix, cookies, pudding, frosting, so long as it is completely incorporated in the mix and then pureed).
Tofu	Soft crumbled tofu.	
Fruit Group	Soft cooked canned fruits chopped to ½" or less- no skins; Drain juice if on thickened liquids; Pureed fresh fruits.	Pineapple, oranges, grapefruit, (may puree); Fruits with seeds, i.e.; grapes, guavas; Dried fruits
Vegetable Group	Vegetables chopped approx. ½" and cooked soft to a mashable texture; broccoli florets, asparagus tips, cauliflower florets, carrots, chopped spinach, cut green beans, beets, onions, peppers, zucchini; Peeled, seedless, minced tomatoes, mashed potatoes- no skins, with gravy or sauce; Soft boiled potatoes, no skins; Soft tator tots. Small amount of onions- mashable chopped ½" & peppers may be combined in cooked vegetables.	Raw Vegetables (including lettuce) except peeled, seedless, minced tomatoes. Baked potato, French fries, refried beans, mashed potato without gravy. Avoid the following- (unless pureed), Vegetables with hulls (corn, peas, dried beans), stringy of course vegetables (cabbage, Brussel sprouts, celery sprouts, asparagus stalks, broccoli stalks, Italian green beans, fried vegetable)

FOODS	ALLOWED	AVOID
Bread, Grains and Cereal Group	Firm (not dry) textured breads without nuts, seeds, and grains. Plain raised donuts and sweet rolls. Plain waffles, pancakes, or French toast without crusts, well moistened with syrup or sauce. Roll with soft crust, (dinner rolls, hamburger buns without seeds, soft bread sticks). Milk toast (with no fluid milk remaining). Cooked cereal, dry cereal that can be softened in milk. Crackers crushed and added to soup. (fully saturated). Spaghetti noodles cut in to ½" pieces, bite size pastas.	White bread, French bread, waffles or pancakes without syrup. Tortillas, Rice, unless pureed, Garlic bread (since it is heated & may become hard) Any product with nuts, seeds, or grains. Long spaghetti noodles. All bran cereal. Refried beans. Avoid the following unless soaked in milk or other liquid of proper consistency with no fluid remaining: Dry breads (cake donuts, cornbread, biscuits, bran muffins, may also puree).
Soups	Strained cream or both type soups, thickened to the proper consistency.	All soup unless strained or pureed and thickened to the proper consistency.
Desserts	Smooth puddings, ice cream or sherbert (melts to thin or honey consistency), gelatin (melts to a thin consistency), moist cakes, (soak thoroughly in milk- then drain off excess fluids.)	Desserts with nuts, seeds, coconut, or crust (pies, tarts cobbler, crisp). Dry items, i.e. cake, hard cookies. No peanut butter, (exception-may be used as a flavoring ingredient in a cake mix, cookies, pudding, frosting, so long as it is completely incorporated in mix and then pureed)
Other	Most smooth condiments and ground herbs	Relish, popcorn, nuts, pickles, coconut.
	Note: all foods may be given if pureed.	Note: all foods may be given if pureed.

LOW FAT/LOW CHOLESTEROL DIET

Description: The Low Fat/Low Cholesterol Diet is designed to lower elevated levels of serum cholesterol and other lipids in an effort to reduce the risk of heart disease. The Low Fat and Low Cholesterol Diet have been combined since the rationale is that both reductions are needed for blood lipid improvement.

NUTRITIONAL BREAKDOWN:

Calories 1800-2000

Protein 90-100 gm

Fat 55-65 gm

Carbohydrates 230-240 gms

Cholesterol 300 mg (less than)

RDA: This diet Is adequate for all age groups and genders except for the following nutrient:
Vitamin D. 10 (µg (mcg) is provided In the low fat/low cholesterol diet.

Vitamin E. 12 mg is provided in the low fat/low cholesterol diet.

A Low Fat Diet may be prescribed without a restriction in cholesterol, i.e. residents with gall bladder disease. In this case, the RD may want to allow eggs, liver and other high cholesterol foods that are moderately low in fat.

RDs for Healthcare menus allow 3-4 tsp of fat dally which is used to flavor vegetables and starches as well as allowed for toast. *Otherwise margarine is not to be given with bread*. Reduced fat/cholesterol spreads may be used that provides 2 gm fat or less per portion and 2 times a day. The reduced fat/cholesterol spread may be used in place of regular margarine for the vegetables and starches. Whipped topping is occasionally allowed up to 1Tbsp. on desserts per the menu.

FOODS	ALLOWED	AVOID
Milk	Fat Free milk (skim milk), yogurt made from fat free milk, sherbet in place of Ice cream, low-fat whipped toppings, (1gm fat or less), fat-free hot cocoa.	Whipped cream, milk shakes, Half and Half, non-dairy creamer, ice cream, whole milk, 2% and 1% milk, yogurt, chocolate milk.
Cheese	Skim milk cheeses preferred (such as Monterey Jack, Mozzarella, Farmers). Reduced-fat cottage cheese and cheeses. May serve 2 oz of American, Cheddar, etc., or 1/2 cup regular cottage cheese/day.	Cheese spreads. Cream cheese.
Meats	Lean meats, trimmed of fat. Peanut butter, 2 Tbsp./day. Breaded patties may be given. Lunch meats, hot dogs or breakfast meats made from TURKEY. Tofu. Limit total meat/meat alternate to 5 oz per day.	Skin on poultry, beef hot dogs, bologna, salami, bacon, liver, canned entrees which have added fat (such as ravioli, tuna in oil, corned beef hash). Lunch meats/spreads other than those made of turkey.

LOW FAT/LOW CHOLESTEROL DIET (continued)

FOODS	ALLOWED	AVOID
Eggs	Three eggs per week plus small amounts which may be seen in recipes (such as 6 eggs per 50 servings in a recipe, i.e., meat loaf, cake, pancakes, etc.) One slice French toast/per week. Egg substitute products: 2 scrambled egg whites = 1 whole egg.	Eggs fried in fat.
Breads/Cereals/ Sugar, etc.	All pastas, rice, breads and crackers. Limit hot breads to only one serving/meal. (No added margarine brushed on hot breads). Pancakes, waffles, cereals, syrups, sugar, spices/herbs.	Coffee cake, donuts, (cake donuts allowed per menu only). Sweet Rolls.
Vegetables	All vegetables. Low-fat potato chips- ½ cup only. Frozen French fries- ½, cup only, baked without added fat. Canned, creamed corn - ½ cup only/day.	Potato chips, deep-fat fried vegetables. Creamed vegetables.
Fruits	All fruits.	
Desserts	Desserts without added fats, (such as angel food cake, plain cake with no icing, gelatin, sherbet, vanilla wafers, fruits, puddings made with fat-free milk). Cookies, if less than 3 gms per serving per day. Syrup and sugar.	Pies, ice cream, Icing, cookies, crisps and cobblers, chocolate candy and pastries.
Fats	3-4 tsp per day of added fat (margarine, oil or mayonnaise). Suggest this be counted in the vegetables and starches, toast, etc. May serve jelly with hot breads and bread at meals. Fat-free salad dressing or low cal dressing if less than 30 cal/Tbsp. Fat-free gravy or 1oz gravy allowed per meal. Cream soup, if made with allowed ingredients. Olives, if given in small amounts such as in a casserole (8 black olives- 1tsp fat). Seeds in small amounts, such as on a bun.	

LIBERAL BLAND

DESCRIPTION: The Liberal Bland diet is a Regular Diet, which excludes foods that have been shown to be irritating to the gastric mucosa or that stimulate gastric acid secretion.

RDA: This diet is adequate for all age groups and genders except for the following nutrient: Vitamin D. 10 µg (mcg) is provided in the regular liberal bland diet.

Between meal snacks may also be ordered, but are not sent routinely with this diet.

Foods: Elimination of foods the patient/resident is unable to tolerate and the following foods:

1. Alcohol
2. Black Pepper
3. Chili Powder
4. Caffeine (coffee, tea, cocoa, cola beverage, chocolate)

LOW RESIDUE DIET (Low Fiber)

DESCRIPTION: This diet is ordered for the treatment of acute diarrhea, colitis, flare up in inflammatory bowel disease, diverticulitis, Crohn's disease, ulcerative colitis, and other gastrointestinal disturbances as well as during the preoperative and postoperative periods for a resident who has undergone abdominal surgery. The rationale for use of the Low Residue diet is to reduce the frequency and volume of fecal output, thereby preventing distention of the bowel, which could further aggravate inflamed tissue. The term residue refers to unabsorbed dietary constituents, metabolic and bacterial products, sloughed cells from the GI tract and intestinal bacteria found in feces after digestion.

A low residue diet is composed of foods, which are smooth in texture, mechanically and chemically non-irritating, easily digested, readily absorbed, and resulting in a minimum of residue in the intestinal tract. in addition to the low residue and low fiber foods listed below, foods greater than 2 grams of fiber per serving are to be avoided.

RDA: Depending upon individual food preferences this diet is adequate in most nutrients for short-term use. If using the diet long-term, provide a multivitamin with minerals. This diet does not meet the RDAs for: Magnesium (290mg), Zinc (10 mg), Vitamin D (10 µg (mcg), Vitamin E (14 mg).

SAMPLE MENU:

Breakfast	Lunch	Dinner
Milk- 8 oz	Milk-4oz	Milk-4 oz
Apple Juice- 4 oz	Roast Turkey- 3 oz	Baked Fish - 2 oz
Fried Egg- 1	Gravy – 1oz	White Rice - #12
White Toast - 1slice	Mashed potatoes – ½, cup	Green Beans- ½ , cup
Margarine - 1 tsp	Carrots- ½ , cup	Snickerdoodle cookie- 1
Farina ¾ cup	White Roll-1 + 1 tsp margarine	Water- 8 oz
Water- 8 oz	Sherbet- #12	
	Water- 8 oz	

FOODS	ALLOWED	AVOID
Milk	Milk Limit to 2 cups of milk or foods made from milk per day. Milk in low in fiber but contributes to stool volume.	Yogurt containing fruit, skins or seeds.
Meat and Alternate	All meats, fish, poultry, eggs, or cottage cheese.	Corned beef, smoked or spiced meats, luncheon meats, fried or fatty meats. Frankfurters, sausage, or any tough, fibrous meats or shellfish. Peanut butter, dried beans, peas, or lentils.
Cheese	Milk cheese when used as milk allowance (1 oz cheese = 1 cup milk)	Any with added nuts, olives, or seeds
Potatoes or Substitute - (limit to No more than% cup per meal)	Cooked white and sweet potatoes without skins, white rice or refined pasta.	All others including fried potatoes, potato chips, or potato skins whole wheat pasta, wiled and brown rice, or hominy.
Fruits	Apricots, peaches & pears without skins, applesauce, canned cherries, canned mandarin oranges, seedless melon, canned pineapple, avocado and fruit juices with no pulp.	Other canned or raw fruits, dried fruits (including prunes), prune juice and fruit nectars. No seeds.

FOOD	ALLOWED	AVOID
Vegetables- limit to no more than 1/2 cup per meal	Well-cooked and canned vegetables without skins or seeds such as asparagus, beets, potatoes, sweet potatoes, mushrooms, peppers, green beans, spinach, carrots & pumpkin. Tomato sauce or	Raw vegetables, onions, all beans, Brussels sprouts, zucchini, whole kernel corn, cauliflower, broccoli, peas, tomatoes, winter squash, sauerkraut or cabbage.
Breads and Cereals	All enriched white breads, rolls, crackers, refined cooked wheat, corn or rice cereals including grits, and farina. Refined dry cereals, including puffed rice and wheat, Rice Krispies, and corn flakes.	Breads, cereals, and crackers containing whole wheat, oatmeal, granola, bran, graham, barley, seeds, nuts, coconut, or dried fruit. Corn bread and quick breads.
Soups	Bouillon and broth-based soups made with allowed ingredients; cream soups made from milk allowance and allowed ingredients.	Highly seasoned soups. Any soup made from vegetables on the avoid list. Any soup from barley.
Desserts and Sweets	Plain cakes, cookies, pies, gelatin or sherbet made from allowed Ingredients. Puddings and custards made from milk allowance. Jelly, plain hard candy, and marshmallows. Molasses, sugar and syrup.	Any made with whole-grain flour, bran, seeds, nuts, coconut, granola or dried fruit. Jam, marmalade, chocolate, and ice cream.
Fats	Oils, butter, margarine, plain sour cream, shortening, cream, cream cheese, plain gravies, smooth salad dressings, mayonnaise, or	Poppy seed, or other salad dressings containing restricted ingredients. Olives, nuts.
Beverages	Allowed milk, fruit juices without pulp and nectars, strained vegetable juices, non caffeine containing beverages.	Pulp containing fruit and vegetable juices, cocoa, alcohol, caffeinated sodas, coffee, and tea.
Miscellaneous	Herbs, spices, flavorings, iodized salt, catsup, or vinegar.	Chili, BBQ or hot sauce, herbs or spices that are seeds. Horseradish, nuts, coconut, seeds, popcorn, or pickles.

HIGH FIBER DIETS

DESCRIPTION: High fiber diets are indicated in the prevention or treatment of constipation, diverticulitis, irritable bowel syndrome, hemorrhoids, diabetes mellitus, cardiovascular diseases, colon cancer, endometrial cancer, Crohn's disease, hypercholesterolemia, and obesity. The rationale for use of this diet is to increase fecal bulk promoting regularity, to normalize serum lipid levels, and to reduce postprandial blood glucose response.

A high fiber diet may be contraindicated in residents with bleeding hemorrhoids and diverticulitis or residents unable to consume large amounts of fluid.

The term fiber refers to indigestible soluble and insoluble carbohydrate found primarily in foods of plant origin including whole grain flours and products, unprocessed (raw) wheat bran, unrefined breakfast cereals, fruits, vegetables, legumes and nuts. Up to 25-40 grams of total dietary fiber is recommended. Too much fiber can cause gas, bloating or diarrhea.

The RDs for Healthcare Menus, provide approximately 25 grams of fiber. A gradual increase in fiber is recommended to avoid stomach upset.

The following is a list of possible foods to be added in any combination if more fiber is needed.

FOODS		**FIBER GM**
Fruit		
Canned	¼ c (or 3) stewed prunes	1.8
	5 prunes canned with liquid	3.3
	½ c canned pears, apricots	2.0
	½ c canned peaches, applesauce	1.5
	½ c prune juice	1.3
	½ c canned pineapple, fruit cocktail	1.0
	½ c mandarin oranges	1.0
Dried	½ c dried apricots	4.7
	1 dried fig	2.3
	¼ c raisins	2.0
	1 dried date or prune	0.6
Fresh	1 c raspberries	4.2
	½ c blackberries	3.8
	1 medium apple (2 ¾)	3.7
	1 orange (2 ¾)	3.1
	1 banana (7 7/8)	2.8
	½ c frozen boysenberries	2.5
	1 nectarine (2 ½ ")	2.2
	½ c blueberries	2.0
	½ c strawberries	1.6
	½ c cantaloupe, honeydew	0.7
	½ c grapes	0.5
	½ c watermelon	0.4

HIGH FIBER DIET continued

FOODS	FIBER GM
Vegetables	
½ c cooked peas	4.4
½ c baked sweet potato	3.0
½ c cooked broccoli, carrots	2.0
1- 4" baked potato	2.3
½ c cooked Brussels sprouts	2.0
½ c cooked cauliflower	1.7
½ c sliced boiled zucchini	1.2
½ c coleslaw	0.9
1 c lettuce	0.8
1 raw tomato	0.7
Cereals	
½ c high fiber cereal (e.g. All-Bran, Bran Flakes)	4-10
1 c oatmeal, regular	4.0
2 T unprocessed wheat bran	3.0
2 T toasted wheat germ	1.8
1 cup farina, regular	1.8
Grains	
1 bran muffin	2.0
1 oz slice whole wheat bread (check your bread)	1.9
1 oz slice wheat bread (check your bread)	1.1
1 oz slice white bread	0.6
Meat and Meat Alternatives	
½ cup canned dried peas and beans	5.0
½ cup canned baked beans	5.0
Fats	
2 T peanut butter, creamy or chunky	2.0
Fiber Supplements	
Administered by nursing	3-5/dose
High Fiber Juice Drinks	
4oz juice- check with food purveyor-often contains	5 gms

Eight glasses of fluids (64 oz.) a day also need to be consumed. Plan 16 oz. with each meal and an additional16 oz. total between meals (such as 4oz 10:00, 4oz 3:00 and 8 oz at H.S.)

CONTROLLED CARBOHYDRATE DIET (CCHO)

It is often called NO CONCENTRATED SWEETS (NCS)/ or
REDUCED CONCENTRATED SWEETS (RCS). Have diet order changed.

DESCRIPTION:

A controlled carbohydrate diet, (CCHO), is a meal plan without specific calorie levels for diabetic residents. Instead of counting calories; the carbohydrates are evenly, systematically and consistently distributed through three meals and H.S. snack in an effort to maintain a stable blood sugar level throughout the day.

RDA: This diet is adequate for all age groups and genders except for the following nutrient:

Vitamin D. 10 µg (mcg) is provided in the CCHO diet.
Magnesium. 390 mg is provided in the CCHO diet. (Low for men 14 years & older)
Vitamin E. 13mg is provided in the CCHO diet.

The small portion diet does not meet all the RDAs of vitamins and minerals and therefore a multivitamin with minerals is recommended.

The carbohydrates are controlled through portion control and avoiding some concentrated sweets. Provide:

Diet sugar Diet jelly Diet gelatin
Diet syrup Diet/fresh fruits

Residents will see a regular dessert approximately 3 times per week, although they may be a smaller portion depending on their total carbohydrate count for the day.

APPROXIMATE COMPOSITION (without snack)

REGULAR:

- Calories 1900-2000
- Protein 88-90gms
- Fat 95-100gms
- CHO 175-205gms

SMALL:

- Calories 1600-1700
- Protein 75-80gms
- Fat 75gms
- CHO 150-180gms

LARGE:

- Calories 2400-2600
- Protein 120-125gms
- Fat 120-125gms
- CHO 225-250gms

Carbohydrates:

Regular:	
Breakfast	60-70gms
Lunch	55-65gms
Dinner	60-70gms
Small:	
Breakfast	50-60gms
Lunch	44-55gms
Dinner	55-65gms
Large:	
Breakfast	80-85gms
Lunch	70-80gms
Dinner	75-85gms

A regular portion of food will be served unless small or large portions are ordered.

Bedtime Snack:
May have juice, milk, or other beverage of nutritional value. Additional snack may be given per RD's recommendations.

Note: Calories are calculated on whole milk. Calories can be reduced by using 2%, 1% or FF milk. The carbohydrates will remain the same.

ENTERAL FEEDINGS

DESCRIPTION

Enteral feedings provide nutrition support for those residents who are unable to consume an adequate oral diet. Enteral feedings are liquid and contain the nutrients to sustain life and can easily pass through a tube. The tubes used to deliver the nutrient rich formula are: nasogastric tube (NGT), gastric tube (GT or PEG) or jejunostomy tube (JT).

Residents who would typically receive their diet in this method are those with dysphagia from neuromuscular weakness, loss of cognition, physical impairment of the upper GT tract, or increased nutrient need.

THE FORMULA

Enteral feedings are to be commercially prepared and designed for use in the GI tract. They are to be ordered through central supply or pharmacy.

ORDERING GUIDELINES

Enteral feeding orders from the physician are to include:

- Type of tube being used – NGT, GT, PEG, or JT
- Name of formula-i.e. Fibersource HN, Nutren 1.0 fiber, Jevity 1.2 cal, Diabetisource AC, Glucerna 1.0 cal, Glucerna 1.2 cal.
- Rate of administration and frequency of feeding per 24 hours – i.e. at 75 ml per hour X 20 hours or 240 ml every 4 hours
- Method of delivery-pump, gravity drip, or bolus
- Total volume and calories to be given in a 24 hour period-i.e. 1000 ml total volume and 1200 kcal total calories
- If pump used, the times the pump is to be off unless total volume not fully delivered.
- Water flush orders to include amount of each flush and how often given – i.e. 100 ml water every 4 hours or 100 ml water before and after each bolus feeding

Example: GT feeding of Fibersouce HN at 80 ml per hour X 20 hours via pump (on 1200 off 0800 or until final volume is delivered).
Provides: 1600 ml and 1920 kcal
Flush GT with 120 ml of water every 4 hours

(ENTERAL FEEDINGS CONTINUED)

Other orders to consider:

- Medications must be in a form that can be administered via tube if the resident can't swallow. Liquid forms are available for some medications, others will have to be crushed. There are medications that cannot be crushed and this is to be considered.
- Water flushes should be done before and after each medication administration to help prevent clogging and rinse medication residue. Typical amounts of flushes are 30-60 ml.

Adequacy

Commercial formulas are available for general use and for specific diseases or conditions. Formulas are available with fiber, without residue, calorie dense, isotonic, and varying amounts of protein, fat and carbohydrate. The dietitian should be consulted if the proper formula or the amount to use is in question. Formulas provide vitamins and minerals therefore supplementation may or may not be needed. Most residents can be properly nourished with enteral feedings that provide 20-35 kcal per kg weight. Calories above or below this level should be referred to the dietitian.

CLEAR LIQUID DIET

DESCRIPTION:

The clear liquid diet is designed to provide clear liquid foods that are fluid at body temperature and leave no residue in the gastrointestinal tract. This diet is indicated as a preoperative and progressive post-operative regime and for residents with acute diarrhea and/or nausea.

The diet is inadequate in all nutrients and should be used for not more than 48 hours unless otherwise prescribed by the attending physician. Calories provided approximately 900.

FOODS;

Soups:
Clear broth, consomme or bouillon

Beverages:
Water, tea, coffee and carbonated beverages

Fruit juices including apple, grape or cranberry

Desserts:
Flavored gelatin, popsicles, plain hard candy

Miscellaneous:
Sugar or sugar substitute

SAMPLE MENU;

Breakfast	Lunch	Dinner
8 oz Apple Juice	8 oz Cranberry Juice	8 oz Grape Juice
8 oz Clear Broth	8 oz Clear Broth	8 oz Clear Broth
4 oz Flavored Gelatin	4 oz Flavored Gelatin	4 oz Flavored Gelatin
Coffee or Tea	Coffee or Tea	Coffee or Tea Sugar
Sugar	Sugar	
10:00	**2:00**	**H.S.**
4oz Grape Juice	4 oz Apple Juice	4 oz Cranberry Juice

In nutritionally compromised residents there are commercial products on the market to increase calorie, protein, vitamins and minerals. These include fortified broths and fortified fruit flavored drinks designed for residents restricted to clear liquid diets.

FULL LIQUID DIET

DESCRIPTION:

The full liquid diet consists of foods which are liquid or become liquid at body temperature and are easily digested. The diet is indicated as a progressive post-operative dietary regime, for acutely ill residents, for residents experiencing extreme difficulty in chewing and swallowing and for duration of wired jaws.

NUTRITIONAL BREAKDOWN (Approximate):
Calories: 2200
Protein: 70 gms
Fat: 100 gms
Carbohydrate: 250 gms

RDA: This diet is not adequate for all age groups and genders.
Residents remaining on this diet for more than one week should be evaluated by their attending physician and dietitian. To continue this diet it is important to include a commercial protein supplement and multivitamin with mineral supplement to meet residents daily nutritional needs.

FOODS;
Soups: Broth, consommé or strained soups

Beverages: Milk, milk drinks, commercial protein supplements, cream, cocoa, eggnog, fruit and vegetable juices, coffee, coffee substitutes, tea and carbonated beverages

Desserts: Custard, plain flavored gelatin, plain ice cream, plain ices, and sherbets, hard candy, popsicles, plain yogurt (no seeds or fruit), pudding

Cereals: Refined cereal gruels, farina, cream of rice cereal

Miscellaneous: Margarine, jelly, salt, mild spices such as nutmeg, cinnamon and paprika, flavorings and syrup

SAMPLE MENU:

Breakfast	**Lunch**	**Dinner**
6 oz. Refined Cereal	8 oz. Cream Soup (strained)	8 oz. Cream Soup (strained)
4 oz Fruit Juice	4 oz. Fruit Juice	4 oz. Fruit Juice
8 oz. Milk	8 oz. Milk	8 oz. Milk
1 tsp. Margarine	3 oz. Vanilla Ice Cream	1/3 cup (#12) Pudding
4 oz. Protein Supplement	4 oz. Protein Supplement	4 oz. Protein Supplement
2 Pkg. Sugar	2 Pkg. Sugar	2 Pkg. Sugar
Coffee or Tea	Coffee or Tea	Coffee or Tea
10:00 4 oz. Milk	2:00 4 oz. Milk	H.S. 4 oz. Milkshake

LOW POTASSIUM DIETS (2-2.5 GMS)

DESCRIPTION:

This diet is usually ordered when a patient is in renal failure, receiving dialysis, or has elevated serum potassium. Potassium content of the diet is controlled to prevent hyperkalemia. Stress, catabolism, and diabetic ketoacidosis can increase potassium levels. Due to the complexity of renal failure, vitamin/mineral supplementation should be left up to the discretion of the physician.

RDA: This diet is not adequate to supply RDAs for all age groups and genders for the following nutrients:

Calcium (Approximately 1000mg)

Magnesium (Approximately 275 mg)

Vitamin D (Approximately 5 µg (mcg))

Vitamin E (Approximately 10-11mg)

Folate (Approximately 315 mcg)

FOODS	ALLOWED	AVOID
Milk: Limit to 8 oz per day	All milks	Puddings, custard , ice cream, and yogurt- (6oz=8oz milk) unless substituted for milk or made with non-dairy creamer. (Pudding and ice cream may be worked into menu).
Meat or Egg Group and Alternates: (Includes Cheese) limit to 6 oz daily	Meat, poultry, fish, eggs, cheese. May use 2 Tbsp peanut butter a day.	Dried beans, split peas, black eyed peas, lentils.
Fruit Group: Limit to 2 servings per day (Y, cup serving)	Apples, applesauce, all berries, cherries, fruit cocktail, grapes, grapefruit, lemon, lime, mandarin oranges, canned peaches/pears, pineapple, watermelon.	Apricots, bananas, papaya, melon (except watermelon), fresh peaches, fresh pears, kiwi, nectarines, oranges and orange juice, pomegranate, pomegranate juice, prune juice, mango, plantain, all dried fruits (including prunes), raisins (small amounts in food allowed).
Vegetable Group: Limit to 2 servings per day (Yz cup serving)	Asparagus, Brussels sprouts, broccoli, beets, canned bamboo shoots, cabbage, carrots, cauliflower, chili peppers, corn, creamed corn, cucumber, egg plant, green beans, hominy, iceberg lettuce, leeks, mushrooms, okra, onions, parsley, parsnips, peas, radish, red & green peppers, rhubarb, sauerkraut, sprouts, summer squash, turnips.	Celery, (may be used 1-2 oz in recipes allowed) potatoes, sweet potatoes, French fries, fresh bamboo shoots, yams, parsnips, pumpkin, potato chips, spinach, and all greens, romaine & leaf lettuce, winter squash, avocado, tomatoes and tomato products (small amounts 1-2 oz in recipes allowed). May have 1 Tbsp ketchup/day. Dried beans, lentils, chickpeas.

LOW POTASSIUM DIETS (continued)

FOODS	ALLOWED	AVOID
Breads, Cereals and Grains: Limit whole grains- no more than 4 servings/day	All breads, cereals-except bran, pasta, pastries	Bran cereal, wheat germ
Other: Limit coffee to 2 cups/day	Herbs, spices, 1oz chocolate, 1oz cocoa powder, condiments, sugar, jellies, desserts- except puddings/custards/ice cream/yogurt (see milk). Fruit desserts made with allowed fruit. Lemonade, punch.	Salt substitutes containing potassium, nuts, & seeds- (small amounts in food allowed), blackstrap molasses.

Follow the regular portions on the menu and avoid the foods listed above. If increased calories are needed, pull from the fat and simple sugar groups.

SAMPLE LOW POTASSIUM MENU:

Breakfast	Lunch	Dinner
4 oz Apple Juice	3 oz Meat w/gravy	8 oz Pearl Barley Soup
6 oz Farina Cereal	1/3 cup Rice	Sandwich with 2 oz Meat
1 Fried Egg	1/2 cup Green Beans	Mayonnaise & Iceberg Lettuce
1 Slice Toast	Biscuit	1/2 cup Coleslaw
Margarine & Jelly	Margarine	1/2 cup Applesauce
4 oz Non Dairy Creamer	3 oz Sherbet	8 oz Coffee
8 oz Coffee	4 oz Punch	4 oz Lemonade
	4 oz Milk	4 oz Milk

Approximately 1900 - 2000 calories and 80 grams of protein

PROTEIN RESTRICTED DIETS

DESCRIPTION:

A protein-restricted diet provides a guide for planning diets for persons with acute or chronic renal failure as well as for liver disease. The goal is to minimize uremic toxicity and prevent protein catabolism. A diet high in simple sugars and fat is used to spare protein. At restricted levels of protein, it is important to use a high quality of protein-rich foods that provide all the essential amino acids to the diet., such as animal proteins, and to spread the protein rich foods throughout the day to reduce the load on the failing kidneys and liver.

RDA: The diet may be inadequate in certain vitamins and minerals such as thiamine, riboflavin, niacin, vitamin D, magnesium, zinc, and iron. Due to the complexity of renal failure, vitamin/mineral supplementation should be left up to the discretion of the physician.

40 Gram Protein Diet:

FOODS:	ALLOWED:	AVOID:
Milk/Beverages:	Carbonated beverages, coffee, tea, non-dairy creamer, coffee rich.	Milk and Milk drinks.
Meat and Meat Substitutes:	Total3 oz protein. Meat, fish, poultry, eggs or cheese daily. (Include at least 1 egg per day)	
Potato, Bread, and Cereals:	Total of 5 servings. One serving = 1/2 cup potatoes, noodles, pasta, cereal, 1slice of bread or small muffin, biscuit, cornbread (2x2 1/2").	
Vegetables:	Total of 2 servings. One serving= 1/2 cup cooked or 1cup raw.	Dried Beans or count 1/2 cup= 1 oz meat.
Fruits:	All fruits and juices.	
Soups:	Broth, bouillon, consommés.	Milk based soups.
Desserts:	1 serving only. One serving= 3 oz sherbet, 1/2 c sweetened gelatin, 2 small sugar cookies. May have baked fruit desserts if on menu.	Cake, all other cookies, ice cream, custard, pudding.
Sweets:	Sugar candies, jelly, jam, honey or marmalade, sugar.	Milk Chocolate
Fats:	Butter, margarine, oil, mayonnaise,	Nuts

SAMPLE 40 GRAM PROTEIN MENU

The 40 gram protein diet provides approximately 1800-1900 calories. Extra calories can be added with margarine, gravies, simple sugars and increased Non-Dairy Creamer.

SAMPLE MENU:

Breakfast:
Fruit Juice 4 oz
Hot Cereal % cup
Egg 1
Toast 1 slice
Margarine 1 tsp.
Non-Dairy Creamer 8 oz
Coffee 8 oz

Lunch:
Roast Beef 1 oz
Gravy 1 oz
Noodles ¼ cup with Margarine
Green Beans ½ cup with Margarine
Bread ½ slice
Margarine ½ - 1 tsp
Gelatin ½ cup
Non-Dairy Creamer 4 oz
Coffee or Water 8 oz

Dinner:
Vegetable Soup 8 oz
Tuna Sandwich (1 oz protein/2 slices bread)
Sliced Onion/Lettuce Leaf Garnish
Canned Peaches % cup
Non- Dairy Creamer 4 oz
Punch 8 oz

H.S.
Juice 4 oz.

60 Gram Protein Diet:

FOODS:	ALLOWED:	AVOID:
Milk/Beverages:	Carbonated beverages, coffee, tea, non-dairy creamer, coffee rich.	Milk and Milk drinks.
Meat and Meat Substitutes:	Total 5 oz protein. Meat, fish, poultry, eggs or cheese daily. (Include at least 1 egg per day).	
Potato, Bread, and Cereals:	Total of 6 servings. One serving= 1/2 cup potatoes, noodles, pasta, cereal, 1 Slice of bread or small muffin, biscuit, cornbread (2x2 1/2").	
Vegetables:	Total of 2 servings. One serving= 1/2 cup cooked or 1 cup raw.	Dried Beans or count 1/2 cup = 1 oz meat.
Fruits:	All fruits and juices.	
Soups:	Broth, bouillon, consommés.	Milk based soups.
Desserts:	1 Serving only. One serving= 2 small sugar cookies, 3 oz sherbet, or 1/2 c sweetened gelatin. May have cake, cookies, pudding, ice cream, baked fruit desserts or dessert bars only when on menu in specified amount.	Cake, all other cookies, ice cream, custard, pudding.
Sweets:	Sugar candies, jelly, jam, honey or marmalade, sugar.	Milk Chocolate
Fats:	Butter, margarine, oil, mayonnaise, gravy	Nuts

SAMPLE 60 GRAM PROTEIN MENU

The 60 gram protein diet provides approximately 1800-2000 calories. Extra calories can be added with margarine, gravies, simple sugars and increased Non-Dairy Creamer.

SAMPLE MENU:

Breakfast:
Fruit Juice 4 oz
Hot Cereal ½ cup
Egg 1
Toast 1 slice
Margarine 1 tsp.
Non-Dairy Creamer 8 oz
Coffee 8 oz

Lunch:
Roast Beef 2 oz
Gravy 1 oz
Noodles % cup with Margarine
Green Beans % cup with Margarine
Bread 1 slice
Margarine 1 tsp
2x2 ½" Frosted Cake
Non – Dairy Creamer 4 oz
Coffee or Water 8 oz

Dinner:
Vegetable Soup 8 oz
Tuna Salad Sandwich (2 oz Tuna/2 slices bread)
Sliced Onion/Lettuce Leaf Garnish
Canned Peaches ½ cup
Non – Dairy Creamer 4 oz
Punch 8 oz

H.S.
Juice 4 oz.

80 Gram Protein Diet:

FOODS:	ALLOWED:	AVOID:
Milk/Beverages:	Carbonated beverages, coffee, tea, non-dairy creamer, coffee rich, 8 oz milk.	**Milk** and Milk drinks above 8 oz/day.
Meat and Meat Substitutes:	Total 6 oz protein. Meat, fish, poultry, eggs or cheese daily. (Include at least **1** egg per day).	
Potato, Bread, and Cereals:	Total of 7 1/2 servings. One serving= 1/2 cup potatoes, noodles, pasta, cereal, 1 slice of bread or small muffin, biscuit, cornbread (2x2 1/2").	
Vegetables:	Total of 2 servings. One serving= 1/2 cup cooked or 1 cup raw.	Dried Beans or count 1/2 cup =1oz meat.
Fruits:	All fruits and juices.	
Soups:	Broth, bouillon, consommés.	Milk based soups.
Desserts:	**1** serving only. One serving= 2 small sugar cookies, 3 oz sherbet, or 1/2 c sweetened gelatin. May have cake, cookies, pudding, ice cream, fruit crisps/cobblers and dessert bars only when on menu in specified amount.	Cake, all other cookies, ice cream, custard, pudding.
Sweets:	Sugar candies, jelly, jam, honey or marmalade, sugar.	Milk Chocolate
Fats:	Butter, margarine, oil, mayonnaise, gravy.	Nuts

SAMPLE 80 GRAM PROTEIN MENU

The 80 gram protein diet provides approximately 1800-2000 calories. Extra calories can be added with margarine, gravies, simple sugars and increased Non-Dairy Creamer.

SAMPLE MENU:

Breakfast:
Fruit Juice 4 oz
Hot Cereal ¾ cup
Egg 1
Toast 1 slice
Margarine 1 tsp.
Non-Dairy Creamer 8 oz
Coffee 8 oz

Lunch:
Roast Beef 3 oz
Gravy 1 oz
Noodles ½ cup with Margarine
Green Beans ½ cup with
Margarine Bread 1 slice
Margarine 1 tsp
2x2 ½" Frosted Cake
Milk 4 oz
Coffee or Water 8 oz

Dinner:
Vegetable Soup 8 oz
Tuna Salad Sandwich (2 oz Tuna/2slices bread)
Sliced Onion/Lettuce Leaf Garnish
Canned Peaches ½ cup
Milk 4 oz
Punch 8 oz

H.S.
Juice 4 oz.
Graham Crackers (4 squares)

RENAL DIET 40-60-80 GRAM PROTEIN, LOW POTASSIUM, LOW SALT MENU

DESCRIPTION: This diet is used for the resident with renal insufficiency or for residents with renal failure not on dialysis. This diet regulates the dietary intake of sodium, potassium and protein to lighten the work of the diseased kidney. This diet has the three restrictions. Each restriction has a specific plan in this manual. This diet is also low in phosphorus.
This diet is approximately1800 -1900 calories. Note: Residents on dialysis i.e. 60, 80 gm protein levels or higher, need to have specific protein level ordered by M.D. The diet order should also include other restrictions such as potassium, sodium & fluid. Low potassium & low salt diet recommended.
SAMPLE MENU:

40 Gram	60Gram	80 Gram
Breakfast:	Breakfast:	Breakfast:
Apple Juice 4 oz	Apple Juice 4 oz	Apple Juice 4 oz
Hot Cereal 4 oz	Hot Cereal 4 oz	Hot Cereal 4 oz
(Mav serve cold cereal except bran)	(Mav serve cold cereal except bran)	(Mav serve cold cereal except bran)
Egg 1 - any style	Egg 1 - any style	Egg 1 - any style
Toast 1 slice, hot bread, pancakes, Per regular portion	Toast 1 slice, hot bread, pancakes, Per regular portion	Toast 1 slice, hot bread, pancakes, Per regular portion
Margarine as desired	Margarine as desired	Margarine as desired
Non-dairy creamer 8 oz	Non-dairy creamer 8 oz	Non-dairy creamer 8 oz
Coffee 8 oz	Coffee 8 oz	Coffee 8 oz
Lunch	Lunch	Lunch
Meat 1 oz	Meat 2 oz	Meat 3 oz
Gravy 1 oz	Gravy 1 oz	Gravy 1 oz
Rice ½ cup with Margarine (avoid potatoes)	Rice ½ cup with Margarine (avoid potatoes)	Rice ½ cup with Margarine (avoid potatoes)
Carrots ½ cup with Margarine (avoid high potassium vegetables and sauerkraut due to salt)	Carrots ½ cup with Margarine (avoid high potassium vegetables and sauerkraut due to salt)	Carrots ½ cup with Margarine (avoid high potassium vegetables and sauerkraut due to salt)
Bread ½ slice or Hot bread ½ serving with margarine (avoid excess whole grain breads)	Bread ½ slice or Hot bread ½ serving with margarine (avoid excess whole grain breads)	Bread ½ slice or Hot bread ½ serving with margarine (avoid excess whole grain breads)
Jelly as desired	Jelly as desired	Jelly as desired
Pineapple ½ cup (avoid high potassium fruit)	Apple Cobbler Dessert	Apple Cobbler Dessert
Non-dairy creamer 4 oz	Non-dairy creamer 4 oz	Non-dairy creamer 4 oz
Lemonade or Punch 4 oz	Lemonade or Punch 4 oz	Lemonade or Punch 4 oz
Dinner:	Dinner:	Dinner:
Casserole (1 oz meat/noodles/sauce) Give ½ of the serving on the menu – (1/3 to ½ cup)	Casserole (2 oz meat/noodles/sauce)	Casserole (2 oz meat/noodles/sauce)
Peas ½ cup with Margarine	Peas ½ cup with Margarine	Peas ½ cup with Margarine
Apple Ring Garnish	Apple Ring Garnish	Apple Ring Garnish
Garlic Bread 1 slice	Garlic Bread 1 slice	Garlic Bread 1 slice
Canned Peaches ½ cup	Canned Peaches ½ cup	Canned Peaches ½ cup
Non-dairy creamer 4 oz	Non-dairy creamer 4 oz	Non-dairy creamer 4 oz
Tea 8 oz	Tea 8 oz	Tea 8 oz

Avoid high potassium fruits and vegetables. See low potassium diet page 34.

LOW PHOSPHORUS DIET (1-1.5 GMS)

DESCRIPTION:

This diet is sometimes ordered in combination with other restrictions for residents with renal failure. Hyperphosphatemia may lead to renal bone disease and dietary control may be necessary in order to achieve acceptable blood levels. Phosphate binders are often prescribed for these residents and it is very important to take the binders with meals. (The binders work on the food consumed in that meal). A low protein and low potassium diet is inherently low in phosphorus. However with the increased protein needed for residents on dialysis, a phosphorus restriction may be needed. Due to the complexity of renal failure, vitamin/mineral supplementation should be left up to the discretion of the physician

FOODS	AVOID
Milk: Limit to 8 oz per day.	Foods prepared with milk as the main ingredient, i.e. pudding, yogurt, ice cream,
Meat Group and Alternatives: Limit to 5 oz meat per day and 1 egg.	Dried beans, cheese, cottage cheese, legumes, and peanut butter.
Fruit Group: Limit to 4 servings per day.	Dried fruits (including raisins and prunes).
Vegetable Group: Limit to 2 servings per day.	Peas (including black-eyed peas), corn, and Lima beans.
Breads, Cereals, and Grains: Limit to 6 servings	Bran cereals, oatmeal, whole grain bread, oat cereal, i.e. cheerios, corn bread.
Other:	Nuts, seeds, cake, coconut, colas, chocolate, cream pie, wheat germ, and unprocessed

A GUIDE TO FLUID MEASUREMENT

DESCRIPTION: Fluid restriction diet orders are usually prescribed by the physician to correct an electrolyte imbalance in kidney and liver conditions. Fluid restrictions are usually 1OOOcc to 1500cc per day. Dietary and nursing departments need to communicate with each other to ensure the correct amount of fluids are given per 24 hours. The amount of fluids to be served at meals should be noted on the tray card. The dietary supervisor and/or dietitian can fill out the Fluid Restriction Guide to ensure communication to both dietary and nursing departments.

FLUID MEASUREMENTS

240cc =	8 ounces or 1 cup
180 cc=	6 ounces or ¾ cup
120cc=	4 ounces or ½ cup
30cc=	1 ounce

TYPICAL MEASURES

Coffee cup holds 8 oz =	240cc
Soup bowl holds 8 oz =	240cc
Sherbet and ice cream cups 3 oz =	90cc
Gelatin cup ½ c =	120cc
Water pitcher – will vary -	750-900cc

TYPICAL FLUID ITEMS

Broth
Cocoa
Coffee
Cream
Eggnog
Gelatin
Ice
Ice Cream
Juice
Nutritional Supplement Drinks
Sherbet
Soda
Soup
Tea
Water

NON-FLUID ITEMS

Baby food
Custard
Gravy
Pudding
Refined cereal
Yogurt
Watermelon

- Fluid items tend to be those items that liquefy at room temperature i.e., Jello, Ice, Ice Cream.
- Drain canned fruits

SODIUM RESTRICTED DIETS

DESCRIPTION:

A sodium-restricted diet is used for control of hypertension and for prevention, control and elimination of edema. Sodium restricted diets should be ordered in terms of milligrams of sodium. Non-specific orders such as low sodium, salt free or avoid salt should be clarified as to the level of sodium allowed. All sodium restricted diets do not receive a salt packet.

RDA: The regular No Added Salt and Low Salt Diets are adequate for all age groups and genders except for the following nutrient:
Vitamin D- 10 µg (mcg) is provided

The 2 gm Na is adequate for all age groups and genders except for the following nutrient:
Magnesium- 415mg (low for men 70 yrs or older).

RECOMMENDED ORDERS

2 gm. Na, Low Salt (2.0-2.5 gm Na), or No Added Salt Diets (2.6-3.5 gm Na). If a physician has not clarified any of these three diets then use the No Added Salt level until the order can be clarified.

REGULAR NO ADDED SALT DIET

This diet is a regular diet with the exception that no salt may be added to food after preparation per recipe. No salt packet or saltshaker is allowed with the patient or resident's meal. The approximate sodium level is 2.6 to 3.5 gm. Na per day.

2.0-2.5 NA (LOW SALT)

This is recommended for renal diets.

Foods used are those allowed on the Regular Diet with the exception of the following heavily salted foods:

AVOID: Heavily salted foods such as:

American (processed) cheese (2oz allowed/week)
Bacon (one slice allowed two times per week)
Bouillon
Corned Beef
Fish Sauce
Ham
Meat tenderizers
Pickles
Processed Luncheon Meat
Salty Crackers
Salty Soups
Sauerkraut
Smoked Meat
Soy Sauce (may use lite)
Olives (may be used as ingredient in recipe)

Food may be lightly salted during cooking. No salt packet or saltshaker is allowed with the patient/resident's meal.

SODIUM RESTRICTED DIETS

2GM NA

The 2 gm Na diet will follow the low salt diet with the additional restrictions of:

BEVERAGES: Avoid canned vegetable juices with salt.

MILK: Limit milk to 2 cups/day. Avoid buttermilk and commercial chocolate mix.

MEAT: Limit to 5 oz / day. 1 egg per day. No processed cheeses.

BREADS AND CEREALS: 1 serving cereal (6 oz), 5 servings breads (roll, pancakes, French Toast, bread, quick-bread) daily.

VEGETABLES: Serve fresh or frozen with only a small amount of salt. May serve canned creamed corn or beets each 1 time/week (1/2 cup).

FRUITS: As desired.

SOUPS: SF soups per recipe (made from SF bases). May have cream soup when on menu and per recipe.

DESSERTS: May have 2 servings of dessert/day.

FATS: SF margarine. May use 3 tsp. regular margarine or butter daily. May serve mayonnaise. (Avoid regular salad dressings.)

The RDs for Healthcare menus for 2 gm Na diets follow these guidelines allowing small amounts of salt in cooking (casseroles, potatoes, rice, etc.). Each day is individually calculated and foods are allowed as much as possible without going over2 gm Na.

LACTOSE RESTRICTED DIETS

DESCRIPTION: This diet provides a restricted intake of lactose in the dietetic management of patients exhibiting lactose intolerance. A lack of the enzyme lactase results in the inability to hydrolyze lactose to glucose and galactose. Milk and milk products are major food sources of lactose and are excluded depending on the individual tolerance of the person.

COMMENT: Typically the infant and child with lactase deficiency will need a more strict control of lactose intake than the adult. With secondary lactose intolerance the diet can be more liberal. Some individuals are able to ingest small amounts of lactose without symptoms while others must avoid this sugar entirely. It is recommended that overloading of lactose at any one meal be totally avoided.

Words that may indicate lactose in food:
Milk, lactose, margarine, buttermilk, milk solids, curds, sweet cream, whey, cheese flavors, and sour cream. Read labels carefully.

Recommend 2-3 glasses lactose free milk or soy milk in place of milk. If no milk is served, the diet will be low in calcium (approximately 700 mg), and low in vitamin D (approximately 2 µg (mcg)). It will also be low in magnesium (approximately 380 mg), for men 14 years and older.

FOODS	AVOID
Dairy Products	Milk, sweetened condensed milk, half & half, evaporated milk, whey, yogurt, cocoa powder. Ovaltine, milk chocolate (7-8% lactose) instant chocolate food supplements, cream, sour cream, cheeses, cottage cheese. May serve soybean milk and buttermilk if lactose free.
Meats, Fish, Poultry, Eggs	Hot dogs, sausages, luncheon meats, processed/breaded meats if lactose added. Creamed meat products.
Vegetables	Creamed vegetables, possibly breaded vegetables- check labels.
Cereal and Breads	Prepared instant cereals, some cold cereals- check labels. Depending upon tolerance, some breads and cereals prepared with milk or milk products may need to be avoided, such as waffles and pancakes.
Potato or Substitute	Instant mashed potatoes or potatoes if milk solids, milk or lactose added.

LACTOSE RESTRICTED DIET (continued)

Soups	Cream soups and commercial soups prepared with milk solids or other lactose containing products
Fats	Cream , powdered coffee cream, margarine or salad dressings containing milk solids, butter, milk gravies.
Desserts	Commercial desserts and prepared mixes with milk or milk products, ice cream, sherbet, pudding, custard, chocolate, whipped topping containing lactose.

Comments- Lactase is a digestive enzyme & supplement that can be chewed and swallowed before eating lactose- containing foods.

Low PURINE DIET

DESCRIPTION: This diet is often ordered in conjunction with anti-gout drug therapy or as an alternative treatment if medications are not tolerated for patients with hyperuricemia, gouty arthritis, or urinary uric acid lithiasis. The rationale is to decrease elevated blood urinary and uric acid levels.

Purine occurs in foods of animal origin excluding dairy products and eggs. Foods that contain 50 mg. or more of purine per 100g serving should be avoided, with the exception of meat, fish, and poultry appearing on the RD's for Healthcare menus. In addition a low fat, calorie reduction (for those overweight), and an alcohol abstinence diet, plus a 2000-300 cc fluid intake is recommended.

RDA: This diet is not adequate to supply RDAs for all age groups and genders due to the removal of many nutritious foods. Many nutrients may be low. A multi vitamin with minerals is recommended.

1. Avoid these foods with +50 mg. purine:

Organ meats, including liver
Meat soups, broths, and gravy (may use vegetable broth)
Meat extracts, bouillon and drippings
Herring, mackerel, scallops, sardines, anchovies
Whole grain bread and cereal
Legumes, lentils, beans, peas
Asparagus
Green peas
Spinach
Mushrooms
Cauliflower
Wheat germ
Bran
Oatmeal

2. Choose fruits, fruit juices, gelatin, vegetables not listed above, sherbet, and non-fat milk for snacks and when additional portions are requested.

3. Choose non-fat milk, and jelly instead of margarine.
   Avoid sausage, bacon, hot dogs due to high fat content.
   Fat retards the excretion of uric acid.

4. Arrange for (gradual) weight loss when appropriate.
   Obesity has a strong correlation with serum urate concentration.
   When ketones develop with rapid weight loss, uric acid excretion is inhibited.

5. Recommend no alcohol.
   Alcohol abstinence will reduce uric acid levels.

6. Plan 2000-3000cc fluids per day.
   Fluid will remove uric acid from the body.

GLUTEN-RESTRICTED DIET (Gliadin Free)

DESCRIPTION: This diet is often ordered in the treatment of celiac disease (CD) or also referred to as celiac sprue, nontropical sprue, and gluten-sensitive enteropathy. Gluten Is a general name given to the storage proteins (prolamins) present in wheat, rye, barley, and oats. Intolerance to gluten can result in the inability of the small intestine to digest and absorb nutrients. This diet eliminates all foods containing wheat, rye, barley, bulgur, millet, wheat germ, and oats. It is important to review labels of all commercial, processed, and prebreaded food items. Words that may indicate gluten are flour, modified food starch, monosodium glutamate, hydrolyzed vegetable protein, cereals, malt or cereal extracts and soy sauce.

NUTRITIONAL BREAKDOWN:

Calories: 1850- 1950, Protein: 85- 90 gms, Fat: 85- 90 gms, Carbohydrates: 195-205 gms

RDA: This diet is not adequate to supply RDAs for all age groups and genders for the following nutrients:

Iron: Approx. 13 mg, Magnesium: Approx. 330-340 mg (low for men 14 years or older)

Vitamin D: Approx. 10 µg (mcg), Vitamin E: Approx. 11mg

FOODS	ALLOWED	AVOID
Milk	Milk, soy milk, cream, buttermilk, plain yogurt, cheese, cream cheese, processed cheese, cottage cheese	Malted milk, instant milk drinks, commercial chocolate milk, sour cream unless gluten free.
Meat and Alternate	Unprocessed beef, pork, veal, fish, poultry, eggs, seeds. Nuts, tofu, peanut butter, soybeans, dried legumes, dried beans.	Meat and meat alternates prepared with gluten containing ingredients or hydrolyzed or texturized vegetable protein (HVP or TVP). Breaded meats, breaded fish, meatloaf made with bread/crumbs, canned meats, hot dogs, luncheon meat, sandwich spread, sausages, bologna, crab croquettes.
Fruits	Fresh, frozen, canned or dried fruit, pure fruit juices	Pie fillings
Vegetables	Fresh, frozen or canned- including potatoes, white or sweet. Add only butter, milk, cream and eggs in preparation.	Scalloped potatoes, creamed vegetables thickened with wheat, barley, rye, oats or flour made from restricted grains.
Breads, Cereals and Grains	Cream if rice, cornmeal, pure corn tortillas rice cakes, bread made from rice, corn, soybean or potato flour, gluten free flour, amaranth, or arrowroot. Hominy grits, gluten free corn flakes, gluten free rice krispies or gluten free puffed rice and cornmeal polenta, cornstarch.	Bread, rolls, biscuits, muffins, corn bread, crackers, donuts, pancakes, or waffles, pretzels, cream of wheat, farina, oatmeal, bran, bran flakes, bread crumbs, croutons, noodles and pasta. All products made from barley, buckwheat, bulgur, durham, millet, oats, rye, wheat or wheat germ, graham flour, matzo meal or seminola.

GLUTEN-RESTRICTED DIET (continued)

FOODS	ALLOWED	AVOID
Soups	Clear broth or soups thickened with cream, cornstarch, potato, soybean or rice flour.	Anything with noodles, anything made with wheat, barley, rye, oats or flours made from restricted grains.
Desserts and Sweets	Pure chocolate, rice pudding, tapioca, gelatin, hard candy, custard, cookies and cakes made from rice, corn, soybean flour.	Cookies and cakes or pies prepared with prohibited flours. Ice cream, sherbet or pudding, unless gluten free.
Beverages	Coffee, tea, sports beverages, carbonated beverages	Hot cocoa mixes, non-dairy cream substitutes, ale, and beer.
Fats	Butter, margarine, oil, mayonnaise, flax.	Commercial salad dressing, gravies or cream sauces thickened with flour.
Miscellaneous	Jelly, jams, marshmallows, syrup, honey, broth, herbs, spices, relish, pickles, vinegar, popcorn, plain potato chips, olives, horseradish, ketchup, Worcestershire sauce, spices and extracts, cornstarch.	Soy sauce, malt vinegar, any flavored vinegar that may have malt vinegar or other prohibited ingredients, mustard, (unless does not have flour, beer or malt vinegar in label).

Note: If in doubt about any ingredient or additive, check with the manufacturer.

Certain grains, such as oats, can be contaminated with wheat during growing and processing stages of production. It's not clear whether oats are harmful for most people with celiac disease, but doctors generally recommend avoiding oats unless they are specifically labeled gluten free. Cross contamination may also occur anywhere ingredients come together, such as on a cutting board or a grill surface. You may also be exposed to gluten by using the same utensils as others such as a bread knife.

SAMPLE GLUTEN-RESTRICTED DIET

BREAKFAST:

Orange Juice- 4 oz Cream of
Rice- ¾ cup
Egg- 1
Gluten Free Slice of Bread, Toasted or serve ½ cup fruit or
can serve double portion of the Cereal
Margarine - 1tsp if needed
Milk 8 oz

LUNCH:

Pork Chop – 3 oz meat
Gravy made with cornstarch- 1oz
Potatoes with Margarine- ½ cup
Carrots with Margarine-½ cup
Gluten Free Bread 1 slice with Margarine
or can serve double Potatoes
Gelatin-½ cup
Milk – 4 oz

DINNER:

Tuna Salad - # 12
Green Salad- ½ cup with Oil and Vinegar
Three Bean Salad- ½ cup
Gluten Free Bread - 1 slice or Gluten Free Roll - 1
with Margarine – 1tsp or can serve double Three Bean Salad
Chilled Melon Cup- ½ cup
Milk – 4 oz

May also provide other fluids- water, juice, punch, lemonade, coffee or tea.

BREASTFEEDING DIET

Description:

To meet extra nutritional demands for milk production, an addition of 500 calories per day over normal calorie needs is recommended. Adequate fluid intake, rest and social support are essential for successful lactation. Protein requirements are increased approximately 20g per day over normal needs. Calcium requirements are increased to 1300mg daily for women 18 years of age and younger and to 1000mg for women 19 years of age and older.

The breastfeeding diet will follow the regular diet with large portions, with the exception of increased ½ C servings of both fruit and vegetables per day and elimination of caffeine and herbal tea which include peppermint.

Nutritional Breakdown:
Calories: 2500-2800
Protein: 120-130g
Carbohydrate: 295-315g

If additional calories are required, nourishments or fortification may additionally be ordered to meet patient's specific needs. Please see the regular diet order, and large portion specification for further detail regarding design of food distribution.

CARDIAC DIET

Description:

The cardiac diet is a fat-controlled and sodium restricted diet. The low fat/low cholesterol diet is designed to lower elevated levels of serum cholesterol and other lipids in effort to reduce the risk of heart disease. Sodium restriction is used for control of hypertension and for prevention and elimination of edema. These restrictions will follow the low fat/low cholesterol diet with the exception that no salt may be added to food after preparation per recipe, and caffeine is to be restricted for heart health. No salt packet or saltshaker is allowed with the patient's or resident's meal. Sodium provided will be 2.6-3.5gm per day unless otherwise specified by the physician.

RDA: This diet is inadequate for all age groups and genders except for the following nutrient: Vitamin D, Vitamin E.

Nutritional Breakdown:
Calories: 1800-2000
Protein: 90-100g
Fat: 55-65g
Carbohydrate: 230-240g
Cholesterol: <300g

Please see low fat/ low cholesterol dietary description for detailed foods permitted in dietary order.

CLEAR LIQUID DIABETIC DIET

Description:

The clear liquid diabetic diet is designed to provide foods in a systematic pattern of consistent carbohydrate delivery in addition to foods that leave no residue in the gastrointestinal tract. This diet is indicated for a diabetic patient or resident with preoperative and progressive post-operative regime and for diabetic patients and residents with acute diarrhea and/or nausea.

Foods are distributed in 3 meals, and 3 nourishments in effort to maintain stable blood sugar control throughout the day.

This diet is inadequate in nutrients and should be used for no more than 48 hours unless otherwise prescribed by the attending physician. Calories provided are approximately 909, with 17 grams of protein.

Foods:

Soups: Clear broth, consommé or bouillon

Beverages: water, tea, coffee,

Fruit juices including apple, grape, or cranberry

Desserts: Flavored gelatin, popsicles

Misc: Sugar substitute

Carbohydrate Pattern:	
Breakfast	45-60g
Nourishment	15-30g
Lunch	45-60g
Nourishment	15-30g
Dinner	45-60g
Nourishment	15-30g

Sample Menu

Breakfast	Lunch	Dinner
8oz Apple Juice	8oz Grape Juice	8oz Cranberry Juice
8 oz Clear Broth	8oz Clear Broth	8oz Clear Broth
4oz Flavored Gelatin	4oz Flavored Gelatin	4oz Flavored Gelatin
10:00am Nourishment	3:00pm Nourishment	8:00pm Nourishment
4oz Enlive	4oz Enlive	4oz Apple Juice

For nutritionally compromised patient/residents, commercial products to increase calorie, protein, vitamins, and minerals including fortified broth and fortified flavored clear fruit drinks may be substituted in appropriate carbohydrate distribution as needed.

FULL LIQUID DIABETIC DIET

Description:

This diet is used when a patient or resident with Diabetes Mellitus must receive a full liquid diet. Full liquid diet foods are foods which become liquid at body temperature and are easily digested. This diet is indicated for diabetic patients who are in need of a progressive post-operative dietary regime, for acutely ill diabetic patients or residents, or for diabetics experiencing extreme difficulty in chewing and swallowing and for duration of with wired jaws.

This diet is inadequate in many vitamins and minerals and should be used for a limited time. Patients and residents remaining on this diet for more than 1 week should be evaluated by the dietitian and physician. To continue this diet, it is important to include a commercial protein supplement and multivitamin with mineral supplementation to meet daily nutritional needs of all age groups

Nutritional Breakdown:
Calories: 1743
Protein: 69g
Fat: 67g
Carbohydrates: 225g

Carbohydrate Distribution	
Breakfast	45-60g
Nourishment	15-30g
Lunch	45-60g
Nourishment	15-30g
Dinner	45-60g
Nourishment	15-30g

Foods:

Soups: Broth, consommé, or strained soups

Beverages: Milk, milk drinks, commercial protein supplements, cream, cocoa, eggnog, fruit and vegetable juices, coffee, coffee substitutes, tea

Desserts: Custard, plain flavored gelatin, plain ice cream, plain ices and sherbets, popsicles, plain yogurt (no seeds or fruit), pudding

Cereals: Refined cereal gruels, farina, cream of rice cereal

Miscellaneous: Margarine, sugar free jelly, salt, mild spices such as nutmeg, cinnamon and paprika

Sample Menu:

Breakfast	Lunch	Dinner
8oz Milk	8oz Milk	8oz Milk
6oz Refined Cereal Gruel	8oz Strained Cream Soup	8oz Strained Cream Soup
4oz Grape Juice	3oz Vanilla Ice Cream	1 Pudding Cup
		4oz Apple Juice
10:00am Nourishment	**3:00pm Nourishment**	**8:00pm Nourishment**
8oz Glucerna	8oz Glucerna	8oz Glucerna

Northern Inyo Hospital

Winter Patient Menu Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Scrambled Egg Buttered Toast Toasted Oats Grape Juice	Biscuit & Gravy Fruit Cup Raisin Bran Cereal Blended Juice	Waffle with Warm Syrup Sausage Patty Hot Oatmeal Orange Juice	Bacon-Egg Scramble Buttered Toast Hot Farina Pineapple Juice	Chocolate chip Pancakes with Warm Syrup Sausage Patty Hot Oatmeal Apple Juice	Scrambled Eggs Cranberry Muffin Raisin Bran Cereal Grape juice	Sweet Roll Baked Vegetable Omelet Hot Oatmeal Blended Juice
Southern Style Beef Patty Cream Gravy Mashed Potatoes Garlic Parmesan Spinach Wheat Roll Ambrosia Pudding	Cheese Enchilada Refried Beans Red & Green Salad Flour Tortilla Raspberry Parfait Square	Herb Baked Chicken Pasta with Creamy Marinara Sauce Cauliflower & Peas Garlic Bread Chocolate Cake	Oven Crisp Fish Cheesy Broccoli Rice Seasoned Baby Carrots Wheat Roll Ice Cream	Meatloaf & Gravy Garlic Mashed Potatoes Lemon Basil Green Beans Cranberry Gelatin Salad Apple Brown Betty	Chicken with Tarragon Sauce Fluffy Brown Rice Mixed Vegetables Wheat Roll Pumpkin Spice Cheesecake	Ham with Spiced Apples Au Gratin Potatoes Seasoned Peas Wheat Roll Chocolate Cream Pie
Chinese Corn Soup Sesame Orange Chicken Imperial Noodles Golden Carrots & Zucchini Fresh Fruit Cup	Pork in Rosemary Sauce with Rice Pilaf Broccoli with Lemon & Dill Wheat Roll Cranberry Crunch Bar	Beef Pot Pie Seasoned Corn with Red Peppers Tossed Green Salad Fresh Fruit	BBQ Pork on a Bun Baked Beans Creamy Cucumber & Celery salad Oatmeal Raisin Cookie	Winter-Time Lentil Soup Creamy Macaroni and Cheese Baked Fresh Zucchini Blushing Pears	Hearty Vegetable Soup Egg Salad Sandwich Potato Chips Orange Slices	Spaghetti with Meatballs Three Bean Salad Garlic Bread Fruit Cup

Milk and Beverage Offered with Every Meal

Photo © David Doerr | Used with permission.

Northern Inyo Hospital

Winter Patient Menu Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Pancake with Apple Topping Scrambled Egg Toasted Oats Orange Juice	Scrambled Egg Buttered Wheat Toast Raisin Bran Pineapple Juice	French Toast Warm Syrup Sausage Patty Hot Oatmeal Apple Juice	Egg Muffin Sandwich Hash Brown Potatoes Hot Farina Grape Juice	Pumpkin Square Bacon Hot Oatmeal Blended Juice	Italian Baked Omelet Buttered Wheat Toast Raisin Bran Orange Juice	Southwestern Breakfast Casserole Stewed Prunes Hot Oatmeal Pineapple Juice
Beef Stew Fresh Green Salad Corn Bread Ice Cream	Fish Fillet with Garlic Butter Barley Pilaf Creamed Spinach Sweet Corn Salad Fruit Bavarian Cream	Italian Lasagna Broccoli with Tarragon Garlic Bread Berry Cheese Bar	Pot Roast Boiled Potatoes Seasoned Carrots Corn Coleslaw Peanut Butter Cup Pudding	Oven Fried Chicken Saucy Penne Spinach with Onions Fresh Italian Salad Cake with Frosting	Salisbury Steak Mushroom Gravy Mashed Potatoes Seasoned Peas Carrot & Raisin Salad Sherbet	Maple Glazed Pork Baked Potato Broccoli with Cheese Sauce Wheat Roll Chefs Choice of Cream Pie
Chinese Roasted Chicken Fried Rice Stir Fry Vegetables Mandarin Asian Salad with Sesame Dressing Almond Cookie	French Onion Soup Hamburger Country Baked Beans Baked Apricot Crunch	Split Pea Soup Turkey & Cheese Sandwich with Dijon Dill Mayo Fresh Fruit	Tamale Pie Spanish Rice Mixed Greens Salad Fruit Cup	Cream of Broccoli Soup Hot Tuna Melt Tater Tots Fruit Ambrosia	Baked Ziti Green Beans with Onions & Red Peppers Garlic Bread Butterscotch Pears	Grilled Chicken Breast on a Bun Special Sauce Texas Fries Tossed Green Salad Fluffy Fruit Dessert

Milk and Beverage Offered with Every Meal

NORTHERN INYO HOSPITAL

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, California
93514
(760) 873-5811 voice
(760) 872-2768 fax

DIETARY MANUAL

Within the dietary documents presented you will find the current dietary menu for hospital patients and the proposed dietary manual. As of January 1st, our menu has had a big makeover. Not only has it expanded to a two week cycle, but includes all new recipes. The pre-select menu has been replaced by standing menu. This change decreased the variation of meals prepared by the chef in order to eliminate the use of many pre-made products for ease, thus allowing our cooks to focus on producing higher quality foods from scratch cooking. The dietary manual includes all commonly ordered therapeutic diets, and is used as a guide for kitchen staff and medical staff to better understand the diet orders terminology, and appropriate use. The dietary manual will be reviewed once a year, and must be updated every five years.

Thank you,

Amber Morin RD, CPT, CLC
Registered Dietitian
Northern Inyo Hospital
Office: (760)873-5811 ext 3284
Cell: (858)692-4702

Improving our Communities one Life at a Time. One Team. One Goal. Your Health!

Web Site
www.nih.org

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

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District

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Web Site
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February 9, 2017

Dear Member of Congress:

We write to you today urging you to support the reintroduction of the bipartisan Critical Access and rural Equity (CARE) Act, legislation that will ensure Critical Access Hospitals (CAHs) are able to maintain high quality care in their rural communities by offering greater clarity to the definition of allowable costs.

CAHs play a vital role providing access to inpatient and outpatient services, as well as 24-hour emergency health care, economic security, and jobs to frontier communities across the nation. We act as safety-net providers and are critical to ensuring that rural communities have access to emergency medical treatment within the "critical hour." Without CAHs, hundreds of thousands of Americans may lose or have limited access to essential care.

Congress developed the CAH designation for small rural hospitals in response to an influx of hospital closures in the 1980s and 1990s. The CAH designation was created to reduce the financial vulnerability of rural hospitals and improve access to health care for rural Americans. While CAHs are reimbursed for 101% of "allowable" costs for providing care, only a portion of CAHs' costs are actually considered "allowable" and qualify for the 101% cost-based reimbursement. In fact, what constitutes an allowable cost by CMS has continued to erode over the past few years. Moreover, there is variation between regions and Medicare auditors regarding the definition of allowable costs.

A clearer definition of allowable costs is absolutely necessary. The CARE Act would clarify the definition of CAH allowable costs to assure that patient- and physician-centered expenses are included as originally intended. The legislation would also clarify commonly cited auditor discrepancies and remove barriers to care by ensuring coverage of the most common diagnostic tests, health clinics, and physician recruitment and retention costs.

Creating a uniform definition of allowable costs would enable CAHs to continue to serve patients across rural America with more certainty with how they will be reimbursed by Medicare for the care they provide every day. We urge you to support the CARE Act today.

Sincerely,

Kevin S. Flanigan, MD, MBA, CEO
Northern Inyo Healthcare District

Peter Watercott, President
Northern Inyo Healthcare District

AMERICA'S CRITICAL ACCESS HOSPITAL COALITION

CAH Allowable Costs

Critical Access Hospitals (CAHs) act as safety-net providers in rural and frontier communities – delivering inpatient and outpatient services, as well as 24-hour emergency care. Congress developed the CAH designation for small rural hospitals in response to an influx of hospital closures in the 1980's and 1990's. The CAH designation was created to reduce the financial vulnerability of rural hospitals and improve access to health care for rural Americans. CAHs make it possible for individuals living with complex medical needs to remain in their communities without travelling long distances to receive the care they require. Additionally, CAHs are critical to make sure that rural communities have access to emergency medical treatment within the "critical hour." CAHs are reimbursed for 101% of "allowable" costs for providing care. An expanded definition of allowable costs is necessary to ensure CAHs can continue delivering care to rural communities.

CURRENT PROBLEM:
To ensure CAHs are able to maintain high quality care in communities with low patient volume and high proportions of Medicare and Medicaid patients, Medicare pays CAHs 1% above the cost of providing care. However, only a portion of CAHs' costs actually qualify for the 101% cost-based reimbursement, which contributes to CAHs' negative margins. Moreover, there is variation between regions and auditors regarding what are allowable costs. America's Critical Access Hospital Coalition identified several of the most common discrepancies CAHs encounter:

- ***Emergency Room Physician Availability Cost:*** Some auditors have been disallowing emergency room physician availability costs over a disagreement with the submitted time study methodology and absence of a written allocation agreement. Many CAHs use a time study method based on their revenue journal to calculate patient-related time. This method was accepted by fiscal intermediaries, but new MACs began requiring periodic time studies from providers. In addition, certain MACs do not follow Provider Reimbursement Manual (PRM) guidance to calculate allowable costs under minimum guarantee arrangements. In some instances, the auditor offsets the entire volume subsidy as Part B without considering CMS's limit calculation.

- ***Certified Registered Nurse Anesthetist (CRNA):*** Several CAHs have recently experienced auditors disallowing CRNA standby time, while prior auditors allowed the cost. This is a huge expense for CAHs, and may limit coverage for districts, which are often an hour from another hospital. This interpretation jeopardizes care in rural areas.

- ***Provider Fees/Taxes:*** CMS has given MACs the authority to determine if provider taxes are allowable on a state-by-state basis. As a result, MACs are only offsetting associated revenue against provider taxes if a pooling arrangement is used (i.e., fees paid by providers are deposited in a separate fund and disbursements to the providers are redistributed from the same fund). For example, if a statewide provider tax is tied to enhancing Medicaid reimbursement to hospitals it is not allowed, but if the statewide provider tax is tied to sending money into the general fund which then uses it to get Federal matching dollars, the tax is allowed. Recently, CMS determined a formula where percentages of the taxes are allowed in certain states.

SOLUTION: CLARIFYING ALLOWABLE COSTS
America's Critical Access Hospital Coalition proposes a legislative solution to expand the definition of CAH allowable costs to include additional patient- and physician-centered expenses. The legislation would clarify commonly cited auditor discrepancies and remove barriers to care by ensuring coverage of the most common diagnostic tests, health clinics, and physician recruitment and retention costs. Creating a more uniform and comprehensive definition of allowable costs enables CAHs to continue to survive and focus on care delivery in rural America.

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114TH CONGRESS
2D SESSION

H. R. 4553

To amend title XVIII of the Social Security Act to clarify reasonable costs for critical access hospital payments under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 12, 2016

Mr. HARPER (for himself, Mr. LOEBSACK, Mr. PETERSON, Mr. PALAZZO, Mr. KELLY of Mississippi, and Mr. THOMPSON of Mississippi) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to clarify reasonable costs for critical access hospital payments under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Critical Access and Rural Equity Act of 2016" or the "CARE Act of 2016".

SEC. 2. CLARIFYING REASONABLE COSTS FOR CRITICAL ACCESS HOSPITAL MEDICARE PAYMENTS.

(a) INCLUSION OF CERTAIN COSTS AS REASONABLE COSTS.—

(1) INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended by adding at the end the following new paragraph:

"(6) In determining payment and reasonable costs under paragraph (1) for inpatient critical access services, the Secretary shall recognize as allowable costs of the critical access hospital at least the following:

"(A) Costs of services that would be considered bona fide emergency services (as defined in section 1861(v)(1)(K)(ii)) if provided in a hospital emergency room, including professional services and any associated surgical on-call and standby costs.

"(B) Costs of a test or procedure performed at a critical access hospital or an entity owned by the critical access hospital, including a clinical diagnostic laboratory test, mammogram (as defined in section 354(a)(5) of the Public Health Service Act), colonoscopy, cardiac

stress test, pulmonary function test, echocardiogram, and bone density study.

"(C) Standby and on-call costs for certified registered nurse anesthetist services, regardless of the number of surgical procedures requiring anesthesia services and regardless of the number of full-time equivalent physicians.

"(D) Costs of services provided by the critical access hospital or satellite facility of the critical access hospital that improve the total health of communities, including immunization programs, health clinics, and medical homes.

"(E) Costs of services provided by an off-campus provider-based clinic described in section 1820(c)(2)(F) of the critical access hospital, regardless of distance of such clinic from a hospital or another critical access hospital.".

(2) OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended by adding at the end the following new paragraph:

"(6) COVERAGE OF CERTAIN ADDITIONAL COSTS AS REASONABLE COSTS.—In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Sec-

retary shall recognize as allowable the costs described in paragraph (6) of section 1814(l).".

(3) CONFORMING AMENDMENT.—Section 1861(v)(7) of the Social Security Act (42 U.S.C. 1395x(v)(7)) is amended by adding at the end the following new subparagraph:

"(E) For provisions further describing costs recognized as reasonable costs for inpatient and outpatient critical access hospital services, see sections 1814(l)(6) and 1834(g)(6).".

(b) TREATMENT OF PROVIDER-BASED CLINICS OF CRITICAL ACCESS HOSPITALS.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(1) in subparagraph (B)(i)(I), by striking "is located" and inserting "subject to subparagraph (E), is located"; and

(2) by adding at the end the following new subparagraph:

"(F) TREATMENT OF OFF-CAMPUS PROVIDER-BASED CLINICS.—Subparagraph (B)(i)(I) shall not apply to an off-campus provider-based clinic (as described in section 485.610 of title 45 of the Code of Federal Reg-

ulations) of a facility designated as a critical access hospital.".

(c) ALLOWING COORDINATION FOR PROVISION OF EMERGENCY SERVICES.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)), as amended by subsection (b), is further amended—

(1) in subparagraph (B)(ii), by striking "makes" and inserting "subject to subparagraph (G), makes"; and

(2) by adding at the end the following new subparagraph:

"(G) ALLOWING COORDINATION FOR PROVISION OF EMERGENCY SERVICES.—The Secretary may waive the requirements under subparagraph (B)(ii), with respect to a facility, if such facility—

"(i) is located not more than 15 miles of another facility or hospital that has an emergency department that satisfies the requirement of subparagraph (B)(ii); and

"(ii) coordinates with such other facility or hospital with respect to furnishing 24-hour emergency care services described in such subparagraph to the area served by such facility.".

(d) TREATMENT OF MEDICAID PROVIDER TAXES FOR CRITICAL ACCESS HOSPITAL REASONABLE COSTS.—

(1) INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)), as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

"(7)(A) In determining payment and reasonable costs under paragraph (1) for inpatient critical access services—

"(i) with respect to a current permissible health care related tax imposed and paid by the critical access hospital for a cost reporting period beginning before the date of enactment of this paragraph, the Secretary shall not, through recoupment or otherwise, disallow payment to the critical access hospital under this subsection on the basis that payments to the critical access hospital under this subsection offset some or all of the costs of such tax; and

"(ii) with respect to a current permissible health care related tax imposed and paid by the critical access hospital for a cost reporting period beginning on or after the date of enactment of this paragraph, the Secretary shall—

"(I) assess the percentage of individuals entitled to benefits under this part who are furnished inpatient critical access hospital services at such critical access hospital during such cost reporting period and who are also receiving medical assistance under the Medicaid program under title XIX during such period; and

"(II) adjust payments under this subsection with respect to such services furnished during such period in a manner specified by the Secretary based on such percentage to take into account such tax.

"(B) For purposes of this paragraph and section 1834(g)(7), the term 'current permissible health care related tax' means a broad-based health care related tax (as defined in paragraph (3)(B) of such section) that is in effect prior to enactment of this paragraph and for which there is not in effect a hold harmless provision described in paragraph (4) of such section.".

(2) OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)), as amended by sub-

section (a)(2), is further amended by adding at the end the following new paragraph:

"(7) TREATMENT OF MEDICAID PROVIDER TAXES.—In determining payment for outpatient critical access hospital services under paragraphs (1) and (2), the provisions of paragraph (7) of section 1814(l) shall apply to payment for such services under this subsection in the same manner as such provisions apply to payment for inpatient critical access hospital services under section 1814(l), except that in applying subparagraph (B) of such paragraph (7), the reference to 'individuals entitled to benefits under this part' shall be deemed a reference to 'individuals enrolled under part B'.".

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