Northern Inyo Hospital

June 21 2017 Regular Meeting

June 21 2017 Regular Meeting - June 21 2017 Regular Meeti

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 21, 2017 at 5:30 p.m.

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

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. Old Business
   A. Approval of NIHD Operating Budget for Fiscal Year 2017 / 2018 (*action item).*
   B. Approval of vendor change for NIHD Benefits Manager (*action item*).
4. New Business
   A. Approval of Nursing Department Policies and Procedures (*action items*):
      - *Language Access Services Program*
      - *Licensure of Nursing Personnel*
   B. Hospital Wide Policy and Procedure annual approvals, Attachment A to this Agenda (*action item*).
   C. Approval of Annual Appropriations Limit, Resolution No. 17-01 (*action item*).
   D. Ratification of NIHD 401(a) Retirement Plan Contribution, Resolution No. 17-02 (*action item*).
   E. Radiology Coverage and Administration Services Agreement (*action item*).
   F. Electronic Communication (Email) Acceptable Use Policy (*action item*).
   G. NIHD Password Policy (*action item*).
   H. Hospital wide Policy and Procedure approval: *Workplace Violence Prevention Policy* (*action item*).
   I. Hospital wide Policy and Procedure approval: *Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities* (*action item*).

Consent Agenda (action items)

5. Approval of minutes of the May 17, 2017 regular meeting
6. 2013 CMS Validation Survey Monitoring, June 2017
7. Financial and Statistical Reports for the period ending April 30, 2017

---

8. Data and Information Committee report (*information item*).
   - *Health Information System replacement recommendation*
9. Chief Executive Officer report (*information item*).
   - *Information Technology Security Report*
   - *Reorganization of select departments*
10. Chief Operating Officer Report (*information item*).
11. Chief Financial Officer Report (*information item*).
12. Chief Nursing Officer Report (*information item*).
13. Chief Human Relations Officer Report (*information item*).
    - *PPAC Committee*
14. Chief of Staff Report; Joy Engblade, MD:
    A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
       - *Provider-Performed Microscopy Competency*
       - *Pre-operative EPT Testing Protocol*
       - *ALARA Program*
       - *Critical Value Reporting of Lab Results*
       - *Dead on Arrival*
       - *Emergency Operations Plan/HICS Plan*
       - *Sterilization Recall Policy*
       - *Food and Drink in Patient Care Areas*
       - *In-service in Infection Control*
       - *Formalin Use and Spill Management*
       - *Infection Prevention Considerations for Immunosuppressed and Pregnant Employees (formerly 'Chickenpox and Shingle' policy)*

- *Severe Acute Respiratory Syndrome (SARS) Coronavirus (SARS-CoV) or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations for Patients*
- *Prevention of Catheter Associated Urinary Tract Infections (CAUTI's) guidelines*
- *Bloodborne Pathogen Exposure Control Plan*
- *Infection Prevention Plan*
- *Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs*
- *Employee Consent Form: Hazardous Drug Risk Acknowledgement*

B. Employee Health Pillars and Infection Prevention Pillars (*information items*)

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

- Young Song, MD (*radiology, provisional active staff*)
- David Kim, MD (*radiology, provisional active staff*)

D. Medical Staff Resignation, Robert Nalumaluhia, PA-C (effective 4/21/17) (*action item*).

15. Reports from Board members (*information items*).
16. 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, 4 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*).

17. Return to open session and report of any action taken in closed session.
18. 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.

2018 Fiscal Budget for Northern Inyo Healthcare District

June 21, 2017

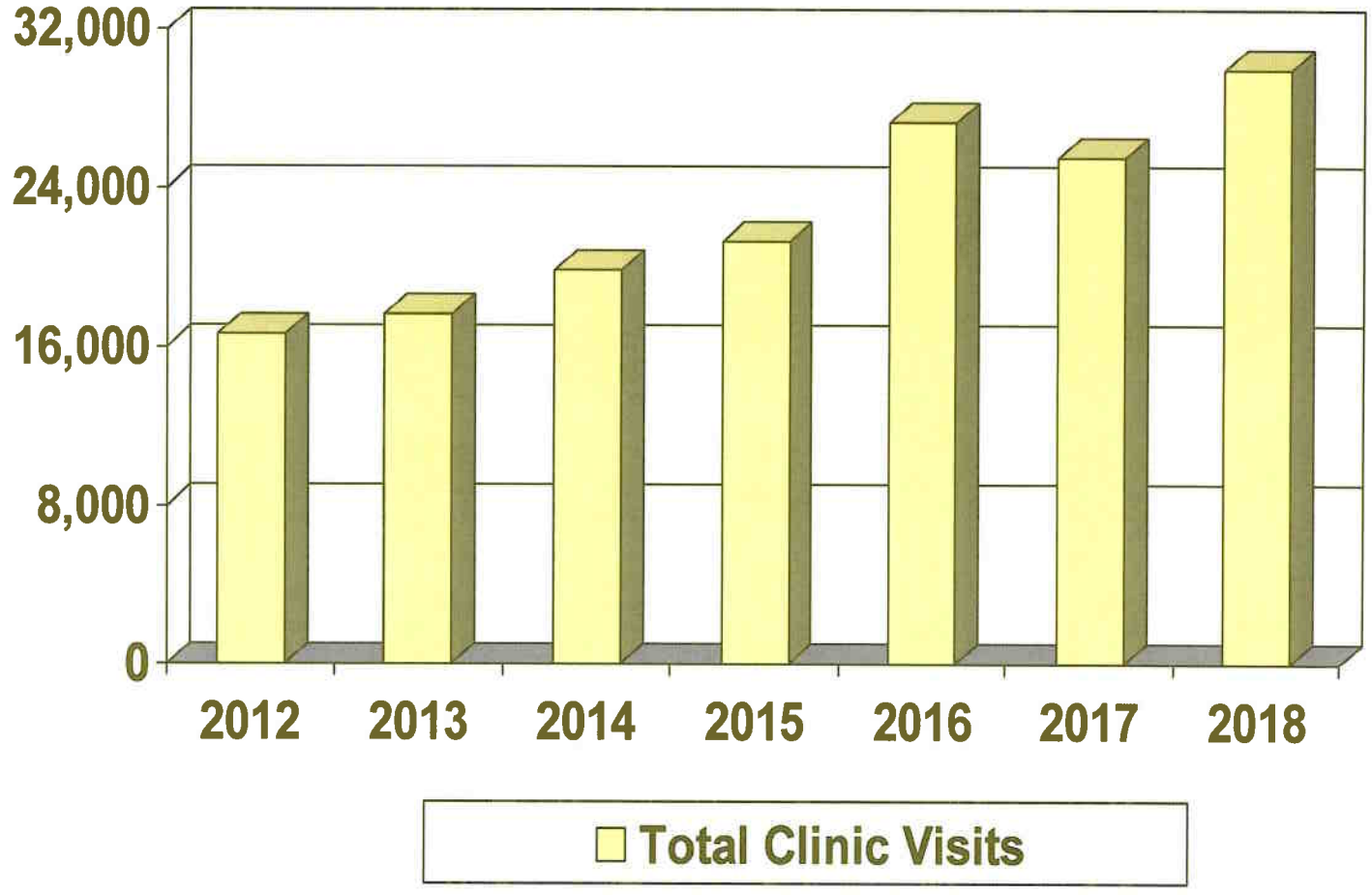
Overview of 2018 Budget

- Patient Volumes
- Salaries & FTEs
- Supplies & Purchased Services
- Capital
- Net Revenues
- Management Request

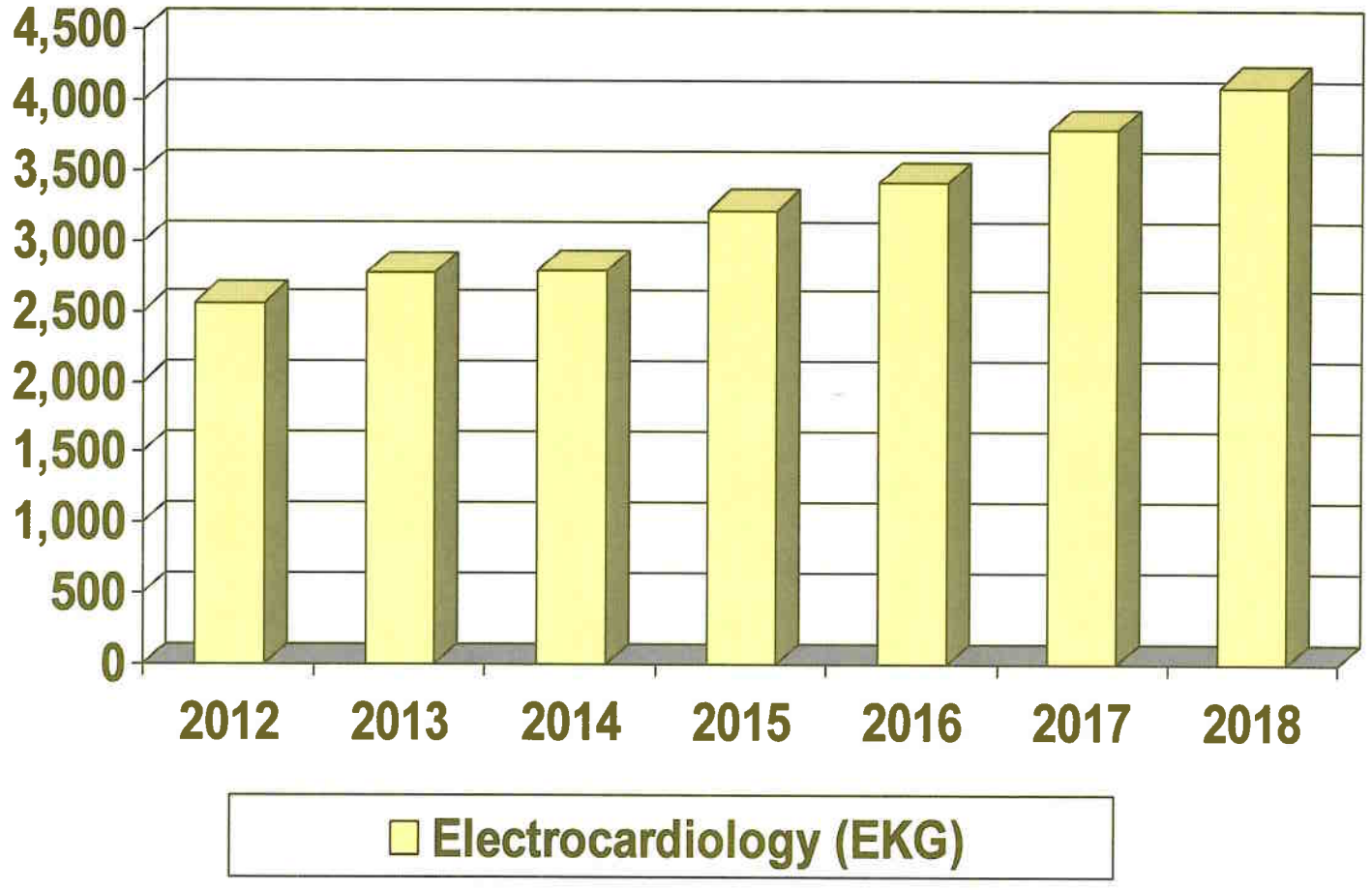
2017/18 Expansion of Services

- Change in support staffing at RHC will add 4,800 additional visits
- Addition of a full time clinical dietician
- Addition of 3.25 physical therapists, .75 speech therapist and 1.10 occupational therapist will increase services to schools and community
- Outpatient revenues increases to 70% of Gross Patient Revenues

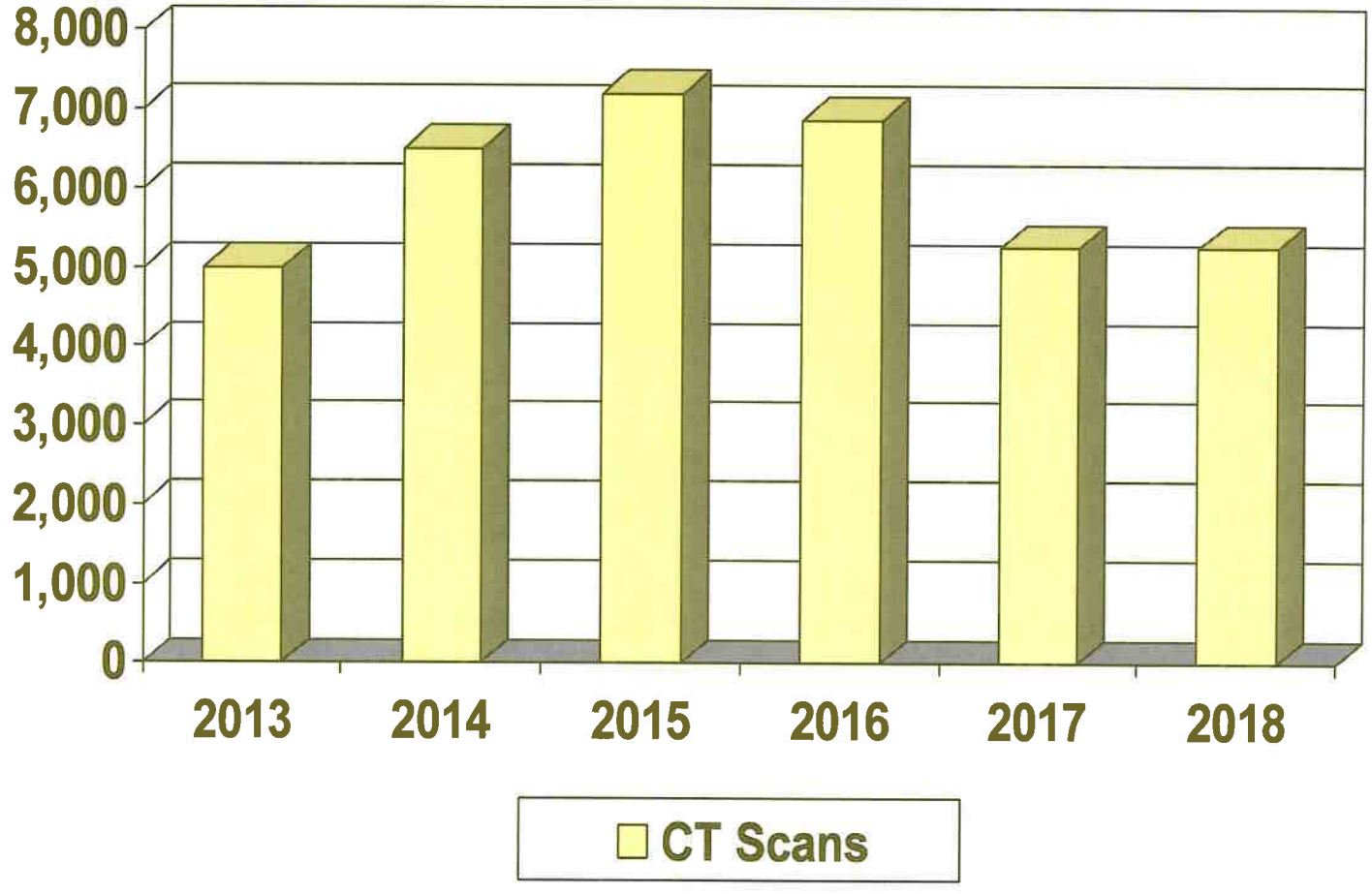
Rural Health Clinic



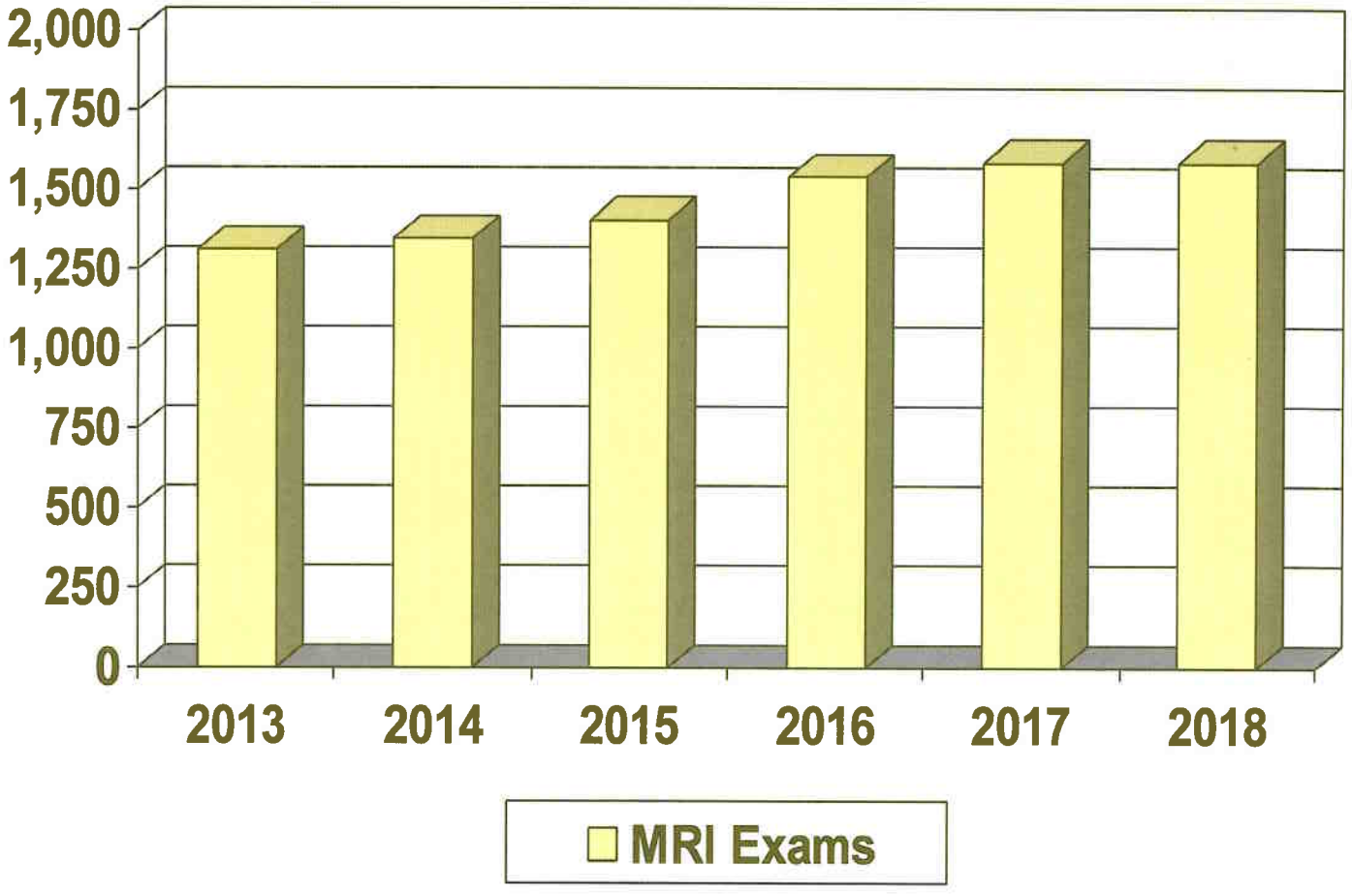
Diagnostic Imaging



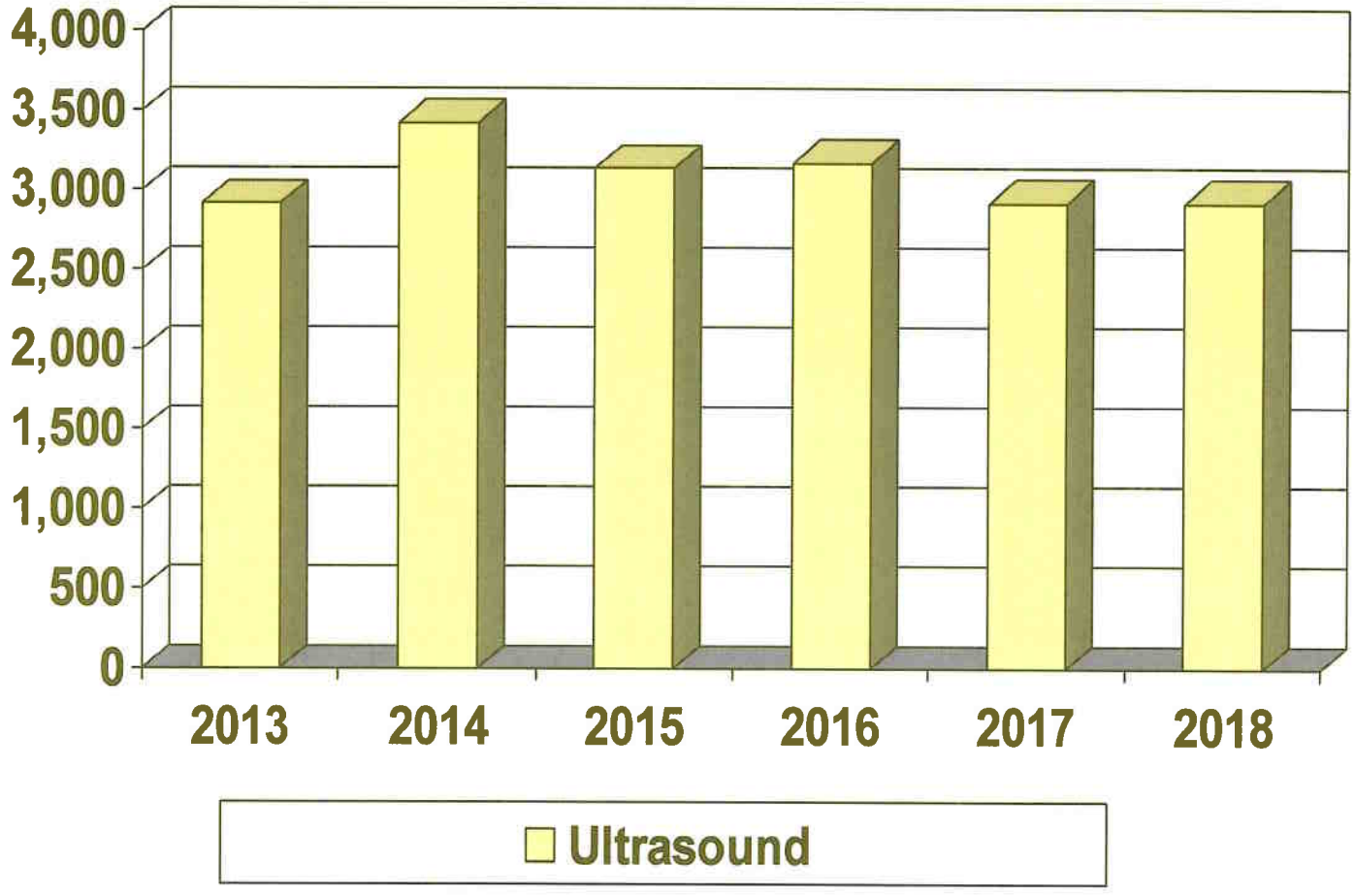
Diagnostic Imaging



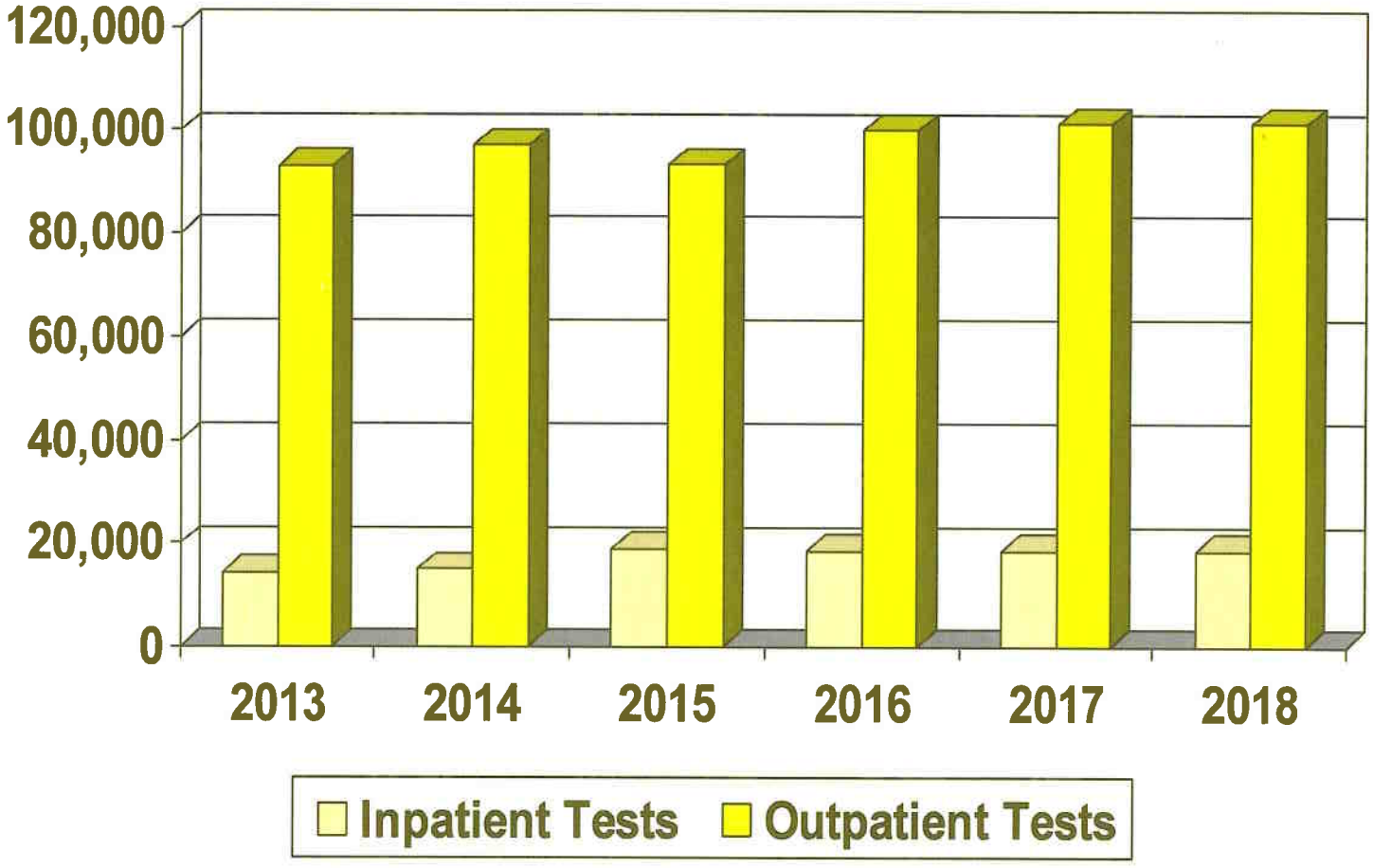
Diagnostic Imaging



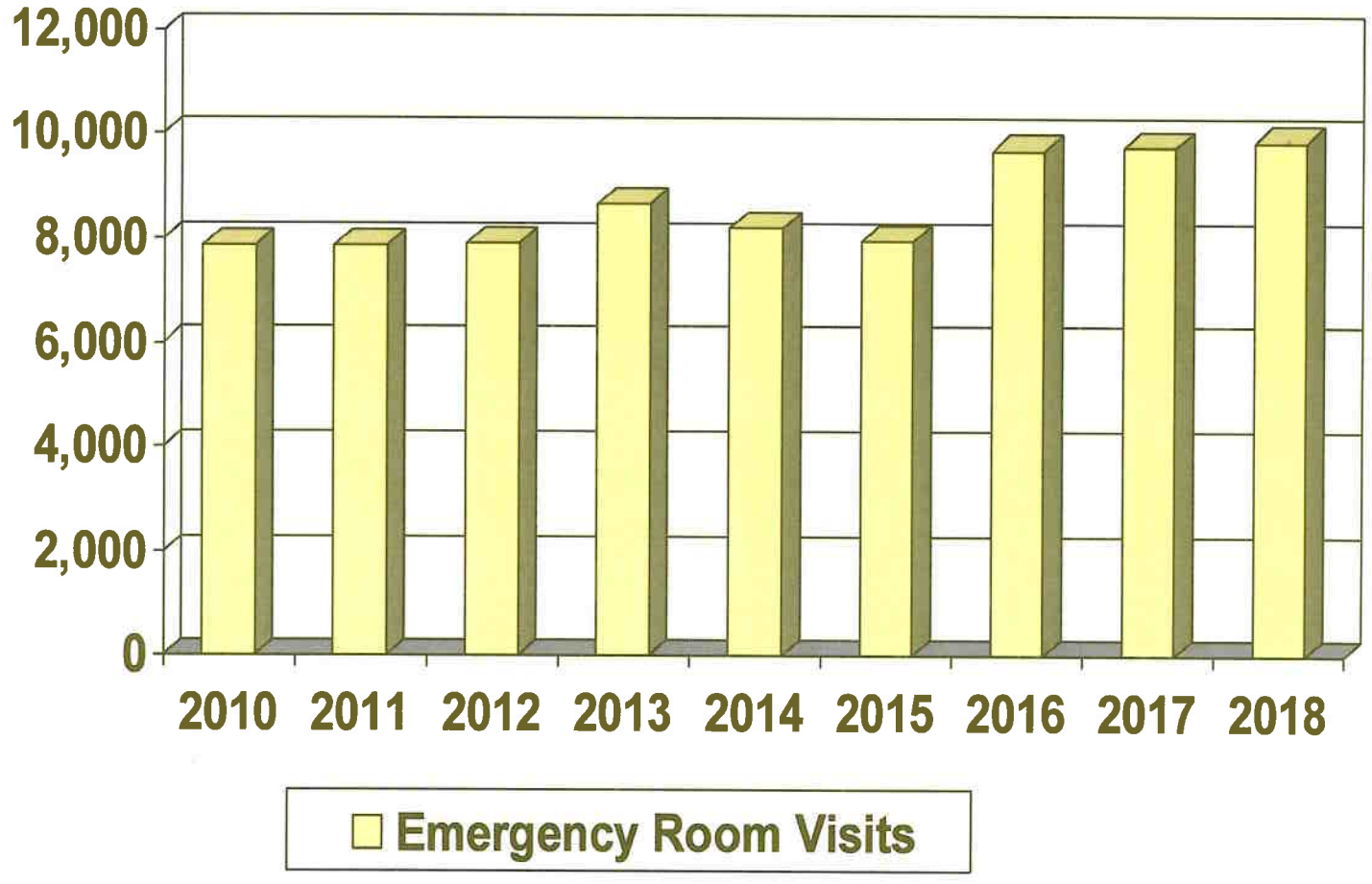
Diagnostic Imaging



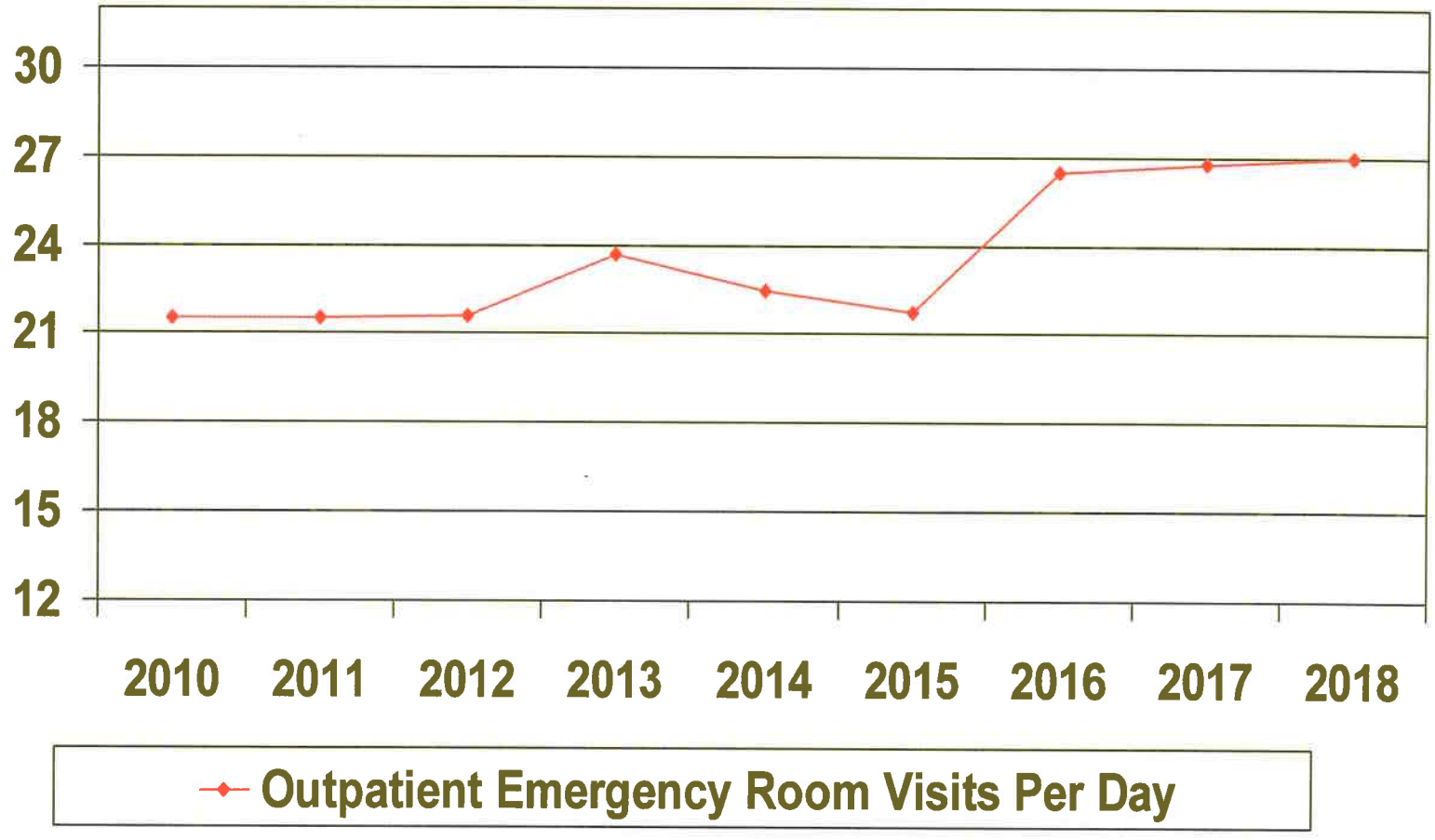
Laboratory Services



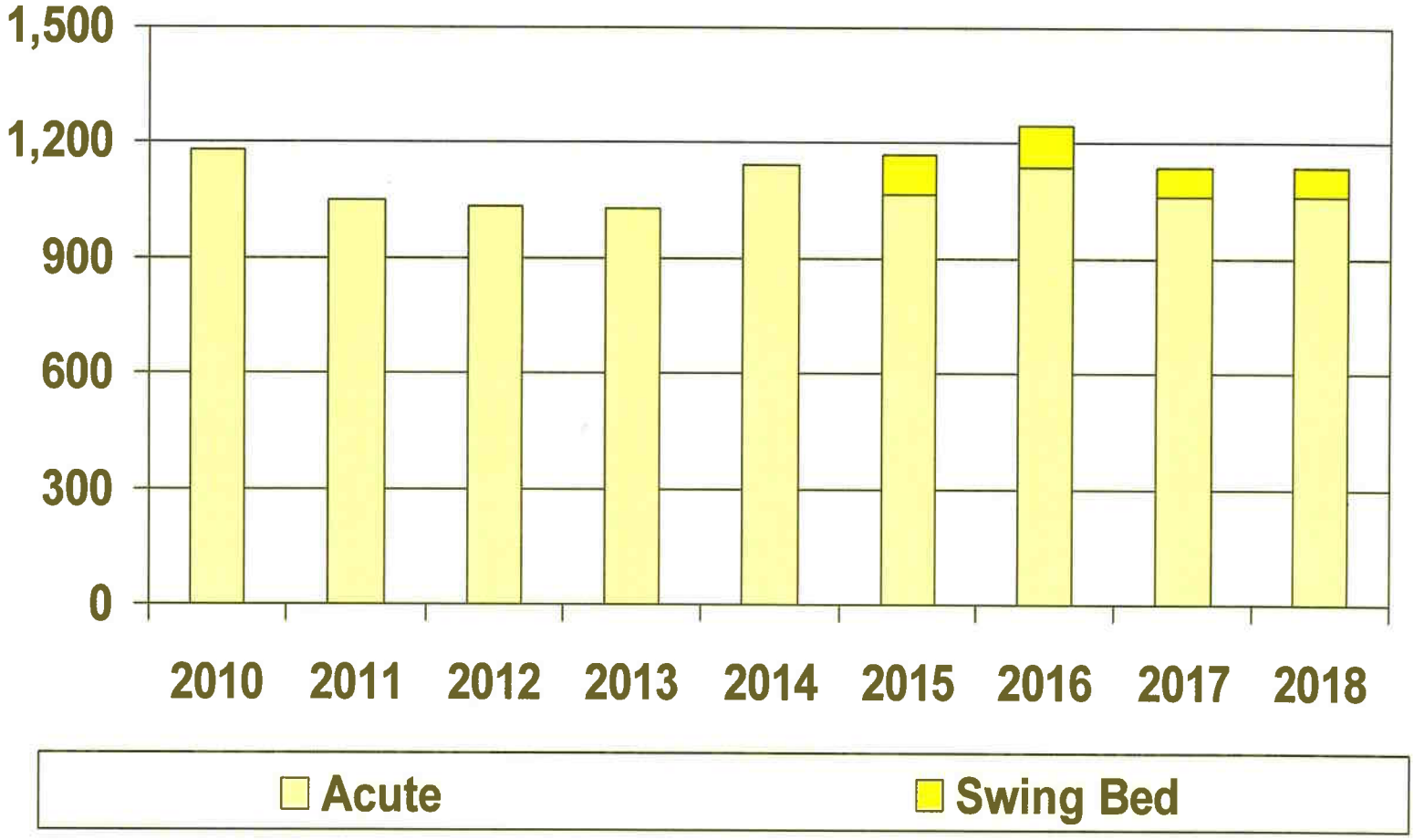
Emergency Room - Visits



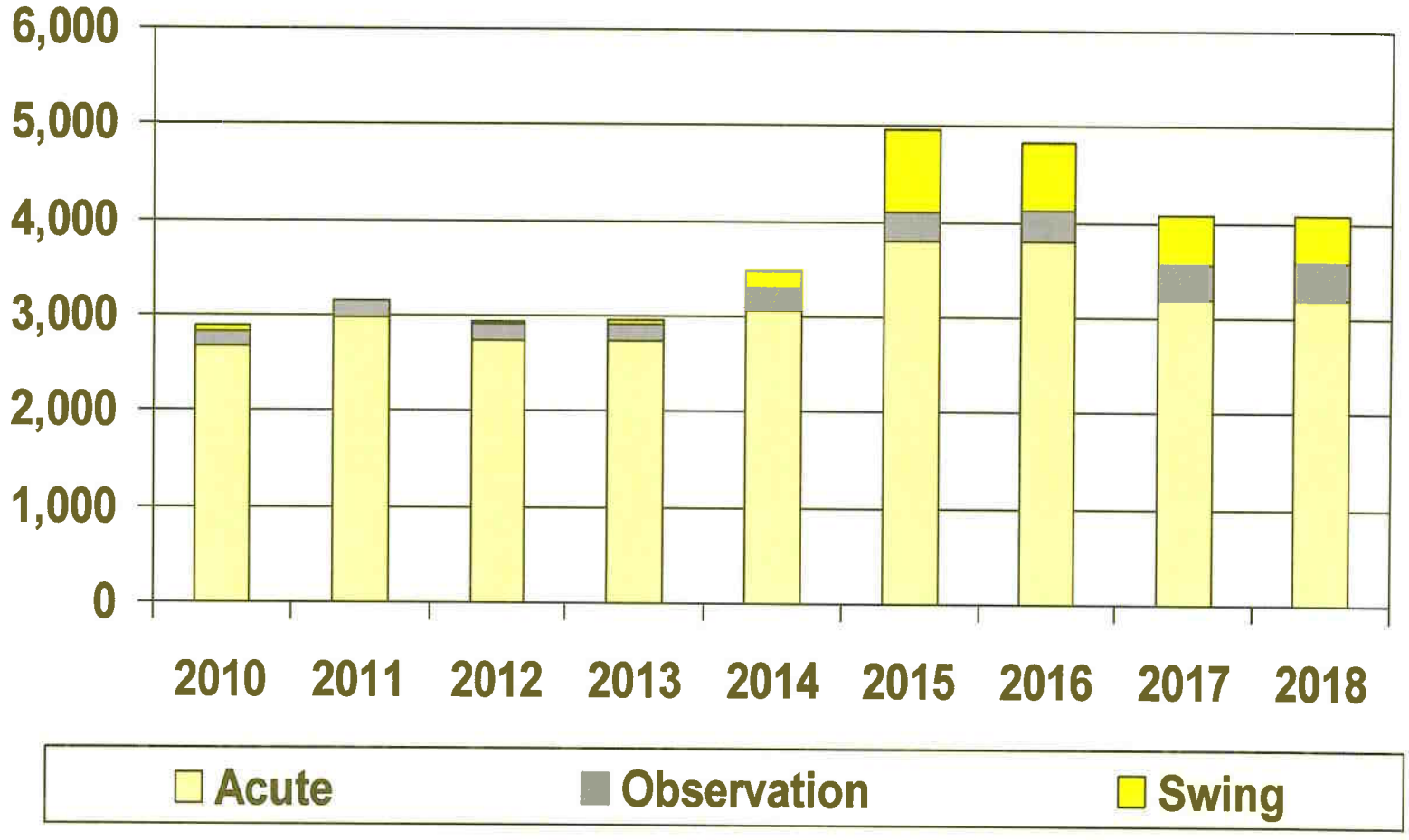
Emergency – Visits Per Day



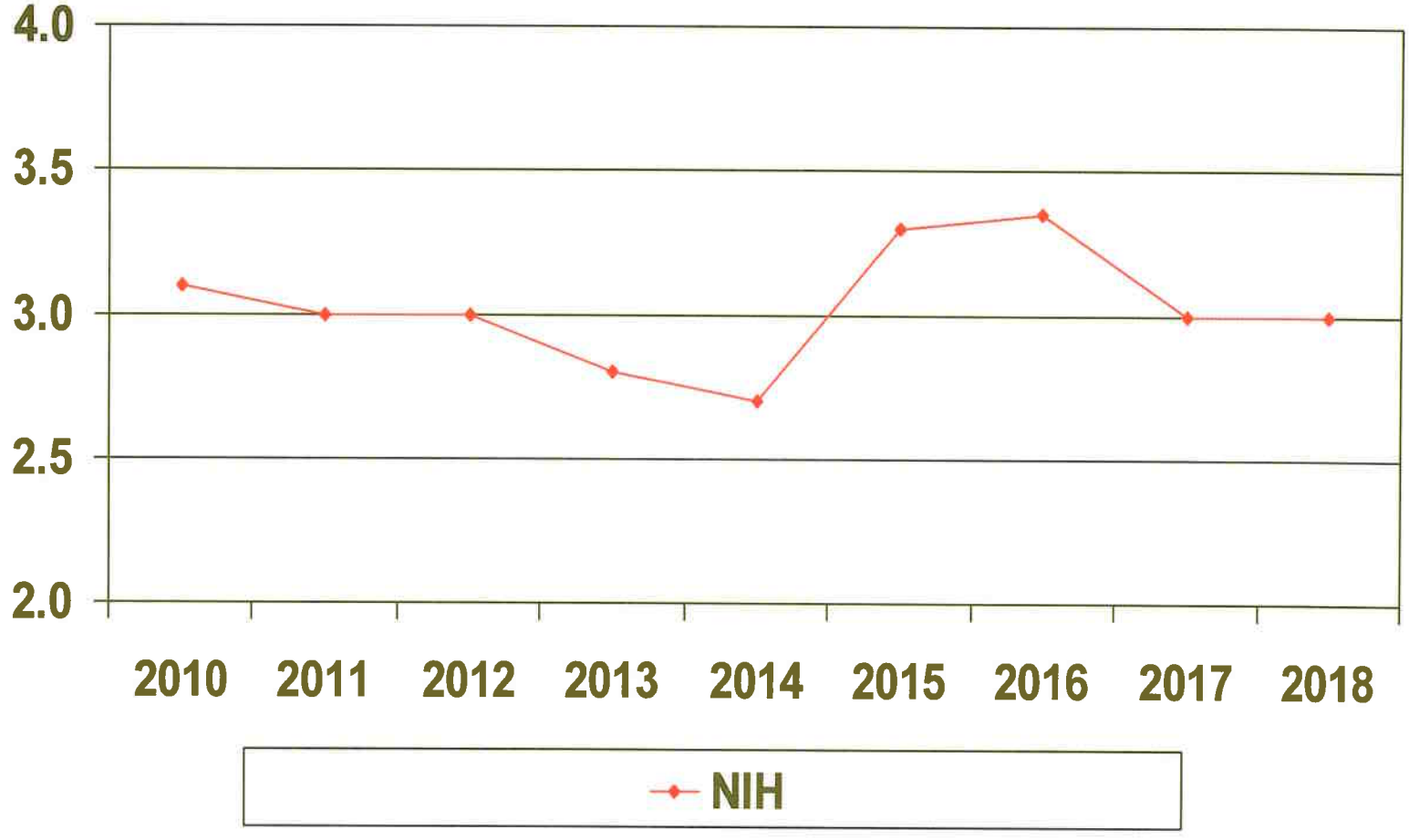
Inpatient – Discharges



Inpatient Unit Days



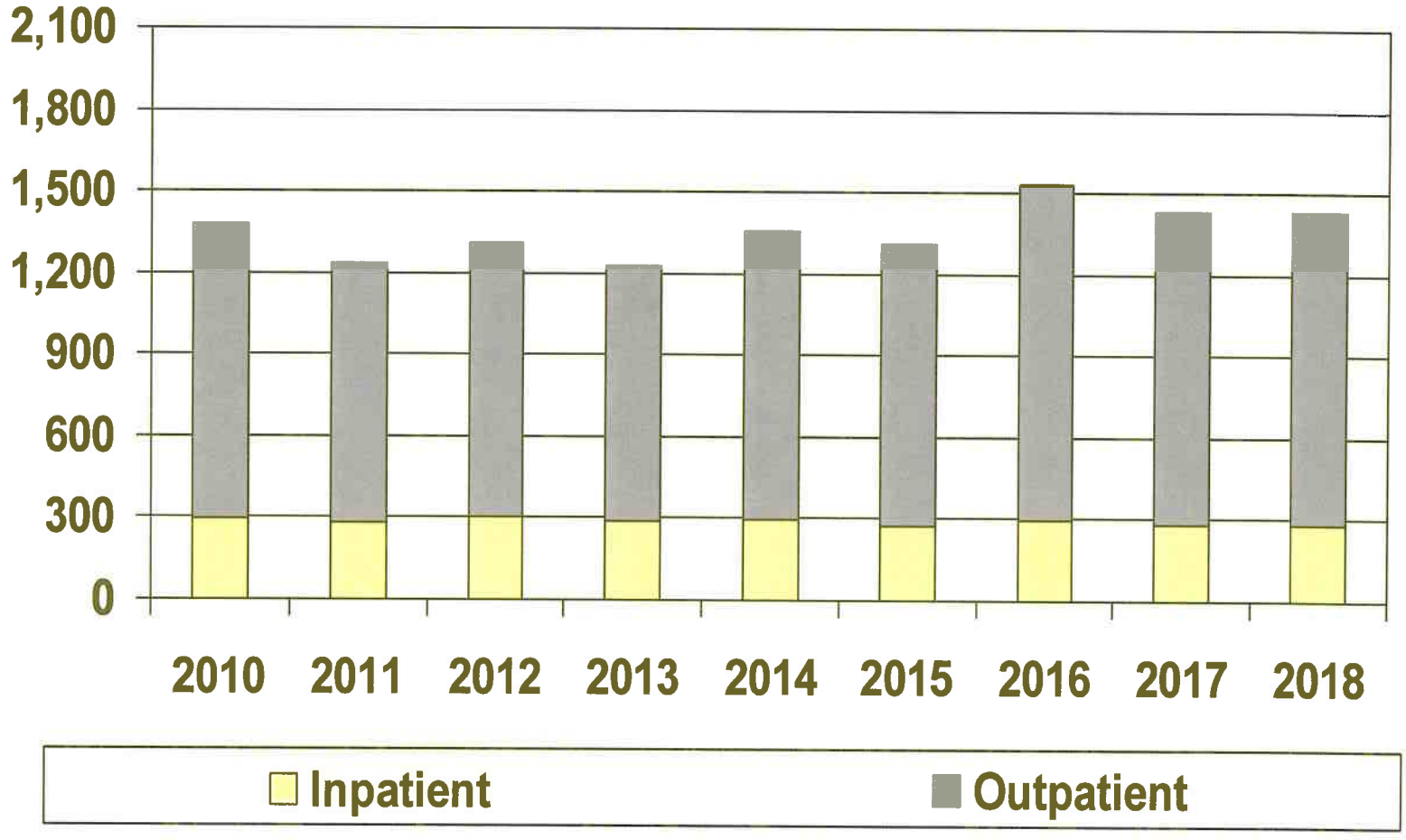
Inpatient - Length of Stay



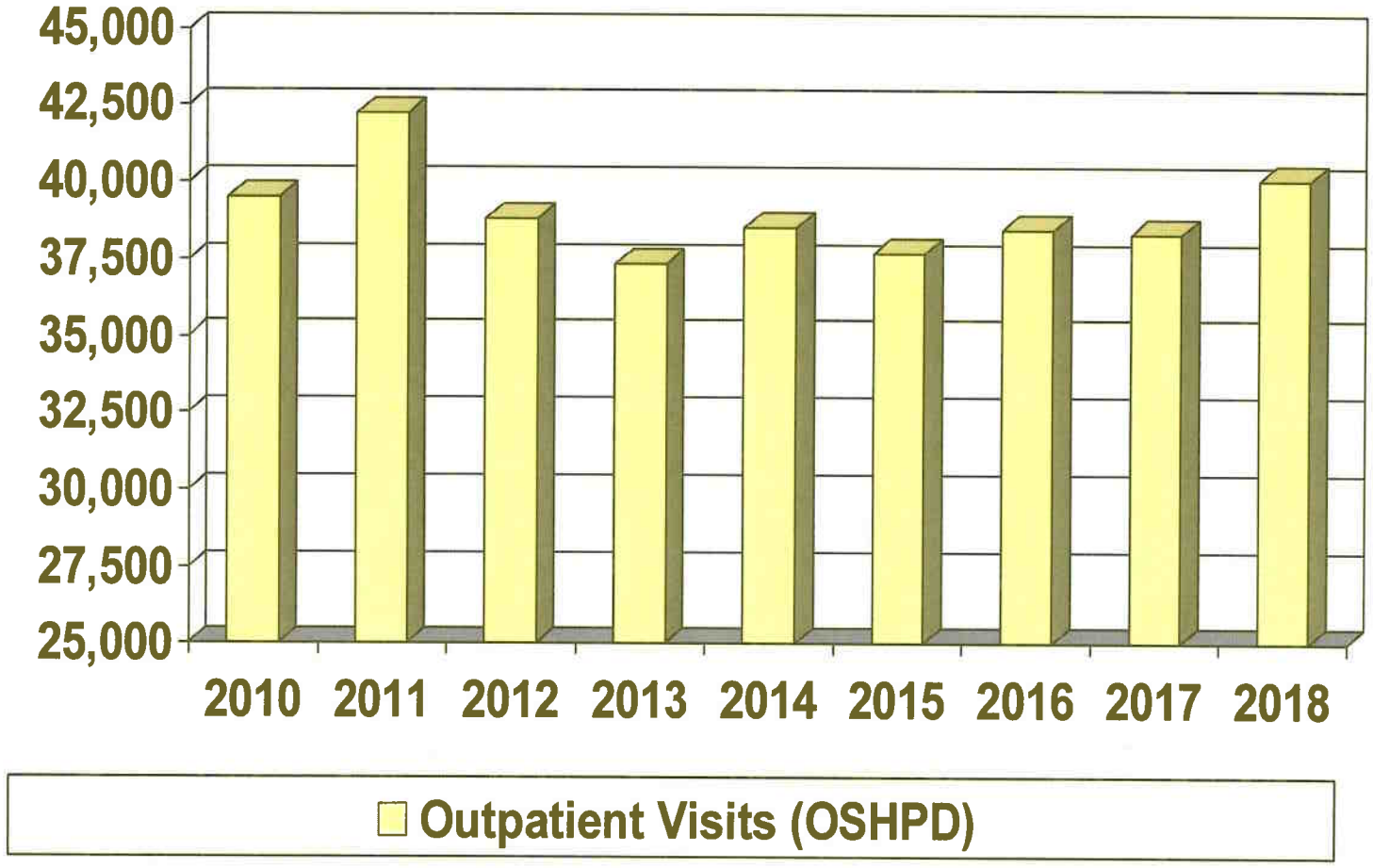
2018 Budget Challenges

- Lack of growth in services, particularly inpatient, surgery, imaging, laboratory and procedures
- Increase in base wages without growth is increasing cost per day
- Full year commitments in anesthesia, compliance, coding, reduced contractors and providers adds expense without enough operating revenue
- Limited Non- IGT settlements expected

Surgical Cases



Outpatient Visits

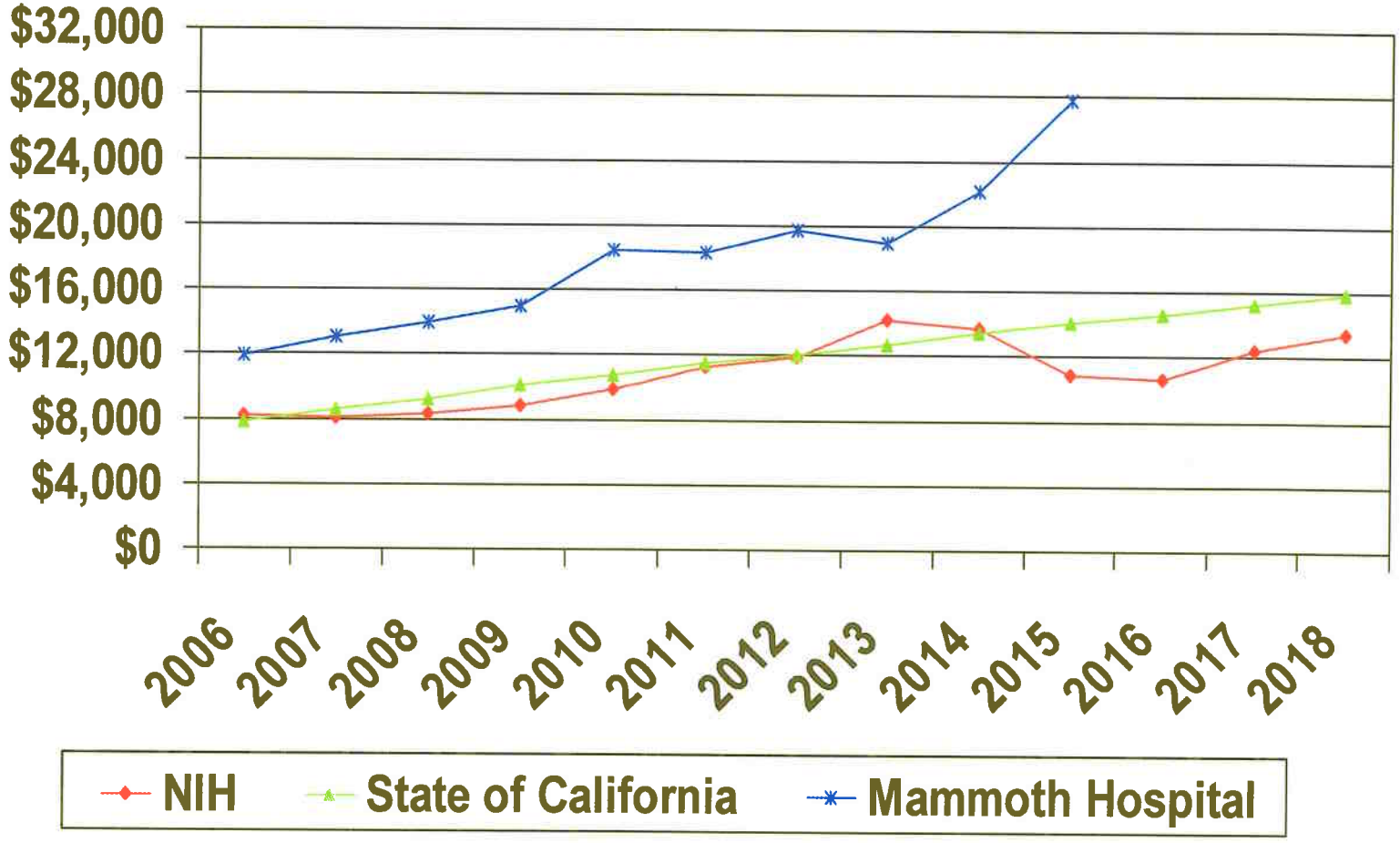


2017/2018 Operating Income

	FY2017	FY2018
Unrestricted Revenues, Gains & Other Support		
Inpatient Service Revenue		
Routine Inpatient Revenue	8,769,794	9,471,378
Ancillary	29,601,655	31,969,787
Total Inpatient Revenue	38,371,449	41,441,165
Outpatient Revenue	88,454,854	96,483,702
Total Gross Patient Revenue	126,826,303	137,924,867
Less Deductions from Revenue		
Patient Service Revenue Deductions	2,558,961	2,763,678
Contractual Adjustments	52,347,313	58,721,512
IGT PassThru 2015 - 2016 at 90% of Contract		(2,879,612)
IGT PassThru 2016- 2017 at 50% of Contract		(2,707,257)
RHC Change in Cost Settlements		(233,157)
Prior Period Adjustments	(4,597,355)	(157,772)
Total Deductions from Revenue	50,308,919	55,507,393
Net Patient Service Revenue	76,517,384	82,417,475
Other Revenue	553,988	904,487
Net Operating Revenue	77,071,372	83,321,962

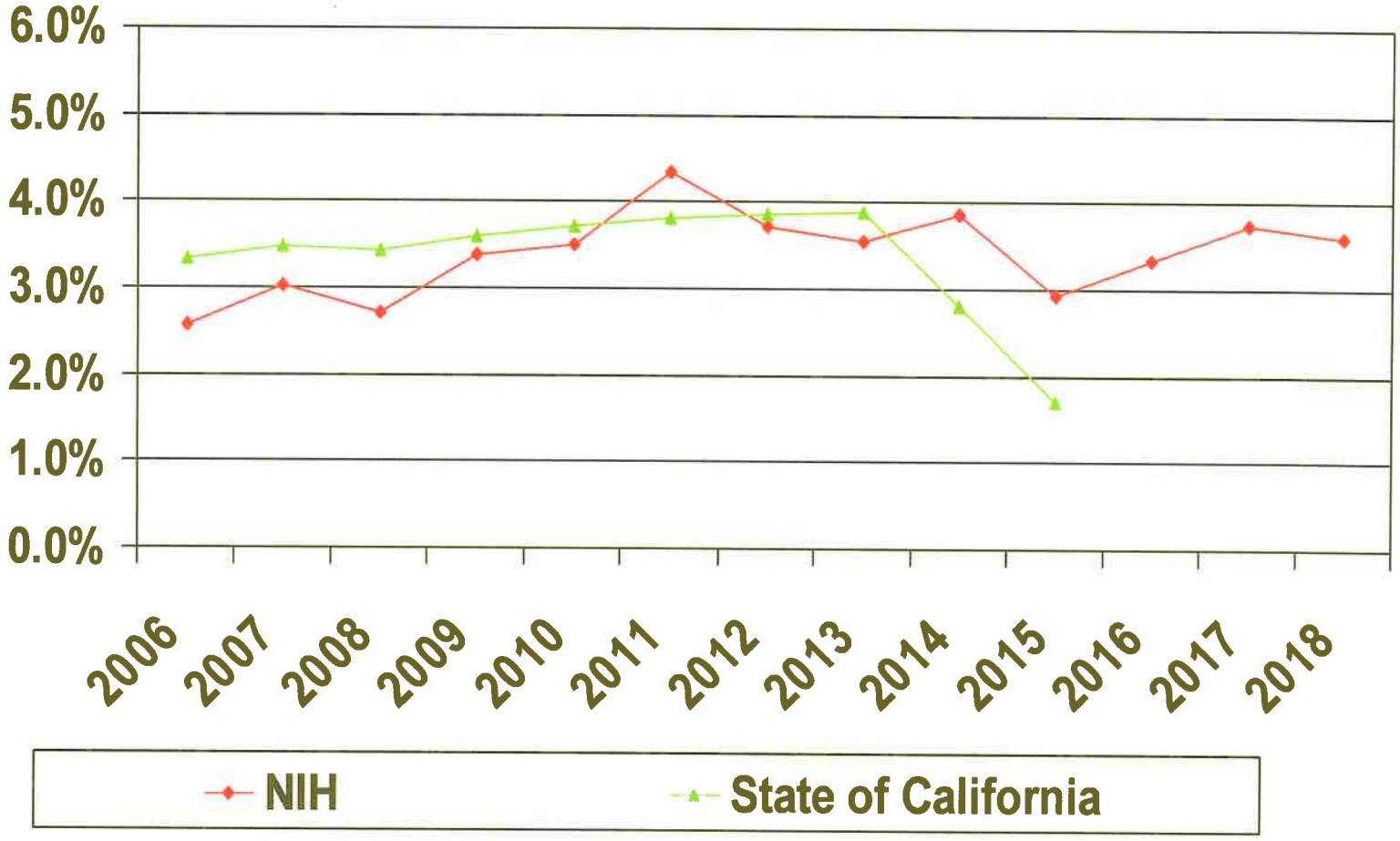
Requesting 8.0% Price Increase, net operating income increases 8.1% when including a full year's worth of IGT (managed medicaid losses).

Average Daily Inpatient Charge

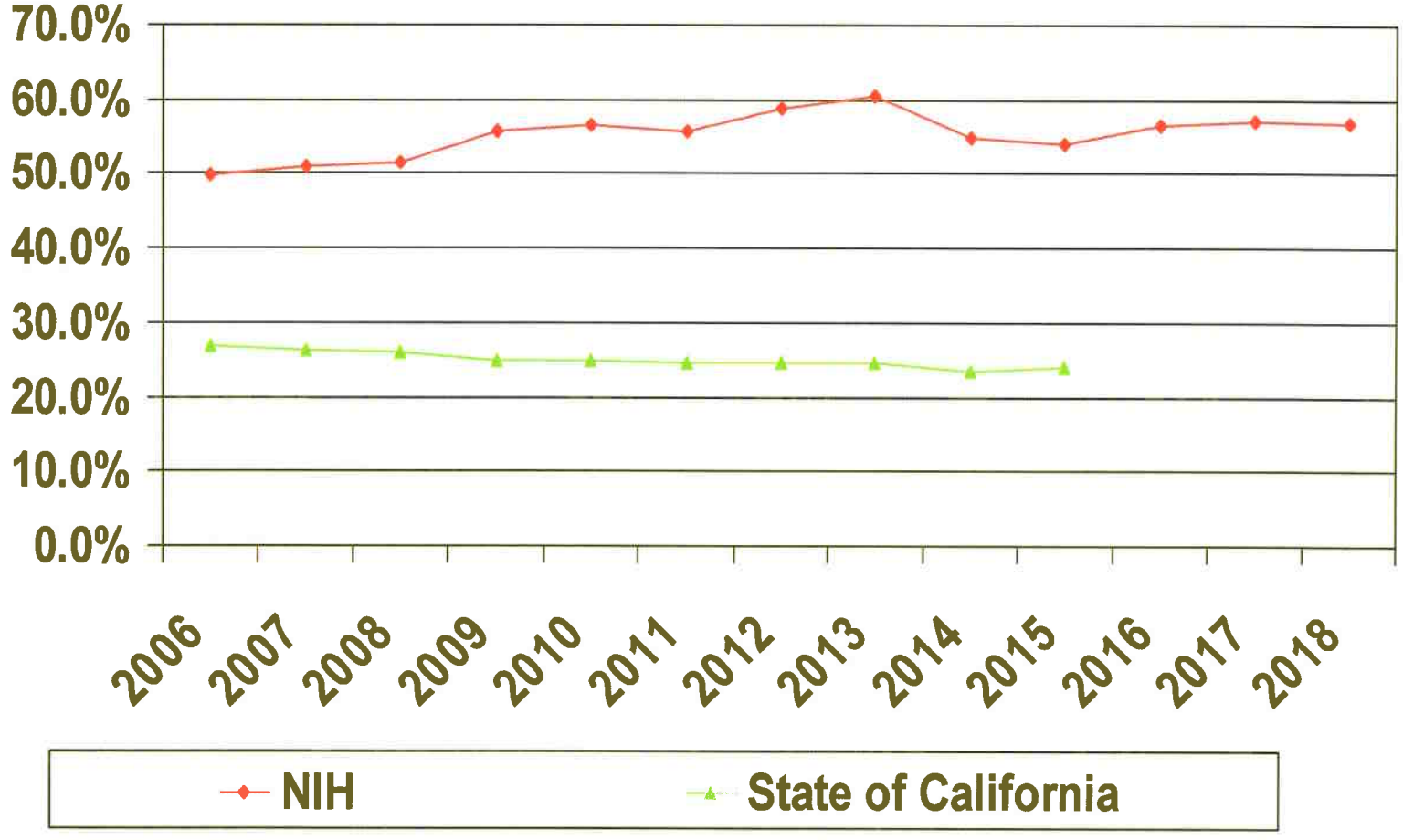


Assumes 4% Rise for California 2016 -2018

Uncompensated Care Costs



Overall Cost to Charge Ratio



2018 rate is 56.85%

Salary and Benefits

Salary Increases of 6.0% (Merit, CA Minimum and Technical)

CPI from February 2016 to February 2017 is up 3.4%.

Benefits

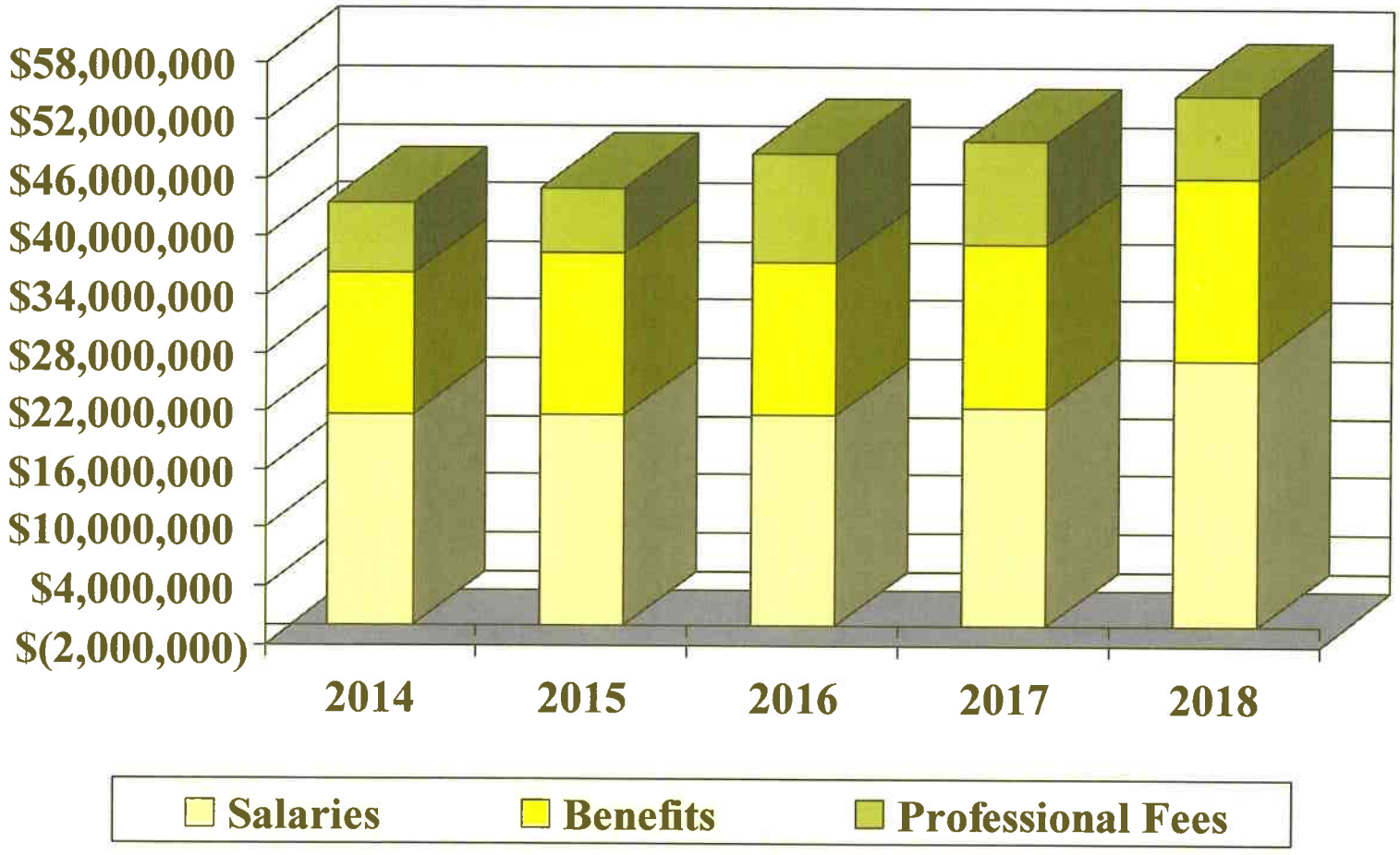
Continuation of Health Plan as is for 2018. Currently recommending change in brokers.

Other benefits (dental, life & pension) will remain at current levels with the worker's compensation costs being flat. As employee turnover occurs, the percentage of employees on the defined benefit pension plan decreases and is expected to drop under 70% during 2018.

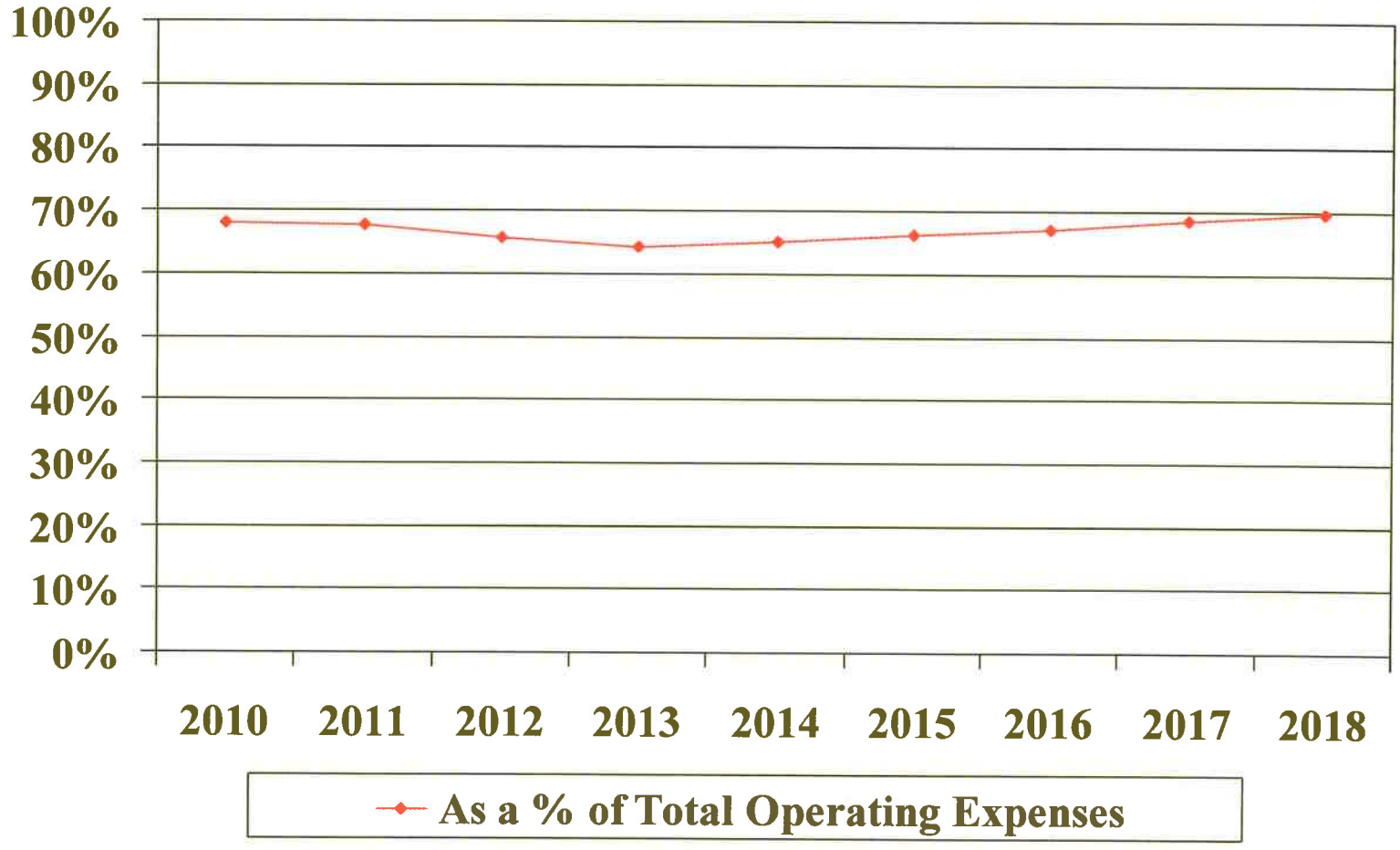
FTEs

Starting with 372 FTEs as of April, 2018; adding 10.4 for RHC, Dietician, Therapies of 5.10, Interpreter, Coders of 2.0, Laundry and Environmental of 2.0, NIA clinics of 4.0, and resource need to a total of 413 with minimal per diem and consultants except coding.

Salaries & Benefits



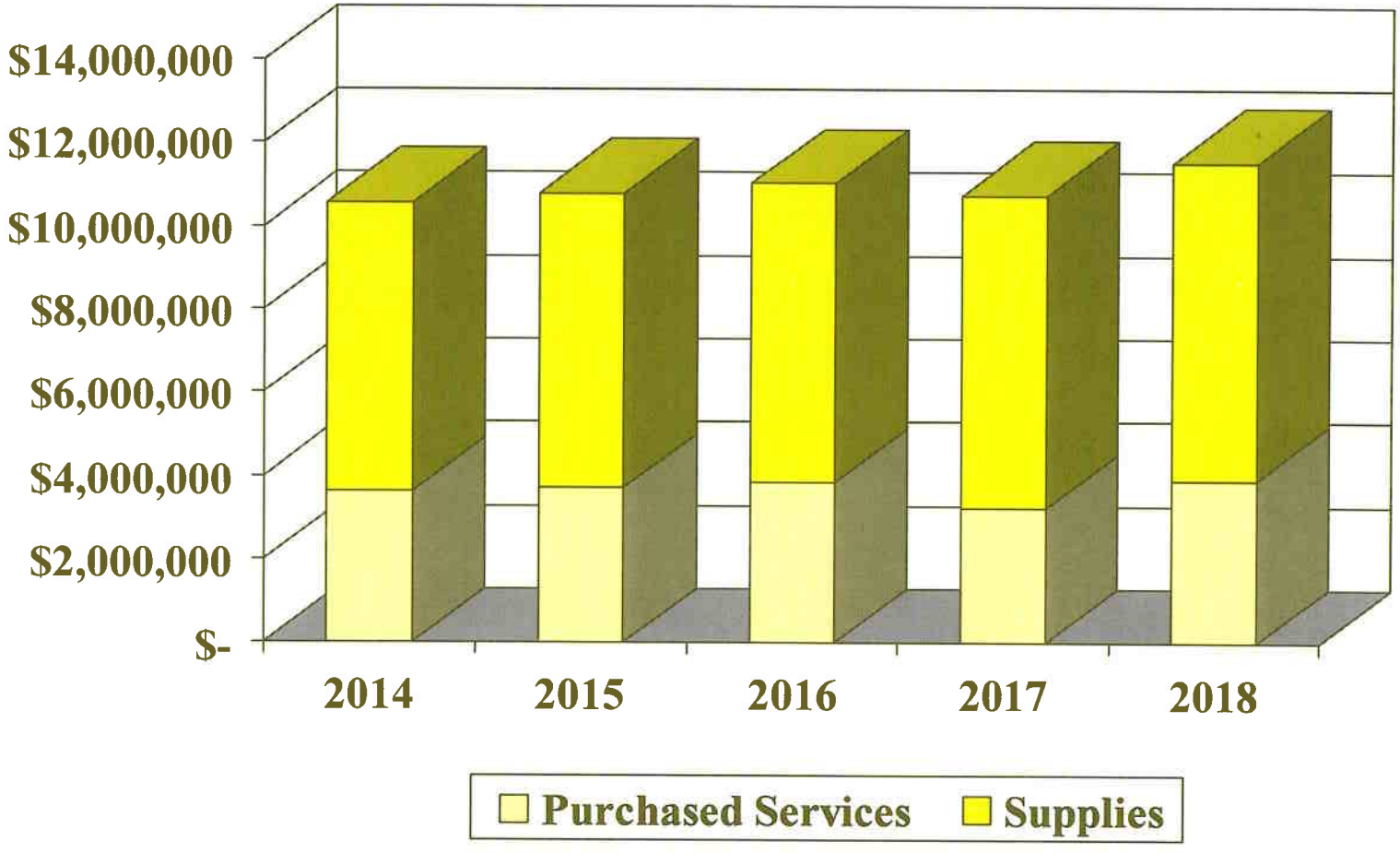
Salaries, Benefits & Professional Fees



Purchased Services

- **Expenses match projected revenues in key diagnostic areas using units of service as common key measure and budget factor**
- **Continues Paragon service contract for entire fiscal year**
- **Service contracts budgeted by month of implementation**

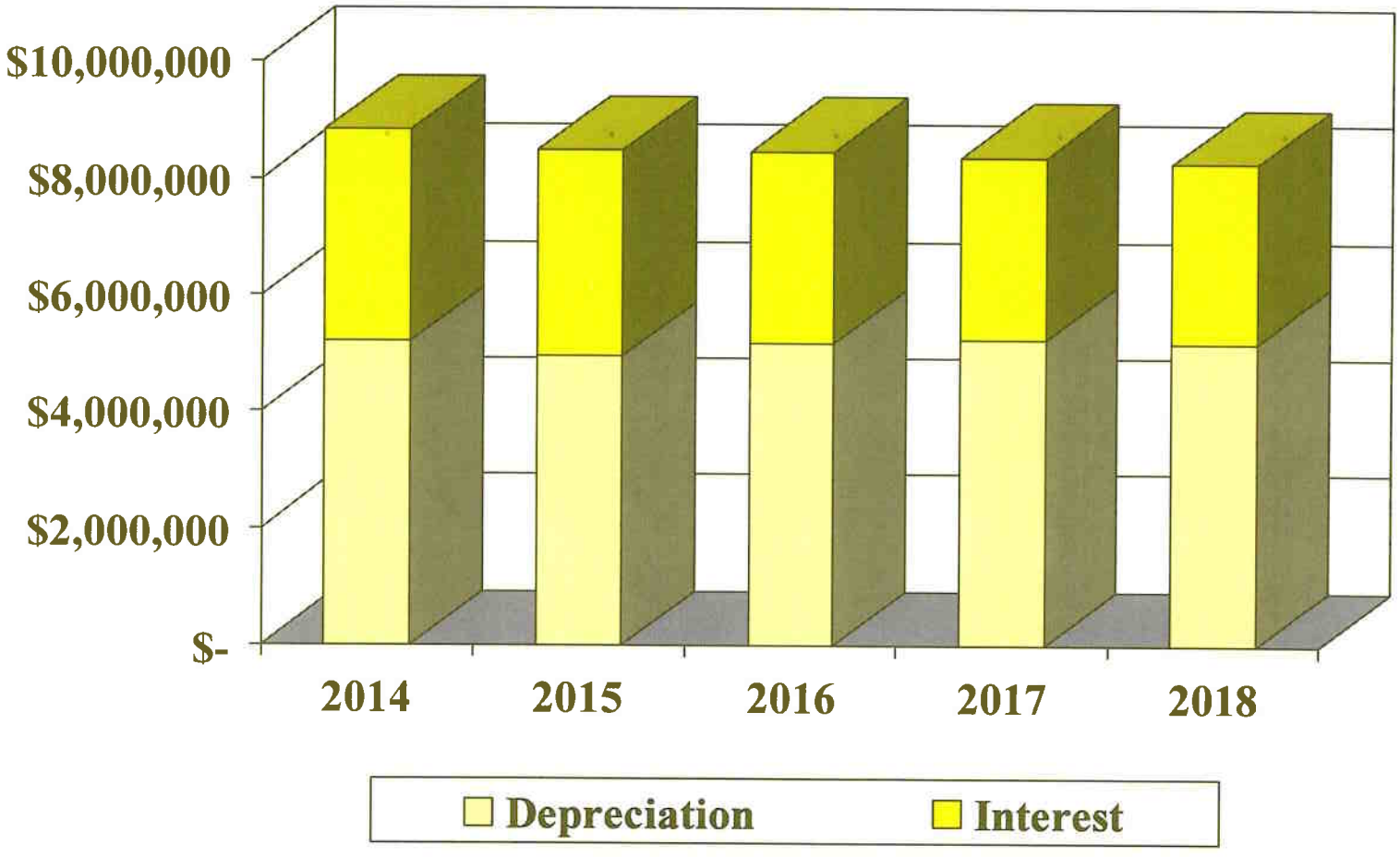
Purchased Services & Supplies



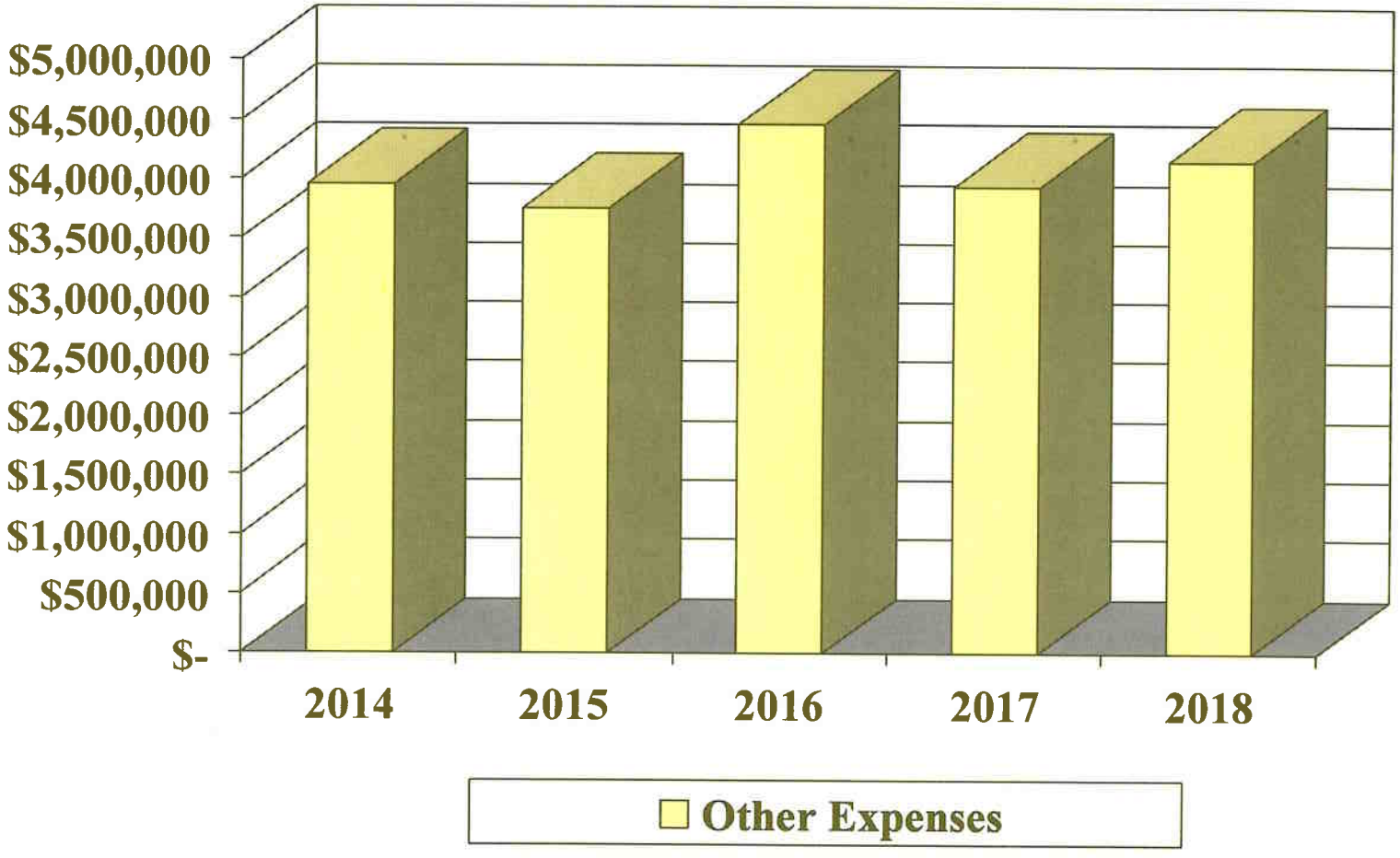
Capital

- New expenditures of $2,985,000 budgeted in depreciation and interest costs without a new EHR
- No gain or loss on disposal of fixed assets budgeted in 2018

Depreciation, Amortization & Interest Expense



Other Expenses



2017/18 Expenses & Net Income

Expenses:	FY2017	FY2018
Salaries and Wages	22,419,635	27,417,080
Employee Benefits	16,902,075	18,725,144
Professional Fees	10,558,236	8,530,525
Supplies	7,036,522	7,635,412
Purchased Services	3,337,144	3,910,569
Depreciation Expense	5,132,212	5,186,752
Bad Debt	2,858,584	2,858,584
Other Expense	3,936,741	4,152,769
Total Expenses	72,181,149	78,416,835
Operating Income (Loss)	4,890,223	4,905,127
Other Income:		
District Tax Receipts	578,071	578,071
Tax Revenue for Debt	1,793,491	1,948,472
Grants and Other Contributions Unrestricted	941,692	500,000
Interest Income	198,339	198,339
Interest Expense	(3,152,422)	(3,067,722)
Other Non-Operating Income	24,846	28,517
Northern Inyo Associates Net Revenue	1,342,864	2,001,773
Northern Inyo Associates Expenses	(5,300,396)	(6,672,577)
340B Retail Program	(120,336)	200,000
Employee Pharmacy Program	-	-
Non-Operating Income (Loss)	(3,693,851)	(4,285,127)
Net Income (Loss)	1,196,372	620,000

Net Operations

- **Net Income of $620,000, .7% net margin**
- **Positive cash flow of $1,600,000**
- **Adequate Financial Ratios**
- **Reduce A/R Days to below 70, Improve Days Cash on Hand**
- **Cost of Capital equal to 5.15%**

Request from Management

- **Approve the Operating Budget for 2017/18**
- **Authorize the increase in prices by 8% as of August 1, 2017**
- **Authorize the creation of any other appropriate documents and resolutions as required to implement the Operating Budget.**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Licensure of Nursing Personnel	
Scope: Nursing Services	Manual: NAM – Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date: 11/1/14

PURPOSE:
To ensure that all Northern Inyo Hospital RN's and LVN's who practice nursing have a current active California license to practice nursing before starting work and thereafter.

POLICY:
1. RN and LVN whose job descriptions meet the requirements for nursing practice in the State of California will maintain a current license to practice as a RN or LVN.
    a. RN license granted from California Board of Registered Nurses.
    b. LVN license granted from California Board of Vocational Nurses and Psychiatric technician examinees.
2. According to California law, RN's or LVN's may be granted temporary permit licenses.
3. RN and LVN staff that does not have an active current license will not be allowed to practice nursing.
4. All licenses including temporary licenses must be renewed on or before the expiration date.
5. Graduate nurses who possess an interim Permit from the California Board of Nursing may practice professional nursing at NIH under the supervision of an RN.
6. The Nursing Services Administrative Assistant/CNO verifies licensure with the Board of Registered Nursing primary verification site.
7. The Nursing Services Administrative Assistant/CNO in collaboration with Human Resources monitors and verifies RN and LVN licensure prior to expiration of Licensure.
8. Nurses are responsible for obtaining their own license and renewal.
9. Advanced Practice Nurse Licensure as an RN and Advanced Practice Nurse shall be maintained by the Medical Staff Office.
10. A RN or LVN with an Interim Permit who fails the examination or does not receive licensure prior to the Interim Permit Expiration, will no longer practice as a nurse.
    a. Staff failing boards may apply for any open position to which they are eligible.

PROCEDURE:
1. Upon hire or on the RN or LVN first day of employment, the RN or LVN license, Temporary license, or Interim Permit shall be viewed by the Nursing Services Administrative Assistant/CNO and the number and expiration date documented on the Licensure Tracking form (see attached) kept in the Nursing Services Administrative Assistant office.
    a. Record of Interim Permit shall be kept in the same manner as the licenses. If the nurse passes the examination, the Interim Permit remains in effect until a regular license is issued or until the Interim Permit expiration date. If the nurse fails the examination, the Interim Permit shall be terminated upon notice by mail, or if the nurse fails to receive the notice, upon the date specified on the Interim Permit.
2. Each month the RN and LVN license file will be reviewed by the Nursing Services Administrative Assistant for next month expirations.
    a. Notice of need for renewal will be sent to the employee and manager via e-mail.
3. Employees who have not renewed their license by the expiration date will:
    a. Be suspended pending license verification. The employee may choose to use PTO.
    b. The RN or LVN will not be allowed to work in another position during the lapsed licensure period.
    c. The RN or LVN has four weeks to complete the requirements for licensure renewal. If licensure is not completed within the four week time frame, the employee will be terminated for employment at Northern Inyo Hospital.

REFERENCES:
1. TJC (2014) CAMCAH Functional Chapter HR 01.02.05. The CAH verifies staff qualifications EP1.

Title: Licensure of Nursing Personnel	
Scope: Nursing Services	Manual: NAM – Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date: 11/1/14

2. California health and Human Services (2010). State of California Statutes Relating to Nurse Practice Act. Regulation and Licensure Sacramento Credentialing Division.
3. This does not replace verification on the BORN website. Employee will be suspended pending licensure verification. Employee may choose to use PTO or Zero Pay.

CROSS REFERENCE:
1. Definition of Nursing

Approval	**Date**
NEC	6/7/17
Board of Directors	
Last Board of Director review	

Developed: 8/11
Reviewed:
Revised: 8/11, 6/13, 7/14
Supersedes: Nurse Licensure Policy
Index Listing:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Language Access Services Program	
Scope: Hospital-Wide	Manual: CPM – Communication (COM)
Source: Language Access Services	Effective Date:

PURPOSE:

The purpose of the Northern Inyo Healthcare District Language Access Service Program is to ensure workforce providing language or communication assistance have the language, and interpreting skills[1] required to assist in providing high quality health care services for Limited English Proficient, non-English speaking, and hearing-impaired patients.

POLICY:

1. It is the policy of NIHD to provide high quality health care services to all patients by ensuring timely and appropriate language or communication assistance to non-English speaking, or limited English proficient patients.
2. NIHD shall provide language or communication assistance through the utilization of any of the resources approved under the Language Access Services Program, which meets the patient's needs and it is within the resources available to NIHD.
3. Non-approved interpreters, language or communication resources (in-person, or remotely via computer, tablet, and/or Smartphone) shall not be utilized to assist workforce members communicating with non-English speaking, or limited English proficient patients.

LANGUAGE ACCESS SERVICES PROGRAM:

Northern Inyo Healthcare District recognizes that access to health care services is the right of every patient. The Program defines the District's language or communication assistance resources, services, levels of service; assessment and training requirements for workforce providing services on behalf of the Program.

Northern Inyo Healthcare District offers qualified medical interpreting services for spoken languages and American Sign Language 24 hours a day, seven days a week.

RESOURCES

The Program utilizes the services of:

a) Qualified approved bilingual workforce members
b) Workforce members qualified as dual-role medical interpreters
c) In-house and contracted professional translation services
d) Telephone-based interpreters from CyraCom®
e) Video Remote Interpreters for American Sign Language
f) Qualified Video Remote Interpreters from the Health Care Interpreter Network (HCIN®), and from CyraCom®

[1] Joint Commission Standard HR.01.02.01 The hospital defines staff qualifications. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.

Title: Language Access Services Program	
Scope: Hospital-Wide	Manual: CPM – Communication (COM)
Source: Language Access Services	Effective Date:

SERVICES

The Program encompasses the following services:

a) Direct patient care services in qualifying languages[2]
b) Limited in-person[3] interpreting services for Spanish-speaking patients
c) Over-the-phone interpreting services in over 200 different spoken languages
d) Video Remote Interpreting for American Sign Language, and for a limited number of spoken languages
e) Translation of Vital Documents in qualifying languages[4]

LEVELS OF SERVICE

Qualified bilingual workforce members, and dual-role medical interpreters must complete all the criteria required for each designation before providing bilingual or interpreting services.

Northern Inyo Healthcare District-qualified medical interpreters are trained on, and adhere to the California Standards for Healthcare Interpreters, including its Professional Ethical Code of Conduct, as set forth by the California Healthcare Interpreting Association; and abide by the Hospital's privacy and confidentiality policies and regulations.

The Northern Inyo Healthcare District's Language Access Services Program includes the following levels of service:

Level I – Qualified Bilingual Non-Clinical
Level II – Qualified Bilingual Clinical
Level III – Qualified Dual-Role Medical Interpreter
Level IV – Medical Interpreter

Level I - Qualified Bilingual Non-Clinical

Definition: A workforce member providing direct services in a qualifying language in non-clinical settings. A qualified bilingual non-clinical workforce member must complete the criteria for dual-role medical interpreters before he/she is allowed to provide interpreting services.

---

[2] As required by the California Health and Safety Code Section 1259 (b)(2)(A), "Language or communication barriers."

[3] Workforce members qualified as dual-role medical interpreters have a primary job, and are not always available to provide interpreting services.

[4] In compliance with California Health and Safety Code Section 1259; and according with Office of Civil Rights Guidance on enforcing Title VI of the Civil Rights Act of 1964, the definition of Vital Documents "may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner."

DRAFT

Criteria: To earn the Qualified Bilingual Non-Clinical designation, the workforce member must:

a) Hold a position in a non-clinical area where utilization of his/her bilingual skill will benefit the Northern Inyo Healthcare District's ability to communicate with patients, by providing direct services in the qualifying language
b) Pass the qualifying language, language proficiency test from LanguageLine Academy℠ at level 3.

Level II - Qualified Bilingual Clinical

Definition: A workforce member providing direct services in a qualifying language in clinical settings. A qualified bilingual clinical workforce member must complete the criteria for dual-role medical interpreters before he/she is allowed to provide interpreting services.

Criteria: To earn the Qualified Bilingual Clinical designation, the workforce member must:

a) Hold a position in a clinical setting where utilization of his/her bilingual skill will benefit the Northern Inyo Healthcare District's ability to communicate with patients by providing direct services in the qualifying language
b) Pass the qualifying language, language proficiency test from LanguageLine Academy℠ at level 3+.

Level III – Qualified Dual-Role Medical Interpreter

Definition: A workforce member providing interpreting services in medical and non-medical settings. *Dual-role medical interpreter's primary job is not interpreting.*

Criteria: To earn the qualified dual-role medical interpreter designation, the workforce member must:

a) Pass the qualifying language, language proficiency test from LanguageLine Academy℠ at level 4. (*Workforce member must pass this test before he/she is approved to take the required interpreters' training)*
b) Complete a comprehensive training (40-hours minimum) for healthcare interpreters, i.e. Connecting Worlds Training for Healthcare Interpreters
c) Complete a medical terminology course in English
d) Complete a medical terminology course in the qualifying non-English language
e) Pass the medical interpreting skills test
f) Complete 8 practicum hours

Level IV – Medical Interpreter

Definition: A workforce member whose primary job is providing interpreting services in medical and non-medical settings.

DRAFT

Title: Language Access Services Program	
Scope: Hospital-Wide	Manual: CPM – Communication (COM)
Source: Language Access Services	Effective Date:

Criteria: (will be listed in job description)

A Qualified Healthcare Interpreter may have completed all training required before hired at NIHD, or it must be completed before he/she provides interpreting services. The workforce member must:

a) Pass a language proficiency test from LanguageLine Academy℠ at level 4;
b) Complete a comprehensive training (40-hours minimum) for health care interpreters, i.e. Connecting Worlds Training for Healthcare Interpreters;
c) Complete a medical terminology course in English;
d) Complete a medical terminology course in the qualifying non-English language;
e) Pass the interpreting skills test; and
f) Complete 8 practicum hours in medical settings.

CROSS REFERENCE P&P:

1. Language Access Services Policy

Approval	**Date**
NEC	6/7/17
Senior Leadership	5/22/17
Board of Directors	
Last Board of Directors Review	

Developed: 5/17
Reviewed:
Revised:
Supersedes:
Index Listings:

DRAFT

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	JUNE, 2017			
	ENVIRONMENTAL SERVICES				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Procedures: Non-Patient Care Equipment: Mini Blinds and Vertical Blinds	6/21/2017			
2	Cleaning Procedures: Non-Patient Care Equipment: Various Non-Patient Care Items	6/21/2017			
3	Cleaning Procedures: Nursing Units: Isolation Rooms	6/21/2017			
4	Cleaning Procedures: Nursing Units: Nursing Stations	6/21/2017			
5	Cleaning Procedures: Nursing Units: Patient Care Areas	6/21/2017			
6	Cleaning Procedures: Nursing Units: Patient Restrooms	6/21/2017			
7	Cleaning Procedures: Nursing Units: Patient Room Occupied	6/21/2017			
8	Cleaning Procedures: Nursing Units: Soiled Utility Rooms	6/21/2017			
9	Cleaning Procedures: Nursing Units: Special Procedure Rooms	6/21/2017			
10	Cleaning Procedures: Nursing Units; Tub Room	6/21/2017			
11	Cleaning Procedures: Patient Care Equipment: Bassinets	6/21/2017			
12	Cleaning Procedures: Patient Care Equipment: Isolettes	6/21/2017			
13	Cleaning Procedures: Patient Care Equipment: Patient Beds	6/21/2017			
14	Cleaning Procedures: Patient Care Equipment: Video Terminal Monitors	6/21/2017			
15	Cleaning Procedures: Patient Care Equipment: Cribs	6/21/2017			
16	Cleaning Procedures: Room/Building Componets: Baseboards	6/21/2017			
17	Cleaning Procedures: Room/Building Componets: Carpet Cleaning	6/21/2017			
18	Cleaning Procedures: Room/Building Componets: Ceilings	6/21/2017			
19	Cleaning Procedures: Room/Building Componets: Dust Mopping	6/21/2017			

Draft: Riesche, Gina (Manager - Emergency Department)
Area: Published

Ref #	Title	TO BOD	APPROVED	COMMENTS
550	Acute CVA Focus Review			
460	Admission of Emergency Room Patient to			
3941	Automated External Defibrillators*			
465	Bite Guidelines, Animals			
470	Cervical Spine Immobilization			
469	Cervical Spine Stabilization Procedure for			
186	Child Abuse or Suspected Abuse or Sexual Assault Guidelines for Victim of			
1438	Code Blue (Cardiac Arrest) Documentation			
221	Code Blue Procedure - Code Blue Team			
558	Communicable Disease Prevention Of Pre			
497	Computer Downtime Emergency			
498	Computer Interface Down Time Emergency			
477	Consent for Medical Treatment			
474	Coroner's Cases			
2260	Crash Cart and Defibrillator Check Policy*			
479	Daily Checklist Procedure ER			
482	Dead on Arrival			
496	Defibrillation/Synchronized Cardioversion and Pacing With The Philips HeartStart			
480	Dental Emergency Protocol			
188	Dependent Adult/Elder Abuse			
483	Discharge Instructions Emergency			
464	Elder Abuse from Licensed Facility			
545	Elevated Blood Pressure in Acute Ischemic Stroke Guidelines for Management			
195	Emergency Care for Ancillary Outpatients Needing Further Observation Treatment			
2283	Emergency Department Level of Care			
1073	Emergency Department Physician on Duty			
249	Emergency Department Record, Use of			
1280	Emergency Medical Screening of Patients			
1277	Emergency Room Overcrowding			
544	Emergency Stroke Protocol			
2293	Entering an ED Admission (observation, surgery, inpatient status) into Health			
499	Evaluation and Medical Screening of Patients Presenting to the Emergency			
504	Evaluation of Pregnant Patients in the			
492	Follow-up Calls Guidelines, Emergency			
493	Follow-up Care Emergency Department			
1989	HI - HICS: Disaster Organization Chart			
809	HIV Test Results Consent for Permission			
446	Interfacility Transfer Guidelines			

189	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer			
1124	Legal Blood Alcohol Intake Form			
501	Medications Emergency Department			
484	Mentally Ill Patients Detention of			
518	MICN Guidelines			
505	Newborn Abandonment			
442	Patient Transfer Accepting a			
553	Patient Valuables and Personal Effects in			
345	Patient With Potential Suicidal Behavior,			
481	Patients Under the Influence of Drugs			
1246	Photo Documentation Policy			
548	Physician Orders Thrombolytic Therapy for Acute Ischemic Stroke with Alteplase			
1279	Pregnant Patient evaluation in the ER			
516	Pre-Hospital Care Policy			
520	Privacy of Emergency Department Patients			
521	Quality Assurance Review Daily Chart			
523	Quality Improvement Program Pre-Hospital			
522	Quality Management Program Emergency			
1240	Rapid Response Team*			
256	Risk Fall Assessment in the Emergency			
3973	Scope of Service for the Emergency			
525	Sexual Assault Exam Policy			
808	Sexual Assault Response Team			
187	Spousal and Domestic Abuse Guidelines			
248	Standards of Care for the Emergency			
533	Suspicious Injury Reporting			
532	Telephone Advice Information			
536	Tetanus Prophylaxis Treatment Guidelines			
543	Thrombolytic Therapy Focus Review			
537	Thrombolytic Therapy for Acute Myocardial			
535	Trauma Patient Care in the Emergency			
551	Triage			
554	Violent Crimes Management of Victims			

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
JUNE 2017

1. RETURN TO WORK FOLLOWING ILLNESS
2. ASSIGNMENTS AND GARNISHMENTS
3. CONFERENCES WITH SUPERVISORS
4. EMPLOYEE DISSATISFACTION
5. TERMINATION BENEFITS
6. TERMINATION
7. LEAVING WITHOUT NOTICE
8. BULLETIN BOARDS
9. LOST AND FOUND
10. SECURITY/SAFETY PROGRAM
11. PACKAGE INSPECTIONS
12. SUGGESTIONS
13. FOOD SERVICE
14. THEFT
15. COMMUNITY RELATIONS
16. CONFIDENTIALITY
17. ELECTRONIC COMMUNICATIONS
18. EMPLOYEE REQUESTS TO BE EXCLUDED FROM PATIENT CARE
19. PERSONNEL FILE INSPECTION
20. PATIENTS' RIGHTS, PATIENTS' RESPONSIBILITIES, AND PROCESS FOR RESOLUTION OF PATIENT GRIEVANCES OR COMPLAINTS

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	JUNE, 2017			
	PHARMACY DEPT.				
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**	**P&P UPDATED**
1	Sterile Products: Cytotoxic Agents	6/21/2017			
2	Single-dose vs Multi-dose Vial Policy	6/21/2017			
3	Sterile Products: Compounding Quality Assurance Program	6/21/2017			

POLICIES TO THE BOD
PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD	JUNE, 2017			
	ENVIRONMENT OF CARE				
	PROPERTY MGMT, SECURITY AND				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Fire Safety Management Plan	6/21/2017			
2	Hazardous Materials & Waste Management Plan	6/21/2017			
3	Medical Equipment Management Plan	6/21/2017			
4	Safety Management Plan	6/21/2017			
5	Security Management Plan	6/21/2017			
6	Utility Systems Management Plan	6/21/2017			

RESOLUTION NO. 17-01
OF THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

WHEREAS, the Northern Inyo Healthcare District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, on May, 2016, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of $583,727.31 for the July 1, 2016 to June 30, 2017 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance, an appropriations limit of $604,858.24 has been calculated for the July 1, 2017 to June 30, 2018 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 15th day of June, 2016 that an appropriations limit of $604,858.24 be established for the Northern Inyo Healthcare District for the 2017-2018 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

NORTHERN INYO HEALTHCARE DISTRICT
RESOLUTION NO. 17-02

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT RATIFYING A 7% CONTRIBUTION TO THE NORTHERN INYO HEALTHCARE DISTRICT 401(a) RETIREMENT PLAN

WHEREAS, the Board of Directors ("Board") of the Northern Inyo Healthcare District ("District") established the Northern Inyo Healthcare District 401(a) Retirement Plan effective January 1, 2013 (the "Retirement Plan"), and subsequently restated the Plan effective January 1, 2016; and

WHEREAS, Section 5.1 of the Plan permits the District to determine the contribution amount to the Plan; and

WHEREAS, the Board previously approved a contribution to the Plan equal to 7% of Compensation on behalf of each Participant (as defined by the Plan) as part of the District's 2016/2017 budget.

NOW, THEREFORE, be it resolved, determined, and ordered by the Board of Directors of the Northern Inyo Healthcare District as follows:

SECTION 1. That, effective June 15, 2016 the District hereby ratifies and approves a 7% contribution to the Northern Inyo Healthcare District 401(a) Retirement Plan on behalf of each Participant, as contemplated by the approved 2016-2017 budget.

ADOPTED this 21st day of June, 2017.

_____
Peter Watercott, President
Northern Inyo Healthcare District Board of Directors

ATTEST:

_____
M.C. Hubbard, Secretary
Northern Inyo Healthcare District Board of Directors

NORTHERN INYO HEALTHCARE DISTRICT

RADIOLOGY
COVERAGE AND ADMINISTRATIVE SERVICES AGREEMENT

This Radiology Coverage and Administrative Services Agreement ("**Agreement**") is effective as of July 10, 2017 (the "**Effective Date**"), between Northern Inyo Healthcare District (the "District") and Bishop Radiology Group, Inc., a California professional corporation ("**Group**").

RECITALS

A. District owns and operates a general acute care hospital located at 150 Pioneer Lane, Bishop, CA 93514 ("**Hospital**") and operates a Radiology Department (the "**Department**") for the provision of professional radiology services to hospital inpatients and outpatients ("**Professional Services**"). District desires to ensure the availability of experienced physicians to meet the needs of Hospital, its medical staff ("**Medical Staff**"), and its patients for these services.

B. District is also in need of an experienced, qualified physician to serve as Radiology Medical Director for the Department, to provide certain administrative services to the Department and to act as a liaison between the Department, the Medical Staff and other departments within the hospital.

C. Group is a professional corporation that contracts with physicians who are duly licensed to practice medicine in California, who are experienced in and are board certified or eligible in radiology (the "**Specialty**"), and who are qualified to provide the services required under this Agreement (each, a "**Physician**," collectively, the "**Physicians**").

D. District wishes to contract with Group, and Group wishes to contract with District, to provide a physician to serve as Radiology Medical Director for the Department and to provide Physicians to provide coverage services upon the terms and conditions set forth in this Agreement.

NOW, THEREFORE, the parties agree as follows:

SECTION 1. GROUP SERVICES

1.1 Coverage Services.

(a) **Services.** Hospital hereby retains Group to provide all Coverage Services (as hereinafter defined) to the Hospital at the Hospital for inpatients and outpatients on an exclusive basis. Group shall be responsible for providing a sufficient number of Physicians to provide on-site and on-call coverage services as required for patient care and operation of the Department and as described on **Exhibit A** attached ("**Coverage Services**"). Group shall be permitted to provide the Coverage Services via the on-site presence of Physicians or via teleradiology using its Physicians and/or a Teleradiology Service Provider (as hereinafter defined) as specified on **Exhibit A** hereof. In the event District desires, during the term of this Agreement, to provide Coverage Services at a location other than Hospital, District shall offer the opportunity to provide such Coverage Services to Group by notice to such effect (the "Offer Notice," which notice shall include District's proposed terms and conditions of the arrangement) before offering such opportunity to any other person. Group may accept or reject such offer or it may respond with a proposal to provide such Coverage Services under alternative terms and conditions, all by notice to District. If District and Group do not enter into a written agreement for the provision of such Coverage Services within twenty-one (21) days following the Offer Notice, District may then offer the opportunity to provide such Coverage Services to another person, but not on terms more favorable to such other person than the most favorable terms that District offered to Group.

(b) **Coverage Schedule.** At least one (1) week prior to the first day of each month, Group shall provide Hospital with an electronic coverage schedule ("**Coverage Schedule**") listing the names of Physicians who will provide Coverage Services each day that month, including whether Coverage Services will be provided on-site or on-call. Group shall ensure that the electronic Coverage Schedule is modified in a timely manner (by the day preceding the Coverage Schedule day in question) so that it is accurate with respect to each day Coverage Services are provided.

(c) **Physicians.** Group shall engage a sufficient number of Physicians that Group in its discretion determines are needed to provide Coverage Services under this Agreement. A list of those Physicians who Group anticipates will provide Services for Hospital under the terms of this Agreement is attached hereto as **Exhibit B**. Group shall immediately give Hospital written notification in the event that any Physician appearing on **Exhibit B** resigns or otherwise fails to satisfy the qualifications for services as a Physician hereunder. In the event Group desires to add a Physician to **Exhibit B**, Group shall ensure that any such physician meets the qualifications set forth in this Agreement and shall immediately notify Hospital, in writing, of such proposed addition. Such a Physician shall be added as a Physician hereunder unless Hospital objects within seven (7) days of receiving notice of the new Physician from Group, which objection shall not be unreasonably made. All obligations and prohibitions imposed on Group pursuant to this Agreement are equally applicable to each Physician engaged by Group to provide Coverage Services. Notwithstanding the foregoing, Group shall be permitted to use (i) the Teleradiology Service Provider to provide final interpretations and (ii) coverage staff (locum tenens physicians) to supplement its Physicians hereunder on a temporary basis provided that such coverage staff satisfies the professional qualifications of Section 2.1.

(d) **Teleradiology Services**. The Parties acknowledge and agree that some Coverage Services will be provided, at Group's sole cost and expense by STATRAD or a similar after-hours radiology services provider selected by Group and approved by District, in advance, with such approval not being unreasonably withheld ('Teleradiology Service Provider") provided that all Physicians providing Coverage Services through the arrangement with the Teleradiology Services Provider satisfy the professional qualifications of Section 2.1. Group shall be financially responsible for all compensation due and owing to the Teleradiology Service Provider for providing Coverage Services to Hospital. Group shall ensure that Teleradiology Service Provider shall comply with all laws, rules, regulations and Medical Staff bylaws and rules and regulations regarding the provision of professional services to Hospital patients via telemedicine. Hospital shall credential the providers providing services to Hospital patients by the Teleradiology Service Provider pursuant to its established policies and procedures. Group shall ensure that any Teleradiology Service Provider shall not bill Hospital nor any Hospital patient for the professional services provided by Teleradiology Service Provider to Hospital patients under the terms of this Agreement.

1.2 Administrative Services.

(a) **Services.** Group shall provide a Physician or Physicians to serve as Radiology Medical Director ("**Medical Director**"). The Medical Director shall be responsible for carrying out Group's administrative responsibilities described in **Exhibit C** and for the overall supervision and operation of the Department, to act as a liaison between the Department, the Medical Staff and other departments within the District and to oversee Group's performance of this Agreement (collectively, "**Administrative Services**"). To the extent allowed by law, the Medical Director shall be responsible to the Hospital's Chief Medical Officer ("**Administrator**") for performance of services under the Agreement.

(b) **Approval.** Group has initially engaged Young Song, M.D. and Arash Radparvar, M.D., to serve as the co-Medical Directors (and shall be collectively referred to herein as the "Medical Director"), and these Physicians are hereby approved and accepted by District. The Medical Director may delegate to other Group Physicians select Administrative Services provided the approved Medical Director retains ultimate responsibility.

(c) **Hours.** The Medical Director shall devote as much time as is reasonably necessary and adequate each month to provide the Administrative Services described in this Agreement.

(d) **Substitute Medical Director.** Group shall cause the Medical Director to inform the Administrator of any extended periods (i.e., one week or more) during which the Medical Director will be unavailable due to vacation, professional meetings, or other personal or professional commitments. During all periods of the Medical Director's unavailability, Group shall engage and provide a substitute Group Physician to serve as Medical Director ("Substitute Medical Director"). For periods of the Medical Director's unavailability more than four (4) weeks, Group shall secure District's prior written approval for the Substitute Medical Director, which approval shall not be unreasonably withheld.

SECTION 2. STANDARDS OF PERFORMANCE

2.1 **Professional Qualifications.** Each Physician providing Coverage Services or Administrative Services shall at all times meet the following professional qualifications and Group shall promptly notify District when it acquires knowledge of any event causing or likely to cause a failure by any Physician to meet these professional qualifications:

(a) Hold an unrestricted license to practice medicine in the State of California;

(b) Be permitted to prescribe medications and hold a valid Drug Enforcement Agency permit;

(c) Hold a certificate or evidence of eligibility for certification by the American Board of Radiology, or be so certified within three (3) years of eligibility;

(d) Be a member of the Medical Staff in category currently pending identified; additionally, the Radiology Medical Director shall be an active member in good standing of the Medical Staff and be subject to all of the attendant privileges, responsibilities and conditions of such membership; and

(e) Be eligible to provide services to beneficiaries under the Medicare and Medi-Cal programs as a participating provider.

2.2 **Representations and Warranties.** Group represents and warrants to District that:

(a) Neither Group nor any Physician is bound by any agreement or arrangement which would preclude Group from entering into this Agreement, or Group or any Physician from fully performing the Coverage Services or the Administrative Services;

(b) No Physician's license to practice medicine in the State of California or in any other jurisdiction has ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

(c) No Physician's medical staff privileges at any health care facility have ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

(d) No Physician or Teleradiology Service Provider (or their provider physicians) have ever been convicted of an offense related to health care, or listed by the Medicare or Medi-Cal programs or any other federal or state agency as debarred, excluded or otherwise ineligible for any federal or state program participation; and

(e) Group has no information that would reasonably indicate that any Physician is not able to perform the services required under this Agreement.

2.3 **Compliance with Rules and Laws.** Group shall comply, and shall ensure that Physicians comply, with all written policies, bylaws, rules and regulations of Hospital and the Medical Staff and applicable standards and recommendations of the Joint Commission. Group also shall comply, and shall ensure that Physicians comply, with all applicable provisions of federal, state and local laws, rules and regulations, as well as rules and regulations of all governmental agencies having jurisdiction over: (i) the operation of the Hospital (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payors whose members/beneficiaries receive care from Hospital. This shall specifically include compliance with applicable and relevant provisions of Title 22 of the California Code of Regulations.

2.4 **Quality Improvement and Risk Management**. Group and each Physician shall participate in:

(a) The quality improvement and risk management programs of Hospital and serve on such quality improvement or risk management committees as may be reasonably required;

(b) On-going quality improvement monitoring activities, such as audits, reviews or investigations, conducted by Hospital in order to evaluate and enhance the quality of patient care. The appropriate review mechanism shall be applied in accordance with the provisions of the Medical Staff Bylaws, accreditation organizations and applicable laws;

(c) Risk management activities designated to identify, evaluate and reduce risk of patient injury associated with care.

(d) Performance Improvement and Peer review activities consistent with hospital licensing and accreditation standards;

(e) The development of and adherence to protocols for the Department, which support evidence-based care, best practices and patient satisfaction.

(f) Regularly consult with the Administrator, Medical Executive Committee and/or other designated party or committees on matters related to the Department including productivity, quality, service and patient satisfaction.

(g) Meet the requirements of Meaningful Use and code patient visits and procedures for billing purposes in a timely fashion.

2.5 **Corporate Compliance Program.** Group and each Physician shall comply with Hospital's corporate compliance program, which shall be provided to the Group prior to the Effective Date and thereafter as amended. Group and Physicians shall cooperate with any corporate compliance audits, reviews and investigations that relate to Group or any Physician and/or any of the services provided by Group or any Physician under this Agreement. In addition, as requested by District, Group and Physicians shall participate in corporate compliance-related seminars and educational programs sponsored by District.

2.6 **Best Efforts.** Group shall devote its best efforts toward carrying out the terms of this Agreement and shall cause Physicians to devote sufficient time to support the efficient and effective operation of the Department.

2.7 **Non-Discrimination.** Group and each of its Physicians shall provide services under this Agreement without regard to any patient's race, color, creed, ethnicity, religion, national origin, ancestry,

citizenship, marital status, age, sex, sexual orientation, preexisting medical condition, physical or mental handicap, financial status, insurance status, economic status, or ability to pay for medical services.

2.8 **Group's Annual Report.** Upon request of the Hospital made no later than the 7th month after the Effective Date, Group agrees to provide an annual report to the Administrator in the 10th month after the Effective Date. The annual report shall include an explanation of Physician staffing and qualifications, call frequency while providing coverage services, patient survey results, any material issues related to the Department, and opportunities for performance improvement.

2.9 **Removal of Physicians.** District may request the immediate cessation of Coverage Services or Administrative Services by any Physician for failure to satisfy the professional qualifications of Section 2.1 or for other reasonable reasons related to his or her performance of Coverage Services upon written notice to Group specifying the reasons thereof. The parties shall immediately identify and attempt to mutually agree upon an appropriate response to the issue raised by the District (e.g. additional education, counseling, termination of employment or engagement with Group, or such other response as may be reasonable under the circumstances). If District and Group cannot mutually agree upon an appropriate response within five (5) business days of District's written notice to Group and/or District is not reasonably satisfied with the results of such response and notifies Group in writing of such dissatisfaction, Group shall temporarily remove such Physician from the Coverage Schedule and/or not assign such Physician responsibilities for providing Administrative Services until (and if) such specific issues have been resolved to District's reasonable satisfaction. District and Group administration shall then meet and discuss alternative staffing arrangements. The parties acknowledge and agree that nothing herein shall affect the rights of a Physician under Hospital's Medical Staff Bylaws, including the right to due process and a hearing thereunder if such Physician is subject to removal pursuant to this Section 2.9. The removal of a Physician pursuant to this Section 2.9 shall not serve as the basis for termination of this Agreement in the event that Group has provided or will be able to provide Coverage Services hereunder through other Physicians or the Teleradiology Service Provider in lieu of the Physician to whom the terms of this Section 2.9 apply.

SECTION 3. PREMISES

3.1 **Equipment, Supplies, Etc.** District shall operate the Department with all customary and necessary equipment, furniture, computers, supplies, maintenance, cleaning, utilities and qualified personnel reasonably required for operation of the Department. The selection, deletion and purchasing of additional or replacement equipment and the selection, removal and retention of personnel shall be the exclusive function of District, with input from the Radiology Medical Director as requested by the Administrator.

3.2 **Use of District Facilities.** Except as set forth in this Section 3.2, any facilities, equipment, supplies, or personnel provided by District shall be used by Group and Physicians solely to provide services under this Agreement and other occasional informal radiology consultation services. District hereby acknowledges and agrees that Group and its Physicians will throughout the term of this Agreement provide professional services at locations other than the Hospital and that certain studies generated at the Hospital may be interpreted by Group and/or its Physicians and Teleradiology Service Providers at offsite locations via teleradiology or other means of transmission. In addition to and notwithstanding anything to the contrary contained herein, Group may provide at any District facility at which Group provides Coverage Services hereunder, outside radiology services for third parties that are unrelated to the Coverage Services being provided hereunder to the District, including but not limited to the interpretation of outside radiology studies, so long as these outside services do not have a material adverse impact upon the delivery of the Coverage Services by Group to Hospital as described herein and are provided using workstations and other equipment owned and operated by Group separately from the District's equipment provided hereunder. Provided, however, that Group shall be permitted to use Hospital's internet connectivity to provide the outside services described in the immediately preceding sentence.

3.3 **Provision of Services via Teleradiology.** District shall at its sole cost and expense provide Group with all information technology (including but not limited to hardware, software, support and ability to transmit images via teleradiology) needed or reasonably requested by Group to provide its services on-site or off-site hereunder and to be able to access electronic medical records, interpret images and dictate final interpretations remotely, including but not limited to diagnostic work station computers and monitors (with appropriate capability to allow Group to fulfill its responsibilities hereunder), printers, computer software (including but not limited to voice recognition software and licenses, software necessary to push images off-site via teleradiology, and such other software as is requested by Group) and other required hardware. The District at its sole cost and expense and responsibility, shall provide and ensure that the methodology and bandwidth used for electronic transmission of images by Hospital to Group for remote interpretation are of such a nature to produce diagnostic images to Group and are HIPAA compliant.

SECTION 4. BILLING AND COMPENSATION

4.1 **Compensation.** District shall pay Group in accordance with **Exhibit D**. This shall include any bonus for meeting certain performance metrics as more fully set out in **Exhibit D**.

4.2 **Billing for Services.**

(a) **Professional Fee Schedule.** Group will establish a schedule of fees for the professional component of medical services delivered to all patients by Group or any Physician, subject to District's approval, which shall not be unreasonably withheld. District will establish a schedule of fees for the technical component of medical services delivered to all patients. Each party's fees schedule will be consistent with the customary fees in the community for the services involved. In no event will fees to Medicare patients exceed the applicable fees or charges published by the Centers for Medicare and Medicaid Services under the then current Medicare Physician Fee Schedule for the Hospital's location.

(b) **Hospital Billing of Technical Component.** District shall bill and collect for the technical component of medical services delivered to all Department patients.

(c) **Billing of Professional Services**. District shall act as Group's designated billing and collection agent. Group hereby assigns to Hospital the right to collect such charges for its Physicians and its Teleradiology Service Providers; for the avoidance of doubt, all references to Group's charges hereunder shall include charges for services rendered by Group and its Physicians and/or Teleradiology Service Providers. Hospital's charges to the patient shall be separate and distinct from the charges by Group. In the event Hospital bills patients through a single invoice combining Hospital and Group charge, the billing shall clearly distinguish Group professional fees and shall disclose that the District is acting as billing agent for Group. Group shall cooperate in the preparation and filing of such documentation and records as are necessary to allow Hospital to efficiently perform its billing duties as set forth herein. Hospital shall use its commercially reasonable best efforts in the billing and collection of the professional component services provided by Group's Physicians and Teleradiology Service Providers. The parties agree that District's collection of professional fees during the term of this Agreement are not anticipated to exceed amounts paid by District to Group for professional services pursuant to this Agreement. At the end of each twelve (12) month period of this Agreement, District shall perform an audit of the professional fees collected for such twelve (12) month period. In the event that professional fees collected during this time exceed compensation paid Group by District pursuant to **Exhibit D** for this same twelve (12) month period, the excess in professional fee collections shall be paid to Group by the District, minus a reasonable fee (not greater than three percent (3%)) imposed by the District for the services provided as a billing agent. Such payment shall be made within thirty (30) days after the completion of the audit.

(d) **Billing Records.** District and Group shall each make, keep and maintain, complete and accurate records of all charges and billings, and each party shall have the right to examine, inspect or make copies of the records of the other party pertaining to such charges and billings, at its own expense if such access is requested by Group to confirm the amounts billed and collected by the District hereunder or as necessary to comply with any laws, rules or regulations.

(e) **Hospital-Contracted Plans.** If Hospital enters into a Hospital services agreement with a third party payor, Group shall negotiate in good faith with such payor to attempt to arrive at a fee schedule acceptable to such payor which will be applicable to Hospital patients covered by Hospital's agreement. For purposes of this Section, good faith shall be evaluated in each instance by Group's willingness to negotiate and offer acceptable rates within the range of prevailing reimbursement rates for physicians practicing in the Specialty in the area. Failure to meet this requirement of good faith shall be deemed a material breach by Group of the terms and conditions of this Agreement, and in such event, Hospital may, at its option terminate this Agreement for cause after providing Group with 30 days prior written notice and opportunity to reach agreement on an acceptable fee schedule during this 30 day period.

4.3 **Expenses.** Neither Group nor any Physician shall incur any financial obligation on behalf of District without District's prior written consent, which consent shall be in District's sole and absolute discretion. Group and Physicians shall be solely responsible for the following: (a) Physician compensation and benefits; (b) professional license fees and professional association membership fees and dues; (c) professional conventions and meetings; (d) professional liability insurance (even though the cost of such insurance increases over the term of this Agreement); and (e) all compensation attributable to any employees, subcontractors, back-up physicians or teleradiology service providers engaged by Group or a Physician.

SECTION 5. TERM AND TERMINATION

5.1 **Term.** The term of this Agreement shall commence on the Effective Date and continue for a period of three (3) years. This Agreement may be renewed for an additional three (3) year term upon mutual Agreement of the parties.

5.2 **Without Cause Termination.** Either party may elect to terminate this Agreement, without cause, upon ninety (90) days' advance written notice to the other party.

5.3 **Immediate Termination by District.** District may terminate this Agreement immediately by written notice to Group upon the occurrence of any of the following events:

(a) The inaccuracy of any representation of Group in Section 2.2 (Representations and Warranties) or failure of Group to remove a Physician after requested by District pursuant to Section 2.9 (Removal of Physicians);

(b) Loss or restriction of Hospital's license or accreditation, or destruction of the Hospital or the portion(s) thereof dedicated to the operation of the Department, such that District is not able to continue the uninterrupted operation of the Department;

(c) Either party becomes insolvent or declares bankruptcy;

(d) If professional liability insurance is not available for Physicians performing Group's Coverage Services under this Agreement;

(e) The dissolution or discontinuance of the operations of Group.

5.4 **Termination for Cause.** Upon material breach of any term of this Agreement by a party (the "Breaching Party"), the other party may immediately terminate this Agreement by notice to the Breaching

Party to such effect, *provided* that, except for a breach described in Section 5.3 or any breach that causes immediate jeopardy to patient care, the party shall have first provided notice of such breach to the Breaching Party and the Breaching Party shall have failed to cure the breach within thirty (30) days after such notice.

5.5 **Legal Jeopardy.** In the event legal counsel for either party advises that this Agreement or any practices which could be or are employed in exercising rights under this Agreement may violate any existing or future law or regulation, or will jeopardize the District's tax exempt status, or jeopardize either party's participation in, or result in fines or penalties under, the Medicare or Medicaid programs or any other third-party payor program, whether governmental or non-governmental, or any accreditation or certification program, the parties in good faith shall undertake to revise this Agreement to comply with such law(s). In the event that the parties are unable to reach agreement on new terms within 30 days of communicating the non-compliance to the other party, either party may immediately terminate the Agreement. Both parties recognize and agree that the rules governing compensation arrangements approved by the Centers for Medicare and Medicaid Services may change during the term of this Agreement. If any portion of the compensation set forth in this Agreement is likely to be materially affected by such modifications to the extent that the compensation hereunder is no longer equal to fair market value, the parties will work diligently and in good faith to modify such compensation to comply with the law and to approximate as closely as possible the economic relationship described in this Agreement.

5.6 **Effect of Expiration or Termination.**

(a) **Continuation of Patient Services.** Upon expiration or other termination of this Agreement, the parties shall be relieved and released from any further duties and obligations under this Agreement except for those obligations that have accrued as of the date of termination or specifically continue beyond the end of the term. Notwithstanding the foregoing, except for termination due to legal jeopardy or risk to patient welfare, if circumstances applicable to particular patients require the continuation of such services after the effective date of this Agreement's termination, Group shall continue to provide for a reasonable period (not to exceed thirty (30) days beyond the date of termination) Coverage Services to any patient for whom Group had professional responsibility.

(b) **Procedural Rights.** Continuation of this Agreement is not a condition of Medical Staff membership. Therefore, this Agreement may be terminated in accordance with its terms or individual Physicians excluded pursuant to Section 2.9 without the necessity of a hearing before the District's Board of Directors, a committee of the Medical Staff, or any other body. Physicians' Medical Staff membership and clinical privileges shall continue unless or until terminated in accordance with the Medical Staff Bylaws. Group represents and warrants that all Physicians are aware of and accept this condition.

SECTION 6. INSURANCE AND INDEMNITY

6.1 **Insurance for Administrative Services.** District shall provide coverage for the Administrative Services provided by Group under this Agreement through its standard policy of insurance or self-insurance in amounts of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the annual aggregate. This insurance shall be applicable only to Administrative Services and not to any Coverage Services nor any professional services provided to patients.

6.2 **Professional Liability Insurance.** Group at its sole cost and expense shall maintain professional liability insurance for services rendered by Group and each Physician in the Department in the minimum amount of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the annual aggregate from an insurance company which is acceptable to District, with such acceptance not being unreasonably withheld. Upon District's request, Group shall provide to District a copy of the

Certificates of insurance evidencing the insurance coverage required under this Section. Such insurance policy or policies shall also provide for not less than thirty (30) days' notice to District of any cancellation, reduction, or other material change in the amount or scope any coverage required under this Section. If Group's professional liability coverage is on a "claims made" rather than an "occurrence" basis, and such coverage is later terminated, or converted to an occurrence coverage (or vice versa), Group shall at its expense obtain prior acts or tail coverage (as applicable) with the same liability limits required above covering all periods that this Agreement is or has been in force.

6.3 **Indemnification**. Each party shall indemnify, defend and hold harmless the other party from any and all liability, loss, claim, lawsuit, injury, cost, damage or expense whatsoever (including reasonable attorneys' fees and court costs) arising out of, incident to or in any manner occasioned by the performance or nonperformance of any duty or responsibility under this Agreement by such indemnifying party or by any of the indemnifying party's directors, trustees, officers, employees, shareholders, agents, contractors or subcontractors, as applicable, specifically including but not limited to any liability associated with Hospital's or District's billing for the Coverage Services provided by Group hereunder. The foregoing indemnity provisions shall not be operative to the extent and where to be operative would result in denial of coverage by any insurer or under any insurance policy that denies coverage for contractually assumed liability, and neither party shall be liable to the other party hereunder for any claim covered by third party insurance, except to the extent that the liability of such party exceeds the amount of such third party insurance coverage. Each party shall make its best efforts to obtain any waivers or riders on insurance policies covering such party as may be necessary to remove any limitations or restrictions in such policies

7.1 **Creation of Medical Records.** Group and Physicians shall cause a complete medical record to be created and maintained for each patient evaluated and/or treated by Group. Group and Physicians shall complete these medical records within the time frame as specified by Medical Staff Bylaws, Rules and Regulations and/or related written Hospital policies and procedures. All medical records shall be kept current and complete and prepared in compliance with all state and federal regulations, the regulations of all accreditation institutions in which District participates, the Medical Staff bylaws, and Hospital's rules and regulations.

7.2 **Patient Records.** Any and all patient records and charts produced as a result of either party's performance under this Agreement shall be and remain the sole property of District. Both during and after the term of this Agreement, Group shall be permitted to inspect and/or duplicate, at Group's expense, any individual chart or record to the extent necessary to meet professional responsibilities to such patient(s) and/or to assist in the defense of any reimbursement inquiry or malpractice or similar claim to which such chart or record may be pertinent; provided, however, that such inspection or duplication shall be conducted in accordance with applicable legal requirements and pursuant to commonly accepted standards of patient confidentiality. Group shall be solely responsible for maintaining patient confidentiality with respect to any information obtained by Group pursuant to this Section. This provision shall survive the expiration or termination of this Agreement for any reason.

7.3 **Record Requirements.** Each party agrees in connection with the subject matter of this Agreement to cooperate fully with the other party in order to assure that each party will be able to meet all requirements for record keeping associated with public or private third-party payment programs.

SECTION 8. ACCESS TO BOOKS AND RECORDS

8.1 **Access.** Group shall maintain and make available all necessary books, documents and records in order to assure that District will be able to meet all requirements for participation and payment associated with public and private third party payment programs, including, but not limited to, matters covered by

Section 1861(v)(1)(1) of the Social Security Act, as amended. With respect to Section 1861(v)(1)(1), it is agreed:

(a) Until expiration of 4 years after furnishing services pursuant to this Agreement, Group shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents, and records of Group that are necessary to verify the nature and extent of costs incurred by District under this Agreement.

(b) If Group carries out any of the duties of this Agreement with a value of $10,000 or more over a 12 month period through a subcontract with a related organization, such agreement must contain a clause to the effect that until the expiration of 4 years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, the subcontract, and any books, documents and records of the related organization that are necessary to verify the nature and extent of costs incurred by District under this Agreement.

8.2 **Limits.** The availability of Group's books, documents, and records shall be subject at all times to all applicable legal requirements, including, without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary of Health and Human Services by regulation.

SECTION 9. INDEPENDENT CONTRACTOR RELATIONSHIP

In the performance of all Coverage Services and Administrative Services and other obligations under this Agreement, it is mutually understood and agreed that (a) Group and the Physicians are at all times acting and performing as independent contractors with respect to the District; (b) no relationship of partnership, joint venture, or employment is created by this Agreement; (c) neither the District nor Group (or any Physician) will hold itself out or act as agent of the other party, or have the power to obligate the other party to third parties in any way without the express written consent of the other party; and (d) neither Group nor any Physician may make any claim against the District under this Agreement for social security benefits, workers' compensation benefits, disability benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind. It is the express intention of the parties that Group, in providing medical services under this Agreement, shall perform said services independently of any direction and control of the District except that Group agrees to perform all services in accordance with the specifications of this Agreement. Group and the Physicians shall owe their first duty to the patients seen under the terms of this Agreement, shall be responsible for them and shall exercise independent medical judgment regarding their care and treatment. The District shall not supervise or oversee the performance of services under this Agreement, except to the extent of quality assurance and peer review undertaken for all physicians on District's Medical Staff.

SECTION 10. CONFIDENTIALITY

10.1 **District Information.** Group recognizes and acknowledges that, by virtue of entering into this Agreement and providing services to District hereunder, Physician and Group may have access to certain information of District that is confidential and constitutes valuable, special and unique property of District. Group agrees that neither Group nor any Physician will at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without District's express prior written consent, except pursuant to Group's or a Physician's duties hereunder or as compelled by law or order of court, any confidential or proprietary information of District, including, but not limited to, information that concerns District's patients, costs, prices and treatment methods at any time used, developed or made by District, and that is not otherwise available to the public.

10.2 **Terms of this Agreement.** Except for disclosure to Group's legal counsel, accountant or financial advisors (none of whom shall be associated or affiliated in any way with District or any of its affiliates) neither Group nor any Physician shall disclose the terms of this Agreement to any person who is not a party to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to in writing by District.

10.3 **Patient Information.** Group shall not disclose, and shall ensure that the Physicians not disclose, to any third party, except where permitted or required by law or where such disclosure is expressly approved by District in writing, any patient or medical record information regarding District patients, and Group shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of District and its Medical Staff, regarding the confidentiality of such information, including, but not limited to, the Federal Health Insurance Portability and Accountability Act, Public Law 104-191 ("HIPAA") and Subtitle D of the Federal HITECH Act ("HITECH Act," 42 U.S.C. §17921 et seq.) and the regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations," 45 C.F.R. Part 160, et seq.), as amended from time to time.

10.4 **Business Associate Requirements.** By signing this Agreement, Group hereby agrees to comply, and to require that any Radiology Medical Director and Substitute Medical Director comply, with the business associate requirements ("Business Associate Requirements") as they appear in the HIPAA security and privacy regulations (in current or amended form) regarding using and disclosing patient-identifiable health care information that is received from District in the course of furnishing Administrative Services under this Agreement. The Business Associate Requirements in effect at the time of the Effective Date of this Agreement are set forth in **Exhibit F** attached.

10.5 **Hospital Responsibilities.** Hospital shall retain administrative and professional responsibility for Hospital services rendered.

SECTION 11. ARBITRATION

Any controversy or claim arising out of or relating to this Agreement, or the making, performance or interpretation of it, will be settled by arbitration in Inyo County, California. The arbitration will be conducted pursuant to the provisions of Part 3, Title 9, Chapters 1 through 5 of the California Code of Civil Procedure commencing with Section 1280, or such California State legislation then in effect, as amended. The party wishing to institute arbitration pursuant to this provision will give notice to the other party of its intent to commence arbitration and will designate in the notice an arbitrator on behalf of such party. Within thirty (30) days after the date of the notice of intent to arbitrate a controversy or claim, the other party will give notice of its nomination of an arbitrator on its behalf. Within thirty (30) days thereafter, each of the arbitrators nominated will designate a third, neutral arbitrator. The decision of the two arbitrators as to the selection of the third, neutral arbitrator will be final and binding upon the parties. The arbitration will be enforceable as provided by California law. Each party will bear the costs of the arbitrator selected by it, and the fee for the third, neutral arbitrator will be shared equally by the parties unless the arbitration tribunal determines otherwise. The prevailing party will be entitled to reasonable attorneys' fees and costs as a part of the arbitration award.

SECTION 12. NOTICES

Any notices or other communications permitted or required by this Agreement shall be made in writing and deemed made on the day personally delivered in writing or via overnight delivery by a mutually recognized carrier or 3 days after mailed by certified mail (or first class mail), postage prepaid, to the other party at the address set forth below or to such other persons and addresses as either party may designate in writing:

If to District: **Northern Inyo Healthcare District,**
~~5189 District Rd~~ 150 Pioneer Lane
~~Mariposa, California 95338~~ Bishop, CA 93514
Attn: Chief Executive Officer

If to Group: **Bishop Radiology Group, Inc.**
38 Bombay
Irvine, CA 92620
Attn: Young Song, M.D.

SECTION 13. MISCELLANEOUS PROVISIONS

13.1 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of California.

13.2 Force Majeure. Either party shall be excused from any delay or failure in performance under this Agreement caused by reason of any occurrence or contingency beyond its reasonable control, including, but not limited to, acts of God, acts of war, fire, insurrection, labor disputes, riots, earthquakes, or other acts of nature. The obligations and rights of the party so excused shall be extended on a day-to-day basis for the time period equal to the period of such excusable interruption. In the event the interruption of the excused party's obligations continues for period in excess of thirty (30) days, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the excused party.

13.3 Assignment/Subcontracting. Neither party shall assign or subcontract their rights, duties, or obligations, under this Agreement, either in whole or in part, without the prior written consent of the other. Notwithstanding the foregoing, the District will have the right to assign its interest in this Agreement to an entity wholly owned, controlled by, or under common control with the District. Any such assignee will assume all of the rights and obligations of the District under this Agreement. In the event that the District is sold to, or affiliates with, another entity or in the event that the District's duties under this Agreement devolve upon some other entity during the term of this Agreement, the District will assign its rights and duties under this Agreement to the newly responsible entity.

13.4 Severability. If any provision of this Agreement is held to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect, unless the provision in question contained a material right or duty of a party under this Agreement.

13.5 Entire Agreement. This Agreement and the Exhibits attached contain all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement and supersedes any prior agreements, oral or written, and all other communications between the parties relating to such subject matter.

13.6 Other Agreements. District represents that its contracts database includes copies of all other agreements under which Group, or any Physician contracting with Group (or any immediate family member of any such Physician), provides services to District.

13.7 No Third Party Rights. The parties do not intend the benefits of this Agreement to inure to any third person not a signatory to this Agreement. Notwithstanding anything contained herein, or any conduct or course of conduct by any party to this Agreement, before or after signing this Agreement, this Agreement shall not be construed as creating any right, claim or cause of action against either party by any person or entity not a party to this Agreement.

13.8 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument. The parties agree that a facsimile or electronic (e-mail) transmission of an executed counterpart of this Agreement shall have the same binding effect on the signatory as an executed and delivered original thereof.

13.9 Survival. The provisions of Sections 2.5 (Corporate Compliance Program), 4.2(c) (Group Billing), 4.2(d) (Billing Records), 4.3 (Expenses), 5.5 (Effect of Expiration or Termination), 6 (Insurance and Indemnity), 8 (Medical Records), 9 (Access to Books and Records), 11 (Confidentiality), 12 (Arbitration), 13 (Notices), 14 (Miscellaneous) and Exhibit D shall survive termination of Agreement.

13.10 Waiver. No waiver of any obligation under this Agreement shall be enforceable unless set forth in a writing signed by the party against which enforcement is sought.

13.11 Amendments. Any amendment to this Agreement shall be made in compliance with applicable law and regulations, including but not limited to the Stark law. No amendment or modification of this Agreement shall be enforceable unless set forth in a writing signed by both parties.

13.12 New Agreements. If this Agreement is terminated during its first year, for any reason, the parties shall not enter into a new agreement for the same or substantially similar services of the Group until a full year has passed from the Effective Date of Agreement.

13.13 Non-Solicitation. Each party agrees that during the term of this Agreement and for a period of one (1) year thereafter, it will not directly or indirectly, utilize the confidential or trade secret information of the other party to solicit or induce any employee, agent or contractor of the other to terminate their then-existing employment or contractual relationship with such party, including but not limited to the Physicians and the Teleradiology Service Providers of Group. A party that violates this Section 13.13 hereby agrees that the breaching party may obtain preliminary and permanent injunctive relief for a violation or threatened violation of any such restrictions without having to prove actual damages or to post a bond, and the non-breaching party shall also be entitled to an equitable accounting of all earnings, profits and other benefits arising from such violation, including but not limited to costs and reasonable attorneys' fees, which rights shall be cumulative and in addition to any other rights or remedies to which the non-breaching party may be entitled in law or equity.

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates set forth below to be effective as of the Effective Date.

DISTRICT:

NORTHERN INYO HOSPITAL DISTRICT

By: KEVIN S. FERNSTEAD MBA

Its: CEO

GROUP:

BISHOP RADIOLOGY GROUP, INC.

By: Young Song

Its: President

MEDICAL DIRECTOR ACKNOWLEDGMENT

The undersigned Physician hereby acknowledges receipt of a copy of this Agreement and accepts the position, and agrees to carry out the duties, of Medical Director as set forth in this Agreement.

Date: 05/18/17

By: _____, M.D.

Arash Radparvar

MEDICAL DIRECTOR ACKNOWLEDGMENT

The undersigned Physician hereby acknowledges receipt of a copy of this Agreement and accepts the position, and agrees to carry out the duties, of Medical Director as set forth in this Agreement.

Date: 5/22/17

By: Young Song, M.D.

PHYSICIAN ACKNOWLEDGMENT

Each undersigned Physician hereby acknowledges receipt of a copy of this Agreement and agrees to carry out the duties of a Physician as set forth in this Agreement.

Date: 5/18/17

David Kim, MD, MBA

Date: 05/18/17

Arash Radparvar, MD

Date: 5/18/2017

Young Song, MD, MPH

EXHIBIT A

COVERAGE SERVICES

Group and Physicians and shall be responsible to perform the following Coverage Services:

(1) Group shall provide, through its own employed or contracted Physicians (and including physicians associated with the Teleradiology Service Provider), Professional Services to patients upon appropriate request or referral from other health care practitioners at Hospital. Group shall develop a system for assuring the availability of Physicians on-site or on-call to Hospital and the Department to ensure that an appropriate level of Professional Services are available 24 hours per day, 7 days per week, 52 weeks per year according to a schedule mutually agreed upon by both parties.

(2) Group shall, at a minimum, provide Coverage Services as follows:

- Weekday Day Shift (Monday – Friday): One (1) Physician on-site at Hospital from 7:00 am through 4:00 pm.
- Weekday Evening Shift (Monday – Thursday): One (1) Physician shall be required to return on-site at the Hospital only for emergent cases that require the physical presence of a Physician and where such services cannot be provided via teleradiology by Physician or by the Teleradiology Service Provider from 4:00 pm to 11 pm.
- Weekday Night Shift (Monday –Thursday): 11 pm – 7:00 am, remote teleradiology coverage through a Physician or Teleradiology Service Provider.
- Weekend Shifts (Friday 4pm through Monday 7:00am): One (1) Physician shall be on-call and able to be present on-site at the Hospital on not more than 60 minutes' notice for emergent cases that require the physical presence of a Physician, and remote teleradiology coverage through a Physician or Teleradiology Service Provider for non-emergent cases that do not require the physical presence of a Physician on-site at the Hospital .
- Legal Holidays: Remote teleradiology coverage through a Physician or a Teleradiology Service Provider.

(3) Group shall provide one (1) Physician from Group who shall be on-site as may be requested by Hospital in cases of natural disaster from 7 a.m. on Monday through 4 p.m. on Friday.

(4) Although Group may have a Physician on-site at Hospital when required above, Group shall have the discretion to have a particular study interpreted via teleradiology by another Physician or a Teleradiology Service Provider with a particular expertise in a particular study.

(5) Coverage Services include only those services described on Exhibit E.

EXHIBIT B

GROUP PHYSICIANS

David Kim, MD, MBA
Arash Radparvar, MD
Young Song, MD, MPH

EXHIBIT C

ADMINISTRATIVE SERVICES

Group shall ensure that the Medical Director shall perform the following administrative services:

1. Implement the Medical Staff's policies and procedures as they relate to the Department;
2. Assist Hospital in the development and implementation of appropriate performance improvement activities and benchmark measures with respect to the radiologic services;
3. Assist Hospital in the organization and implementation of an effective utilization management program with respect to radiologic services;
4. Coordinate and consult with the Medical Staff and the staff of the Hospital regarding the efficiency and effectiveness of radiologic services, and make recommendations regarding improving outcomes and performance indicators;
5. Perform or have performed at Hospital's expense a review of claims to ensure that the delivered care is commensurate with community standards and that bills accurately reflect the care delivered by the Physicians performing services on behalf of Group.
6. Develop, review, and provide training programs for Physicians participating in services at the Hospital;
7. Assist Hospital with ensuring that the Department is operated in accordance with all requirements of the Joint Commission and all applicable licensing requirements, and all other relevant requirements promulgated by any federal, state or local agency;
8. Prepare such reports and records as may be required by this Agreement or as reasonably required by Hospital or the Medical Staff;
9. Participate in Hospital and Medical Staff committees as agreed to by Hospital and Group;
10. Participate in continuing medical education, research and teaching activities as agreed to by Hospital and Group;
11. Advise and assist in the development of protocols and policies for the radiologic service;
12. Monitor the compliance of Physicians performing services hereunder with written Hospital and Medical Staff rules and bylaws;
13. Participate in the development and monitoring of schedules for all professional services provided in the Department to ensure that the safety of patients, providers, and staff and the needs of patients and their attending physicians take precedence over other Group concerns;
14. Monitor and evaluate the clinical abilities and performance of all physicians performing services on behalf of Group hereunder;
15. Ensure that all Physicians performing services on behalf of Group hereunder communicate and coordinate care with referring physicians on a timely basis;
16. Participate with Hospital management to plan radiologic services and develop an annual budget.
17. Serve as the Radiation Safety Officer.
18. Supervise and train radiology personnel in conjunction with Hospital's Director of Diagnostic Imaging.

EXHIBIT D

COMPENSATION

Base Compensation:

Years 1-3- $1,180,000 to be paid in equal monthly allotments of $98,333.33 on or before the 5th day of each month, provided, however, that District shall pay Group a signing advance of $25,000 within five (5) days of the full execution of this Agreement, and the first five (5) monthly payments to Group during the initial year of the Term shall be reduced by $5,000 per monthly payment to offset the amount of the signing advance.

Performance Bonus:

Group shall be entitled to a performance bonus each contract year as follows:

- For a turnaround time (measured from receipt of all relevant images and patient history to completion of the preliminary report) that is forty (40) minutes or less on at least ninety percent (90%) of STAT cases only over the period of each contract year, the Group shall be entitled to the sum of ***Six Thousand Dollars ($6,000)*** per contract year. The turnaround time shall be measured by looking at a random sample of 100 patient STAT cases.

- For documentation of closed loop communication of critical findings on at least ninety percent (90%) or more of cases over the period of each contract year, the Group shall be entitled to the sum of Six ***Thousand Dollars ($6,000)*** per contract year. The metric shall be measured by looking at a random sample of 100 patient charts.

The performance incentives, if any, shall be paid to Group within 30 days of the end of each contract year.

EXHIBIT E

SERVICES

1. **Services.** During the term of this Agreement, Group shall provide the following services for Hospital patients:

    a. General radiography
    b. Fluoroscopy
    c. Contrast imaging in CT
    d. Magnetic resonance imaging
    e. Ultrasound and Doppler Ultrasound
    f. Nuclear Medicine SPECT-CT
    g. 3D CT
    h. CT and MR angiography
    i. Cardiac CT
    j. Coronary Artery CT
    k. Nuclear Cardiology
    l. Image-Guided Biopsy (excluding image-guided biopsy of the breast)
    m. Bone Density Scans

2. **Excluded Services.** District and Group agree that the Services shall exclude the following services:

    a. Breast Imaging
    b. Radiologic Interventional Pain Management Services
    c. Vascular and interventional radiology services other than image guided biopsy (but excluding image-guided biopsy of the breast)

EXHIBIT F

NORTHERN INYO HEALTHCARE DISTRICT BAA

See attached.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Electronic Communication (Email) Acceptable Use Policy	
Scope: Northern Inyo Healthcare District (NIHD)	Manual: Information Technology
Source: Information Technology	Effective Date:

PURPOSE:

Email is a critical mechanism for business communications at Northern Inyo Healthcare District. Use of Northern Inyo Healthcare District's electronic mail systems and services are a privilege, not a right, and therefore must be used with respect and in accordance with the mission of NIHD.

The objectives of this policy are to outline appropriate and inappropriate use of Northern Inyo Healthcare District's email systems and services in order to minimize disruptions to services and activities, as well as comply with applicable policies and laws.

SCOPE:

This policy applies to all workforce members, NIHD Board Members and clinically privileged physicians and allied health professionals. This policy applies to all email systems and services owned by NIHD, all email account users at NIHD (both temporary and permanent), and all district email records.

DEFINITIONS:

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

Restricted Information: Describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or in transit. This includes PHI/ePHI and Other Medical Staff and AHP Communication as defined in this section.

Electronic Protected Health Information* or *ePHI: Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape or other media.

Other Physician and AHP Communication: Some examples of Other Physician and AHP Communication includes, but is not limited to:

- Notice of proposed changes and revisions to the Medical Staff Bylaws and Policies & Procedures;
- CME opportunities;

DRAFT

- Notification of medical record delinquencies;
- CEO memoranda;
- Licensure/certificate expiration notices;
  Medical Staff Service/Committee meeting notices.

POLICY:

1. Email access at NIHD is controlled through individual accounts and passwords. Each user of NIHD's email system is required to read and acknowledge understanding of this email acceptable use policy. It is the responsibility of the workforce member, NIHD Board Member or clinically privileged physician or allied health professional to protect the confidentiality of their account and password information.

2. All email communication from NIHD workforce members to NIHD's clinically privileged Physicians and AHP's will only be sent to valid nih.org email addresses.

3. All email communication from NIHD's clinically privileged Physicians and AHPs should only be transmitted using a nih.org email address with the following exception:

   EXCEPTION
   Telemedicine Staff: Emailing of Restricted Information/Other Physician and AHP Communication from NIHD's clinically privileged telemedicine physicians to NIHD's Workforce and/or to any other entity or person should only be transmitted using a nih.org email address **or** an email address associated with the organization with whom NIHD has an agreement. Any exception request to use another organization's email address will be reviewed on a case by case basis by the NIHD executive team, the IT department and Medical Staff Admin office.

4. NIHD often delivers official communications via email. As a result, all workforce members, NIHD Board Members, clinically privileged physicians and allied health professionals NIHD email accounts are expected to check their email in a consistent and timely manner so that they are aware of important announcements and updates, as well as for fulfilling business and role-oriented tasks.

5. Email users are responsible for mailbox management, including organization and cleaning. If a user subscribes to a mailing list or list serve, he or she must be aware of how to unsubscribe from the list, and is responsible for doing so in the event they no longer wish to subscribe to the mailing list or list serve.

6. Email users are expected to remember that email sent from NIHD email accounts reflects on the district. Please comply with normal standards of professional and personal courtesy and conduct.

Title: Electronic Communication (Email) Acceptable Use Policy	
Scope: Northern Inyo Healthcare District (NIHD)	Manual: Information Technology
Source: Information Technology	Effective Date:

7. Acceptable Email Signatures – Email users will clearly identify their name, relevant certifications, job title and department. In order to conserve space graphics other than the district logo is prohibited in email signatures.
   Example:
   Name, certifications
   Title and Department
   Northern Inyo Healthcare District
   Improving our communities, one life at a time. One Team. One Goal. Your Health!

8. Auto forwarding of emails to accounts outside of NIHD is strictly prohibited.

9. NIHD does not permit emailing unencrypted Protected Health Information (PHI). Emails sent outside the nih.org domain are not always protected from interception during transmission and may be read at their destination by individuals other than the intended recipient. A secured email solution (i.e. encryption) must be utilized for all email messages containing Restricted Information. – See "Communicating Protected Health Information Via Electronic Email" policy

10. Email messages that include or could potentially include confidential NIHD information may not be forwarded, or otherwise transferred to non-NIHD accounts, including but not limited to, personal and commercial email accounts such as Gmail, Yahoo, Hotmail, etc.

11. Email access will be terminated when the workforce member, NIHD Board Member or clinically privileged physician or allied health professional terminates their association with NIHD. NIHD is under no obligation to store or forward the contents of an individual's email inbox/outbox after the term of their employment has ceased.

12. The following activities are deemed inappropriate uses of NIHD email systems and services, and are strictly prohibited. Inappropriate use includes, but is not limited to:

    - Use of email for illegal or unlawful purposes, including copyright infringement, obscenity, libel, slander, fraud, defamation, plagiarism, harassment, intimidation, forgery, impersonation, soliciting for illegal pyramid schemes, and computer tampering (e.g. spreading of computer viruses).
    - Use of email in any way that violates NIHD's policies, rules, or administrative orders, including, but not limited to the NIHD Code of Business Ethics and Conduct
    - Sending of unreasonably large email attachments. The total size of an individual email message sent (including attachment) should be 10 MB or less. If the need arises to transfer a larger amount of data please contact the NIHD IT department for file transfer rights.
    - Opening email attachments from unknown or unsigned sources. Attachments are the primary source of computer viruses and should be treated with utmost caution.

DRAFT

- Sharing email account passwords with another person, or attempting to obtain another person's email account password. Email accounts are only to be used by the registered user.
- Excessive personal use of NIHD email resources. NIHD allows limited personal use for communication with family and friends, independent learning, and public service so long as it does not interfere with staff productivity, pre-empt any business activity, or consume more than a trivial amount of resources. NIHD prohibits personal use of its email systems and services for unsolicited mass mailings, non-NIHD commercial activity, political campaigning, and dissemination of chain letters.

13. The email systems and services used at NIHD are owned by the district, and are therefore its property. This gives NIHD the right to monitor any and all email traffic passing through its email system. This monitoring may include, but is not limited to, review by the legal team during the email discovery phase of litigation, observation by management in cases of suspected abuse, or to monitor employee efficiency.

14. Archival and backup copies of email messages may exist, despite end-user deletion, in compliance with NIHD's records retention policy. The goals of these backup and archiving procedures are to ensure system reliability, prevent business data loss, meet regulatory and litigation needs, and to provide business intelligence.

    - Backup copies exist primarily to restore service in case of failure. Archival copies are designed for quick and accurate access by company delegates for a variety of management and legal needs. Both backups and archives are governed by the company's document retention policies.

15. Use extreme caution when communicating confidential or sensitive information via email. Keep in mind that all email messages sent outside of NIHD become the property of the receiver. Consider not communicating anything that you wouldn't feel comfortable being made public. Demonstrate particular care when using the "Reply All" command during email correspondence to ensure the resulting message is not delivered to unintended recipients.

16. Any allegations of misuse should be promptly reported to the Human Resources and Information Technology departments. If you receive an offensive email, do not forward, delete, or reply to the message. Instead, report it directly to the IT HelpDesk.

PROCEDURE:

1. All workforce members, NIHD Board Members and clinically privileged physicians and allied health professionals (AHP) will be issued nih.org email addresses by the NIHD IT

DRAFT

Department. (Telemedicine staff may opt out if using an email address associated with the organization with whom NIHD has an agreement)

2. All workforce members, NIHD Board Members and clinically privileged Physicians and AHPs will be trained on how to set-up their email accounts and/or personal computer email access through: Hospital-wide general orientation, and/or scheduled orientation with the IT Department.

3. All clinically privileged Physicians and AHPs, NIHD Board Members or exempt workforce members wishing to access their nih.org email remotely may follow the URL web link where they will be asked for their login credentials:

   https://webmail.nih.org

4. Any questions on emailing restricted information should be referred to the Information Technology Department.

REFERENCES:

CROSS REFERENCE P&P:

1. Communicating Protected Health Information Via Electronic Mail (Email)

Approval	**Date**
Executive Team	
MEC	
Board	

Developed: 3/2017
Reviewed:
Revised:
Supercedes: Intranet Email Policy and Auto Forwarding Policy

Responsibility for review and maintenance: Director of Information Technology

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Password Policy	
Scope: District Wide	Department: Information Technology
Source: Director of Information Technology	Effective Date:

PURPOSE:

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members including but not limited to- employees, members of the Board of Directors, contractors and vendors with access to NIHD systems are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

1. To establish a standard for creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

SCOPE:

The scope of this policy includes all NIHD workforce members (as described above) who have or are responsible for an account (or any form of access that supports or requires a password) on any system that resides at any NIHD facility, has access to the NIHD network, or stores any non-public NIHD information.

POLICY:

1. All passwords must be changed on at least a quarterly basis (no less than every 90 Days)
2. Passwords must not be inserted into email messages or other forms of electronic communication.
3. All user-level and system-level passwords must conform to the guidelines described below.
    a. Password must contain a minimum of 8 characters and maximum of 15 characters
    b. Passwords must contain a combination of capital and lowercase letters ,numbers and symbols
    c. Passwords should not contain easily recognizable words (i.e. Bishop, Inyo, NIH)
    d. ***Password exception for DMS***– Passwords can **only** contain capital or lowercase and not in combination. Example – "TgAgm487&" the password would have to be "tgagm4878&" or "TGAGM4878&"
4. Passwords are not to be shared with anyone, including administrative assistants.
5. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Department.
6. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
7. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook, etc.).

REFERENCES:

HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3

Committee Approval	**Date**
Executive Team	
Board of Directors	

Developed: 1/1/2004
Reviewed:
Revised: 4/28/2017
Supersedes: Password Policy
Responsibility for review and maintenance: Director of Information Technology
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT

EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Workplace Violence Prevention Policy	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

POLICY:

Northern Inyo Healthcare District (NIHD) is committed to providing a safe and healthful work environment for our patients, visitors, employees, volunteers, contractors, suppliers, members of the medical staff and members of the public. NIHD has zero tolerance for any act of violence or any threat of violence that occurs on NIHD property. This prohibition against threats or acts of violence applies to all NIHD patients, visitors, employees, volunteers, and members of the medical staff, contractors, suppliers, and members of the public.

NOTE: This is a ZERO-TOLERANCE policy, meaning that NIHD shall take appropriate action to correct any violation of this policy, after an investigation into the facts and circumstances of each reported incident.

NIHD prohibits retaliation against an individual who has alleged that a workplace violence incident has occurred, who has participated in an investigation of a workplace violence incident or who has reported an incident of workplace violence to law enforcement.

PROCEDURES:

I. Workplace Violence includes, but is not limited to, the following:

A. The use of physical force against a NIHD employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

B. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

C. The following are the four (4) workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

2. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.

Title: Workplace Violence Prevention Policy	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.

4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

II. Identifying and responding to risks:

A. Workplace Violence Prevention Assessment Team (V-PAT). NIHD has established the V-PAT, which shall convene on an ad hoc basis, consisting of:

Chief Operating Officer
Chief Nursing Officer
Chief, Accounting Officer
Chief Human Resources Officer
Director, Human Resources
Director, Project/Property Management (includes Safety Officer and Security professionals)
Director of Maintenance
Director, Administrative Staff, RHC/NIA
Manager, Emergency Department/Disaster Planning
Employee Health professional
Quality Assurance and Performance Improvement Assistant
Others as determined appropriate

B. The V-PAT is responsible for:

1. Hazard assessment
2. Workplace safety and security assessment
3. Hazard correction, control and prevention
4. Development and implementation of a Workplace Violence Prevention Plan
5. Annual evaluation of the Workplace Violence Prevention Plan

C. Hazard Assessment. A Hazard Assessment shall include a review of the following records:

1. OSHA logs
2. Quality Review Reports (QRR)
3. Worker's Compensation reports

Title: Workplace Violence Prevention Policy	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

4. Environment of Care reports
5. Human Resources Department records
6. Workplace Violence Incident Reports
7. Workplace Violence Incident Response and Investigation Forms
8. Area crime statistics

D. Workplace Safety and Security Assessment: A workplace safety and security assessment shall be conducted to identify and evaluate safety and security risks, nature and extent of hazards, conditions, and/or situations that may exist that could place an individual in danger of violence.

NOTE: The V-PAT may seek assistance and/or input from sources to include; local law enforcement, employee assistance program counselors, NIHD liability insurance carrier, and/or a security/safety specialist.

E. Hazard Correction, Control and Prevention. Based upon information gathered during the Hazard Assessment and the Workplace Safety and Security Assessment, the V-PAT shall implement appropriate hazard corrections which may include engineering controls, new equipment, workplace design and/or policy/procedure development.

F. Development and Implementation of a Workplace Violence Prevention Plan. The V-PAT shall lead the development and implementation of a Workplace Violence Prevention Plan.

G. Annual Evaluation of the Workplace Violence Prevention Plan. The V-PAT shall undergo an evaluation of the Workplace Violence Prevention Plan annually. Such evaluation shall be documented.

III. Training and Communication

All employees shall receive training at new employee orientation and annually thereafter and this training shall be documented. Certain employees may receive specific training depending upon their particular job and/or work location and such training shall also be documented. When there is a change to equipment, work practices or the work environment due to hazard correction, affected employees shall be trained and such training shall be documented.

Title: Workplace Violence Prevention Policy	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

IV. Incident Reporting and Investigations

A. All incidents under this policy shall be documented immediately using the Workplace Violence Incident Report Form.

B. All incidents under this policy shall be reported to any of the following: Security Officer, Department Head, House Supervisor, Director, Human Resources Department, any Chief, the Administrator on Call (AOC), or the Chief Executive Officer (CEO). Incidents of workplace violence may also be reported to law enforcement and/or any relevant regulatory agency.

C. All Workplace Violence Incident Report Forms are to be submitted to the Quality Assurance and Performance Improvement Department during business hours (Monday through Friday, 8 am – 4:30 pm). Outside of business hours, all such report forms are to be submitted to the House Supervisor or the AOC.

D. All post-incident responses including any investigation shall be documented using the Workplace Violence Incident Response and Investigation Form.

V. Support for Victims of Violence

Victims of incidents under this policy may have to contend with a variety of medical, psychological, and legal consequences. NIHD shall assist victims by:

A. Referring victims to appropriate medical care
B. Referring victims to appropriate community resources.
C. Providing flexible work hours or short-term or extended leave as appropriate.
D. Cooperating with law enforcement personnel in the investigation of any crime.

VI. Record Keeping

The Quality Assurance and Performance Improvement Department shall maintain records of all Workplace Violence Incident Report forms and all Workplace Violence Incident Response and Investigation forms under this policy. Access to such records shall be limited to a need to know basis as determined jointly by the Director, Human Resources and the applicable Chief. Records of employee injuries shall be maintained in Human Resources in accordance with OSHA requirements. Confidentiality of patient information and employee records shall be maintained.

NORTHERN INYO HEALTHCARE DISTRICT

EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Workplace Violence Prevention Policy	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

VII. Responsibility

A. The Chief Human Resources Officer is responsible for administering the Workplace Violence Prevention Plan and ensuring that this Plan is communicated to all relevant persons including other employers of employees working at a NIHD facility.

B. Chiefs, Department Heads, and supervisory personnel are responsible for the enforcement of this policy. Chiefs, Department Heads and supervisory personnel are required to report, in writing using the Workplace Violence Incident Report form, any incidents of workplace violence without delay.

C. All persons including members of the medical staff, employees, suppliers, contractors, visitors, patients, and volunteers are expected to follow all policies and procedures and to report acts of violence immediately.

REFERENCES:

Workplace Violence Prevention in Health Care Regulation (Title 8, CCR, Section 3342)
Occupational Safety and Health Act of 1970
The Joint Commission Standards: EC.01.01.01, EC.02.01.01, EC.02.06.01, EC.03.01.01, and EC.04.01.01

Committee Approval	**Date**
Human Resources	6/2/2017
Executive Team	6/5/2017
Board of Directors	

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

PURPOSE:

1. To define the requirements for non-employees to explore healthcare careers under the supervision of Northern Inyo Healthcare District (NIHD) staff.
2. To set forth the requirements for participants in the learning internship, clinical or academic rotations, and career shadowing programs and to ensure compliance with relevant laws, regulations, policies and procedures applicable thereto.

POLICY:

Northern Inyo Healthcare District (NIHD) believes its ability to meet the needs of our patients and community is related to its ability to attract and retain adequate numbers of qualified, competent and diverse employees who provide high quality service in a healthcare setting. To accomplish this, NIHD's leadership will foster workforce development programs that include developing a pipeline of talent within the community. It is, therefore, NIHD's policy to establish learning internships, clinical or academic rotations and career shadowing opportunities to attract persons interested in working in the healthcare industry.

DEFINITIONS:

Learning Internship: A learning internship opportunity is for any individual who is looking for an opportunity to explore healthcare careers or healthcare processes. This opportunity is generally for the duration of a semester.

Clinical or Academic Rotation: A clinical or academic rotation opportunity is for any individual or group of individuals under the supervision of an instructor that provides direct application of classroom objectives and is generally focused in patient care areas. An affiliation agreement between the educational institution and NIHD prior to the start of any clinical or academic rotation.

Career Shadowing: A career shadowing opportunity is for any individual who requests an observation of a specific position or department for a specific date(s) and times.

PROCEDURE:

1. Opportunities under this policy are coordinated through the Human Resources Department.

    a. Human Resources will refer the request to the Department head(s) where the request is being made.

Title: Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/22/2017

b. The Department head will then review and receive approval from their Chief.
c. If a shadow experience can be accommodated, the Department head:
   1) Notifies HR of approval of request and dates they can accommodate.
   2) Notifies the individual or group to start the pre-requisite requirements.

2. Prior to the commencement of the opportunity, the assigned NIHD supervisor will ensure the individual or group completes the required information packet and turns it into Human Resources for approval. Upon approval, the individual or group will onboard with Human Resources and then be released to the assigned NIHD supervisor to begin the opportunity.

3. The NIHD supervisor will:
   a. Orient the individual or group to their role, the department, and NIHD.
   b. Ensure that all NIHD policies regarding patient confidentiality and privacy are enforced throughout the opportunity.
   c. Ensure that the individual or group meets the objectives of the opportunity.

4. The NIHD supervisor and the individual or group will complete an evaluation form at the end of the program to ensure that the program undergoes continuous improvement.

5. Human Resources will review the program annually and periodically as feedback warrants.

REFERENCES:

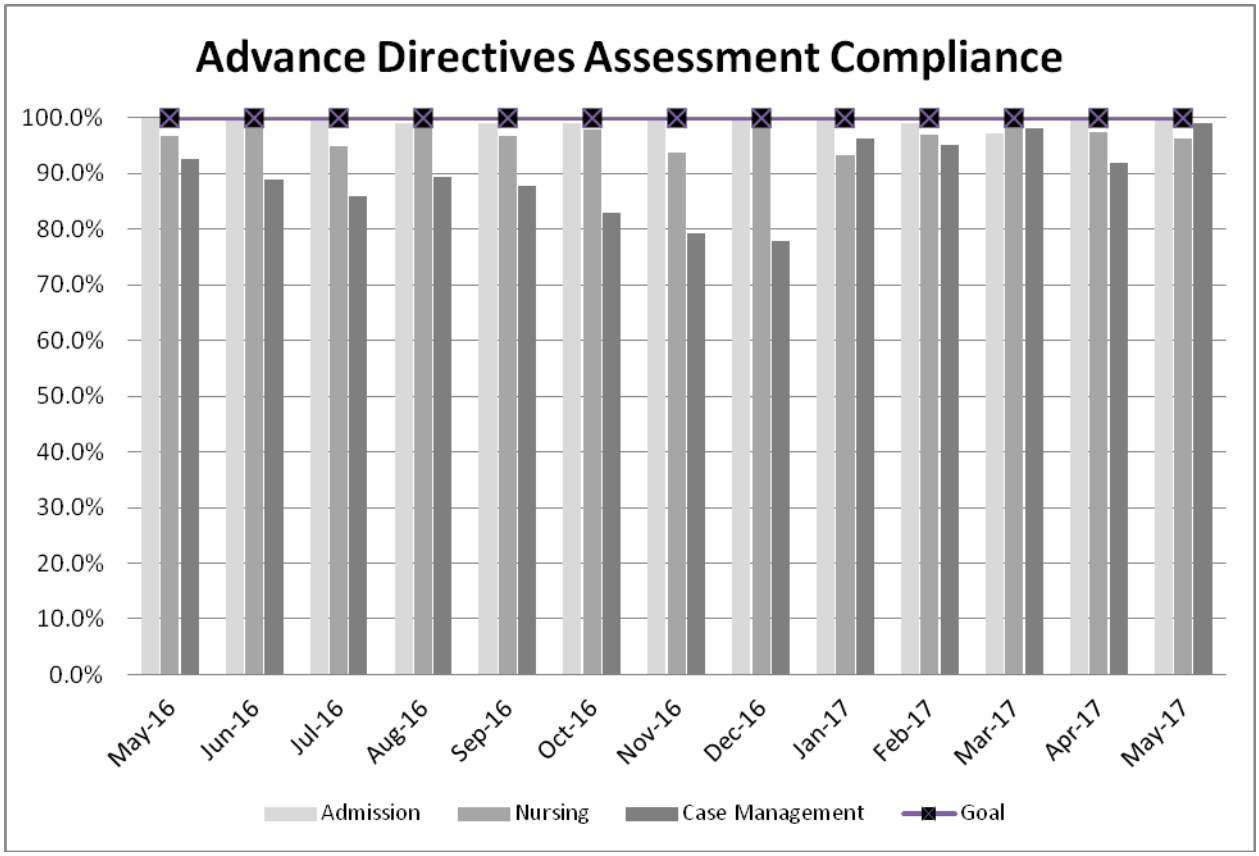
The Joint Commission Standards HR.01.02.07, HR.01.03.01, HR.01.04.01, PI.02.01.01, and PI.03.01.01

Committee Approval	**Date**
Human Resources	6/2/2017
Executive Team	6/5/2017
Board of Directors	

2013 CMS Validation Survey Monitoring-June 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.

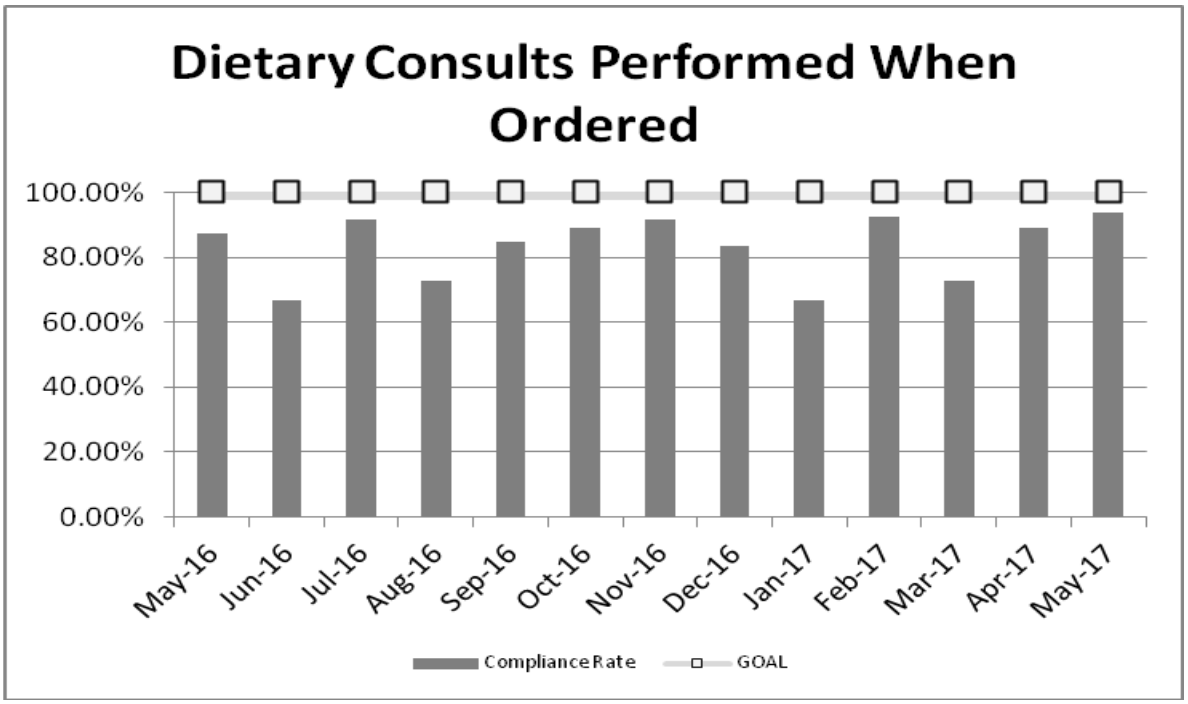


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

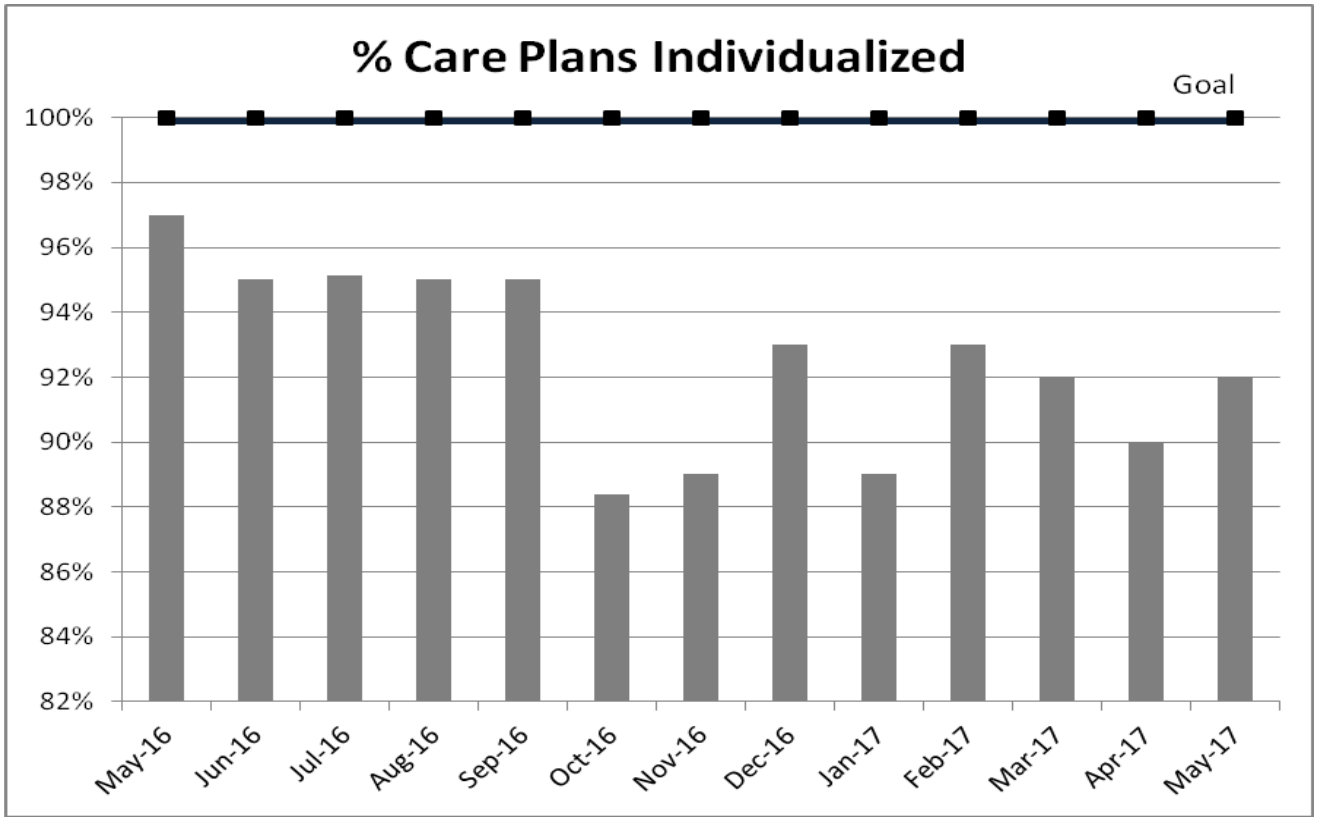
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.

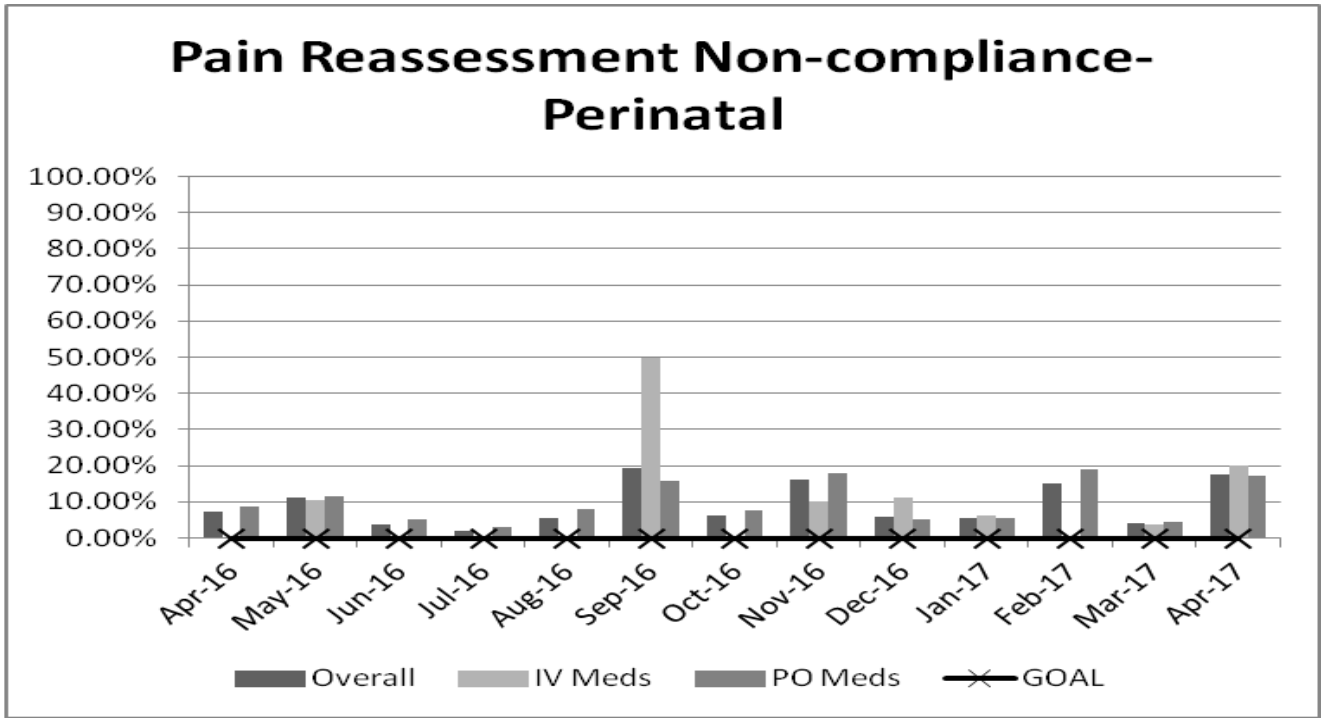


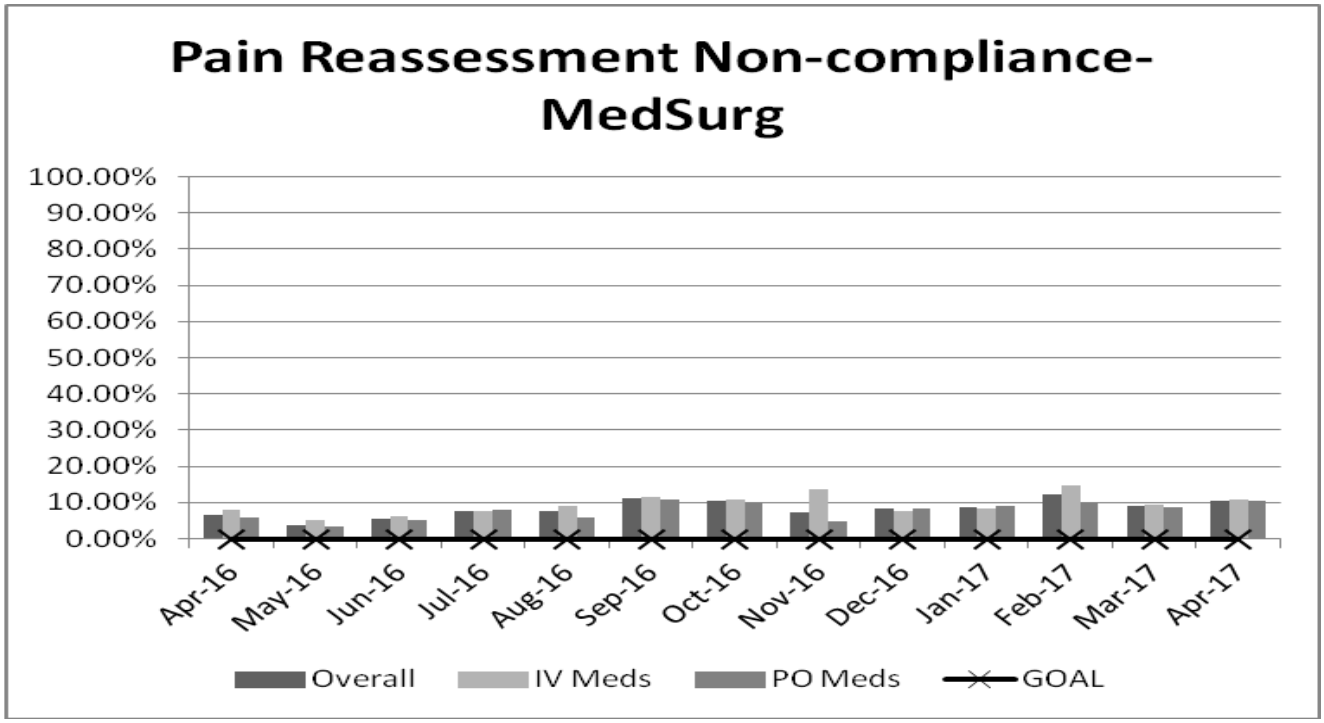
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

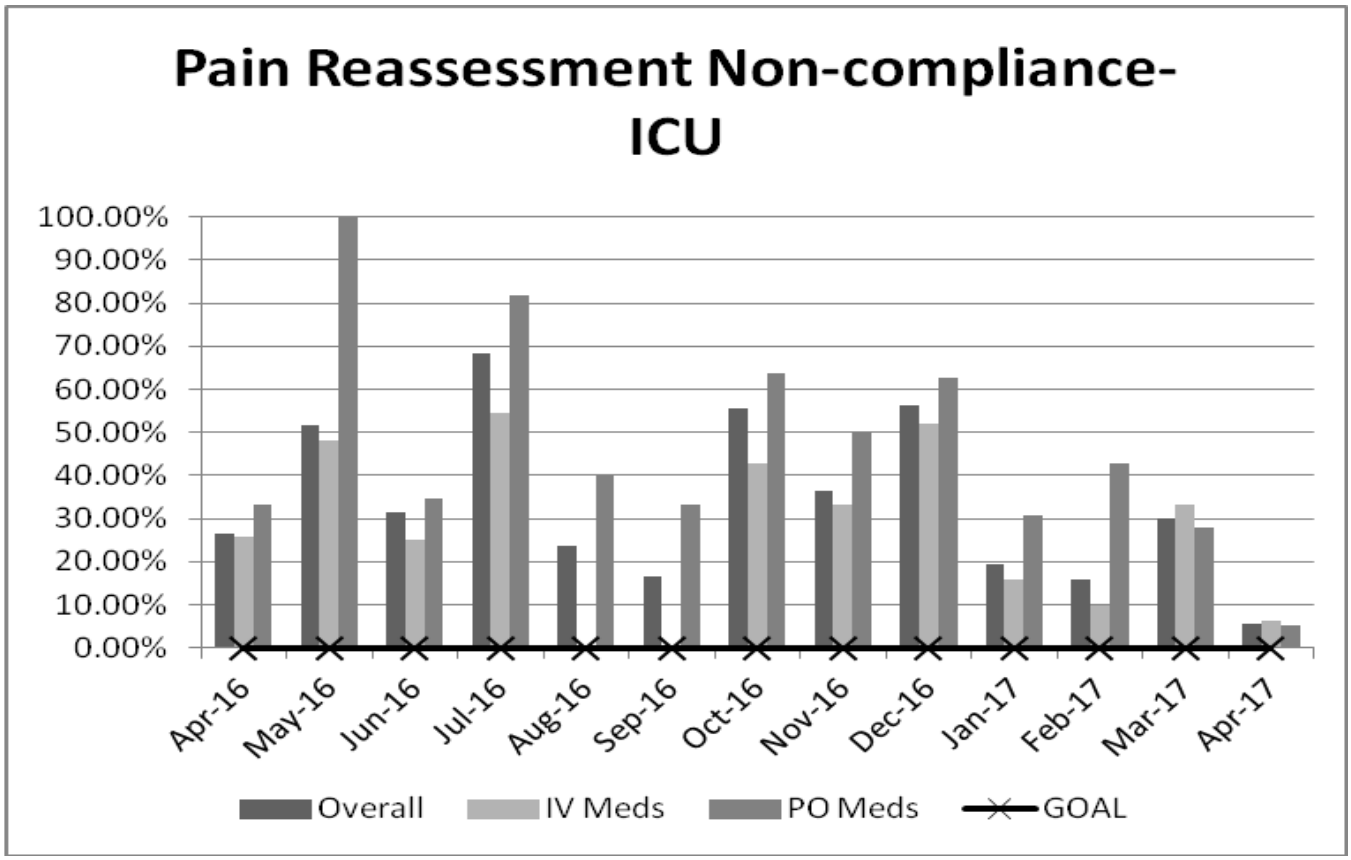


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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.

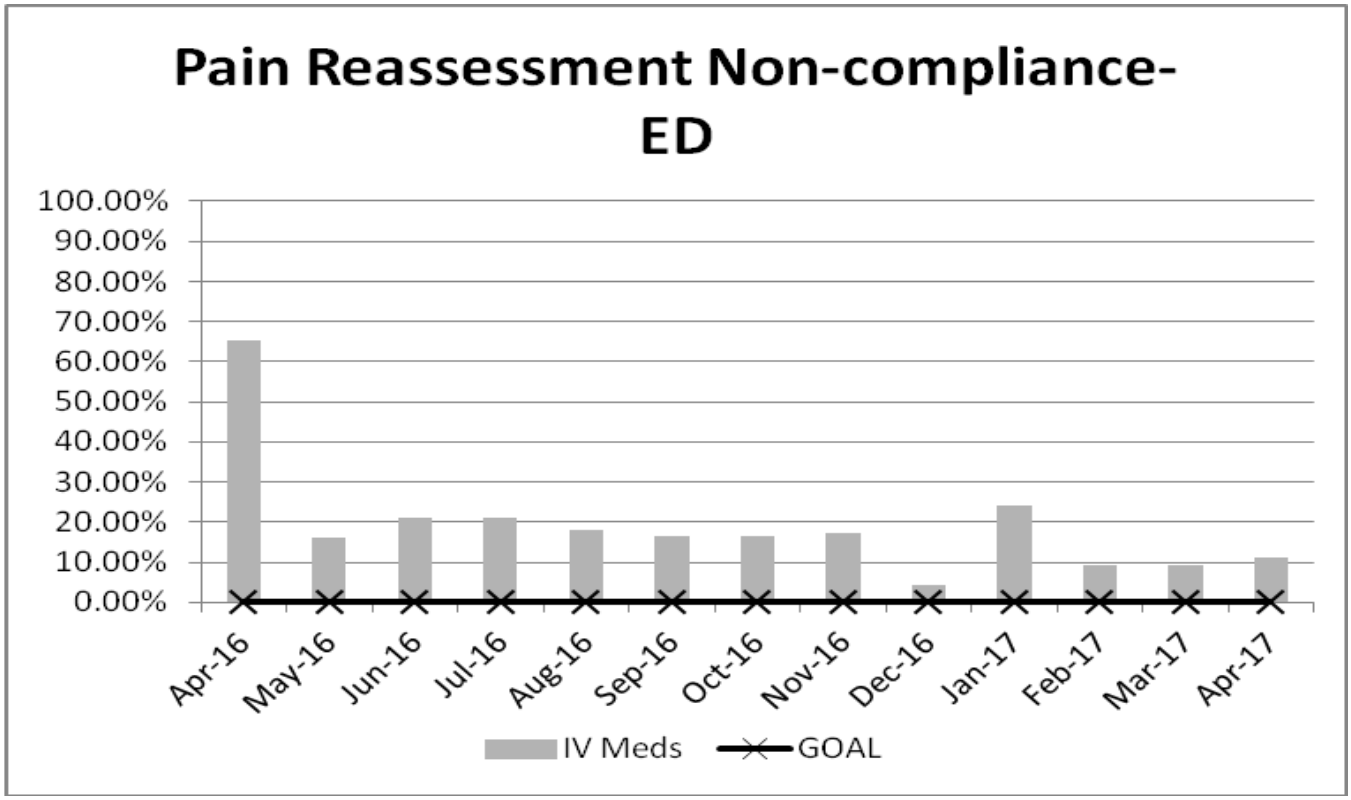


Table 6. Restraint chart monitoring for legal orders.

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

*No restraint orders for this time interval

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending April 30, 2017

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,172	$ 1,098,129	43
Equipment Fund Savings Account	$ 26,724	$ 26,724	-
Total Board Designated Funds:	**$ 1,124,896**	**$ 1,124,853**	**$ 43**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 716,761	$ 1,058,492	$ (341,731)
Nursing Scholarship Savings Account	$ 33,036	$ 33,036	$ -
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,016	$ 100,016	$ -
Total Specific Purpose Funds:	**$ 849,889**	**$ 1,191,620**	**$ (341,731)**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,974,785**	**$ 2,316,473**	**$ (341,688)**
	-	-	

***Bond and Interest Saving Account Activity is the result of payment of General Obligation Bonds**

Northern Inyo Healthcare District

Financial Indicators as of April 30, 2017

	Target	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16
Current Ratio	>1.5-2.0	3.51	3.41	3.45	3.53	3.69	2.85	2.95	2.60	2.15	2.05	1.98
Quick Ratio	>1.33-1.5	2.96	2.88	2.90	2.93	2.92	2.46	2.41	2.20	1.83	1.74	1.71
Days Cash on Hand prior method	>75	159.55	160.80	157.10	151.40	140.37	160.86	145.43	157.98	168.91	162.64	161.90
Days Cash on Hand Short Term Sources	>75	76.12	77.66	79.99	71.85	62.90	85.97	67.02	77.60	86.56	91.08	96.57
Debt Service Coverage	>1.5-2.0	1.91	2.07	2.23	2.17	2.13	2.46	2.30	2.80	3.18	2.03	1.95
Operating Margin		6.06	6.01	6.83	6.30	5.59	7.48	6.43	8.37			
Outpatient Revenue % of Total Revenue		69.76	69.43	69.11	69.10	69.28	68.11	67.48	67.03			
Cash flow (CF) margin (EBIDA to revenue)		2.59	3.41	4.27	3.94	3.71	5.43	4.53	7.01			
Days in Patient Accounts Receivable	<60 Days	86.00	85.10	76.70	80.80	77.70	75.60	75.00	77.80	78.50	73.10	63.20

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

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

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

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

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

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

Northern Inyo Healthcare District
Balance Sheet
Period Ending April 30, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	2,742,509	2,936,898	(194,389)
Short-Term Investments	12,430,316	12,527,786	(97,469)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	2	(2)
Other Investments	779,134	779,134	-
Patient Receivable	61,028,358	60,019,107	1,009,250
Less: Allowances	(46,485,545)	(45,692,045)	(793,501)
Other Receivables	679,477	646,596	32,882
Inventories	3,617,598	3,615,343	2,255
Prepaid Expenses	1,307,686	1,450,852	(143,166)
Total Current Assets	**36,099,533**	**36,283,672**	**(184,140)**
Internally Designated for Capital Acquisitions	1,124,896	1,124,853	43
Special Purpose Assets	849,889	1,191,620	(341,731)
Limited Use Asset; Defined Contribution Pension	819,358	1,118,722	(299,364)
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	-	41,839	(41,839)
Revenue Bonds Held by a Trustee	2,855,137	2,694,928	160,209
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,793,805**	**20,316,487**	**(522,682)**
Long Term Investments	1,750,000	1,750,000	-
			-
Property & equipment, net Accumulated Depreciation	80,824,444	81,150,672	(326,228)
Unamortized Bond Costs	-	-	-
Total Assets	**138,467,782**	**139,500,832**	**(1,033,050)**

Northern Inyo Healthcare District
Balance Sheet
Period Ending April 30, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	374,159	434,407	(60,248)
Accounts Payable	1,756,095	1,301,606	454,489
Accrued Salaries, Wages & Benefits	5,264,980	5,285,481	(20,500)
Accrued Interest and Sales Tax	251,687	441,401	(189,714)
Deferred Income	97,288	145,932	(48,644)
Due to 3rd Party Payors	1,122,302	1,593,023	(470,721)
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**10,294,032**	**10,629,370**	**(335,338)**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	721,338	722,593	(1,254)
Accreted Interest	10,645,997	10,535,448	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,872,559**	**90,763,265**	**109,294**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,260,026	36,259,984	42
Temporarily Restricted	849,889	1,191,620	(341,731)
Net Income (Income Clearing)	191,275	656,593	(465,318)
Total Net Assets	**37,301,191**	**38,108,197**	**(807,006)**
Total Liabilities and Net Assets	**138,467,782**	**139,500,832**	**(1,033,050)**

NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Apr-17 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending April 30, 2017

	-569	or	-16%	less IP days than in the prior fiscal year
$	(5,265,829)	or	-14.00%	under budget in Total IP Revenue and
$	1,146,738	or	1.6%	over budget in OP Revenue resulting in
$	(4,119,091)	or	-3.7%	under budget in gross patient revenue &
$	(1,487,442)	or	-2.3%	under budget in net patient revenue

Year-to-date Net Revenue was			$	64,068,159
Total Operating Expenses were:			$	60,595,008
				for the fiscal year to date
$	(147,658)	or	-0.2%	under budget. Salaries and Wages were
$	(2,214,621)	or	-10.3%	under budget and Employee Benefits
$	307,003	or	2.2%	over budget due to Pension & Health Claims
			74%	Employee Benefits Percentage of Wages

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

$	1,692,633	or	24.0%	Professional Fees continue to run over budget due to contracted or registry personnel also seen in Salaries & Wages being under budget.
$	363,017	or	6.5%	Supplies running over budget premarily in Surgery and Patient Supplies
$	325,966	or	16.7%	Bad Debt Expense running over budget
$	69,535	or	2.2%	Other Expenses are continuing to run over budget

Other Information:

$	3,938,455			Operating Income, less
$	(3,747,180)			loss in non-operating activities created a net income of;
$	191,275	$	(904,947)	Under budget.
			40.12%	Contractual Percentages for Year and
			41.00%	Budgeted Contractual Percentages including

$ 5,649,630 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals include the Final settlement for Medicare fiscal year 2015 cost report. We evaluated the 3rd party liabilities for all other Medicare and Medi-Cal open Cost Reports based on current available information resulting in a change in the Prior Year Activities for contractual allowances. Finally, there was an adjustment due to correction for $495K from Grants to Contractual activity for PRIME IGT receipt from October 2016 bringing the total PRIME IGT receipts for the fiscal year to $1,985,000.

Non-Operating actives included:

$	(3,429,614) loss	$	(23,569)	under budget in Medical Office Activities
$	(32,707)	$	(153,471)	under budget in 340B Pharmacy Activity

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of April 30, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	17-Apr-17	01-May-17	Local Agency Investment Fund	Northern Inyo Hospital	0.88%		12,180,316.43
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				SHORT TERM INVESTMENTS		$	12,430,316.43
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				LONG TERM INVESTMENTS		$	1,750,000.00
				TOTAL INVESTMENTS		$	14,180,316.43
1	16-Apr-17	01-May-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.88%		819,358.30
				LAIF PENSION INVESTMENTS		$	819,358.30
							14,999,674.73

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period ending April 30, 2017

		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	247	2,904	3,473	(569)	-16%
Total Patient Days without NB	229	2,622	3,150	(528)	-17%
Swing Bed Days	6	328	595	(267)	-45%
Discharges without NB	86	891	956	(65)	-7%
Swing Discharges	2	52	91	(39)	-43%
Days in Month	30	304	305		
Occupancy without NB	7.63	8.63	10.33	(1.7)	-16%
Average Stay (days) without NB	2.66	2.94	3.29	(0.4)	-11%
Average LOS without NB/Swing	2.65	2.73	2.95	(0.2)	-7%
Hours of Observation (OSHPD)	627	7,449	5,769	1,680	29%
Observation Adj Days	26	310	240	70	29%
ER Visits All Visits	825	8,392	7,889	503	6%
RHC Visits (OSHPD)	3,110	23,582	22,811	771	3%
Outpatient Visits (OSHPD)	3,094	32,311	32,124	187	1%
IP Surgeries (OSHPD)	20	228	259	(31)	-12%
OP Surgery (OSHPD)	112	1,013	1,016	(3)	0%
Worked FTE's	350.00	332.00	323.00	9	3%
Paid FTE's	376.00	370.00	366.00	4	1%
Hours Worked to Hours Paid%	93.1%	89.7%	88.3%	1.5%	2%
Payor %					
Medicare		40%	40%	1%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		33%	35%	-1%	
Indigent (Charity Care)		1.1%	0.3%	0.8%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending April 30, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	711,186	862,603	(151,417)	7,557,861	8,740,993	(1,183,132)
Ancillary	2,123,474	2,849,476	(726,002)	24,791,959	28,874,656	(4,082,697)
Total Inpatient Service Revenue	2,834,660	3,712,079	(877,419)	32,349,820	37,615,649	(5,265,829)
Outpatient Service Revenue	7,618,509	7,252,844	365,665	74,642,289	73,495,551	1,146,738
Gross Patient Service Revenue	**10,453,169**	**10,964,923**	**(511,754)**	**106,992,109**	**111,111,200**	**(4,119,091)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	271,416	169,290	102,126	2,084,323	1,715,473	368,850
Contractual Adjustments	4,441,661	4,326,329	115,332	46,489,256	43,840,126	2,649,130
***Prior Period Adjustments**	**(669,712)**	-	(669,712)	(5,649,630)	-	(5,649,630)
Total Deductions from Patient Service Revenue	**4,043,364**	**4,495,619**	**(452,255)**	**42,923,950**	**45,555,599**	**(2,631,649)**
Net Patient Service Revenue	**6,409,805**	**6,469,304**	**(59,499)**	**64,068,159**	**65,555,601**	**(1,487,442)**
Other revenue	40,066	52,083	(12,017)	465,305	527,780	(62,475)
Total Other Revenue	**40,066**	**52,083**	**(12,017)**	**465,305**	**527,780**	**(62,475)**
Expenses:						
Salaries and Wages	2,070,267	2,118,240	(47,973)	19,250,224	21,464,845	(2,214,621)
Employee Benefits	1,465,227	1,377,986	87,241	14,270,471	13,963,468	307,003
Professional Fees	825,503	695,784	129,719	8,743,260	7,050,627	1,692,633
Supplies	608,873	550,295	58,578	5,939,341	5,576,324	363,017
Purchased Services	190,653	331,158	(140,505)	2,675,005	3,355,711	(680,706)
Depreciation	388,842	414,340	(25,498)	4,188,164	4,198,649	(10,485)
Bad Debts	217,116	192,100	25,016	2,272,577	1,946,611	325,966
Other Expense	264,946	314,449	(49,503)	3,255,966	3,186,431	69,535
Total Expenses	**6,031,427**	**5,994,352**	**37,075**	**60,595,008**	**60,742,666**	**(147,658)**
Operating Income (Loss)	**418,443**	**527,035**	**(108,592)**	**3,938,455**	**5,340,715**	**(1,402,260)**
Other Income:						
District Tax Receipts	48,644	47,978	666	486,439	486,175	264
Tax Revenue for Debt	150,920	70,719	80,201	1,509,200	716,617	792,583
Partnership Investment Income		-	-		-	-
***Grants and Other Contributions Unrestricted**	**(484,214)**	8,219	(492,433)	116,108	83,286	32,822
Interest Income	17,368	17,965	(597)	179,769	182,040	(2,271)
Interest Expense	(262,859)	(237,024)	(25,835)	(2,647,418)	(2,401,845)	(245,573)
Other Non-Operating Income	2,151	2,137	14	71,041	21,653	49,388
Net Medical Office Activity	(368,175)	(340,775)	(27,400)	(3,429,614)	(3,453,183)	23,569
340B Net Activity	12,404	11,917	487	(32,707)	120,764	(153,471)
Non-Operating Income/Loss	**(883,761)**	**(418,864)**	**(464,897)**	**(3,747,180)**	**(4,244,493)**	**497,313**
Net Income/Loss	**(465,318)**	**108,171**	**(573,489)**	**191,275**	**1,096,222**	**(904,947)**
Contractual Percentages	39%	41%		40%	41%	

***Per Office of Statewide Health Planning Directive, the PRIME IGT moved from Grants to Prior Year Adj**

CALL TO ORDER	The meeting was called to order at 5:38 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Joy Engblade MD, Chief of Staff Kelli Huntsinger, Chief Operating Officer Carrie Petersen, Chief Accounting Officer John Tremble, Interim Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Alison Murray, Interim Chief Human Relations Officer Sandy Blumberg, Executive Assistant
ABSENT	Phil Hartz, Member At Large
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 are limited to a maximum of three minutes each. No comments were heard.
OLD BUSINESS	Interim Chief Financial Officer John Tremble stated the Northern Inyo Healthcare District (NIHD) management team continues work on trimming the budget for the 2017 / 2018 fiscal year. He explained how sequestration and reductions to Medicare reimbursements continue to be among the biggest challenges to bringing in a positive budget, stating that if necessary NIHD administration will bring the lowest possible price increase to the Board when attempting to balance next year's budget. Current Medicare reimbursement reductions went into effect on a 'temporary basis' five years ago and have yet to be lifted, and they cost the District an average of $450,000 per year in lost revenue.
NEW BUSINESS	
NURSING DEPARTMENT POLICIES AND PROCEDURES	Chief Nursing Officer Tracy Aspel called attention to approval of the following Nursing Department policies and procedures: - *Outpatient Infusion Charge Descriptions* - *Charge Sheet and Charge Description in the PACU* - *Dress Code in the OP PACU* It was moved by John Ungersma MD, seconded by Mary Mae Kilpatrick, and unanimously passed to approve all three nursing department policies and procedures as presented.

ANNUAL HOSPITAL WIDE POLICY AND PROCEDURE APPROVALS

Mr. Watercott called attention to the list of policies and procedures being presented for annual approval as listed on Attachment A to the agenda for this meeting. It was moved by Doctor Ungersma, seconded by M.C. Hubbard, and unanimously passed to approve all policies and procedures included on Attachment A to the agenda as presented.

JOINT COMMISSION LAB SURVEY

Chief Operating Officer Kelli Huntsinger reported the Joint Commission recently conducted a 3-day survey of the NIHD Laboratory Department, and the Lab passed that survey with no significant deficiencies being noted. The District did receive several requests for minor improvements which will be addressed in advance of a June 30 deadline. Ms. Huntsinger noted the surveyor's report was complimentary and that the intent of the survey is education for the purpose of future improvement.

STATE SURVEY, NIHD RURAL HEALTH CLINIC

Doctor Flanigan reported the State of California recently conducted a California Health and Wellness survey at the NIHD Rural Health Clinic (RHC), and the Clinic received a 98th percentile overall score with no corrective action plans being requested. Doctor Flanigan noted this is an impressive accomplishment especially in light of the recent change to the leadership model at the RHC. He commended Stacey Brown MD; Tracy Drew NP; Dan David RN; Jannalyn Lawrence RN; and RHC staff on this accomplishment.

ELECTRONIC HEALTH RECORD NEXT STEPS

Doctor Flanigan provided an update on steps taken regarding potential replacement of NIHD's Electronic Health Record (EHR). He reviewed the work done to date by management and a "brain trust" of 50 to 60 District employees who are helping to assess the best EHR for the District moving forward. Doctor Flanigan stated the EHR vendors currently being considered are Athena Health; Cerner; and EPIC; noting an important element of the decision will be feeling comfortable that the company that is chosen will remain viable into the future. He additionally noted that the current market trend is going toward cloud-based systems. NIHD management and staff will continue to attend system demos and conduct a thorough assessment of the available options, and will report their findings back to the Board of Directors. It was additionally noted that implementation of a new electronic health record would take up to 9 months to accomplish.

POSSIBLE VENDOR CHANGE FOR BENEFITS MANAGER

Mr. Tremble called attention to a proposal to change NIHD's benefits manager to Keenan HealthCare and participate in a California Critical Access Hospital Network (CCAHN) group purchasing program. The goal of the group program is to reduce employee medical plan expenses, network access fees, and stop-loss costs for rural hospital participants. NIHD's current benefits manager is Pinnacle Claims Management, and a switch would create no change to employee benefits but would help to reduce the District's employee plan expenses. The proposal is being presented as an information item at this meeting, and it will be placed on

the June regular agenda as an action item. Mr. Tremble noted that if approved, the change in NIHD benefits manager would become effective January 1, 2018.

NIHD INPATIENT CHARGES COMPARISON

Mr. Tremble also called attention to an average charge per inpatient day comparison of NIHD's charges to the State of California as a whole; to Mammoth Hospital; and to other area hospitals. The comparison shows NIHD to be less expensive than the California state average and significantly less expensive than Mammoth Hospital, the District's nearest neighbor. If an increase to the price of patient services in the upcoming fiscal year becomes necessary in order to balance the budget, an increase of up to 10% would still keep NIHD under the state average and well below Mammoth Hospital's charges.

CONSENT AGENDA

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

- *Approval of minutes of the March 1, 2017 special meeting*
- *Approval of minutes of the April 19, 2017 regular meeting*
- *Approval of minutes of the May 5, 2017 special meeting*
- *2013 CMS Validation Survey Monitoring for May 2017*
- *Financial and Statistical Reports for the period ending March 31, 2017*
- *Hospital Wide Pillars of Excellence quarterly report, July 1 2016 to June 30 2017*

It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve all consent agenda items as presented, with a housekeeping change being made to the minutes of the May 5 2017 special meeting.

PATIENT EXPERIENCE COMMITTEE REPORT

Chief Nursing Officer Tracy Aspel RN provided a Patient Experience Committee report which outlined the Committee's progress made toward achieving the goals of the District's Strategic Plan. Ms. Aspel outlined plans for continuous improvement to patient satisfaction scores, noting NIHD is currently utilizing patient satisfaction data compiled by Press Ganey Inc..

WORKFORCE EXPERIENCE COMMITTEE REPORT

Interim Chief Human Relations Officer Alison Murray provided an update on work accomplished by the Workforce Experience Committee, which seeks to identify opportunities for improvement to the employee experience. Ms. Murray noted that the Employee Satisfaction Survey is now complete, and data collected in that survey is currently being reviewed with managers.

COMPLIANCE OFFICER REPORT AND POLICY AND PROCEDURE APPROVAL

Compliance Officer Patty Dickson provided a Compliance Department quarterly report which reviewed the number and types of information breeches that have occurred at the District year-to-date. The report additionally provided an update on Public Records requests; and an overview of internal audits conducted. Ms. Dickson also called attention

to approval of an updated Compliance Department policy and procedure titled *False Claims Act Employee Training and Prevention*. Following review of the information provided it was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the updated policy and procedure titled *False Claims Act Employee Training and Prevention* as presented.

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, procedures, protocols, and order sets:

POLICY AND PROCEDURE APPROVALS

- *Venous Blood Collection*
- *Insulin Continuous Subcutaneous Infusion Self Management of the Patient in the Acute Setting*
- *Consent Form: Videotaping, Voice Recording, and Photography in the Perinatal Unit*

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

PERINATAL CRITICAL INDICATORS

Dr. Engblade also called attention to approval of *Perinatal Critical Indicators for 2017*. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve the proposed *Perinatal Critical Indicators for 2017* as presented.

MEDICAL STAFF APPOINTMENT/ PRIVILEGING

Dr. Engblade additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the Temporary Medical Staff appointment and privileging of John Franklin MD (internal medicine), temporary assignment until December 31 2017. It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the Temporary Medical Staff appointment and privileging of John Franklin MD as requested.

ADDITIONAL PRIVILEGES

Doctor Engblade also reported the Medical Executive Committee recommends approval of additional surgical privileges for Richard Meredick MD (orthopedic surgery) as follows:

- *Biopsy*
- *Excision Biopsy Tumors (including ganglion, etc.)*
- *Pathological Fracture Fixation*

It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve the additional surgical privileges for Richard Meredick MD as requested.

BOARD MEMBER REPORTS

Mr. Watercott asked if any members of the Board wished to report on any items of interest. Director Kilpatrick commented that she is thrilled with the direction things are going at the District, and she appreciated the

recent Daisy Award presentation and recognition of hospital staff during Hospital Week. Ms. Kilpatrick is also very impressed with Infection Prevention efforts and the many performance improvement projects currently underway at NIHD. No other comments were heard.

CLOSED SESSION

At 7:33 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, 4 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*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:30 pm the meeting returned to open session. Mr. Watercott reported the Board took action to reject a Claim Against the District filed by Jennifer Scott, MD. He additionally acknowledged settlement of a lawsuit filed by Margaret Egan for an amount within a limit previously determined by the District Board.

ADJOURNMENT

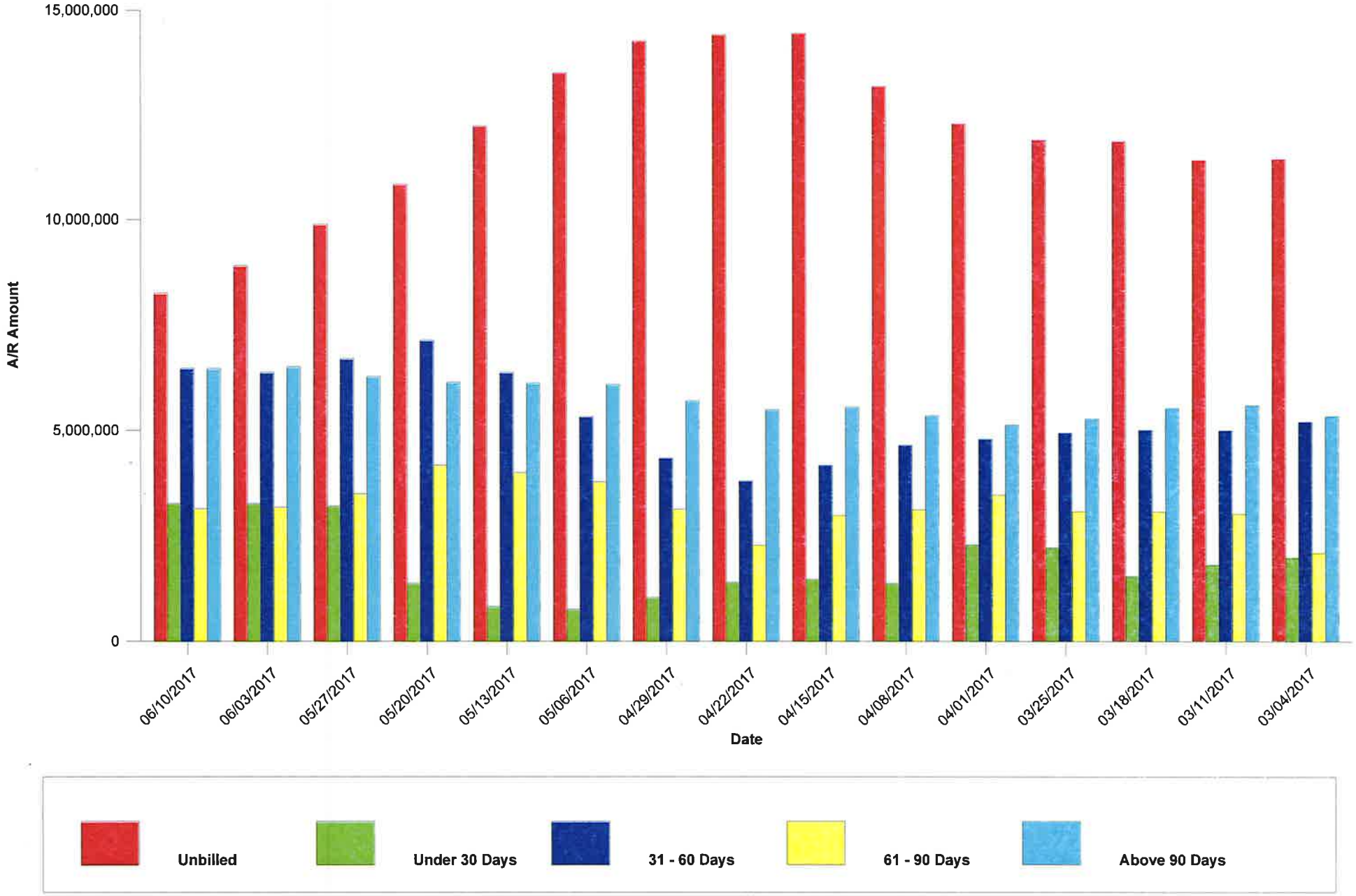
The meeting adjourned at 8:31 pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

Today's Date: 06/13/2017 12:05
Report Date: 06/10/2017
Criteria: Age By - Discharge Date, All Plans

NORTHERN INYO HOSPITAL FACILITY
A/R Summary



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

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

TO: NIHD Board of Directors
FROM: Joy Engblade, MD, Chief of Medical Staff
DATE: June 6, 2017
RE: Medical Executive Committee Report

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

1. **Policy/Procedure/Protocols/Order Sets (action items)**
   - *Provider-Performed Microscopy Competency*
   - *Preoperative EPT Testing Protocol*
   - *ALARA Program*
   - *Critical Value Reporting of Lab Results*
   - *Dead on Arrival*
   - *Emergency Operations Plan/ HICS Plan*
   - *Sterilization Recall Policy*
   - *Food and Drink in Patient Care Areas*
   - *Inservice in Infection Control*
   - *Formalin Use and Spill Management*
   - *Infection Prevention Considerations for Immunosuppressed and Pregnant Employees (formerly 'Chickenpox and Shingles' policy)*
   - *Severe Acute Respiratory Syndrome (SARS) Coronavirus (SARS-CoV) or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations for Patients*
   - *Prevention of Catheter Associated Urinary Tract Infections (CAUTI's) Guidelines*
   - *Bloodborne Pathogen Exposure Control Plan*
   - *Infection Prevention Plan*
   - *Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs*
   - Employee Consent Form: Hazardous Drug Risk Acknowledgement

2. **Employee Health Pillars and Infection Prevention Pillars (information items)**

3. **Medical Staff Appointment/Privileges (action items)**
   - Young Song, MD (radiology – provisional active staff)
   - David Kim, MD (radiology – provisional active staff)

4. **Resignations (action item)**
    - Robert Nalumaluhia, PA-C (effective 4/21/17)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Provider-Performed Microscopy Competency	
Scope: Perinatal, Outpatient Clinics	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

I. PURPOSE

Centers for Medicare and Medicaid Services (CMS), and the State of California laboratory regulations require that all laboratories have on-going mechanisms to monitor accurate patient test management. Federal CLIA '88 regulations classify all provider-performed microscopy (PPM) as "moderately complex" testing. Therefore all individuals performing PPM, or overseeing PPM procedures (PPMP) performed by trainees, are required to successfully complete a periodic assessment and be credentialed and privileged by Northern Inyo Healthcare District (NIHD). This is to ensure that all providers are proficient in PPMP and reporting test results.

II. PROCEDURE

All testing providers are evaluated for competency on PPM including pre-analysis, analysis and post-analysis components by a colleague. The Point of care (POC) coordinator and department supervisor(s) will develop a program for competency assessment and acceptability standards based on The Joint Commission (TJC) requirements, procedure manuals, and departmental policies. Supervisors and managers will evaluate common group deficiencies, review current policies and procedures and take corrective action to improve performance.

A. Test Menu

Provider-performed microscopy includes the following 4 tests at NIHD:

1. Fern Test
2. KOH (potassium hydroxide) Preparation
3. Direct Wet Mount
4. Urine Sediment

B. Competency

For practitioners new to NIHD or newly requesting PPM privileges, successful initial competency testing must be followed by a 6 month and 12 month evaluation. After the first year, all practitioners will be evaluated annually or as needed.

1. Competency for PPM is assessed using all of the following six methods as required by CMS and TJC:
    a. Direct observation of routine patient test performance, including patient preparation, specimen handling, processing and testing
    b. Monitoring recording and reporting of test results
    c. Review of worksheets, QC records and preventative maintenance records
    d. Direct observation of performance of microscope maintenance and function checks
    e. Assessment of test performance through testing external PT samples or testing previously analyzed specimens (blind testing)
    f. Assessment of problem solving skills
2. NIHD's POC department utilizes an online competency challenge program hosted by the University of Washington to assess problem solving skills. A link to this program along with additional instructions on how to log into the program is sent via email by the POC team. There are approximately five questions and 80% of the questions must be answered correctly to pass
3. Independent performance with no to little additional support is considered successful
4. Competency is assessed by a qualified colleague
5. Personnel qualified to observe and assess competency are providers fully credentialed and current on PPM competency assessment

draft

6. Observed competency is documented on a competency checklist and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

C. Proficiency testing

The POC department contracts with the Wisconsin State Laboratory of Hygiene (WSLH), a CMS approved proficiency testing program that meets regulatory requirements for variety and frequency of testing. Proficiency testing will be conducted bi-annually and consists of two images (paper and online version).

1. Proficiency samples are rotated among providers who perform patient testing
2. Testing personnel tests the proficiency samples the same way that patient samples are tested
3. The practitioners who perform the proficiency testing and the medical director of the laboratory sign attestations documenting that proficiency samples were tested in the same manner as patient specimens
4. Testing personnel reports proficiency sample results the same way that patient samples are reported
5. Proficiency records are kept for two years; proficiency performance evaluations are kept for 5 years
6. A failure is unsuccessful performance in an event and warrants an investigation using the "Proficiency Testing Checklist for Corrective Action"; the investigation is documented and records are kept for 5 years

III. CORRECTIVE ACTION

Reassessment of provider competency must occur when problems are identified with provider performance

A. Criteria for Remediation

Remedial actions are necessary for the following reasons:

1. When testing personnel fails an assigned proficiency test(s)
2. When deficiencies are being observed during competency assessment; this will be at the discretion of the observer
3. When deficiencies are being observed during routine patient testing; this will be at the discretion of the supervisor
4. When an individual fails to comply repeatedly with testing requirements
5. When testing staff is non-compliant with regulatory requirements after reasonable attempts of contact have been made by the supervisor and/or POC department

B. Failure of online competency assessment modules

1. One time failure: Practitioners are allowed to retake the module after one failure. The POC department will sent a notification via email allowing the practitioner to retake the exam.
2. Repeat failure: On repeat failure, the practitioner must be mentored prior to being allowed to retake the examination a second time.

C. Mentoring

After determination that remediation is required, the following process will be initiated:

1. Department supervisor will be notified that individual will require mentoring and that he/she is prohibited to perform PPM without supervision until remediation is complete

draft

Title: Provider-Performed Microscopy Competency	
Scope: Perinatal, Outpatient Clinics	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

2. Department supervisor will assist to identify mentors who have passed the competency assessment and have current privileges in the area(s) of PPM for which the practitioner failed competency
3. Practitioner must correctly interpret ten patient samples with a mentor in each of the examination types that the practitioner failed
4. The Mentor will complete an attestation that the practitioner has successfully completed the ten sample review
5. Attestation will be filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

D. Non-compliance

When it has been determined that a provider is non-compliant with following the remediation procedure the following steps will be taken:

1. Notification of department supervisor and/or compliance officer that the individual may not perform PPM testing effective immediately
2. Privileges to perform PPM testing will be revoked until provider has complied with mentoring requirements

IV. REFERENCES

1. 2017 Comprehensive Accreditation Manual of Laboratory and Point-of-Care Testing, The Joint Commission, HR.01.04.01 & HR.01.06.01
2. U.S. Department of Health and Human Services, CLIA ’88 Final Rules, Federal Register, Subpart M, §493.1355 - §493.1365, U.S. Government Printing Office, Wash. DC, www.eCFR.org, March 6, 2017
3. CADPH-Laboratory Field Services. Laws and Regulations Relating to Clinical Laboratories, Excerpts from the California Business and Professional Code and Regulations, Berkeley, CA, January 1, 1991

Approval	**Date**
Medical Director of the Laboratory	
CCOC	3/27/17
Medical Services/ICU Committee	
Peri/Peds Committee	
Medical Executive Committee	
Board of Directors	
Last Board of Director review	

Developed: 3/16
Reviewed:
Revised:
Supersedes:
Index Listing:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Preoperative EPT Testing Protocol	
Scope: Laboratory, PACU, Surgery	Manual: CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 12/06/06

PURPOSE:
To ensure that all female patients between the ages of childbearing age have an early pregnancy test (EPT) performed the day of any elective surgery prior to the start of anesthesia if one has not been done in the prior week.

POLICY:
1. The nurse preparing a female patient of child bearing potential for any elective surgery will explain the need for an EPT either by urine or blood sample to the patient. An order is not required.
2. The exceptions are:
    a. Patients scheduled for cesarean section
    b. Patients that have had a prior hysterectomy, bilateral tubal ligation / fulguration,
    c. Patients for whom the anesthesiologist deems the test unnecessary or have already had an EPT done as ordered by the surgeon.
3. Prep nurse will obtain urine specimen and send to lab for EPT.
4. Should the urine sample be unobtainable, the prep nurse will ask the surgeon for an order for a blood EPT.
5. A copy of the result will be placed in the patient's chart prior to the initiation of anesthesia.

PROTOCOL:
1. The RN preparing the patient for surgery will:
    - Determine if the patient is a female of childbearing potential (age 11-52 or from the onset of menses until the woman has not had a menstrual cycle in over a year)
    - Check to see if an EPT has already been done (ordered by surgeon as part of the preoperative work-up).
    - Explain the need for a urine test to ascertain pregnancy status and obtain verbal permission from the patient to proceed with test.
    - Place a copy of the test results in patient's chart.

2. In the event that urine is not obtainable prior to surgery, the RN will have the EPT done by a blood test.
    - Submit request to NIH Laboratory via computer for a blood EPT; the test should be run STAT.
    - Have the phlebotomist obtain the specimen, or get blood when starting the IV, ensure the vial is properly labeled, and ensure the specimen gets to the lab as quickly as possible.
    - Place a copy of the test results in patient's chart.

REFERENCES:
Ambulatory Anesthesiology June 23 2015, Society for Pediatric Anesthesiology Delegates Advisory Winter 2012, American Society of Anesthesiology 10-26-2016, Preoperative Pregnancy Testing in Ambulatory Surgery Anesthesiology October 1995

Approval	**Date**
Clinical Consistency Oversight Committee	
Surgery –Tissue Committee	4/26/17
Medical Executive	6/6/17
Board of Directors	
Last Board of Director Review	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Preoperative EPT Testing Protocol	
Scope: Laboratory, PACU, Surgery	Manual: CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 12/06/06

Revised: 10/25/06, 07/10AW, 05/11AW, 10/11, 10/2012AW, 3/17AW
Reviewed:
Index Listing: Pregnancy Testing, Early Pregnancy Testing, EPT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:
The purpose of establishing an ALARA (as low as reasonably achievable) Program is to incorporate practices, procedures and quality assurance checks to keep occupational and medical exposure to radiation as low as reasonably achievable.

Definitions:

ALARA – "as low as reasonably achievable," acronym for the philosophy of keeping medical and occupational radiation exposure as low as reasonable achievable.

RSO – Radiation Safety Officer

RSC – Radiation Safety Committee

POLICY:
The term ALARA is an acronym for maintaining radiation exposures, and effluent releases of radioactive material in uncontrolled areas "as low as reasonably achievable" taking into account the available technology, economic costs in relation to benefits to the public health and safety, and other societal and socioeconomic considerations in their relationship with the utilization of radioactive materials and radiation – producing equipment in the public interest.

The ALARA philosophy extends to exposure to individuals in the performance of their duties (Occupational exposure) and to patients undergoing medical evaluations and treatments.

To achieve this goal, the management should address dose reduction for both workers and patients.

Although the program presented here is developed specifically for occupational exposure considerations, management should incorporate into their program those procedures, practices, and quality assurance checks that can eliminate unnecessary or extraneous radiation exposures to patients without compromising the quality of medical service. Such practices and checks include, but are not limited to:

a) Use of appropriate and well-calibrated instrumentation and equipment.
b) Use of appropriate digital imaging techniques
c) Use of organ shields in diagnostic radiology.
d) Staying with the well-established dosage limits unless deviation is absolutely essential in the judgment of the responsible physician.

1. Management Commitment

a) We, the management of Northern Inyo Hospital, are committed to an efficient medical use of radioactive materials and radiation producing equipment by limiting their use to clinically indicated procedures, utilizing efficient exposure techniques, and optimally operated radiation equipment; limiting dosages to those recommended by the manufacturer unless otherwise necessary, using calibrated diagnostic and related instrumentation; and using appropriately trained personnel.

b) We commit to the program described below for keeping occupational individual and collective doses ALARA. Toward this commitment, we hereby describe an administrative organization for radiation safety and will develop all necessary written policy, procedures, and instruction to foster the ALARA philosophy within our institution. The organization will include a Radiation Safety Committee (RSC) and a Radiation Safety Officer (RSO).

c) We will perform a formal annual review of the radiation safety program, including ALARA considerations. The review will cover operating procedures and past dose records, inspections, and recommendations of the radiation safety staff or consultants.

d) We will modify operating and maintenance procedures, equipment, and facilities if these modifications will reduce exposures and the cost is justified.

2. Radiation Safety Committee

a. Review of Proposed Users and Uses
   (1) The RSC will thoroughly review the qualifications of each applicant with respect to the types and quantities of radioactive materials and radiation-producing equipment and methods of use for which application has been made, to ensure that the applicant will be able to take appropriate measures to maintain exposure ALARA.
   (2) When considering a new use of radioactive material or radiation producing equipment, the RSC will review the efforts of the applicant to maintain exposure ALARA.
   (3) The RSC will ensure that the users justify their procedures and that individual and collective doses will be ALARA.

b. Delegation of Authority

(The judicious delegation of RSC authority is essential to the enforcement of an ALARA program.)

   (1) The RSC will delegate authority to the RSO for enforcement of the ALARA program.
   (2) The RSC will support the RSO when it is necessary for the RSO to assert authority. If the RSC has overruled the RSO, it will record the basis for its action in the minutes of the quarterly meeting.

c. Review of ALARA Program

   (1) The RSC will encourage all users to review current procedures and develop new procedures as appropriate to implement the ALARA concept.
   (2) The RSC will perform an annual review of occupational radiation exposure. A special meeting may be called for particular attention to instances in which the

investigational levels in Table 1 are exceeded. The principal purpose of this review is to assess trends in occupational exposure as an index of the ALARA program quality and to decide if action is warranted when investigational levels are exceeded (see Section 4 below for a discussion of investigational levels). Maximum legal limits of occupational exposure are listed in Table 2, for reference.

(3) The RSC will evaluate the institution's overall efforts for maintaining doses ALARA on an annual basis. This review will include the efforts of the RSO, authorized users, and workers as well as those of management.

Table 1
Investigational Levels*

	Investigational Levels (mrems/calendar quarter)	
	Level I**	Level II**
1. Whole body; head and trunk; active blood-forming organs; or gonads, lens of eye	312	624
2. Lens of Eye	936	1872
3. Extremities	3125	6250
4. Skin of whole body	750	2250
5. Thyroid uptake	0.1 uCi	0.3 uCi

*Note that investigational levels in this program are not new dose limits but serve as checkpoints above which the results are considered sufficiently important to justify investigations. See Section 4 for further discussion.
**Investigational levels are as listed on Radiation Detection Company Dosimetry Report.

Table 2
Maximum Annual Levels*

	Maximum Annual Occupational Dose limits in mrem
1. Whole body	5,000
2. Extremities, Skin	50,000
3. Lens of the eyes	15,000
4. Fetus	500

*Legal limits for occupational radiation exposure, NCRP Report No. 116, Table 19.1

2. Radiation Safety Officer

a. Annual and Quarterly Review

(1) *Annual review of the radiation safety program.* The RSO will perform an annual review of the radiation safety program for adherence to ALARA concepts. Reviews of specific methods of use may be conducted on a more frequent basis.

(2) *Quarterly review of occupational exposures.* The RSO will review at least quarterly the radiation doses of authorized users and workers to determine that their doses are ALARA in accordance with the provisions of Section 5 of this program and will prepare a summary report for the RSC.
(3) *Quarterly review of records of radiation surveys.* The RSO will review radiation surveys in unrestricted and restricted areas to determine that dose rates and amounts of contamination were at ALARA levels during the previous quarter and will prepare a summary report for the RSC.

b. Education Responsibilities for ALARA Program

The RSO (in cooperation with authorized user) will ensure that radiation workers and, as applicable, ancillary personnel are trained and educated in good health physics practices and procedures.

(1) The RSO (or designee) will schedule briefings and educational sessions to inform workers of the ALARA program efforts.
(2) The RSO (or designee) will ensure that authorized users, workers, and ancillary personnel who may be exposed to radiation will be instructed in the ALARA philosophy and informed that management, the RSC, and the RSO are committed to implementing the ALARA concept.

c. Cooperative Efforts for Development of ALARA Procedures

(1) Radiation workers will be given opportunities to participate in formulating the procedures that they will be required to follow.
(2) Radiation workers will be instructed in recourses that may be taken if they feel that ALARA is not being promoted in the workplace.

d. Reviewing Instances of Deviation from Good ALARA Practices

The RSO will investigate all know instances of deviation from good ALARA practices and, if possible, will determine the causes. When the cause is known, the RSO will implement changes in the program to maintain doses ALARA.

3. Authorized Users

a. New Methods of Use Involving Potential Radiation Doses

(1) The authorized user will consult with the RSO and/or RSC during the planning stage before using radioactive materials and radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trials runs may be helpful.
(2) The authorized user will review each planned use of radioactive materials or radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trial runs may be helpful.

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

4. Establishment of Investigational Levels in Order to Monitor Individual Occupational Radiation Doses (External and Internal)

This institution hereby establishes investigational levels for occupational radiation doses which, when exceeded, will initiate review or investigation by the RSC and/or the RSO. The investigational levels that we have adopted are listed in Table 1. These levels apply to the exposure of individual workers. The following actions will be taken at the investigational levels stated in Table 1.

a. Personnel Dose Less than Investigational Level I

Except when deemed appropriate by the RSO, no further action will be taken in those cases where an individual's dose is less than Table I values for the investigational Level I.

b. Personnel Dose Equal To or Greater Than Investigational Level I But Less Than Investigational Level II

The RSO will review the dose of each individual whose quarterly dose exceeds the investigational Level I and will report the results of the reviews at the first RSC meeting following the quarter when the dose was recorded. If the dose does not equal or exceed Investigational Level II, no specific action related to the exposure is required unless deemed appropriate by the Committee. The committee will, however, review each such dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the committee minutes.

c. Personnel Dose Equal to and Greater Than Investigational Level II

The RSO will investigate in a timely manner the causes of all personnel doses equaling or exceeding Investigational Level II and, if warranted, will take action. A notification letter will be sent to all personnel with doses equaling or exceeding Investigational Level II. A report of the investigation and any actions taken will be presented to the RSC at its first meeting following completion of the investigation. The details of these reports will be included in the RSC minutes.

d. Reestablishment of Investigational Levels to Level Above Those Listed in Table 1

In cases where a worker's or a group of workers' doses need to exceed an investigational level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices. Justification for new investigational levels will be documented.

The RSC will review the justification for and must approve or disapprove all revisions of investigational levels.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

REFERENCES:

1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20
4. NCRP Report No. 116, Table 19.1
5. Radiation Detection Company Dosimetry Report

CROSS REFERENCE P&P:

1. Dosimetry Program - Occupational Radiation Exposure Monitoring Program

Approval	**Date**
Radiation Safety Committee	5/16/17
Radiology Services Committee	5/16/17
Medical Executive Committee	6/6/17
Board of Directors	
Last Board of Director review	1/18/17

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:

1. To prevent delays in taking action in responding to critical tests and critical results that may have the potential for serious harm to the patient
2. To define critical results
3. To establish a communication process with the responsible caregiver

POLICY:

General Lab

1. A current listing of Critical Values will be maintained in this policy which will be found in the Lab library Section in the Clinical Laboratory Policy and Procedure Manual. Critical values are also defined in the LIS to allow automated flagging and also appear in bold red type on computer screen.
2. Critical results generated by automated analyzers shall be verified by repeat analysis. Specimen redraws may be required when quality of the specimen is in question (eg: hemolysis affected analyte, tubes not filled, improper transport to lab etc). All documentation of results is through the preprogrammed call documentation feature within the LIS.
3. Acceptable length of time for reporting critical lab values is defined as that time between the completion of the test (identifying the critical result) and receipt by the responsible caregiver. Refer to procedure under each General Lab section for specific time frames.
4. Clinical Laboratory Scientists (CLS) are responsible for notifying the physician or other responsible caregiver.
5. Patients at other Healthcare Facilities: Critical results will be called to the primary nurse. If unable to deliver critical results to the appropriate personnel, the results may be given to the CLS at that facility.
6. The CLS will require verification of the reported results by requesting a "read back" patient's name, date of birth, test name and results.

NURSING

1. The Registered Nurse is responsible for notifying the ordering provider of critical results that are reported from the Clinical Lab Scientist
2. The Registered Nurse is responsible for documenting the conversation with the provider.

RESPIRATORY THERAPY:

1. The Respiratory Therapist is responsible for analyzing blood gases
2. The Respiratory Therapist is responsible for notifying the provider of critical results
3. The Respiratory Therapist is responsible for documenting the conversation with the provider in the ABG analyzer
4. If a critical result is identified the Respiratory Therapist will reanalyze blood gas

DRAFT

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

DEFINTION:

Critical results are those findings (even from routine tests) whose value reflects a potential life threatening situation that requires rapid communication of results to the responsible caregiver (Defined as physician, Advance Practice Provider (APP), nurse, except in certain instances when the patient has had recent lab results with the same critical limits violated or improved.

Due to the patient demographics of this hospital, the critical test result reporting time frame is from the time the result is available to the time the result is received by the ordering provider/responsible caregiver. Reporting time frame is from 30 or 60 minutes, dependent upon in or out-patient status and the test being reported.

PROCEDURE:

GENERAL LAB: Specific lab Section Reporting Policy

1. Chemistry
    a. Perioperative, Inpatient Units or Emergency Department
        - CLS or Respiratory therapist will report within 30 minutes of determining the results of the test.
    b. Outpatient clinics
        - CLS or Respiratory therapist will report within 60 minutes of determining the results of the test.
        - If unable to contact physician within 60 minutes after initial contact attempt, the Emergency Department physician will be contacted to help assess situation and contact patient if appropriate.

2. Hematology
    - Perioperative, Inpatient Units or Emergency Department
    - CLS will report within 30 minutes to the nurse after confirmation of the result
    a. Outpatient clinics
        - CLS will report within 60 minutes to the ordering physician or to a responsible caregiver.
        - If unable to contact physician immediately, CLS will try to call through the Physician Contact Phone list.
        - If unable to contact physician within 60 minutes after initial contact attempt, the Emergency Department physician will be contacted to help assess situation and contact patient if appropriate.
3. Transfusion Services / Serology

DRAFT

a. Perioperative, Inpatient Units or Emergency Department

- CLS will call within 30 minutes of result confirmation to an attending RN.

b. Outpatient clinics
   - CLS will call within 60 minutes of result confirmation to the physician
   - If the physician cannot be reached within 60 minutes, the CLS will contact the Emergency Department physician on duty to assess the situation and contact the patient if appropriate.

4. Microbiology
   a. Gram stain Results on Perioperative, Inpatient Units or Emergency Department
      - CLS will call the Hospitalist on all Inpatients within 30 minutes after processing of the specimen in Micro.
   b. Gram stain Results on Outpatients
      - CLS will call the ordering physician or responsible care giver within 60 minutes after processing the specimen in Micro.
      - If unable to contact physician within 60 minutes after initial contact attempt, the Emergency Department physician will be contacted to help assess situation and contact patient if appropriate.

C. Documentation of report
1. Required information for giving report
   1. Name of contact person
   2. Date and time notified
   3. Name of critical value reported
   4. Critical Value
   5. Confirm the patients name and date of birth
   6. CLS initials
   7. Documentation of any delays or problems in notification
2. For reports that are in the Lab Information System (LIS), use the preprogrammed call documentation features provided. See C.1.
3. For testing not reported through the LIS, documentation is done on the lab copy of the report and then scanned into the patient's medical record. See C.1 for information to record on lab copy.

DRAFT

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

NURSING PROCEDURE:

1. Emergency Department, Inpatient Units, Outpatient Infusion, Surgery and Clinics
    a. The nurse will contact the physician within 30 minutes of being notified of critical result
    b. Documentation will include:
        - Date and time nurse notified by lab
        - Date, time and name of provider notified
        - Name and value of critical result reported
        - Documentation of any delays or problems in notification
2. Outpatient Clinics:
    a. The nurse will contact the physician within 30 minutes of being notified of critical result
    b. Documentation will include:
        - Date and time nurse notified by lab
        - Date, time and name of provider notified
        - Name and value of critical result reported
        - Documentation of any delays or problems in notification
3. Respiratory Therapy:
    a. The Respiratory Therapist will contact the physician within 30 minutes of critical result identified.
    b. Documentation will include:
        - Date and time nurse notified by lab
        - Date, time and name of provider notified
        - Name and value of critical result reported
        - Documentation of any delays or problems in notification

Physician notification escalation process:

- Nurse/RT will attempt to notify the physician as defined below
- A physician will be immediately notified:
- Call the provider (ordering or covering) #1
- If no response after 15 minutes, call physician #1 again
- If no response after an additional 15 minutes, call physician #1 again if unable to reach, call the Emergency department physician

DRAFT

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

CRITICAL LIMITS BY DEPARTMENT

CHEMISTRY

TEST	LOW LIMIT	HIGH LIMIT
Acetaminophen		50 ug/mL
Alcohol (ETOH)		300 mg/mL
Calcium	6.0	14.0 mg/dl
Carbamazepine		12 ug/mL
HCO_3, Bicarbonate (ABG)	15	40 Meq/L
Creatinine		5.0 mg/dL
Digoxin		2.5 ng/mL
ECO_2	10	40 mmol/L
Gentamycin (Random)		8.0 µg/mL
Gentamycin (Trough)		2 .1 µg/mL
Glucose, (>1 year)	50	400 mg/dL
Glucose, (age 0 to 28 days)	30	300 mg/dL
Glucose, (28 days to 1 year)	40	400 mg/dL
Lactic Acid		5.0 mmol/L
Lithium		2.0 mmol/L
Neonatal Bilirubin		18.0 mg/dL
pH (ABG and Venous)	7.20	7.60 units
pCO2 (ABG)	20	70 mmHg
pCO2 (Venous)	15	70 mmHg
pO2 (ABG)	40	mmHg
Phenytoin (Dilantin)		30 ug/mL
Phenobarbital		40 mg/ML
Potassium (K)	3.0	6.0 Meq/L
Potassium (<10 days)	3.0	8.0 Meq/L
Salicylate		30 mg/dL
Sodium	120	160 Meq/L
Tobramycin (Random)		8 µg/mL
Tobramycin (Trough)		2 .1 µg/mL
Troponin I		0.6 ng/mL
Valproic Acid		200 µg/mL
Vancomycin (Trough)		25 µg/mL
Vancomycin (Random)		30 ug/mL

DRAFT

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

HEMATOLOGY

TEST	LOW LIMIT	HIGH LIMIT
Hemoglobin	7.0	20.0 g/dL
WBC	2500	20,000 µL
Platelets	30,000	800,000 ul
Protimes		50.0 sec
INR		4.5
Ptt (if not on heparin) Ptt (on heparin)		40.0 sec 90.0 sec
Fibrinogen	100	Mg/dl
CSF (*See Microbiology*)*		10 WBC's

TRANSFUSION SERVICES / SEROLOGY

1. Positive Antibody Screens
2. All Units Crossmatched are incompatible
3. Blood is unavailable
4. Positive RSV on children <5 years old
5. Positive C. difficile result

MICROBIOLOGY

1. Positive gram stains (organisms seen) from these sites:
   a. CSF
   b. Blood cultures
   c. Body fluids (from normally sterile sites)
      - Pleural
      - Thoracentesis
      - Joint fluid

REFERENCES:

1. The Joint Commission E-dition Critical Access Hospital. (2017). National Patient Safety Goal 02.03.01 Report critical results of tests and diagnostic procedures in a timely manner.

CROSS REFERENCE P&P:

1. DI Timeliness for Critical Results
2. Point of Care Accu-Check Blood Glucose Testing

DRAFT

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Critical Value Reporting of Lab Results	
Scope: Lab, Nursing and Respiratory Therapy, NIHD clinics	Manual: Laboratory, CPM – Diagnostic Test and Lab Test (DLT)
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

Approval	**Date**
CCOC	6/5/17
Medical Services/ICU	6/5/17
Perinatal Pediatric Committee	5/26/17
Emergency Services Committee	5/31/17
MEC	6/7/17
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised: 4/26/16, 5/17 LW/RC
Supersedes: 03/06/12, 07/28/15
Index Listings: Critical lab, critical, critical values

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Dead on Arrival	
Scope: Departmental	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 10/04/06

PURPOSE:
To provide the Emergency Department staff with current guidelines for managing patients dead on arrival. Dead on arrival being defined as a patient brought to the Emergency Department who is dead and for whom any resuscitation efforts would be futile.

POLICY:
Pre-hospital providers and law enforcement agencies who cannot determine death in the field, will bring patients to the Emergency Room to be pronounced legally dead by a physician. Please note that when death can be determined in the field by an agency, i.e., ALS/Paramedic, the coroner is then contacted to legally pronounce the patient. Penal Code does not allow any agency to transport directly to the morgue to be pronounced.

PROCEDURE:
1. The physician in the Emergency Room will examine the body.
2. The deceased should be placed in an unoccupied room, if possible.
3. Family members should be shown to the waiting room or a quiet area.
4. The physician should speak with the family as soon as possible.
5. Forms to be completed after pronouncement of the patient:
    a. An Emergency Room Department record.
    b. Release of Body to Mortuary.
    c. Organ Procurement Notification.
6. Authorities to be notified:
    a. If an accident or suicide, notify appropriate law enforcement agency.
    b. If a coroner's case, notify the coroner.
    c. Notify Nursing Supervisor.

CORONER CASES:
1. Clothing, personal effects or valuables should not be removed before coroner arrives. Items already removed should be placed in a bag, labeled and given to the coroner. Personal effects should not be given to the family until released by the coroner.
2. If the coroner orders an autopsy, family permission is not necessary.
3. If the family has no preference or there is no family, the coroner should specify to which mortuary the body would be removed.
4. Coroner should notify family of death if this has not already been done.
5. Coroner is responsible for identifying unknown D.O.A. He may authorize hospital to assist in this identification.

NON-CORONER CASES:
1. Mortuary
    a. The relatives should specify agent for disposal of body.
    b. If no relatives, coroner to specify mortuary.
    c. Emergency Room staff should call the appropriate mortuary after determination by coroner or relative.
2. Valuables
    a. Relatives sign for possessions.
    b. If no relatives, valuable are placed in safekeeping.
3. If an autopsy is to be performed, a family member must sign authorization.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Dead on Arrival	
Scope: Departmental	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 10/04/06

4. Agency picking up the body must sign "Release of Body to Mortuary".

NURSING RESPONSIBILITIES:

1. If possible, a nurse should accompany doctor when he notifies family.
2. Ask family if they wish assistance, i.e. minister, priest, friend.
3. Provide emotional support.
4. Where appropriate, arrange for community support follow-up for relatives, i.e., social worker, psychiatric help.

DOCUMENTATION:

Release of patient information.
Organ donation policy.

Approval	Date
CCOC	4/24/2017
Emergency Services	5/18/2017
Medical Executive Committee	6/6/2017
Board of Directors	
Last Board of Director review	

Initiated: 4/92
Reviewed: 4/17kp
Revised: 03/2000; 02/02, 03/05, 02/08 AS, 08/11 AS
Index Listings: DOA – Dead on Arrival; Coroner's Case: Deceased Patients – ER Policy

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Emergency Operations Plan / HICS Plan	
Scope: NIHD	Manual: Safety
Source: DON Emergency Services	Effective Date: 8/2008

POLICY

Northern Inyo Healthcare District Emergency Operations Plan (EOP) follows the HICS format. Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the incident command system (ICS) design of the Hospital Incident Command System (HICS). HICS provides for an "All Hazards" approach to manage emergencies. HICS has a defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. Northern Inyo Healthcare District has identified nine leadership positions that may be activated when activate HICS plan. These include Incident Commander, Liaison, Safety Officer, PIO, Medical Tech/Specialist, Operations Section Chief, Planning, Logistics and Finance Administrator. These positions will be filled with most appropriate staff member on duty when HICS is activated. These people will be relieved when senior Healthcare District staff becomes available.

HICS materials (job action sheets, vests (found only on Disaster Cart), organization chart, and documentation forms) are located in the Disaster Manual and Disaster Cart and brought to the Incident Command Center (ICC) upon activation of Code Triage.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

This Emergency Operations Plan (EOP) is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the Healthcare District. NIHD has adopted the National Incident Management System (NIMS) at an organization level. NIMS uses a system approach to integrate the best of existing processes and methods for a unified national framework for incident management. NIHD has incorporated the 17 elements of NIMS compliance into this Emergency Operations Plan.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Hospital and the Public Health Department. NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and/or medical supply vendors. Established Memorandums of Understanding (MOU) and/or Agreement (MOA) will be shared with local emergency management prior to an incident occurring.

NIHD will participate in local, regional, and or state multidiscipline and multi-agency drills twice per year. Exercise activities will address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of causalities through the Healthcare District system, resource management, security procedures, specialty

lab testing, and or site/facility safety. Exercise will be conducted through drills, tabletop, functional, and or full scale exercises.

SCOPE

The Emergency Operations Plan is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of patients, staff, and visitors, or the environment of NIHD, or adversely impact upon the Healthcare District's ability to provide healthcare services to the community based upon the Hazard Vulnerability Analysis. The Program is also designed to assure compliance with applicable codes and regulations.

This plan covers all Healthcare District facilities (Main, Rural Health Clinic) and its implementation is the responsibility of all personnel.

GOALS

1. Adhere to the NIHD's mission statement.
2. Prevent or lessen the impact that an emergency may have on the institution and the community (mitigation).
3. Identify resources essential to emergency response and recovery and facilitate their access and utilization (preparedness).
4. Prepare staff to respond effectively to emergency situations that affect the environment of care (response) and test response mechanisms.
5. Plan processes for reestablishing operations after the incident (recovery).

OBJECTIVES

The Healthcare District addresses emergency management.

The Healthcare District conducts a hazard vulnerability analysis* to identify potential emergencies that could affect the need for its services or its ability to provide those services. (see attached)

The Healthcare District establishes the following with the community:

- Priorities among the potential emergencies identified in the hazard vulnerability analysis
- The Healthcare District's role in relation to a communitywide emergency management program
- An "all-hazards" command structure within the Healthcare District that links with the community's command structure

The Healthcare District develops and maintains a written emergency management plan describing the process for disaster readiness and emergency management, and implements it when appropriate.

At a minimum, an emergency management plan is developed with the involvement of the Healthcare District's leaders including those of the medical staff.

The plan identifies specific procedures that describe mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each priority emergency.

The plan provides processes for initiating the response and recovery phases of the plan, including a description of how, when, and by whom the phases are to be activated.

The plan provides processes for notifying staff when emergency response measures are initiated.

The plan provides processes for notifying external authorities of emergencies, including possible community emergencies identified by the Healthcare District (for example, evidence of a possible bioterrorist attack).

The plan provides processes for identifying and assigning staff to cover all essential staff functions under emergency conditions.

The plan provides processes for managing the following under emergency conditions:

- Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients)
- Staff support activities (for example, housing, transportation, incident stress debriefing)
- Staff family support activities
- Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water)
- Security (for example, access, crowd control, traffic control)
- Communication with the news media

The plan provides processes for evacuating the entire building (both horizontally and, when applicable, vertically) when the environment cannot support adequate care, treatment, and services.

The plan provides processes for establishing an alternate care site(s) that has the capabilities to meet the needs of patients when the environment cannot support adequate care, treatment, and services including processes for the following:

- Transporting patients, staff, and equipment to the alternative care site(s)
- Transferring to and from the alternative care site(s), the necessities of patients (for example, medications, medical records)
- Tracking of patients
- Interfacility communication between the Healthcare District and the alternative care site(s)

The plan provides processes for identifying care providers and other personnel during emergencies.

The plan provides processes for cooperative planning with health care organizations that together provide services to a contiguous geographic area (for example, among organizations serving a town or county) to facilitate the timely sharing of information about the following:

- Essential elements of their command structures and control centers for emergency response
- Names and roles of individuals in their command structures and command center telephone numbers
- Resources and assets that could potentially be shared in an emergency response
- Names of patients and deceased individuals brought to their organizations to facilitate identifying and locating victims of the emergency

The plan identifies backup internal and external communication systems in the event of failure during emergencies.

The plan identifies alternate roles and responsibilities of staff during emergencies, including to whom they report in the Healthcare District's command structure and, when activated, in the community's command structure.

The plan identifies an alternative means of meeting essential building utility needs when the Healthcare District is designated by its emergency management plan to provide continuous service during an emergency (for example, electricity, water, ventilation, fuel sources, medical gas/vacuum systems).

The plan identifies means for radioactive, biological, and chemical isolation and decontamination.

The Healthcare District regularly tests its emergency management plan.

The Healthcare District tests its emergency management plan twice a year, either in response to an actual emergency or in a planned exercise.
Note 1: Tabletop sessions, though useful, are not acceptable substitutes for exercises.

Hospitals that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated patients.

Hospitals that have a defined role in the communitywide emergency management program participate in at least one communitywide exercise a year.
Note 1: "Communitywide" may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.
Note 2: Exercises for Element of Performance 2 and 3 may be conducted separately or simultaneously
Note 3: Table top sessions are acceptable in meeting the community portion of this exercise.

Planned exercise scenarios are realistic and related to the priority emergencies identified in the Healthcare District's hazard vulnerability analysis.

During planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement. This individual may be a staff member of the organization who is not participating in the exercise.

During planned exercises the Healthcare District monitors at least the following core performance areas: Event notification including processes related to activation of the emergency management all hazards command structure, notification of staff, and notification of external authorities.

During planned exercises the Healthcare District monitors at least the following core performance areas: Communication including the effectiveness of communication both within the Healthcare District as well as with response entities outside of the Healthcare District such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community.

During planned exercises the Healthcare District monitors at least the following core performance areas: Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security.

During planned exercises the Healthcare District monitors at least the following core performance areas: Patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.

Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical (including physicians), and support staff.

The Healthcare District modifies its emergency management plan in response to critiques of exercises.

Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements must be put in place until final resolution.

The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

Emergency Department Manager (ED Manager) will be responsible to track the organizational adoption of NIMS, command and management, preparedness planning, training, exercises, resource management, and communication and information management activities from year to year with a goal of improving overall emergency management capability.

ORGANIZATION AND RESPONSIBILITY

The Board of Directors receives regular reports of the activities of the Emergency Management Program from the Safety Committee Chair. The Board reviews the reports and, as appropriate, communicates concerns about identified issues, deficiencies and regulatory compliance.

Medical Staff: The Emergency Department Physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The Medical Staff reviews the EOP Plan at the Department and MEC.

Quality Improvement Committee receives regular reports of the current status of the Emergency Management Program through the Safety Committee. Quality Improvement Committee reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Safety Committee Chair. The ED Manager makes recommendations to Senior Leadership for purchase of supplies and equipment necessary for the improvement of the emergency response capability.

The ED Manager works under the general direction of the Chief Nursing Officer (CNO) and the Administrator. The ED Manager, in collaboration with the Resuscitation Committee is responsible for managing all aspects of the Emergency Management Program. The ED Manager advises the Safety Committee regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

All Healthcare District personnel are considered essential to the operation of the Healthcare District. HICS allows for easy expansion of the basic incident command structure to include additional personnel assignments designed to accommodate the needs of specific disaster situations. Designated staff have been assigned to fill HICS positions and trained to assume these rolls. In some emergencies, the Healthcare District may establish a personnel pool to supplement or staff essential response or operating functions. In those situations, employees may be assigned responsibilities commensurate with their abilities but outside their normal

job responsibilities. Employees who are assigned key roles in the HICS are issued identification vests and name badges, designed to clearly identify their role in the response effort.

Department Directors are responsible to implement their departmental emergency duties and take whatever actions are necessary to maintain needed services including maintaining a current emergency call-back telephone list. Depending on the scope and nature of the emergency some departments may be asked to close and send all available employees to the labor pool to assist with more acute needs. Department Directors are also responsible for educating their staff regarding emergency procedures. In addition they are responsible to be familiar with the specific roles which may be assigned to them or their department should the function(s) be activated by the Incident Commander. Each department must complete and submit a status report to the Incident Command Center (ICC) immediately following Code Triage. General guidance for emergency incidents is provided in the Management of the Environment of Care Manual for the immediate situation, i.e. Civil Disturbance, Bomb Threat, Earthquake Protocol, Utility Failures, etc. The Department Director will notify the Incident Command Center of additional staffing needs and request approval to utilize the call-back list to provide personnel necessary to cover necessary staff positions. Department Directors are responsible for determining the department level of response needed for the emergency, based upon such information as:

The nature and severity of the emergency;
Direction from the Incident Commander;
Number of victims;
Types of injuries;
Time of day;
Current staffing;
Conditions and availability of the Healthcare District, its equipment and materials available.

Volunteers are responsible for knowing the overhead page, Code Triage, for the activation of the Emergency Preparedness Plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

HAZARD VULNERABILITY ANALYSIS (HVA)

The Resuscitation Committee, with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. The result of the HVA will be reviewed with Healthcare Coalition and a county HVA will also be developed. Both of these processes will be completed annually. Results will be shared with the Safety Committee, Department Heads, and the Board of Directors.

MITIGATION, PLANNING, RESPONSE AND RECOVERY

The job action sheet of HICS includes sections addressing mitigation, planning, response, and recovery.

- **The Mitigation Section** describes equipment and human activity designed to be put in place in advance to minimize the impact of an emergency.
- **The Planning Section** describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. These planning descriptions include a list of available supplies and equipment and any required maintenance or inspection.
- **The Response Section** describes the command structure required to manage the plan after initiation, during the emergency situation, and sustaining operations during protracted disruptions.
- **The Recovery Section** describes the processes for moving from emergency operations back to normal operations, and the process for assessing and implementing a full recovery of the structure and all internal components and systems.

COMMUNICATIONS SYSTEMS

Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, an emergency phone system, public and satellite telephones, two-way radios, Ham radios, and cellular phones. The implementation of the emergency plan focuses on maintaining vital patient care communications.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plan language will be used in training and tested during drill exercises.

COMMUNITY-WIDE RESPONSE INVOLVEMENT

NIHD is part of Section VI (6). The Emergency Response Group works with local, county and state planning agencies to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

Title: Emergency Operations Plan / HICS Plan	
Scope: NIHD	Manual: Safety
Source: DON Emergency Services	Effective Date: 8/2008

COMMAND STRUCTURE

NIHD has chosen to use the ICS (Incident Command System) model to manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.

COMMUNITY PLANNING

NIHD participates in the Inyo County Emergency Planning through the Unified Command and the Healthcare Coalition. The groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. The discussions of the group are used to guide the development of the NIHD Emergency Operations Plan and planning.

INITIATION OF EMERGENCY

The Administrator or Administrator on Call, and the Nursing Supervisor on Duty, have authority to activate the Incident Command Center (ICC) and initiate CODE TRIAGE, or other portions of the emergency plan whenever a defined emergency exists. The person activating the emergency plan and/or the EOC, serves as the Incident Commander until relieved by a senior Administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is always better to activate the EOC, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events. Each Emergency Operations Plan (HICS) clearly states the process for implementation of the plan. The description includes the command structure for the plan, the conditions, or criteria requiring activation of the plan, and the individual(s) responsible for implementation of the plan. The simplest implementation procedure is immediate activation of the response using an equipment-activated alarm for the fire plan. More complex response procedures involving setting up a command center and ICS response team are required for most emergencies, including major utility failures and community-based emergencies.

The Healthcare District may receive three principle notifications: Advisory, Alert and or Activation.

- **An Advisory** is given when no system response is needed but the potential for a response exists.
- **An Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **An Activation** is given when a response is required.

The local Public Health Department or emergency management office will usually receive these notifications.

Important information to obtain as soon as possible should include but not be limited to:

- type of incident, including specific hazard/agent, if known
- location of incident
- number and types of injuries
- special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

NIHD and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

NOTIFICATION OF CIVIL AUTHORITY

Whenever a situation adversely affects the Healthcare District's ability to provide services to the community, the Healthcare District notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Dept of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Dept of Health Services, Licensing and Certification Program.

STAFF NOTIFICATION

Staff is notified of EOP plan implementation in several ways: audible overhead page, telephone, pagers, or runners in the Healthcare District. Telephone trees, pagers and other means of communication are used to notify staff away from the Healthcare District.

STAFF IDENTIFICATION

NIHD uses the regular staff identification badge to identify caregivers and other employees during mass casualty or major environmental disasters. Everyone coming into the facility needs to have a visible NIHD ID in order to enter. Staff without ID's must go through Labor pool, be positively identified, and receive a temporary badge or other approved alternate.

Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title and as more senior staff become available, and during longer incidents, jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the

media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification to each responding group will display.

STAFF COVERAGE OF CRITICAL POSITIONS

The Emergency Operations Plan includes processes for the Incident Commander and Departments heads to communicate to determine staffing needs and to assign available staff to critical responder positions. Some response procedures assign departments or individuals specific roles automatically to assure timely and effective implementation. HICS includes organizational charts and processes to assure staff coverage.

MANAGEMENT OF PATIENT CARE ACTIVITY

There is an Emergency Operations Plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, for evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and about current patients for planning, patient management, and informing relatives and other; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

1. **very high-risk** – could only be cared for in an acute facility
2. **high risk** – could be transferred to an acute care facility
3. **moderate risk** – would be transferred to another facility
4. **low risk** – could be transferred home
5. **minimum risk** – could be discharged immediately

DISASTER CREDENTIALING (See Healthcare District Policy)

EMERGENCY LOCATIONS FOR PATIENT CARE

All patients will enter through Emergency Department, after triage outside, as appropriate. Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of the Code.

- **Triage Area** - Emergency Parking Lot beside Emergency Department
- **Immediate Care Area** - Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Physical Therapy
- **MORGUE** – To be arranged by County EOC

EMERGENCY LOCATIONS FOR NON-PATIENT CARE

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – Medical Records Department

- **Labor Pool** - Cafeteria
- **Family Center/Human Services Center** – Respiratory Therapy
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center** – Respiratory Therapy

Procedures also address the transportation and housing of staff that may not be able to get to or from the facility during an emergency or who may need housing and other services for their families to be available for service. A procedure is in place for incident stress debriefing. Staffs who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals, social services or chaplain.

Arrangements are made with vendors and other services to assure availability of supplies, materials, food and water in a timely fashion.

Release of information to the news media follows the procedures developed by the Public Information Officer (PIO)[4] who would act as spokes persons for the organization. The Incident Commander will release information as appropriate to the situation. In larger incidents, the local Emergency Operations Center of Inyo County may act as spokesperson for the overall emergency and Healthcare District information.

STAFF AND FAMILY SUPPORT

Because all Healthcare District personnel are considered essential during emergency response situations, the Healthcare District recognizes its responsibility to provide meals, rest periods, psychological, and other personnel support. In addition, the Healthcare District recognizes that providing support, such as communication services and dependent care, to employees' families during emergency situations allows employees to respond in support of the essential functions of the Healthcare District. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency child care
- Emergency transportation
- Staff/family lodging and meals
- Psychological and bereavement counseling
- Staff/family prophylaxis or immunization

ETHICAL OPERATING PROCEDURES

In emergency situations, certain standing policies and procedures of the Healthcare District and rules and regulations of the Medical Staff may be waived by the Incident Commander, the Medical Care Director or the other first-tier incident command center staff to ensure that essential patient care can be rendered and that the facility can be secured.

EVACUATION

A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the Healthcare District inoperable or unsafe for occupancy, and would be implemented with the involvement of the CEO or senior leadership available.

SURGE AND ALTERNATE CARE SITES

Alternate care sites include Jill Kinmont Boothe School; City Hall, Pine Street School Gym; and the Fairgrounds.

The Incident command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

RECOVERY PLANS

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc) has been recorded for baseline

Documentation for Federal Emergency Management Agency (FEMA) assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of the emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and staff in all departments affected by the plans are trained as part of organization wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the Emergency Operations Plan (HICS), and actual outages of utility systems.

CHEMICAL AND RADIOACTIVE ISOLATION AND DECONTAMINATION

The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

EDUCATION AND TRAINING

Each new staff member of NIHD participates in a general orientation that includes information related to the Emergency Operations Plan. Examples of such information include: the Emergency Operations Plan (HICS), job-specific roles, emergency communication plans, location of emergency supplies and equipment, and disaster management procedures.

The Human Resources Department conducts the general orientation program. The general orientation program is scheduled by the Human Resources Department, and records attendance for staff members who complete the general orientation program. They also track and reschedule staff members who did not to attend the general orientation program.

New staff members also receive a department-specific orientation. Each department manager provides new staff members with a department-specific orientation to their role in the Emergency Management Program. All staff members of NIHD participate at least once each year in a continuing education Program. Information specific to the Emergency Management Program is included in the continuing education Program. The Safety Officer collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 will be available to all Healthcare District personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident; all directors and nursing supervisors. [1]

Title: Emergency Operations Plan / HICS Plan	
Scope: NIHD	Manual: Safety
Source: DON Emergency Services	Effective Date: 8/2008

PERFORMANCE OF DRILLS/EXERCISES

NIHD is a Healthcare District that offers emergency services and has a defined role in community-wide emergency management therefore the emergency management plan is tested twice a year, in response to and actual or in a planned exercise. One exercise a year includes a communitywide exercise and an influx of actual or simulated patients.

During planned exercises, an individual(s) is designated whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement. The following core performance areas are monitored during planned exercises: event notification including processes related to notification of external authorities, communication including the effectiveness of communication both within the Healthcare District as well as with response entities outside of the Healthcare District such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community, resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security, patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

All exercises are critiqued by a multi-disciplinary process that includes administration, clinical (including physicians), and support staff to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.
After a drill or exercise, a corrective action report will be created. In the corrective action report, the following points will be addressed for each identified issue:

- The identified action to correct the issue or deficiency
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action will be incorporated into plans and procedures once completed.

The EOP is modified in response to critiques of exercises. Future planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements are put in place until final resolution. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

The ED Manager maintains performance indicators to objectively measure the effectiveness of the Emergency Management Program. The ED Manager determines appropriate data sources, data collection methods, data collection intervals, analysis

techniques and report formats for the performance improvement standards. Personnel, equipment, and management performance are evaluated to identify opportunities to improve the Emergency Management Program. The performance measurement process is one part of the evaluation of the effectiveness of the Emergency Management Program. A performance indicator is established to measure at least one important aspect of the Emergency Management Program. The current performance indicators for the Emergency Management Program are:

1. # Drills
2. # actual implementation of HICS
3. # pts treated in ED requiring decontamination
4. # incidents of mass causality

In addition, all the objectives listed at the beginning of this plan are evaluated for effectiveness during the annual evaluation.

ANNUAL EVALUATION

The ED Manager is responsible for coordinating the annual evaluation of the seven functions associated with Management of the EC. The ED Manager is responsible for performing the annual evaluation of the Emergency Management Program.

The annual evaluation examines the objectives, scope, performance, and effectiveness of the Emergency Management Program and the Hazardous Vulnerability Analysis. The annual evaluation uses a variety of information sources including the reports from internal policy and procedure review, incident report summaries, Safety Committee Meeting minutes, Safety Committee reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a balanced summary of the Emergency Management Program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer term future.

The annual evaluation is presented to the Safety Committee who reviews and approves the report. The deliberations, actions, and recommendations of the Committee are documented in the minutes. The annual evaluation is also distributed to the Chief Executive Officer, the Quality Improvement Committee, and other Department Heads as appropriate. Once the review is finalized, the ED Manager is responsible for implementing the recommendations in the report as part of the performance improvement process.

Title: Emergency Operations Plan / HICS Plan	
Scope: NIHD	Manual: Safety
Source: DON Emergency Services	Effective Date: 8/2008

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.

b. **Incident Planning Guides (IPGs)**: Plans that describe the specifics of how the organization plans to respond to specific emergency situations as identified by HVA and other analysis.

c. **Emergency Operations Plan (EOP) –** The Program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.

d. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

e. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIHD or on the ability of NIHD to conduct normal patient care and business activities.

REFERENCES

1. National Incident Management System (NIMS)
   http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml
2. Appendix 1. NIMS Implementation Activities for Hospitals and Healthcare Systems
3. National Bioterrorism Hospital Preparedness Program (NBHPP)
4. Hospital Incident Command System (HICS) Manual http://www.emsa.ca.gov
5. LA County Hospital Regional Response Plan
6. Emergency Management (EM) Principles and Practices for Healthcare Systems
7. Training of Hospital Staff to Respond to a Mass Casualty Incident
8. IS-242 Effective Communication
9. IS-702 National Incident Management System
10. CAMH's Manual EC 4.10 and EC 4.20

Title: Emergency Operations Plan / HICS Plan	
Scope: NIHD	Manual: Safety
Source: DON Emergency Services	Effective Date: 8/2008

11. Los Angeles County Hospital Regional Response Plan Umbrella Health Care Entities agreement
12. Federal Emergency Management Agency, FEMA, Higher Education Project (Appendix: Select Emergency Management-Related Terms and Definitions - 501KB MS Word): http://training.fema.gov/EMIWeb/edu/hazdisusems.asp
13. Federal Emergency Management Agency, FEMA, State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning: http://www.fema.gov/plan/gaheop.shtm
14. Department of Veterans Affairs. Emergency Management Program Guidebook. 2005: http://www1.va.gov/emshg/page.cfm?pg=114
15. NFPA 1600, Standard on Disaster/Emergency Management and Business Continuity Programs 2004 Edition: http://www.nfpa.org/assets/files/pdf/nfpa1600.pdf

Approval	**Date**
CCOC	4/5/17
Safety Committee	4/12/17
Emergency Services	5/18/17
Medical Executive Committee	6/6/17
Board of Directors	
Last Board of Director review	

Developed:
Reviewed: 8/08; 8/09; 8/2010; 7/2011as
Revised: 10/07; 8/09; 7/2011as; 4/17
Supersedes: HI – HICS_ Emergency Management Plan

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Sterilization Recall Policy	
Scope: Sterile Processing	Manual: Sterile Processing
Source:	Effective Date:

PURPOSE:
To assure that all items available for patient care are properly sterilized. Should failure of sterilization process occur, all items processed may be retrieved by sterile processing personnel.

To assure sterilization, the sterilization date is applied to all sterilized items and packaging is considered sterile unless the integrity of the packaging has been compromised.

POLICY:
Sterilizers are checked daily for proper functioning by use of live spore cultures. The biological system is incubated and monitored in sterile processing and read in 24 hours per manufacturer literature.

Sterilization records are kept in the sterile processing unit. If during culture period growth of any kind takes place, the perioperative director of nurses and operating room coordinator are notified. The attending physician is notified when applicable.

Sterilizing in the affected autoclave is discontinued until the biomedical engineer and/or sterilizer service provider has serviced the sterilizer to correct any problem.

All items sterilized in that autoclave from the time of the last negative culture are recalled and reprocessed per procedure.

PROCEDURE:

RETRIEVAL PROCESS:

- Every item sterilized in the sterile processing area is marked with internal indicators sensitive to time and temperature, as well as, external autoclave sensitive tape. Each item sterilized is marked with sterilization date and is considered sterile until its integrity is compromised.
- Each item is marked with date, autoclave letter and load number and is recorded on Ver Doc Steamload Release System (load envelope) for that load when sterilized.
- If failure of sterilization cycle is indicated either by graph indicator or internal or external pack indicators, all items from that autoclave cycle are retrieved per record of Ver Doc Steamload Release System (load envelope). Previous loads are spot-checked for sterilization.
- Biomedical engineer is notified and autoclave is not used until fault is identified and repaired.
- Sterilized supplies in all units are checked for integrity prior to use.
- Any item where the packaging integrity has been compromised will be returned to sterile processing for reprocessing.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Sterilization Recall Policy	
Scope: Sterile Processing	Manual: Sterile Processing
Source:	Effective Date:

DEFINITIONS:
Sterilization may be defined as the established and approved process by which all forms of microorganisms are destroyed. There are effective ways to obtain sterilization. They are:

1. Saturated steam under pressure
2. Ethylene oxide gas
3. Dry Heat
4. V Pro processed instruments
5. Steris processed instruments

Ethylene oxide gas is not utilized at this institution.
Dry Heat is not a method utilized at this institution.

Sterilization life of packages:
The sterilized packages are considered sterile unless the integrity of the packaging has been compromised.

DOCUMENTATION:
All positive biological cultures that indicate recall of a product are documented in the log book in sterile processing and also in the quality assurance log book including possible causes of failure and maintenance/service representative findings.

The positive biological culture should be sent to the laboratory for sub culturing (**The recall should not be delayed during this testing**).

REFERENCE:

1. Central Supply Training Manual / Current & Relevant JCAHO & Title 22 Standard
2. AORN RP Sterilization
3. AAMI ST79

Approval	**Date**
NEC	5/3/17
Infection Control	5/23/17
MEC	6/6/17
Board of Directors	
Last Board of Director review	1/18/17

Index Listings: Sterile Processing Recall Policy/Sterilization Recall/ Recall Sterilization
Revised 02/01; 05/2011 BS BS 9/12; 05/2015 BS, 5/17 AW

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Food and Drink in Patient Care Areas	
Scope: NIHD Clinical Care Areas	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 1/1/15

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

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

PROCEDURE:

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

DESIGNATED BEVERAGE AREAS:

Department	Designated area	Department	Designated area
ICU	Nurses Station	Rehab Services	Staff Break Room
Acute/Sub-acute	Nurses Station	Cardiopulmonary	Respiratory Office EKG Break Room PFT when no patient in room.
Perinatal	Behind Nurses Station by Sink	Diagnostic Imaging	Office Space, Break Room, Non-Clinical Tech work area
PACU:	Counter area near patient Refrigerator	RHC	Front Office: Designated countertop Back Office: Designated counter top
Outpatient Infusion:	Break Room	Bishop Pediatric	Break Area
Operating Room:	OR Lounge	RHC Women's Clinic	Front Office: Staff Lounge Back Office: Provider/Nurse Desk
Emergency Department	Nurses Front Desk and Lounge	Surgery Clinic	Kitchen/Office Area Admission staff: At Desk

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Food and Drink in Patient Care Areas	
Scope: NIHD Clinical Care Areas	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 1/1/15

Laboratory	Non-Clinical area, Break Room	Ortho Clinic	Break Room
Phlebotomy	Not designated at this time	Admission Services	Work Stations

REFERENCES:

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

Approval	**Date**
CCOC	4/24/17
Infection Control	5/23/17
MEC	6/6/17
Board of Directors	
Last Board of Directors Review	

Developed: 10/2014
Reviewed:
Revised: 4/17 RC

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Inservice in Infection Control	
Scope: NIHD	Manual: CPM
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

PURPOSE:
To provide employees with ongoing education to help prevent Healthcare Associated Infections (HAI's), employee exposures, and review of current or updated policy and procedures.

POLICY:

1. All new employees are oriented to the infection control policies throughout the hospital, as well as the employee health program and personal hygiene principles.
2. Inservice programs are given by the Infection Preventionist, as needed, for ongoing education in infection prevention and to reaffirm proper techniques.
3. New employees who will have contact with body substances will meet with the Infection Preventionist, Employee Health Nurse or designee who will ascertain that the employee understands the principles of the infection prevention program and give additional instruction as needed.
4. Annual infection prevention in-services or educational training shall be mandatory for the following departments, whose employees may have contact with body substances while performing their tasks:
    - Nursing
    - Lab
    - ~~Physical Therapy~~ Rehab Services
    - ~~Respiratory Therapy~~ Cardiopulmonary
    - Maintenance
    - Pharmacy
    - EKG
    - Environmental Services
    - Radiology
    - Pharmacy
    - Laundry ~~(Sorters)~~
    - Dietary

5. Annual in-services or educational training shall cover:
    a. An overview of infection control principles covering modes of transmission, prevention, and control.
    b. Strategies to reduce risks for and/or prevent healthcare associated infections in patients, employees and visitors.
    c. A review of infection prevention guidelines and policies.
    d. Education requirements from state and federal regulatory agencies.

PROCEDURE:

1. The Infection Preventionist, Employee Health Nurse or designee will work in conjunction with each of the above department directors/managers and/or nursing education to schedule educational inservice or assigned training.
2. Employees may be assigned Policy and Procedures to read.
3. Educational Programs may be assigned to employees.
4. Attendance will be monitored by attendance records, meeting minutes, competencies or confirmation of completion of educational programs.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Inservice in Infection Control	
Scope: NIHD	Manual: CPM
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

REFERENCES:

1. The Joint Commission (2017). Critical Access Hospitals Infection Prevention and Control. IC.01.04.01. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

CROSS REFERENCE P&P:

1. Aerosolized Transmissible Disease Plan
2. Bloodborne Pathogen Exposure Control Plan

Approval	**Date**
CCOC	4/24/17
Infection Control Committee	5/23/17
MEC	6/6/17
Board of Directors	
Last Board of Directors Review	

Developed: 2/95
Reviewed:
Revised: 2/95; 6/97; 9/2000; 6/03; 09/05; 8/2008; 2/10bss; 6/11jb; 9/12 BS 3/17rc
Supersedes:
Index Listings: Inservice

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Formalin Use and Spill Management	
Scope: Surgery, Laboratory	Manual: – Infection Control – Environmental (ICE)
Source: Perioperative DON	Effective Date:

PURPOSE:
To ensure understanding of appropriate technique for filling specimen container with formalin solution and appropriate method for spill management

POLICY:
This policy is to be utilized when filling specimen containers with formalin and for managing formalin spills**.**
Those handling formalin should have reviewed this policy and the SDS Sheet on Formalin**.**
Formalin is to be stored in tightly closed container at room temperatures

EQUIPMENT:

Formalin Solution (obtain from Pathology)

Goggles/Face Shield: MUST wear protective eyewear when filling specimen containers with formalin solution. Goggles/Face shield are located on shelf near formalin container.

Sensor:

- The formalin station has a battery operated sensor located on the left hand side of the system with the sensor wire located inside the left lower corner of the upper part of the station.
- The battery needs to be checked monthly to assure it is working properly.
- This sensor will alarm if there is a formalin leak into the container.

PROCEDURE:

1. Apply patient identification label to container.
2. Place specimen in appropriate size container to allow for adequate coverage of specimen with formalin solution.
3. Apply label specifying formalin is in container.
4. Wearing appropriate eyewear, fill container with formalin solution and place lid on container.
5. Place specimen container in tube transport container and send to aboratory/pathology.
6. Make sure appropriate electronic paper work has been sent to laboratory/pathology.

EMERGENCY AND FIRST AID PROCEDURE FOR MANAGEMENT OF FORMALIN SPILL.

EYES: Flush thoroughly with either the eye wash station solution or with lukewarm water for at least 15 minutes and get medical attention immediately.

SKIN: Remove contaminated clothing. Wash skin with mild soap and water. Flush 15 minutes with water

in review

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Formalin Use and Spill Management	
Scope: Surgery, Laboratory	Manual: – Infection Control – Environmental (ICE)
Source: Perioperative DON	Effective Date:

INHALATION: remove to fresh air, if symptoms persist, get medical attention

INGESTION: Contact poison control center and obtain medical attention immediately

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED:
****Follow SDS for skin or mucous membrane exposure as stated above.**

Risk Assessment:
- Evaluate the type of material spilled and identify the source
- Utilize the "spill kit" located next to formalin station

Protective Clothing:
- Wear appropriate protective clothing including gloves to prevent skin contact
- Wear appropriate eye protection (goggles/face shield) located on side of cart and in spill kit

Containment:
- Immediately cover with Formaldehyde Neutralizer Pads to soak up solution or spray/pour FORMALEX solution on spill. Let stand 15-18 minutes
- Ventilate area if necessary. Contact maintenance if fan is needed to evacuate fumes

Begin Clean Up:
- Use Formaldehyde Neutralizer solution to wipe up area with rags or paper towels and gloves

Disposal of Used Materials:
- Discard all pads, rags and gloves in RED Biohazard bag
- Make sure all disposable items are discarded into the outside trash
- Contact maintenance personnel for assistance if needed

Decontaminate:
- Clean all tools and reusable materials properly before reuse
- Wash out inside of formalin station with clean soap and water and dry

Restock Materials:
- Reorder spill kit from purchasing

REFERENCES:
1. SDS Information on Formldehyde (Z-Fix). Formalex Solution information.

in review

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Formalin Use and Spill Management	
Scope: Surgery, Laboratory	Manual: – Infection Control – Environmental (ICE)
Source: Perioperative DON	Effective Date:

2. Spill kit information

Approval	**Date**
CCOC	4/24/17
Infection Control Committee	5/23/17
MEC	6/6/17
Board of Directors	
Last Board of Director review	1/18/17

Developed: 1/2002 BS
Reviewed:
Revised: 11/2011 BS, /10/2016 BS 4/17aw

in review

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Chickenpox and Shingles~~~~Chickenpox and Shingles~~ Infection Prevention ~~and Control~~ Considerations for Immunosuppressed and Pregnant Employees.	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

PURPOSE:

Exposure precautions and guidelines for Immunosuppressed and pregnant employees.

POLICY:

Northern Inyo Healthcare District (NIHD) shall provide infection prevention and control guidelines for Immunosuppressed and pregnant employees to prevent the transmission of occupationally associated and healthcare associated infections (HAI's).

PROCEDURE:

1. Immunosuppressed and Pregnant Health Care Workers and patients should not be exposed to persons with Varicella zoster virus (chickenpox or herpes zoster, shingles) regardless of their immune status.
2. Staff shall contact the Employee Health Nurse or Infection Preventionist to discuss concerns related to occupational exposure and potential exposure to patients.
3. All staff of childbearing age shall be encouraged to discuss immunizations for vaccine preventable disease prior to pregnancy with their physician.
4. Employees with immunosuppression as a result or therapy should be evaluated by their personal physician their risk of working in a healthcare environment. The employee shall provide information from their physician indicating their ability to work, and outlining any indicated work restrictions. This information must be provided to their Department Director/Manger and Human Resources.
5. Standard precautions shall always be followed when caring for patients for a potential exposure to bloodborne pathogens or other potential infectious materials (OPIM).
6. All employees shall use appropriate PPE when caring for patients that require transmission based precautions.

DEFINTION:

Varicella Zoster Virus (VZV): Causes chickenpox and herpes zoster (shingles). Chickenpox follows initial exposure to the virus and is typically a relatively mild, self-limited childhood illness with a characteristic exanthem, but can become disseminated in immuncompromised persons. Reactivation of the dormant virus results in the characteristic painful dermatomal rash of herpes zoster (shingles).

FACTS ABOUT CHICKENPOX AND SHINGLES:

1. Second cases of chickenpox have occurred.

2. Shingles is a chickenpox virus.

3. Shingles does not transmit shingles to other persons.

4. Localized shingles does not transmit chickenpox to healthy persons.

draft

Title: ~~Chickenpox and Shingles~~~~Chickenpox and Shingles~~ Infection Prevention ~~and Control~~ Considerations for Immunosuppressed and Pregnant Employees.	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

5. To protect the hospital from legal complications and avoid concern of Immunosuppressed and pregnant health care workers and patients, the above extra precautions will be taken.

GUIDANCE CHART FOR PREGNANT EMPLOYEES:

Infection	Guidance
Acquired Immune Deficiency Syndrome (AIDS)	Because transmission does not occur with casual contact, no work restriction is necessary. Protective attire should be worn when blood and body substances is anticipated.
Cytomegalovirus (CM	Work restriction due to pregnancy is not necessary.
Hepatitis B (Serum Hepatitis)	Staff is urged to participate in the hospitals Hepatitis B Vaccination Program prior to pregnancy. Because transmission does not occur with casual contact, no work restriction is necessary. Care should be used with sharps as there is a risk of acquisition is through contaminated needlesticks. Protective attire should be worn when blood and body substances is anticipated.
Herpes Simplex Type II	No restrictions necessary.
Methicillin Resistant Staph Aureus (MRSA)	Work restriction is not necessary.
Parvovirus B19 (Fifth Disease)	Work restriction shall be determined by Employee Health based upon staff immunity as children with parvovirus can shed the virus for long periods of time. Pregnant staff who are not immune (i.e., have not had parvovirus B19) should not have direct contact with patients.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Chickenpox and Shingles~~~~Chickenpox and Shingles~~ Infection Prevention ~~and Control~~ Considerations for Immunosuppressed and Pregnant Employees.	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

Infection	Guidance
Rubella (German Measles)	Work restriction shall be determined by Employee Health based upon staff immunity. Pregnant staff who are not immune (i.e., have not had German measles or the rubella vaccine) should not have direct contact with patients
Tuberculosis	Work restriction is not necessary. Wear a NIOSH (N95) approved respirator which was fit tested.
Vancomycin Resistant Enterococci (VRE)	Work restriction is not necessary.
Varicella (herpes zoster (shingles), chickenpox)	Should not be exposed to persons with chickenpox or shingles[RC1]

REFERENCES:

1. Centers for Disease Control and Prevention. (2016). Transmission. Retrieved from https://www.cdc.gov/shingles/about/transmission.html
2. Centers for Disease Control and Prevention. (2016). Preventing Varicella-Zoster (VZV) Transmission from Zoster in Healthcare Settings. Retrieved from https://www.cdc.gov/shingles/hcp/hc-settings.html
3. Kim J-H, Roberge RJ, Powell JB. (2015). Effect of External Airflow Resistive Load on Postural and Exercise-Associated Cardiovascular and Pulmonary Responses in Pregnancy, BMC Pregnancy and Childbirth 2015;15:45-52
4. National Foundation for Infectious Diseases. (2009). Facts about chickenpox and shingles for adults. Retrieved from http://www.nfid.org/publications/factsheets/varicellaadult.pdf
5. Roberge RJ, Kim J-H, Powell JB. (2014) N95 Respirator Use During Advanced Pregnancy, American Journal of Infection Control 42: 1097-1100

CROSS REFERENCE P&P:

1. Adult Immunization in the Healthcare Worker
2. Injury and Illness Prevention Program
3. Work Related Accidents/Exposures

Approval	Date
CCOC	**4/24/2017**
Infection Control Committee	**5/23/17**
MEC	**6/6/17**
Board of Directors	

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Chickenpox and Shingles~~~~Chickenpox and Shingles~~ Infection Prevention ~~and Control~~ Considerations for Immunosuppressed and Pregnant Employees.	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

Last Board of Directors Review	

Developed: 7/2000
Reviewed: 06/03; 09/05; 8/2007; 5/11 bss, 9/12 BS, 11/15 NH
Revised: 4/2017rc
~~**Supercedes**~~**Supersedes**: Chickenpox and Shingles
Index listing: Chicken pox, Shingles, Pregnant

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

PURPOSE:
To provide guidance on early identification to prevent potential healthcare associated infections (HAI's) transmission of suspected or confirmed Severe Respiratory Syndrome Coronavirus (SARS-CoV) or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) to patients, staff or visitors

POLICY:

1. Early detection of MERS-CoV or SARS-CoV shall be accomplished by screening patients with symptoms of a respiratory infection, for history of travel within 14 days for MERS-Cov and within 10 days of symptom onset for SARS-CoV when patients have traveled to certain countries.

    - Implementation of Respiratory Hygiene/Cough Etiquette (i.e., placing a mask over the patient's nose and mouth) *and place patient in Airborne Infection Isolation Room*

    - Physical separation from other patients in common waiting areas if unable to place patient in isolation

    (Note: See definitions for identified countries and Clinical Features and Epidemiologic Risks)

2. Healthcare staff in close proximity and/or in contact with the patient shall don personal protective equipment (i.e., gown, N95 respirator or Powered Air Purifying Respirator (PAPR), gloves and eye shield).

3. Clinicians and healthcare professionals shall immediately report Patient Under Investigation (PUI) for MERS-CoV or SARS-CoV infection to the state or local health department.

4. State and local health departments should immediately report PUIs for MERS-CoV or SARS-CoV infection to CDC. Probable cases should also be reported.

5. The Infection Preventionist or designee shall be immediately notified by House Supervisor when a patient is suspected of having MERS-CoV or SARS-CoV.

6. Clusters of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) should be evaluated for common respiratory pathogens. If the illnesses remain unexplained, providers should consider testing for MERS-CoV or SARS-CoV, in consultation with state and local health departments.

7. The Infection Preventionist, House Supervisor or designee shall notify administrator on call (AOC), and the Infection Control Medical Staff Chairperson.

8. Limit hospital staff personnel from entering patient's room.

DEFINTIONS:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

1. **Middle East Respiratory Syndrome Coronavirus (MERS-CoV**): is viral respiratory illness that was recently recognized in humans. It was first reported in Saudi Arabia in 2012 and has since spread to several other countries, including the United States. Most people identified as infected with MERS-CoV developed severe acute respiratory illness, including fever, cough, and shortness of breath. MERS has been linked to travel to, or residence in, countries in and near the Arabian Peninsula within 14 days. Countries considered in the Arabian Peninsula and neighboring include: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE) and Yemen.
2. **Severe acute respiratory syndrome (SARS):** is a viral respiratory illness caused by a called SARS-associated coronavirus (SARS-CoV). SARS was first reported in Asia in February 2003. The illness spread to more than two dozen countries in North America, South America, Europe, China and Asia before the SARS global outbreak of 2003 was contained. . Countries affected by SARS outbreak Beijing, Guangdong Province, Hong Kong, Shanxi Province, Taiwan Province, Singapore, Viet Nam, and Canada. If persons have traveled to these countries SARS-CoV is raised if, patients presents within 10 days of symptom onset.

Modes of Transmission

- Contact Transmission: The most common mode of transmission, contact transmission is divided into two (2) subgroups: direct contact and indirect contact
    - Direct transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person
    - Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object or person
- **Droplet:** Droplet transmission is a form of contact transmission, and some infectious agents transmitted by the droplet route also may be transmitted by the direct and indirect contact routes
- **Airborne:** Airborne Transmission has not been excluded, including aerosolization of small infectious particles generated during aerosol-generating procedures. ~~Refer to the NIHD Aerosolized Transmissible Disease Plan and~~

PROCEDURE:

1. **Obtain and document recent travel history: MERS 14 days, SARS 10 days within symptom onset.**
2. Patient placement:
    - Patients with suspected SARS-CoV or MERS-CoV should be isolated masked and placed in Contact Precautions and Airborne Isolation Infection Room (AIIR). f ~~several options are listed~~
        - ~~Airborne Isolation Room: Acute/Subacute Room 5, ICU Room 1, Outpatient Infusion Room 6.~~
    - Patient to be separated from other patients/visitors as soon as possible.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

3. **Staff don N95 mask or** Powered Air Purifying Respirator (PAPR)
4. **If AIIR is not available, the patient should be transferred as soon as possible to a facility where an AIIR is available.**
5. Notify Infection Preventionist of designee immediately of all patients admitted with suspected MERS or SARS
6. All cases of suspected SARS-CoV or MERS-CoV that meet the current case definition must be ~~should~~ reported immediately ~~one working day~~ to the local health department.

7. Visitors should be limited to the immediate family only and only if necessary and for short periods. Close contacts (e.g., family members) of SARS-CoV or MERS-CoV patients with either fever or respiratory symptoms should be instructed not to visit patients ~~with SARS or MERS.~~

8. Educate patient, family members and visitors about isolation procedures, hand hygiene, and Respiratory Hygiene/Cough Etiquette

9. Healthcare workers who have unprotected direct contact with a SARS-CoV patient should report the exposure to Employee Health or Infection Prevention as soon as possible. The HCW must complete a screening form and be instructed to monitor their temperature in the morning and in the evening for at least 10 days. If a fever or cough develops, the HCW should be instructed to seek medical evaluation immediately. The SARS evaluation form is located on the NIHD Intranet.
http://intranet/Forms/Infection_Surveillance?SARS%20Screening%20Form

10. Healthcare workers who have unprotected direct contact with a MERS-CoV patient should report the exposure Employee Health or Infection Prevention as soon as possible.

CLINICAL FEATURES AND EPIDEMIOLOGIC RISK:
A person who has both clinical feature and epidemiologic risk should be considered a patient under Investigation (PUI) and be placed in appropriate

SARS-CoV

Clinical Features	and	Epidemiologic Risk
Fever > 100.4, Chills, rigors, sometimes accompanied by headache, myalgia, mild to severe respiratory symptoms, diarrhea, Radiographic finding atypical pneumonia. Severe Cases: Often evolve rapidly, progressing to respiratory distress.	and	A history of Travel (including transit in an airport) within 10 days of onset of symptoms to an area currently or recently documented or suspected community transmission of SARS-CoV, or Is part of a cluster of cases of atypical pneumonia without an alternative diagnosis *or* Close contact within 10 days of onset of symptoms with a person known or suspected of having SARS-COV

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

MERS-CoV

Clinical Features		Epidemiologic Risk
Severe illness Fever[1] *and* pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence)	and	A history of travel from countries in or near the Arabian Peninsula[2] within 14 days before symptom onset, *or* close contact[3] with a symptomatic traveler who developed fever[1] and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula[2]. *– or –* A member of a cluster of patients with severe acute respiratory illness (e.g., fever[1] and pneumonia requiring hospitalization) of unknown etiology in which MERS-CoV is being evaluated, in consultation with state and local health departments in the US.
Milder illness Fever[1] *and* symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath)	and	A history of being in a healthcare facility (as a patient, worker, or visitor) within 14 days before symptom onset in a country or territory in or near the Arabian Peninsula[2] in which recent healthcare-associated cases of MERS have been identified.
Fever[1] *or* symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath)	and	Close contact[3] with a confirmed MERS case while the case was ill.

PRECAUTIONS INSTITUTED:

- Standard
- Droplet
- Airborne N/95 or Powered Air Purifying Respirator (PAPR)
- Contact

PERSONAL PROTECTIVE EQUIPMENT (PPE) when entering room:

1. Respirators: N-95 mask Fit or PAPAR tested to each individual care giver
2. Facial Shields or Eye Protectors
3. Gowns: Disposable gowns are to be worn if substantial contact with the patient or environmental surfaces is anticipated.
4. Gloves
5. PPE must be removed prior to leaving the patients room.

HANDWASHING:

- Before touching a patient
- Before clean/aseptic procedure
- After body fluid exposure risk
- After touching a patient

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

- After touching patient surroundings.

- If hands are not visibly soiled, an alcohol-based hand rub can be used.

TRANSPORTING PATIENTS:

1. Patients should not be transported to other areas of the hospital unless absolutely necessary.
2. If patients must be transported, place a surgical mask over patient's nose and mouth.
3. HCW will wear N-95 mask OR PAPR.
4. Refer to Lippincott Procedures: Contact precautions Critical note

PATIENT CARE EQUIPMENT:

1. Patient care equipment (e.g., thermometers, blood pressure cuffs, stethoscopes and commodes) should be kept in the patient's room. Use disposable equipment whenever possible.
2. Reusable equipment should be cleaned per protocol before re-use.
3. Non-disposable equipment must be cleaned and disinfected at the site of use with approved disinfectant.

LINENS, WASTE AND ROOM CLEANING:

1. Soiled Linen shall be handled as contaminated.
2. **Soiled linen shall be handled as little as possible.**
3. **Gloves and Impervious gown must be worn when handling contaminated laundry/textiles**
4. Minimize textile agitation when handling laundry to prevent the transfer of Microorganisms to others and the environment.

ENVIRONMENTAL SERVICES:

1. **EVS staff shall don PPE when cleaning patient room**
2. **Follow standard hospital procedures on cleaning and disinfecting environmental surfaces and equipment on transmission based rooms**
3. **Environmental Services will remove PPE prior to exiting room.**

REFERENCES:

1. California Department of Public Health. (2013). All Facilities Letter: Middle East Respiratory Syndrome Coronarivirus- Health Alert. Retrieved from https://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-13-13.pdf
2. Centers for Disease Control and Prevention (CDC). (2016). Middle East Respiratory Syndrome (MERS). Retrieved from https://www.cdc.gov/coronavirus/mers/
3. Centers for Disease Control and Prevention (CDC), MERS Home, Healthcare Professionals, *Interim Infection Prevention and Control Recommendations for Hospitalized Patients with Middle East Respiratory Syndrome Coronavirus (MERS-CoV)*, updated December 8, 2015, http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html
4. Centers for Disease Control and Prevention (CDC), Middle East Respiratory Syndrome (MERS), Healthcare Professionals, *MERS Clinical Features*, page last updated February 4, 2015, http://www.cdc.gov/coronavirus/mers/clinical-features.html

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: : Quality Nurse/Infection Control Preventionist	Effective Date: August 2007

5. Centers for Disease Control and Prevention (CDC), SARS Home, Guide for Communities, Infection Control in Healthcare, Home and Community Settings, III. Infection Control In Healthcare Facilities, *Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)*, Version 2/3, http://www.cdc.gov/sars/guidance/i-infection/healthcare.html
6. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, page last updated December 9, 2010, http://www.cdc.gov/hicpac/2007ip/2007isolationprecautions.html
7.

CROSS REFERENCE P&P:

1. Aerosolized Transmissible Disease Plan
2. Airborne Infection Isolation Room (AIIR)
3. Lippincott Procedures: Contact, Airborne, Respiratory hygiene and cough etiquette, ambulatory care, and Reportable Disease.
4. Initial Evaluation of Exposure Incident
5. Handling Soiled Linen

Approval	**Date**
CCOC	4/24/17
Infection Control Committee	5/23/17
MEC	6/6/17
Board of Directors	
Last Board of Directors review	

Developed: 5/2003
Reviewed: 01/2006; 8/2007;8/2008,9/10bss; 8/11RC;9/12bs
Revised: 3/17rc
Supersedes: Severs Acute Respiratory Syndrome (SARS) Infection Control Recommendations for Hospitalized Patients
Index Listings: SARS, Severe Acute Respiratory Syndrome; Severe Acute Respiratory Syndrome, SARS

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

PURPOSE:
To provide evidenced-based guidelines for the prevention of Urinary Catheter Associated Infections (CAUTI) ~~reduce the incidence of catheter associated UTI's by employing effective infection control measures.~~

POLICY:

1. Northern Inyo Healthcare District (NIHD) will implement an evidenced-based approach to urinary catheter use, insertion and maintenance.
2. ~~Urinary catheterization should be done only when medically necessary.~~ Insert indwelling urinary catheters according to established evidence-based guidelines for catheter necessity. Indwelling catheters should not be used for the convenience of healthcare workers.
3. Strict aseptic technique must be maintained during catheterization.
4. Catheter necessity will be evaluated daily with the physicians and documented in the Medical Record.
5. Catheters should be removed as soon as medically possible and does not meet the established NIHD guidelines for catheter necessity.
6. A closed drainage system must be maintained. In the event that the system is compromised, the catheter drainage system will be replaced.

~~The following is a guideline of preventive measures; for catheterization and care follow specific policies in the Med-Surg Manual.~~

DEFINTION:
1. A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney.

2. Catheter Associated Urinary Tract Infection (CAUTI): A UTI where an indwelling catheter was in place that meets the National Health and Safety Network (NHSN) data definitions.

BACKGROUND:
Urinary tract infections (UTIs) are the fourth most common type of healthcare-associated infection, with an estimated 93,300 UTIs in acute care hospitals in 2011. UTIs additionally account for more than 12% of infections reported by acute care hospitals1. Virtually all healthcare-associated UTIs are caused by instrumentation of the urinary tract.

Approximately 12%-16% of adult hospital inpatients will have an indwelling urinary catheter at some time during their hospitalization, and each day the indwelling urinary catheter remains, a patient has a 3%-7% increased risk of acquiring a catheter-associated urinary tract infection (CAUTI).

Comment [RC1]:

Comment [RC2]: Replace the catheter and drainage system

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

CAUTI's can lead to such complications as prostatitis, epididymitis, and orchitis in males, and cystitis, pyelonephritis, gram-negative bacteremia, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in patients. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality. It has been estimated that each year, more than 13,000 deaths are associated with UTIs.

CAUTI PREVENTION PROGRAM:

PREVENTIVE MEASURES:

1. Asses for alternatives for indwelling catheter and if patient meets catheter necessity indication

   a. Consider Bladder Scan to measure urine to avoid unnecessary catherization

   b. Assess Catheter Necessity daily for NIHD approved indications

   - Acute urinary retention or bladder outlet obstruction
   - Neurogenic bladder dysfunction
   - Chronic indwelling catheter on admission
   - Need for accurate urine output measurements in critically ill patients
   - Perioperative use for patients undergoing urologic surgery or other procedures on structures of the genitourinary tract
   - Prolonged surgery (with removal of catheters inserted for this purpose in the PACU)
   - Procedures in which you anticipate large-volume infusions or diuretic administration or which require intraoperative monitoring of urinary output
   - Gross hematuria in patients with potential clots that may require irrigation
   - Incontinent patients with an open sacral, perineal wounds, or skin grafts
   - Patients who require prolonged immobilization (for example, potentially unstable thoracic or lumbar spine and multiple traumatic injuries such as pelvic fractures)
   - Improved comfort for end-of-life care if needed
   - Hospital approved indication (for example, epidural catheter in place)

2. Catheter Insertion:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

a. Prior to indwelling catheter insertion provide patient or caregiver information regarding "Catheter-Associated Urinary Tract Infection.

Links to education:

English version:
http://intranet/Education/InfectionPrevention/Patient%20Information_CA-UTI1.pdf
Spanish Version:
http://intranet/Forms/Infection_Surveillance/Patient%20Information_CA-UTI_Sp.pdf

b. Hand hygiene will be performed prior to catheter insertion.

c. Use aseptic technique prior to site preparation, equipment and supplies

~~The use of strict aseptic technique and sterile equipment is imperative in infection prevention.~~

d. Clean the urethral meatus prior to catheter insertion with soap and water

e. The appropriate catheter tray shall be selected for each catheterization.

f. As small a catheter as possible, consistent with good drainage, should be used to minimize urethral trauma

g. The urethra shall be adequately lubricated prior to insertion.

h. Document the insertion of the catheter in the patient's record

Local anesthesia with topical Lidocaine product approved for use in this facility may be used, see ~~policy~~ Lippincott Procedures: ~~–~~Indwelling urinary catheter (Foley) insertion, male

3. Securing the Catheter

a. Provide enough slack before securing the catheter to prevent tension on the tubing.

Note: Excessive movement of the catheter in the urethra may cause irritation and urethral traction and may facilitate access of bacteria to the bladder.

b. The drainage tubing should be secured to the thigh with tape or a catheter strap; tape tubing rather than catheter.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

c. For an immobile male (for chronic Neurogenic or paralyzed patient), the catheter may be taped to the lower abdomen, which prevents penile/scrotal fistula formation.

d. Catheters shall, at all times, be positioned over the leg; contamination from the rectal area is very likely if the catheter is positioned under the leg.

4. Catheter Care:

a. Perform hand hygiene prior to indwelling catheter maintenance care

b. Nursing personnel shall perform perineal care routinely ~~every 8 hours~~ and as needed. Use a peri-bottle with soap and water for perineal cleaning if patient incontinent of stool.

c. Catheter care shall be directed toward keeping the perineal area, catheter and meatus clean, using soap and clean water and washcloth. Thorough rinsing with clean water is important to remove soap and encrustations. While performing perineal care always clean wiping away from the urinary meatus

d On each shift, nursing personnel will inspect perineum/catheter for cleanliness, appropriate taping and placement over leg. The catheter should not be manipulated unnecessarily.

e. Mo~~re frequent cleaning will be necessary if soiling with drainage or stool occurs.~~

f. ~~Catheter care with Povodine-Iodine and Betadine ointment is not believed to be effective in preventing catheter-associated UTI's.~~

5. Maintain a Closed Drainage System:

a. Inspect urinary catheter system for disconnections and leakage daily

b. Replace the catheter and drainage system using sterile technique when breaks in sterile technique, disconnection or leakage occur.

c. If irrigation is necessary to remove clots:

1. Follow NIHD approved Lippincott Procedure: Bladder Lavage. ~~policy for bladder irrigation.~~
2. Perform hand hygiene prior to procedure
3. Routine catheter irrigation is not indicated.

draft

d. If it becomes necessary to change the drainage bag, the catheter-tubing junction must be disinfected **prior** to separation by thorough cleansing (scrubbing) with alcohol swab.

6. Urinary Flow:
   a. Unobstructed flow shall be maintained.
   b. Keep the catheter collection bag below the level of the bladder at all times including during transport and ambulation
   c. The catheter and tubing should be kept from kinking
   d. Catheter plugs are not to be used.
7. Drainage Bags:
   a. It is not necessary to change the urinary drainage bag unless it leaks or sediment accumulates.
   b. If a bag change is indicated, aseptic technique shall be employed.
   c. Perform hand hygiene prior to emptying the drainage bag.
   c. When emptying the drainage bag, the drain spigot must never touch the measuring container.
   d. Leg bags are not routinely used for hospitalized patients, but may be indicated for discharge planning, if to be used at home. – Physician to designate.
   e. ~~Most drainage systems have anti-reflux valves, if not, bags should be kept below bladder level.~~
8. Specimen Collection:
   a. Perform Hand Hygiene prior

   ~~Follow procedure as indicated under policy "Bladder Catheterization" section on **specimen collection from Foley catheter.**~~

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

b. ❖ Small Urine Sample for culture or urinalysis: Thoroughly disinfect the needless sampling port with alcohol pad and then allow to dry. ~~Use aseptic Technique to obtain urine sample form needless port.~~

❖ Large volume for special analysis (not for culture), obtain sample from drainage bag using sterile technique

9. Catheter Change:
   a. Indwelling catheters should not be changed if functioning well.
   b. Catheters must **not** be "pushed in further" or advanced once the catheter tubing is no longer sterile. If this is necessary, remove and replace catheter using aseptic technique. Cleaning the tubing will *not* render it sterile
10. Documentation Requirements:
   a. Indication for indwelling catheter insertion
   b. Date and time of insertion
   c. Catheter size and Type
   d. Urine color and appearance
   e. Daily Necessity
   f. If does not meet daily necessity actions taken
   g. Date and time of removal
   h. Amount removed from balloon
   i. Toleration of procedure.

CROSS REFERENCES:

1. Lippincott Procedure: Indwelling urinary catheter (Foley) care and management
2. Lippincott Procedure: Indwelling urinary catheter (Foley) insertion, female
3. Lippincott Procedure: Indwelling urinary catheter (Foley) insertion, male
4. Lippincott Procedure: Indwelling urinary catheter (Foley) removal
5. ~~Foley Removal Protocol~~

REFERENCE:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines	
Scope: Nursing Services	Manual: CPM Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 8/1/2015

1. Association for Professionals in Infection Control and Epidemiology. (2014). APIC Implementation Guide: Guide to Preventing Catheter-Associated Urinary Tract Infections, . Retrieved from http://apic.org/Resource_/EliminationGuideForm/0ff6ae59-0a3a-4640-97b5-eee38b8bed5b/File/CAUTI_06.pdf
2. Centers for Disease Control and Prevention. (2016). Healthcare-associated infections: Tap CAUTI toolkit implementation guide. Retrieved from https://www.cdc.gov/hai/prevent/tap/resources.html
3. Centers for Disease Control and Prevention. (2015). Catheter-associated Urinary Tract Infections (CAUTI). Retrieved from https://www.cdc.gov/hai/ca_uti/uti.html
4. Centers for Disease Control and Prevention. (2017). Device-associated module UTI. Retrieved from https://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
5. HICPAC, Guideline For Prevention Of Catheter-Associated Urinary Tract Infections 2009; Carolyn V. Gould, MD, MSCR [1]; Craig A. Umscheid, MD, MSCE [2]; Rajender K. Agarwal, MD, MPH [2]; Gretchen Kuntz, MSW, MSLIS [2]; David A. Pegues, MD [3] and the Healthcare Infection Control Practices Advisory Committee (HICPAC) [4]; http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf
6. Infections, 2009. Retrieved from https://www.cdc.gov/hicpac/cauti/001_cauti.html
7. Institute for Healthcare Improvement (IHI). (2017). How-to guide: Prevent Catheter Associated Urinary Tract Infection. Retrieved from http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventCatheterAssociatedUrinaryTractInfection.aspx
8. The Joint Commission (2017) NPSG 07.06.01 Implement evidenced-based practices to prevent catheter-associate urinary tract infections (CAUTI). Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

Approval	**Date**
CCOC	04/24/17
Infection Control Committee	05/23/17
Medical Executive Committee	06/06/17
Board of Executive	
Last Board of Directors Review	

Initiated: July, 1985
Revised: 1/95, 8/97; 9/98; 10/99, 5/03, 5/05, 7/10bss, 2/11 bss, 9/12 BS, 5-14bss, 2/17RC
Reviewed: 5/15 nh,
Index Listing: Guidelines for Prevention of Catheter Associated UTI's

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

PURPOSE:

The goal is of this ~~exposure control~~ plan is to minimize or eliminate health care worker exposure to bloodborne pathogens. This plan focuses on safer work practices, personal protective equipment, and engineering and administrative controls. Adhering to this plan ensures compliance with all applicable laws and regulations relating to bloodborne pathogens exposure, and is in accordance with Cal/OSHA's Bloodborne Pathogens Standard (Title 8, California Code of Regulations, Section 5193). This plan continues our commitment to providing a safe and healthy environment in which to deliver patient care.

POLICY

Northern Inyo Healthcare District is committed to providing a safe and healthy environment for its entire staff. This policy and procedure will be followed by all employees and physicians working within this facility who may be potentially exposed to bloodborne pathogens. Failure to follow this ~~these~~ policy and procedure may result in disciplinary actions. ~~This policy refers to information found in Policy Manager. The specific chapters referred to throughout this policy are found under the area named "The Orange Infection Control manual," abbreviated as "OICM/" .~~

DEFINITIONS

Bloodborne pathogens – Pathogenic microorganisms that may be present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface or in or on an item.

Decontamination – The use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering controls – Controls such as sharps disposal containers, needleless systems and sharps with engineered sharps injury protection that isolate or remove the bloodborne pathogens hazard from the workplace.

Engineered sharps injury protection – A physical attribute built into a needle device used for withdrawing other potentially infectious materials accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; or a physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Exposure incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Formatted: Not Strikethrough

Formatted: Font color: Auto

Comment [RC1]: Added

Formatted: Not Strikethrough

Draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

Occupational exposure – A job category where skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials could be reasonably anticipated.

Other potentially infectious materials (OPIM) –

- Human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV or HCV:
  - –Cell, tissue, or organ cultures from humans or experimental animals
  - –Blood, organs or other tissues from experimental animals
  - –Culture medium or other solutions

Source individual – Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Standard precautions – An approach to infection control. Standard precautions expand the universal precautions concept *(see below)* to include all other potentially infectious materials with the intent of protecting employees from any disease process that can be spread by contact with a moist body substance. This isolation technique includes substances such as feces, urine, saliva and sputum that were not included in Standard universal precautions unless they contained visible blood.

Universal precautions – Is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other bloodborne pathogens. ~~An approach to infection control, created in 1985 largely in response to the HIV epidemic. It applies to blood and body fluid precautions standards~~ly to all persons regardless of their presumed infection status. Universal Precautions emphasizes the use of Personal Protective Equipment (PPE) barrier to prevent contact with blood and other potentially infectious materials Precautions apply to blood, semen, and vaginal secretions; amniotic, cerebrospinal, pericardial, peritoneal, pleural, and synovial fluids; and any other body fluid visibly contaminated with blood.

Comment [RC2]: Remove

EXPOSURE DETERMINATION

The exposure determination looks at all job classifications to determine the potential for occupational exposure to blood or other potentially infectious materials. Health care worker job classifications listed

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

below have been determined to be at risk for occupational exposure. This list includes those job classifications in which only some employees have occupational exposure. All elements of this exposure control plan apply to all employees in these jobs.

- Admission Services
- Biomedical engineers
- Central Supply
- Diagnostic Imaging ~~Radiology~~
- EEG / EKG technicians
- Environmental Services
- Laboratory employees
- Language Services
- Laundry
- Maintenance/Plant Operations
- Nursing- All
- Pharmacy
- Physicians
- Rehab Department ~~Physical therapists/aides~~
- Respiratory therapists
- Security
- Social Services

Comment [RC3]: New we have been completing post exposure eval on MDs

Comment [RC4]: Remove Department change

METHODS OF COMPLIANCE

This section reviews the numerous work practices and procedures necessary to minimize or eliminate unprotected exposure to bloodborne pathogens. Compliance with these practices and procedures is MANDATORY and is a condition of employment.

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.~~ NIH Policy, "Standard Precautions" in the OICM~~

Comment [RC5]: Adopted Lippincott Procedure Standard Precautions added to Cross reference section

Standard precautions are used in all patient care to prevent contact with blood and OPIM. The following body fluids are always treated as if infectious for HBV, HCV or HIV:

* Human blood, blood components and products made from human blood

* **Other potentially infectious materials**

- –semen
- –vaginal secretions

draft

- –cerebrospinal fluid
- –synovial fluid
- –pleural fluid
- –pericardial fluid
- –peritoneal fluid
- –amniotic fluid
- –any other body fluid contaminated with blood such as saliva or vomitus
- –any unfixed tissue or organ from a human

In circumstances where it is difficult or impossible to differentiate between body fluid types, those fluids are assumed to be potentially infectious.

The Infection Preventionist of Northern Inyo Healthcare District (NIHD) is responsible for overseeing the use of standard precautions by all health care workers in this setting.

Engineering Controls:

Engineering controls are used to minimize or eliminate occupational exposures to bloodborne pathogens. These controls include, but are not limited to:

- Sharps with engineering controls, such as needleless systems
- Needle devices and non-needle sharps
- Handwashing facilities
- Leak proof specimen containers
- Laboratory safety hoods where appropriate
- Pneumatic Tube Safety

Use of Needleless Systems, Needle Devices, Non-needle Sharps

These devices represent a very effective means of reducing potential staff injuries. The following systems/devices are in place:

The *CLAVE CONNECTOR* needleless system(s) will be used for:

- Administering fluids or medications
- Any other procedures involving the potential for an exposure incident for which a needleless system is available as an alternative to using a needle device

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

When a needle or sharp is required, engineered sharps injury protection such as

**AUTOGARD /~~SAF-T-INTIMA~~ IV CATHS*

**MONOJECT SAFETY SYRINGES*

**VACUTAINER BUTTERFLY / PUNCTURE GUARD / NEEDLE-PRO*

**SAFETY TIP NEEDLES*

**NEEDLE-PRO BLOOD GAS KIT*

**BLOOD TRANSFER SETS*

**TIP PROTECTORS*

**EDGE SAFETY DEVICE*

**HYPODERMIC NEEDLE-PRO*

**SAF-T HOLDER DEVICE*

*~~*BAKSNAP SAFETY SYRINGE FOR NUCLEAR MEDICINE~~*

WILL BE USED FOR: ~~will be used for:~~

- Withdrawing other potentially infectious materials
- Accessing a vein or artery
- Administering medications or fluids
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

Non-needle sharps (e.g., scalpels, lancets) shall have engineered sharps injury protection mechanisms. The following non-needle safer devices are in use:

**TENDERLETT LANCETTS*

**DISPOSABLE SCALPELS*

Engineered sharps injury protection devices are not required in the following situations only:

- An engineering control is not available in the marketplace.
- A licensed health care professional, directly involved in a patient's care, determines in the reasonable exercise of clinical judgment, that the use of the engineering control will jeopardize the patient's safety or the success of a medical or nursing procedure involving the patient. In such cases, the use of this exception shall be investigated and documented by the Infection Preventionist or designee, and must be approved by the NIHD Infection Committee.

Comment [RC6]: No longer carry

Comment [RC7]: Spoke with Rich in Nuclear ed no longer use after trail period

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- The employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing incidents than the alternative used by the employer.
- There is no reliable or specific safety performance information available on the safety performance of the safety control for this facility's procedures. This facility is actively determining whether the use of engineering controls lacking reliable or specific safety performance information will reduce the risk of exposure incidents occurring in this facility.
- The use of engineering controls will be re-evaluated annually during the yearly review of this exposure control plan. Additions or deletions will be made at that time or as indicated by ongoing monitoring activities.

  Evaluations of effective engineered sharps injury protection devices will follow the Safer *Sharps and Work Practices Evaluation Process*. New devices will be evaluated annually as available, and otherwise as needed.

Work Practice Controls:

The use of standard precautions is an integral part of this exposure control plan and of NIHD infection prevention program. Standard precautions will be practiced whenever exposure to blood or OPIM is anticipated. When differentiation between body fluid types is difficult or impossible, all other potentially infectious materials will be considered potentially infectious materials.

Work practice controls/procedures have been implemented to minimize exposure to bloodborne pathogens. Each department manager/supervisor is responsible for implementing, evaluating and monitoring compliance with these work practices. Infection Preventionist and Department Safety Officers will monitor work practices as part of routine rounds through each area.

Specific infection control policies and procedures are in place to address work practices and procedures centered on the concept of standard precautions. The minimization and elimination of exposure to blood and OPIM is the primary goal.

The following is a summary of work practice controls:

- Hands will be washed with soap and water or alcohol based hand rub (ABHR) before patient contact, after the removal of gloves or other personal protective equipment and immediately following contact or exposure to blood or Other potentially infectious materials before clean/aseptic procedure, and after touching patient surroundings. **Hands must be washed with soap and water if there is any visible contamination with blood or other fluids.**
- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other potentially infectious materials.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure (e.g., nurses' station).

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials may be present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
- Specimens of blood or other potentially infectious materials will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.
- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend "biohazard." These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.
- Equipment that may be contaminated with blood or other potentially infectious materials will be decontaminated prior to servicing or shipping. If decontamination is not feasible, a biohazard-warning label (that meets the Cal/OSHA requirements) will be attached to the equipment identifying the contaminated portions. Information will be conveyed to all affected employees, servicing people and/or the manufacturer prior to handling to ensure that appropriate precautions are taken.
- Pneumatic Tube System: In case of a biohazard spill in the system:
  - The employee should immediately dial "911 and hit the "Special Function" key. This disables the system and prevents other tubes from becoming contaminated.
  - During the day notify maintenance and during off hours notify the Nursing Supervisor.
  - To prevent this problem, all employees who may place either blood or urine in the tube, need to remember how important it is to carefully seal every biohazard bag.
  - To prevent possible hand contamination, open all tubes slowly and carefully.
  - Pneumatic Tube educational video available on NIHD Intranet>Education>Clinical Equipment Videos. ~~There is a pneumatic tube policy and a pneumatic tube Medcom for more information.~~

Comment [RC8]: Pneumatic tube policy referenced below no longer use MedCom

Draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care will be performed using the following effective patient-handling techniques and other methods designed to minimize risk of a sharps injury:

- Contaminated needles and syringes, and other sharps will not be bent, broken, recapped or otherwise manipulated and will be disposed of in rigid-walled disposable sharps containers. ***Exception***: Syringes that contain radioactive pharmaceuticals that must be returned to the pharmaceutical company for disposal may be recapped using a safety device designed for this purpose or by the "one-handed" method. ~~(As of 1/1/12, radiology has a trial using Baksnap safety syringes that do fit into the nuclear shield)~~
- Reusable sharps will be placed in labeled, puncture resistant, leak-proof containers for appropriate cleaning and sterilization. Cleaning of such sharps will not require employees to reach their hands into sharps containers.
- Disposable sharps will not be reused under any circumstances.
- Contaminated sharps will be immediately, or as soon as possible after use, disposed of in rigid, puncture-resistant, leak proof containers which are labeled "Sharps Waste" or with the international biohazard symbol and the word "Biohazard."
- Sharps container seals must be leak resistant and difficult to reopen.
- Sharps containers will be readily available and easily accessible for all situations in which sharps are used or can be anticipated to be found, including dietary trays and laundry, if applicable.
- Sharps containers will be maintained in the upright position and will be replaced when reaches the fill line ~~three-fourths full~~ to avoid overfilling.
- Broken glassware that may be contaminated will not be picked up by hand, but by mechanical means such as a brush and dustpan, tongs or forceps.

Comment [RC9]: Spoke to Rich in Nuclear Med no longer use the syringe too large to fit into Nuclear shield

Personal Protective Equipment:

~~*(as specified under each set of precautions in the OICM.)*~~

Personal protective equipment is an essential component of a plan to reduce or eliminate exposure to bloodborne pathogens. The following policies and procedures will be adhered to:

- Personal protective equipment will be used in conjunction with engineered controls and work practice controls.
- Where the potential for occupational exposure exists, staff will be provided, at no cost to the employee, appropriate personal protective equipment such as gloves, gowns, aprons, laboratory coats, splash

draft

goggles, glasses, face shields, masks, mouthpieces, resuscitation bags, pocket masks, hoods, shoe covers, etc.

- Appropriate personal protective equipment will not permit blood or other potentially infectious materials to pass through (e.g., impervious gowns) or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use.
- Hypoallergenic gloves, glove liners, powderless gloves, and other similar alternatives will be readily available to those employees who experience allergenic problems with the standard gloves.
- Department managers will insure that personal protective equipment in the appropriate size is readily available and utilized when necessary to provide the needed level of protection from anticipated exposure.
- The Infection Preventionist will monitor compliance by checking use of personal protective equipment as part of the environmental rounds, and department managers will monitor compliance on a day-to-day basis.
- Employees will be provided training on the appropriate use of personal protective equipment. Training will be completed at the time of initial assignment to a job classification or task/procedure that presents the potential for blood, body fluid or other potentially infectious material exposure.
- A staff member may temporarily and briefly decline to use personal protective equipment only under rare and extraordinary circumstances. If he/she believes, based on their own professional judgment, that its use would prevent the delivery of health care or public safety services or would pose an increased hazard to worker safety, then they may decline to use the personal protective equipment. If this occurs, the Infection Preventionist will investigate and document the circumstances to determine whether changes should be implemented to prevent a similar occurrence in the future. NIHD encourages employees to report all such instances.
- NIHD will be responsible for the cleaning, laundering, repairing, replacing and disposing of personal protective equipment as needed to maintain effectiveness at no cost to the employee.
- Any garment(s) penetrated by blood or other potentially infectious materials will be removed immediately or as soon as feasible, and placed in the designated area or container for storage until washed or disposed of by the facility.
- All personal protective equipment will be removed prior to leaving the work area and patients room
- Employees are responsible for placing their personal protective equipment, after removal, in a designated area or container for storage, washing, decontamination or disposal.
- Employees will wear gloves when it is reasonably anticipated that they will have hand contact with blood or other potentially infectious materials, mucous membranes and non-intact skin when performing vascular access procedures, and when handling or coming into contact with contaminated items or surfaces.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Disposable gloves will be replaced, as soon as practical when contaminated, torn or punctured or when their ability to function as a barrier has been compromised.
- Disposable gloves will not be washed or decontaminated for reuse.
- Heavy duty, utility gloves may be decontaminated for reuse; however, they must be discarded if cracked, peeling, torn or exhibit any signs of deterioration that would compromise their barrier protection.
- Employees will wear masks in combination with eye protective devices such as glasses with solid sidepieces, goggles or face shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
- Gowns, aprons, lab coats or similar outer garments will be worn whenever the potential for exposure to blood or other potentially infectious materials is likely.
- Surgical caps or hoods, and impermeable shoe covers or boots will be worn in instances where "gross contamination" is anticipated (e.g., autopsies, orthopedic surgery, labor and delivery).

Cleaning and Decontaminating the Work Site:

Listed below are cleaning and decontaminating policies and procedures that must be followed:

- Environmental Services is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning is scheduled appropriately and proper methods for cleaning and decontaminating are followed. A written schedule for cleaning and decontaminating the worksite has been developed and is posted in Environmental Services work stations and in the Environmental Services manual
- All dirty linen is handled in compliance with standard precautions. All appropriate steps are taken to minimize or eliminate potential exposures. If the soiled linen is wet and presents the likelihood of causing exposure, a plastic bag will be used to prevent leakage or exposure. ~~*(SECTION 2.pg.12 OICM)*~~
- Linen will be bagged or containerized at the point of use and will not be sorted or rinsed in this location.
- The Infection Control Committee is responsible for reviewing and approving policies and procedures that address proper cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated. ~~*SECTION 3 OF THE OICM*~~

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a disinfectant with a hepatitis B or tuberculocidal claim.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.
- Protective coverings such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal

The California Medical Waste Management Act, in conjunction with this plan, will provide direction on the proper disposal of biohazardous waste to include sharps waste and wastes contaminated with blood or OPIM. The following will be placed in red plastic bags marked with the word and symbol for "biohazard" and disposed of using the biohazard waste pathway:

- Liquid or semi-liquid blood or other potentially infectious materials
- Contaminated items that contain liquid or semi-liquid blood or are caked with dried blood and are capable of releasing these materials when handled or compressed
- Contaminated sharps
- Pathological and microbiological wastes containing blood or **other potentially infectious materials** ~~OPIM~~

~~*Refer to NIH policies for "HANDLING AND DISPOSAL OF NEEDLES/SHARPS" and "HANDLING OF INFECTIOUS WASTE" POLICY" in the OICM*~~

Comment [RC10]: See Cross Reference Policies

Hepatitis B Vaccination Program:

In an effort to provide maximum protection from hepatitis B infection, NIHD offers a vaccination program, at no employee cost, to all staff that has potential occupational exposure to bloodborne pathogens. Components of the program are outlined below:

- The vaccination program will be discussed with applicable staff following the training outlined in this plan and within 10 days of initial assignment and annually during the bloodborne pathogens training program. The safety of the vaccine and the advantages of receiving the vaccine will be reviewed with all applicable staff. Details for receiving the vaccine also will be included.
- Vaccine will be provided when indicated by Employee Health as part of the initial employment physical for all new employees with potential exposure to blood or other potentially infectious materials. Employee Health follows up with each employee until the vaccination series is complete.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Current employees also will be offered the HBV vaccine free of charge from Employee Health. The vaccine is offered to physicians and other individuals who are not employees (i.e. students, volunteers, contract employees).
- All employees have the right to decline immunization and are required to complete and sign the declination statement. If the employee subsequently changes his/her mind and requests the vaccine, it will be provided at no cost to the employee.

Post-Exposure Evaluation and Follow-Up:

A bloodborne pathogen exposure prophylaxis protocol has been implemented to provide an immediate, confidential medical evaluation and follow-up of employees exposed to blood or other potentially infectious materials. This protocol is in accordance with the most recent recommendations of the U.S. Public Health Service.

Note: *The Standard requires providers to follow procedures as recommended by the U.S. Public Health Service. The Centers for Disease Control and Prevention periodically issue new recommendations. Providers, and in particular, medical professionals who conduct post-exposure evaluations, need to keep updated on the CDC's recommendations.* Current recommendations and checklists are incorporated into packets and outlined below to ensure comprehensive and appropriate treatment.

- The protocol and information packets are available from the infection policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.
- Medical evaluation, counseling and follow-up will be conducted by the Nursing Supervisor, Emergency Department, and Infection Preventionist, and Employee Health.
- All medical records will be maintained in the patient's confidential employee health file.
- The treating health care professional will provide to the employee, within 15 days, a copy of his/her written opinion following the post-exposure evaluation and follow-up.
- The Infection Preventionist, Employee Health, or designee will advise the employee-patient of the right to refuse consent of post-exposure evaluation and follow-up from his/her health care employer. If consent is refused, a confidential medical evaluation and follow-up will be made immediately available by an outside health care professional. Medical evaluation and laboratory tests will be provided at no cost to the employee.

Reporting and Documenting Sharps Injuries:

All sharps related injuries will be reported as an occupational injury following the facility's Occupational Injury and Illness Reporting procedure ~~*OICM SECTION 4, PG 1 "DEFINITION AND MANAGEMENT OF OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS.*~~ All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury. A report denoting the frequency of use of the types and brands of sharps

Comment [RC11]:

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

involved in exposure incidents will be generated and reported to the Safety and Infection Control Committees annually. Frequency of use will be approximated by product ordering trends. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury.

In addition, all sharps injuries will be recorded on the sharps injury log within 14 working days of the date the incident was reported. The log will be maintained for a minimum of five years by Employee Health.

The log will include the following information

- Job classification of the exposed employee.
- Date and time of the exposure incident.
- Type and brand of the sharp involved, if known.
- A description of the exposure incident which must include:
  - –Job classification of the exposed employee.
  - –Department or work area where the exposure incident occurred.
  - –The procedure the exposed employee was performing at the time of the incident.
  - –How the incident occurred.
  - –The body part involved in the exposure incident.
  - –If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation, or after activation.
  - –If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury.
  - –The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury.

Communicating Hazards to Employees:

In addition to the provisions of standard precautions, the following hazard communication provisions are implemented as part of the exposure control plan:

- Biohazardous waste will be collected in red bags pre-printed with both the word **BIOHAZARD** and the biohazard symbol.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Warning labels with the legend **BIOHAZARD** will be affixed to refrigerators and freezers containing blood or other potentially infectious materials and all other containers used to store, transport or ship blood or other potentially infectious materials.
- Biohazardous wastes will be labeled with the legend **BIOHAZARDOUS WASTE** or **SHARPS WASTE** as appropriate. Labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.

The following items *do not* require hazard labels/signs:

- Containers of blood or blood products already labeled as to their contents and released for transfusion or other clinical use.
- Individual containers, tubes and specimen cups of blood or other potentially infectious materials placed in biohazard labeled bags or containers for storage, transport, shipment or disposal.
- Primary specimen containers, as all staff are trained to use standard precautions when handling patient specimens.
- Laundry bags and containers, as both staff and laundry workers are trained in standard precautions.
- Biohazardous (regulated) waste which has been decontaminated (e.g., processed in a sterilizer) prior to disposal.

Note: *The California Medical Waste Management Act also requires hazard-warning signs/labels of biohazardous waste. The requirements of this exposure plan are not intended to supersede these requirements but augment them.*

Information and Training:

All employees and physicians covered by this plan will be provided training at the time of initial assignment to an at-risk job classification.

Training will be provided by the Infection Preventionist or assigned training. Training will be provided in the language and vocabulary appropriate to the employee's education, literacy and language background.

Training will occur:

- At the time of initial assignment to an at-risk job classification.
- Annually, within 12 months of the previous training.
- When changes affect the employee's occupational exposure, such as new engineering, administrative or work practice controls, modifications of tasks/procedures or institution of new tasks/procedures. This training may be limited to these changes.

The training program will contain, at a minimum, the following elements:

- Copy and explanation of the Standard – A copy of Cal/OSHA's Bloodborne Pathogens Standard is available for review in the Infection Prevention department and this plan.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of bloodborne pathogens.
- Modes of transmission – A general explanation of the modes of transmission of bloodborne pathogens.
- Employer's exposure control plan – An explanation of the plan and how an employee can obtain a copy.
- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Hepatitis B vaccination – Information on the hepatitis B vaccine, including its efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Recordkeeping:

Records covered in this section are available through Human Resources, Employee Health, and Infection Prevention. Records must be made available under these circumstances:

- All records (training records, medical records and sharps injury log) will be provided upon request to Cal/OSHA and NIOSH for examination and copying.
- Employee training records will be provided upon request to employees and employee representatives.

draft

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

- Employee medical records will be provided to the subject employee upon request for examination and photocopying. Anyone with written consent from this employee may also request the medical records.
- The sharps injury log is available upon request to examine and photocopy, and will be made available to employees and to employee representatives upon request.
- The sharps injury log will be maintained in by Employee Health for a minimum of five years.

Medical Records

A medical record for each employee who performs duties that may result in an exposure incident will be maintained by Employee Health. These records will include the following information:

- The name and social security number of the affected employee.
- A copy of the employee's hepatitis B vaccination status including the dates of all hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all examination and medical testing results, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional.

  These records will be kept confidential and will not be disclosed or reported without the employee's expressed written consent except as required by Title 8, California Code of Regulations, Section 3204, and other applicable laws. These records will be maintained within the above listed departments for at least the duration of employment plus 30 years.

Training Records

Full documentation of training must be completed for all employees trained. Documentation will be maintained by, and be the responsibility of, department managers and the Infection Preventionist. Documentation will be maintained for a minimum of three years from the date of training and then transferred to permanent storage.

Training records must include, at a minimum, the following:

- Date of training session
- Summary of content
- Names and job titles of attendees
- Names and qualifications of trainers

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

Annual Review

A review of bloodborne pathogens is conducted each year. This review will be conducted by the Infection Preventionist. Frontline health care workers—those who have contact with patients and use sharps frequently—will be included in this review. As part of the review process, the committee will consider the effectiveness of the program in preventing "exposure incidents" and will include a review of current engineering controls and work practice. The Infection Preventionist Manager is responsible for reviewing and updating the Bloodborne Pathogen Exposure Control Plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. The annual review process will include soliciting input from frontline healthcare workers who have contact with patients and use sharps frequently.

The actual CAL/OSHA Standard for Bloodborne Pathogens can be found in the following 3 links:

- Link to Standard 5193 Bloodborne Pathogens: https://www.dir.ca.gov/title8/5193.html
- Link to Revisions to above (also needs to be included as the 2nd link related to a complete bloodborne pathogen standard) http://www.dir.ca.gov/oshsb/bloodpathapprvdtxt.pdf
- 3rd Link related to bloodborne pathogen's standard: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

CROSS REFERENCE P&P

1. Handling of Soiled Linen
2. Exposure Evaluation
3. Handling and Disposal of Needle/Sharps
4. Handling of Infectious/Non-Infectious Waste
5. Hepatitis Prophylaxis/Needles Stick Policy
6. Injury and Illness Prevention Program
7. Lippincott Standard Precautions
8. Personal Protective Equipment (PPE's) Putting On
9. Personal Protective Equipment (PPE's) Removing with critical notes

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bloodborne Pathogen Exposure Control Plan**	
Scope: NIHD	Manual: CPM **Infection Control Patient Care (ICP)**
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 02/2010

10. Personal Protective Equipment (PPE's) and Supplies

11. Pneumatic Tube Use

REFERENCES:

1. Centers for Disease Control and Prevention (2013). Infection Control: Frequently asked questions-Bloodborne Pathogens-Occupational Exposure. Retrieved from https://www.cdc.gov/oralhealth/infectioncontrol/faq/bloodborne_exposures.htm

2. State of California: Department of Industrial Relations (Last accessed 2/20/2017). Exposure control plan for Bloodborne Pathogens. Retrieved from https://www.dir.ca.gov/dosh/dosh_publications/expplan2.pdf

3. United States Department of Labor: Occupational Safety and Health Administration (OSHA) (Last accessed 2/20/2017). Bloodborne Pathogens and Needlestick Prevention. Retrieved from https://www.osha.gov/SLTC/bloodbornepathogens/evaluation.html

Responsibility for review and maintenance: Infection Control Practitioner

Approval	**Date**
CCOC	**04/24/2017**
Infection Control Committee	**1/26/10; 2/28/12**
MEC	
Board of Directors	

Initiated: 1/2010
Revised: 2/17 RC
Reviewed: 5/10, 8/11LA; 2/12; 9/12LA; 12/15 NH,

Index Listings: Exposure Control Plan, Needlestick, Exposure

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

INFECTION CONTROL MISSION STATEMENT

To improve the quality of health by identifying, preventing and controlling the risks of acquiring and transmitting infections among patients, visitors, team members, volunteers and all other healthcare providers, while utilizing evidence based practices and principles.

The Infection Control (IC) Program incorporates Administrative support to ensure adherence to the program standards.

Through orientation and an ongoing continuing education program, Northern Inyo Healthcare District (NIHD) ~~Hospital~~ ensures that all team members are effectively trained and educated on infection control issues and procedures. The IC Program ensures that all team members safely interact with our customers.

Adherence to the established IC Program standards is continuously monitored through surveillance. Problems identified through surveillance are analyzed, evaluated, and monitored for resolution. Surveillance is used to identify opportunities to improve care while playing an integral role in continuous quality improvement effort.

The continuously developing Infection Control Program is part of ~~Northern Inyo Hospital's~~ (NIHD) ongoing commitment to provide high quality healthcare. Through the Infection Control Program, (NIHD) ~~Northern Inyo Hospital~~ systematically involves each team member in the process of maintaining a safe environment for our patients, visitors, team members and other healthcare providers.

The driving force behind every recommendation and action of the Infection Control Program is:

- To protect the patient/family
- To protect the Health Care Worker (HCW), and others in the Health Care environment
- Provide the same high level of precautions for all patients, visitors and employees
- To accomplish this in a cost-effective manner whenever possible.

~~The same high level of precautions is provided for all patients and employees.~~

SUMMARY OF THE INFECTION CONTROL COMMITTEE DUTIES

Northern Inyo Healthcare District ~~Hospital's~~ Infection Control Committee has a wide scope of responsibilities and duties. Some of these responsibilities are advisory in nature. The Infection Control Plan delineates the full scope of responsibilities and duties by frequency as listed:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

ANNUAL

~~Annual Team Member Education~~
[RC1]Infection Control Program Evaluation
Evaluation of Infection Control Goals
Approve new FY Infection Prevention Pillars
Approve required Policy and Procedures

QUARTERLY

Infection Control Committee Meeting
Submit ~~Quarterly~~ Infection Prevention Pillars of Excellence ~~Reports~~ to

- ~~Safety Committee,~~
- Medical Executive Committee~~,~~
- Board of Directors[RC2]
- Quality Assurance and Performance Improvement

CONTINUOUS

Identify, Correct, Address Problems or Issues
Monitor and Evaluate Outstanding Problems or Issues
Issue Recommendations to leadership as needed
Development and Implementation of Infection Control Policies
Healthcare – Team Member Education
Orientation Education
Nursing Education
Surveillance Activities

STATEMENT OF PURPOSE

A. All hospitals run the risk of nosocomial infections, meaning infections acquired in the hospital. These infections may be endemic or epidemic which may affect patients, team members, and others who come into contact with patients.

B. Northern Inyo Healthcare District is committed to providing an effective hospital wide program for the surveillance, prevention and control of infection. The infection control process is designed to lower the risks and to improve the rates or trends of epidemiologically significant infections. The surveillance, prevention and control of infection includes processes and activities both in direct patient care and in patient care support coordinated and carried out by the hospital. It also links with external organizational support systems to reduce the risk of infection from the environment, and the community.

C. The infection control process and its supporting mechanisms are based on current scientific knowledge, acceptable practice guidelines, applicable laws and regulations, sound epidemiologic principles and research on

draft

nosocomial infections. It takes into consideration the following factors: the facility's geographic location, patient volume, patient population served, the hospital's clinical focus and number of team members.

D. The Infection Control Program addresses and prioritizes issues defined by the hospital to be epidemiologically important to the hospital. Information regarding risk, rates and trends in nosocomial infection is used to improve prevention and control activities and to reduce nosocomial infection rates to the lowest possible level. The Infection Control Program is connected with the Inyo County Health Department to ensure appropriate follow-up of infection is implemented within the communities and rural areas served by Northern Inyo Healthcare District.

GOALS AND OBJECTIVES[RC3]

~~A. To improve compliance with hand hygiene for patients, team members, volunteers, licensed independent practitioners, students, and visitors.~~

~~B. To identify and reduce the risks of acquiring and transmitting multi-drug resistant infections to patients, team members, volunteers, licensed independent practitioners, students, and visitors.~~

~~C. To establish, review and evaluate nosocomial infection data and risk factors found during surveillance activities, and then recommend and initiate appropriate improvement activities to address issues related to infection control.~~

~~D. To identify and reduce the risks of acquiring surgical site infections.~~

~~E. To limit the transmission of infections associated with procedures or devices, i.e. ventilators, central lines, and Foley catheters.~~

~~F. To limit the number of infectious diseases exposures to bloodborne pathogens associated with the used of needles or sharp objects through the development of an occupational safety program.~~

~~G. To limit the number of infectious disease exposures to patients, health care team members, volunteers, licensed independent practitioners, students, and visitors, with the use of education and development of employee health program.~~ [RC4]

~~H. To increase compliance with influenza vaccinations for team members, volunteers, students, and licensed independent practitioners with the use of education and policy development.~~[RC5]

~~I. Network with health care agencies and other organizations in the community to identify and prevent transmission of infections, and assure continuation of services on all levels.~~

~~J. Establish goals each year in conjunction with the Infection Control Committee and the Northern Inyo Healthcare District Strategic Plan.~~

~~K. Evaluate Infection Control annual goals to determine if they were: met, partially met or not met for each element~~.

LEADERSHP AND RESPONSIBILITY

A. Board of Directors

The Board of Directors has the final authority and oversight of the Infection Control Program. The Board monitors and supports organizational efforts to continuously improve the quality of patient care services and customer satisfaction. The Board ensures the necessary resources and education for the hospital to achieve these goals. The Board delegates the responsibility of maintenance of the Infection Control Program to the Medical Executive Committee and Chief Executive Officer.

B. Medical Executive Committee

Draft

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

The Medical Executive Committee is responsible for overseeing the Infection Control Program and delegates the development and monitoring of infection surveillance, prevention and control processes to the Infection Control Committee. The Medical Executive Committee receives information related to actions taken to resolve issues of infection control and, if necessary, acts upon any issues related to infection control. The Medical Executive Committee grants the Infection Preventionist ~~Control~~ Manager authority, under the direction of the Infection Control Committee Chair or his/her designee, to institute surveillance, prevention and control measures of studies, when there is reason to believe that any patient or team member may be in danger. In the absence of the Infection Preventionist ~~Control~~ Manager, ~~cross-trained~~ nursing staff trained in Infection Prevention practices assumes the Infection Control responsibilities and are able to take appropriate actions as outlined in Infection Control Policies.

C. Chief Executive Officer

The Chief Executive Officer of the Hospital serves as a liaison between the Board of Directors and the Medical Executive Committee. He/She ensures that all hospital departments, programs, and disciplines participate in and provide support for the Infection Control Program.

D. Infection Control Committee

(See attached structure appendix 1)

E. Infection Control Medical Staff Chairperson

The Infection Control Medical Staff Chairperson acts as a resource for the Infection Control Manager. This person will have training and/or experience in infection control as stated in *Senate Bill 158* (Attachment 1) and will review the Infection Control Program, including rates, make recommendations as needed and have input into policies and procedures.

F. Infection ~~Control~~ Preventionist Manager

The Infection Preventionist ~~Control~~ Manager assumes the responsibility of managing and carrying out the infection surveillance, prevention and control functions within NIH. This person has training in infection surveillance, prevention and control as well as knowledge and job experience in the areas of epidemiological principles and infectious disease, sterilization, sanitation and disinfection practices. This individual also is knowledgeable in adult education principles and patient care practice. This person maintains records and logs of incidents related to infections and communicable disease. The Infection Preventionist ~~Control~~ Manager and/or designee reviews culture and sensitivity testing, reviews antibiotic usage reports, reports suspected infections, conducts ~~unit~~ department specific periodic rounding ~~risk assessments quarterly,~~ [RC6]infection control annual risk assessment and implements isolation procedures in accordance with hospital policy, maintain policies and procedures that are specific to patient care activities and are based on recognized guidelines and applicable laws and regulations. The Infection Preventionist ~~Control~~ Manager has input into staff education to ensure all team members are competent to participate in infection monitoring, prevention and control activities. The Infection Preventionist ~~Control~~ Manager refers cases for physician review and communicates pertinent clinical infection control information to the Infection Control Committee.

draft

G. Clinical Informatics Nurse ~~Quality~~ Specialist ~~(INQS)~~ supports the infection control process, including data collection, data analysis, interpretation and presentation of findings and helps the hospital achieve program objectives.

SCOPE AND INTEGRATION:

Surveillance prevention and control of infection covers a broad range of processes and activities that are coordinated and carried out by the hospital: (1) in direct patient care and in patient care support and (2) health care team members. The Infection Control Program also links with external organizational support systems to reduce the risk of infection from the environment, including air, food and water sources. The Infection Control Program is a coordinated process to reduce the risk of endemic and epidemic nosocomial infections in patients and team members. It is adopted by the NIHD Administration, Medical Staff, and team members of NIHD to provide for the surveillance and control of infections. The infection control process is integrated with the hospital's overall process for assessing and improving organizational performance. The hospital tracks risks, rates and trends of nosocomial infections. It uses this information to improve prevention and control activities and to reduce nosocomial infection rates to the lowest possible levels. Special monitoring of the environment, continuous evaluation of infection control policies and procedures, and periodic review of the clinical use of antibiotics is utilized. The Infection Control Program also interfaces with the local health department to ensure continuation of care, appropriate follow-up and control of infection as appropriate.

The hospital wide Infection Control Program for surveillance, prevention and control of infection is defined to include the following:

A. Inpatient and outpatient areas

All areas with inpatient beds and all areas where patient care services are provided on an outpatient basis:

- ~~Medical Surgical Telemetry Adult~~ Acute/Subacute
- ~~Medical Surgical Pediatrics~~
- Swing
- Inpatient Hospice
- Intensive Care Unit
- Perinatal Services
- Emergency Department
- Perioperative Services
- Outpatient Infusion Center
- Rural Health Clinic and other clinics

B. Service/Diagnostic Areas

All areas that provide specialized patient treatment or diagnostic services. The nature of these services forces practitioners to put infection control principles into practice:

- Laboratory
- Diagnostic Imaging
- Cardiopulmonary
- Rehabilitation Services

draft

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

C. Support Services

All hospital departments/services that support diagnostic or therapeutic patient care activities and have an identified role in infection control:

- Admission Services
- Biomedical Engineering
- Case Management
- Environmental Services
- Rehabilitation: PT/OT/ST
- Health Information Services (Medical Records)
- Laundry Services
- Plant Operations
- Materials Management
- Security
- Volunteer Services
- Quality Assurance/Performance Improvement

D. **Employee Health Services**

Employee Health and Infection Control functions collaborate with the Medical Staff to reduce the transmission of infections, including vaccine preventable diseases, from patients to health care team members or from health care members to patients. Mechanisms or processes designed to reduce the risk of endemic and epidemic nosocomial infections are in patient care and health care team member health activities. These mechanisms include:

- Case findings and identification of demographically important nosocomial infections, to provide surveillance data for the hospital
- Reporting of information about infections internally and, as indicated, to public health agencies.
- Implementation of strategies to prevent or reduce the risk of nosocomial infections in patients, team members and visitors.
- Implementation of strategies to control outbreaks of nosocomial infections when such are identified.

METHODOLOGY

A. Case findings and identification of demographically important nosocomial infections provide surveillance data. Nosocomial infection data, using, as appropriate, rates stratified by infection risk or focused infection studies, are collected on an ongoing basis.

B. In addition to the use of planned surveillance methods, special studies may be conducted that include:
   - The investigation of clusters of infections above expected levels.
   - The investigation of single cases of unusual or epidemiologically significant nosocomial infections.
   - A focus on procedures with significant potential for nosocomial infections, particularly when the procedure is new or substantially changed.
   - The comparison of a group of infected patients with an uninfected control group to detect statistically significant risk factors for which control measures can be developed.

C. The Infection Control Manager or designee will conduct outbreak investigations whenever appropriate by following any or all of the below steps if indicated:
   1. Verify the diagnosis and confirm possible outbreak
   2. Implement immediate control measures if needed

draft

3. Define the outbreak; refine as the outbreak investigation progresses
4. Conduct case findings by making a line listing that may contain:
    i. Name and Medical Record Number
    ii. Age, sex, diagnosis
    iii. Unit or location
    iv. Date of Admission
    v. Date of Symptom Onset
    vi. Procedures
    vii. Symptoms
    viii. Positive Cultures and pertinent labs
5. Form Outbreak Control Team, if preliminary assessment suggest actual outbreak. The team may include all or some of the following:
    i. Infection Preventionist
    ii. Infection Control Medical Staff Chairperson
    iii. Microbiologist
    iv. Lab Manager
    v. Administrator on call
    vi. Inyo County Health Officer
    vii. Strategic Communications Specialist
    viii. Administrative Assistant
6. Hospital Incident Command Center will be followed as necessary.
7. Evaluate control case (ex: any new cases)
8. Communicate findings with leadership.
9. Keep record of all data and communication.

D. Interventions to reduce infections risks other than those directly related to prevention of transmission may include the following strategies
    - The Surveillance function itself.
    - Review positive microbiology/Lab results
    - Institution of prevention and control measure as indicated(e.g. isolation, improved hand hygiene, active surveillance of cultures, and environmental cleaning)
    - Perform Surveillance for healthcare –associated infection
        - Follow CDC National Healthcare Safety Network (NHSN) definitions
        - Prospective surveillance: Monitor patients during hospitalization and post discharge
        - Retrospective surveillance: Indentify infections via chart reviews
    - Monitored incidence of healthcare-associated device-related or procedure-related infections
        - Central catheter-associated bloodstream infections
        - Ventilator -associated events
        - Surgical site infections
        - Catheter-associated urinary tract infections
    - Conduct periodic tracer activity
    - Ensure compliance with The Joint Commission Critical Access Hospital requirements and the California Department of Public Health regulations.

E. The assessment of reasons for infection rates not being reduced by surveillance alone and interventions undertaken to address problems in the following areas:

draft

- Knowledge – innovative educational approaches beyond the routine or standard in services.
- Behavior – activities by managers to change behavior.
- Systems – such as staffing, sink number and placement, control of over-crowding, lack of proper equipment and supplies.

NOTE: NIHD is prepared to respond to an influx, or the risk of an influx, of infectious patients.
See *Infection Control: ~~Managing an Influx of Infectious Patients.~~ Northern Inyo Healthcare District Surge Plan*

POLICIES AND PROCEDURES

A. Policies and procedures are based on recognized guidelines and applicable law and regulations. Policies and procedures address prevention and control mechanisms used in all patient care and service areas to prevent the transmission of infection among patients, team members, medical staff, contractors, volunteers and visitors; and also, address specific environmental issues.

B. Policies and procedures address the following:
- Measures that is scientifically valid, applicable in all seeing, and practical to implement.
- The relationship between team member activities and the infection prevention and control program.
- Various methods used to reduce the risk of transmission of infection between or among team members and patients.
- Appropriate patient care practices, sterilization, disinfection and antisepsis, and pertinent environmental controls.
- Educational and consultative roles of the Infection Preventionist ~~Control Coordinator.~~

C. All infection control policies and procedures will be re viewed/revised tri-annually or as needed by the Infection ~~Control~~ Preventionist Manager with approval of the Infectious Control Medical Staff Chairperson and prior to submission to the Medical Executive Committee.

REPORTING AND COMMUNICATION

A. Information about infections is reported both internally and to public health agencies, providing clinical practitioners with valid epidemiological measures of the risk of infection in their patients. This will allow them to take action to reduce those risks and decrease infection rates.

B. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action and the infection was not communicated by the referring organization, the Infection ~~Control~~ Preventionist Manager will inform the referring organization. Upon discharge, the case manager and/or nurse caring for the patient will inform the accepting facility of any infections the patient may have, site treatment and any special precautions. If the patient is transferred to another facility and there are pending laboratory results the transfer form will be completed indicating "Pending Lab Culture and the ordering physician will be notified via telephone and fax with laboratory results. If the ordering physician is no longer caring for the patient, the ordering physician will inform the laboratory technician of the physician or facility caring for the patient.

draft

C. Donor/Tissue postoperative infections/complications identified through surveillance activities that are suspected of being directly related to the use of the tissue will be investigated promptly. Notification of the post-transplant infection or adverse event will be reported to the tissue supplier by the Infection ~~Control~~ Preventionist Managers~~s~~ as soon as the hospital becomes aware of the event.

D. Infection Control committee meetings will be conducted not less than quarterly and more often as needed. Minutes will be recorded by the Medical Staff Office.

E. Findings, quality assessment activities, performance improvement recommendations, actions and follow-up evaluations will be forwarded to Infection Control Committee members, other medical staff committees as appropriate, Medical Executive Committee and the Board of Directors.

F. Review ~~Comparison~~ of infections ~~rates~~ and surveillance data within the hospital will be completed ~~annually~~ quarterly through Infection Prevention Pillars and Infection Committee Database.

EDUCATION

A. Education is conducted based on the employee's job description and/or status with Northern Inyo Healthcare District ~~Hospital~~. Education in infection control measures is conducted upon hire and annually. ~~Refer to the *Infection Prevention Education Plan Policy and Procedure*~~[RC7]~~.~~

B. Infection Control Education is based upon:

- Ongoing review and analysis of nosocomial infection data and risk factors.
- Notifications from the Inyo County Health Department, Centers for Disease Control and Prevention(CDC) and California State Department of Public Health (CDPH) regarding emerging issues, trends or communicable diseases.
- Regulatory requirements. Refer to the *Senate Bill 158*, Attachment 1.

CONFIDENTIALITY

A. NIHD has written policies and procedures related to the release of information which are intended to protect the privacy of patients. Confidentiality of infection control data and reports shall be in accordance with established hospital policy, Medical Staff Bylaws, state law and federal regulations and shall be maintained as "confidential and protected."

B. Members of the Medical Staff, clinical staff, appointed members of the organizational committee and project teams with delegated responsibilities for assessing and evaluating organizational performance improvement shall be granted authority to access health care records to perform quality review functions.

RESOURCES

a. There are multiple resources for information about infection prevention and control. Although not an exhaustive list, several professional associations and governmental websites are listed below. In addition, local and health state departments offer a wealth of information.

- Center for Disease Control and Prevention
  www.cdc.gov

- HICPAC

draft

Healthcare Infection Control Practices Advisory Committee
www.cdc.gov/ncidod/hip/HICPAC/factsheet.htm

- U.S. Department of Labor – Occupational Safety & Health Administration
  www.osha.gov
- U.S. Food and Drug Administration
  www.fda.gov
- American Public Health Association
  www.apha.org
- American Society for Healthcare Engineering
  www.ashe.org
- Association for Professionals in Infection Control, Inc.
  www.apic.org
- The Society for Healthcare Epidemiology of America, Inc.
  www.shea-online.org
- The Infectious Disease Society of America
  www.idsociety.org

CROSS REFERENCE:

1. NIH Medical Staff Bylaws and Rules Amendment, (6/18/2003), Infection Control Committee p. 7 &8.
2. Infection Control: Northern Inyo Healthcare District Surge Plan ~~Managing an Influx of Infectious Patients.~~
3. Scope of Service –Infection Prevention

REFERENCE:

1. All Facilities Letter 14-36 California Department of Public Health, 12/19/2014, Regarding SB 1311: Antimicrobial Stewardship Programs.

2. APIC - "Infection Prevention Program in Critical Access Hospitals" Teresa Fulton, RN, MSN, CIC, Chief Quality Officer, Whidbey General Hospital, 2013, http://www.apic.org/…/Day_1-_Infection_Prevention_for_CAH-_Web.pdf

3. APIC . (2016). Outbreaks and Infection Emergencies. Retrieved from https://www.cdph.ca.gov/programs/hai/Documents/15Outbreaks_Final051115.pdf

draft

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

4. Centers for Disease Control and Prevention. (2016). Infection Control in Health Care Facilities. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/

5. Centers for Disease Control and Prevention. (2017). Infection Control Assessment Tools. Retrieved from https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html .

6. Centers for Disease Control and Prevention. (2016). Infection Prevention and Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf

7. Centers for Disease Control and Prevention. (2016). Principles of Epidemiology in Public Health Practice, Third Editions an Introduction to applied epidemiology and biostatistics Lesson 6: Investigating an outbreak. Retrieved from https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section2.html

8. *Senate Bill No. 158, Florez.* Sept. 25, 2008, *California*. Retrieved from https://www.cdph.ca.gov/services/boards/Documents/SB158chaptered09_25_08.pdf

9. The Joint Commission (January 2017) Critical Access Hospital: Infection Prevention and Control (IC) IC01.05.01. ~~TJC: (2014) CAMCAH Standards: *Infection Prevention and Control*~~

Committee Approval	**Date**
CCOC	**3/13/2017**
Infection Control Committee	**5/23/17**
MEC	**6/6/17**
Board of Directors	
Last Board of Director Review	

Developed: 2/13/99
Reviewed: 1/11
Revised: 6/03, 9/05, 1/08, 1/09, 1/10, 2/15, 4/17rc
Replace: Goals of the Infection Control Program dated 2/22/2011
Infection Control Committee Responsibilities

APPENDIX 1

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Prevention Plan	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

Medical Staff Committee
Infection Control Committee
Per ~~Bylaws~~Bylaws amended 2/17/2016 ~~approved 6/18/2003~~

Reports to: Medical Executive Committee
Chairperson: Member of the Medical Staff with CME in Infection surveillance, prevention and control
Membership: Two active Medical Staff members representing other services

- Nurse Manager Infection Prevention ~~Control~~ or other designee of the Director of Nursing

Without vote:

- CEO or Designee
- Chief Performance Excellence Officer
- Inyo County Public Health Officer
- Coordinator Laboratory Microbiology
- Cardiopulmonary Director
- Environmental Services Manager
- Dietary
- Other departments as designated in the Bylaws

Convenes: Quarterly

PURPOSE:

1. The Infection Control Committee selects, designs, evaluates, revises and approves the type and scope of surveillance activities.
2. Action to prevent or reduce the risk of nosocomial infections in patients, team members and visitors will be initiated.
3. Action to control outbreaks of nosocomial infections will be initiated as soon as identified.
4. Ongoing review and analysis of nosocomial infection data, risk factors, and, as needed, special studies that related to infection prevention and control will be conducted.
5. The Infection Control Committee members are responsible for bringing clinical, administrative and epidemiological expertise to the committee, participating in data evaluation and reviewing/approving infection control policies and procedures.

Dev. 11/2014, Revised 2/2015,
Appendix 1: Reviewed 5/17 RC

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs	
Scope: NIHD	Manual: Pharmacy, CPM - Medication (MED)
Source: Director of Pharmacy	Effective Date:

PURPOSE:
The provide guidelines for Northern Inyo Healthcare District (NIHD) activities in controlling occupational exposures to hazardous drugs as defined by the American Society of Health-System Pharmacists[1] and the National Institute for Occupational Safety and Health (NIOSH)[2] and in managing disposal of drugs classified as hazardous per the Resource Conservation and Recovery Act (RCRA).

This policy will cancel the NIHD Policy titled: "Pharmaceutical and Medical Waste Management"

SCOPE: This policy will apply to setting where personnel may be exposed to occupationally hazardous drugs (OHDs) in the workplace and to areas generating waste containing environmentally hazardous drugs (EHDs)

Background:
a. Preparation, transportation, administration and disposal of OHDs and certain EHDs may expose pharmacy personnel, nurses, physicians, environmental service employees and other health care workers or facility staff to potentially hazardous levels of the chemicals through acute and chronic workplace exposure. Routes of exposure include inhalation of dusts or aerosols, dermal absorption, ingestion, self inoculation and contact with excreta or body tissue from patients treated with these drugs.
b. OHDs are characterized by genotoxicity, carcinogenicity, teratogenicity, reproductive toxicity or serious organ toxicity at low doses.[1] Lists of OHDs have been compiled by OSHA[2] and are updated biennially. These lists serve as references for NIHD in creating a district-wide list of OHDs. (Appendix A)
c. A number of pharmaceuticals are identified as pharmaceutical waste that is hazardous to the environment (EHDs) and their management and disposal are regulated by the Environmental Protection Agency (EPA) and the California Medical Waste Management Act (CAMWMA). These drugs are classified as hazardous waste under the applicable regulations and while they may or may not pose an occupational hazard to workers, they do have additional regulations regarding their management and disposal. While there is overlap between lists of IHDs and EHDs, there are many pharmaceuticals that fall only into one category.

POLICY:
It is the policy of NIHD to eliminate or, when elimination is not feasible, to minimize employee exposure to OHDs and to properly manage and transfer EHDs and OHDs for hazardous waste disposal. It is also the policy of NIHD to manage all non-hazardous pharmaceutical waste in a manner consistent with the CAMWMA in a manner to prevent it from entering sewers or landfills untreated.

1. NIHD will implement a comprehensive program to eliminate or minimize employee exposure to OHDs per USP 800 guidance[3]. Further, NIHD will implement a comprehensive program to appropriately manage disposal of EHDs per RCRA and CAMWMA requirements.
2. NIHD will appoint a pharmacist as the Hazardous Drug Officer and establish a multi-disciplinary hazardous drug committee. The Committee will be chaired by the Hazardous Drug Officer (HDO) and will consist of representatives from safety, employee health, pharmacy, nursing, environmental services and others, as appropriate. The Committee will develop an OHD safety and health plan as described in USP 800 guidance. A key element of this plan will be to perform and document multi-

disciplinary risk assessments to determine which employees will be enrolled in the OHD medical surveillance program.

3. NIHD will appoint a member of the Pharmacy staff as the primary point of contact (POC) for the management of pharmaceutical waste. The pharmaceutical waste POC will have oversight for each area in which pharmaceutical waste in generated and the responsibility to ensure written procedures are developed, implemented and maintained.

PROCEDURE: PHARMACEUTICAL WASTE MANAGEMENT

Scope: This policy applies to all categories of pharmaceuticals used within NIHD. It includes but is not limited to OHDs, EHDs, controlled substances (CS) and Non-regulated pharmaceuticals (NRPs). Non-regulated pharmaceuticals include all medications not listed as an OHD, EHD, or CS.

Background: Many pharmaceuticals meet the definition of hazardous waste. The EPA, California Department of Public Health (CADPH), and Drug Enforcement Administration (DEA) address the management of pharmaceutical waste generated from health care facilities. Surveyors from The Joint Commission (JC) include pharmaceutical waste management in their surveys. Because of the risks associated with the improper disposal of both regulated and non-regulated pharmaceutical waste, a program to properly manage and dispose of these wastes is required.

Classification: There are six categories of pharmaceutical waste that require management as part of this pharmaceutical waste management program:

a. Non-regulated pharmaceutical waste: Pharmaceuticals that must be disposed of properly but that are not classified as OHD, EHD or CS
b. RCRA Hazardous waste
    a. P Listed waste (acutely hazardous)
    b. U Listed waste (toxic but not acutely so)
c. Trace chemotherapy waste: empty (less than 3% of original volume) containers used in the preparation or delivery of antineoplastics
d. Bulk chemotherapy: Full or partially full (greater than 3% of original volume) containers or equipment used in preparation or delivery of antineoplastics.
e. Dual waste: A mixture of both hazardous and non-regulated pharmaceutical waste.
f. Controlled substance waste: Includes controlled substances that remain after administration of the appropriate dose to the patient, a damaged, partially used or a controlled substance that is otherwise not-returnable.

Pharmaceutical Waste Determination: Each medication within the facility must have a dedicated waste determination and for hazardous medications, a hazard determination. Each medication non included on the NIHD Hazardous drug list will be handled as non-regulated pharmaceutical waste or as a controlled substance if so classified by the DEA.

1. Common P-listed pharmaceuticals (not an inclusive list):
    a. P001 – Warfarin

   b. P012 – Arsenic Trioxide
   c. P042 – Epinephrine
   d. P075 – Nicotine
   e. P081 – Nitroglyerin
   f. P204 – Physostigmine
2. Common U-listed pharmaceuticals (not an inclusive list):
   a. U058 – Cyclophosphamide
   b. U059 – Daunomycin
   c. U150 – Melphalan
   d. U151 – Mercury
   e. U010 – Mitomycin C
3. The determination of which wastes are hazardous is listed in the NIHD Hazardous drug list which will be updated annually or when a new medication is added to the formulary.
4. Hazardous Waste Profiles
   a. Any pharmaceutical waste requiring management as a hazardous waste must be profiled for proper disposal. Manifesting and profiling will be completed with the hazardous waste hauler as well as facilities and pharmacy personnel.
   b. The contracted hazardous waste hauler will identify proper manifesting procedures as part of the contractual relationship with NIHD.
5. Informing Staff who handle EHDs and OHDs. Healthcare staff who handle EHDs and OHDs must be made aware of the proper mechanisms by which to dispose of their pharmaceutical wastes. These staff must be trained at time of assignment and annually thereafter and this training must be documented in writing. In addition to the management and disposal requirements of this policy, other best management practices may be employed to further streamline the process for the user. Recommended practices include:
   a. Placing stickers or labels on shelves and on the product, where possible, to identify the disposal mechanism for pharmaceuticals.
   b. Removal warnings will be placed in the automated dispensing cabinets to remind users that the pharmaceutical being removed is hazardous and must be disposed of as hazardous waste.
   c. All medications prepared in the pharmacy that are hazardous will be identified as such.
6. Container Selection and Management
   a. The color-coding system established in this policy is designed to standardize the management of the various categories of pharmaceutical waste. This system is modeled after current industry practice and appropriate containers are readily available through various supply chains.
      i. Blue and white: non-regulated pharmaceutical waste for incineration
      ii. Yellow: Trace chemotherapy waste for incineration
      iii. Black: RCRA hazardous, Bulk chemotherapy and Best management practices hazardous wastes (many OHDs)
   b. Containers must meet applicable regulatory standards (EPA, CAMWMA, Department of Transportation (DOT).
   c. Containers must be properly labeled per applicable regulatory standards (EPA, DOT, OSHA, CAMWMA, etc). Labels must be readily visible to personnel in those areas.
7. Accumulation Points:

   a. NIHD will identify an accumulation site for storage of pharmaceutical waste once it leaves the pharmacy or patient care areas. The accumulation site will be the central location for eventual transport off-site for processing.
   b. Non-regulated waste and controlled substance waste will be stored separately from hazardous waste. The accumulation site will conform to all applicable regulatory standards.
   c. The accumulation site will be under the control of Facilities personnel

8. Inspections:
   a. Collection of hazardous waste may present a significant risk of non-compliance. Therefore the accumulation site will be inspected monthly by representatives of Pharmacy, Facilities, and Safety.
   b. The monthly inspection will note the following:
      i. Condition of containers
      ii. Appropriate placement of waste containers throughout the facility
      iii. Proper segregation of wastes
      iv. Proper container labeling
      v. Appropriate dates on the containers for accumulation and removal
      vi. Appropriate completion and maintenance of log sheets
      vii. Training documentation
9. Disposal of Controlled Substances:
   a. Requirements for the disposal of controlled substances are delineated in guidance from the DEA. The DEA requires that controlled substances by disposed of so they are non-retrievable. Disposing of controlled substances via the drain, toilet or sewer is not environmentally appropriate or legal in California. Partially used or contaminated controlled substances must be wasted and the wastage documented by two licensed health care providers.
   b. NIHD has elected to adopt a separate waste pathway for the disposal of controlled substances.
      i. NIHD will place separate containers for the disposal of controlled substances throughout patient care areas.
      ii. These containers will be provided by pharmacy and contain a chemical that immediately destroys the controlled substance once it is placed within the container.
      iii. The waste of controlled substances will still need to be documented and witnessed by two licensed providers.
      iv. Once filled, the containers will be shipped off-site by a separate pathway from non-regulated and hazardous wastes.

PROCEDURE: PROCEDURES FOR SAFE HANDLING OF OCCUPATIONALLY HAZARDOUS DRUGS (OHDs) AND ENVIRONMENTALLY HAZARDOUS DRUGS (EHDs)

1. Safety Data Sheets (SDS). SDSs for OHDs and EHDs used within NIHD will be readily available to employees. NIHD will maintain these SDSs via links on the intranet home page.
2. OHD Preparation Precautions
   a. OHD preparation must be performed in an area with access limited to authorized personnel only. OHDs may contaminate surfaces in preparation areas. Eating, drinking, smoking, chewing gum, taking or administering medications, applying cosmetics and storing food in

the preparation area is prohibited. Procedures for spills and emergencies must be posted in or adjacent to the preparation area. Appropriate personal protective equipment must be worn during the preparation, administration and disposal of OHDs as defined in the NIHD Hazardous Drug List (NIHD-HDL).

b. Preparation of parenteral OHDs as well as any compounding of non-parenteral OHDs must be done in a Class II, Type B or Class III Biological Safety Cabinet (BSC) that meet the current National Sanitation Foundation Standard, or a negative pressure Compounding Aseptic Containment Isolator (CACI) that meets International Standards Organization (ISO) Class 5 Air Quality Standards. Internal and External exhausts for the hoods must have high efficiency particulate air (HEPA) filters. All hoods used for the preparation of OHDs must be externally vented. Commercially available oral OHD products which only require unit dosing will not need to be prepared in a containment device but do require preparation in a segregated area with appropriate PPE use as defined in the NIHD Hazardous Drug List.
c. The exhaust fan or blower in the hood must be on at all times except when the hood is being mechanically repaired or moved or if required for cleaning or decontamination. If the blower is turned off, the hood must be decontaminated and cleaned before use. Each hood must be equipped with a continuous monitoring device to allow confirmation of adequate airflow. The outside exhaust of these hoods must clear of and vented away from air intake units. The hoods and exhaust systems must be connected to backup emergency power.
d. All hoods and BSCs used for the preparation of OHDs will be placed within negative pressure rooms, connected to positive pressure anterooms per USP 797 and USP 800 requirements.
e. The cabinet must be cleaned and decontaminated as required by UPS 797 and 800 standards as well as internal pharmacy procedure consistent with hood manufacturer standards. Decontamination must consist of surface cleaning with water and detergent followed by through rinsing. Spray cleaners or germicidal agents are prohibited. During cleaning and contamination, all personnel will wear appropriate PPE as required by pharmacy policy and the NIHD hazardous drug list. A NIOSH approved respirator, gown and gloves will be worn by the worker during the cleaning. Cleaning will proceed from most contaminated to least contaminated areas and the drain/spillage areas will be cleaned twice. All materials from the decontamination process must be handled as hazardous waste and disposed of as such.
f. All hoods must be serviced and certified by a qualified and certified technicians at least every 6 months. HEPA filters must be changed per manufacturer instruction or when contaminated by accidental spill or otherwise damaged. Used filters must be disposed of properly depending upon the location from where they were taken.
g. All contaminated needles, syringes and IV tubing used to prepare OHDs will be disposed of intact. Clipping or capping of needles is prohibited. Priming IV sets or expelling air from syringes must be carried out in the designated hood. If done at the site of administration to the patient, the IV line will be primed with a non-drug containing solution or a back flow closed system must be used..
h. NIHD mandates the use of a closed system transfer device (CSTD) for preparation and administration of certain OHDs as defined by the CSTD policy.
i. Handling of OHD tablets and other oral dosage forms must follow USP 800 guidance.

3. <u>Transporting and Storage</u>

a. In addition to standard pharmacy labeling practices, all syringes and IV bags containing OHDs must be labeled with a distinctive warning label identifying it as an OHD.
b. Access to areas where OHDs are stored are limited to authorized personnel within the pharmacy. Storage in patient care areas will clearly identify the medication as an OHD.
c. Transport will occur in sealed plastic bags and/or containers to avoid breakage. Personnel involved in transporting OHDs and EHDs within the hospital will be trained in spill procedures.

4. Drug Administration. Only appropriately qualified/certified personnel will administer OHDs.
    a. Personnel administering OHDs must wear appropriate PPE as defined in the NIHD Hazardous Drug List. Preparation for administration of OHDs on the ward or clinic will be carried out on trays lined with a plastic-backed absorbent pad so the plastic can be gathered as waste for appropriate disposal at the end of the procedure.
    b. Contaminated needles, syringes and IV tubing/bags will be disposed of intact. Needles will not be capped, cut or crushed. In rare instances where recapping of a needle is required, only the one handed method will be used.
    c. The administration of aerosolized OHDs (e.g. Pentamidine) requires special engineering controls (negative pressure) in addition to appropriate PPE.
5. PPE.
    a. The PPE required to safely handle each OHD in each process will be determined by the Hazardous Drug Committee and referenced on the NIHD Hazardous Drug List.
    b. Gloves. Gloves will be powder free and will be specifically designated for handling OHDs. Gloves for handling OHDs will conform to the American Society of Testing and Materials (ASTM) standard D6978 or its successor. Certain activities may require double gloving as assessed by the HDC and NIHD-HDL. Because all gloves are permeable to some extent, they will be changed every 30 minutes during use or immediately if punctured, torn or contaminated with a spill. Hands must be washed with soap and water before gloves are put on and after they are removed.
    c. Gowns. Gowns must be selected and worn based upon the OHDs being handled. A Protective disposable gown made of ployethelene-coated polypropylene or other laminate material with a closed front, long sleeves and elastic or know-closed cuffs will be worn. The cuffs will be tucked under the gloves unless double gloving is specified. If double gloves are worn, the outer glove will be worn over the gown cuff and the inner glove under the gown cuff. Gowns and gloves used in the preparation area will not be worn outside the OHD preparation area.
    d. Chemical Goggles and Face Shields. Whenever splashes, sprays or aerosols of OHDs may be generated, chemical barrier face and eye protection will be used. Eyewash facilities must also be available in the OHD preparation area.
    e. Respirator. Personnel administering aerosolized OHDs must wear a NIOSH-approved respirator appropriate for each OHD as determined by the HDC. Fitting of the respirator is personnel specific and must be certified by the employee health department.
6. Caring for Patients Receiving OHDs. Per the NIHD-HDL and existing NIHD Blood-Borne Pathogen exposure policy, appropriate precautions must be observed to prevent contact with blood or other potentially infectious materials.

a. Personnel dealing with any blood, body fluids, urine or excreta from patients who have received OHDs within the last 48 hours must wear appropriate PPE per the NIHD-HDL and risk assessment by the HDC. Hands must be washed thoroughly after contact with the above substances.
b. Linen contaminated with OHDs, urine or excreta from patients who have received OHDs within the last 48 hours must be placed in specially marked impervious plastic laundry bags. Linen soiled with blood or other potentially infectious materials as well as contaminated with urine or excreta must also be managed per NIHD soiled linen policy.

7. Medical Surveillance
    a. Personnel with potential exposure to OHDs will be considered for placement in the medical surveillance program (MSP) based upon the recommendations of the HDC. Selection of individuals for medical surveillance must be based on exposure assessment performed by the HDC.
        i. All personnel who directly handle OHDs, including nurses, pharmacists and pharmacy technicians at a minimum will be enrolled in the MSP. Other personnel will be enrolled based upon a determination of the HDC.
        ii. Medical surveillance consists of pre-placement, periodic and termination examinations. Employee health status, medical history and collection of data elements including a medical (including reproductive) history and work history to assess exposure to HDs, physical examination, and laboratory testing. Methods used to assess exposure history include a review of:
            1. Records of HDs handled, with quantities & dosage forms
            2. Estimated number of HDs handled per week
            3. Estimates of hours spent handling HDs per week and/or per month
            4. Performance of a physical assessment and laboratory studies linked to target organs of commonly used HDs such as a baseline complete blood count.
        iii. All personnel who are exposed to OHDs will receive training, including written documentation of the risks of exposure to OHDs and will sign a statement of understanding regarding training and compliance with PPE and safety requirements.
    b. Pregnant, attempting to become pregnant or breastfeeding women must be informed of the hazards that OHDs may pose to the health of their children. Staff members identified above with be offered a transfer to duties that do not involve preparation of administration of OHDs.
8. Post Exposure Actions.
    a. In case of skin contact with OHDs, follow the manufacturer's instructions per the SDS. This generally involves immediately removing contaminated clothing, flushing the affected area with water and washing the area with soap or other inactivator as specified by the manufacturer.
    b. In case of eye contact with OHDs, flush with water for a minimum of 15 minutes. Continue irrigation until ophthalmologic examination is obtained.
    c. Report to the Emergency department for additional treatment and documentation of the exposure. Particular attention to the eyes, mouth, nasal mucous membranes and skin will be included in the physical examination for acute exposure.

d. Personnel who do not routinely work with OHDs that have a situational exposure to OHDs should be evaluated and followed on an individual basis. The employee health nurse will make the determination about the need for further follow-up past acute treatment.

9. Spill Control
   a. A spill clean-up kit, clearly labeled, will be kept in each area where OHDs are prepared, administered or accumulated for disposal or transport. When transporting OHDs or patients under active treatment with OHDs, a spill kit must transport with the patient.
   b. Clean –up of spills. The American Society of Health System Pharmacists considers a small spill to be less than 5ml. The 5ml threshold should be used to categorize spills as large or small. Small spills, large spills and spills in BSCs must be cleaned following hood cleaning and decontamination protocol. When a large spill occurs, the area should be isolated and aerosol generation avoided. Clean-up personnel should wear appropriate PPE, as noted above, including a NIOSH-approved respirator if there is any suspicious of airborne powder or that an aerosol has or will be generated. Clean-up personnel must be trained to clean up large spills. Materials used during a spill clean-up of any size must be coordinated with the HDO to ensure compliance with applicable regulations and policies.
10. Training and Information Dissemination.
   a. All personnel involved in any aspect of the handling of covered OHDs will receive training on the hazards, appropriate handling and disposal procedures of OHDs present in the work area. This training will cover topics including the use of appropriate PPE, medical surveillance, post-exposure actions, spill control, etc. Such information will be provided at time of an employee's initial assignment to a work area where OHDs are present. Annual training is required. All training must be documented in writing. Employees must acknowledge training completion and also acknowledge the risks of failure to follow the standards outlined in this policy and in USP 800.
   b. This policy will be made available to all users, the HDO in conjunction with the HDC must ensure appropriate personnel are properly trained on the requirements.

Approval	**Date**
CCOC	5/22/17
Pharmacy and Therapeutics	
MEC	
Board of Directors	

Attachments:
NIHD Hazardous Drug List (01 FEB 2017)
Hazardous Drug Risk Acknowledgement Form

Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs	
Scope: NIHD	Manual: Pharmacy, CPM - Medication (MED)
Source: Director of Pharmacy	Effective Date:

Reviewed:
Supersedes:

Hazardous Drug Risk Acknowledgement

Name of Employee:

I understand working with or near hazardous drugs in health care settings may cause skin rashes, infertility, miscarriage, birth defects and possibly leukemia or other cancers.

I understand that Northern Inyo Healthcare District (NIHD) maintains detailed policies and procedures on the proper storage, handling, transport and disposal of hazardous drugs. NIHD pharmacy has put in place a variety of administrative, engineering and work practice controls to reduce the risk of occupational exposure to hazardous drugs. I understand NIHD policies and procedures will be reviewed and/or amended on an annual basis and the policies and procedures seek to reflect information, standards and regulations from relevant local, state, and federal regulatory bodies as well as practice standards from professional associations.

I have been provided with didactic training that reflects the policies and procedures on the hazardous drugs and have been afforded the opportunity to ask questions. After completion of the training I have been required to take and successfully pass written testing. I have also had my hazardous drug handling techniques observed and documented on NIHD Hazardous Drug competency form. Review of hazardous drug information and competency evaluation will occur annually.

I understand NIHD policies and procedures and agree to comply with them at all times. I also agree that I will immediately seek out my Manager or my direct supervisor should a question occur during work activities.

I acknowledge that failure to follow the established policies and procedures may put me at risk of exposure to hazardous substances which can lead to acute effects such as skin rashes; chronic effects, including adverse reproductive events such as infertility, miscarriage, or birth defects; and possibly the development of cancer.

_____ _____

Signature of Employee Date

NORTHERN INYO HEALTHCARE DISTRICT
Department: **Employee Health**
Pillars of Excellence: FY 2017

Indicator	Baseline	Goal	Q1 July – Sept	Q2 Oct – Dec	Q3 Jan – Mar	Q4 April - June	YTD
Quality Control							
1. Medication Refrigerator Temp. Monitoring and Alarm Response a. Events causing vaccine waste b. Number of events outside of Temp Range	100% 0 FY 15 N(2)	100% 0 0	100% 0 1	100% 1 @RHC 1	100% 0 0	Pending	100% n(1) N(2)
Service							
2. Annual Staff survey on Employee Health with Survey Monkey format. N =Total number of responses and % of employees.	FY 16 N (138) 34% FY15 N (133) 33% FY 14 N (110) 27%	1 survey Yearly w/ Increase in total response and %	0	0	0	Pending	Survey is Done in the 4rth Quarter
3. Required vaccines given for Healthcare Personnel a) all types (except flu) b) influenza only	FY 16 All (107) Flu (470) FY 15 All (65) Flu(447)		n(37) All Other n(180) Flu	n(22) All Other n(284) Flu	n(31) All Other n(9) Flu	Pending	N(90) All Other N(473) Flu Only
4. TB Tests done: a. n= administered by Employee Health as requested from staff per 2014 service survey. b. N = Total done by Employee Health and E.D. together	FY 16 n(270) FY 15 n(189)		n(100) N(110)	n(69) N(72)	n(67) N(78)	Pending	n(236) N(260) 91% done by Emp. Health
Quality							
5.Employees = n out of TB test compliance for periodicity from total healthcare personnel=N (b) for Denominator Information	FY 2016 n(19) N(580) Calendar Year 2014 n(115) N(559)	<5% Late Tests	n(12)	n(7)	n(5)	Pending	n(24) N(621) 4% Late
6.Total Employee exposures to: a. Blood and body fluids via percutaneous sharps injury b. splash & spray to mucous membranes of blood/body fl.	2011-15 5 yr Mean 8.2/year All kinds	0 0 Goal of Zero	1 0	2 0	4 4	Pending	N(7) N(4) 11/ year

NORTHERN INYO HEALTHCARE DISTRICT
Department: **Employee Health**
Pillars of Excellence: FY 2017

Quality (Con't)	Baseline	Goal	Q1 July – Sept	Q2 Oct – Dec	Q3 Jan – Mar	Q4 April - June	YTD
8. Ergonomic Related Injuries a. Total Number of Employees with Injuries due to all categories and causes in the workplace (except Exposures)	2013 & 14 2 yr. mean N (38.5) per year	Reduc-tion in Injuries	3	5	23	Pending	N(31)
b. Total Number of Employees Injured due to Ergonomics and/or SPH	2013 & 14 2 yr. mean N(16.5)	Reduc-tion in Injuries	2	3	4		N (9)
c. % of the total injuries reported that are related to SPH and/or Ergonomics combined categories	2013 & 14 2 yr. mean 43%	Decrea -sed to 20% of all types	67%	60%	17%	Pending	% of Total injuries 29% SPH & Erg
9. Number of employees w/ Ergonomic trainings = N [(c)] Number of classes per Clinical Education Dept.	Per new Title 22 Regulation	All clinical staff. # class held	N (6) n (3)	N(14) n(3)	N (17) n(5)	Pending	N(37) participants n(11) classes
10 # of Departments receiving Ergonomic/Safety Rounds.[(d)]	FY 16 N(14)	Annually One per Dept. for 12 Depts	N(3)	N(2)	N4)	Pending	N(9)
11. Facility Influenza Flu vaccination mandatory reporting to CDC & CDPH	2013-14 Flu Izz. Not Mandated:	95% Or more		N=#staff Total n = izz	N=#staff Total n = izz		
a. Flu Vaccine-Facility-wide all Healthcare team (includes MDs)	2013-14 N(496) n (431) 87%	90%		N(575) n(551) 96%izz	N(621) n(599) 96% izz		N(621) n(599) 96%
b. Flu Vaccine-Declined	2013-14 n (62) 13%	10% OR LESS		n(16) 3%	n(17) One added		n(17) 3%
c. Flu Vaccine Status of Healthcare Team Unknown if Recv'd.				n(8) 1%	n(5) Three Less		n(5) 1%

NORTHERN INYO HEALTHCARE DISTRICT
Department: **Employee Health**
Pillars of Excellence: FY 2017

People	Baseline	Goal	Q1 July – Sept	Q2 Oct – Dec	Q3 Jan – Mar	Q4 April - June	YTD
12. a. New Employee Health Physicals performed	FY 16 N(74) FY 15 N(79)	Info. Only	34	26	22	Pending	N (82)
12.b. Health Records reviewed for NEW Contractors, MDs & Non-Employees on-boarding	FY 16 N(121) FY 15 N(90)	Info. Only	22	23	21	Pending	N(66)
13.a. Separated Employees N= Total 13.b. % with baseline employees from each Fiscal Year for separation rate. (Does not include contracted staff)[f]	FY 16 N(86) 21% FY 15 N(80) 19.8%	Info. Only Base-Line # 409	N(25)	N(20)	N(14)	Pending	N(59) 14% Turnover in first 3 Qtrs.
14.a Medical Records provided to all employees, current and separated.	FY 16 N(88) FY 15 N(75)	Info. Only	N (26)	N (23)	N(28)	Pending	N (77)
14b.Records provided to separated employees, as a % of total medical records requests. [g]	FY 16 n(41)	Info. Only	n(7) 37%	n(4) 21%	n(9) 32%	Pending	n (20) 26%

(a)Policy changes for the Immunization of Healthcare Personnel were made in the 4rth quarter, to provide only vaccines that are recommended or required following the CDC guidelines. Employees were referred to their private medical provider for Shingles and Pneumonia vaccine, which are not required.

(b)Policy changes regarding TB testing for current employees – was approved 12/17/2014 with new interval for screening of employees being up to two years (24 months) interval which changed rate of employee compliance due to the new TB screening policy. The total number of HCW tracked for flu vaccination for 2016-17 is used as the denominator for reporting TB screening which is 621 of all types of team members. These HCW are requested to have TB testing as well as flu vaccination.

(c)Pillar indicator is a cross-over from Clinical Nursing Education to correlate injuries occurrence with prevention activities for employees participating in ergonomics and safe patient handling equipment trainings that are typically scheduled for all new clinical employees and others on an as needed basis.

(d) Twelve departments receiving Ergonomic/Safety Rounds are: Emergency Dept, Med/Surg, ICU, Peri-Operative, Infusion Center, Perinatal, Rural Health and Women's Health Clinics, Diagnostic Imaging, Laboratory/Phlebotomy, Cardiopulmonary, Pharmacy, and Rehabilitation Services.

(e)N is the total number of employees, independent practitioners, contract personnel, volunteers, and students who worked at least a day between October 1 and March 31 as reported to the NHSN.

(f)Using the 2015 Fiscal Year where 80 employees separated from July 1, 2014 – June 30, 2015, the total separated employees is divided by total current employees: 80/404 x 100 = 19.8% for FY15 is used for a baseline measurement. On July 1, 2015 there were 404 employees noted per payroll. The total number of employees on July 1, 2016 is 409: 299 Full-time, 68 Part-time, and 42 Per Diem on the payroll and 3 Contracted Department Managers. 86/409 x 100 = 21%. In January, 2017 there were 425 employees. The Denominator of employees for FY 17 will be counted on July 1, 2017.

(g)Medical records for employee health requires scanning of paper documents and data entry into the Immunization database. The conversion to electronic records is a project that has been under consideration since Jan. 2015, but has not been analyzed as a process including all of the departments that could be potentially involved. The satisfaction of requests for employee health records, and providing copies in a timely and confidential manner is being tracked in order to obtain engagement by stakeholders for a future process to plan better use of technology and systems. N is the total number of people requesting records both current and former employees. Records provided only to former employees is "n". Goal to have records requested prior to employee "off-boarding".

NORTHERN INYO HOSPITAL

Nursing Services

Department: Infection Prevention

Pillars of Excellence: FY 2017

Indicator	Baseline	Goal	July-Sept Q1	Oct-Dec Q2	Jan-Mar Q3	April June Q4	YTD
Quality Control							
1. #Timely Communicable Disease (CD) reporting for **ED and Inpatients** per Title 17 (does not include clinic pts.) % Compliance with Title 17	FY 16 N (28) 19(68%)	**90% CDs on time**	**11** **100%**	6 **100%**	42 **100%** 41 ED/IP 1 Report from Lab		59 **100%**
2. Validation Survey for NIH Blood Culture Contaminants to trace department of draw and contaminant bacteria. *Based on Positive Blood Culture only* N=# of Contaminants D= # + Blood Cultures	FY16 D(90) N(4) 4%	**20%**	(N) 1 (D) 36 **2.8%**	(N) 2 (D) 16 **13%**	(N) 1 (D)13 **7.7%**		(N) 4 (D) 65 **6.1%**
Service							
1.Positive lab cultures reviewed = N in order to report # of infections = (n) to NHSN for these:	FY2016 N(1709)		399	336	273		1008
a. The number of CLABSI Reported to NHSN	FY2016 N(0)	**0%**	**0** 79 CVC Days	**0** 60 CVC Days	**0** 66 CVC Days		**0** 205 CVC Days
b. The number of positive C-diff Infections reported to NHSN that are Hospital Onset versus Community Onset *Note: Patient days excludes Newborns*	FY2016 D(12) N(3)	**0**	2 1CO/HO 1CO *908* Pt Days **NO HO**	3 2 CO/HO 1CO *679* pt days **NO HO**	1 Jan CO Feb 0 Mar 0 804 **NO HO**		6 3CO/HO 3CO 2391 Pt Days **NO HO**
c. The number Surgical Site Infections (SSI) Reported to NHSN SSI Rate is Based on all Reported Surgeries to NHSN by NIH. *Note NHSN Risk Adjusts SSI Rates per 100 surgical procedures to SSI (ex: 100 Hernia Procedures used to calculate Hernia SSI)* *R/T (Reported to)*	FY 2016 N(6) D(319)	**0**	**2 SSI** Colon SB 92 Surgeries R/T NHSN	**3 SSI** Colon Ovary Hip 85 Surgeries R/T NHSN	**2 SSI** Colon C/S 67 9 more after coded Surgeries R/T NHSN		**7 SSI** 3 Colon 1 SB 1 Ovary 1 Hip 1 C/S 244 253 Surgeries R/T NHSN
d. The Number of Catheter Associated UTI's (CAUT's) reported	FY2016 0%	**0**	**1** 184	**0** 189	**0** 159		**1 CAUTI** 532

NORTHERN INYO HOSPITAL

Nursing Services

to NHSN			Days	Days	Days		Days
e. VAE : Ventilator Associated Events 1. VAC: Ventilator Associated Condition 2. IVAC: Infection-related Ventilator Associated Complication 3. PVAP: Possible Ventilator Associated Pneumonia	FY 2016 VAE 1 PVAP 1	**0**	**0** 6 vent Days	**0** 5 Vent Days	**0** 9 Vent Days		**0** 22 vent days
Quality							
1. Hand Hygiene compliance per W.H.O guidelines N Compliant D Observed	FY 2016 86%	**90%**	(N)334 (D)391 85%	(N)258 (D) 296 87% Late Submission (N) 286 (D) 328 87%	(N) 252 (D) 257 98%		N)844 (D)944 89%
2. When Hand Hygiene non-compliant the number of observations receiving "Just in Time Training" N Educated D # Non compliant	New	**90%**	(N)6 (D) 56 **11%** 0%	(N)13 (D) 22 **59%** Late Submission (N)17 D26 **65%**	(N)4 (D) 5 80% Missed 1 education Opptun		(N) 23 (D) 83 **28%** 0%
3. Compliance of documentation of VAE Prevention in ICU N (compliance) D # of patients	FY2016 New Patient days 34	**85%**	N(3) D(5) **60%** See note below	(N) 0 (D) 2 **0%**	(N) 0 D(6) **0%** 1pt expired after 2 HRs		N(3) D(11) **27%**
4. Patient Rounding and educating patients and or family members on patient's in contact precautions Goal: 60% of the patients will have a visit from Infection Prevention staff during patient stay	New	**60%**	Missed July (N) 6 (D) 8 **75%** **Aug-Sept**	(N) 13 (D) 17 2 R/O **76%**	(N) 24 (D) 30 80%		(N) 19 (D)25 **76%** Missed July

NORTHERN INYO HOSPITAL

Nursing Services

5. Inpatient Vaccination *Order Set and Screening Documented for Flu a. All eligible inpatients given Flu vaccine b. Flu Vaccine status screening not completed for all inpatients October through March. STATUS 1: Influenza vaccine was given during this hospitalization STATUS 2: Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization. STATUS 3: Documentation of patient's or caregiver's refusal of influenza vaccine STATUS 4: Documentation of an allergy sensitivity to influenza vaccine, anaphylactic STATUS 5: None of the above / not documented / unable to determine from MR documentation **GLOBAL POPULATION** : Length of stay less than 120 days **IMM2 INITIAL POPULATION:** ○ 6 month old and older, ○ Did not expire before discharged, ○ Visit during Flu Season, ○ Not transferred or discharged to another acute care hospital ○ Vaccination supply was available ○ Patients who did not leave Against Medical Advice (AMA)	59% Flu Screen Complete	**90%**	Out of season Reported to IQR	**Global Population** **319** S 5 = 106 S 4 = 3 S 3 = 47 S 2 = 132 S 1 =31 **a. 67%** **b. 33%** Note: S5 not pulling data correctly	**Global Population** **347** S 5 = 125 S 4 = 3 S 3 = 50 S 2 = 150 S 1 =19 **a. 64%** **b. 36%** Note: S5 not pulling data correctly		**Global Population** **666** S 5 = 189 S 4 = 5 S 3 = 96 S 2 = 326 S 1 =50 **a. 72%** **b. 28%** Note: S5 not pulling data correctly

Dev. 3/11